

The Pill at 40—A New Look at a Familiar Method

We celebrate the 40th anniversary of the introduction of the oral contraceptive pill in a world considerably different from the one we knew four decades ago. How much of the change we have experienced can be traced, directly or indirectly, to the pill? Since this method first became available in 1960, many articles have been written about its impact on society. Like other publications, Family Planning Perspectives has periodically examined the pill's influence on women's roles and on the separation of reproduction from sexuality. As we begin a new century, however, we believe it is valuable to take a look at several other issues that have—despite their importance—received less attention.

The experts we asked to address these topics seem to agree that the pill has played a complex role in how we think, communicate and interact. Indeed, they may raise at least as many questions as they answer. Have oral contraceptives allowed women freedom from the risk of pregnancy, only to subject them to a physician's rigid ideas of how they should take them? Has the pill given women more control over contraception, only to burden them with responsibilities they would prefer to share with their partners? Has it encouraged women who grew up with the pill to talk about contraception and sex with their daughters, only to find that their daughters want them to believe they are taking the pill to alleviate painful menstrual cramps? Is the pill a way for black women to gain bodily autonomy, or a tool used by white society to limit black fertility? Did we think the pill had liberated us from the hated condom, only to find that we now need both? Given the dearth of new methods on the horizon, it is likely that we will struggle with these and other questions far into the 21st century.

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Whose Pill Is It, Anyway?

By Anita L. Nelson

As we enter the the birth control pill's fifth decade of use in the United States, we appreciate how much the pill has changed. The doses, types and mixes of hormones through the menstrual cycle have all undergone great evolution in an attempt to minimize adverse side effects while maintaining high contraceptive efficacy. Nevertheless, under the control of health care providers, third-party payers and politicians, how the birth control pill is prescribed and used within the medical model remains rigid. It is time to ask ourselves, whose pill is it? We commonly say that the provider "gives" the pill to the patient and that she "takes" it. The only way women have a voice in this system is by deciding not to take the pill—by "noncompliance" and by "discontinuing" the pill—the way it is offered to them.

When viewed from the patient's perspective, today's medical practitioners hold a woman's pills hostage until she undergoes the routine health screening that the experts believe she needs, including a pelvic exam. They do so despite the fact that a pelvic exam can discover virtually nothing that would exclude a woman from using birth control pills. Although a pelvic exam is critical to discovering many important health problems, such as sexually transmitted diseases (STDs), cervical dysplasia, ovarian cancer and uterine fibroids, bundling contraception with general health care decreases and limits a woman's access to contraception. The decision to join or separate those issues should be the woman's. Men are not required to undergo STD screening or prostate exams to obtain a prescription for Viagra. Bundling all sexual health services may be important in gaining access for women who could not otherwise afford

those services, but there may be other ways to achieve our goals without building such tall barriers around birth control pills for all women.

How women use the pill is also severely limited by unnecessary controls. Why do we still advise so many women as a matter of course to start their pills on Sunday now that we have packaging that permits first-day starts? Starting on the first day of menstrual bleeding provides immediate onset of action and obviates the need for a backup method. Historically, the Sunday-start pattern was introduced to ensure that women would bleed during the week and be available for tidy coital activity on weekends. But what about the woman who works on Saturday and Sunday and who wants to enjoy her partner on Tuesday or Wednesday? Many providers are so wedded to the "one size fits all" approach that they make no provision for that woman. One doctor told me that he still prescribes the Sunday start so that he can know where his patients are in their cycles just by knowing the day of the week. That is wonderful for the doctor, but where does it leave the woman?

Why are women using the pill forced to have monthly withdrawal periods? We have decades of experience using pills to suppress menses for women with endometriosis¹ and to occasionally move menses around to accommodate special events like honeymoons. The grandmothers and mothers of our current patients may have preferred "natural" cycling in 1960, but many of today's women have other priorities. Yet, we routinely continue to cycle women with three weeks of active pills and one week of placebos or subsuppression doses. What does cycling

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do for women? It allows them to experience menstrual cramping, headaches and bloating, and provides an opportunity for the next crop of eager, easily excited ovarian follicles to be recruited and selected. We accept monthly cycling and work hard to ensure it despite the fact that the single greatest cause of lost days of work and school for young women is dysmenorrhea.² Women endure a host of discomforts during those active-pill-free days.³ Yes, it would cost third-party payers the price of an additional four packs of pills each year, and yes, manufacturers of sanitary napkins and tampons would suffer an economic loss—but are we more concerned about their economic interests or the health and well-being of our patients?

