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# It's time for common sense on using Norplant

By **DOUGLAS J. BESHAROV**

Racist social engineering, "slow genocide," "technocrat equivalent of ethnic cleansing," "paternalistic domination of women," — those are some of the things being said by the opponents of Norplant, the new, long-lasting contraceptive.

But that's not what you hear from the women actually using Norplant. According to surveys, most are recommending it to their friends.

"I'm telling all my clients about it," one suburban Virginia hairdresser proclaims. "I was always depressed when I was on the pill. Since I started using Norplant, my mood has been great."

What's going on? Are these people talking about the same contraceptive?

Norplant is the first major new contraceptive since the pill was introduced in the 1960s. It works by slowly releasing low dosages of a synthetic hormone that mimics progesterone, the hormone produced during pregnancy, through six matchstick-sized capsules that are implanted under the skin on the inside of the upper arm. The resulting fan-shaped pattern is usually invisible, although the implants can be felt.

The implant, which lasts for five years, is more than 99 percent effective in preventing pregnancy; so, once the capsules are inserted, a woman no longer has to worry about contraception. If the capsules are removed, fertility is restored within one menstrual cycle.

Like other forms of contraception, it has its drawbacks. Some women experience irregular menstrual bleeding, headaches, weight gain, nausea and hair loss.

Although careful research on possible side effects is continuing, Norplant has already gone through rigorous clinical trials and no serious health risks were detected. One million women were using Norplant in 16 countries before the FDA approved it for use here in December, 1990.

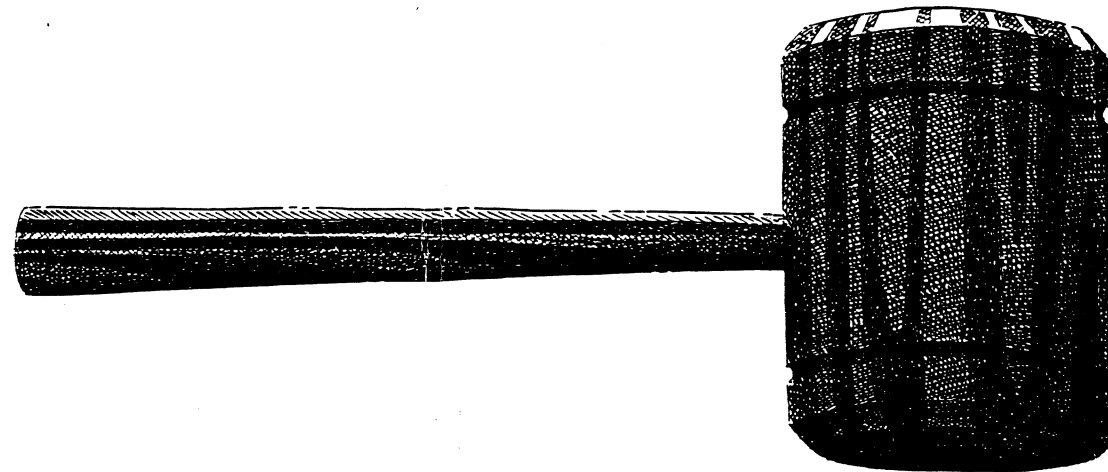
Since that time, more than 600,000 American women have sought the automatic protection from pregnancy that it affords. Less than 5 percent have had the capsules removed, either because of side effects or because they wanted to get pregnant.

In a clinical study conducted by the University of California at San Francisco, women were asked what features they most liked about Norplant. The most frequent response was "effectiveness" followed by "ease of use." Here's how one 17-year-old put it: "I was on the pill, but I couldn't remember to take it every day, and then I got pregnant. I just decided that if I got this everything would be a lot easier."

Norplant's very effectiveness is what has made it controversial. Upon learning about this amazing new contraceptive, some people's first reaction was to try to force it on women who "shouldn't be having children."

Only 23 days after the national media first carried stories about the FDA's approval of Norplant, and without knowing more than what he learned from one news clipping, a California judge incorporated it into the criminal sentence of a pregnant mother of four who was convicted of child abuse. (After first choosing Norplant as preferable to jail, the woman changed her mind and appealed the sentence.)

Then came a slew of legislative proposals to encourage or even mandate women on welfare to use Norplant. In Tennessee, a proposal to pay welfare mothers



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\$500 to get Norplant passed one house of the legislature.

So far, nothing has come of such ideas, but they have raised honest, although exaggerated, fears about social control over the reproductive decisions of disadvantaged women, particularly those of racial and ethnic minorities. And, in doing so, they have poisoned the atmosphere, making suspect even voluntary programs to increase the availability of Norplant.

