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R E P O R T

CONTRACEPTIVE UPDATE

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R E P O R T

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Contents

ARTICLES

4

“THE CONTRACEPTIVE CONUNDRUM”

Andrea Tone, Ph.D.
Author and Professor
School of History, Technology, and Society
Georgia Institute of Technology, Atlanta, GA

9

“POLICIES NEEDED TO INCREASE AWARENESS OF EMERGENCY CONTRACEPTION”

Kirsten Moore, M.P.A., President and CEO
National Reproductive Health Project
Washington, DC
and
Kate Smith, J.D.
SIECUS Public Policy Associate

13

“CONTRACEPTIVES CHOICES: NEW OPTIONS IN THE U.S. MARKET”

Vicki E. Long, M.S.N., C.N.M.
Adjunct Assistant Professor
Uniformed Services University of the Health Sciences
Bethesda, Maryland
Nurse Midwife, Private Practice
Annapolis, MD

19

“STERILIZATION MOST WIDELY USED CONTRACEPTIVE METHOD IN WORLD”

EngenderHealth
New York, NY

22

“SEX IN THE MEDIA: DO CONDOM ADS HAVE A CHANCE?”

24

“PROTECTING AGAINST UNINTENDED PREGNANCY:
AN OVERVIEW OF STANDARD CONTRACEPTIVES”

ALSO IN THIS ISSUE...

FROM THE EDITOR

“Contraceptive Choice: Responsibility of Both Women and Men”
By Mac Edwards 2

FROM THE PRESIDENT

“New Approaches to Contraception Are Needed”
By Tamara Kreinin, M.H.S.A. 3

POLICY UPDATE

“Election 2002: What Does It Mean for Reproductive and Sexual Health”
By William Smith, SIECUS Director of Public Policy 27

CONTRACEPTIVE CHOICE:
RESPONSIBILITY OF BOTH WOMEN AND MEN

Mac Edwards

This is the first issue of the *SIECUS Report* we have published on the subject of contraception since I became editor nearly eight years ago. So it is truly a “Contraceptive Update.”

When I started researching the topic and seeking authors, I had misgivings about putting the *Report* together because I had limited knowledge about contraception.

As I talked to many people in this field, I learned a lot about long-standing contraceptive methods as well as newly available methods.

Just consider—Mirena, the intrauterine system; Ortho Evra, the contraceptive patch; NuvaRing, the contraceptive ring; Implanon, the progesterone implant; Lea’s Shield, the cervical cap; and Essure, the female sterilization device.

MANY MEN UNINFORMED

I realized, however, as I continued to research the topic, that I was not alone. Many men are uninformed about contraception.

Our society tends to view contraception as a woman’s issue. This update, for example, includes articles about contraceptive choices, emergency contraception, and policy issues. For the most part, they focus exclusively on women.

I’m sure this will not surprise anyone. After all, we are talking about preventing pregnancy, and only women can become pregnant.

At the same time, I think we can all agree that it is unfair to put all the burdens and responsibilities for pregnancy prevention on women. Men play an important role in family planning—not just on a personal level but also as policymakers, health care providers, researchers, and product marketers.

It seems important to me that we work to increase the knowledge that men have about contraception as well as their involvement in contraceptive use, decision-making, and communication concerning this issue.

One way to work toward this goal is through the research and development of male methods of contraception. As I worked on this issue, I realized that there has not been a new male method introduced since the condom over a century ago.

GOOD NEWS

We have included information in this *SIECUS Report* about a \$9.5 million grant which the National Institutes of Health

has just awarded to the University of Washington to establish a Male Contraception Research Center that will help expedite development of new contraceptives specifically for men.

Dr. William J. Bremner, who will serve as director of the university’s new Center as well as its principal investigator, says that contraception for men is a neglected area of research.

“A variety of safe and effective contraceptive methods is necessary to respond to the needs of people of different backgrounds and ages, both male and female, throughout the world,” he said.

The establishment of this Center is very good news—and an important “Contraceptive Update.”

A REAL REVOLUTION?

Readers of this *SIECUS Report* will likely notice that two of our featured articles paint different pictures of the field of contraceptive technology.

On the one hand, professor Vicki Long provides us with an overview of new contraceptive options. Long, who is also a nurse practitioner, points out that these methods are now offered alongside a number of long-standing products and that women today have more options than ever before.

On the other hand, professor and writer Andrea Tone questions in our lead article whether we can consider these new options a second contraceptive “revolution.” She terms them “minor improvements” or “new delivery vehicles” and points out that they rely on technology that has been in place since the advent of the pill.

CONCLUSION

Before concluding, I want to urge you to read the policy update in this issue of the *SIECUS Report* on “Election 2002: What Does It Mean for Reproductive and Sexual Health?” by William Smith, *SIECUS* director of public policy.

It provides an excellent overview of the recent federal elections during which the Republican Party gained control of both the U.S. Senate and the U.S. House of Representatives.

All of us need to keep informed about activities in Washington because this turn of events does not bode well for reproductive and sexual health. We will keep you updated in future issues of the *SIECUS Report*.

NEW APPROACHES TO
CONTRACEPTION ARE NEEDED

Tamara Kreinin, M.H.S.A.

This January our country will celebrate the thirtieth anniversary of one of the most talked about legal decisions in our history. *Roe v. Wade*, the landmark case in which the Supreme Court ruled that it was unconstitutional for states to ban abortions, will enter its third decade as legal doctrine. But it will do so on shaky ground.

Although none of us can truly predict the future of abortion rights in our country, it is fair to say that the current Administration and the incoming Republican-controlled Congress are hostile to reproductive rights. They will likely make a number of attempts to limit access to abortion and cut funding for family planning services, both at home and abroad. Over the next two years, they will also have the opportunity to affect judicial rulings through nominations of federal judges and, perhaps, one or more Supreme Court justices.

The subject of abortion receives a lot of attention in politics and the media, and the fate of *Roe v. Wade* has been hotly debated, perhaps from the moment the decision was handed down. However, those of us working for reproductive and sexual rights know that true choice is not just about keeping the constitutionally protected status of abortion. True reproductive choice is only possible when all people have the skills, knowledge, and access to health care they need to carefully plan their families.

Access to family planning has come a long way since 1873 when the Comstock Act classified all contraception as obscene. This issue of the *SIECUS Report* makes it clear, however, that we still have a long way to go.

AVAILABILITY OF METHODS

I was taken aback, yet again, by the fact that sterilization remains the number one method of contraception and the first modern method of contraception that many women, particularly in developing countries, have ever used. While sterilization remains an important option—it is highly effective and economically viable—it is a permanent decision. This means it is only appropriate for those individuals or couples who want to put an end to their reproductive years. It does not, however, help those who want to time the birth of their children or even those who simply want to keep their options open.

The popularity of sterility seems to speak to the lack

of other inexpensive and effective contraceptive options for women. Little progress has been made in this area. It is clear that neither the pharmaceutical companies nor the government view research and development as a priority.

CONTRACEPTIVE ACCESS

For many women, contraception is hard to obtain. Many prescription plans in this country classify contraceptives as nonessential. This means that many women must pay full price for birth control pills, diaphragms, or the new patch. Ironically, but not surprising, Viagra is covered.

This problem of access speaks only to those Americans who are lucky enough to have health insurance. The uninsured or the underinsured have an even harder time obtaining these contraceptive methods, all of which require a visit to a health care provider.

Accessibility is likely to become worse in today's political climate, where cuts to family planning budgets loom. Moreover, adolescent women will likely face an even harder time obtaining contraceptives in the coming years, as laws requiring parental consent are likely to become more prevalent.

EDUCATION ON BIRTH CONTROL

Adolescents are faced with an even bigger obstacle to contraception—lack of knowledge. Teen pregnancy rates in the United States are among the highest in the industrialized world. Yet we continue to balk at giving our teenagers the information they need.

Instead, the federal government is spending millions of dollars to ensure that abstinence is the only method of birth control about which teens are aware. And while abstinence can be an effective method of preventing pregnancy, it, too, can fail—especially if young people don't have the critical thinking and negotiation skills to remain abstinent.

CONCLUSION

The ability to carefully plan when to have children is a basic right of individuals of all ages. It is time that we call on pharmaceutical companies to bring new products to the market, on the federal government ensure access to contraception regardless of income, and on all adults to help young people obtain the information and education they need.

THE CONTRACEPTIVE CONUNDRUM

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At the dawn of a new millennium, we are faced with a contraceptive conundrum of far-reaching import. On the one hand, the United States has one of the highest unwanted-pregnancy rates in the Western world. More than half of the 6.3 million pregnancies in the United States each year are unplanned or unwanted. On the other hand, recent developments have yielded a dizzying array of new, effective female technologies.

How do we explain the disjunction between the availability of a cornucopia of effective technologies and patterns of everyday use?

One answer is that Americans want more and better options. Although there is no such thing as a perfect contraceptive, we yearn for methods that have fewer side effects and aesthetic drawbacks. Americans desire contraceptives that will do more than prevent pregnancy—like protect us from sexually transmitted diseases (STDs), clear up acne, and prevent cancer. We are discontented with methods that fall short of our high—some would say unrealistically high—expectations.

THE SITUATION

A *Seinfeld* episode aired shortly after the V.L.I. Corporation of California announced that it would stop manufacturing the Today Sponge.

In the episode, Elaine bought as many boxes of the disposable sponge as she could find, depleting her precious reserve only when she met a man she deemed “sponge worthy.”

The episode resonated with loyal users and woman’s rights activists distressed by the sudden withdrawal of one of the few new contraceptives since plastic IUDs and the pill.

The sponge was approved by the U.S. Food and Drug Administration (FDA) in 1983, and its disappearance in 1995 had nothing to do with the device’s safety or reliability. Rather, the manufacturer decided not to upgrade its factory’s air and water supply, which the FDA had cited as substandard.

That left women with one nonprescription female method, the Reality condom.¹ Available in the United States since 1993, Reality has had its own share of problems.

Described by its manufacturer, a small Chicago firm, as a “soft, loose-fitting plastic pouch that lines the vagina,” it is more popular in overseas markets, especially in Africa, than in the United States.

Despite its obvious benefits to women—Reality is

female-controlled and can protect women from STDs such as AIDS—it is “not popular,” one Planned Parenthood spokeswoman recently admitted. It is big and bulky, and it makes some women squeamish. Some women have reported that it squeaks during intercourse.

Female condoms are expensive, too. Through the assistance of the United Nations Joint Program on AIDS (UNAIDS), women in Zimbabwe, South Africa, and Zambia can get them free or at cost. In the United States, the one-use female condoms cost about three dollars each.²

CONTRACEPTIVE REVOLUTION?

A 1985 poll found that 60 percent of American women were dissatisfied with contraceptive options.³ Since then, many new methods have been marketed. But it is unclear to what extent most of these devices represent a decisive break from previous technologies.

In what the media has hailed as the “second” contraceptive revolution, the FDA has approved six new birth control products in the last two years: Mirena, a hormone-releasing IUD, Lunelle, a monthly hormone shot, Nuva Ring, a hormonal vaginal ring, Ortho Evra, a hormone patch, Lea’s Shield, a cervical cap, and most recently, Essure, a mechanical device that sterilizes women by creating scar tissue in their Fallopian tubes.⁴

On the one hand, the opportunity to wear a patch instead of swallowing a daily pill is a significant improvement for some women. On the other hand, a majority of new methods rely on hormones to prevent pregnancy—technology that has been in place since the advent of the pill. The repackaging of old contraceptive science has prompted some critics to question the reality of this second contraceptive revolution, and to encourage pharmaceutical companies to develop more non-hormonal options.

