PREGNO!

a young woman's guide to the pill & other contraceptives

A Do It Now Foundation Publication by Jennifer James & Colleen Pixley

PREGNOT!

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by Jennifer James & Colleen Pixley

Illustrations by Rich Needham

Ch-Ch-Changes: Contraception Today

Percentage of women (15-44) using contraception, 1982:	56
Women using contraception in 1995:	64
Using contraceptives during first intercourse, 1990's:	76
During first intercourse, pre-1980:	50
Decline, women using no contraception, 1982-95:	30
Contraceptive users who also used condoms, 1988:	15
Contraceptive users who also used condoms, 1995:	20
Women using the pill in 1988: 31. In 1995:	27
Women using diaphragm in 1988: 6%. In 1995:	2
IUD users in 1988: 2%. In 1995: Less than	1

*All numbers represent percentages

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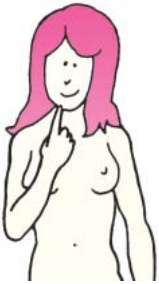

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Rule #1 in not getting pregnant: Don't have sex.

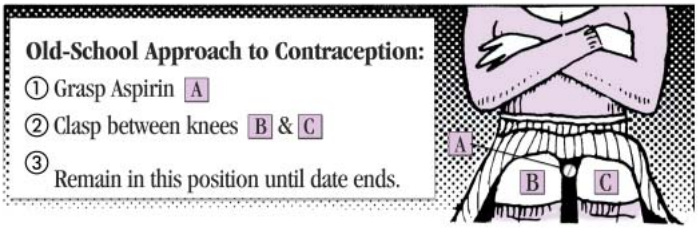
That's an interesting (and fool-proof) approach to birth control, but one that's clearly not for everybody. So what's Rule #2?

It's this: Don't have sex without contraceptives. That's probably a more useful (and more practical) approach for more women than Rule #1, *or* its corollary that you won't get pregnant if you hold an aspirin snugly between your knees on a date.

That's also why for years, the favored contraceptive for millions of women around the world has been the Pill.

(No need to explain *what* pill. Since word first leaked out about its development in the late 1950's, everybody's known *what* pill as soon as you mention the pill.)

Since oral contraceptives are effective and easy to take, they've achieved great acceptance as a birth control technique. In fact, until recently (and until AIDS) many women considered the Pill the *only* way to stay non-pregnant.



And the Pill remains awfully popular. In the year 2000, birth control pills were still being taken by 10.4 million women in the United States, or 27 percent of the female population in their childbearing years.

That's why we've put together this booklet. Because in spite of its popularity, the Pill has never been shown to be totally safe. And safer contraceptive techniques have never been shown to be totally effective.

And with every day seemingly bringing more bad news about AIDS and about who's at risk and why, it's important that every woman have access to information about birth control methods that provide the protection we all need against pregnancy and AIDS.

So if you're interested in staying pregnancy-free and protected against AIDS, give a listen-and some thought-to the points we raise in this booklet. Then make the birth control decision that's best for you.

Because all the pills and implants and hormones in the world aren't as powerful-and as precious-as you are, and we want to help you keep things that way.

So what is the pill, anyway?

Actually, the Pill is not any one thing, but several, depending on the exact blend of synthetic hormones found in any particular preparation.

Known medically as *anovulatory* agents (since they block ovulation, or the release of the egg cell by the ovary), oral contraceptives today fall into two main groups: combination pills and mini-pills.

Combination pills contain varying amounts of two synthetic hormones, progestin and estrogen, while mini-pills contain smaller amounts of progestin only.

Oral contraceptives have been around, in one form or another since 1960, when the first Pill was introduced. They are highly effective when used as directed, with combination-type OC's rated as slightly more effective than mini-pills.

The two types of pills are also taken differently. Combination pills are taken for 21 consecutive days with a seven-day break before and during menstruation, while mini-pills are taken every day.

