

Over 20 Million Aborted:

**WHY PLANNED PARENTHOOD TARGETS
THE
INNER-CITY**

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La Verne Tolbert, Ph.D., has 35 years experience in the field of teen pregnancy prevention. Her interests began in 1975 when was invited to become a board member of Planned Parenthood in New York City. The education that she received about abortion and population control during her five-year tenure laid the groundwork for continued research in this field. An author and curriculum writer, Dr. Tolbert teaches in the graduate school at Azusa Pacific University, Azusa, CA.

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The figure of 20 million represents the number black babies aborted:

www.abortionfacts.com/statistics/us_stats_race.asp

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Planned Parenthood, the nation's primary abortion provider, has clinics in inner-city neighborhoods throughout America. On one corner, there may be a Planned Parenthood Comprehensive Clinic, and within just a few short blocks, another clinic, this time a Planned Parenthood *Express*. To service minors, clinics are either located directly on school grounds or within short walking distances of schools. The question begs to be asked: Why does Planned Parenthood target the inner-city?

Margaret Sanger

An exploration of Planned Parenthood's founder, Margaret Sanger (1879-1966) and her philosophy may provide a clue. In her autobiography, she expresses disdain for the poor whom she calls the wretched of humanity.¹ Eugenics—the improvement of the race through controlled breeding—identifies certain ethnic groups as dysgenic, meaning they are biologically defective or deficient and therefore unworthy of procreation.

Sanger's mission was to “stop the multiplication of the unfit...[for] race betterment” to guarantee “a cleaner race.”² “Birth-control,” said Sanger in 1920, “is nothing more or less than the facilitation of the process of weeding out the unfit, or preventing the birth of defectives, or of those who will become defectives.”³

Sanger's 1939 Negro Project may provide further rationale for the proliferation of Planned Parenthood clinics throughout inner-cities. The proposal, which called for hiring Colored ministers and selecting a Negro Advisory Council who would *appear* to run a family planning campaign, was to popularize family planning in southern black communities using community people as spokespersons.⁴

Although Sanger decried the fact that blacks believed “that God sends them children,”⁵ she believed that the best educational approach was through religion. “We do not want the word to get out that we want to exterminate the Negro population, and the Minister is the man who can straighten out that idea if it ever occurs to any of their more rebellious members.”⁶ Has her tactic of working in communities and through churches been so successful that clinics abound in our neighborhoods?

Although these combined reasons may provide a backdrop for discussion, the answer is *No*. Sanger's personal mission alone did not propel Planned Parenthood to such national status. To do so involves a shared goal, multiple committed partnerships, and the sustained dedication of financial resources—a monumental strategy that only the United States government could achieve.

Organization Meets Opportunity

As an organization, Planned Parenthood met opportunity. What began with Sanger's Birth Control Federation in 1916 had, by 1960, become a national movement. Renamed Planned Parenthood Federation of America (PPFA), popularizing birth-control for the poor had a three-fold purpose—controlling the growth of the population to preserve a quality of life;⁷ (2) producing children of higher intelligence in keeping with the ideals of the Eugenics philosophy;⁸ and (3) controlling population growth through the Malthusian⁹ strategy of monitoring one's own fertility.¹⁰

The organization in place, opportunity surfaced when African American women, who were perceived to be particularly fecund or fertile, became the focus of the government's national family planning efforts.¹¹ Reducing the size of traditionally large black families¹² was a priority that eventually would impact other minorities as well.

The Commission on Population Growth and the American Future

In July, 1969, President Nixon asked Congress to create a Commission on Population Growth and the American Future to study population growth and its effect on federal, state, and local governments.¹³ In October of that same year, the National Center for Family Planning Services was established in the Health Services and Mental Health Administration (HSMHA) of the Department of Health, Education, and Welfare (DHEW). The federal government, though quite late in doing so, had a commitment to assuming a “responsible role in family planning efforts.”¹⁴

This would be achieved by developing a “meaningful federal and private partnership among all interested groups” to address “this area of great social need.”¹⁵ Grants and contracts would be awarded to support those services which encouraged “consumer participation and consent.” According to Acting Director Scheyer,

In a country of 200 million, a growth rate of one percent per year produces enough additional people to populate a new Washington metropolitan area every year. And we are feeling the impact—in the crowding of cities, the sprawl of suburbia, the vanishing wilderness, the trespass of pollution. Every one of us feels it where it hurts most—in the quality of our lives....

