In 1950, scriptwriter Julia Singer and her husband Simon produced an educational film for the Planned Parenthood Federation of America set in Tucson, Arizona.¹ They wanted to help local Mexican-American and Native-American families by making a film about family planning for them. Soon, Planned Parenthood distributed it across the United States.

Casting local schoolteacher John Samano and his wife Rosa as leading actors, the producers claimed to show the real story of a couple of Mexican-origin and their struggle to have a healthy child. An advertisement brochure (see Figure 1) described the film (which has, unfortunately, not been preserved in the Planned Parenthood archives) as follows:

A Planned Parenthood Story opens, on the pathetic funeral of a second infant boy, dead at birth, and on scenes of its crib being dismantled, its clothing put away, Rosa and John turn to their church, are led to the clinic. Here they learn how to build up Rosa’s health and space the arrival of another baby — which in the finale, they are looking forward to, with confidence that this one will have an even chance of survival.²

The film brochure thus describes the family as helpless after the loss of their child and blames the mother’s weakness for it. The couple were most likely Hispanics, which means they were part of the Spanish-speaking minority that lived in New Mexico and Arizona since before the Contract of Guadalupe Hidalgo (1848). Nevertheless, employers, social experts and civil society activists often mistook such people for Mexican immigrants. In the 1940s and 1950s birth rates as well as infant mortality rates were still high among families of Mexican origin in the Southwest, while they had declined for Anglo Americans. In the film, the family’s first resource for help was a Presbyterian church, which then referred the couple to a local Planned

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¹ This article is based on research conducted as part of the project “Reproductive Decision-Making in Germany and the USA in the Second Half of the 20th Century” within the Collaborative Research Center 1150 “Cultures of Decision-Making” at Münster University, which was sponsored by the German Science Foundation. A generous grant from the Gerda Henkel Foundation enabled me to conduct archival research in Massachusetts.

Parenthood clinic. There, they received information about birth control methods, which the mother could use to restore her health before becoming pregnant again and then give birth to a healthy child.

The film promoted family planning as a simple solution to infant and maternal mortality. Since mainline protestant churches were among the primary supporters of Planned Parenthood in the postwar era, the organization relied on churches to direct families in need to their clinics. At the same time, the film presented a simple narrative of Mexican-American families living in a premodern void and only learning about modern principles of family planning through outsiders. It ignored traditional knowledge networks that operated through extended families or midwives, dismissing them as ineffective and anti-modern. Meanwhile, it offered a linear path to the ideal nuclear family with two or three planned and spaced children through birth control.

This article will investigate family-planning programs for immigrant families in the United States and West Germany in the second half of the twentieth century. After some conceptual considerations regarding the history of knowledge, which underlies the analysis, it will briefly discuss the overpopulation scares of the postwar years as a background to family planning campaigns. The article’s first main section will discuss the Planned Parenthood campaigns of the 1950s and 1960s and initiatives by Chicana feminists to educate Mexican Americans. The second main section will move to West Germany and study an initiative by the German family-planning organization Pro Familia to reach Turkish immigrant women. The conclusions will discuss networks for reproductive knowledge dissemination accessible to migrant families.

I. The history of knowledge as an approach to migration research

In debates about migration and family size in the second half of the twentieth century, overpopulation scares intersected with racism. Anthropologist Leo Chávez has shown that press coverage in the 1970s frequently used war metaphors and depicted Mexican women’s...
reproductive functions as a threat to the United States. Sociologist Elena Gutiérrez has investigated discourses of race and Latina women’s fertility and traced how representations of “hyperfertile” Mexican women were directly linked to coercive sterilization practices from the 1920s up until the 1970s.

At the same time, sociological research since the 1970s has also demonstrated that the second generation of immigrant families did begin to desire smaller families but was not able to reduce the number of children; and that only third-generation immigrants succeeded in attaining the hegemonic small family norm. These findings suggest that first-generation immigrants stuck to concepts of reproduction that they had brought along from their home countries. Second-generation immigrants seemed to have adopted principles of family planning of the host country but failed to put those into practice. Mexican American civil rights activists in the 1970s argued that the reasons for this lay in structural discrimination in family planning clinics as well as antiquated attitudes towards sexuality. To put these findings into perspective, one must critically analyze which type of information about contraceptives was available to immigrant women.

In order to investigate this, I approach immigrant access to family planning from a history of knowledge perspective. Migrant knowledge here refers to information that migrants were able to acquire about their host society. This includes knowledge about migration routes and visa processes but also about customs and everyday essentials in the host society, such as where to obtain medical care or contraceptives.

Knowledge is human-made and thus subject to historical change. As historian Philip Sarasin points out, knowledge is anchored in certain locations but one of its most important features is that it circulates. To overcome Sarasin’s distinction between scientific or rational knowledge and traditional forms of belief, this paper focuses on tracing the production and circulation of reproductive knowledge in a non-judgmental fashion that takes into account both scientifically validated methods and well-meaning advice from family and friends (for instance, about the withdrawal method of contraception).

