

Why do We Still Have a Federal Office of Population Affairs?

INTRODUCTION

The Office of Population Affairs was created in 1970 to administrate Title X, which was established “to provide access to contraceptive services, supplies, and information to all who want and need them.”¹ Specifically, Title X funding is supposed “to assist individuals in determining the number and spacing of their children through the provision of voluntary, confidential and low-cost education, counseling, and related comprehensive medical services to eligible clients.”²

President Richard Nixon, creator of Title X, declared in 1969 that providing family planning services for low-income Americans should be a “national goal.”³ Reasonable people can disagree about the proper role of the federal government in assisting individuals in “determining the number and spacing of their children,” but for nearly five decades, billions of dollars of Title X funding have been allocated to that purpose. As the fiftieth anniversary of Title X approaches, an examination of what these funds have accomplished and whether they should be continued is long overdue.

The desire to use federal funds for population control did not begin with President Nixon.



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President Lyndon Johnson reflected the views of many prominent scientists and thinkers when he said in 1965 that, “[L]ess than five dollars invested in population control is worth a hundred dollars invested in economic growth.” President Johnson, like many educated Americans of his day, believed that controlling the number of children born to lower-income mothers would “promote public health and welfare.”⁴

Of course, it is now well-documented that this point of view was taken to extremes that any reasonable person would find repugnant. These excesses included the federally funded sterilization of low-income and minority women in 32 states,⁵ many of whom were coerced. After eugenics fell out of fashion, the goal of reducing low-income and minority birthrates was expressed in the more benign sounding phrase:

“pregnancy prevention.”

More recently, the Office of Population Affairs (OPA) has begun to frame the argument for federally funded family planning services as a “reproductive health” concern. But the uncomfortable truth is that the goal of effectively preventing pregnancy in a large population and the goal of increasing

1 Department of Health and Human Services. Retrieved from: <https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html>

2 Department of Health and Human Services. Retrieved from: <https://www.hhs.gov/opa/about-opa/mission/index.html>

3 Martha J. Baily, “Reexamining the Impact of Family Planning Programs on US Fertility: Evidence from the War on Poverty and the Early Years of Title X,” *American Economic Journal: Applied Economics* (April 2012). Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3348617/>

4 Congressional Records: Public Law 91-572, 84 Stat. 1504, Dec. 24. 1970. Retrieved from: <http://uscode.house.gov/statutes/pl/91/572.pdf>

5 Lisa Ko, “Unwanted Sterilization and Eugenics Programs in the United States,” PBS (January 29, 2016). Retrieved from: <http://www.pbs.org/independentlens/blog/unwanted-sterilization-and-eugenics-programs-in-the-united-states/>

reproductive health are often in conflict.⁶ The reality many policy makers do not want to face is that the contraceptive methods that are most effective in preventing pregnancy—and thus pushed aggressively by many Title X-funded clinics—also increase women’s risk of both contracting dangerous or even fatal STD’s and facing long-term fertility challenges.

This report will demonstrate that when faced with the choice between lower birthrates and women’s health, the Office of Population Affairs has consistently chosen policies and programs which prioritize the reduction of poor and minority birthrates over the reproductive health of poor and minority women.

At least partially due to these decisions, the black American community in particular finds itself facing below-replacement level birthrates as well as a reproductive health crisis. Black women are twice as likely as white women to face infertility when they want to become pregnant,⁷ and several times more likely to carry a variety of dangerous and often fatal sexually transmitted diseases.⁸

Fertility in the United States is nearing its historic low,⁹ while STD infection rates are reaching record highs year after year.¹⁰ This is not the recipe for public health and economic growth that America was promised with the creation of the OPA and Title X. It is well past time to rethink the model of federally funded family planning and begin anew

with an outlook that truly prioritizes public health.

A BRIEF HISTORY OF THE OPA, TITLE X AND AMERICAN EUGENICS

It is impossible to understand the creation and implementation of the OPA and Title X without understanding the eugenics movement in America. The term “eugenics” was coined by Francis Galton, a 19th Century English scientist, who wanted to selectively breed humans for positive traits. However, American scientists and thinkers—including Planned Parenthood founder Margaret Sanger—quickly became more interested in eliminating from the gene pool what they perceived as “negative” traits.