As we approach the 40th anniversary of the pill, we have to ask ourselves whether these control issues have had a deleterious impact on women's desire to use the pill and on their motivation to use it correctly. For example, have we done everything we can to maximize the ben-

efits an individual woman can derive from the pill, and have we clearly explained them to her? In the most recent survey sponsored by the American College of Obstetricians and Gynecologists, 58% of American women could not name one single noncontraceptive benefit of the pill.⁴

This lack of information tends to perpetuate the negative image so many Americans have about this wondrous little pill and to reduce its successful use. Could the pill's relatively high failure rate in typical use, compared with its potential effectiveness in perfect use, be related to our failure to effectively inform women about the positive impacts of the pill and to our exclusion of their priorities from our calculus?

Today, we can more clearly see these subtle control issues and observe their negative impacts on our patients' enthusiasm to take the pill. We have an opportunity to adapt our practices to involve our patients more actively. We can commit ourselves to helping patients tailor their pill use in ways that best fit their lives. Di-

versity and individualization are key. We may be quite surprised at how meaningful involvement in decisions about pill-taking could affect a woman's adherence to her chosen pill regimen. Can we imagine how well women would take their pills if they could use them to control when (and if) they menstruated? I think today would be a good day to find out.

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The Pill and Men's Involvement in Contraception

By Jacqueline E. Darroch

Approval of the oral contraceptive pill for marketing in the United States 40 years ago was the culmination of a long search for a way to give women reliable control over their own fertility. The goal of finding a means for women, on their own, to prevent pregnancy reflected the burden many women had borne for centuries when their wishes about when and how many children to have were overridden or ignored by their male partners.

The introduction of the pill (along with that of the IUD and easier methods of contraceptive sterilization) during the 1960s changed the link between sexuality and contraception and altered the balance of male-female involvement in contraceptive use. Before the pill became available, contraception meant almost exclusively a method used at the time of intercourse (such as the condom, the diaphragm and withdrawal) or related to the timing of intercourse (periodic abstinence). The only contraceptive option not related to intercourse, sterilization, was little used.

For the most part, methods of contraception available before the pill usually implied the involvement, or at least the

knowledge, of both the woman and the man at or around the time of intercourse. With the advent of the pill, the realm of contraception became increasingly a female arena. In 1995, female methods accounted for 63% of all contraceptive use reported by women aged 15-44.¹ The change over the past four decades came primarily at the expense of joint use, with the proportion relying on some form of periodic abstinence dropping sharply; a smaller decline occurred in the proportion of women relying on their partner to use a method.

And, to a large extent, contraceptive use—especially use of female methods—has become disengaged from intercourse. In 1995, 94% of women using contraceptives themselves were using coitus-independent methods, primarily the pill and tubal ligation. Because the only coitus-independent method available to men is vasectomy, 68% of men practicing contraception were using the condom or withdrawal.

The availability of an array of highly effective female methods that are independent of intercourse, and therefore largely outside the control and even the knowledge of a woman's male partner, is a great achievement. Nevertheless, this accomplishment has drawbacks as well as benefits. As women gained more control of con-

traception, men were distanced from method choice and use. Some men have undoubtedly been glad to leave this responsibility to women. Others, it is probably fair to say, have been excluded by women who see fertility control as their sole prerogative. The heavy reliance on methods independent from intercourse has meant that sexual partners do not need to alter their behavior around intercourse or even discuss contraception in the context of sexuality.

These changes have pluses and minuses on an interpersonal level. They also have implications for our reactions to the HIV and STD crises, for gender roles related to sexuality and reproduction, and for our readiness to take advantage of potential new contraceptive methods for men.

The methods that most men and women prefer to use for prevention of pregnancy—those that women control and that don't have to be used at the time of intercourse—are ineffective against sexually transmitted diseases (STDs). Prevention of STDs, including HIV, depends on partners' openness to discussions of their sexual and infection risk status and on use of the male condom, the only proven method of protection for those at risk of infection. Although condom use has risen, a minority of couples—even those in which one or both partners have

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other sexual relationships—use condoms. Has the availability of the pill and other coitus-independent methods been a factor in today's low levels of condom use? In separating contraception from sexuality, they lowered the likelihood that people would gain competence and comfort talking about sex and developing skills for integrating method use into intercourse.

