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Contraception and Abortion, Foes or Friends?

by

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Thirty-two years ago, July 26, 1968, in the midst of the “sexual liberation” wave, Pope Paul VI gave his famous encyclical *Humanae Vitae*, in which he condemned with clarity and firmness the use of any contraceptive technique for “family planning” purposes.

All these years later, the time has come to make a judgment on the insight of this encyclical, with a better knowledge of the physical and moral consequences of the contraceptive pill.

The promoters of contraception opposed the moral judgment of Pope Paul VI. They presented the so-called “pill” as an antioviulatory agent, respectful of human life, with nothing intrinsically wrong attached to its action. And they insisted on the fact that the pill was “the most effective remedy against abortion” (*Evangelium Vitae* n° 13), and, as such, a true gift to humanity.

In the following report we would like to answer these two questions, in the light of present knowledge:

- Are oral contraceptives respectful of human life?
- Is contraception the true way of preventing abortion?

We will deal here only with oral contraception¹, either as combined estrogen-progestogen preparation – the so-called “contraceptive pill” – or as low-dose, progestogen-only preparation, the so-called “mini-pill.”

We will not consider in this study the other methods of modern contraception – “postcoital contraception”, long-lasting intramuscular

injectable progestogen, implants, and intrauterine devices, because they are clearly abortive in their action and outside of the ethics of contraception.²

I. The Abortivity of Oral Contraceptives

Oral contraceptives have been presented as purely antioviulatory agents, and all the discussion which preceded and immediately followed the publication of the encyclical *Humanae Vitae* took this affirmation for granted. However as early as the 1950s³ it was already clear that the mechanism of the highly effective compound estrogen-progestogen could not be limited to a pure prevention of ovulation. Today, for the combined oral contraceptive and, even more, for the progestogen-only pill, an abortifacient action has been demonstrated which does change the ethical perspective about these contraceptives.

A. The Estrogen-Progestogen Pill⁴

It is known today that the infertility which results from the action of combined oral contraceptives is caused by the intervention of these compounds on least at three levels:

- on the hypothalamic-pituitary-ovarian axis
- on the cervical mucus
- on the uterine endometrium

1) Ovarian function is generally suppressed, but some "escape ovulations" do happen with combined oral contraceptives.

The inhibition of ovulation by estrogen-progestogen compounds is strong.⁵ The first contraceptive pills which were delivered to the market in the 60s contained high concentrations of estrogens and progestogens and certainly acted by blocking ovulation. The initial formulation of the combined oral contraceptives was of 0.150 mg. mestranol, 9.85 mg. norethynodrel. Mestranol was then replaced by the more potent Ethinyl Estradiol, which made it possible to reduce the dose of estrogen in the pill.

Because of the incidence of side effects and complications, especially thromboembolism, associated with the use of these early contraceptive pills, respective concentrations of estrogens and progestogens in the contraceptive pill subsequently have been reduced. The first important change occurred in the late 1960s when there was a massive shift from higher dose pills to the "classic" pill, containing only 50µg. of estrogen (as

ethinyl estradiol) and a lower dose of progestogen (1 mg. of a 19 nortestosterone derivative, as an example, norethisterone acetate).

These preparations were themselves superseded in the mid-1970s by "low-dose pills", containing only 30-40 µg. estrogen and 1 mg. or less progestogen. Finally, in the 1980s, phasic and 20 µg. ethinyl estradiol preparations were introduced.

A more relative inhibition of the pituitary gonadotropic function⁶ has resulted from this lowering of the doses of active ingredients in the contraceptive pill, allowing more elevated plasmatic concentrations of FSH (Follicle Stimulating Hormone) and of LH (Luteinizing Hormone)⁷, and therefore a less effective suppression of ovarian activity.⁸ Indeed, plasmatic concentrations of estradiol and progesterone remain low when oral contraception is sought after with these new low-dose compounds.⁹ These formulations, which contain less of the steroids¹⁰, as well as the triphasic compositions, do inhibit effectively the pituitary-ovarian function.¹¹ However, the effectiveness of their antioviulatory action can be incomplete in those persons who are more resistant to this inhibition.¹² Taking certain medications jointly with oral contraceptives (especially psychotropic drugs and antibiotics), and the occurrence of gastrointestinal disturbances (gastroenteritis, diarrhea), can also lessen the ovarian suppression activity of the oral contraceptives.¹³

