Population Control, Family Planning, and Maternal Health Networks in the 1960s/70s: Diary of an International Consultant

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SUMMARY: Over the past decade historians have explored the rise of the mid-twentieth-century population/family planning movement on both the international and the local levels. This article bridges the gap between these studies by exploring the work diaries of Dr. Adaline Pendleton (“Penny”) Satterthwaite, a midlevel technical advisor who traveled to over two dozen countries for the Population Council from 1965 to 1974. Penny’s diaries draw our attention to a diverse network of advocates who mediated between international population activists, state actors, and local communities while also acting as conduits for the transnational spread of strategies and resources. Her experiences also provide evidence of the coercive practices, gendered tensions, and political conflicts shaping the movement while illustrating the resistance and engagement of local actors, the existence of health- and women-centered approaches even during the high period of population control, and the many structural and social barriers shaping family planning projects in practice.

KEYWORDS: population, family planning, maternal health, transnational history, women’s history, international philanthropy, public health
In August 1974 Dr. Adaline Pendleton Satterthwaite found herself constructing a vulva out of foam rubber at a nursing school in Oaxaca. Satterthwaite—an American obstetrician-gynecologist (OB-GYN) known to most as Penny—was in Mexico on behalf of the New York–based Population Council to observe a new project for integrating traditional midwives (empíricas) into the Maternal Child Health/Family Planning program. She tread carefully, aware of the “delicate” relationship between the United States and Latin America in the 1970s. But Penny was more interested in the day-to-day challenges of public health than the contours of international politics. She focused on practical issues, like charting the availability of medical services for women and fixing the broken obstetrical mannequin in Oaxaca.

Indeed, although fashioning vulvas out of foam was not exactly in Penny’s job description, she made note of it in her work diary, concluding that “cosmetically the result was acceptable but whether or not it will be useful functionally is another question since the sponge was rather soft.”

By the time Penny arrived in Mexico in 1974, she had nine years of experience working abroad for the Population Council. As a result she was firmly embedded in a post–World War II network devoted to raising awareness of population issues and spreading contraception around the world. Nongovernmental organizations like the Population Council, Pathfinder Fund, and International Planned Parenthood Federation (IPPF) led the way in the 1950s, mobilizing philanthropic money to fund research, send out supplies, and provide technical advisors for local family planning associations and state programs across Asia,


Africa, Latin America, and the Caribbean. Major donors like the U.S. Agency for International Development (USAID) and United Nations (UN) followed in the mid-1960s. By the early 1970s the study and control of population had become a multimillion-dollar, thoroughly transnational endeavor.3

Recent histories have stressed the value of studying this movement through an equally transnational lens. Allison Bashford traces a diverse network of demographers, doctors, scientists, feminists, and laymen activists who linked population growth to questions of security and geopolitics in international conferences from the interwar years onward.4 According to Matthew Connelly, by the mid-1960s these networks had consolidated into a “diversified but single-minded population establishment”5 led by American experts and organizations that “aimed to convince or coerce people to plan smaller families . . . without having to answer to anyone in particular.”6 Drawing on the records kept by those at the helm of this establishment, Connelly argues that apocalyptic narratives of overpopulation with eugenic and neo-Malthusian undertones fueled the dramatic rise in financial aid in the mid-twentieth century and served as a catalyst—or at least a justification—for a range of coercive practices, from the use of financial incentives to entice birth control “acceptors” to mass sterilization campaigns. But Connelly stresses that all campaigns were inherently flawed in


5 Connelly, Fatal Misconception (n. 3), 177.

6 Ibid., 7.
their elitist orientation, tendency to view human beings “not as individuals but as a population that could be shaped through the combined force of faith and science,”\(^7\) and foundational belief “that one could know other people’s interests better than they knew it themselves.”\(^8\)

National-level studies have tended to present a more complicated story.\(^9\) From India to Iran to Jamaica, we see local movements that long preceded the expansion of the international

\(^7\) Ibid., xi.

\(^8\) Ibid., 378.

community and had their own internal logic and nuances. In Trinidad mid-twentieth-century discourses of “overpopulation” encountered a local movement rooted in liberal conceptions of personal freedom and rights; in Peru local doctors, educators, and even Catholic missionaries took the lead in providing services in the wake of a hesitant state. Even the more aggressive programs in India and China were less coherent than they appear at first glance, shifting over time and inconsistent in their application on the ground. Population programs could also intersect with women’s own efforts to control their reproduction in ways that complicate a straightforward narrative of either convincement or coercion from above. Looking locally thus provides us with a more nuanced understanding of the many layers of power relations that shaped the way this movement worked out in practice. Yet we also lose some of the power of the transnational approach adopted by Bashford and Connelly. Clinics in 1930s Jamaica and South Africa look remarkably similar, but we cannot see whether this was a coincidence or a direct transfer; advocates in Barbados and Egypt were more attentive to questions of social and economic inequality than those at international conferences, but it is

10 Bourbonnais, Birth Control in the Decolonizing Caribbean (n. 9).

11 Necochea López, History of Family Planning (n. 9).


13 For this argument, see Bourbonnais, Birth Control in the Decolonizing Caribbean; Klausen, Race, Maternity, and the Politics of Birth Control; Lopez, Matters of Choice; and Schoen, Choice & Coercion (all n. 9).
not clear if these are special examples or representative of broader phenomena. Each local case study thus appears as both similar and unique at the same time, neither separated from nor wholly captured by developments on the international level.

Recent thematic studies that focus on particular elements of the population movement (communication strategies or technologies like the IUD, for example) provide one approach to bring local studies into deeper communication with one another.¹⁴ In this article, however, I take up Raul Necochea López’s call to explore in more depth the work of midlevel field workers, advisors, and consultants.¹⁵ These were the technical specialists, doctors, nurses, social workers, and enthusiastic volunteers who served as the “faces and hands”¹⁶ of international organizations, mediating between high-profile donors and local actors. They traveled transnationally, allowing us to get a broad vision of the movement and see firsthand the transfer of ideas and materials from one place to another, but they were also connected to activities in the field: planning projects, overseeing studies, working with practitioners, and going out into the field to deal with practical issues. Neither the directors of aid programs nor their targets, field workers occupied a space in between, allowing us to see what happened


¹⁶ Ibid., 371.
when top-down directives encountered on-the-ground realities and the possibilities for negotiation and change created in this space.

While Necochea López and others have explored the work of such midlevel actors in individual countries,17 this article follows one actor—Penny Satterthwaite—in her journey across multiple countries during her nine years spent as a technical advisor with the Population Council (1965–74). Created in 1952 with funds from the Rockefeller Foundation, the Population Council was a key player in the mid-twentieth century, providing international scholarships, sending out advisors, and supporting trials of new methods, including a new generation of plastic intrauterine devices (IUDs).18 Penny’s work centered initially on providing medical overview of international studies of Lippes Loop and Margulies Spiral IUDs,19 but she also observed other projects for the council and provided general advice to state programs, doctors, and independent advocates. Her primary postings were in Thailand, Pakistan, and Venezuela, but she traveled to over two dozen countries for the council and worked under a variety of conditions. In Pakistan she was integrated into a state family


planning bureaucracy with an already aggressive population program in place. In Thailand, Venezuela, and many other countries where states were more ambivalent about (or even outwardly hostile to) population control, she worked quietly with local doctors and researchers running studies funded by a mix of international agencies and local foundations, often under the rubric of “maternal health” or “family health.” As a doctor who liked to be involved in “the action as well as in the desk work,” Penny also spent a good portion of time training doctors and nurses, visiting clinics, speaking to midwives and patients in the field, and occasionally even conducting IUD insertions and sterilizations (not to mention repairs of obstetrical models) herself. (See Table 1).

