

MONEY FOR NOTHING



A policy backgrounder from the

Population Research Institute



MONEY FOR NOTHING

**How “Reproductive Health Care” is
Driven by a “Demographic Imperative”
and Ignores the Real Health Needs of
Women in the Developing World.¹**

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Executive Summary

Proponents of “reproductive health care” assert that the 1994 population conference in Cairo marked a watershed between two radically different approaches to reducing the fertility of women in the developing world. They concede that, prior to Cairo, population control programs were driven solely by a narrow demographic imperative.

Following Cairo, however, they maintain that a broad approach to improving “reproductive health” was adopted that not only encouraged smaller families, but also did so in the context of providing “client-centered” programs that conferred significant health and welfare benefits to their target population. They also claim that the rhetorical shift to “reproductive health” has led to reductions in maternal mortality, infant mortality, and the absolute number of abortions.

These several claims are misleading, if not altogether false. The following report documents how:

- The careless administration of anti-fertility drugs and devices in the developing world has done grave harm to women’s health.
- “Reproductive health care” is *not* health care.
- Population control *cum* reproductive health programs has failed to address women’s real health needs, as they themselves perceive them.
- The arguments used to support an exclusive focus on contraception and sterilization (“latent demand,” and “unmet need”) are little more than rationalizations used to justify a near exclusive focus on fertility reduction at the expense of primary health care.
- Family Planning clinics make a pretense of offering primary health care services in order to lure women in, at which time they are subjected to pressure to accept “reproductive health” services.
- “Reproductive health” programs, despite claims to the contrary, have arguably led to increases in maternal mortality, infant mortality, and the absolute number of abortions.

This report concludes that the health needs of women in the developing world could be better met by redirecting existing resources to primary health care, including obstetric care.

“... a poor and exploited woman who is sterilized is still poor and exploited. But with our ideological blinders, all we see as the source of such a woman’s problems is her fertility. It is but a short step, even in the name of compassion, to the coerced or forced administration of birth control. If a woman’s problems are caused by her fertility, and if she refuses to acknowledge this reality, it is for her own good, so the reasoning [of the population controllers] goes, to persuade, or demand, or force her to stop having children.”

Angela Franks

*Margaret Sanger’s Eugenic Legacy*¹

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“Children and women are to be the Trojan Horse
for dramatically slowing population growth.”

James Grant
U.N. Children’s Fund (UNICEF)²

The U.S. Agency for International Development spends hundreds of millions of dollars each year on programs falling under the general rubric of “reproductive health care.” But do such programs truly improve the health of women (and children)? Or are they, as James Grant of UNICEF suggests, merely a convenient disguise for a continued assault on fertility?

Nearly everyone now concedes that, prior to the 1994 Cairo conference on population and development, USAID’s programs were driven by a narrow demographic imperative. Those who viewed population growth as the primary threat to the future of humanity, not to mention to the biosphere and to the planet itself, were in charge. They insisted on top-down, or “vertical,” family planning programs, in which quotas for contraceptive prevalence were set by funding agencies on the basis of their own calculations of the “unmet need” for contraception. They used various measures, including bribes, sanctions and propaganda campaigns, to ensure the compliance among the target population, and to reach their desired “contraceptive prevalence rate.”³ Their programs are rightly characterized as a kind of contraceptive imperialism, imposed as they are from the capitals of the former colonial powers on the developing nations of Africa, Asia and Latin America.

All that changed following Cairo, argue proponents of “reproductive health care.” As a result of that conference, they say that vertical family planning programs were abandoned in favor of a client-centered approach. The broad approach to improving “reproductive health” that followed not only encouraged smaller families, they argue, but did so in the context of providing programs that conferred significant health and welfare benefits to their target populations. They also claim that the rhetorical shift to “reproductive health” has led to reductions in maternal mortality, infant mortality, and the absolute number of abortions.

All of these claims are misleading, if not altogether false. Merely calling programs designed to disable reproductive systems “reproductive health care,” does not mean that they are, in fact, improving women’s health in a meaningful way. Anti-fertility drugs and devices continue to be carelessly administered in the developing world and continue to inflict grave harm on the health of women. Moreover, the arguments used to support an exclusive focus on contraception and sterilization (that there is a “latent demand” and “unmet need” for contraception) are little more than rationalizations used to justify a near exclusive focus on fertility reduction at the expense of primary health care. Were this not so, family planning clinics would not need to make a pretense of offering primary health care services in order to lure women in so that they can be pressured to accept “reproductive health” services.

We will show in this report that “reproductive health care” programs have failed to address the real health needs of developing world women as they themselves perceive them. Nor have such “reproductive health care” programs led to reductions in maternal mortality, infant mortality, and the absolute number of abortions. Were the money spent on “reproductive health care” spent instead on primary health care, countless lives could be saved.

Population Control – A History of Unsafe Interventions

In some cases, the population controllers do not merely turn a blind eye to problems, but have deliberately engaged in seemingly unethical, if not criminal, acts. After the Food and Drug Administration (FDA) in 1970 declared high-estrogen birth-control pills to be unsafe, the pharmaceutical companies were left with warehouses full of the now-unmarketable contraceptive. Syntex executives offered to sell the United States Agency for International Development (USAID) their entire stock at a heavily discounted price. Dr. Thor Ravenholt, director of the Office of Population, who by all accounts appeared to be less concerned about safety than in checking fertility cheaply, was only too happy to accept.⁴

Dr. Malcolm Potts, a leading contraceptive researcher then serving as the International Planned Parenthood Federation (IPPF)'s medical director, was among those who defended this decision to distribute the dangerous pills.⁵ The FDA's regulation of oral contraception in the U.S. was, in his words, "a lot of pompous nonsense,"⁶ and maintained that the high-estrogen pills carried a minimal health risk. As far as the painfully swollen breasts that the pill could cause, women should not complain: "It makes your breasts more beautiful and that is good for everyone — including the tailors who have to make bigger brassieres."⁷

One health debacle followed another. Less than two years later, USAID, executives of the now-defunct A.H. Robbins Company, and the Pathfinder Fund conspired to dump hundreds of thousands of dangerous, unsterilized contraceptive devices — unmarketable in the United States — into the developing world.⁸ These devices were a spider-shaped intrauterine device (IUD) called Dalkon Shields.

The Dalkon Shield was arguably the worst contraceptive ever visited upon the world's women with the possible exception being Norplant. Within five years of its introduction into the U.S. in January 1971, 18 Dalkon Shield users had died, several hundred had suffered life-threatening septic abortions, and many thousands had developed uterine infections which often resulted in sterility.⁹ More than 161,000 American women filed personal injury claims against the manufacturer, A. H. Robbins, which was forced to pay out \$2.5 billion in damages and went bankrupt as a result.¹⁰ The question that we should ask ourselves, says James Miller, is this: "If the Dalkon Shield took such a toll in the United States, which has the finest medical services in the world, how many deaths and injuries did it cause in countries where medical care is often grossly inadequate?"¹¹

The Dalkon Shield was dumped on developing countries by A. H. Robbins' executives with the aid of the fanatical Dr. Ravenholt. The Office of Population which he directed had a budget of \$125 million to spend on the purchase and overseas distribution of contraceptives, and Robbins' executives knew from past dealings with him that he would likely jump at a cut-rate deal on Dalkon Shields.¹² To encourage Dr. Ravenholt to introduce "this fine product into population control programs and family planning clinics throughout the Third World,"¹³ Robbins' international marketing director told him the company would knock 48 percent off the going price — but only if USAID would agree to accept the Dalkon Shields in bulk packages, unsterilized, with only one inserter for every 10 intrauterine devices (IUDs), and with only one set of instructions with every 1,000!

All IUDs sold in the U.S., per FDA regulations, come in individual, sterilized packages, with a sterile, disposable inserter for each device, and a separate set of instructions. Each of the concessions demanded by Robbins put women in the developing world at greater risk of infection, but Dr. Ravenholt inked the deal anyway. To make absolutely sure that the fertility of the world's poor was the agreed-upon market, and that none of the dangerous devices would somehow find their way back into the U.S., Robbins sent a memo to USAID in January 1973 specifying that the nonsterile IUDs could not be used in the U.S. or other developed countries. The IUDs were not sterilized, the company wrote, "for the purpose of reducing price... [and are] intended for restricted sale to family planning/support organizations who will limit their distribution to those countries commonly referred to as 'less developed.'" ¹⁴

Hundreds of shoebox-sized cartons, each filled with 1,000 unsterilized Dalkon Shields, 100 applicators, and a single set of instructions, were shipped to clinics in El Salvador, Thailand, Israel, and 38 other countries. Altogether, USAID purchased and shipped more than 700,000 Shields for use in the developing world. ¹⁵ Slightly more than half of the Shields went to International Planned Parenthood Federation (IPPF). The rest were distributed through the Pathfinder Fund, the Population Council, and Family Planning International Assistance, all major grant recipients of USAID. ¹⁶

Stories about complications from the Dalkon Shield had begun to appear in the nation's press, even before Dr. Ravenholt signed the Robbins contract. Scientific studies in peer reviewed medical journals criticizing the high rate of Shield complications were published in 1973-74, yet the overseas shipments continued unabated. Even high-profile Congressional hearings on the Shield, held in May and June of 1973 and widely reported in the media, did not deter USAID, which got out of the Dalkon Shield business only *after* the device was withdrawn from the U.S. market. ¹⁷ Even then, shipments continued for several months. Dr. Ravenholt initially responded to critics by placing the blame on victims: If women in poor countries were dying of IUD-related infections, he said, it was a result of their own promiscuity. ¹⁸

How many women in the developing world died from having dangerous and unsterilized Dalkon Shields inserted in their uteruses? Author Morton Mintz puts the death toll at "hundreds, possible thousands, of women outside of the United States." ¹⁹ This could be an underestimate. In places where there are no doctors, and no antibiotics, pelvic inflammatory disease can be fatal. Unsterilized Dalkon Shields, with their spider-like arms constantly irritating the lining of the uterus, seemed almost designed to cause such infections.

Are similar abuses occurring today? One could argue that the continued distribution of Norplant by USAID — years after the U.S. manufacturer has taken the device off the market for safety reasons — is comparable. Encouraging the self-injection of Depo Provera is another example of a questionable practice that violates FDA regulations and may lead to serious side effects or even death. Dr. Ravenholt supported the over-the-counter sale of Depo Provera and birth control pills, and their widespread distribution by "paramedical" staff with only minimal training — both practices that also contravene FDA regulations. ²⁰ Similarly, he sponsored sending container loads of Depo Provera overseas over a decade before it was approved by the FDA for use in America. ²¹ While it may be common in the developing world for medical treatments to be used over-the-counter due to the paucity of trained medical profes-

sionals, it is difficult to justify this for a situation where no disease is being treated, as is the case for contraceptives.

Even today, the population controllers do not seem as concerned with the safety of the devices, drugs and practices that they promote around the world to curb fertility as they should. They argue that the risks of dying in childbirth in the developing world are so great that the use of almost any contraceptive device or sterilization technique is justified to spare a woman this fate.

“Reproductive Health Care” is Not Health Care

The diversion of human and financial resources away from primary health care into fertility reduction programs has a negative impact on the general health of a population, contributing to the rise of HIV/AIDS, the comeback of malaria, and a resurgence in other infectious diseases as I have shown elsewhere.²² But what about the direct effect of reproductive health care programs themselves on the overall health of women and their families? Here, too, there are problems:

- (1) Family planning programs deliberately court medical problems by denying routine medical care, such as physical exams, in the name of efficiency.
- (2) These programs, inadvertently or otherwise, cause health problems, such as ectopic pregnancies subsequent to sterilization, which are then routinely ignored.
- (3) They have engaged in acts that appear criminal in retrospect, such as the dumping of unsterilized and dangerous IUDs on the developing world, or the testing of powerful, steroid-based contraceptives on unsuspecting women as noted above.

Each of these practices results in significant morbidity and mortality. We’ll take a look at each in turn.

Concerned primarily with reducing the fertility of as many of the poor as possible, the population controllers have long advocated overlooking their other health needs. Frances Hand Ferguson, for example, who was president of the Planned Parenthood Federation of America in the 1950s,²³ had little patience with doctors who wanted to treat the whole person: “[The medical profession] has held us back And I think they still are. They talk about total medical care, and it’s a great concept, but for instance, pap smears — well, that’s marvelous for every person that comes into a clinic, but ... it seems to me that’s over-gilding the lily. Take that money and use it to reach other people, more people in the Appalachians, or offer more birth control methods.”²⁴

“I’d rather do less good service to more people, than perfect service to fewer people,” Ferguson, who later became vice-president of IPPF, was quoted as saying.²⁵ This attitude continues to hold sway at the Planned Parenthood Federation of America (PPFA) as well, to judge from Pamela Maraldo’s brief tenure as president in the 1990s, which ended when she tried to broaden the range of health services offered by Planned Parenthood clinics. The nation’s premier abortion, sterilization, and contraception organization was apparently not interested.

Reflecting this same attitude, USAID has long discouraged its family planning surrogates, including Planned Parenthood, from providing any other health services. In the early nineties, in fact, USAID’s Office of Population officially rebuked IPPF (of all organizations!) for providing “unnecessary” health care, complaining that:

...All too often, in our view, family planning programs impose numerous medical barriers to service which we are convinced hinder program effectiveness and impact, especially for hormonal contraceptives. Common examples of what we

mean by medical barriers include unnecessary laboratory tests; excessive physical exams (e.g. pelvic and breast); holding the oral contraceptive “hostage” to other reproductive medical care (e.g. pap smears and STD tests); restrictions on the number of OC [oral contraceptive] cycles dispensed...excessive follow-up schedules (e.g. every three months, including counseling, weight, blood pressure, breast check, etc.); conservative medical thinking (e.g. taking a woman off the Pill for a while if she develops a headache just to play it “safe,” or denying a postpartum woman with an enlarged thyroid the Pill until the gland becomes smaller); excessive counseling and history-taking in such a way as to include a lot of irrelevant information rather than the important things, the net effect being to increase waiting time and see few[er] clients...²⁶

In other words, USAID told its agents at IPPF, cut out most medical histories, diagnostic tests, and follow-up visits, and simply get as many women as possible on the Pill (or sterilized, fitted with IUDs, implanted with Norplant, etc.).

