Population Policy for Americans: Is the Government Being Misled?

Population limitation by means of federally aided birth-control programs for the poor is questioned.

Judith Blake

Pressure on the federal government for "action" to limit population growth in the United States has intensified greatly during the past 10 years, and at present such action is virtually unchallenged as an official national goal. Given the goal, the question of means becomes crucial. Here I first evaluate the particular means being advocated and pursued in public policy, then I present alternative ways of possibly achieving the goal.

The prevailing view as to the best means is remarkably unanimous and abundantly documented. It is set forth in the 17 volumes of congressional hearings so far published on the "population crisis" (*1*); in "The Growth of U.S. Population," a report by the Committee on Population of the National Academy of Sciences (*2*); in a statement made by an officer of the Ford Foundation who was asked by the Department of Health, Education, and Welfare to make suggestions (*3*); and, finally, in the "Report of the President's Committee on Population and Family Planning," which was officially released this past January (*4*). The essential recommendation throughout is that the government should give highest priority to ghetto-oriented family-planning programs designed to "deliver" birth-control services to the poor and uneducated, among whom, it is claimed, there are at least 5 million women who are "in need" of such federally sponsored birth-control assistance.

By what logic have the proponents of control moved from a concern with population growth to a recommendation favoring highest priority for poverty-oriented birth-control programs? First, they have assumed that fertility is the only component of population growth worthy of government attention. Second, they have taken it for granted that, to reduce fertility, one sponsors birth-control programs ("family planning"). Just why they have made this assumption is not clear, but its logical implication is that population growth is due to births that couples would have preferred to avoid. Furthermore, the reasoning confuses couple control over births with societal control over them (*5*). Third, the proponents of the new policy have seized on the poor and uneducated as the "target" group for birth-control action because they see this group as the only remaining target for a program of voluntary family planning. The rest of the population is handling its family planning pretty well on its own: over 95 percent of fecund U.S. couples already either use birth-control methods or intend to do so. The poor, on the other hand—at least those who are fecund—have larger families than the advantaged; they not only use birth-control methods less but they use them less effectively. The family-planning movement's notion of "responsible parenthood" carries the implication that family size should be directly, not inversely, related to social and economic advantage, and the poor are seen as constituting the residual slack to be taken up by the movement's efforts. Why are the poor not conforming to the dictates of responsible parenthood? Given the movement's basic assumptions, there are only two answers: the poor are irresponsible, or they have not had the opportunity. Since present-day leaders would abhor labeling the poor irresponsible, they have chosen to blame lack of opportunity as the cause. Opportunity has been lacking, in their eyes, either because the poor have not been "educated" in family planning or because they have not been "reached" by family-planning services. In either case, as they see it, the poor have been deprived of their "rights" (*2*, p. 22; *6*). This deprivation has allegedly been due to the prudery and hypocrisy of the affluent, who have overtly tabooed discussion of birth control and dissemination of birth-control materials while, themselves, covertly enjoying the benefits of family planning (*7*).

So much for the logic underlying recent proposals for controlling population growth in the United States. But what is the evidence on which this argument is based? On what empirical grounds is the government being asked to embark on a high-priority program of providing contraceptive services to the poor? Moreover, what, if any, are some of the important public issues that the suggested policy raises—what are its social and political side effects? And, finally, is such a policy, even if appropriate for the poor and even if relatively unencumbered by public disapproval, relevant to the problem of population growth in America? If demographic curtailment is really the objective, must alternative policies be considered and possibly given highest priority?

Turning to the alleged need for government-sponsored birth-control services, one may ask whether birth control has in fact been a tabooed topic among the middle and upper classes, so that the less advantaged could be said to have suffered "deprivation" and consequently now to require government help. One may then question whether there is a mandate from the poor for the type of federally sponsored service that is now being urged, and whether as many as 5 million women are "in need" of such family-planning assistance.

Has Birth Control Been a Tabooed Topic?

The notion that the American public has only recently become willing to tolerate open discussion of birth control has been assiduously cultivated by congressmen and others concerned with government policy on population. For example, Senator Tydings credited Senators Gruening and Clark and Presi-

The author is chairman of the Department of Demography, University of California, Berkeley.

dent Johnson with having almost single-handedly changed American public attitudes toward birth control. In 1966 he read the following statement into the 28 February *Congressional Record* (*8*).

> The time is ripe for positive action. Ten years ago, even five years ago, this was a politically delicate subject. Today the Nation has awakened to the need for Government action.
>
> This change in public attitude has come about through the efforts of men who had the courage to brook the tides of public opinion. Senator Clark is such a man. Senator Gruening is such a man. So is President Johnson. Because of their leadership it is no longer necessary for an elected official to speak with trepidation on this subject.

A year later, Senator Tydings reduced his estimate of the time required for the shift in public opinion to "3 or 4 years" (*9*, p. 12; *10*). Senator Gruening maintained (*11*) that the "ninety-eight distinguished men and women" who testified at the public hearing on S. 1676 were "pioneers" whose "names comprise an important honor roll which historically bears an analogy to other famous lists: the signers of the Declaration of Independence, those who ratified the Constitution of the United States and others whose names were appended to and made possible some of the great turning points in history." Reasoning from the continued existence of old, and typically unenforced, laws concerning birth control (together with President Eisenhower's famous anti-birth-control statement), Stycos, in a recent article (*12*), stated:

> The public reaction to family planning in the United States has varied between disgust and silent resignation to a necessary evil. At best it was viewed as so delicate and risky that it was a matter of "individual conscience." As such, it was a matter so totally private, so sacred (or profane), that no external agents, and certainly not the state, should have anything to do with it.