Forty years after the pill was acclaimed as a way for women to take control over their bodies and their reproductive lives, increasing attention is being focused on acknowledging and expanding men's involvement in reproductive and contraceptive decisions and behavior. People have been somewhat stymied, however, by the need to define desirable parameters for men's contraceptive involvement. Besides their actual use of condoms, vasectomy or withdrawal, what role can men play in contraception? If a couple relies on a female method, men can provide support that ranges from helping to pay for method costs and picking up supplies to offering empathy for women experiencing uncomfortable side effects. Will there be greater balance when men also have more method options?

After such a long period when almost all contraceptive method advances were for women's methods, systemic methods

for men have moved into clinical trials. While much remains to be done, there is reason to expect that within the next decade men too will be able to select a reversible method of contraception that is not linked to intercourse. Will we be ready? The benefit of experience with women's methods has both raised the demands for safety and prior testing for side effects and, hopefully, lowered expectations that a new method will be "perfect" and suitable for everyone throughout their reproductive lives.

But the field of male contraceptive development has been plagued by questions of whether men will be willing to use systemic methods, and whether women will trust their contraceptive protection to a male method that they cannot verify is being used. These are realistic questions, given our lack of experience with male methods, and given differences in the effects of unintended pregnancy on women and men. The impact of unintended pregnancy on men has been heightened by efforts to enforce financial support of any children they have, especially when men cannot override a woman's decision to carry a pregnancy to term.

Even though the focus of pregnancy prevention over the past four decades has been almost exclusively on women, it is clear that some men are willing to assume

responsibility for contraception and that some women are comfortable with that arrangement. Male methods now account for 38% of all reversible contraceptive use, and 28% of reproductive-age women who use contraceptive sterilization rely on their partner's vasectomy.² However, it is questionable how many women would be willing to rely on men's use of a systemic, undetectable method, except in the context of a long-term, committed relationship.

Facing ongoing challenges related to contraception and sexual relationships even 40 years after the introduction of the pill does not negate the important differences this breakthrough has made for women's—and men's—lives. But the context has changed, and new challenges have arisen. Some are the negative challenges of HIV and other STDs—that women and men become more capable and willing to deal openly with sexuality and to integrate condom use into intercourse. Others are more positive—men's interest in becoming more involved in sharing contraceptive responsibility and the potential availability of systemic methods for men.

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Mothers, Daughters and the Pill

By Paula J. Adams Hillard

In the 1960s and 1970s, oral contraceptives were new. Some observers argued that the pill ushered in the sexual revolution by freeing women from the worry that sexual intercourse would inevitably lead to pregnancy. Indeed, trends in rates of sexual activity among adolescents over the years suggest that there really have been changes in sexual behavior: In 1970, fewer than 50% of 19-year-olds had experienced intercourse, while by 1985, more than 50% of 17-year-olds were sexually experienced.¹

In the 1960s and 1970s, most young women did not tell their mothers that they were sexually active or that they were taking oral contraceptives. They were introduced to responsibility about reproductive issues through visits to family planning clinics, and most of those visits were made alone or with a girlfriend, not with their mother. Many of the clinicians who provided contraceptive services for adolescents in that era were aware that assurances of confidentiality were of paramount importance to many teenagers.²

The teenagers of the 1960s and 1970s have now reached middle age; many have adolescent children. Has the pill made a difference in how we relate to our daughters (and sons)? Has the pill made a difference in our beliefs about family communication? I believe that it has. About 80% of women born since 1945 have taken oral contraceptives.³ They grew up with the pill. They took it for granted. They assumed that their sexual lives could be separated from their decisions about parenting and conception. And so do their daughters. But their own mothers did not have the same confidence that they could control their reproductive lives as successfully. This change, occurring over two generations, is attributable to oral contraceptives.