Even in these studies where relatively important doses of ethinyl estradiol (50 µg.) are used, the LH urinary elimination remains within the limits of normality, and in some women (in one cycle out of five), the study of plasmatic estradiol concentrations shows that ovarian follicles do develop despite the use of the contraceptive pill (Elstein et coll., 1974)¹⁴ Ultrasonographic scanning of the ovaries confirm that, in 30 to 50% of the treatment cycles, ovarian follicle-like structures do develop to a diameter of 10 mm or greater, before gradually diminishing in size.¹⁵ When women were monitored by daily pelvic ultrasonography along the whole cycle, it has been found that, in at least 5% of the cycles, a rupture of the follicle wall occurred and ovulation was then detected.¹⁶ Hormonal assessment in blood confirmed the reality of these ovulations.

Thus, with the pills offered today on the market, ovulations are indeed verified despite contraception, at the rate of one for ten or twelve cycles.¹⁷ Such "escape ovulations" can be followed by fertilization, if there is sexual intercourse within the five days following the ovulation.

2) Combined oral contraceptives thicken cervical mucus

It is probable that part of the contraceptive effect of the estrogens-progestogens compounds is due to their action on the uterine cervix. They transform cervical mucus into the progestogenic type, thick and scanty, with impaired spin-barkeit and poor or no ferning pattern.¹⁸ This makes it more difficult for the spermatozoa to penetrate across the cervix.¹⁹

3) Combined oral contraceptives impair endometrial receptivity

The third way in which combined oral contraceptives may achieve female sterility is by maintaining the uterine endometrium in an atrophic state, non-receptive to the implantation of a possible embryo. Here, it is the gestogen part of the contraceptive which is responsible. It provokes a morphological dystrophy of the uterine mucous membrane.²⁰

Histological study²¹ of endometrial biopsies from women taking combined oral contraceptives shows that from cycle day 5 through 24 the proliferation of endometrial glands is suppressed. At first the stroma appears dense and fibrous, then it becomes edematous, and eventually it may undergo pseudodecidual changes. Arterioles are poorly developed or absent from large areas of the endometrium; venules, however, may sometimes be dilated to large sinuses; in contrast to the suppression of glandular proliferation, the secretory activity is accelerated at the beginning. However, it decreases from mid-cycle on and the glands then remain narrow and straight. The secretory activity of the endometrium never develops to the extent characteristic of the late secretory phase of a menstrual cycle.

Examined under scanning and transmission electron microscopy, endometrial surface appears altered, with fewer ciliated cells and incomplete secretory modifications.²² Endosonographic assessment²³ shows that, in women taking low-dose combined oral contraceptives, the endometrial thickness is lower than 8 mm for all cycles, showing a pronounced effect of the oral contraceptives on the endometrium, which impairs endometrial receptivity.

The study in endometrial tissue specimens of the expression of these integrins which are closely associated with endometrial receptivity (Somkuti et al., 1996)²⁴, shows that in the endometrium of combined oral contraceptive users, there are significant alterations in cycle-dependent integrin expression ($\alpha 1\beta 1$, $\alpha 4\beta 1$ and $\alpha v\beta 3$) with a specifically increased glandular $\alpha 4\beta 1$ and decreased $\alpha v\beta 3$ expression. This altered expression of the integrins corresponds to an unreceptive endometrium and predisposes to implantation failure or early pregnancy loss. These alterations thus provide evidence that the morphological changes observed in the endometrium of women taking combined oral contraceptives have

functional significance and that reduced endometrial receptivity does indeed contribute to the contraceptive effect of the oral contraceptives.

4) The abortive effect of combined oral contraceptives

From this study, we can conclude that the present combined oral contraceptives do allow on one hand some development of ovarian follicles with possible ovulation and subsequent fertilization, and, on the other hand, makes impossible the nidation of the product of this fertilization. Therefore, they do have an abortifacient effect.

We lack a reliable and easy to use method to detect a living embryo before its implantation. Therefore, it is not possible to have a precise idea of how many early abortions can be brought on by the use of combined oral contraceptives. We can only make a guess from the difference calculated between the total number of possible escape ovulations and the number of actual pregnancies observed in women taking oral contraceptives.