And what is most tragic and most ironic is that we, who need it least, have readily accessible to us and to our wives the means of deciding how many children shall share our large and well-spaced houses and our trips to the beach. Those who lack our ways of buffering the pressure of population on their lives also lack the means to decide how many shall share their lot.¹⁶

Contract and Partnership with Planned Parenthood

With DHEW'S task of developing family planning programs and coordinating with other federal and private efforts to assure community family planning services, the HSMHA contracted Planned Parenthood to provide comprehensive services to the low-income population. The National Center for Family Planning Services in the HSMHA established “a meaningful federal and private partnership” by officially incorporating Planned Parenthood into the federal government under the umbrella of DHEW.¹⁷

Through the Family Planning Services and Population Research Act of 1970 (Title X), Planned Parenthood received federally-funded grants to provide a “radically simplified delivery system” by establishing free or low-cost non-medical clinics in poor, inner-city neighborhoods.¹⁸ A pilot program in Forsyth County, North Carolina, for example, demonstrates that walk-in clinics attract the poor to utilize clinic services.¹⁹

Subsequently, autonomous clinics located within high-risk communities were to be developed as entities that were separate from hospitals to service the “immediate target”—the “five million women in this country who are in need of subsidized services”.²⁰ Of this population, three critical age groups were identified: teenagers and young adults 15-22 years old, women in their middle and late twenties, and those 28-30. Scheyer noted that “reduction in population growth achieved as a by-product of the enrichment of individual and family living can enrich the lives of every one of us.”²¹

A Catchy Phrase

“Equal opportunities for the poor” became the catch-phrase for Planned Parenthood’s services to minority women.²² It was acknowledged that “skill, tact, and innovation” were necessary to make services appealing and non-threatening.²³ Low clinic utilization in New York, however, caused Planned Parenthood to reexamine its strategy. It recommended more drastic solutions such as the decentralization of public schools to accommodate “school-based family planning information and education programs.”²⁴

Sex education went hand-in-hand with providing contraceptive and birth-control services for teenagers.²⁵ Mary Calderone, medical director of Planned Parenthood, established the Sex Information and Education Council of the United States (SIECUS) in 1970 to serve as a national clearinghouse for sex education curricula for all public schools.²⁶ The next step was the amendment of parental notification and consent laws to provide services to minors of any age.²⁷

The Final Report

In 1972, the Commission, chaired by John D. Rockefeller 3rd, issued its final report noting that “small differences in family size will make big differences in the demands placed on our society.”²⁸ It was determined that population was part of the crisis of environmental deterioration, racial antagonisms, the plight of the cities, and the international situation.

Perspectives for addressing the population were to (1) slow growth by freedom from unwanted childbearing; (2) include minorities and women into the mainstream of America; and (3) recast American values toward the ecology system. “The time has come to challenge the tradition that population growth is desirable: What was unintended may turn out to be unwanted, in the society as in the family.”²⁹

Goals to improve the quality of life included slowing and eventually halting U.S. population growth by promoting an average of two children per family, and passing the Equal Rights Amendment so that women would find meaningful work outside of the home. To address the crisis of overpopulation among blacks, the government committed to the “full support of all health services related to fertility,” and to “an extension of government family planning project grant programs.”³⁰ Stating that the task for fertility-related services was too important to be left to voluntary organizations or to private efforts, the government assumed leadership responsibility for an extensive information and education component in addition to the mass provision of services.

The Commission mandated generous federal funding of Planned Parenthood, a commitment that continues today. It authorized \$225 million in fiscal year 1973, \$275 million in fiscal year 1974, \$325 million in fiscal year 1975, and \$400 million each year thereafter in Title X grants for fertility related health services for inner-city women.

