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The Availability of Birth Control: Victoria 1971-1975

Effective methods of birth control became more available in Victoria between 1971 and 1975. The possible effects of this on unplanned and unwanted fertility should be taken into account in explanations of the general decline in fertility of the period.

However, all methods did not become more available for all people. Unmarried people, poorer people, and migrants were disadvantaged, especially in so far as contraception was concerned. Continuing problems in gaining access to suitable methods of contraception may help to explain a persistence of unwanted fertility, either aborted or carried to term.

In Victoria the early seventies witnessed a rapid decline in births: from 1971 to 1975 the crude birth rate fell from 21.45 per 1,000 to 16.65, and total births from 75,498 to 61,897.[1] No doubt changes in people's beliefs about the numbers of children they wanted and could support, that is changes in planned fertility, played a considerable part in this decline. However, the period from 1971 to 1975 was also a time of considerable expansion in the availability of the means of birth control, both contraception and abortion, so that an increasing ability to control unplanned and unwanted fertility may also have been a factor.

This paper is an attempt to provide an overview of historical changes in the practical availability of birth control between 1971 and 1975, in the hope that an exercise of this sort may be useful to others engaged in analysing the various causes of recent changes in fertility. For, when the restrictions on access experienced in the sixties are contrasted with the relative liberalization of the early seventies, we may wish to give greater weight to an increased ability to avert unplanned and unwanted births rather than concentrating on the attitudinal changes affecting planned births alone. However, the increase in availability was not uniform. People did not benefit equally, and this was especially true of contraception. Thus, the second aim of this paper is to contribute towards an

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understanding of why unwanted fertility, either aborted or carried to term, should continue to occur.

To an extent, the nature of the birth control techniques in use at a given time determines the focus of a discussion of their availability. Some of the older methods, like withdrawal, douching and calendar rhythm, are of the do-it-yourself variety, their availability depending only on a modicum of knowledge and cooperation between partners. Other older methods, condoms, diaphragms, spermicides, involve specific appliances. For these methods, the laws controlling the sale and advertising of appliances, and the attitudes of those whom the law deems fit to be sellers, comprise a further variable affecting availability. When we come to the more effective modern methods, that is the oral contraceptive, the IUD, sterilization, and legal abortion, we see that these methods all have one common characteristic. In our society, their availability depends on the help and intervention of doctors.

The more recently developed periodic abstinence methods, the sympto/thermal and ovulation methods, have been widely promoted in Victoria and are of considerable importance in the recent history of birth control in this state. There is also certainly a continuing need for the older appliance methods, the diaphragm and condom. Though this is acknowledged, this paper is chiefly concerned with changes in the availability of the more effective modern methods, for it is these methods which have the greatest potential to affect fertility.

Thus, leaving aside in this present instance all the subjective elements of fear, embarrassment, ignorance and interpersonal conflict that may affect the use of birth control, the fact that the more effective methods are controlled by doctors is central to a history of changes in their availability. The conflicts over what methods should be available and who should have access to them have largely taken place within a medical context, in which the policies of medical institutions and private doctors, and the social pressures and controls affecting them, have been crucial.

Changes in these policies, and the constraints under which they have been formulated, will be discussed under three headings: formal availability, attitudes of private doctors, and the development of clinics.

FORMAL AVAILABILITY

'Formal availability' refers, here, to levels of permission extended by bodies considered to have authority; authority, that is, either over all people, or over the medical profession in particular. The most obvious sources of authority are those institutions (both courts and parliaments)

that have the power to make and interpret the law. The Australian Medical Association (AMA), however, and its Victorian Branch, are also important.

The churches, as guardians and interpreters of traditional morality, could also be seen as a source of authority. Though authority becomes problematic for religious bodies which now lack the power to resort to direct sanctions of the kind held in reserve by legal institutions and professional associations, doctors who have religious convictions may be more likely to be swayed by edicts bearing on their behaviour as professionals than, for example, women patients whose lives are more directly affected. In Victoria, as will be argued below, the continuing opposition of the Catholic Church to all forms of birth control, except those based on periodic abstinence, has affected the provision of services, as have laws and the professional ethics of doctors.