Does the evidence support such impressionistic claims? How did the general public regard government sponsorship of birth control long before it became a subject of congressional hearings, a National Academy report, and a Presidential Committee report? Fortunately, a question on this topic appeared in no less than 13 national polls and surveys conducted between 1937 and 1966. As part of a larger project concerned with public knowledge and opinions about demographic topics, I have gathered together the original data cards from these polls, prepared them for computer processing, and analyzed the results. The data are all from Gallup polls and are all from national samples of the white, adult population. Here I concentrate on adults under 45—that is, on adults in the childbearing age group.

Table 1. Percentages of white U.S. men and women between the ages of 21 and 44 who, in various national polls and surveys made between 1937 and 1964*, expressed the opinion that birth-control information should be made available to individuals who desired it.

Year	Men		Women	
	%	N	%	N
1937	66	1038	70	734
1938	67	1111	72	548
1939	74	1101	73	630
1940	72	1127	75	618
1943	67	628	73	866
1945	64	714	70	879
1947	76	353	75	405
1959	78	301	79	394
1961	82	336	81	394
1962	85	288	80	381
1963	78	323	79	373
1964	89	324	86	410

* The questions asked of respondents concerning birth control were as follows. In 1937: Do you favor the birth control movement? In 1938, 1939, 1940, 1943, 1945, and 1947: Would you like to see a government agency (or "government health clinics") furnish birth-control information to married people who want it? In 1959, 1961, 1962, and 1963: In some places in the United States it is not legal to supply birth-control information. How do you feel about this—do you think birth-control information should be available to anyone who wants it, or not? In 1964: Do you think birth-control information should be available to anyone who wants it, or not?

The data of Table 1 contradict the notion that Americans have only recently ceased to regard birth control as a tabooed topic. As far back as 30 years ago, almost three-quarters of the women questioned in these surveys actively approved having the *government* make birth-control information available to the married. By the early 1960's, 80 percent or more of women approved overcoming legal barriers and allowing "anyone who wants it" to have birth-control information. The figures for men are similar. The question asked in 1964—the one question in recent years that did not mention illegality—brought 86 percent of the women and 89 percent of the men into the category of those who approved availability of birth-control information for "anyone who wants it." Furthermore, in judging the level of disapproval, one should bear in mind that the remainder of the respondents, in all of these years, includes from 7 to 15 percent who claim that they have "no opinion" on the subject, not that they "disapprove."

An important difference of opinion corresponds to a difference in religious affiliation. Among non-Catholics (including those who have "no religion" and do not attend church) approval has been considerably higher than it has been among Catholics. Among non-Catholic women, over 80 percent approved as early as 1939, and among non-Catholic men the percentages were approximately the same. The 1964 poll showed that 90 percent of each sex approved. Among Catholics, in recent years about 60 percent have approved, and, in 1964, the question that mentioned neither the government nor legality brought opinions of approval from 77 percent of the women and 83 percent of the men.

Clearly, if birth-control information has in fact been unavailable to the poor, the cause has not been a generalized and pervasive attitude of prudery on the part of the American public. Although public officials may have misjudged American opinion (and may have mistakenly assumed that the Catholic Church "spoke for" a majority of Americans, or even for a majority of Catholics), most Americans of an age to be having children did not regard birth control as a subject that should be under a blanket of secrecy and, as far back as the 1930's, evinced a marked willingness to have their government make such information widely available. It seems unlikely, therefore, that poorer sectors of our population were "cut off" from birth-control knowledge primarily because informal channels of communication (the channels through which most people learn about birth control) were blocked by an upper- and middle-class conspiracy of silence.

What has happened, however, is that pressure groups for family planning, like the Catholic hierarchy they have been opposing, have been acting as self-designated spokesmen for "public opinion." By developing a cause as righteous as that of the Catholics (the "rights" of the poor as against the "rights" of a religious group), the family planners have used the American way of influencing official opinion. Now public officials appear to believe that publicly supported birth-control services are what the poor have always wanted and needed, just as, in the past, official opinion acceded to the notion that such services would have been "offensive" to certain groups. Nonetheless, the question remains of whether

Table 2. Mean number of children considered ideal by non-Catholic women, according to education and economic status, for selected years between 1943 and 1968.

Date	Age range	Level of education*			Income or economic status†				Total respondents	
		College	High school	Grade school	1	2	3	4	$\bar{X}$	N
1943	20–34	2.8	2.6	2.6	2.9	2.7	2.7	2.5	2.7	1893
1952	21 +	3.3	3.1	3.6	3.3		3.3	3.3	3.3	723
1955‡	18–39	3.1	3.2	3.7	3.2	3.1	3.2	3.5	3.3	1905
1955§	18–39	3.3	3.4	3.9	3.4	3.3	3.4	3.7	3.4	1905
1957	21 +	3.4	3.2	3.6	3.3		3.2	3.5	3.3	448
1959	21 +	3.5	3.4	3.9	3.5		3.5	3.6	3.5	472
1960‡	18–39	3.1	3.2	3.5	3.1	3.2	3.3	3.2	3.2	1728
1960§	18–39	3.2	3.4	3.6	3.2	3.3	3.5	3.4	3.4	1728
1963	21 +	3.2	3.4	3.5	3.3	3.3	3.5	3.5	3.4	483
1966	21 +	3.1	3.3	3.7	3.2	3.2	3.4	3.7	3.3	374
1967	21 +	3.1	3.3	3.4	3.3	3.2	3.1	3.4	3.3	488
1968	21 +	3.2	3.3	3.7	3.2	3.0	3.4	3.6	3.3	539