Her travels left behind a particularly rich trail of sources, including an oral history held at the Schlesinger Library, records in the Population Council Collection at the Rockefeller Archives, and a personal archive at Smith College. The latter includes a work diary she kept throughout her nine years with the council that runs over two thousand pages and includes detailed discussions of the day-to-day work of global family planning advocacy. Of course the diary provides us with only a partial perspective: namely, of an American woman from a middle-class background whose stay in each country was limited.

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22 The diary is divided into eight folders and lacks page numbers; I have used the title of folder and her dating system (month/day/year) in referencing.
What she saw and understood only scratched the surface of each country’s political and social dynamics, and her diary cannot capture the rich complexity of in-depth local studies. The diary was also produced for a particular audience, sent back in installments to her superiors in the New York office every few months. Still, the remarkably frank and comprehensive nature of the diary and its broad, transnational scope make it an undeniably rich source through which to gain an intimate understanding of the work of this advocate. These source collections also allow us to draw some preliminary conclusions about how the family planning movement operated on the ground.

In the following pages I begin by tracing Penny’s background and position her within the movement. I argue that while Penny worked with population control advocates and recognized demographic arguments, her motivation came primarily from her concern for patients, coupled with a spiritually inflected commitment to social service. Most of the people Penny worked with across the globe similarly came from a medical, public health, and/or social welfare background and had been converted to the cause through their personal experiences working with women and families. However, the movement also pulled in an exceedingly diverse spectrum of advocates, from community volunteers to religious leaders to patients themselves. Her diaries also suggest that if population conferences and the upper echelons of population organizations were dominated by “expert” men from the Global North, local actors (particularly local women) were the key figures on the ground: female nurses, social workers, and field workers, in particular, were primarily tasked with bringing the message of family planning to communities. Intermediary actors from both the Global North and the Global South also served as conduits, translating policies and approaches from one place to another and forming a network of health professionals that sat underneath the high-level population activist community described by Bashford and Connelly.
After charting the diversity of the global family planning movement, the second half of this article takes up Connelly’s critique of the population control mentality more directly. I begin by documenting the very real ways that this mentality could translate into coercion on the ground, particularly in Pakistan, where pressure to meet IUD targets appears to have driven a range of unethical practices in the late 1960s. But Penny’s diaries also capture the long history of resistance to such aggressive measures throughout the high period of population control. Local doctors in several countries defied efforts to impose particular methods, field workers fudged the numbers, women dropped out of research studies, and communities occasionally turned on programs with such force that they were able to bring them to a halt. Penny’s diaries also illustrate the many other complications shaping attempts to spread contraceptives more broadly beyond the limits of the population control ideology. Indeed, even projects more oriented toward maternal health and patient well-being were constrained by practical conditions of scarcity, the personal biases of practitioners, and the incredible variation in women’s demands and bodies across time and space.

Penny’s diaries thus provide us with a more complex portrait of the international population movement during its peak in the mid-1960s to mid-1970s. They also allow us to see how middle actors like Penny and her local colleagues struggled to juggle politics and practice, navigate gender tensions, and balance the competing interests of international donors, local states, and patients. Over time, many came to realize the limits of the international development structure and the damaging effects of aggressive population control campaigns. Others seem to have recognized the value of a high-quality, woman-centered approach from the outset, but had neither the resources nor the support from above to implement this vision. Their work suggests that the roots of the later reproductive rights movement may have come not only from outside but also from within the population.
establishment, while also reminding us of the many structural and social barriers that continue
to shape reproductive health beyond the era of high population control.

The Converts: Birth Control Advocates and Transnational Networks

Born in California in 1917, Adaline Pendleton rooted her pursuit of a medical career in an early passion for social service driven in part by her “ecumenical” Christian faith. After completing medical school at the University of California and surgical training in San Juan, Puerto Rico (1944–46), Penny met and married William Satterthwaite, a conscientious objector with training in nursing and artificial limb construction. Just five months after Penny gave birth to son David in April 1947, the family moved to China to work as medical missionaries under the Congregational Christian Mission Board. The Satterthwaites’ time in China, however, proved politically and personally tumultuous. In November 1947 the American Consulate left Peking in the face of Mao Zedong’s advancing revolutionary army; in the spring of 1949 Bill died suddenly of a pulmonary embolism, leaving Penny alone with their now two-year-old son. But Penny remained in China for two more years, working for a village maternal health program. In her oral history she recalled feeling uncomfortable with the “religious fanaticism” surrounding Mao but also inspired by the “enthusiasm and the discipline of the Chinese youth” and the country’s wide-scale mobilization of paramedical workers. Penny contrasted this approach to American doctors who “tried to make of the whole experience of childbirth a complicated and surgical procedure.”


24 Ibid., 9.

25 Ibid., 10.
Still, Penny worried about her son’s well-being in a country in conflict and decided to return to the United States in 1951. In 1952 she became the only OB-GYN at the Ryder Memorial Missionary Hospital in Humacao, Puerto Rico.²⁶ Facing some six hundred deliveries a year, Penny was forced to put her new health philosophy into practice and relied heavily on nurses to deliver most uncomplicated obstetrical cases. It was here as well that Penny first became involved in family planning work, in part out of concern for the high rate of sterilizations on the island.²⁷ As she recalled in her oral history, “I had a number of women come to me at the Ryder who had been operated on, sterilized by others, and had lost a child, or had remarried, and were very unhappy that they had had an operation. In fact, this was one of the reasons that made me anxious to find some other acceptable reversible method.”²⁸ Penny also remembered her earlier frustration as a medical intern at a Catholic hospital on the U.S. mainland, where most of the staff had refused to do sterilizations or teach birth control methods. As she remembered, “It was to me very, very wrong . . . women with heart disease, obvious medical complications, were being hospitalized almost the entire pregnancy, in order to . . . make them produce a baby, when they obviously needed some type of advice.”²⁹ For Penny, birth control was thus primarily a matter of medical ethics and her responsibility as a practitioner. She stressed the “almost sacred relationship between a woman and her

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²⁶ Ibid., 9–10.
²⁷ On the history of birth control in Puerto Rico, see Briggs, *Reproducing Empire* (n. 9).
²⁹ Ibid., 12.
physician”\textsuperscript{30} and noted that her work was driven first and foremost by “the problems of my patients and their families.”\textsuperscript{31}

Penny’s engagement with demographic arguments in favor of birth control appears more sporadic and tangential. In her oral history she recalled speeches at an IPPF meeting in San Juan in 1955 that drew her attention to “the problems of population growth in Puerto Rico”\textsuperscript{32} and cited her later work with the Population Council as making her aware of “public health issues, demographic realities and resource constraints.”\textsuperscript{33} But Penny did not seek out a more active role in the population movement; it came for her. Specifically, she was approached in 1955 by Clarence Gamble, a well-known American philanthropist who had helped organize the first trials of the Enovid oral contraceptive pill in Río Piedras, Puerto Rico. Gamble had scoped Ryder as a second location for clinical trials of the pill and solicited Penny’s collaboration. She recalled that Gamble provided her with a social worker and “a nice red Jeep” to help her recruit new pill trial participants.\textsuperscript{34}

\textsuperscript{30} SSC, APS, B20, “Thailand: Trip to Iran, 1966,” A. P. Satterthwaite, “Clinical Experience with New Contraceptive Technology” (Fourth National Congress of Iranian Gynecologists and Obstetricians, Shiraz, Iran, 4/18/66), 1.


