Letters

Birth Control—Population Policy

Judith Blake ("Population policy for Americans: Is the government being misled?" 2 May, p. 522) has stated well the complexities and social implications of any birth control program. However, two of her assumptions bear questioning. One, she argues that if the poor really wanted more birth control information they could get it. As evidence to their ingenuity when highly motivated, she cites their ease in access to illegal narcotics which are supposedly unavailable. The problem of illicit narcotics "pushing" to the young is well known, whereas family planning agencies which might "push" birth control information and create motivation for their product are usually hard-pressed for funds. Furthermore, in some states it is illegal for public agencies and clinics to give this information. The poor, one could argue, should have the opportunity for as much information about birth control as the more well-to-do.

Two, she states "that existing pressures still attempt to make the reproductive and occupational roles coterminus for all women who elect to marry and have children." The educated homemaker today, as evidenced by the wealth of popular and professional literature on the subject, has increased opportunity and encouragement to pursue interesting work outside the home (*1*). Increased longevity and leisure time, decreased family size, greater educational opportunities, and need for skilled labor are given as reasons for this trend. The availability of contraceptives as well as abortion for the upper income and better educated woman gives her greater freedom in limiting and planning her family in line with her personal desires.

I don't think we should assume that the poor and less educated are given the same opportunity for this kind of planning.

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References

1. M. S. White, Ed., *The Next Step* (Radcliffe Institute for Independent Study, Cambridge, Mass., 1964); E. Peterson, *Daedalus* **93**, 61 (1964); F. I. Nye and L. W. Hoffman, *The Employed Mother in America* (Rand McNally, Chicago, 1963); *American Women: Report of the President's Commission on the Status of Women* (Government Printing Office, Washington, D.C., 1963).

Let me vote agreement with Blake's assertion that "the problem of inhibiting population growth in the United States. . . is well beyond the point of 'needing' birth control methods." She's right: family planning, alone, won't solve our population growth problem. But Blake and the other demographers who throw their own statistics at their colleagues to undermine existing programs do no service to the cause of inhibiting U.S. population growth.

The growing attendance at public clinics and Planned Parenthood facilities is evidence that tens and hundreds of thousands of poor women, white and black, want convenient, dignified health service in controlling their fertility. The "five million" figure for the poverty group of women in the child-bearing years may be an over-estimate, as Blake believes, or a gross under-estimation of the number of women who do not know how to obtain family planning advice from physicians, as I believe. But even if the figure is only a few tens of thousands, it is a genuine health need recognized by the medical profession and public health officials. Blake implies that the dedicated workers in the family planning movement are engaged in a form of genocide, yet it is she who would have the government desist in its efforts to help poor women escape the cycle of almost perpetual pregnancy that mires many of them in poverty.

The answer to our population problem doesn't lie in stopping useful programs, just because they aren't the total answer. The major job remains, as I think Blake suggests, in convincing affluent Americans that they must limit their family sizes. In many ways the U.S. population explosion is more serious for the world than the explosions in Asia and Latin America. We now use well over half the world's nonreplaceable raw materials to support about 6 percent of the world's population. Our growth makes new demands on these resources and further imperils the world we bequeath to our children.

Blake believes that the low acceptance of the idea of pills for unmarried women is a major argument against birth control programs. Yet she suggests that removing the illicit label from deviant sexual activities will help solve the population problem. Her suggestion is not without merit, but we'll have fewer unwanted babies from the distribution of pills to the responsible youth who ask for them than from regularizing unusual couplings. And I'd warrant a quicker public acceptance for the pills than for irregular unions. . . .

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. . . Blake asserts that there exist among the poor many alternatives to the pill and IUD and that substitution of "scarce medical and paramedical attention for all contraceptive methods now being used by poor couples" has implications which "border on the fantastic." I suggest she take a few hours from her computer on Oxford Street and spend them at the Planned Parenthood Clinic in Hunters Point, San Francisco. There she would find that among those alternatives are various folk medicines of no value and the use of wire coat hangers to induce abortions.

No doubt Blake has spent considerable time with teenagers in minority and poverty groups and has ascertained *their* feelings about birth control methods and information. My own field experiences with teenage discussion groups in the Bay area has been that what information is available is generally inaccurate, distorted, and fear- and anxiety-arousing.

I sympathize with Blake's concern for questions of sexual morality—it is a theme family planners hear often. However, she fails to appreciate the fact that for the teenagers in question sexual relationships are a fact of life, with or without contraception. . . .

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As executive director of a Planned Parenthood affiliate, I am now administering two federal contracts, one with the Office of Economic Opportunity, and

one with the Department of Health, Education, and Welfare. In all my negotiations relating to the contracts, no mention has been made of population control. Despite Blake's claims, obviously OEO and HEW do not think of family planning in that context. OEO asked us to administer a contract providing free birth control care—not just information, but also medical care—for women (including families and unwed women) who could not afford a private physician. Our clients are not welfare clients since MediCal pays physicians to provide birth control for them. OEO wished to provide an element of medical care to those with low incomes. HEW asked us to administer a program to improve the health of mothers and children, again for those with low incomes, both married and unwed. Certainly OEO and HEW are not being misled in the directions suggested by Blake. . . .

We know that, among our patients, there are many who become evangelists for birth control among their friends and neighbors, once they receive care. We believe that this word-of-mouth information brings others to our clinics. The demographers and other scientists often overlook the importance of attitude change in the social order. In fact, they rarely mention it. We know it is real. . . .

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Blake makes one excellent point. As a physician engaged in the practice of psychiatry, I wholeheartedly agree that the weight of cultural pressure on women to find their major satisfaction in child-rearing will strongly affect any birth control program, and none should therefore be implemented without considering this factor. Beyond that, I take serious exception to her arguments.

