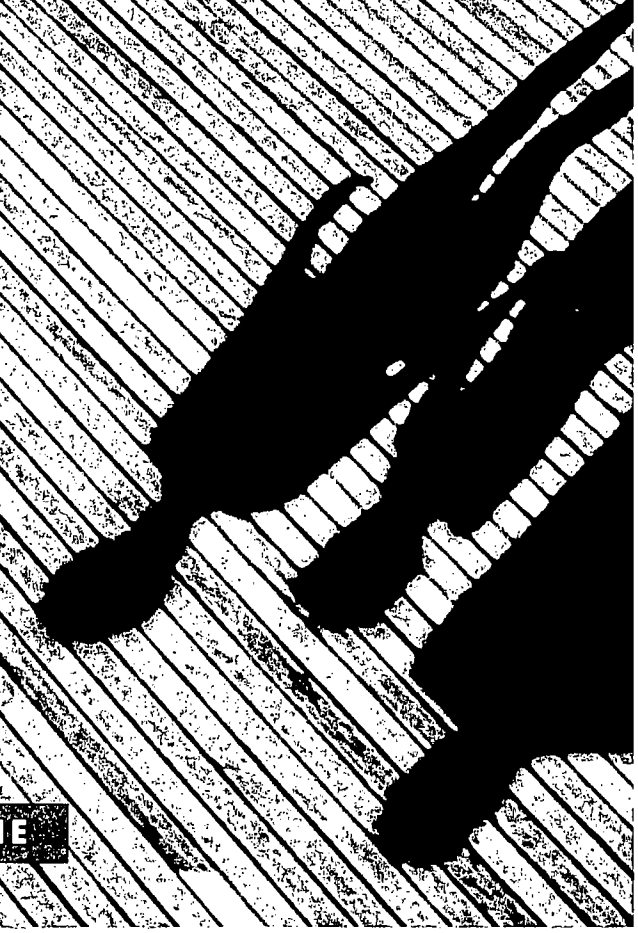
SUMMARY

The Best Intentions

Unintended Pregnancy and the Well-Being of Children and Families



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Methodology

The potential effect of a 35% cut in U.S. funding for family planning is estimated by gathering and sometimes reconciling information from a wide variety of sources, ranging from national censuses and population estimates to country-specific surveys of women of reproductive age and special studies of contraceptive use and of pregnancy outcomes.

The estimates that follow reflect the knowledge and expertise of the following organizations: The Alan Guttmacher Institute, The Futures Group, Population Action International and the Population Reference Bureau, in consultation with the Population Council. The basic steps in reaching the estimation are as follows.

The first step in estimating the impact of the funding cut begins with determining how many of the couples who depend on U.S.-funded family planning programs will lose their access to contraceptives.

- Population censuses and estimates indicate an estimated 829 million women of reproductive age are living today in developing countries other than China (which receives no U.S. family planning program support).
- Surveys of women in developing countries show that roughly 247.5 million of these women and their partners use modern methods of contraception to lengthen the time between the births of their children or to avoid having more children than they already have.
- Because of their poverty, 190.5 million, or 77%, of the couples in developing countries outside of China who are using modern contraceptive methods rely on public-sector family planning programs.
- The United States contributes about 17% of all public funds spent on family planning in developing countries other than China, accounting for 32.4 million couples using modern contraceptive methods. [Of these couples, 12.6 million are estimated to be protected by contraceptive sterilization or long-lasting methods including hormonal implants (such as Norplant) or intrauterine devices (IUDs).]
- On an annual basis, 19.8 million couples depend on U.S. supported programs to obtain contraceptive supplies, such as pills, condoms or injectables, or to start use of a long-term method, such as voluntary sterilization, hormonal implant or IUDs.
- A cut in program resources of 35% means that 12.9 rather than 19.8 million couples will be able to be served in a year's time, leaving 7 million couples without access to contraceptive supplies or services.

The second step is estimating what effect losing U.S.-supported family planning services will have on the couples who are depending on them for contraceptive care.

- There are few other contraceptive choices in developing countries for women who lack access to modern contraceptives. A conservative estimate is that of the 7 million women losing services because of U.S. funding cuts 2.8 million will turn to traditional methods and 4.2 million will use no contraceptive.
- Because pregnancy rates are so much higher among couples relying on no method or on a traditional method than if they use a modern contraceptive, 4 million more unwanted pregnancies are expected in developing countries due to the drop in family planning program resources.
- About 40% of these unintended pregnancies are likely to end in induced abortion, even though it is often not legal and performed in unsafe conditions – accounting for 1.6 million abortions among the expected additional unwanted pregnancies.
- Some 47% of the unintended pregnancies are likely to end in unwanted births with the remaining 13% resulting in spontaneous abortions or miscarriages – accounting for 1.9 million unwanted births among the expected additional unwanted pregnancies.
- Maternal mortality rates in developing countries are high, about 4.1 deaths per 1,000 women giving birth, leading to an estimated 8,000 additional deaths due to pregnancy among the women facing additional unintentional pregnancies.
- Infant mortality rates in developing countries are high, with about 7.2% of all babies born dying before their first birthday, leading to an estimated 134,000 additional infant deaths among the women facing additional unintentional pregnancies.

services are provided in a more integrated manner.

Reflecting American Values

Making family planning services widely available to all who want them is one of the surest ways to foster self-sufficiency, promote preventive health care and basic education, nurture strong and healthy families, and enhance the quality of life for all of us. In many ways, family planning reflects the core values that most social conservatives – indeed, most Americans – hold so dearly. It is ironic that the strongly held antiabortion views of some conservatives have been extended into the realm of family planning, which has long enjoyed strong bipartisan support in Congress and around the country as a means to reduce the incidence of abortion.

The American public supports humanitarian assistance – family planning and reproductive health services, child survival, education, environmental protection – not only as a necessary price for world leadership but also as the right thing for a wealthy country to do. In a recent nationwide poll conducted by the University of Maryland, those surveyed felt that 5% of the national budget was an appropriate level for the United States to spend on development assistance. Currently, less than 1% of the federal budget is earmarked for international aid, and less than half of that amount goes to humanitarian assistance.

Contributing "our fair share" to alleviate poverty and promote better health and nutrition among developing societies is a strongly held American value, one that has driven U.S. international assistance for many decades. And making quality family planning services available to all who want them has been a central tenet of American humanitarian aid. Clearly, it must remain so if our efforts are to succeed in improving the lives of women, supporting families worldwide and benefiting our own lives here at home.

Major Sources

The Alan Guttmacher Institute (AGI), *Hopes and Realities: Closing the Gap Between Women's Aspirations and Their Reproductive Experiences*, New York, 1995.

The United Nations Children's Fund (UNICEF), *The Progress of Nations*, New York, 1996.

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Issues in Brief

The Alan Guttmacher Institute
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Endangered: U.S. Aid for Family Planning Overseas

In the wake of groundbreaking international accords calling for greater political and financial attention to population and development issues, the United States is failing to fulfill its commitments. During the last two years, ultraconservatives in Congress have doggedly attacked U.S. participation in the International Conference on Population and Development in Cairo and the Fourth World Conference on Women in Beijing and have made U.S.-aided family planning programs a favorite target of their hostility. Cleverly using the divisive issue of abortion, they have attacked family planning efforts as promoting abortion by encouraging promiscuity, sabotaging parental authority and threatening family life.

Frustrated in their attempts to restore heavy-handed policies imposed on international family planning programs during the Reagan years, key members of the U.S. House of Representatives set out, instead, to undermine these programs through draconian funding restrictions. They succeeded: In 1995, while funding for most humanitarian aid was reduced by 20%, family planning was singled out for extraordinarily harsh treatment – a far deeper cut and a complicated allocation scheme that reduced even further the amount of funds actually available. Lawmakers gave no reprieve in 1996, as the disproportionate funding cut was extended for a second year. Another congressional test of this issue, however, is already slated for February 1997.

This Issues in Brief *explores the political climate confronting family planning assistance. It describes the human toll that deep funding cuts will take in the form of more unplanned pregnancies and abortions, more women dying during pregnancy and childbirth, and more infant deaths. Finally, it discusses why U.S. leadership is critical to the global family planning effort and why this is fully consonant with American traditions and values.*

The 1994 congressional elections ushered into the House of Representatives a formidable bloc of antiabortion conservatives. Facing an electorate that is basically prochoice, however, they had few potential targets within their reach. Foreign assistance became an easy mark, and the restoration of the so-called Mexico City policy became a rallying cry.

The Mexico City policy was first enunciated by the Reagan administration at the 1984 United Nations' population conference in that city; it was revoked by President Clinton nearly 10 years later. The policy deemed population growth a "neutral" phenomenon; to the extent it could be considered a problem, it would be solved by "market forces." The policy also declared that, henceforth, the United States would no longer "promote" abortion worldwide – something that, in fact, had been prohibited by law since 1973. The latter goal would be achieved by imposing strict new conditions on indigenous, private organizations abroad – conditions that could not be imposed on similar U.S.-based institutions. Under the Mexico City policy, these overseas organizations would be disqualified from receiving U.S. family planning aid if – with their own funds and in accordance with the laws of their own countries – they provided any abortion-related information or services.

The House endorsed the reimposition of the Mexico City restrictions on several occasions in 1995 but was rebuffed by the Senate each time. The Senate's refusal to reinstate these discriminatory and imperialistic restrictions, even after the House countered with varying versions, resulted in a lengthy showdown between the two chambers. As a consequence, a second – but equally devastating – assault by family planning opponents began to unfold: to decimate the program's funding.

In January 1996, almost four months into the new fiscal year and under immense pressure to head off a third governmentwide shutdown, both the Senate and the White House were forced to accept a self-described "compromise" proffered by the House leadership. As the price for dropping the Mexico City language, family planning would be stripped of much of its funding. First, an overall funding cut of 35% – a much deeper cut than that sustained by

development assistance generally – was imposed. Second, to punish family planning even further, an unprecedented and complex set of funding rules would be imposed. No funds would be made available until July 1 – a full nine months into the fiscal year – and, perhaps most severe of all, the funds, once released, could only be doled out in monthly installments over the next 15 months.

The fiscal 1997 budget process brought more of the same. Still stymied by Senate and White House opposition to the Mexico City restrictions, the far-right demanded an extension of the same funding conditions. However, another test of the issue was built into the equation. The new law requires Congress to vote – by February 28, 1997 – on a presidential "finding" (itself to be delivered by February 1) as to whether the funding limitations are having "a negative impact on the proper functioning" of the international family planning program. Assuming the president reports that they are, and both the House and Senate agree, the fiscal 1997 money will be released on March 1 instead of July 1.

A Major Setback

Meanwhile, the impact on the lives of millions of women who are served by these programs, and on their families, will be profound. As nations head into the 21st century, the largest generation in history is just reaching adulthood. The choices these young women and men make about family size will depend greatly on the contraceptive and reproductive health services available to them, and will help shape their futures and the world's thereafter.

Moreover, given that women are the primary caretakers and household managers throughout much of the developing world, their health and well-being undeniably determines how their children – especially their daughters – will fare in life. In the immediate future, the relatively dismal state of women's reproductive health throughout much of the developing world can be expected to worsen as a direct result of the severe cutback in U.S. family planning aid.

According to a 1996 report from the United Nations Children's Fund (UNICEF), almost 600,000 women die during pregnancy and childbirth each year; 75,000 of these women die attempting to abort an unwanted pregnancy themselves or with the help of an untrained and unsafe provider. All told, these deaths render at least one million children motherless every year.

UNICEF further estimates that for every woman who dies, "approximately 30 more incur injuries, infections and disabilities which are usually untreated and unspoken of, and which are often humiliating and painful, debilitating and lifelong." Improving access to quality family planning services, notes UNICEF, is paramount to improving maternal and child health in developing countries. It is well documented that mortality rates for women and children are highest when births are spaced too close together, when a woman has many children (more than four) and when births occur too early or too late in a woman's life. Yet the campaign by abortion opponents to decimate government-supported family planning services only assures that women and their families in the developing world will know more suffering and death.

Measuring the Impact

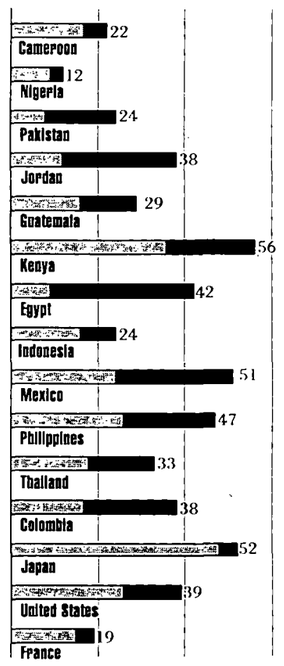
In early 1996, a consortium of expert organizations undertook an effort to quantify the impact of the steep reduction in family planning aid. Their calculations, which take into account only the 35% cut to the program's overall funding level, are conservative by design (see Methodology, page 4). Excluded from the analysis is the combined effect of the nine-month moratorium and the monthly "metering" of funds, which only add to the financial hardship.

Based solely on the one-year, 35% cut, the consortium estimates that:

- 7 million couples in developing countries who would have used modern contraceptive methods will not have access to these methods.
- As a result, 4 million more women will experience unintended pregnancies, leading in turn to:
  - 1.9 million more unplanned births and 1.6 million more abortions (the remainder of the unintended pregnancies will end in miscarriages);
  - 8,000 more women dying during pregnancy and childbirth, including from unsafe abortion; and
  - 134,000 more infant deaths.

chart 1
Unplanned Births

Many women say their last birth was mistimed or unwanted...



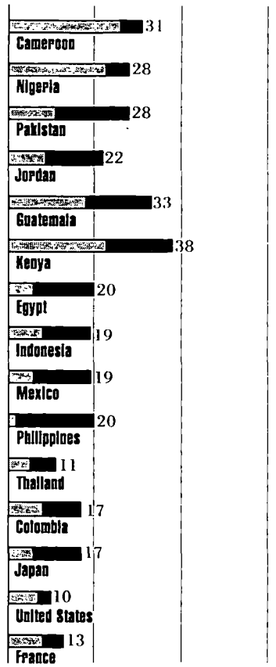
Source: AGI, *Hopes and Realities*

Unmet Needs

The devastating cuts to U.S. family planning assistance abroad come at a time when increased access to family planning and related reproductive health care is crucial. Although progress has been made, the unmet need for quality contraceptive services remains considerable.

chart 2
Unmet Need

...and need family planning to postpone or end childbearing.



Source: AGI, *Hopes and Realities*

Over the last three decades, the size of the average family has fallen from roughly six children to about three. By having fewer children, parents are in a better position to provide for them and improve the family's quality of life overall. However, while women are striving – and succeeding, albeit with great difficulty – to have smaller families, a gap still exists between the number of children women say they want and the number they actually have. Many women give birth before they and their partners feel they are ready to care for a child, and substantial proportions of women – more than 50% in some countries – say their last birth was mistimed or unwanted (Chart 1).

The use of effective contraceptive methods has increased rapidly over the past 30 years throughout the developing world. Yet nearly 230 million women worldwide – roughly one in six women of reproductive age – are still in need of modern contraceptive methods to postpone or avoid future childbearing (Chart 2).

The high level of unmet need for family planning is a key reason why women have great difficulty in spacing their pregnancies and bearing the number of children they want. Determined to avoid an unplanned, unwanted birth, many women – in the absence of family planning or following a contraceptive failure – resort to unsafe abortion. Worldwide, more than one-quarter of pregnancies – about 52 million annually – end in abortion, often performed clandestinely and under unsanitary conditions.

Meeting the Challenges

Helping women narrow the gap between their childbearing desires and what they actually experience is at the heart of U.S. family planning assistance. Enabling women to have the number of children they want, and when they want them, is central to the quality of their lives and the well-being of their families. And women's success in achieving their reproductive goals has important implications for the social and economic welfare of the communities and nations in which they live and, ultimately, for the future of the world.

Rapid population growth severely reduces the likelihood that developing societies can move out of poverty or that women can contribute to development on an equal footing with men. Providing women with the means to control their fertility, primarily through improved access to quality family planning services, is, therefore, fundamental to human progress.

In this light, it is important to recognize that the impact of deep cuts to U.S. family planning aid will extend well beyond the delivery of contraceptive and reproductive health services to women and couples. Ongoing U.S. efforts to improve literacy rates and primary school education of girls, promote good nutrition, improve maternal and child health, and enhance women's participation in the economic and political spheres of society will feel the sting as well.

On the ground, these programs rarely operate in a vacuum, independent of each other. Rather, over the years, they have become increasingly integrated, partly to maximize resources but largely because such efforts naturally complement and reinforce one another. The extensive cuts to family planning assistance inevitably will affect other development endeavors.

U.S. Leadership

Currently, about three-quarters of the roughly $4 billion spent to provide family planning services in developing countries is borne by the countries' own governments and by the women and men who use these services. The remainder is contributed by developed countries. Financial support from developed country governments – both to other governments directly and to indigenous nongovernmental organizations (NGOs) working in those countries – clearly plays a pivotal role in meeting the rapidly increasing contraceptive needs of couples in the developing world. And, it is no exaggeration to say that the U.S. program is the anchor of the global family planning effort on which other countries' contributions depend for stability and direction.

Should U.S. support for international family planning continue to erode, it is unrealistic to expect that other donor countries will – or could – make up for the loss of U.S. government funds. No other country, nor international organization for that matter, has the extensive field presence nor the vast array of technical resources and experience that the U.S. family planning effort has developed over the decades.

Moreover, American leadership has been crucial to forging alliances among governments and the private sector so that family planning and related social

table 2
Curable STDs

Region	New yearly infections (millions)	Yearly rate per 100 adults
World	**333**	**11**
South & Southeast Asia	150	18
Sub-Saharan Africa	65	25
Latin America & Caribbean	36	15
East Asia & Pacific	23	3
Eastern Europe & Central Asia	18	11
Western Europe	16	8
North America	14	9
North Africa & Middle East	10	6
Australasia	1	9

Source: World Health Organization (WHO), *An Overview of Selected Curable Sexually Transmitted Diseases*, Geneva: WHO, 1995.

What is more, by reducing genital wart infections, all barrier and spermicidal methods offer some protection against the development of cervical cancer. However, while the effects of spermicidal methods on reducing the risk of certain STDs is clear, the evidence on their effects on HIV transmission remains inconclusive.

Other modern contraceptive methods also confer some health protection. The pill helps reduce a woman's chance of developing endometrial or ovarian cancer, and the longer it is used, the lower the risk. What is more, among women with chlamydia and gonorrhea, hormonal contraceptives reduce the chance of pelvic infection, ectopic pregnancy and infertility.

Family planning and reproductive health service providers help improve and even save the lives of both women and men by educating couples about healthy sexual behavior, the benefits of condom use, and STD prevention and treatment, and by linking clients and their families to other preventive and curative health services.

Empowering Women

Access to family planning services is affirmed as a universal human right in many United Nations documents. More concretely, it contributes to the advancement of women and to the fuller development of society.

Women who are able to defer childbearing until their 20s improve their chances of having time to obtain adequate schooling, develop work skills and acquire broad life experience. And women who bear only the number of children they want have increased opportunity and time to be in the labor market and to build competence and achieve personal fulfillment. Such participation in society enhances women's sense of self-worth and improves the well-being of their families.

The relationship between women's empowerment and family planning is often mutually reinforcing: As women obtain more education and gain the skills and confidence they need to go out into the world and earn money of their own, their desire and ability to plan their childbearing also grows. Moreover, women who practice family planning are more likely than those who do not to seek other types of health care services for their children and themselves.

Taking Effective Action

Helping women avoid high-risk and unwanted pregnancies remains an urgent health priority—especially where access to prenatal and emergency obstetric care is inadequate, and nutrition and overall health are poor. And the use of the latex condom is the only effective way known to prevent the transmission of STDs—including HIV—among sexually active couples.

What is more, in many parts of the developing world, a woman's first referral to other important health services is often made through her initial contacts with a family planning provider, be it a clinic, community-based distributor or outreach worker.

In many developing countries, it will be difficult—and will take decades—to improve overall health and living conditions, and to change deeply entrenched, discriminatory cultural practices and attitudes that harm women and jeopardize their health. While these broad goals should continue to be pursued, the more widespread provision of family planning services is an achievable (and highly cost-effective) way of improving both women's lives and the well-being of couples and families everywhere.

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Credits

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Issues in Brief
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THE ALAN GUTTMACHER INSTITUTE
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Support for Family Planning Improves Women's Lives

Like the use of the telephone, the practice of family planning is so widespread and so routine in the United States that we almost take for granted its far-reaching benefits. Because American women using effective modern contraceptives can decide when to have their children and are able to bear only the number they want, they can plan their educational careers and their work, family and personal lives with an assurance that would have been impossible for their grandmothers.

In the developing world, family planning can bring these same benefits to women and do even more: By helping women prevent ill-timed or unwanted pregnancies, it can also save their lives and protect their health.

And for couples everywhere, the use of the condom and some other contraceptives helps protect against the spread of sexually transmitted diseases (STDs), which threaten the well-being and sometimes the survival of men and women worldwide.

Despite the many ways in which family planning benefits women and their families throughout the world, the support of developed countries—an essential component of financing and improving access to these necessary services in developing countries—is often under threat of being reduced or even eliminated. This *Issues in Brief* examines the advantages for women and society that family planning services bring, and that would be compromised if these services were curtailed.

High-Risk Childbearing

Every year, 585,000 women—99% of them in developing regions—die from causes related to pregnancy. These causes include the direct health consequences of high-risk pregnancies, unsafe abortions and difficult deliveries, as well as problems that arise soon after delivery. Maternal mortality ratios (representing the number of women who die every year from pregnancy-related causes per 100,000 live births) in Africa, Asia and Latin America are 10–100 times the ratios in the industrialized world (Table 1, column 1). UNICEF points out that "no public health problem shows greater disparity between rich and poor countries than maternal mortality."

The major causes of maternal deaths are similar throughout the developing world, although the relative importance of each varies from one region to another. Overall, the leading causes are hemorrhage, or excessive bleeding (accounting for 24% of all maternal deaths); preexisting conditions that are complicated by pregnancy (20%); sepsis, or acute infection with fever (15%); complications of unsafe induced abortions (13%); eclampsia (12%); obstructed or prolonged labor (8%); and ectopic pregnancy and other conditions (8%).

According to the World Health Organization (WHO), for every maternal death that occurs worldwide, an estimated 30 additional women suffer pregnancy-related health problems that can be permanently debilitating. Each year, approximately 17 million women are affected with such conditions as uterine rupture, uterine prolapse (a displacement from the normal position), hemorrhage, vaginal damage, urinary incontinence, obstetric fistula (a muscle tear that allows urine to seep into the vagina) and pelvic inflammatory disease (which can lead to permanent sterility).

The vast majority of pregnancy-related complications that lead to health problems or death can be prevented in the first place, or successfully treated, if the right medical care is available. High-quality and accessible prenatal and maternity care services are the major reasons for the low levels of death and disability associated with pregnancy and childbearing in developed countries. In the developing world, unfortunately, services are often of poor quality, and coverage is inadequate or, in some areas, completely lacking.

Most women in developing countries still give birth at home, helped by a close family member or traditional birth attendant. Fewer than one in five women obtain assistance from a trained doctor or nurse when they give birth in Burundi, Niger, Yemen, Bangladesh and Pakistan; fewer than one-half receive professional medical assistance in Ghana, Kenya, Mali, Nigeria, Senegal, Uganda, Egypt, Morocco, India, Indonesia, Bolivia and Guatemala. Even when women deliver in a hospital, the equipment, supplies, drugs, or operating rooms and trained staff needed to do cesarean sections or manage emergencies may be lacking.

table 1
Maternal Health Risks

Country and survey year	Maternal deaths per 100,000 live births	% of women 20–24 with at least 1 birth by age 18	% of women 30–34 with at least 4 live births
Sub-Saharan Africa			
Botswana, 1988	250	26	53
Burkina Faso, 1992–1993	930	32	80
Burundi, 1987	1,300	8	69
Cameroon, 1991	550	46	63
Central Afr. Rep., 1994–1995	700	38	58
Côte d'Ivoire, 1994	810	44	69
Ghana, 1993	740	25	59
Kenya, 1993	650	28	68
Liberia, 1986	560	44	59
Madagascar, 1992	490	31	67
Malawi, 1992	560	38	74
Mali, 1995–1996	1,200	46	75
Namibia, 1992	370	18	45
Niger, 1992	1,200	53	81
Nigeria, 1990	1,000	35	68
Rwanda, 1992	1,300	8	67
Senegal, 1992–1993	1,200	34	70
Tanzania, 1996	770	25	64
Togo, 1988	640	30	74
Uganda, 1996	1,200	39	77
Zambia, 1992	940	34	72
Zimbabwe, 1994	570	23	58
North Africa & Middle East			
Egypt, 1995	170	15	46
Morocco, 1992	610	7	46
Sudan, 1989–1990	660	17	59
Tunisia, 1988	170	3	56
Asia			
Bangladesh, 1993–1994	850	47	60
India, 1992–1993	570	28	50
Indonesia, 1994	650	16	31
Pakistan, 1990–1991	340	17	62
Philippines, 1993	280	8	40
Sri Lanka, 1987	140	5	28
Thailand, 1987	200	9	18
Turkey, 1993	180	11	30
Latin America & Caribbean			
Bolivia, 1993–1994	650	19	48
Brazil, 1996	220	16	18
Colombia, 1995	100	18	21
Dominican Republic, 1996	110	22	30
Ecuador, 1987	150	16	44
El Salvador, 1985	300	u	47
Guatemala, 1995	200	26	56
Mexico, 1987	110	19	45
Paraguay, 1990	160	16	37
Peru, 1991–1992	280	12	36
Trinidad & Tobago, 1987	90	13	30
Developed Countries			
France, 1994	13*	2	6
Japan, 1992	16*	1	2
United States, 1995	13*	9	7

*Adjusted for underreporting; ratio based on national vital statistics would be lower. *Note:* u=unavailable. *Sources:* **Mortality**—United Nations Development Programme, *Human Development Report, 1996*, New York: Oxford University Press, 1996, pp. 154–155; **births by age 18**—The Alan Guttmacher Institute (AGI), *Into a New World: Young Women's Sexual and Reproductive Lives*, New York: AGI, 1998, Appendix Table 4, col. 3, p. 52; **at least four births**—for developing countries, special analysts of data from Demographic and Health Surveys; for France, Laverty J, *Fécondité et calendrier de constitution des familles: Enquête Famille de 1990*, INSEE Résultats 579, Paris: Institut National de la Statistique et des Études Économiques, 1997; for Japan, special tabulations of the 1992 National Fertility Survey; for the United States, special tabulations of the 1995 National Survey of Family Growth.