Focusing on migrant women’s agency to determine the number of children they had, this article investigates how immigrant families could access reproductive knowledge. This encompasses all knowledge necessary to determine the size of one’s family, including knowledge about the basics of human procreation, contraceptive means, legal
access to contraceptives, abortion or assisted reproduction, as well as moral and ethical debates surrounding reproduction in the host country. It also includes practical knowledge about how and where to obtain an (illegal) abortion, traditional knowledge pertaining to natural family-planning methods and hegemonic ideals of family size in both the home and the host country. Civil society actors, such as physicians and other experts, family-planning organizations, churches, women’s rights groups and extended family networks were important circulators of reproductive knowledge.

Migrant families found themselves in the specific situation of having to position themselves vis-à-vis different hegemonic norms of family size, since they lived their everyday lives in transcultural spaces marked by everyday practices of fusing, mixing, negotiating, adapting or rejecting cultural practices of both the host and the home society. According to migration historians Christiane Harzig and Dirk Hoerder, within a transcultural setting, the agency of migrant families depended on the cultural and social capital they were able to acquire in the host country. In that sense, immigrant women needed social capital to determine their reproductive agency and adjust their families to hegemonic concepts of family in both the host and home country. Immigrants could gain or lose social capital through professional aid and networks of extended families and neighbors. These networks were especially important, as immigrants might often find themselves cut off from public debates in both the home and the host country and thus missed out on social change in both societies.

II. The beginning of birth-control campaigns targeting Latinos in the United States

Since the early 1940s, local Planned Parenthood chapters in Texas and Arizona targeted Mexican American women by printing Spanish-language leaflets. In the first Spanish-speaking brochures, the
simplicity and inaccuracy of the language is striking. A 1941 leaflet for a Planned Parenthood clinic in El Paso (see Figure 2) simply uses the slogan “Muchos Niños [many children]” and translates “birth control” literally as “control de partos [control of births].”\(^\text{13}\) The leaflet is extremely simple and evasive, it assumed the clients were semi-literate and Catholic — the authors presumably thought that a leaflet with language that was too complex or offered specific information could scare them away. The goal was to get women to come into the clinic, where they would receive all information deemed necessary and a counsellor would pick the contraceptive he/she considered best — in Planned Parenthood clinics, this was the diaphragm.\(^\text{14}\) However, counsellors were also willing to inform Catholic women about the rhythm method as they considered an unreliable contraceptive means better than no birth control at all.

Planned Parenthood began to coordinate work with Mexican and Puerto Rican families in 1953 as contract labor programs caused a new wave of Spanish-speaking migrants to come to the United States. The federation itself had come into being when the American Birth Control League and the Birth Control Research Center merged in 1938 and changed its name to Planned Parenthood Federation of America in 1942.\(^\text{15}\) The association maintained a network of somewhat independent birth control clinics, affiliates in each state, and a national headquarters in New York. While the federation had sought alliances with the eugenics movement in the 1930s, it avoided any such association after the outbreak of World War II. Nevertheless, population control activists were still dominant.\(^\text{16}\) Leading members, such as the birth control pioneer Margaret Sanger, ornithologist William Vogt (Planned Parenthood President in 1942) and gynecologist Alan Guttmacher (president from 1962 to 1970), saw overpopulation as the greatest threat to world peace and prosperity.\(^\text{17}\) In the pamphlet “The Population Bomb” (1959), businessman Hugh Moore claimed that population growth would lead to hunger, totalitarian regimes, and in the end another global war.\(^\text{18}\)

In their campaigns, postwar family planners subscribed to an interpretation of family structure that followed sociologist Talcott Parsons’ version of modernization theory. In 1941, Parsons had observed that the isolated nuclear family with a breadwinning father, homemaking mother, and two or three children was the best fit for the industrial social order of the modern United States.\(^\text{19}\) While in a premodern, agricultural society the extended family composed of many children and extended kinship networks served as an institution of social

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13 “Muchos Niños” (April 16, 1941), PPFA Records II, Box 91, Folder 25, all translations by the author of this paper.
14 Cathy Moran Hajo, Birth Control on Main Street: Organizing Clinics in the United States 1916-1939 (Urbana, 2010), 50.
15 See Moran Hajo, Main Street, 17.
17 See Rickie Solinger, Pregnancy and Power: A Short History of Reproductive Politics in America (New York, 2005), 141.
18 Moore, Hugh, “The Population Bomb” (1959), PPFA Records II, Box 97, Folder 94.
security, in a modern, industrial society the nuclear family, which had severed all ties to their extended kin, could invest their income into a family home, educate the children and rise into the middle classes. While fathers brought home the family income, mothers invested their reproductive labor into socializing the children to be good democratic citizens. Even though historians have dismissed modernization theory as a Western-centric teleological model that failed to take into account (post-)colonial dependencies and multiple modernities, social actors in the 1950s believed in it as a normative concept for explaining contemporary society and for modeling individual families accordingly. Under a modernization paradigm, civic organizations adjusted social work programs for immigrants and pathologized minority families that did not fit the norm as premodern and undemocratic. Latino families were stereotyped as being too large, too patriarchal and within the prevailing discourse of anti-Catholicism, too Catholic. Their countries of origin were marked as premodern, and immigrants were told to modernize their attitudes towards family planning in order to gain access to middle-class lifestyles. That it was accelerated industrialization rather than premodern family structures that had left families poor and dislocated, especially in the case of Puerto Rico, did not fit into population planners’ campaigns.