\textsuperscript{34} SL, SROHP, “Oral History: Adaline Pendleton Satterthwaite” (n. 19), 20.
The trials in Puerto Rico would turn out to be foundational, leading to FDA approval of the pill in 1960.\textsuperscript{35} For her part Penny was struck by the high demand for birth control she encountered. One of the project’s central difficulties, she recalled, was that “we always had more people wanting to participate in our studies than we had drugs to supply.”\textsuperscript{36} However, Penny also felt increasing frustration with Gamble, who seemed interested narrowly in reductions of birth rates rather than the broader maternal health work she was doing at the hospital, including Pap smears, endometrial biopsies, and studies of cervical lesions.\textsuperscript{37} She also found herself uncomfortable with proposals by other contraceptive researchers, including a double-blind study of ten thousand women designed by Gregory Pincus. As she recalled, “I found that I had to withdraw because I could not honestly . . . women came to my clinic already decided. They came because their friends told them; they came because they wanted an IUD, or they wanted pills, or they wanted something else, and to open an envelope and say no, you’ve got to have this, or you’ve got to have that, just wasn’t acceptable to my patients, and so I just couldn’t participate in it.”\textsuperscript{38} Still, Penny felt an increased calling toward medical research, and particularly an interest in alternatives to the pill. In November 1961, with funding from the Population Council, she began to provide plastic Margulies Spiral and

\textsuperscript{35} For more on Penny’s work on the pill trials, see Kathryn Lankford, “Who Created the Pill? Clinical Trials of Enovid and Other Contraceptives in Humacao, Puerto Rico” (paper, Knowledge from the Margins: Social Justice and Sustainability Conference, East Lansing, Mich., August 18–19, 2015).


Lippes Loop IUDs to her patients, tracking the results and reporting back to the council her enthusiasm for the broad applicability of the method.³⁹

By the time Penny formally joined the Population Council as a technical advisor in 1965, she was known as a serious clinical researcher in the field of contraception, with several important publications under her belt.⁴⁰ She described herself as a “missionary,” eager to go wherever the need was greatest and her training could be of use.⁴¹ Her diaries illustrate that everywhere she went Penny found kindred spirits with a similar passion for family planning. She attended luncheons with “devoted” doctors in Taiwan,⁴² met many a “convert of F.P. [Family Planning]” in Venezuela,⁴³ and talked to doctors in Pakistan who described it as their “duty” to talk to women about family planning.⁴⁴ These were not exceptions: her diaries reference at least fifty supporters in Thailand and seventy in Pakistan. Some of these actors were well known in their national contexts, such as Dr. Nafis Sadik in Pakistan, the deputy

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⁴⁴ SSC, APS, B14, “Diaries, 1970 (Pakistan),” 2/20/70.
director of the government’s Family Planning Council. Others worked more quietly and independently. Thailand’s minister of health, Dr. Winich Asavasena, for example, supported a range of clinical contraceptive studies despite the government’s opposition to family planning in the mid-1960s.\textsuperscript{45} Other doctors and practitioners also took matters into their own hands, working outside of and/or long before the formation of family planning associations and state programs. Dr. Chatr at Lord Sin Hospital in Bangkok brought back a stack of Lippes Loops to insert following a trip to the United States in November 1965;\textsuperscript{46} Dr. Altafunesa Begum in Dacca did insertions of the IUD in her house;\textsuperscript{47} An unnamed “nurse-midwife” in Soi Fa, Thailand, ran a family clinic out of her home;\textsuperscript{48} while a doctor in Roi Et gave out pills that he bought with his own money.\textsuperscript{49} At nearly every hospital Penny visited across the globe doctors reported doing female sterilizations, usually on women with many children or medical indications. These activities, however, were rarely recorded under the rubric of “population control” or “family planning,” suggesting that the records we have from governments and organizations may be just the tip of the iceberg of birth control practice in these years.\textsuperscript{50}


\textsuperscript{47} Ibid., 4/27/66.

\textsuperscript{48} Ibid., 6/7/66.

\textsuperscript{49} Ibid., 12/27/66.

\textsuperscript{50} For example, only 82 of 902 sterilizations performed at the main maternity hospital in Venezuela in 1971 were listed under the “Family Planning” service. SSC, APS, B14, “Diaries, 1972 (Peru & Venezuela),” 1/10/72.
Indeed, while Bashford notes that discourses surrounding “health” as a justification for population/family planning barely made a dent at international forums until the 1970s, most of the local-level advocates Penny encountered in her travels were firmly based in the fields of public health and medicine, whether as doctors, nurses, midwives, or social workers. Some had been converted to the cause after hearing prominent advocates speak at conferences or through their training abroad, but most were driven by the “obvious patient demand.” Doctors described the medical complications and emotional turmoil faced by expecting patients. Many appear to have been “shocked into action” by the high rate of incomplete and septic abortion cases that reportedly made up around one-third of maternity ward admissions from Indonesia, Iran, and Venezuela. Nurses, public health workers, and midwives (including both trained and traditional practitioners) also described tragic cases of women

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51 Bashford, Global Population (n. 4), 20.


56 Ibid., 4/20/66.

57 SSC, APS, B10, “Corr. Family & friends: 1960–64,” Letter to Family, 4/14/63. The importance of abortion rates as a critical motivating factor is also stressed by that national-level literature on Latin America. See, for example, Necochea López, History of Family Planning (n. 9); Zárate Campos and González Moya, “Planificación familiar” (n. 17).
dying from complicated childbirths. A rural Mexican empírica named Regina Lopez, for example, described a patient who had a retained placenta for four days during one of her births. Although she advised the husband that they should seek out family planning advice in Oaxaca, the woman soon fell pregnant again and died in labor. Regina pledged to accompany future cases to Oaxaca herself.

If those who worked in the field of maternal health made the most obvious allies, advocates came in many shapes and sizes. A Township Registry clerk in Taipei encouraged new fathers to take their wives to family planning clinics, some petrol dealers in Pakistan gave out contraceptives to their customers, an independent publisher from Mexico published paperbacks on sex education, and a nun in Pakistan distributed a pamphlet on family planning methods to Catholic Physicians. As studies of Latin America have argued, individual pastors and Catholic organizations could play key roles in promoting family planning at the local level through creative interpretations of doctrine, even after Pope Paul VI issued his 1968 *Humanae vitae* encyclical reaffirming the Church’s ban on artificial birth control methods. For her part, Penny came across several Catholic priests who told their

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64 See, for example, Necochea López, *History of Family Planning* (n. 9), 130–32; and Juan Alejandro Lopera López, “Paternidad o procreación responsable: Iglesia católica, Acción
parishioners to be guided by their conscience, and some even got directly involved. Sister Denis of the Escuela de Peuricultura in Caracas, for example, offered two hours per week of family planning training, including the Church-approved rhythm method but also pills and referrals for IUD insertions. Penny also recorded the active support of a group of Islamic religious leaders in Iran and local maulvis in a district of Pakistan who argued that family planning was a critical part of the Islamic commitment to maternal health and welfare.