Today's mothers know that their daughters can receive oral contraceptives without parental involvement, much as they themselves did. But because they know this, many of them have made decisions about how they want to parent, based on their own experiences as adolescents. They have

decided that they want to do a better job of communicating with their children about healthy sexuality than their parents did with them. They talk about many things that their parents left undiscussed—contraception, STDs, HIV, homosexuality and oral sex. Not that these conversations are easy. They talk about these things with their children in part because they feel that they are too important to ignore, but also because the times in which they live have made it dangerous not to. They talk about these things because they can't ignore the availability of oral contraceptives, nor would they want to. As parents, they know that they need to talk about oral contraceptives as an option for their daughters. For some of today's mothers, the pill changed life for the better (fewer menstrual cramps, predictable periods and reliable contraception), while for others it caused uncomfortable or

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even frightening side effects.

As a consequence of this knowledge, many mothers of adolescents help their daughters obtain medical and gynecologic care; they often make the appointments and accompany their daughters to see a clinician who will provide appropriate health education and preventive guidance. The clinicians who provide care for today's adolescents recognize the importance of confidentiality, but also understand that adolescents grow up within the context of a family.

In my practice, I see many adolescents; I see most of them with their mothers. As I have grown as a clinician, I have come to recognize the importance of fostering healthy communication between mothers and daughters. When I see a new patient, I allow time to talk with the mother and daughter together, to speak with each privately, and then to meet again together. This process allows an adolescent to keep whatever information she chooses confidential, but allows the sharing of information and health concerns.

When I talk about oral contraceptives, I feel that it is most helpful if both mother and daughter can hear about the risks, benefits and potential side effects. Of course, many daughters today still choose not to tell their mothers of their need for contraception. They may instead request that oral contraceptives be described to their mothers as therapy for cramps, irregular periods or heavy bleeding. In addition, many older adolescents come for gynecologic visits alone. But I encourage

them to try to talk with their mothers. I do believe that this is easier today than in years past, in part because so many of today's mothers have themselves taken the pill, and because the pill has evolved from a revolutionary new pharmacologic development into an assumption of modern life and health.

Most mothers of adolescents know or will soon come to know the essential fact of parenting—that they are preparing their children to make decisions for themselves. While they would like to protect them from making foolish, dangerous or inappropriate choices, they can only provide them with the information, support and encouragement to make smart and healthy choices.

But most mothers of adolescents today recognize that knowledge is power. They want to provide knowledge about contraceptive options to their daughters. They want them to know that they can effectively protect themselves from unintended pregnancies, but that sexually transmissible infections are a potentially problematic, morbid or even life-threatening possibility. They want them to be safe—from pregnancy, from infections and from emotional hurt; they want to protect them from an intimate relationship that is premature, exploitive, unequal or ill-advised. They would like for them to postpone having intercourse until they are cognitively, socially, emotionally and developmentally mature enough to make responsible choices. And mothers and daughters today do talk about these issues—and I believe that is so because oral contraceptives helped to set

the stage, shaped the mothers' own behaviors and helped them think about how they would like to have been parented.

The pill becomes the focus of many mother-daughter discussions relating to adolescent growth and development, achievement of independence, individuation and responsible choices. That is a good thing; these issues need to be addressed.

In general, the interactions that I observe between today's mothers and adolescents seem healthier than those of a generation ago. The fact that women can successfully postpone childbearing until they actively choose to parent is an assumption of modern life. I believe that this assumption has and is shaping today's families, and that the pill played and is playing a major role in the transformation of relationships between mothers and daughters.

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Black Women and the Pill

By Dorothy Roberts

In 1969, Toni Cade wrote an essay entitled "The Pill: Genocide or Liberation?" about the rift between men and women over the role of birth control in the black liberation movement.¹ Cade recalls a political meeting in which a tall brother stood up and "castigated the Sisters to throw away the pill and hop to the mattresses and breed revolutionaries and mess up the man's genocidal program."² Cade rejects both the sexist implication that women's only role in the struggle is to bear children and the naïve faith that simply producing more children will improve conditions for black Americans. She doesn't believe that

the pill alone can liberate anyone, but asserts that it gives women critical control over a major part of their lives. Still, the black man who condemned the pill as a genocidal tool was not a paranoid lunatic. He failed to understand the pill's importance to black women's self-determination, but his concerns about birth control as a form of genocide arose from a real history of reproductive abuse. Cade's honest and provocative essay raises themes about black women's relationship to birth control that still resonate today.

