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COMPARATIVE STUDY OF RELATED HEALTH FERTILITY ATTITUDES AND BEHAVIOR OF FAMILIES RESIDING IN A POVERTY AREA, PITTSBURGH, 1969

by

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CHAPTER I

INTRODUCTION

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CHAPTER I

INTRODUCTION

Since man has been on the earth, there have been many developments that have influenced his thoughts, values, and behavior patterns. Several major developments have tremendously accelerated during the past few centuries and are reaching a culmination in this century. Developments such as the population explosion, the population implosion, population diversification and the accelerated tempo of technological and social change have profoundly affected the family. Since these developments are still going on, they are bound to continue to influence the family during the remainder of the century.

This Country provides a particularly dramatic example of the developments noted above. When the first national census was recorded in 1790, this nation had slightly less than four million people.[1] Now, only one hundred and eighty years later, the U. S. Population had reached approximately

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[1]"The First Time Uncle Sam Counted," U.S. Department of Commerce, Bureau of the Census, pp. 1-2.

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205 million.[1] The U.S. is the fourth nation in the world to reach a population of this size. With an annual increase of 1.0 per cent, the doubling time for the U.S. population is roughly 70 years.[2] This has often been referred to by demographers, politicians, and health experts as the U.S. population explosion.

In 1790, 95 per cent of the American people lived in rural areas. By the time of the eighteenth census in 1960, 70 per cent of the population lived in cities and 63 per cent lived in metropolitan areas defined by the Federal government as cities of 50,000 or more.[3] This is what is becoming commonly referred to as the population implosion, a process that continues.

A profound alteration in the nature of the family cycle has occurred, a change brought about by a combination of demographic and social trends. Several phenomena which account for this change are increased nuptiality, the tremendous increase in the proportion of the population that is married; the decreasing age of the partners at the time of marriage; the decreasing age at which childbearing

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[1]The 1969 World Population Data Sheet - Population Reference Bureau. Wash., D.C., April, 1969.

[2]Ibid.

[3]Op.cit., The First Time, etc., p. 2.

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begins, the increased concentration of childbearing in the years before the woman reaches thirty years of age, and the general use of family planning methods. As a result of such changes, the age of the parents when the last child leaves home for marriage has been lowered.[1] The number of years in which many couples are freed from childbearing and rearing has tremendously increased.[2]

A. The Research Focus

The study objective is to identify whether a relationship exists between differential participation in the private and public health systems and its influence on desired family size and selected fertility practices. Such information should prove useful to health planners, social workers and other professionals who are concerned with providing adequate preventive health care such as family planning information and services to urban low income families. Do such health factors as use of private or public medical care, high and low preventive health orientation and worry regarding health of the family influence birth control perceptions and practices? This research undertaking

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[1]Leslie Corsa, "United States: New Efforts, But Still Not Enough," in Bernard Berelson Family Planning Programs, an International Survey (New York: Basic Books, Inc., 1969), pp. 145-156.

[2]Lee Rainwater, "Family Planning in Cross-National Perspective: An Overview" Journal of Social Issues, (October, 1967), pp. 1-11.

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represents an exploratory effort to describe the various ways lower class couples of procreative age cope with the biological facts of reproduction and related decision making regarding child spacing and family size limitation. These both constitute legitimate activities of family planning.[1] For the purpose of this study, treatment and counseling for sub-fecundity are not included.

Previous fertility research indicates that one of the primary factors accounting for low birth rates is the voluntary use of modern contraceptive methods.[2] While the relationship between socioeconomic factors and the use of contraceptives has been established, the dynamics of this relationship have not been fully explored and indicate the need for additional research. This Study addresses the following general hypotheses for lower income families:

> 1. There are attitudinal differences toward (dependent variable) family planning between families who use private health services and families who primarily rely on tax supported public health services (independent variable).
>
> 2. There are behavioral differences in utilization of family planning (dependent variable) between families who use private health services and families who rely primarily on tax supported public health services (independent variable).

---

[1]For the purpose of this study Family Planning will be referred to as the use of any medical or non-medical means by which contraception is prevented or postponed. It also is referred to as fertility regulation, contraception, birth control and planned parenthood (Need for Subsidized Family Planning Services, 1968:4).

