'Feminine as her Handbag, Modern as her Hairstyle'[1]

THE UPTAKE OF THE CONTRACEPTIVE PILL IN NEW ZEALAND

'Pill Slashes Birthrate', read an *Otago Daily Times* headline in May 1965. The article described the 'phenomenal usage' of the Pill by New Zealand women, estimating that it was used by 'one-third of New Zealand women of child-bearing age'.[2] New Zealand, which led the world in granting women the vote, appeared once more to be at the forefront of change. One leading physician made this comparison when he suggested that the impact of the Pill might 'have greater social significance than votes for women'.[3] Six years after the Pill was introduced in New Zealand in 1961, 20% of women of reproductive age were users, compared to approximately 8% of women in the United States and 3% of British women.[4] The only comparable usage was amongst Australian women. Although by the early 1970s Canada, Germany and the Netherlands all had higher usage rates, the initial rapid uptake was an Australasian phenomenon.[5] And New Zealand user rates remained high compared to Britain: by 1975, estimates suggested that 35% of New Zealand women were Pill users compared to 19% in Britain, the place from which many New Zealanders had emigrated, and after which New Zealand's health system was frequently modelled and compared.[6]

What were the factors that led to the initial rapid uptake of the Pill in New Zealand? Our aim is to explore the cultural specificities that made the New Zealand experience unique. Our sources include oral histories with seven doctors and four drug detailers who were practising at the time of the introduction of the Pill. Seven other doctors answered a survey questionnaire. We have also drawn on Health Department files, advertisements in the medical press, popular literature, interviews with women who took the Pill in its early days, and studies by medical students carried out during the first decade of Pill use. We suggest that New Zealand's tradition of ready access to general practitioner care, and openness to the pharmaceutical industry at the time, meant the Pill spread rapidly.

The Pill developed within an international framework. Following breakthroughs early on in Europe and later in Mexico, trials took place in Britain, Haiti, Hong Kong, Israel, Japan, Puerto Rico and the United States. Soon the Pill was being manufactured and distributed around the world. As a country where the Pill was initially taken up with great alacrity, New Zealand has a significant place in the international story of the contraceptive pill. Despite

its small population size, by 1973 all the major pharmaceutical companies were selling the Pill in New Zealand, with the nearest manufacturing plants located in Australia.[7] Why the uptake should have differed in various contexts remains largely unexplored, although Hera Cook's comparative work on England and Australia argues that Australian women had a tradition of female-controlled contraceptive methods that perhaps paved the way for rapid uptake of the Pill.[8]

In her 1999 preface to the Waikato University Population Studies Centre's *New Zealand's Contraceptive Revolutions*, Barbara Glennie, National President of the National Council of Women, was adamant, stating 'There is no doubt that a major social revolution has come about with the introduction of the hormonal contraceptive pill' and suggesting that the monograph would tell New Zealanders 'how and why' this was so. The book, based on extensive survey data, provides a wealth of information about contraceptive usage. It does not, however, ask how people – both doctors and their patients – came to learn about new methods.[9]

Helen Smyth, a former publicity officer for the New Zealand Family Planning Association (NZFPA), published *Rocking the Cradle: Contraception, Sex and Politics in New Zealand* in the year 2000. Smyth discusses how a group of visionary women set up the NZFPA in the late 1930s in an attempt to publicize contraceptive methods. Their efforts were hindered by a lack of support from the medical profession and from the government, circumstances that kept the NZFPA small.[10] Two unpublished studies, by Danielle Cara Moreau and Claire Gooder, explore the social context of changing values that facilitated the introduction of the Pill. Moreau argues that the Pill divorced sex from reproduction, prompting sexual matters to be discussed within a discourse of 'choice' and 'rights'.[11] Gooder's study is based around the university town of Dunedin, exploring how this context influenced the tenor and perspective of the debates and the impact of the Pill in a student community. These studies provide essential background for our analysis.[12]

New Zealand's population reached 2.5 million in 1961.[13] The demographic shifts consequent on reproductive behaviour are fully explored in Pool et al., *The New Zealand Family from 1840: A Demographic History*.[14] Both Pākehā and Māori had high birth rates. By 1960, the Pākehā total fertility rate stood at 4.0 while the Māori rate was 6.9.[15] New Zealand's relatively low population density and demand for labour meant that under- rather than overpopulation was an ongoing concern.[16] In the years 1960–1965, New Zealand's Total Fertility Rate began a decline but still stood at 3.79, third amongst Western developed countries, just behind Ireland and Iceland, and substantially more than the United Kingdom's rate of 2.83.[17]

Demographics indicate that patterns of behaviour were changing. The rate of ex-nuptial births per 1000 unmarried Pākehā women rose continually from 11.67 in 1945, reaching 14.85 in 1951, 17.79 in 1956, and 24.14 in 1961. At 5.77% of live births, the New Zealand illegitimacy rate was higher than that of Australia, Canada, the United Kingdom and the United States, but lower (the government statisticians consoled themselves) than that of Sweden.[18] The rising levels of illegitimacy were indicative of sexual experimentation and changing sexual/moral values, which not only impacted on the unmarried but were also likely to have had an effect on expectations of sexual behaviour within marriage itself. Hera Cook's study of English sexual behaviour argues, in fact, that the rise in marital fertility from the late 1930s to the 1960s 'was almost certainly caused by increasing rates of coitus'.[19] A new expectation of sexual expression, rather than restraint, was perhaps prompted first by the exigencies of wartime and then by a buoyant economy in the post-war world. Unlike the depression era, when an additional child might tip a family economy towards disaster, the full employment of the 1950s gave families confidence in the future.

