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WOMEN AS "AT RISK" REPRODUCERS: BIOLOGY, SCIENCE,  
AND POPULATION IN U.S. FOREIGN POLICY

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Introduction

This essay analyzes some of the ways in which the scientific paradigm and the biological models of medicine and demography affect women by their influence over population policy, an important aspect of our foreign policy in the Third World. We will argue both that the scientific paradigm has significantly shaped U.S. population policy and that it has had specifically negative effects on women. We further suggest that the detrimental impact of U.S. population policy on women, inherent in the scientific and technological approach, has been strongly reinforced by bureaucratic decision-making, itself a product of scientific influence. The single-mindedness of the policies we criticize did not arise simply from the overzealousness of one individual, however comforting it may be sometimes to have a specific target for our frustration, but derived from approaches, habits of thought, and patterns of decision-making that are deeply embedded in our society, and that will consequently be difficult to change.

The scientific approach to population policy has made a key difference in a number of ways. It has determined the definition of the population problem and supported technological rather than structural solutions. It has mandated a medical relationship between

population programs and women, with all the attendant asymmetries which have characterized relations between a male-dominated medical establishment and female patients. It has encouraged the treatment of women as objects, to be manipulated by social engineering and experimented on in contraceptive research. Thus, bureaucratic decision-making and the scientific paradigm have key elements in common, elements that combine to produce the greatest distance between bureaucrats and medical experts, on the one hand, and the "target population" of fertile women on the other.

In the Agency for International Development,<sup>1</sup> women are viewed primarily as "at risk reproducers." This biological definition of women has justified their exclusion from the highly technical, productivity- and growth-oriented forms of assistance. Despite the 1973 Congressional mandates that AID promote "growth with equity" to the "rural poor majority" and "integrate women in development," it is virtually only through population policy and related material/child health programs that AID reaches women. This overwhelming orientation toward women as mothers reinforces a narrow view of women, and ultimately prevents any genuine redistribution of agency resources between men and women.<sup>2</sup>

### U.S. Population Policy

Although General Draper's report on military aid<sup>3</sup> recommended as early as 1959 that the U.S. government provide population assistance to nations that requested it, this did not become official policy until Richard Gardner made a speech containing an offer of such assistance before the

U.N. General Assembly in December, 1962, which was confirmed by President Kennedy in April, 1963. President Johnson announced a program to "seek new ways to help deal with the explosion of world population and the growing scarcity in world resources" in January, 1965, which provided the mandate for AID's involvement. The program grew rapidly, from \$2.1 million in FY 1965 to \$50 million in FY 1969, levelling off at \$200 million per annum in the late 1970s. In 1966 the U.S. Congress amended the Foreign Assistance Act of 1969 and included specific provisions in the Food for Peace Act of 1966 "to assist voluntary family planning programs in countries requesting such help."<sup>4</sup>

Initially, AID -- chief U.S. bilateral assistance agency to more than sixty developing countries -- was reluctant to become involved in birth control programs. AID, an unpopular agency dealing with an issue that lacks widespread public support in the U.S., is heavily dependent upon what has been termed a "four-fold Congressional obstacle course," in authorizing and appropriating assistance. For this, AID must not only maintain good relations with Congress, but also create constituencies which assist it through these hurdles.<sup>5</sup> In the early 1960s, AID feared Catholic opposition in Congress to overt, visible family planning. Indeed, only in 1963 did a birth control advocate replace the birth control opponent who directed AID's health program. Moreover, AID itself had placed contraceptive devices on the prohibited list for commodity assistance since 1948.<sup>6</sup> Such self limitations are explained by the bureaucratic protectionist strategies AID pursues.

Important changes in AID's political environment prompted greater risk-taking on AID's part. Various congressional committees, above and

beyond those monitoring foreign assistance, aired population matters. A bureaucratically aggressive epidemiologist, Dr. Reimert T. Ravenholt, was hired in 1966 and pushed vigorously for removing contraceptives from the prohibited list and for increasing funding, particularly earmarked funding in defiance of higher level agency executives who jealously guard the autonomy of their internal budget process. Earmarked funding was perceived to have cut into other programs at a time of declining appropriations. The late 1960s and early 1970s were low points in AID's already minimal popularity, given AID's association with an overall foreign policy which included opposition to Allende in Chile, AID's large Vietnam program and counterinsurgency programs elsewhere. By contrast, the population issue was popular, and new visibility for AID's role here became part of a strategy for survival.

AID's Population Branch of the Health Service became the Population Service. A Bureau of Population and Humanitarian Assistance was created in 1972, in population's "heyday," with dramatic increases in specialized staff in Washington and in the country Missions. At the first population conference held by the Organization for Economic Co-operation and Development (OECD) in 1968, Ravenholt described the "fundamental principles" of AID's population policy as (1) to give aid in response to specific requests "to stimulate and supplement a country's own efforts,"<sup>7</sup> (2) to consider only programs in which individual participation is "wholly voluntary" as eligible for support, and (3) to provide needed assistance on request rather than insist on "any specific population policy" for another country. These self imposed restrictions are carefully geared to both the popular consensus and foreign acceptability.

The purpose of family planning had been spelled out by Congress in

Title X of the Foreign Assistance Act of 1967:

. . . voluntary family planning programs to provide individual couples with the knowledge and medical facilities to plan their family size in accordance with their own moral convictions and the latest medical information can make a substantial contribution to improve health, family stability, greater individual opportunity, economic development, a sufficiency of food, and a higher standard of living.<sup>8</sup>

What emerged from this set of directives was a program of funding, half of which was bilateral and half of which sent through intermediaries such as the UNFPA\* and IPPF,\*\* to multilateralize U.S. assistance in this area, and additional funds to smaller organizations seeking more effective programs. A substantial proportion went to research efforts, both in applied demography (what factors appear to affect the birth rate and the likelihood that women will "accept" contraceptives) and into medical research for improved contraceptive methods. Part of these early funding strategies must be understood in terms of the constituency building efforts of AID offices, and Population's inability to spend all its appropriations.