[2]Donald S. Bogue, Sociological Contributions to Family Planning Research (Chicago: University of Chicago, 1966), pp. 1-34.

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Fertility surveys generally address one or more of the following major objectives:[1]

1. To discover social factors associated with fertility differences.

2. To study the fertility expectations and behavior of significant portions of the population, cross-sectionally and over time, for the purpose of analyzing the current fertility and projecting future fertility.

3. To provide baseline and change measurement for specific populations in connection with family planning action programs.

Often researchers focus only on one of these objectives while others address combinations of the above. This research is a point-in-time study which represents an effort to test the relationship between selected health variables and fertility attitudes and behavior. The study population has been randomly drawn from among lower class families residing in an OEO officially designated poverty area in Pittsburgh, Pennsylvania.[2,3]

In order to clarify the terms used in the hypotheses, the following descriptive information is provided. The study population has been selected from an officially designated urban poverty area in Pittsburgh. The study respondents have

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[1]James T. Fawcett, "Psychology and Population." An Occasional Paper of the Population Council. (New York: 1970), pp. 29-30).

[2]See Appendix A, The Concept of "Lower Class Families."

[3]Designated poverty area refers to specific Census Tract areas, 24A located in the Spring Hill District and 21D located in Manchester. Both are located in the City of Pittsburgh and have been designated by the Office of Economic Opportunity as a poverty area.

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been classified as belonging to lower class families. Attitudes regarding family planning addresses such concepts as number of children desired, attitude toward official family planning agencies, ideal child spacing intervals, husbands' attitudes toward family planning and current contraceptive practice and importance of having the number of children desired. These represent several of the dependent variables which this study analyzes. Other dependent variables as fertility behavior patterns include such practices as actual family size, use of Pittsburgh Planned Parenthood, and present contraceptive methods in use to delay or prevent births and confidence in that method and parity when couple first used family planning method.

The concept of accessibility can be viewed as a set of objective positions or conditions which provide the individual with certain opportunities to use relevant health services.[1] Differential access to and use of private and public health services can be expected to influence differential utilization of family planning.

Many sociological and public health studies endeavor to identify and document asymmetrical relationships in order to predict and enhance selected activities such as health and welfare policy and delivery of services. This researcher has

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[1]Neal Gross, Ward Mason and Alexander McEachern, Explorations in Role Analysis Studies of the School Superintendent Role (New York: John Wiley and Sons, Inc., 1966), p. 48.

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postulated that differential participation in defined areas of the health system will influence selected fertility beliefs and performance. In order to conduct the analyses, several test variables such as race, age, religion, socioeconomic status, and socialization have been included.

A review of the literature to date does not suggest a direction for the study hypotheses, however, research findings in a number of countries, both developed and modernizing, indicate that the major justification for use of birth control tends to be more economic than health oriented.[1] Certainly where one has no or very inadequate access to modern health services one would expect to find high fertility. Since the hypotheses are addressed to an urban population which has available and uses either private or tax supported health services, it is difficult to indicate the hypotheses direction given the current body of fertility knowledge regarding urban lower class families.

The analyses of the hypotheses are considered within the context of the situation which exists within the urban poverty area selected for the study. This involves presenting the basic demographic and social situation which normally exists within the Spring Hill and Manchester areas. Attitudes concerning whether or not family planning services should be

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[1]J. Mayone Stycos, "A Critique of the Traditional Planned Parenthood Approach in Underdeveloped Areas." Research In Family Planning (Princeton, N.J.: Princeton University Press, 1962), pp. 486-488.

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available to low income Pittsburgh residents, who the providers of service should be, the purpose of the local Planned Parenthood Organization and where one should go for such services also are presented. In 1968, a vociferous political duel erupted in the city over the use of OEO funds to support a Planned Parenthood Clinic in the predominantly black Homewood-Brushton area of the City.

