The contraceptive revolution of the 1960s and 1970s brought the pill, the IUD, the injectable, and the implant, all extremely effective forms of reversible contraception if used correctly. Yet despite the millions of dollars poured into research, that revolution did not bring many improvements in contraceptive safety. On the contrary, the health risks of these methods are considerable and are compounded by their misuse in population programs. They also do not guard against sexually transmitted diseases such as HIV/AIDS.

Today there is a need for a second contraceptive revolution. "Without giving up the high effectiveness, convenience, and relatively low cost of today's contraceptives," write Judith Bruce and S. Bruce Schearer, "tomorrow's contraceptives must be safe in both the short- and long-term; fully reversible and free of effects on future fertility...on breast-feeding infants and on lactation."

The irony is that such methods already exist, in the form of barrier contraceptives—spermicides, condoms, diaphragms, cervical caps—though there is great need and scope for their improvement. Yet with the exception of the condom, these safe, simple, revers-
ible contraceptives are unavailable in many, if not most, Third World family planning programs, and in Western countries people are also often discouraged from using them. Less than 2 percent of contraceptive users worldwide use female barrier methods, and only 6 percent use condoms.²

Within the population community, the prejudice against barrier contraceptives runs deep. "The diaphragm was useful in the Western world when services had to be based in clinics and before IUDs or pills were invented," wrote Dr. Malcolm Potts, one of the most prominent researchers in the field, in 1976. "It is a Model-T Ford, still running in a few places, but insignificant at a world level.³

Are barrier methods really so anachronistic and insignificant—or could they be the foundation of a second contraceptive revolution, in which health and safety come first?

BARRIER METHODS REVISITED

The needs of millions of men and women throughout the world are being neglected because of a one-sided concentration on high technology birth control methods.

—Judith Bruce and S. Bruce Schearer, 1984

Unlike antique cars, barrier methods are still a very useful technology. During the first half of the twentieth century, the diaphragm and condom were the most common forms of contraception in the United States. Although their use declined with the development of the pill and IUD, barrier methods are gaining favor again as more people grow wary of the side effects of modern methods and want to protect themselves against sexually transmitted diseases (STDs), especially AIDS. Condom use is especially high in Scandinavian countries, and is highest of all in Japan, where nearly 70 percent of all contraceptive users rely on condoms.⁵ Barrier use, however, remains considerably lower in developing countries than in developed ones.

What are the advantages of barrier methods? Unlike hormonal contraceptives and the IUD, they cause no known major side effects. When used with the backup of legal abortion, they are the safest by far of all reversible contraceptives in terms of mortality risks.⁶ They do not cause any delay in or risk to fertility after cessation of use and, in addition, help to protect users from a number of sexually transmitted diseases, which are a primary cause of infertility and morbidity in many parts of the world. Barrier methods also reduce the risk of acquiring cervical cancer—a major killer of women, while hormonal methods may increase it. (See Box: Barriers to AIDS.)

BARRIERS TO AIDS

Barrier methods have a vital role to play in the fight against AIDS. Although condoms are the main defense against sexual transmission, not only do they sometimes fail, but men often fail to use them. This has grave implications for women, who face a higher risk of acquiring HIV though heterosexual sex than do men. By the year 2000 as many or more women will be infected with HIV than men, and according to the World Health Organization (WHO), the primary mode of transmission is now heterosexual sex.

For many women getting men to wear condoms is difficult, if not impossible. Within relationships women can suffer harassment, abandonment, or physical violence if they insist on condom use, and forced sex is all too common. Women-controlled methods are thus an essential option, though questions remain regarding their efficacy.

For example, recent research is contradictory as to whether nonoxynol 9, a common ingredient of spermicides, reduces the risk of acquiring HIV. A study of sex workers in the Cameroon found that consistent use of nonoxynol 9 vaginal suppositories reduced their risk by 90 percent compared to women who used the suppositories infrequently; on the other hand, a study of sex workers in Kenya found that daily use of contraceptive sponges that contained nonoxynol 9 may have increased their risk of HIV infection, probably because the frequent use of the chemical caused cervical and vaginal abrasions which speed HIV transmission. As a result, public health advocates are unsure what message to convey to women. The New York State Department of Health recommends condoms or abstinence as the best prevention against AIDS, followed by the diaphragm used with a spermicide containing nonoxynol 9, with nonoxynol 9 alone the last resort.