New Zealand's prohibition on contraceptive advice to under-16-year-olds and ban on contraceptive advertising under the 1954 Police Offences Amendment Act both contributed to and were indicative of a furtive atmosphere with regard to contraception. The conspiracy of silence on the subject was maintained by the Department of Health's refusal to take a stand for or against contraception: it maintained that birth control was 'solely a question of public morals, not of public health'.[20]

Before the Pill, no one method of contraception stood out as in common use and it is difficult to assess the reliability of the available methods. In fact, people may have placed value on factors other than reliability in their quest to control family size, as Kate Fisher suggests in her study *Birth Control, Sex, and Marriage in Britain 1918–1960*.[21] Methods that allowed spontaneity and preserved an idea of female sexual modesty may have been preferred by couples who regarded no method as totally reliable and did not wish to be too calculating in the planning of their families.[22] Fisher's study ends, however, in 1960 – just before the coming of age of a new and more highly educated baby-boomer cohort, who may have sought greater control over their sexual and reproductive lives. Pre-Pill contraceptive practices are not well documented in New Zealand, though evidence suggests that in the decade preceding 1961, those practising contraception used abstinence, condoms, diaphragms and *coitus interruptus*. According to one doctor we interviewed, who began practising in the 1950s, *coitus interruptus* was one of the most popular methods at that time.[23] It required considerable male self-control,

and cooperation between couples, but was free and considered 'natural', unlike barrier methods.[24] Douching, a widespread method in the USA, was rarely used in Australia[25] and seems to have been equally uncommon in New Zealand. Quinine pessaries and other spermicides could be purchased by mail order. All these methods were available without medical advice.

Condoms had a reputation for failure: none were manufactured in New Zealand and the quality was poor. The unpopularity of condoms was made worse by the fact that they had to be imported by boat via the tropics where, it was thought, the rubber would perish in the heat.[26] Thicker condoms were more reliable – one mail-order service offered 'a sheath that can be used and rinsed any number of times and be perfectly reliable'[27] – but were significantly less appealing.[28] Issued to troops in times of war, condoms were also associated with venereal disease and illicit sex. According to Dr Margaret Sparrow, early adopter of the Pill and long-time advocate of family planning, they were regarded as 'seamy, horrible things, not something that married people would use'.[29] Although no data exists about condom use in New Zealand prior to the Pill, condom use was 2.5 times higher in the United Kingdom than in Australia between 1955 and 1959.[30] As noted, similarities in New Zealand and Australia's contraceptive experiences, when compared to Britain, may indicate a similar lower usage in New Zealand. However, Australia's larger Catholic population (25% in 1961, compared to New Zealand's 14% in 1956) would have likely influenced contraceptive practices. Before and after the introduction of the Pill, condoms continued to be more significant in Britain than New Zealand. Paul Jobling has argued that the condom had a long history of use in Britain as a preventative against sexually transmitted diseases as well as a contraceptive that 'was not seriously challenged' until the introduction of the contraceptive pill.[31]

New Zealand did not, it seems, have a strong tradition of diaphragm use. To be effective, these had to be properly fitted by a doctor; however, few doctors had the necessary set of fitting rings and those who did rarely received sufficient training and certainly not in medical school.[32] Some women purchased diaphragms directly from a pharmacy with no fitting at all.[33] Badly fitted diaphragms are ineffective, and thus diaphragms had a reputation as unreliable. In 1937 one woman complained that 'all the rubber caps sold by them [chemists] at 8/6 perish very quickly at the seam. I have had three in six months'.[34] It is unclear how much things improved over the next few decades.

Dr Ashton Fitchett, who practised in Wellington, was one of those GPs advising patients on contraception in the pre-Pill era.[35] Dr Fitchett (b.1926) finished his training in 1953, taking his first appointment in Karamea in the

same year. In 1955 he set up as a sole practitioner in Brooklyn, Wellington. At that time he thought the available contraceptives inefficient and limited in appeal to patients. He advised against *coitus interruptus* as unreliable and he found condoms were very unpopular with his patients because they were uncomfortable: dry on the outside and easy to tear and puncture. In addition, the popular view of condoms was that they were for casual sex, while diaphragms were for married women. These reputations affected not only what doctors would recommend, but what women were willing to accept. Dr Fitchett recalled that advertising for diaphragms was aimed at upper-class women, and that diaphragms could be tricky to fit and use. They would not be fitted until a woman had begun a sexual relationship, to avoid perforating the hymen during fitting. Dr Fitchett felt that contraceptive advice was an important part of his practice. He was familiar with the consequences of unplanned and unwanted pregnancies: he helped young unmarried women arrange adoptions and, like other GPs, was aware of backstreet abortionists.

Abortion as a form of contraception had caused concern for decades, marked by the deliberations of the 1936 Committee of Inquiry in Abortion. The ensuing McMillan Report regarded the state provision of birth control clinics as unnecessary, as the country needed more, not fewer, births. The committee recommended tightening control over contraception by prohibiting the sale of contraceptives to young people, banning birth control advertisements, restricting sales of all contraceptives to chemists and hospitals,[36] and firmly placing control over contraception in the hands of doctors.[37] The Inquiry began a debate over birth control that had implications for the introduction of the Pill 24 years later. Medical professionals were designated those fit to judge whether a patient's request for contraception was proper, with the emphasis on necessity rather than choice.