Modern contraceptive methods have been available in the Pittsburgh area for some time. Planned Parenthood with its satellite clinics in the urban areas, as well as medical doctors in private practice, local hospitals and the Allegheny County Board of Assistance provide birth control information and services to middle and/or low income families. Since Pittsburgh provides a situation in which the hypotheses can be tested, this research endeavors to develop a theoretical linkage between use of public and private health services and fertility beliefs and practices among urban lower class families in an OEO designated poverty area.

B. Scope of National Fertility Research

There have been several important studies conducted during the past thirty years which have presented social explanatory factors for differential fertility in the United States. Most noteworthy among these researchers are the Indianapolis and Princeton Studies, the Growth of American Families Study, and the National Fertility Studies. The

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Indianapolis Study was conducted in 1941 with 1444 fecund white Protestant couples in which both the wife and husband had at least an eighth grade education. This study provided an early indication that economic status contributed to differential fertility.[1] The Princeton Study was viewed as a successor to the Indianapolis Study and focused upon women of particular parity. All interviews were conducted soon after the birth of the second child. This study was based upon obtaining information from 1,165 white women living in one of the seven largest metropolitan areas in the U.S. This was a longitudinal study where 905 of the original panel of respondents were interviewed three years later and 814 six to ten years later, toward the end of their reproductive periods.[2] The main dependent variable in these studies was the total number of children desired. Several of the independent variables in these studies included religion and socioeconomic status.

An impressive array of social data has emerged during the past fifteen years from various fertility researches.[3]

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[1]Clyde Kiser, Pascal Whelpton, "Resume of Indianapolis Study of Social and Psychological Factors Affecting Fertility." Demographic Analysis, Selected Readings (Glencoe, Illinois: The Free Press, 1967), pp. 146-166.

[2]Charles Westoff, Robert Potter and Philip Sagi, The Third Child: A Study In The Prediction of Fertility (Princeton, N.J.: Princeton University Press, 1963), p. 5.

[3]Ronald Freeman, Pascal Whelpton and Arthur Campbell, Family Planning Sterility and Population Growth (New York: McGraw-Hill Book Co., 1959).

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Such studies have indicated a pattern of desired family size of two to four children. The majority tend to support a desire for three or four children. However, these studies do not address differential health service use and its relationship to fertility among low income families.

Analysis of the data resulting from the present study may indicate a significant relationship between differential use of health services, preventive health orientation and fertility performance. Whatever the results of the data analyses are they should prove beneficial for suggesting alternatives for improving both the quantity, i.e., making family planning services accessible, and the quality of providing adequate professional expertise and modern safe contraceptive methods available to the low income urban couple.

C. Poverty and Population

The United States is regarded as basically a middle class country, however, large segments in the U.S. population live in poverty conditions that are very little different from the misery experienced in developing regions of the world. A disproportionate number of the next generation is being reared in poverty. Of all the children under eighteen years of age presently growing up in nonwhite families, approximately seventy per cent are being raised in poverty.[1]

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[1]Mollie Orshansky, "Children of the Poor," Social Security Bulletin (July, 1963), pp. 4-9.

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Nearly half of the children growing up in poverty today are members of families with five or more children whose risk of living in poverty is four times greater than a family with one or two children.[1]

The average American has many opportunities to interact with the products of science and technology as they increase man's choices at a bewildering rate. Unlike most people in the world who are struggling to survive, the majority of Americans have the potential to create their society and life styles rather than merely adapt to the constraints of physical, biological and social conditions. To examine conditions of the poor and near poor in America, one must develop a relative view of poverty. Most Americans who are labeled as poor are not on a near-starvation diet. Nor do most live on city streets lacking a roof over their heads. Both conditions characterize the poor in many underdeveloped areas of the world, however, the poor of contemporary America are poor because they have fallen far behind the rest of society in which they live. This is the meaning of poverty in any affluent society. Today it is not possible to identify an absolute standard, i.e., a sustenance band which separates the poor from the nonpoor. The standards of society obviously change with time, place and possibilities. As the U.S. advances economically, new standards emerge. Those whose

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[1]Frederick Jaffe, "The United States: A Strategy for Implementing Family Planning Services," Studies In Family Planning. No. 17 (February, 1967), pp. 5-12.