Women targeted by birth control programs could also become important advocates of the cause. Of course not all women were interested; Penny visited many clinics with “disappointingly low” attendance. But Penny’s diaries are filled with stories of women who walked miles to visit an IUD clinic or even commissioned buses to go to the city as a group. Thai doctors, for example, described “carloads of women” arriving in Potharam in 1964 to participate in a contraceptive research project. Some women were particularly assertive about


what they wanted, pressing doctors, nurses, and midwives to set up sex education classes or supply family planning methods. A twenty-six-year-old woman who came to a hospital in Mérida, Venezuela, with a hemorrhage, for example, was “adamant” that the doctor should insert an IUD immediately; when he advised her to come back after she recovered, Penny noted that “she could hardly be convinced to leave the clinic without the IUD.” Others obtained condoms, foam tablets, and even pills from local pharmacies without obtaining a prescription. Some also became active volunteers themselves. Penny described, for example, an “intelligent but unlettered” thirty-nine-year-old Pakistani woman with nine pregnancies who took it upon herself to assist a state mobile IUD clinic whenever it visited her village. This grassroots activism could be incredibly effective. A 1966 IUD project funded in part by the Population Council and hosted at Chulalongkorn Hospital in Bangkok, Thailand, managed to attract ten times the number of women directly informed of the program (some of whom had traveled over two hundred kilometers). Indeed, the demand exceeded the capacity of the staff; by August there were some two thousand women on the waiting list. The Population Council’s report attributed this directly to the power of word-of-mouth communication.

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between local women. Through these efforts, women became not only objects but also subjects and even advocates of family planning.

Assertive women could also be found at other levels of the movement. If international population conferences remained dominated by a “jet set” group of male experts, local female nurses and social workers were on the front lines in all of the countries Penny visited. They approached women in postpartum wards at hospitals and village health clinics and gave presentations on family planning, while also providing instruction in basic methods and referrals. In Pakistan female paramedical workers gave out pill prescriptions and inserted IUDs themselves; by 1968–69 lady family planning visitors (LFPVs) were reportedly doing some 80 percent of IUD insertions. Pakistan also had a high number of women doctors working at the Family Planning Council as well as at the district level and in hospitals. Even in places where the medical profession was more thoroughly male, OB-GYN wards usually had at least a few prominent female doctors who seem to have been disproportionately

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75 Ibid., 234.


involved in family planning projects, perhaps particularly drawn to the work due to their own experiences (indeed, some were IUD users themselves).\(^{78}\)

These women faced a number of gendered barriers in their work. Female doctors in Pakistan and Thailand, for example, complained that junior male doctors were promoted before them,\(^ {79}\) and female staff at a hospital in Venezuela reported being driven away by the “disordered” sexual behavior of their male boss.\(^ {80}\) A group of female family planning counselors in Venezuela expressed their frustration that the chief of service was publishing their paper under his name.\(^ {81}\) Penny was somewhat dismissive of these concerns in her diary, noting her surprise that “this example of ‘male chauvinism’ should be anything new for these professional women in Venezuela.”\(^ {82}\) She also downplayed the struggles she may have faced as a single mother and a woman practicing medicine in the 1940s to 1970s in her 1974 oral history.\(^ {83}\) When asked by interviewer James Reed whether she considered herself a “feminist,” Penny said no, that she had not had “any real problem, and therefore, I’ve never


\(^{79}\) SSC, APS, B14, “Diary, 1967 (Thailand and Pakistan),” 1/10/67. See also RA, PC, RG2, B137, F1302, Adaline P. Satterthwaite, to Dr. N. R. E. Fendall (Rex), Letter, 11/2/69.


\(^{82}\) Ibid., 11/22/72.

felt that I needed to be a campaigner on this subject; I mean, I just haven’t felt discrimination.”

Penny’s diaries, however, suggest that she was not quite as insulated from gender tensions at the time as she later remembered. She recorded a number of incidents where she felt that local advocates would have preferred a male technical advisor. She sometimes found her ideas marginalized, then refashioned as a male colleague’s suggestion and accepted. Penny also sometimes grew clearly frustrated with the gendered double standards of population programs. In one meeting in Pakistan, for example, a doctor asked if they might consider training auxiliary personnel to give vasectomies. As Penny wrote, “The reply was ‘no’—that it would never be accepted to have a sub-professional cadre using a scalpel, especially where there is such an obvious connection with sex. (Obviously this is a man speaking about men! It was all right for men to propose paramedicals to work in the genital tract of women with IUD insertion!)” She also described a conflict with a Brazilian doctor who described her as “aggressive” after she disagreed with him about a policy. Although she apologized to him, she admitted in her diary that “it is surely going to be very difficult for me to work with him if one has to defer to him at every point.” Indeed, in an interesting twist on gender stereotypes, Penny frequently commented on the “emotional” outbursts and “insecure”

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84 Ibid., 53.


86 SSC, APS, B15, “Diary Notes, 1973 (Venezuela-Bangladesh),” 2/24/73, 3/5–9/73.


88 SSC, APS, B14, “Diaries, 1972 (Peru & Venezuela),” 9/14/72, 9/15/72.
nature of her male colleagues.\textsuperscript{89} A local bureaucrat, for example, was described as “so emotional . . . we wish we could slip him a tranquilizer!”\textsuperscript{90} While this could be read as a reflection of negative stereotypes of local actors, Penny also described a fellow male American advisor as “hypersensitive,”\textsuperscript{91} suggesting a broader effort to establish herself as a female voice of reason among a sea of volatile men. Penny also worked particularly well with her local female colleagues, including Dr. Sasichan Vimuktanon in Thailand, Dr. Ela Bacalao in Venezuela, and Dr. Nafis Sadik in Pakistan.\textsuperscript{92} These actors in turn vouched for Penny, requesting that she stay on as an advisor in their country and/or providing references after she left the council.\textsuperscript{93} Sadik, for example, praised her ability to get along “extremely well with people of all races, religions and cultures.”\textsuperscript{94}

If Penny’s personal skills helped her navigate some of the tensions of international consultancy work, she could not entirely escape her American background. Indeed, Penny’s diaries remind us that critiques linking population control to northern imperialism were


\textsuperscript{91} SSC, APS, B14, “Dairy 1968 (Pakistan),” 3/17/68.

\textsuperscript{92} SSC, APS, B14, “Diary, 1967 (Thailand & Pakistan),” 10/2/67.


widespread through the 1960s and 1970s, particularly in Latin America.\textsuperscript{95} In Venezuela, where she was tasked with opening a regional office for the Population Council in 1971, Penny became a subject of direct controversy. In an interview with a local paper, a Dr. Armando Diaz Lovera accused the IPPF, Population Council, and USAID of promoting “population control” and specifically called out the work of “una llamada Dra. Satterthwaite” on a postpartum IUD insertion program as “evidence of coercion.”\textsuperscript{96} At an Evening Forum shortly after, Diaz Lovera again accused the Population Council and Satterthwaite in particular of “coercing Venezuelans to practice FP,” apparently unaware that she was in the audience.\textsuperscript{97}

If Penny faced some blowback, however, the weight of international politics fell primarily on local advocates who found themselves having to “bend over backwards not to be accused of being ‘controlers’ and pawns of the CIA.”\textsuperscript{98} Her diaries illustrate a variety of strategies used to navigate the tense politics of birth control. Some doctors deliberately focused their lectures on individual family welfare and women’s health rather than delving into broader questions of national population growth or economic development.\textsuperscript{99} Others, like researcher Elizabeth Caldera, preempted critiques by pointing out that “the problems of

\textsuperscript{95} SSC, APS, B14, “Diaries, Jan–May 1971 (Pakistan),” 5/24/71. On Latin American resistance to U.S.-led efforts, see Connelly, \textit{Fatal Misconception} (n. 3), 286; Necochea López, \textit{History of Family Planning} (n. 9).