For black women, the politics of the pill doesn't fall into a simple liberal-conservative dichotomy. The meaning of birth control is complicated by the racist denigration of black childbearing, including deliberate campaigns to limit black ferti-

ity; sexist and religious norms within the black community; and many white feminists' ignorance about the unique issues facing black women. Black women's attitudes about the pill are shaped by a broader social context that includes racial injustice as well as gender inequality and religious traditions. This social context generated debates about race and birth control among blacks and white policymakers not only when the pill was introduced in 1960, but also at the inception of the birth control movement 30 years earlier and with the approval of long-acting contraceptives 30 years later. Black women's perspective on birth control—recognizing its potential for both liberation and oppression—makes an important contribution toward development of a

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more just vision of reproductive freedom.

The pill gave black women greater control over reproduction than ever before. Why should this seemingly positive development be so controversial? One reason is the role white-dominated birth control programs played in furthering racial injustice. As black Americans agitated for their civil rights, the white backlash included reproductive regulation. The pill was introduced at a time when scientists such as Arthur Jensen and William Shockley were promoting genetic explanations of racial differences in intelligence-test scores. During the 1960s and 1970s, thousands of poor black women were coercively sterilized under federally funded programs. Women were threatened with termination of welfare benefits or denial of medical care if they didn't "consent" to the procedure. Southern blacks claimed that black women were routinely sterilized without their consent and for no valid medical reason—a practice so widespread it was called a "Mississippi appendectomy." Teaching hospitals in the North also performed unnecessary hysterectomies on poor black women as practice for their medical residents. During this period, state legislators considered a rash of punitive sterilization bills aimed at the growing number of blacks receiving public assistance.

It is not surprising, then, that many blacks saw the pill as just another tool in the white man's efforts to curtail the black population. Two studies published in the *American Journal of Public Health* showed a widespread worry among blacks that family planning programs were a potential means of racial genocide, especially if the programs provided sterilization and were run by whites.³

Black concerns about family planning

had arisen decades earlier during Margaret Sanger's crusade for birth control. As Sanger allied herself with the burgeoning eugenics movement, the call for birth control veered away from its radical, feminist origins to include programs to regulate the poor, immigrants and blacks, based on theories of genetic inferiority and social degeneracy. Some blacks of the period, including the nationalist leader Marcus Garvey, opposed birth control as a form of "race suicide." Yet black women in disproportionate numbers enthusiastically used the few birth control clinics that were available to them. The prominent civil rights figure W.E.B. DuBois publicly endorsed birth control as a means of improving black health and denounced the argument that blacks should rely on a high birthrate to fight discrimination. Blacks' advocacy of birth control as a tool for racial betterment sharply differed, however, from the eugenic agenda. White eugenicists promoted birth control as a way of preserving an oppressive social structure; blacks like DuBois promoted birth control as a way of toppling it.

More recently, efforts to encourage poor black women to use long-lasting contraceptives such as hormonal implants and injectables have resurrected the debate about race and birth control. The eugenic overtones of an editorial in *The Philadelphia Inquirer* suggesting the implant as a solution to inner-city poverty set off a firestorm of criticism.⁴ A group of black ministers in Baltimore denounced the introduction of the implant in the city's predominantly black high schools for "push[ing] the issue of social control of an ethnic minority by the majority population whose culture and values may be different."⁵

For nearly a century, black women have

found themselves at the center of controversies about birth control's role in the struggle for racial and sexual equality. They have battled not only men—white and black—who discounted the importance of women's bodily autonomy, but also white women who discounted the significance of racism. The dominant women's movement has focused myopically on abortion rights at the expense of other aspects of reproductive freedom, including the right to bear children, and has misunderstood criticism of coercive birth control policies. Attending to black women's perspective on the pill and other contraceptives can help to transform the movement for reproductive freedom. It can help us understand that there is nothing contradictory about advocating women's freedom to use birth control while opposing abusive birth control practices. Social justice requires both equal access to safe, user-controlled contraceptives and an end to the use of birth control as a means of population control.

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Will the Pill Become Obsolete in This Century?

By John Guillebaud

Forty years after the contraceptive revolution brought about by the pill, there is still a demonstrable unmet need for more effective contraception, part of which will—we hope—be met by better contraceptives. More is required than the usual call for better services and improved sexual health education and counseling to use existing methods better.