If we assume that escape ovulations do happen in 5% of the cycles while taking combined oral contraceptives, and if we estimate that fertilization can follow in 25% of these cases we would have a possibility of 1.25 fertilizations for 100 cycles. That is around ten fertilizations for 100 women per year. Taking into account the Pearl index for combined oral contraceptives which is around 1,²⁵ we would have for each one embryo able to implant and develop despite contraception, nine embryos eliminated early due to reduced endometrial receptivity. This means that a woman taking low-dose combined oral contraceptives for 15 years would lose approximately 1.3 embryos in this way.²⁶

B. Progestogen-Only Pills (The Mini-Pill)

The situation is quite different with the low-dose progestogen-only pills. These have been developed in recent years as an alternative to combined oral contraceptives. Called "mini-pills"²⁷ because of their reduced steroid content²⁸, these compounds are particularly well-suited to women with contraindications to the estrogen in combined oral contraceptives, for women who experience side effects with the combined pill, for breastfeeding mothers, and for older women.

1) Progestogen-only pills do not suppress ovarian activity

Different from combined oral contraceptives, progestogen-only pills do not have a significant action on the hypothalamic-pituitary-ovarian axis.²⁹ They suppress ovulation in less than 50% of the contraceptive

cycles.³⁰ Most of the cycles during low-dose progestogen administration are probably ovulatory, as suggested by endometrial morphology and clinical determinations.³¹ As a result, an important follicular activity³², inversely proportional to the amount of administered progestogen³³, can be evidenced in women taking this kind of oral contraceptives.

2) Progestogen-only pills thicken cervical mucus

Under the effect of progestogen-only oral contraceptives, cervical mucus is highly viscous, scanty, opaque, and cellular³⁴, gestagenic-type.³⁵ The meshwork which constitutes the infrastructure of the cervical secretion appears greatly tightened, giving the typical appearance of cervical mucus in the late luteal phase.³⁶ On penetration tests, sperm cells remain on the surface of the mucus or are trapped in the superficial layers of the wool. Sperm penetration comes to a stop 3-4 cm from the sperm-mucus contact point.³⁷ In vivo post-coital sperm penetration tests in women taking the mini-pill show that, in 70-80 percent of the time, there is little or no penetration.³⁸ A direct, sperm agglutinating effect of the progestogens in vitro has also been reported.³⁹ However, some spermatozoa do pass through the barrier of cervical mucus despite the tightening of its meshwork.⁴⁰ Indeed, there is a relatively high incidence of ectopic gestations in patients using progestogen-only oral contraception.⁴¹ The risk of ectopic pregnancy among women using this form of contraception may be increased from two to five-fold when compared with women of childbearing age.⁴²

3) Possible action on Fallopian tubes

A possible explanation of the high incidence of ectopic pregnancy in mini-pill users is altered tubal motility. In vitro studies have shown that 19-norsteroids diminish the intensity and frequency of peristaltic tubal movements.⁴³ On the other hand, a decrease of ciliation has also been observed in the infundibular and ampullar regions of the oviduct, with microvilli scarce and of irregular height in women given steroidal contraceptive treatment.⁴⁴ But other investigators did not find any abnormality upon histological examination of tubal epithelium in mini-pill users.⁴⁵ Progestins could also reduce the intensity and frequency of cilia action, thus slowing the rate of ovum transport (McCann, 1994).⁴⁶ On the whole, there is no clear-cut evidence concerning these supposed effects.

4) Progestogen-only pills oppose the implantation of early embryos in the endometrium

It is the endometrium which is the main site of action of low-dose oral progestagens. Progestagens interfere with the normal, cyclic development of the endometrium⁴⁷, and in that way prevent the implantation of early embryos. Animal studies have shown that progestogen makes implantation impossible in 84% of all cases, which prevents pregnancies at a 100% rate.⁴⁸

The endometrium of women taking low-dose, progestogen-only oral contraceptives presents, during the first part of the contraceptive cycle, a proliferative aspect, with varying degrees of mitotic activity.⁴⁹ Early secretory activity reaches a maximum on days 13 to 15, but never progresses to a full development. This abortive, secretory phase is followed by a regression of the glands.⁵⁰ Suppression is total, during the whole cycle, with glandular atrophy, compact stroma, fibrosis, moderate decidual reaction, for women taking 300 µg norethindrone or 30 µg norgestrel per day.⁵¹ Electron microscopy shows that the endometrium in development during the first part of the cycle presents an irregular secretory pattern, with presecretory changes observed in some cells in each gland while the remainder of the cell components retains proliferative features. Such an irregular cell maturation is not compatible with a normal implantation.⁵²

In agreement with this morphologic "suppression" of the endometrium, studies of the action of oral progestogen-only contraceptives on the uterine biochemistry of rats have shown⁵³ have shown a general depression of the metabolic status of the uterus. There is a diminution in energy production in the uterus under the influence of the progestogen.

