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CONTRAGESTION: BUILD BACK BETTER

Introduction

After over three decades of experience in birth control methods and both medical and surgical pregnancy terminations, I am questioning the scientific representation of human reproductive health.

The term “abortion” refers to the expulsion of a fetus from the uterus before it has reached the stage of viability ^[1]. In human beings, viability occurs usually about the 20th week of gestation¹. Despite the availability of ultrasound technology for over five decades and its provision of precise anatomical imaging, healthcare providers continue to use the term “abortion” even in early pregnancy when the fetus is not yet constituted. The single term abortion is used to describe a broad spectrum of procedures aimed at terminating pregnancies. Such procedures can occur within the first to third month of pregnancy, before reaching the fetal stage.

The need for a scientific approach to birth control representation dates to the 1980s, with Prof. Baulieu’s discovery of the anti-progesterone activity of mifepristone ^[2]. In 1988, Roberts established that the 4 stages in fertility control are contraception, contranidation, contragestion, and abortion ^[3]. Nevertheless, a binary framework of female fertility control persists, revolving around the dichotomy of contraception versus abortion. My proposal introduces a comprehensive three-stage model: contraception/contragestion/abortion. This model seeks to reflect the intricate dynamics of human reproductive anatomy and physiology, because it is “neither contraception nor abortion” ^[4].

Mifepristone (RU-486)

Mifepristone is a derivative of norethindrone. In 1970, in Paris, Prof. Baulieu and his team identified progesterone receptors in uterine cells, giving the prospect of a new path for birth control ^[5]. “The receptors are like a keyhole, and we were trying to produce a false key”, explained Baulieu (Greenhouse, 1989a). Baulieu in turn gave the idea to Roussel” ^[2]. In 1982, the first trials of the antiprogesterone pill, RU (Roussel Uclaf) 486 took place in Switzerland. The idea of a once-a-month contraceptive was already present. The hope that RU-486 might become a once-a-month contraceptive led gynecologist Raymond Faraggi to predict: “If it works, it will be the end of contraceptives and the end of abortion. No more daily pills, no more IUDs, you take a pill on the 25th to 28th day of your menstrual cycle regularly, every month. It means the end of abortion, anyway, and

an end to all our problems” ^[2]. As early as 1985, several publications by Prof. Baulieu reported the antiprogesterone action of mifepristone, knowing that “a few hours interruption of progesterone action prevents pregnancy” ^[5]. Mifepristone disrupts endometrial receptivity for several hours by binding with progesterone receptor. Prof. Baulieu will use the terms contragestive agent and contragestion to define mifepristone’s mode of action, when used to interrupt early pregnancy. The use of mifepristone quickly proved to be safer and cheaper than the practice of surgical aspiration for early unwanted pregnancy.

The data collected through clinical trials conducted by Prof. Baulieu and his colleagues suggest that mifepristone can be used for: voluntary termination of pregnancy between 6 and 10 weeks, inducing menstruation during the fifth week of amenorrhea, or it can serve as a post-coital contraceptive ^[5].

40 years later, have we really done better? In 1909 the first insertions of IUDs were made by Dr Richard Richter, but it wasn’t until 50 years later that this method of contraception became available. Do we still need so much time to improve women’s sexual and reproductive health?

Mifepristone as a new mean of birth control encounters strong resistance from the conservative public, as the resistance to medical contraception at its beginning, and now as the resistance against sex education.

Mifepristone, not the only victim of the abortion debate

When will birth control be recognized as being equal in importance with other areas of human health? Is there a law on knee sprains or bronchitis? In birth control, the patient-physician “colloque singulier” is being undermined by those who intend to concern themselves with what is surely none of their business. Regardless of the years of study and certifications obtained by the doctor, the psychological well-being of the patient, conscience, expertise, and even integrity of those involved in unwanted pregnancies are scrutinized. Thus, patients report feeling guilt, and above all betrayal due to the intrusive nature of regulatory requirements, dictating how women’s privacy and health care providers’ actions should be managed. In the end, it takes a law to decide for them. In Canada, with no law about abortion, are there more mental or physical health problems linked to reproductive health?

Abortion has been a social phenomenon, described since Antiquity: yet the debate often devolves into the opposing

factions clashing with one another. Men are excluded from the debate of their reproductive health, even though they are involved in pregnancy on a biological level: the embryo's origin is one half, one the other. Only a few studies dedicated to men in abortion situations have been carried out, as usually scientific attention has been focused on female body, female mind, and female social concerns. And yet Couvade Syndrome exists when the pregnancy goes on [6]. Can you imagine what can happen in male body, when its genetic material is being eliminated by female body? In abortion, there is a confusion between rights for women, because it is their bodies, and biology, in which two people are involved. The right to terminate an unwanted pregnancy is a matter of gender justice for women. However, it is important to acknowledge and maybe also respect the emotions and perspectives of men, when decisions regarding pregnancy termination are made. The decision to have an abortion is up to a woman, but both women and men are involved in abortion, therefore the scientific research must be gender equal [7,8].

Can a gender inequality in science, specifically the overlooking of men's reproductive health in abortion, contribute to abortion ban, as a revenge for men?

Epistemicide

“The contraception with RU-486 has just started. The RU seems to be a very efficient post-coital contraceptive when taken within 72 hours after an unprotected intercourse. Two trials have had a rate of success of 100%. The RU in ordinary contraception could be used either just after ovulation or during all the cycle with very low doses. Trials have just started [9]. What happened after numerous publications of peer-reviewed studies by various authors since the late 80s reporting on the contraceptive and contragestive efficacy and safety of mifepristone? [9-13].