The general weakening of standards continues. In 1997 the PPFA did away with required blood tests and laboratory exams for chlamydia and gonorrhea prior to insertion of IUDs. PPFA explained that it had changed its own guidelines from “must” to “as indicated” to be “consistent” with the 1994 US Agency for International Development guidelines for developing countries, which say a routine pre-exam (a separate visit) should not be required, since two visits may be a barrier to IUD use, and hence to lowering the birth rate.²⁷ The fact that both sexually transmitted diseases have reached epidemic proportions among young women in the U.S., especially in the South, was apparently considered irrelevant.

Such practices lend credence to the assertion that, when it comes to women’s health, USAID cares more about how many women are sterilized or contracepted than about how many are made healthier, even when health is defined strictly in “reproductive” terms. This is certainly true of USAID-funded programs in Kenya, asserted a prominent Kenyan physician, Dr. Stephen Karanja, during an interview: “If you are to give any woman any contraceptive — and especially hormones, which are very strong drugs medically — if you are to give pills, Norplant, Depo Provera, you will first do a clinical examination on this woman,” maintains Dr. Karanja, the former head of the Kenyan Medical Association. “You need to take a very good medical history. This is *never done* in Kenya. They are given these [hormones] without this. So now you have an accumulation of side effects, like high blood pressure.”²⁸

Most so-called “modern” contraceptives have been tested in field trials on healthy women of the developed world. Their use on women in the developing world without prior medical histories or exams, who are malnourished, anemic, or suffer from other health problems, can have a markedly deleterious effect on women in the developing world. For instance, many women in Bangladesh who were given Norplant suffered serious side effects. According to Farida Ahktar, an activist concerned with the plight of poor women, Bangladeshi women who had received Norplant suffered side-effects much more serious than those admitted by Norplant’s proponents: continuous bleeding far heavier than a normal menses, weakness in the limbs, severe pain and significantly blurred or double vision.

Ahktar reported that women who took Norplant “fainted quite often, you know, which was not the case before.” Other women complained that “[the family planners] were telling us we were supposed to be very happy after taking this Norplant, but why is our life like hell now?” Not only were these adverse side-effects not noted, desperate cries from the women to have the implants removed were simply ignored.²⁹

Dr. Karanja, an obstetrician-gynecologist by training, has seen the results of such an approach. He often sees patients who have been harmed by these powerful, steroid-based contraceptives. “High blood pressure was never really a major African disease,” he explains, “but now we have blood clots, liver problems, and problems with bleeding. In Africa where tropical diseases already cause women to be weak with poor blood levels, when they start bleeding irregularly or continuously because of these contraceptives, you literally reduce them to cripples. The woman is the center of the African family. If you want to destroy the African family, attack the mother. And I ask myself, why does the US attack the center of the African family? These women walk around with difficulty because of anemia, with swollen legs, with livers damaged. There are women who are going into heart failure because of bleeding, because of [contraceptive] drugs.”³⁰

Dr. Karanja is particularly critical of the indiscriminate “social marketing” of Depo-Provera, noting that it “cause[s] terrible side effects to the poor people in Kenya, who do not even have competent medical check-ups before injection.”³¹

These accusations were confirmed by Population Research Institute (PRI) investigators, who discovered on a 2003 visit to Kenya that Depo-Provera kits were being sold over-the-counter without a prescription. Dilapidated “pharmacies,” even grocery stores, sell this powerful, steroid-based drug for pennies in the capital city of Nairobi, and the accompanying propaganda encourages women to attempt self-injection in unsupervised settings.³² Kits purchased by the author were advertised as having been “Manufactured in Belgium by Pharmacia and Upjohn, and distributed by PSI Kenya. PSI stands for Population Services International, one of the principal recipients of USAID family planning/population stabilization funds. Encouraging the self-injection of drugs, which in the United States can only be administered by a health care professional, raises serious questions of medical ethics. These drugs are not being used to treat a disease or disorder, and their unsupervised use could only be justified if the associated risk were insignificant, which it is clearly not. But this is not only an extreme case of the lack of quality health care — no preliminary examinations, no proper medical record keeping, and no follow-up care — These are characteristics of population control programs in general.

The African women who are given powerful, steroid-based contraceptives are often not properly informed of the serious side effects that can result. On its website, the manufacturer of Depo Provera prominently lists a number of serious complications that can be caused by the drug, including “delay in spontaneous abortion,” “fetal abnormalities,” “thrombotic disorder” (blood clots), “ocular disorders” (“a sudden partial or complete loss of vision”), and “lactation” (the passing of the drug through breast milk to nursing infants).

The Depo Provera packaging designed by the population controllers for Kenyan women contains no such off-putting warnings. The so-called “bilingual patient information leaflet”

— actually just a single 3½” by 8” sheet of paper — contained the following question and answer in English and a major Kenyan tribal language, Kikuyu:

“Is Megastron [another brand name for Depo-Provera] Safe?”

“Yes, it is safe for use. Severe side effects, like heavy bleeding is unusual. Some women may experience missing periods or spotting, but there is no need for undue concern.”

Taking Depo-Provera while not under a doctor’s care is a dangerous game, rendering women vulnerable to potentially serious and even fatal side effects, but those who are victimized by this social marketing scheme will never know it — unless they actually experience blood clots, birth defects, or blindness. As Dr. Stephen Karanja has commented, “I see women coming to my clinic daily with swollen legs — they cannot climb stairs. They have been injured by Depo-Provera, birth control pills, and Norplant. Many are maimed for life ... I look at [these women] and I am filled with sadness. They have been coerced into using these drugs. Nobody tells them about the side effects, and there are no drugs to treat their complications.”³³

The indiscriminate distribution of contraceptives to women in the developing world, who are often malnourished and in poor health to begin with, creates additional health concerns. And, as Dr. Karanja suggests, the lack of follow-up care can in some cases be fatal. For example, there is danger of ectopic pregnancy following sterilization. Tubal ligation does not always prevent conception, but it often prevents the developing embryo from entering the uterus. Instead, the embryo implants at the site of the ligation, resulting in a tubal pregnancy. With tubal pregnancies, the thin-walled fallopian tube is subject to rupture when the fetus grows following a couple of months of gestation, and when it ruptures the resulting hemorrhaging can be fatal if medical attention is delayed.

Ectopic pregnancies are by no means as rare as might be thought, occurring in an estimated 7 out of every 1,000 “sterilized” women.³⁴ Women who have been ligated in sterilization campaigns may be at even greater risk, given the hurried, “assembly-line” fashion in which such procedures are carried out. Moreover, such women are generally given no warning about the *possibility* that they might again become pregnant. Not knowing that they are at risk of an ectopic pregnancy, they are unlikely to seek medical care until it is too late.

Consider what this means for the women of Peru, more than 300,000 of whom were sterilized in the mid-to-late nineties.³⁵ It means that somewhere between two and three thousand have suffered, or will suffer, an ectopic pregnancy. Most of these women live in rural areas, without easy access to even primary health care. Moreover, they were given no information about the risks of ectopic pregnancy (or any other risks, for that matter), before, during, or after they were ligated. This is clearly medical negligence. Not having been forewarned of the danger, they will be unlikely to seek medical attention until they are acutely ill, and appropriate intervention may be delayed even beyond this point by misdiagnoses. Many of these women will therefore die — unnecessarily.

In 2003 I wrote to Anne Peterson, then director of the Global Health Bureau of USAID, to request that Global Health fund a small and inexpensive educational campaign to warn women

in Peru of the dangers of ectopic pregnancy following sterilization. “A few ads and educational brochures, placed in strategic markets, would save hundreds of lives, by alerting women of the dangers that they face, and prompting them to seek early intervention,” I wrote.³⁶

If women were made aware of the danger that they faced, I argued, and urged to seek medical treatment if they experienced the symptoms of ectopic pregnancy, many hundreds of lives could be saved. This would not only reduce Peru’s maternal mortality rate, but would also help to mitigate the harm that the sterilization campaign had caused — and was continuing to cause — among Peruvian women. I was hopeful that USAID, which often justifies its programs in terms of “reducing maternal mortality,” would feel a particular obligation to help. After all, it had materially supported the sterilization campaign in its early years.

Anne Peterson’s response was to say that tubal ligations significantly reduced the risk of ectopic pregnancy, although she did not provide any supporting evidence.³⁷ Instead, she merely asserted that the events in Peru had already reduced maternal mortality by putting fewer women at risk of ectopic pregnancy, and that nothing further need be done. It is difficult to say which is more astonishing; the claim that there are *benefits* to be derived from forced-pace sterilization campaigns, or the willful neglect of a serious health risk *that the campaign itself has created for an entire class of women – the poor*.

This response, from the chief administrator of all U.S. family planning programs, is in accord with the philosophy of the population controllers in general. They appear to absolve themselves of responsibility for the disease, injuries and deaths that result from their programs on the grounds that they are serving the greater good, namely, reducing the birth rate and hence the population. Reducing maternal mortality among women they consider to be “at-risk reproducers” is merely a consequence of this, their primary aim.³⁸

What Women Want

How do those whose bodies are being rendered infertile, namely, women in the developing world, view such programs? And how do they assess their own health care needs? If it is true that shutting down a woman's reproductive system markedly improves her and her family's well-being, then you would expect women in, say, Ecuador, Kenya or Ghana to recognize this, and to be clamoring for ever more Depo-Provera, Norplant, condoms, IUDs, and birth control pills. Yet the evidence noted below suggests that the supposed beneficiaries of reproductive health programs are clamoring for anything and everything *but* reproductive health care. It is only by arrogantly rejecting the real health and other needs of poor women, as the women themselves express them, that priority can be given to fertility control.

Who wants reproductive health care? Not the people of Ghana, according to a 2001 survey carried out by PRI in the city of Takoradi.

Takoradi, a port city located on the Ghanaian coast, is a transportation and marketing hub. It is the capital of the Western Region of Ghana and has a population of 350,000. The major east-west highway, carrying national and international heavy transport, as well as almost everything else, traverses the city. The residents are small shop owners and tradesmen, mechanics and other service providers, and agricultural proprietors and workers. Television and telephones, both conventional and cellular, are widely available. Most of the inhabitants have received some education, and literacy rates are high. Like West Africans in general, the residents of Takoradi are religious, with half identifying themselves as Christians, a quarter as Muslims, and the rest adhering to various animistic faiths.

A total of 397 individuals of both sexes were interviewed by one of four trained interviewers on one of Takoradi's main thoroughfares, selected at random from the constant stream of passersby.³⁹ Those interviewed were shown a list of 15 different health programs, and asked to rank order the list in terms of their own personal needs, putting their most pressing need first and their least important need last. The health programs listed were:⁴⁰ Malaria Eradication, Leprosy Treatment, Reproductive Health⁴¹, Syphilis Treatment, Polio Prevention, Clean Water Programs, Natural Family Planning, Sleeping Sickness, Gonorrhea Treatment, Tuberculosis Treatment,

Table 1	
Desirability of Health Programs in Africa	
<i>Health Program</i>	<i>Overall Mean</i>
Malaria Eradication	4.16
Natural Family Planning	5.23
Clean Water Program	5.30
Measles Prevention	5.54
HIV/AIDS Prevention	5.86
Tuberculosis Treatment	7.14
Cholera Treatment	7.32
Polio Prevention	8.38
Leprosy Treatment	8.44
Yellow Fever Treatment	8.91
Sleeping Sickness	9.32
Syphilis Treatment	9.89
Gonorrhea Treatment	9.97
Any Other Programs	11.04
Reproductive Health	13.66

Explanatory Note: The data on health needs reported by respondents was entered into a database and the mean rank order was calculated for each category of health care. The higher the rank order for a particular kind of health care (lower numbers), the greater the need for such health care expressed by the respondents

Yellow Fever Prevention, HIV/AIDS Prevention, Cholera Treatment, Measles Prevention, and “Other Programs.”

What do these modern Africans have to say about their health care needs? They list their most pressing concerns as Malaria Eradication, Natural Family Planning, Clean Water, Measles Prevention, and HIV/AIDS Prevention. Now malaria, measles and HIV/AIDS are all diseases that run at epidemic, or near-epidemic, levels in Ghana, confirming the good judgment of those we surveyed. Ghanaians are also aware that polluted drinking water is a vector for the transmission of cholera and other diseases, and so would like to see the water supply made safe. The only mild surprise in this cluster of top-ranked health needs is the presence of NFP, which was welcomed by many respondents as a safe and natural means of regulating their fertility, a point to which I will return in a moment.

Second-order health needs listed included Tuberculosis Treatment, Cholera Treatment, Leprosy Treatment, Polio Prevention, Yellow Fever, Sleeping Sickness, and Syphilis and Gonorrhoea treatment. These are all diseases that, although not affecting the large percentage of the population that, say, HIV/AIDS does, are nonetheless endemic to Ghana. Here again, the views of those we spoke with accord well with Ghana’s epidemiological realities.

The single most striking result of the survey was the dismal showing of Reproductive Health. This category of health care, defined as “the limitation of childbearing by means of contraception and sterilization,” came in dead last. Even the unspecified “Other Programs” came in higher, suggesting that the Ghanaians would prefer almost any kind of health care to the kind of fertility-reduction programs that they have been subject to for the past few decades. The disdain elicited by reproductive health care is further underlined in the “comments” section, where one reads such remarks as “Stop reproductive health; it’s not good,” “We don’t need reproductive health programs.” “Stop reproductive health; eradicate malaria,” and so on.