\textsuperscript{97} SSC, APS, B15, “Diary Notes, 1973 (Venezuela-Bangladesh),” 5/21–25/73.

\textsuperscript{98} SSC, APS, B14, “Diaries, 1972 (Peru & Venezuela),” 10/2/72.

\textsuperscript{99} Ibid., 6/28/72, 10/7/72.
development in Venezuela were not either/or socio-economic change and Family Planning but ‘both and.’

Venezuelan Dr. Liendo Coll argued that a country should provide family planning services regardless of its population or economic situation, as it was “uno de los derechos fundamentales de la mujer [one of women’s fundamental human rights].” Penny’s local colleagues also jumped to her defense in Venezuela and told her not to take the attacks seriously. A friend at the family planning association, however, did suggest that in light of the controversy she might want to reconsider her nickname. Since “peni” was Spanish for “penis,” Penny wrote, “it would be literally foreign penetration in the family planning movement!”

Penny was generally unsympathetic when it came to the political dimensions of family planning and could be aloof or dismissive when it came to reading the local social and political context. Her knowledge of local languages in Thailand and Pakistan was minimal, and even her relatively strong Spanish could falter (in the above quote, for example, she may have mistaken “peni” for “pene”). Reading her diary, one can also imagine her rolling her eyes at several points as she added “(politics)” in brackets to her commentary. For example, when discussing the plan to review Mexico’s national Maternal/Child Health and Family

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102 SSC, APS, B14, “Diaries, 1972 (Peru & Venezuela),” 9/28/72, 10/1/72, 10/19/72, 11/3/72, 11/6/72.

Planning program, she wrote, “It is very important that this be done by a Mexican not by APS [Adaline Pendleton Satterthwaite]. (Politics).”¹⁰⁴ In doing so, she failed to appreciate the value of local knowledge and the importance of diverse representation in family planning programming and evaluation. At other times, however, she recognized that American advisors could be genuinely damaging to a program, especially when they did not work with locals as “counterparts.”¹⁰⁵ Penny and her local colleagues also appear in the pages of her diary as early critics of the structure of development aid, complaining about the excessive time spent on grant and report writing,¹⁰⁶ the inability of different organizations to work together effectively,¹⁰⁷ and the inherent limits of a system built on a “parade of short-term experts.”¹⁰⁸ Reflecting from Pakistan, Penny lamented how consultants from different international agencies “come through in all sorts of fields writing reports and going away without any apparent intent of becoming involved in application or implementation. . . . I would think the Pakistanis would be completely confused—at least I am!”¹⁰⁹ Far from the naïve optimists who believed modern science and guidance from the Global North could solve the world’s


¹⁰⁵ SSC, APS, B14, “Diary 1968 (Pakistan),” 12/16/68. See also SL, SROHP, “Oral History: Adaline Pendleton Satterthwaite” (n. 19), 47.


problems, these intermediary actors appear astutely aware from the outset of the limits of the international development model.

Penny’s diaries also point to a heavy circulation of actors within regions and across the Global South more broadly. Visitors (administrators and doctors mostly, but also nurses and midwives) from Singapore, India, Pakistan, Greece, and Turkey visited Thailand during Penny’s stay; the Pakistan program hosted observers from Indonesia, Kenya, Tunisia, Nigeria, Turkey, Trinidad, Peru, and beyond.¹¹⁰ Some areas of the South—such as Singapore, India, and Colombia—appear to have become hubs for training and supplies. These interactions fueled the exchange of techniques as well as physical materials. Pakistan’s program, for example, adopted the Thai checklist for paramedical prescription of oral pills;¹¹¹ Venezuelans experimented with the Thai referral card system.¹¹² American consultants like Penny could act as a conduit for this exchange of information, carrying family planning flipbooks from Thailand to Indonesia,¹¹³ leaflets from Ghana to Mauritius,¹¹⁴ and copies of IUD manuals from Pakistan to Singapore.¹¹⁵ But individual doctors from the Global South also traveled internationally during these years to share their expertise. Dr. Mahabir of Trinidad gave

¹¹⁰ Visitors are recorded in Penny’s diaries and listed in the monthly reports. See, for example, RA, PC, B199, F1918, “Pakistan: Monthly Reports.”

¹¹¹ SSC, APS, B14, “Diaries, 1970 (Pakistan),” 1/30/70.


courses in Mauritius on IUD insertions,\textsuperscript{116} while Dr. Gutierrez of Mexico trained the Egyptian Dr. Rizk on culdoscopic sterilization (a method of tubal ligation), who then visited Pakistan to train doctors there.\textsuperscript{117} Experts from the Global South also took up positions within international organizations in the 1960s and 1970s. For example, Penny welcomed her friends Dr. Cummins of Barbados and Dr. Adriasola of Chile to Pakistan on a UN mission in 1968, providing them with a behind-the-scenes look at the program.\textsuperscript{118}

In the process these actors built a network of maternal health practitioners that developed in tandem with, but was not fully captured by, the high-level population networks traced by Bashford and Connelly. Indeed, Penny’s diaries provide us with a vision of the international population movement that looks more decentralized, shaped by local doctors, nurses, midwives, volunteers, and patients as much as by wealthy Western philanthropists, and influenced by daily experience and practical concerns as much as by globalized political ideologies and social theories. Recognizing this more diverse spectrum of advocacy, however, should not lead us to conclude that mid-twentieth-century family planning programs were benign or unproblematic. As Penny’s diaries illustrate, intermediary actors sometimes found themselves compelled by the grip of top-down population control; at other times their own biases could prove as equally powerful barriers to the well-being and rights of their patients.


\textsuperscript{117} SSC, APS, B14, “Diaries, 1970 (Pakistan),” 1/5/70, 9/23/70.

\textsuperscript{118} SSC, APS, B14, “Dairy 1968 (Pakistan),” 1/24/68, 2/22/68, 2/23/68.
Targetitis and the Complicated Female Body

Penny confronted the power of the population control mentality most clearly during her time in Pakistan in the late 1960s, when the state program was most aggressive and most narrowly focused on the IUD. The government’s Third Five-Year Plan (1965–70) included a mass campaign supported by a host of international donors.119 Although the program continued to supply conventional contraceptives, the central focus was on the promotion of the Lippes Loop IUD.120 Family planning officers (FPOs) were given targets on numbers of insertions expected each month and local doctors and LFPVs were charged with promoting the IUD in clinics and mobile “camps” where hundreds of women might receive the device in a day. In many places the IUD was promoted to the exclusion of any other methods; one internal study, for example, found that on average 90 percent of women who accepted the IUD knew of no other contraceptive method.121 Vasectomy campaigns that followed adopted a similarly aggressive approach. In one district where vasectomy camps were conducted, an estimated 93 percent of those interviewed knew of no other method of family planning,122 suggesting not even a minimal concern for contraceptive choice.

