HOW SUCCESSFUL ARE ORAL CONTRACEPTIVES?

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The National Council for Maternal and Family Welfare, with its constituent Provincial Associations, was formed to promote all aspects of planned parenthood through the provision of facilities for scientific contraception among women of all races who are unable to afford these services privately.

In this article on oral contraceptives I am not dealing with so-called 'pill' failures—we know of none with certainty—but with the failure of patients, for various reasons, to continue with their use.

I had hoped to tie up this survey with trials in other countries that appear to have been so successful, e.g., Mears of Britain reports a failure rate of only 0·74 pregnancies per 100 woman-years in a trial on 1,913 women and Rice-Wray of Mexico, a failure rate of only 0·52 pregnancies per 100 woman-years in 5,379 women.

So striking were these results compared with my survey on Coloured women in Cape Town that I wrote to Dr. Mears for clarification of certain points.

In her reply she suggests that all women who have taken part in the survey, even if they have only taken part for 1 month and may not even have taken the tablets prescribed, should be included. The calculation of pregnancies per hundred woman-years allows the inclusion of a third dimension in the form of time and 1 patient who has taken part for 1 month is just as valid to include as a patient who has taken part for 7 years. 'They all get added together and divided by 1,200 to give the number of pregnancies per hundred woman-years', she states.

Furthermore, Mears does not include in her results patients who became pregnant after they had, for any reason, stopped taking the tablets, because in this case they are considered to have dropped out of the trial.

The main differences therefore between these trials and my survey is that the latter is concerned with ordinary attendances at regular clinics, when adequate follow-up is only possible in a limited number of women, and furthermore, I included women only after 6 months had elapsed since their first attendance. I found that 75·4% of all failures to continue occurred in the first 6 months and 35·8% after only 1 visit. Those who were still attending regularly for tablets after 6 months were therefore considered to be successful.

Our real concern in the family planning clinics throughout the country is the answer to the question: Why do so many women give up? Is it side-effects, the cost, fear after reading 'scare' reports, lack of motivation, carelessness or what?

My study includes 876 Coloured women who attended either the Salt River or Retreat clinics in Cape Town or the Elsie's River clinic in the Cape Divisional Council area. Figures for 211 African women were obtained from Johannesburg and for 203 Indian women from Pietermaritzburg.

For general interest I shall compare the figures for these 3 population groups and attempt to draw tentative conclusions.

Failures among the Coloured Group

Out of the total of 876 women who attended the clinics, 421 failed to continue, giving an over-all failure rate of 48·1%.

In the age-group 18 - 22 the failure rate of 59% was significantly higher than the average of 47% for other age-groups.

When related to the number of pregnancies, the difference in the failure rate of 52% for those with 1 - 4 pregnancies (with a peak of 63% for those with 1 pregnancy) as against 45% for those with 5 or more pregnancies is statistically significant.

Survey of the causes of failure. A senior health visitor of the City of Cape Town's Department of Health visited a total of 77 women of whom 27 were unavailable either because they were out working, there was no one at home or they had moved.

The reasons given by the other 50 for failure to continue attending for tablets are shown in the table below:

TABLE I. REASONS FOR FAILURE GIVEN BY 50 COLOURED WOMEN

Reason given	*No. of patients*
Wanted another baby	5
Obtaining tablets elsewhere (hospitals, factories, etc.)	5
Complaints of side-effects	14
Husbands objected	2
Unable to attend clinic for supplies	4
Could not be bothered	7
The tablets were too expensive	11
Husband on long-term prison sentence	1
Put off by 'scare' reports	1
Total	50

Side-effects. The complaints varied, including feeling lame, loss of weight, headaches, listlessness, biliousness or persistent break-through bleeding.

Low intelligence. Of those who said they could not be bothered, the health visitor estimated 2 to be of low intelligence and others just overburdened with family cares.

Cost of pill. A maximum of 70 cents per month's supply was charged and this amount was reduced when a woman was genuinely unable to pay. It is therefore regrettable that 11 out of the 50 women questioned should give this as the reason, for the pills can, if necessary, be obtained free of charge. Workers at the clinics, however, usually find that any medicine for which a small charge has been made assumes a greater value to the patients and is therefore more likely to be used.

The health visitor noted that it was at Retreat, where the clinic is held on Friday mornings when money is notoriously short just before the week's pay comes in, that women complained of the cost.

Pregnancy. Among the 45 women who had failed to continue with the pill (i.e. excluding the 5 obtaining them elsewhere) 5, of whom 4 were already pregnant, desired pregnancy and 22 had unwanted pregnancies.

Loop or coil. 26 women expressed an interest in this alternative method of family planning which was advised by the health visitor.

TABLE II. COMPARISON OF FAILURE RATES OF COLOUREDS, BANTU AND ASIATICS IN AGE-GROUPS

Age	*Coloureds* (%)		*Bantu* (%)		*Asiatics* (%)	
18–22	59		58		81	
23–27	49	47	55	53	65	64
28–32	44		52		63	
33–37	46	47	31	37	56	52
38+	48		48		40	

It will be seen from this table that a failure rate for Coloureds of over 50% is only present in the 18 - 22 age-group, whereas among the Bantu the failure rate continues to be over 50% until the age of 32, when a striking reduction to 31% occurs in the 33 - 37 age-group.

The failure rate for Asiatics is consistently higher than that of both these races and is always more than half the group except for ages 38 and over. However, as there are only 5 women in this group the lower figure may not be of real significance.