Who Is Most at Risk?

Young Women and Mothers over 35. The risks of dying during pregnancy or childbirth are higher for women younger than 20 and for women 35 and older than for other women (Chart A). Teenagers' physical growth is usually incomplete, and their bodies have not developed sufficiently for pregnancy and delivery to proceed easily. Chronic malnutrition—which is widespread in poor countries—exacerbates the problem of insufficient or stunted physical growth. In addition, very young women are even less likely than older women to obtain prenatal or delivery care—especially if they are unmarried.

The younger the adolescent, the greater her maternal risk. In Jamaica and Nigeria, for example, women younger than 15 are 4–8 times as likely to die during pregnancy or delivery as are women aged 15–19. Although pregnancies at such early ages are common only in certain parts of the world, many women in all developing regions have their first child by age 18. In most of Sub-Saharan Africa, in Bangladesh and India, and in one of the poorest countries of Latin America—Guatemala—25–53% of women aged 20–24 had their first child before their 18th birthday (Table 1, column 2).

Maternal risk is elevated for older women in part because they frequently have had many births and have spaced births closely, risk factors discussed next.

Women with Many Children. Women who have had five or more children are about 2–3 times as likely to die during pregnancy or childbirth as are those with two or three children. Millions of women worldwide face this increased risk, given the large family sizes that are typical in many regions. For example, the proportion of women aged 30–34 who have already had four or more children is especially high—ranging from about 40% to 80%—throughout Africa and the Middle East and in some Asian countries (Table 1, column 3).

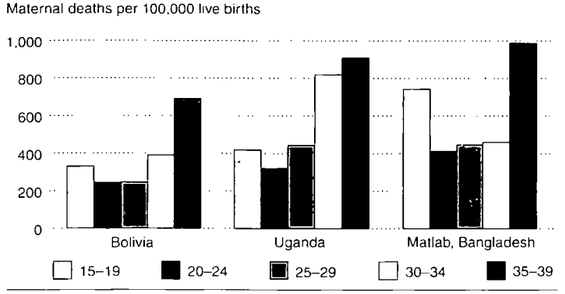
For women who become pregnant many times, the problem is not just that they are more often exposed to obstetric risk, but also that frequent pregnancy, childbirth and breastfeeding deplete women's physical resources and stamina. This makes it more difficult for them to fight the effects of heavy blood loss, infection or trauma during childbirth and after a delivery or abortion.

Women with Closely Spaced Pregnancies. Maternal depletion also threatens safe childbearing among women who become pregnant again before they have had time to recover fully from an earlier birth. This problem, too, is common: Births spaced less than two years apart account for one in 10 of all births in developing countries as varied as Liberia, Malawi, Senegal, Morocco, Sudan, India, Turkey, Bolivia, Brazil and Peru. They represent more than one in seven births in Madagascar, Niger, Tunisia, Pakistan, the Dominican Republic, and Trinidad and Tobago.

Even in developed countries, a short interval between pregnancies is a risk factor, moderately raising levels of preterm delivery and intrauterine growth retardation.

chart a
Maternal Mortality

Both younger and older women face an elevated risk of dying during pregnancy or childbirth.



Sources: Bolivia and Uganda—Demographic and Health Surveys, 1993–1994 and 1996, respectively; Bangladesh—Koenig MA et al., Maternal mortality in Matlab, Bangladesh, 1976–1985, *Studies in Family Planning*, 1988, 19(2):69–80.

Women with Unwanted Pregnancies. Every year, an estimated 190 million women throughout the world become pregnant, and many of them did not want to conceive. In Latin America, an average of 40% of women of reproductive age who do not want to become pregnant for at least a couple of years, or ever again, are not using an effective contraceptive method; in Sub-Saharan Africa, the proportion is 85% (Chart B). Such women often cannot avoid having an unplanned pregnancy. It should come as no surprise, therefore, that many women seek abortions, and each year approximately 20 million of them obtain abortions under conditions in which the procedure is illegal and therefore unsafe, greatly increasing their risk of maternal morbidity and mortality.

Lowering Maternal Risk

Family planning reduces the total number of pregnancies among women of childbearing age. For this reason alone, it can substantially lower levels of maternal mortality and morbidity. Furthermore, by helping women—especially those at highest risk—to space and limit their pregnancies, it can do more.

Even in parts of the world where women customarily marry as adolescents, contraceptive use to postpone pregnancy until after the teenage years would reduce maternal mortality associated with very early childbearing. What is more, women who wait to begin childbearing are less likely to have a large number of children than those who first give birth at a young age. And those who start practicing family planning early in their married lives are less likely than those who delay to have closely spaced births.

Finally, the prevention of unwanted pregnancies would mean a reduction in the more than 76,000 maternal deaths that result from unsafe abortions each year in developing countries—almost 15% of the total number of maternal deaths in these countries. The associated reduction in maternal morbidity might be even more impressive, given that 30 women suffer pregnancy-related disabilities for every woman who dies.

Offering STD Protection

Millions of men and women throughout the world suffer from STDs. In addition to the discomfort and embarrassment these diseases cause, some STDs greatly increase the likelihood of HIV transmission during sexual intercourse, and can have other serious health consequences.

Worldwide, the most common bacterial STDs (which are curable) are gonorrhea, trichomoniasis, candidiasis, syphilis, genital ulcers resulting from chancroid, and chlamydia. The most common viral STDs (which are incurable, though not necessarily untreatable) are hepatitis, herpes, genital warts and HIV.

An estimated 333 million new infections with curable STDs—or 11 for every 100 adults—occur worldwide every year (Table 2). In absolute numbers, South and Southeast Asia is the worst affected region. But an individual's risk of contracting one of these STDs is highest (one in four) in Sub-Saharan Africa.

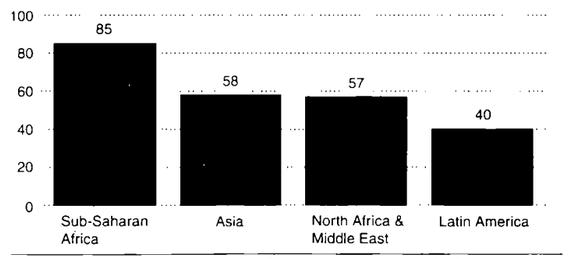
According to the WHO's most recent global estimate, every year, 5.9 million individuals become infected with HIV—an increase over previous estimates. The vast majority of new infections are in Sub-Saharan Africa (four million) and South and Southeast Asia (1.3 million)—the regions with the highest STD rates.

Next to complete sexual abstinence—an impractical goal for most people—the most effective protection against the spread of both bacterial and viral STDs is the latex condom. If used correctly, this method—while offering contraceptive protection—can dramatically reduce the likelihood that an infected man or woman will pass the disease to a sexual partner.

The female condom, the sponge, and the diaphragm or cervical cap used with a spermicide also have the potential to reduce STD transmission.

chart b
Nonuse of Effective Methods

Many women who do not want to become pregnant are not using effective contraceptive methods.



Note: Percentages are regional averages, based on women aged 15–44, weighted by population size. *Source:* Special analysis of data from Demographic and Health Surveys.

held in Cairo. At this historic gathering, policymakers pledged to focus on individuals' reproductive and sexual health needs. Such a focus, they agreed, would enable women, men and young people to lead healthier and more productive lives, and would, in turn, promote sustainable development and lower population growth rates.

The key question facing policymakers is how—and, to some extent, whether—they can fulfill their financial commitments to ensure that individuals most in need will have access to a full range of reproductive health care services. In addition to family planning, these include STD screening and treatment, maternity and postpartum care, safe abortion (where the procedure is legal) and routine gynecologic care. At the Cairo conference, both donor and developing country governments pledged new funds to fight STDs, yet that promise has gone largely unrealized, in part because U.S. political and financial leadership in the reproductive health field has faltered in recent years.

The U.S. Challenge

Beginning in 1995, the long-simmering legislative feud over domestic abortion policies spilled over to the international arena, wreaking havoc with U.S. family planning and reproductive health care efforts overseas. Over the past three years, Congress has imposed deep funding cuts on the U.S. Agency for International Development's population assistance program, effectively scuttling its expansion into the provision of more comprehensive STD services. Continued funding at these depressed levels means that, in developing countries, far fewer resources will be available for STD care in family planning settings and that the burden of STDs will continue to fall on the primary caregivers and household managers—women.

Clearly, there is a compelling need for STD services. For decades, U.S. lawmakers have acknowledged the fundamental role of disease prevention and treatment in social and economic development, which remains a cornerstone of American foreign assistance. To the detriment of millions, however, the long-term impact of STDs has gone unnoticed.

Fortunately, times are changing. The global consensus that emerged in Cairo recognizes the toll of STDs on individuals and society overall, but the funding to carry out this new public health mandate is crucial. The United States was instrumental in shaping this enlightened worldview and should endeavor to follow through on its political and financial commitments to STD prevention and treatment. The quality of life for individuals and families worldwide will be greatly enhanced.

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Credits

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Sexually Transmitted Diseases Hamper Development Efforts

Improving the health conditions of individuals and families in the developing world has long been a priority for American humanitarian aid. As a result of 30 years of U.S. assistance, maternal and infant death rates have dropped in many regions, significantly more couples are using contraceptives to plan their families and more children are living past their fifth birthday.

Nevertheless, despite the tremendous progress brought about by investments in maternity care, family planning, child immunization and better nutrition, one crucial element of maternal and child health has been sorely neglected: the prevention and treatment of sexually transmitted diseases (STDs). Historically, STDs have also been overlooked in the global fight against infectious diseases; as a result, they continue to drain the lives of young and old throughout the developing world.

The vast majority of STDs are spread through sexual intercourse—which is perhaps the most important reason for the lack of public discourse on their impact—and women of childbearing age (15–44) are disproportionately affected. In addition, each year, millions of infants begin their lives disadvantaged by an STD they contracted from their mother; STD infections in newborns compromise their health, both immediately and in the coming years.

STDs are a serious problem not only because they are widespread, but also because they may have delayed, long-term consequences, including poor maternal health, ectopic pregnancy, infant illness and death, cervical cancer, infertility and increased susceptibility to HIV. Millions of men and women suffering these and other effects of STDs are hindered in their ability to provide for their families and contribute to their society. For countries struggling to develop economically, the health and economic costs are immense.

The toll of STDs also hampers U.S. international aid. American assistance aimed at improving educational, health and economic conditions overseas becomes less effective, and therefore more costly, when a substantial proportion of recipients are suffering from STDs. Thus, although this is not always well understood by policymakers and the public, the United States has a considerable stake in combating the burgeoning STD epidemic in developing countries. This *Issues in Brief* examines the incidence and consequences of STDs in developing countries, and describes why a strengthened U.S. commitment to the prevention and treatment of these diseases is needed.

STDs Are Widespread

Worldwide, more than 400 million adults become infected with an STD every year. Four STDs that are spread primarily through heterosexual contact are completely curable—trichomoniasis, chlamydia, syphilis and gonorrhea. These account for 333 million STD infections, or about 80% of the worldwide total (Chart A). Some 9% of all persons aged 15–44 in North America contract one of these STDs annually, but the rate rises to 25% in Sub-Saharan Africa. Trichomoniasis alone has been detected in more than 40% of women attending prenatal clinics in Uganda and Botswana.

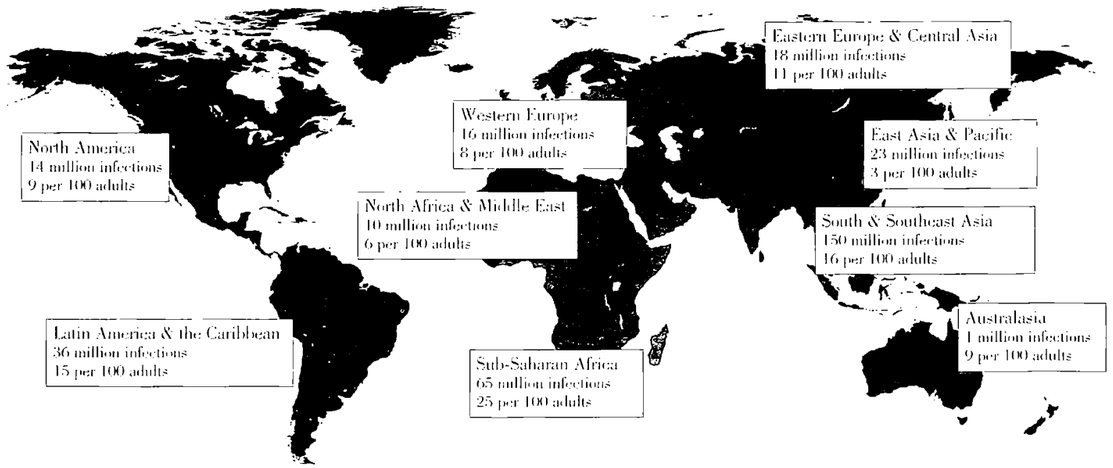
Every day, about 16,000 people (or nearly six million people each year) become infected with HIV, a startling number, given the short period of time since the virus emerged. Some nations have been hit harder than others. Among developing nations, for example, the United Nations estimates that more than 20 million people in Sub-Saharan Africa are HIV-positive, and most are unaware of their infection. While fewer than 1% of India's adults have the virus, India has the largest number of HIV-infected people in the world: 3–5 million, 89% of whom are younger than 45.

Globally, women and children represent a large proportion of those infected with HIV: In 1997, an estimated 36% of new HIV infections occurred among women; 10% were among children younger than 15. In Latin America, HIV infections among women and teenagers, who contract the disease primarily through heterosexual intercourse, have been increasing sharply. Throughout Africa, heterosexual intercourse was responsible for an estimated 85% of new HIV infections in 1997.

Because STDs strike relatively young persons and treatment often is not sought or is inac-

chart a
333 Million Infections

Each year, 11 of every 100 adults worldwide are newly infected with gonorrhea, chlamydia, syphilis or trichomoniasis—all curable STDs.



Source: World Health Organization (WHO), *An Overview of Selected Curable Sexually Transmitted Diseases*, Geneva: WHO, Global Programme on AIDS, 1995.

cessible, delayed or inadequate, the impact of these infections on individuals' health is high. The impact on society also is substantial, since STDs affect primarily men and women who are forming families and contributing to the work force. The World Bank and the World Health Organization have led efforts to develop measures to quantify the burden of disease. One of the best-known measures is the number of healthy years of life lost as a result of illness or premature death.

Each year, STDs, including HIV, account for 6% of healthy years of life lost among women aged 15–44 worldwide. The annual occurrence of four STDs—syphilis, gonorrhea, chlamydia and HIV—along with pelvic inflammatory disease (PID), a result of some STDs that often leads to sterility among women, accounts for the loss of more than 51 million years of healthy life among men, women and children worldwide (Chart B). Women lose a disproportionate share of healthy years of life to STDs, largely because of PID.

Symbiotic STDs

A mutually reinforcing link exists between HIV and other, more common STDs. One of the principal reasons HIV prevalence is so high in developing countries is that STD levels were high before the epidemic. The susceptibility of people to HIV infection is 2–9 times as high if they already have certain infections, particularly syphilis and chancroid. Similarly, HIV facilitates the transmission, hampers the diagnosis and accelerates the progression of other STDs. For example, human papilloma virus—which is closely associated with cervical cancer—progresses at a much faster rate in HIV-infected women than in others.

Early and effective treatment of STDs, especially those that result in genital ulcers, can reduce the incidence of HIV infection. In one Tanzanian community, a program that allowed for the diagnosis and treatment of STDs without using expensive laboratory tests reduced HIV incidence by about 40%.

Groups at Greatest Risk

Women. A variety of biological and social factors make women more susceptible to STDs than men. Women are physiologically more vulnerable than are men to contracting STDs when they have unprotected sex (i.e., without using a condom) with an infected partner. Additionally, STDs in women are more likely to be asymptomatic; if women are unaware of their infection, they will not seek timely care and hence may experience serious complications. Further, the use of traditional vaginal medications and douching may increase a woman's risk of acquiring an STD. With the exception of HIV, STDs may have more life-threatening consequences for women (PID, ectopic pregnancy and cervical cancer, for example) than for men.

Married and monogamous women are often at higher risk of contracting STDs than might be expected, because of the high-risk behaviors that are relatively common among men in many countries: intercourse with multiple partners and with commercial sex workers. Moreover, in some countries, women's low social and educational status conspire to deny the majority of them the power and knowledge to protect themselves against STDs. In many cultures, few women are able to negotiate the conditions of their sexual lives or the effective use of protective measures with a partner. In fact, many women consider STD-related symptoms such as abdominal pain or vaginal discharge a normal condition, not realizing that their suffering is caused by a contagious disease and can be treated.

Infants of Infected Mothers. Infants born to women with an active STD are highly likely to be infected before, during or after delivery. Globally, the probability that the mother's HIV infection will be transmitted to the infant at birth ranges from about 20% to 40%; this mode of transmission accounts for 5–10% of all HIV infections worldwide. The consequences of STD infection are serious for the newborn: stillbirth or prematurity, permanent damage to vital organs and possibly death.

Should an infant manage to escape STD infection at birth, he or she is likely to feel the impact of the disease in other ways. By the end of 1997, more than eight million children had lost their mother or both parents as a result of AIDS before they had reached the age of 15. Further, untreated STDs can severely impair parents' ability to work outside the home and provide for their family adequately, increasing the risks to their children's health and well-being.

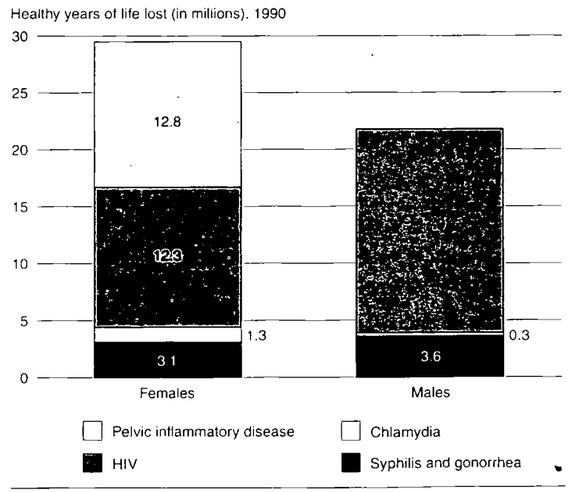
Teenagers. Sexually active teenagers, especially males, tend to engage in riskier behavior than adults: They have more partners, have more high-risk partners and often do not use condoms. Consequently, sexually active teenagers, along with adults younger than 25, generally have the highest STD rates of any age-group. Married adolescent women who themselves may be monogamous are at risk of acquiring STDs if their husbands have sexual encounters outside the marriage.

Additionally, biological and social factors heighten the risk for young girls and teenage women. Young women contract STDs more easily than adults because they have fewer protective antibodies and the immaturity of their cervix facilitates the transmission of an infection. In some societies, sexual coercion has emerged as a major risk factor for young girls; many are forced to have sex or are given gifts or money in exchange for sex, precisely because they are seen as being disease-free.

Youth who are infected with an incurable STD—genital warts, herpes or HIV—bear the debilitating effects of the disease for the rest of their lives. Many become infertile and are unable to have families of their own.

chart b
STDs' toll

STDs account for the loss of millions of healthy years of life.



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What Is Needed?

STD prevention efforts are critical and should be of highest priority for policymakers, a 1997 World Bank report declared. The sooner developing countries act to contain the spread of STDs, especially HIV, the more manageable and less severe the problem will be in future years. In particular, the Bank concluded, reaching groups most prone to spread STDs (such as sex workers, their customers and youth) with prevention programs will have the largest impact in reducing infection rates throughout a population.

In a number of countries, national prevention campaigns, using a variety of messages targeted for specific audiences, have proven effective in helping people adopt healthier behaviors. Messages that should be promoted widely among the general public include the importance of reducing the number of sexual partners, the effectiveness of condoms in protecting against infection and the benefit of dual method use, or simultaneously using a condom to prevent STD transmission and another contraceptive method to prevent unintended pregnancy.

How and in what clinical settings STD-related counseling and medical services might best be offered are less clear. These questions have long bedeviled health advocates and policymakers. In the United States, for a variety of reasons, largely separate networks of family planning clinics and STD clinics have evolved. Recently, this two-track system has come under criticism; opponents urge that whenever possible, STD prevention, screening and treatment services be fully integrated within family planning and primary care settings, which are considered conducive to providing counseling and services to help individuals meet their pregnancy and STD prevention needs.

In developing countries, where the existing formal health system may provide inadequate or no STD services, there is an opportunity to think through these infrastructure issues from the beginning, with an eye toward developing a more integrated, comprehensive approach to STD care.

The Global Response

The extent of STDs and their impact on families and society first received formal recognition from the world community at the 1994 United Nations–sponsored International Conference on Population and Development,

Issues in Brief

A Response to Concerns About Population Assistance

The preference of couples for small families—well established in the United States, Japan and other industrialized countries—is now evident throughout the world. While average family size in the developing world is still very high by industrialized countries' standards, couples clearly want, and are having, fewer children. It is a trend that transcends culture, religion, ethnicity and national origin. The trend has been supported by the rapid dissemination of information and knowledge about contraception and by the increased availability of family planning services.

Since the 1960s, the United States has played a critical role in facilitating couples' desires for smaller families. Both the domestic family planning program, which provides subsidized services to the poor, and the international population assistance program were conceived about 30 years ago, at the urging of Presidents John F. Kennedy, Lyndon Johnson and Richard Nixon and with the bipartisan support of Congress.

Initially, some countries in the developing world rejected the view that there was reason for concern about the rate at which their population was growing. Many had regarded their own rapid population growth as a desirable or at least a neutral phenomenon. Over the years, however, governments from the developing and industrialized world alike have come to recognize the mutually reinforcing benefits of slowing population growth, supporting their peoples' desires for smaller families, improving the health of women and children, and giving women and girls a chance to participate fully in the life of their communities and nations.

This extraordinary consensus was evident at the 1994 United Nations–sponsored International Conference on Population and Development (ICPD), held in Cairo. Some 200 governments from every region of the world affirmed the validity of demographic concerns, but stressed that all population policies and programs must be responsive, first, to meeting the needs and desires of individuals and families. They also emphasized that these policies must be considered and implemented in the context of overall development strategies and that, above all, they must take into account the centrality of women in the family and in society.

The United States played a major role in these deliberations and, even prior to the Cairo conference, had acted to broaden the scope of its own population program. The premise of that program, now reflected in the worldwide consensus, is that the most effective strategy to reduce unwanted childbearing and slow rapid population growth is one that relies on family planning at its core but is closely intertwined and integrated with other development strategies (see box).

However, just months after the ICPD officially embraced the importance of population and development as an issue and outlined key strategies to address it, Congress brought the U.S. program to a halt.

Population Aid Program

The U.S. Agency for International Development (USAID) administers the U.S. population assistance program. In 1994, USAID reorganized and created the Center on Population, Health and Nutrition to foster a closely coordinated and integrated effort among its existing activities in these areas. The center's priorities include family planning and reproductive health; basic health information and services for youth; maternal and child health and nutrition; child survival; human immunodeficiency virus and AIDS prevention; and environmental health. These programs are mutually supportive and highly interdependent.

The population assistance component consists mainly of preventive, voluntary family planning activities, but also includes prevention of sexually transmitted diseases, breastfeeding initiatives, reduction of female genital mutilation, treatment for complications of unsafe abortion and provision of follow-up family planning. Population aid also includes distribution of contraceptive supplies; research on new contraceptive methods and into ways to promote greater program effectiveness; policy evaluation; training; and information and education efforts. By law, the USAID program does not include support for abortion.

The Alan Guttmacher Institute
New York and Washington

After appropriating a record $547 million for population assistance in FY 1995, Congress slashed the program's funding by a third and imposed onerous limitations that greatly exacerbated the funding cut: None of the funds appropriated in FY 1996 were made available until July 1996, nine months into the fiscal year, and once available, the money could only be allocated at the rate of 7% a month for the next 15 months. Essentially the same formula has been continued into FY 1997.

The reasons for singling out this program for such harsh treatment stem from the politics of abortion and concerns raised by skeptics of population assistance in general and family planning in particular. This *Issues in Brief* identifies and attempts to respond to concerns that have been raised in the course of the ongoing debate.

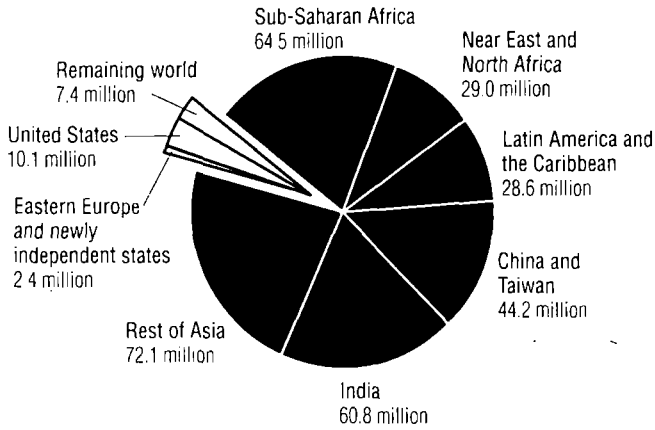
What Population Problem?