Another possible line of defense against HIV would be the development of an intravaginal microbicide, which would kill the virus. It could take a number of forms: foam, suppository, or film, and could be used secretly if it had no taste or scent. There could also be
a non-contraceptive version for women who wanted to get pregnant but protect themselves at the same time. Currently, a coalition of researchers and women's health activists are pushing for more funds to be allocated to developing microbicides.¹

In general, women's needs have been neglected in AIDS research, detection, and treatment, or else women have been scapegoated, as in the case of prostitutes, who are far more likely to acquire HIV from their male partners than the other way around.² Population control programs can also stand in the way of HIV prevention. Not only do they push contraceptives which do not protect women from HIV and other STDs, but methods which involve the use of needles and trocars, such as Depo-Provera, Norplant, and the new "vaccines," could be an additional risk factor in settings where instruments are not adequately sterilized. And the persistent targeting of women means that men do not learn to act responsibly—by using condoms, for example.

Privately some contraceptive researchers admit they made a big mistake twenty to thirty years ago when they decided to neglect barrier methods and STD prevention in the quest for ever more effective and technologically sophisticated means to prevent births. We are now reaping the grim harvest of that neglect.

The WHO has endorsed barrier methods as particularly suitable for lactating mothers, since they do not affect either milk quality or quantity. They may also be especially appropriate for the increasing numbers of sexually active unmarried young people throughout the world, who are either unwilling or unable to get contraceptives through formal channels and who face a high risk of sexually transmitted disease.⁷

And the disadvantages? Minor side effects include allergic reactions to spermicides or latex. More serious ones are incidences of toxic shock syndrome in women who have left the diaphragm or contraceptive sponge in place for extended periods of time, and higher rates of urinary infections among diaphragm users. Earlier studies suggested that spermicides may cause a higher rate of miscarriage and birth defects among women who continue to use them after conception, but these have been discredited.⁸

The primary criticism leveled against barrier methods, especially from population control quarters, is their high failure rate. According to Population Reports, for example, female vaginal methods "are less effective than oral contraceptives, IUD's, and voluntary sterilization."⁹

Yet, in reality, the clinical data on the performance of barrier methods varies widely, ranging from a pregnancy rate of 2 per 100 users per year, comparable to the pill and IUD, to a high of 30. What accounts for such a difference?

Most studies show that long-time, experienced users of barrier methods have more success in preventing pregnancy. According to Bruce and Schearer, successful use also depends on "full information, competent instruction and follow-up support."¹⁰ Because barrier methods must be used with each act of intercourse, their efficacy requires cooperation between partners.

When comparing how effective barrier methods are in relation to other reversible contraceptives, it is important to remember that in many Third World countries high pregnancy rates result from improper use of the pill. And in terms of continuation rates, the side effects of the pill, IUD, and injectables cause from 40 to 70 percent of users of these methods to abandon them within two years. In fact, fear of adverse effects prevents from one quarter to one third of married women of reproductive age from using any contraceptives at all!¹¹ Even in population control terms, the modern "miracle" methods are not that effective, so why then are barrier methods the subject of so much scorn?

The prejudice against barrier methods has several roots. First, poor people, especially the illiterate, are alleged to be too embarrassed and ignorant about their bodies even to attempt to use them. Second, the methods are deemed "inconvenient," "awkward," and "intrusive." In many settings they may be difficult to wash, store, and dispose of. Third, their use requires that a couple be willing and able to cooperate with each other; a woman cannot use barrier methods surreptitiously, like Depo-Provera. Last, but not least, many population people argue that it takes too much time and resources to educate people about them and to provide adequate follow-up.
Do these arguments really add up to a decisive case against barrier methods? Many problems could be overcome if the methods were introduced with sensitive instruction and follow-up and a stress on joint male-female responsibility for contraception. Sanitation, storage, and disposal problems, though difficult, are not insurmountable. As for costly education and follow-up, shouldn't family planning programs devote resources to these crucial activities in the case of all contraceptives?