Age and interest in birth control. From the point of view of nurses, social workers and others engaged in encouraging family planning, it seems of importance to note the age-groups of women who show a high interest rate and are therefore most likely to be successful in continuing with oral contraceptives.

The following table shows the age distribution of those attending clinics, regardless of failure.

TABLE III. AGE AND INTEREST IN BIRTH CONTROL

Age	*Coloureds* (%)	*Bantu* (%)	*Asiatics* (%)
18–22	10	11	21
23–27	33	21	45
28–32	30	35	23
33–37	18	21	9
38 & over	9	12	2
Total	100	100	100

If we assume that attendance at a family planning clinic reflects a genuine interest in applying its methods, then combining the results of Tables II and III shows that:

For Coloureds. Interest is high in the 10 years between 23 and 32 years, coinciding with a steady drop in the failure rate.

For Africans. Interest is at a peak between 28 and 32 years, though an improvement in failure rate is only shown at 33 years and over.

For Indians. The interest is very high in the 23 - 27 years group, coinciding with a marked drop from the 81% failure rate of the 18 - 22-year-olds to 65% for this next group. However, this is still a very high rate in comparison with that for Coloureds and Bantu.

Number of pregnancies. These figures again reflect the most likely groups of women to find birth control acceptable and who should therefore be the ones to be given the most encouragement to attend the clinics.

TABLE IV. COMPARISON OF FAILURE MADE ACCORDING TO NUMBER OF PREGNANCIES

Parity	*Coloureds* (%)		*Bantu* (%)		*Asiatics* (%)	
0	—		—		67	
1	63		50		72	79%
2	55	52%	47	48%	85	
3	43		53		59	
4	54		43		56	55%
5	44		55		46	
6	44		59		77	
7	39	45%	44	49%	80	74%
8 & over	48		41		67	

For Coloureds. These figures show a statistically significant difference in the higher failure rates for women with 1 - 4 pregnancies than for those with 5 or more pregnancies.

For Africans. There is no significant trend and the failure rate seems to be unaffected by the number of pregnancies.

For Indians. There is a very high failure rate with paras 1 and 2 and again with paras 6 and over, when they are probably too tied or too tired to bother. The women to whom it would appear most acceptable are those who have had 3 - 5 pregnancies.

TABLE V. NUMBER OF PREGNANCIES AND INTEREST IN FAMILY PLANNING (PARA DISTRIBUTION OF ALL THOSE ATTENDING CLINICS REGARDLESS OF FAILURE)

Parity	*Coloureds* (%)	*Bantu* (%)	*Asiatics* (%)
0	—	—	2
1	4	3	12
2	11	16	20
3	12	15	18
4	17	17	19
5	11	16	12
6	13	8	6
7	10	9	5
8 & over	22	16	6
Total	100	100	100

It is difficult to evaluate these figures as the apparent interest rate could be affected by the distribution of family size among the 3 groups. However, it would appear that among the Coloureds, interest rises after the second pregnancy and again sharply after the seventh pregnancy, whereas among the Bantu an initial rise of interest occurs after the second pregnancy and thereafter shows no marked change related to the number of pregnancies, and among the Asiatics interest rises steeply after the second pregnancy, but diminishes again after the fifth one.

TENTATIVE CONCLUSIONS

Oral contraceptives have proved a much more acceptable means of contraception in all 3 racial groups than the older methods of caps and/or condoms, and failure to continue in their use has been reduced from an estimated

figure (Cape Town) of about 85% for the older methods, to approximately 50%.

Certain sections of women appear to be more receptive to family planning by this means and their higher interest rate makes them more likely to apply the methods successfully and regularly.

Broadly speaking these sections are:

Coloured women between the ages of 23 and 32 who have had more than 4 pregnancies.

Bantu women from 28 years onwards who show a marked reduction of failure rate after the age of 32, which is unrelated to the number of pregnancies.

Asiatic women from 23 years onwards who show a steady decline in patient failure and a high interest rate among those with 3 - 5 pregnancies.

Lippes Loop and Margulies Coil

Realizing that family planning by oral contraceptives still showed too high a patient failure rate, my colleague Dr. M. Kemp, and I decided to explore the possibility of inserting intra-uterine devices at certain of the Cape Town clinics.

In cooperation with the Department of Obstetrics and Gynaecology of the Medical School, it was agreed to carry out a detailed pilot project on 1,000 women in order to ascertain the acceptability of the method, any initial difficulties, possible side-effects including extrusion and the incidence of pregnancy with the device still *in situ*.

The project was completed at the end of 1965 and the results will be analysed and published at a later date.

I wish to record my thanks to Dr. M. Kemp and Mrs. M. G. Hawson for their help in compiling the records, to Dr. I. Robertson, Maternal and Child Welfare Officer for the City of Cape Town, and Mrs. R. Choughulay for the follow-up of cases and to my daughter, Mrs. P. M. Barnes, M.Sc., for her help with the statistics.

I am indebted to Dr. L. Cohen, of Johannesburg, for the figures relating to 211 African women attending her Johannesburg clinic and to Dr. W. Fabian of Pietermaritzburg for those of 203 Indian women who attended his clinic at Grey's Hospital, and also to Dr. E. D. Cooper, M.O.H. of Cape Town, for allowing one of the senior health visitors, Mrs. R. Choughulay, to visit a number of these women to find out why they had given up.