* Level of education is measured by the highest grade completed. † Levels 1 to 4 for economic status range in order from "high" to "low." ‡ Minimum ideal (results from coding range answers to the lowest figure). § Maximum ideal (results from coding range answers to the highest figure).

or not publicly supported services are actually appropriate to the attitudes and objectives of the poor and uneducated in matters of reproduction. Is the government responding to a mandate from the poor or to an ill-concealed mandate from the well-to-do? If there is no mandate from the poor, the provision of birth-control services may prove a convenience for certain women but is likely to have little effect on the reproductive performance of the poor in general. Let us look at the evidence.

Is There a Mandate from the Poor?

The notion that the poor have larger families than the affluent only because they have less access to birth-control information implies that the poor *desire* families as small as, or smaller than, those of the well-to-do. The poor are simply unable to realize this desire, the argument goes, because of lack of access to birth-control information. The National Academy of Sciences Committee on Population stated the argument very well (*2*, p. 10).

> The available evidence indicates that low-income families do not want more children than do families with higher incomes, but they have more because they do not have the information or the resources to plan their families effectively according to their own desires.

The committee, however, presents none of the "available evidence" that "low-income families do not want more children than do families with higher incomes." Actually, my data supply evidence that runs counter to the statement quoted above, both with respect to the desired or ideal number of children and with respect to attitudes toward birth control.

I shall begin with the preferred size of family. A number of national polls, conducted over some 25 years, provide data concerning opinions on ideal family size. In addition, I include tabulations of data from two national surveys on fertility (the "Growth of American Families Studies"), conducted in 1955 and 1960 (*13, 14*). My detailed analyses of the results of these polls and surveys are given elsewhere (*15*) and are only briefly summarized here. Table 2 gives mean values for the family size considered ideal by white, non-Catholic women, according to education and economic status.

The data lend little support to the hypothesis that the poor desire families as small as those desired by the middle and upper classes. Within both the educational and the economic categories, those on the lower rungs not only have larger families than those on the higher rungs (at least in the case of non-Catholics) but say they want larger families and consider them ideal. This differential has existed for as long as information on preferred family size in this country has been available, and it persists. It thus seems extremely hazardous to base a major governmental effort on the notion that, among individuals (white individuals, at least) at the lower social levels, there is a widespread and deeply held desire for families as small as, or smaller than, those desired by the well-to-do. No major survey shows this to be the case.

Not only do persons of lower socioeconomic status prefer larger families than the more affluent do, they also generally favor birth control less. Tables 3 and 4 show the percentages of white men and women who expressed approval of birth control in surveys made between 1937 and 1964, by educational level and economic status, respectively.

Looking at the educational differential (Table 3), one finds that, in general, the proportion of those who approve birth control drops precipitately between the college and grade school levels. As far back as the early 1940's, over 80 percent of women and 75 percent of men with some or more college education approved government action on birth control. By 1964, over 90 percent of both sexes approved. By contrast, only 60 percent of men and women with an elementary school education approved in the 1940's, and, despite a rise in approval, there is still a differential. When non-Catholics alone are considered, the educational difference is even more pronounced in many cases.

Turning to economic or income status (Table 4), one generally finds the same results. The high proportions (close to 100 percent) of women in the highest and next-to-highest economic brackets who, in recent years, have approved birth-control efforts is noteworthy, as is the fact that approximately 80 percent of women in these brackets approved such efforts as far back as the 1930's. On the other hand, men and women in lower income brackets have been slower to approve birth-control policies.

Despite the inverse relationship just described, I may have overemphasized the lesser approval of birth-control programs on the part of persons of lower economic and social status. After all, in recent years approval often has been high even among people at the lowest social levels. Among women with only a grade school education, the percentage of those favoring birth-control programs averaged 73 percent in polls taken between 1959 and 1964; among men at the lowest educational level, the corresponding average was 66 percent. Yet it is undeniably true that, throughout the period for which data are available, the people who needed birth-control information most, according to recent policy pronouncements, have been precisely the ones who were least in favor of a policy that would make it widely available.

The truth of this conclusion becomes more evident when we move to an analysis of a question asked on the

Table 3. Percentages of white U.S. men and women between the ages of 21 and 44 who, in various national polls taken between 1943 and 1964, expressed the opinion that birth-control information should be made available to individuals who desired it. The percentages are given by level of education*; the numbers in parentheses are total numbers of respondents in each category.

Year	Men			Women		
	College	High school	Grade school	College	High school	Grade school
1943	75 (184)	68 (284)	56 (157)	82 (216)	74 (442)	60 (207)
1945	74 (202)	62 (360)	58 (140)	83 (216)	68 (434)	56 (207)
1947	91 (84)	72 (199)	67 (66)	81 (89)	74 (228)	72(81)
1959	88 (89)	76 (163)	65 (49)	91 (55)	79 (279)	68 (41)
1961	88 (102)	81 (188)	67 (46)	84 (81)	81 (265)	78 (50)
1962	91 (93)	85 (171)	61 (23)	84 (79)	82 (258)	66 (44)
1963	86 (105)	79 (178)	53 (40)	81 (80)	78 (251)	81 (42)
1964	92 (107)	88 (188)	83 (29)	94 (79)	86 (293)	74 (38)

* The level of education is measured by the last grade completed.