Parallel to the overpopulation debates, contract labor programs started with the Bracero Program in 1942, in which male Mexican contract laborers received a visa to the United States for five years to overcome the labor shortage in agriculture. Many immigrant workers overstay their visas and brought along their families. In contrast to the Bracero Program, Operation Bootstrap (1947) was a contract labor program for Puerto Rican workers aimed at men and women that placed them in both industrial and agricultural labor. The distinction between Mexican immigrants and Puerto Rican migrants was due to their U.S. citizen status. Since Puerto Ricans had been granted American citizenship in 1917, they could move frequently between Puerto Rico and the mainland United States, even though they were still racialized colonial subjects.


25 For more information on the Bracero program, see Deborah Cohen, Braceros: Migrant Citizens and Transnational Subjects in the Postwar United States and Mexico (Chapel Hill, 2013).

Puerto Rico, which was an American protectorate since 1898, became the testing ground for population control measures. On the island, commentators considered overpopulation and poor education the main causes of poverty rather than the accelerated industrialization and colonization policies that historians have identified as the causes of economic hardship. Measures ranged from sterilization campaigns in the 1930s to the first medical trials of oral contraceptives in 1953, as many doctors on the island were U.S.-trained. American foundations poured money into campaigns and Puerto Rico became the first Spanish-speaking territory with an active family-planning organization and a network of birth control clinics since 1937. With Operation Bootstrap, the U.S. government intended to both fix labor shortages on the mainland and solve the perceived overpopulation problem on the island.

In the wake of the Bracero Program and Operation Bootstrap, Planned Parenthood started to perceive Latino migrants in the United States as potential clients. In 1953, the topic came up during a national board meeting. Federation president William Vogt then described Spanish-speaking families seeking family planning advice as a problem of uncontrolled immigration, stating that there was a proliferation of “illegal entry” of people that were “50% illiterate, their health poor, badly in need of contraceptive service.” On the one hand, he advocated for immigration control, while on the other hand, he associated a lack of education with poor health and large families. Since Planned Parenthood could not change immigration restrictions, the association aimed at educating immigrants. First, they translated into Spanish a speech by the Indian Planned Parenthood activist Lady Rama Rau that insinuated that all population problems of the Global South were alike. Then, they brought the Puerto Rican physician and family planner Ofelia Mendoza to the mainland to study how to reach Spanish-speaking clients in the United States. Mendoza conducted her study among Spanish-speaking (that is, Puerto Rican) migrants in New York and concluded that a high percentage of those attending local family planning clinics in Harlem and the Bronx were Protestants who could be easily attracted by the medium of film.

In 1958, Mendoza herself produced the brochure Hacia un Hogar Feliz (Towards a Happy Home), which was aimed at Spanish-speaking patients in the United States. It referred to current themes in family planning campaigns such as the emphasis on making every child a wanted child and warned against the dangers of unwanted children.

28 See Laura Briggs, Reproducing Empire: Race, Sex, Science and US Imperialism in Puerto Rico (Berkeley, 2002), 80; 90.
31 See Minutes of the 1954 Board of Directors Meeting, MSP LOC Microfilmed, Reel 120.
32 Ibid.
34 For the conceptualization of the figure of the Wunschkind, see Sven Bergmann, “Wunschkind,” in What Can A Body Do? Figurationen des Körpers in den Kulturwissenschaften, ed. Netzwerk Körper (Frankfurt am Main, New York, 2012), 236–237; for the United States and the Hispanic context, see Minian, Indiscriminate, 67.
for society. Readers learned that if parents were unprepared and their child was unwanted, it would turn into “un enfermo físico o mentalmente, un niño rebelde o hasta un criminal [a physically or mentally ill child, a rebellious child or even a criminal],” since all criminals came from “hogares desorganizados [broken homes].” Mendoza based her argument on current psychological research that associated an unhappy home with neurosis and maladjustment, criminal or despotic tendencies in adult life, and warned against the social cost of unplanned parenthood for both the individual child and society as a whole. Mendoza presented “control de natalidad” and “planificación de familia”, which were the contemporary Latin American terms, as the only solution. In the brochure she warned that home remedies to induce abortions, which friends, neighbors or pharmacists recommended, would only destroy a woman’s health. Clandestine abortion would be a crime and sin as well as a danger to a woman’s physical and mental health. Only when the health of the mother was in danger, would a legal abortion “performed by a competent doctor” be available, in all other cases birth control must serve as “medicina preventiva [preventive medicine].” However, it was not enough to ask a pharmacist for advice. A specially trained doctor should examine a woman and fill out a prescription since the device (which, although not explicitly mentioned probably alluded to a diaphragm) had to be fitted individually. Mendoza’s brochure favored a formal information network and expert advice as the only reliable sources of information on contraceptives. It acknowledged the existence of informal knowledge networks of friends, relatives or over-the-counter drugstores, but dismissed them as insufficient or even dangerous. Instead, Mendoza sought to replace knowledge disseminated through these networks with formal professional networks. Still, she used complex language and correct terminology and mentioned different methods to control fertility like birth control, partial abstinence, sterilization and abortion.