Schools and Curriculum

The Commission also recommended that states eliminate legal restrictions and make contraceptives available to minors in settings considered to be appropriate for them—their schools. Teachers and school administrators were to receive training and curriculum integrated with family planning information.³¹

With oversight from the DHEW and the National Institute of Mental Health, sex education would be made available to all teenagers in combination with “community efforts sponsored by youth-oriented groups, Planned Parenthood centers, and similar groups.”³² California Senator Alan Cranston objected.

I do not believe the Commission has placed sufficient stress on the role and responsibilities of parents regarding the provision of birth-control information and services... Society and schools should make every effort to encourage child and parent to discuss these matters honestly and openly. Our educational programs should stress this.

I have similar concerns about medical authorities providing contraceptive services to unemancipated teenagers without parental consent or knowledge. I strongly believe that it should be the obligation of the health professional to counsel the unemancipated teenage patient to raise this issue with his or her parents.³³

Despite similar passionate arguments, the majority vote carried. Now, legal statutes on parental rights had to be changed accordingly. “To implement this policy, the Commission urges that organizations, such as the Council on State Governments, the American Law Institute, and the American Bar Association, formulate appropriate model statutes.”³⁴ And they did.

Condoms and Clinics

With a common national agenda, attention now turned to deciding which contraception was most effective for teenagers. Condoms were the solution.³⁵

African American teenagers from single-parent homes were identified as high-risk of pregnancy and in need of specialized services through school-based clinics (SBCs).³⁶ Researchers also documented that since whites managed to avoid illegitimacy, African American adolescents who were given “social rewards for motherhood”³⁷ were to be the primary focus of fertility-related services.³⁸

The SBC was seen as “the best hope of reducing the incidence of the ‘unwed mother syndrome’ among inner-city children.”³⁹ Schools were encouraged to “prevent unwanted births” by publicizing the “location of contraceptive services for teenagers.”⁴⁰

By 1973, there were two SBCs operating on school grounds.⁴¹ The first clinic opened quietly in a Dallas high school in 1970,⁴² but opening the second in 1973 in a junior/senior high school in St. Paul, Minnesota proved problematic. Objections from parents, teachers, and community leaders forced a 2-year delay, but the Board of Education finally granted its approval with the stipulation that contraceptives not be distributed on school grounds.⁴³

Clinic enrollment remained low until a range of additional services were added to boost students' participation. These included athletic, job and college physicals, immunizations, and a weight-control program.⁴⁴ "Specialized procedures, tests, and consultations" were "arranged" at nearby hospitals.⁴⁵

Lowering the Voting Age

With the legalization of abortion in 1973, laws regarding parental consent were further challenged. The voting age had been lowered from 21 to 18, which meant that late adolescent teenagers could be recognized as adults and receive contraceptive services.⁴⁶ Reversal of parental consent laws finally occurred in 1977 with the *Carey v. Population Services International* Supreme Court decision which ruled that contraceptives were to be made available to all minors without parental notification or consent.⁴⁷

This cleared the way for SBC staff to remove a girl from school for an abortion without informing her parents. Here's how it works. In the morning,⁴⁸ SBC nurses drive the student from her school to a nearby Planned Parenthood facility where the abortion is performed. The student is transported back to school in the afternoon.

Planned Parenthood instructs the "woman"—she is not to be called a "girl" no matter her age—that she does not have to inform her parents about the abortion.⁴⁹ Girls and boys may also opt for sterilization, again without parental notification or consent. While the regular school nurse may not give a child an aspirin without her parent's consent, SBC nurses perform pelvic examinations and prescribe medications.⁵⁰

Expensive Operations

School-based clinics are expensive operations. Costs for services, which are primarily for salaries, range from \$90,000 to over \$300,000 per clinic.⁵¹ Even with substantial Title X and state grants, Medicaid, and social services⁵² along with funding from private foundations, the cost-effectiveness of SBCs was not proven.⁵³ Still, by 1985 there were 13 clinics identified as "comprehensive, multiservice units" providing abortions.⁵⁴ Researchers reported 85.3 fewer live births at clinic schools.⁵⁵