As might be expected in an area combining intense personal value conflicts on the one hand and ambivalence about the U.S. role and power on the other, the population program has been subjected to a variety of criticisms. On one end of the spectrum, at the World Population Conference in Bucharest in 1974, the U.S. was accused of doing too much, of mounting a "genocidal" policy directed at the non-white peoples of the world. This accusation came uncomfortably close to being accurate for domestic U.S. population policy which has not adopted an anti-natalist strategy vis-a-vis the population as a whole, but which has been involved in sterilization programs directed toward the non-white poor. At the other end, critics concerned with the inability of voluntary "family planning" programs to

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\*United Nations Fund for Population Activities  
\*\*International Planned Parenthood Federation

make a measurable dent in what they see as an ecologically disastrous population growth rate have accused AID of doing much too little and have advocated more coercive measures, including withholding food aid from countries that do not have effective programs of population control.<sup>9</sup>

Ravenholt's own inundation approach, emphasizing maximum availability of contraceptives, goes beyond the limited capability of public health programs to reach the target population. This too has provoked criticism on grounds that the popular female contraceptives (the pill and the IUD) could not be provided in the absence of public health support without endangering the health of the women using them,<sup>10</sup> and from those who argued that population office purchasing allowed unethical drug companies to "dump" contraceptives (such as the Dalkon Shield or Depo-Provera) which were not FDA approved, or for which approval had been withdrawn, in the U.S.<sup>11</sup>

AID's inundation approach was summarized thus in 1968:

During the past decade oral contraceptives have far outpaced other forms of contraception in LDC's assisted by AID. Through FY 1976 AID has purchased more than 450 million monthly cycles of oral contraceptives. The price has been kept below 15 cents per monthly cycle by consolidated central purchasing of guaranteed quantities of oral contraceptives. Since the advent of lubricated, colored condoms, the usage rate of this method has increased rapidly -- more than 8 million gross have been purchased by AID. IUDs continue to be an important element of the program, but have not increased in usage as have pills and condoms. In order to make sure that everyone has contraceptive services consistent with their ethical and religious beliefs, AID also provides diaphragms, spermicides, thermometers, charts, and support for the utilization of the safe period methods.<sup>12</sup>

Abortion was not a method promoted by AID for it was excluded by the Helms Amendment. Sterilization was encouraged, but injectable progesterones like Depo-Provera, which had not received FDA approval, could not be

supplied by AID directly. UNFPA and IPPF, however, were free to do so.

Demography and Population Policy: Hysteria for the Masses. Multivariate Analysis for the Elites

Books began to appear in the mid-1950s that called attention to the population crisis, arguing that Malthus was right and warning that population in the near or medium term would outrun the resources to feed and maintain it.<sup>13</sup> However, it was not until Paul Ehrlich's The Population Bomb, published under the auspices of the Sierra Club in 1968, that popular attention focused on the issue. Ehrlich's strident prologue began:

The battle to feed all of humanity is over. In the 1970s and 1980s hundreds of millions of people will starve to death in spite of any crash programs embarked upon now.<sup>14</sup>

A central feature of the book is the "scenarios," one of which shows the "average housewife" (of a university professor!) trying to feed her family in what is intended to be a projection of daily life as population presses on limited food resources:

Jane Gilsinger was not worried about anyone's nuclear capacity (the previous paragraph had her husband worried about development of Japanese nuclear capacity and the possibility of war). Like most American housewives in 1983, she was preoccupied with how to feed her family adequately and safely. George made a good living . . . Still, at a cost of \$12 a pound, steak had become a memory for them as for most other Americans. She didn't really understand what the failure of the corn crop had to do with beef prices -- but apparently it was a lot.<sup>15</sup>

She then raises with her husband the President's plan to introduce food rationing, and he tries to educate her on the full extent of the crisis:

. . . Even with rationing, a lot of Americans are going to starve to death unless this climate change reverses. We've seen the trends clearly since the early 1970s, but nobody believed it would happen here, even after the 1976 Latin American famine and the Indian Dissolution. Almost

a billion human beings starved to death in the last decade, and we managed to keep the lid on by a combination of good luck and brute force.<sup>16</sup>

There is both unconscious sexism and racism in Ehrlich's account. In conditions of scarcity the wealthy countries can justify the use of "brute force." Despite starvation, Jane is still a housewife and her husband a university professor supplementing his income by government consulting; men are the scientists who can understand the complex relationships relevant to this issue, but women cannot even see the linkage between the supply of corn and the price of beef(!).

But what made Ehrlich's book so powerful and credible was its basis in "scientific fact." Statistics and geometric expansion models are used to show how small differences in population growth rates will dramatically reduce the time it takes for a population to double; the importance of the fact that over 50% of the world's population is under the age of 15; and the effect of modernization on reducing the death rate. Ehrlich buttressed his arguments that potential increases in food production are very limited, and that pollution levels are increasing dramatically, by statistical evidence of negative trends. The message is clear: scientists see the trends (but people aren't listening), and science must have a role in finding a "solution" to the problem.

In The Population Bomb, science "proves" the existence of a crisis. Pseudo-scientific projections into the future are then used to make the case that family planning is not enough. Stronger, even coercive, population control measures are required now. Despite the implicit extension of this argument to the rest of the world, there is little discussion of how population control might work outside of the U.S. or what factors enter into fertility decisions in developing countries. Instead, Ehrlich lumps

all women together as reproducers. In evolutionary terms we are all "equal," and evolutionary "science" can be used to explain human fertility in a generalized "cultural" context:

. . . A self-reinforcing selective trend developed -- a trend toward increased brain size.

