



IPPF Medical Bulletin

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Abortion, public health, and human rights

Pramilla Senanayake, Upeka de Silva

The decision to undergo an abortion is deeply personal, and is best made in the privacy of a consultation between the woman and her healthcare provider. Yet in many countries her access to safe abortion will be obstructed by people who know nothing about her. Her individual wishes become subordinate to public and political concerns. Thus, as the ideological debates rage on, women across the world (young women especially) resort to less safe methods of abortion. Of 46 million abortions performed worldwide each year, 20 million meet the World Health Organization's definition of unsafe: the operator lacks adequate skills and training, or the environment does not fulfil minimal medical standards, or both.¹ Of women who have abortions in these circumstances, about 70 000 die every year. These deaths are preventable. Clearly, through its toll of sickness and death, unsafe abortion is a public health issue. Here we review the issues in terms of public health and the right to reproductive self-determination.

Sexuality, contraception, and unplanned pregnancy

Ultimately, every woman has an abortion for the same reason – because she can not cope with a particular pregnancy at a particular time.² Numerous factors could determine her unwillingness to carry the pregnancy to term – for example, age, economic instability, a strained or unstable relationship, coerced non-consensual sex. Often the decision is driven by a need to balance roles and responsibilities within socially defined boundaries.³ The public health approach to abortion must take account of the realities of women's lives and a key aspect is their access to contraception, including emergency contraception. A thorough understanding of women's sexual and reproductive lives will include matters of sexuality; and, if women are to make informed choices, they will require information and services that take account of social and cultural differences. In the past, women who opted for abortion were often accused of irresponsibility and blamed for taking insufficient care. Such an idea has no place in a modern service, being based on the false notion that every woman has access to reliable contraception, has a cooperative partner, and has complete control over when and with whom she has sex.

The international scene

Internationally, the 1990s saw a large shift in favour of safe abortion with the new focus on women's sexual and

reproductive health rights. The consensus documents and Programmes of Action of the International Conference on Population and Development (ICPD) 1994, the Fourth World Conference on Women 1995, and the respective five-year reviews in 1999 and 2000 displayed a progressive liberalisation of attitudes. Paragraph 8.25 of the 1994 ICPD Programme of Action urged "all governments and relevant intergovernmental and non-governmental organisations to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services". But Cairo+5 went further, with paragraph 63 stressing the importance of ensuring access to safe abortion in accordance with the law. At national level, abortion laws have been liberalised in several countries through the efforts of non-governmental organisations (NGOs), government ministries, and other interested parties. At one end of this spectrum is Nepal, where Parliament amended the civil code in 2002 so that a woman who opted to have an abortion was no longer at risk of a jail sentence. At the other is South Africa, where the Choice on Termination of Pregnancy Act 1996 exemplified that nation's commitment to women's sexual and reproductive health rights and wellbeing. Yet the hard-won gains in sexual and reproductive health rights still face numerous challenges.

Progress in sexual and reproductive rights has been greatly hindered by the interventions of two US Administrations – the Mexico City Rule introduced under President Ronald Reagan, then reimposed by President George W Bush in 2001 and known as the Global Gag. According to this rule, international NGOs receiving USAID funds are prohibited from performing abortions or actively campaigning for safe abortion services. Thus, family planning associations (FPAs), especially in developing countries, have been obliged to make a hard choice between losing vital US funds or keeping silent about a major public health and human rights issue affecting their communities. Furthermore, as a consequence of the forced separation of family planning services from abortion-related services, increasing numbers of women are denied access to comprehensive sexual and reproductive health services such as pre and post abortion family planning. By refusing to sign up to the Global Gag Rule, the FPAs in Kenya, Zambia, and Nepal lost a total of about \$1.4 million and had to close many clinics that were providing a full range of sexual and reproductive health services to socially excluded and underserved clients. The long-term consequences of these clinic closures, in terms of socioeconomic hardship as well as reproductive ill-health, will be severe.

