A male contraceptive pill

To the editor — In his News & Views article, Malcolm Potts draws attention to the pitiful resources available for the development of improved methods of fertility regulation at a time when the need is so clear[1]. However, in proposing that a "diversion of funds and skills" into the development of a male hormonal contraceptive may be "counterproductive," he chooses to ignore public demand and the significant scientific advances that have been made during the last few years. This is particularly surprising given that Potts must be aware of the recommendations of the International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995) as well as the increasing demand from men and women, all of whom seek the development of methods that will enable men to share the responsibility and burden of family planning. He must also be aware of the results of two recently completed multicenter clinical trials[2,3] coordinated by the World Health Organization that clearly demonstrate not only the feasibility of developing a safe and effective hormonal contraceptive for men but also — if the enthusiasm of the trial participants is anything to go by — that this approach will find ready acceptance with users and their partners. Of course, several years of development and testing are needed before a male "pill," or more probably an injectable preparation given at quarterly intervals, will be available, but it is reasonable to predict that such a product will be available early next decade.

As a direct consequence of insufficient commitment and funding, the only family planning methods that men can use, apart from abstinence or withdrawal, are the condom and vasectomy, both of which have problems of acceptability. If the opinions expressed by Potts are allowed to dictate future research strategies, this pathetic situation will go unchanged.

P.D. GRIFFIN
Research on Methods for the Regulation of Male Fertility
UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
World Health Organization
1211 Geneva 27, Switzerland

To the editor — Pott's conclusion that men would not be susceptible to a systemic method to interrupt their fertility or that such a method might not be physiologically or socially sound is naive and should not go uncontested. He appears to have overlooked the successful research efforts over the past two decades to develop a hormonal male contraceptive. These efforts have clearly demonstrated that — as for ovulation in women — spermatogenesis can be suppressed in men by the application of sex steroids. Two large-scale multicenter trials, performed under the aegis of WHO (ref. 2, 3), have shown that testosterone administration to men suppresses spermatogenesis to azoospermia or severe oligozoospermia, resulting in a degree of contraceptive protection similar to oral contraceptives taken by women. Simultaneously, long-acting testosterone preparations are being developed[4], allowing intervals of at least three months between injections in order to make hormonal male contraception practicable. In combination with gestagens[5] or GnRH antagonists[6], testosterone may become an even more potent male contraceptive.

Admittedly and unfortunately most of the pharmaceutical industry has so far observed these developments rather passively. There are signs that this attitude is changing. Some companies have been sufficiently encouraged to initiate further trials, both with the intention of bringing hormonal contraception for men to the market but also in recognition of the clinical needs in the sadly neglected broader context of the overall reproductive health of men.

Referring to hormonal male contraception in its advanced state of development as "counterproductive" undermines the efforts of those researchers responding to the public demand for a male contraceptive and the public health needs of men generally. Note that 83% of the couples participating in the WHO studies did so because of dissatisfaction with their current contraceptive methods. Potts might also reread the statements issuing from the International Women's Health Coalition (Mexico, 1993) and the Cairo and Beijing conferences. All endorsed as a high priority the need to develop methods with which men could increase their participation in family planning. If he is really concerned about "today's global population crisis," Potts should support rather than antagonize the already advanced development of hormonal male contraception.

EBERHARD NIESCHLAG &
GEOFFREY M.H. WAITES
Institute of Reproductive Medicine of the University Domagkstr. 11, D-48129 Münster, Germany

Potts replies — A method of male contraception would be useful, and Griffin, Nieschlag and Waites remind us of good scientific leads. Unfortunately, good intentions will not make new contraceptives. The Cairo conference drew attention to male methods, but it also set the international community a goal of $5.7 billion a year by the year 2000 to support reproductive health. The United States has cut its 1996 family-planning donation by almost 90%, and we may be lucky to reach a total of $1 billion for everything — services, commodities, training and research. I suggest that we will serve more needs by focusing on one short-term goal rather than plodding after several long-term leads such as male pills. A woman-controlled vaginal preparation to reduce HIV infection and control fertility is particularly attractive because it is relatively low technology and will save lives. You cannot spend the same penny twice: Money and scientific skills allotted to one area necessarily detract from another. It is not a question of not wanting to develop a new male contraceptive but rather a case of prudent management of exceedingly limited resources for the maximum benefit of the greatest number of people in the shortest possible time.

MALCOLM POTTS
School of Public Health, University of California Berkeley, California 94720, USA

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