Writing on the legal availability of birth control in the early seventies, Finlay and Glasbeek state that 'quite considerable obstacles existed to the free propagation of the means of limiting population growth'.[2] The Summary Offences Act (Victoria 1966) continued prohibition of the advertising of contraceptives and the assumption was 'that this prohibition also extends to the advertising of family planning clinics and their services'.[3]

Contraceptives could only be sold in chemists' shops and could not be openly displayed. Though the Health (Contraceptives) Act (Victoria 1974) effected some modifications the situation was still very restrictive, and in May 1977 the Family Planning Association considered that the availability of condoms may even have declined as a consequence of the new act.[4] The act did permit some forms of advertising, subject to the approval of the Chief Health Officer. However, during the period 1971 to 1975 general media coverage of the more controversial clinics was certainly of greater significance in publicizing the existence of family planning facilities.

The Crimes Act (Victoria 1958) set the age of consent for girls in Victoria at 16 years, or 18 if unmarried. Age of consent laws present problems to doctors when asked to give contraceptive advice to teenagers. While legal opinion may have been that they were unlikely to be charged with aiding and abetting a crime,[5] and none in fact were, many may have felt uneasy about this and about the legality of advising minors generally. Here, at least, the change in the age of majority from 21 to 18 (amendment to the Commonwealth Marriage Act, July 1973) probably assuaged some professional anxieties.

In Victoria, the law on abortion, as was the case in other states, was copied from the 1861 Offences Against the Person Act in the United

Kingdom, which made it an offence for a woman herself, or any other person, to 'unlawfully' procure a miscarriage.[6] While the 1861 Act is statute law, that is law made by act of parliament, definitions of what is 'lawful' have depended on judges' decisions, that is common law.

In 1969, Justice Menhennitt, presiding over the Davidson case, broadened the definition of lawfulness in Victoria considerably. He ruled that a doctor did not act unlawfully if, acting in good faith, he terminated a pregnancy for the purpose of preserving the life or the physical or mental health of the pregnant woman. Further, he stipulated that the onus of proof rested with the Crown, not the accused.[7] Though the Menhennitt ruling represented considerable liberalization, it took some time for doctors generally to realize that the legal climate had changed. This has been blamed on the conservative circular put out by the Victorian Branch of the AMA in 1971 which recommended doctors to continue to restrict availability.[8]

This document advised that a second opinion be always obtained, that if the woman were married the husband's consent be obtained 'for it is possible that he may have a civil claim for damages against the doctor', that the operation be carried out in a hospital, and that the medical superintendent of that hospital be fully informed of the circumstances.[9] While many doctors may have realized that AMA advice and legality were two separate entities, but nonetheless have wished to behave in ways approved by the profession, others are said to have believed that documents issuing from the Branch Council did in fact represent the state of the law.[10]

There have been no laws specifically about sterilization in Australia, and lawyers, while feeling that a special statutory provision might have clarified the position, have been of the opinion that sterilization operations, performed with the consent of the patient, were perfectly legal.[11]

This notwithstanding, A. W. Burton, author of *Ethics and the Law* (1971), advised his readers that sterilization for contraceptive purposes was quite probably illegal.[12] More importantly, until mid 1971 the AMA's Code of Ethics had stated: 'Except for therapeutic reasons no medical practitioner should perform an operation for sterilization on a male or a female.' In 1971 this clause was deleted, with no replacing clause. The AMA generally recognized the procedure as ethical, though felt that the consent of spouses should be required.[13] This official change on the part of the professional body undoubtedly had more effect on medical practice than legal opinion. The spousal consent requirement, however, had no basis in law and probably led to some restrictions in availability.

In summary, though the law was modified in 1974, the sale and advertising of contraceptives was tightly controlled throughout the period and the availability of the methods affected, principally condoms and spermicides, did not in fact alter. However, the Menhennitt ruling on abortion and the AMA's change of policy on sterilization did amount to changes in the formal availability of birth control. The change in the age of majority in 1973 may also have increased availability for people aged 18 to 21.

ATTITUDES OF PRIVATE DOCTORS

We have two relatively recent studies that present some evidence on the attitudes of private doctors in Melbourne to birth control. These can give us some idea of the difficulties people may have encountered within the private health system.