1966 Gallup poll: Do you think birth-control pills should be made available free to all women on relief who are of childbearing age? This question presents the public with the specific issue that is the focus of current policy—namely, birth control especially for the poor. A summary of the replies to this question is given in Table 5, together with average percentages of people who, in the five surveys made between 1959 and 1964, replied that they approved birth control generally.

It is clear that the overall level of approval drops when specific reference to a poverty-oriented birth-control policy is introduced. The decline is from an average of approximately 80 percent for each sex during the period 1959–64 to 65 percent for men and 71 percent for women in 1966. Of most significance, however, is the fact that the largest proportionate drop in approval occurs among members of the "target" groups themselves—the poor and uneducated. In particular, there is a remarkable drop in approval among men at this socioeconomic level. There is a 42-percent decline in approval among men who have had only a grade school education and a 29-percent drop among those with a high school education. Among the college-educated men the drop in approval is only 6 percent. The results, by income, parallel those by education: there is a 47-percent drop for men in the lowest income group but only a 9-percent drop for those in the highest income bracket. Even if the tabulations are restricted to non-Catholics (data that are not presented here), the results are essentially the same.

If the ghetto-oriented birth-control policy urged on the federal government meets with limited public enthusiasm, how does the public view extension of that policy to teen-age girls? This question is of some importance because a notable aspect of the pressure for government-sponsored family-planning programs is advocacy of making birth-control information and materials available at the high school level.

The Committee on Population of the National Academy of Sciences urges early education in "family planning" in order to prevent illegitimacy (*2*, p. 13).

> . . . government statistics show that the mothers of approximately 41 per cent of the 245,000 babies born illegitimately in the United States every year are women 19 years of age or younger. Thus a large proportion of all illegitimate children are progeny of teen-age mothers. To reduce the number of such children born to teen-age mothers, high-school education in family planning is essential.

Katherine B. Oettinger, Deputy Secretary for Family Planning of the Department of Health, Education, and Welfare, importunes us not to "demand the eligibility card of a first pregnancy before we admit vulnerable girls to family planning services" (*16*). The Harkavy report states (*3*, p. 29):

> Eligibility requirements should be liberal with respect to marital status. Such services should be made available to the unmarried as well as the married. . . . Eligibility requirements should be liberal with respect to the age of unmarried women seeking help. This will undoubtedly pose some problems, but they may not be insurmountable. Some publically supported programs are already facing them (for example, in Baltimore).

Representative Scheuer from New York has berated the federal government for not "bringing family planning into the schools." He has cited the "desperate need for family planning by unmarried 14-, 15-, and 16-year-old girls in school [which] is so transparently evident that it almost boggles the imagination to realize that nothing has been done. Virtually no leadership has come from the federal government" (*9*, p. 18).

Obviously there is little recognition in these statements that such a policy

Table 4. Percentages of white U.S. men and women between the ages of 21 and 44 who, in various national polls taken between 1937 and 1964, expressed the opinion that birth-control information should be made available to individuals who desired it. The percentages are given by economic status (levels 1–4*); the numbers in parentheses are total numbers of respondents in each category.

Year	Men				Women			
	1	2	3	4	1	2	3	4
1937	78 (112)	70 (406)	61 (520)		67 (69)	78 (293)	64 (372)	
1938	65 (125)	74 (453)	62 (521)		80 (51)	73 (232)	70 (259)	
1939	78 (116)	75 (432)	73 (553)		71 (68)	77 (260)	71 (302)	
1940	79 (131)	75 (443)	68 (553)		80 (49)	78 (258)	71 (311)	
1943	76 (80)	72 (219)	62 (330)		80 (90)	79 (272)	68 (500)	
1945	73 (67)	66 (286)	62 (352)		83 (75)	77 (264)	64 (531)	
1947	86 (42)	77 (123)	72 (188)		92 (38)	71 (119)	73 (237)	
1959	83 (101)	76 (120)	73 (79)		83 (139)	82 (152)	72 (95)	
1961	93 (42)	85 (80)	87 (103)	69 (111)	88 (41)	80 (97)	80 (76)	81 (138)
1962	82 (45)	89 (71)	86 (94)	80 (74)	82 (51)	80 (75)	84 (110)	77 (140)
1963	88 (60)	84 (79)	76 (96)	61 (97)	87 (67)	79 (107)	79 (98)	75 (100)
1964	90 (67)	87 (26)	93 (82)	85 (79)	96 (90)	90 (87)	85 (104)	78 (120)

* Levels 1 to 4 for the years 1961–64 range from income of $10,000 and over down to incomes under $5000. Prior to 1961, levels 1 to 3 represent "upper," "middle," and "lower" income brackets.

Table 5. Percentages of white U.S. men and women between the ages of 21 and 44 who, in a 1966 poll, expressed approval of free distribution of birth-control pills for women on relief, and average percentages of individuals in this age group who, in polls taken between 1959 and 1964, expressed approval of birth control. Percentages approving and numbers of individuals interviewed are given as totals and also by education and economic status of the respondents.

Item	Men			Women		
	1966		1959–64 (av. %)	1966		1959–64 (av. %)
	%	N		%	N	
Total	65	264	82	71	385	81
Education						
College	82	98	87	75	197	87
High school	58	142	82	70	392	81
Grade school	38	24	66	59	32	73
Economic status						
1	79	80	89	70	110	87
2	69	75	84	76	99	82
3	59	65	83	70	91	80
4	39	41	74	67	76	78

might engender a negative public response. Yet such a possibility cannot be discounted. The results of the 1966 question "Do you think they [the pills] should be made available to teen-age girls?" suggest that a policy of pill distribution to female adolescents may be viewed by the public as involving more complex issues than the mere democratization of "medical" services. These results, tabulated by social level, are shown in Table 6.

