

Editorial

## Freedom closes the gap

We found ourselves strongly disagreeing with a recent editorial in *Contraception* by Wells et al. [1] when they asserted, “Thirty years ago, our approach to uncontrolled population growth in developing countries was to flood them with contraceptives. After millions of dollars without making an appreciable dent, we have come to understand that improving contraceptive practice is more dependent on women’s literacy and education than on the actual access to contraceptives” [1]. We also asked why those who are often warm friends and who work together with a common enthusiasm to improve all aspects of family planning can also end up adopting profoundly different explanations of why family size falls. We all accept that modern contraception improves the health of women and their families and that it is central to the autonomy of women in modern societies, yet for half a century, family planning has been riven by this deep and sometimes counterproductive fault line. On one side are those who emphasize that easy access to modern contraception, backed by honest information, helps drive up the contraceptive prevalence rate. On the other side are those who assert that changes in socioeconomic factors are a prerequisite for greater contraceptive use.

Part of the explanation, we suggest, lies in the fact that for decades, controversy over family planning preempted any possibility of collecting objective information on contraceptive use and abortion. Controversy over family planning is so universal that it may represent an age-old tension between evolved male and female reproductive agendas [2,3]. Whatever their origin, such controversies are particularly passionate and persistent in the United States. It took almost a hundred years for the Comstock laws restricting access to contraceptives to be reversed in the 1965 Supreme Court ruling *Griswald v. Connecticut* [4]. Indeed, in 1957, when Pincus, Rock and Chang first developed oral contraceptives in Massachusetts, it was illegal to use contraceptives in that state [5]. In 1936, a humane judge, in a case known as *United States vs. One Package*, had contrived a way to sidestep the Comstock laws. The judgment framed contraception as a medical prescription and therefore outside the remit of the Comstock laws. It was a clever and useful ruse, but it obscured the true nature of family planning, which is

ultimately a consumer choice. The advent of the Pill and a renaissance in IUDs in the 1950s and 1960s reinforced the medicalization of contraception.

The 1960s also saw the emergence of global concern over the adverse social and economic impact of rapid population growth. Charismatic leaders such as banker General Bill Draper Jr., obstetrician Alan Guttmacher and physician-epidemiologist Rei Ravenholt translated this concern into a worldwide family planning effort. Although international family planning never exceeded more than 1% of the foreign aid from wealthy nations, it formed the basis of highly visible programs in many developing countries.

While there was little useful data on contraceptive use prior to the 1960s, there was a wealth of information on socioeconomic variables; and the classic description of the demographic transition then — as still in many places now — posited that family size fell in response to socioeconomic progress in such areas as urbanization, wealth, education and child survival. Davis [6], the distinguished demographer from UC Berkeley, wrote in 1967 an article in *Science* dismissing the efforts of USAID to increase access to contraceptives as “either quackery or wishful thinking.” His criticism set back political support for family planning, and in 1969 Ravenholt [7] wrote a rejoinder saying, “Bearing and rearing children is hard work, and few women have unlimited enthusiasm for the task... It seems reasonable to believe that when women throughout the world need only reproduce when they choose, then the many intense family and social problems generated by unplanned, unwanted, and poorly cared for children will be greatly ameliorated and the now acute problems of too rapid population growth will be reduced to manageable proportions.”

The Kingsley Davis/Ravenholt debate has colored every international conference on Population and Development. In Bucharest 1974, the slogan was “Development is the best contraceptive.” In Mexico City 1984, the developing countries asked for help in family planning, while in 1994 in Cairo, the emphasis swung back to a more holistic approach, effectively reducing attention to both family planning and population growth. Today, advocates still line up on either side of the same fault line, as do we and our friends writing last year’s editorial.

We find compelling the empirical evidence that making contraception available increases the CPR even before socioeconomic improvements. Writing in *The Lancet* in 2006, Cleland et al. [8] described, “The promotion and availability of family planning...[as] one of the most significant public health success stories of the past century...family planning decreases maternal and child mortality, empowers women, reduces poverty, and it lessens stress on the natural and political environment.” Wherever attention has been given, as in Thailand or Iran, to making a variety of contraceptives and voluntary sterilization available, including reducing the non-evidence-based barriers to fertility regulation that are so prevalent [9], then the disparity of contraceptive use between the educated and uneducated has been greatly reduced. Where the freedom of access and correct information has remained constrained, as in the Philippines, the gap in CPR between the educated and uneducated has remained wide. If you maintain, as Wells et al. did, that “improving contraceptive practice is more dependent on women’s education than the actual access to contraception,” then it also implies that illiterate and uneducated women are not going to use contraception even if realistically available with correct information. If that were true, the world would never get out of poverty. A series of hearings in the British Parliament in 2006 on population and the Millennium Development Goals concluded, the goals of reducing poverty, improving nutrition, reducing infant and maternal mortality and achieving universal education and gender equality are all “difficult or impossible to achieve with the current levels of population growth in the least developed countries and regions” [10,11].

No doubt, differences of opinion on the factors driving the demographic transition will persist into the future. The common ground among family planning professionals could be to give unconditional priority to ensuring that contraception and safe abortion, along with supporting information, are available to all women everywhere. Education is

important for women and men, their families and their communities, but it is not a prerequisite fertility decline and giving women options over their childbearing.

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