In 1972 Barson and Wood sent out 183 questionnaires to general practitioners in Melbourne asking whether or not they would give birth control advice in various circumstances.[14] They received replies from 113 doctors. Of these, 96 (85%) were prepared to advise the unmarried, but only two would prescribe the pill to a patient under 16 without parental consent. Forty-nine (43%) would refer female patients for sterilization for contraceptive reasons, and 59 (52%) thought abortion a 'legitimate last resort method of birth control'.

Refusal to give birth control advice was associated with regular church attendance, especially among Catholic doctors who numbered 13 among those returning the questionnaire. No Catholic doctor would fit an IUD, four never prescribed orals, and nine would never advise unmarrieds on birth control. The authors of the study assumed that the 70 non-respondents would probably also have been hostile to birth control, which would inflate percentages refusing considerably. Possibly it is unreasonable to assume that all would have been hostile, but it does seem likely that, in 1972, young unmarried people seeking contraception, and any person seeking abortion or sterilization, could have met with obstacles in the profession, notwithstanding the legality of their requests.

There is some evidence from the second, smaller, study by Francis that the situation may have changed by 1975.[15] Francis interviewed 15 general practitioners and seven obstetrician/gynaecologists randomly selected from those practising in the Doncaster/Templestowe and Eltham areas of Melbourne. She found that they all felt that 'the attitudes of the medical profession and the community towards family planning had changed during 1971-1975'.

Eight of the doctors in this sample of 22 said that in 1971 they would not have prescribed the pill for minors and single women at an initial

visit, but in 1975 only two (the two Catholic doctors in the sample) would still have refused. All felt that their attitudes to sterilization and abortion had changed, but nonetheless were uneasy with these methods and felt that many people requesting them were 'selfish'.

In 1976 the Royal Commission on Human Relationships commissioned an Australia wide survey of 1,653 General Practitioners.[16] While neither the samples nor the questions are directly comparable, it provides some more broadly based evidence on sterilization and abortion which can be compared with that collected by Barson and Wood in 1972. Of the 1,145 who responded, 49% of metropolitan doctors and 47% of country doctors had recommended abortion in the previous 12 months, and 83% of metropolitan and 87% of country doctors tubal litigation. From this it would seem that while the proportion of private doctors prepared to recommend abortion had not changed between 1972 and 1976, the proportion prepared to recommend sterilization had increased considerably.

In Barson and Wood's study only 38 doctors (34% of 113) were, at that time, prepared to initiate discussions on family planning. As some people may be too embarrassed to raise the topic, or too ill informed to ask the right questions, the effect of this silence may have been to deny the possibility of effective decision making for them. The Royal Commission discovered a greater readiness to raise the subject of birth control in various specific situations (e.g. at post partum check ups or gynaecological consultations).[17] However, only 53% of metropolitan doctors and 52% of country doctors brought up the subject as a normal part of history taking.

From the evidence that we have it would seem that some liberalization occurred within the private doctor system during the early seventies. However, the evidence also shows that some doctors refused to prescribe some methods and that a number withheld services from the unmarried. In addition, a professional reluctance to initiate birth control discussions may have been especially inhibiting in view of the fact that some tentative enquiries could have met with refusal elsewhere.

DEVELOPMENT OF CLINICS

Special purpose clinics have the potential to make good some of the deficiencies of the private health system in that a patient who has been refused, or who fears the possibility of refusal, has an alternative means of gaining access to birth control methods. If her (or his) embarrassment or fear of approaching a doctor is at all a complex matter, as it well may be, the clinic may have the advantage that there nobody need explain

their intentions. The physical presence of client and professional can be all that is needed to demonstrate that the one would like birth control advice and that the other is prepared to give it. Added to those for whom the private system has proved inadequate are those who seldom consult private doctors at all. These are mainly the poor and South European migrants.[18] For them, if there are no public clinics they will have no access to doctor controlled methods.

Thus, if special purpose clinics were to contribute substantially to an increase in the availability of birth control we would expect them to offer all medically safe and effective methods impartially to all who needed them without discrimination. Further, we would expect that their services would be presented in such a way as to minimise the inhibition of shyness, and to attract all sections of the public who were at risk, especially those who, traditionally, do not consult private doctors.