The debate over whether there is such a condition as overpopulation and, if so, what it means and what to do about it may continue for decades to come. It is clear, however, that dilemmas involving population issues confront virtually all nations. Depending on the country, these might include high rates of teenage and unintended pregnancy, migration across national borders, urbanization, an aging population (in industrialized countries) and the youth bulge (in the developing world). These, among other factors, affect a key determinant of the quality of life: the balance between population growth and economic development.

Indeed, it is just such a balance that countries are striving to achieve. The ICPD's *Programme of Action* summarizes the issue this way: "Efforts to slow down population growth, to reduce poverty, to achieve economic progress, to improve environmental protection, and to reduce unsustainable consumption and production patterns are mutually reinforcing. Slower population growth has in many countries bought more time to adjust to future population increases."

chart a
Population Growth

From 1996 to 2000, the world will gain 319 million people.



Source: T. McDevitt, *World Population Profile: 1996*, USAID and U.S. Bureau of the Census, Washington, D.C., 1996.

The disconcerting fact is that the world's current population of almost six billion is growing by 81 million people each year (equivalent to about one-third the population of the United States), but economic development and the availability of renewable natural resources are not keeping pace with this growth. In addition, after years of rapid population growth, a record number of people are about to enter the childbearing years. Thirty-five percent of the population in the developing world is under the age of 15 (as opposed to 20% in the developed world); in Sub-Saharan Africa, about half of the population is younger than 15. This means that even if all couples were to have only two children (enough to replace themselves), the world's population would continue growing for many years to come because of the large absolute number of people having children. As Chart A indicates, the world's population is expected to increase by 319 million people by the turn of the century.

The "population problem" also can be defined in terms of women's self-described "unmet need" for high-quality family planning services. An estimated 230 million women worldwide do not have access to effective contraceptive methods and services, representing approximately one in six women throughout the developing world. The reasons for this unmet need include a lack of accurate information, poor-quality services and less than the full range of contraceptive choices, as well as legal, cultural and economic obstacles.

A compelling indicator of the failure to help women meet their childbearing goals is the 52 million abortions—half of them illegal—that occur worldwide each year, according to the World Health Organization. Another is the large number of pregnancies that women report ending as unwanted or mistimed births: about 60% in Kenya; 50% in Japan, Mexico and the Philippines; and 40% in Egypt, Jordan and the United States.

These indicators of a population problem do have solutions. Making abortion less necessary can be achieved in large part through greater access to preventive family planning services. And that, in turn, could be expected to significantly lower the staggering number of maternal deaths that occur each year in connection with pregnancy and childbirth.

In addition, reducing the rate of unintended pregnancy, and therefore improving women's ability to achieve their own childbearing goals, would not only benefit the lives of individuals, but also have a significant impact globally. If all unwanted births were prevented, the annual number of births worldwide would drop from 130 million to 122 million—a decline of almost 19% in the global rate of population growth.

Is Progress Possible?

In light of the seemingly overwhelming size and scope of the population problem, ameliorating the situation may appear impossible. There are encouraging signs, however. The United Nations' recent announcement that the planet is growing by 81

million people annually may sound daunting, but the fact that it is *only* 81 million more people each year means that global population growth already is slowing down.

Between 1985 and 1990, which was the peak period of population growth in human history, the world's population grew by 87 million people annually. The decline in the growth rate that has been observed more recently has been attributed to the introduction of programs in the 1960s and 1970s that enabled people to begin to have the smaller families they wanted by increasing access to family planning services. More recent efforts to enhance women's economic power and social status have also played a key role.

The drop in the population growth rate to about 1.5% per year (from 2.5% in the 1960s) largely reflects a decrease in the average number of children each woman is having. Over the last 30 years, average family size in developing countries has dropped from 6.0 children to 3.3. This phenomenon also corresponds to improvements in related health and social indicators, such as lower infant mortality rates and improved female literacy. Together, these results suggest that at both the global and the individual levels, there has been enormous progress.

Over the same period, developing countries gradually have begun to adopt formal policies addressing the issue of population growth. Of the 125 developing countries that participated in the ICPD, more than half reported that they already have policies in place. Further, virtually all developing countries subsidize family planning programs, even if they have not yet adopted a formal policy. The combination of financial and technical resources, political commitment, and laws and policies that protect and respect the rights and conscience of the individual and promote personal health and well-being are equally key to the success that worldwide efforts have seen so far.

U.S. Interests and Funds

In 1969, President Nixon told Congress that investing in international population assistance is important to the United States "whether it is moved by the narrowest perception of national self-interest or the widest vision of a common humanity." Even then, it was becoming clear that stabilization of the global population growth rate would be critical to creating a climate of economic and political stability. It was also apparent from the experience of American women that access to family planning would contribute significantly to the health of women and their children in developing countries, and that giving these women more control over their childbearing decisions would afford them greater educational and economic opportunities.

The population assistance program has shown itself to be in the economic interest of the United States by laying the groundwork for export markets. Indeed, half of the top 35 consumer countries of American agricultural products are former or current recipients of U.S. population aid. More prosperous economies create the possibility of more consumers: U.S. exports to the developing world increased more than 14% in 1993 alone, dwarfing exports to industrialized countries.

Population growth also affects the U.S. interest in encouraging political stability and building strategic alliances. Most analysts have concluded that rapid population growth, in conjunction with poverty and scarcities of natural resources, has been linked to instances of political upheaval all over the world, particularly in Haiti, Mexico, Pakistan and, most recently, Rwanda.

The international population aid program is also consistent with the fundamental American value of helping the most vulnerable members of society and providing the tools for them to help themselves in the future. Experience has shown that increased use of family planning is associated with higher levels of education among women and girls. Further, according to the U.S. Census Bureau, the eight million infant deaths that occur annually worldwide are likely to be cut in half by 2020 if current programs continue, because of improvements in child survival *and* reductions in high-risk births.

The United States initiated its population assistance program with all of these considerations in mind. Today, the developing countries themselves account for three-quarters of the $4 billion spent worldwide each year on family planning services; it is impossible, however, for them to absorb the full cost of this critical endeavor. Often, they must rely on outside donors for technical assistance, supplies, training and even direct services.

Historically, the United States has been the largest donor country; in 1994, it contributed almost 40% of the approximately $1.2 billion in population aid given collectively to developing countries. But the total U.S. per capita contribution, even at its peak, amounted to only $1.78—placing the United States fifth behind Norway ($9.47), Denmark ($6.27), Sweden ($5.08) and the Netherlands ($2.85), and on a level with Finland, Germany, Australia and the United Kingdom.

Put another way, the federal government spent $554 million in FY 1994 in response to the needs of some 15 million American women for subsidized family planning services. That same year, the United States allocated only $463 million toward family planning programs overseas in an effort to respond to the 230 million women in the developing world who need services.

For this small price, the U.S. population aid program over three decades has acquired a unique role and vast capacity that cannot be easily transferred or replicated by any of the existing donors without losing valuable time and expertise. The United States has established an extensive field presence, and it is the only donor that works widely both with the public and private sectors and with nonprofit as well as for-profit entities—all of which are integral to the success and ultimate self-sustainability of local programs. The U.S. Agency for International Development (USAID), which administers the population program, is widely recognized for its high level of technical expertise upon which other countries rely.

Similarly, the United States is the only donor country that conducts research on new contraceptives and program operations, which not only are essential in guiding an effective family planning services program but also sometimes directly benefit American women. It was USAID-funded research, for example, that led to the two most recently approved major methods of birth control in the United States: Norplant and Depo-Provera.

Finally, to the extent that U.S. policymakers wish to have any real policy influence on the worldwide effort to stabilize population growth rates, the United States must remain a major financial player. Issues of special concern to the United States include the quality of family planning services, the availability of a wide range of method choices (including natural family planning) accompanied by full and accurate information, an emphasis on preventing unintended pregnancy and an insistence that programs are truly voluntary and free of coercion.

Concerns About Coercion

Coercion and cultural imperialism are real and serious concerns that arise in connection with family planning programs; to protect against them requires ongoing vigilance. Not only are both anathema from an individual rights perspective, but experience has demonstrated that the most successful programs are purely voluntary, promote maximum choice of family planning methods and are provided in a culturally sensitive manner in response to what women say they want.

Coercive family planning practices are expressly prohibited by U.S. law under both the domestic and the international programs. This is not to say that coercion has not occurred or will not occur in the future, either here or elsewhere, but it is condemned as a matter of policy. As with any law, constant attention is required to assure compliance. This is especially true since coercion can manifest itself directly as well as indirectly.

China's one-child-per-family policy, for example, has been associated with instances of forced sterilization and abortion that have warranted worldwide opprobrium. Limiting the range of available contraceptives, which occurs in some family planning programs, is a more subtle form of coercion. Ensuring full and informed consent and true choice in the decision on whether to use family planning services is neither easy nor simple, but is necessary and of the highest priority from both the U.S. and the international perspectives.

As for the specter of cultural imperialism, preventive *voluntary* family planning programs are specifically designed with the full input and participation of indigenous groups, women in particular. The charge that these women are availing themselves of contraceptive services as a result of the imposition of Western values is belied by worldwide survey data. Indeed, women in developing countries are seeking out family planning services and having fewer children because *they* want smaller families.

Over the past 30 years, what people consider ideal family size has declined steadily, according to extensive surveys of married women of reproductive age. Kenyan women in the 1980s, for example, said they wanted about seven children, but today they say they want no more than four. The same downward trend is evident in every region of the world, regardless of religion and culture, and in such diverse places as Senegal, Egypt, Morocco, Bangladesh, Colombia and Peru. While overall fertility rates have also fallen over the same period, large gaps remain between the number of children women say they want and the number they actually have.

Large proportions of women throughout the world report that their most recent birth was unplanned—either unwanted or mistimed: 25–40% in much of Asia, North Africa and the Middle East, and 50–65% in some Latin American countries. The same phenomenon is also evident in several areas of Sub-Saharan Africa, even though women there generally want larger families than in other parts of the world.

Maternal and Child Health

Given that infant mortality is one of the world's most glaring and preventable tragedies, it has been argued that increasingly scarce U.S. resources might be better spent if family planning funds were redirected toward prenatal care, childhood immunization and disease control programs. The reality is that family planning is as integral to an effective maternal and child health strategy as these other necessary activities. The facts show that family planning saves lives, of women *and* children.

Infants born less than two years after their sibling are almost twice as likely to die as those born after a longer delay. This occurs because they are more likely to have a low birth weight, making them more vulnerable to illness. Births too close together frequently affect the older children as well; premature discontinuation of breastfeeding, for example, can lead to malnutrition, dehydration or infection. Further, illnesses in a family with many young children can spread rapidly and be severe, especially in poor countries with inadequate sanitation and crowded living conditions.

Birthspacing is one of the main reasons cited for the promotion of family planning in developing countries. In many such countries, one in five infant deaths could be averted by birthspacing alone. No one is suggesting the abandonment of other available programs known to help save the lives of children; rather, the data show that further progress in child survival would only be impeded if investment in such a low-cost, low-tech strategy as family planning were not sustained.

If family planning's contribution toward lower infant mortality and better child health were its only health rationale, that would be enough. It is not, however. The tragedy of maternal death and disease receives far less attention than the plight of children, but its impact reverberates throughout the developing world. Increased access to family planning can go a long way toward helping women avoid pregnancies that too often and in too many countries are still life-threatening.

The World Health Organization estimates that

close to 600,000 women die each year of causes related to pregnancy and childbirth; 99% of these women live in developing countries. Among them, 75,000 die from unsafe, illegal abortion—often self-induced—that leads to infection or hemorrhage. Furthermore, as the United Nations Children's Fund (UNICEF) points out, for each woman who dies, about "30 more... incur injuries, infections and disabilities which are usually untreated and unspoken of, and which are often humiliating and painful, debilitating and lifelong."

UNICEF notes that "the first and most obvious step towards reducing the toll of maternal mortality and morbidity is to make high-quality family planning services available to all who need them.... Meeting only the existing demand for family planning would reduce pregnancies in the developing world by up to a fifth, bringing at least an equivalent reduction in maternal deaths and injuries."

Prevention or Abortion?

Family planning means pregnancy prevention. Since 1973, U.S. law has expressly prohibited federal funds provided under the Foreign Assistance Act from being used to perform or advocate abortion as a method of family planning. Confusion persists, nonetheless, about the international family planning program's relationship to abortion. There is no evidence, however, nor any credible reason to suspect, that U.S. funds are being used contrary to the dictates of the law. Instead, the argument has shifted to one that alleges "indirect" support for abortion or the "promotion of abortion." Program skeptics even claim that family planning causes more, not fewer, abortions.

It is indisputable that increased reliance on effective contraception results in fewer abortions. Common sense leads most people to that conclusion, and so does the research. The only question is how quickly lower levels of abortion are attained. That question pertains because there are situations where both contraceptive prevalence and abortion rates rise, creating confusion about cause and effect. In reality, what this phenomenon reflects is the strong desire for smaller families, which then motivates people to seek out all available means to achieve their desired family size. As preventive family planning programs become better established in the culture, and as couples begin to shift to more effective contraceptive methods, recourse to abortion declines.

The experiences of cities in Mexico and Colombia illustrate the point. For example, as contraceptive use rose from the mid-1970s onward in Mexico City, so did the abortion rate, which peaked in the mid-1980s at 41 per 1,000 women aged 15–49. As the culture of effective contraceptive use has taken hold, however, the abortion rate has declined to 25 per 1,000 women. A similar pattern has been observed in Bogotá, where the abortion rate has fallen from 50 per 1,000 women to 30 per 1,000 since the mid-1970s.

The highly organized national family planning programs in these two countries may be credited with the current downward trend in abortion rates. This trend is in stark contrast to the situation in Brazil, where no national family planning program exists but desired and actual family size are relatively small. The abortion rate, now 39 abortions per 1,000, is likely to remain high until Brazil too makes the transition to the widespread availability and more effective practice of contraception.

table 1
Russian Trends

Measure	1990	1991	1992	1993	1994
% of women using contraceptives*	19	20	22	23	24
Abortions per 1,000 women	109	100	90	82	76

*Data are from the Russian Ministry of Health and represent pill and IUD use only; statistics for barrier methods are unavailable, and statistics for oral contraceptives understate actual prevalence, since the pill is also sold over the counter. *Source:* L. Thomas, International Planned Parenthood Federation, London, personal communication, 1996.

The states of the former Soviet Union present a compelling case for how the introduction of high-quality contraceptive services can reduce abortion rates dramatically. In Russia, abortion is legal and has been used—in the absence of any contraceptives—as the major method of birth control. In fact, it was the only choice available in answer to the prevailing desire for smaller families. While abortion rates are still very high, the recent introduction of family planning has already resulted in a significant drop in the abortion rate (see Table 1). Similarly, abortion was the primary means of birth control in Hungary until the late 1970s, by which time contraceptive use had risen to about 50%. Once reliance on family planning became more the norm in Hungary, the abortion rate dropped by more than two-thirds.

These patterns suggest reason for concern about the impact of suddenly withdrawing family planning programs just as contraception is beginning to replace abortion. It is especially troubling for regions such as Africa, where the fertility transition is in its earliest stages. As increasing numbers of people feel more strongly about having fewer children, the absence of quality family planning services will inevitably encourage more abortions—legal or not, safe or not.

Public Support for Aid

A recent survey confirms that foreign aid is unpopular among Americans, apparently because most people think the United States is spending far more than it actually is. Most people questioned estimated that the United States is spending 15% of the federal budget on foreign aid, 15 times the actual amount of 1%. When asked what they thought the appropriate amount should be, most respondents indicated a level that turned out to be five times the present spending level. Less than half of the 1% the federal government spends overseas is reserved for development aid, which provides support for population, health, nutrition and environmental programs.

Americans cite protection of the global environment as one of the most compelling reasons for the United States

to support development assistance. And "overpopulation" is often volunteered as a significant factor contributing to environmental degradation. So, international population aid should be, according to most Americans, a central component of U.S. humanitarian programs overseas. Indeed, this rationale supports the U.S. position that its population program is the cornerstone of its approach to sustainable development, a process whose objective is to enhance the quality of life for people today without unduly compromising the resources necessary to sustain future generations.

Many public opinion surveys have shown that population growth is an issue of concern to most Americans. A 1994 *Time*-CNN poll found that 55% of Americans view "overpopulation" as a "very serious" problem; an additional 31% view it as "somewhat serious." Four-fifths of those surveyed believe this is a problem that will eventually affect the United States.

Perhaps for this reason, 72% of Americans support U.S. subsidies "to make birth control and family planning" more available in developing countries. Why do so many people support family planning assistance, even assistance overseas? According to a 1994 survey conducted for the Pew Global Stewardship Initiative, 91% of Americans do so because they believe that "all men and women in the world who want birth control should be able to get it."

The Future at a Crossroads

Even though the world's population growth rate appears to be slowing down, the world's population promises to continue to grow significantly over the coming decades as the largest cohort in history enters its reproductive years. The greater the degree to which women's increasingly prevalent and ever-stronger desire for smaller families can be addressed today, especially through better access to effective contraceptive services, the more likely that world population will stabilize at fewer than 10 billion people by the middle of the next century.

The United States has played a major role in raising worldwide awareness about individual family planning needs and global population trends, and through its strong financial and policy leadership, has established its prominence in addressing those challenges. Its relatively small investment pays significant dividends in strengthening the global economy, protecting the environment and saving the lives of women and children throughout the developing world. As First Lady Hillary Rodham Clinton noted recently in La Paz, Bolivia, in reaction to that country's extremely high maternal mortality rate, "Family planning campaigns at work in Bolivia and elsewhere represent sensible, cost-effective and long-term strategies for improving women's health, strengthening families and lowering the rate of abortion."

Despite being a program that is popular with Americans and one that provides services that people in the developing world need and want, this worldwide effort is in doubt. U.S. participation in the international program has been under siege over the last two years, largely in the name of opposition to abortion. It is a sad irony, since the research shows unequivocally that family planning leads to fewer, not more, abortions. Indeed, a consortium of research organizations (including The Alan Guttmacher Institute) concluded that the recent cuts imposed by Congress could be expected to result in 1.6 million *more* abortions.

Thus, whether the motivation is reducing abortion, improving the health of women and children, enhancing women's status, helping to alleviate world poverty, promoting economic development overseas, protecting the global environment or pursuing the economic self-interest of the United States, restoring a strong U.S. commitment to international population assistance will be essential to future progress.

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Campaign Home

Facts and Stats

- ***How bad is the problem?***
  - The United States has the highest rates of teen pregnancy and births in the western industrialized world. Teen pregnancy costs the United States at least $7 billion annually.[1]
  - More than 4 out of 10 young women become pregnant at least once before they reach the age of 20—nearly one million a year.[2] Eight in ten of these pregnancies are unintended[3] and 80 percent are to unmarried teens[4].
  - The teen birth rate has declined slowly but steadily from 1991 to 1996 with an overall decline of 12 percent for those aged 15 to 19. These recent declines reverse the 24-percent rise in the teenage birth rate from 1986 to 1991. The largest decline since 1991 by race was for black women. The birth rate for black teens aged 15 to 19 fell 21 percent between 1991 to 1996. Hispanic teen birth rates declined 5 percent between 1995 and 1996. The rates of both Hispanics and blacks, however, remain higher than for other groups. Hispanic teens now have the highest teenage birth rates. In addition, despite the recent declines in teen birth rates in general, the overall teen birth birth rate for 1996 is still higher than it was in the early to mid 1980s when the rate was at its lowest point. Also, most teenagers giving birth before 1980 were married whereas most teens giving birth today are unmarried. For more detail, including state by state rates, visit the web page of the National Center for Health Statistics.[5]
  - The younger a sexually experienced teenaged girl is, the more likely she is to have had unwanted or non-voluntary sex. Close to four in ten girls who had first intercourse at 13 or 14 report it was either non-voluntary or unwanted.[6]

- ***Who suffers the consequences?***
  - Teen mothers are less likely to complete high school, (only one-third receive a high school diploma)[7] and more likely to end up on welfare (nearly 80 percent of unmarried teen mothers end up on welfare).[8]
  - The children of teenage mothers have lower birth weights[9], are more likely to perform poorly in school[10], and are at greater risk of abuse and neglect.[11]
  - The sons of teen mothers are 13 percent more likely to end up in prison while teen daughters are 22 percent more likely to become teen mothers themselves.[12]

- ***What helps prevent teen pregnancy?***
  - The primary reason that teenage girls who have never had intercourse give for abstaining from sex is that having sex would be against their religious or moral values. Other reasons cited include desire to avoid pregnancy, fear of contracting a sexually transmitted disease (STD), and not having met the appropriate partner.[13] Three of four girls and over half of boys report that girls who have sex do so because their boyfriends want them to.[14]
  - Teenagers who have strong emotional attachments to their parents are much less likely to

become sexually active at an early age.[15]

- Most people say teens should remain abstinent but should have access to contraception. Ninety-five percent of adults in the United States—and 85 percent of teenagers—think it important that school-aged children and teenagers be given a strong message from society that they should abstain from sex until they are out of high school. Almost 60 percent of adults also think that sexually active teenagers should have access to contraception.[16]
- Contraceptive use among sexually active teens has increased but remains inconsistent. Two-thirds of teens use some method of contraception (usually a condom) the first time they have sex.[17] A sexually active teen who does not use contraception has a 90 percent chance of pregnancy within one year.[18]
- Parents rate high among many teens as trustworthy and preferred information sources on birth control. One in two teens say they "trust" their parents most for reliable and complete information about birth control, only 12 percent say a friend.[19]
- Teens who have been raised by both parents (biological or adoptive) from birth, have lower probabilities of having sex than teens who grew up in any other family situation. At age 16, 22 percent of girls from intact families and 44 percent of other girls have had sex at least once.[20] Similarly, teens from intact, two-parent families are less likely to give birth in their teens than girls from other family backgrounds.[21]

- ***When should I talk to my child about sex?***
  - Before they make you a grandparent. One of every 3 girls has had sex by age 16, 1 out of 2 by age 18. Three of 4 boys have had sex by age 18.[22]
  - Surprise: Your teen wants to hear from you. Seven of ten teens interviewed said that they were ready to listen to things parents thought they were not ready to hear.[23] When asked about the reasons why teenage girls have babies, 78 percent of white and 70 percent of African-American teenagers reported that lack of communication between a girl and her parents is often a reason teenage girls have babies.[24]

- ***Do teens wish they had waited to have sex?***
  - Yes. A majority of both girls and boys who are sexually active wish they had waited. Eight in ten girls and six in ten boys say they wish they had waited until they were older to have sex.[25]

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DRAFT -- DO NOT CIRCULATE

Family Matters

The National Campaign to Prevent Teen Pregnancy has reviewed recent research about parental influences on their child's sexual behavior. From this review, we think that some clear lessons emerge for parents and for other adults who are involved with children and teenagers.

Most fundamentally, **there is much that parents and adults can do to reduce the risk of kids becoming pregnant before they've grown up.** In particular, they can help them delay becoming sexually active. Four factors can help to make the influence of parents and adults on teen sexual behavior especially powerful:

a. Whether **the young person himself** sees his relationship with his parent(s) as strong and close generally. That is, does the young person herself perceive her relationship with her parent(s) as being a "well connected" one, with a rich array of interactions and communication?

b. Whether the parent(s) provide appropriate levels of **monitoring and supervision.**

c. Whether parents themselves are clear about their **own values** pertaining to sexual behavior and make a concerted effort over time to communicate their values to their children.

d. The extent to which those parental values are **apparent** to the young person; that is, does the parents' behavior match their stated values, and does the parent talk about his or her values openly?

Sexual risk-taking among young people seems especially low when all four factors are present. Having only one present is not as powerful. For example, a parent may feel she is doing a good job of communicating her values to her son – she brings relevant subjects up often and emphasizes a few key ideas that she feel especially strongly about. But because her son doesn't regard her as a credible source of information or values, and because he doesn't respect or trust her very much, the communication about sexual values has little beneficial impact on her son.

So, what to do??

1. Most fundamentally, **build a strong relationship with your children from an early age**, one that emphasizes mutual trust and respect, and encourages independence and good decision-making. Express love and affection clearly and often, not just for specific accomplishments. Listen carefully to what they say and pay careful attention to what they do. Strive for a relationship that is warm, firm, and rich in communication.

2. **Spend time with your child engaged in activities that suit his age and interests, not just yours.** A rich history of frequent, small, meaningful and close exchanges builds a "bank account" of affection and trust that forms the basis for future communication with her about specific topics, including sexual behavior. Be supportive and be interested in what interests him. Attend her sports events; learn about his hobbies; tell your children about your own childhood and the problems you faced at their age. Help them to build self-esteem by mastering skills (self-esteem is earned, not given).

3. **Think about and clarify your own sexual values, and discuss them with your children and teens.** Tell them candidly and confidently what you think and why you take these positions. Be sure to have a two-way conversation, not a one-way lecture. Learn and study about teen sex, pregnancy and other risks. What do you think constitutes a mutually respectful relationship between men and women? between girls and boys? Under what circumstances is sexual intimacy acceptable? understandable? Who is responsible for setting limits in a relationship and how is that done, realistically? What do you really think about school-aged teenagers being sexually active -- perhaps even becoming parents? Were you sexually active as a teenager? What do you know and think about contraception? Do you know about the serious consequences of teen pregnancy, or is it not such a big deal, particularly compared to other problems like violence? If you're unclear about these issues, your child will sense it. And, by the way, make sure your behavior matches your words!!

4. **Talk with your children early and often about sex, and be specific.** Kids have lots of questions about sex and they say that the source they'd most like to get answers from is often their parent(s). Initiate the conversation. Tell them about love, sex, and what the difference is. Conversations about sex should begin early in a child's life and continue through adolescence. Resist the idea that there is ever just one conversation -- you know: "the talk" -- the truth is that parents and kids should be talking about sex and love all along. Many inexpensive books and videos are available to help with any detailed information you might need, but don't let your lack of detailed technical information make your shy. Kids need as much help in understanding the *context* of sex as they do in understanding how all the body parts work. Here are the kinds of questions kids say they want to discuss:

> How will I know when I'm ready to have sex? Should I wait till marriage?
> How do I tell my boyfriend no to sex without hurting his feelings? How do I manage pressure from a girl to have sex?
> Will having sex make me popular?
> Everyone else is doing it -- is it really "okay to delay?" How do I do that?
> Can you get pregnant the first time?
> Isn't contraception dangerous?

