Robert Kistner that a diaphragm might exert a protective effect against possible penile infection with the virus.

Two months later the FDA's committee held its own meeting on the pill and cervical cancer in situ. Following the session, the committee issued a statement saying that "the data now available do not confirm or refute a causal relation between hormonal contraceptives and cervical carcinoma (a precancerous condition) in situ. The committee recommends periodic medical examination of patients receiving oral contraceptives, including repeated examinations of the breasts and regular Pap smears at six- or 12-month intervals."

One leading cancer epidemiologist summed up what may turn out to be a consensus. "By itself, neither the Melamed-Dubrow nor the Wied study is convincing. But when several studies are all alike, there may be fire. We're worried about it. We don't want to sweep it under the rug, but we don't want to scare women all over the world unless there's something to it."

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ORAL CONTRACEPTIVES: GOVERNMENT-SUPPORTED PROGRAMS ARE QUESTIONED

(By Marti Mueller)

Last year a VISTA volunteer in Alaska watched in dismay as an Eskimo woman being treated in a federally financed birth-control center was handed a sack of oral contraceptives, given no counseling on how to take them, and told to come back in a year.

At a time when questions are being raised about the safety of the pill, the federal government has become one of the major distributors of the oral contraceptive in family-planning programs for the poor. Some doubts have been expressed about how safely these programs are administered. Officials within the Food and Drug Administration (FDA) have suggested in the past, for example, that its parent, the Department of Health, Education, and Welfare (HEW) has been lenient in monitoring side effects and adverse reactions to the pill and in supervising general medical health standards in its own programs. One reason for such shortcomings, if they exist, may be that, while HEW programs are federally financed, many are administered on the local level by states, cities, and private organizations, and, as former HEW Assistant Secretary Philip Lee has said, "in many cases we are buying into the existing program."

Lee also commented to *Science* that the quality of care for the poor in the United States is well below what it should be. "We thought we were doing much better than we are doing," Lee said. "The poor were not getting adequate care, either therapeutic or diagnostic." Lee who was named this week to be chancellor of the University of California Medical Center, estimates there are 5 million women of child-bearings age at or below the poverty level in the United States. He told *Science* that giving medically supervised family-planning guidance to the entire 5 million would cost about $30 per woman, or about $150 million in all. (This year Congress appropriated about $50 million for birth control programs for the poor, which now serve about a million women.) Many federal family-planning programs are financed in part by the Office of Economic Opportunity (OEO) and by HEW. Some of these programs are operated under such services as Medicaid, Aid to Families with Dependent Children (AFDC), and maternal and child health services. They operate in the slums of large cities and in economically depressed rural areas where doctors are few and facilities often minimum. Other government agencies also provide family-planning services (the Department of Defense purchases and provides pills for about 200,000 military dependents, and AID provides an estimated 14 million women with contraceptives of all kinds in its programs abroad). But the major domestic effort to reach the poor has been through HEW and OEO.

FDA's concern over HEW programs has been focused primarily on HEW's administration of the oral contraceptive. While there is no federal regulatory agency with power to ensure that the pill is dispensed safely, FDA does set distribution standards, and some of its members feel HEW has made "pale"