Therefore, low dose oral progestogens interfere with the cyclic development of the endometrium, allowing either an irregular cellular maturation, or suppressing it. Under the mini-pill, the energetically deprived uterus during conception would be in a "sleepy state", unprepared for the implantation of an embryo.

5) The abortive action of the "mini-pill."

Oral progestogen-only contraceptives neither suppress ovulation consistently nor prevent totally the passage of spermatozoa through the uterine cervix. So, it must be their suppressive action on the endometrium which prevents development of a pregnancy. The mini-pill allows probable fertilization in a large number of cases, but does not permit development of an embryo – at least in the uterus – because it hinders its implantation. Therefore this is not a contraceptive action but an abortifacient one.

If we assume that ovulation can occur in 37% of the contraceptive cycles of women taking the mini-pill, with fertilization following in 25% of these cases, then nine fertilizations could occur per 100 cycles. That is to say, 75 fertilizations occur per 100 women per year, in women taking the mini-pill. Given that the Pearl index for the mini-pill varies between 1.5 and 6, with a mean value⁵⁴ of 3.75 (3.1 for the 25-29 age group),⁵⁵ there could be, for each 3.75 embryos able to implant and develop, 71 embryos eliminated early per 100 women per year. Thus, a woman taking the mini-pill continuously would have about 10 early abortions during 15 years of sexually active life.⁵⁶ However, given that the mini-pill is taken by less than 10% of contraceptive users, the total amount of these abortions is much smaller than the number of abortions caused by combined oral contraceptives.

C. Discussion

Oral contraceptives, therefore, provoke early abortions, more than one in her active sexual life for the woman taking the combined pill, and up to ten abortions for the woman taking the mini-pill. This cannot be overlooked.

1) Is the number of abortions caused by oral contraceptives too small to be considered a problem?

One could answer that the number of abortions related to the use of oral contraceptives is relatively small when compared to the number of spontaneous abortions which occur after fertilization and before implantation, because of genetic defects, immunological incompatibilities, or grave malformation.⁵⁷ But the fact that there may be spontaneous abortions does not justify abortions caused by contraceptives, any more than the daily occurrence of human death by car accidents could justify homicide through planned auto collisions.

On the other hand, if we relate the abortions induced by oral contraceptives to the total number of women using such medications, we arrive at some impressive figures. B. Bayle estimates, for example, that between 120,000 to 400,000 embryos a year are aborted this way in France. This is almost as many as there are induced abortions in that country.⁵⁶

2) Are these abortions not to be considered as such because they concern only pro-embryos?

A second argument for not considering problematic those abortions induced by oral contraceptives is to declare that they are not true embryos. Different investigators, such as A. McLaren⁵⁹ and also theologians, such as Rev. Norman Ford of Melbourne, Australia⁶⁰ maintain indeed that, before the 15th day following fertilization, or at least before its implantation in the uterus (which starts approximately on day 5 after fertilization, the early embryo cannot be considered as a true individual because its blastomeres are totipotent and can multiply to form other embryos once detached, as occurs naturally with monozygotic twins.⁶¹

But the fact that a totipotent cell can divide into two individual beings does not contradict the continuity in the development of the embryo.⁶¹ We do not have in the early embryo an indeterminate system which could originate, by division, two determinate systems. There is, instead, a first being from which can arise, through accidental detachment of one cell, another being with its own genetic program.

Some may also say, on theological grounds, that the embryos eliminated by oral contraceptives do not have the same value as true human beings because they have not yet been informed by a rational, human soul.⁶³ Not only is this thesis philosophically incorrect⁶⁴, but it also lacks any biological grounding. It has been indirectly disapproved by the Church in repeated condemnations of induced abortions (*Declaration on Procured Abortion*, Congregation for the Doctrine of the Faith, November 25, 1974; "extending from conception to birth," *Evangelium Vitae* 58).

II. Oral Contraception and the Practice of Abortion

After recognizing the abortive effect of oral contraceptives, one can ask if the connection is limited to pharmacology and early embryology, or if it goes further.