But there was, quite literally, a rub. Babies had bigger and bigger heads. There were limits to how large a pelvis could conveniently become. To make a long story short, the strategy of evolution was not to make a woman bell-shaped and relatively immobile, but to accept the problem of having babies who were helpless for a long period while their brains grew after birth. How could the mother defend and care for her infant during its unusually long period of helplessness? She couldn't, unless Papa hung around. The girls are still working on that problem, but an essential step was to get rid of the short, well-defined breeding season characteristic of most mammals. The year round sexuality of the human female, the long period of infant dependence on the female, the evolution of the family group, all are at the roots of our present problem . . . Sex in human beings is necessary for the production of young, but it also evolved to ensure their successful rearing . . . (O)ur urge to reproduce is hopelessly entwined with most of our other urges.<sup>17</sup>

It is not clear if readers are to conclude from this that women are biologically at fault for the year round manipulation of male urges and their imposition of marriage, or simply that we should not get bogged down in the variety of cultural determinants of fertility behavior. But using this rhetoric and backed by statistics foretelling imminent doom, "concerned scientists" and policy makers brought the population issue to congressional hearings and helped organize a new popular constituency in favor of dramatic policy initiatives.

For AID, family planning now became the priority, separate from and prior to AID's stated goal of promoting stable economic development. State Department Deputy Assistant Secretary for Environment and Population Affairs, Christian Herter, testified that "without continued resolve . . . unchecked

population growth will continue to contribute to social malaise, unemployment, internal tensions, and possible conflicts among neighbors."<sup>18</sup> Language tended to be crisis-oriented, militaristic, and designed to eliminate value considerations. Economists' cost/benefit analyses on the "number of births averted" figured from \$150 to \$1,000 savings in their formulae.<sup>19</sup> Dean Rusk referred to our "losing battle to feed the hungry," and argued that population problems could be "as dangerous as nuclear problems,"<sup>20</sup> and Senator Clark equated the Vietnamese refugee camps with "rabbit warrens."<sup>21</sup> Charts were carted to Capitol Hill with figures on excess numbers of births over deaths per year, week, day, and hour; AID's 1971 report on population even calculated this down to the second!<sup>22</sup> The campaign was on.

Ehrlich had used science to define and draw mass attention to the population issue and to reinforce the male as scientific problem-solver for the less mobile, less intelligent females. A much more sophisticated scientific methodology conditions demographic analysis, which in turn is funded and used by policy-makers searching for solutions to "the population problem." In contrast to Ehrlich's work, the thrust of most demographic research to assist U.S. population policy has been to explore the factors that produce increases or decreases in the birth rate and to explain why developed societies tend to have low birth rates while transitional societies -- with fewer resources to go around -- maintain high birth rates even after the death rate has declined markedly and for a substantial period of time.

A number of hypotheses have been developed seeking to isolate the "key variable" that will explain fertility behavior, beginning with the obvious question as to whether couples have knowledge of and access to

contraceptive techniques. But knowledge and availability do not predict actual use of contraceptives, so the search has spread to the factors that affect household decision-making and to the education, employment, and legal status of women. Household analysis -- "the new home economics" -- has looked at the present and future economic value of children, with the result that the most significant decline in birth rates, associated with urbanization, industrialization, and a sustained level of economic development (the "demographic transition") is explained by demographers in large part by the changing "cost/benefit" ratio of child rearing: as societies modernize, the cost of raising children increases, but they are less essential -- and less likely -- to support parents in their old age. For the majority of countries that have not achieved sufficient modernization to have entered demographic transition, however, the search for the magic variable has proven frustrating.

This makes the situation difficult for feminists who want to argue (within AID and other donor organizations) that improvements in female status, education, and employment will bring about the much desired reduction in fertility. The tactic of slipping "women in development" in under the population issue is made necessary by the sad fact that there is a much deeper national consensus on population control than there is on U.S. involvement in improving the status of women. Yet, repeated studies have failed to prove a consistently reliable relationship between "women's status" variables and fewer births. Nancy Bird-sall concludes that female employment, for example, is "neither a necessary nor sufficient condition for fertility reduction,"<sup>23</sup> noting that "(S)tudies in Puerto Rico, Chile, Costa Rica, and Taiwan indicated that female employment did appear to result in lowered fertility; but in the Philippines and Thailand, female working status actually appeared to increase fertility."<sup>24</sup>

Ultimately, it is not whether women work, but whether they leave their homes to work, that seems to make the difference -- but who knows how long that "social law" will hold.<sup>25</sup> Similar complications exist with other variables that might logically be thought to be at the heart of the decision on family size, including infant mortality rates and even various approaches to "cost/benefit" household calculations on the economic worth of children. As a result, policy makers have contracted a series of studies involving multivariate analyses to sort through what is clearly a complex set of factors.

The conventional feminist critique of social scientific studies in support of modernization efforts is that they have systematically excluded women: for example, census definitions defining work as paid, full-time, and outside the home exclude women from labor force statistics and thus discount the significance of their labor in programs designed to increase productivity or provide training, credit, or social services.<sup>26</sup> Similarly, women's contributions in agriculture have been invisible and their potential role in ameliorating a global food crisis underestimated.

Obviously, women's roles in reproduction cannot be so easily ignored; the way in which they are included in population research, however, illustrates the flaws in the scientific approach. First, both the aggregate data analyses of demography and the "rational household" assumptions of the new home economics distance the policy-oriented "observers" from the "observed" -- the women whose fertility behavior they are attempting to predict.

Second, researchers do not always bother to figure in variables relating to women. As a review of AID commissioned studies on fertility concludes:

The seven socioeconomic variables which they ultimately identified as being most powerfully associated with fertility decline are: adult literacy, primary and secondary school enrollment, life expectancy, infant mortality, percentage of males in the nonagricultural labor force, GNP per capita, and percent population in cities of 100,000 and above. They are quick to point out that improvements in the role and status of women are missing from this list because of the difficulty of finding appropriate data.<sup>27</sup>

A U.N. representative testified at the Population and Development hearings that we know little about the status of women because it is linked with culture and is not a quantitative variable, unlike infant mortality.<sup>28</sup>

Third, although Ravenholt recognized that women's literacy, employment, and income distribution influenced fertility, such recognition played little part in his office's funding priorities. A GAO-commissioned study reported that only 4 percent of the Population Office's research budget from 1965 to 1976 went to research on fertility determinants.<sup>29</sup> Fourth, the structure itself is flawed. Social engineers don't attempt to work with families or women directly, but try to manipulate them into having fewer children by changing "factors" that are presumably easier to alter than the fertility decision itself.