To the limited extent that barrier methods have been introduced in Third World family planning programs, it is not surprising that they have sometimes proved less effective than the so-called modern techniques. As Bruce and Scheerer explain, biases against barrier methods tend to be self-fulfilling:

The policymakers' prophecies of the incompetence of poor women are confirmed by the results that occur when barrier methods are introduced with little or no understanding of rural women's culture, and without thorough education and follow-up.12

More often than not, barrier methods are simply not made available or are promoted with far less enthusiasm than the pill, IUD, or sterilization. Population Reports notes that negative "providers' attitudes" are instrumental in restricting access to them, and that their popularity might well increase if their benefits were stressed.13

Indeed, there are a number of encouraging examples of the successful promotion and use of barrier methods in Third World settings. A Bombay clinic achieved an effectiveness rate of 90 percent for the diaphragm among women who maintained contact with the clinic, and success was not correlated with variations in income level, education, or availability of tap water.14 In Brazil the Colectivo Feminista Sexualidade e Saude in Sao Paulo provides diaphragms to 40 percent of its 2,000 contraceptive clients with supportive sexuality education, training, and follow-up. Continuation rates are high, and accidental pregnancies appear to be few.15

In a number of countries, the vigorous promotion of condoms through both commercial channels and family planning programs has led to a significant increase in use.16 Unlike the pill, condoms and spermicides are well-suited to mass distribution and social marketing schemes, since they do not require medical supervision.

Even if barrier methods were to prove only moderately effective or personally acceptable, they could be an important option for women who want to space births, who have access to safe abortion, or who are disillusioned with other contraceptives. At the very least, people should have the choice.

Donor agencies have played an important role in restricting that choice, particularly when it comes to female methods. For example, AID gave an average of only 25,000 diaphragms per year between 1978 and 1982, as opposed to providing an average of 8.5 million women with oral contraceptives annually during the same period. AID's record is much better on the condom—it now provides over a half billion a year.17

The rationale given for this bias is that AID and other agencies are simply responding to requests from Third World family planning programs, and if there is not much demand for barrier methods, then why should they provide them?

As we have seen, however, contraceptive demand is heavily influenced by the donor agencies themselves. If barrier methods were promoted with the same determination as the pill, IUD, injectable, and sterilization to governments and family planners, the contraceptive experience of many people might be very different indeed.

The bias against barrier methods in family planning programs is matched by their relative neglect in contraceptive research. Two of the major research institutions, the Population Council and the WHO Human Reproduction Program, do virtually no research on barrier methods. Since 1987 the U.S. National Institute of Child Health and Human Development has devoted 10 percent of its contraceptive research budget to barrier methods, and AID's Contraceptive Research and Development Program almost 15 percent.18 Systematic exclusion from research programs has led to stagnation in barrier technology: Many of its current drawbacks reflect what Bruce and Scheerer call an "unnecessary obsolescence."19

Yet in the field of barrier technology, even minor improvements could make a major difference in terms of acceptability. Despite the low level of resources, new products have been developed and old products refined and improved. These include the contraceptive sponge, with research funded by AID and the National Institutes of Health; the cervical cap, whose introduction and testing in
the U.S. were initiated by the feminist health community; the female condom, only recently brought to market; improved male condoms, e.g., condoms made from polyurethane; and varieties of spermicide foams and tablets. Unfortunately, it is doubtful these products will reach developing countries in any sizeable quantity in the near future given the population community's current obsession with Norplant and other long-acting technologies.

Yet there are some grounds for hope. In the past ten years, public pressure, especially from the women's health community, consumer demand, and the threat of AIDS have helped to increase funding for barrier research from a few isolated drops to a slow trickle. Although these are hopeful signs, much more positive action is needed now, if the tide is to be turned and barrier methods are to occupy the prominent place they deserve in contraceptive technology.

THE NATURAL WAY

Like barrier methods, natural family planning (NFP), or periodic abstinence, as it is also called, provides an important alternative to hormonal and surgical forms of birth control. Natural family planning involves a woman identifying the fertile and infertile periods in her monthly cycle by employing the following techniques: the calendar or “rhythm” method, which charts the time of ovulation according to the pattern of a normal menstrual cycle; the temperature method, which identifies ovulation by a rise in body temperature; the mucus or Billings method, which both predicts and identifies ovulation by changes in the consistency of cervical mucus; and the symptothermal method, which combines elements of the other three and which in several studies has proved the most effective. Because all these methods help to pinpoint the fertile period, they can be used to increase the chances of getting pregnant as well as to prevent pregnancy.

