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# CONTRACEPTIVE TECHNOLOGY 1978-1979

9th Revised Edition

# UPDATE: New developments as we go to press

**Pregnancy Tests,** Chapter 15

E.p.t. (early pregnancy test), a do-it-yourself pregnancy test for home use, was marketed in early 1978. It is a two-hour urine test similar to the assays described in our chapter, and costs $10-12. It has the *advantage* of offering patients privacy to determine for themselves whether or not they are pregnant, and the *disadvantage* that a pelvic exam to determine the number of weeks pregnancy may not be pursued by all patients. As with many pregnancy tests, there is a high incidence of false negative tests in early pregnancy.

**Contraceptive Effectiveness,** Chapter 1

A new contraceptive effectiveness study appeared in 1977. "Contraceptive Failure Among Married Women in the United States, 1970-1973" by B. Vaughn, J. Trussell, J. Menken, and E.F. Jones, *Family Planning Perspectives,* Volume 9, Number 6, November/December 1977, is a useful addition to our understanding of method effectiveness (life table calculations) for delayers and preventers.

**Combination Oral Contraceptives,** Chapter 4

The prospective oral contraceptive studies from England give cause for increasing concern about risks of long-term use of oral contraceptives. Beral (*Lancet,* October 1977) reported an *excess death rate* of 20/100,000 among women who had ever used oral contraceptives. This is a far greater excess risk than previous reports that surveyed vascular disease as a Pill-related cause of death. Further, vascular effects *persist* after Pills are discontinued. The significance of these findings for U. S. Pill users is not yet clear.

In April, 1978 the FDA required that detailed labeling information for patients be given with each supply of Pills—another step towards fully informing patients.

**Progestin-Only Contraceptive,** Chapter 5

Depo-Provera was *rejected* by the FDA for use as a long-acting contraceptive in the U.S.A. in March-April, 1978.

**Natural Family Planning,** Chapter 10

The official Catholic community has begun an active involvement in family planning with their acceptance of natural family planning. Creative approaches for teaching, evaluating, and practicing the natural methods are proliferating.

**Spermicidal Foam and Encare Oval,** Chapter 9

Concern has been raised over the effectiveness rates of the newly marketed Encare Oval, a vaginal suppository which melts, then foams to release nonoxynol 9. Effectiveness rates cited by the Oval manufacturer are derived from a very unconventional study design. Careful effectiveness studies are needed. Meanwhile, the authors believe the safest approach is to consider the Oval on a par with foam for effectiveness.

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## Preface and Dedication

This is the ninth edition of *Contraceptive Technology,* and we would like to recognize the contributions of many people who have assisted us in this effort to provide up-to-date information about family planning.

On the inside cover, you will find a long list, by state, of the people whose ideas and efforts, corrections and suggestions have made this book what it is. Birth control technology changes rapidly, and *Contraceptive Technology* has evolved with the help of many fine people. In particular, we would like to thank Dr. Ward Cates of Atlanta and Dr. Jack Lippes of Buffalo for their extensive help in preparing this edition of *Contraceptive Technology.*

Here are the two most important changes in our book this year:

1. Chapter 22 presents new material on contraceptive interactions. This chapter goes into the nutritional effects of family planning, outlines a vast array of biochemical changes (alterations in laboratory values) produced by contraceptives, and describes drugs that may diminish the effectiveness of oral contraceptives if taken simultaneously (such as Dilantin and Rifampicin).
2. The book has been divided into what we hope is a more logical approach to birth control technology. Section I deals with the technology of contraception, abortion, and sterilization. Section II covers several topics pertaining to the humane delivery of fertility control services.