Most population experts begin with "logical hypotheses" based on their (Western) experience rather than by immersing themselves in the real life decision environments of women -- much less Third World women. By one account, 75 percent of the studies have used women as the unit of analysis, though couples and "households" have been credited with the decision, ignoring conflict between men and women in fertility decisions. Male pronatal values have been understood as machismo -- those irrational (and inferior) activities that wiser gringos, of course, have long overcome.

Theories and available data, not the complexities of female experience, are the starting point of such studies. "Independent variables" are the social engineer's props -- few in number and amenable to government "interventions." Like Jane Gilsinger in Ehrlich's scenario, women are seen as objects of policy manipulation, incapable of direct understanding or direct action. This image of female passivity is further reinforced by the single-minded definition of women in this literature as reproducers. Ehrlich's sexism is merely a modern echo of the Aristotelean view that women are mere receptacles of the male life-force, and not full citizens of the polis.

Occasionally, the arbitrariness of particular policy prescriptions reveal the tenuousness of the model, as when Edward Pohlberg advises that child care services should not be provided for women in order to increase their "role conflict," and thus reduce their desire to have children,<sup>30</sup> or when anti-natalist arguments are used to rationalize failures to improve women's health. Sandra Tangri<sup>31</sup> admits that population policies are manipulative, but argues that "some degree of manipulation is almost inevitably a feature of any social intervention." She suggests that putting female personnel in charge of programs involving women lessens the degree of manipulation because women are "reciprocally vulnerable."<sup>32</sup>

This bald statement of the affirmative action case<sup>33</sup> does not hide the fact that Tangri has caved in to the "scientific" rationale. By suggesting that "reciprocity" can exist, just because females do the manipulating, she is providing feminist legitimacy to the top-down, social engineering approach. The fact that women manage population programs does not eliminate class, race, and other differences that distinguish the interests, experiences,

and vulnerability of women with professional training from those of the women whose fertility they are "managing."

In sum, social science approaches distance the observers from the observed, rationalize manipulation, and are used to justify the continued exclusion of most women from taking direct, knowledgeable, self-aware control over their own fertility. In extreme cases, scientific rationales can hide other agendas that would receive less political support -- or might even come under attack -- if they were articulated. Thomas Littlefield reports an interview with a "top lieutenant" of the family planning program in a southern state in the United States. In response to a question about whether there were "racial genocidal" motives to the program, the official replied:

Not at the time. I must admit that now I have some reservations about the possibility there may have been some genocidal motives on the part of some people. I really don't think it was a national genocidal policy. But, as is the case with many technological and scientific advancements, there are unanticipated spinoffs . . . . When you look at the service design, the blacks were relatively over-served . . . . The primary recruiting area for patients -- the catchment area, we called it -- was the postpartum ward of the large teaching hospital, the charity hospital . . . . That kind of recruitment was not extended to the local Baptist hospitals where the medically indigent whites were delivering.<sup>34</sup>

Other "spinoffs" may be more intentional. Both Ravenholt and Ehrlich have made no bones about the fact that they fear the possibility of violence between rich and poor nations if population growth is not brought under control. In Ehrlich's words, overpopulation "does not normally mean too many people for the area of a country. Overpopulation occurs when numbers threaten values,"<sup>35</sup> when their numbers threaten our values.

Demography and the new home economics have had a major role in identifying the population crisis, stipulating its causes, and prescribing its solutions, but medical science was the initial model used by Ravenholt. Doctors have had a key role to play by inventing and promoting particular contraceptive methods and designing and staffing "delivery systems" by which most female contraceptives -- the IUD, the pill, sterilization, and abortion -- are provided to women who decide to limit their fertility. Barbara Ehrenreich and Dierdre English have already identified some of the effects the development of "scientific medicine" in the 19th century had on women. The victory of "scientific" medicine over other forms of healing made possible the development of a medical profession that restricted entry in general, but from which women (who had been midwives and herbalists in the first half of the century) were virtually proscribed. In addition, the profession relied heavily on the earnings gained from treating middle and upper class women, for "invalidism and physical and emotional frailty" were an integral part of the Victorian feminine ideal.<sup>36</sup> As E. Richard Brown notes in his study of the Rockefeller Medicine Man, women's illnesses were associated with their reproductive organs. This meant that women were subjected to unnecessary surgery and excessive medical attention, while lower class women received little or no medical care:

Gynecological surgeons preyed upon the supposedly delicate nature of upper middle-class women and the terrible consequences of having a 'tipped' uterus or sexual appetite. Hysterectomies, ovariectomies, and cliteridectomies were prescribed for these and other female maladies.<sup>37</sup>

In the U.S. and overseas, the medical establishment is deeply involved in population programs. In most countries only licensed doctors can prescribe pills, sterilize patients, or perform abortions,<sup>38</sup> although the pressure

to expand programs has outrun available manpower and paramedical staffs have been trained to insert IUDs and in China to perform abortions. In contrast to the Victorian United States, medical "profits" are low, and doctors do not treat patients almost exclusively drawn from the middle class. But the hierarchical relationship between doctor and patient, the view that female fertility is a kind of sickness and the primary reason for health services to treat women, and the relative exclusion of women from the medical profession are factors common to both situations.