An estimated 7 percent of contraceptive users worldwide employ some technique of natural family planning. In only six Third World countries—Haiti, Mauritius, Peru, the Philippines, South Korea, and Sri Lanka—are more than 5 percent of married women of reproductive age known to use the method. Ireland and Poland are the two industrialized countries with the highest use.

NFP has been promoted primarily by the Catholic Church, which sanctions the method as the only acceptable form of contraception, stressing the moral value of abstinence during the fertile period. The two main international organizations that teach and promote NFP are the International Federation for Family Life Promotion (IFFLP) and the World Organization of the Ovulation (Billings) Method (WOOMB). WOOMB only promotes the mucus method and is hostile to the others.

NFP's success in preventing pregnancy largely depends on training, motivation, and cooperation between partners. Failure rates are quite high in some studies—up to 30 percent—whereas in others they are comparable to the more effective contraceptives. In one project in India where close follow-up was top priority, only three pregnancies were reported among 813 women in the first year. Among the advantages of the method are that it is cheap, demands no regular source of supply, causes no side effects that require medical supervision, and encourages active participation by both partners.

If used without any contraceptive backup, NFP has the major drawback of requiring abstinence during the fertile period. Many of the pregnancies that do occur result from couples deciding not to abstain, or husbands forcing their wives to have intercourse. Audrey Bronstein describes some of the “sexual politics” which emerged in an NFP training course she attended in El Salvador:

A number of women said that abstinence didn't work, because the husbands often came home drunk and would beat them if they didn't agree to have sex. They also said that if the women tried to refuse too many times, the men would go off, and find other women. On the positive side, they felt that where there was a small understanding between the couple, practicing abstinence increases the man's respect for his wife, and will help create a “dialogue” between the two.

In Kenya a missionary teaching the method reported, “Women show up by the hundreds, but the men do not want to make the effort to keep the rules, even if they see the need to limit their families.” To some extent, the problem of abstinence can be overcome by the use of barrier methods on fertile days (especially the condom, which does not interfere as much with mucus symptoms).
However, many NFP promoters are against these "artificial" methods for religious reasons, just as they are against abortion in the event of method failure.

Like barrier methods, NFP has been neglected by population agencies, though NFP organizations have received small amounts of funding from AID, UNFPA, WHO, and the British, Canadian, and German governments. Under Reagan, AID increased its support of NFP, mainly under pressure from antiabortion forces in the United States. In FY 1985 AID devoted over $7 million to NFP activities, as opposed to only $400,000 in 1980.27

Population agencies typically base their case against NFP on three main grounds: effectiveness, the need for careful counseling, and cost. "Where competition for scarce government family planning dollars and an urgent need to promote fertility control require strict attention to cost- and time-effectiveness," wrote the Population Crisis Committee, "experts usually assign NFP a lower priority than other, more effective methods."28

As we have seen, however, the more "effective" contraceptives also have high failure and low continuation rates when introduced improperly. NFP's success does depend on careful counseling, but so do the effectiveness and ethical use of almost all contraceptives. According to the WHO, the once-a-month follow-up required by NFP "is greater than could be provided in national family planning programs," and the cost often prohibitive.29 Yet otherwise natural family planning is free aside from the cost of a thermometer or charts.

Surely, when everything is added up, teaching one woman NFP is not more costly than providing that person with many cycles of pills, the IUD, or sterilization and treating their side effects. One wonders if the issue is not really costs but profit, for NFP is the one contraceptive method where no profits accrue to either the pharmaceutical industry or the medical profession.

NFP research also suffers from lack of funds. From 1980 to 1983 it received only 0.6 percent of expenditures for contraceptive research and development, for example.30 However, research is underway on more accurate ways of determining ovulation, through better thermometers, tests on urine, mucus, and saliva, and even a way to monitor temperature changes in the hands.31 The development of a foolproof, convenient way to identify the fertile period would greatly enhance both the acceptability and reliability of natural family planning.