We would like to dedicate this edition of *Contraceptive Technology* to two individuals who have made vast contributions to the task of defining the limits, the effectiveness, and the risks associated with contraceptive methods that are used today. *Contraceptive Technology 1978-1979* is dedicated to Dr. Christopher Tietze and Sarah Lewit. Christopher Tietze and Sarah Lewit, a husband and wife team, have separately and jointly written more than 200 articles, mostly in the field of human fertility and its regulation. Christopher Tietze, a native of Austria with an M.D. from the University of Vienna, came to this country in 1938. He has worked for the Johns Hopkins University School of Hygiene and Public Health, the U.S. Department of State, and the National Committee on Maternal Health. He is currently a Senior Fellow at the Population Council's Center for Policy Studies. Sarah Lewit, a graduate of Brooklyn College, was employed by the Department of Health, Education and Welfare and by the National Committee on Maternal Health before she joined the Population Council in 1967 as a Research Associate. Since 1973, she has worked as a freelance

writer. Tietze and Lewit were co-recipients of Planned Parenthood's Margaret Sanger Award in 1973.

As many have done before and as many will do in the future, our message to Christopher Tietze and Sarah Lewit is simple but heartfelt: Thank you.

Robert A. Hatcher, M.D.
Gary K. Stewart, M.D.

The photograph of Dr. Christopher Tietze and Sarah Lewit was taken by Robert Gilbert, New York City, N.Y.

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## Introduction: Principles of Family Planning

We believe that. . .

1. *Voluntary family planning is an important health measure.* The availability or unavailability of services has an enormous impact on the health of an individual, a relationship, a family, a community, and, indeed, an entire nation.

2. *Unless a certain method is contraindicated, patients have a right to make a voluntary, unpressured decision concerning birth control methods.* Practitioners should avoid labeling certain methods as "good" or "bad" or presenting methods in any biased manner.

3. *It is the family planning practitioner's responsibility to provide thorough information to, and to encourage questions from, the patient.* Each patient has a right to all information necessary for informed consent.

4. *Patients have a right to be treated with dignity in a private setting.* This facilitates frank discussions of embarrassing questions and personal matters and mitigates the fear of examination.

5. *Patients have a right to complete confidentiality in data systems and medical records.*

6. *Family planning practitioners are responsible for providing high quality health education to the community as well as to individual patients,* In order to be responsive to the community, practitioners should cooperate with schools, community groups, and local health programs. Also, there should be communication with the community through use of news media and printed materials.

7. *Each member of society has a right to family planning care regardless of ability to pay or social status.* Family planning is a right of each individual, including teenagers, prisoners, psychiatric patients, and those who are poor.

8. *Birth control, abortion, and sterilization are vital components of a voluntary, comprehensive family planning program.*

9. *Participation of male partners in family planning adds an important dimension to care.* This encourages couples to share responsibility for decisions, widens the scope of the family planning education program, and aids the practitioner in understanding and treating the patient.

10. *Family planning clinics can provide many non-contraceptive services to patients.* We cannot assume that every individual coming to a family planning clinic is there for contraception. Patients may be there for a

Pap smear, breast examination, treatment of a vaginal infection, V.D. test, or evaluation of an infertility problem. They may be practicing abstinence and may have no current need for contraception.

11. *The family planning clinic can facilitate the entry of individuals into other components of the health care system.*

12. *Population concerns should not be the major focus or objective in a family planning clinic.* Our patients for the most part do not come for services out of concern for world population pressures. Patients may be antagonized by the association of their medical clinics with efforts to achieve population stabilization.*

*This principle, discouraging population education within a family planning clinic, has been criticized repeatedly by readers of *Contraceptive Technology* who feel that population education should occur in the family planning clinic setting. The authors of *Contraceptive Technology 1978-79* unanimously agree that population pressures are already significantly diminishing the quality of life on this little spaceship called earth. We all would like to see population stabilization. The question is WHERE should population education occur? We obtained extensive comments from individuals on our patient advisory committees and from employees of family planning programs. Several comments opposed to population education in the clinic setting by patients and staff are noteworthy:

"There is a population explosion, but people come to the clinic for personal reasons."

"I personally feel that discussion of population problems in our clinic would be a waste of time."

"I personally feel that population concerns have no place in a family planning clinic. I think our patients come here for medical services not to hear or read about how many people are in the world."

"If you discuss population in the family planning clinic with written material, posters, or personal comments, the wrong person, that is, a militiant person, might get hold of it and cause trouble."