The New Zealand medical profession, apart from some intrepid women doctors, was unsupportive of the Family Planning Association, and the late development of NZFPA services is partly due to their power at the time. We speculate that resistance to the NZFPA remained stronger in New Zealand than in particular areas in the UK or the USA because of the influence of general practitioners and their capacity as family advisors. The first birth control clinics in the USA and the UK opened in 1916 and 1921 respectively, and by the 1960s family planning clinics were firmly established as important providers of contraceptives for some sectors of the population.[38] While America's panic over population explosion meant increased support for family planning, New Zealand was more concerned with population decline and 'race suicide'. In 1946 the New Zealand

government commissioned an inquiry to address the problem of slow population growth. The subsequent report was scathing towards the NZFPA and warned that the use of contraception and other forms of birth control could potentially 'destroy the moral stamina of the nation'.[39] In 1948 Britain held a similar inquiry, which concluded, by contrast, that contraception should not only be accepted, but be a duty of the National Health Service.[40] The American Public Health Association gave official approval to family planning as a legitimate aspect of public health in 1958.[41]

Despite opposition from the New Zealand branch of the British Medical Association (NZBMA), the women of the Family Planning Association persevered, with part-time family planning clinics opened in Auckland in 1953, Christchurch in 1956, and Wellington and Dunedin in 1959. Clinics were organized on the British Family Planning Association (FPA) model and staffed by former British FPA personnel.[42] The NZBMA censured any doctors who advertised, including those who derived publicity through working for the organization. By the end of the 1950s, when the Pill was about to be launched, NZFPA had two clinics in Auckland, two in Wellington and four others around the country. However, it had a more important role in providing information by mail than in actually seeing patients: its staff responded to letters of request from women by posting advice on which chemists stocked condoms, lists of sympathetic doctors trained (or at least willing) to fit diaphragms, information pamphlets, library books, and condoms and spermicides.[43] Once the NZFPA began supplying education through the mail, they were inundated with requests, which suggests that there was an unmet need for information on effective birth control. But the slow pace of change and controversial nature of contraception (for the married and unmarried) was reflected in a 1966 circular memo sent by the Health Department to all Medical Officers of Health, which reiterated that it was 'not considered that family planning should be included as a necessary or desirable part of New Zealand's public health programme'.[44]

Earlier, in 1960, the NZBMA issued a report on the 'proper' place for discussion of contraception, perhaps reflecting the older age and more conservative views of the leaders of the organization:

> The natural, proper and best kind of association in that regard is; 1. husband and wife, 2. family doctor, 3. clergyman of whatever denomination, 4. legal advisor. We do not think that the private, personal and intimate purposes can be served as well by lay societies … requiring press publicity and subscriptions, but no professional status.[45]

The following year, however, the NZBMA revised its view that it was unethical for doctors to work for the NZFPA, while maintaining that 'only

danger to the health and life of a patient should be adequate prerequisites when providing contraception' and that 'on no account were "reasons of convenience or indulgence" admissible'.[46]

This shift in the NZBMA's attitude towards the NZFPA coincided with increased publicity surrounding the contraceptive pill. New Zealand doctors learned very little about contraception in medical school.[47] From 1941 contraception was made part of the curriculum at Otago Medical School, in part thanks to lobbying by the NZFPA. However, actual teaching on the subject was minimal, limited to a single one-hour lecture over the entire course of study.[48] Dr Roger Ridley-Smith (b.1931) recalled attending this single lecture on contraception when he was a medical student in the late 1950s. He remembers that IUDs, condoms, diaphragms and spermicidal creams were discussed and that 'it was pointed out to us in med. school that nothing really worked particularly satisfactorily'.[49] This message conveyed the reluctance of the medical profession to get involved with contraceptive advice, whether because of its controversial nature, a male-centred embarrassment and ignorance in dealing with female patients, or an unwillingness to engage in the tricky business of fitting diaphragms. The lecture was full of bawdy jokes,[50] and when Dr Margaret Sparrow was a medical student in 1962, the lecture theatre was packed, not just with medical students: 'somehow the whole campus knew when it was'– another indication of unmet needs.[51]

Even with their limited knowledge and training, doctors were often asked about contraception. The family doctor's consulting room was thought by the NZBMA to be the most 'natural' and 'proper' situation to receive contraceptive advice; yet many doctors found the process awkward, their training insufficient, and the available methods inadequate. When surveyed, women expressed their dissatisfaction 'with their family doctors over birth control consultations' and complained about a 'lack of interest in them and their problems about contraception'.[52] Not only were women dissatisfied, but doctors felt ill-equipped to meet patient demands.