As a result, there is often a gap between women's needs and the objectives -- and practices -- of population programs. AID's postpartum program, proudly described in annual reports, reaches women about family planning techniques in the obstetrics ward. Such women are definitely part of the "target" group, obviously fertile, and acceptance rates are high. These glowing reports usually begin with the obligatory tribute to Margaret Sanger, emphasizing human rights, women's rights, and choice.<sup>39</sup> But such programs are designed to reach women when most vulnerable to these usually male experts. The language used to describe women often depersonalizes them, labelling them "acceptors" or "targets." In setting goals for contraceptive use, the term is "number of monthly cycles" reached. Although it pays lip service to the need for studies on women's opportunities, family concepts, values, and the like, AID's Population Office does otherwise in actual practice. When Congressmen queried Ravenholt on children as "social security," his response was how he'd heard this "ad nauseam . . . Ask women in maternity wards. They want help."<sup>40</sup>

In the Rockefeller Medicine Man, Brown makes a linkage between scientific medicine and capitalism that is parallel to our analysis of demography, but expands our argument in important ways. First, medicine is a means of cultural domination: "medicine can convert and colonize the heathen."<sup>41</sup>

Medical research institutes funded by Rockefeller were the "temples of the new religion," each helping to "spread abroad in the public mind a respect for science and for the scientific method."<sup>42</sup> Brown concludes that "(s)cientific medicine, as part of the fervent campaign for science, helped spread industrial culture, albeit a capitalist industrial culture, throughout the land and indeed the world."<sup>43</sup>

Part of the explanation he offers for this is the identity between the scientific world-view and industrialism, both of which are alien to traditional cultures. Scientific medicine turns attention away from competing values and ideologies, focusing instead on the search for appropriate technique:

Members of any society or social class whose existence is intimately tied to industrialism will find scientific medicine's explanations of health and disease more appealing than mystical belief systems. The precise analysis of the human body into its component parts is analogous to the industrial organization of production. From the perspective of an industrialist, scientific method seems to offer the limitless potential for effectiveness that science and technology provide in manufacturing and social organization. Just as industry depends upon science for technically powerful tools, science-based medicine and its mechanistic concepts of the body and disease should yield powerful tools with which to identify, eliminate, and prevent agents of disease and correct malfunctions of the body.<sup>44</sup>

Rockefeller money did not support medical research that investigated the relationship of social factors to health and disease . . . It ignored the impact of the social, economic and physical environment on disease and health.

In the Third World the process is reversed and the successes of scientific medicine pave the way for industrial capitalism. We would argue that, through the population program, women are the front-line recipients of this assault.

The process of advancing capitalism through scientific medicine, and advancing medicine through population control has two significant implications for women. "Technique" has translated into the emphasis on contraceptive devices, how to make them effective (if not always safe), and how women might be induced to use them -- not on the broader political, economic or social context.

Second, the convergence of medical and industrial values has had an impact on sexuality in general, and women's sexuality in particular. It is worth asking how science and modernization (urbanization and industrialization) historically combine to create a new sexual economy that provides the moral underpinnings for the industrial order. There are parallels between the population control movement of our generation and the "purity movement" of the 19th century.<sup>45</sup>

The metaphors and symbols of the (purity) reformers expressed external fears of Oedipal conflict and the potentially destructive power of sexuality. But they also provided an ideal sexual and moral regimen for the newly urbanized Northeastern middle class, some of whom listened to their lectures, read their books, and participated in health reform organizations. The purity advocates' belief in a closed energy system and their insistence that work and energy be directed toward socially acceptable goals helped industrialize and bureaucratize a once agricultural people. The purity reformers stressed the values of deferred gratification, hard work, sobriety, seriousness, individualism, and good health. In the precarious world of antebellum America, these habits were valuable attributes, for too early a marriage, too many children, or too dissipated a life could mean financial and social ruin.<sup>46</sup>

Female sexuality is under traditional, often patriarchal control in most Third World societies. Modernization and population control apparently share the goal of restraining male sexuality as well, in the

interests of "seriousness," "sobriety," and upward social mobility. And, learning to "control" sexuality -- by taking the pill, replacing the IUD regularly, or going through the kinds of future calculations that are required to decide on sterilization -- is learning to control "nature," to calculate, to "reckon" costs and time.

The female ability to control fertility with or without male knowledge has potentially profound implications for the traditional patriarchal patterns of male/female relations. But when women themselves under the guidance of a male-dominated medical system are taught to see contraceptive methods as just a "technique," they will be less able to conceive of control over their own fertility as a means to independence or as a power resource. The close association of family planning and medical science makes U.S. promotion of contraceptive use much more palatable to Third World elites and reduces any potential danger to the male/female status quo.

#### The Contraceptive Inundation Strategy

The Population Office's declared policy emphasizing supply of contraceptives and labelled by supporters and detractors as "inundation," has come under attack from a variety of critics. Some have seen AID's policy of distributing contraceptives in bulk as dangerous to women's health and an inappropriate image for U.S. foreign policy. Feminists have criticized the office for failing to take broader developmental issues regarding women into account. Others have argued that the program has wasted resources in creating and delivering a supply for which it has not created an adequate demand.

In addition, a majority of these critics have placed the responsibility for choosing this strategy directly on the shoulders of Dr. "Ray" Ravenholt, who, as we have noted, headed the population program in AID from its inception in 1967 to 1979. They have argued that he was too zealous to see the population issue in its broader developmental context or that his attitudes about women were extremely sexist. There is no doubt that, historically, Dr. Ravenholt's view of the priorities for the Population Office ruled the day. We would argue, however, that different leadership might well have settled on the same strategy because the reasons for doing so are both "scientific" (in the sense we have used that term in this paper) and bureaucratic. Thus any bureaucratic office with a special mandate in this area would have been pushed strongly in the same direction.