The Global Gag Rule also puts at risk the Millennium Development Goals adopted by the United Nations in 2000. One of these is to achieve a 75% reduction in maternal mortality from 2000 to 2015. Unsafe abortion is a major cause of maternal mortality; and there is also a clear relation between maternal mortality and poverty. In the words of Dr Eunice Brookman-Amisshah, head of the Ipas Africa Alliance for Women's Reproductive Health and Rights, "maternal mortality can not and will not be reduced by 75% by 2015, nor will goals related to poverty reduction and economic development be achieved, without attention to unsafe abortion".⁴

A noteworthy feature of the Global Gag Rule is that it is “do as we say”, not “do as we do”; most women in the USA have ready access to abortion. However, within the USA itself there is continuous pressure to restrict the existing abortion laws. One strategy exploits the remarkable advances lately achieved in fetal medicine: attempts are being made to raise the legal status of the fetus, and “anti-choice” lawmakers have put forward a theory of fetal personhood. The proposed Unborn Victims of Violence Act would create a new separate offence of killing or injuring a child in utero. A fetus could thus be deemed a victim of crime, independent of the pregnant woman who suffers the physical injury, severely undermining the woman’s right to choose abortion.⁵

What difference does the law make?

Clearly, a woman’s ability to terminate an unwanted pregnancy safely depends greatly on the attitude of the law; and, in the absence of a safe and legal method, she may well opt for an unsafe one. However, for many women the law is not the prime consideration: they are more concerned about the societal norms and attitudes within their immediate community. Therefore, achievement of this aspect of reproductive autonomy requires something over and above national legislation; abortion has to become “legal” in people’s minds if women are to stop resorting to unsafe clandestine abortions and become able to exercise their reproductive choice with safety and with dignity.

Does legalisation increase the number of abortions? Opponents of abortion often say that it does, but there is little evidence to support this argument. Indeed, the world’s lowest abortion rates are found in countries (such as the Netherlands) with liberal abortion laws and comprehensive easily accessed sexual and reproductive health services.⁶ Where the law forbids it, abortion is simply less visible and more dangerous.

When discussing the impact of the law, it is important to recognise that even under restrictive abortion laws some women will have the resources to evade them by obtaining private care or travelling to countries where the law is more liberal. The corollary is that, under the most liberal law, some women will encounter economic or social barriers to abortion that still make them prefer an unsafe procedure. Sometimes procedural barriers to services such as mandatory counselling, waiting periods, and consent requirements introduce intolerable delays and undermine a woman’s autonomy. In some countries the immediate priority is not to legalise abortion but rather to make safe services available to the full extent of existing laws.⁴

Service providers

In the past, the medical profession has provided some of the strongest support and some of the greatest impediments to provision of safe abortion. A particular difficulty arises for

clinicians who feel they owe a duty of care to the fetus as well as to the woman. Service providers need to be trained on how to provide respectful care to their clients and not display punitive or judgmental attitudes based on their personal beliefs. Additionally, healthcare managers must be sensitive to the possibility of burn-out, with its adverse effects on quality of care, in staff involved in abortion and abortion-related services. Indeed, the needs of the providers deserve as much attention as the client’s rights. The key to a successful service is to select staff with a common vision and commitment to women’s health, and then maintain their morale and motivation by support and counselling. A good example is the Broussais Clinic in Paris, where the goal is not only to perform the correct procedure but also to empower women to make decisions about their overall health and wellbeing. A similar mission has been adopted by Parivar Seva Sanstha in India, which strives to enhance women’s quality of life by improving their reproductive health: women who seek to terminate pregnancy have the right to do so with safety, dignity and personal support.⁷

A way forward

The challenge for advocates of reproductive freedom is to persuade the uncommitted public, who influence societal norms, that motherhood is a voluntary state, not to be forced on any woman; and that violation of this freedom is socially pernicious. Whether the audience is healthcare professionals, religious leaders, or the general public, a key argument is that safe abortions save lives. The question then arises, to what extent does society value these lives? As Ann Furedi commented, “a mark of the civilised society can be judged not only by the value placed on the ‘unborn child’ but by its respect for the life of the woman who carries it”.⁸

Dr Pramilla Senanayake, MB, PhD, FRCOG, retired from the post of Assistant Director-General of IPPF in June 2003, after 28 years with the Federation. Upeka de Silva is a junior professional officer at IPPF.