To address opposition to new clinics from parents, clergy, and the community, clinic staff was advised not to dispense contraceptives during the first year of operation.⁵⁶ The Center for Population Options offered technical and advisory support to promote SBCs and in 1994, seeking a less controversial name for itself, was recast as Advocates for Youth.⁵⁷ Reports cite poverty statistics and the number of poor children without medical coverage as rationale for the expansion of SBCs.⁵⁸ The AIDS pandemic opened the door to "safe sex education" and more condoms in schools. Sexual activity increased.⁵⁹

By 1986, there were 60 SBCs throughout the United States.⁶⁰ By 1988, there were over 150 SBCs,⁶¹ which is surprising since researchers recognize that SBCs are unsuccessful in impacting pregnancy rates.⁶² Additionally, where there are clinics, there is an increase of 120 pregnancies per 1,000 among 15- to-19 year olds.⁶³ But this did not stop their expansion. By 1991, there were 239 SBCs and SLCs—school-linked clinics (clinics located near school grounds).⁶⁴ By 1995, there were 607.⁶⁵

Lawsuits challenged condom distribution based on parental rights in New York, Massachusetts, Pennsylvania, and Washington. Where laws could not be broadly interpreted, the recommendation was to change laws because of the “large number of dysfunctional families in which parents do not act in the best interests of their children.”⁶⁶

With condoms in classrooms and bathrooms, is contraceptive use among teenagers increasing? An evaluation of 4 SBCs in California demonstrates that the availability of contraceptives on site, “which has been thought to be an important convenience factor contributing to positive contraceptive adoption,” was not found to be significant.⁶⁷

Contraceptive use is not related to whether contraceptives are dispensed on site, whether health education and counseling are provided by a health educator, whether contraceptive services are part of a comprehensive array of services that include medical or counseling services, or whether a family planning visit results in the dispensing of contraceptives or a prescription for contraceptives.⁶⁸

Clinics in...Kindergarten?

Despite these and similar findings, there is urgency to open a clinic in every public school—elementary through high.⁶⁹ Although African Americans are only 13% of the population, SBCs are concentrated in schools that are attended by black children.⁷⁰ The ethnicity of the entire student clinic population is Latino (44 percent), African American (28 percent), White (24 percent), Asian (3 percent), other (1 percent), and Native American (<1 percent).⁷¹

By 2005, there were 869 school-based health centers (SBHCs) as they are more favorably labeled. New York has the largest number of clinics in schools K-5 with a total of 195. California, with 140, has the second-largest concentration of SBCs, 35% of which are located in elementary schools.⁷² In all, pregnancy testing (76%) is a primary service. But evaluation of SBCs demonstrates “little evidence that school-based comprehensive sex education strategies are effective.”⁷³

The presence of SBCs on school grounds may imply a sexually permissive environment that encourages sexual activity. Condom availability may send social cues to males that it is expected and accepted that they engage in sexual intercourse. More female virgins may transition to non-virgin status in clinic schools.⁷⁴ In health classes, presentations by SBC nurses desensitize teens by exposing them to explicit sex education. Students play games like “The Condom Race” where they sit in groups blindfolded and race to roll and unroll candy colored condoms on anatomically correct, erect penises. The group that wins receives...more condoms.⁷⁵

Abstinence Education

Abstinence education is not a focal point for black children because social science researchers deem it unrealistic.⁷⁶ However, “self-control, self-respect, delayed gratification, planning for the future, building healthy friendships and other values essential to abstinence education are necessary for every area of life, not just in the delay of sexual activity”.⁷⁷ Teenagers’ future orientation, educational goals, religiosity, and the presence of both parents in the home, are factors which reduce the risk of early coitus.⁷⁸

Abortion—an enterprise that targets minority communities where blacks reside—is big business in America. School administrators lack funds to procure lab equipment or computers or fix crumbling buildings⁷⁹ but there’s ample tax and foundation dollars for SBCs. Perhaps it’s time that the government takes another look.

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