There were no birth control clinics in Victoria until 1967. Thus the brief historical sketch which follows also, by implication, sheds painful light on dominant attitudes to sexuality and procreation. For example, Dr Kelvin Churches made it a matter of public record in the Tracey-Maund Memorial Lecture in 1976 that the Royal Women's Hospital had, until 1970, only dispensed contraceptive advice to those women whose lives would have been endangered by pregnancy.[19]

In response to this dearth of services, the Brotherhood of St Laurence established Melbourne's first family planning clinic, in 1967, open one half day a week in the inner suburb of Fitzroy.[20] Research workers at the clinic discovered that the women they interviewed felt strongly that family planning should be incorporated in major hospitals and that some who had been referred by maternity hospitals had been bewildered by the fact that they could not get family planning advice from these hospitals.[21]

In October 1969 the Victorian Family Planning Association was formed and by 1971 was running two clinics, at the Infant Welfare Centre associated with the Queen Elizabeth Hospital for Mothers and Babies in Carlton, and also at the Queen Victoria Hospital in the city. In January 1971 the Queen Victoria Hospital set up its own clinic, offering contraception to all post partum patients for the first time, and a few months later the Royal Women's followed suit with the establishment of a smaller clinic.[22]

During 1972 the Family Planning Association, after a prolonged legal fight, was incorporated under the Companies Act and declared a Benevolent Society within the meaning of the Hospitals and Charities Act.[23] This meant that it then had the legal status necessary to take advantage of the offer of a private donation ($20,000), receive a state government grant ($15,000), and buy a property in the inner suburb of

Richmond which, in 1973, became the centre of the association's activities.

In all other states the Family Planning Association worked with state health departments to set up regional centres in suburbs and country areas. Victoria followed a different pattern. In 1971 the Health Department, through the Department of Maternal and Child Welfare, began to establish family planning sessions in Infant Welfare Centres in collaboration with local Municipal Councils. A considerable expansion in services occurred between 1971 and early 1975, with family planning sessions being established in 26 suburban centres.[24]

The Family Planning Association claimed that this pattern of expansion was inefficient.[25] This claim was later borne out by the findings of the Royal Commission on Human Relationships.[26] Planning deficiencies apart, it might not seem important which body assumed responsibility for the development of clinics. Indeed, some might think it desirable that a government body should have been involved rather than a private association. In fact, in this area, as the history of birth control services at the Royal Women's illustrates, government bodies either lacked the will, or were too timid, to adopt policies that would have promoted services effectively.[27] During the early seventies the Family Planning Association took up a public education role enthusiastically. The Health Department did not.

During the same period in which general contraceptive services were being expanded, Catholic family planning was also growing. From the mid fifties the Catholic Family Welfare Bureau had offered help with the rhythm method and, later, the basal body temperature method. In 1968 the papal encyclical *Humanae Vitae* restated the Church's opposition to means of birth control other than those based on periodic abstinence and demands for advice became so heavy that a separate Catholic Family Planning Centre was established in Fitzroy. It offered the sympto/thermal method, a combination of the basal body temperature method and vaginal mucus symptoms, and at that time called it the 'ovulation method'.[28]

In early 1972 a dispute about methods led Dr J. J. Billings and his wife, Dr E. L. Billings, to resign from the Centre's medical board and lay claim to the name 'ovulation method' under copyright for a method based on vaginal mucus symptoms alone. Billings then established an ovulation method clinic at St Vincent's Hospital, a major public hospital, where he was dean of the clinical school. St Vincent's did not offer any other form of birth control.

Later in 1972 Cardinal Knox offered the Billings organization rooms

in East Melbourne where the 'Natural Family Planning Centre' was established. By the end of 1974 it had proliferated 15 suburban branches and 16 country centres. Ovulation method clinics were set up at two private hospitals, Cabrini and Sacred Heart and, in addition to its domination of services at St Vincent's, the method had been allocated special facilities in four Health Department clinics.[29]

Though the ovulation method was heavily promoted during the early seventies, the Catholic Family Planning Centre continued to offer the more reliable sympto/thermal method in Fitzroy, and in seven country centres. In addition, a sympto/thermal method clinic was established at the Mercy Maternity Hospital (also a public hospital where no other methods were offered).

A further aspect of the growth of birth control services during the period was the expansion of legal abortion services. Some part of this took place in public hospitals, though facilities there were limited. Dr Wainer's Fertility Control Clinic was, however, of great importance, both as a provider of services and as a demonstration to private doctors and the general public that, AMA advice nothwithstanding, the law was in fact less restrictive than had been supposed.