As Carl Djerassi, who first synthesized a steroid oral contraceptive, recently told me:

The relevant dictionary definition of ‘revolutionary’ is ‘constituting or bringing about a major or fundamental change.’ The recently introduced modifications in delivering the steroid ingredients in the pill—for instance through a vaginal rings or patches—or introducing another monthly injec-

tion or a medicated IUD all represent developments that are years, if not decades, old. Calling these minor modifications “revolutionary” is an irrational and self-promotional claim. This does not mean that minor improvements or new delivery vehicles for old ingredients are not useful, but “revolutionary” they are not.⁵

In addition, two products, Norplant and Lunelle, have recently been recalled, raising concerns that new options do not necessarily mean better ones. Significantly, no new male methods have been marketed.

One wonders what George Bernard Shaw, who considered the rubber condom the greatest invention of the nineteenth century, would say of the state of contraceptive technology now.

LITIGATION SLOWS PRODUCT RESEARCH

In the early 1980s, a government report predicted that there would be 20 new contraceptives available by the year 2000.⁶ Despite important product breakthroughs, we have fallen short of that goal.

It is ironic in a post-Roe v. Wade world that the most frequently used contraceptive in the country—by a wide margin—is irreversible female sterilization. FDA approval of Essure, which can be inserted without the expense or risk of general anesthesia, is likely to increase the popularity of tubal ligation. In a very real sense, Americans are still waiting for the heralded “second contraceptive revolution” to arrive.

One problem is that the pace of contraceptive research slowed in the late 1970s and early 1980s. The biggest deterrent to new product development was the increased cost of liability insurance.

Litigation was the only recourse for women injured by the Dalkon Shield. But women’s legal successes caused insurance premiums to skyrocket. Contraceptive research in the United States ground almost to a halt as the nation’s leading pharmaceutical firms swapped birth control initiatives for less risky ventures.

Promising projects were tabled or scrapped. Leading scientists left the field. The number of American companies active in contraceptive research fell from a dozen in the early 1970s to two in the late 1990s.⁷

The cost of product liability insurance affected various contraceptives differently. Some methods, such as the pill, enjoyed a wide enough profit margin to be self-insured.

Manufacturers of oral contraceptives spent only a few cents to manufacture a month’s supply of oral contraceptives in the 1980s but charged several dollars. Because the pill requires repeat purchases, pharmaceutical companies can set aside some of their profits to cover the cost of potential

lawsuits. The same cannot be said for long-acting methods such as the IUD that necessitate only a one-time purchase.⁸ In the late 1980s, more research money was being spent on modifications of existing steroidal contraceptives than on new methods that might cost less to consumers.⁹ Contraceptive choices in the year 2003 reflect this decades-old orientation.

SMALL BUSINESSES NOT INVOLVED

And, of course, the staggering cost of product research and development and the risk of lawsuits effectively preclude the possibility of an entrepreneurial renaissance—a contraceptive research program powered by small business people.

Government grants to academic centers and the work of nonprofit groups like the Population Council can go only so far to fill the product development void.

Government funding tends to be short-term. New medical technologies are rarely developed in a few years, and contraceptives are no exception. In addition, funding for contraceptive research is highly politicized and inherently unstable.

The strength of the pro-life movement, for instance, has stymied government-backed research on methods that work after fertilization has occurred. The Agency for International Development (AID) is barred by law and the National Institutes of Health (NIH) by policy from funding research into any method that interrupts pregnancy.¹⁰

Nonprofit organizations such as the Population Council have stayed active in the field of contraceptive research, but like universities and development agencies, they have been hit hard by the liability issue. Without profits with which they can compensate potential injured users, they must rely on private-sector partners to bring products to market.

The Population Council developed Norplant, but it needed a pharmaceutical firm to handle distribution and marketing. It found one in Wyeth-Ayerst Laboratories, a division of the American Home Products Corporation and one of the few pharmaceutical firms actively engaged in contraceptive research in the late 1980s.

The company marketed the subcutaneous implant in 1990. But when silicone-gel breast implants began to be taken off the market in 1992, Norplant fell under suspicion because its rods were made of silicone (although not silicone gel). Insertions of Norplant fell from 800 a day in 1990 to fewer than 60 in 1995.

In addition, women scarred by the insertion and especially the removal of Norplant filed tens of thousands of lawsuits against Wyeth.¹¹

As has been the case throughout American history, medical education lagged behind technological development, and inadequate physician training was one reason for the problem. But another reason for the problem was that

women's health groups had lobbied manufacturers not to develop biodegradable implants. They feared that capsules that dissolved would rob women of the option of having Norplant removed before the drug's five-year term was up.¹²

In 2000, after receiving reports that the implants were releasing lower-than-expected amounts of the hormone levonorgestrel, the company urged Norplant users to adopt a second method of birth control as a back-up. Although subsequent studies found the implants more than 99 percent effective, Wyeth called it quits. In July of 2002, the company announced that it was permanently withdrawing Norplant from the U.S. market. Having already settled more than 30,000 of the over 50,000 lawsuits filed against it, Wyeth also agreed to pay for Norplant's removal until December 31, 2002.¹³

QUESTION OF ACCEPTABLE RISK

Manufacturers called the mass filing of product liability lawsuits against Wyeth the "Norplant syndrome." Women's health groups called it justice. Separating these opposing views is a question that remains unresolved: What defines the threshold between acceptable risk and product liability? In 1970, Carl Djerassi astutely predicted that unless consumer attitudes changed, lawsuits would thwart reproductive research. Women expect too much, he complained. If they want more and better contraceptives, they must be content with a higher degree of medical risk.

"The consumer...suffers from the delusion that drug safety and drug efficacy are all-or-none propositions," he argued. "The fact that people experience side effects from 'safe' drugs should be no more surprising than the fact that occasionally some people die when 'safe' airplanes crash."¹⁴

Many scientists, doctors, and family planning advocates agree. In 1996, the Committee of the Institute of Medicine, a branch of the National Academy of Sciences, renewed its 1990 recommendation that Congress enact tort reform to shield manufacturers of contraceptives from costly product liability lawsuits.

Women's groups vigorously object to this proposal. The right to sue and collect damages is the only recourse available to consumers who have been injured or hurt, and it must be preserved, they say. The fear of lawsuits might limit women's birth control options, but is also keeps them safe. The history of contraceptives tells a story of technological triumph, but also of too much grief.¹⁵

QUESTION OF USE

But if product development troubles and a corresponding dissatisfaction with existing methods explain some of the contraceptive conundrum, they do not explain it all.

The technologies available in the United States also exist in countries that have much lower rates of unintended pregnancy. In fact, pregnancy rates among women under

age 20 are higher in the United States than in any other developed country except Hungary.

This is not because young adults in the United States have more intercourse than they do elsewhere. In Sweden, for instance, intercourse among young adults is more prevalent, yet rates of pregnancy, birth, and abortion are significantly lower. The reason is simple. Young adults in Sweden use contraceptives more frequently than their American counterparts.¹⁶

It is not the availability of technology that determines patterns of contraceptive use but the specific contexts in which women and men encounter it. In Sweden, contraceptive supplies and services are available at cost and sexuality education, including contraceptive instruction, is compulsory.

In the United States, more than 70 years after the military quietly acknowledged that asking young male recruits "to just say no" does little except increase the incidence of sexually transmitted diseases, we still cling to the belief that abstinence is an effective medical and social policy.

Birth control education in U.S. public schools is minimal, the distribution of free contraceptives unheard of. Many politicians expressed moral outrage when the former U.S. Surgeon General Jocelyn Elders, emphasizing the importance of adolescent pregnancy prevention, declared she would happily coronate herself the "condom queen" and "wear a crown on my head with a condom on it" if only she could "get every young person in the United States who is engaging in sex to use a condom."¹⁷

QUESTION OF AFFORDABILITY

At the same time, politicians opposed to the diffusion of contraceptive programs profess great shock when teenage girls become "welfare moms." Of course, few women yearn for the indignities that are part and parcel of accepting welfare payments, just as no woman is born *wanting* to have an abortion. If we want to reduce the frequency of these events, we must multiply our efforts to make contraceptives available to all.

Empowering women and men to exercise freedom of contraceptive choice is not the same as choosing methods for them. The history of contraceptives is replete with examples of birth control coercion, perpetuated in the name of the public good and usually carried out at the expense of poor women and women of color.

Since the 1970s, when the worst sterilization abuses were checked by new, rigid federal guidelines, other concerns have surfaced. Health care activists, feminists, and minority rights advocates have warned about the abuse of Norplant and Depo-Provera, contraceptives that, though reversible, are still long-term.

One legislator in Kansas proposed that welfare mothers be offered a lump cash payment for using Norplant—a suggestion that would pressure financially vulnerable women to

undergo a surgical procedure to save taxpayers money. It may not be eugenics, but it is certainly not freedom of choice.¹⁸

In this country, when it comes to contraceptives, availability means affordability. It is not enough to promote sexuality education. We must make sure that contraceptive technologies are available to women and men regardless of their financial situation.

QUESTION OF HEALTH COVERAGE

I recently interviewed Lorraine, mother of three, one of the millions of working Americans caught in the health care crisis. She works full-time in the service industry. Her employer offers her no health care; he himself is a struggling small business man.

For years, Lorraine made too much money to qualify for Medicaid but not enough to afford over-the-counter contraceptives—never mind a visit to the doctor. She has had four abortions. One was caused by the ingestion of the abortifacient pennyroyal, which grows wild in the area where she lives. It almost killed her. Recently her circumstances changed. She applied for Medicaid and had her “tubes tied.”¹⁹

Lorraine’s lot improved significantly once she got health care, but even Americans with health insurance often discover that coverage for contraceptives is limited.

HMOs and traditional fee-for-service plans generally cover prescription drugs. But a 1998 study by the Women’s Research and Education Institute in Washington found that two-thirds of the nation’s largest group health plans exclude reversible contraceptives, classifying them as an unnecessary drug.

This exclusion forces women to pay, on average, 68 percent more on out-of-pocket prescription expenses than men. And it encourages women who cannot afford to dole out hundreds of dollars for the pill to undergo sterilizations, which more insurance plans cover.

With access to reversible methods tied to income, it is not surprising that sterilizations are more popular among low-income women, especially Hispanics and blacks, than they are among affluent women and non-Hispanic whites.

When HMOs do cover reversible contraceptives such as the pill, they usually cover only part of the cost, and then typically only the few brands included in the HMO’s formulary.

Should a woman need a differently formulated pill, for instance, she often must shoulder the full expense of her prescription. “We allow our insurance companies to be biased against women,” noted Dr. Mitchell Creinin, the director of family planning at the University of Pittsburgh. “If men were the ones who got pregnant, you know it would be different.”²⁰

Nothing illustrates the veracity of Creinin’s claim more than the willingness of insurance companies to cover the expensive anti-impotence drug Viagra (which currently

costs about 10 dollars *per pill*) but not reversible contraceptives such as the pill.