Why two different types?

Mostly due to health considerations. Combination pills contain a small amount of the female hormone estrogen, which reduces spotting or breakthrough bleeding.

However, many of the health risks associated with oral contraceptives have been linked to estrogen, which has led to the development of progestin-only mini-pills.

So how do the pills work?

Before we can fully answer that one, we're first going to need to do a short review of Sexual Physiology 101.

When a little girl is born, her ovaries contain hundreds of thousands of tiny sacs, called follicles, each of which contain an egg cell, or ovum. But unlike males, who produce hundreds of billions of sperm cells in their lives, only 400-500 of a woman's follicles ever develop to maturity.

When a follicle matures, an egg cell is released which moves into the Fallopian tube, where it either meets up with a sperm cell or it doesn't, and fertilization either does or does not occur.

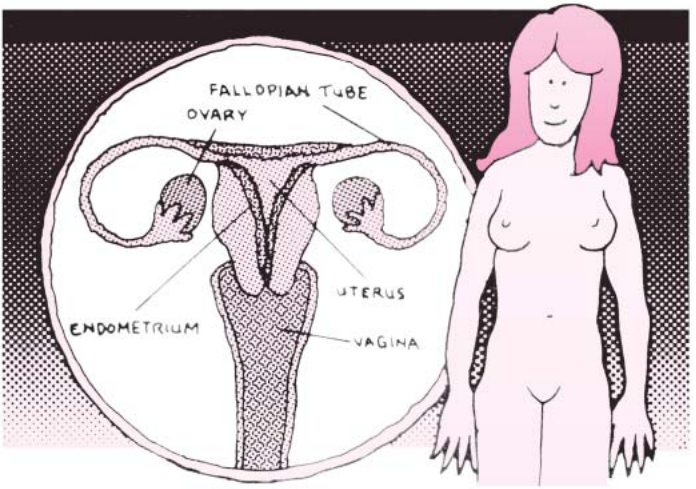
The egg cell then moves to the uterus where, if it's been fertilized, it embeds itself into the endometrium, the blood-rich lining of the uterus, which

provides a safe, supporting environment for an implanted embryo. If the egg is unfertilized, both it and the endometrium are washed away in the menstrual blood flow.

Sound simple so far?

It isn't. Because all aspects of ovulation are controlled by hormones, the most important of which are estrogen and progesterone (which are both secreted by the ovaries) and two pituitary hormones, follicle stimulating hormone (FSH) and luteinizing hormone (LH).

This is where it gets complicated. Because it's the effects and interplay of these hormones that provide the basis for ovulation-or the prevention of ovulation, depending.



Depending on what?

Depending on whether you take the Pill or not.

Otherwise, during the first week of the menstrual cycle, pituitary secretions of FSH spur development of the follicle, which in turn increases the growth and thickening of the uterine lining. Then, just when the follicle is about to rupture (and release the egg), estrogen levels drop, which causes the pituitary to increase levels of LH, which triggers ovulation.

During ovulation, the now-ruptured follicle releases progesterone, which signals the uterine lining to prepare itself for implantation of a fertilized egg, if a fertilized egg comes along. If none shows up, both estrogen and progesterone levels drop, and we're back where we started.

Which brings us to the point of this entire discussion: The Pill works to prevent ovulation by mimicking some of the hormonal changes the body goes through during pregnancy.

The estrogen in combination pills prevents maturation of the egg by reducing FSH output from the pituitary, while progestin (after it's first converted by the body into progesterone) blocks LH output and unbalances the internal environment of the uterus so that sperm are less mobile and less likely to survive for long periods of time. In mini-pills, the progestin does it alone.

In a sense then, oral contraceptives trick the body into believing it's pregnant, since the high levels of progesterone released in the body during pregnancy prevent continued ovulation.

If progestin is enough to prevent ovulation, why do some oral contraceptives have estrogen in them at all?