While Mendoza’s brochure was rather sophisticated both in the use of graphics and language, the 1966 brochure “Ser Padre, Ser Madre [Being father, being mother]” switched back to extremely easy language to present the absolute basics about human procreation and birth control. For instance, it explained about oral contraceptives: “Hay unas pastillas especiales que si se toman según las instrucciones, impiden que el ovario produzca ovulos. Sin ovulo no puede haber embarazo. Su doctor puede explicarle,
o en la clínica le explicarán todo sobre estas pastillas. [There are some special pills that if you take them according to the instructions, stop the ovary from producing egg cells. Without egg, there can be no pregnancy. Your doctor can explain to you, or at the clinic, they will explain everything about these pills.]”36 That was all the information about the complex contraceptive in the brochure. Information about other contraceptive methods including the IUD, condoms, or the rhythm method were no more detailed, and women were told on each page to consult a doctor or a clinic. Doctors, however, also tended to use simplified and less accurate language when speaking with non-native speakers as patients.37 Through this, vital information about the correct use of contraceptives could get lost. It also meant that doctors would choose a contraceptive for a woman rather than letting the patient choose the contraceptive herself. The brochure framed contraception as a medical issue and doctors had the right to choose a treatment for their patients. In this way, they often dismissed a woman’s complains about minor side effects or did not inform her about more serious ones.

Rather than passing on current information about the pill’s side-effects, Planned Parenthood recycled outdated themes for their Spanish-speaking brochures such as contrasting a nice-looking, planned middle-class family to an untidy, unplanned, poor family.38 Picking up the narrative from a 1948 English-language brochure, the 1968 brochure “Ustedes Pueden Planear Su Familia [You can plan your families]”39 (see Figure 3) contrasted a middle-class family owning consumer goods such as a car or tricycle to the unplanned, poor family. In contrast to the original, this brochure showed graphically that if a family had fewer children, each one would have more food on the table. This alluded to instances of hunger among Mexican migrant worker families that became visible to the American public during the 1966 United Farm Workers strike, when Mexican-origin migrant farm workers organized nationwide boycotts of grapes to point out that their extremely low wages could not feed fruit pickers’ families.40 Rather than blaming low wages for hunger, however, this brochure blamed family size. The message was that through rational family planning, one could avoid starvation, child labor and labor unrest.

The brochure also referred to contemporary debates about machismo, when addressing the man in the family: “Es una virtud del hombre de verdad cuidar de su mujer e hijos. El Jefe de la familia

37 See Birgit Heimerl, Die Ultraschallprechstunde: Eine Ethnographie pränataldiagnostischer Situationen (Bielefeld, 2013), 200.
38 See “The Story of Two Families” (1948), PPFA Records II, Box 99, Folder 100.
39 “Ustedes Pueden Planear Su Familia” (1968), PPFA Records II, Box 100, Folder 50.
decide con su esposa cuantos hijos pueden criar y educar. [It’s a real man’s virtue to be able to take care of his wife and children. The boss of the family decides with his wife how many children they can raise and educate.]41 This shows how birth control activists perceived Spanish-speaking families as clinging to patriarchal family structures.42 The common narrative that was perpetuated in some Planned Parenthood brochures was that if families had a more egalitarian relation between husband and wife and only few children, they could move to a better apartment and send their children to college.43 Here, however, the brochure relied on patriarchal structures to appeal to the father’s masculine duties to provide for a family. This shows that campaigns were rather pragmatic in trying to get their message to what they perceived as an uneducated and premodern immigrant population.

41 “Ustedes Pueden Planear Su Familia” (1968), PPFA Records II, Box 100, Folder 50.
43 See “La Sortija de Compromiso” (1964), PPFA Records II, Box 93, Folder 59.
III. Narratives on knowledge circulation in Planned Parenthood brochures

Since the mid-1960s, narratives of planned families not only promised affluence, they also promoted family planning as a safeguard against social decline for working-class families. Planned Parenthood commissioned the bilingual brochure *Escape from Fear*/*Amor Sin Temor* [Love without fear] (see Figure 4) from Marvel comics, which told the story of a factory worker Ken/Joaquin, who had a fight with his wife Joan/Marta because she would not have sex with him for fear of another pregnancy. Marta had experienced two unplanned pregnancies after using over-the-counter contraceptives like douches and sponges and feared that with another child, she would not be able to keep up the nice appearance of the household. Joaquin became distracted at work due to his conflicts at home and had an accident operating a machine. The factory doctor, who treated his injuries, told him about a Planned Parenthood clinic. There, his wife met Doctora Sánchez, who presented her with contraceptives approved by the American Medical Association such as the pill, the IUD or the diaphragm. While the comic did not say which contraceptive the wife chose, she happily recommended the clinic to her sister.

