growing number of uninsured and underinsured individuals, undue emphasis on technical interventions and increasing neglect of the human side of caring, high administrative costs and outrageous profits, care that is too often of poor quality and delivered in inappropriate settings, and financial incentives for doctors that set them at odds with patients. National health insurance offers an affordable option for universal access without punitive restrictions. ☐

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The Quality of Data Reported on Birth Certificates

The letter by Kirby[1] recommending a moratorium on the publication of statistical analyses based on the check-box items from birth certificates was stimulated by an article by Watkins et al.[2] The check-box format was adopted in the 1989 revision of the US standard certificate of live birth because previous efforts to obtain information via open-ended questions had resulted in inappropriate, inconsistent, and incomplete entries, along with underreporting.[3,4] Data from check-box items have been used to accurately monitor changes in attendant and place of delivery, changes in cesarean delivery and vaginal birth after cesarean delivery, and patterns of tobacco use among pregnant women.[5–7] Despite the new format, Watkins et al. corroborated our own analyses indicating that check boxes have not overcome the problems inherent in detecting and reliably recording congenital anomalies as part of the birth registration process.

Watkins and her colleagues do an excellent job of pointing out the limitations of information about congenital anomalies reported on birth certificates. The key problem is substantial underreporting of birth defects on the birth certificate. Watkins et al. conclude that for even the most obvious anomalies, the birth certificate is not a good source of such information.

Despite its shortcomings, we agree with Watkins et al. that information about congenital anomalies from the birth certificate can be used "as long as one remains cognizant of the limitations," and we also agree that birth certificate data provide "at least low-end estimates of birth defect rates." Moreover, the information reported has been shown to be useful for identifying populations at risk and for suggesting avenues of more in-depth research, although the data are probably not adequate for case–control studies. We therefore continue to recommend that information about congenital anomalies from birth certificates be used with great caution. The severe limitations of the check-box format in terms of congenital anomalies do not apply to other check-box items, and the recommendation of a moratorium is unwarranted.

The vital statistics system operated by the National Center for Health Statistics (NCHS) and its state partners is in transition; electronic birth registration has become common, and the periodic process of revising the US standard certificate of live birth will soon begin. One challenge to the National Vital Statistics System is the fact that hospital stays for delivery have shortened, sharply reducing the time available to collect the information needed to complete the birth certificate. However, meeting these challenges in a way that ensures data quality and completeness is a high priority of NCHS and the states. ☐

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Ethical and Health Implications of Directive Counseling on Long-Acting Contraception

Moskowitz and Jennings[1] propose to override widely accepted principles of informed consent, according to which clients have the right to make their own decisions about contraception in an unpressured atmosphere.[2] These principles form the basis of the declarations on reproductive health and rights adopted at the international conferences recently held in Cairo and Beijing.[3] Instead, the authors suggest adopting a medical model based on a counselor's judgment that long-acting contraception is in a woman's "best interest." In our opinion, the only people capable of asserting their best interests are clients themselves.

The proposal ignores lessons of history in the international family planning field. As one example, recent work has demonstrated that a "cafeteria approach" with contraceptives is more successful than restricting methods[4] (whether through nonavailability or directive counseling).

To reduce unwanted pregnancy and improve reproductive health, we would, first, strongly advocate risk reduction counseling for men, unconventional but critically important clients in family planning settings. Recent work in both the family planning and acquired immunodeficiency syndrome (AIDS) prevention fields is turning toward the man's role, and communication between partners, to achieve long-term protective behaviors in a couple.[5]

Second, we would support greater education about postconception techniques when prevention fails (emergency contraception and abortion).

Third, we would urge a renewed focus in family planning clinics on preventing disease. The chasm between family planning and human immunodeficiency virus (HIV)/sexually transmitted disease care providers must be bridged in order to give women access to the full gamut of reproductive health services in one visit.[6,7] There are many good reasons why this integration should be located in the family planning clinic.[8]

Moskowitz and Jennings maintain that directive counseling on long-acting contraceptives is designed for women's own protection from risk. They would do well to ask themselves, "Risk of what?" Although they touch briefly on the role of condoms in family planning clinics, they fail to address the concrete scenario of a woman at high risk for both HIV/sexually transmitted dis-