SUCCESS OR FAILURE: THE PREVENTION OF UNWANTED PREGNANCIES

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Population control is not an idea new to the twentieth century. Although natural calamities historically have acted as checks on the world's population, nevertheless, people have sought artificial ways to limit their reproduction since primitive times. In fact, birth control in some form has been attempted for at least several thousand years.(1)

Despite its historical background, the birth control movement was slow in gaining momentum in the United States. While several individuals crusaded for population control in the early 1900's, there was little government interest in the field of family planning until the mid-1960's, since both Federal and State governments feared their involvement in such programs would antagonize religious and political groups. While the Kennedy Administration did sponsor research on human reproduction and contraception, it was not until the Johnson Administration that there was full support for family planning, including the allotment of Federal funds for the first national scope family planning programs. This dramatic change in the government's support of family planning programs is illustrated by President Nixon's message to the Congress on Population, July 18, 1969, in which he stated that:

> "It is my view that no American woman should be denied access to family planning assistance because of her economic condition; I believe, therefore, that we should establish as a national goal the provision of adequate family planning services within the next five years to all those who want them but cannot afford them. This we have the capacity to do."

During the last decade, therefore, public opinion in the United States has grown to recognize that family planning is vital to the individual and national health and well-being.

The primary concern of the family planning movement as it has evolved has been to stress the welfare of the family and the advantages of well-spaced and limited numbers of children. The movement is above all familistic, stressing the rights of parents--and of women, especially--to have the number of children they want.

While the emphasis on voluntary family planning as a health measure of considerable significance for both the individual family and the community is readily accepted, the interest of public welfare departments has also focused attention on the added dimension of family planning as a social measure, since the availability of family planning services is a crucial part of community efforts to reduce poverty and dependency.

An unwanted first birth is often a precipitating factor in becoming a welfare recipient, especially for young unmarried women. In addition, unwanted births can also perpetuate welfare dependency and mitigate the effectiveness of other social service programs designed to reduce or eliminate the need for public assistance.(2)

Problems stemming from improper child-spacing, lack of prenatal and postnatal care and misuse of contraceptives are all areas of concern to health care professionals, in addition to the health and social consequences of unwanted children.(3)

What then, has been the Federal government's role in promoting family planning services? In December 1970, Congress enacted the Family Planning Services and Population Research Act which legislated specific authority to assist in making comprehensive voluntary family planning services readily available to all persons desiring such services.

To help accomplish these goals, either new Federal programs were created or those already in existence extended their commitment to the field of family planning--among them at that time were the Children's Bureau; the Office of Economic Opportunity; Maternal and Child Health Services; and the Social and Rehabilitation Service. The National Center for Family Planning Services, established in October 1969, was the first Federal agency devoted exclusively to supporting family planning services. During its existence, the Center provided leadership in the extension of family planning services through special service project grants and other supporting programs.

Since these early beginnings of the Federal government's direct involvement in making family planning services available for all citizens, many changes have taken place, some of them, organizational and program changes.

This rapid expansion of family planning programs brought to the forefront the need for, and lack of, accurate and current information on the nature and extent of family planning services provided by public and private programs and the extent to which the total need for subsidized services was being met.

It was in such an atmosphere that the National Family Planning Services Data Collection System was developed as an answer to the legislative requirements and responsibilities imposed by the newly created Federal programs in this area. Primary responsibility for the methodological development and actual implementation of the data collection was assigned to the National Center for Health Statistics (NCHS), part of the Department of Health, Education, and Welfare.

This paper is based primarily upon data from two of the survey mechanisms developed under this system: the National Reporting System for Family Planning Services and the National Inventory of Family Planning Service Sites. The National Reporting System collects data on the numbers and characteristics of patients, number and types of visits made to clinics, and the number and types of services provided. In addition, the system also collects data about clinics and

projects through which the patients are served. The projects that participate in the National Reporting System include both Federally-funded and non-Federally funded family planning projects. However, the majority of the clinics are funded by Titles V & X. The National Inventory provides location and characteristics data on all family planning clinics in the U.S., regardless of their funding. It is estimated that between 80 and 90 percent of the facilities in the National Reporting System are also in the National Inventory.