Here again, expert advice was privileged over freely available contraceptive information. But rather than dismissing informal networks, the comic presented knowledge dissemination as a drama in three acts. First, the father of the family receives information from his doctor, which he passes on to his wife. She then decides to seek out a formal knowledge network in the family planning clinic and the Spanish-speaking doctor. After that, she passes on her new knowledge to her relatives. This shows that in addition to Protestant churches, Planned Parenthood began to rely on informal family networks among immigrants to transmit information about where expertise was available. Also, it used immigrant doctors as counsellors, since they could more easily gain trust among women.

44 “Escape from Fear” (1962), and “Amor Sin Temor” (1965), PPFA Records II, Box 93, Folder 61-62.
However, not all Puerto Rican migrant women were happy with comics conveying the message about family planning. In 1970, Mrs. M., a Puerto Rican woman, who described herself as middle-class, wrote a protest letter to Planned Parenthood president Alan Guttmacher after seeing him in a TV talk show dismissing fears about fatal side effects of the pill. She complained that information about the pill available to her came in the form of comics and when she tried to ask her doctor about her concerns “[h]e pooh-poohed my fears like I was making them up.” Furthermore, she was surprised to learn that the pill was originally intended as a short-term contraceptive between two pregnancies, since she had been taking it as a long-term solution. Guttmacher replied that he also thought that it was unfortunate to use comics as means to convey reproductive knowledge but that, in his experience, immigrant women would not read brochures that were more sophisticated. Yet, Mrs. M.’s letter of complaint showed that these women were concerned with the pill’s side effects, that they were not getting sufficient information from experts and that they were receiving most information from public media in their host country. Such information was, of course, only available to those immigrants who spoke sufficient English and who lived in areas where they could access a television — not, for instance, in migrant labor camps or isolated rural colonias.

Mrs. M. wrote her protest letter in the context of a controversy about side effects of the pill, which arose after journalist Barbara Seaman published her monograph The Doctors’ Case against the Pill (1969). When it became available in 1960, the oral contraceptive pill became the birth control means of choice, even though it was Federation policy until 1968 not to inform women about serious side effects such as blood clotting. The book connected oral contraceptives to a long list of side effects ranging from fatal blood clots to cancer, and Seaman argued that women and doctors lacked information to make an “informed decision” about their contraception. Feminists picked up Seaman’s argument and demanded access to knowledge on reproductive medicine in order to counter the paternalistic and judgmental attitudes of most doctors. According to historian Kristina Schulz, feminist initiatives became experts in reproductive medicine against their will, since they believed that granting women access to information about their bodies would liberate them from a population control complex consisting of doctors, pharmaceutical companies and the state. Sociologist Kathy Davies conceptualizes second-wave feminism as an epistemological project because initiatives like the Boston Women’s Health Book Collective,
which issued the famous handbook *Our Bodies, Ourselves* (1971), juxtaposed medical knowledge with women’s experience and local knowledge to enable women make their own reproductive decisions when to have healthy children. Their writings served to deconstruct myths about women’s reproductive functions, and female lay authors used their own experiences to create new knowledge about women’s bodies.

Yet the young, academically trained members of the Boston Women’s Health Book Collective were privileged, as they were able to go to medical libraries, research and edit information on birth control. Migrant women, who did not speak the host country’s language and had little formal education, were much more vulnerable to exploitative attitudes by medical experts. Therefore, in 1977 the Chicana feminist group Amigas Latinas en Acción por Salud (ALAS) published a first Spanish translation of *Our Bodies, Ourselves* aimed at Spanish-speaking women living in the United States. However, the translation was controversial, as it assumed living conditions and concepts of individualism to be the same for white women as for Latinas.

Chicana feminism emerged in the late 1960s out of the Chicano movement, a movement that emerged in the late 1960s and fought for civil rights of Mexican Americans and Mexican immigrants as farm workers, city dwellers, landowners and students. While activists used the term Chicano to denote every person of Mexican-origin, here it serves as a self-referent for activists. Within this movement, second-generation immigrant women experienced sexism in student organizations like African American and Anglo American women did. While on an external level they displayed unity with their male peers and dismantled allegations of machismo by Anglo American social sciences as a harmful stereotype, internally, they fought for more active roles within marriage and the movement. They combined the agendas of the second-wave feminist movement and the civil rights movement by setting up community health centers that distributed contraceptives and offered other women’s health services.

Even before the translation of *Our Bodies, Ourselves*, Chicana feminists were disseminating reproductive knowledge as both activists and researchers. Marta Cotera, who was a University of Texas archivist, set up a free clinic in Crystal City, Texas, in 1968. She argued that antiquated and ambivalent attitudes towards sexuality were the causes of the high numbers of teen pregnancies among Mexican Americans. Rather than distributing information about contraceptives randomly, as Planned Parenthood had done, she suggested conducting a thorough study of

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51 See Kline, *Bodies*, 3.

52 See Davis, *Making*, 175.

53 See Benita Roth, *Separate Roads to Feminism: Black, Chicana and White Feminist Movements in America’s Second Wave* (Cambridge, 2004), 137.

the “types of programs communities would accept, and types of institutions or individuals which should provide these types of services.” The social work student Sally Andrade, who conducted such research for her Ph.D. thesis at a free clinic in Austin, found out that while religion was not a decisive factor, Mexican American women often did not approach family-planning clinics because they considered them to be white middle-class institutions.