Writing in *Nature*, Dr. Laura Rivard explains, **“Not surprisingly, ‘undesirable’ traits were concentrated in poor, uneducated, and minority populations.** In an attempt to prevent these groups from propagating, eugenicists helped drive legislation for their forced sterilization (Norrgard 2008). The first state to enact a sterilization law was Indiana in 1907, quickly followed by California and 28 other states by 1931 (Lombardo n.d.). These laws resulted in the forced sterilization of over 64,000 people in the United States (Lombardo n.d.). **At first, sterilization efforts focused on the disabled but later grew to include people whose only “crime” was poverty.** These sterilization programs found legal support in the Supreme Court. In *Buck v. Bell* (1927), the state of Virginia sought to sterilize Carrie Buck for promiscuity as evidenced by her giving birth to a baby out of wedlock (some suggest she was raped). **In ruling against Buck, Supreme Court Justice Wendell Holmes opined, “It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for imbecility, society can prevent those who are manifestly unfit from continuing their kind....Three generations of imbeciles is enough”** (Black 2003). This decision legitimized the various sterilization laws in the United States. In particular, California’s program was so robust that the Nazi’s turned to California for advice in perfecting their

6 “Simultaneous prevention of unintended pregnancy and STIs: a challenging compromise,” *Human Reproduction Update*, Volume 20, Issue 6, 1 November 2014, Pages 952–963, (June 16, 2014). Retrieved from: <https://academic.oup.com/humupd/article/20/6/952/2952635>

7 Centers for Disease Control and Prevention. Retrieved from: <https://www.cdc.gov/nchs/data/nhsr/nhsr067.pdf>

8 Centers for Disease Control and Prevention. Retrieved from: <https://www.cdc.gov/std/stats16/minorities.htm>

9 Centers for Disease Control and Prevention. Retrieved from: <https://www.cdc.gov/nchs/nvss/vsrr/nativity.htm>

10 Centers for Disease Control and Prevention. Retrieved from: <https://www.cdc.gov/stdconference/2018/media.htm#news>

own efforts. Hitler proudly admitted to following the laws of several American states that allowed for the prevention of reproduction of the ‘unfit’ (Black 2003).”¹¹

Although the article in *Nature* suggests that eugenics “lost power” in the 1940’s, forced sterilizations actually continue among poor and minority women through the present day. Thousands of Native American women and girls were forcibly sterilized in the 1960’s and 1970’s by the Indian Health Service,¹² and as recently as 2011, the state of California was discovered to be sterilizing poor and minority women without their consent.¹³

PERSISTENT ABUSE OF LONG-ACTING REVERSIBLE CONTRACEPTION (LARC’S)

Long-Acting Reversible Contraception (LARC’s) include contraceptive injections (Depo Provera), intrauterine devices (IUD’s) and contraceptive implants (Norplant). They are beloved by the OPA for their effectiveness in preventing pregnancy, and because they give healthcare providers greater control over women’s and girls’ reproduction.¹⁴ However, LARC’s have been fraught with abuse by judges, lawmakers, and healthcare providers since

11 Teryn Bouche and Laura Rivard, “America’s Hidden History: The Eugenics Movement,” *Nature* (September 18, 2014). Retrieved from: <https://www.nature.com/scitable/forums/genetics-generation/america-s-hidden-history-the-eugenics-movement-123919444>

12 Erin Blakemore, “The Little-Known History of the Forced Sterilization of Native American Women,” *JSTOR Daily* (August 25, 2016). Retrieved from: <https://daily.jstor.org/the-little-known-history-of-the-forced-sterilization-of-native-american-women/>

13 “California governor signs inmate sterilization ban,” *Reuters* (September 25, 2014). Retrieved from: <https://www.reuters.com/article/us-usa-california-prisons/california-governor-signs-in-mate-sterilization-ban-idUSKCN0HL07720140926>

14 A more popular way of phrasing this is that LARC’s do not depend on patient compliance (remembering or deciding to take a pill or utilize a barrier method) for their effectiveness. The cold, hard reality is that only a healthcare provider can insert an IUD or contraceptive implant or administer a contraceptive injection, and once done, a woman or girl must wait for the injection to wear off or return to the healthcare provider to have the implant or IUD removed. Thus, LARC’s make women dependent on healthcare providers for daily control of their reproduction.

their development.