The attitude of the population establishment is not the only obstacle to more widespread promotion of natural family planning. Since many of NFP's advocates oppose other forms of birth control, they are against NFP's inclusion in comprehensive family planning programs. Affiliates of WOOMB, for example, issued this declaration:

A fundamental concept of the philosophy of WOOMB is the acceptance of periodic abstinence and the rejection of artificial contraception, abortion and sterilization, each member [of WOOMB] undertaking not to counsel for or dispense such methods of birth control.32

This approach to NFP not only limits its availability, but ultimately restricts women's choice. Many women, for example, might be willing to use natural family planning with the backup of barrier methods and/or abortion, but in their absence are worried about high failure rates. Others may choose NFP only at certain times during their reproductive years, when they are more concerned with spacing births and are willing to accept an earlier than expected pregnancy. At other times they may well want access to other contraceptives.

Fortunately today, in addition to support from more traditional advocates of natural family planning, support is also building among women disillusioned with the side effects of other contraceptives and interested in a more holistic approach to birth control, in which a woman's knowledge of her own body and male cooperation are key. Such advocacy could help change the tenor of natural family planning, so that it is both more acceptable and accessible in the future.

ON THE HORIZON: DARK CLOUDS AND GLIMMERS OF LIGHT

Years ago, when I was myself working in endocrinological research, vaccination ideas like this were raised and promptly dismissed as unethical and dangerous; I do not think the balance of argument has changed, except that the threat has come closer, and people are now actually being exposed.

—GRAHAM DUKES, World Bank advisor on pharmaceuticals, commenting on current contraceptive "vaccine" research.33
Although public pressure and the AIDS epidemic have led to some shift in direction, the biased pattern of contraceptive research, development, and promotion we have witnessed in recent decades is likely to continue, especially given the resurgent population crisis mentality of the 1990s. One of the most worrying areas of research is on "fertility regulating vaccines," as they are commonly called in the literature. Feminist researcher Judith Richter prefers to use the term "immunological contraceptives" to distinguish them from vaccines against diseases.

As health activists point out, "Vaccination against disease works by stimulating a person's body to defend itself against a specific type of germ.... Pregnancy, however, is not a disease but a natural body process. Immunological contraceptives cause the immune system to attack a body function which would otherwise be protected." As health activists point out, "Vaccination against disease works by stimulating a person's body to defend itself against a specific type of germ.... Pregnancy, however, is not a disease but a natural body process. Immunological contraceptives cause the immune system to attack a body function which would otherwise be protected."35

Immunological contraceptives differ according to whether they are targeting reproductive hormones, eggs, sperm, or early embryos. The most advanced methods are directed at the pregnancy hormone human chorionic gonadotrophin (hCG) and are designed to be effective for one to two years. Part of the hormone hCG is combined with a foreign substance, typically part of a tetanus or diphtheria toxoid, and injected into a woman. When her immune system defends itself against the toxoid, it also attacks hCG produced by her own body, thus preventing pregnancy from taking place.

Immunological contraceptives currently account for an estimated 10 percent of worldwide public spending on contraceptive research—in 1992, the WHO's Human Reproduction Program spent almost one million dollars, or 16 percent of its annual contraceptive research budget, on them. Other agencies conducting research are the Population Council, the U.S. National Institute of Child Health, Contraceptive Research and Development Program (CONRAD), and the National Institute of Immunology in India.

Population control is a key motivation behind immunological contraceptive research. In 1982 Rodney Shearman, a contraceptive researcher, wrote that immunological contraceptives would be an "antigenic weapon" against "the reproductive process, a process which left unchecked threatens to swamp the world." Similarly, Vernon Stevens, one of the most prominent scientists working in the field, described them as "a new method for more effectively meeting the challenge of ever-increasing global population expansion."36

Immunological contraceptives pose a number of problems and serious health risks which make it questionable whether they should be developed at all. In the case of hCG methods, these include:

1. **Temporary irreversibility.** So far there is no way to halt the immune reaction if a woman experiences side effects, is pregnant when she receives the vaccine, or becomes so while the reaction is still occurring.

2. **Unpredictable effectiveness.** It typically takes over five weeks for a woman to develop an effective immune response after taking the vaccine, and this "lag time" differs considerably for different women. In the meantime another contraceptive method must be used. There is also no one standard time when the immune response declines to the point where a woman can get pregnant. Blood must be drawn to determine the beginning and cessation of the immune response. As women health activists have pointed out, the vaccine is actually much less reliable than other contraceptive methods.