The clinic was set up, in East Melbourne, late in 1972, and expanded considerably in mid 1973.[30] Though it was a centre of fiery public controversy from the beginning, the existence of a women's movement strongly committed to the right of fertility control, possibly provided a deterrent to politicians tempted to yield to conservative pressures.[31] By February 1975 the Fertility Control Clinic, though still a focus of concern and demonstrations, had won a degree of community acceptance. Referrals from private doctors (non-existent in the beginning) accounted for 42% of patients by September 1974, and even some public hospitals were referring patients.

From the above discussion it can be seen that, while the special purpose clinics that were developed during the early seventies made good some of the deficiencies in the provision of medically controlled methods of contraception, they by no means filled all of them. Restrictions on advertising not only constrained those clinics which wished merely to announce their existence, they also inhibited those who had the will to reach out to the timorous and reassure people uncertain of their possible reception. Unfortunately the Health Department which controlled the greatest number of clinics appeared to lack even such a will.

The Family Planning Association's Richmond clinic was the only major centre providing services for the young and unmarried but it was unable to advertise the fact and the 'family planning' euphemism could

have deterred some. Men and teenagers were unlikely to have felt comfortable about attending clinics in Infant Welfare Centres: indeed, only mothers already attending the centres were likely to know of their existence.

Some public patients were better off than before in that, if they had already given birth to a child, the maternity hospital may have offered them birth control or, alternatively, when taking the child to an Infant Welfare Centre they could have found out about the Health Department's family planning clinics. Those who did not have young children were less likely to have been reached.

People living outside the Melbourne metropolitan area were also not well catered for and only 11 of the 26 Health Department clinics were established in the more deprived Western suburbs. Two public hospitals, St Vincent's and the Mercy Maternity Hospital, only offered relatively ineffective periodic abstinence methods. In as much as it is difficult for people to make independent judgments contrary to the advice of medical professionals, the emphasis on these methods in these hospital clinics and in four of the Health Department's Infant Welfare Centre clinics may have disadvantaged some women.

Though some efforts were made to provide interpreter services and multilingual pamphlets, it seemed that success in reaching non-English speaking migrants was limited.[32] While it is difficult to provide adequate interpreter services for consultations of this kind, and many migrants (especially women) are not fully literate in their native language and cannot benefit from printed information about services, it may be that, for cultural reasons, some migrants choose not to use a medical method rather than that the service fails to reach them. Many non-attenders at the Queen Victoria's post natal family planning clinic were Greek women intending to practice withdrawal.[33] We need to know more about the reasons for choices of this kind and what consequences they have for the people involved.

Though they must necessarily represent a considerable improvement over the situation prevailing in the sixties, special purpose contraceptive services were, in 1975, imperfect. Those best served were married, English speaking women living in Melbourne who had recently given birth and who were fortunate enough to encounter a clinic offering a range of effective methods. Others were less well off; and, because they were less likely to be reached by clinics offering contraception, the development of accessible, legal, abortion services could have been of considerable importance for them.

CONCLUSION

Though birth control became more available in Victoria between 1971 and 1975 the pattern of the development of services was uneven. Especially where contraception was concerned, those people in a dependent relationship to mainstream society, the young, the poor, and migrants, fared least well. They would, therefore, have had a greater need of abortion should unplanned and unwanted pregnancy have become for them, not a dim possibility, but an immediate reality. Their failure to use effective contraception should not be seen in terms of personal inadequacy alone: if no one offered it to them they were often ill placed, and ill equipped, to ask for it.

Though abortion and contraception are different processes, their effects are the same in that, if they are used, fewer babies will be born. I do not wish to claim that an increase in the practical availability of birth control explains the downturn in fertility of the early seventies. Other possible causes which may have affected planned fertility (for example, economic change, modern feminism, environmental concerns) have not been considered and, after all, birth rates have been known to decline in societies which had little access to effective methods of birth control.[34] In this paper I have tried to outline the ways in which birth control, as one variable among a number, altered between 1971 and 1975. While this is a more modest undertaking than a full attempt at explanation would be, the changes described have been considerable and should not be discounted if recent trends in fertility are to be understood.

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