Prior to examining the data from these two survey mechanisms, background information will be given on recent trends in the total fertility rate and age specific birth rates for the United States. These show that the total fertility rate, which provides the implications of current levels of fertility for completed family size, has declined from a postwar peak of 3,724 births per 1,000 women in 1957 to the record low level of 1,895 in 1973. Age specific birth rates have declined with little interruption since 1957 among women in almost every age group. However, since 1957, the decline in the birth rate and in the fertility rate has been a gradual one. Table 1 contains preliminary data from 1975 that indicate that the birth rate was 14.8 and the fertility rate 66.7. Not much change has occurred in the birth rate between 1975, 1974, and 1973, and only a change of 5% occurred from 1972's birth rate of 15.6. In addition, there was only a 9% change in the fertility rate between 1972 and 1975. The fertility rate per 1,000 women aged 15-44 years dropped from 86.5 in 1969 to 66.7 in 1975, a decrease of close to 25%.(4),(5)

In spite of this constant decline in the birth and fertility rates, there still existed a substantial need for subsidized family planning services, such as those provided by the Federal government. This was due to the fact that, as late as 1974, it was estimated that of the 3.4 million women served by organized family planning programs, 1.8 million were in families with income below the poverty level; 2.2 million were in families at or below 125 percent of the poverty level, and 2.5 million were in families at or below 150 percent of the poverty level.(6)

According to data from the 1974 Inventory of Family Planning Service Sites, most of the organized family planning services being provided in this country are from public funds, with the Department of Health, Education, and Welfare providing the bulk of them. Table 2 shows that sixty-nine percent of the clinics in the country received some funding from the Department of Health, Education, and Welfare. State and county governments also were contributors to a substantial number of clinics. It is believed that the data from the 1975 Inventory will indicate similar findings.

As Table 3 indicates, the number of clinics providing family planning services increased by 18.2% from 1973 to 1974, and by only 2.2% from 1974 to 1975. However, the number of patients served by these clinics increased by 22.0% from 1973 to 1974, and by 24.5% from 1974 to 1975. Forty-three point seven percent of these total patients in 1975 were new patients. These figures indicate that organized family planning programs have grown during a period of overall U.S. fertility decline.

However, most of the fertility decline has been attributed to a reduction in unwanted and mistimed births, which has resulted from the more consistent use of contraception and a greater use of the most effective contraceptive methods. Of the 4,500 medical clinics that responded to the 1974 National Inventory of Family Planning Service Sites, Table 4 indicates that 99.6% of them employed oral contraceptives; 94.2% employed the intrauterine device and another 90% employed foam. (Obviously most clinics employ several different methods).

Data from the National Reporting System indicates that a majority of the female patients in family planning clinics employ one of the more effective methods of contraception--the pill or the IUD. For each year between 1969 and 1975, Table 5 shows that a minimum of 79.3% of the female patients used either the pill or the IUD--usually considered two of the most effective methods--with an average use of 83.5% for these two methods over these years. For all four of the methods listed in Table 5 (the pill, IUD, diaphragm and foam), the average use over this same time span was 90.7%. These figures tend to indicate that patients being served by organized family planning programs select and use the more efficient contraceptive methods.

The data in Table 6 also support this assumption, for, as this table indicates, 571,527 new patients (41.1%) used no method before enrolling in the clinic, while only 92,505 patients (6.7%) used no method after enrolling in the clinic (as reported at their last visit).

Before enrolling in the clinic 562,905 new patients (40.5%) used the pill, while as of their last visit 933,534 new patients (71.4%) used the pill. This increase from 562,905 to 993,534 represented an increase of more than 76% use of the pill. (7)

The number of patients being served in family planning clinics has continued to grow, the numbers being limited (in the opinion of the authors) only by the availability of services. Table 7 indicates that from the first year for which estimates are available (1969), the number of patients enrolled in family planning clinics has grown from less than 80,000 to more than 3.2 million women at the end of calendar year 1975. More than half, or 56.3%, of these women were not newly enrolled but had been in the program prior to 1975. In fact, the yearly increases in the proportion of continuation patients are all significant increases at the 95% level.

In addition to these data from the National Reporting System and the National Inventory, findings from other sources also support this premise that family planning programs in the United States are having a substantial impact in preventing births that are unwanted or mistimed.

Data from the 1970 National Fertility Study(8) were used by Cutright and Jaffee in a study to determine the effects of family planning programs on the fertility of low-income U.S. women. The authors concluded that the U.S. family planning

program has--independent of other sociodemographic factors--reduced the fertility of low-income women by helping them to prevent unwanted and mistimed births. According to the authors, the program works because it gives women of lower socio-economic status access to modern and effective methods of contraception that they would not otherwise have. As a result, the rates of unwanted and mistimed pregnancy of patients are lower than those of comparable women who lack access to organized clinic programs. (9)

Charles F. Westoff, codirector of the 1970 National Fertility Study has stated that the results of this study indicate that the sharp marital fertility decline in the United States in the 1960's is entirely attributable to a reduction in unplanned births. This was accomplished by more consistent use of contraception, greater use of the most effective contraceptive methods and improved efficacy in their use. (10)