Apparently, enabling a man to achieve orgasm rates higher on our list of priorities than protecting a woman from the long-term consequences of his short-term delight.

OVER-THE-COUNTER MAY BE THE ANSWER

In the absence of universal health care or prescription drug coverage, one way out of the contraceptive conundrum may be the development of more affordable over-the-counter methods, which would increase men’s and women’s options without tethering contraceptive use to the medical marketplace from which millions are excluded.

In the 1920s, Margaret Sanger demonized the over-the-counter birth control trade, believing that the surest way of making contraceptives respectable was to place control of their distribution in doctors’ hands.

Today, to meet the needs of women and men who lack sufficient resources, we must supplement reliable medical methods with inexpensive over-the-counter options. Imagine a world with not just cheap contraceptives on every street corner, but with cheap contraceptives that work on every street corner, finally freed from the risk of injury and the stigma of illegitimacy that, even today, thwart the best efforts of many Americans to take charge of their procreative destinies and their lives.

Andrea Tone adapted and expanded upon the epilogue of her new book Devices and Desires: A History of Contraceptives in America expressly for SIECUS Report readers. The epilogue was adapted with permission from the publishers Hill and Wang, a division of Farrar, Straus and Giroux LLC. Her book, which was published last summer, is available in bookstores nationwide.

—Editor

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NEW \$9.5 MILLION NIH GRANT TO SUPPORT MALE CONTRACEPTION RESEARCH CENTER

The National Institutes of Health (NIH) has awarded a five-year, \$9.5 million grant to the University of Washington to establish a new interdisciplinary Male Contraception Research Center.

Dr. William J. Bremner, who is chair of the University's Department of Medicine, will serve as director of the new center and as a principal investigator.

"Contraception for men has been a neglected area of research," Bremner said, "and there has been no new reversible-mode contraceptive since the invention of the condom hundreds of years ago. To prevent unwanted pregnancies and the resultant health risks and social consequences of abortion and unwanted children, new easily usable contraceptive techniques must be made available.

"Nearly one-third of contraception in the United States is now accomplished by male techniques (15 percent by vasectomy and 15 percent by condoms), demonstrating that men are willing to use contraceptives. We wish to provide new hormonal methods that are fully effective and may have additional health

benefits—for example, in preventing prostate disease," he added.

The new center will be part of the Cooperative Contraceptive Research Centers Program, funded by the Contraception and Reproductive Health Branch of the National Institute of Child Health and Human Development and will be designed to expedite development of new approaches to regulating fertility.

The program supports a wide range of interactive research projects, with the ultimate goal of developing knowledge that may lead to clinically useful products. Two other centers in the program are located at the University of California at Davis and the Population Council of Rockefeller University in New York. There are also affiliated projects at the University of Virginia in Charlottesville, VA, and the Jackson Laboratories in Bar Harbor, ME.

"A variety of safe and effective contraceptive methods is necessary to respond to the needs of people of different backgrounds and ages, both male and female, throughout the world," Bremner said.

POLICIES NEEDED TO INCREASE AWARENESS OF EMERGENCY CONTRACEPTION

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In September 1998, the Food and Drug Administration (FDA) approved for the first time a dedicated emergency contraception (EC) drug product for use by women to prevent pregnancy if taken within 72 hours of unprotected intercourse.¹

Despite experts' predictions that wide scale use of EC could dramatically lower the unintended pregnancy and abortion rate, knowledge of its availability and use has proved disappointingly low within the United States.

While both the U.S. House of Representatives and the U.S. Senate have introduced legislation relating to its accessibility and use, they have taken virtually no action. This is not true across the country. State legislatures have succeeded in introducing and passing laws that would make EC more accessible, thus increasing use and decreasing unintended pregnancies.

WHAT IS EC?

EC is a high dose of birth control pills that can reduce a woman's chance of becoming pregnant by 75 to 89 percent if taken within 72 hours of unprotected intercourse. It does not protect against sexually transmitted diseases (STDs), including HIV.

EC is not, as often believed, the "abortion pill" (or mifepristone, also known as RU-486). While mifepristone induces expulsion of an already-implanted egg, EC inhibits ovulation, fertilization, or implantation. EC cannot cause abortion. If an egg is already implanted in a woman's uterus, EC will not terminate the pregnancy, nor will it cause any harm to the developing fetus.

In fact, EC is so safe that a growing number of major medical and public health organizations have publicly supported efforts to make EC available over-the-counter, including the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American Public Health Association.

EC meets the FDA's criteria for over-the-counter status: it is safe, effective, and easy to use; it does not have serious or harmful side effects; it is not dangerous for individuals with particular medical conditions; and women can self-diagnose their need for it.

KNOWLEDGE/USE

A July 2002 survey indicates that more than 60 percent of American voters do not know what EC is.² It is also estimated that only two percent of American women have ever used EC.³ This significant lack of knowledge and use is attributed to a dearth of awareness about the product, a lack of access to it, and misconceptions about what it is and how it works.

Any policy efforts to increase knowledge and use of EC must tackle the significant barriers that women face. Consider the following:

- Only 20 percent of obstetricians and gynecologists routinely talk about EC with their patients⁴
- Almost half of university-based health clinics in the United States do not offer EC⁵
- Finding a pharmacy that stocks EC is a challenge, as evidenced by the fact that nearly half of the pharmacies in New York City carry neither Preven nor Plan B, the two EC products approved by the FDA⁶
- Surveys in six states demonstrate that fewer than 40 percent of hospitals provide EC to rape victims⁷
- A recent survey of Catholic hospitals in California found that 70 percent do not provide EC to rape victims⁸

It is estimated that EC has the potential to reduce unintended pregnancies and abortions by 50 percent. Proponents must work to implement policies that will help eliminate barriers.⁹ In other words, they must work to put policies in place that educate the public and make EC easily available.

POSITIVE STATE EFFORTS

During the past 12 months, 22 bills were introduced in 14 states that would increase access to and availability of EC.¹⁰ Seven resolutions promoting access to EC were also introduced in three states.¹¹ These bills focus on public education and awareness, pharmacists' ability to dispense EC without a prescription, over-the-counter (OTC) status for EC, and the immediate availability of EC for victims of sexual assault.

State laws in Alaska, California, and Washington currently allow pharmacists to dispense EC without a doctor's prescription. Legislation was also introduced in 2002 in

three states—Hawaii, New York, and Virginia—that would allow physicians or nurse practitioners to delegate their authority to prescribe certain medications to pharmacists through “collaborative agreements.”

New Mexico pharmacists will also soon be able to dispense EC by authority granted to them by the state’s Board of Pharmacy. The New Mexico Board of Pharmacy has issued a “written protocol” which allows pharmacists who have completed a training course to dispense EC. The New Mexico Medical Board must adopt the resolution before it can go into effect.

Given that women should take EC within 72 hours of unprotected sexual intercourse—and it is more effective the sooner it is taken—these agreements help alleviate problems women often face in finding a doctor on short notice or over a weekend.

EC also holds tremendous promise for victims of sexual assault. California, Illinois, and Washington have enacted laws requiring hospitals to provide EC to such victims. Eight states—Arizona, California, Delaware, Florida, Hawaii, New Jersey, Washington, and Wisconsin—introduced legislation in 2002 that would require hospitals to provide EC to rape victims upon request or refer them to a facility that would provide it.

Weaker bills in Maryland and South Dakota would require hospitals to provide information about EC but would not require them to dispense it or make referrals to a facility that would.

NEGATIVE STATE EFFORTS

Even though “collaborative agreements” and New Mexico’s “written protocol” policies have improved EC accessibility, state refusal clauses still have the potential to significantly harm the effectiveness of any pro-active measures.

Twelve states currently have refusal clauses allowing health care professionals and/or facilities to refuse to provide contraception-related services.¹² Some states have tried introducing laws that would give pharmacists the right to refuse to provide EC, among other drugs.

There have also been attempts by some states to pass contraceptive coverage laws with refusal clauses. This means that employers and insurers could refuse to cover EC and other reproductive health drugs. While these tactics have proved largely unsuccessful, EC opponents will likely continue to attempt to expand such clauses.

FEDERAL EFFORTS

Although not as successful as state efforts, the U.S. Congress has introduced several bills that would increase education about EC as well as availability of EC to victims of sexual assault. No hearings were held on these bills during the 107th Congress, so legislators will have to re-introduce them when the 108th Congress convenes in January 2003.

The Emergency Contraception Education Act (S. 1990 and H.R. 3887) would educate the public about EC by directing the U.S. Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) to develop and distribute information about EC to both the public and health care providers.

The information would include a description and explanation of EC as well as recommendations for its use. At the end of the 107th Congress, the Senate bill had nine cosponsors and the House bill had 90 cosponsors.

The Compassionate Care for Female Sexual Assault Survivors Act (H.R. 4113) would require all federally-funded hospitals to offer EC to sexual assault victims. At the end of the 107th Congress, this bill had 65 cosponsors.

U.S. Rep. Melissa Hart (R-PA), an outspoken opponent of EC, also introduced an EC bill in this session of Congress. The Schoolchildren’s Health Protection Act (H.R. 3805) would deny federal education funding to any elementary or secondary school that provided access to EC.

This bill would impose a disproportionate penalty on those districts where local decision-makers have opted to improve access to EC. Rep. Hart attempted to include this provision in the Labor, Health and Human Services appropriations bill last year but was forced to withdraw it.

She will likely revive her efforts during the appropriations process in the next Congress.

CALL FOR SUBMISSIONS

The *SIECUS Report* welcomes articles, reviews, or critical analyses from interested individuals. Upcoming issues of the *SIECUS Report* will have the following themes:

Young People Talk about Sex

April/May 2003 issue

Deadline for article submission:

February 14, 2003

The Debate about Sexual Addiction and Compulsion

June/July 2003 issue

Deadline for article submission:

April 18, 2003

Monitoring Sexuality Education in the United States/ Tenth Anniversary

August/September 2003 issue

Deadline for article submission:

June 1, 2003

PUBLIC SUPPORT FOR EC

While policymakers continue to treat EC as a controversial issue, the public soundly supports it.

A recent poll found that once voters are informed about EC, almost three in four (72 percent) favor legislation aimed at expanding public health information about it.¹³

In addition, more than three in four voters (77 percent) support teens having access to information about EC, demonstrating the public's recognition that it has potential as a logical and safe way to prevent pregnancy and as a better option for young women than abortion.¹⁴

Support for EC crosses partisan lines. Eighty-one percent of Democrats, 76 percent of Independents, and 60 percent of Republicans favor legislation that would expand public health information about EC and its availability.¹⁵ Even among voters opposed to abortion, 45 percent support this type of EC legislation.¹⁶

Voters also overwhelmingly support legislation that would require hospitals to inform victims of sexual assault about the availability of EC.¹⁷ In addition, more than three in four Catholic voters support such legislation.¹⁸

CONCLUSION

While progress has certainly been made since the FDA's approval of the first EC drug in 1998, the drug's full promise is still far from recognized.

The fact that much of the public and many policymakers still erroneously associate EC with mifepristone demonstrates that public education is still needed. This is an issue on which abortion opponents and pro-choice advocates should be able to find common ground.