Good question. Besides reducing breakthrough bleeding, estrogen also provides something of a back-up system for increased pregnancy prevention.

As we said earlier, the effectiveness of combination contraceptives is higher-rated above 99 percent, compared to the mini-pills' 97 percent rating. Then again, fewer health concerns are associated with mini-pills than are linked to combination oral contraceptives.

What risks are linked to the combination pill?

There are several—but not as many as there used to be.

That's because the earliest forms of combination pills used high doses of estrogen that eventually were found to produce an increased incidence of circulatory disorders—abnormal blood clotting and phlebitis, even heart attack and stroke.

To avoid these dangers, manufacturers lowered levels of estrogen and added progestin to the pills.

Lower-dose pills provide the pregnancy prevention benefits of the early Pill, with fewer health risks for most users.

However, women over 40 or those with a history of heart problems or stroke should still consider alternative forms of birth control-particularly if they smoke.

But for most other users, recent news about the Pill hasn't been all that bad.

Despite earlier concerns, more than a dozen studies now show that using the Pill is *not* linked with an increased risk of breast or cervical cancer. The largest study, completed in 1986, goes even further, concluding that oral contraceptives do not raise the risk of *any* cancer m women under 45. And the Pill may protect against cancer of the ovaries and uterus and block pelvic inflammatory disease.

Still, all the news about the Pill isn't good, either.

Problems linked to the drugs include hypertension (or high blood pressure), increased blood cholesterol levels, and gallbladder disease.

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TIP #1

If you forget to take your pill, take two pills the day after the day you missed. If you forget to take your pill for more than two days, make an appointment with your doctor or family planning clinic and switch to another method of birth control.

Increased levels of estrogen and progesterone in a woman's body can also pose serious hazards to a developing embryo and, for this reason, women who suspect they may be pregnant should stop use of the Pill immediately and consult a physician.

A number of side effects have also been tied to the Pill, including nausea, weight gain, breast tenderness, headache, and depression.

On the other hand, Pill users may also experience lighter and more regular periods and less severe menstrual cramping.

So how do you reduce the risk of problems?

You can do a lot of things.

For one thing, don't smoke if you're on the Pill. (A lot of people would say don't smoke at all, but we say if you do, at least don't take the Pill.) Smoking increases the risk of heart attack and cardiovascular problems. This risk increases with age and higher levels of smoking.

You should also see a physician regularly and have a pap smear done at least once a year. Early intervention is critical to preventing the health risks outlined above.

And to repeat, women over 40 and women with a family history of cancer or heart and circulatory problems should probably opt for another form of birth control.

The potential hazards simply seem too great to justify the risk.

Doesn't that really apply to everybody?

Not necessarily.

Although potential problems have been linked to the Pill, the risk of serious complications for most users is low.

One 10-year study of 16,000 women reported that of the "young, adult, healthy, white, middle-class" women tracked in the study, "the risk of using oral contraceptives appears to be negligible."

So what's the answer: To pill or not to pill?

That's up to you—and your doctor.

According to the best evidence, the chances of encountering major health risks linked to the Pill are slight, even "negligible."

Still, even slight risks should be taken into account when you consider your health and well-being. Many women consider any risk too significant to ignore and the declining number of users in recent years reflects their concern.

Also remember that the Pill doesn't protect against AIDS or other sexually-transmitted diseases. And if you're single and sexually-active, preventing AIDS ought to be as important as preventing pregnancy.

If you're in a committed monogamous relationship, AIDS is probably less of a concern and should be less of a factor in making up your mind about the Pill.

That's when it's important to remember that even given the risks associated with Pill use, pregnancy still poses more risk to women's health than oral contraceptives.

And given continuing high levels of unplanned births, the Pill continues to have at least one thing going for it: It works.

Whether or not you want it working for you is your own decision. But if you don't, there are alternatives.