The point is: Be an "askable parent" and answer the questions -- if you don't know the answer, find it and then share the information. And be a parent with a point of view. Don't be afraid to say, for example:

I don't think kids in high school should be having sex; they're too young to manage it, especially given today's risks..

Finding yourself in a sexually charged situation is not unusual; you need to think about how you'll handle it *in advance*. Have a plan.

It's OK to think about sex. Most people do! But it's not okay to get pregnant/ get somebody pregnant.

(For boys) Having a baby doesn't make you a man. Being able to wait/acting responsibly does.

(For girls) You don't have to have sex to keep a boyfriend. If sex is the price of loyalty, find someone else.

5. **Supervise and monitor your children and adolescents.** Establish rules, curfews, and standards of expected behavior, preferably through an open process of family discussion and respectful communication. If they get out of school at 3 pm and you don't get home from work until 7 pm, who is responsible for making certain that your child is not only safe, but also is engaged in useful activities? Where are they when they go out with friends? Are there adults around? Remember: supervising and monitoring your kids' whereabouts doesn't make you a nag; it makes you a parent.

6. **Know your children's friends and their families.** Friends have a strong influence on friends, so help your children and teenagers become friends with kids whose families share your values. Some parents of teens even arrange to meet with other parents to establish common rules and expectations. It is easier to enforce a curfew that all your child's friends share rather than one that makes him different.

7. **Discourage early, frequent and steady dating.** Group activities among young people are fine and often fun, but beware allowing young younger teens to begin one-on-one dating much before 16 or 17. Let your child know about this strong preference throughout childhood -- don't wait until presented with real situations; otherwise they'll think you just don't like a particular person or invitation.

8. **Take a strong stand against your daughter dating a boy more than 2 years older than she is. And don't allow your son to develop an intense relationship with a girl more than 2 years younger than he is.** Older guys can seem glamorous to a young girl -- sometimes they even have money and a car to boot! But the risk of matters getting out of hand increases with significant age differences. The power differences between older boys/men and younger girls can lead girls into situations they are not able to handle, including unwanted sex and sex with no protection..

9. **Help your teenagers to have options for the future that are more attractive than early pregnancy and parenthood.** The chances that your son or daughter will delay first sex, pregnancy and parenthood are increased if the future is bright. This means helping them to set meaningful goals for the future, talking to them about what it takes to make future plans come true and helping them reach their goals, teaching them to use free time in a constructive way, and explaining how becoming pregnant -- or causing pregnancy -- can derail the best of plans. Community service, for example, can not only teach job skills, but can also put teens in touch with a wide variety of committed and caring adults.

10. **Value education highly.** Encourage your child to take school seriously and give generous amounts of your own personal time to your children's schools. School failure is often the first sign of trouble and can end in teenage parenthood. Be very attentive to your child's progress in school and intervene early if things aren't going well. Meet with teachers and principals, guidance counselors and coaches as needed. Know about homework assignments and support your child in getting them done. Volunteer at the school. Schools want more parental involvement, not less.

11. **Know what your kids are watching, reading and listening to.** The media are chock full of material that makes early sex -- and even early pregnancy and parenthood -- seem acceptable and inconsequential. Sex rarely has meaning, pregnancy seldom happens, and no one who is having sex ever seems to be married or even especially committed to anyone. Is this consistent with your expectations and values? If not, it is important to talk about what the media portrays and what you think about it all. If certain programs or movies offend you, say so, and explain why. If certain magazines value women and girls only for what they look like, tell your children and teens why you dislike such material.

Teenage Pregnancy: The Case For Prevention

An Analysis of Recent Trends & Federal Expenditures Associated With Teenage Pregnancy

ADVOCATES FOR YOUTH

EXECUTIVE SUMMARY

Recent declines in teen sexual activity and increases in contraceptive use by sexually active teens have resulted in reduced rates of teenage pregnancy and births. Nevertheless, the United States continues to exhibit the highest rates of adolescent births in the industrialized world.

The social and economic consequences of too-early childbearing for teens and their children can be grave and long-lasting. The public costs associated with teenage pregnancy also are great. Advocates for Youth estimates that, in fiscal year 1995 alone, the federal government spent over **$39.3 billion** to help families that began with a teenage birth.

Increased public commitment to prevention is clearly warranted. In FY 1995, the federal government allocated **less than one-fifth of $1 billion ($131million)** for teen pregnancy prevention, or **three hundred times less** than the amount of expenditures to support families begun by a teenage birth.

It is unquestionably important that the U.S. government continue to help young families, but it is also necessary that the nation reduce the number of adolescents who will require this support in the future by increasing investment in pregnancy prevention. For example, in 1996 the Alan Guttmacher Institute estimated that publicly subsidized contraceptive services annually avert 385,800 teen pregnancies, consequently preventing 154,700 teen births and 183,300 abortions.[1] For every dollar invested in publicly subsidized contraceptive services, U.S. taxpayers save $3.00 in Medicaid costs for pregnancy and neonatal related health care alone.[1] Just as important, 385,800 fewer teens suffer the emotional, social, and economic consequences of an unwanted pregnancy.

Tragically, current levels of pregnancy prevention funding are insufficient to sustain recent declines in teenage pregnancy rates. Census Bureau projections indicate that, by the year 2005, 13 percent more young people ages 10-19 will live in the United States than did in 1995. Higher levels of prevention investment will be necessary simply to sustain current teenage pregnancy rates.

Investments in pregnancy prevention must be made wisely. Returns on prevention investments are maximized when dollars are allocated to the most effective and promising approaches. Research indicates that comprehensive sexuality education—including information on abstinence as well as contraception—can delay the onset of sexual activity and increase contraceptive use by sexually active teens. Contraceptive availability programs—such as family planning clinics and condom availability—also reduce risky adolescent sexual behavior. Youth development programs, which motivate teens to avoid pregnancy by helping them develop their skills and abilities, are particularly effective for young people at high risk for too-early childbearing.

Unfortunately, in 1996, Congress allocated $50 million to fund abstinence-until-marriage (abstinence-only) education. This represents over **38 percent** of the total prevention investment ($131 million) made in the previous year, and there is *no* evidence that abstinence-only education effectively reduces adolescent pregnancy. If the abstinence-until-marriage education funds were invested instead in adolescent contraceptive services, the savings would be at least three-fold in averted Medicaid expenses for pregnancy and neonatal-related care.

Congressional funding of ineffective pregnancy prevention strategies reflects American discomfort with adolescent sexuality and with sexually active youth. By age 19, over 70 percent of teens have had sexual intercourse. Twelve million American teens are sexually active. Yet, Congress continues to allocate precious prevention dollars to programs that withhold information about contraception.

U.S. adolescent sexual behavior differs little from that of their peers in other industrialized countries. Public policy in these countries, however, reflects a commitment to helping sexually active teens avoid sexually transmitted diseases and unplanned pregnancy. In Sweden and the Netherlands, for example, investments to increase access to sexuality education and contraceptive services have helped sustain a teen birth rate that is one-ninth that of the United States. In 1990, the teen birth rate in the United States was six times higher than in France, almost twice the birth rate in the United Kingdom, and more than double that of Canada.[2] These findings indicate that the U.S. should:

- Reduce the costs of teenage pregnancy through investment in prevention rather than in limiting federal support for families began by a teen birth.

- Invest wisely. Prevention funding should be allocated to scientifically evaluated strategies which reduce teenage pregnancy and too-early childbearing, such as comprehensive sexuality education, contraceptive services, and youth development programs.

INTRODUCTION

Despite recent declines in teen pregnancy, the United States continues to have the highest adolescent birth rate of all industrialized countries. Continuing this decline is a primary interest of policy makers and community members alike. Early pregnancy affects not only adolescents but also families, communities, and the nation as a whole. Factors linked to teenage pregnancy are complex and range from poverty, school failure, and behavioral problems to family distress and restricted access to health services. Preventing these pregnancies, however, is no easy task.

In 1986, Advocates for Youth began calculating federal expenditures to support families that began with teen births. Advocates calculated this figure on a regular basis in order to highlight the public and social consequences of too-early childbearing. In 1993, some members of Congress argued that the large costs associated with teen childbearing were best addressed by cutting appropriations for social services and other welfare benefits. This misguided policy ignores the inevitable and enormous health, education, and juvenile justice costs incurred when we fail to assist young families and other individuals in need.

To provide context for the expenditures to support young families, Advocates for Youth now also calculates the federal dollars allocated to the prevention of teen pregnancy. To meet the challenge of teen pregnancy prevention, the U.S. government operates and funds numerous programs that help adolescents prevent too-early childbearing. The federal government expends far more money, however, to provide services for families begun with a teenage birth. Clearly, society has an obligation to provide funds *both* for prevention and for support of families begun by teens. So long as prevention dollars remain inadequate, the United States will continue to have very young families in need of support.

This year for the first time, Advocates additionally calculated the amount of money *invested* by the federal government in preventing adolescent pregnancy. Advocates chose to examine the investments and expenditures on the national level because the federal government is the largest funder of prevention programs, sets national priorities by its funding decisions, and supports the greatest number of prevention programs consistently found across the nation.

In fiscal year 1995, the federal government spent over $39.3 billion to help families that began with a teenage birth (including families currently headed by adults) and invested less than one-fifth of $1 billion ($131million) in helping adolescents prevent a first birth.* These are conservative figures, since limited data were available to quantify how many adolescents are being reached by prevention as well as intervention programs.

The figures provide a reflection of the nation's weak commitment to preventing teenage pregnancy compared to its stronger obligations to support families begun by a teenage birth. The

* One billion is 1,000 millions.

calculations indicate that, despite the potential for saving public dollars by reducing teenage pregnancy and childbirth, the United States is not investing enough in preventing teen pregnancies and protecting young people's futures.

While this study reflects a snapshot of the situation in fiscal year 1995, Advocates believes the policy implications apply to the future as well. The welfare reform initiatives of 1996 are likely to result in a decline in funding for services for low-income families. At the same time, public dollars are likely to increase for welfare-to-work programs, such as job training and day care. This shift in emphasis may eventually lower expenditures of the nature described in this analysis. Without an increase in federal dollars allocated to effective prevention programs, the nation is unlikely to fully realize the economic savings predicted by the sponsors of welfare reform.

Concurrently, some projections show that, from 1995 to 2005, there will be a 13 percent increase in the number of young people ages 10-19 who live in the United States.[4] As the population of teenagers expands, so will the number of those at-risk of teenage pregnancy. Without a significant investment in pregnancy prevention, the number of those requiring support after a teen birth will continue to rise.

STATISTICS AND TRENDS IN TEEN PREGNANCY AND CHILDBEARING

Adolescent pregnancy and early childbearing are not new phenomena; young American women have traditionally become pregnant and given birth during the teen years. In fact, the adolescent birth rate was the highest ever in the late 1950's and early 1960's.

Myths About Teen Pregnancy

Myth: Today, teens are giving birth at unprecedented levels.

Fact: The teen birth rate is significantly lower in the 1990s than in the 1950s and 1960s. In 1996, the teen birth rate was 54.7 births per 1,000 females ages 15 to 19 compared to 81 per 1,000 in 1950 and 89 per 1,000 in 1960.[8,9]

The contemporary view of teen pregnancy as a social and moral problem is closely related to changes in family structure and the economy. Young people of the 1950's and 1960's tended to marry young (often following a premarital conception) and to have relatively large families; and one wage earner, even without a high school diploma, could find work to support a two-parent household with children.[3] Today, both teens and adults are more likely to have children outside of marriage. In 1960, 15 percent of all teen births occurred outside of marriage; in 1995, 76 percent of teen births occurred to single women. Despite an increasing number of single-parent households, it has become difficult for one wage earner to support children adequately.[5]

The following facts highlight recent trends in teenage pregnancy and early childbearing.

Most teenage pregnancies and births are unintended and occur to older adolescents.

- Nearly two-thirds of all adolescent pregnancies occur to women ages 18 to 19.[6]
- Nearly 82 percent of teenagers report that their pregnancies are unintended; overall, about 25 percent of all unintended pregnancies occur among teenage women. Women over 40 are almost as likely as adolescents to say that their pregnancies were unintended.[7]
- Among teenage women, approximately nine percent of 14-year-olds, 18 percent of 15- to 17- year-olds, and 22 percent of 18- to 19-year-olds experience a pregnancy each year.[6]
- The birth rate for 15- to 19-year-old adolescents declined 12 percent from 1991 to 1996, reversing the trend from 1986 to 1991, when the birth rate increased 24 percent. The teen birth rate declined from 62.1 in 1991 to 54.7 births per 1,000 females ages 15 to 19 in 1996.[8]

Myths About Teen Pregnancy

Myth: Teenagers are responsible for the vast majority of unintended pregnancies.

Fact: Of all unintended pregnancies, 75 percent are experienced by adult women. Further-more, in 1987, about 50 percent of pregnancies among women aged 20-34 were unintended, while more than 75 percent of pregnancies to women over 40 were unintended.[7]

- Birth rates dropped in all adolescent subgroups between 1991 and 1996. There was a decrease of 14 percent in those ages 10 to 14; 12 percent for those ages 15 to 17; and eight percent for those ages 18 to 19.[8]
- In 1950, the birth rate was 81 births for every 1,000 girls ages 15 to 19; in 1960, the birth rate was 89 births for every 1,000 teenaged girls this age.[9] In comparison, the 1996 teen birth rate was 54.7 births per 1,000 females ages 15 to 19.[8]

The abortion rate among teens has declined over the past two decades.

- Adolescents obtain about 20 percent of all abortions performed in the United States each year.[10]
- Since 1980, both the numbers of abortions and the abortion rate among teens ages 15 to 19 have decreased. The adolescent abortion rate in 1980 for this age group was 42.8 compared

Myths About Teen Pregnancy

Myth: Adolescents account for most out-of-wedlock births.

Fact: Thirty-three percent of all out-of-wedlock births are experienced by adolescents, down from 50 percent in 1970.[5]

to 25 per 1,000 teens in 1993.[11,12]

- Between 1980 and 1990, the abortion rate decreased by 24 percent among sexually experienced women ages 15 to 19. This may be related to the declining pregnancy rate; it is also possible that restrictive laws, limited availability of abortion providers, and decreased public funding have limited the ability of teens to choose abortion.[13]

Contraceptive use among teens, particularly condom use, increased considerably during the last decade, and sexual activity rates have declined.

- In 1993, although slightly more than half of all high school students reported ever having had sexual intercourse in the years 1993-1995, rates among high school seniors declined during the same years from 68.3 percent in 1993 to 66.4 percent in 1995. Rates among ninth graders also fell from 37.7 percent in 1993 to 36.9 percent in 1995.[14,15]

- Seventy-six percent of young women ages 15 to 19, who first had intercourse between 1990 and 1995, reported that they used contraception, up from 45 percent in 1982.[16,17]

- Contraceptive use among young men has also increased. In 1993, 59.2 percent of high school males reported condom use at most recent intercourse compared to 60.5 percent in 1995.[14] This is particularly significant since condoms also provide protection from HIV and other STDs.

Myth: African-American teens are responsible for dramatic increases in out-of-wedlock births.

Fact: The non-marital birth rate for African-American teens has risen only four percent since 1970 while the rate for white teens has tripled from 10.9 to 35.5 per 1000 women.[5]

- The Centers for Disease Control and Prevention attributes recent declines in adolescent pregnancy and birth rates to a leveling off of sexual activity and increased condom use among sexually active youth.[8]

CALCULATING THE FEDERAL EXPENDITURES AND INVESTMENTS FOR TEENAGE PREGNANCY: THE COST STUDY METHODOLOGY

Since 1986, Advocates for Youth has calculated the amount of money the federal government spends in a single year on behalf of all families in which the first birth occurred when the mother was a teenager—even when the mother is no longer a teenager. The Cost Study is intended to draw public attention to the need to invest federal dollars in preventing adolescent pregnancy.

pregnancy and childbearing. For example, costs are not included for job training, housing subsidies, subsidized school meals, special education, foster care, and day care programs, because there is greater variability of individuals who utilize these programs, as compared to national programs, such as AFDC, which are consistently more available across the country.

Expenditures to Support Families Begun with a Teen Birth		Investments to Prevent Pregnancies and First Births Among Teenagers	
Medicaid health care services	$19.3 billion	Medicaid family planning services	$77.4 million
Maternal and Child Health Bureau, Title V	$3 million	Maternal and Child Health Bureau, Title V	$862,500
Aid to Families with Dependent Children	$7.6 billion	Public Health Service Act, Title X	$48 million
Food Stamps	$10.5 billion	Community Health Centers	$200,000
Special Supplemental Food Program of Women, Infants, and Children	$1.9 billion	Healthy Schools, Healthy Communities	$600,000
Social Services Block Grant (Title XX of the Social Security Act)	$13.3 million	Centers for Disease Control and Prevention	$835,500
Adolescent Family Life Act	$4.5 million	Adolescent Family Life Act	$2.2 million
TOTAL: $39.3 Billion		TOTAL: $131 Million	

Federal Expenditures: Providing Services and Support to Families Which Began with a Teen Birth

Using the formula described above, Advocates calculated the federal expenditures on families begun by teens via seven federally funded assistance programs.[22] These expenditures were then totaled to ascertain federal dollars spent directly to support these families.

The amount spent in FY95 to provide social services for families which began with a teen birth was **39.3 billion dollars ($39,268,749,354)**.

Redressing teen pregnancy means accepting the reality that 12 million American teens are sexually active and that a large number of these teens lack access to family planning counseling and services. Society has an obligation to help these young people make informed, responsible decisions about the prevention of unintended pregnancies and too-early childbearing.

The United States compares poorly with other industrialized nations in terms of addressing adolescent sexuality and pregnancy prevention—the nation has the highest teen birth rate of all developed countries. In countries such as Sweden and the Netherlands, where the national governments have made significant commitments to family planning and comprehensive sexuality education, teen pregnancy rates are significantly lower. For example, in the Netherlands—where teenage sexual activity is about the same as in the United States, but where teens receive more education about sexuality and have better access to family planning services—pregnancy rates are only one-seventh those of the United States. Data from 1990 indicates that the teen birth rate in the United States is six times higher than in France, almost twice the birth rate in the United Kingdom, and more than double that of Canada.[2]

In general, most of these countries provide comprehensive sexuality education, affordable and accessible family planning services, and broad "safe sex" messages. Philosophically, these countries accept that adolescents, especially older teens, may well be sexually active. Therefore, programs and policies focus on teaching young people protective behaviors and skills, as well as providing accurate information about sexuality. While United States youth tend to be as sexually active as their peers in industrial Europe, they are often both uninformed and uncomfortable about sexuality and reproduction, as well as how to access reproductive and sexual health care.

CONCLUSION

As noted, rates of adolescent pregnancy, childbearing, and abortion have been declining for several years. To continue these welcome trends, however, the country must make political and economic commitments to prevention programs that work. In general, the nation can and must take steps to protect our young people:

- Reduce the costs of teenage pregnancy through investment in prevention rather than in limiting federal support for families which began by a teen birth.

- Invest wisely. Prevention funding should be allocated to scientifically evaluated strategies which reduce teenage pregnancy and too-early childbearing, such as comprehensive sexuality education, contraceptive services, and youth development programs.

Planned Parenthood®
Federation of America, Inc.

January 15, 1999

Noa Meyer
Office of the First Lady
Old Executive Office Building
Washington, DC 20500

Dear Noa;

Enclosed is the information that we discussed via our phone conversation today. As I mentioned on the call, Barbara Snow from our New York office will also be faxing additional materials to your attention.

Please let me know if we can be of further assistance. I can be reached at 202-785-3351.

Sincerely,

Ronnie Todaro
Director
State and Affiliate Program Development

1120 Connecticut Avenue, N.W., Suite 461, Washington, DC 20036 (202) 785-3351 FAX (202) 293-4349

Responsible Choices

Action Agenda

Planned Parenthood®

Planned Parenthood® Federation of America

Planned Parenthood® Action Fund

810 Seventh Avenue, New York, New York 10019-5882
Phone: 212-261-4302 www.plannedparenthood.org

May 1998 Produced by Public Media Center

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found out I was pregnant...My son is going without a lot of things he'd have if he had two parents. You need a family. You need to be stable. I'm alone except for my baby. -- Jayme, 19

- I got pregnant at the age of 14 and had no clue what to do...people these days seem to talk of only two or three solutions to teen pregnancy, although most people forget another -- adoption. It was the best yet hardest decision of my life. I look at all I am doing now and think where I would be with a baby. I was not and will not be ready to take care of a baby for a few years...Plus the most important to me is that my baby has two parents who love each other. -- Jennifer, 15

*The sources for these stories are available on the NCPTP website

Stories

The following stories were taken from *Sex etc.*, a website run by teenagers for teenagers.

Abortion

Erin's Choice
By Arlene Brens

It was the most difficult decision Erin ever made. When she first found out she was pregnant at the age of 18, she and her friend screamed with excitement at the idea of having a baby. It seemed so sweet. Then reality hit.

"How am I going to tell my Mom? How will I support the baby? Will my boyfriend support me if I keep it?"

The questions scared her.

"If I was going to keep the baby, I wanted my boyfriend to be there for me through every step of the pregnancy and after the baby was born, especially since I was just finishing high school. I didn't want to do this alone," she says now, three years later. At first, Richard, then 19, wanted to keep the baby. He said he would support Erin's choice. They talked and decided they would become parents. They were going to get an apartment and begin their life together.

Then Richard changed his mind. He started seeing other girls. He told Erin, "The baby isn't mine." Next, Erin found out that Richard had been sentenced to prison. So she decided to have an abortion. "I just couldn't tell my mom," says Erin. "She's Catholic and doesn't believe in abortion. I was afraid she wouldn't accept me any more as her daughter and that she'd say 'I told you so.' "

Even though Richard said he would go with her to get the abortion, he kept putting it off until finally she couldn't wait any longer. Two of her close friends went with her to the clinic. They held her hand. And they helped pay for the abortion. (Richard never gave Erin the money he

had promised, either.)

Erin says the abortion hurt physically a little--"like huge cramps." Emotionally, she felt "knocked out."

Afterwards, her friends just held her as she cried for her baby. Erin still feels she made the best choice for the situation she was in at the time. She still hasn't told her mom. But she has learned to be careful. She has had sex with only one guy since the abortion. And she always uses birth control.

"In a way, I regret my decision because when I think of how old my baby would be now or what she would be like, I feel terrible and start to cry. I wonder if she would have had my eyes or my nose," says Erin. "But when I think of how young I was and how Richard and I aren't together anymore, I know I made the right decision for myself and for the baby, because I wasn't ready."

Teen Parenthood

Shannon's Choice
By Samantha Nay

Shannon King is 15. She is a sophomore at a regular high school, in a regular town, and she planned on living a regular life. But last July, Shannon found out she was pregnant. "I cried. I was scared. I didn't know what to do," she remembers. At 15, Shannon was faced with probably the most important decision she would ever have to make. Would she keep her child? Would she miss out on being a teenager in order to raise her baby? Would she take on the enormous responsibility of being a mom when the only responsibility she knew was getting her homework in on time and making her curfew?

For most people, this decision would have taken a lot of thought, but for Shannon, all it took was the plus sign on the home pregnancy test--and a gut feeling. "I couldn't picture giving the baby up for adoption," explains Shannon, who had her baby in February. "I feel abortion is wrong. And my family is here to help me. I have someone to turn to." Her ex-boyfriend and the baby's father, Kevin, was only 13 when Shannon found out she was pregnant.

Shannon didn't discuss her decision with Kevin. He was already dating other girls when she found out she was pregnant, she says. She doesn't want Kevin to be part of their daughter's life, but she is counting on Kevin's mother to help. His mom has promised to take care of the baby and give Shannon money. She's also counting on her own parents to help, even they're not happy about her decision. Shannon knows she will have to grow up faster. She knows she will to be home-schooled and will have to find someone to take care of her baby when she goes back to school. She has canceled her plans to go to college. And she has had to ask others to support her and her child. Basically, her life has totally changed. But all this doesn't matter to Shannon. Her baby is part of her. And she says she wants to be there to finish what she started.

THE WHITE HOUSE
WASHINGTON

Feb. 20th

-Planned Parenthood. org
Marina Sanger

-Population Action International

-NARAL

Petschesky
Rosalyn Patchesky

Susan Cohen - AGI
296-4012

THE WHITE HOUSE
WASHINGTON

20th
Travel - intro of POTUS
family centered

21st
family event (w/ or w/o POTUS)
Possible charter

22nd
mtg w/ family Planning
Advocates - need TPs

23rd
Social Security Speech
(Nicole)

25th

24th
(Maile) Foster Care -
aging out Budget
announcement

28th
Microcredit awards
@ wh w/ POTUS as well as
Budget announcement
(did last yr.)
(NEC)
- Possible 2nd event

- Pediatric AIDS remarks
(Jen)

29th
- VS Conf of Mayors on
Millum Comm - Ellen
- Childrens hospitals - Jen

3rd
WH - Mentoring event
announcing mentoring grant
(Neera)

LEVEL 1 - 29 OF 64 STORIES

The Independent (London)

October 4, 1992, Sunday

SECTION: THE SUNDAY REVIEW PAGE; Page 37

LENGTH: 571 words

HEADLINE: BOOK REVIEW / A mother of invention

BYLINE: By JAN DALLEY

BODY:

WE expect a lot from our heroines. Nobody questions if the buildings Edison hoped to electrify were used for worthy causes; no one is surprised if male social reformers turn out to have the politics of Brooks's and the morals of the gutter. But in the women's movement we tend to assume that good deeds are done by good people, and for good reasons. In the case of Marie Stopes, **pioneer of birth-control** and prophet of 20th-century attitudes towards female sexuality, there is shock and horror when it is revealed - as it is, eloquently, in June Rose's able biography - that Stopes was arrogant, snobbish, cruel, racist, an emotional tyrant and a monster egotist. Worse: her crusade for **birth-control** became confused with an interest in eugenics and racial purity.