EC is a way to prevent unintended pregnancies and, therefore, abortions. In addition, parents see EC as part of a package of prevention. When coupled with comprehensive sexuality education and an emphasis on abstinence, EC offers young people the information and tools they need to make healthy decisions about sex and pregnancy.

Given the political climate in Washington, DC, it is unlikely that federal EC legislation will succeed in the upcoming Congress. For the immediate future, state legislatures will likely serve as the primary venue to help increase knowledge, use, and availability of this contraceptive option.

For more information about EC and how to find a health care provider, visit www.backupyourbirthcontrol.org or call 1 (888) NOT-2-LATE.

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EMERGENCY CONTRACEPTION BILLS IN 2001 – 2002

| | PERMIT PHARMACISTS TO DISPENSE EC | | REQUIRE ACCESS TO EC FOR SEXUAL ASSAULT | | EDUCATE PUBLIC ABOUT EC | |
|-----------------------|--|--|--|---------------------------------------|----------------------------------|-------------------------|
| | <i>Bill Number</i> | <i>Any Action Taken</i> | <i>Bill Number</i> | <i>Any Action Taken</i> | <i>Bill Number</i> | <i>Any Action Taken</i> |
| AZ | | | SB 1334 | | | |
| CA | SB 1169 (2001) | Enacted | AB 1860 | Enacted | | |
| DE | | | HB 564 | | | |
| FL | | | SB 2-E ¹ SB 2246 HB 125 | | | |
| HI | HB 2124 HB 2806 SR 35 SCR 73 HR 137 HCR 194 | Passed House Adopted by House Passed House | HB 1802 SB 727 (2001) HB 46 (2001) | Passed House | | |
| IL | | | SB 114 (2001) HB 430 (2001) | Enacted ² Passed House | | |
| KS | | | HB 2311 (2001) | | | |
| MD | | | HB 930 ³ | | | |
| MI | | | | | HB 6235 | |
| MN⁴ | SF 1775 (2001) HF 2068 (2001) | | SF 1461 HF 1860 (2001) | | | |
| MO | | | | | HCR 35 | |
| NH | HB 1276 (2001) | Failed to Pass House | | | | |
| NJ | | | SB 956 AB 297 | | | |
| NY⁵ | SB 6323 AB 9653 | | SB 1743 (2001) SB 2347 (2001) AB 2214 (2001) | Passed Assembly | SB 4884 (2001) AB 3577 (2001) | |
| SD | | | HB 1157 ⁶ | | | |
| VA | SB 623 HB 1263 | Passed Senate | | | | |
| WA | | | SB 6537 HB 2690 | Enacted | | |
| WI | | | SB 391 AB 724 | Passed Senate Failed to Pass House | | |
| Federal | | | HR 4113 | | HR 3887 S 1990 | |

Source for state legislative data: NARAL's State-by-State Guide to Legislative Bills. Available on-line at: <http://mail.naral.org/longdoc.nsf?OpenDatabase>

1. Florida's bill would have appropriated funds and given priority in payment to health facilities that inform victims of rape about EC and provide access to EC for victims of rape.
2. Illinois' law requires only that hospitals inform victims of rape about EC. Hospitals are not required to provide EC.
3. The Maryland bill requires information only (no access to EC is mandated by the bill).
4. In 2002, Minnesota introduced two resolutions, SF 3447 and HF 3704, urging the FDA to make EC available over the counter. Both of the resolutions died without action.
5. In 2002, the New York City Council also introduced three resolutions. These resolutions would: (1) require pharmacies to post a notice if they do not dispense EC (INT 278); (2) require the City to provide funding only to hospitals that inform rape victims about the availability of EC (INT 281); and (3) require the Department of Health to make EC available at health facilities (INT 285). All resolutions are in committee.
6. The South Dakota bill requires information only (no access to EC is mandated by the bill).

CONTRACEPTIVE CHOICES: NEW OPTIONS IN THE U.S. MARKET

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Choice in contraceptive options was a static issue in the United States until recently.

It appeared that options were shrinking when Norplant was taken off the market last summer due to perceived negative side effects and when there was a delay in the arrival of the long-anticipated levonorgestrel-containing intrauterine system. Yet new methods are now here, offering greater variety among the old standards. At the same time, efficacy questions about tried and true methods have surfaced.¹

This article will provide an overview of new methods currently available in the United States, focusing on the efficacy and safety of each choice. It will also highlight standard methods that have gained popularity, explore new problems with standard methods, and discuss other new products on the horizon.

TWO QUESTIONS

Before reviewing contraceptive methods, I feel it is important for readers to think of them in terms of two basic questions: “How well do they work?” and “Are they safe?” Although these are simple questions, the answers are far from easy.

Concerning how well contraceptives work, those who counsel individuals on their choice need to understand the concepts of *perfect* versus *typical* use.²

Perfect and *typical* use rates are used to help individuals make realistic personal decisions about the success of a contraceptive choice. For example, women who recognize they are not good at taking a pill on a daily basis would need to consider *typical* rather than *perfect* use statistics to determine if they could expect combined oral contraceptive pills to work for them.

Specifically:

Perfect use implies that an individual uses a contraceptive method “consistently according to a specified set of rules”³

Typical use reflects on “how effective methods are for the average person who does not always use methods correctly or consistently”⁴

The challenge is not to mix *perfect* use rates for one method with *typical* use rates for another.

Safety is also a complicated issue. Those who counsel individuals need to understand that some methods are risky for certain individuals and not for others. For example, women who smoke are at increased risk for cardiovascular disease when they use combined oral contraceptives.

NEW METHODS

The new contraceptive methods currently available in the U.S. market primarily involve hormones. They include Mirena, the progestin-releasing intrauterine system; Ortho Evera, the contraceptive patch; and NuvaRing, the contraceptive ring.

There are also a host of generic oral contraceptives currently available that are confusing clinicians and patients alike. (See box 2.) Many times clinicians may order a brand name with which a woman is familiar only to have the pharmacist substitute an appropriate generic brand from the woman’s health insurance plan. The brand names, packaging, and pill colors often confuse users.

Mirena. This progestin-releasing intrauterine system (also known as LNG 20-IUD) releases 20 micrograms of levonorgestrel daily into the uterus.⁵ It emits progestin that thickens the cervical mucus, making it impenetrable to sperm. It is reversible but is intended to last for five years.

The consistent release of progestin mitigates some complaints of heavy bleeding and painful periods common with non-hormonal IUDs. It is therefore recommended for perimenopausal women with complaints of heavy bleeding.⁶ It is also ideal for many women not at risk for STDs.

In terms of safety, it reduces ectopic pregnancy risk, decreases menstrual bleeding by 70 percent (after initial irregular bleeding), and has a high continuation rate. It may also decrease the risk of Pelvic Inflammatory Disease (PID).⁷

Its availability is an issue for some clients. This is, however, improving. In terms of *perfect use*, it is 99.9 percent effective in preventing pregnancy. In terms of *typical use*, it is 99.9 percent effective.*

Ortho Evera. This is a 4.5 centimeter square patch, very

thin and pliable, that delivers a consistent dose of estrogen and progesterone components over a weekly period. Two days are needed for a woman to achieve a therapeutic level of the patch's components.

The patch is designed for women to wear on the torso (excluding the breasts), to change weekly for three weeks, and to leave off for a week so menses occurs.⁸ It works like combined oral contraceptives by inhibiting ovulation. It may also alter cervical mucous, thus slowing motility in the upper reproductive tract and causing the development of a less than satisfactory endometrium.⁹

As with "the pill," the method is not without risk even though it is extremely safe for most women. Its greatest risks center on cardiovascular complications. Women who smoke are at increased risk just as they are when they use combined oral contraceptives.

The patch was extensively studied in various situations to test adherence. Sensitivity to the adhesive is a possibility. Efficiency, safety, and mechanisms of action are similar to combined oral contraceptives. It is sometimes slightly less effective in women who weigh over 198 pounds. Breast tenderness is an initial complaint, but this wanes over time.

The manufacturer has developed written materials to familiarize new users and to guide them through possible pitfalls. Extra patches are available in the unlikely case one should come off. There is also a rebate program available to women who have to return to the pharmacy for additional patches when one falls off.¹⁰

A benefit of this trans-dermal method of contraception is the constant, steady delivery of hormones over time. Consider that every time a contraceptive pill is ingested the levels rise and fall with the metabolic process. The patch

may take two days to reach an effective level, but it maintains that level for nine days. Changing the patch weekly provides a consistent level throughout use. This, coupled with the ease of compliance, makes it highly desirable for women who are not good at taking pills.

Just introduced in March, the patch is already the second most popular form of non-oral birth control in prescriptions and sales according to figures from IMS Health.¹¹

In terms of perfect use, it is 99.7 percent effective in preventing pregnancy. In terms of typical use, it is 92 percent effective.*

NuvaRing. This contraceptive ring, which was introduced in June, is another innovative device providing a steady delivery of hormones over time. It contains familiar estrogen and progesterone components contained in a two-inch round, one-eighth-inch thick ring.

The ring is designed for women to wear intra-vaginally for three weeks, after which they should discard it and replace it with another a week later. It is not recommended that woman remove it during intercourse. It can however be removed if replaced within three hours.

Efficacy is not affected if the ring is out of the vagina for less than three hours. Users may notice an initial increase in vaginal discharge, but this improves over a few cycles. Efficacy, safety, contraindications, and mechanism of action are all similar to combined oral contraceptives and the contraceptive patch. The same precautions also apply.¹⁴ It should find acceptance with individuals interested in ease of compliance.

The NuvaRing is accompanied by a support system for new users, including an hourglass timing device to warn clients when it is time to remove the old ring and insert a new one.

CONTRACEPTIVE RESOURCES

These are some publications which readers will find informative about contraception:

CONTRACEPTIVE TECHNOLOGY, EIGHTEENTH REVISED EDITION

This new edition of "The Bible of Contraception," published by Ardent Media, New York, NY, is due in Spring 2003. It will contain all the latest data on new contraceptive methods as well as revised efficacy data for all methods, STD treatment guidelines, and EC. It contains one of the best resource lists for contraceptive issues. It is the "must have" contraceptive resource.

MANAGING CONTRACEPTION 2002-2003

Available as a pocket guide or in download format (Acrobat PDF format) from The Bridging the Gap Foundation,

spearheaded by Dr. Robert A. Hatcher. The pocket guide is invaluable for individual's day-to-day practice. There is a concise, up-to-date web site, offering reliable links and a "Question and Answer" section appropriate for clinicians and clients: www.managingcontraception.com

MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE

This document outlines data pertinent to medical contraindications for a wide range of contraceptive options. It was designed to aid in the development of guidelines for family planning programs. See www.who.org for ordering information.

Patient and clinician literature is very comprehensive. As with the contraceptive patch, there is a web site.

In terms of perfect use, it is 99.7 percent effective in preventing pregnancy. In terms of typical use, it is 92 percent effective.*

Non-contraceptive benefits account for the great popularity of combined oral contraceptives. These extend to the new contraceptive patch and ring. There are significant reasons why women not in need of contraception choose to use a combined product. These include improved menstrual symptoms, decreased acne, and decreased risk of epithelial ovarian and endometrial cancer.¹³

EMERGENCY CONTRACEPTION

A discussion of current contraceptive options in the United States would not be complete without mentioning three forms of emergency contraception (EC)—Paraguard, Preven, and Plan B. The first is an IUD containing copper; the latter two are hormonal methods.