It may be seen that, in general, a proposal for distribution of pills to teen-age girls meets with very little approval. There is more disapproval among women than among men. Even among women under the age of 30, only 17 percent approve; among men in this age group, 29 percent approve. At no age does feminine approval reach 20 percent, and in most cases it is below 15 percent. Furthermore, restriction of the results to non-Catholics does not raise the percentages of those who approve the policy. Most noteworthy is the socioeconomic gradient among men. Whereas 32 percent of college-educated men approve distribution of pills to young girls, only 13 percent of men with a grade school education do. Thirty-three percent of men in the highest income bracket approve, but only 13 percent in the lowest bracket do.

Clearly, the extension of "family planning" to poor, unmarried teen-agers is not regarded simply as "health care." Individuals may approve, in a general way, a wider availability of birth-control information without approving federal expenditure to facilitate a high level of sexual activity by teen-age girls. One suspects that explicit recognition and implied approval of such activity still comes hard to our population, and that it comes hardest to the group most involved in the problems of illegitimacy and premarital conception—namely, the poor and uneducated themselves. The extreme disapproval of a policy of pill distribution to teen-age girls that is found in lower-class groups (particularly among lower-class men) suggests that a double standard of sexual behavior is operative in these groups—a standard that does not allow open toleration of the idea that the ordinary teen-age girl requires the pill, or that a part of her junior high school and high school education should include instruction in its use.

Can "Five Million Women" Be Wrong?

The most widely publicized argument favoring federal birth-control programs, and apparently the one that elected officials find most persuasive, is the claim that there are approximately "five million" poor women "in need" of publicly subsidized birth-control help (*17*). I list below some of the principal assumptions upon which this estimate is based—all of which introduce serious upward biases into the evidence.

1) It is claimed that women at the poverty and near-poverty levels desire families of 3.0 children. While this may be true of nonwhite wives at this economic level, it is not true, as we have seen, of white women, who comprise a major share of the "target" group and who, on the average, desire a number of children closer to 4 (especially if Catholics are included, as they are in the "five million").

2) It is assumed by the estimators that 82 percent of all poor women aged 15 to 44 are at risk of conception (that is, exposed sexually), in spite of the fact that only 45 percent of poor women in this age group are married and living with their husbands. In arriving at the figure of 82 percent, the estimators assumed that all women in the "married" category (including those who were separated from their husbands and those whose husbands were absent) were sexually exposed regularly, and that half of the women in the "nonmarried" category—that is, single, widowed, and divorced women—were exposed regularly. Information is scarce concerning the sexual behavior of widows and divorced women, but Kinsey's data on premarital coitus leads one to believe that the assumption of 50 percent for single women may be high. Among the women with a grade school education in Kinsey's sample, 38 percent had had coitus at some time between the ages of 16 and 20, and 26 percent, at some time between the ages of 21 and 25. Moreover, as Kinsey emphasizes, these encounters were characteristically sporadic (*18*).

3) The proportion of sterile women among the poor is assumed to be 13 percent, although the Scripps 1960 "Growth of American Families Study" showed the proportion among white women of grade school education to be 22 percent (*14*, p. 159).

4) No allowance is made for less-than-normal fecundity, although the Scripps 1960 study (*14*, p. 159) had indicated that, among women of grade school education, an additional 10 percent (over and above the 22 percent) were subnormal in their ability to reproduce.

5) It is taken for granted by the estimators that no Catholic women would object, on religious grounds, to the use of modern methods, and no allowance is made for objection by non-Catholics, on religious or other grounds. In other words, it is assumed that all women "want" the service. Yet, in response to a question concerning the desirability of limiting or spacing pregnancies, 29 percent of the wives with grade school education who were interviewed in the Scripps 1960 study said they were "against" such limitation or spacing (*14*, p. 177). Among the Catholic wives with grade school education, the proportion "against" was 48 percent, although half of these objectors were "for" the rhythm method. Similar objections among the disadvantaged have been revealed by many polls over a long period.

6) Perhaps most important, the estimate of 5 million women "wanting"

and "in need of" birth-control information includes not only objectors but women who are already practicing birth control. Hence, in addition to all the other biases, the estimate represents a blanket decision by the estimators that the women require medical attention regarding birth control—particularly that they need the pill and the coil. In the words of the Harkavy report (*2*, attachment A, p. 19):

> This may be considered a high estimate of the number of women who need to have family planning services made available to them in public clinics, because some of the couples among the poor and near poor are able to exercise satisfactory control over their fertility. However, even these couples do not have the same access as the non-poor to the more effective and acceptable methods of contraception, particularly the pill and the loop. So, simply in order to equalize the access of the poor and the near-poor to modern methods of contraception under medical supervision, it is appropriate to try to make contraceptive services available to all who may need and want them.

Yet the 1960 Scripps study found that, among fecund women of grade school education, 79 percent used contraceptives (*14*, p. 159). The 21 percent who did not included young women who were building families and said they wanted to get pregnant, as well as Catholics who objected to birth control on religious grounds. As for the methods that women currently are using, it seems gratuitous for the federal government to decide that only medically supervised methods—the pill and the coil—are suitable for lower-income couples, and that a mammoth "service" program is therefore required. In fact, the implications of such a decision border on the fantastic—the implications that we should substitute scarce medical and paramedical attention for all contraceptive methods now being used by poor couples.