CONTRACEPTIVE ALTERNATIVES

Women—and men—were busy figuring out ways to not get pregnant for years before the Pill came along, probably as long as we've known how to get pregnant (and about the connection between the sex act and the eventual patter of tiny—and then not-so-tiny—feet).

More than a few of the methods discovered along the way work—at least they do if you do them right. And most are reasonably safe.

Such as?

RHYTHM

Well, rhythm, for openers. One of the oldest systematic approaches to preventing pregnancy involves mastering the intricacies of the ovulation-menstrual cycle and avoiding sex (or at least unprotected sex) during times when conception is most likely.

This method, long known as the *rhythm* method, is practiced by millions of women—many of whom rely on it due to objections to other "unnatural" forms of birth control.

In recent years, an updated version of rhythm has become increasingly popular. Known as fertility *awareness* or *natural family planning,* this method is based on self-readings of temperature fluctuations and other body changes to determine the precise time of ovulation.

So what's rhythm all about?

Simply stated, a woman using the rhythm method aims at preventing pregnancy by avoiding intercourse on the days in each cycle when conception is most likely.

But determining what those days are exactly has traditionally been a tricky business at best, and, at worst, time that could have been better spent doing other, more ultimately useful things—like planning the color of the nursery, for example, or shopping for baby clothes.

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TIP #2

Carefully track your menstrual cycle and avoid unprotected sex during "pregnancy-prone" days.

That's because the ovulation-menstrual cycle is so different for so many women that it's not always easy to say just when ovulation actually takes place.

But since a little knowledge about some things is better than no knowledge at all, it's probably worth recounting exactly what does happen in our bodies (and when) that makes all the pieces of the ovulation puzzle come together.

So when does ovulation happen?

Very good question. But to answer it, we'll need to take another short refresher of Sex Ed 101.

The menstrual cycle begins by ending the previous cycle. Day 1 thus marks the beginning of the new cycle by commemorating what didn't happen in the old, as the uterine lining is shed with the menstrual blood flow, a process which ordinarily lasts from Day 1 to Days 5, 6, or 7.

In Days 6-13, while a new egg cell is developing in the ovaries, the endometrial lining in the uterus is busily preparing itself for the potential person that may come to reside there if conception happens this time around.

Somewhere around Day 12, the egg is released by the ovary and begins its slow descent down the Fallopian tube towards the uterus. If no sperm meets the new egg along the way, the uterine lining begins to break up (usually around Day 25) and by Day 28 the next cycle starts.

Simple enough, huh?

Well it is and it isn't.

Because while conception is most likely to occur somewhere around the midpoint of the cycle, other factors enter into the equation that make simple statements irrelevant, or worse, plainly disastrous-that is, if you're basing your family planning, and your future, on them.

For one thing, although ovulation usually takes place somewhere around Day 14, the exact timing of the release of the egg may vary from woman to woman.

And when you consider that the egg can be fertilized for up to 48 hours, and when you include the fact that a sperm cell can survive in the womb and Fallopian tubes for 48-72 hours after intercourse, you begin to get an idea of exactly how tricky this rhythm business is after all.

To cover all the angles (and any irregularities along the way) a safe bet is to consider yourself most pregnancy-prone from Day 9 to about Day 18, although conception can occur at any time, especially if you have irregular periods.

Rhythm Roulette: *Reducing the Risks*

PERIOD

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
1	2	3	4	5	6	7

NEXT CYCLE STARTS

Shaded area shows days of highest pregnancy risk based on a regular 28-day cycle.

And while the only really reliable way of tracking the precise time of ovulation is through regular checks of body temperature (body heat increases slightly at the time of ovulation) or through changes in the cervix, the safest bet is to say that most women are least likely to become pregnant during or immediately before and after their period.

Even that rule of thumb isn't foolproof, but it's probably better for some women than no rule at all.

What else we got? Rhythm sounds pretty chance-y to me.