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Combined oral contraceptives with very-low-dose oestrogen

Sunanda Gupta

When first introduced, combined oral contraceptive (COC) pills contained 150 µg of ethinylestradiol. Since that time, the dose of oestrogen has come down greatly, such that most pills now contain only 30–35 µg (‘standard strength’). With some pills the dose is even lower, just 15–25 µg. Such very-low-dose (‘low-strength’) preparations can be expected to have fewer oestrogen-associated side-effects than standard-strength pills. However, dose reduction carries the risk that cycle control might become poorer. This review will address the evidence on the risk–benefit profile of low-strength preparations, compared with standard-strength preparations.

Contraceptive efficacy

Of paramount importance is the efficacy of a COC in preventing pregnancy, and, with optimal user compliance, standard-strength preparations are highly reliable in this respect. Low-strength pills seem equally effective in suppressing ovulation, and a WHO study comparing six different COCs with ethinylestradiol content ranging from 20 to 50 µg found no significant differences in their contraceptive efficacy.¹ Subsequent US and UK clinical trials support this conclusion, which is also applicable to pills containing as little as 15 µg ethinylestradiol. A theoretical concern with low-strength pills is that, because they provide lower circulating concentrations of oestrogen, missed doses could more quickly lead to risk of pregnancy. Some manufacturers therefore designed 24-day 15 µg pills with a

shortened (4 days) pill-free interval to reduce the risk of breakthrough ovulation if women miss pills immediately before or after the hormone-free interval. Many trials have been done in highly controlled circumstances, and there are few studies comparing the “real-life” performance of low-strength preparations with standard-strength preparations.

Cycle control

Acceptability and adherence to the contraceptive regimen are important in influencing cycle control. COCs usually reduce menstrual loss to about half the pre-pill level, and this is particularly advantageous in countries where iron-deficiency anaemia is common. Some workers have expressed concern that reduction of the oestrogen dose from 30 µg to 20 µg will predispose to breakthrough bleeding and intermenstrual bleeding. However, published evidence is reassuring. Rosenberg et al² randomised 463 women to three types of COC – two containing 20 µg and the other containing 35 µg – and found negligible differences in cycle control. Poindexter’s review reached a similar conclusion.³ However, a recent meta-analysis of seven studies with five different pills indicates that cycle control with low-strength pills depends on the degree of ovarian suppression. Examining ovarian activity as indicated by follicular diameter and oestrogen levels, Endrikat et al⁴ noted that high ovarian suppression correlated with good cycle control (in terms of less frequent intermenstrual bleeding). The oestrogen dose is not the only factor influencing cycle control; the type and dose of progestogen are important, with gestodene-containing pills giving somewhat better cycle control than desogestrel-based pills. Other factors which complicate interpretation and appear not to have been accounted for in some trials include smoking, chlamydial infection, and inconsistent pill use; all these can influence breakthrough bleeding – cigarette smoking by a possible increase in oestrogen catabolism.

Today, women are increasingly attracted to continuous rather than intermittent use of COCs. 20 µg pills have been used in this way for six months to a year,⁵ with a substantial reduction in the number of bleeding days and 88% of women amenorrhoeic during cycles 10–12. The incidence of vaginal spotting is lower with continuous administration than with cyclic administration. With continuous use of a 20 µg pill, the total monthly dose of ethinylestradiol will be lower than that with cyclic use of a 30 µg pill.