The position of the general practitioner as contraceptive consultant in New Zealand differed from the role of doctors in the UK or the USA. Because British women could access contraception at family planning clinics, Lara Marks suggests, British general practitioners did not become really involved in contraception until the advent of the Pill.[53] They received little or no education about contraception at medical school, and many did not believe contraceptive advice was appropriate to the role of the GP. In the United States, growing numbers of doctors had provided contraception advice from the 1940s but contraception increasingly became the domain of obstetricians and gynaecologists.[54] These specialists adopted the Pill readily,

partly because they charged a fee and thus had financial incentive to meet patients' needs. Most American women taking the Pill had been provided with it by a specialist rather than by Planned Parenthood;[55] however, the high cost of specialists' fees was restrictive. A 1982–1986 study of contraceptive practice in 20 developed countries found that use of the Pill was highest in areas where contraceptive health care was usually provided by a GP or family doctor, and lowest in countries where contraceptives were provided by specialists: because general practitioners provided a greater variety of health care services, they were more familiar and more accessible.[56]

The NZBMA saw its members as the foremost educators for women on health matters, a view instantiated in the 1957 founding of the *New Zealand Family Doctor*, a magazine that, despite its title, was aimed primarily at 'the mothers of young families'. Inspired by the success of the British Medical Association's *Family Doctor*, the publisher Wilson and Horton produced the magazine in cooperation with the NZBMA and the association's members wrote much of its content.[57] Pictures of babies and children adorned successive covers, and the advice within ranged from a monthly letter to a woman experiencing her first pregnancy ('My Dear Janet'), by the Professor of Obstetrics and Gynaecology at the University of Otago, to explorations of various illnesses, more general nutritional advice, child guidance and psychological matters. Readers' letters were welcomed and the magazine acted as a health forum primarily for women, offering beauty and fashion advice as part of well-being. 'The health and well-being of you and your family', the first editorial declared, 'are very much our concern.' While keen to offer advice, the editors stressed that they were not in the business of diagnosis or treatment. 'This', they were clear, 'is the function of your family doctor, and of the various specialist services which he commands.'[58] Despite its broad coverage and focus on family and women's health, the *New Zealand Family Doctor* contained little material that directly addressed contraception until the advent of the contraceptive pill, a prescription medicine.[59] Learned 'scientific' opinion on the workings of hormones was a safe topic for public discussion since it did not need to refer to the workings of the genitals.[60]

Family doctors were readily available in New Zealand and since the introduction of the 1938 Social Security Act, doctors and medications were well subsidized. New Zealand had a higher ratio of doctors to patients than the UK. By 1963, in England and Wales, the average list size of a general practitioner stood at 2382 patients.[61] In New Zealand, figures for the previous year suggest the 'effective' population per general practitioner averaged 1766.[62] A tradition of freely accessing medical services, and, as one observer noted, a ready acceptance of both continuous medication and continuous

medical supervision under the Social Security system, helped set the scene for the rapid uptake of the Pill.[63]

The Pill met general practitioners' needs: it was simple and quick to prescribe – unlike diaphragms and spermicidal jellies, which involved embarrassing and time-consuming lessons in fitting technique.[64] Like most doctors, Roger Ridley-Smith 'just thought it was marvellous, there was no question about it, the Pill virtually took over, it was just fabulously convenient. Very, very few suffered from side effects that really bothered them.'[65] Dr Jules Nihotte, a GP who opened his practice in the small town of Seddon in 1957, commented that the Pill was a 'great innovation' for a solo doctor: 'A lot easier for the doctor than fitting a diaphragm and instructing the patient how to use it with spermicidal gel. A lot less premeditated and messy for the woman about to have sex. A lot less final than the other alternative at the time – tubal ligation.'[66] The Pill was seen as convenient for both the woman *and* her doctor.

Women who went to their GP for contraception were more likely to be prescribed the Pill than those women who went to family planning clinics. There were a number of reasons for this. Family Planning clinics in Britain, the USA and New Zealand were committed to offering a wide range of contraceptives, and continued to offer a variety of products even after the advent of the Pill.[67] The NZFPA greeted the Pill with caution and continued to offer women a range of barrier methods, an attitude of careful and informed decision-making that was reflected in the title of the NZFPA magazine *Choice*, first published in 1963.[68] In British clinics, the diaphragm remained the most commonly recommended contraceptive.[69] In the USA, the Pill was the most common method women asked for at Planned Parenthood clinics, but all of Planned Parenthood's posters, pamphlets, and television and radio advertising advocated a choice of whatever method worked best for an individual.[70] Constrained by lack of information, inclination, training and time, few doctors in private practice offered as wide a range of contraceptive options as family planning clinics.

When the Pill was introduced, the majority of NZFPA doctors were female, whereas the majority of GPs were male. Like family planning, sex education was similarly demarcated as the preserve of female doctors in this time. Something about the 'domestic' or private nature of sexual matters, perhaps, gave it this gendered slant, and once it had been feminized, male doctors were discouraged from taking an interest.[71] Differences between male and female doctors' attitudes to the Pill may also have played a role. A 1967 survey of British general practitioners found that male doctors were more likely to prescribe the Pill than female doctors, partly because

female doctors were more concerned with the risks associated with the Pill and were thus more likely to offer diaphragms or IUDs.[72] All of the initial doctors of the NZFPA were women, and the organization as a whole was wary about side effects and did not recommend long-term use.[73] Dr G.I.M. Swyer, an eminent London endocrinologist visiting New Zealand (and sponsored by the pharmaceutical company Schering), scoffed at their caution, telling the *Otago Daily Times* that the NZFPA was 'simply falling behind the times'.[74]

By the 1950s many doctors appear to have accepted that married couples were entitled to use contraceptives.[75] Dr Bill Clay (b.1922), in practice in Hillsborough in Auckland, saw the Pill as a great answer to the problem of unwanted pregnancy, which he regarded as 'one of the great fears / ruining factors of marriages'.[76] Requests for prescriptions from married women were enthusiastically met. Dr Edgar Turner also welcomed the Pill:

> Being newly in general practice (1963), I was keen to 'grow' my practice, and being able to offer a new form of contraception was helpful in letting the community know I was a forward thinking young doctor. I had a particular interest in maternity care and family planning was a natural corollary to my practice.[77]

Although it was clearly still a form of contraception, the Pill's newness meant that it was unhampered by the historical associations of illicit sex, awkwardness, premeditation or embarrassment associated with condoms, the diaphragm or *coitus interruptus*. It could be marketed as a modern contraceptive for married couples, as a tool for marital harmony, equality and choice. Advertisements directed at the profession insisted on the ease of prescribing and indicated that both old hands in the profession and new recruits could responsibly prescribe this product.[78] Claire Gooder's analysis of these advertisements suggests the messages they wished to convey. The first advertisement from the *New Zealand Medical Journal*, January 1964, emphasized how easily the Pill was incorporated into 'the pattern of her life … effective, simple, safe, acceptable – aesthetically preferred'.[79] As Gooder has noted, 'these claims went right to the heart of the advantages oral contraception was seen to have over other forms of contraception: it was effective, easy to use, apparently safe and could be taken independently of coitus'.[80] Early advertisements stressed the importance of the Pill as a means of family planning.[81] To counter arguments that taking the Pill was unnatural, the pharmaceutical company advertisements promoted the Pill as 'Nature's Contraceptive'[82] and as 'essentially feminine'.[83]

Doctors were also influenced by leaders in the profession. A number of doctors mentioned the importance of Professor Harvey Carey, of the only

postgraduate school of obstetrics and gynaecology at National Women's Hospital, in promoting oral contraception and his helpfulness in 'tailored' Pill formulations. 'Carey's Rosary', a series of hormonal pills strung together taken to regulate the menstrual cycle, according to Dr Fitchett, was a great boon to Roman Catholic women as it enabled the 'safe period' to be truly safe.[84]

Opposition to the Pill on the grounds of religion appears to have been muted in New Zealand. The population was fairly homogeneous, with an overwhelming Protestant majority; opposition to the Pill from Roman Catholics (about 15% of the population) did not hinder its progress a great deal.[85] Dr Ridley-Smith was in attendance when a Catholic doctor on a speaking tour addressed an audience about the rhythm method. There was a torrent of heavy criticism from women in the audience who got up and said they 'knew a woman' who had problems and unplanned pregnancies while using the rhythm method. They strongly rejected the message. Dr Ridley-Smith suspects that after the lecture even more of the Catholic women who were present went on the Pill. Since many patients of Catholic doctors went elsewhere to get the Pill, those doctors soon began prescribing the Pill in order to maintain the viability of their practices.[86]

Pharmacists were one possible barrier to access to the Pill. In the Hamilton suburb of Hillcrest, both chemists were Catholic and neither stocked oral contraceptives. A letter from one interested party to the Minister of Health in 1964 complained about this situation, arguing that chemists are 'a public amenity', 'should not discriminate against people' and should stock all drugs available on prescription.[87] Since 1941, 'medicines, drugs, approved appliances, and materials' prescribed by general practitioners and included in the Drug Tariff were free to patients, which created a view of pharmacists as public servants although they ran private businesses.[88] The Ministry of Health replied to the complaint: because oral contraceptives were not covered by the terms of the Drug Tariff, chemists could not 'be compelled to dispense them'.[89] Patients in small towns were those most affected by a reticent doctor or chemist. In the rural centre of Fairlie, a 40-minute drive from the larger urban centre Timaru, the doctors were happy to prescribe the Pill but the Roman Catholic chemist would only fill Pill prescriptions if they were for approved medical conditions. Otherwise, the drug detailer commented, 'you got on your bike and rode into Timaru'.[90]

Of particular significance to Pill uptake were the free postnatal visits to general practitioners allowed for by the 1938 Social Security Act.[91] Having only recently given birth, many women were anxious to enjoy their babies without the anxiety of an unplanned pregnancy. A small 1963 study of early

users of the Pill found that 13 out of 20 married women had been told about the Pill by their doctors, who had recommended it to them usually at a postnatal examination, although one woman had it recommended to her at a premarital examination and another had had it prescribed for dysmenorrhoea. Of the others, five had learned about the Pill from friends, and two said they had first read about it in magazines and then approached their doctor for oral contraception. Nine women stated that they were using the Pill 'because their doctor had recommended it'.[92] Dr Andrew Burt, who practised in the suburb of New Brighton in Christchurch, discussed contraception at postnatal visits. In effect, such women were seen to have accepted the responsibility of motherhood so questions about propriety were less likely to arise. Dr Burt recalled about 50% of Pill prescriptions would be in response to requests from patients and the other 50% an acceptance when he offered it.[93] Dr Ridley-Smith also discussed contraception during these visits: he recalled, patients would ask '"where do I go from here?" and you say "this is the pill" and you tell them about it, spend a few minutes describing it and on the whole it was very satisfactory.'[94]

Although some doctors had read of the Pill's development in magazines and others had heard bits and pieces about it from colleagues, the most direct information came from pharmaceutical company representatives. Dr Ashton Fitchett first read about the Puerto Rico Pill trials in *Time* magazine. In 1959, a drug detailer from the West German pharmaceutical company Schering told him of the hormonal contraceptive pill and gave him a packet of Anovlar, saying the Pill would soon be available in Wellington. When a woman who had heard about the Pill at a dinner party asked him for it, he gave her the Anovlar. He jokingly remembered the result was a perfect contraceptive: the Pill made her cranky and she could not bear her husband near her.[95]

During the 1960s new drugs were being developed at a great rate. Pharmaceutical companies employed travelling representatives to inform doctors of the latest products. From the time the Pill was first introduced, rival drug companies employed medical detailers to visit doctors and pharmacists and sell the latest Pill formulations. The drug detailing profession was still fairly new in New Zealand and doctors were at first welcoming of detailers and keen to hear about new drugs. Detailers played a significant role through encouraging the rapid spread of positive information about the Pill. Pharmaceutical companies advertised the Pill as the 'modern' contraceptive. Because it was a medicine that required prescription, medical detailers had to 'sell' their product to doctors, who then had to sell it to their patients.