While EC is actually not new, it is often called “the best kept secret” in family planning. Though not recommended as a consistent contraceptive alternative, it exists as a back-up for contraceptive errors.

Preven and Plan B are two dedicated products, both containing the progestin levonorgestrel. Preven also contains estrogen and causes more nausea. Plan B is, therefore, usually the preferred choice. Actually, any oral contraceptive containing levonorgestrel or norgestrel can also be used for EC. The dosage varies based on which birth control pill an individual uses.² These two progesterones are the only two that have been recognized for this use. This does not mean that others cannot be effective.

Paraguard, the IUD containing copper, can be used as EC when inserted up to five days after inadequately protected intercourse. It is possible for Paraguard to work when inserted as many as seven days after intercourse, if ovulation is known to have occurred three days after intercourse. The mechanism interferes with implantation and may act as a contraceptive if inserted prior to ovulation.

The method is most appropriate for women who plan to continue with an IUD as their contraceptive method. It is not widely utilized in the United States due to cost and lack of access.

Hormonal methods include Preven (containing both estrogen and progesterone) and Plan B (progesterone only). They involve taking the product within 72 hours of unprotected intercourse and repeating the dose after 12 hours. It is theoretically possible that the method will prove effective if initially taken after 72 hours.¹⁴

Nausea is not uncommon when using products containing estrogen, and some clinicians recommend using an over-the-counter anti-nausea product one hour before

ingestion. Plan B, the progestin-only product, will help individuals avoid this side effect.

The mechanism of action for hormonal methods centers around preventing pregnancy. They are not abortifacient. This is an important distinction for clients who would find abortion unacceptable.

Treatment initiated within 72 hours after unprotected intercourse reduces the risk of pregnancy at least 75 percent.*

More information on EC is available at 1/800-NOT-2-LATE or at www.not-2-late.com.

NEW POPULARITY OF STANDARD METHODS

In addition to new products, women are turning with increasing frequency to a number of standard contraceptive methods that have been on the market for a while. They include the mini-pills as well as the injectable contraceptives Depo-Provera and Lunelle.

Mini-pills. These progestin-only oral contraceptives alter cervical mucous, tubal motility, and endometrial factors. Well known products are Micronor, Nor-QD and Ovrette. Women should take one pill daily without the placebo break common with combined oral contraceptives. This will contribute to high rates of irregular bleeding, but consistent use is associated with the eventual absence of bleeding for some women.¹⁵

Because they do not contain estrogen, the pills are an excellent choice for women for whom estrogen is inadvisable. They are also an excellent choice for lactating women.

These pills do not suppress ovulation as readily as combined hormonal methods, which makes the timing of the dosage critical. Taking them three hours late may decrease effectiveness. Given the small window of time in which to take the pill, some women may find the regimen too demanding.

While most counselors have always found these pills a viable option, mini-pills have recently found a new respect. Data on effectiveness has also improved. Their perfect use and typical use rates are quoted as 99.7 percent and 92 percent respectively in preventing pregnancy, making them equal to combined oral contraceptives for the first time.*

Depo-Provera and Lunelle. These two injectable contraceptives are now available in the United States.

Depo-Provera, which is now the most popular form of non-oral contraceptive in the United States,¹⁴ is a progesterone-only injection, designed for women to take intramuscularly (IM) once every three months.

It inhibits ovulation and also causes the alteration of cervical mucous and upper genital tract motility. It may initially cause irregular bleeding but may eventually result in

lack of menstrual periods.

There are a number of non-contraceptive reasons a woman may choose Depo-Provera. It is used to treat endometriosis and is also likely the safest method for women on anti-seizure medication. It also decreases sickle cell crises.¹⁷

A unpopular side effect is unwanted weight gain, up to 13 pounds over three years according to the manufacturer. The delay of menstruation after discontinuation may also interfere with reproductive plans.

Depo-Provera is assigned a 99.7 percent perfect use effectiveness rate in preventing pregnancy and a 97 percent typical use effectiveness rate.*

Lunelle involves an IM injection of a combination of estrogen and progesterone every month. It is used in much the same way as other combined hormone methods. It does, however, have less untoward effects on triglycerides and clotting than similar contraceptives.¹⁸ Fertility returns much more quickly than with Depo-Provera.

Lunelle's prefilled syringes were recalled in October after a doctor noticed an underfilled syringe. But even before the recall, Lunelle's popularity may have been limited because it can be administered only by a doctor or nurse. It is hoped that the pre-filled syringes will return to the market by Spring 2003. The recall did not include packaged vials.¹⁹ Lunelle is assigned a 99.5 percent perfect use effectiveness rate in preventing pregnancy and a 97 percent typical use effectiveness rate.

NEW PROBLEMS WITH STANDARD METHODS

While new contraceptive methods have appeared, women have also found new problems with standard methods. They include efficacy problems with the pill and safety issues concerning the role of the spermicide nonoxonyol-9 in HIV transmission.

The pill. Efficacy data has changed for this second-most popular contraceptive choice in the United States. (The most popular choice in the United States remains female sterilization.)

The authors of *Contraceptive Technology* will soon publish data indicating that the pill is slightly less effective than previously thought even with perfect use. Specifically, the data indicates the perfect use effectiveness rate is 99.7 rather than 99.9 percent. The typical use effectiveness rate is now 92 percent during the first year of use.²⁰

Another concern is new data indicating increased failure in very low-dose pills for women weighing more than 150 pounds. There is also concern about the use of generic products. New data indicates that differences in the response rate of different products could change effectiveness.²¹

These new data essentially level the playing field for combined oral contraceptives, progestin-only pills, the con-

traceptive patch, and the contraceptive ring. They now all have the same perfect use and typical use rates. In fact, the effectiveness rate of progestin-only pills actually increased. Many clinicians previously considered mini-pills much less effective than they really were. Data now indicates they are very effective. This is very important news for women with estrogen-related side effects who previously avoided them as a method. It will be interesting to see how the comparisons hold up over time.

Nonoxynol-9. One old method has had recent safety issues surface about its use. Concern about the role of the spermicide nonoxynol-9 in HIV transmission has prompted re-thinking of strategies in dual use of male condoms and spermicide for couples at risk for HIV exposure.

It is now known that an increase in vaginal inflammation resulting from nonoxynol-9 use may actually increase the risk of individuals becoming infected.²²

Male condoms without spermicide still remain effective for protection against many sexually transmitted infections.

ON THE HORIZON

There are a number of new contraceptive products on the horizon as well as new education opportunities to help clinicians and patients avoid repeat problems with the use and side effects of implant products.

Lack of knowledge regarding the Norplant implant resulted in its removal from the market earlier this year. New implants have the potential for the same effects so it is important that individuals educate themselves about usage and side effects.

Implanon. This single-rod progesterone implant, which is only four centimeters in length, inhibits ovulation and alters motility in the reproductive tract. It releases a small, constant dose of the same progesterone used in the new vaginal ring. Designed for three years of use, it will include a device to help women insert and remove it through simplified procedures. In trials, it reported no pregnancies in over 53,000 menstrual cycles.²³

Jadelle. This two-rod (4.3 centimeters in length) implant system manufactured by Wyeth, the former manufacturers of Norplant, will require insertion and removal by a trained clinician. It works by continuously releasing progesterone to inhibit ovulation. It has a first year failure rate of 0.2 percent. It was determined as effective as Norplant in its first three years of use.²⁴ Side effects are similar to Norplant, with periods of breakthrough bleeding a primary complaint. Eventual lack of menstruation is considered a desired side effect. The need for medical intervention to discontinue the method is a possible disadvantage for some women.

Lea's Shield. This cervical cap allows the release of cervical fluids and air. It is elliptical in shape, slightly larger in the posterior portion to provide for a good fit on the cervix. It is made of medical-grade silicone rubber and acts like other barrier methods. Although it will come only as a one-size-fits-all cap, it still requires a prescription. It is currently available over-the-counter in Germany, Austria, Switzerland, and Canada.²⁵ Reports indicate that it is comfortable and easy to use. It is a good option for those not desiring to use hormonal contraception. Individuals can wash and reuse it for one year. Effectiveness data is currently limited.²⁶

Essure. This device and procedure is designed to cause sterility. Unlike traditional female sterilization, it does not require surgical anesthesia, incision, or result in any visible scar. A small metal spring is inserted into each fallopian tube through the vaginal canal and uterus. Over a three-month period, the spring reacts with tubal tissue to create an occlusion, thus blocking access to the egg by sperm. In clinical trials, it had a 99.8 percent perfect use effectiveness rating. It will have the benefit of permanent sterilization without the disadvantage of a surgical procedure.²⁷

CONCLUSION

Contraceptive choices have increased significantly in the United States. Many will help to improve utilization and patient acceptance.

At this point, we must look to the horizon for other new developments. Even so, the variety that is now available is a very positive step in the right direction.

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—Editor

* See Table 31-1 in *Contraceptive Technology (eighteenth revised edition, Ardent Media, New York, in press)* for information about the percentage of women experiencing an unintended pregnancy during the first year of typical use and the first year of perfect use of contraception.

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ARE GENERIC ORAL CONTRACEPTIVES EQUAL?

Generic medications have been around for years, and they have generally performed well, providing low-cost alternatives for many users.

However, questions continue to arise as to why some individuals have varying responses to products that are so-called equivalent. The Association of Reproductive Health Professionals (ARHP) has published a report on bioequivalence testing that indicates a theoretical possibility exists for a 28 percent decrease in potency of generic oral contraceptives.

This means that a 20 microgram oral contraceptive

could fall below what is currently assumed the lowest effective dosage for preventing pregnancy. At the least, the lower dosage could cause increased side effects. At the most, it could increase the chance of pregnancy.

Source: M. Crenin chair, ARHP Consensus Conference, "Understanding Low-Dose Oral Contraceptives," *Clinical Proceedings*, August 2001. (This publication was supported by an unrestricted educational grant from Wyeth-Ayerst Pharmaceuticals.) For more information, see www.arhp.org

STERILIZATION MOST WIDELY USED CONTRACEPTIVE METHOD IN WORLD

EngenderHealth
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Contraceptive sterilization is one of the oldest modern methods of fertility control, dating to the nineteenth century. Yet, as we advance into the twenty-first century, contraceptive sterilization (hereafter referred to as sterilization) continues to warrant considerable attention and study by those involved in the field of family planning and reproductive health care.

Why? The answer is simple: Despite the development and introduction of many new contraceptive methods over the last 15 years, sterilization is the most widely used method in the world, in developing and developed countries alike.

Couples and individuals around the world choose sterilization because they want to limit or end childbearing, rather than space future births. For some women, reversible methods are unavailable or inconvenient; for others, contraceptive use may begin only after they have achieved or surpassed their desired fertility.

For many, then, sterilization is their first method. The method requires no action on the part of the user beyond election of the initial surgical procedure. It produces a minimum of side effects, while generally offering a lifetime of contraceptive protection.

Moreover, female sterilization requires no ongoing cooperation by the sexual partner or spouse, thereby representing a contraceptive option for women who may be powerless to ensure such cooperation. Thus, quality sterilization services will always be a crucial component of any comprehensive family planning service.