Before the FDA approved Depo Provera, clinical trials were conducted on several thousand black women in Atlanta, at Grady Memorial (a public hospital) in many cases without proper consent.¹⁵ According to a study published by New York University Press, “When the FDA audited the Grady Clinic’s study, it found serious deficiencies in the design and conduct of the clinic’s testing protocol, including inaccurate screening, defective informed consent procedures, and no follow-up of the women. **The FDA audit team concluded that the clinic had sacrificed scientific assessment of the drug’s health risks to its acceptability in promoting family planning goals.** The agency terminated the clinic’s program, but its risk management flaws were not publicly exposed and its research was not discredited until the FDA’s Public Board of Inquiry, chaired by Judith Weisz, held hearings in 1983. Yet the women whose health had been harmed by their participation in the Grady Clinic’s study went without a legal remedy.”¹⁶

The first generation IUD Dalkon Shield, was developed by Dr. Hugh Davis. In touting the benefits of methods such as IUD’s over the Pill, Davis highlighted the “problem” of poor and minority pregnancy and lamented that so many suburban (white) women were preventing pregnancy:

“It is especially tragic that for the individual who needs birth control the most—**the poor, the disadvantaged, the ghetto-dwelling black**—the oral contraceptives carry a particularly high hazard of pregnancy as compared with methods requiring less motivation...It is the suburban middle class

15 Jean Latz Griffin, “Birth Control Shot Stirs Health, Ethics Fears,” *Chicago Tribune* (November 18, 1992). Retrieved from: <https://www.chicagotribune.com/news/ct-xpm-1992-11-18-9204150346-story.html>

16 William Green, “The Grady Hospital Study: The Corruption of Contraceptive Research,” *NYU Press* (2017). Retrieved from: <http://nyu.universitypressscholarship.com/view/10.18574/nyu/9781479876990.001.0001/upso-9781479876990-chapter-002>

woman who has become the chronic user of the oral contraceptives in the United States in the past decade...Therein, in my opinion, lies the real hazard of the presently available oral contraceptives.”¹⁷

The device ended up being recalled after 18 women died and thousands more suffered permanent infertility, pelvic infections and other complications. Many women who complained were told by their providers that their symptoms were due to poor personal hygiene.¹⁸

As soon as Norplant was released in 1991, many legislators were excited to use it coercively on poor and minority women. According to the ACLU, “In 1991, 1992, and 1993, legislators in more than a dozen states introduced measures that, had they passed, would have coerced women to use Norplant. Some of these bills would have offered financial incentives to women on welfare to induce them to use Norplant. Other legislation would have required women receiving public assistance either to use Norplant or lose their benefits. Some bills would have forced women convicted of child abuse or drug use during pregnancy to have Norplant implanted...In both the judicial and legislative schemes to manipulate women into using Norplant, some **women would be forced or induced to take Norplant even when it posed a danger to their health.**”

The use of LARC’s and permanent sterilization are strongly encouraged by both Medicaid and the OPA through innocuous sounding “quality” measures. These metrics measure the “quality” of the services they provide solely on the basis of preventing

pregnancy,¹⁹ without regard to negative side effects, disease prevention or reproductive system damage. In other words, according to both Medicaid and the OPA, a method of contraception is considered of high quality (and therefore encouraged and incentivized for use) if it prevents a woman or girl from becoming pregnant, even if it also leaves her permanently sterile, ill from side effects, or deformed or dead from an STD.

FERTILITY AND DISEASE RATES AMONG POOR AND MINORITY WOMEN

Birthrates in the United States are now below replacement rate. And this decline in fertility has been the sharpest among racial minorities.²⁰ Even when adjusting for numerous factors including socioeconomic and marital status, black women are more than twice as likely as white women to face infertility.²¹

Furthermore, these lower birthrates have not been associated with an improvement in reproductive health. STD rates among all Americans are skyrocketing, but these rates are notably worse among low-income and minorities.