In sum, the argument supporting a "need" for nationwide, publicly sustained birth-control programs does not stand up under empirical scrutiny. Most fecund lower-class couples now use birth-control methods when they want to prevent pregnancy; in the case of those who do not, the blame cannot simply be laid at the door of the affluent who have kept the subject of birth control under wraps, or of a government that has withheld services. As we have seen, opinion on birth control has been, and is, less favorable among the poor and the less well educated than among the well-to-do. In addition, the poor desire larger families.

Table 6. Percentages of white U.S. men and women who, in a 1966 poll, expressed approval of making birth-control pills available to teen-age girls. Percentages approving and numbers of individuals interviewed are given by age group, by education, and by economic status.

Item	All religions				Non-Catholics			
	Men		Women		Men		Women	
	%	*N*	%	*N*	%	*N*	%	*N*
Age								
Under 30	29	86	17	149	34	65	19	102
30–44	19	172	8	238	20	133	7	169
Education								
College	32	98	15	100	36	75	13	71
High school	18	142	9	264	19	110	9	180
Grade school	13	24	11	35	6	17	14	28
Economic status								
1	33	80	11	113	35	58	11	75
2	20	75	13	105	24	58	14	72
3	19	65	7	94	18	50	5	64
4	13	41	16	82	15	33	14	66

Although it may be argued that, at the public welfare level, birth control has, until recently, been taboo because of the "Catholic vote," most individuals at all social levels have learned about birth control *informally* and without medical attention. Furthermore, the most popular birth-control device, the condom, has long been as available as aspirin or cigarettes, and certainly has been used by men of all social classes. When one bears in mind the fact that the poor have no difficulty in gaining access to illegal narcotics (despite their obvious "unavailability"), and that the affluent had drastically reduced their fertility before present-day contraceptive methods were available, one must recognize and take into account a motivational component in nonuse and inefficient use of contraceptives. Indeed, were relative lack of demand on the part of the poor not a principal factor, it would be difficult to explain why such an important "market" for birth-control materials—legal or illegal—would have escaped the attention of enterprising businessmen or bootleggers. In any event, any estimate based on the assumption that all poor women in the reproductive group "want" birth-control information and materials and that virtually all "need" publicly supported services that will provide them—including women with impaired fecundity, women who have sexual intercourse rarely or not at all, women who object on religious grounds, and women who are already using birth-control methods—would seem to be seriously misleading as a guide for our government in its efforts to control population growth.

Moreover, the proposal for government sponsorship takes no account of the possible advantages of alternative means of reaching that part of the "market" that may not be optimally served at present. For example, competitive pricing, better marketing, and a program of advertising could make it possible for many groups in the population who are now being counted as "targets" for government efforts to purchase contraceptives of various kinds. When one bears in mind the fact that an important reason for nonuse or lack of access to contraceptives may be some sort of conflict situation (between husband and wife, adolescent child and parent, and so on), it becomes apparent that the impersonal and responsive marketplace is a far better agency for effecting smooth social change than is a far-flung national bureaucracy loaded with well-meaning but often blundering "health workers." The government could doubtless play an initial stimulating and facilitating role in relation to private industry, without duplicating, on a welfare basis, functions that might be more efficiently handled in the marketplace.

Would the Policy Have Side Effects?

The possible inadvisability of having the government become a direct purveyor of birth-control materials to poverty groups becomes more clear when we consider some of the risks involved in such a course of action.

Even if the goal of reducing family size were completely and widely accepted by the poorer and less well educated sectors of the population, we should not assume that the general public would necessarily view a policy concerned with the means and practice of birth control (in any social group) as it views ordinary medical care—that is, as being morally neutral and obviously

"desirable." Birth control is related to sexual behavior, and, in all viable societies, sexual behavior is regulated by social institutions. It is thus an oversimplification to think that people will be unmindful of what are, for them at least, the moral implications of changes in the conditions under which sexual intercourse is possible, permissible, or likely. An issue such as distribution of pills to teen-age girls runs a collision course with norms about premarital relations for young girls—norms that, in turn, relate to the saliency of marriage and motherhood as a woman's principal career and to the consequent need for socially created restrictions on free sexual access if an important inducement to marriage is not to be lost. Only if viable careers alternative to marriage existed for women would the lessening of controls over sexual behavior outside of marriage be unrelated to women's lifetime opportunities, for such opportunities would be independent of the marriage market and, a fortiori, independent of sexual bargaining. But such independence clearly does not exist. Hence, when the government is told that it will be resolving a "medical" problem if it makes birth-control pills available to teen-agers, it is being misled into becoming the protagonist in a sociologically based conflict between short-run feminine impulses and long-run feminine interests—a conflict that is expressed both in relations between parents and children and in relations between the sexes. This sociological conflict far transcends the "medical" issue of whether or not birth-control services should be made widely available.