This aggressive program quickly fell prey to unethical practices. In her travels around the country Penny observed a range of abuses directly, including the insertion of IUDs on women with contraindications, in rapid succession without any discussion of side effects, and


using poor technique that led to perforations of the uterus and other complications. One LFPV reported that field workers were removing loops at the end of the year, reinserting a new loop, and counting it as a “new case” to hit their targets; some women were reportedly given milk and medication in return for accepting an IUD. Penny also reported cases of “unsuspecting men” pressed into vasectomies with little understanding of the procedure or motivated by promises of food or cash. These practices were directly related to pressure from above. As one doctor reported to Penny in 1967, “Targets which were intended as guidelines had become rigid directives. A threat was always present at the district level and this was transmitted to the FPO.” A letter from the secretary of the Family Planning Council Enver Adil to provincial secretaries in 1967 indeed stressed that district officers “need have no hesitation in replacing inefficient or inept staff placed under them” if they were not reaching their targets after three months of employment. LHV reported feeling powerless to stand up to their superiors, and one doctor told Penny that the whole campaign

123 Ibid., 8/22/69.
124 Ibid., 3/3/69.
126 SSC, APS, B14, “Dairy 1968 (Pakistan),” 5/30/68.
had been “completely demoralizing.”\textsuperscript{130} Penny also became frustrated and cynical as she observed the declining standard of care,\textsuperscript{131} reporting back to the Population Council that the pressure placed on women to accept the IUD was “little short of coercion.”\textsuperscript{132}

Penny’s diaries thus provide us with a vivid, first-person account of the very real abuses driven by the mid-twentieth-century panic over population growth and the toll it took on patients as well as practitioners. But her notes also illustrate the consistent and sometimes powerful resistance of local actors even at the pinnacle of the movement. The Pakistan Medical Association, for example, refused to cooperate with the state’s program throughout Penny’s tenure in the country,\textsuperscript{133} citing the rash of complications they had seen firsthand as a result of the frantic nature of IUD insertions.\textsuperscript{134} Some doctors started refusing to send out staff for IUD camps;\textsuperscript{135} others simply wrote down false numbers. One doctor in Pakistan, for example, admitted to Penny that while he’d recorded 108 vasectomies, in reality he had done

\textsuperscript{130} SSC, APS, B14, “Diary 1968 (Pakistan),” 7/30/68.

\textsuperscript{131} SSC, APS, B14, “Diary 1968 (Pakistan),” 5/30/68.


\textsuperscript{133} SSC, APS, B14, “Diary, 1967 (Thailand and Pakistan),” 7/4/67. See also SSC, APS, B14, “Diary, 1969 (New York–Pakistan),” 8/16/69, 8/18/69, 9/30/69.


\textsuperscript{135} SSC, APS, B14, “Diary, 1969 (New York–Pakistan),” 8/22/69.
only 8.\textsuperscript{136} Several doctors estimated that as many as 20 to 25 percent of reported IUD cases in some areas were “bogus.”\textsuperscript{137}

As Penny and her local colleagues argued, the aggressive program was not only damaging to individuals but ultimately counterproductive.\textsuperscript{138} The pressure from above may have increased IUD insertions initially, but the poor practices and rash of complications served in the end to discredit both the state program and the IUD.\textsuperscript{139} Rumors of side effects and negative experiences spread quickly around Pakistan, leading many women to abandon the program or start demanding pills instead.\textsuperscript{140} Among women attending a rural health center in Rajshahi in 1969, for example, Penny recorded that “the most emphatic statement was not coil because of stories of neighbors or relatives who had bleeding and other complications; [the women] asked for pills instead.”\textsuperscript{141} Pakistani women also appear to have adopted a variety of passive tactics to resist the state program more broadly. They had the IUD removed

\begin{flushleft}
\textsuperscript{136} Ibid., 4/2/69.
\textsuperscript{137} SSC, APS, B14, “Diaries, 1970 (Pakistan),” 2/11/70.
\textsuperscript{138} SL, SROHP, “Oral History: Adaline Pendleton Satterthwaite” (n. 19), 42. See also SSC, APS, B20, “Pakistan: Reports, 1984, n.d.,” Medical Aspects of the Pakistan Family Planning Program, 6.
\textsuperscript{140} SSC, APS, B14, “Diary, 1967 (Thailand & Pakistan),” 11/13/67.
\end{flushleft}
by a village dai (midwife), accepted birth control pills and then left them to sit on the shelf or fed them to the family chickens, and evaded follow-up from intrusive research trials by giving false addresses.

Pakistani women were not alone in their efforts to maintain some degree of control over their reproductive lives and set limits to family planning programs. As local studies have found over and over again, even women who were anxious for relief from childbirth were rarely passive consumers or indiscriminate users of birth control. The Lippes Loop IUDs appear to have proved particularly unsatisfactory in spite of the high hopes of researchers like Penny. From Taiwan to Egypt to Mauritius, trials reported that some 50 to 60 percent of women dropped out and/or had the loops removed within one or two years, usually citing side effects such as bleeding, abdominal pain, pelvic infections, and/or expulsions.

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145 See Bourbonnais, Birth Control in the Decolonizing Caribbean; Klausen, Race, Maternity, and the Politics of Birth Control; Lopez, Matters of Choice; and Schoen, Choice & Coercion (all n. 9).

insisted on removals even after doctors tried to convince them to try a different IUD or undergo treatment for side effects. Researchers also learned that the same communication networks that could facilitate family planning advocacy could also thwart it. Rumors of an abnormally high rate of perforations at a Singapore hospital in 1966, for example, ultimately brought a postpartum IUD program to an end. As Penny stated frankly, “The situation being what it is, the women of Singapore (and the profession also) have lost confidence in the IUD.” Even the program at Chulalongkorn hospital in Thailand cited above, which had grown so rapidly through word-of-mouth communication among women, saw a sharp drop-off after only one year following a “spate of anti-IUD publicity.”

Rumors and bad press could sometimes provoke violent opposition to family planning projects. By July 1968 the aggressiveness of Pakistan’s family planning program combined with a general wave of backlash against the state and international community, fuelling a crisis situation. A rumor that one man had died and another suffered serious infection following vasectomy apparently created such a reaction that the local district officer was


147 See, for example, RA, PC, RG2, A2, S2, B201, F1931, M. L. Kashetra Snidvongs, Charanpat Israngun, Aree Somboonsuk, Demrong Rienprayura, and A. P. Satterthwaite, *Immediate Post-Partum IUD Insertions: Chulalongkorn Medical School and Hospital*, 4.


149 Ibid., 10/11/66.

attacked in his Jeep and stoned by villagers. In December 1968 a brick was heaved through
the back window of a UNICEF Volkswagen carrying Penny and colleagues; the brick
shattered the glass, although they managed to get away unscathed. Participants in
Pakistan’s International Family Planning Conference in January 1969 in Dacca also had a
picnic lunch interrupted when a group of students carrying black flags walked by them and
proceeded to tear down the “Family Planning” sign in front of the local health center.

