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## The Contraceptive Gap: Millions for Cosmetics, Pennies for Better Birth Control

By DOUGLAS J. BESHAROV

LINDA HAD an abortion at age 17, her first baby the next year and two more by the time she was 21. With hundreds of thousands of unwed mothers like Linda who seem to have made welfare a way of life, the public and politicians are clamoring for tougher welfare rules. Proposals to deny benefits to minors, to deny additional benefits for additional children, to time-limit benefits altogether, to go after deadbeat dads and so forth, are all designed to undo the culture of illegitimacy that has taken hold in so many low-income communities.

Why are there so many Lindas? Culture and poverty play an undeniably powerful role. Western European countries, with rates of teen sexual activity as high as ours, for example, have rates of teen pregnancy and parenthood that range from a half to a sixth of the American rate. So a tougher response to irresponsible parenthood will undoubtedly make a difference.

But to stem the tide of out-of-wedlock births, another powerful factor must also be addressed: the inadequacy of current contraceptive methods. It's not that available birth control methods don't work, they just don't work well enough for the group most at risk. If contraception were easier and more reliable, pregnancy rates would likely drop.

Consider Linda's history. She tried condoms, but, as she told her counselor at a D.C. Planned Parenthood clinic, "they failed." Then she tried the pill, but she found its side effects debilitating. Two years ago, she had Norplant inserted in her arm, but she again suffered from severe side effects. A few months ago she had the implant removed. Given her problems with hormonal methods, Linda is unwilling to try Depo-Provera. At age 25, she has now decided to be sterilized.

Linda is not alone. In a 1988 study, women told researchers from the National Center for Health Statistics that about 60 percent of their pregnancies were unintended. In an Alan Guttmacher Institute study the year before, about half of all abortion patients said that they had been practicing birth control during the month in which they became pregnant.

How unreliable are existing methods? Based on various studies, James Trussell of Princeton University estimates that the failure rate in clinical trials (usually involving married couples) was only 0.1 percent for the pill, 2 percent for the condom and 6 percent for the diaphragm. However, the failure rates among "typical users" were substantially higher: 3 percent for the pill, 12

percent for the condom and 18 percent for the diaphragm.

Poor women are 50 percent more likely to report that they experienced a contraceptive failure than are middle-class women. Still, problems with birth control are widespread throughout society. What's going on?

By now, the many ways that condoms can fail should be well known. But the reasons for high failure rates among pill users are less obvious. The modern birth control pill contains much lower dosages of estrogen than the pill used in the 1960s and 1970s. While these newer pills cause significantly fewer side effects, they also require more precise use. Missing even just one pill is an invitation to pregnancy, as Patty Aleman, formerly a nurse-practitioner at the Capitol Women's Center relates. "One college freshman came in for an abortion and said she was taking the pill. When I pressed her about it, she said, 'Well, I did miss three days.' "

The lifestyles of many low-income women make it harder for them to use the pill consistently. Virginia Cartoof, a former social worker in inner-city Boston, found that many of her clients lived in crowded households where pills got lost. Often, there was no money to replace them immediately. Others moved from place to place and would forget to take their pills along.

Other women, like Linda, suffer side effects from the pill—and, if they have high blood pressure, may slightly increase their risk of stroke. Although the pill's side effects are real, they have become exaggerated in the minds of many women. For example, a Gallup poll commissioned by the American College of Obstetricians and Gynecologists found that 75 percent of women surveyed believed that the pill caused "serious health problems." One-third thought pills caused cancer while an additional 30 percent thought pills were linked to heart attacks and strokes. Actually, women who have used the pill have a lower rate of endometrial and ovarian cancer than women who have never used it.

The intra-uterine device (IUD), although among the safest and most effective (99 percent) of contraceptives, also suffers from an undeservedly negative reputation. The Dalkon Shield has not been sold for over 20 years, yet the catastrophic problems caused by it -- pelvic inflammatory disease and subsequent infertility -- still linger in the minds of many women. Today, only 2 percent of U.S. women using birth control use the IUD. In Western Europe, the IUD is 10 to 20 times more popular.

Well-founded or not, such health concerns deter many women from using the pill or IUD. Anomalously, poor women tend to be more concerned about these side effects and less likely to tolerate them than their middle-class counterparts.

Men don't help matters. Their aversion to condoms is well-known. Seventy-five percent of 20- to 39-year-old men interviewed by researchers at Battelle Human Affairs Research Center in Seattle, for example, said that condoms reduced sensation. But some disadvantaged men don't want their girlfriends to use contraception either. Kay Armstrong, research director of the Southeastern Pennsylvania Family Planning Association, studied women in drug treatment

programs; she found that many of the women were afraid to use birth control because it "implies something negative about the relationship," in the words of one client.