STERILIZATION SERVICES

Among the many factors that affect the quality with which contraceptive sterilization services are delivered, three require special attention: actual service-delivery modalities, fees and compensation programs, and the cost of service provision.

While sterilization services are provided in an inherently medical context, men's and women's access can be broadened if services are offered during the postpartum period, through mobile outreach, or in male-only clinics (for vasectomy). Likewise, while fees and compensation for providers have led to concern over the potential for coercing clients into accepting sterilization, there is little evidence that such approaches have promoted reliance on this method.

The provision of quality sterilization services hinges on the client's ability to make a well-informed, voluntary

decision (informed choice), his or her authorization to proceed with the surgical procedure (informed consent), and the client's participation in true two-way communication with a health care worker about the risks and benefits of the procedure (counseling).

In helping a client make an informed decision, providers need to assess the client's needs, offer appropriate method options, fill in knowledge gaps, help the client make his or her own choice, and encourage utilization of other appropriate reproductive health services.

The spread of HIV and other STIs across the globe since 1985 has important implications for women and men considering or already using sterilization. Like most contraceptive methods, sterilization fails to offer any protection against STIs, including HIV. Thus, it is imperative for family planning providers to ensure that men and women seeking to use sterilization understand safer-sex practices and how to protect themselves and their partners from these diseases.

Incidence and prevalence. Reliance on both male and female sterilization has grown substantially since 1980, when 99 million couples were estimated to be using sterilization; by 1995, this number had climbed to about 223 million couples—180 million women using female sterilization and 43 million men using vasectomy. The number of female sterilization users in 1995 was 42 million higher than 1990 estimates; in contrast, in 1995, the number of vasectomy users was only 1 million more than 1991 levels.

Use of female sterilization services seems to have increased in regions where it had been low, particularly in Sub-Saharan Africa. Thus, in nations such as Botswana, Cape Verde, Kenya, Mauritius, Namibia, South Africa, and Swaziland, sterilization prevalence rates are now five percent or higher. The introduction of minilaparotomy services (sterilization under local anesthesia provided by nonspecialized doctors or by appropriately trained and supervised nurse-midwives) into family planning programs in Sub-Saharan Africa may account for some of this increase in use.

Who uses female sterilization? Since only individuals and couples who want no more children elect to be sterilized, it is not surprising that sterilization is more common among older women.

Nevertheless, the prevalence of female sterilization and the age at which women obtain a sterilization are inversely related: In countries where prevalence is high, the median

age is generally low, while in low-prevalence countries, women often are not sterilized until older ages.

In high-prevalence regions such as Asia and Latin America and the Caribbean, half of sterilized women have three to four children. Yet overall, the number of births among sterilized women ranges from a median of two or fewer in China and the United States to five or more in Africa. In Asia and Sub-Saharan Africa, most sterilization users reside in rural areas, while in North America, North Africa, and Latin America and the Caribbean, the majority of users live in urban locales.

Sterilization procedures performed at some time unrelated to a pregnancy (known as interval sterilizations) are more common than postpartum sterilizations in many countries located in North Africa, Sub-Saharan Africa, and South Asia. In contrast, postpartum sterilizations are more common in some countries in Latin America and the Caribbean.

Regardless of when a sterilization is performed, though, for many women it is their first experience with modern contraception: It is often the case that more than 50 percent of women using female sterilization have never used a modern contraceptive method.

FEMALE STERILIZATION

Even though tubal sterilization usually involves abdominal surgery, it is one of the safest operative procedures: Complications are rare and occur in fewer than one percent of all female sterilization procedures. Moreover, the likelihood of failure is very low, at less than two percent even 10 years after surgery.

There are two broad elements in the performance of female sterilization: the means of reaching the fallopian tubes, and the methods used to occlude the tubes. The selection of a procedure is determined by such factors as the timing of sterilization in relationship to pregnancy; the need for other gynecological procedures; the woman's health; the provider's training, expertise, and experience; the cost and logistics of maintaining equipment; and the availability of back-up services.

Female sterilization results in few long-term side effects. The overall risk of ectopic pregnancy is low (although if a pregnancy occurs, the probability that it will be ectopic is high). Perceived alterations in women's menstrual flow, length, or pain following tubal sterilization (referred to as poststerilization syndrome) have been debated and studied, but research carried out in the United States has shown no strong evidence for the existence of such a syndrome.

MALE STERILIZATION

The situation with male sterilization is similar to that of female sterilization: Vasectomy is one of the safest and most effective contraceptive methods, with very low complication

rates (especially with no-scalpel vasectomy) and failure rates generally thought to be in the range of two to four per 1,000.

While potential physiological effects and long-term sequelae of vasectomy have been studied extensively over the past few decades, research has offered reassurance that this method has no serious long-term negative effects on men's physical or mental health.

There is little evidence for a causal association between prostate cancer and vasectomy, and a panel of experts convened by the U.S. National Institutes of Health in 1993 concluded that no change was necessary in the practice of vasectomy.

No-scalpel vasectomy, which requires local anesthesia and only a small incision, has helped to revitalize vasectomy provision in many countries (Colombia, Mexico, Thailand, and the United States among them), and was the impetus for introducing vasectomy services in others (such as Kenya and Turkey).

However, experimental nonsurgical methods of occluding the vas are unlikely to become available in the near future, as a result of questions not only about their efficacy, but also about their ability to be offered in low-resource settings.

FUTURE TRENDS

Projections suggest that sterilization reliance will increase substantially through 2015, especially in areas of Latin America and the Caribbean and in Sub-Saharan Africa. In Asia, by contrast, the prevalence of sterilization is likely to decline as reversible methods become more widely available, particularly in countries (such as China, India, and South Korea) where sterilization usage is currently greatest.

Countries where sterilization prevalence is moderate, such as Bangladesh and Pakistan, will see more modest declines to 2015. Method prevalence is also expected to rise modestly in Vietnam and more dramatically in the Philippines between 2000 and 2015, however, and Indonesia can anticipate a slight rise in prevalence as well.

Potential users of sterilization (defined as fecund women who are in union, want no more children, are not using a contraceptive method, and report that they are considering sterilization as their preferred method) have characteristics similar to women already using sterilization: About half are age 30 or older, their mean number of children and educational level vary widely by country, and they are more often rural residents.

Overall, sterilization prevalence over the next 15 to 20 years is not likely to differ dramatically from levels seen at the beginning of the century, although the numbers of sterilization users may increase simply as a factor of population growth.

Future levels of reliance on contraceptive sterilization in any particular country may vary as a result of unpredictable factors, however, such as changes in sterilization's legal status,

the development of new contraceptive methods, or shifts in economic circumstances affecting family planning programs.

Continued monitoring of these factors, as well as of societal attitudes toward sterilization and fertility regulation, will be crucial to understanding and anticipating demand for contraceptive sterilization services in both developed and developing countries.

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EMERGENCY CONTRACEPTION (EC) LIKELY PLAYED ROLE IN ABORTION RATE DECLINES

More than 1.3 million abortions were performed in the United States in 2000—110,000 fewer than in 1994. The Alan Guttmacher Institute (AGI) has just published an analysis showing that 46 percent of the reduction was likely due to the use of emergency contraception (EC).

EC is a specific dose of birth control pills taken within 72 hours of unprotected intercourse or insertion of an IUD within seven days. Such intervention stops ovulation, fertilization, or implantation.

The study, published in AGI's *Perspectives on Sexual and Reproductive Health*, surveyed 10,683 women in the United States who had abortions in 2000-2001.

The analysis pointed to previous research indicating that seven percent of all women 15 to 44 years of age do not use contraceptives and that these women account for about half of all abortions.

Specifically, the data indicated that of women who did not use contraceptives:

- 33 percent said they did not think they would become pregnant
- 32 percent said they had concerns about methods, including side effects and problems with methods in the past
- 26 percent said they did not expect to have sexual intercourse
- 22 percent said they had not thought about contraception or had not yet begun using a method
- 12 percent said they had problems accessing contraceptives
- 5 percent said they were ambivalent about pregnancy

- 2 percent said they did not want their parents to know they were sexually active
- 1 percent said they were forced to have sexual intercourse

Of those women who used contraceptives:

- 76 percent said they had used contraceptive pills inconsistently
- 49 percent said they used condoms inconsistently
- 42 percent said they used condoms that had broken or slipped out of place

“Our findings indicate that women and their partners continue to need better information and resources to help them use contraceptive methods consistently and correctly,” said Dr. Jacqueline E. Darroch, AGI senior vice president and vice president for science and an author of the study published in the current issue of *Perspectives on Sexual and Reproductive Health*.

“EC is a particularly promising solution, especially for those women who have had sex without a contraceptive because they did not expect to have sex, or for those who realize that they used their method incorrectly,” she continued.

The analysis was based on the commonly held estimate that EC will prevent three out of four unwanted pregnancies.

EC was estimated to have averted 4,000 abortions in 1994, the last time AGI conducted a similar survey.

For more information, go to the AGI web site at www.guttmacher.org

SEX IN THE MEDIA: DO CONDOM ADS HAVE A CHANCE?

Few would argue that sex does not permeate the media in the United States.¹ Research shows not only that the incidence of sexual content on television has risen steadily over the years but also that the media may serve as important sex educators for young people.² Nevertheless, there are few messages on television that help teens and adolescents learn about responsible sexual behavior and sexual health.³

The news is, of course, not all bad. Some adolescents at least believe that the media has taught them that they should use condoms. The Teen Media Project, a current five-year project funded by the National Institute of Child Health and Human Development (NICHD) and conducted by researchers Jane Brown, Carol Pardun, and Kelly L'Engle of the University of North Carolina found that both African American and White young females and African American young males believed that the media states they should use condoms. Unfortunately, white males were less likely to think the media portrayed the message of using condoms.

Still this finding provides reason for media outlets to more aggressively send appropriate messages to an impressionable audience.

MEDIA COMMERCIALS

We know that many teens consume large amounts of sexual media images just from the advertising alone! A one-hour television show can have upwards of 40 commercials. It is not surprising that many of these ads use sex to sell.

Whether it's a Victoria Secret's commercial that depicts a shove-it-in-your-face approach to sexual appeal, or a more subtle Toyota Camry commercial that exclaims some people are just "too sexy for their cars," or a Caress body wash commercial that shows a woman slowly removing her clothes, sex is a prominent part of television viewing for America's youth.

And it's not just television commercials. Recent ads in teen magazines have depicted a tampon with the headline "Size matters," and a couple French kissing with the headline "there's more than one way to share a Starburst."

WHAT ABOUT CONDOM ADS?

Clearly, teens are seeing sexual images in the media. Is it unreasonable to expect that some of those messages should

depict the dangers of unprotected sex—and tell teens how they can protect themselves with condoms?

Even though the evidence points to the impact that the media have on shaping our social values, networks have only recently allowed paid condom advertising on the airwaves, and they restrict not only the time of day the advertisements can air but also the message and tone of the ads.⁴

With the large number of sexual messages being conveyed in television programming, it seems incongruous to avoid references to sexual risks and responsibilities in the programming itself.⁵ It is perhaps just as incongruous not to allow contraceptive advertisements on TV or, if allowed, to restrict their opportunity for effectiveness.⁶

We know that 80 percent of young people have intercourse during their teenage years.⁷ We also know that young people simply aren't protecting themselves as well as they should.