So what? Or rather, why should we be surprised? Stopes needed the will of a pile-driver (and all its subtlety) to defy the weight of convention and do her work. Born Marie Carmichael Stopes (she married twice, but never changed her name), she was a second-generation New Woman. Her mother Charlotte, a woman of daunting rectitude and scholarship, was distant with her two daughters, preferring to follow her academic interests; only Marie's mild and loving father, Henry, a passionate amateur palaeontologist, gave her warmth and support - and implanted her early interest in science.

Something - competition with her high-achieving mother? - made Marie fanatically ambitious. She set herself to storm the bastions of the male scientific establishment, gaining an honours degree in one year, a doctorate soon after. As an eminent botanist she travelled to Japan (where she spent 18 months) and Canada (where she married one Reginald Ruggles Gates), and lectured extensively. She applied to accompany Captain Scott on his second Antarctic expedition, and was outraged to be ruled out solely on grounds of sex.

She was, in fact, a paragon of pioneering achievement even before she began the work that made her famous. But love and sex were a great problem for Marie. Her prolific writings - plays, novels, stories and, as her biographer succinctly puts it, ''unfortunately'' also poems - reveal a gushy romantic dreamer within the uncompromising scientist. She was vaguely bisexual, entering into passionate if non-physical relationships with women, and her miserable first marriage was ended on the grounds of non-consummation. But her interest in her own, considerable, sexuality (the unfortunate Ruggles Gates described her as ''super-sexed to a degree which was almost pathological'', but then he would, wouldn't he?) was a subject where the scientist and the romantic in her could

The Independent (London), October 4, 1992

meet. Camping alone on a windswept beach after her divorce, she kept a ''Tabulation of Symptoms of Sexual Excitement in Solitude'', complete with charts and notes.

It was in 1918 that her ground-breaking Married Love was published - printed by a small press with a handsome private subsidy from the dashing RAF officer Humphrey Roe, who became her second husband. Fame and fortune, and plenty of trouble, came soon after. Marie founded the free birth control clinics that still carry her name and, at 44, she finally became a mother. Until the end of a long life (she died in 1958), she never let up on her goals. June Hall gives a picture of a woman of extraordinary and enduring achievement: it would be ridiculous to want her to be nice as well.

LANGUAGE: ENGLISH

LEVEL 1 - 31 OF 64 STORIES

Orlando Sentinel Tribune

September 27, 1992 Sunday, 3 STAR

SECTION: ARTS & ENTERTAINMENT; Pg. F11

LENGTH: 693 words

HEADLINE: A PIONEER IN FIGHTING FOR RIGHT TO **BIRTH CONTROL**

BYLINE: Reviewed By Susan M. Barbieri, of The Sentinel Staff

BODY:

When it comes to reproductive freedom, the similarities between the climate of 1992 and the early 1900s are startling. Ellen Chesler's biography of **birth control pioneer** Margaret Sanger serves as an ironic look at history's cyclical battle over women's bodies.

"Every woman in the world today who takes her sexual and reproductive autonomy for granted should venerate Margaret Sanger," Chesler writes in the introduction to Woman of Valor: Margaret Sanger and the **Birth Control** Movement in America.

Overpopulation was a hot topic in the intellectual circles of Sanger's day.
Sanger advocated voluntary family planning as the solution; but then, as now, the birth control issue was explosive because some linked it with abortion. Sanger patiently explained the difference between prevention and abortion and her belief that availability of birth control would cut the number of abortions.

So for 50 years she fought government, the Catholic church and other formidable opponents. Her story spans the radical movements of pre-World War I to the family-planning initiatives of the Great Society era. She published a newsletter called "The Woman Rebel," railed against the "Comstock laws" that banned contraceptive distribution and was thrown in jail. She married twice, bore two sons and had a number of lovers - including writer H.G. Wells and sexologist Havelock Ellis.

"Margaret Sanger was an immensely attractive woman, small but lithe and trim. Her green eyes were flecked with amber, her hair a shiny auburn hue, her smile always warm and charming," Chesler writes. Men adored her. However, she could also be extremely stubborn and difficult.

Sanger was utterly devoted to her cause. She envisioned a united front of women who would claim the legalization of contraception, along with greater public candor about sexuality, as a fundamental right.

Women always had sought to control fertility. In the 1800s and early 1900s, contraceptive tracts and devices were distributed widely, but the options were primitive and unreliable. It was estimated that one out of every five to six pregnancies in America was terminated in the 1850s. More than 1 million pregnancies had been aborted by 1930, representing 40 percent of all conceptions.

As one of 11 children whose mother died young and whose father barely could

support the family, Sanger's sympathy for poor women fueled her political indignation. Lecturing before Socialist women in New York in 1910 and 1911, Sanger condemned public prudery for prohibiting open discussion of sexuality and reproduction, leaving women "innocent victims of their own ignorance."

Sanger promoted gender equality and healthier, happier families. She pleaded eloquently for a "new morality" expressing women's responsibility to refuse to bring unwanted children into the world.

The mail was her link to the masses. Thousands of the letters she received were lost, but surviving examples bear witness to the tragic circumstances of women who were unable to find reliable contraceptive advice. Still, Sanger couldn't interest President Roosevelt in legalizing birth control - even though she had studies showing that millions were dying needlessly from the complications of self-induced or illegal abortions.

It was not until 1970 that Congress rewrote the Comstock laws and formally removed the label of obscenity from contraception. Two years later, the Supreme Court, in Eisenstadt v. Baird, extended the right of contraceptive practice to the unmarried.

Late in life, Sanger was honored in Sweden for her work. In her speech, she said she always had believed it was her duty to place motherhood on a higher level than "enslavement and accident." By 1963, she was bedridden but still irrepressible, as evidenced by this snippet from Parade magazine:

"I realized what was coming - the population explosion we hear so much about today, women having more and more babies until there's neither food nor room for them on earth. And I tried to do something about it."

Sanger Quote

GRAPHIC: PHOTO: (Margaret Sanger); Sanger advocated voluntary family planning.

LANGUAGE: ENGLISH

COLUMN: Books

Woman of Valor: Margaret Sanger and the Birth Control Movement in America

By Ellen Chesler

Simon & Schuster, $27.50, hardcover, 468 pages

LOAD-DATE: May 14, 1993

LEVEL 1 - 33 OF 64 STORIES

August 17, 1992

SECTION: Vol. 239 ; No. 37 ; Pg. 480; ISSN: 0000-0019

LENGTH: 175 words

HEADLINE: Marie Stopes and the Sexual Revolution._book reviews

BODY:

June Rose. Faber & Faber, $ 22.95 (256p) ISBN 0-571-16260-6

Marie Stopes (1880-1958), a successful British botanist, was also a **pioneer of birth control** and sexual freedom. Rose (Modigliani), who obtained access to her subject's private papers, has written an objective and readable study of the life of the woman who, with the assistance of her second husband, Humphrey B. Roe, opened Great Britain's first birth control clinic in London in 1921. The sexual frustration Stopes had experienced during her first marriage inspired her to write and publish, after great difficulty, Married Love (1918), an explicit guide to sexual intercourse and, in the same year, Wise Parenthood, which clearly described available methods of contraception. Although her autocratic nature enabled Stopes to surmount opposition to her emancipated ideas and the controversies they provoked, as Rose observes, it sometimes estranged her from her family and friends. This is an important contribution to women's studies. Illustrations not seen by PW (Oct.)

IAC-NUMBER: IAC 12532394

IAC-CLASS: Magazine; Trade & Industry

LANGUAGE: ENGLISH

LOAD-DATE: August 28, 1995

LEVEL 1 - 43 OF 64 STORIES

Los Angeles Times

June 8, 1991, Saturday, Home Edition

SECTION: Part A; Page 26; Column 1; Metro Desk

LENGTH: 153 words

HEADLINE: DR. MIN-CHUEH CHANG; HELPED TO DEVELOP **BIRTH CONTROL** PILL

BYLINE: By Associated Press

DATELINE: WORCESTER, Mass.

BODY:

Dr. Min-Chueh Chang, a developer of the **birth control** pill and a **pioneer** in research that made in vitro fertilization possible, has died. He was 82.

Chang, who died Wednesday of unreported causes, did much of his work at the Worcester Foundation for Experimental Biology, where he rose to the rank of scientist emeritus.

Last year, he was elected to the National Academy of Sciences, the most prestigious honor that can be given to an American scientist short of the Nobel Prize.

In 1951, Chang began studying synthetic progestins' effects on reproduction. The research, done with Dr. Gregory Pincus, a founder of the foundation, led to the development of an oral contraceptive in 1959.

Chang also is credited with carrying out basic research in the 1950s into techniques that made it possible to fertilize a human egg with sperm outside the body, resulting in the births of so-called "test-tube babies."

LANGUAGE: ENGLISH

LEVEL 1 - 46 OF 64 STORIES

The New York Times

April 7, 1991, Sunday, Late Edition - Final

SECTION: Section 1; Part 1; Page 32; Column 1; National Desk

LENGTH: 244 words

HEADLINE: Somers H. Sturgis, 86, **Birth Control Pioneer**

BODY:

Somers Hayes Sturgis, a **pioneer** in **birth control** research who was a founder of the first abortion clinic in Massachusetts, died Wednesday at his home in Cambridge, Mass. He was 86 years old.

He died of lung cancer, said his daughter, Joan Sturgis Mann.

Dr. Sturgis was an advocate of abortion rights for many years. In 1973, six weeks after the Supreme Court ruling legalizing abortion, he opened the Crittendon Hastings clinic in Boston.

In the 1930's and 40's, Dr. Sturgis collaborated on a series of reports from the Harvard School of Medicine that demonstrated that estrogen inhibits ovulation. Information from his research with Dr. Fuller Albright formed the basis of the contraceptive pill.

Dr. Sturgis was born in Groton, Mass., and attended the Groton School. At Harvard University, where he graduated in 1927, he majored in fine arts. He then entered the medical school, and graduated in 1931. He received his post-graduate training at Massachusetts General Hospital.

He was chief of the department of gynecology at the Peter Bent Brigham Hospital, now Brigham and Women's Hospital, in Boston, from 1951 to 1969, and a professor of gynecology at Harvard from 1951 to 1971.

He is survived by his wife, Frances Ann; three daughters, Ms. Mann, of Brooklyn; Ann F. Watt, of Cambridge; and Margaret Ratheau, of Marlboro, Vt.; seven grandchildren; a sister, Susan B. Goodale, of Ipswich, Mass., and a brother, Warren, of Southbury, Conn.

LANGUAGE: ENGLISH

LOAD-DATE: April 7, 1991

LEVEL 1 - 47 OF 64 STORIES

The New York Times

January 23, 1991, Wednesday, Late Edition - Final

NAME: Alexander C. Sanger

SECTION: Section B; Page 2; Column 2; Metropolitan Desk

LENGTH: 632 words

HEADLINE: Another Sanger Leads Planned Parenthood

BYLINE: By NADINE BROZAN

BODY:

The grandson of Margaret Sanger, the fiery **birth-control pioneer,** has become president and chief executive of Planned Parenthood of New York City.

The new leader of the largest Planned Parenthood affiliate, Alexander C. Sanger, is a former Wall Street lawyer and executive who has also served on the board of the nonprofit organization.

"With all her success, my grandmother left some unfinished business, and I intend to finish it," Mr. Sanger said in an interview at the agency's headquarters at 380 Second Avenue.

Elected unanimously last month by the board of trustees, he succeeds Diana M. Gurieva, who resigned after 20 months in the post for personal reasons.

Fighting Federal Rules

The New York organization has an annual budget of $18 million, a staff of 250 and 85,000 visits a year to its clinics. Mr. Sanger, 43 years old, takes the reins at a critical juncture in its history. It is a lead plaintiff in a lawsuit to be decided this year by the United States Supreme Court that challenges 1988 Federal regulations barring recipients of Federal family-planning funds from discussing abortion with their clients.

"If the decision goes the wrong way," Mr. Sanger said, "we will close down rather than stop counseling about abortion. But I will vigorously go to the state, the city and private funders and get every penny I can to keep our clinics going. We've already started some preliminary planning for that."

In particular jeopardy is the Hub, a multiservice center for adolescents that Planned Parenthood operates in the South Bronx in conjunction with the Bronx-Lebanon Hospital Center. "It receives almost half a million dollars in Federal funds a year, and is a beacon of hope for kids in the South Bronx," he said.

Despite the legacy of his grandmother, the founder of Planned Parenthood, and of his father, Dr. Grant Sanger, a surgeon who was a board member of the

Margaret Sanger Research Bureau, Mr. Sanger took a circuitous route to his new post.

He graduated from Princeton University, where he wrote his senior thesis on his grandmother, and Columbia Law School, and also holds two master's degrees. He was a partner at White & Case, the Wall Street law firm, before becoming chief executive of Sanger Plastics and later Old Line Plastics. He is married to Jeannette Watson, the owner of Books & Company on Madison Avenue, and has two sons and a stepson.

'Name Is Invaluable'

While Mr. Sanger has no public reputation in the field of birth control and abortion services beyond the inner circles of the organization, he has served for seven years on the board of Planned Parenthood of New York City, the largest of 170 affiliates nationwide.

He acknowledged that his name would be an asset. "Like it or not, my last name is invaluable and recognizable and important to many people," he said. "But I intend to be out on the front lines of our issues. That is why I'm here, why I want to do this job."

A week after taking office on New Year's Day, he delivered eight speeches at a conference sponsored by the organzation on "America's Birth Control Crisis." He plans to testify in favor of Chancellor Joseph A. Fernandez's plan to make condoms available to New York City high school students, and later this month will go to Albany for the annual meeting of Family Planning Advocates and "to lobby the Legislature and the Governor."

Mr. Sanger said he would formulate his agenda based on an evaluation of his organization's strengths and shortcomings. "Right now we have three clinics in the city and I want to have 10 more," he said. "There are so many areas that are underserved. We currently have a small storefront office in central Harlem, and it is my first priority to see if we can transform that into a clinic."

GRAPHIC: Photo: Alexander C. Sanger, the new president and chief executive of Planned Parenthood of New York City. (Don Hogan Charles/The New York Times)

LANGUAGE: ENGLISH

LOAD-DATE: January 23, 1991

LEVEL 1 - 50 OF 64 STORIES

Chicago Tribune

July 28, 1990, Saturday, NORTH SPORTS FINAL EDITION

SECTION: NEWS; Pg. 11; ZONE: C

LENGTH: 113 words

HEADLINE: Dr. J.L. Brodie, a **pioneer** on **birth control**

BYLINE: Associated Press

DATELINE: PORTLAND, Ore.

BODY:

Dr. Jessie Laird Brodie, an internationally known physician who pioneered **birth-control** legislation and education in Oregon in the 1930s, died Wednesday. She was 92.

In 1930, Dr. Brodie opened a private practice in her Northeast Portland home. Specializing in pediatrics, gynecology and marriage counseling, she continued to operate her own office until 1960.

During the early years of her practice, Dr. Brodie took a leadership role in the area of family planning, a subject that continues to cause considerable social discomfort decades later.

In 1934 she led a successful campaign to pass legislation to regulate the quality and sale of contraceptives.

LANGUAGE: ENGLISH

LEVEL 1 - 51 OF 64 STORIES

THE ORANGE COUNTY REGISTER

September 21, 1989 Thursday EVENING EDITION

SECTION: HEALTH-TECH; Pg. E01

LENGTH: 1041 words

HEADLINE: Father of 'the pill' calls for new research

BYLINE: Mike Woods, The Toledo Blade

BODY:

Dr. Carl Djerassi, father of "the pill," says the American pharmaceutical industry has virtually abandoned research on new methods of **birth control.**

The situation, he says, all but guarantees that no fundamentally new method of contraception -- such as a male pill, an anti-fertility vaccine or a once-a-month menses inducer -- will be available in the United States for 10 to 20 years.

And, as a result, he predicts there will be no significant reduction in the number of abortions -- currently about 1.5 million -- performed each year.

"Many people ignore the fact that the incidence of abortion reflects the state of contraception. In the Soviet Union, the country with the highest per capita abortion rate in the world, the quality of **birth control** is exceedingly poor and the pill is essentially unavailable. Japan, the country with the third or fourth highest abortion rate, is the only industrialized country in which the pill is not approved for contraceptive use."

Djerassi, professor of chemistry at Stanford University, says fear of product-liability suits has driven American drug companies away from birth control research and development.

In 1951, Djerassi and a group of co-workers at Syntex Laboratories Inc. developed a synthetic version of progesterone that became the active ingredient in birth control pills. Progesterone is a female sex hormone that prevents women from ovulating during pregnancy.

But because legal and product liability costs for oral contraceptives are higher than for any other category of drugs, Djerassi says, there will be no fundamentally new birth control methods until Congress modifies the exposure to liability of manufacturers for new contraceptives and vaccines.

A no-fault insurance program that limits manufacturers' liability would be the most important incentive for getting US drug companies

back into development, he said. Such a program would compensate victims for medical costs, loss of earnings and pain and suffering and would be financed through a surcharge on the price of the contraceptive.

In a report in Science, the journal of the American Association for the Advancement of Science, Djerassi describes a broad retrenchment of the pharmaceutical industry.

In 1970, 13 major pharmaceutical companies, including nine US firms, had research and development programs on contraceptives. Today there are four, only one of which is a US company.

No new active ingredients have appeared in pills sold in the United States since 1960. In contrast, three new ingredients were introduced in the 1980s in Europe, where women now have access to the world's most advanced birth control pill.

Djerassi says top priority in research on new contraceptive methods should go to development of a new spermicide with anti-viral properties. "The acquired immune deficiency syndrome epidemic alone justifies putting this item at the top of the list."

Second priority would go to a once-a-month pill that women would take to induce menstrual flow only during those months when they had unprotected sexual intercourse. The woman would take the pill at the expected time of their menstrual period, without waiting to see if she had missed a period time or taking a pregnancy test. Such a pill, he says, "could become the single most effective method for reducing the 40 to 50 million abortions performed annually throughout the world."

Third priority would be development of a reliable test for predicting ovulation that could be used by couples practicing the "rhythm method," or natural family planning. Since sperm have a fertile life span of three days, the test would need to predict ovulation at least three days in advance.

Djerassi assigns fourth priority to a reliable and easily reversible method of male sterilization that would make vasectomy a more acceptable fertility control method for young men with no children. Vasectomy, used by millions of men, often can be reversed now. But reversal requires expensive microsurgery.

Fifth priority would be development of a pill taken by the male.

Sixth would be the most revolutionary of all: development of an anti-fertility vaccine that would gradually wear off over a set period.

The vaccine, he says, could have a major impact in decreasing America's teen-age pregnancy and abortion rates, which are the highest in the industrialized world.

Djerassi points out that even if research and development on new contraceptive methods resumed today, no fundamentally new method could be available for 12 to 20 years. Authorities believe it would take that

long to complete stringent government testing requirements to establish the new product's safety and effectiveness.

CHART: Identifying priorities for improving birth control

According to Dr. Carl Djerassi, **pioneer of the birth control** pill, no fundamentally new method of birth control will be available in the United States for at least 10 years. He says top priorities in research for new contraceptive methods should include:

Spermicide with anti-viral properties.

Once-a-month pill to induce menstrual period.

Development of reliable test for predicting ovulation that could be used by couples practicing the rhythm method.

Reliable and easily reversible method of male sterilization.

Male birth control pill.

Development of an anti-fertility vaccine that would gradually wear off over a set period of time.

GRAPHIC: BLACK & WHITE PHOTO; CHART; Dr. Carl Djerassi, pioneer of 'the pill,' says no-fault insurance is the key to getting US drug companies back into development of contraceptives.; CHART; Identifying priorities for improving birth control - see end of text

LANGUAGE: ENGLISH

LOAD-DATE: April 10, 1997

LEVEL 1 - 55 OF 64 STORIES

Los Angeles Times

August 16, 1988, Tuesday, Home Edition

SECTION: Part 1; Page 1; Column 1; Foreign Desk

LENGTH: 1979 words

HEADLINE: KENYAN A **BIRTH CONTROL PIONEER;**
10-MINUTE OPERATION AIDS FAMILY PLANNING IN AFRICA

BYLINE: By MICHAEL A. HILTZIK, Times Staff Writer

DATELINE: NYERI, Kenya

BODY:
The first time Dr. Joseph Kanyi performed the operation, his nurses fled.

"I thought they were going for tea," he recalled in his whitewashed office one day recently, 13 years later. "But they never returned."

It was not tea, but the unfamiliarity of Kanyi's procedure that drove the nurses away: It was the first time that they had seen abdominal surgery performed using only local anesthesia.

"They disapproved of doing the operation while the patient was awake," Kanyi said. His staff gone, Kanyi glumly canceled the three other operations he had scheduled for that day. Racked by frustration and embarrassment, he spent a sleepless night.

That was the inauspicious beginning of Kanyi's pioneering work in birth control, or "family planning," in the preferred terminology of Africa. The woman on the table was Kanyi's first patient for a procedure known as a minilaparotomy, a simple and convenient method of performing tubal ligations, or surgical sterilizations.

After years of searching for a simple way to provide his rural patients with the permanent contraception they desired, Kanyi had learned the technique abroad and brought it to his tiny clinic here in the shadow of majestic Mt. Kenya. With a three-inch incision and an hour's surgery, since reduced to 10 minutes, he could surgically sterilize a woman and have her out of his clinic and on her way home that day.

Within a year of that first operation, with a new staff of nurses, Kanyi was performing hundreds of the voluntary procedures annually. Since that discouraging day in 1975, he has done 3,500. In Kenya, the leader in Africa in the procedure, the 300 doctors and nurses he has trained perform 9,000 every year.

It is on women's shoulders that the burden of Africa's population explosion falls disproportionately. Often bearing as many as eight or 10 children, they

are frequently left to support the children on their own. By a wide margin, it is women who have the greatest incentive for birth control and who suffer its myriad inconveniences.

Thus, to thousands of women, and perhaps to the continent as well, the minilaparotomy has been a godsend, for in few other places on Earth is birth control more urgent than in Africa.

In population growth, as in so many other fields, the continent seems forever out of step with the rest of the world. In the 19th Century, for example, it was the only continent, Antarctica aside, to suffer a declining population.

Then the European colonists arrived with their own ideals of medical care and disease eradication. Africa's infant mortality rate dropped, and life expectancy increased.

Since 1950, education and medicine have cut Kenya's infant mortality rate from 163 deaths per 1,000 births to about 70 today. Life expectancy at birth in the same period has risen to 53 years from 39.

High Fertility Rate

Conventional wisdom dictates that, high mortality rates being the leading inspiration for high fertility, African birthrates should be falling. Yet in Kenya, to take one example, the fertility rate -- the average number of children born per woman -- has scarcely budged: It was 8.2 in 1950, and it is 8.12 today.

One reason may be that the drop in the infant mortality rate is not so clearly visible to rural villagers.

"Even though the rate is down, as many children die as in the past because there are so many more children," said Dr. Eric Krystall, head of the Family Planning Private Sector program, a privately financed group operating in Kenya. "In Kenya, there are still 70,000 child funerals a year, so we still have a job convincing people."

Although Kenya has the world's highest natural growth rate, its problem is mirrored by many other nations in sub-Saharan Africa. With mathematical inevitability, the continent's human population has begun to outstrip the land's ability to support it.

In 1950, the region supported about one-fifth as many people as all of the developed world; by 1985, it had closed the gap to about a third. United Nations statistics indicate that in the year 2025, even assuming Africa's growth rate falls to 0.72% annually from today's 1.84%, the continent will have 1.1 billion people, equal to all the people in the developed world.

Bride Price

The population impact already cuts across all economic categories in Africa. In Rwanda, the tiny central African nation with the continent's heaviest density, population growth has so reduced the size of most families' cattle herds that the traditional price of a bride, a cow, has become hard to meet. On the alternative cash market, brides fetch as much as $1,350. This spring, the government responded to this inflation by fixing the price of a bride at three

hoes.

Africa's fragile ecology suffers as well. In Niger, where the growth rate will double that destitute West African country's population to 13.6 million in 23 years, the U.S. Agency for International Development blames the population explosion for contributing to extensive deforestation and desertification, as people strip the country's forests for wood to burn.

Even if Africa were to sharply cut back its fertility and growth rates today, the continent's future is etched in stone for decades to come. Half its population is below the age of 15; in many countries, this youthfulness might presage an explosion of industry and economic vitality. In the straitened lands of Africa, it portends a geometric increase in population and an overwhelming strain on inadequately developed resources.

More and more, African governments have come to recognize population growth as their paramount economic curse. Even some Muslim countries, with traditional censures against birth control, have instituted official programs.

Few Use Birth Control

But all falter in the face of logistical, educational and cultural obstacles. In Kenya, where family planning is a national policy aggressively supported by every government minister, a 1980 international study showed that only 29% of women had ever used any form of birth control, including 18% who used such traditional methods as rhythm and abstention.

In other countries, the rate is much lower -- 6% to 10% use modern methods in Niger, 4% to 6% in the destitute West African nation of Burkina Faso and 3% in sub-Saharan Africa's most populous nation, Nigeria.

Few subjects are as charged with contention and emotion as family planning in Africa. National programs have collapsed after confronting unexpected tribal sensitivities. In semi-literate societies, the mine field of misunderstanding can be catastrophic.

For example, the male equivalent of the minilaparotomy, the vasectomy, is rare to the vanishing point throughout Africa. Men and women alike equate it with castration and fear it causes impotence.

Rumors, Misconceptions

"Rumors and misconceptions are bad even in the United States," says one family planning expert active in Kenya. "In Africa, they spread like wildfire. If a contraceptive user in some village becomes ill, a rumor spreads identifying the method with the illness, even if it's unrelated."

Kanyi himself recalls hours of sessions with his patients disabusing them of common fallacies. Some women believed that if they conceived while using an IUD, "it would go through the baby's heart, or the baby would come out holding it." Others feared that contraceptives would make them frigid, or cause birth deformities.