Proponents of family planning may view these results as contradictory, asking how the Ghanaians can praise Natural Family Planning (NFP) on the one hand, while damning reproductive health care on the other. Is it possible to answer the objection that the two family planning methods are merely different means to the same anti-natal end?

As it turns out, the people of Ghana have a far better understanding of the differences between Natural Family Planning and reproductive health care than the population controllers. And they vastly prefer a method over which they have intimate control — NFP — to often permanent methods imposed by foreign governments and organizations.⁴² Those we talked to were not using NFP as shorthand for “family planning. And those who expressed, in the “comments” section, a desire for *more* education in NFP were not thereby expressing a preference for *fewer* children. Indeed, in the Ghanaian context it is just as likely that they would use this additional education in NFP to conceive a child as it is that they would use it to delay conception. Ghana’s Total Fertility Rate of 3.84, as reported by the U.N. Population Division, is close to the desired fertility expressed by Ghanaians in surveys.⁴³ Their interest in NFP centered on the fact that they themselves, and not some distant, even foreign, government agency, would determine the number and spacing of their children.

Those whom were interviewed were not uneducated, but highly westernized and educated residents of one of Ghana's most modernized cities. Note also that their prioritization of their health care needs was highly rational, that is to say, that it accords well with the real diseases and health problems with which they and their families must contend on a daily basis. Why should their views on their own health care needs, including their rejection of so-called reproductive health care, not be taken seriously in planning foreign aid programs?⁴⁴

Meeting the real health needs of women in the developing world, as they themselves define those needs, would mean funding primary health care. Instead, those committed to population control ignore the views of third world women. They view their fertility as a threat, and act to neutralize that perceived threat by enacting programs that have the primary goal of disabling the reproductive systems of those same women they proclaim to be helping. To paraphrase feminist Angela Franks, if women's fertility is causing social, economic, environmental, or health problems (as the population controllers believe), and if women refuse to acknowledge this reality, it is for the greater good that they be persuaded, or compelled, or forced to stop having children. Kingsley Davis and other population alarmists have long said that it is necessary, in the interest of reducing population growth, to make it less pleasant for women to do what so many of them enjoy doing, namely, raise children.⁴⁵

Still, population control organizations find it highly inconvenient that their programs are not greeted with joy by their "targets," and they go to great lengths to disguise or explain away this fact. Overseas, they work overtime to create the impression of robust popular and government support for their anti-natal programs, recruiting local surrogates, suborning government ministries of health and education, launching media blitzes, and sponsoring contraceptive giveaways. This façade falls away in discussions with donors, during which they — arrogantly, in my view — suggest that the women's reluctance to contracept comes about because they either do not know their own minds, or because they simply do not know what is good for them (or their country, or the environment, etc.)

The “Latent Demand” and “Unmet Need” for Modern Contraceptives

Because so many women in the developing world are not contracepting, the population controllers have contrived the concept of “latent demand” as a cover for their intrusive activities. Population controllers “latent demand” means that, while a woman has an obvious need for a modern contraceptive, she is kept from demanding it by ignorance, fear, superstition, or what Marxists called a “false consciousness,” hence it remains “latent.” Elena Zunega, the former Executive Director of Mexico’s National Population Council, insisted to me that a substantial percentage of women in Mexico between the ages of 15 and 45 who were not contracepting have such a “demanda latencia,” or “latent demand.”⁴⁶

To suggest that a woman does not know her own mind in such a private and important matter as childbearing is, at the very least, patronizing. Still, this term continues in common usage among the population controllers, in large part because it suggests that they are only supplying what women are *demanding*, and thus helps to maintain the pretense of voluntarism. Of course, what population controllers like Ms. Zunega really mean when they say “latent demand” is something along the lines of *the percentage of women in a population we believe should be rendered surgically or chemically infertile*.⁴⁷

Closely related to the “latent demand” is the concept of “unmet need.” This is the percentage of women in a given country who are said to have a “need” for modern contraceptives that is not being “met.” This parameter is critically important to the control effort because it is used to help determine everything from funding priorities for population programs, down to the actual numbers of drugs and devices that will be shipped to given countries. For example, when President Bush decided in June 2002 to cut off funding to the U.N. Population Fund, USAID proposed to reprogram the funds to other population control programs based on their calculations of the levels of “unmet need” shown in Table 2. Their calculations of the percent of women who have such a need for modern contraceptives ranged from a high of 40% in Haiti to a low of 5% in Romania.

How do USAID and other population control agencies arrive at the number of women in a given country who have an “unmet need” to be contracepted or sterilized? Certainly not, as the term itself suggests, by respectfully asking a representative sample of women about their actual contraceptive needs. Rather, the “unmet need” for modern contraceptives is circuitously *inferred* from survey questionnaire data as the percentage of women who (1) say they wish to delay the birth of their next child (or want no more children) and who also (2) say they are *not* using modern means of contraception.⁴⁸

Even members of the demographic community have roundly criticized this flawed methodology for calculating “unmet need.”⁴⁹ In the words of Nicholas Eberstadt, “It is by no means clear that this method measures either the unmet demand for modern contraceptives, or the fraction of the female population exposed to unwanted pregnancy. Women not using modern contraceptives may be practicing traditional (albeit less pleasant or less effective) means of birth control.”⁵⁰ Or, one might add, they may be using Natural Family Planning (NFP) — that is, abstaining from intercourse during the fertile period — a practice that is becoming increas-

ingly common in Africa, Asia and Latin America. The population controllers discount both traditional methods *and* NFP, but it was the use of traditional methods that enabled Europeans to lower their birthrates a century before modern contraceptives were invented. As for NFP, recent advances have made it as effective as many modern contraceptive methods — without the unpleasant chemical side effects. This is not the rhythm method. Finally, static calculations of “unmet need” deny the essential humanity of couples in the developing world. Not every unexpected pregnancy results in the birth of an unwanted child. A woman who expresses a desire to delay the birth of her next child is not, in the main, likely to love that baby any less for arriving a few months early.

Table 2
Unmet Need for Contraception: Estimates for USAID-Assisted Countries
 (from Ross/Winfrey)

Country '02 ²	Percent	MWRA ¹	Unmet Need	Unmet Need	Pop Fund
	Unmet Need	(,000)	(,000)	>10% (,000)	(\$m)
India	16%	197,755	31,248	11,471	11.9
Pakistan	32%	24,998	7,934	5,435	1.4
Ethiopia	36%	9,866	3,532	2,545	4.9
Nigeria	18%	20,572	3,600	1,543	11.8
Bangladesh	15%	27,268	4,172	1,445	24.5
Russia	14%	33,244	4,604	1,280	4.0
Congo (DROC)	24%	8,423	2,044	1,202	1.0
Philippines	19%	11,614	2,178	1,016	17.0
Nepal	31%	4,547	1,426	972	6.5
Uganda	35%	3,453	1,195	849	6.2
Yemen	39%	2,497	964	714	1.0
Kenya	24%	4,495	1,072	623	6.0
Tanzania	22%	5,093	1,110	601	4.0
Ukraine	14%	10,996	1,561	462	1.9
Ghana	23%	3,342	768	434	7.3
Afghanistan	20%	3,979	804	406	0.0
Cambodia	33%	1,774	578	401	3.0
Cote d'Ivoire	28%	2,227	617	394	2.2
Senegal	35%	1,499	522	372	3.3
Madagascar	26%	2,331	595	362	4.2
Burkina Faso	26%	2,209	571	350	2.2
Malawi	30%	1,771	526	349	2.3
Mali	26%	2,102	541	330	5.8
Haiti	40%	936	373	279	4.5
Rwanda	36%	1,051	374	269	0.6
South Africa	15%	4,935	740	247	1.1
Morocco	16%	4,042	651	247	1.8
Cameroon	20%	2,324	458	226	2.2
Zambia	27%	1,356	360	224	3.1
Guatemala	23%	1,692	391	222	9.5

Country '02 ²	Percent	MWRA ¹	Unmet Need	Unmet Need	Pop Fund
	Unmet Need	(,000)	(,000)	>10% (,000)	(\$m)
Bolivia	26%	1,259	328	202	13.0
Benin	26%	1,134	292	178	2.2
Uzbekistan	14%	4,393	600	161	0.8
Togo	32%	707	228	158	2.2
Guinea	25%	1,064	261	154	2.2
Ecuador	17%	1,966	339	143	0.0
Egypt	11%	11,614	1,301	139	23.3
Bulgaria	23%	931	210	117	1.2
Eritrea	28%	594	163	104	0.5
Azerbaijan	15%	2,086	309	100	1.5
Liberia	24%	513	124	73	0.5
Honduras	17%	907	157	66	6.0
El Salvador	17%	905	157	66	4.0
Armenia	15%	1,233	182	59	2.9
Zimbabwe	13%	1,039	237	53	2.0
Georgia	15%	958	142	46	1.2
Jordan	14%	871	124	37	12.8
Jamaica	17%	482	83	35	1.8
Dominican Republic	12%	1,325	156	24	1.6
Kyrgyz Republic	12%	806	94	113	0.3
Tajikistan	11%	974	107	10	0.2
Peru	10%	4,008	409	8	14.0
Turkmenistan	10%	738	75	1	0.2
Moldova	7%	1,025	69	-34	0.2
Kazakhstan	9%	2,795	243	-36	0.8
Hungary	4%	1,150	48	-67	0.5
Mozambique	7%	3,322	223	-110	5.2
Romania	5%	5,005	225	-275	2.8
Indonesia	9%	38,561	3,538	-318	12.5
Total Assisted	17%	495,556	85,937	36,381	\$271.1
Non-Assisted	18%	172,580	27,646	10,388	
Total	17%	668,135	113,583	46,769	

John A. Ross and William L. Winfrey, "Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate," *International Family Planning Perspectives*, 28(3) (September 2002) p. 138-143.

(Endnotes)

- 1 MWRA is an abbreviation for "Mils [Thousands] of Women of Reproductive Age."
- 2 Pop Fund '02 is short for "USAID Population Funding Levels for Fiscal year 2002."

Now it is surely no accident that each and every one of these methodological shortcomings strengthens the case for population control by *inflating the percentage of women in developing countries who are said to require the services of the population controllers*. "Unmet need," like

“latent demand,” has proven to be very helpful to the population controllers as they design their programs and justify their budgets, not least because it creates the impression that, in so doing, they are but serving the “deepest”, if unspoken, needs of womankind.

If this sounds too critical a reading, consider how the population controllers would behave if they were truly interested in meeting the reproductive health needs of women, as women themselves understand them. Their way forward would be simple and straightforward. They would merely have to ask women how many children they wished to have, and then provide the means for maternal and infant health care programs necessary to safely achieve that number. Surveys show that parents throughout the developing world, just like parents from wealthy countries, have pronounced views on their own “desired family size.” So these numbers would be easy to obtain.⁵¹

The problem with this approach — from the population controllers’ point of view — is that “desired family size” is almost always higher than “actual family size.” Women in many parts of the world, from the wealthy West to the least developed parts of sub-Saharan Africa, insist that they would like to have *more* children than they actually have, not fewer. Women in the U.S., Canada, and France, for instance, express a desire for two or three children, instead of the one or two they currently average.⁵² African women have similar disparities between their fertility desires and their fertility outcomes. A summary of surveys conducted since 1990 reported that, “among the 28 sub-Saharan African countries surveyed, desired family size averages 5.7 children. In the Ivory Coast, for example, desired family size was 5.9 children, while actual fertility was 5.2.”⁵³

What this means is that the population controllers cannot, at one and the same time, pursue their anti-natal agenda *and* respect the fertility desires of women in the developing world. There is simply no way to reconcile these two mutually antagonistic goals. Instead, they serve the first, and pay lip service to the second. The use of spurious measures of flawed design, which supposedly reflect the reproductive health needs of women, instead appear to be calculated to serve an anti-natal agenda.

Unlike Dr. Thor Ravenholt, who could be blunt, modern controllers are careful to hide their anti-natal agenda behind concepts such as “latent demand,” “unmet need”, and “reproductive health care.” Occasionally, however, the mask slips. PRI investigator Joseph Meaney, visiting a UN refugee camp in Albania in 1999, was struck by the fact that many of the Kosovo refugee women he was speaking to were eager to have more children. When he mentioned this to a United Nations Population Fund doctor, the man exploded with distain for his charges: “They’re refugees, don’t you see! They *can’t* have children!”⁵⁴

The Cairo Conference on Population: Rhetoric and Reality

The 1994 Cairo conference marks a watershed in the rhetoric, if not the reality, of population control programs. Largely because of opposition from a consortium of Catholic and Muslim countries, the *Programme of Action* that resulted contains no population projections, no demographic analyses, no universal right to abortion, and no hard targets for contraceptive acceptance, fertility decline, or population levels. What survived the prolonged and often fractious negotiations was a pastiche of less controversial policies centering not on the numbers but on what came to be called “reproductive health care.”

This outcome was initially quite a disappointment for the hard-line controllers who, in the words of Adrienne Germain, “argued that Cairo’s ‘reproductive health approach’ will be far more expensive and less efficient than vertical family planning programs. Rather, they say, priority should be given to meeting the unmet need for contraception, as conventionally defined. They further argue that ‘population’ resources, small to begin with, certainly should not be stretched to cover the kind of ‘social engineering’ — that is, health, empowerment, and rights — mandated by the ICPD. If there is to be any ‘social engineering,’ they say, it should take the form of incentives or other persuasive measures directly targeted on fertility and, in particular, contraceptive use.”⁵⁵ In other words, they wanted to continue the hard sell, complete with hard targets, and relying upon bribes, sanctions and propaganda campaigns to ensure compliance.