For years, the very name "pill" has been synonymous with contraception. This has maintained ignorance of any alternatives beyond condoms and sterilization. How-

ever, the supremacy of the pill is now being challenged. For a start, in a world in which sexually transmitted infections (STIs) are rife, it cannot be relied on for safer sex. In addition, public confidence in oral contraceptives has been shaken by periodic reports that pill use may increase the risk of such serious health problems as breast and cervical cancer and cardiovascular disease.

A good example was the "mother of all UK pill scares" brought about in October 1995 by a letter sent individually to every

doctor by the Committee on the Safety of Medicines (the UK equivalent of the U.S. Food and Drug Administration). This communication was intended to advise physicians of a very small absolute increased risk of venous thromboembolism related to use of pills containing either desogestrel or gestodene (two third-generation progesto-

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gens) instead of levonorgestrel or norethindrone. But the manner of the announcement led the UK media and general public to perceive it as a serious problem affecting all types of oral contraceptives. The major independent provider of legal abortions reported an 11% increase between December 1995 and February 1996, and 61% of the women involved said they had failed to finish their current course of pills.¹

A third problem is one expressed well by the following anecdote:

When he was creating Adam, God informed him that he had two pieces of good news for him and one piece of bad news. He continued, "The first good news is that I am going to create for you an organ called the brain. With this gift of mine, you will be able to think and to learn, and if you use it well you will be a good steward, caring for all the other amazing creatures I have made."

"Thank you very much," said Adam. "What's the other good news?"

"Well," said God, "I have given you another organ: the penis. With it, you will be able to give your wife Eve much pleasure, and receive the same back from her. And with my help, children will be conceived through this organ, so that you will be fruitful and multiply."

"Thank you for that second gift," replied Adam. "But what's the bad news?"

"You will never be able to use both organs at the same time," God said.

This little story encapsulates why the oral contraceptive, well though it has served us, is unlikely to retain its preeminence to the end of this new century. In the anecdote, this disjunction between the brain and genitalia is a feature of the man, Adam—rightly, as it certainly seems to affect men more strongly than women. The vast majority of men in almost every country, from their teenage years on, do have

the information that penis-in-vagina equates to a real risk of conception and, outside of monogamy, of a sexually transmitted infection. But, they too often do not apply that knowledge to their "second organ"—in the proper use of condoms, for example—especially when their "first organ" is under the influence of alcohol or other drugs.

Although the disjunction between knowledge and behavior appears to be most acute for men, it also affects women's use of contraceptives. With the pill, there is at least the advantage that nothing has to be done to prevent pregnancy in the heat of the sexual moment. Yet there are many obstacles to good compliance.² Not only do women have to remember to take a tablet at more or less the same time every day, but in any new relationship those who have stopped using the pill during a period of sexual inactivity must also restart in time.

The observation that so many unintended conceptions occur at the start and finish of relationships implies that many women also fail to meet the challenge to use their brain and their sexual organs at the same time.

A better future model would be a reversible method with a different "default mode" than the pill. That is, instead of requiring repeated decisions to avoid conception, such a method would require only one such decision when the user was sure he or she wanted to remain child-free for a number of years. (In principle, the method could be for use by either sex.) After acting on that decision, individuals would be free of all contraceptive responsibility and nothing else would need to be done until they were good and ready for conception. Until then, the method would have the ideal default state—contraception—unlike the pill, whose default state is conception!

Contraceptive utopia is inhabited by perfect users of perfect methods. The methods are free of side effects, are 100% effective, protect against STIs and are completely user-friendly in the manner just de-

scribed. Implants, IUDs and the new levonorgestrel-releasing intrauterine system for women are current methods that point the way forward. Unlike the pill and the condom, they do have the correct default state; however, none are free of side effects (especially irregular bleeding), nor are they protective against STIs. They are not therefore usually methods of first choice for teenagers.

Thus, we particularly need more methods that are both usable by adolescents and completely forgettable once instituted. Without a crystal ball, it is difficult to predict what these methods will be: Innovative compounds such as antiprogestins and new slow-release technologies will be necessary.³ But they are most likely to be implantables of one kind or another, ideally with instant user-reversibility. Until we develop methods with all the advantages of the pill but without its inappropriate default state and lack of STI protection, it is unlikely to become obsolete. We can only hope that, sometime during this century, all societies will at last have access to and learn to use improved, completely forgettable contraceptive methods perfectly, so making side effects, unplanned pregnancies and STIs dimly remembered problems of the past.

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