Even as birth control officials struggle to gain acceptance for their

methods, the efficacy of traditional methods has been declining. African women, for example, have traditionally breast fed their children for their first two years or even longer. Breast-feeding diminishes a woman's fertility, and in many African tribes it is also taboo to have sex with a breast-feeding woman, so that helped to space children naturally.

Social Taboos

In many traditional societies it was also taboo for a woman to have any more children once her oldest daughter became pregnant -- another social limit on fertility.

But as Africa becomes more urbanized, population experts say, traditional restrictions disappear.

"In cities there are fewer taboos," said one population official in Nairobi. "Breast feeding is no longer a child's sole nourishment, for example. Women are productive well into their 40s."

With modern contraceptive methods, one problem is the continual difficulty of getting devices to the users.

"There are problems both on the supply and the demand side," remarked one foreign aid official in Africa involved in population matters. In the past, some countries have been afflicted with erratic supplies of such contraceptives as Depo-Provera, an injectable contraceptive popular in Africa but not yet approved for use by women in the United States.

Users of most contraceptives also are inconvenienced by the need to travel to remote clinics to renew their supplies -- every three months in the case of Depo-Provera. For this and other reasons, many older African women have long sought a permanent birth-control technique to substitute for the need to use temporary methods for what might be as much as 20 years between the birth of their last wanted child and the end of their period of fertility.

"They would ask why I couldn't give them a method to get them out of the queue," Kanyi recalled. "It became rather a challenge to me."

Not Uncommon Method

Of course, a method did exist: tubal ligation, or the cutting of a woman's Fallopian tubes to block the movement of the ovum into the uterus. Not uncommon in the developed world, this method of surgical sterilization created huge problems for doctors and patients in Africa.

The conventional procedure required the patient to check into a hospital for more than a week, go under the knife for hours and subject herself to general anesthesia. Any of those factors alone would be enough to discourage most of Kanyi's potential patients.

In the cash economy that prevails in most of Africa, that much time out of pocket was insupportably costly. Such a long sojourn away from home, as well as the long scar, also made it impossible for a woman to keep her operation confidential -- more than an inconvenience in societies where she might feel the

sting of disapproval or even ostracism for taking such a permanent step. General anesthesia also frightened potential patients.

So tubal ligations tended to be performed in sub-Saharan Africa only on "women who were most desperate," said one leading expert in surgical contraception in East Africa. "They were those with a ruptured uterus, or 13, 14 kids, or several Caesarean sections."

New Set of Concerns

The advent of the minilaparotomy has changed that, although the availability of such an easy and permanent method of birth control has brought its own array of problems. The Family Planning Assn. of Kenya and other family planning agencies here have financed an extensive program of counseling to screen patients, rejecting those for whom permanent contraception might be a grave mistake. In Kenya's polygamous tribes, out-of-favor wives might be pressured by their husbands to undergo sterilization.

Counselors in Kenya generally recommend the procedure only to women who have had six children or more.

"If a woman comes in at the age of 24 and with one child, it's very questionable," said one family-planning worker. "What if the child dies, or the woman is divorced and remarries? There would be very heavy pressure on her in that case to produce children in the subsequent marriage."

But counselors find that among appropriate patients, acceptance of the procedure runs very high.

"When we tell clients it just takes 10 to 15 minutes," said Jennifer Mukolwe, executive director of the Family Planning Assn., "they say, 'My goodness, it's just like going to the market -- and no one even has to know.' "

LANGUAGE: ENGLISH

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LEVEL 1 - 22 OF 63 STORIES

The San Francisco Chronicle

MAY 10, 1995, WEDNESDAY, FINAL EDITION

SECTION: NEWS; Pg. A2

LENGTH: 640 words

HEADLINE: Gynecologists Salute Birthday of the Pill c

BYLINE: Sabin Russell, Chronicle Staff Writer

BODY:

The **birth control** pill turned 35 yesterday, and 4,000 gynecologists just happened to be in San Francisco to celebrate.

In town for the annual meeting of the American College of Obstetricians and Gynecologists, the doctors are spending most of the week discussing the latest findings on matters such as menopause, childbirth and alternatives to hysterectomy.

But they couldn't pass up a chance to mark one of the great moments in the **history of birth control.**

''The pill started in controversy, and controversy seems to have strengthened it, rather than weakened it,'' said Dr. Celso-Ramon Garcia, a Philadelphia gynecologist who led clinical testing of the popular oral contraceptive in Puerto Rico during the late 1950s.

At a press conference called to mark the anniversary, Garcia said that early researchers could not find an American hospital willing to conduct trials of the pill, and major drug companies that later reaped billions selling it were unwilling to bankroll its development.

Today, an estimated 10 million women hold prescriptions for the pill in the United States alone. Besides sterilization, it is the most popular form of birth control in America.

''There ought to be tremendous fireworks to celebrate this anniversary,'' proclaimed Ruth Westheimer, the sex educator better known as Dr. Ruth, whose frank talk on television and radio about human sexuality has made her a media celebrity.

Mainstream Americans first learned of the birth control pill May 9, 1960, when the Associated Press reported that the Food and Drug Administration had quietly agreed to add contraception to the list of approved uses for a drug already being prescribed for a variety of menstrual disorders.

Word that the drug, called Enovid, was an extraordinarily effective contraceptive had already spread among gynecologists and their patients. According to its manufacturer, G. D. Searle & Co., as many as half a million

American women may have been taking the pill for birth control by 1959.

A combination of synthetic versions of the hormones estrogen and progestogen, the pill has proved more than an effective birth control method: Its introduction brought about a revolution that challenged American sexual mores and paved the way for large numbers of women to enter the workplace.

The pill not only liberated women from unwanted pregnancy, said Dr. Ruth, but enabled millions to get more enjoyment out of sex. ''A woman cannot have sexual satisfaction if she's worried,'' she said.

Yet the sexual revolution heralded by the pill has left a troubling legacy. Thirty-five years after its introduction, according to the New York-based Alan Guttmacher Institute, the United States has the highest rate of teenage pregnancy in the industrialized world.

''Over one-half the pregnancies in this country are still unplanned,'' said Dr. Anita Nelson, medical director of the Women's Health Care Clinic at Harbor-UCLA Medical Center.

Part of the problem is that many women still do not trust the pill.

According to Nelson, 25 percent of the women surveyed in 1993 believed the failure rate for oral contraceptives is greater than 20 percent. In reality, only 6 percent of all pill users become pregnant each year, and the failure rate for those who adhere strictly to instructions is less than one in 1,000.

At 35, the pill itself has undergone major reformulations. Today, estrogen levels are only 20 percent, and progestogen levels about 10 percent, of those in the original pill.

The lower dosages have decreased side effects, although pill users still face a slightly higher risk of stroke and heart attack and some experience problems such as irregular bleeding. One manufacturer estimates that half the women who try the pill eventually switch to other contraceptives.

GRAPHIC: PHOTO,Lena Young inspected packages of birth control pills at the Ortho-McNeil Pharmaceutical plant in Raritan, N.J. , BY FEATURE PHOTO SERVICE

LANGUAGE: ENGLISH

LOAD-DATE: May 10, 1995

LEVEL 1 - 23 OF 63 STORIES

USA TODAY

May 4, 1995, Thursday, FINAL EDITION

SECTION: LIFE; Pg. 1D

LENGTH: 1299 words

Woman's Relief over availability of the Pill

HEADLINE: THE PILL TURNS 35 / A new era for women was born, too

BYLINE: Marilyn Elias

BODY:

Karen Robillard, 54, remembers exactly when she heard about the pill. She was in her early 20s, a department store buyer, engaged and desperate for reliable **birth control.**

Driving to work one day in Providence, R.I., she heard "this startling news" on the radio.

"My first reaction was 'Yesssss!' I remember talking to my girlfriends about it, and we all felt it was too good to be true."

Other **birth control** methods "were a pain, and they didn't work very well. . . . Then if you got pregnant, what could you do? In those days you had to hide your head in shame. Someone I knew got an abortion in a third-floor apartment in East Providence, but that was frightening to think about."

Robillard's doctor hesitated to prescribe oral contraceptives for a single woman. "He said, 'There's time for this,' but I said, 'The time is now!' "

She wasn't alone in that emphatic response. The Food and Drug Administration approved the pill's final product labeling as a contraceptive 35 years ago today. By now, 4 out of 5 sexually active women have used the pill. It's still the most popular reversible method of birth control, chosen by about 10 million women in this country.

Even as oral contraceptives now appear old hat, new uses and controversies over the pill are emerging. But whatever lies around the bend probably looks no more dramatic than the changes already spurred by pill use.

As the first female-controlled method not linked to the sex act, the pill ushered in an era of wider sexual activity, without worry over unwanted babies. "It was an enabler, a big catalyst allowing women to make major changes in their lives," says Susan Scrimshaw, dean of the school of public health at University of Illinois, Chicago.

"It made it so much easier to postpone, to space children and then to choose smaller families. For the first time, you didn't

have to feel beholden to a biological destiny." That

unprecedented freedom eased the way for women to pursue education and careers without forgoing relationships or family. "If the pill hadn't been discovered," says Scrimshaw, "we'd have less perfect methods, and employers wouldn't have been as willing to let women in en masse."

This wasn't all good news, she adds. Ambitious women who were students in the '60s sometimes postponed too long, not realizing their biological clocks wouldn't tick forever. "The pill indirectly contributed to fertility problems we're seeing now in women in their 30s and 40s," Scrimshaw says.

Oral contraceptives still are favored by younger women: Usage peaks in the late teens and 20s. By ages 35 to 39, only 11% of women using birth control take pills, compared with 61% of those 18 to 19 years old.

Young women today, though, face sex-related problems their pill-popping mothers couldn't have imagined. "Pregnancy is no longer the worst thing that can happen to them. They can die from sex," says Dr. Judith Reichman, a Los Angeles gynecologist.

She prescribes pills, "but only with a lecture on how this can't protect them from AIDS or sexually transmitted disease. They're getting more condom-conscious but still don't want to give up the better birth control you get from pills." (About 1 in 6 women whose partners use condoms has an accidental pregnancy every year vs. 1 in 14 for those on the pill.)

Pill use is dropping among married couples, largely because more than half of them now choose sterilization after all wanted babies have been born. And condom use is growing, "but too slowly," among young, unmarried women, says Jacqueline Darroch Forrest of the Alan Guttmacher Institute, New York City.

Today's pill carries nowhere near the hormone punch of the Enovid capsule approved in 1960. Versions now on the market have one-fifth to one-third as much estrogen and one-10th the progestin.

Pill boosters tout its proven benefits: cutting a woman's risk of ovarian and uterine cancer; lowering the incidence of pelvic inflammatory disease and benign breast lesions that often prompt surgical biopsies; even improvements in symptoms of rheumatoid arthritis.

Oral contraceptives, though, aren't for everyone. Even with lower estrogen doses, pills can promote potentially fatal blood clots; they're not recommended for smokers over 35, women with hypertension and those at high risk for blood clots or heart disease. They can intensify migraine headaches, too.

The most heated recent criticism of pills centers on a possible link to breast cancer. Most studies show no tie for women overall, "but we're beginning to see a consistent link between taking the pill and breast cancer diagnosis before 35," says Dr. Herbert Peterson, chief of the women's health and fertility branch at the Centers for Disease Control and Prevention.

Peterson's own national study of 5,000 women, ages 20 to 54, paints a mixed picture for pill users:

-- Before age 35: A 40% increase in breast cancer.

-- 35-44: same as non-users.

-- 45-54: 10% lower risk.

But only 8% of women are under 40 when they're diagnosed with breast cancer, so the pill's beneficial effect on older women's cancer rates, if it holds up, may save lives in the long run.

Peterson speculates that pills, like pregnancy - which they mimic by suppressing ovulation - raise short-term breast cancer rates because they spur growth of tumors already in the breast. That's why higher rates show up in younger women: They're the fertile ones taking pills, which make their cancers grow rapidly and become apparent sooner.

Pregnancy lowers long-term breast cancer risk, and pills may do the same, he says. About 3 out of 5 women diagnosed with breast cancer are 60 or older. A federal study is, for the first time, looking at whether pill use affects breast cancer rates in these older women. Results will be out in the year 2000, Peterson says.

Even as scientists study how youthful pill use affects women later, there's a growing trend to prescribe oral contraceptives during peri-menopause, which lasts an average of four years before menopause. Pills stop the typical symptoms of abnormal bleeding and sporadic hot flashes, Reichman says. Many women go directly from them onto hormone replacement.

Not everyone is delighted with the prospect of women taking synthetic sex hormones from teen age to old age.

"We're concerned about the possibility of an additive harmful effect. Taking the pill and hormone replacement is going where no woman has gone before," cautions Cindy Pearson of the National Women's Health Network, Washington, D.C. "It's possible there may be health problems, there certainly hasn't been enough study to prove there won't be."

Still, Forrest predicts a rosy future for the pill. "It's by no means perfect - we don't have a perfect method. But for years to come, I think it's going to be mostly the pill and condoms."

Robillard, who rejoiced at the pill's birth 35 years ago, lately has found herself suggesting it to her teen-age daughter. "She has just fallen in love, and I'm biting my nails. She assures me that she's not ready for the pill - thank God!

"But when the time comes, I told her I'd take her to get them."

The Pill - approved as a birth control device 35 years ago today - has been used by four out of five sexually active U.S. women.

About a third (34.3%) of all women 15 to 44 used non-surgical contraceptives in 1990, the latest data available. The breakdown:

Pill 49%

Condom 31%
Other (Rhythm, abstinence, withdrawal, etc.) 13%

Diaphragm 5%
IUD 2%

GRAPHIC: GRAPHIC, color, Suzy Parker, USA TODAY (Pie chart)

LANGUAGE: ENGLISH

LOAD-DATE: May 05, 1995

LEVEL 1 - 37 OF 63 STORIES

The Plain Dealer

May 21, 1993 Friday, FINAL / ALL

SECTION: TODAY; Pg. 9C

LENGTH: 597 words

HEADLINE: PICKING UP TORCH FROM HIS GRANDMOTHER

BYLINE: By LAURA YEE; PLAIN DEALER HEALTH REPORTER

DATELINE: CLEVELAND HEIGHTS

BODY:
Alexander C. Sanger remembers his famous grandmother as someone who never took no for an answer.

Like the times when naysayers hurled tomatoes and dirt at her as she began in 1912 to advocate the importance of **birth control** - a phrase she coined. Still, Margaret Sanger persevered.

Or the time when she and her sister in 1916 opened the country's first contraception clinic in Brooklyn, N.Y. Nine days and 900 patients later, authorities shut down the clinic and threw Margaret Sanger in jail for 30 days.

Eventually, she prevailed in her mission to help protect the reproductive rights of women. Today, there are 168 affiliates of Planned Parenthood, an organization founded on her work and unwillingness to take no for an answer.

"We've made great progress," says Alexander Sanger, president and chief executive officer of Planned Parenthood in New York City. "No other movement has been this successful."

Sanger provided several anecdotes about his grandmother Wednesday at the local Planned Parenthood 65th anniversary forum as if to illustrate how the battle that his grandmother began waging 81 years ago is not all that different from the one he continues to fight today.

During his grandmother's time, no one was allowed to discuss birth control, and doctors, who feared losing their licenses, would not address the issue. Religious groups and courts that believed birth control was anti-family were also impediments for Margaret Sanger, who died in 1966.

Alexander Sanger said he believes women must continue to say 'no' as anti-abortionist and other groups attempt to shut down clinics and terrorize doctors who perform abortions.

Constituents must still lobby the government to reverse laws that impinge on the right of women to control their own bodies, he said. And he thinks the country's future doctors must be encouraged to include abortion and the

history of the birth control movement in their training.

"My grandmother knew that the price of liberty is eternal vigilance," Sanger said, borrowing a few words from Thomas Jefferson. "She knew it would be a constant fight after what she had been through."

Part of that vigilance, Sanger said, is to be prepared for the protests that Operation Rescue plans to stage in Cleveland this summer.

Gather political support, he advised. Get laywers to put injunctions in place and form coalitions with women's organizations and other groups to get volunteers. Form human blockades against the anti-abortionists.

"I mean for this to sound like combat," Sanger said after his speech at the College Club in Cleveland Heights. "Because that's exactly what it is."

But he cautioned pro-choice advocates not to resort to terrorist tactics.

"The time is right for us to take the moral high road," he said. "We must talk about morality and responsibility because that's what we're all about."

Sanger, a partner in a law firm and a businessman before taking the Planned Parenthood position, said he is also aware that there's no time to waste.

With the change in political climate that came with the Clinton administration, pro-choice groups have to accomplish as much as possible in the next 3 years.

Sanger said there should be an increase in federal funding for contraceptive research and that every community should fight to ensure that health care reform does not hinder a woman's right to abortion.

"We've come a long way but we still have a lot of work to do," he said. "We started out facing obstacles we can't imagine, but today our beliefs and services are woven in the fabric of the nation."

GRAPHIC: PHOTO by PD/JAMES A. ROSS:; ALEXANDER SANGER: "We've come a long way but we still have a lot of work to do."

LANGUAGE: ENGLISH

LOAD-DATE: May 24, 1993

LEVEL 1 - 38 OF 63 STORIES

Newsday

March 23, 1993, Tuesday, CITY EDITION

SECTION: PART II; LECTURE ON 1916 BROOKLYN CLINIC; Pg. 55

LENGTH: 626 words

HEADLINE: The Legacy Of Sanger's **Birth Control** Battle

BYLINE: By Esther Iverem. STAFF WRITER

BODY:

A DECADE OF escalating violence at abortion clinics, culminating in the murder two weeks ago of a Florida physician, echoes a time earlier in the century during the struggle to legalize both abortion and **birth control.**

And then, Brooklyn was at the heart of the controversy.

During a lecture and slide presentation tomorrow night at 6:30 at the Brooklyn Historical Society, author Ellen Chesler will describe how, in 1916, feminist activist Margaret Sanger established the country's first **birth control** clinic, inside a storefront tenement in the Brownsville section of the borough.

"Unwittingly, Sanger controlled the course of birth control in America," Chesler said of the Brooklyn clinic during an interview last week. "Even today, birth control clinics are independent, nonprofit organizations rather than in hospitals."

An account of the clinic's weeks of existence before it was closed down and Sanger and her sister Ethel Byrne were imprisoned is included in Chesler's book, "Woman of Valor," a biography of Sanger published last year by Simon and Schuster.

According to Chesler, the Brownsville clinic was born during a time when condoms were illegal and women were routinely maimed by "birth control" douches made from Lysol and chlorine bleach. Though abortion was legal in the country until the early to mid-1800s, by that time a combination of the medical establishment, religious fundamentalists such as Anthony Comstock and others, succeeded in passing laws that banned abortion, birth control and pornography, which were lumped together as degenerate.

Chesler is quick to point out that though the laws did restrict a woman's right to choose, they also put an end to some level of medical quackery.

Sanger selected Brownsville for her clinic, Chesler said, because it, along with the Lower East Side, was the place where newly arrived immigrants lived and because it was a place of desperate poverty and language barriers. In poor communities such as this, she believed, the ability to limit family size could

greatly affect a family's well being.

"MOTHERS! CAN YOU AFFORD TO HAVE A LARGE FAMILY?" said a circular advertising the clinic in English, Yiddish and Italian. "DO YOU WANT ANY MORE CHILDREN? IF NOT, WHY DO YOU HAVE THEM?"

"Sanger believed that one of the reasons women were so downtrodden was because they couldn't control their fertility," Chesler said. "And they were constantly being infected and dying from illegal abortions and gynecological devices invented by quacks."

Under these conditions, "the women of Brownsville patiently stood in line for service," Chesler writes in her book, which lists the location of the clinic as Amboy Street near the corner of Pitkin Avenue. "There were 464 recorded clients during the several weeks the facility remained open. Surviving photographs show them handsomely attired in shirtwaists and billowing skirts. Draped in a shawl to protect against the autumn chill, one young mother hovers over a graceful wicker baby carriage in a romantic tableau that conceals the full dimension of the neighborhood's dispiriting poverty."

Sanger opened the clinic to test New York State's anti-birth-control laws on First Amendment grounds. For a 10- cent fee at the clinic, they provided birth control information and sex education. They were cautious not to dispense birth control devices but did have in their inventory the Mizpah Pessary, a device commonly available in pharmacies at the time and used by women with distended wombs. But the pessary could also be effective as a birth control device.

Before Sanger, birth control was awkwardly referred to by names such as "feminine hygiene" or "family limitation," Chesler said. "They didn't know what to call it."

GRAPHIC: 1) Sophia Smith Collection, Smith College photo- The Brownsville birth-control clinic, the first in the nation. 2) Photo- (A circular advertising an abortion clinic)

LANGUAGE: ENGLISH

LEVEL 1 - 45 OF 63 STORIES

July, 1989

SECTION: Vol. 8 ; No. 6 ; Pg. 114; ISSN: 0730-7004

LENGTH: 354 words

HEADLINE: Before **birth control:** unwanted children often abandoned by guilt-free parents; family report

BYLINE: Gilman, Lois

BODY:

Before **birth control**

Unwanted children were often abandoned by guilt-free parents

Modern family planning methods may be controversial. But as late as the 18th century, it was common for European parents to abandon their unwanted children. That's historian John Boswell's startling conclusion in The Kindness of Strangers: The Abandonment of Children in Western Europe from Late Antiquity to the Renaissance (Pantheon, $ 24.95). As Boswell puts it, "Abandonment was postnatal **birth control.**"

The children weren't abandoned with the expectation they'd die, Boswell thinks. Parents left them in public places, hoping they'd be picked up by strangers to be reared as their own. "Parents had specific hopes that their children would have a better life," he says.

The Romans believed it was noble to care for foundlings. After 400 A.D., growing concern about genealogy led adults to pretend the waits they reared were biologically theirs.

Boswell maintains that until the 14th century, the mortality rates of the abandoned were only a bit higher than contemporary death rates for other infants. But in the 1300's, foster care was supplanted by the foundling home. Disease ran rampant through the new institutions, and abandonment became synonymous with death. Those who survived were not much better off. Truly strangers in their own lands, foundlings had to make their way alone, lacking even an adoptive parent's last name to bind them to legitimate society.

"We tend to think there has been steady progress in family planning in Western society," says Boswell, "but in the Renaissance, things actually went backwards."

What is the 20th century parent to make of what seems like the heartless measures of the past? "We need to realize that in different times and places

there are and have been a great many different ways for parents to discharge what they regard as parental responsibility," says Boswell. As The Kindness of Strangers emphasizes, certain family problems transcend time and place: Like our forebears, we're still seeking a civilized way to deal with the burden of too many children.

IAC-NUMBER: IAC 07942699

IAC-CLASS: Health; Magazine

LANGUAGE: ENGLISH

LOAD-DATE: August 04, 1995

LEVEL 1 - 59 OF 63 STORIES

January, 1984

SECTION: Vol. 101 ; Pg. 30; ISSN: 0023-7124

LENGTH: 2220 words

HEADLINE: Women's health: the story of the century.

BYLINE: Weinhouse, Beth

BODY:
Women's Health

THE STORY OF THE CENTURY

The life they saved was yours

Imagine yourself a woman in 1883, about to give birth. Whether it's your first child or not (and chances are it isn't, since there is no effective **birth control** available), you are terrified, because you know that mothers and babies die in large numbers during delivery or soon afterward. For the last several months, you've been confined to your house, because it isn't considered proper for a pregnant woman to be seen in public. Now the contractions have started, and you've summoned a midwife to your home. If there are any complications, your midwife will be almost helpless; her function is mainly to offer emotional support and to help care for your family while you are bedridden.

If you are an exceptionally educated, enlightened woman, you might summon a physician to your home, or even enter a "women's hospital,' just starting to come into vogue. There, doctors dressed instreet clothes and with unwashed hands, unwashed instruments and barely rinsed sponges attend your delivery, spreading germs and infection. Puerperal infection (called childbed fever) is the leading cause of maternal death. The only anesthesia available is a rag soaked in chloroform or ether. If you have complications, your chances for a successful delivery are dismal, even in a hospital. Caesarean section is a dangerous operation, often fatal to the mother. The doctor's alternative is to remove the child whatever way possible . . . usually dead. As you recuperate from your delivery, you are not permitted even to sit up in bed until the sixth day and then for only two hours. You aren't allowed out of bed until the ninth day, and you're sent home on the tenth. If the birth was difficult, you may have to remain in the hospital for a number of weeks.

After you have recovered from this terrible ordeal, you can look forward to having another child soon . . . and another, and another. With luck, if you don't die in childbirth, you may reach the age of fifty--the average life

expectancy. With more luck, a few of your many children will live to adulthood (one in ten children dies before the first birthday).

The picture in 1883 was grim indeed, but even then there were a few hints of the more modern and enlightened health care to come . Primitive practices, such as bloodletting with leeches, or ovariotomies (operations to remove the ovaries, performed unnecessarily by many doctors to treat a variety of unrelated complaints, such as overeating and attempted suicide) were falling out of favor. The practice of washing hands and instruments before surgery was catching on with a few progressive doctors. And women were starting to realize that they didn't have to take to their beds each month during their menstrual periods.

But 1883 is perhaps most significant for the births of two people who would change the future of women's health care: George Papanicolaou, the physician who developed the Pap test to detect cervical cancer in its earliest stage; and Margaret Sanger, the nurse who became America's foremost advocate of birth control.

For many years after 1883, conditions changed little from those of the childbirth just described (with the exception of moderate improvements in hygiene within the hospitals). But after the turn of the centry there was an important leap in women's health care . . . and nurses brought about much of the change. Imagine their horror as they repeatedly and helplessly watched other women die giving birth. And imagine their frustration at being unable to help the "lucky' women who survived but suffered lacerations and other injuries during birth that would plague them for the rest of their lives. Nurses knew something had to be done, and their response was to introduce the concept of prenatal care, one of this century's most important contributions to women's health care.