No barriers appeared to exist to the introduction of new drugs to New Zealand. Companies educated doctors via their detail men, who gave out free samples.[96] Initially there was some uncertainly about the regulations covering the 'anti-fertility tablets', as one Medical Officer of Health described the new contraceptives.[97] In February 1961, the Medical Officer of Health in Hamilton wrote to the Director-General:

> The local president of the Pharmacists' Guild phoned me today and told me that travellers were visiting chemists and providing Tabs Conovid suggesting that they could be sold to the public. I understand that these tablets contain oestrogens and therefore are restricted drugs.[98]

The Managing Director of Peryer Ltd, the firm distributing Conovid on behalf of Searle, denied that travellers had been acting in this way, but wrote to the Department of Health for clarification. He enquired as to whether 'Conovid is a restricted drug and whether it may be dispensed by a chemist or only on the prescription of a medical practitioner'.[99] The answer was direct: drugs containing 'Androgens, Oestrogens, Progestogens, either natural or synthetic, their derivatives, and preparations of them and their derivatives' came under the sixth schedule of the Food and Drug Regulations 1946 and therefore could only be sold by pharmacies and on prescription.[100] The Health Department recognized that it would be difficult to control the sale of the Pill and that despite having previously avoided any policy on contraception, it was now forced to deal with the development of hormonal contraception.[101]

New Zealand was seen as a favourable market to explore. According to Peter Thomas, a pharmacist-trained medical detailer for Parke Davis in 1966, drug companies used New Zealand as a launching pad for new drugs in the 1960s and 1970s because it was a small and isolated market that could easily be controlled.[102] Bill Price, who became a detailer for Upjohn in 1960, agreed that New Zealand was commonly used as a trial area for new drugs because it was a small, largely sophisticated and highly literate market of a Western nature.[103] A trial in New Zealand, companies hoped, would answer questions before drugs were launched into larger societies.

Initially visits from drug reps may have been a novelty, but competition quickly heated up. Peter Thomas recalls that competition between Parke Davis and Schering was 'hot' and the Pill was a very important new product. For him, the Pill had a big impact on detailing: it was an exciting field, 'safe contraception was the ultimate and here it was'.[104] An immigrant German doctor, unable to practise in New Zealand, was the detailer for Schering, whose Pill 'Anovlar' became the 'best selling contraceptive outside the USA'.[105] Doctors responded enthusiastically to a detailer who was a member

of their profession and could explain his products in their terms.[106] Dr Edgar Turner, who practised in Beckenham in Christchurch, found the Schering reps very helpful: 'their information and samples were very useful to me in being able to put patients on this new product'.[107]

Hormonal products were relatively new so there was a lot for detailers to discuss about the Pill, and for some companies the Pill may have become a large part of their turnover. Detailers were equipped with information graphs and free samples. Once there were a dozen brands on the market, detailers were keen to get doctors using their brand. In small towns, if the doctor could be persuaded to adopt one brand, the pharmacist would only have to stock that brand, which was more efficient for them. Pharmacists, however, were also under pressure to stock the cheapest product, since there was no subsidy for the contraceptive pill.

In 1964, the Director of Clinical Services of the Department of Health suggested that the New Zealand price of the Pill, at 16s.4d., was high to the patient and 'grossly out of line with the United Kingdom price', which apparently did not inhibit patient demand.[108] If prescribed for gynaecological reasons, the Pill could receive a subsidy, but the patient paid for it if it was purely for contraceptive purposes. Prices, however, dropped steadily, to as low as 11s.6d. for a packet of 20 or 21 Pills for the most popular brands in 1967. Greater variation in prices between brands became apparent by 1969 and multiple packets offered lower prices: by that date, for example, six packets of 22 Lyndiol cost $4.92.[109]

The promotional activities of medical detailers were vitally important to the rapid uptake because they allowed information about the Pill to be spread quickly. But while doctors received plenty of free gifts and invitations to complimentary dinners at expensive restaurants accompanied by lectures on the new drugs, the Pill essentially sold itself: it seemed 'the perfect answer'.[110] Competition between companies meant that doctors were given large numbers of free samples from detailers representing rival brands. Some Pill samples would just arrive in the mail. The quantity of free samples enabled doctors to assist their patients by giving them an opportunity to try out the Pill. Dr Margaret Sparrow began taking the Pill herself when her medical student husband was doing a GP run and received Anovlar from a drug detailer. She took it with alacrity, having already had two unplanned pregnancies while using a diaphragm, which had resulted in the interruption of her medical studies. Dr Sparrow recalled: 'I never saw a GP in my whole contraceptive pill taking career; I just went from one free sample to the next!'[111] The prevalence of free samples was such that Peter Thomas recalls pharmacists cooperating in a scheme whereby they collected the samples

from doctors, packaged them up and sent them to medical aid abroad, to the Pacific in particular.[112] Dr Ashton Fitchett would take free samples out of their boxes and put them in a big heap; when women asked him for the Pill he would spread the samples out like cards and say 'you can take your pick'.[113]

Bill Price, a detailer for Upjohn, remembers that the provision of free samples appears to have been tightened up after a scandal when a detailer was found to have been distributing samples to unmarried nurses at the Waikato hospital. He remembered that detailers had to be licensed after this 1965 episode and stringent rules were introduced governing the distribution of samples.[114] We have been unable to find any documentary confirmation of this event and other sources suggest that the provision of free samples did not abate.