In France, mifepristone received marketing authorization in 1988. However, its application in contraception is presently restricted to terminating pregnancies within the first nine weeks of gestation. This restriction overlooks the drug's other potential therapeutic uses, which have been frequently described since its approval. This raises the question of whether such limitations constitute an epistemicide, leading women to resort to less reliable alternatives like the levonorgestrel 1.5 mg morning-after pill.

Epistemicide occurs through the silent restriction of all other potential indications for mifepristone in birth control, limiting its use solely to the termination of early unwanted pregnancies. Furthermore, it prevents us from recognizing the broader implications of mifepristone, i.e. that early pregnancies can be terminated through medical procedures rather than dramatic and compulsory surgical interventions.

Mifepristone is more than just a therapeutic technique for women's health: mifepristone demonstrates different stages of pregnancy, giving way to different management approaches, and consequently different prognoses and risks. This is how the term contragestion came to be used to scientifically define its mode of action. **Thus, mifepristone introduces a clear break in the binary representation of female birth control contraception/abortion.**

Three stages of birth control

The three stages of female fertility control are anatomically and functionally very different and must therefore be referred to in different ways.

- Prior to fertilization, the ovaries and/or uterus are blocked by hormonal or non-hormonal means: this is known as contraception.
- When fertilization occurs (which may be the case for IUD wearers) and nidation follows, but there is still about 25% probability of spontaneous elimination of the product of fertilization, this stage is referred to as contragestion, bearing in mind that mifepristone is a contragestive drug.
- When the pregnancy is sufficiently developed to have every likelihood of giving rise to a viable birth, the word abortion is used to designate the termination of this progressive pregnancy, beyond nine weeks of gestation, according to the scientific definition of abortion.

It is essential to distinguish between these three stages, and to be able to name them differently:

- The anatomical situations are different.
- The medical and surgical means used to control fertility are different.
- The hazards and iatrogenic risks are different: terminating a pregnancy at six weeks is different from terminating a pregnancy at 20 weeks.
- The issue doesn't revolve around moralizing one situation over the other; such debates are outdated. Rather than that, it is about employing distinct terminology when the anatomical facts, medical and surgical methods, as well as the associated hazards and risks, vary.

Labeling the termination of a pregnancy, which has a 25% probability of stopping spontaneously, as abortion is inaccurate because the outcome of the pregnancy is uncertain. Ignorance (because it is too early to know if pregnancy is going to continue or not) should not equate a miscarriage with the intentional termination of a pregnancy.

For women, miscarriage and voluntary termination are completely different situations. Interrupting the start of a pregnancy (which may stop on its own) by swallowing pills at home and interrupting a 20-week pregnancy with a 400-gram fetus through a surgical procedure that involves anesthetic, hemorrhagic, infectious, and surgical risks, are not the same.

Having eyes is not enough to see [14]?

This question needs to be asked when the word “abortion” is used indiscriminately to designate both a medical and a surgical procedure, whether on an “egg”, an embryo, or a fetus, with no regard for any prognostic factor relating to the anatomo-physiological evolution of the situation.

The anatomo-linguistic confusion is sealed using metonymic trickery (metonymy is the replacement of one word by another from the same lexical field). For example, in a consultation, we can still hear: “you/I kill a life”. The biological definition of life is birth: to live, one must be born. When the term “child” is used to describe the presence of an egg/embryo/fetus, it inaccurately portrays the anatomical phase, as the reproductive process hasn't progressed to the stage of a fully formed child. Here again, the use of **emotionally charged words** (killing

a life...) causes a cognitive block that obscures the rhetorical manipulation of the anatomical evidence.

The question of voluntary termination of pregnancy is also one of confrontation between definitions/representations of the word life: the biological representation of the word life (to be born) confronts its religious representation (fertilization stage). Female reproductive health is history's last bastion of resistance to modernity. And let's not forget that the clitoris was only fully described in 1998 by Helen O'Connell.

The issue is not about being for or against, or of wanting to impose one's personal vision of "good" or "evil" on others, along with "good behavior": the term abortion, used regardless of the term of the pregnancy, belongs to the moral and religious lexical field and not to the scientific lexical field.

My question is as follows: during a medical consultation, can precise terminology be employed to describe medical or surgical procedures, selecting a suitable term devoid of religious connotations?

The debate on abortion is a wake-up call on:

- Scientific gender neutrality, undermined by female anatomical epistemicide in sexual and reproductive health.
- The use of rhetoric, especially the use of metonymy, to maintain domination over the bodies of others.
- The deliberate and unacceptable use of words with strong emotional content: "to kill", "to kill a life", "to kill a child", words or expressions that block out the anatomical evidence by means of emotional awe.

The issue is not about being for or against, the debate on abortion is about respect for others, scientific rigor, access to care and gender equality. The debate on abortion transcends the act itself. The debate on abortion is the dialectical tool for access to human rights, by revealing the strategies of forced mental incorporation of an obsolete narrative that has run out of steam.

Human rights are not just a discourse: human rights are the capacity to choose and to act: the situation of abortion is a matter of natural right, and natural right is what a person has by virtue of belonging to humanity. The right to freedom is a natural right: people become free when they act, not when they undergo what they do not choose.

The three stages model of birth control, contraception, contragestion and abortion is a claim of a scientific approach in woman's reproductive health. When a woman is diagnosed with HPV, she is not informed that she has a cancer, the time factor is acknowledged. It is imperative to maintain scientific precision and accuracy in discussions surrounding female reproductive health, prioritizing anatomical rigor over emotions and non-scientific representations. Gender equality deserves anatomical rigor.

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