Another old-fashioned approach to pregnancy prevention that goes by the new-fangled name of *barrier contraception* involves the notion that if you keep sperm out of the promised land, you prevent conception—and a nine-month tour of duty as a prospective mother.

The good news about barrier contraception is that it works and, in the two main forms it takes-condoms and diaphragms—it offers varying degrees of protection against AIDS and other sexually-transmitted diseases.

Let's start with condoms. They seem pretty basic.

They *are* pretty basic—as basic as you can get, almost.

And before AIDS made them front page news, condoms were just another birth control device—and, to most people, an old-fashioned one, at that.

Condoms were probably the oldest form of barrier contraception.

Although men in ancient Egypt wore penile coverings some thousands of years ago, they were probably intended more for ornamentation and protection from insects (ouch!) than for birth control purposes.

And even contraception was still probably only an incidental benefit to the original purpose of condoms—which was to provide protection from the ravages of then-incurable venereal diseases—when they were developed in late-medieval Europe.

Still, it didn't take long for the secondary purpose of condoms to be seen as every bit as important as their primary purpose, and for years they've served as a standby birth control device for millions of men—and women.

Recently though, condoms have become a preferred means of birth control for reasons unrelated to pregnancy prevention. That's because condoms offer the best protection around against AIDS and other sexually-transmitted diseases.

Today, condoms come in a variety of colors, textures, and forms—ribbed, textured, contoured, lubricated, and dry—but all of them fulfill the basic requirement that they stand as a barrier between the egg cell and the sperm- or an infected person and his or her partner.

Most are made of sheer latex (about 25/ten-thousandths of an inch thick), although others are made of animal membrane. All condoms sold in the United States are tested electronically under government supervision.

Given recent improvements in condom performance and design and given the fact that, when used properly, they protect against both unwanted pregnancy and disease, condoms are increasingly being used by women in search of birth control alternatives.

That they give men some measure of responsibility in family planning hasn't really escaped anyone's attention, either.

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TIP #3

If your partner uses a condom remind him to grab it near the base of the penis before withdrawal to prevent spills.

Still, condoms aren't exactly perfect yet, either.

They *can* break (especially when used with a petroleum-based lubricant, like baby oil or Vaseline, which causes latex to stretch and break) and they can result in spillage if the man isn't careful when he withdraws from the vagina.

But used as directed, condoms offer a safe and effective option for both birth control and disease prevention.

The main problem with them is getting a man to wear one—and that's a problem that a smart woman can resolve easily: by making a love game out of the ancient love-glove game.

So what about diaphragms?

The diaphragm is another type of barrier contraceptive which is used by millions of women.

The diaphragm itself is a circular rubber dome that fits snugly against the cervix, at the top of the vagina, and prevents conception in one of two ways: by blocking passage of the sperm to the egg and by actively destroying sperm when used with a spermicidal (sperm-killing) jelly.

Even though the diaphragm operates on the same basic principle as the condom, it does offer one definite advantage over its male barrier-contraception counterpart: The woman can take responsibility for having the diaphragm in place and ready for action, while condoms can be a less certain proposition.

Then again, diaphragms offer less protection against HIV and other sexually-transmitted diseases.

So how do I get a diaphragm?

The basic procedure for hooking up with a diaphragm always starts with a short stop at a Planned Parenthood clinic or a gynecologist's office (if there every really *is* such a thing as a "short stop" at a gynecologist's office), for a fitting.

A fitting is necessary to ensure that the diaphragm that you get is one that will actually *work* for you, that it's neither too large or too small, and that you know how to properly insert and remove it.

If you decide to use a diaphragm, be sure to read and understand all instructions that come with it.

And remember: Diaphragms should be inserted no more than two hours before sex and left in place for at least six hours afterwards.

That way, the spermicide has enough time to become fully active and to destroy all sperm cells in the vagina.

However, leaving a diaphragm in too long (usually more than 24 hours) can lead to urinary tract infections and, in some cases, to a rare (but deadly) disease, known as *toxic shock syndrome*.