Rich from many points of view, the recent encyclical of Pope John Paul II, *Evangelium Vitae*, has brought a new dimension to the discussion of contraception started by *Humanae Vitae*. In commenting on the "anti-life" aspects of contraception, the Pope declares:

Certainly, from the moral point of view, contraception and abortion are *specifically different* evils: the former contradicts the full truth of the sexual acts as the proper expression of conjugal love, while the latter destroys the life of a human being; the former is opposed to the virtue of chastity in marriage, the latter is opposed to the virtue of justice and directly violates the divine commandment "You shall not kill." But despite their differences of nature and moral gravity,

contraception and abortion are often closely connected, as fruits of the same tree...(E.V. 13)

Thus, in this very important passage, John Paul II denounces not simply the abortivity of the contraceptive pill, but the mere existence of a connection which would exist between contraception and abortion.

A. The Assertion: "Contraception is the most effective remedy against abortion."

1) The position of the promoters of contraception.

This statement of John Paul II is all the more surprising because, although it is the first time that such an accusation appears in an official Church document, it directly opposes the basic argument of all the promoters of "Family Planning", from the earliest days of the I.P.P.F. to the more recent publications of the FNUAP or of the WHO on this question. This argument lies in the quasi axiomatic affirmation that "contraception, if made safe and available to all, is the most effective remedy against abortion."(E.V. 13).

Following this argument, oral contraceptives would represent indeed a "lesser evil" compared to the greater evil of voluntary abortion. The promotion of oral contraception, because it would lead to a decrease in the number of voluntary abortions, and particularly the unsafe ones, would be therefore more than justified. On the contrary, opposition to contraception, for religious or cultural reasons, would not do any good, because it would increase recourse to abortion.⁶⁵ The Catholic Church has actually been accused of indirectly promoting abortion because of its intransigent stand against hormonal contraception. John Paul II writes:

The Catholic Church is...accused of actually promoting abortion, because she obstinately continues to teach the moral unlawfulness of contraception (*Evangelium Vitae* 13).

Given this, one wonders why the Pope has judged it necessary to disagree publicly with this opinion in the most official document of the Church. Neither *Humanae Vitae* nor any later document of the Magisterium has dared to express such disagreement.

2) The position of *Evangelium Vitae* 13.

If we now analyze this thesis in favor of promotion of contraception, we find that in the assertion "Prevention is better than abortion", there is an obvious weakness. The opposition between contraception and abortion is taken for granted, and no effort is ever made to prove it. But does increased contraception really mean decreased induced abortions? The Holy Father expresses clear doubts about it, again in the same paragraph of *Evangelium Vitae*:

When looked at carefully, this objection is clearly unfounded. It may be that many people use contraception with a view to excluding the subsequent temptation of abortion, but the negative values inherent in the "contraceptive mentality"...are such that they in fact strengthen this temptation when an unwanted life is conceived. (*E.V.* 13)

John Paul II supports these doubts by the statement that it is precisely in the places where the teaching of the Church on contraception is not welcomed that abortion is strong:

Indeed, the pro-abortion culture is especially strong precisely where the Church's teaching on contraception is rejected. (*E.V.* 13)

Thus, if we follow John Paul II, the practice of contraception, far from bringing down the recourse to abortion, could in fact favor it.

This affirmation of John Paul II is not, in fact, based on mere opinion. If in 1968, Pope Paul VI did not have the necessary data to bring forth such an argument in *Humanae Vitae* due to the relative newness of contraception then, statistics are now available which demonstrate the accuracy of the Pope's judgement. These statistics, which will only be sampled in the present study, show that one passes easily from contraception to abortion, that contraceptive users are the main applicants for legal abortion. Also, these statistics show that the spread of contraception in different countries has not brought about the decrease in voluntary abortions which had been expected.

B. The Practice of Contraception May Lead to Abortion.

1) Contraceptive users are the main applicants for abortion.

In a study carried out in Sweden⁶⁶, on a sample of 2,621 women of Göteborg, aged 19 to 24 years, followed from 1981 to 1986, and of whom 89% were using oral contraception, it was found that 43% of these became pregnant during that period, and that 44% of these pregnancies were

terminated by a legal abortion. Thus, despite an easy access to contraception and its general use, the abortion rate in that group remained high.