A joint Kaiser Family Foundation and YM magazine survey found that 58 percent of sexually experienced teens do not use contraception every time they have sex and 40 percent have not talked with a partner about sexually transmitted diseases (STDs).⁸

AMERICANS FAVOR ADS

Some broadcasters worry that the public disapproves of condom advertising, and some worry they would lose sponsors that don't want their advertisements run alongside condom ads.⁹

These worries, however, may amount to very little. A recent survey found that 71 percent of Americans favor allowing condom ads on TV—37 percent support the ads running at any time while 34 percent support the ads running at certain times, such as after 10 p.m. Even more support exists for televised condom ads among adults under 50 years of age, 82 percent of whom say condom ads should be allowed.¹⁰

There is a public service poster that says "Talk to your kids about sex. Everyone else is." That is certainly a message we can send the advertising industry and advertisers as well.

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PREVENTING HIV AND OTHER STDs

Some people mistakenly believe that by protecting themselves against pregnancy they are automatically protecting themselves from HIV, the virus that causes AIDS, and other sexually transmitted diseases (STDs). But the male latex condom is the only contraceptive method considered highly effective in reducing the risk of STDs.

Unlike latex condoms, lambskin condoms are not recommended for STD prevention because they are porous and may permit passage of viruses like HIV, hepatitis B, and herpes. Polyurethane condoms are an alternative method of STD protection for those who are latex-sensitive.

Because it is a barrier method that works in much the same way as the male condom, the female condom may provide some protection against STDs. Both condoms should not be used together, however, because they may not both stay in place.

According to an FDA advisory committee panel, it appears, based on several published scientific studies, that some vaginal spermicides containing nonoxynol-9 may reduce the risk of gonorrhea and chlamydia transmission. However, use of nonoxynol-9 may cause tissue irritation, raising the possibility of an increased susceptibility to some STDs, including HIV.

As stated in their labeling, birth control pills, Depo-Provera, IUDs, and lambskin condoms do not protect against STD infection. For STD protection, a male latex condom can be used in combination with non-condom methods. The relationship of the vaginal barrier methods—the diaphragm, cap and sponge—to STD prevention is not yet clear.

This was reprinted from the web site of the U.S. Food and Drug Administration (FDA). See www.fda.gov

PROTECTING AGAINST UNINTENDED PREGNANCY: AN OVERVIEW OF STANDARD CONTRACEPTIVES

I am 20 and have never gone to see a doctor about birth control. My boyfriend and I have been going together for a couple of years and have been using condoms. So far, everything is fine. Are condoms alone safe enough, or is something else safe besides the Pill? I do not want to go on the Pill.

—Letter to the Kinsey Institute for Research in Sex, Gender, and Reproduction

This young woman is not alone in her uncertainty about contraceptive options. A report by the National Academy of Sciences' Institute of Medicine titled *The Best Intentions: Unintended Pregnancy and the Well-being of Children and Families* attributed the high rate of unintended pregnancies in the United States in part to Americans' lack of knowledge about contraception. About six of every 10 pregnancies in the United States are unplanned, according to the report.

Being informed about the pros and cons of various contraceptives is important not only for preventing unintended pregnancies but also for reducing the risk of illness or death from sexually transmitted diseases (STDs), including AIDS.

The U.S. Food and Drug Administration has approved a number of birth control methods, ranging from over-the-counter male and female condoms and vaginal spermicides to doctor-prescribed birth control pills, diaphragms, intrauterine devices (IUDs), injected hormones, and hormonal implants. Other contraceptive options include fertility awareness and voluntary surgical sterilization.

[This list provides definitions of standard contraceptive methods. The FDA has not updated it to include recently introduced contraceptive methods that are discussed in this SIECUS Report. —Editor]

BARRIER METHODS

Male Condom. The male condom is a sheath placed over the erect penis before penetration, preventing pregnancy by blocking the passage of sperm. A condom can be used only once. Some have spermicide added, usually nonoxynol-9 in the United States, to kill sperm. Spermicide has not been scientifically shown to provide additional contraceptive protection over the condom alone. Because they act as a mechanical barrier, condoms prevent direct vaginal contact with semen, infectious genital secretions, and genital lesions and discharges.

Most condoms are made from latex rubber, while a small percentage are made from lamb intestines (sometimes called "lambskin" condoms). Condoms made from polyurethane have been marketed in the United

States since 1994. Except for abstinence, latex condoms are the most effective method for reducing the risk of infection from the viruses that cause AIDS, other HIV-related illnesses, and other STDs.

Some condoms are prelubricated. These lubricants don't provide more birth control or STD protection. Non-oil-based lubricants, such as water or K-Y jelly, can be used with latex or lambskin condoms, but oil-based lubricants, such as petroleum jelly (Vaseline), lotions, or massage or baby oil, should not be used because they can weaken the material.

Female Condom. The Reality Female Condom consists of a lubricated polyurethane sheath shaped similarly to the male condom. The closed end, which has a flexible ring, is inserted into the vagina, while the open end remains outside, partially covering the labia.

The female condom, like the male condom, is available without a prescription and is intended for one-time use. It should not be used together with a male condom because they may not both stay in place.

Diaphragm. Available by prescription only and sized by a health professional to achieve a proper fit, the diaphragm has a dual mechanism to prevent pregnancy. A dome-shaped rubber disk with a flexible rim covers the cervix so sperm can't reach the uterus, while a spermicide applied to the diaphragm before insertion kills sperm.

The diaphragm protects for six hours. For intercourse after the six-hour period, or for repeated intercourse within this period, fresh spermicide should be placed in the vagina with the diaphragm still in place. The diaphragm should be left in place for at least six hours after the last intercourse but not for longer than a total of 24 hours because of the risk of toxic shock syndrome (TSS), a rare but potentially fatal infection. Symptoms of TSS include sudden fever, stomach upset, sunburn-like rash, and a drop in blood pressure.

Cervical cap. The cap is a soft rubber cup with a round rim, sized by a health professional to fit snugly around the cervix. It is available by prescription only and, like

the diaphragm, is used with spermicide.

It protects for 48 hours and for multiple acts of intercourse within this time. Wearing it for more than 48 hours is not recommended because of the risk, though low, of TSS. Also, with prolonged use of two or more days, the cap may cause an unpleasant vaginal odor or discharge in some women.

Sponge. The vaginal contraceptive sponge has not been available since the sole manufacturer, Whitehall Laboratories, voluntarily stopped selling it in 1995. It remains an approved product and could be marketed again.

The sponge, a donut-shaped polyurethane device containing the spermicide nonoxynol-9, is inserted into the vagina to cover the cervix. A woven polyester loop is designed to ease removal.

The sponge protects for up to 24 hours and for multiple acts of intercourse within this time. It should be left in place for at least six hours after intercourse but should be removed no more than 30 hours after insertion because of the risk, though low, of TSS.

Vaginal spermicides alone. Vaginal spermicides are available in foam, cream, jelly, film, suppository, or tablet forms. All types contain a sperm-killing chemical.

Studies have not produced definitive data on the efficacy of spermicides alone, but according to the authors of *Contraceptive Technology*, a leading resource for contraceptive information, the failure rate for typical users may be 21 percent per year.

Package instructions must be carefully followed because some spermicide products require the couple to wait 10 minutes or more after inserting the spermicide before having sex. One dose of spermicide is usually effective for one hour. For repeated intercourse, additional spermicide must be applied. And after intercourse, the spermicide has to remain in place for at least six to eight hours to ensure that all sperm are killed. The woman should not douche or rinse the vagina during this time.

HORMONAL METHODS

Combined oral contraceptives. Typically called “the pill,” combined oral contraceptives have been on the market for more than 35 years and are the most popular form of reversible birth control in the United States. This form of birth control suppresses ovulation (the monthly release of an egg from the ovaries) by the combined actions of the hormones estrogen and progestin.

If a woman remembers to take the pill every day as directed, she has an extremely low chance of becoming

pregnant in a year. But the pill’s effectiveness may be reduced if the woman is taking some medications, such as certain antibiotics.

Besides preventing pregnancy, the pill offers additional benefits. As stated in the labeling, the pill can make periods more regular. It also has a protective effect against pelvic inflammatory disease, an infection of the fallopian tubes or uterus that is a major cause of infertility in women, and against ovarian and endometrial cancers. The decision whether to take the pill should be made in consultation with a health professional. Birth control pills are safe for most women—safer even than delivering a baby—but they carry some risks.

Current low-dose pills have fewer risks associated with them than earlier versions. But women who smoke—especially those over 35—and women with certain medical conditions, such as a history of blood clots or breast or endometrial cancer, may be advised against taking the pill. The pill may contribute to cardiovascular disease, including high blood pressure, blood clots, and blockage of the arteries.

One of the biggest questions has been whether the pill increases the risk of breast cancer in past and current pill users. An international study published in the September 1996 journal *Contraception* concluded that women’s risk of breast cancer 10 years after going off birth control pills was no higher than that of women who had never used the pill. During pill use and for the first 10 years after stopping the pill, women’s risk of breast cancer was only slightly higher in pill users than non-pill users.

Side effects of the pill, which often subside after a few months’ use, include nausea, headache, breast tenderness, weight gain, irregular bleeding, and depression.

Mini-pills. Although taken daily like combined oral contraceptives, mini-pills contain only the hormone progestin and no estrogen. They work by reducing and thickening cervical mucus to prevent sperm from reaching the egg. They also keep the uterine lining from thickening, which prevents a fertilized egg from implanting in the uterus. These pills are slightly less effective than combined oral contraceptives. (See Vicki Long’s article for updates on the efficacy of the mini-pill. —Editor)

Mini-pills can decrease menstrual bleeding and cramps, as well as the risk of endometrial and ovarian cancer and pelvic inflammatory disease. Because they contain no estrogen, mini-pills don’t present the risk of blood clots associated with estrogen in combined pills. They are a good option for women who can’t take estrogen because they are breast-feeding or because

estrogen-containing products cause them to have severe headaches or high blood pressure.

Side effects of mini-pills include menstrual cycle changes, weight gain, and breast tenderness.

Injectable progestins. Depo-Provera is injected by a health professional into the buttocks or arm muscle every three months. Depo-Provera prevents pregnancy in three ways: It inhibits ovulation, changes the cervical mucus to help prevent sperm from reaching the egg, and changes the uterine lining to prevent the fertilized egg from implanting in the uterus. The progestin injection is extremely effective in preventing pregnancy, in large part because it requires little effort for the woman to comply: She simply has to get an injection by a doctor once every three months.

Intrauterine devices. An IUD is a T-shaped device inserted into the uterus by a health-care professional. Two types of IUDs are available in the United States: the Paragard CopperT 380A and the Progestasert Progesterone T. The Paragard IUD can remain in place for 10 years, while the Progestasert IUD must be replaced every year.

It's not entirely clear how IUDs prevent pregnancy. They seem to prevent sperm and eggs from meeting by either immobilizing the sperm on their way to the fallopian tubes or changing the uterine lining so the fertilized egg cannot implant in it. IUDs have one of the lowest failure rates of any contraceptive method.

