To open our conversation today, I am going to talk to you about the history of contraceptive health care and the ways in which physicians, nurses, and women patients negotiated over access to reproductive health care – in this case birth control – and the ways in which women experienced services offered to them -- sometimes as voluntary, other times as involuntary, sometimes as a welcome relief from constant pregnancies, at other times as intrusions into their private lives that came with pressure and intimidation.

Prior to 1936, birth control programs – the systematic delivery of contraceptives – did not exist. If women sought birth control prior to the mid-1930s, they could appeal to their private physicians – and if they were married, already had children, and were fortunate to have a sympathetic physician, the physician might fit them with a diaphragm. Women without such access could try their luck on the black market where mostly German immigrants produced black market contraceptives. But until 1936, the distribution of contraceptive devices and the dissemination of information about such devices was considered obscene and, under the Comstock law, passed in the late 19th cent., prohibited.

In 1936, the US Court of Appeals for the 2nd Circuit ruled that the Comstock law could not be applied to physicians who disseminated medical devices and information. The case, US v. One Package of Japanese Pessaries, overturned the classification of birth control obscene and a vast array of commercial contraceptives began to flood the market. By the late 1930s, physicians and nurses began to establish contraceptive field trials across the country to test contraceptive devices. Researchers struck agreements with pharmaceutical companies to receive contraceptives for nominal fees. With help from local doctors and nurses, they tested foam powder in NC and PR, condoms in the Appalachian mountains, contraceptive jelly in Logan co. WV. In the 1950s, they set up field trials for the bc pill in KY and PR. The programs they established allowed health professionals to simultaneously test the effectiveness of particular birth control devices, improve maternal health, and offer families, many of whom were poverty stricken in the midst of the Great Depression, a way to limit the number of children they had.

One person central to a number of contraceptive field trials was Clarence Gamble, heir to the soap firm Procter and Gamble. Gamble had studied medicine. Then, rather than practice, he developed a contraceptive foam powder which he was eager to test. An ardent eugenicist, Gamble hoped that his foam powder could curb the reproduction of families whom he saw as eugenically unfit. In 1937, he struck a deal with the state director of public health in North Carolina: He offered the state a year’s supply of foam powder and sponges if state officials disseminated his supplies through county public health clinics across the state. NC state officials agreed and in 1937 they established the first state supported bc program in the country.

Gamble hired a birth control nurse, Lena Hillard, who traveled through Watauga County in the western part of the state. Hillard went door to door to offer women foam powder and condoms, gave careful instructions on their use, and kept records of the number of pregnancies among the users. She chronicled her experiences in colorful letters to Gamble, where she talked about... – Husband: the devil has tempted me in my weakest spot – trading chickens for Trojans.

Indeed, across the country, a patchwork of services emerged to address the contraceptive needs of poor women. Developed by public health officials, private physicians, and non-profit organizations such as
the American Birth Control League, physicians and nurses began to offer family planning through clinical services or traveling nurses.

Services existed on a continuum between two extremes: On one end, officials saw contraceptive services as an integral part of ph services which, if offered alongside prenatal/postnatal care and increased supervision of midwives, could improve the health of mothers and infants.

On other end were clinics that offered only contraceptive services to the exclusion of any maternal or other reproductive health care. Supporters of these services argued that general health services wld divert funds that were needed more urgently for birth control work. Here, officials thought it more important to reach as many women as possible. As a result, they stressed quantity – reaching many women – over quality – providing comprehensive services.

How did women receive these services: For many women, the contraceptive services offered in these clinics in the 1930s and 40s provided the only access to any kind of birth control. And many took advantage of these programs. Lacking access to even the most basic health services, the simple contraceptive services offered were convenient. They did not require a physician for fitting, supplies could be distributed by visiting nurses or sent through the mail, and they could be safely used by women who lived with only minimal sanitary facilities [outhouses], without electricity and under overcrowded conditions.

Many poor women took advantage of state-supported bc programs. Neither minority nor poor white clients necessarily experienced contraceptive offers as coercive or unwanted. Indeed, the quality of their experiences depended on the extent to which officials integrated contraceptive advice into broader health and social services and on women’s personal interactions with health professionals. At the same time, women had their own agendas, often unanticipated by ph and pw officials and they did not always see eye to eye with the largely white middle class professionals who ran services. They welcomed the services, participated in them, and helped shape the contraceptive programs. They exchanged information with neighbors, complained about side effects, and demanded to switch to a different contraceptive if they found the one they received unsatisfactory. In short, they behaved like educated consumers. And sometimes they were able to exert some influence over the distribution of contraceptives. e.g. complaints to Hillard about foam powder [itching, burning, women got pregnant]

It won’t come as a surprise when I say that like today, African American women were most likely to be underserved. Black health and social work professionals regularly demanded better health and contraceptive services for African American women. Indeed, while programs in black communities have frequently been criticized as race genocide, black women were more likely to receive inadequate or no services than to become the target of population control programs. Public health officials in Nashville and Berkely Co. S.C., for instance, established a birth control program particularly geared at African American clients – the so-called Negro Project, supported by the BCFA as demonstration projects for services to African American clients. The program had a profound impact on many women in Nashville and Berkely County. For most, these services represented their first contact with the medical profession. And the physical examinations they received revealed a number of serious health conditions. Many patients were referred to family physicians or clinics for further treatment. Health officials and the BCFA considered the demonstration project a success. Women had cooperated fully and were eager and grateful for the services.
Nevertheless, at the end of 18 months, the director of the SC program concluded that he had demonstrated the program’s success and discontinued the services, indicating that white health officials continued to view contraceptive and med services to AfAm as dispensable.

In the 1960s, under President Johnson’s war on poverty, bc services moved from ph to pw departments. Wallace Kuralt, father of the late Charles Kuralt, set up one of the model birth control programs in Charlotte, NC. With the help of the Director of Public Health in Charlotte, he developed a program which offered a whole range of services with a cafeteria style a selection of contraceptives, including the birth control pill. Kuralt argued that women had a right to decide whether or not they wanted to use family planning. And his services to the poor, which included day care for children, cooking classes for women, and home maker services in case of family emergencies, were comprehensive in their approach to reduce the level of poverty in Charlotte and surrounding Mecklenburg county. But Kuralt stood in contrast to many public health and welfare officials who were convinced that poor women were really unable or unwilling to prevent conception. In Robeson County and any number of other places, clinics began to move to contraceptives that required little or no client cooperation, in particular the IUD.

The low price and ease of use made the IUD attractive to population controllers skeptical about poor and minority women’s ability to control conception. The IUD did not require women’s daily cooperation and many welfare officials tied receipt of social services to women’s participation in birth control programs. By taking reproductive control out of women’s hands and separating contraceptive advice from general health services, services shifted from voluntary to involuntary. By the late-1960s, the rise of the black power movement criticized all family planning programs as race genocide.

The structural context of service delivery, then, is crucial to a determination of the voluntary or involuntary nature of services. Coercion/involuntary service delivery is most likely to happen when structural context prevents full access and free choice among a range of options. When health insurance or clinic policy artificially restrict women’s choices, where service delivery is influenced by pre-conceptions about women’s suitability to one option over another, when government policy dictates service delivery not in line with best medical practices, women are more likely to experience service delivery as involuntary. Women who have full access to health and reproductive care and can make informed choices among a range of options are unlikely to experience health care delivery as coercive or non-voluntary.