To say that African Americans are overrepresented in population of those infected with STDs is a profound understatement. In the most recent years for which complete data is available, HIV infection rates in the United States were 13.8 per 100,000 population and 49.4 among African

19 Susan T. Muskett, “Margaret Sanger’s Eugenics Heyday in the Federal Government,” Public Discourse (February 5, 2016). Retrieved from: <https://www.thepublicdiscourse.com/2016/02/16180/>

20 Lyman Stone, “Baby Bust: Fertility is Declining the Most Among Minority Women,” Institute for Family Studies (May 16, 2018). Retrieved from: <https://ifstudies.org/blog/baby-bust-fertility-is-declining-the-most-among-minority-women>

21 Melissa F. Wellons, Cora E. Lewis, Stephen M. Schwartz, Erica P. Gunderson, Pamela J. Schreiner, Barbara Sternfeld, Josh Richman, Cynthia K. Sites, David S. Siscovick, “Racial Differences in Self-Reported Infertility and Risk Factors for Infertility in a Cohort of Black and White Women: The CARDIA Women’s Study,” Fertility and Sterility (November 2008). Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2592196/>

17 Alan Guttmacher, “Where is Science Taking Us?” Saturday Review 43 (February 6, 1960): 50-51; Quoted in *Lethal Imagination: Violence and Brutality in American History*.

18 Clare L. Roepke, Eric A. Schaff, “Long Tail Strings: Impact of the Dalkon Shield 40 Years Later,” *Open Journal of Obstetrics and Gynecology* (December 2014). Retrieved from: http://file.scirp.org/pdf/OJOG_2014112714582934.pdf

Americans. Despite making up about 12 percent of the population, African Americans account for 45 percent of the total HIV infections, 62 percent of infected women, percent of infections attributed to heterosexual contact, and 64% of children under 13 infected with HIV.²²

Other STDs are no different. African Americans make up 55.4 percent of all reported gonorrhea cases and 38.1 percent of all syphilis cases. The rate of chlamydia among black women is 5.7 times the rate among white women, and 7.3 times higher among black men the rate among white men.²³

The uncomfortable reality is that certain kinds of sexual behavior carry serious mental, emotional, and physical consequences for participants. Offering “family planning” services which consistently prioritize lower birthrates among poor and minority women at the expense of their reproductive health and overall wellbeing will predictably lead to skyrocketing rates of disease and infertility, and so they have.

THE OPA, TITLE X AND ABORTION

Abortion has had a dramatically disproportionate effect on poor and minority women and children. More than 19 million black babies have been aborted since *Roe v. Wade* overturned state restrictions on the procedure in 1973. Each year, more than a third of all abortions are performed on black women. And in cities like New York, there are thousands more black babies aborted than born alive in any given year.

This was not unexpected. President Nixon himself expressed confidence that Americans would favor legal abortion, because the “aborted generally are the little black bastards.”²⁴ At the time of the founding of the OPA, many black leaders,

including the members of the Black Panther Party,²⁵ congressional candidate—and eugenic sterilization victim—Fannie Lou Hamer,²⁶ comedian Dick Gregory²⁷ and many others saw abortion as a tool of black genocide. To assuage these fears, the congressional act that founded the OPA specifically stated that “None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning.”²⁸

However, Planned Parenthood—the nation’s largest abortion provider—has consistently received tens of millions of Title X dollars each year.²⁹ According to its own annual report, in a single year Planned Parenthood performed 327,653 abortions, while referring only 1,880 women for adoption services.³⁰ Although in theory Planned Parenthood does not use Title X funds for abortion as method of family planning, it performs abortions in the same facilities that receive Title X funds for family planning services. Someone who pays the rent on a massage parlor that is also a brothel cannot reasonably say that he does not fund prostitution.

Just as doctors who receive kickbacks from certain pharmaceutical companies tend to prescribe more of that company’s drugs, Planned Parenthood

25 “American Black Nationalists on Population Control,” *Family Planning* (November 20, 2008) Retrieved from: <http://stanford.edu/group/womenscourage/cgi-bin/blogs/familyplanning/2008/11/20/american-black-nationalists-on-population-control/>

26 Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* New York: Doubleday (2007), pp. 189-190.