3. **Risk of birth defects.** The impact of the vaccine on the developing fetus is not known. This is a critical gap in knowledge, given the high risk of accidental pregnancy associated with the vaccine.

4. **Allergic reactions.** Reactions, sometimes severe, can occur to the diphtheria and tetanus toxoids used in vaccine formulations. This necessitates the availability of advance screening and emergency medical treatments.

5. **Risk of permanent sterility and auto-immune disorders.** No one knows whether or not long-term use of the vaccine could lead to permanent sterility. Equally troubling is the vaccine's potential for causing or worsening auto-immune disorders, in which the immune system reacts against body organs or cells. Such disorders, which include rheumatoid arthritis, lupus, and diabetes, are already more common in women than in men.

6. **Cross-reactivity.** The vaccine formulations used by the Population Council and Indian researchers cross-react with another im-
portant reproductive hormone, hLH (human luteinizing hormone), produced continually by the pituitary gland. Possible risks include menstrual disorders and inhibition of ovulation, as well as auto-immune disorders. The WHO itself is concerned about the long-term impact of these formulations, and uses a different one which does not cross-react with hLH.37

7. Interaction with AIDS. Vaccines offer no protection against HIV and other sexually transmitted diseases. They are likely to be less effective in people with damaged immune systems as the result of HIV infection and could possibly aggravate HIV-related illnesses by putting an additional demand on the immune system.

8. Potential for abuse. As Judith Richter and Faye Schrater have pointed out, immunological contraceptives could easily be used coercively. Moreover, offering them as "vaccines" gives a false sense of safety. If people have negative experiences with them, it could give all vaccines a bad name, a potential public health disaster.

Already, documented violations of medical ethics have occurred in clinical trials in India, where misinformation and inadequate informed consent procedures have even been captured on film. German film-makers Ulrike Schaz and Ingrid Schneider show an Indian woman enrolling in a vaccine trial being told:

We have got a new injection...the effect of the injection stops children for one year... You need not be afraid of this. The injection has no side effects. You see, this injection is absolutely 100 percent effective...we'll also put in a copper-T [for use during the lag period]. Continuous copper-T is not very good. If you have it 3 years, 6 years, then there is the risk of cancer. That's why we want you to change.38

Women were asked to sign the consent forms in English, even though few understood the language.

As a result of these concerns, in 1993 a coalition of community groups, women's organizations, and health activists issued an open letter to researchers, funders, and the press calling for a halt to immunological contraceptive development and redirection of funds towards safer methods which people can control themselves.39 The research nevertheless continues, with Phase II trials of the WHO hCG vaccine now underway in Sweden.

Meanwhile research on males continues to lag behind, though it is now receiving more attention than in the past. Not surprisingly, concern about safety and side effects appears to be higher in male contraceptive research than in female. "We want to go very slowly," said one researcher at the University of California. The female pill "was applied very rapidly, and later we found a series of very serious complications."40 The WHO also found greater reluctance among men than women to volunteer for clinical trials.41

Hopes that a pill for males (made of Gossypol, a derivative of cottonseed oil) was just around the corner were dashed when clinical trials in China revealed a number of serious side effects, including temporary paralysis and heart ailments caused by a severe drop in blood potassium levels, and a high rate of permanent sterility. The WHO withdrew all funding of Gossypol research in China, but the Chinese government is pressing on.42

Other avenues of male contraceptive research include testosterone injections, combined androgen-progestogen injections (some of which contain the same hormone used in Depo-Provera), male immunological contraceptives, simpler forms of vasectomy, reversible plugs which block the passage of sperm in the vas deferens, and simpler heat-based methods, such as application of hot water and insulated underwear, since heat has long been known to depress sperm production.43

In the "better late than never" category, support is building for promoting breast-feeding as a fertility control measure in family planning programs.44 And it is important to mention here that despite the population establishment's bias against traditional methods, withdrawal continues to be a major form of fertility control, utilized by 8 percent of contraceptive users worldwide.45 Unfortunately in 1988 the WHO stopped its research on indigenous plants and herbs used for contraception—this remains a seriously underfunded (practically nonexistent) branch of contraceptive research.