Birth preparation classes seemed to be the vehicle through which activists could reach Hispanic couples. In 1976, the Chicana feminist journal Caracol presented a successful campaign for birth preparation classes in San Antonio that mixed knowledge transmitted through experience with scientific evidence. A Mexican-origin couple, who already had children, taught the class, which both men and women attended together. In these classes, they showed Planned Parenthood films and invited Planned Parenthood nurses as guest speakers. In this way, they mixed traditional networks with modern ideas about reproduction. Since the class was led by a Spanish-speaking couple, power relations shifted, and reproductive knowledge no longer appeared as a collection of white middle-class notions of family imposed on Chicanas, thus enabling them to pass on vital scientific knowledge.

The emergence of the New Social Movements in the late 1960s thus shifted the ways in which clinics transferred reproductive knowledge to immigrant women. Formal networks and Anglo-American medical doctors lost their privileged position as the feminist movement began to criticize their paternalistic attitudes and their insufficient information on the side effects of the pill. At the same time, civil rights organizations discredited family-planning clinics as middle-class institutions that often had population-control goals in mind. Therefore, family planners started to make use of informal immigrant networks and second-generation immigrant professionals became the most relied upon bearers of reproductive knowledge in their communities.

IV. Family planning and guest workers in 1970s West Germany

In the late 1940s, American family planners were as concerned about population growth in the recent enemy countries of Germany and Japan, as they were about Latino minorities in the American Southwest. Planned Parenthood founder Margaret Sanger had taken Hitler’s claim to seek Lebensraum in the East literally, and assumed that, if the German (and Japanese) population continued to grow, another world war would follow. For Sanger, the overpopulation...
scare was an argument to send contraceptives to postwar Germany, financially support the founding of a West German family-planning association, and have Germany and Japan become founding members of the International Planned Parenthood Federation (IPPF) in 1952.

Pro Familia — The (West) German Association for Marriage and Family — was founded through the initiative of Berlin gynecologist Anne-Marie Durand-Wever and Kassel social worker Ilse Lederer, who had met Sanger at a conference of the British Family Planning association in 1948. Together with the controversial social hygiene professor Hans Harmsen, who had actively promoted eugenic sterilization during the Nazi era, they founded Pro Familia with IPPF funding in 1952. However, already during the 1957 IPPF regional conference hosted by Pro Familia in Berlin, differences between the West German and U.S. activists became apparent. While Sanger and the Planned Parenthood activists were promoting global population control, Harmsen argued that the most pressing problem for family planners in Western Europe was the proliferation of illegal abortions. Thus, Pro Familia wanted to promote contraceptives as a means to fight illegal abortion rather than overpopulation. Pro Familia continued to exchange information with Planned Parenthood, especially about oral contraceptives, but they did not follow a thorough population-control approach.

Pro Familia did not target immigrants in the 1950s and 1960s and did not perceive them as threat within the context of overpopulation scares. On the contrary, since 1964 German birth rates declined, and Pro Familia officials assumed that only immigration helped keep reproduction rates above the zero-population-growth level.

Guest worker programs in West Germany started in 1955 with agreements with Italy. Spain and Greece followed in 1960, Turkey in 1961, then came Morocco, Korea (both 1963), Portugal (1964), Tunisia (1965),

60 Anne-Marie Durand-Wever and Hans Harmsen, Letter to Margaret Sanger (July 20, 1952), The Margaret Sanger Papers (unfilmed), Sophia Smith Collection, Smith College, Northampton, Mass (hereafter cited as MSP unfilmed) Box 63, Folder 2; for Harmsen’s involvement with the Nazi sterilization program, see Sahine Schliermacher, Sozialethik im Spannungsfeld von Sozial- und Rassenhygiene: Der Mediziner Hans Harmsen im Centralausschuss für die Innere Mission (Husum, 1998).


and Yugoslavia (1968). Contract labor programs originally hired both male and female workers, who arrived independently and not as family units. Some met and married in Germany, others had spouses abroad. The so-called Anwerbestop (stop in recruitment) in 1973 made circular migration impossible, so migrant workers had to choose between permanently returning to their home countries, living in permanent long-distance relationships or bringing their families along. 1.6 out of the 2.6 million foreign workers chose to stay and bring along their families.

Like the contract labor programs in the U.S., guest worker programs in the 1960s West Germany were not part of a large-scale migration policy, but were intended to solve a short-term labor shortage. Nevertheless, by 1973 it became apparent that many Turkish-origin families were staying for good. As programs in West Germany started some twenty years later than in the United States, it was in a different discursive setting that Germany family planners started to consider labor migration a movement of families. While debates in the in the 1960s United States had focused on curbing overpopulation, in the 1970s questions of women’s choice and reproductive rights had moved into the center of campaigns.