That's what seems to be happening in Baltimore. In that city, 10 percent of the girls aged 15 to 17 years old have a baby each year. In an attempt to do something about this social and human catastrophe, the city's health department developed a plan to have its 10 school-based health clinics add Norplant to the list of contraceptives they already dispense.

The first school to offer implants was the Laurence G. Paquin School, a special facility for pregnant and parenting teenagers. Community activists have denounced the plan as racist for targeting a predominantly poor, minority population. "You're trying to control the reproduction of a race," says Rev. Melvin Tuggle, a minister in Baltimore's Garden of Prayer Baptist Church.

Both sides of this controversy — those who want to force women to use Norplant and those who fear that it is part of a racist plot to reduce African American births — are out of touch with the realities of women's reproductive lives. Both sides are assuming that many women have babies because they want to. But it's more complicated than that.

Even when contraceptives are used, many women get

pregnant. By now, the many ways that condoms can fail, through nonuse as well as misuse, should be well known. But many people may not understand how so many women who claim to be on the pill become pregnant.

The modern pill contains much lower dosages of estrogen and progesterone than the earlier versions. While these newer pills cause significantly fewer side effects, they require more precise use. Missing just one day puts a woman at risk of pregnancy. Missing more days is an invitation to pregnancy, as Patty Aleman, a nurse practitioner at the Capital 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 teenagers are not consistent with maintaining this kind of daily routine. Virginia Cartoof, a former social worker in inner-city Boston, found that many of her young clients lived in crowded households where pills got lost. Other women did not always spend the night in the same place, and would forget to take their pills along.

A quarter of all pregnancies are now terminated by an abortion, according to Alan Guttmacher Institute. In 1988, that was approximately 1.6 million abortions. Although white women account for about 65 percent of the total, the abortion rate for blacks is almost three times the white rate. But again the differences are largely economic, not racial: Low-income women of both races have almost triple the abortion rate of middle-class women.

Even if Norplant's only benefit was to reduce the anguish of abortion, it would be worthwhile. In fact, it is often after an abortion that young women decide they want the implant.

Many women do not want to have a baby but, for moral or other reasons (such as seeking an abortion too late in their pregnancies), do not or cannot get an abortion. Thus, in 1988, 12 percent of a representative sample of women who had a baby in the last four years said that their children had been "unwanted." For women below the poverty line, the figure was 25 percent.

These realities have led many women to turn to sterilization. Since the early 1960s, Lorraine Klerman, the director of the Maternal and Child Health Program at the University of Alabama, has studied inner-city adolescent mothers and their problems. She says that young people in the programs she followed 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."

Frank Furstenberg, a sociologist at the University of Pennsylvania, conducted an 18-year, longitudinal study of 322 primarily low-income Baltimore women who gave birth as teenagers. He found that there was "high incidence of voluntary sterilization" among the women who were in their late 20s and early 30s.

Indeed the rates were so high — more than half the women were sterilized — that some might suggest a conspiracy to sterilize inner-city minorities. But sterilization rates in the population as a whole are also high. In fact, sterilization is the single most common form of contraception in America today.

Put simply, large numbers of American women of all races and economic statuses resort to sterilization because they are dissatisfied with existing methods of birth control. Thus, the availability of Norplant should actually lower the rate of sterilization, or at least result in delayed sterilization.

The Center for Addiction and Pregnancy at Baltimore's Francis Scott Key Hospital, for example, operates a comprehensive program for drug addicts who are pregnant or already parents. All women who enter the program are required to choose a method of contraception. Between June 1991 and April 1992, 50 percent of patients chose Norplant. Half that number, 24 percent, chose sterilization.

The association between poverty and dim life prospects on the one side and unwise child-bearing on the other is too obvious to ignore. In 1989, 27 percent of all births were out of wedlock, with 19 percent of white babies and 64 percent of black ones being born out of wedlock.

As University of Pennsylvania professor Elijah Anderson notes, "Most middle class youths take a stronger interest in their future and know what a pregnancy can do to derail it. In contrast, many [inner-city] adolescents see no future to derail — hence they see little to lose by having a child out of wedlock."

Because those people who have the most to look forward to are the most responsible about their sexual practices, it is not too much of an exaggeration to say that good education and real opportunities in life are the best contraceptives. But, until those ideals are achieved, Norplant is an important option.

Rather than being an instrument to control disadvantaged women, Norplant can empower them. It gives women better control over their fertility. All we have to do is make sure it is readily available to those who want it.

Over 120 years ago, Ralph Waldo Emerson pointed out that, if you build a better mousetrap, the world will beat a path to your door. In the field of contraception Norplant is that better mousetrap. And both sides of the Norplant debate would be wise to just step out of the way.

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