Further, we would argue that inunation is atypical bureaucratic product a result not only of the demographic and medical biases of those who made population policy in the 1970s, but also of "bureaucratic politics." Specialized offices survive in AID (or any other bureaucracy subject to congressional or budgetary review) because they perform their tasks visibly and efficiently -- or create the image of doing so. Under this hypothesis, any expenditures made by the Office that were not directed toward the maximum dispersion of contraceptive devices (and provided there was also reasonable proof that they were used) are subject to criticism on cost-effectiveness grounds. As early as the 1967 Population Crisis Hearings, the direct approach was praised as being "simplest (managerial-wise) and cheapest."<sup>47</sup> But the Population Office had to face the fact that supply did not always create demand, and this dictated that some proportion of its budget would

go toward research intended to increase use -- including attitudinal research, multivariate analyses of the kind analyzed earlier, efforts to create more acceptable contraceptive devices, and pilot programs to find effective delivery systems. Because demographic research did not yield instant answers, it is not surprising that the Population Office resisted using what it considered scarce resources on "unproductive" research. Action, money movement,<sup>48</sup> and securing constituencies are the name of the successful political game at AID. Even before Ravenholt, Leona Baumgartner likened family planning to the 1930's "malaria eradication campaign" in Brazil and to later "yellow fever conquests."<sup>49</sup>

Putting population efforts in a "broader developmental context" makes logical and perhaps political sense, but such cooperation -- which requires a certain "fuzziness" of goals -- is not a recipe for bureaucratic success. Development was the task of the Agency as a whole, and the Population Office would have been foolish to try to compete to create effective development programs; its mandate was population, and money spent in broader programs would only assist some other part of the Agency. Thus there was resistance to using Population money to help Women in Development efforts and, not surprisingly, the Women in Development Office guarded its comparatively paltry funds against use by Population, Health, or other purposes for which there were established offices and budgets, and among which there was competition for resources and visibility.

Finally, the emphasis on technique, the use of a wide range of

delivery mechanisms while relying on the core networks of health and family planning services, and the unwillingness to become involved in integrated or holistic approaches to contraceptive use are not only consistent with bureaucratic imperatives but are also politically expedient. Research on factors affecting fertility may not provide simple answers, but it is cheaper than the woman-centered approach and more politically acceptable: the search for "factors" provides Third World policy-makers with incremental options, not a full-scale critique of power or income distribution or an attack on institutions of male dominance. As long as there is proof of unmet demands, it is also possible for the Office to stave off demands for "coercive" measures which would be politically risky and well beyond its bureaucratic capability.

However, changes were taking place in the international and domestic political contexts through the central Population Office's ten-year reign. Besides the new mandates of 1973, which gave the minority egalitarian advocates inside the agency some legitimacy, a variety of United Nations conferences criticized both U.S. "demographic imperialism" and general world-wide neglect of women in the development process. The International Women's Year Conference, expanded into the International Women's Decade, stimulated the expansion of international feminism and specific women in development and feminist domestic constituencies. Besides that, there was growth, diversity, and hybridization in the population constituency itself. Overlaying all this was the periodic reorganization within AID, efforts to "decentralize" to regional Bureaus and Missions during John Gilligan's tenure as administrator, and various opportunities for bureaucratic players

to vie for the superiority of their definition and control over population policy. This resulted in competition between the "demand-siders," also known as "developmentalists," as they called themselves, and the "supply-siders" epitomized by Ravenholt. Years of careful maneuvering shifted the balance of bureaucratic power.

In a 1976 AID policy paper, "U.S. Population Related Assistance," analysts concluded that the direct supply of contraceptives was not sufficiently effective in reducing world birth rates, but that broader policy reforms were needed to support smaller families, development, and variables that increased demand. AID submitted language to Congress leading to the creation of Section 104.d of the International Development and Food Assistance Act, which called upon AID to administer all AID projects so as to build motivation for lower fertility by modifying conditions that support higher fertility. Internally, 104.d prompted new internal procedures which required that "fertility impacts" of projects be considered (joining the procedural environmental-, economic-, and woman-impact statements). Oversight fell on the Policy Bureau rather than the Population Office.

The result was to spread population efforts across a wider set of bureaucratic actors. Always, some had been ruffled at Ravenholt's style; a combination of reprimands, the airing of dirty agency laundry on conflicts in the 1980 Senate appropriation hearings, technical title demotion, and a shift of population resources to other agency offices all undermined him via this "integrationist" approach.

But was there real change? There was a shift from Ravenholt's medically-oriented approach to the demographic/scientific approach of 104.d, but that was still warped by bureaucratic imperatives, and challenged neither power

realities between men and women, nor between "experts" and "acceptors." As for a more woman-centered approach, several AID executives simply used the existence of a Women in Development Office to "prove" how AID was already sensitive to women and women's opportunities, despite the WID Office's low funding and minimal effects on the overall agency portfolio and procedures.<sup>50</sup>

Thus it is ironic that Sharon Camp, of the Population Crisis Committee, in testimony before the Senate Committee on Appropriations, Foreign Assistance and Related Programs in 1979<sup>51</sup> defended inundation in the strongest of terms. She argued that the Office's programs had been successful and cost-effective in the 1970s:

(S)ome would go so far as to suggest that funds appropriated for population planning could be more effectively used for health, agriculture, or women's projects, even though population funds represent only about 16 percent of bilateral assistance and less than 5 percent of our total development effort . . . Pessimistic estimates of motivation levels and family planning acceptance also lead to a strong emphasis on research -- both on social science research to identify other determinants of fertility and on bio-medical research to identify methods of contraception which require lower levels of motivation.<sup>52</sup>

Then she fended off the claims of other offices which would divert funds from the contraceptive program and chided the Agency for its internal controversies which have reduced Congressional confidence and commitment.

I have purposefully carried this argument ad absurdum to underline two points. First, most of the AID budget is already devoted to those things that are supposed to increase demand for family planning. We should not convert them into pseudo-population programs; neither should we rob the population program to support these other goals. Second, we should not become immersed in major social science research projects on the determinants of fertility which provide us with no useful recommendations for specific, cost-effective action.<sup>53</sup>

She concluded: "Any effort to improve the well-being of women now in their reproductive years and to reduce population growth rates must place primary emphasis on the incremental improvement and wider distribution of all effective contraceptive methods already available," adding, "In this respect we must pay tribute to the Office of Population for moving singlemindedly toward this objective despite enormous obstacles and continuing controversy."<sup>54</sup>

We have come full circle, but because neither of these approaches could get beyond medical or demographic "science" to a truly woman-centered analysis, we have made no advance.