In the beginning, Pro Familia had only run four birth control clinics, and focused on training doctors in prescribing contraceptives and advocating for legal changes. From 1972 to 1976, the organization underwent tremendous changes because it took part in a model project of pregnancy crisis counseling initiated by the German Federal Agency of Health Education. When West Germany decriminalized first term abortion under certain conditions in 1976, this included the requirement that the pregnant woman undergo mandatory counseling and Pro Familia was on the forefront of offering such counseling. This transformed the organization, as it opened 102 new clinics within nine years and hired new staff that were involved with the student and feminist movement. They brought along feminist convictions about universal women’s rights to control their fertility. In Frankfurt and Berlin, Pro Familia worked closely together with feminist initiatives. The Berlin Kreuzberg affiliate collaborated with a feminist health center run by Brot und Rosen, which had published the self-help guide Frauenhandbuch No. 1 in 1973 and was very critical of paternalistic attitudes among doctors and pharmaceutical companies. Brot and Rosen members joined Pro Familia, and once they had the majority in the Berlin
affiliate, they voted its president—a physician opposed to legal abortion—out of office.\textsuperscript{72}

Clinic staff noticed a need for contraceptive information among immigrant women, when these women started to attend pregnancy crisis counseling in disproportionately high numbers.\textsuperscript{73} Therefore, in 1978, Pro Familia published glossy brochures in five foreign languages—Turkish (see Figure 5), Italian Spanish, Portuguese and Croatian—to inform women about contraceptives and abortion.\textsuperscript{74} Compared to the Spanish-language brochures in the United States, the brochure for Spanish guest workers in Germany used accurate technical terms for contraceptives in Iberian Spanish or direct translations from German, and presented a wide range of contraceptives to choose from.\textsuperscript{75} All brochures showed families in modern clothes and more modern contexts than the American brochures did. Rather than transmitting the negative narrative that unplanned families caused hunger and poverty, the well-dressed smiling children conveyed the positive message that family planning produces happy modern families.

Clinics in Berlin and Hamburg also hired Turkish interpreters and nurses.\textsuperscript{76} In 1978, the Berlin Kreuzberg clinic became the first to set up special counseling for immigrant women.\textsuperscript{77} With financial support from the Federal Agency for Health Education, it conducted an experiment to counsel Turkish-origin women in their homes in 1981.\textsuperscript{78} Two female Pro Familia counsellors (who were either trained social workers or physicians), a sociologist as a participant observer

\begin{itemize}
\item \textsuperscript{72} Ilse Brandt, Letter to Hermann Hummel-Liljegren (April 2, 1979), in BArch N 1336/249.
\item \textsuperscript{73} See PRO FAMILIA, “Konzeption für ein Programm zielgruppenorientierter Familienplanungsberatung” (May 1981), BArch N 1336/605.
\item \textsuperscript{74} “Familienplanung — Warum — Womit? Deutschsprachige Arbeitsvorlage” (1978), BArch N1336/605.
\item \textsuperscript{75} “Planificación familiar ¿Por qué y Cómo?” BArch N1336/605.
\item \textsuperscript{76} See “Familienplanungszentrum Hamburg Erfahrungsbericht 82,” BArch N 1336/757, 26.
\item \textsuperscript{77} Ilse Brandt, Letter to Hermann Hummel-Liljegren (April 2, 1979), BArch N 1336/249.
\item \textsuperscript{78} Getrud Tietze, “Jahresbericht zum Modellprojekt Familienplanung für Ausländer. Familienplanung bei türkischen Frauen in ihrer Wohnung” (December 1981), BArch N 1336/870.
\end{itemize}
and a Turkish interpreter would arrange a visit to the home of a Turkish-origin client. That woman would invite her mother-in-law and other female relatives to the meeting and they would have an informal chat about reproduction. The interpreter guided the conversation, while the German-origin counselors took a passive role. If a woman reported a specific problem (such as infertility or fear of being pregnant), they would arrange an appointment at the Pro Familia clinic later on.

Pro Familia based this practice on the feminist concept of consciousness-raising, where women gathered to relate their own experiences in order to raise awareness about their oppression as women. Here, the informal gatherings served not to raise political awareness, but to circulate information about contraception and available counseling. At the same time, by asking women to invite members of their extended families, it drew on traditional knowledge transmission through family networks.

Through the trial, Pro Familia met with 78 Turkish-origin women and learned that most of them had—and wanted—two children. Many requested help with problems not directly related to reproduction, such as conflicts at work or with landlords. 60 out of 78 women used some kind of birth control; the rest were either pregnant, wanted to be pregnant, were not in a relationship or in menopause; only three women did not practice family planning at all. Among the women, the pill was by far the most popular method, followed by the withdrawal method, often used when women experienced side effects of the pill. Women and their partners were concerned about side effects, but did not seem to be aware of the feminist debates on this topic. A surprisingly large number had had abortions, most of them illegally in Turkey before the legal reform in Germany in 1976. One woman also reported that she regularly went to Turkey to get Depo Proveda — a long-term hormonal contraceptive that Germany had not approved yet. This shows that women — even those who were linguistically and religiously isolated — had some form of knowledge about family planning and desired to keep their families small. They knew about some modern contraceptives as well as outdated practices, and they were able to access methods in their home country that were unavailable in the host country either through formal or informal networks. Some of these methods were unreliable and unsafe from the counselors’ standpoint, but they still showed that immigrant women actively planned their families, had knowledge of procreation and chose the methods that seemed most practical to them.