According to many women in Armstrong's study, birth control is often equated with prostitutes and trading sex for drugs. "Some women preferred to hide their use of contraceptives and avoid their partners' wrath . . . . One woman's partner cut up the condoms and sponges she had received from the family planning counselor," noted Armstrong.

For men who have had few successes in life, getting a girlfriend pregnant can be a way of showing masculine prowess like "so many notches on one's belt," according to Elijah Anderson, a University of Pennsylvania sociologist who studied disadvantaged black teens in a Philadelphia neighborhood. Patricia Stern, a graduate student at Penn, found that control was also a central theme in the sexual relations of white inner-city youths. "Boys 'get girls pregnant' to keep them from 'being with' other guys," she noted.

Is it any wonder, then, that Linda decided to be sterilized? Again, she is not alone. University of Pennsylvania sociologist Frank Furstenberg conducted an 18-year, longitudinal study of 322 primarily low-income women in Baltimore who gave birth as teenagers. He found that, by their late twenties and early thirties, an astounding 57 percent of these relatively young women had been sterilized.

Many people are uncomfortable with the idea of sterilization, especially when poverty and race are involved. Our history of involuntary sterilization comes too easily to mind. But that is not what is happening.

Lorraine Klerman, the director of the Maternal and Child Health Program at the University of Alabama, described how the inner-city adolescent mothers she has studied since the 1960s had a set number of children in mind. After that, "They got tired of getting pregnant, they got tired of having abortions, so they got sterilized."

In fact, sterilization is the most common form of contraception in the United States—for all racial and income groups. Of women ages 15 to 44 who use birth control, 40 percent rely on female or male sterilization, according to the National Center for Health Statistics.

As they pass their prime childbearing years, even larger proportions of women rely on male or female sterilization: 47 percent of women in their early thirties, 65 percent of women in their late thirties, and an astounding 73 percent of women in their early forties.

Sterilization rates do not differ by race. They are about 40 percent for both white and black women. The similar overall rates, however, mask an important racial difference: White men are 14 times more likely to have had a vasectomy than are black men.

Nor does sterilization differ by family income. Forty-one percent of women with family incomes below 150 percent of the poverty line rely on sterilization compared to 36 percent of women

with family incomes above 300 percent of the poverty line.

But sterilization is no answer for women who have not yet completed their childbearing, let alone for those who have not even begun.

For a while, many people thought that Norplant might be a panacea. Norplant is 99 percent effective at preventing pregnancy; does not require a daily decision—or male approval; and is fully reversible. It is not, however, appropriate for women who have sex sporadically (like teenagers) and does not protect against sexually transmitted diseases. More importantly, Norplant's popularity seems to have dropped sharply in the wake of media reports describing the difficulty some women have had in getting the implant removed, and with the availability of Depo-Provera, the three-month injectable contraceptive. But the latter, because of its short period of efficacy, does not provide the same level of protection.

For young teens abstinence is surely the best way to curb out-of-wedlock births. But only 12 percent of out-of-wedlock births are to teens under 18, only 30 percent to those under 20. Premarital sex seems to be here to stay, so if we are going to reduce the number of out-of-wedlock births (as well as abortions), we need to offer Americans better contraceptive choices.

A first priority should be an educational campaign to rehabilitate the IUD and the pill. But a technological fix is also necessary. Unfortunately little is being done to develop better contraceptives. Only one pharmaceutical company still conducts research on improved methods of birth control; the federal government adds a scant \$ 38 million annually for contraceptive research. Compare that to the estimated \$ 600 million spent to develop new cosmetics, fragrances and toiletries, and you can see where our priorities really are.

In 1990, the National Academy of Sciences Committee on Contraceptive Development concluded, "The product liability crisis which has emerged over the last decade has clearly limited the interest of the American pharmaceutical industry in the development of new contraceptive products. The extensive in-house research programs that most companies maintained until the mid-'70s are a thing of the past."

Reforming welfare to encourage more responsible childbearing is finally on the public agenda. But the high sterilization rates among all income groups demonstrates the parallel need for improved contraceptives, for the middle class as well as the poor.

A better condom would be a good place to start. Given the hostility of many men to the condoms currently available and the growing problem of AIDS and other sexually transmitted diseases, real improvements in barrier forms of contraception are sorely needed. As Dr. Vanessa Cullens of the Francis Scott Key Medical Center in Baltimore only half-jokingly says, "What we need is a condom that makes sex so wonderful that everyone will want to use it."

Well, you get the idea.

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