Actually, the issue of sexual morality is only one among many potentially explosive aspects of direct federal involvement in family-planning programs for the poor. Others come readily to mind, such as the possibility that the pill and other physiological methods could have long-run, serious side effects, or that racial organizations could seize on the existence of these programs as a prime example of "genocide." Eager promoters of the suggested programs tend to brush such problems aside as trivial, but the problems, like the issue of sexual morality, cannot be wished away, for they are quite patently there (*9*, p. 62). There *are* risks involved in all drug-taking, and it is recognized that many of the specific ones involved in long-term ingestion of the pill may not be discovered for many years. No one today can say that these are less than, equal to, or greater than the normal risks of pregnancy and childbirth. Equally, a class-directed birth-control program, whatever its intent, is open to charges of genocide that are difficult to refute. Such a program cannot fail to appear to single out the disadvantaged as the "goat," all the while implying that the very considerable "planned" fertility of most Americans inexplicably requires no government attention at all.

Population Policy for Americans

It seems clear that the suggested policy of poverty-oriented birth-control programs does not make sense as a welfare measure. It is also true that, as an inhibitor of population growth, it is inconsequential and trivial. It does not touch the principal cause of such growth in the United States—namely, the reproductive behavior of the majority of Americans who, under present conditions, want families of more than three children and thereby generate a growth rate far in excess of that required for population stability. Indeed, for most Americans the "family planning" approach, concentrating as it does on the distribution of contraceptive materials and services, is irrelevant, because they already know about efficient contraception and are already "planning" their families. It is thus apparent that any policy designed to influence reproductive behavior must not only concern itself with all fecund Americans (rather than just the poor) but must, as well, relate to family-size goals (rather than just to contraceptive means). In addition, such a policy cannot be limited to matters affecting contraception (or even to matters affecting gestation and parturition, such as abortion), but must, additionally, take into account influences on the formation and dissolution of heterosexual unions (*19*).

What kinds of reproductive policies can be pursued in an effort to reduce long-term population growth? The most important step toward developing such new policies is to recognize and understand the existing ones, for we already have influential and coercive policies regarding reproductive behavior. Furthermore, these existing policies relate not merely to proscriptions (legal or informal) regarding certain means of birth control (like abortion) but also to a definition of reproduction as a primary societal end and to an organization of social roles that draws most of the population into reproductive unions.

The existence of such pronatalist policies becomes apparent when we recall that, among human beings, population replacement would not occur at all were it not for the complex social organization and system of incentives that encourage mating, pregnancy, and the care, support, and rearing of children. These institutional mechanisms are the pronatalist "policies" evolved unconsciously over millennia to give societies a fertility sufficient to offset high mortality. The formation and implementation of antinatalist policies must be based, therefore, on an analysis and modification of the existing pronatalist policies. It follows, as well, that antinatalist policies will not necessarily involve the introduction of coercive measures. In fact, just the opposite is the case. Many of these new policies will entail a *lifting* of pressures *to* reproduce, rather than an *imposition* of pressures *not* to do so. In order to understand this point let us consider briefly our present-day pronatalism.

It is convenient to start with the family, because pronatalism finds its most obvious expression in this social institution. The pronatalism of the family has many manifestations, but among the most influential and universal are two: the standardization of both the male and the female sexual roles in terms of reproductive functions, obligations, and activities, and the standardization of the occupational role of women—half of the population—in terms of child-bearing, child-rearing, and complementary activities. These two "policies" insure that just about everyone will be propelled into reproductive unions, and that half of the population will enter such unions as a "career"—a life's work. Each of the two "policies" is worth considering.

With regard to sex roles, it is generally recognized that potential human variability is greater than is normally permitted *within* each sex category. Existing societies have tended to suppress and extinguish such variability and to standardize sexual roles in ways that imply that all "normal" persons will attain the status of parents. This coercion takes many forms, including one-sided indoctrination in schools, legal barriers and penalties for deviation, and the threats of loneliness, ostracism, and ridicule that are implied in the unavailability of alternatives. Individuals who—by temperament, health, or constitution—do not fit the ideal

sex-role pattern are nonetheless coerced into attempting to achieve it, and many of them do achieve it, at least to the extent of having demographic impact by becoming parents.

Therefore, a policy that sought out the ways in which coercion regarding sex roles is at present manifesting itself could find numerous avenues for relieving the coercion and for allowing life styles different from marriage and parenthood to find free and legitimatized expression. Such a policy would have an effect on the content of expectations regarding sex roles as presented and enforced in schools, on laws concerning sexual activity between consenting adults, on taxation with respect to marital status and number of children, on residential building policies, and on just about every facet of existence that is now organized so as exclusively to favor and reward a pattern of sex roles based on marriage and parenthood.

As for the occupational roles of women, existing pressures still attempt to make the reproductive and occupational roles coterminus for all women who elect to marry and have children. This rigid structuring of the wife-mother position builds into the entire motivational pattern of women's lives a tendency to want at least a moderate-size family. To understand this point one must recognize that the desired number of children relates not simply to the wish for a family of a particular size but relates as well to a need for more than one or two children if one is going to enjoy "family life" over a significant portion of one's lifetime. This need is increased rather than lessened by improved life expectancy. Insofar as women focus their energies and emotions on their families, one cannot expect that they will be satisfied to play their only important role for a diminishing fraction of their lives, or that they will readily regard make-work and dead-end jobs as a substitute for "mothering." The notion that most women will "see the error of their ways" and decide to have two-child families is naive, since few healthy and energetic women will be so misguided as to deprive themselves of most of the rewards society has to offer them and choose a situation that allows them neither a life's work outside the home nor one within it. Those who do deprive themselves in this fashion are, in effect, taking the brunt of the still existing maladjustment between the roles of women and the reproductive needs of society. In a society oriented around achievement and accomplishment, such women are exceptionally vulnerable to depression, frustration, and a sense of futility, because they are being blocked from a sense of fulfillment both at home and abroad.