In a study done in Finland from 1976 to 1993,⁶⁷ to check the efficacy of a promotion campaign for contraceptives among adolescents, the investigators did find a decrease in the number of abortions, from 4,143 to 1,513. However, the reduction observed in childbirth, from 5,376 to 1,655, was even more important. These adolescents, while using contraception, did in fact continue to have recourse to abortion. In all the provinces where contraceptives were promoted, at the end of the 1990s, the number of abortions did not drop but rose instead, and did not start to diminish before the 1990s, in parallel with the drop in the birth rate. Thus, the first effect of this promotion of contraceptives was to lead users to adopt a more negative attitude toward respect for life of the unwanted child.⁶⁸

K. Sidenius and N.K. Rasmussen⁶⁹ observe that 90% of the 110 teenagers admitted for an abortion in Herlev Hospital, Copenhagen, Denmark, from 1977 to 1978, had previously received information on contraception and that 60% of them did use some form of contraception. Most of these adolescents had started to have sexual relationships before age 15. All of these abortions were therefore the result of contraception failures.

The Allan Guttmacher Institute (affiliated with the American Federation for Family Planning) published a study in 1996, carried out in 1994-1995 on 10,000 women who requested an abortion. This study shows that 57.5% of these women did use a contraceptive method, at least during the month before contraception.⁷⁰

V.A.H. Pearson et al.⁷¹, in a study published in 1995 about undesired pregnancies among adolescents, reported that 80% of these adolescents declared that they were using a contraceptive during the period in which they had conceived. These rather surprising results are corroborated by E.S. Williams⁷² who observed a proportion between the use of a contraceptive at the time of the first sexual relations and the subsequent occurrence of a pregnancy. As this proportion cannot be explained only by contraceptive failures, this investigator suggests that the practice of contraception may lead, among unmarried young persons, to an increase in sexual promiscuity with a multiplication of the number of sexual relations. This, in turn, would be responsible for the epidemic of unwanted pregnancies.

2) Spread of modern methods of contraception has not brought the expected drop in voluntary abortions.

If we look now at the general statistics on abortion throughout the different countries, we do not find a decrease in induced abortions since the beginning of widespread contraception. More often, we find a plateau or even a relative increase in abortions.

In the United States, for instance,⁷³ the reported number of abortions rose continuously, parallel to the spread of contraception, from 988,267 in 1972 to 1,429,577 in 1980, leveling off between 1980 and 1984. Between 1993 and 1994, the annual number declined from 22 to 21 per 1,000 women aged 14-44 years. This small decline is related to the parallel decline in child birth.

In Great Britain⁷⁴, in 1971, 95,000 legal abortions were recorded per 783,000 births. That is one abortion for every eight births. In 1986, the number of legal abortions grew to 148,000, while there were only 661,000 births. That is one abortion for every four births. Thus, the number of voluntary abortions in this country did increase in a noticeable way, precisely during the period when oral contraceptives were the most widely promoted and used.

In France, the total number of registered abortions has only slightly diminished in the last twenty years, from 250,00 per year in 1976, immediately after the legalization of abortion, to 220,000 per year in 1994.⁷⁵ Meanwhile, contraception has become part of the life of French women, with 70% of them between the age of 18-49 using a contraceptive method.⁷⁶ Mrs. Blayo, from the "Institut national d'Etudes Démographiques", has declared: "This slowness (*in the diminution of abortion*) alarms those who thought that the spread of medicalized and very efficient contraceptive methods could rapidly resolve the problem...To encourage couples to an ever greater mastery of their reproduction evidently brings them determination not to accept failures."⁷⁷ In other words, promotion of contraception leads people to more adamantly reject the child who dares to present itself despite contraception.

C. Contraception and abortion are "fruits of the same tree."

Faced with these results, one has to admit that contraception has obviously not helped to decrease abortion in the way expected. This is because one passes easily from contraception to abortion. Therefore, there must be something in common between them, despite their obvious differences. Pope John Paul II puts it this way in *Evangelium Vitae*:

The close connection which exists, in mentality, between the practice of contraception and that of abortion is becoming increasingly obvious. (EV13).