First, I consider that the opinion poll system of dealing with such a complex and overdetermined matter as family planning is so superficial as to cast grave doubts on any conclusions drawn from it. Nevertheless, even at that level of investigation more evidence is needed. For instance, where are the comparative statistics on women who want to practice birth control versus women who actually do? What reasons are given by those who do not? More importantly, I see no correlation with sociological studies. To take an obvious example, in one well-documented lower-class subculture, there is a matriarchal family organization with historical roots, perpetuated by lower employment opportunities for the males and reinforced by the prevailing welfare policy of giving aid to dependent children only when the father is absent. This gives obvious economic advantage to larger family size, not to mention the emotional advantage to the mother for whom relationships with children are the only enduring ones. Were these factors taken into account in interpreting answers from such women? Furthermore, I cannot imagine anyone opposing an educational or agricultural improvement program on the grounds that of the "target group" only 78–85 percent were in favor of it! (Table 4, p. 525).

Second, *all* women require medical attention regarding any effective means of birth control. Far from being discriminatory, this "blanket decision by the estimators" is absolutely correct. The condom is not an acceptable alternative: (i) it is not always reliable; (ii) it has serious psychological as well as physical drawbacks to sexual satisfaction for both men and women and is thus less likely to be used consistently; (iii) for at least the portion of the "target group" which is on welfare, it is a luxury item for which there is no official provision; (iv) most importantly, it delegates to the man the responsibility for effective birth control—surely one of woman's most basic rights is to decide for herself how many children she will have. As for the unscrupulous businessmen who might be assumed to have entered this market —they have. One has only to read the misleading advertising for "hygienic suppositories" which "kill germs on contact" and then listen to the pathetic stories told by poorly educated women who thought such language was a euphemistic description of reliable birth control methods. . .

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Because they believe that medically prescribed contraceptives are the only ones couples should use, these readers (like the creators of the mythical "five million women") regard the large-scale need for government birth-control clinics as axiomatic. But the proposition that only "medical" methods are acceptable and effective is debatable. Many couples are known to choose other methods voluntarily and to use them effectively. Moreover, well-known "natural experiments" disprove the exclusive medical emphasis. There is the case of France, where both contraception and abortion have been legally suppressed, and yet family size has continued to be small. There is also the United States, where, in the face of silence and indifference concerning contraception by most physicians, couples reduced their fertility to very low levels during the Depression and continued to keep reproduction under remarkable control even while they chose to have larger families in the years that followed. Had these couples waited for the medical profession to spark their birth control efforts, they would have waited in vain.

It is significant that the current programmatic emphasis on the pill and the coil, and the denigration of other contraceptive means whose effectiveness is somewhat less, stems very largely from the prior (and passive) assumption that abortion will continue to be unavailable as a birth control method. We are thus led to believe that the all-out objective is 100 percent effective contraception instead of 100 percent effective birth control. Yet the medical profession could do much to help rectify this imbalance in the birth control picture, instead of primarily devoting its family planning efforts to bandwagon pill and coil programs—programs that emphasize effectiveness and lack of "trouble" to the exclusion of other medically relevant considerations.

The blinders that the pill and coil bias places on reasoning are well illustrated by Barnhouse-Beuscher's out-of-hand rejection of the condom. Her position bypasses the fact that the medically relevant consequences of sexual intercourse are, unfortunately, not confined to pregnancy. Sexual contact also spreads disease. Since (Reynolds claims) lack of sexual restraint is a "fact of life" among many teenagers, the condom would appear to be an epidemiologically ideal method for them because it combines two types of prevention in one. Its use would help greatly in controlling the emerging epidemic of venereal disease among young people in this country. The condom may have some drawbacks to be sure, but then so has venereal disease.

My caveats concerning the need for government birth control services are not negated by the experiences of patients in the clinics mentioned by Frank, Johnson, and Reynolds. Surely the latter must know that one cannot extrapolate from clinic groups whose problems, by definition, do not constitute a representative sample of the experi-

ences of nonclinic populations. Let me remind these readers (and Weissman as well) that I did not claim that all persons have optimum access to family planning. I simply questioned the need for and appropriateness of massive, class-oriented, government intervention at the clinical level—especially since there are still unexplored and unexploited resources in the private sector.

The possible "side effects" discussed in the article (such as charges of genocide and of encouraging sexual activity by teenage girls) are smoldering public issues (not personal objections, as suggested by Frank and Reynolds). When these are combined with the possibility of physiological side effects from birth control drugs, the potential explosiveness of the mixture cannot be entirely ignored. However, I do not argue that the government should hesitate to act because of a threat of this sort—if the issue is one clearly involving national welfare and requiring its resources and authority. I have argued, rather, that no one has demonstrated convincingly that family planning "deprivation" in the United States today is such an issue.

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Social Science in the Marketplace

Willeke's letter (16 May) discusses the problem of plans developed by technical experts and subsequently "rejected by the people." He urges a better understanding of such resistance to social changes and suggests that the services of social scientists be used to implement proposals that might otherwise be rejected.

Thompson's original article (14 Mar., p. 1180) reported the defeat of a conservation plan. Willeke refers to controversies surrounding the fluoridation of municipal water supplies and the planning of freeways in urban areas. Using social scientists to help secure the adoption of proposals of these types raises important ethical issues. Should the scientist (whether "social" or "physical") make his services available to all who request it? Can social scientists adopt such a "morally neutral" position? Ten years ago I was active in several campaigns involving fluoridation of municipal water supplies. Shortly thereafter I refused to participate in a social-