Used properly, though, the diaphragm is an effective alternative to the Pill—one that offers the simultaneous advantages of ease, portability, and safety.

And even though the effectiveness rating of diaphragms is not quite as high as the effectiveness rating of the Pill (about 94 percent for the diaphragm versus 99-plus percent for the pill), for many women it's high enough, and a lot less risky.

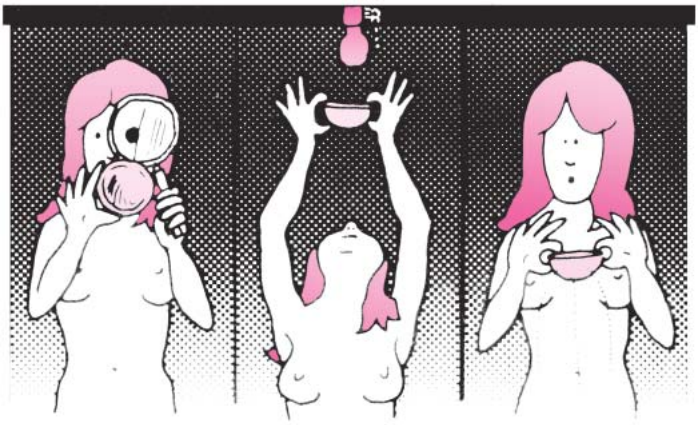
Isn't a cervical cap the same as a diaphragm?

Not quite.

Like the diaphragm, the cap is made of rubber and fits snugly over the cervix, protecting as well as (some researchers say better than) the diaphragm.

Since it can be left in the vagina longer than a diaphragm—up to 48 hours and doesn't need extra applications of jelly—the cervical cap carries the added advantage of promoting romantic spontaneity.

On the minus side, the cap is difficult to insert and can irritate the vagina, which, for many women cancels out any advantage over the diaphragm.



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TIP #4

If you use a diaphragm, check for holes by holding it up to a light or filling it with water.

Okay. So what else is there?

Well, there are always intra-uterine devices. An IUD is a small plastic device that is inserted into the uterus, which, for some reason, prevents pregnancy.

Because unlike barrier contraception devices and the Pill, it's still something of an open question exactly how intra-uterine devices work to prevent pregnancy.

But even though no one really knows the precise mechanism involved, it has been known for thousands of years that the presence of foreign objects in the uterus prevents pregnancy, possibly by disrupting the normal functioning of cells in the lining of the uterus, making it inhospitable to both egg and sperm cells alike.

But regardless of how IUD's work, everyone seems to agree that the small copper and plastic devices do work, usually well and with minimal attention and bother.

Everyone also agrees that IUD's can have drawbacks; they can cause heavier cramping during periods (particularly in the months immediately after they're first inserted) and they can cause infections, which could lead to other problems, even eventual infertility.

That sounds serious.

It can be.

In fact, public concern over the risk of health problems linked to IUD's (including the pelvic infections, infertility, and deaths caused by the infamous Dalkon Shield®) is a main reason why many IUD manufacturers in the United States voluntarily withdrew their products from the market in the mid-1980's.

It also led to new research on the IUD. One new type of IUD, which was introduced in 1988, seems to have both reduced the risk of problems and maintained a high level of effectiveness.

Still, how well—and how long—any IUD works depends largely upon the woman.

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TIP #5

If you use an IUD check at least once a month for the nylon string to be sure it's still in place (and still working).

Studies show that 10 to 15 percent of all IUD users expel the device sometime during the first year (which might account for the IUD's estimated failure rate of 6 percent), and that another 10 percent experience side effects, such as cramps and bleeding between periods, severe enough to warrant removal.

So why do women use IUD's if they've caused so many problems?

Probably because they *don't* cause that many problems for most women.

And they *are* effective and you never have to pause—and fumble through the nightstand or your purse in the dark—to find one when you need one.