Other COC effects, beneficial and adverse

Early effects

The most obvious advantage of low-strength COCs, compared with standard strength, is a lesser tendency to cause nausea, vomiting, cramps, breast discomfort, and headaches. All these are substantially less frequent with low-strength pills. For example, in Rosenberg’s trial, abdominal bloating, breast tenderness, and nausea were reduced by 50% with 20 µg ethinylestradiol preparations compared with 35 µg pills.² The low incidence of side-effects with these pills can be expected to encourage adherence to the schedule and thus enhance contraceptive efficacy. Another favourable effect of COCs is the reduction of dysmenorrhoea and of premenstrual symptoms; low-strength pills seem as effective as standard-strength pills in this respect.

One phenomenon for which the pill often gets blamed is weight gain, and this led to the idea that reduction of the oestrogen content might help women control their weight. However, in reality the pill makes little or no difference. A study of women taking low-strength pills showed no change in body weight in 74%, loss of more than 2 kg in 12%, and gain of more than 2 kg in 14%.⁶

With standard-strength pills there is a small increase in the risk of gallstones during the early years of use. With low-strength formulations there is little or no excess risk of gallstones. Standard-strength COCs reduce the risk of development of functional ovarian cysts and benign breast disease to half that in non-users, but this protection is probably conferred by the progestogen rather than the oestrogen. Data are unavailable for low-strength pills

Long term effects

Here I briefly examine the main non-contraceptive effects, positive and negative, associated with standard-strength COCs and see whether the published work indicates differences for low-strength preparations.

Ovarian and endometrial cancer

COCs confer important protection against ovarian and endometrial cancer, which persists for 10–15 years after the pill is stopped. So far there are no direct data on protection by low-strength pills; since they inhibit ovulation, some protection against ovarian cancer seems likely.

Skin

COCs are effective against adolescent acne or mild hirsutism, by reducing testosterone, dihydrotestosterone, and dehydroxyepiandrosterone sulphate. Low-strength preparations have a positive effect on androgen metabolism and seem no less useful. Pills containing desogestrel and gestodene improve adolescent acne. Thiboutot et al⁷ recently reported a placebo controlled trial in which a pill containing 20 µg ethinylestradiol and 100 µg levonorgestrel proved effective in adolescent acne.

Fibroids

Standard-strength pill users are less likely to develop fibroids than women who have never used COCs; their relative risk is 0.4. In women who already have fibroids, use of low-strength pills has been found to lessen the duration of menstrual flow while the size of the fibroids was unchanged.

Bone

There is some reason to think COCs will favourably affect bone. The evidence comes mainly by extrapolation from results of hormone replacement therapy in postmenopausal women. Regimens that include 10 µg ethinylestradiol have yielded a net gain in bone mineral density.⁸ Seemingly this benefit is related to oestrogen dosage, with doses below 15 µg associated with a net loss of bone mass and doses greater than 25 µg associated with a net gain, but a recent randomised controlled prospective trial reported no appreciable modification in bone density with a 20 µg pill at one year of use.⁹

Colorectal cancer

Use of standard-dose pills has been reported to lower the risk of colorectal cancer by 50% compared with non users. There is no evidence of this protective effect with low-strength COCs.

Breast cancer

Current and recent users of standard-strength COCs are at slightly increased risk of breast cancer. There are no data on low-strength pills, but in Beral’s 1996 meta-analysis the risk does not appear to be dose-related.¹⁰

Cervical cancer

Long-term use of oral contraceptives is recognised as a cofactor in increasing the risk of cervical cancer in women who are positive for cervical human papillomavirus (HPV) DNA. A recent large review of epidemiological studies conducted in the past 40 years indicated a high rate of cervical intraepithelial neoplasia III in HPV-positive women

using hormonal contraceptives, the risk ratio increasing with duration of use of COCs.¹¹ This review controlled for the potential confounding factors smoking, HPV status, and number of partners, but not for age at first intercourse, which can independently influence the risk. At present there are no data on the relation of this risk to low-strength pills.