#### Conclusion

In this paper, we have attempted to outline the way in which demographic and medical approaches to defining and solving the population problem have made women the targets of family planning policies rather than providing the opportunity for women to take control of their own fertility. It is our view that these approaches are not only manipulative and reinforcing of traditional patterns of female dependency, despite their revolutionary potential, but that they are also less effective than women-centered policies have the potential to be. We also drew attention to the congruence between AID's population policies and other "modernizing" forces that undermine Third World interests and contribute to U.S. dominance: the linkage between medicine and capitalism, and the dictates of bureaucratic "rationality." Critics of the population program have decried "U.S. imperialism," but not the scientific and "rational" underpinnings of that power, or the power of hierarchical, "policy-making" bureaucracies in general.

Ironically, as we shall see, the critic of U.S. population policy who comes closest to making our case is Kingsley Davis, who attacks the "technological" approach of current policy, who sees the placing of population programs "in the hands of respected medical personnel" as an evasion of the issue, and who focuses on the individual family as the appropriate unit of analysis:

In viewing negative attitudes toward birth control as due to ignorance, apathy and outworn tradition, and 'mass communication' as the solution to the motivation problem, family planners tend to ignore the complexity of social life. If it were admitted that the creation and care of new human beings is socially motivated, like other forms of behavior, by being a part of the system of rewards and punishments that is built into human relationships, and thus is bound up with the individual's economic and personal interests, it would be apparent that the social structure and economy must be changed before a deliberate reduction in the birth rate can be achieved.<sup>54</sup>

The changes that would be necessary, Davis concludes, would be "changes in the structure of the family, in the position of women, and in sexual mores."<sup>55</sup>

Unfortunately, the point of Davis' article is that "family planning" is not enough. "Population control" is necessary, and the techniques advised include strong sanctions against unmarried mothers, pressures to postpone marriage, and increasing the costs of having children after marriage while making all forms of birth control, including abortion, easily available. To do this, the government must use its economic power and its control over education, combining economic rewards and punishments with a new system of social rewards and punishments taught through the schools.<sup>56</sup>

This approach has the advantage of recognizing the role of social

values and the emotional as well as economic context in which fertility decisions -- and non-decisions -- are made. This is a female-sensitive view to the degree that it recognizes the full context in which women must act; it is not female-centered, however, in that it still treats women as the object of policy manipulation rather than as the primary actors in the drama. Increasing women's economic options may have the desired effect of reducing birth rates, or it may simply make women vulnerable to exploitation both as producers and as reproducers. Sanctions against illegitimate births reinforce female dependence on males, and social values that postpone marriage are often accompanied by severe controls over female sexuality.

As Judith Blake has pointed out, lifting existing social pressures to reproduce should be tried before imposing strong sanctions against reproduction,<sup>57</sup> sanctions that will inevitably have harsh consequences for women, particularly in societies where women achieve economic support and social status primarily from this role. Although demography, medical science, and bureaucratic specialization have combined to push us toward inundation or modified inundation efforts, successful population policies cannot be pursued in isolation. The "population problem" can only be solved if we stop manipulating women and devote our resources instead to giving them power over their own lives, recognizing the power they now have over ours.

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Footnotes

1. Both authors worked in the Women in Development Office at A.I.D., Jaquette from 1979-1980, and Staudt during 1979 under the Inter-governmental Personnel Exchange Act.
2. On redistribution, see K. Staudt, Gender Redistribution Within Bureaucracy (New York: Praeger, 1984, forthcoming). Although these other programs pose interesting questions worth analyzing for their biological assumptions, they remain beyond the scope of this paper.
3. See Reimert T. Ravenholt, "The A.I.D. Population and Family Planning Programme: Goals, Scope, and Progress," Population and International Assistance and Research (Proceedings of the First Population Conference of the Development Centre, Organization for Economic Cooperation and Development, Paris, 1969), p. 51.
4. Ibid., p. 53.
5. See Staudt, op. cit., Chapters 3 and 7, on A.I.D. structure, context, and reviews of population policy.
6. This restriction was removed in 1967.
7. Ravenholt, op. cit., p. 54.
8. Ibid., p. 56.
9. E.g., Garrett Hardin, "Carrying Capacity as an Ethical Concept," in George L. Lucas, Jr., and Thomas W. Ogletree, eds., Lifeboat Ethics (New York: Harper and Row, 1976), pp. 120-140.
10. John H. Sullivan (Assistant Administrator, Asia Bureau, U.S. Agency for International Development), "International Population Control: Alternative U.S. Responses in the Coming Decade," in Eliot Glassheim, Charles Cargille and Charles Hoffman, eds., Key Issues in Population Policy (Washington, D.C.: University Press of America, 1978), passim, and Barbara Ehrenreich, Mark Dowd, and Stephen Menken, "Genocide, The Accused: The U.S. Government," Mother Jones (November, 1979), pp.
11. Ibid. They are joined in this critique by an unlikely ally, Mrs. Randy Engel, Director, U.S. Coalition for Life, testifying in "Population and Development: Overview of the Trends, Consequences, Perspectives, and Issues," Hearings before the Select Committee on Population, Vol. 1, 95th Congress, 2nd Session, 1978, pp. 340-341.
12. Willard Boynton (A.I.D. Office of Population), "A.I.D. Population Policy," in Key Issues in Population, op. cit., pp. 78-79.
13. E.g., Karl Sax, Standing Room Only (Boston: Beacon Press, 1955), and The Population Explosion (New York: Foreign Policy Association, 1956).