The National Survey of Family Growth, which provides data on fertility, fertility planning, and related aspects of maternal and child health, is a relatively new survey of the National Center for Health Statistics. Table 8, which presents 1973 data from the first cycle of this continuing survey, also demonstrates the impact of family planning programs in the U.S. By 1973, almost 7 in 10 married couples of reproductive age were using some type of contraception. According to Mr. Westoff, who has analyzed these data in conjunction with those from the National Fertility Studies, "It seems highly probable that by the end of the 1970's, almost all married couples at risk of unintended pregnancy in the United States will be using contraception, and almost all contraceptors will be protected by the most effective medical methods. We are rapidly approaching universal, highly effective contraception practice." (11)

Another source of data is the National Natality surveys conducted by the National Center for Health Statistics, which include a probability sample of women who have given birth during the year. According to these survey data, the proportion of births that were unwanted has declined substantially after 1968, when 13 percent of them were unwanted. By 1972, the percent of unwanted births had dropped to 8 percent. The decline in unwantedness was more pronounced among black wives than white wives so that, by 1972, only about one-fifth more black than white births were classified as unwanted. (12)

These data from selected studies on the availability and utilization of family planning services illustrate the growing acceptance in recent years of the idea that effective family planning practices offer undeniable health and welfare benefits to all individuals, and especially to low-income families. The provision of family planning services, especially to those who cannot afford private care, has been shown to be one of the most cost-effective preventive health care programs.(2) More important than economic considerations, however, are the medical and social benefits to be derived from successful fertility management. By providing family planning services which enable individuals to freely determine the number and spacing of their children, the quality of life for all individuals, but particularly the economically disadvantaged, will be improved. And this, despite all the various stated and unstated objectives, has been the ultimate goal of the family planning services program in this country--to raise the quality of life for all persons.

Thus, from a time just twenty years ago when it was common to provoke acrimonious debate over the socioeconomic as well as the moral issues involved in family planning, the concept today is almost universally accepted, tacitly or officially, as a sensible approach to improving the quality of life for all.

Tables are available upon request from the author.

References and Footnotes

(1) Westoff, Leslie Aldridge and Westoff, Charles F., From Now to Zero: Fertility, Contraception and Abortion in America. Boston: Little, Brown, and Co., 1971.

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(3) Thomas, Richard K., Family Planning in Memphis, Tennessee; Knowledge, Practice and Attitudes, Memphis Regional Medical Program, 1975.

(4) Provisional Statistics, Annual Summary for the U.S., 1975, NCHS Monthly Vital Statistics Report, Vol. 24, No. 13, June 30, 1976.

(5) Health: United States 1975, DHEW Publication No. (HRA) 76-1232.

(6) The poverty threshold for a nonfarm family of four persons was $5,038 in 1974, about 11 percent higher than the 1973 cutoff of $4,540. The poverty thresholds are updated each year to reflect changes in the annual average Consumer Price Index.

(7) It should also be noted that only 458,469 (81.4%) of the original 562,905 patients who used the pill prior to enrollment were still using the pill at the last visit. That is a decrease of more than 104,000 patients using the pill. Looking at it from this angle, the number of women who actually began taking the pill after enrolling in the clinic was 535,065. Therefore, the net increase in women taking the pill was 430,629 while the actual number of new "starts" was 535,065.

(8) Mr. Charles F. Westoff and Ms. Norman B. Ryder were codirectors of the 1965, 1970, and 1975 National Fertility Studies, conducted under contract by the Office of Population Research, Princeton University for the

Center for Population Research of the National Institute of Child Health and Human Development.

(9) Cutright, Phillips and Jaffe, Frederick S., "Family Planning Program Effects on the Fertility of Low-Income U.S. Women," Family Planning Perspectives, Vol. 8, No. 3, May/June 1976.

(10) Westoff, Charles F., "The Yield of the Imperfect: the 1970 National Fertility Study," Demography, Vol. 12, No. 4, Nov. 1975.

(11) Westoff, Charles F., "Trends in Contraceptive Practice: 1965-1973" Family Planning Perspectives, Vol. 8, No. 2, March/April 1976 p. 57.

(12) A report on the findings of the 1968, 1969, and 1972 surveys has been written by Robert H. Weller, Professor of Sociology at the Center for the Study of Population, Institute for Social Research, Florida State University. This NCHS report, entitled Wanted and Unwanted Childbearing in the United States, 1968, 1969, and 1972, is scheduled for publication in 1977.