In sum, the problem of inhibiting population growth in the United States cannot be dealt with in terms of "family-planning needs" because this country is well beyond the point of "needing" birth control methods. Indeed, even the poor seem not to be a last outpost for family-planning attention. If we wish to limit our growth, such a desire implies basic changes in the social organization of reproduction that will make nonmarriage, childlessness, and small (two-child) families far more prevalent than they are now. A new policy, to achieve such ends, can take advantage of the antinatalist tendencies that our present institutions have suppressed. This will involve the lifting of penalties for antinatalist behavior rather than the "creation" of new ways of life. This behavior already exists among us as part of our covert and deviant culture, on the one hand, and our elite and artistic culture, on the other. Such antinatalist tendencies have also found expression in feminism, which has been stifled in the United States by means of systematic legal, educational, and social pressures concerned with women's "obligations" to create and care for children. A fertility-control policy that does not take into account the need to alter the present structure of reproduction in these and other ways merely trivializes the problem of population control and misleads those who have the power to guide our country toward completing the vital revolution.

References and Notes

1. *Hearings on S. 1676, U.S. Senate Subcommittee on Foreign Aid Expenditures* (the 1965 and 1966 Hearings each comprise seven volumes; the 1967–1968 Hearings, to date, comprise three volumes) (Government Printing Office, Washington, D.C.).
2. "The Growth of U.S. Population," *Nat. Acad. Sci.–Nat. Res. Council Pub. 1279* (1965).
3. O. Harkavy, F. S. Jaffe, S. S. Wishik, "Implementing DHEW Policy on Family Planning and Population" (mimeographed, 1967; available from the Ford Foundation, New York).
4. "Report of the President's Committee on Population and Family Planning: The Transition from Concern to Action" (Government Printing Office, Washington, D.C., 1968).
5. K. Davis, *Science* **158**, 730 (1967); J. Blake, in *Public Health and Population Change*, M. C. Sheps and J. C. Ridley, Eds. (Univ. of Pittsburgh Press, Pittsburgh, Pa., 1965).
6. In the words of the Committee on Population, "The freedom to limit family size to the number of children wanted when they are wanted is, in our view, a basic human right . . . most Americans of higher income and better education exercise this right as a matter of course, but . . . many of the poor and uneducated are in fact deprived of the right."
7. W. J. Cohen, *Family Planning: One Aspect of Freedom to Choose* (Government Printing Office, Washington, D.C., 1966), p. 2. Cohen, former Secretary of Health, Education, and Welfare, says: "Until a few years ago, family planning and population problems were considered 'hush-hush' subjects. Public discussion was curtailed not only in polite society, but in the legislative and executive branches of the government as well."
8. *Hearings on S. 2993, U.S. Senate Subcommittee on Employment, Manpower, and Poverty, 89th Congress, Second Session, May 10* (Government Printing Office, Washington, D.C., 1966), p. 31.
9. *Hearings on S. 1676, U.S. Senate Subcommittee on Foreign Aid Expenditures, 90th Congress, First Session, November 2* (Government Printing Office, Washington, D.C., 1967), pt. 1.
10. Senator Tydings (D–Md.) said at the Hearings on S. 1676 (see 9): "As recently as 3 or 4 years ago, the idea that Federal, State or local governments should make available family planning information and services to families who could not otherwise afford them was extremely controversial. But in a brief period of time there has been a substantial shift of opinion among the moral leadership of our country, brought about in large measure by the vigorous efforts of the distinguished Senator from Alaska, Ernest Gruening, the chairman of this subcommittee."
11. E. Gruening, "What the Federal Government is now Doing in the Field of Population Control and What is Needed," speech presented before the U.S. Senate, 3 May 1967.
12. J. M. Stycos, in *World Population and U.S. Government Policy and Programs*, F. T. Brayer, Ed. (Georgetown Univ. Press, Washington, D.C., 1968).
13. R. Freedman, P. K. Whelpton, A. A. Campbell, *Family Planning, Sterility and Population Growth* (McGraw-Hill, New York, 1959).
14. P. K. Whelpton, A. A. Campbell, J. E. Patterson, *Fertility and Family Planning in the United States* (Princeton Univ. Press, Princeton, N.J., 1966).
15. J. Blake, *Demography* **3**, 154 (1966); *Population Studies* **20**, 27 (1966); *ibid.* **21**, 159 (1967); *ibid.*, p. 185; *ibid.* **22**, 5 (1968).
16. *Family Planner* **2**, 3 (1968).
17. The estimate (by Arthur A. Campbell) under discussion here may be found in the Harkavy report (see 3, attachment A, pp. 4–19). Another estimate has been circulated by the Planned Parenthood Federation in a brochure entitled *Five Million Women* (Planned Parenthood, New York).
18. A. C. Kinsey, W. B. Pomeroy, C. E. Martin, P. B. Gebhard, *Sexual Behavior in the Human Female* (Saunders, Philadelphia, 1953), pp. 291 and 337.
19. K. Davis and J. Blake, *Econ. Develop. Cult. Change* **4**, 211 (1956).

20. I make grateful acknowledgment to the Ford Foundation for support of the research presented in this article and to the National Institutes of Health (general research support grant 1501-TR-544104) for assistance to Statistical Services, School of Public Health, University of California, Berkeley. I am also indebted to Kingsley Davis, whose critical comments and helpful suggestions have greatly advanced my thinking. The Roper Center and the Gallup Poll kindly supplied me with polling data.