27 Dick Gregory, “My Answer to Genocide,” *Ebony* (October 1971).

28 Congressional Records: Public Law 91-572, 84 Stat. 1504, Sec.1008 Dec. 24. 1970. Retrieved from: <http://uscode.house.gov/statutes/pl/91/572.pdf>

29 Danielle Kurtzleben, “Fact Check: How Does Planned Parenthood Spend That Government Money?” *NPR* (August 5, 2015). Retrieved from: <https://www.npr.org/sections/itsallpolitics/2015/08/05/429641062/fact-check-how-does-planned-parent-hood-spend-that-government-money>

30 Planned Parenthood 2013-2014 Annual Report, retrieved from: https://issuu.com/actionfund/docs/annual_report_final_proof_12.16.14_

22 Centers for Disease Control and Prevention. Retrieved from: <https://www.cdc.gov/std/stats16/minorities.htm>

23 *Ibid.*

24 The Nixon White House Tapes, March 30, 1972.

has been shown to both profit from and have an inflationary effect on the abortion rate in America.³¹ And according to its records, Planned Parenthood spends over one million dollars lobbying for pro-abortion legislation each year.³² If the OPA cannot find any better organization to receive its funding than the nation's largest provider and promoter of abortion, perhaps it is time to start anew.

WHERE DO WE GO FROM HERE?

For nearly half a century, the Office of Population Affairs has spent billions of federal dollars to disseminate contraception—especially sterilization and LARC's—among poor and minority women in America, while simultaneously providing significant funds to the nation's largest abortion provider. American birthrates are nearing an all-time low, while the percentage of babies born out of wedlock remains historically high. Sexually transmitted diseases rage out of control, many becoming resistant to treatment. Yet to address these concerns, defenders of the OPA demand more money to (temporarily or permanently) sterilize more women.

It is long past time for a new approach. This approach must unapologetically prioritize sexual

health over lower birthrates. It must acknowledge some unpopular but common sense truths:

- 1.** Certain sexual behaviors—including sex with multiple partners and without barrier methods—are incompatible with sound physical and mental health
- 2.** Babies born to higher income white women are not inherently more desirable for society than babies born to lower income minority women
- 3.** For a healthy woman above the age of consent, becoming pregnant is not inherently harmful
- 4.** Contracting a sexually transmitted disease is always inherently harmful
- 5.** Lower-than-replacement birthrates are harmful to society both socially and economically

With these in mind, healthcare providers serving low-income and minority women should prioritize:

- 1.** Treating every patient as an individual with inherent dignity and autonomy
- 2.** Educating patients about healthy sexual behaviors and decision making, disease prevention, as well as how to recognize signs of reproductive health and disease
- 3.** Providing methods of contraception that decrease, rather than increase, a patient's likelihood of contracting a harmful or fatal STD
- 4.** Helping infertile women who desire children to become pregnant, regardless of their race or income, and withholding funding from organizations that promote abortion as a method of family planning
- 5.** Helping pregnant women connect to prenatal

³¹ Studnicki, J. and Fisher, J.W. (2018) Planned Parenthood: Supply Induced Demand for Abortion in the US. *Open Journal of Preventive Medicine*, 8, 142-145. <https://doi.org/10.4236/ojpm.2018.84014>

³² Planned Parenthood 2018 Profile Summary, Center for Responsive Politics, retrieved from: <https://www.opensecrets.org/lobby/clientsum.php?id=D000000591&year=2018>

care and adoption services if needed

Out-of-wedlock childbearing remains a tremendous social challenge for the United States, but it is merely a symptom of underlying unhealthy sexual behaviors. Only when that root cause is addressed holistically can we hope to see reductions in both non-marital births and sexually transmitted diseases and population-wide gains in reproductive health.

Right now, some local and state level programs—as well as countless private charities— are working to provide services with this approach in mind. In addition to healthcare, they connect vulnerable patients to a variety of holistic services, including counseling and mentoring, classes on life skills, budgeting, parenting, stress management, job training, job placement and getting a GED certificate, as well as other material support.

Response to these programs has been overwhelmingly positive, but they face an uphill battle when billions of dollars of federal funds are spent each year to de-incentivize the behaviors they are trying to promote. Perhaps America will decide that fifty years of the OPA and Title X is more than enough.



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