tic and international services, research, and education. Its recommendation on domestic family planning services again was justified, not in terms of population control, but as a health and social measure (1, pp. 15–16) :

"Excessive fertility can drive a family into poverty as well as reduce its chances of escaping it. The frequency of maternal deaths, the level of infant mortality, and the number of children who are chronically handicapped are all markedly greater among the poor than in the rest of the population. One of the most effective measures that could be taken to lower mortality and morbidity rates among mothers and children would be to help the poor to have the number of children they desire."

As for immediate programs to further reduce the incidence of unwanted pregnancy among the rest of the population, the committee recommended (1, p. 15) expansion of biomedical research for improved contraceptive techniques and expansion of social research; increased education in population dynamics, sex, and human reproduction, and improved training programs for physicians and other relevant professionals. It stated explicitly (1, p. 37) that these recommended programs "are only *one* of the important factors that influence population trends," and called for a Presidential Commission on Population to, among other things, "assess the social and economic consequences of population trends in the U.S. . . . [and] consider the consequences of alternative population policies" (1, pp. 37–38).

These reports only reiterate what has been the basic justification for publicly funded family planning services for the poor for more than a decade. The leaders of the U.S family planning movement have not advanced this program as a means of achieving population stability, because it has been evident that the poor and near-poor, who constitute only about one-quarter of the U.S. population, are not the major contributors to U.S. population growth, despite their higher fertility.

Blake believes the U.S. policy should aim toward a zero rate of population growth, as is her right. But she has no right to accuse family planners of misleading the public into believing that extension of family planning to the poor would bring about such population stability—a claim they have never made. Of course, any reduction in births, wanted or unwanted, will result in *less* natural increase and, other things being equal, *less* population growth. Elimination or reduction of unwanted pregnancies among the poor and near-poor would thus reduce *somewhat* the rate of population growth, though not eliminate it entirely (8).

PRUDERY—OR POLITICS?

Another straw man erected by Blake is the assertion that denial of birth control services to the poor has been attributed by advocates of family planning to the "prudery and hypocrisy of the affluent, who have overtly tabooed discussion of birth control and dissemination of birth control materials." As proof that this has not been the case, she cites opinion polls going back to 1937 showing majority support for making birth control information available to those who desire it.

The proof is irrelevant in two major respects. First, the issue is not *information* about birth control, but *availability of services* (a distinction which Blake obscures throughout her article). And second, the operative factor in regard to the poor has not been generalized approval or disapproval, but the policies in regard to provision of contraceptive services of public health and welfare institutions on which the poor depend for medical care. As she notes, it was evident as long ago as the 1930's that most Americans approved of birth control and practiced it in some form (although it was not until the late 1950's that the mass media began to carry relatively explicit birth control material). But this public-opinion base did not control the policies of public institutions or the attitudes of political leaders. In most tax-supported hospitals and health departments there were explicit or implicit prohibitions on the prescription of contraceptive methods and materials, and many states had legislative restrictions which were enforced primarily in public agencies. To change these policies required protracted campaigns, which began in the New York municipal hospitals in 1958 (9), continued in Illinois, Maryland, Pennsylvania, and other states in the early 1960's, and culminated in legislative actions in 1965 and 1966 in at least 15 states and congressional action in 1967 in the Social Security and Poverty legislation.