The IUD's image suffered when the Dalkon Shield IUD was taken off the market in 1975. This IUD was associated with a high incidence of pelvic infections and infertility, and some deaths. Today, serious complications from IUDs are rare, although IUD users may be at increased risk of developing pelvic inflammatory disease. Other side effects can include perforation of the uterus, abnormal bleeding, and cramps. Complications occur most often during and immediately after insertion.

TRADITIONAL METHODS

Fertility awareness. Also known as natural family planning or periodic abstinence, fertility awareness entails not having sexual intercourse on the days of a woman's menstrual cycle when she could become pregnant or

using a barrier method of birth control on those days.

Because a sperm may live in the female's reproductive tract for up to seven days and the egg remains fertile for about 24 hours, a woman can get pregnant within a substantial window of time—from seven days before ovulation to three days after. Methods to approximate when a woman is fertile are usually based on the menstrual cycle, changes in cervical mucus, or changes in body temperature.

“Natural family planning can work, but it takes an extremely motivated couple to use the method effectively.”

Withdrawal. In this method, also called *coitus interruptus*, the man withdraws his penis from the vagina before ejaculation. Fertilization is prevented because the sperm don't enter the vagina.

Effectiveness depends on the male's ability to withdraw before ejaculation. Also, withdrawal doesn't provide protection from STDs, including HIV. Infectious diseases can be transmitted by direct contact with surface lesions and by pre-ejaculatory fluid.

Surgical sterilization. Surgical sterilization is a contraceptive option intended for people who don't want children in the future. It is considered permanent because reversal requires major surgery that is often unsuccessful.

Female sterilization. Female sterilization blocks the fallopian tubes so the egg can't travel to the uterus. Sterilization is done by various surgical techniques, usually under general anesthesia.

Complications from these operations are rare and can include infection, hemorrhage, and problems related to the use of general anesthesia.

Male sterilization. This procedure, called a vasectomy, involves sealing, tying, or cutting a man's vas deferens, which otherwise would carry the sperm from the testicle to the penis. Vasectomy involves a quick operation, usually under 30 minutes, with possible minor postsurgical complications, such as bleeding or infection.

This was reprinted from the web site of the U.S. Food and Drug Administration (FDA). See www.fda.gov

ELECTION 2002: WHAT DOES IT MEAN FOR REPRODUCTIVE AND SEXUAL HEALTH?

William Smith

SIECUS Director of Public Policy

Confident in victory, Republicans have decided they are on the right track and have therefore basically re-elected their leadership in the U.S. Congress.*

The November 25 issue of *The Washington Post* reported that the Bush Administration and conservative Republicans will now push their social agenda since they have regained control of the Senate.

In the aftermath of the election, Democrats began devouring each other, feeding into news stories that characterized their defeat in the mid-term election as a “disaster” and “a massive debacle.” In one instance, a struggle ensued between young Democratic moderates and the party’s status quo over replacing retiring minority leader Richard Gephardt (D-MO).

If the objective political observers have it right, these actions were misguided.

For example, Charlie Cook of the Cook Political Report has an entirely different take. Writing for the *National Journal’s Congress Daily*, he used phrases like “no tidal wave” and “no seismic shift” to describe the most recent election. In summary, he said, “No wave happened in 2002, only a light breeze that was sufficient to tip a number of the closest races to Republicans.”

While Cook and others may be right, the policy implications of the election for reproductive and sexual health advocates could indeed represent a tidal wave—one that threatens to engulf a woman’s right to choose and to significantly restrict the resources and information available to Americans about sexual health.

THE SENATE AND CHOICE

The Democrat’s one-vote margin in the Senate prior to the 2002 election did not produce a great deal of progressive legislation. In fact, some of their proposals differed little from what their Republican colleagues might have staked out. Yet, the Democratic majority did help block the most conservative of threats to reproductive rights passed by the U.S. House of Representatives.

This was obvious when the Senator Trent Lott (R-MS) went on record pledging a swift passage of the so-called partial birth abortion ban in the Senate. The legislation—an

attempt to further erode the constitutionally protected rights to abortion services guaranteed by the *Roe v. Wade* decision in 1973—has not come up for a vote in the Democratically-controlled Senate but was passed during the 107th session in the House. Lott is intent on delivering the slippery-slope legislation to President Bush’s desk, where it is expected to quickly become law.

Legislation aside, the biggest threat to reproductive and sexual health in a new Republican-controlled Senate is the appointment of President Bush’s judicial nominees. Pro-choice advocates have voiced concern about the fragile makeup of the U.S. Supreme Court for years. Given the slim 5 to 4 margin of victory in the Supreme Court’s *Stenberg v. Carhart* ruling in 2000—when Nebraska’s broadly-worded ban on so-called partial birth abortion was struck down—and the fact that we are experiencing the longest period without a Supreme Court vacancy in over a century, there is real and genuine concern about a Bush appointee who would support a fundamental reexamination and possible overturning of the *Roe v. Wade* decision.

Lower level courts are also at increasing risk. Senator Lott has indicated that the White House will re-nominate two anti-choice appellate court nominees defeated in the Democratically-controlled Senate: Texas Supreme Court Justice Priscilla Owen and U.S. District Court Judge Charles Pickering.

The only obstacle to stopping the judicial activism of the Bush Administration lies with the Senate’s ability to filibuster a nomination. Maintaining a filibuster, and thereby killing a nomination, requires only 41 members. But there is now an anti-choice majority in the Senate and the Senators with a mixed record on choice may find blocking a nominee politically unappealing.

THE CONGRESS AND OTHER ISSUES

In total, the 107th Congress was hardly a friend to reproductive and sexual health issues. Just how much worse the 108th Congress will be depends on how the Bush Administration and the Republican leadership view the election. Do they agree with insiders like Charlie Cook, who felt the victory was a slight tip in power, or with groups like the Family

Research Council, who boldly pronounced: “This Republican Congress was elected because of the pro-life vote, and they need to heed that vote.”

Apparently, the Family Research Council’s spin on the election, coupled with the thinly veiled preemptory threat to move their agenda, seems to be winning out. *The Washington Post* has reported that key lawmakers and White House officials have confirmed a plan to curb abortion access, expand the role of faith-based organizations in social service delivery, and increase funding for abstinence-only-until-marriage programs.

Under pressure from groups like Focus on the Family and the Family Research Council, the House Republican leadership effectively killed a landmark bankruptcy bill in its last hours before adjournment because it contained a provision that anti-abortion rights activists did not like. The provision would have made anti-abortion rights protesters pay any fines they incurred as a result of protesting even if they filed for bankruptcy.

The broader specifics of the push for a new social agenda remain vague, but another recent procedural move in the House illustrates how it will likely be accomplished. Most of the controversial issues like family planning, teen pregnancy, STD/HIV prevention, and abstinence-only-until-marriage program funding come through the annual appropriations bills. Speaker of the House Dennis Hastert (R-IL) and the White House found it nearly impossible to reach consensus within their own G.O.P. Conference in the House on spending levels for fiscal year 2003. Consequently, the country is three months into fiscal year 2003 with only two of the 13 spending bills passed.

In a tactical move to shore up his own authority and assure final spending levels that are authorized by the White House on all appropriations bills, Hastert forced through a rule in the G.O.P. Conference that requires the Conference’s

conservative steering committee to approve all subcommittee chairmen of the Appropriations Committee. In theory, the rule will keep subcommittee chairmen in line with overall Republican (i.e., White House) spending levels and priorities. In practice, it likely means that subcommittee chairmen will either agree with the Republican leadership or lose their highly coveted positions of authority when the White House presents a budget with more money for abstinence-only-until-marriage programs and no increases for family planning.

CONCLUSION

Until Members return to their desks and take up the people’s business, it is difficult to predict what will happen in the 108th Congress. Politics is always a fickle game, especially when international issues threaten to engulf all things domestic and make them disappear from the public’s eye.

And suppose that Charlie Cook is right and our current media-magnified perception of a massive Democratic debacle in the mid-term election is not reality? It probably matters little, if at all, because it is perception that triumphs and wins the minds of men and women.

That perception currently threatens an ideological conservative ascendance that does not bode well for reproductive and sexual health.

* *A major exception was U.S. Senator Trent Lott’s (R-MS) decision not to assume the role of Majority Leader of the Senate as a result of a racially-charged statement he made at the 100th birthday party of outgoing Senator Strom Thurmond (R-SC). The new Majority Leader is U.S. Senator Bill Frist (R-TN)*

For more information on judicial appointees, go to www.NeverGoBack.org, a project of the Feminist Majority Foundation.

CATHOLICS FOR FREE CHOICE PUBLISHES SURVEY ON EMERGENCY CONTRACEPTION

Catholics for Free Choice, a nonprofit organization in Washington, DC, has published a survey titled *Second Chance Denied: Emergency Contraception in Catholic Hospital Emergency Rooms*.

Conducted by Ibis Reproductive Health of Cambridge, MA, the survey of 600 Catholic hospitals nationwide focused on the circumstances under which they provided Emergency Contraception (EC).

Results indicate that five percent provided EC on request; 23 percent provided it to rape victims only; six percent left the decision to the attending physician; 55 percent

would not dispense it under any circumstance; and 11 percent were unsure or non-responsive.

The publication points out that guidelines developed by the Catholic bishops seeks to ensure that Catholic hospitals do not violate church teaching, which prohibits all contraception.

For more information, contact Catholics for a Free Choice, 1436 U Street, N.W., Suite 301, Washington, DC 20009. Its web site is www.catholicsforchoice.org

INSTRUCTIONS FOR AUTHORS

Submitting Articles and Book and Audiovisual Reviews for Publication in the *SIECUS Report*

Each issue of the *SIECUS Report* features groundbreaking articles and commentary by leaders and front-line professionals in the field of sexuality and education, along with news, special bibliographies on varied topics, book and audiovisual reviews, recommended resources, and advocacy updates. All of this comes to members and other subscribers six times each year.

Manuscripts are read with the understanding that they are not under consideration elsewhere and have not been published previously. Manuscripts not accepted for publication will not be returned. Upon acceptance, all manuscripts will be edited for grammar, conciseness, organization, and clarity.

To expedite production, submissions should adhere to the following guidelines:

PREPARATION OF MANUSCRIPTS

Feature articles are usually 2,000–4,000 words. Book and audiovisual reviews are typically 200–600 words.

Manuscripts should be submitted on 8½ x 11 inch paper, double-spaced, with paragraphs indented. Authors should also send a computer disk containing their submission.

All disks should be clearly labeled with the title of submission, author's name, type of computer or word processor used, and type of software used.

The following guidelines summarize the information that should appear in all manuscripts. Authors should refer to the current issue of the *SIECUS Report* as a guide to our style for punctuation, capitalization, and reference format.

Articles

The beginning of an article should include the title, subtitle, author's name and professional degrees, and author's title and professional affiliation.

Articles may incorporate sidebars, lists of special resources, and other supplementary information of interest. Charts should be included only if necessary and should be submitted in camera-ready form. References should be numbered consecutively throughout the manuscript and listed at the end.

Book Reviews

The beginning of a book review should include the title of the book, author's or editor's name, place of publication (city and state), publisher's name, copyright date, number of pages, and price for hardcover and paperback editions.

Audiovisual Reviews

The beginning of an audiovisual review should include the title of the work, producer's name, year, running time, name and address of distributor, and price.

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