Some Pakistani officials dismissed the unrest, blaming it on radical students or
political interests. Follow-up investigations on specific cases did seem to confirm that at
least some of the supposed deaths from IUDs or vasectomies were actually from unrelated
causes. As Penny recognized, however, “unfortunately there is undoubtedly some truth in
these oft-repeated rumors.” In any case, the resistance was so strong that several trials were
forced to close down. In February 1969 officials were told to relax pressure to achieve
targets, by May Secretary Adil had been replaced by a Mr. Ali K. M. Ahsan, who opened
his first meeting by condemning the “targetitis” that had plagued the previous program.

151 SSC, APS, B14, “Dairy 1968 (Pakistan),” 7/19/68.
152 SSC, APS, B14, “Dairy 1968 (Pakistan),” 12/7/68.
154 SSC, APS, B14, “Dairy 1968 (Pakistan),” 5/29/68, 7/7/68, 7/19/68, 8/2/68, and 9/13/68.
156 Ibid., 5/29/68.
157 Ibid., 8/1/68, 8/7/68, and 11/26/68.
159 Ibid., 5/14/69.
called for a broader program offering multiple methods and more comprehensive training for paramedical staff.\textsuperscript{160} Although Penny observed that many of the old practices (and rumors) persisted into 1970,\textsuperscript{161} some clinics did begin to offer a wider selection of methods and better quality care. In some cases this led to an increase in new cases;\textsuperscript{162} in others Penny noted that “not as large a volume of work was being done, but it was genuine.”\textsuperscript{163} Scandals in other countries could also fuel better practices. The high rate of perforations at the hospital in Singapore mentioned above, for example, led to an official decision directing workers to offer a cafeteria choice of methods and “objectively discuss all methods without prejudice.”\textsuperscript{164}

For many local practitioners these were welcome changes. Indeed, even during the height of Pakistan’s aggressive IUD campaign, Penny encountered individual doctors, LFPVs and midwives who took the time to conduct the procedure with care, treating women with respect and providing thorough reassurance and follow-up.\textsuperscript{165} For these actors the new approach simply recognized the value of what they were already doing. Local doctors in other areas of the world also maintained their patient-centered priorities during the peak period of the population control movement. Dr. Merchán, head of the main maternity hospital in Venezuela, immediately vetoed the Population Council’s suggestion of paying doctors per

\textsuperscript{160} Ibid., 7/4/69 and 7/28/69.
\textsuperscript{161} Ibid., 10/4/69, 9/22/69; “Diaries, 1970 (Pakistan),” 6/8/70.
\textsuperscript{162} SSC, APS, B14, “Diaries, 1970 (Pakistan),” 2/6/70.
\textsuperscript{163} Ibid., 10/7/70.
\textsuperscript{164} SSC, APS, B14, “Diary, 1966 (Thailand-Taipei),” 10/12/66.
insertion, out of fear that doctors might put the financial payout ahead of their patients’ best interest.\(^{166}\) Along with his colleague Dr. Liendo Coll, Merchán argued that the service should be judged based on the “the level of medical care which the women receive” rather than the number of acceptors.\(^{167}\) For some, the woman/patient-focused approach was a matter of principle; for others, it was simply common sense. As Penny noted repeatedly, women who received proper care from the outset were more satisfied, making them more likely to retain the method and recommend it to others.\(^{168}\)

But even those physicians who agreed in principle with the cafeteria-style approach or who valued quality of care faced a number of barriers that limited free choice on the ground. Supplies of different methods were often scarce or unpredictable, dependent on support from international donors and states whose priorities fluctuated.\(^{169}\) The pill was particularly hard to integrate into large-scale programs due to its comparatively high cost;\(^{170}\) it also had to be refilled each month, making it vulnerable to the whims of the international market and state interference. A clinic in Brazil, for example, could not maintain sufficient stock to give out

\(^{166}\) SSC, APS, B14, “Diaries, 1972 (Peru & Venezuela),” 10/17/72.


\(^{169}\) See, for example, SSC, APS, B14, “Diary, 1966 (Thailand-Taipei),” 12/30/66 Trip Summary.

long-term supplies, and so women had to wait in line each month to get a new batch;\textsuperscript{171} women in Venezuela were forced to switch to the IUD when pills were periodically held up at customs.\textsuperscript{172} Clinics also frequently struggled to maintain enough staff, leading to long waits or rushed services. At one clinic in Rio de Janeiro in 1972 women had to wait three months for an appointment.\textsuperscript{173} Improper equipment could also jeopardize quality of care for even the most skilled practitioner.\textsuperscript{174} Penny experienced this firsthand when she went out in the field to insert IUDs in Pakistan in February 1967 and found that the inserters for the Lippes Loops went soft after only a few procedures.\textsuperscript{175}

Compounding all of these factors were the biases of various practitioners for or against certain methods, sometimes based on medical indications, but also based on personal experiences or prejudices against patients’ ability to use methods like the pill consistently. Some were quite firm in their positions: doctors at one hospital in Thailand, for example, were reportedly split into two groups: “those pro and those contra IUD.”\textsuperscript{176} But these biases could also operate more subtly. Penny observed, for example, how a doctor or nurse might introduce several methods but put the stress on one or the other, leading to considerable

\begin{flushright}
\textsuperscript{171} SSC, APS, B14, “Diaries, 1972 (Peru & Venezuela),” 2/22/72.  \\
\textsuperscript{172} SSC, APS, B15, “Diary Notes, 1973 (Venezuela-Bangladesh),” 7/9–12/73.  \\
\textsuperscript{173} SSC, APS, B14, “Diaries, 1972 (Peru & Venezuela),” 2/21/72.  \\
\textsuperscript{174} SSC, APS, B14, “Diary, 1967 (Thailand & Pakistan),” 9/14/67, 10/30/67.  \\
\textsuperscript{175} Ibid., 2/28/67, 3/1/67, 3/2/67.  \\
\textsuperscript{176} SSC, APS, B14, “Diary, 1966 (Thailand-Taipei),” 6/22/66.
\end{flushright}
variations in acceptance rates from one clinic to the next. All of the above meant that the contraceptive services offered in most countries were limited and inconsistent: which methods and what degree of choice were available varied substantially not only from country to country, but from village to village, clinic to clinic, and doctor to doctor. As local observers recognized, this inconsistency hit the poor hardest of all, whose limited resources and mobility constrained their ability to seek out the services that best fit their priorities.

Practitioners and field workers also had to deal with the complex nature of women’s needs, desires, and physical bodies. Penny and her colleagues did notice some commonalities that seemed to hold across different contexts: the widespread interest of local actors in birth control even in restrictive contexts, the remarkably similar drop-out rates from the IUD across countries, and women’s demand for quality care. But women’s interest in contraception could also vary considerably not only from household to household, but also across an individual woman’s life span, which rarely fit into the neat “planning” paradigm promoted by advocates. Women’s ability and motivation to tolerate different side effects also varied with their biology, social context, and structural conditions. Sporadic bleeding following IUD insertion, for example, could have a stronger impact on anemic women, women living in cultures where bleeding was taboo, and women without access to medications to manage it.

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179 See, for example, SSC, APS, B14, “Diary, 1966 (Thailand-Taipei),” 10/6/66.
factors, as Penny recognized, undermined the effectiveness of family planning programs designed with populations rather than individuals in mind.