Advocates of a “reproductive health care” approach, including Germain herself, sought to reassure the hardliners that the “demographic imperative” — that is, the need to control population growth — remained the top priority. “[A] reproductive health approach will be more cost effective in *meeting demographic goals* ... by reducing dropout and failure rates, and ... by appealing to the younger individuals and couples who, in demographic terms, need to ...*contracept earlier and longer*. Proponents of the ICPD also look to broad ‘social engineering’, rather than fertility-centered propaganda or incentives ... That is, we argue for creation of socio-economic conditions in which it makes sense for individuals to have *two or fewer children*.” [Italics added]

Germain concluded by reassuring hard-line controllers that these presumably costly social engineering programs would not compete with their existing programs for funding. Rather, they would be paid for by “broader development agencies and budgets, not from family planning budgets; nor would ministries of health and family planning be responsible for their implementation.” This new money, according to Germain, would ensure that the reproductive health approach would not compete with, but work alongside, existing top-down, numbers-driven population control programs. This point bears repeating: *The hard-line approach was slated to continue, with or without the infusion of new funds necessary to initiate full-service reproductive health care programs.*

In the event, the UNFPA’s fundraising drive, and those of related organizations, stalled shortly after take-off. In the years since, it has issued increasingly frantic calls for donor countries to “honor” the ICPD commitments — that is, put more money into population control — only to have these increasingly ignored.⁵⁶ Of the projected billions that these new commitments to reproductive health care supposedly required, only a fraction has been raised.⁵⁷

Caught between the demands of the Cairo agreement for reproductive health care programs, on the one hand, and the reality of existing family planning commitments and essentially static budgets, on the other, the population bureaucracy has had to improvise. They have done so by dressing up existing fertility control programs in the guise of reproductive health care. And they now tout such “reproductive health” programs as a great boon to women and children. Among the many benefits of reducing the birthrate they list lower maternal mortality, reduced infant mortality, improved overall health, and higher living standards. These claims are markedly inflated, if not entirely bogus, as we will see in a moment.

But first let’s talk about an even more egregious violation of informed consent and women’s rights involving a deliberate deception. In some parts of the world, women are lured into reproductive health centers on the promise of receiving primary health care. Once they arrive, however, they are subject to pressure to limit their fertility. This might accurately be called “health care bait and switch.”

Health Care Bait and Switch

Precisely because the “demand” for family planning is so latent, it must be vigorously shaken awake by incentives. One commonly used ploy is to offer one or more very limited primary health care services in order to entice women into visiting a family planning clinic, in which surroundings they can then be pressured to undergo sterilization or to contracept. These bait-and-switch tactics were fine-tuned in a series of experiments carried out in Matlab, Bangladesh, in the early eighties.

The World Bank, USAID and other donor agencies set up what critic Betsy Hartmann calls a “human laboratory” at the International Center for Diarrheal Disease Research in Matlab, Bangladesh.⁵⁸ Selected health services — such as prenatal care, training of traditional midwives, oral rehydration for diarrhea, tetanus immunization of pregnant women — were added, in Hartmann’s words, “to its family planning program in different “packages” in order to see which ones had the greatest effect on enhancing [family planning] field worker credibility and thus increasing contraceptive use. ... Through a series of regression equations, the researchers concluded that only a minimal Mother and Child Health (MCH) package achieved the desired result and that further expansion of MCH services to include, for example, prenatal care and midwife training was not essential to increased contraceptive use.”⁵⁹

What bait proved sufficient to lure women in? The study revealed that Bangladeshi women would expose themselves to family planning pressure in return for a manufactured packet of oral rehydration salts worth about five cents. It cautioned against including some kinds of health care, such as a salt-and-molasses rehydration method, because it took the focus off family planning. Teaching the village women about this locally available rehydration method, which used condiments from their own kitchens, diverted “attention away from family planning to new and complex health education and community organization activities.”⁶⁰ Better that the women have to come in to the clinics for their manufactured rehydration packets — and their pills, Norplant, and IUDs.

The “bait and switch” approach produced results pleasing to the controllers. Birth rates went down in Matlab, where a much higher percentage of women of reproductive age are contracepting, or have been sterilized, than in neighboring areas. The lead researchers happily report that this came about even though the people in Matlab are neither healthier, nor better off economically, than their neighbors, asserting that this answers in the affirmative “one of the central questions in the population field: Can family planning programs in the developing world succeed in the absence of extensive socio-economic development?”

This “Matlab model” has since been applied to population control programs worldwide. It has become a byword for the provision of very limited health services, often no more than oral rehydration packets, with the intention of gaining access to women’s reproductive tracts. If promoting family planning at the expense of desperately needed basic health care seems an offense against justice, then engaging in the *pretense* of providing health care while actually promoting family planning is unquestionably unethical. The controllers defend themselves by claiming that their programs reduce infant and maternal mortality but, as we will see below, these claims are highly exaggerated, if not entirely false.

Do Population Control Programs Reduce Maternal Mortality?

The population controllers left Cairo fuming at their failure to set global targets for such things as contraceptive acceptance, fertility decline, or population growth. But they quickly realized that the “reproductive health approach” that emerged from the deliberations provided them with new ways to justify their anti-natal project. First of all, it gave them access to a new and powerful rhetoric centered on women’s reproductive rights. Equally important, it allowed them to advance an innovative set of numbers-based arguments, this time not based on global population growth, but on the supposed ability of their programs to help women and children by reducing maternal and infant mortality. As UNICEF executive James Grant bluntly put it at the time, “Children and women are to be the Trojan Horse for dramatically slowing population growth.”⁶¹

The campaign to hype the problem of maternal mortality, and to advance family planning as the solution, was begun in earnest in 1996 with the release of a major UNICEF report called *The Progress of Nations*. Prepared under the direction of then-executive director Carol Bellamy, the report estimated “almost 600,000 deaths among women in developing countries from pregnancy and childbirth-related causes each year.”⁶² The statistics in the UNICEF paint a grim picture of what it revealingly called “the toll of motherhood on young women’s lives,” estimating 140,000 deaths from hemorrhaging, 100,000 deaths from sepsis, 40,000 from obstructed labor and, among other causes, 75,000 deaths among women attempting to abort themselves. “One quarter of all adult women in the developing world are affected by injuries related to pregnancy and childbirth,” it pronounced, “...injuries that are painful, humiliating and often permanent. ...For every woman who dies, approximately 30 more suffer injuries and disabilities.”⁶³

Maternal mortality is “one of the most neglected tragedies of our time,” thundered Bellamy, who suggested that a “conspiracy of silence” had hitherto shrouded the issue from public view. “If the toll of maternal death and injury is to be reduced, then the silence that surrounds the issue needs to be broken,” says the UNICEF report. “Family planning services should be available to all who need them.”⁶⁴ Although the report also goes on to discuss the need for good quality health care and better nutrition, pride of place is given to the simple-minded expedient of reducing maternal mortality by reducing the number of women who become mothers.

It was hard to take this rhetorical outburst seriously, especially since the controllers had for years been using the same false logic in Bangladesh, China, India, and elsewhere. Besides, the numbers did not add up. The new number for maternal mortality — which was actually 585,000, not 600,000 — was 20 percent higher than earlier estimates, although few new surveys of the problem had been conducted. (The number previously bandied about was 500,000, a number whose string of zeros suggests its lack of precision.) There were other problems with the report. For example, if one in four adult women have suffered “injuries related to pregnancy and childbirth,” that would mean that something on the order of 500 million women are affected. Yet the report also claims that “for every woman who dies, approximately 30 more suffer injuries and disabilities,” which results in a much lower figure of 17,550,000 for those allegedly injured or disabled.⁶⁵

Consider the source, critics also said, pointing out that the report was compiled by UNICEF, the World Health Organization, and Johns Hopkins University. All three organizations were committed advocates of anti-natal policies, and all three stood to benefit if spending on family planning programs was increased. In short, the report was properly understood as a self-serving marketing device for more family planning funding, rather than an objective look at what is — and what ought to be done about — an admittedly real and pressing problem. Still, the media reported the new numbers as fact, not fiction.

Earlier that year, the Congress had voted to slash America's "population assistance" funding by over one-third, dropping it from \$580 million down to \$380 million. This dramatic \$200 million cut completely negated Clinton-era funding increases, returning spending levels to roughly what they had been under the previous administration of President George H. W. Bush. The population control lobby responded with its usual scare tactics, but with a post-Cairo twist: This time its leading members did not fall back on their shop-worn scenarios of famine, war, and environmental disaster, but instead predicted that the cuts would cause vast and needless suffering among women and children. The head of the United Nations Population Fund (UNFPA), Nafis Sadik, prophesied that "17 to 18 million unwanted pregnancies are going to take place, a couple of million abortions will take place, and I'm sure that 60,000 to 80,000 women are going to die because of those abortions — all because the money has been reduced overnight."⁶⁶

The problem was, once again, that Sadik's numbers did not add up. "Treated as a serious prognosis," wrote demographer Nicholas Eberstadt in response, "Dr. Sadik's prophecy would have had some remarkable implications. For its arithmetic to work, for example, population growth in such places as Latin America and Indonesia ... would basically have to double from one year to the next. To all but the most committed anti-natal advocates, the implausibility of the official UNFPA assertion was patent."⁶⁷

The Sadik prophecy was quietly jettisoned, and a new set of numbers from the Alan Guttmacher Institute, the research arm of the Planned Parenthood Federation of America, became the basis for the controllers' counterattack.⁶⁸ These numbers are both considerably more modest and incredibly more precise than Sadik's. Instead of 17 to 18 million unwanted pregnancies in the developing world, the Guttmacher report predicts *exactly* 3,956,544. And, of these women, the report goes on, *exactly* 7,894 will die in pregnancy and childbirth. As a result of an increase in high-risk births, 134,000 more infants will die as well. Complete with a section on methodology, details of calculations, and a lengthy list of references, the report had all the trappings of a scientific treatise.

"[F]or all its seeming rigor and statistical precision, this Guttmacher study is nothing but an elegant fantasy," wrote Nicholas Eberstadt at the time. "... By the logic animating this exercise, less public money for contraception would mean that a corresponding proportion of adults would automatically stop practicing birth control. These Guttmacher assumptions would be perfectly reasonable if Third World parents were blind automatons or headless beasts. ... Since it is completely tone-deaf to the very human qualities at the center of the family formation process, the Guttmacher calculations cannot provide a realistic estimate of the demographic consequences of Congress' impending population fund cutbacks. In truth, that impact is probably

incalculable. Depending upon how couples behave, it is possible that those cutbacks would have a small demographic impact — or virtually none at all.”⁶⁹ Eberstadt characterized the report as “junk science” that the population-control lobby “brought to Capitol Hill in the hope of influencing legislation.”

Not only were the assumptions underpinning the Guttmacher report flawed, but the actual numbers, for all their apparent precision, were fudged. We at PRI ran their numbers again — accepting, for the sake of argument, Guttmacher’s unlikely claim that 7 million or so couples not be able to contracept as a result of the funding cutback. We were surprised by what we found. At nearly each step in their calculations, we uncovered a hidden “fudge factor” which worked in their favor. In their zeal for population control, Guttmacher had inflated the number of unwanted pregnancies by 81%, and the number of maternal and infant deaths by a whopping 121%.⁷⁰ We decided to include this damning recalculation in a longer study, *not as our estimate of maternal mortality, but as evidence of Guttmacher’s duplicity*. The bulk of our report, called *Innocents Betrayed*, was devoted to ways of saving the lives of women and children by redirecting the \$200 million to primary health care programs.⁷¹

We issued our report, only to be surprised a second time by the extremes to which the neo-Malthusian lobby would go in its bid for funding. The Guttmacher study had originally been requested by Senator Mark Hatfield, who was using it as the centerpiece of his campaign in the Senate to restore the \$200 million in lost population funding. Now he seized upon our critique of Guttmacher’s maternal mortality estimate, and attempted to turn it to his purpose. In a speech on the Senate floor, he waved our report in the air. “Even the Population Research Institute admits that the funding cut will result in several thousand deaths,” he intoned. “Even one maternal death is too many.”

In the years since, such demographic demagoguery has become routine. Those who would cut population control spending, or even redirect it away from IPPF and other groups that promote abortion, are said to be callously indifferent to the increase in maternal and infant deaths that would follow. If they happen to be pro-life, they are also accused of betraying their own principles by “causing” the death of women and babies. When President George W. Bush reimposed the Mexico City policy in 2001, the U.N. Population Fund was quick to assert that U.S. denial of funding to international family planning organizations that promote abortion will result in the deaths of 4,700 mothers and 77,000 of their babies each year. *World Watch* added the now standard slur that “It’s one of the great ironies of right-wing politics in the United States that the self-styled “pro-life” activists devote the most vigorous of their activities to promoting policies that increase death.”⁷²

The above claims are pure fiction. The real world impact of funding decreases (or increases) on demographics is probably unknowable, because human beings deliberately regulate their procreation. As Eberstadt has remarked, “[I]f the Guttmacher methodology were actually valid, the population funding increase during the [early] Clinton years should be credited with bringing birth rates in Third World countries down significantly — but not even the neo-Malthusian lobby has been bold enough to make this extravagant claim.”⁷³

When birthrates do fall — for whatever reason — the absolute number of women dying in pregnancy and childbirth will obviously decline as well. This reduction in the maternal

mortality *rate* — the number of deaths per year per 100,000 women of reproductive age — is trumpeted as a central benefit of family planning, yet it is more accurately described as an *unintended consequence of family planning used as a marketing ploy*. The real key measure is the maternal mortality *ratio* — the number of maternal deaths per 100,000 live births — a figure that has shown little change under the impact of even the most intense family planning programs. Even the controllers admit as much. “Family planning can decrease maternal deaths, but it cannot help women give birth safely,” Deborah Maine *et al* point out. “Only access to emergency obstetric care can do that.”⁷⁴

The bitter irony behind the controllers’ claims to lower maternal mortality is this: The maternal health services vital for safe delivery become *less available when population control becomes a priority*. While population control programs are a drain on health personnel, resources and budgets in general, maternal and infant health care programs are the first to suffer — simply because they are the first to be co-opted. Health workers who would otherwise be attending births are off meeting targets for contraceptive “acceptors.” When Bangladesh, at the urging of the World Bank and other foreign donors, in 1984 instituted a “crash program” for reducing the birth rate, the Swedish International Development Authority (SIDA), in the words of Betsy Hartmann, “expressed concern that incentives and disincentives were ... competing with other health services ... by diverting the attention of health workers away from Mother and Child Health (MCH) services toward sterilization.”⁷⁵ Although SIDA ultimately pulled out of the five-year, \$270 million Population III project in protest, the project itself continued nonetheless under the guidance of the World Bank.