**COOPERATION OR COOPTATION?**

In recent years women's health advocates have been invited to engage in dialogues with contraceptive researchers to share concerns and ultimately to create a "common ground," a "collaboration between the users of technology and the creators of it."46 The
WHO's Human Reproduction Program and the New York-based International Women's Health Coalition are among the chief initiators of this strategy.

On the positive side, these dialogues attest to the growing power of the international women's health movement and the willingness of some scientists to incorporate feminist approaches in their work. For example, the 1993 Declaration of the International Symposium on Contraceptive Research and Development for the Year 2000 and Beyond contains a number of recommendations addressing women's concerns, such as including women's health advocates in all decision-making and advisory bodies that guide contraceptive research and placing emphasis on methods which are user-controlled and protect against STDs.47

On the negative side, dialogues have sometimes muted dissent and served to legitimize the contraceptive research agenda without altering it in any significant way. Words are cheap; action is not.

For example, in 1989 the WHO invited a handful of critics to a symposium on contraceptive vaccines attended mainly by scientists who had a direct interest in the research. Although the critics—women's health advocates and social scientists among them—voiced serious concerns about the vaccine's health risks and the potential for abuse, their comments were sanitized in the final report. According to the WHO, the outcome of the meeting was a grand hurrah for further vaccine research.48

Another WHO-sponsored meeting in 1992 invited many more women health advocates to dialogue with vaccine researchers. In the final document, their critical comments are reported more comprehensively, including their concern "that their names and presence would be used to legitimize both the content and the process of research in an area about which many were doubtful." Their doubts—and in some cases outright opposition—have led to no major changes in the research agenda, however.

There have also been attempts to involve women's health advocates in the introduction and monitoring of Norplant. Referring to a series of such meetings in India, an activist writes that although they were ostensibly designed to open up a dialogue, their main purpose was to "to divine [women's] arguments, appropriate their language and finally exhaust them."50

As a result of these experiences, many women's health advocates are arguing for a more strategic approach to involvement with the research establishment. They acknowledge that meetings can offer opportunities for gaining access to important information and in some cases for pushing policy reform, but recognize the fundamental power imbalance between the agencies who control the funds and the activists whose voices are heard only at the agencies' discretion. Precautionary measures, such as reserving the right to make dissenting comments which will be published, unedited, in official reports, are one way to address this imbalance.

The situation becomes even trickier when women's groups are asked to monitor contraceptive trials. Not only could their involvement serve to legitimize the introduction of a drug like Norplant, but it also could take time and energy away from other pressing work. On the other hand, access to the trials means access to the women subjects and to vital information. Do you or do you not agree to participate? There are no easy solutions to these dilemmas, and they are only likely to get more problematic as the new population "consensus" seeks to dull the edge of the women's movement by drawing activists into the fold.

And if you're not in, you're out. A marginalization process is already occurring in which a sharp line is drawn between those women who are willing to cooperate with the establishment and those who, for whatever reason, are not. Women who are opposed to a particular technology—Norplant or the vaccine, for example—are often branded as extremists who oppose all technologies, when in reality they do not. This false dichotomy makes it more difficult to maneuver, to choose strategically when and how to cooperate, since once a woman is branded as an extremist, most doors are shut. To be acceptable to the establishment one must buy the line that more funding for contraceptive research is a high priority. But shouldn't the house be put in order first before it is expanded? Population control, prestige, and profit still largely guide contraceptive research, determining the nature of the technologies produced. Although men and women could use more contraceptive choices, one must be vigilant about who is doing the choosing.

Priorities also need to be questioned. Why is there more interest in contraceptive research than in reducing maternal mortality?
The Swedish International Development Authority (SIDA) recently took the courageous step of redirecting 30 percent of its funds for contraceptive research to a large maternal mortality study. This is a small but important challenge to the status quo.

In the end, increasing access to safe, voluntary contraception is more a social problem than a technical one. It may be a long time—or forever—before the “perfect” contraceptive is produced. Meanwhile, greater equality between men and women, emphasis on health, safety, and the prevention of sexually transmitted diseases, rather than demographic effectiveness, and safe, accessible abortion services would go a long way toward improving women’s experiences of birth control. If there is to be a second contraceptive revolution, let it start with a revolution in values.