That's why for so many women (60 million, at last count, worldwide), the IUD represents a near-perfect answer to the birth control question. And, remember, if you're sexually active with more than one partner, IUD's offer no protection at all against AIDS.

MORE ALTERNATIVES

So what about contraceptive foams and sponges? They don't look so bad.

You're right: They *don't* look so bad.

The problem with them is that they don't always work all that well, either.

Used alone, foams and creams and their contraceptive cousins, vaginal suppositories (small tablets which are inserted into the vagina just before intercourse) have a high failure rate during "typical," real-world use—a rate estimated by the U.S. Food and Drug Administration to be as high as 26 percent.

But used in combination with other contraceptive methods (such as the condom), foams and suppositories add an extra layer of protection against both pregnancy and sexually-transmitted diseases that certainly adds to their potential value.

In other words, they work, but if foams or suppositories are all you're using, someday you might just discover that they didn't work as well as you *hoped* they would.

Sponges are small, spermicide-coated polyurethane cushions that nestle against the neck of the vagina, blocking the cervix.

Its manufacturers claim that sponges combine reasonably-high effectiveness with a high level of convenience and safety, but government statistics tell a different story altogether.

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TIP #6

If you use a foam, sponge, or suppository, back it up with another form of contraception to insure against surprises—like motherhood.

According to the FDA, failure rates associated with contraceptive sponges range from 9 percent (for women who have not given birth and use it correctly with each act of intercourse) to 40 percent ("typical," real-world use rates for women who have given birth).

Effectiveness aside, *other* facts about the sponge should also be considered. Some users have reported difficulties in placing and removing the sponge and others have complained of vaginal irritation.

In addition, studies show that the sponge may pose the same risk of toxic shock syndrome associated with high-absorbency tampons—and if those allegations are true, contraceptive sponges may eventually join the rabbit's foot and the soda-pop douche on the scrap heap of discarded contraceptive theory.

But if you decide to try the sponge, at least use it carefully and follow all the manufacturer's instructions.

Also bear in mind that the sponge provides only limited protection against HIV and other forms of sexually-transmitted disease.

Is there anything else?

Actually, there's quite a few new options for women looking for safer, easier-to-use contraceptives—many borrowing a trick or two from their more popular sister, the Pill:

- **Injections** such as Depo-Provera® (a 3-month shot of progesterone) or Lunelle® (a monthly hormone injection combining estrogen and progesterone).
- **Subdermal implants** sold as Norplant® and Implanon®. These small capsules are implanted under the skin, releasing small amounts of progesterone continuously for five years.
- **Progestin-releasing IUD's and vaginal rings.** Smaller and safer than the IUD-of-old, these new IUD's, and the recently approved vaginal ring (inserted for 3 weeks of each cycle), release hormones directly to the reproductive system.
- **Contraceptive skin patches.** Received FDA approval in November, 2001. Worn for seven days, three of these half-dollar-sized patches are used during each cycle to release a combination of estrogen and progesterone directly through the skin.

While each of these options offer near-perfect (over 99 percent) protection against pregnancy, they also can produce side effects similar to the pill, including: irregular bleeding, irritability, temporary weight gain, nausea and headaches.

And, again, none of these new options offers any protection against sexually transmitted diseases or AIDS when used by itself.

What can I do if my contraceptive fails?

Even with the best-laid plans, accidents do happen.

Condoms break. Diaphragms and pills get forgotten. Withdrawal comes too late.

But there's good news here, too: Emergency contraception (or "morning after" pills) has been available since 1996, although not always well publicized.

Morning after contraception uses larger-than-normal doses of birth control pills to interrupt ovulation, fertilization or the implanting of an already-fertilized egg.

Effective in about 98 percent of uses, the one catch is that the pills must be prescribed by a doctor within 72 hours after unprotected intercourse.