Increased contraceptive use in the Matlab project area of Bangladesh — that playground for population controllers — has had little effect on the maternal mortality ratio. The maternal mortality *rate* has followed the birthrate downward, as expected, but the maternal mortality *ratio*, as Betsy Hartmann points out, “has remained roughly the same since there has been no reduction in the health risks associated with each individual pregnancy.” Hartmann accuses the Matlab Institute⁷⁶ of “perpetuating the high risks associated with pregnancy in rural Bangladesh through its conscious decision *not* to provide basic maternity care as part of its family planning program. According to its own study, direct obstetric causes such as postpartum hemorrhage, toxemia, and postpartum sepsis accounted for 77 percent of all maternal deaths in the project area. Many of these could have been avoided with basic maternity care, including the training and equipping of traditional midwives, one of the “packages” that [the Matlab Institute] decided is not necessary to increase contraceptive acceptance. Clearly for [the Institute], preventing pregnancy takes priority over protecting pregnant women.”

Speaking at a recent U.N. conference, Dr. George Mulcaire-Jones of Maternal Life International pointed out that 60% of births in Africa occur in the most primitive conditions, without the aid of skilled birth attendants whose presence is the “fundamental determinant in reducing maternal death.” Mulcaire-Jones was asked by the International Planned Parenthood Federation (IPPF) about ways of increasing contraception and family planning services as a way of reducing maternal deaths. Mulcaire-Jones replied that reproductive health funding already goes mostly to family planning, “leaving little for basic and emergency obstetrical care.” For example, 70% of all reproductive health funds in Zambia are allocated to family planning, with only 15% for antenatal care and 15% for safe births. Mulcaire-Jones stressed the need for

a paradigm shift, since “a [hemorrhaging] pregnant woman doesn’t need contraceptives, she needs emergency obstetrical care.”⁷⁷

At the same event, former Peruvian Minister of Health, Dr. Fernando Carbone, stated that over the last 20 years Peru has focused on providing family planning services because “we found that we received [international] aid if we implemented [such] policies”. However, the maternal mortality rate failed to drop as expected. The Peruvian government found that “75% [of maternal deaths] were [due to] causes that were not being focused on” by family planning services, such as poor antenatal care and lack of “attention at delivery.” These problems were exacerbated by the recent, UNFPA-supported sterilization campaign in Peru, which has led many poor women to avoid health centers because they feared that they will be coerced into a tubal ligation.⁷⁸

Finally, while the controllers carefully calculate the numbers of women they have indirectly “saved” through their contraception and sterilization programs, they ignore the lives lost *as a direct result of those same programs*. Most forms of contraception — and all forms of sterilization — carry an associated mortality risk, a risk that is much higher for undernourished African, Asian, and Latin American women than it is for well-fed Western women. If a Nigerian woman implanted with an IUD develops a fatal case of Pelvic Inflammatory Disease, or if a ligated Peruvian woman perishes from peritonitis, should not these deaths be counted against the controllers’ claims to reduce maternal mortality? Many think so. Says Hartmann: “[M]any feminists in the population field are calling for a wider definition of maternal mortality (“reproductive mortality”), which would include not only deaths associated with pregnancy, but those related to contraceptives.” And, I might add, sterilization. So far this request has been met with silence.⁷⁹ The controllers are not nearly as eager to address the costs of their programs as they are to tout their imagined benefits.

Carrying their argument through to its logical conclusion, the controllers would eliminate maternal (and infant) mortality *by eliminating pregnancy altogether*. No one could doubt the efficacy of this approach. One could likewise eliminate all traffic fatalities by the simple expedient of absolutely forbidding the use of motor vehicles. Yet few researchers or policymakers concerned with traffic safety would propose such a radical solution. Instead they would propose safer roads, improved driver’s training, and better safety restraints — unless they had a hidden agenda, such as banning the internal combustion engine, and were using a feigned concern for human life to justify their environmental extremism. The best way to reduce maternal and infant mortality is to provide proper prenatal care, and to have all births attended, but this would not advance the controllers not-so-hidden agenda of restricting the number of births.

Under pressure, the UN Population Fund recently endorsed the importance of skilled obstetrical care in reducing maternal mortality. Its report, *Maternal Mortality Update 2004: Delivering into Good Hands*, acknowledges that “efficient emergency interventions for [obstetric] complications are key to saving women’s lives.” Dr. Mulcaire-Jones says that the UNFPA report largely validates what the pro-life community has said all along: that reducing maternal deaths comes down to the kind of skilled obstetrical care given women — adequate training and clean, well-supplied birthing facilities — and has little to do with introducing notions of reproductive rights.⁸⁰

Despite this admission, the UNFPA continues to justify its campaign to contracept women primarily in terms of reducing maternal mortality.⁸¹ When the agency signed a five-year agreement with the Philippine government to promote “reproductive health,” it was touted by the UNFPA as a way to keep Philippine women from dying of pregnancy-related causes.

Do Population Control Programs Reduce Infant Mortality?

Another benefit of family planning asserted by the controllers is lower infant mortality.¹ Fewer children born obviously translate into fewer infants dying in their first few days, weeks, or months of life. But the infant mortality *rate* — the number of infants under the age of one dying per 1000 births in a given year — like the maternal mortality ratio, often remains stubbornly high. Why would fewer newborns not equate with better care for each, especially under a contraceptive regime that limits the number of high-risk births to both teenagers and women in their forties?

In the Matlab experiments, for example, despite rocketing contraceptive prevalence rates, infant mortality rates remained largely stagnant. Other countries with intensive family planning programs have likewise seen only modest declines in infant mortality. Demographer John Bongaarts has explained this counterintuitive result in terms of a higher proportion of first births and births after short intervals, both of which lead to higher infant mortality. Of Matlab, Bongaarts writes “What little decline [in infant mortality] that did occur was probably due in large part to maternal and child services introduced at the same time.”⁸² These were precisely those “services” that Matlab researchers were, in the words of Betsy Hartmann, “striving to keep to a minimum so as not to interfere with family planning. . . . In recent years, infant mortality rates have declined somewhat in Bangladesh, mainly due to extensive childhood immunization programs, though they still remain unconscionably high.”⁸³

In recent years, the family planning programs have emphasized “spacing” children, that is, they have encouraged women to contracept for several years after the birth of a first child before conceiving a second. Survival rates of children who are spaced two or three years apart are generally higher than those who are born at shorter intervals, especially in parts of the world where women and infants may not be well-nourished. The controllers offer this as evidence that their programs have in fact benefited their target populations.⁸⁴ Of course, this also serves as a fertility control measure, since it is a truism in demography that fertility delayed is fertility denied.

At the same time, every policy intervention has unintended consequences. Before the controllers are allowed to congratulate themselves on reducing infant mortality rates, they must answer the charge that their programs have directly contributed to the rise of an epidemic of female feticide and infanticide in Asia.

Agricultural societies place a high value on children, especially sons, who work as field laborers from a young age and provide economic security to their elderly parents. The value of children declines with industrialization, as the demands of education take children out of the home economy and pension programs provide substitute support in old age. To embark upon fertility reduction campaigns in the absence of industrialization and pension programs, especially in the presence of a strong preference for sons, is to condemn large numbers of girl children to death *in utero* or after birth.

This can be seen most clearly in China, where the brutal and punitive one-child policy has

¹ The Infant Mortality Rate is the number of deaths of infants under one year of age per thousand live births in a given year.

been a death sentence for tens of million of girls and created a striking gender imbalance. In normal human populations about 106 baby boys are born for every 100 baby girls, a disparity that evens out over time as the boys suffer higher infant and child mortality rates. Since the early 1980s, however, the sex ratio at birth in China has climbed steadily higher, until today it stands at about 117 boys for every 100 girls.⁸⁵ In some provinces, the ratio is even higher. Hainan Province, in the far south, currently has the most skewed rates in the country, with 135 boys born for every 100 girls. One pediatrician on Hainan Island estimates that 70% of the newborns born in the hospital where she works are boys.

In the early years of the one-child policy the age-old Chinese practice of female infanticide made a startling comeback, as unwanted baby girls by the hundreds of thousands were dispatched at birth by smothering, drowning, abandonment, or neglect.⁸⁶ As ultrasound machines found their way into clinics in China's towns and villages, however, sex-selective abortion became the more common method for eliminating these unwanted girls. Most second- and third-trimester elective abortions in China today are performed on women who have discovered — or whose husbands or in-laws have discovered — that they are carrying a girl. Infanticide continues, albeit at a lower rate.

Table 10.3

Sex Ratios at Birth for East Asian and South Asian Countries

Afghanistan	1.0500
Bangladesh	1.0600
Bhutan	1.0500
Burma	1.0600
Cambodia	1.0450
People's Republic of China	1.1160
India	1.1192
Japan	1.0522
North Korea	1.0500
South Korea	1.0822
Laos	1.0420
Macau	1.0501
Maldives	1.0499
Mongolia	1.0500
Nepal	1.0500
Pakistan	1.0500
Singapore	1.0770
Sri Lanka	1.0440
Taiwan	1.0950
Thailand	1.0535
Vietnam	1.0740

U.S. Census Bureau, International Database, 2006 figures.

Other countries with vigorous family planning programs in East and South Asia have also shown striking increases in the sex ratio at birth. South Korea, which has had a *de facto* two-child policy for decades (government officials who have more than two children, for example, are denied promotions), was registering nearly 116 baby boys for every 100 baby girls born by 1993. In India, with its ongoing “compul-suasion” campaign, there are 94 women for every 100 men, compared with a worldwide ratio of 106 women for every 100 men. Bangladesh, Nepal, Sri Lanka, Bhutan, Pakistan, Vietnam, and Taiwan also report unnaturally high sex ratios among newborns.⁸⁷ As in China, sonograms are used by parents in these countries to learn the sex of their unborn baby, and the less desired gender is aborted.

Both the UNFPA and the Chinese government deny that this plague of “female feticide and infanticide” is in any way connected with their family planning programs, preferring to explain these practices as “manifestations of son preference and patriarchal structures which prevail across the region.”⁸⁸ But then how does one explain the obvious correlation between the *intensity* of previous population control efforts and the *severity* of the sex ratio skewing? After all, the most skewed ratios belong to countries with the most coercive programs, such as China, India, and Vietnam, where “excess” fertility was a crime and was punished as such. The least-skewed sex ratios belong to countries like Taiwan, whose people may have been predisposed to have fewer children by anti-natal propaganda, but where out-and-out coercion was absent. In either case, sexist abortions are in part a response to such fertility reduction programs, which leave parents, objectively (or subjectively) with no alternative but to selectively eliminate girls if they are to stay within their allotted (or desired) quota of children *and* provide for their own support in old age.

How many little girls have been eliminated? In 2000 the UNFPA estimated that there were 79 million women “missing” from South Asian countries, and explicitly blamed discrimination against unborn girls for their disappearance from the population. The Chinese government reports that two million more boys than girls are born each year, a number which suggests that something on the order of 2 million baby girls are the victims of sex-selective abortion or infanticide annually.

In a tacit admission that the one-child policy is responsible, the Hainan provincial government now allows a second child to a couple whose first child is a girl.⁸⁹ Other provincial governments are attempting to bribe couples into bearing and keeping their baby daughters, offering them a monthly income in their old age, free schooling and housing grants, and better employment opportunities. Still, the elementary schools are filled with pampered “little emperors” while the orphanages are filled with abandoned baby girls. China has become one of the principal sources of adoptive children — nearly all of whom are female.

The Chinese government has belatedly tried to ban the use of medical equipment — ultrasound machines and amniocentesis — to determine the sex of the unborn baby. Vietnam, whose two-child policy mimics China’s one-child policy in important respects, has drafted a nearly identical law. Similar measures in other countries have failed to curb the practice, however. India outlawed ultrasound tests to determine an unborn child’s sex in 1994, yet a recent study showed that 995 out of every 1000 children aborted are female! The doctor doing the ultrasound — justified on the basis of some medical necessity — circumvents the law with a

wink and a nod to the parents; no words are ever spoken. It remains to be seen whether an even harsher measure recently passed by New Delhi, which requires revoking the medical license of any doctor caught performing sex-selective abortions, will have any impact at all. A doctor so accused could always claim that the abortion was not being done for reasons of sex at all, but rather for the health of the mother or for suspected fetal abnormality.⁹⁰

Some Chinese provinces have gone even further. Anhui and Guiyang provinces, for example, have forbidden *all* elective abortions past the first trimester of pregnancy. The population control police, who commonly coerce women into abortions up to the point of childbirth, are naturally exempted from this rule.⁹¹ The Chinese government apparently believes that, while it is wrong to abort a child just because she's a girl, it's perfectly alright to abort a child just because her parents already have one child.

Attributing Beijing's sudden concern for unborn girls to nascent gender sensitivity is probably a mistake; it is the growing imbalance between men and women that has the Chinese government worried. There will be 40 million single men in China by the year 2020, according to Chinese government estimates. These are men who will never be able to find brides because of the absolute shortage of females.⁹² Enforced "bachelorhood" in a culture where marriage has historically been almost universal could turn Chinese society into a tinderbox. It is already creating a host of social pathologies, from prostitution and sex crimes, to wife-buying and selling, to baby-kidnapping and trafficking. Beijing is moving to ban sex-selective abortions because women are in increasingly short supply and China needs to "produce" more of them. The obvious solution to the problem — abandoning the one-child policy and permitting couples to have as many children as they wish — is evidently not under consideration.