Pregnant women in 1883 were not given any medical attention until they went into labor. They ate and drank what they pleased, and if they were poor, they often worked long hours in sweat shops right up until delivery and returned to work soon afterward. Pregnant women were not checked for high blood pressure or venereal disease, and they did not receive pelvic exams or blood and urine tests.

DEATH RATES DROP

Organized prenatal care in America began in Boston in 1901, when a group of concerned nurses, reacting to the growing body of knowledge on the importance of health care during pregnancy, began visiting some of the women enrolled in the home delivery service of the Boston Lying-In Hospital. By 1912, these nurses were visiting women an average of three times before delivery, teaching them how to take proper care of themselves during their pregnancies. The idea caught on in other parts of the county. Now instead of waiting, ignorant and terrified, pregnant women could actually participate in their own health care. This was truly a milestone for women. And in areas with these first prenatal programs, maternal-and infant-mortality rates began to decrease.

By this time, Margaret Sanger had begun her mission. A nurse herself, she had reacted to the plight of her sex differently. Working among the poor of New York City, Sanger was appalled to see women who were old and tired before forty because of their many pregnancies. What she found even more painful was having to watch women die from dangerous, illegal abortions they had turned to in

desperation. She was determined to be able to help these women when they begged her for a way to avoid further pregnancies.

Sanger studied contraceptive methods in Europe, and when she came back to America, she began to spread the word, using the term "birth control,' which she coined. Although Sanger was persecuted and prosecuted, she continued her work and passed contraceptive information on to as many women as she could. In 1917, she helped found the National Birth Control League, which eventually became the Planned Parenthood Federation of America. In the 1920s, the diaphragm became widely available. Gradually, women were gaining control of their bodies and being liberated from what Sanger saw as sexual servitude.

THE JOURNAL'S ROLE

What were male physicians doing for women's health care during this time? They were not passing out birth control devices or information. The male-dominated medical establishment was firmly opposed to the idea of birth control; in fact, the American Medical Association didn't even acknowledge the benefits of contraception until 1937. But doctors had begun to treat cervical cancer, for the first time, with radium--discovered by the Curies in 1898. Although the method was crude, it paved the way for today's more successful treatments.

How did people find out about these advances in medicine? The history of women's health care in this country is intertwined with the history of

Ladies' Home Journal. In 1913, LHJ published one of the first articles for the general public on cancer and the importance of early detection and treatment. The article was endorsed by the chairman of the Cancer Campaign Committee of the Congress of Surgeons of North America. Doctors had started to recognize that people could take considerable responsibility for their health.

Ladies' Home Journal continued to publish educational and historically important articles on health care. In 1936, a four-part series titled "Why Should Mothers Die?' charged that most childbed deaths could be prevented by more enlightened medical practices, such as scrupulous cleanliness to prevent infection. The article described, quite specifically, how the Chicago Maternity Center, "where mothers are almost one hundred percent safe,' had improved its care by, among other things, beginning prenatal care from the moment a woman reports her pregnancy and by aborting dangerous or high-risk pregnancies. (By World War II, the majority of the births took place in a hospital, not at home.)

Again, in the 1940s, the Journal's article "Killer of Women' about cervical cancer and the importance of the Pap smear helped to transform medicine. The Pap smear had been developed in the 1920s but had been practically ignored by physicians, who weren't interested in examining healthy, nonpregnant women. But after the Journal's article launched a media carpagin, women began to demand the simple test that could save their lives.

NEW HEALTH CHOICES

Women's health care progressed rapidly. By the 1950s, doctors were more confident about performing Caesarean sections--thanks to the availability of sulfa drugs and antibiotics to prevent infection, better anesthesia and new

surgical techniques. Also in the 1950s, LHJ readers by the hundreds wrote to the magazine protesting cruelty in the maternity wards, denouncing such hospital practices as: attempting to postpone delivery until the doctor arrived by holding the mother's legs together; refusing permission for a husband to stay with his wife during labor, much less accompany her into the delivery room; deny women a choice of general or local anesthesia, or none at all; refusing to answer questions or being unsympathetic about discomfort or pain. Again, women were demanding the right to competent and humane medical care.

By the 1960s, a myriad of health-care choices ushered in the modern era of women's medicine: the Pill went on the market; abortion and sterilization laws were liberalized; and use of local anesthetics for childbirth became common, so a woman could be aware of what was happening in the delivery room; or she could choose not to have anesthetic at all as natural childbirth became popular.

Today, all of us benefit from the knowledge gained over the last century. We now expect to be healthy, and we aggressively seek qualified medical care when we do not feel well. And, for the first time, the 24,000-member American College of Obstetricians and Gynecologists (an organization founded in 1951) has elected a woman president, Dr. Luella Klein.

"I don't think there's any question that women are healthier than ever before. Physiologically, our bodies are "younger' now at a given age than they were one hundred, or even twenty-five, years ago,' says Dr. Klein, who believes that effective birth control is the biggest single reason for the health we enjoy today. "Women are having fewer children now, and spacing their children further apart,' she says, "It's a big change from around the turn of the century, when women had one baby after another, and men usually buried a couple of wives.'

And Dr. Klein concurs that, besides birth control and improved medical technology, women themselves have brought about much of the positive change. Says Dr. Klein, "Women today are aware of proper nutrition, weight control, the importance of exercise, the value of a regular breast self-exam and a regular annual exam by a physician, including a Pap smear.'

Today, medical advances occur at an astonishing rate. "The whole field has changed as much in the last ten years as in all the time before,' claims Dr. Klein. She cites such achievements as in-office sterilization operations for both men and women and fertility research (such as artificial insemination, laser surgery and in-vitro or test-tube fertilization) which allows more couples to have children. And now almost any woman who wants to can have a baby. "Even high-risk women--older women, diabetics, women high blood pressure, spinal-injury victims--can be helped to have normal pregnancies,' says Dr. Klein.

Amniocentesis (removing and testing a small amount of fluid from the womb) can detect fetal abnormalities in very early stages of pregnancy. A brand-new test called chorion villus biopsy--in which a tiny piece of the tissue that attaches the placenta to the uterus is sampled--can detect birth defects as early as the eighth week of pregnancy. Ultrasound and other new "imaging' technologies allow doctors to see a baby while it is still in the womb--and even to treat it or operate on it if necessary. And in the field of cancer "we've had remarkable success treating cervical and endometrial cancer, and a vaginal and

vulva cancers,' says Dr. Klein.

NEW DIRECTIONS

And more than ever, women are determining their own health care. We no longer tolerate being treated like children by our physicians, or being told that our very real pains--of menstruation or of childbirth--are psychological. We demand information and often insist on second opinions. According to Dr. Klein, the increasing number of women physicians is also helping to change medicine. "Women doctors, I think, put somewhat more emphasis on prevention and health maintenance,' she says. "And there's a big advantage to being a woman in this field. For instance, I didn't have to be told dysmenorrhea menstrual cramps was real--I knew!' And young male doctors, who have gone through their medical training with women, have a different and better attitude, too.

As positive as all these changes are, and as lucky as we are to be living today, instead of one hundred years ago, there is still much research to be done. But, at the current rate of medical progress, it's likely that we will see many more exciting breakthroughs during our lifetime.

IAC-NUMBER: IAC 03070159

IAC-CLASS: Health; Magazine

LANGUAGE: ENGLISH

LOAD-DATE: June 28, 1995

LEVEL 1 - 61 OF 63 STORIES

The Washington Post

January 30, 1977, Sunday, Final Edition

SECTION: Book World; Brief Notices; E8

LENGTH: 318 words

HEADLINE: WOMAN'S BODY, WOMAN'S RIGHT;
A Social **History of Birth Control** in America

BYLINE: By Linda Gordon

BODY:

Birth control methods (some useless or even dangerous, others remarkably effective) have existed since ancient times, but have not always been put to use.

One explanation, according to Linda Gordon, a professor of history at the University of Massachusetts, is that strictures on **birth control** fluctuated according to social need. Among some nomadic people, where dependents were a liability, infanticide was practiced. In agricultural societies on the other hand, where many people were needed to get the work done, prohibitions on **birth control** were strict.

But the main reason women have not made more use of birth control, Gordon maintains, is their poor attitude toward themselves. In other words: "Birth control use is more a measure of women's increased self-esteem and sense of opportunity than a cause of it." The modern birth control movement beginning in the late 19th century was thus an arduous struggle from within as much as from without - against fear, superstition, ignorance and prejudice.

In appraising the gains of the birth control movement over the last hundred years, Gordon points out that women still must rely on faulty if not dangerous methods - the Pill and IUDs - anc concludes that the only real achievement of the movement so far has been the legalization of abortion. Certainly she understates the advances in the understanding of female physiology which, along with improved techniques, have given women more control than ever before. But she argues very persuasively that while control over reproduction is fundamental, it is only a first step toward sexual equality.

This book is filled with provocative ideas and facts which will dispel many conventional notions on the subject. It's a shame that few readers will be tempted to forage through the thicket of dull, turgid writing in which they are hidden. (Grossman/Viking, $12.50)

Carol L. Eron

GRAPHIC: Illustration, no caption, by Grandville

LANGUAGE: ENGLISH

Parenthood Federation; **Zimbabwe**, Women's Action Group.

Summary Points

- Adolescents, broadly defined as 10-19-year-olds, account for one-fifth of the world's people. In 1995, they numbered nearly 1.1 billion—913 million in developing countries and 160 million in developed countries.
- Worldwide, approximately 15 million births occur among adolescent women each year. They account for slightly more than 10% of all births.
- The higher a woman's level of education, the more likely she is to delay marriage and childbearing.
- Women aged 15-19 are two to three times more likely than women aged 40-44 to have at least seven years of education.
- In the past 20-30 years, adolescent childbearing has declined in many countries of Asia, North Africa and the Middle East. However, 30% or more of young women in Latin America and 50-60% in Sub-Saharan Africa still have their first child bef ore the age of 20.

Policy Implications

- Provide parents of adolescents with information and support that will help them to guide their children into adulthood.
- Continue to increase the accessibility of schooling for all young people, but especially for girls and young women.
- Help young people understand the possible consequences of sexual relationships and encourage them to take responsibility for their actions.
- Institute sex education in schools without such programs and improve and expand on existing efforts.
- Permit and encourage pregnant adolescents to attend school—during pregnancy as well as after birth.
- Raise awareness of sexual abuse and train providers to identify and counsel youth subjected to sexual violence.
- Initiate educational and mass media programs that explain the value of postponing childbearing beyond adolescence.
- Improve access to affordable contraceptive services that enable young people who are sexually active, both married and unmarried, to prevent unwanted pregnancies.
- Emphasize the importance of preventing STDs, including AIDS, and alert adolescents to the consequences of such infections.
- Provide pregnant adolescents, married and unmarried, with access to prenatal care.
- Implement the abortion sections of the Programme of Action of the International Conference on Population and Development and the Platform for Action of the Fourth World Conference on Women, which state that where abortion is not against the law, it sh ould be safe and accessible; that women should have access to quality services for the management of complications arising from abortion; and that countries should consider reviewing laws that punish women who have undergone illegal abortion s.[10]

HEADLINE: HILLARY CLINTON PUSHES EQUALITY IN S. AMERICA / CALLS FOR EXPANDING
WOMEN'S LEGAL, POLITICAL, MEDICAL RIGHTS

BYLINE: By William Douglas. WASHINGTON BUREAU

DATELINE: Buenos Aires

BODY:

Buenos Aires - In a country where the name of the late first lady Eva Peron still elicits cheers, first lady Hillary Rodham Clinton yesterday drew applause by calling for an expansion of legal, political and medical rights for women.

Democracy will thrive, Clinton said, "when women are not barred by law, by ignorance, by tradition or by intimidation" from making their voices heard at the ballot box and in society.

"In short, empowering even more women to seek and claim their rights as citizens and as human beings will ensure that democracies - old and new - survive and thrive in the Twenty-First Century," she told an audience at a packed opera house.

While the president has used this trip to Venezuela, Brazil and Argentina to push for more free trade within Latin America, the first lady has participated in events that highlight the plight of women and children in the region.

In Caracas, Venezuela, she met with women who are trying to work their way out of poverty through modest, government-sponsored loans. In Brazil, she traveled to a poor neighborhood school whose students are receiving help through a corporate sponsorship program. Following her speech yesterday, Clinton met privately with members of Mothers of the Plaza de Mayo, women whose relatives - a total of 30,000 - disappeared during the military dictatorship here from 1976 to 1983.

During her address, Clinton described empowerment as "being able to lead lives free of sexual and domestic violence. And it means access to justice under law, to education, to health care, to credit and property ownership."

Clinton also spoke of personal empowerment and the need to respect a woman's right to choose her own path, whether it's as a married, full-time homemaker or a full-time career woman.

"It should no longer be a one-size-fits-all prescription for the way a

woman's life should be lived," Clinton said.

Newsday (New York, NY), October 17, 1997

The first lady made her remarks at the Colon Theater in an appearance sponsored by Argentina's National Federation for Women. The audience of 1,200 was one of the most enthusiastic crowds that she and the president have encountered on their their seven-day, three nation Latin American tour.

Hillary Clinton expressed awe about speaking on a stage graced by the likes of legendary singers Enrico Caruso and Maria Callas. The first lady received enthusiastic applause when she called domestic violence criminal, not cultural, and cited access to family planning and reproductive health services as critical "to advancing the progress of women."

Clinton did not state her position on abortion. In a country that is 92 percent Catholic, the only time she used the word abortion was in describing a decline in the number of such procedures at a family planning program in Salvador de Bahia, Brazil.

But spokeswoman Marsha Berry said that when Clinton talks about family planning and reproductive rights, that includes abortion.

Still, some abortion rights advocates here accepted Clinton's comments as support in their battle to get abortion legalized here.

"I liked what she had to say because she emphasized reproductive rights," said Mabel Bianco, president of Argentina's Foundation for the Study and Resarch of Women. "It will help us as we are fighting in this country for reproductive rights."

When Clinton finished her speech, fliers streamed from the upper boxes that read in Spanish, "In Argentina each day, more than 1,000 women commit abortion in secrecy. Each day, one woman dies from it." The fliers demanded access to "safe and efficient" anti-contraception methods and "legal abortion in order not to die."

Before joining her husband on this tour, Hillary Clinton visited Panama. The first lady has kept an active schedule since Chelsea Clinton, their only child, left home to attend Stanford University last month.

"I am, as you may know, an empty-nest mother now," said Clinton, who turns 50 next week. "I called my daughter last night to tell her that I had seen just a small sample of tango because she loves dance in all forms and wrote a paper in

Latin American history on tango and its origin."

GRAPHIC: 1) AP Photo-Hillary Rodham Clinton greets the audience yesterday at the Colon Theater in Buenos Aires. 2) Agence France-Presse Photo-Buenos Aires Mayor Fernando De La Rua presents President Bill Clinton with a key to the city in a ceremony at Plaza San Martin. Meanwhile, Hillary Rodham Clinton was cheered for touting women's rights in the Argentine capital. (p. A04 NS)

LANGUAGE: English

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DATE: JANUARY 8, 1999

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HEADLINE (HILLARY CLINTON AND ABORTION)

1ST STORY of Level 1 printed in FULL format.

Los Angeles Times

July 2, 1998, Thursday, Home Edition

SECTION: Part A; Page 16; Foreign Desk

LENGTH: 898 words

HEADLINE: THE PRESIDENT IN CHINA;
FIRST LADY AGAIN SOUNDS THEMES FOR WOMEN'S RIGHTS;
DIPLOMACY: IN LOCAL GATHERINGS, HILLARY CLINTON DISCUSSES EMPOWERMENT AND
CRITICIZES BEIJING'S ABORTION POLICIES.

BYLINE: JONATHAN PETERSON, TIMES STAFF WRITER

DATELINE: SHANGHAI

BODY:

At a restored synagogue here, she admired a Torah to highlight American support for freedom of religion in China. At a medical center in Beijing, she applauded Chinese research on spina bifida and other birth defects.

And in this city's modern library Wednesday, she played on the popular aphorism that "women hold up half the sky," taking aim at China's practices of forced abortion and sterilization to limit family size.

"Women can't hold up half the sky," declared Hillary Rodham Clinton, "if they are denied the freedom to plan their own families."

A world away from the embarrassments of the investigation into Monica Lewinsky's alleged relationship with her husband or even lingering fallout from the Paula Jones sexual harassment case, the first lady is conducting a China trip of her own. It is much lower key than that of the president, with whom she has appeared across China, typically taking the background role expected of a leader's spouse.

Yet Mrs. Clinton also has managed to fit in a round of her own appearances, often reflecting her cherished themes of women's rights, children's well-being and health care.

At these local gatherings, she has heard Chinese women speak candidly about abusive husbands, exploitative employers, housing woes of divorcees and the need for education in China's increasingly unregulated economy.

In a village near the Chinese city of Xian, a professor told her that some families now sell their donkeys so their daughters can afford college tuition. Mrs. Clinton later lamented at another appearance that many able young women "may not have a family to sell a donkey" to pay for their schooling.

In sub-Saharan Africa, the former Soviet Union, Eastern Europe, northern Thailand, the Philippines and the Andes Mountains of South America, this first lady has made a practice of seeking out those sorts of conversations, always in the hope of gleaning a little bit of insight that might be put to wider use.

"She's always gone out of her way to meet with women and girls," Melanne Verveer, the first lady's chief of staff, said as Mrs. Clinton, with daughter Chelsea and Secretary of State Madeleine Albright, observed exhibits in the old synagogue. "What she's often said," Verveer continued, "is that we face common challenges."

Sometimes she is the one facing challenges--to make the best of a situation engineered by well-meaning foreign hosts. In a stifling, overcrowded legal conference room in Beijing, where microphones were spewing out ear-splitting feedback, Mrs. Clinton settled into the chair reserved in her honor--the biggest and cushiest--only to sink and sink until she sat half a head lower than everyone around her.

Still, she remained composed and kept the conversation moving, earnestly asking one participant for examples of "major important cases" that the legal center has handled. At another point, she wanted to know how a client had "found her way to the center to seek legal assistance."

If Americans are divided in their views of the first lady, the Chinese have mixed feelings too. While often speaking of her in admiring tones, in random interviews some also seemed taken aback by her unabashedly modern style.

"She is very able, very aggressive as a lawyer," said a woman in her late 20s who identified herself as Miss Tang. "She is totally unlike any of the Chinese leaders' wives."

A career woman in her mid-40s, who, like many in this nation unaccustomed to freedom of expression, declined to provide any name, observed of Mrs. Clinton: "She is a lawyer and a politician. She may be a good partner, but I don't know if she is a good wife and mother. For most of the people, it is very hard to make a balance."

While the president's movements require a huge motorcade and bring a retinue of staffers and press that can impart a circus-like atmosphere to events, Mrs. Clinton can maneuver a bit more easily, accompanied typically by just a few staffers.

In China, her appearances have included participating in a round-table at Beijing University, meeting with physicians from the Beijing Medical Center and the U.S. Centers for Disease Control and Prevention, as well as visiting a girls school and retraining center in Shanghai.

It was in Beijing in 1995, at the United Nations Fourth World Conference on Women, that she delivered a well-received speech, replete with implied criticism of the Beijing regime for its policies of forced abortion.

That appearance made a big impression on Mrs. Clinton and her close aides. "While we spoke different languages and came from different places, we shared a universal belief--that women's rights are human rights and that human rights are women's rights," Mrs. Clinton on Wednesday recalled of the U.N. conference.

Los Angeles Times July 2, 1998, Thursday,

In her remarks at the Shanghai library, which aides had described in some ways as a sequel to the 1995 address, Mrs. Clinton said that progress for society depends broadly on women "having equal access to life's tools of opportunity" such as medical care, education, employment and legal rights. "Only when we create a world where every citizen enjoys fundamental freedoms and every child is valued and given equal opportunities--then, and only then, will we be able to say with honesty, 'Yes, women hold up half the sky.' "

Times staff writers Maggie Farley and Tyler Marshall contributed to this report.

GRAPHIC: PHOTO: Hillary Rodham Clinton listens to Rabbi Arthur Schneider during tour of restored synagogue in Shanghai. PHOTOGRAPHER: Reuters

LANGUAGE: English

The Associated Press

January 22, 1997, Wednesday, AM cycle

SECTION: Washington Dateline

LENGTH: 483 words

HEADLINE: Gore, Hillary Clinton defend abortion rights

BYLINE: By JAMES ROWLEY, Associated Press Writer

DATELINE: WASHINGTON

BODY:

The 24th anniversary of the Supreme Court's landmark decision legalizing abortion was marked Wednesday by protest, a bomb scare and condemnation of anti-abortion terrorism by Vice President Al Gore.

"To those who committed the horrible deeds of Tulsa and Atlanta, I say this ... the American people will not tolerate your cowardly crusade," Gore said of recent abortion-clinic bombings in those cities.

As he and first lady Hillary Rodham Clinton spoke to the National Abortion and Reproductive Rights Action League, tens of thousands of abortion opponents rallied near the White House, then marched to Capitol Hill to protest the Supreme Court's 1973 Roe vs. Wade decision.

The marchers included many schoolchildren, seminarians wearing long black robes bearing religious icons and busloads of members of the Knights of Columbus, a Catholic men's group.

Randall Terry, leader of the anti-abortion Operation Rescue group, told marchers their job was to "carry the banner of resistance and replace evil politicians."

At a rally on the Ellipse, freshman Rep. Kenny Hulshof, R-Mo., voiced concern that Gore and Mrs. Clinton would "point to random acts of violence in an effort to taint our worthy cause.

"But just as we must call for an end to violence outside those clinics, let us continue to pray for an end to the violence inside those clinics," Hulshof said.

Protest leaders vowed to push legislation to ban a late-term procedure known as a "partial-birth" abortion. Clinton vetoed a bill passed by Congress last year to outlaw the procedure, and Republican leaders vow to bring up the measure again this year.

The anniversary got off to a shaky start several hours before the speeches when a worker at the hotel where Gore and Mrs. Clinton appeared found a small fusing device used in grenade training. The device, with less force than many firecrackers, went off in the employee's hand two blocks from the hotel.

Police said there was no evidence the incident was related to the abortion controversy, even though it was found within a block of a Planned Parenthood clinic.

Gore, referring to earlier clinic bombings, said the administration would "find the terrorists who committed these heinous acts and we will pursue you to the fullest extent of the law."

Mrs. Clinton voiced hope for a dialogue with abortion opponents - "people of good faith who do not share extremism as their rallying cry."

Gore also said there is room for people on both sides of the issue to work together, but pledged, "We will not allow a woman's right to choose to be taken away."

NARAL President Kate Michelman told supporters that the right to obtain an abortion remained under attack, citing restrictions adopted by states.

Combined with the threat of violence, restrictive laws mean "it's not a safe place in America today for a woman to obtain an abortion she needs," Michelman said.

LANGUAGE: ENGLISH

September 5, 1995

SECTION: SPOTLIGHT STORY

LENGTH: 1027 words

HEADLINE: HILLARY CLINTON: LASHES OUT OVER ABORTION AND STERILIZATION

BODY:
On 9/5, in her first public appearance at the U.N.'s Fourth World Conference on Women in Beijing, Hillary Rodham Clinton

"lashed out" at gov't-coerced sterilization and abortions that are "practiced widely" in China and other developing countries. But the first lady did not mention China or any other country specifically by name in her speech. Her comments "echoed" those of many critics of China's family-planning programs who claim that abortion and sterilization are used as gov't-sponsored birth-control techniques, often against the will of women. H.R. Clinton, in her speech, "Women and men must also have the right to make the most intimate of all decisions free of discrimination, coercion and violence, particularly any coercive practices that force women into abortions or sterilizations" (Farley/Tempest, L.A. TIMES, 9/5). NPR's Mary Kay Magistad: "Hillary Clinton minced no words in expressing her discontent about the way China has handled some of its duties as host of the U.N. Women's Conference and of the companion nongovernmental forum. ... Mrs. Clinton said in her speech that women must enjoy the right to participate fully in the social and political lives of their countries." H.R. Clinton: "Let me be clear. Freedom means the right of people to assemble, organize and debate openly. It means respecting the views of those who may disagree with the views of their government" (9/5). ABC's Compton: "This was something of a watershed moment for Mrs. Clinton. She has tangled on domestic policy before, but never on delicate foreign policy" ("GMA," 9/5). Clinton also called for increased access to health-care and family-planning services for the world's women. Her comments are "likely to please" factions of Congress which have urged the first lady to use the Beijing conference and a platform to condemn human-rights abuses. Pro-life Rep. Chris Smith (R-NJ) held a press conference on 9/4 calling for H.R. Clinton to make such a "condemnation." Smith is part of the 44-member U.S. delegation and has accused the Chinese of conducting thousands of "forced abortions and forced sterilizations." He had attempted to cut funding for the trip, but when he failed, Smith joined the delegation so he could speak out publicly in China (L.A. TIMES, 9/5).

WHAT SHE HAS TO SAY: H.R. Clinton headed to Beijing "amid criticism" that the Chinese will use her presence to "whitewash" human rights abuses. But the first lady also used her weekly column to "take a shot" at critics who have called the conference a "radical gathering" (Ball, N.Y. DAILY NEWS, 9/4). The first lady said nothing about the "international outrage" over China's

behavior as "ungracious host." H.R. Clinton writes, "It saddens me that a historic event like this is being misconstrued by a small but vocal group of critics trying to spread the notion that the U.N. gathering is really the work of radicals and atheists bent on destroying our families" (Orin, N.Y. POST, 9/4). WH press sec Mike McCurry on H.R. Clinton: "She is not going there to extend the diplomatic dialogue with China." But some political analysts and Clinton critics said that the first lady's decision to go will have an "enormous impact" on the "troubled" U.S.-Sino relationship (Nelkirk, CHICAGO TRIBUNE, 9/3). The first lady will be continuing on to Mongolia after her time in Beijing. WH spokesperson Neel Latimore said that H.R. Clinton was "encouraged" by the State Dept. to visit the new democracy and her focus will be on women, children and families (AP/MIAMI HERALD, 8/31).