Circulatory system

Risks of COC-related venous thromboembolism (VTE), myocardial infarction, and stroke have declined over the years, presumably because of the reduction of oestrogen dosage. VTE appears to be an oestrogen dose related effect, and women using the old high-dose COCs were far more subject to venous thrombosis than are those using modern standard-dose pills.¹² The type of progestogen is, however, important here. Whether a decrease in ethinylestradiol from 30 µg to 20 µg will further lessen morbidity from VTE and ischaemic heart disease is uncertain, but pills containing 20 µg are reported to have less pronounced, though statistically significant, effects on coagulant and fibrinolytic indices than 30 µg pills. As regards HDL cholesterol, a large comparative study of different oestrogen doses showed a trend to more favourable indices (HDL increase of 3%) with 20 µg pills containing desogestrel or gestodene.¹³ The clinical relevance of this biochemical change, if any, remains to be determined.

As regards ischaemic stroke, the excess risk associated with COCs appears to be related to oestrogen content. In a case-control study by Lidegaard et al¹⁴ the risk of cerebral thromboembolic attack was 2.5 times higher with 50 µg pills than with 20 µg pills. However, there is no clear evidence that low-strength pills are safer in this respect than those containing 30–35 µg. The risk of haemorrhagic stroke does not vary with oestrogen dose.

Conclusion

In principle, it is desirable to decrease the doses of both oestrogen and progestogen in COCs to the minimum consistent with contraceptive efficacy. On existing evidence, the main advantage of very-low-oestrogen pills is their low rate of side-effects such as nausea, bloating, headache, and breast tenderness. There may be less margin for error in pill-taking, but this has not been evident in the published work. Regarding long-term effects, there is no clear evidence of an advantage for low-strength preparations. There is a need for long-term epidemiological studies on risk–benefit profiles including protection against endometrial and ovarian cancer. Low-strength preparations at present seem useful in adolescents who are concerned about acne or hirsutism and in women who wish to regulate their menstrual cycles or have light and painless periods; they also have theoretical advantages in women with risk factors for circulatory disease and older women who need safe and effective contraception with relief of climacteric symptoms. Both

News

Non-latex versus latex condoms

The Cochrane Library is an electronic database of regularly updated reviews conducted according to the principles of “evidence-based medicine”. An energetic contributor to the Library is the Cochrane Fertility Regulation Group, and its latest contribution concerns non-latex male condoms – products developed in the 1990s mainly for people with allergies to latex. Gallo and colleagues sought out all randomised controlled trials that compared a non-latex condom (polyurethane film or synthetic elastomers) with a latex condom. From the data examined, they say that one of

standard-strength and low-strength pills carry a small excess risk of circulatory disease; this can be minimised, as with all COCs, by a blood-pressure check before use and by avoidance of smoking.

Dr Sunanda Gupta, MFFP, FRCOG, is consultant in community gynaecology and honorary clinical lecturer, St Bartholomew's and Queen Mary's School of Medicine and Dentistry, London, UK. Address for correspondence: Hurst Road Health Centre, Hurst Road, Walthamstow, London E17 3BL, UK. E-mail: Sunanda.Gupta@WF-pct.nhs.uk

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the non-latex products (eZ-on) protected less well against pregnancy than its latex counterpart; for the other two (Avanti and Standard Tactylon), no differences emerged. The non-latex condoms were associated with higher rates of clinical breakage. The conclusion from this review is that, despite the higher clinical breakage rates, the new condoms ‘provide an acceptable alternative for those with allergies, sensitivities or preferences that might prevent the consistent use of latex condoms’. Exactly how they compare with latex in terms of contraceptive efficacy is a question for further research.

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