All this is to say that, while population control programs may indirectly reduce infant mortality, they may also be a contributing factor to other forms of neonatal mortality. By encouraging (or compelling, or coercing) Asian couples into limiting their family size, they greatly exacerbate the problem of female feticide and infanticide. Whatever modest reduction in infant mortality rates in East, Southeast, and South Asia the controllers may properly take credit for, this hardly offsets the cost of condemning tens of millions of viable unborn baby girls to an untimely death.

Some population control programs contribute indirectly to maternal and infant mortality in other ways. In China and Vietnam, for example, heavy fines are levied on the families of "illegal" children, and the children themselves are denied residency, food rations, healthcare, and even schooling. Elements of such policies are found in South Korea, India, and other countries with rigorous family planning programs. By negatively impacting family finances and access to government health and other services, such punitive policies negatively affect the health of families which violate birth restrictions.

Finally, practices such as coercive abortion and sterilization take a toll in human lives. Yemlibike Fatkulin, a member of China's Uyghur minority⁹³, testified before the U.S. Congress about the effect of coercive birth control policies upon her people:

[U]nder the pretext of 'ensuring a steady growth in minority populations'... the Chinese government launched a series of extensive birth control and forced

sterilization campaigns all over East Turkestan, targeting the Uyghur women. In the summer of 1998, my cousin Eneytull Habibil's wife Mangnehan was about to have twins at Turpan Yar village 5-star hospital. However, the twins were immediately aborted after hospital officials learned that they already had a child. ... My relative Kerimhan's three babies were all aborted by Chinese doctors in Turpan Yar's village 5-star hospital. As a result of forced abortion, she developed severe bleeding problem until this very day. ... According to some Uyghur family planning workers, in order to fulfill the quota of abortions, sometimes Chinese doctors are forced to kill the newborn Uyghur babies. As a result, this birth control system has led to the deaths of many Uyghur mothers and children every year.⁹⁴

Do Population Control Programs Reduce Abortions in General?

All population control organizations assume that increased contraception means less abortion. For example, UNFPA claims that “Where abortion is safe and widely available, and other reproductive health services are in place, rates of abortion tend to be low. The simple conclusion is: better contraceptive services for all people will reduce abortion.”⁹⁵

This claim is repeated *ad nauseum* by abortion advocates. For example, a 2007 report by the Guttmacher Institute and the World Health Organization (WHO) asserts that the “unmet need for contraception” in Latin America is the cause of the region’s high abortion rate. But the estimate of 33 abortions per 1,000 women aged 15-44 per year that it offers is unsupported by empirical evidence.⁹⁶ In Columbia, for instance, Guttmacher reports hundreds of thousands of abortions, yet PRI was informed by the Columbian Vice Minister for Health in early 2008 that the Ministry has recorded only about 50 abortions since the legalization of abortion in May 2007. Guttmacher’s numbers for abortions would appear to be off by many orders of magnitude.

We need look no further than our own back yard to recognize how questionable the claim that contraception reduces abortion is. In the United States, virtually anyone can get any contraceptive they want from any drug store or pharmacy. There are condom machines in restrooms, schools and restaurants. School-based clinics and thousands of Planned Parenthood Federation of America (PPFA) and other family planning clinics go out of their way to ensure that our sons and daughters have access to a complete range of contraceptives and abortifacient devices. In the United States, fully 94.8% of sexually active women are either sterile or use some form of contraception — yet the abortion rate has not changed significantly since 1975.⁹⁷

The Alan Guttmacher Institute, the research arm of PPFA, acknowledges that there are two million contraceptive failures in the United States each year. Dr. Louise Tyrer, Medical Director of the Planned Parenthood Federation of America, confirmed that “More than three million unplanned pregnancies occur each year to American women; two-thirds of these are due to contraceptive failure.”⁹⁸ Nearly 60 percent of all abortions in the USA — more than 870,000 annually — are performed on women who were using contraception at the time they became pregnant.⁹⁹

Contraceptive failure also explains why handing out contraceptives to teenagers does not reduce the rates of teenage pregnancy and abortion. A careful study by British economist David Paton found no evidence that “the provision of family planning reduces either underage conception or abortion rates,” in part because providing such services “increases the rate of sexual activity among teenagers.”¹⁰⁰ Whatever “protection” from pregnancy contraceptives offer is offset by higher rates of artificially stimulated sexual activity.

On a worldwide level, contraceptive use in developing countries has increased from about 8% of all couples in 1960 to about 60% of all couples in 1998. If contraceptives were really the answer to reducing “unwanted pregnancies,” we should have seen a precipitous drop in the number of abortions performed worldwide over this period of time. Yet the Alan Guttmacher Institute in 2007 estimated that the number of abortions per year was still running at 42 million or so, which is largely in line with earlier estimates.¹⁰¹ In other words, we have flooded the world with contraceptives, but the abortion rate remains high.

The reason for this apparently paradoxical phenomenon is quite simple: Population control groups implement widespread contraception, claiming that it is the “answer to unwanted pregnancies” and that it will “cut down on unsafe abortions.” As contraception becomes more widely available, it begins to fail in hundreds of thousands of cases, and so the population controllers must then agitate for unrestricted abortion as a backup measure.

Many of the world’s most experienced demographers and population experts, not to mention leading abortion advocates, have acknowledged that more contraception leads to more abortion. Dr. Malcolm Potts, the former Medical Director for the International Planned Parenthood Federation, said in 1979 that “As people turn to contraception, there will be a rise, not a fall, in the abortion rate.”¹⁰² Dr. Christopher Tietze, the world’s most experienced abortion statistician, seconded this hypothesis when he said that:

A high correlation between abortion experience and contraceptive experience can be expected in populations to which both contraception and abortion are available ... women who have practiced contraception are more likely to have had abortions than those who have not practiced contraception, and women who have had abortions are more likely to have been contraceptors than women without a history of abortion.¹⁰³

Tietze also said that “Within 10 years, 20 to 50 percent of pill users and a substantial majority of users of other methods may be expected to experience at least one repeat abortion.”¹⁰⁴ Note that Tietze is speaking about *repeat* — second or later — abortions here. He calculated that the abortion rate in a country with moderately effective contraception programs will be 1,000 per 1,000 women over their reproductive lifetimes, for an average of *one per woman*.¹⁰⁵

Population experts are well aware that contraception is very unreliable and leads to millions of “unwanted pregnancies” each year. Therefore, they know that the only way to effectively cut population growth is to advocate the legalization of abortion as a back-up to correct these millions of “contraceptive failures.” Population statistician Emily C. Moore reflected the reality of contraceptive failure when she wrote: “Since contraception alone seems insufficient to reduce fertility to the point of no-growth, and since population experts tell us that eliminating unwanted fertility [is necessary], we should permit all voluntary means of birth control (including abortion) so as to avert the necessity for coercive measures.”¹⁰⁶

Reducing the Maternal Mortality Ratio

What would a serious effort to reduce the number of women dying in pregnancy and childbirth entail? First, it would recognize that the underlying problem is poverty. Women in developing countries die in childbirth *not* because they have not been chemically or surgically sterilized, but *mostly because they are poor and in ill health*.

The effect of poverty on maternal mortality is aptly illustrated by Sub-Saharan Africa, which has the highest maternal mortality ratio in the world: 1,030 maternal deaths per 100,000 live births. Within this region, the country that suffers the greatest number of maternal deaths is Nigeria. In 1990 Africa’s most populous country recorded 44,000 deaths, or one out of every thirteen maternal deaths in the world.¹⁰⁷ Why? Kelsey A. Harrison, professor of Obstetrics and Gynecology at the University of Port Harcourt in Nigeria, reports that:

*instances abound where women are dying in the hands of good doctors just because they do not have the money to pay. . . High maternal mortality in Nigeria, estimated to be 1,000 per 100,000 births, will not go away as long as three fundamental issues prevail: mass poverty with gross inequalities, unbooked emergencies, and illiteracy, which bestrides and underlies both. . . . High maternal mortality is a manifestation of gross underdevelopment. Hence its permanent reduction requires societal transformation.*¹⁰⁸

Unbooked emergencies — pregnant women with medical emergencies — account for 70 percent of all maternal deaths in Nigeria. Many poor women do not receive any form of prenatal care and deliver their children far from the nearest medical facility. Others are seen by health professionals for the first time when they arrive at a hospital in severe distress. Many of these are suffering acutely from difficult labor, pregnancy complications in an advanced state (obstructed labor, uterine rupture, obstetric fistula, or retained placenta), or other diseases (malaria, anemia and bacterial infections such as active pulmonary tuberculosis). And if they are not able to pay, they are often denied life-saving treatment. Those poor women fortunate enough to experience a relatively uncomplicated delivery often suffer from postpartum neglect leading to life-threatening health problems such as severe blood loss and infection.¹⁰⁹

What *will* ultimately save the most mothers — and enable them to live their lives at a level of well-being they do not now enjoy — is a comprehensive attack on the underlying causes of ill health and poverty. The death toll could and should be significantly reduced over the short term by providing emergency obstetric care. It could be brought down even further by primary health care programs that include prenatal check-ups. This would enable high-risk pregnancies to be identified *before* the onset of labor. Over the long run, it could be virtually eliminated by ending, through economic development, the poverty that is its root cause.

The only way to ensure that every pregnant woman is healthy and at minimum risk is to provide her with comprehensive maternal health care during her pregnancy and delivery. This solution, although essential over the long term, is many years, even decades, off for most developing countries. How can we best help the millions of poor women at risk of dying in the meantime? The best short-term solution for the vast majority of cases of maternal mortality and morbidity among poor women in developing nations is to broaden the availability of emergency obstetrical care and encourage all births to be attended. This commonsensical approach has even been endorsed by the UNFPA:

Obstructed labor, hemorrhage and postpartum infection (maternal sepsis) are among the major causes of maternal mortality. . . . Reducing maternal mortality to reach the goals accepted by the international community (reduce the 1990 level by half by year 2000 and by half again by 2015) calls for broad availability of emergency obstetrical care to handle complications of birth and delivery. It also calls for attended birth to be the norm rather than the exception.¹¹⁰

To address the underlying health problems which later give rise to maternal morbidity and mortality we must also solve the problem of malnutrition in developing countries. The UNFPA

itself identified malnutrition as a key contributing factor to many maternal deaths:

Malnutrition contributes more than any other factor to disease and injury worldwide. It contributed to 5.9 million deaths in 1990 and played a role in fully 15.9 per cent of all morbidity (illness). Most of the people who died were in Africa and South Asia, and many were in the first years of life when children are especially vulnerable. Poverty was the main underlying cause, but a disproportionate number were female.... Malnutrition and associated health problems among young girls are far more common than they need be, even in poor families. Malnutrition for girls in early life contributes to health problems later on. It contributes to anemia, a risk which intensifies after the start of menstruation. *In developing countries, iron-deficiency anemia is the third leading cause of disease for women between ages 15 and 44.... Malnutrition and anemia contribute to many of the problems found in pregnancy and delivery and play a part in many maternal deaths.*¹¹¹(emphasis added)

United Nations studies show that there are direct mathematical correlations between maternal, child and infant health and the provision of certain basic services. Maternal, child and infant health improves as:

- Access to safe water improves.
- Access to sanitation facilities improves.
- Trained health workers attend more births.
- Immunizations against disease increase. Of particular interest are acute respiratory virus (ARV), diphtheria, dengue fever, hemophilus influenza Type B, hepatitis B, Japanese encephalitis, measles, meningococcal, mumps, pertussis, poliomyelitis, rotavirus, pneumococcal disease, shigella, tuberculosis, typhoid fever, varicella (chickenpox), vitamin A deficiency, and yellow fever.
- Proper child nutrition programs are instituted.
- Illiteracy decreases.
- Commercial energy use increases.¹¹²

The overlap between the health-related items on this list and our survey results is striking, and further underlines the soundness of African views on the subject. The non health-related items on this list — such as an improved diet, higher literacy rates, and increased energy use — suggest that the best way to reduce maternal mortality in a developing country is to improve its economy, eliminate illiteracy, and reduce poverty. Even Hillary Clinton, a staunch supporter of population control, acknowledged as much at the UNFPA's Hague Forum when she said that "No nation can move forward when a large share of its women are illiterate and impoverished."¹¹³

Misguided Strategy

Instead of attacking the problems of maternal and infant mortality at their roots, the controllers focus almost exclusively on the provision of contraception and sterilization. Take, for

example, the UNFPA's programs in Nigeria. The UNFPA's 1996 *Inventory of Population Projects in Developing Countries Around the World*, the last such report available,¹¹⁴ outlines the agency's overall country strategy for Nigeria:

The Governing Council approved \$35 million for a five-year programme starting in 1992. The programme will: decrease maternal and infant mortality; achieve a lower population growth rate through the reduction of fertility by voluntary fertility regulation compatible with the social and cultural conditions of the country and the economic and social goals of the nation; enhance the status and condition of women and encourage their full participation as equal partners in the development process of the country; continue the population education programme for secondary schools and organized labor; and promote (IEC) [information, education and communication] campaigns for special target groups, with special emphasis on the promotion of Safe Motherhood; promote community and NGO [non-governmental organization] involvement in programme development, implementation, monitoring and evaluation.

This country strategy, which is typical of the strategies for all of the developing countries in which the UNFPA operates, suggests a broad-based program in which efforts to reduce maternal and infant mortality are given priority over the wholesale distribution of contraceptives for population control purposes. *But closer examination of UNFPA projects reveals that this is not the case.* The *Inventory* provides details on UNFPA's 22 projects in Nigeria during the 1993-1997 time period. These include:

- Three community reproductive health service projects (with a strong emphasis on providing contraceptives, in particular condoms) — at a total cost of \$840,482;
- Three contraceptive supply projects — total cost \$6,151,000;
- Seven Maternal and Child Health/Family Planning projects, which consist of increasing the availability and accessibility of contraceptives — total cost \$4,839,000;
- One "Safe Motherhood" project, which seeks to improve cooperation between traditional birth attendants and the medical staff in the communities — total cost \$373,000;
- "Family Health Soap Opera Television Series" (designed to popularize anti-natal attitudes) — total cost \$658,000;
- Seven projects designed to perform research and data analysis on population policies. These projects primarily include the collection and analysis of demographic data, cartography and census work, planning, and coordination, monitoring and evaluating various population programs — total cost \$3,367,552.