RAMIFICATIONS: H.R. Clinton's decision to attend the conference sent a "strong signal" to the political world that H.R. Clinton, after a "relatively low" profile since the '94 elections, has "re-emerged in the domestic public arena with full force." Princeton Univ.'s Fred Greenstein: "She's always been in and out. Like phases in the moon, she's moving toward full moon again." But Univ./WI's Charles Jones said that Clinton's trip triggers old perceptions that the first lady plays a "too-dominant, too influential role" in the Clinton admin. Jones added that if relations improve with China many Americans will jump to the conclusion that H.R. Clinton played a behind-the-scenes role. Additionally, conservatives would likely become "energized" if H.R. Clinton became vocal on issues like abortion and other women's issues. Dem political consultant David Walker said that "people who liked Hillary before are going to like her now. People who hated her before are going to hate her. That is not changing because of China. This provides fodder for conservatives but endears her to liberals" (TRIBUNE, 9/3).

LANGUAGE: ENGLISH

LOAD-DATE: September 5, 1995

11TH STORY of Level 1 printed in FULL format.

The Commercial Appeal (Memphis)

September 24, 1993, Friday, FINAL EDITION

SECTION: NEWS, Pg. A9

LENGTH: 299 words

HEADLINE: HILLARY CLINTON EXPECTS PLANS TO OFFER ABORTION

BYLINE: Reuters

DATELINE: WASHINGTON

BODY:

First lady Hillary Rodham Clinton, an architect of President Clinton's health care reforms, said Thursday she expected most new health plans would offer abortion services.

"I believe in legal abortion; I believe in safe abortion; but I want abortions to be rarer than they are now. And we think through this plan, which emphasizes family planning, we will get to that point," Mrs. Clinton said in an interview with CNN.

"Abortion services will be available in most plans as they currently are in most insurance company plans. But there will be plans that for conscience-exemption reasons will be exempt," she said.

The abortion issue is certain to be a flashpoint in Congress and among religious and social interest groups in the coming year.

Mrs. Clinton said the increased access to medical care for women contained in the health plan would help more women receive family planning counseling and medical help to prevent unwanted pregnancy.

The conscience exemption would allow health plans and doctors to decline to perform abortion. As administration aides have described it in recent weeks, the health proposal guarantees a woman's right to reproductive services, but does not specifically mention abortion.

Clinton's lack of specificity on this issue has left abortion rights

suppporters and opponents at loggerheads over what the proposal actually means for women. Both camps said Thursday they would mount major advertising and phone pressure campaigns aimed at influencing congressional action on Clinton's plan.

Under the health care reform proposals, "We are not increasing the availability or decreasing the availability of abortion," Mrs. Clinton said.

"We are trying to really strike a balance so that we provide what is available now," she said.

LOAD-DATE: March 25, 1996

WHITE HOUSE

Office of the Press Secretary

For Immediate Release June 19, 1995

Remarks by First Lady Hillary Rodham Clinton at Mother Teresa's Home for Infant Children Washington, D.C.

MRS. CLINTON: Thank you all. Thank you very much. And I too am so pleased that this day has come, and it has come with the support, and caring, and love and contributions of so many people. I want to begin by thanking His Eminence, Cardinal Hickey, Monsignor Duffy, Sister Sylvia, Mayor Barry, Congresswoman Norton, and all who have participated in bringing this day to fruition. I also want again to greet and thank Mother Teresa. We take great inspiration from your work and from your ceaseless pursuit of what you believe in.

Earlier I was speaking with Mother and she looked at me and said, "This is a gift of love but I've been told I cannot give the gift of peace because I don't give peace to anyone." And I told her that one of my favorite sayings from another woman whom I admired, Eleanor Roosevelt, when she too would be criticized for pursuing what she believed in, she would often say, "I consider my job to comfort the afflicted and to afflict the comfortable." And so today we have one of those rare moments when the afflicted and the comfortable come together on behalf of the future.

I'm often asked what it is I would like to see happen above all else in our country and in our world and there are so many things to wish for, aren't there? So many things to pray for, so many things to work for. But certainly at the top of my answer would be a world in which all boys and girls are loved and cared for. First, by the families into which they are born, then into families-- if those families are not able to take care of them, and assume the responsibilities for raising them-- then by extended families and by really the family of us all who more and more we have to recognize are all interconnected. And then, finally, by the families that those boys and girls grow up in, whom they in turn invest with love and caring to create societies that value every single child as a gift to be nurtured.

We know we are a long way from that even in our own country, and some days I fear we are retreating from that vision instead of moving toward it. But we have to continue to work to build

those kinds of conditions for every child. That is why most of us, I believe, are here today because we do recognize our own blessings and we do believe that each of us has a responsibility, not only to our own children, but to all children.

When I visited the home run by the Missionaries of Charity in New Delhi, I was struck forcefully by the love that emanated from every corner of that building. Near it was a home that wouldn't pass inspection in any town in America. There were too many cribs with too many babies too close together. I am sure there were not enough toilets or enough space for what was being done there, by some kind of regulatory formula, but all I knew was that there was enormous love and care and concern being given to those children. You can sense it when you walk into buildings where children are cared for, can't you? You can feel the difference when you walk in the door of a child care center, school, or a hospital, or a shelter where children are cared for and you can know in the gut of your soul whether or not you would leave your own child there.

That is the test for every single facility that we have for any child in America. I call it the "Chelsea test." Some of you might call it the Jane or the Jack or the Mary or the Charles test. But that should be the test. So by that test this house passes with flying colors. You can already sense it is a place where not only those who come here get the care and love they need but it will have ripple effects throughout this neighborhood and community.

This has been about 16 months of hard work. As the Cardinal said, I first spoke with Mother Teresa about this after the National Prayer Breakfast and then we both agreed that each of us could work together to help promote better conditions for our children, that each of us could do what we believe our own purpose sets us to doing, and that we could, by working together, create this opportunity.

The truth is that this is just a beginning and it will grow and have meaning in people's lives as lives here are saved and changed and allowed to go forward. I'm particularly pleased that this house will serve as a place from which children will be adopted under the responsibility of Catholic Charities, and I would personally plead that everyone who knows of this house, everyone who knows of other places like it, will do all that can be done to promote adoption of the children here in our own country. We have more than 400,000 children languishing in foster care in America.

Many parents are discouraged from adopting because of the high profile cases that unfortunately demonstrate that on a rare occasion an adoptive family may not be able to keep the child whom they have adopted. Those are rare occurences. They should

not be permitted to discourage Americans from adopting American babies and children. So please use this occasion to do all that you can to promote adoption, not only of the babies who will come here, but of all babies and children. They all deserve homes and families in America today.

I want to join in thanking Mayor Barry and the District government and especially Hampton Cross, who worked miracles. It is not easy under any circumstances to get the necessary permission to do this and I join in the Mayor's plea that the example of this house will serve as an example for the rest of the District government so that we can all begin to cut through red tape on behalf of human needs and services for our people.

I also want to commend Catholic Charities for forming a partnership with the Sisters on behalf of children in this district and I want to thank the lawyers who worked so hard donating their time. Many more hours than they ever thought when they agreed to do this to bring about all of the necessary changes that were required. I particularly want to thank Marna Tucker and Debbie Pollock for your countless hours of help on behalf of this effort. And I also want to say a personal word of thanks to Melanne Verveer on my staff for helping to coordinate this effort.

Let me end by saying that this home will be an extraordinary place for the children and mothers who come here I know that it will serve as an example of what all of us can do if we're willing to work on behalf of one another and particularly on behalf of our children. I want to thank Mother Teresa for this gift of love and for the work that she and the Sisters are doing throughout our community here in America and around the world.

It is my hope that all of us will think in our own ways about what else each of us can do to ease the passage, to help soothe the troubles of people around us. There is so much need and as we rethink what government's responsibility is let's remember we are our government. In a democracy, there is no "us" and "them" and if we say we want government to do things other than what it has been doing in providing direct services to people, then we have to govern ourselves in such a way that we make up the difference. Otherwise we will live to see a society in which our dreams for all of our children, instead of becoming closer to a reality, recedes further and further away and that on this day is something none of us should want to see happen. Thank you all for being part of this.

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ALAN F. GUTTMACHER 1898-1974

The Alan Guttmacher Institute, an independent, nonprofit, tax-exempt organization with offices in New York and Washington, D.C., was established in 1968 to provide research, policy analysis and education in the fields of reproductive health, reproductive rights and population. It was named to honor a distinguished obstetrician-gynecologist, author and leader in reproductive rights. While Alan F. Guttmacher was president of the Planned Parenthood Federation of America and a leader in the International Planned Parenthood Federation in the 1960s and early 1970s, he saw the need for the institution that now bears his name, and he nurtured its development.

The entry in *Who's Who* is factual, terse:

Guttmacher, Alan Frank, physician; b. Balt., May 19, 1898; s. Adolf and Laura (Oppenheimer) G.; A.B., Johns Hopkins, 1919, M.D., 1923; D.Sc. (hon.), Brandeis U., Dartmouth Coll., 1970; m. Leonore Gidding, July 22, 1925; children—Ann (Mrs. Robert Loeb), Sally (Mrs. Eric Holtzman), Susan (Mrs. Ben Green). Intern Johns Hopkins Hosp., 1925–26; asst. in anatomy Johns Hopkins, 1923–24, U. Rochester, 1924–25; various positions from resident to asso. prof. obstetrics Johns Hopkins, 1926–52; practice medicine, specializing in obstetrics and gynecology, Balt., 1929–52, N.Y.C., 1952—; former chief obstetrics and gynecology Mt. Sinai Hosp.; emeritus prof. obstetrics-gynecology Mt. Sinai Med. Sch.; vis. prof. Einstein Med. Sch. Pres. Planned Parenthood Fedn., 1962; bd. dirs. Margaret Sanger Research Bur. Recipient Lasker award, 1947; Bronfman award, 1970. Diplomate Am. Bd. Obstetrics and Gynecology. Fellow Assn. Obstetrics and Gynecology, N.Y. Acad. Medicine, N.Y. Obstet. Soc. (past pres.). Author: *Life in the Making*, 1933; *Into This Universe*, 1937; *Pregnancy and Birth*, 1957; *Babies by Choice or Chance*, 1959; (with J. Rovinsky, Williams, Wilkins) *Complications of Pregnancy*, rev., 1965; *Complete Book of Birth Control*, 1961; *Planning Your Family*, 1964; *Birth Control and Love*, 1969; *Understanding Sex*, 1970. Home: 1185 Park Av New York City NY 10028 Office: 810 7th Av New York City NY 10019

It describes a man who lived a long and eventful life, but conveys neither a sense of him as a person nor of his place in history. To those who worked with him, Alan Guttmacher was:

Inspired leader
Patient teacher
Reluctant boss
Irreverent skeptic
Indignant advocate

Irrepressible boat-rocker
Old Testament prophet
Compassionate friend.

And much more. He never was comfortable with the complexities of organizational life or the ways of bureaucracies; yet no one was better able to unite the Planned Parenthood organization or summon it to carry out its historic mission. He looked like an old-fashioned man and had a penchant for old-fashioned virtues; yet his rapport with teenagers was magnificent and he refused, as he put it, "to acknowledge the immutability of the present." He abhorred the cant which, in his experience, was often associated with power; yet more than most he was able to move the powerful. He was given to strong opinions and direct relationships; but even those with whom he sharply disagreed walked away from the encounter respecting and loving him. He was enraged by injustice and hypocrisy and impatient with the glacial pace of progress; yet he knew that each fear of change, however irrational, must be dealt with, and that a revolution is composed of a thousand steps, most of them small. Never for a moment did we doubt that we were in the presence of an authentic and special human being.

"At heart I am a teacher; teaching gives me more satisfaction than any other activity. It makes little

difference whether the students are in the primary grades, high school, college, or graduate school."

He spent his life as a physician, specializing in obstetrics and gynecology, and later concentrated on the voluntary control of fertility. But the unifying principle of this life was a broad concept of social medicine and of the social use of knowledge. He saw medicine as a humanistic profession at the service of the people, assisting in meeting their personal needs and at the same time contributing to the solution of society's problems. While others were obsessed with a supposed conflict between the personal and the societal, he found the dichotomy itself spurious. We may not know if taking care of the personal needs of individuals will "solve" the problems of poverty and population, he would say, but who knows what would? We know it is doable, now, he argued, and if each person received the respect and dignity he deserves, it could not but have a significant effect on the larger problems.

In the early 1930s, long before it became fashionable, he decided that women had the right to a

straightforward account of what they could anticipate in pregnancy, that the useful knowledge hoarded by organized medicine had to be demystified and made more generally available. He began to write a series of books, revised periodically over four decades as medical knowledge grew, which were read and reread by three generations of young women who wanted to manage pregnancy, delivery and aftercare successfully. In 1961, he broke ground by authoring the first paperback on birth control, the forerunner of dozens of popular books and pamphlets which were to follow. Today he might be described as a premature "consumer advocate," a pioneer in "informed consent" and an early voice in support of women's right to know about and control their bodies. But when Alan Guttmacher began his educational program for American women, he received few plaudits from his colleagues, some of whom viewed writing for the laity as professionally disreputable.

"No woman is completely free unless she is wholly capable of controlling her fertility;

and...no baby receives its full birthright unless it is born gleefully wanted by its parents."

He joined the birth control movement in the 1920s when he was an intern, after witnessing a woman die from a botched abortion. In Baltimore, he was an effective advocate, organizer and worker for family planning at The Johns Hopkins and Sinai Hospitals and the Planned Parenthood affiliate. Following his appointment as Director of Obstetrics and Gynecology at New York's Mt. Sinai Hospital in 1952, he assumed increasing leadership of the national Planned Parenthood organization, first as member, then as volunteer chairman of Planned Parenthood's National Medical Committee and, in 1962, as full-time national President. In the 1960s he took major responsibility for the work of the International Planned Parenthood Federation, serving as chairman of its Medical Committee and travelling to scores of Asian, African and Latin American nations to lecture to physicians, work with program personnel, talk with ordinary people and meet with heads of state.

His whirlwind schedule would have exhausted younger men. His actions were informed by a pervasive social consciousness: his purpose, to end discrimination in medical care based on class or race, to set things right. Almost as soon as he arrived in New York he was appalled to learn that the city's municipal hospitals, which provided the bulk of medical care for the poor, prohibited physicians from prescribing contraception. In the mid-1950s, Alan Guttmacher and a handful of colleagues laid the groundwork for the public campaign in 1958 to end the unwritten ban. His role was to persuade, cajole, badger, shame—through any and every legal means—to rally the city's sometimes reluctant medical leadership to change what he regarded as a discriminatory practice which disgraced his beloved profession. The campaign he led succeeded beyond the most optimistic hopes of those of us who participated. It established the policy framework for the provision of family planning services by public health agencies throughout the country in the 1960s.

"While flying, I work at frenzied pitch, either writing or studying. There must be something about a cabin pressurized at 5,000 feet or the absence of a telephone which stimulates my adrenal glands."

He travelled to Washington innumerable times in the last decade to appear before Congressional committees and meet with Administration officials. Whenever he was asked for help, he gave assistance generously. And he made a difference. In 1966, he put the issue before the country simply and squarely:

"We really have the opportunity now to extend free choice in family planning to all Americans, regardless of social status, and to demonstrate to the rest of the world how it can be done. It's time we got on with the job."

Fortunately, he lived long enough to see the national family planning program—which now includes thousands of hospitals, health departments and community agencies—make rapid strides toward this goal. He had the satisfaction of witnessing many of the principles of voluntary fertility control to which he devoted his life inscribed in the law of the land by the U.S. Supreme Count in the Griswold and Baird cases on contraception and the Wade and Bolton cases on abortion.

To those of us who worked with Alan Guttmacher, it has been an exalting experience. We shall miss him deeply. We have been privileged to know and work with a rare human being. We can pay Alan F. Guttmacher the homage and respect he richly deserves by completing the social changes for which he fought and by building a society in which every child is wanted, loved, healthy and brought into the world with the best care that modern medicine can offer.

Frederick S. Jaffe
March 20, 1974

Reprinted from *Family Planning Perspectives*, 1974, 6(1): 1-2;
Frederick S. Jaffe was the first president of the Alan Guttmacher Institute, from its founding in 1968 until his death in 1978.

Quotes from the writings of Alan F. Guttmacher.
Photos courtesy of Ann Guttmacher Loeb.

FINANCIAL STATEMENT

Statement of Financial Position

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release October 15, 1998

Promoting School Safety, Preventing Youth Violence and Encouraging Learning

-- The Clinton Administration Record --

Making Our Schools and Communities Safer and Drug-Free

Forging School-Based Partnerships Between Schools and Law Enforcement. Under the new School-Based Partnerships grant program, the Clinton Administration released $16.4 million in grants to 155 law enforcement agencies in September. The School-Based Partnerships grants will be used by policing agencies to work with schools and community-based organizations to address crime at and around schools. This initiative emphasizes using principles of community policing and problem-solving methods to address the causes of school-related crime. The grants will help forge or strengthen partnerships between local law enforcement and schools to focus on school crime, drug use and discipline problems.

Helping Teachers and Principals Respond to the Early Warning Signs of Troubled Youth. President Clinton directed the Secretary of Education and the Attorney General to develop a guide to help teachers and principals identify and respond to the early warning signs of troubled youth that can lead to school violence. In August 1998, the Departments of Justice and Education released Early Warning, Timely Response: A Guide to Safe Schools. This guide provides schools and communities with information on how to identify the early warning signs and take action steps to prevent and respond to school violence. Every school in the nation received a copy of the guide.

Issuing the First Annual Report on School Safety. In December 1997, President Clinton called for an Annual Report on School Safety, which will be released on October 15, 1998. The report will include: an analysis of all existing national school crime data and an overview of state and local crime reporting; examples of schools and strategies that are successfully reducing school violence, drug use and class disruption; actions that parents can take locally to combat school crime; and resources available to schools and communities to help create safe, disciplined and drug-free schools.

Strengthening and Expanding the Safe and Drug-Free Schools and Communities Act. In 1994, President Clinton expanded the Drug-Free Schools Act into the Safe and Drug-Free Schools Act, making violence prevention a key part of this program. The Safe and Drug-Free Schools Program provides support for violence and drug prevention programs to 97% of the nation's school districts. Schools use these funds to keep violence, drugs and alcohol away from students and out of schools. The President's FY99 budget expands the Safe and Drug-Free Schools program by $50 million to fund 1,300 Drug and Violence Prevention Coordinators that will help junior high and middle schools across the country develop and implement effective strategies to keep our kids safe and away from drugs.

Enforcing Zero Tolerance for Guns and Other Weapons in Schools. In October 1994, President Clinton signed into law the Gun-Free Schools Act, requiring states to have in effect a law requiring local education

agencies (LEAs) to expel students who bring guns to school. The President issued a Presidential Directive later that month to enforce "zero tolerance" for guns in schools, a policy requiring the expulsion of students who bring guns to schools. In school year 1996-97, the U.S. Department of Education estimates that, under zero tolerance policies, 6,093 students were expelled from public schools for bringing a firearm to school.

Supporting Civic, Community and Faith-Based Organizations. Recognizing the important role that civic, community and faith-based organizations can play in reducing crime, the Administration launched a new Values-Based Violence Prevention Initiative to make $2.2 million in grants available to 16 community-based collaboratives, including religiously-affiliated organizations, that target youth violence, gangs, truancy, and other juvenile problems by promoting common-sense values and responsibility.

Providing Safe After-School Opportunities for Up to Half a Million Children a Year. Last year (FY98), the 21st Century Community Learning Centers program was expanded by $40 million. This funding will enable 315 rural and urban schools in 36 states to provide school-based after-school programs, including on weekends and during the summer. This year, the President proposed a major expansion of this program to provide safe and educational after-school opportunities for up to 500,000 school-age children in rural and urban communities across the country. In addition, the Education Department released a report in June 1998, titled Safe and Smart: Making the After-School Hours Work for Kids. This report shows that after-school programs can lower juvenile crime and improve academic performance. Safe and Smart was sent to every school district in the country.

Cracking Down on Truancy. Truancy prevention initiatives have been shown to keep more children in school and dramatically reduce daytime crime. The Education Department issued a guidebook to the 15,000 school districts nationwide which outlines the central characteristics of a comprehensive truancy prevention policy and highlights model initiatives in cities and towns across the country. Since then, the Education Department has provided grants to local school districts to develop innovative truancy prevention programs of the kind described in the guidebook.

Encouraging Schools to Adopt School Uniform Policies. School uniforms have been found to be a promising strategy to reduce violence while promoting discipline and respect in school. Because of this, the Clinton Administration has encouraged schools to consider adopting school uniform policies by sharing with every school district a school uniforms manual prepared by the Department of Education in consultation with local communities and the Department of Justice. Since the President highlighted school uniforms, a growing number of schools have adopted these policies including: New York City, Dade County, San Antonio, Houston, Chicago and Boston.

Supporting Curfews at the Local Level. Community curfews are designed to help keep children out of harm's way and enhance community safety. Because of their success, President Clinton has encouraged communities to adopt curfew policies. A 1997 survey by the U.S. Conference of Mayors has shown that 276 of 347 cities surveyed -- or 80 percent -- had youth curfew laws, up from 70 percent in 1995.

Developed a Comprehensive Anti-Gang and Youth Violence Strategy. President Clinton has proposed a comprehensive strategy to (1) target gangs and violent youths by hiring new prosecutors and probation officers, and expanding anti-gang task forces and the use of racketeering statutes (i.e., RICO) for gang-related offenses; (2) crack down on kids and guns by prohibiting violent juveniles from buying guns

and increasing penalties for selling handguns to youths; and (3) keep kids off the streets and out of trouble by expanding after-school programs and promoting anti-truancy initiatives and youth curfews.

Keeping Guns Out of the Hands of Children. A number of laws and initiatives are keeping guns out of the hands of children and away from criminals. For instance, since the Brady Law's enactment, 250,000 felons, fugitives and stalkers have been denied handguns, and the 1994 Crime Bill banned 19 of the deadliest assault weapons and their copies -- keeping assault weapons off America's streets. The Youth Crime Gun Interdiction Initiative (YCGII) is cracking down on the illegal gun markets that supply firearms to juveniles and criminals in 27 target cities. The YCGII has already traced more than 93,000 guns, providing law enforcement with crucial investigative leads about illegal gun trafficking. The Administration's FY99 budget proposal contains an expansion of YCGII. In addition to these programs, President Clinton signed a directive to every federal agency, requiring child safety locking devices with every handgun issued to federal law enforcement officers. And, in an historic agreement, eight major gun manufacturers have voluntarily agreed to provide child safety locking devices with all their handguns, helping to protect our children.

Encouraging Conflict Resolution. The Departments of Education and Justice have developed and distributed 40,000 conflict resolution guides to schools and community organizations, providing guidance on how to develop effective conflict resolution programs; Education and Justice are training community officials and educators on these conflict resolution measures.

Targeting Young People with a National Anti-Drug Media Campaign. In July 1998, President Clinton launched the national expansion of the Anti-Drug Media Campaign first proposed in last year's drug strategy and budget. The 5-year, $2 billion campaign is designed to let teens know -- when they turn on the television, listen to the radio, or surf the Net -- that drugs are dangerous, wrong and can kill you.

Building and Strengthening 14,000 Community Anti-Drug Coalitions. In 1997, President Clinton signed into law the bipartisan Drug-Free Communities Support Program. Over the next five years this program will provide $143.5 million to help community coalitions rid their streets of drugs -- the coalitions are made up of young people, parents, media, law enforcement, religious and other civic organizations and school officials. Under this program, the President recently announced new Federal assistance to enhance grassroots efforts in 93 communities in 46 states to prevent youth drug abuse. This assistance will fund the work of broad-based community coalitions to target young people?s use of drugs, alcohol and tobacco.

Strengthening Schools, Promoting Discipline and Supporting Learning

Working Toward Smaller Classes with Well-Prepared Teachers. President Clinton has proposed helping school districts reduce class size in grades 1 3 to a nationwide average of 18 students by helping them to hire an additional 100,000 well-prepared teachers. This initiative will help children learn to read well in the early grades by giving them more individualized attention, will help teachers get the training and preparation they need to succeed and help educators maintain discipline and order which fosters a better learning environment.

Providing Early Education to More Children with Head Start and Early Head Start. Since 1993, the Clinton Administration has expanded Head Start by 57 percent, from $2.8 billion in FY93 to $4.4 billion in FY98. Now, 830,000 children are enrolled in Head Start, 200,000 more today than in 1992. In addition, the landmark Head Start Act Amendments of

1994 established the Early Head Start program, which expands Head Start to low-income families with children under three and to pregnant women. Under the President's budget, by 1999 nearly 50,000 infants, toddlers and their families will be served by Early Head Start. Studies have shown that investments made during the early stages of life reduce tendencies towards violence later in adulthood. Additionally, early investments also ensure that children are ready to learn when they enter school.

Replacing Crumbling Schools with Safer Ones. The proposed School Modernization Initiative will, if enacted, provide communities with interest-free bonds to help renovate, modernize and build over 5,000 schools nationwide.

Teaching Every Child to Read by the Third Grade. More than 1,000 colleges have committed work-study students to tutor children in reading, and thousands of AmeriCorps members and senior volunteers are organizing volunteer reading campaigns. In addition, a proposed early literacy bill, such as the America Reads Initiative, will provide more tutors after school, improve the teaching of reading in our schools, and help parents help their children learn to read.

Striving for Excellence with National Education Standards. Seeking high national standards for all students, the President has proposed a first-ever national test in 4th grade reading and 8th grade math. Goals 2000 is helping States to establish voluntary standards of excellence and to plan and implement steps to raise educational achievement. In addition, the Title I program is helping more than 10 million disadvantaged students reach high academic standards by giving them extra help with basic and advanced skills.

Expanding Choice and Accountability in Public Schools. The number of public charter schools has increased from only one charter school in the nation in 1993 to more than 1,000 charter schools this year, providing greater choices in public education to families across the nation. The Administration has also called for an end to social promotion, aggressive intervention in failing schools, and higher standards for students, teachers and schools.