14. Paul R. Ehrlich, The Population Bomb (New York: Ballantine Books, 1968), p. xi.
15. Ibid., pp. 52-53.
16. Ibid., p. 53.
17. Ibid., p. 14.
18. "Foreign Assistance and Related Agencies Appropriations for 1976," Hearings before a Subcommittee of the Committee on Appropriations, House of Representatives, 94th Congress, 1st Session, Part 2, p. 628.
19. John Montgomery, "Population Policies as Social Experiments," in John Montgomery, Harold Lasswell, Joel Migdal, eds., Patterns of Policy: Comparative and Longitudinal Studies of Population Events (New Brunswick, N.J.: Transaction Books, 1979), p. 45.
20. "Population Crisis," Hearings Before the Subcommittee on Foreign Aid Expenditures of the Committee on Government Operations, U.S. Senate, 90th Congress, 1st Session, Part 1 (1967), p. 790.
21. Ibid., p. 619.
22. "Population Program Assistance: Aid to Developing Countries by the U.S., Other Nations, and International and Private Agencies" (Washington, D.C.: Agency for International Development, Technical Assistance/Population, December, 1971), p. 5.
23. Nancy Birdsall, "Review Essay: Women and Population Studies," SIGNS: Journal of Women in Culture and Society, Vol. 1, No. 3, Pt. 1 (1976), p. 705.
24. Ibid., p. 705.
25. Ibid., p. 708. For additional information see Helen Ware, Women, Demography, and Development (Canberra: Australian National University, 1981), pp. 99-104; Leslie Corsa and Deborah Oakley, Population Planning (Ann Arbor: University of Michigan Press, 1979), pp. 129ff.
26. E.g., Ruth B. Dixon, "Women in Agriculture: Counting the Labor Force in Developing Countries," Population and Development Review, Vol. 8, No. 2, September, 1982.
27. Steven Sinding, Study of Family Planning Program Effectiveness (Washington, D.C.: Agency for International Development, Bureau for Program and Policy Coordination, Office of Evaluation Discussion Paper No. 5, April 1979), p. 6.
28. Vol. 1, p. 43, op. cit. Earlier, attention to women was altogether missing from the 17 independent variable lists of a "family planning advocate," who distinguished himself from "demographers" (Donald

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- Bogue, "Family Planning Research: An Outline of the Field," in Family Planning and Population Programs: A Review of World Development, Bernard Berelson, ed., Chicago: University of Chicago Press, 1966) and even from comparative micro field studies. Scarlett Epstein and Darrell Jackson, eds., The Feasibility of Family Planning: Micro Perspectives (Oxford: Pergamon Press, 1977).
29. "Reducing Population Growth Through Social and Economic Change in Developing Countries: A New Direction for U.S. Assistance," General Accounting Office, April 5, 1978, p. 51.
  30. Cited in Virginia Gray, "Women Victims or Beneficiaries of U.S. Population Policy?", in Political Issues in U.S. Population Policy, Virginia Gray and Elihu Bergman, eds. (Lexington, Mass: Lexington Books, 1974), p. 179.
  31. Sandra S. Tangri, "A Feminist Perspective on Some Ethical Issues in Population Programs," SIGNS, Vol. 1, No. 4.
  31. id., p. 901.
  33. A.I.D.'s record on female professionals and policy makers in population is not good. As late as the 1978 Population and Development Hearings, when this question was raised repeatedly by Congressmen, agency executives admitted that only one in five professionals were female, better though than the 12 percent of female professionals in the rest of A.I.D. (Vol. III, p. 146). Even among those testifying at the many hearings on population ranged from one in ten women at the 1967-68 Population and Development Hearings to the all-time high of one in five at the 1978 Population and Development Hearings. At 1973 Appropriation Hearings, the highest ranking woman at A.I.D., Harriet Crowley, testified only to that fact, but said nothing more (according to "Foreign Assistance and Related Agencies, Appropriations for 1974," Hearings before a subcommittee of the Committee on Appropriations, House of Representatives, 92nd Congress, 2nd Session, Part II, p. 895). But which women are these, for what purpose are they testifying, and most importantly, in what bureaucratic context do they operate?
  34. Thomas B. Littlewood, The Politics of Population Control (Notre Dame: University of Notre Dame Press, 1977), p. 147.
  35. Ehrlich, op. cit., p. 9.
  36. E. Richard Brown, Rockefeller Medicine Men: Medicine and Capitalism in America (Berkeley: University of California Press, 1979), p. 92. See also Sara Delamont and Lorna Duffin, The Nineteenth Century Woman: Her Cultural and Physical World (London: Barnes and Noble Books, 1978).
  37. Brown, op. cit., p. 92.
  38. Gray, op. cit.
  39. See, for example, Population Program Assistance, 1971, op. cit., p. 33.

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40. 1976 Appropriation Hearings, p. 736.
  41. Brown, op. cit., p. 122.
  42. Ibid., p. 127.
  43. Ibid., p. 17.
  44. Ibid., p. 119.
  45. See Jayme A. Sokolow, Eros and Modernization: Sylvester Graham, Health Reform, and the Origins of Victorian Sexuality in America (Madison, Wisc.: Associated University Presses, 1983).
  46. Ibid., p. 93. On "control," see Peter E. S. Freund, The Civilized Body: Social Domination, Control, and Health (Philadelphia: Temple University Press, 1982).
  47. Judith Tandler emphasizes this in Inside Foreign Aid (Baltimore: Johns Hopkins University Press, 1975).
  48. "Family Planning Around the World," in Family Planning and Population Programs: A Review of World Development (Chicago: University of Chicago Press, 1966), p. 288.
  49. See Staudt, op. cit.
  50. Senate Hearings Before the Committee on Appropriations, Foreign Assistance, and Related Programs, FY 1980, 96th Congress, 1st Session, HR 4473, 1979.
  51. Ibid., pp. 267-268.
  52. Ibid., p. 273.
  53. Ibid., p. 274.
  54. Kingsley Davis, "Population Policy: Will Current Programs Succeed?", Science, Vol. 158, #3802, November 10, 1967, p. 733.
  55. Ibid., p. 734.
  56. Ibid., p. 738.
  57. Judith Blake, "Population Policy for Americans: Is the Government Being Misled?", in Daniel Callahan, ed., The American Population Debate (Garden City, NY: Doubleday and Company, 1971).