Over the decade, as competition between drug companies heated up, attitudes towards medical detailers changed: many doctors began to resent the time taken up and limited the number of reps they would see. Detailer Bill Price recalled:

> There weren't so many medical representatives working, not all of the companies had come to New Zealand in the early 60s and probably our acceptance was about 90%. The majority of doctors would see you at least two to three times a year. That changed in the seventies to where, because more people arrived and there was more pressure on them, some doctors started only seeing you once a year.[115]

From 1964, an important source of information about the Pill was the advertising in the pages of medical journals, the only publications exempt from the restriction on contraceptive advertising. *New Ethicals*, the authority on pharmaceuticals, distributed free to over 2750 New Zealand doctors in 1965, noted that the amount of advertising for the Pill was 'unprecedented'.[116] By 1966 *New Ethicals* advertised 17 different brands of the contraceptive pill made by eight different drug companies.[117] The access that pharmaceutical companies had to doctors, therefore, played an important role, through advertising, samples and the information they provided.

Women quickly found out about the Pill through popular magazines and word of mouth. New Zealand women, it seems, were in search of a safe, effective, accessible contraceptive under their own control, and they asked their doctors for the Pill. An earlier culture of restraint, even within marriage, began to be questioned by women who saw themselves as sexual subjects rather than objects.[118] Dr Y.W.W. Dawson of Whangarei wrote to the Minister of Health in 1964, requesting the Ministry issue a statement recommending the Pill 'for medical reasons only'. He was concerned that the government was

placing a heavy administrative burden on the Medical Profession. There are a large number of women who have no intention of accepting the responsibility of motherhood … Hordes of importunate females are likely to descend on our surgeries demanding prescriptions.[119]

Unfortunately for Dr Dawson, a new balance of power in the doctor–patient relationship did come about. Watkins suggests that in United States media coverage of the Pill meant that women began to *ask* their doctors for the prescriptions they wanted.[120] New Zealand women might well have been reading the same magazines.[121] 'Women', noted Dr Ashton Fitchett, 'are great advertising agents.'[122]

News of the Pill spread through *Time* magazine, *Life* and the *Reader's Digest*. During the 1950s and 60s, the Australasian edition of *Reader's Digest* magazine, like the *New Zealand Family Doctor*, was an important source of health information for New Zealanders. The Australasian version of *Reader's Digest* differed only slightly from the American original: it contained Australasian advertising and the occasional small article about Australia or New Zealand. Every monthly edition contained at least one health-related article. Dr John Mein believed that every doctor had to subscribe to *Reader's Digest* in order to keep abreast of the health matters concerning patients. Dr Mein supposed it was in every doctor's waiting room. His own waiting-room copies were well thumbed, and health-related articles were often the focus of waiting-room discussions.[123] The first mention of the Pill was in the October 1958 article 'What progress towards more effective birth control?', where the Pill trial in Puerto Rico was outlined amongst other research on pea extracts and foam-producing tablets.[124] Articles in the *Reader's Digest* gave updates on trials of new contraceptive technologies but located the developments in the context of overpopulation in underdeveloped countries.[125] The New Zealand context was very different, but alert readers were being informed that a contraceptive revolution was in the offing.

The foremost attraction of the Pill lay in its effectiveness. In one small New Zealand study of Pill use in women aged 30–50, carried out in 1971, the author found that three-quarters of the women surveyed had unplanned pregnancies. Five out of twelve women said their families were a mixture of unplanned and planned children while three of the twelve said that all their children were unplanned.[126] Hera Cook cites Myra Woolf's 1967 study of 6300 British married women, which found that 73% of women with families of four or more children 'said they had more children than they considered ideal'.[127] Although some level of fatalism about unplanned pregnancies through unreliable contraception may have existed, for women who had experienced contraceptive failure while using *coitus interruptus*, condoms and diaphragms, the Pill offered new peace of mind. There were other advantages as well. 'He thinks it's marvellous' was

the 'almost uniform' reply of married women surveyed about their husband's attitudes in 1963.[128] Mrs D. reported how the use of condoms had 'caused ill-feeling' between her and her husband over the years but they persisted in the interests of family planning. Her husband's delight with the Pill had improved the sexual relationship, which she believed was 'a prerequisite for a happy marriage'.[129] She was not alone; other women reported that part of their preference for the Pill above other methods was 'that their husband's enjoyment and aesthetic appreciation is much increased'.[130] Women themselves found the fact that the Pill involved 'no mechanics' or 'mucking about' one of its great attractions. Use of the Pill was firmly established amongst married women by the late 1960s. The introduction of the contraceptive pill in 1961 coincided with rising levels of education for girls and increased participation by young women in tertiary education. It also coincided with a booming birth rate. By 1961, half of all women were married before age 22 and the median age of first birth fell from 25.5 in 1945 to 22.9 in 1964.[131] These were the young women who aspired to lives that were different from those of their mothers, as Helen May has charted.[132] The uptake of the Pill was initially most rapid precisely in this age group.[133]