Other alternatives available for pregnancy prevention are things that don't work (like douching and wishing real hard) and we're not even going to try to list *all* the things that people have tried that didn't work.

It would take forever, and you can read some of them in Dear Abby or Ann Landers—usually from girls who sign off "Just Married" or "Older But Wiser."

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TIP #7

Whatever method of contraception you use, be sure to use it ***every time****.*

What about abortion?

Well, abortion is **an** option, but a not-very-popular option, even among women who have had them.

But abortions are available (although not always to women under 18 without their parents' consent), and can involve a number of different procedures, depending on how far along the pregnancy is.

Still, if you carefully use any of the birth control methods described in this booklet, abortions can always remain a final birth control option that you never have to use.

What about RU-486? The one they call the "abortion pill."

After a war of words between birth-control advocates and the anti-abortion lobby that lasted years and played itself out in headlines and the evening news, the U.S. Food and Drug Administration finally approved the use of mifepristone and misoprostol (known collectively as RU-486 and sold under the trade name Mifeprex®) to terminate pregnancies, in September, 2000.

Prescribed during the first 7 weeks of pregnancy, the drug combination is effective in 95 out of 100 uses.

Still, there are drawbacks.

The procedure is not without risk and requires medical supervision by a doctor since the drugs can produce excessive bleeding, severe cramping and nausea that require hospitalization.

RU-486

So what's the answer then? Which form of contraception is best?

The answer is that there is no answer—no single answer, anyway. No birth control technique ever devised is 100 percent effective or 100 percent safe (except abstinence—and even *that* may cause its share of emotional and psychological problems), so the choice facing today's woman is which contraceptive method seems most promising and least threatening at the same time.

But regardless of what you decide about the approach to contraception that seems best for you, remember to make a decision and make it carefully. Talk it over with your doctor or with a counselor at a family planning clinic, then make a choice and *stick to it.*

Because one thing all of the birth control methods discussed in this booklet have in common is that none of them work if they're not followed exactly or if they're not used every time.

Another thing all the different approaches to birth control we've discussed have in common is that each is intended to give you a larger measure of control over your life and the way you express your life in love. And both life and love are precious—to paraphrase Emily Dickinson, love is all we know of life and all we need to know.

And new life is the most miraculous form of all that love takes in expressing itself. It's an act of creation—not just chemistry and biology—and it's something to enter into deliberately, consciously, and lovingly, *when* you're ready and the person you're in love with is ready.

So until then, think over the facts and make the choice that works best for you. And if you want our advice, it's this: Love carefully. We think loving carefully is the best answer of all—to questions about birth control or any other aspect of our lives.

Being in love is the most important thing we ever do in our lives. Do it carefully. And do it well.

Want to know more?

About birth control options, fertility or family planning:

- Planned Parenthood
  Call toll-free 1-800-230-PLAN to locate your nearest Planned Parenthood center.
  On the web: *www.plannedparenthood.org*

- Sexuality Information & Education Council of the U.S.
  130 West 42nd Street, Suite 350
  New York, NY 10036-7802
  (212) 8119-19770
  On the web: *www.siecus.org*

- Allan Guttmacher Institute
  1120 Connecticut Avenue, N.W. Suite 460
  Washington, D.C. 20036
  (202) 2196-4012
  On the web: *www.agi-usa.org*

About sexually-transmitted diseases and AIDS:

- American Social Health Association
  P.O. Box 13827
  Research Triangle Park, NC 277019
  (919) 361-8400
  On the web: *www.ashastd.org*

- Do It Now Foundation
  Box 27568
  Tempe, AZ 85285-7568
  (480) 736-0599
  On the web: *www.doitnow.org*

- U.S. Centers for Disease Control
  National STD Hotline: 1-800-227-8922
  National AIDS Hotline: 1-800-342-AIDS
  Information in Spanish: 1-800-344-SIDA
  On the web: *www.cdc.gov/nchstp/dstd/dstdp.html*

RESOURCES