Indeed, by the mid-1960s—a time when high-level population control advocates were still touting the IUD as a one-size-fits-all method for “the masses”\(^\text{180}\)—field workers like Penny were already warning colleagues that “no single method will be suitable for all women in all cultures.”\(^\text{181}\) By the time of her oral history in 1974, Penny had drawn the conclusion that “we were a little overenthusiastic about the IUD. I think we thought it was going to be more of a panacea than it was, and we probably over-pushed it.”\(^\text{182}\) Penny was particularly critical of the aggressive approach in Pakistan, but also took issue with some of the basic assumptions of the international population movement. She concluded that “you couldn’t translate the experience of Puerto Rico to Thailand or Pakistan”\(^\text{183}\) and insisted that decisions about family planning had to be made by countries themselves rather than “outsiders.”\(^\text{184}\)

When her interviewer pressed her on the continued fear that rapid population growth would lead to global collapse, Penny replied simply, “Well, it may well come. . . . But still, I don’t

\(^{180}\) Takeshita, *Global Biopolitics of the IUD* (n. 14), 33.


\(^{183}\) Ibid., 38.

\(^{184}\) Ibid., 50.
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see how we can do anything about it."\textsuperscript{185} The following year she resigned from the Population Council.

Conclusion

Penny’s evaluation of the population movement in 1974 reflected a decade of experience as a field worker on the front lines, where she had seen both the widespread demand for contraceptives and the inadequacies in the system that had developed to supply them. She was not alone in her assessment. By the mid-1970s several actors within the Population Council had begun to openly criticize the organization’s approach, leading to structural changes within and the selection of a new president (George Zeidenstein) with a vision of human welfare and women-focused programs.\textsuperscript{186} A growing discourse of health and rights also began to gain ground in the 1970s and 1980s within the World Health Organization (WHO), IPPF, and the United Nations Fund for Population Activities (under the directorship of Pakistan’s Nafis Sadik from 1987 to 2000).\textsuperscript{187} These developments did not overturn the population control mentality overnight; aggressive practices in India and China reached their peak in the 1970s and 1980s,\textsuperscript{188} and a USAID program in Pakistan in the late 1970s doubled down on the inundation approach explicitly condemned by actors like Penny.\textsuperscript{189} It would take an organized

\begin{footnotes}
\item[185] Ibid., 51.
\item[186] Connelly, *Fatal Misconception* (n. 3), 315, 329, 332.
\item[189] Robinson, “Family Planning Programs and Policies” (n. 20), 327.
\end{footnotes}
women’s movement to embed considerations of women and reproductive rights into a new international paradigm—the “Cairo consensus”—that emerged from the International Conference on Population and Development (ICPD) in 1994 and continues to shape international advocacy today.\textsuperscript{190}

These shifts created new opportunities for actors like Penny. Although her records are sparser after her retirement from the council, she appears to have become a more critically engaged and selective international advocate in the following years, choosing short-term consultancies with agencies that were committed to integrated maternal-infant health rather than a narrow vertical approach to family planning. She also mobilized her networks to ensure that projects she engaged with were responsive to local needs. Before agreeing to a position in Nepal in 1981, for example, she wrote to a Nepalese colleague to make sure the project was not “simply being imposed on Nepal by USAID as a condition of their assistance.”\textsuperscript{191} By the mid-1980s Penny had also signed up to the mailing list of the International Women’s Health Coalition,\textsuperscript{192} and in 1993 received a copy of the “Women’s Declaration on Population Policies,” a document that would play a key role in defining the reproductive rights agenda


\textsuperscript{191} SSC, APS, B12, “General Correspondence, 1979–82,” Letter to [Bai Kopal] K. C., 10/15/81.

\textsuperscript{192} SSC, APS, B12, “General Correspondence, 1983–84,” Pouru Bhiwandiwala to “Colleague and Friend,” Letter, 7/17/84.
adopted at the 1994 ICPD. One can only speculate as to how Penny (now age seventy-seven) viewed the conference, but many of the critiques raised by activists (of aggressive state coercion, of a disregard for the variation in women’s bodies and needs, for example) would undoubtedly have resonated with her.

Exploring Penny’s personal trajectory and experiences on the ground thus illustrates the role that international field workers could play as both missionary-style enthusiasts and early critics of the population movement, drawing attention to the tensions underlying international aid, challenging more aggressive programs, and building alternative advocacy networks and visions of family planning. It suggests that the motivations behind one’s work mattered: Penny’s maternal health background and patient-centered approach provided her with a different take on the value of targets and coercive methods than those concerned solely with population growth. Her work also illustrates how experiences on the ground could shake the core beliefs of even the most committed advocates: over the course of ten years Penny transformed from an enthusiastic international IUD missionary to a more cautious and reflexive advocate. At the same time her diaries illustrate the limitations of actors like Penny, whose position and biases as a white middle-class American professional woman sometimes limited her ability to fully appreciate the sensitivities of local politics and the structural hierarchies that shaped her work. Tracing the life histories of Penny’s local counterparts and fellow traveling consultants—the doctors, nurses, and social workers who come in and out of the story above—may provide one avenue to expand our understanding of the international

family planning movement further and provide an even more textured account of this
movement in practice.

As her diaries suggest, the work of these actors challenges the image of a “single-
minded population establishment” operating with complete impunity. If their work was
constrained by the more rigid imperatives of a leadership inflicted with “targetitis” in the mi-
twentieth century, midlevel practitioners could provide at least some check on the system
through their critical role in implementation. Their work may also have laid the foundation
from within for the larger shifts in the international paradigm to come. Indeed, Penny’s
diaries point to many actors who were primed and ready for the kind of changes the
international women’s movement proposed. But Penny’s diaries also draw our attention to a
number of structural barriers—supply shortages, poor infrastructure, practitioner bias, and the
diversity of women’s bodies and needs—that have long shaped even less coercive
reproductive health work in practice. These challenges are unlikely to be erased by the shift
from a “population control” to a “reproductive rights” paradigm at the international level; in
fact, declines in international funding in the past two decades may make these barriers all the
more pressing.195 As Penny’s diaries attest, it will take more than a shift in ideological
orientation to ensure reproductive freedom in practice. It is also a question of material
resources: money to support conscientious workers and a full range of contraceptive options,
proper facilities to ensure quality care, and enough foam to replace a vulva on a broken
obstetrical mannequin, should the need arise.

194 Connelly, Fatal Misconception (n. 3), 177.

195 On declining funds, see Steven W. Sinding, “Overview and Perspective,” in Robinson and
Ross, Global Family Planning Revolution (n. 9), 1–12 quotation on 10.
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<table>
<thead>
<tr>
<th>Primary posting</th>
<th>Short trips for Population Council</th>
<th>Outside consultancies</th>
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<tr>
<td>3/1966–6/1967</td>
<td>Thailand</td>
<td>Taiwan, Hong Kong, Iran, Pakistan (2×), Singapore (2×), Indonesia, Chile</td>
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<tr>
<td>6/1967–8/1971</td>
<td>Pakistan</td>
<td>Italy, Singapore, Egypt, Colombia, Venezuela, Thailand, Malaysia, Philippines</td>
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<tr>
<td>9/1971–11/1973</td>
<td>Venezuela</td>
<td>Mexico, Geneva (2×), Washington, Dominican Republic (6×), Brazil (3×), Peru, Egypt, Puerto Rico, Bangladesh</td>
</tr>
<tr>
<td>11/1973–10/1974</td>
<td>N/A (short-term consultancies only)</td>
<td>Dominican Republic, Mexico (2×)</td>
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</table>

Table 1. Penny's work with the Population Council
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