79 For the role of Turkish German family homes as the gathering place of extended relatives, see Vierra, Turkish, 79.
81 Tietze, “Jahresbericht,” 35.
82 Ibid.
Pro Familia Berlin concluded that in order to reach Turkish immigrants, they had to assist with housing and economic difficulties as well as reproductive questions. It seemed impossible for them to make contact with Turkish women’s groups unless they found a client that was willing to invite them. Therefore, Pro Familia suggested reaching out in teams of two, one German and one Turkish counselor. The Turkish counselor did not need to have a professional degree, but should be more than just an interpreter. She should take the initiative and guide the conservation. The German counsellor should be a trained social worker or physician and offer expertise when needed. In this way, Pro Familia’s approach was similar to the San Antonio birth preparation classes, as immigrants took the lead and native-born professionals provided expertise when required. The major difference was that the German-Turkish model focused on women only, while US-Mexican model explicitly included men.

V. Conclusion

Immigrant families moved into the focus of American family planners in the 1950s, at a time when curbing global population growth was the underlying motive. In West Germany, as immigrants were perceived as single and transient, immigrant families slipped under the radar of family planning clinics until they appeared in abortion counseling in the late 1970s.

Brochures that addressed Spanish-speaking immigrants in the United States picked up current trends in family-planning campaigns such as the promise of affluence through planned families and the dangers of an unwanted child. They approached immigrant families from a top-down perspective, used simplified and inaccurate language, and referred potential clients to doctors in family planning clinics for more precise information. In this way, they disseminated only the most basic knowledge about the concept of family-planning and failed to pass on essential information on contraceptives and their side effects. Activists in the civil rights and feminist movements of the late 1960s began to question these practices and demanded full disclosure about the side effects of oral contraceptives. Chicana feminists tested new approaches that combined traditional forms of knowledge dissemination through experienced couples and expert presentations to reach Latino families more effectively.

In West Germany, under the influence of second-wave feminism, family planning clinics started to reach out to immigrant families.
and thus chose similar approaches of using native speakers and informal networks to enter immigrant women’s living rooms. Despite their feminist agenda, they still promised modern and happy families through family planning. They were surprised to learn about Turkish women’s agency in determining their reproductive choices, even when modern family-planning clinics did not reach out to them. This shows that immigrant families, and especially women, were not as ignorant of concepts of family planning as experts often assumed.

As Pro Familia’s findings demonstrate, immigrant women could actively access four types of networks to receive reliable reproductive knowledge in addition to public media reports. These networks can be defined according to their degree of formality, but this distinction does not aim to rank the validity of the knowledge transmitted in these networks. Instead, it highlights differences in the degree of familiarity between various agents of knowledge circulation.

Formal networks consisted of doctors, social workers or lawyers in the host country who had a professional, distant relation to the individual woman. The problem here was, as the Puerto Rican letter writer pointed out, that doctors often had paternalistic attitudes toward immigrant women and dismissed their complaints. In addition, there was the language problem; specifically, doctors tended to use simple language and therefore did not convey all necessary information. A doctor’s offices could be a place to obtain contraceptives but not necessarily knowledge.

Semi-formal networks comprise voluntary associations like family planners and women’s rights groups, such as Pro Familia or Planned Parenthood, as well as feminist campaigns and Protestant churches that directed immigrants to family planning clinics. Their actors followed a political agenda and often had sympathy with the individual woman. They were the ones active in translating scientific information into the women’s native languages. But, depending on the organization, counsellors could also be biased, as the example of Planned Parenthood’s fight against overpopulation shows. Feminists were more privileged than immigrant women in gaining access to scientific information, but soon they started initiatives that mixed traditional and modern ways of knowledge dissemination.

Informal networks consist of family and friends that have little professional interest but a lot of sympathy for the individual woman. Through such networks Turkish women accessed illegal abortion in
Turkey, and Mexican women learned of over-the-counter contraceptives. This information was not always accurate; it could be ineffective or even dangerous at times. While in the 1950s Planned Parenthood warned against relying on those networks, since the late 1960s they productively started to work with them as a means of spreading information about where to obtain expert knowledge or to legitimize experts who came into immigrant communities.

Formal networks in the home country, finally, allowed Turkish women, for instance, to obtain contraceptives from doctors in Turkey; likewise, Puerto Rican family planners published brochures for emigres. With technological progress, the networks in the home countries became more easily accessible; women could travel home more frequently and consume media from their home countries thanks to the rise of satellite television in the 1980s. Today, migrants can more easily find information about birth control in their native languages online or even import contraceptives.

Yet, historically, immigrant women especially had problems accessing formal knowledge networks in their host countries due to stereotypes, linguistic problems and structural racism. Civil society networks were often well meaning but contributed to stereotypical attitudes and biases about overpopulation. As a result, informal networks in the host country and formal networks in the home country were extremely important actors in disseminating reproductive knowledge. They helped immigrant women gain agency to determine their reproduction and to have the number of children they wanted. As women became more fluent in the host countries’ language, they began to access formal networks more easily and to adjust the number of their children to the host countries’ ideal. Thus, knowledge and language became important factors that helped immigrant families approach the family ideal of the host country.

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