M. Rhoneimer⁷⁸ rightly observes that John Paul II does not say that abortion is the consequence of an anti-life mentality which would be already present in the contraceptive mentality. John Paul II writes instead:

...the negative values inherent in the "contraceptive mentality" – which is very different from responsible parenthood...are such that they in fact strengthen this temptation (of abortion) when an unwanted life is conceived.(EV13)

Thus, for the Pope, contraception comes first, not as a mere by-product of an anti-life mentality, but with its own negative specificity of contradicting the truth of the sexual act. In the contraceptive mentality, it is not hate for the life of a possible child which comes first. In fact, the possible child is not even thought about. What comes first is the intention to have sexual intercourse with someone of the other sex, with the associated intention to prevent this freely decided sexual intercourse from giving origin to a new life. Thus, as M. Rhonheimer puts it,⁷⁹ the contraceptive mentality plunges its roots into a sexual behavior in which one exonerates oneself from one's procreative responsibility. As a consequence, the parents who find themselves with the "misfortune" of a conception, fruit of the failure of contraception, do not feel truly responsible for this new life. They have indeed chosen to not be the cause of a new life by excluding the procreative dimension of their sexual acts. In this case, the baby is "truly unwanted." Pope John Paul II puts it in *Evangelium Vitae*:

...abortion becomes the only possible decisive response to failed contraception (EV13).

In that perspective, it is understandable that a woman could enter into the abortion mentality the same way she entered into the contraception mentality. She does not, really, want to suppress a human life as such; she does not even consider that life to be a real one. What she does want is not to assume the responsibility of her sexual behavior. In both the acts of contraception and abortion, there is a kind of self-inflicted blindness. The woman considers only her own situation, the conflict in which she feels entangled and the way to protect herself from the unwanted consequences of her sexual life. She will simply deny any value to the life which has started in her body, against her lifestyle choice, or she will despise it.

Conclusion

This study of the connections between oral contraception and voluntary abortion suggests the following remarks:

1) In the quest for an “ideal contraceptive”, more effective but with fewer side effects and less risk of complication, pharmacological research renders contraception more and more abortifacient. This does not seem to concern public opinion so much, ever since it was decreed that the early embryo was not an embryo. What would have been a major obstacle to contraception at the time of the encyclical *Humanae Vitae* is now accepted without resistance. This is either through ignorance or voluntary, self-inflicted blindness coming from the contraceptive mentality. Finally, the distinction between contraception and abortion becomes more blurred every day. It even disappears with the “menstrual regulation method”⁸⁰, using *mifepristone*, the famous abortive pill RU-486⁸¹, promoted by Pr. Etienne-Emile Baulieu.⁸² The same drug, RU-486, can be used either as a “contraceptive” or “contragestative” to induce an early abortion.

2) Oral contraception, far from being, as its promoters claimed, “the most effective remedy against abortion” (*Evangelium Vitae* 13) finds today abortion as its ultimate development. This, after contraception has failed. It is misleading to promote contraception as an antidote to abortion; it is slanderous to accuse those who oppose contraception as promoting abortion. The fact is, contraception and abortion are interconnected, “fruits of the same tree.”

3) The root of the problem seems to lie in the contraceptive mentality, which seeks to exclude the procreative aspect of sexual acts and to remove all responsibility for the procreative consequences when they do occur. This bears the hallmark of behavioral characteristics of modern liberal society: a “self-centered concept of freedom” (*EV*13), a denial of truth.

4) The solution to the problem of responsible parenthood does not lie in the spread of contraception. The Church asks parents to procreate in a responsible, reasonable way for the sake of their children. Periodic continence and other natural methods, seem to be the real answer. Using periodic continence, parents do not deny the reality of sexual acts and do not reject their procreative dimension. They simply abstain from carrying out the acts which may lead to procreation. The embryo is still respected for what it is – a human being – and parents assume their responsibility in accepting the child when it comes. There is no room for abortion. We can

add that these so-called "natural methods" have been used for years now, and that their scientific efficacy is well recognized.⁸³

Thirty years after the publication of *Humanae Vitae* the prophetic character of this document appears more and more obvious. At that time, Pope Paul VI did not have the data which are now at our disposal. He could not know for certain that the spread of the pill would not bring about the expected decrease in abortions. He could not know for certain that this would create havoc in new families, exaggerate the tendency of people toward self-centered attitudes and self-blindness, and would bring the disastrous consequences which we know today.

Despite this lack of certain knowledge, the Pope stood firm in his condemnation of the pill. However, his attitude was not one of blind intransigence. It is because Pope Paul VI fully understood the far-reaching consequences of the voluntary dissociation of the union between procreation and sexual acts that he could stand fast. The last thirty years of unabated contraception have drained the resources of international institutions, without bringing the peace, joy, and harmony predicted by Margaret Sanger. The Pope was right when he considered "the pill" not as a gift from science but as Pandora's box.

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