Of the 22 Nigerian population projects listed, 14 are "grassroots" efforts. Only one of these, the "Safe Motherhood" project, will have any lasting impact on maternal health, and it is budgeted to receive only one percent of the total population funding.¹¹⁵

The reason why maternal mortality rates remain high, according to Dr. Robert Walley, the founder of Matercare International and an obstetrician-gynecologist of many years of experience in Africa is “the promotion by governments, their funding agencies and international health organizations of what is now known as “reproductive health,” which is simply a euphemism for abortion and contraception.” Dr. Walley goes on to say that, “It is estimated that billions of dollars are spent by our governments and private agencies on birth control programs, but only a small fraction is spent on emergency obstetric care which would help mothers survive their pregnancies. . . [T]o be a maternal death, a mother must be pregnant. The question is how do birth control pills or condoms help a mother with obstructed labor or a postpartum hemorrhage. In my experience the women who die want to be mothers but are poor, young and have no influential voice to speak on their behalf. [They] are denied emergency care which is readily available and inexpensive. . . . There is not the will or compassion to do what is necessary.”¹¹⁶

The UNFPA effort in Nigeria, as in the developing world as a whole, is heavily weighted toward preventing pregnancy in order to, as its own country strategy suggests, “lower [the] population growth rate.” However loudly the UNFPA and other population control groups trumpet the slight reduction in maternal mortality that follows from their massive campaigns to prevent pregnancy, it is clear that this is merely a secondary effect of its primary goal: to reduce the number of babies born. But the young African women who die in childbirth for the most part want to be mothers, as Dr. Walley says. They just do not want to perish as a result.

Saving Lives by the Numbers

Still, the controllers insist that their programs are all about saving the lives of women (and children) in the developing world. If this is so, we should answer, then there are far more cost-effective ways to go about this than by sterilizing and contracepting women in large numbers. In fact, if the money used to fund family planning is instead used to support basic health care and authentic economic development, the lives of *ten times* as many women and children could easily be saved.

Let us take, by way of example, the 1999 U.S. funding cut of \$25 million to the UNFPA. The controllers, after pledging to “do whatever it takes to restore funding for UNFPA”, claimed that this action “has deprived 870,000 women in developing countries of modern contraception, leading to half a million unintended pregnancies, 200,000 abortions and “thousands of maternal and child deaths.”¹¹⁷

- Let us assume what we earlier doubted, namely, that for \$25 million the UNFPA can actually prevent 500,000 pregnancies in developing countries.
- Let us further specify that all this money will be spent in Sub-Saharan Africa which, at 1,030 deaths per 100,000 live births, has the highest maternal mortality rate of any area in the world.
- Under these assumptions — all of which favor the UNFPA prophecy — the \$25 million in spending on contraceptives would save $5 \times 1,030 = 5,150$ women's lives.
- This translates into an average cost of \$25 million / 5,150 or \$4,854 per life saved.

But how many lives would be saved if this money were instead spent on immunizations or attended births? If our goal is to save as many mothers and babies as possible with this \$25 million, then we would be far better off supporting:

- **Maternal tetanus immunizations:** Studies have shown that, depending on the area, an average expenditure of from \$27 to \$225 on maternal tetanus immunizations will avert a mother's death — an average of \$126 per life saved.¹¹⁸ This means that the lives of 198,400 African mothers could be saved by maternal tetanus immunizations — nearly forty times as many lives saved than if \$25 million were spent on contraception and sterilization.
- **Breastfeeding promotion:** The same \$25 million spent on breastfeeding promotion among AIDS-free mothers would save the lives of more than 50,000 African infants, about ten times as many as would be saved if the money were spent on contraception and sterilization.¹¹⁹
- **Attending births:** United Nations statistics prove that maternal and infant mortality decreases dramatically if deliveries are attended by skilled personnel. In those nine African countries where an average of only 15% of all births are attended, the maternal mortality ratio averages 1,340 per 100,000 births. In those nine countries where an average of 83% of all births are attended, the maternal mortality ratio averages 320 per 100,000 births, a tremendous decrease.¹²⁰ Attended births also significantly reduce infant mortality. As the percentage of attended births increases from an average of 15% to an average of 83% in the countries mentioned above, infant mortality is halved, from 11,600 per 100,000 to 5,800 per 100,000.¹²¹ This means that maternal mortality decreases by 15 deaths per 100,000 and infant mortality decreases by 85 deaths per 100,000 for every percentage point improvement in attended births. At \$50 per attended birth, \$25 million would allow an additional 500,000 births to be attended, saving the lives of 7,500 mothers and 42,500 infants — a total of 50,000 lives saved, nearly ten times as many lives saved than is claimed would be saved if the money were spent on contraception and sterilization.

The controllers wrongly blame those who cut funding for their programs for causing the deaths of women and children. But their own activities divert funds from the real and pressing health needs of real people.

- If \$25 million is given to the UNFPA (or other family planning/reproductive health groups) instead of to maternal tetanus immunizations, more than 193,000 women will die.
- If \$25 million is given to the UNFPA (or other family planning/reproductive health groups) instead of spent on breastfeeding promotion, more than 50,000 African infants will die.
- If \$25 million is given to UNFPA (or other family planning/reproductive health groups) instead of paying health care workers to attend births,

2,350 women and 42,500 infants will die.

There are real opportunity costs to funding the UNFPA and other population control programs in lieu of authentic health care programs, costs that are paid in the coin of human lives.

Childbearing and Poverty

Population control does not jumpstart, and may even inhibit, the economic development of nations.¹²² But what economic calculus should we apply to individuals, especially to women? What are the economic and social consequences of restricting the childbearing of poor women in developing countries for the women themselves?

Poor people — and especially poor women — in developing nations often perceive the developed nations as fundamentally hostile to their way of life, an impression we reinforce when we inundate them with contraceptive devices and chemicals, or attempt to impose on them our laws governing sterilization and abortion. Typifying this overbearing attitude is George Foulkes of the United Kingdom, who said at the recent UNFPA-sponsored Hague Forum that “We need to make contraceptives and condoms as easy to get hold of in the developing countries as a can of Coca-Cola.”¹²³ This same kind of cultural imperialism is evident in Hillary Clinton’s comment, offered at an 18 October 1997 meeting on the role of women in Buenos Aires, that “the only road to improve the life of women is the massive promotion of contraceptive methods.”¹²⁴ The poor women of developing countries rightly translate this message to mean “We developed countries want you to have fewer children, or none at all, and we will not help you care for the children you already have.”

Feminists more radical than Hillary regard marriage as a form of bondage, and childbearing as a curse. Yet it is a serious mistake to project these views onto women in the developing world. The imposition of birth control on developing world women in the impossible expectation that this is all they need to free themselves from “patriarchy” is just as much of a myth as the notion that driving down the birthrate will jumpstart economic development. For the vast majority of women in the developing world, the real curse would be to remain single and/or childless, since family formation is their most important strategy for achieving both upward mobility and economic security.

Children confer status in nearly all peasant societies, and in many they are the only form of economic security that is readily available to women. In certain West African tribes, for example, fertility is so highly valued that women who have not borne children are buried apart from the rest of the group. Rapidly *decreasing* fertility places elderly women in an especially precarious position. They are often robbed of their traditional means of support in old age — their children — and have no alternative means of survival. “It used to be that older women could depend on their adult children to care for them in old age,” Ambassador Julia Alvarez from the Dominican Republic has pointed out. “In 1960, a Jamaican woman had an average of six children; by 1990 she was likely to have fewer than three. Now...typically she has two. Who will supply the support system for this mother when she is old?”¹²⁵

Conclusion

One may bemoan all this as hopelessly retrograde, but one cannot purposefully destroy existing cultural and economic arrangements which benefit women without first ensuring that alternative arrangements are available. Not unless you are willing to let women in the developing world pay a terrible price. Yet the controllers have no compunctions about trying to impose on traditional societies anti-natal attitudes and a lifestyle that is not only totally foreign to their experience, but is also totally unsuited to their present conditions. Most women in the developing world would be horrified at the thought of living the life of the typical radical feminist — early and promiscuous sexual activity, with serial relationships and perhaps serial abortions, forced to work outside the home by the lack of a stable family life, ending life with one child or none. Such a life would seem a curse, not a blessing.

When Christian missionaries attempted to convert the natives this was denounced by the secular humanists as “cultural imperialism.” Their own enterprise, funded and endorsed by the most powerful nation on the planet, is a far more pernicious example of the same. If it is not cultural imperialism to take from poor and vulnerable people their very attitudes towards life and family and bend them to our will, what is?

Decades after most of us became aware of, and sensitized to, the dangers of cultural imperialism, many controllers fail to appreciate the motivations and desires of individuals who may wish to have children. Indeed, they not only ignore the pro-natal views of those upon whom they visit their programs, they positively scorn them. Whether they are trying to contracept or sterilize women directly, or educate and employ them out of hearth and home, they blithely dismiss what are sometimes called the “demand side” issues in population policy with all the dogmatic certainty of unrepentant Marxists.

They take a jaundiced view of childbearing that they are eager to trumpet its shortcomings, as the following quote from a family planning book: “Mothers are more likely to die in childbirth if they have large number of children; they will also spend a high proportion of their adult lives pregnant, breast-feeding, and providing childcare.” But what if women enjoy feeling a new life growing within them, enjoy the bonding experience of breast-feeding, and enjoy caring for their small children. What then? Then their views must be swept aside.

Lurking behind all the woman-friendly rhetoric and rationalizations, the reality of what Adrienne Germain calls the “demographic imperative” remains. Women and children are merely means to an end, used as a Trojan Horse for dramatically slowing, even reversing, population growth.¹²⁶ And so they are.

(Endnotes)

- 1 Angela Franks, *Margaret Sanger's Eugenic Legacy: The Control of Female Fertility* (Jefferson, NC: McFarland, 2005), 244.
- 2 World Bank 1993 International Development Conference, Washington, D.C., 11 January 1993, 3. Also quoted in *PRI Review* 3(5)(September-October 1994): 9.
- 3 Contraceptive prevalence rate is defined by the World Health Organization as the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time. See <http://www.who.int/whosis/indicators/compendium/2008/3pcf/en/index.html>
- 4 See Chapter 2 of my *Population Control: Real Costs and Illusory Benefits* (Transaction Press, 2008) for a summary of Dr. Thor Ravenholt's dedication to population control at all costs.
- 5 Potts served as the Medical Director of IPPF from 1969 to 1978. He later became the director of the International Fertility Research Program.
- 6 Quoted in Franks, 215.
- 7 Barbara Ehrenreich, Mark Dowie, and Stephen Minkin, "The Charge: Gynocide; The Accused: The U.S. Government," *Mother Jones*, November 1979, 26-37, at 33-34.
- 8 The following section is based on James A. Miller's magisterial account of the Dalkon Shield debacle. See James A. Miller, "The Case of the Dalkon Shield," *PRI Review* 6(5) (September/October 1996): 3, 4.
- 9 Morton Mintz, *At Any Cost: Corporate Greed, Women, and the Dalkon Shield* (New York: Pantheon, 1985), 3-4.
- 10 Nicole Grant, *The Selling of Contraception: The Dalkon Shield Case* (Columbus: Ohio State University Press, 1992), 44.
- 11 James A. Miller, "The Case of the Dalkon Shield," *PRI Review* 6(5) (September/October 1996): 3, 4.
- 12 Dowie and Johnston, "A Case of Corporate Malpractice," *Mother Jones*, November 1976, 36-50, at 49. Ehrenreich *et al*, 28.
- 13 Dowie and Johnston, "A Case of Corporate Malpractice," *Mother Jones*, November 1976, 36-50, at 49. Ehrenreich *et al*, 28.
- 14 Ehrenreich *et al*, 28-29.
- 15 Mintz puts the figure at "more than 697,000 Shields (43), while Grant gives a precise 708,568 (43), and writer Dowie and Johnston, in their *Mother Jones* articles, say the number was "769,000 Shields."
- 16 Miller, 4.
- 17 Hearings of the Committee on Government Operations, U.S. House of Representatives, "Regulation of Medical Devices (Intrauterine Contraceptive Devices)," 93rd Congress, 1st session (Hearings: May 30, 31; June 1, 12, 13, 1973.), 306-24.
- 18 Ehrenreich, 30.
- 19 Mintz, 4-5.
- 20 Phyllis Piotrow, *Draper World Population Fund Report: Voluntary Sterilization*. (Washington, D.C.: Draper World Population Fund, 1976), 155. Cited in Franks, 214. For the details of Ravenholt's shipments of Depo-Provera overseas prior to FDA approval, see my *Population Control*, Chapter 2.
- 21 Note that I am not speaking here of emergency medical care, which in many parts of the world is quite rightly provided by paramedical personnel out of sheer necessity. Massive contraceptive distribution schemes are not driven by medical necessity, however, but by the ideology of population control. Such schemes violate accepted practice not because of the lack of medical facilities and licensed physicians, but because they are driven by a nonmedical purpose, namely, reducing the number of children born.
- 22 See my *Population Control: Real Costs and Illusory Benefits* (Rutgers, New Jersey: Transaction Press, 2008), especially chapter 6.
- 23 Ferguson was a birth-control activist who served as president of PPFA from 1953 to 1956, vice president of IPPF from 1959 to 1962, board member of the America Eugenics Society from 1957 to 1963, the Euthanasia Society of America from 1955 to 1962, and the Association for Voluntary Sterilization (now Engender Health) from 1956 to 1995.
- 24 Cited in Angela Franks, 117.
- 25 Quoted in Franks, 36.