The uptake of the Pill coincided with growing dissatisfaction amongst New Zealand women with their status in society. Marriage and the family were increasingly subject to critique. The effectiveness of the Pill promised to release young women of the 1960s and 1970s from reliving their mothers' lives, seemingly tied to domesticity. The numbers of women working part-time once their children were at school were steadily rising. Between 1951 and 1961, the numbers of married women participating in the workforce rose from 24.4% to 37.6%.[134] As the increasing attention given to the role of women and the new concept of 'suburban neurosis' indicate, in the 1960s change was in the air. The Pill, therefore, contributed not just to changes in sexual behaviour but to changed expectations: women hoped to plan their families with certainty, abandoning the fatalism of an earlier generation. They welcomed a method that gave them control.

In 1968 Dr Fraser McDonald referred to New Zealand women as the 'Negroes of their society', drawing attention to high levels of depression amongst suburban women.[135] In the same year, a new and provocative magazine, *thursday*, specifically targeted at educated women in their early 20s, ran a cover depicting a woman and the headline 'Who says I'm a Cabbage?'. The article inside explored the question of women's role through case studies of a number of individuals.[136] A 1969 cover pictured four young women sitting on steps (we assume of a university) with a large caption that read, 'I have been to university, worked hard, passed exams, got my B.A.,

grown up … and now nobody wants me'. Employers, a columnist argued, were skeptical that young women would stay in jobs and refused to invest in their training.[137] Blocked from the exciting careers that their higher education had promised, young women began focusing on discrimination against them, not only in employment but in all avenues of life.

On 23 January 1969 *thursday* ran an article entitled 'Unmarried women and the Pill', which reported: 'We are told that making the Pill available to unmarried women will "encourage promiscuity".' The author concluded, 'The resentment against supplying unmarried women with the pill implies that easily available contraceptives must remain the prerogative of men. But surely the fair and logical extension of such thinking is that chemists should first demand from male customers their marriage lines and evidence of confetti in trouser turn-ups?'[138] And while there was definitely evidence of sexual double standards, in the case of the Pill the privileged group was the married at the expense of the unmarried, rather than one side of a male/female divide. Condoms and the Pill, though both contraceptives, were seen as filling completely different roles. By 1969 Dr Margaret Sparrow was receiving large numbers of requests for the Pill from unmarried women.[139] Although initially reticent, the Family Planning Association unofficially supplied the Pill to unmarried women in 1970.[140]

Danielle Moreau argues that the Pill did not cause a radical change in sexual behaviour: 'Instead, it provoked a change in mentality which eventually allowed women to frame their reproductive lives within the discourse of "choice" and "rights".'[141] Without detailed records of intimate behaviour it is difficult to judge patterns of sexual behaviour. It may be that sex within marriage did change as the Pill put an end to patterns of restraint that existed earlier.[142] Dr Margaret Sparrow remembers the development of a new discourse amongst students at Victoria University where she worked: 'the growing realisation of how much control of your reproduction is so basic to what you can do'.[143] When married women began to take the Pill, they started a revolutionary new way of thinking about reproduction and women's rights. As Moreau suggests, 'The real sexual revolution took place in heads, not in beds.'[144] Another of our medical respondents reinforced this view, suggesting that the Pill contributed to a more assertive demeanour in the women who adopted it.[145]

Under the heading 'Quick Kiwis', New Zealand's Ministry of Economic Development noted in 2007 that 'New Zealanders are usually quick to embrace new technology'.[146] Our concern here has been to shift the focus of historical discussion from the Pill's impact, to the question of uptake. Many of the factors that have made New Zealanders users of cell phones and debit cards no doubt influenced their reception of the Pill: a well-educated, reasonably prosperous

and relatively homogeneous population. The story of the rapid uptake of the Pill is particular, however, and suggests the centrality of the role of the medical profession and the historical development of the health-care system.

The ready uptake of the Pill in New Zealand was made possible by two preconditions. The first of these was the ready access that pharmaceutical companies, through their detailers, had to doctors. The small and literate population of the country, the lack of barriers to the introduction of the Pill, and the expectation that its safety had been tested elsewhere, meant that companies were free to distribute and promote their wares and they did so vigorously. Drug detailers were responsible for educating doctors about the Pill, which they did very effectively.

The second precondition for the rapid uptake of the Pill was the tradition through which women saw their doctors regularly because of state subsidies for medical care, for childbirth and for certain medications. The free postnatal visit provided the ideal occasion for doctors to discuss contraception with women, and given the high fertility rates, they were seeing a good proportion of women in their fertile years. Within a few years of its introduction, the popularity of the Pill saw it being used by the majority of those practising contraception. This marked the first time one method of contraception became significantly more popular than others.

Women of the baby boom generation were seeking a reliable method of birth control and doctors were seeking to meet their needs. When the Pill was offered as a solution to unwanted fertility, it fit with traditional prescribing patterns and doctors eagerly adopted it for their married, and in some cases their single, patients. Both the modern woman, wearing her Mary Quant miniskirt, and the modern doctor, alive to the promises of hormonal preparations, saw in the Pill the dawn of a new age.

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NOTES

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