- 26 “International News,” *Ms. Magazine*, November/December 1992, 15.
- 27 “PPFA clinics drop pre-test,” *Network*, Winter 1997, 2,7. *Network* is a quarterly publication of Family Health International, Research Triangle Park, North Carolina, and is funded in part by USAID.
- 28 Steven Mosher interview with Dr. Stephen Karanja, published under the title of “The Sword of Damocles: Population Control and AIDS Destroy African Families” in the *PRI Review* 10(5) (October/December 2000): 3,6,9
- 29 “Norplant alleged to cause blindness: Abuse of women in Bangladesh, Haiti documented,” *Population Research Institute Review* 6(3) (May/June 1996): 6. See also, “Plea to Stop Use of Norplant, Depo Provera on Women,” *The Independent* (Bangladesh), 11 April 1996, in which Akhtar’s organization, Ubinig, called these devices “inhuman” and “dangerous” to the health of poor Bangladeshi women.
- 30 Karanja, “Sword of Damocles,” 9.
- 31 Stephen Karanja, “Health System Collapsed,” *PRI Review* 7(2) (March/April 1997): 10.
- 32 Many drugs in Kenya are sold without a prescription, of course, but these come in the form of capsules, not injectables. While access to medical care is limited in parts of the countryside, the cities are relatively well supplied with clinics.
- 33 Karanja, “Health System Collapsed,” 11
- 34 These findings are reported in “The Risk of Ectopic Pregnancy After Tubal Sterilization” by Herbert Peterson, Zhisen Xia, Joyce Hughes, Lynne Wilcox, Lisa Tylor, and James Trussell for the U.S. Collaborative Review of Sterilization Working Group in the *New England Journal of Medicine* 336 (13 March 1997):762-767.
- 35 PRI carried out two separate investigations of the Peruvian sterilization campaign at the behest of the Peruvian Bishops’ Conference, and documented the many instances of medical negligence that occurred during its heyday from 1996-1999. See my *Population Control: Real Costs and Illusory Benefits* for particulars of our findings, especially pages 84-89.
- 36 Letter to Anne Peterson, Director of the Global Health Bureau, USAID, dated 7 January 2004.
- 37 Letter of Anne Peterson, Director of the Global Health Bureau, USAID, to Steven Mosher dated 10 February 2004.
- 38 See Jane S. Jaquette and Kathleen A. Staudt, “Women as “At Risk” Reproducers: Biology, Science, and Population in U.S. Foreign Policy,” in *Women, Biology, and Public Policy*, Virginia S. Shapiro (Ed), *Sage Yearbooks in Women’s Policy Studies* (Beverly Hills: Sage Publications, 1985), 235-268, at 236. Cited in Franks, 214.
- 39 Randomness was approximated by four factors: 1. Passersby were hailed as they walked along one of two major thoroughfares. No attempt was made to seek out interviewees on the basis of sex, ethnic group, religious affiliation, or other characteristics. 2. The interviews were conducted at the rate of 20 or 30 per day over a two-month period. 3. The only age restriction imposed on the respondents was that they must be over 18. 4. The influence of language factors on the selection of respondents was minimized by the fact that each interviewer was fluent and literate in English, Fanti, and at least one ethnic language.
- 40 Other information collected included sex, age, religion, marital status, and prior history of contraception, sterilization, and abortion.
- 41 “Reproductive health,” was explained to respondents as the provision of contraceptives or sterilization, while “Natural Family Planning,” or NFP, was described as a natural, i.e., nonsurgical and nonchemical, means of conceiving or delaying children.
- 42 These and other advantages of Natural Family Planning are discussed by numerous authorities. See, for example, <http://ccli.org/nfp/basics/advan>
- 43 For the current Total Fertility Rate in Ghana, see the United Nations Population Division, *World Population Prospects: The 2006 Revision*, “Population Database,” available online at <http://esa.un.org/unpp/index.asp?panel=2>. For desired fertility levels see, *inter alia*, The Population Council, “Project: The End of the Fertility Transition in the Developing World,” at http://www.popcouncil.org/projects/SS_FertilityTransDeveloping.html
- 44 Similar results were obtained from a survey of Kenyan women. See Steve Mosher, James Mosimann, Raphael Wanjohi, “Reproductive Behavior of Kenyan Women and their Attitudes towards Health Aid,” unpublished study, 19 May 2004, 33 pages.

- 45 Kingsley Davis, "Population Policy and the Theory of Reproductive Motivation," *Economic Development and Cultural Change* 25, Supplement, 1977, 174-78.
- 46 Steven Mosher Interview with Elena Zunega, 31 March 2004, National Population Council headquarters, Mexico City.
- 47 Those who would deny certain classes of people the right to reproduce are not motivated solely by a desire to reduce the "surplus population," in Charles Dickens phrase. Reproductive health programs have often been used to selectively target racial, ethnic, and religious minorities, as I document in *Population Control: Real Costs and Illusory Benefits*, especially Chapter 5, "'Human Rights and Reproductive Wrongs.'
- 48 The actual questionnaire casts an even wider net, by including in the calculation of "unmet need" those who (1) say they want to wait two or more years for their next birth, (2) are unsure whether they want another child, (3) want another child, but are unsure when to have the birth, and say that a pregnancy in the next few weeks would be a problem, (4) who say that the pregnancy was mistimed, (5) who gave birth within the last six months and say the birth was mistimed, (6) who do not want any more children, (7) say that they did not want to become pregnant, (8) gave birth within the last six months and say they did not want the birth. In other words, all those women who would not be thrilled to be pregnant *right now* are assumed to be candidates for contraception. See http://www.measuredhs.com/help/Datasets/Need_for_Family_Planning_Currently_Married
- 49 See, for examples, the criticisms summarized by John B. Casterline and Steven W. Sinding in *Unmet Need for Family Planning in Developing Countries and Implications for Population Policy*, Policy Division Working Paper No. 135 (New York: The Population Council, 2000), accessed on 5 May 2007, at www.popcouncil.org/pdfs/wp/135.pdf.
- 50 Nicholas Eberstadt, "The Premises of Population Policy: A Reexamination," *The Nine Lives of Population Control*, ed. Michael Cromartie (Washington, D.C.: Ethics and Public Policy Center, 1995), 31.
- 51 Surveys of family planning practices and fertility customarily include questions about "desired family size" precisely because this is one of the major elements influencing the birthrate.
- 52 These numbers are from the 1997 Gallup Poll, "A Global Study of Family Values," which also found that the ideal number of children was greater than the actual fertility in many countries of the world. A summary of the poll can be found at <http://www.hi-ho.ne.jp/taku77/refer/valupoll.htm>
- 53 "The Reproductive Revolution Continues," *Population Reports* 31(2) (Spring 2003), especially Table 7, "Desired Family Size."
- 54 Joseph Meaney, "Refugees' Rights vs. 'Reproductive Rights': UNFPA Population Control Campaign Threatens Kosovars," *PRI Review* 9(3) (April/May 1999):1. See also, Austin Ruse, "Kosovar Refugee Women 'Just Say No.'" *PRI Review* 9(4) (June/July 1999): 1.
- 55 Adrienne Germain, "Addressing the demographic imperative through health, empowerment, and rights: ICPD implementation in Bangladesh," *Health Transition Review*, Supplement 4 to Volume 7, 33-36.
- 56 See, for instance, Eric Onstad, "West Misses Cash Target to Curb Population Growth." Reuters, 12 February 1999.
- 57 Sally Ethelston *et al.*, *Progress and Promises: Trends in International Assistance for Reproductive Health and Population*, (Washington, DC: Population Action International, 2004), 2, 5; Fact Sheet: "How Donor Countries Fall Short of Meeting Reproductive Health Needs," (Washington, DC: Population Action International, October 2005).
- 58 Researcher John Briscoe, who was working at the Institute as the time, warned that the emphasis on population research would be "to 'prove' that population growth can be reduced without any change in the health conditions, poverty or social (in)justice." Quoted in Hartmann, 235.
- 59 Hartmann, 236.
- 60 James F. Phillips, Ruth Simmons, J. Chakraborty, and A. I. Chowdhury, "Integrating Health Services into an Maternal Child Health-Family Planning Program: Lessons from Matlab, Bangladesh," *Studies in Family Planning* 15(4)(July-August 1984). Quote in Hartmann, 236.
- 61 World Bank 1993 International Development Conference, Washington, D.C., 11 January 1993, 3. Also quoted in *PRI Review* 4(5)(September-October 1994):9.
- 62 "Report focuses on 'conspiracy of silence' ", UNICEF, <http://www.unicef.org/ponannou.htm>, accessed on June 7, 1996. Under Carol Bellamy, UNICEF shifted its focus from child survival to a feminist agenda, including promotion of sexual promiscuity and abortion. While serving as a state senator in New York, Bel-

- lamy twice voted against legislation that would protect a baby born alive after an abortion. (See Douglas Sylva, "UNICEF Devolves," *National Review Online*, 31 October 2003).
- 63 "Pregnancy and childbirth: Major causes of death and disability for women in developing world, according to UNICEF," UNICEF Press Release, 11 June 1996.
- 64 "Pregnancy and childbirth: Major causes of death and disability for women in developing world, according to UNICEF," UNICEF Press Release, 11 June 1996.
- 65 Multiplying the number of maternal deaths (585,000) by 30 (the number injured or disabled for each death) results in 17,550,000 women allegedly injured or disabled. According to the very first line of the UNICEF press release, "one in every four women in the developing world dies or is disabled through pregnancy and childbirth." This means that, according to UNICEF, the total number of women in the developing world would be $17,550,000 \times 4 = 70,200,000$. At the time of the UNICEF report, however, there were actually in excess of 2.2 billion women in the developing world, not a mere 70 million.
- 66 Quoted in Nicholas Eberstadt, "Birds, Bees, and Budget Cuts," *PRI Review* 6(2) (May/June 1996):2. Sadik was speaking to *The New York Times*.
- 67 *Ibid.*, 2.
- 68 "Estimates of Number of Additional Abortions, Maternal Deaths and Infant Deaths Resulting from a 35% Cut in USAID Funding for Family Planning for All Countries Excluding China," Alan Guttmacher Institute (AGI) Memorandum dated 6 March 1996.
- 69 *Ibid.*, 12.
- 70 An Analysis of the Alan Guttmacher Institute Memorandum entitled "Estimates of Number of Additional Abortions, Maternal Deaths and Infant Deaths Resulting from a 35% Cut in USAID Funding for Family Planning for All Countries Excluding China" dated 6 March 1996.
- 71 *Innocents Betrayed: A Side of Family Planning the White House Does Not Discuss* (White Paper, Population Research Institute, 1997), 18 pp.
- 72 "Weapons of Mass Destruction," *WorldWatch* (July/August 2003), 4.
- 73 Eberstadt, *op. cit.*, 12.
- 74 Deborah Maine *et al.*, "Reproductive Health Issues," in Robert Cassen *et al.*, eds., *Population and Development: Old Debates, New Conclusions* (New Brunswick, NJ: Transaction Publishers, 1994), 203-227.
- 75 Hartmann, *Reproductive Rights and Wrongs*, 231.
- 76 The Institute's full name is the International Center for Diarrheal Disease Research (ICDDR). It is located in Matlab, Bangladesh.
- 77 "US-Sponsored Panel Calls for Focus on Main Causes of Maternal Mortality", *Friday FAX*, Catholic Family and Human Rights Institute, 22 October 2004.
- 78 "US-Sponsored Panel Calls for Focus on Main Causes of Maternal Mortality", *Friday FAX*, Catholic Family and Human Rights Institute, 22 October 2004.
- 79 Hartmann, 239.
- 80 Quoted in Gail Instance, "Family Planners Attack the Philippines," *GFL News* 4(3)(June/July 2005): 7.
- 81 The UNFPA's "Three-Pronged Strategy for Reducing Maternal Mortality" begins by insisting that "all women have access to contraception to avoid unintended pregnancies." <http://www.unfpa.org/mothers/index.htm>
- 82 John Bongaarts, "Does Family Planning Reduce Infant Mortality Rates?" *Population and Development Review* 13(2) (1987):331.
- 83 Hartmann, 238, 239.
- 84 The literature suggests that optimal birth spacing, generally defined as three years or longer, has the potential to reduce infant mortality by a quarter in less developed countries.
- 85 Jonathan Watts, "China offers parents cash incentives to produce more girls," *The Guardian*, 16 July 2004; Steven Ertelt, "China Offers Families Money to Have Girls Babies Instead of Abortions," *LifeNews.com*, 12 August 2004
- 86 John Aird, formerly the head of the China Branch of the U.S. Census Bureau, has discussed this in detail in his *Slaughter of the Innocents: Coercive Birth Control in China* (Washington, DC: AEI Press, 1990)
- 87 Korea Institute for Health and Social Affairs and U.N. Population Fund, "Sex Preference for Children and Gender Discrimination in Asia" (Seoul: KIHASA, 1996). "2000 Report on Human Development in South Asia," (Mahbub Ul Haq Human Development Center, Islamabad, Pakistan, 2000).

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- 89 Louisa Lim, “China fears bachelor future,” BBC News, 7 April 2004
- 90 “Asian Sex Selection a Problem,” *PRI Review* 10(6) (November/December 2001), 14.
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- 92 Louisa Lim, *China fears bachelor future,* BBC News, 7 April 2004
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- 94 Yemlibike Fatkulin, “The Plight of the Uyghur People,” *PRI Review* 11(4)(September-October 2001):10.
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- 97 United States Department of Commerce, Bureau of the Census. Statistical Abstract of the United States 1997 [117th Edition]. Washington, DC: United States Government Printing Office, 1997. Table 110.
- 98 Dr. Louise Tyrer, Medical Director of Planned Parenthood of America, letter to the editor, *The Wall Street Journal*, 26 April 1991.
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