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material needs do not improve or improve only slightly suffer a relative loss. Those who are labeled poor today would certainly not be poor by the standards of 1870, when telephones did not exist and running water in homes was uncommon. Thus poverty in America is determined by prevailing standards of what is needed for health, efficiency, nurture of children, social participation and the maintenance of self-respect and respect of others.[1]

Social policies reflect social values and social values reveal what is important to a group or nation. Policies toward the poor are especially revealing in depicting what is important to a group or nation. The way one looks upon the poor and how one regards the sources of their difficulties will affect the kinds of proposals one makes to improve conditions and how one implements proposals once they are made.

D. Theories of Poverty

Several theories regarding the poor seem to prevail. One view is that only selected segments of the poor deserve to be helped.[2] This theory suggests that most of the poor are the "undeserving poor," content in squalor, resistant

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[1]S. M. Miller and Frank Riessman, Social Class and Social Policy (New York: Basic Books, Inc., 1968), pp. 35-66.

[2]T. Gladwin, "An Anthropologist Looks At Poverty," Social Welfare Forum (New York: Columbia University Press, 1963), p. 13.

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to work and sponging off society. This view leads to the type of social policy which attempts to reduce payments to the poor and to make them as uncomfortable as possible. The Newburgh incident in upstate New York in 1961 illustrates the harshness that can prevail when the poor are viewed as "undeserving." Another theory which is a variant of the undeserving poor concept is the argument that many if not most of the difficulties of the poor arise from the way in which they deal with their problems - the "self-defeating poor." Thus poverty becomes equated with incompetence. An essential element of this theory is that the poor lack the ability to defer gratification. This statement is comparative with the middle class as the contrasting standard-bearer. The middle classes are believed to be distinguished by the presence and significant operation of the ability to accept later rewards instead of immediate satisfactions, to bank their impulses, and to plan effectively for the future. This comparison of course is not valid. The rise of consumer debt among the middle classes, the refrain of not being able to make ends meet despite affluent income levels, the competition between work and the coffee break suggest that important changes have taken place in the middle classes or perhaps that the middle classes with their Protestant Ethic was never wholly as described. Consequently, the actual behavior of the poor is frequently compared with

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the official norms rather than the actual practices of the better off. Moreover, in order to compare the two groups' capacity to defer, one has to assume that they equally desire the deferred objectives, that they are making equal sacrifices in deferring and that they have equal opportunity to realize success at the end of the deferment period.[1]

E. Poverty and Family Planning

An apparent public health concern involving medically indigent families which this study addresses is the difficulty some families experience in spacing and/or limiting the number of some families experience in spacing and/or limiting the number families have more children than they want.[2] Contrary to popular stereotypes, recent studies such as the Growth of American Families and the National Fertility Studies suggest that lower income Americans want as few, or even fewer children than do those of higher socioeconomic status. Lower class families incur a high number of pregnancies because they do not use contraceptives as regularly and/or successfully as do upper class couples. There are several explanations for this. Contrary to popular misunderstanding and myths about sex in the lower class, Rainwater suggests that there

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[1]S. M. Miller and Fr. Riessman, op. cit., pp. 44-46.

[2]Frederick Jaffe, "Family Planning and Poverty," Journal of Marriage and the Family, Vol. 26 (November, 1964), pp. 467-472.

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is at this level a striking incidence of shame and embarrassment.[1] This attitude seriously impedes frank and supportive discussion of birth control among partners in or out of the marriage relationship.

These lower income partners come into the relationship with large areas of ignorance. Their background of sex education in the home and street has generally consisted of warnings and prohibitions. Furthermore, many lower class couples doubt that planning can really be effective, or that they can actually gain some control over their own personal destinies. Some couples also disagree over whose responsibility contraception is. They are often unable to get beyond the polarized position of each insisting that the other should take the responsibility. Many lower class women also accept a very passive role in sex relations, and they will not consider any birth control technique that might possibly interfere with the male's pleasure.[2]

Recently certain developments have combined to alter the situation significantly. Public awareness of the problem has been heightened by open discussion of the world's population explosion and intense population pressures in various countries. Public hopes for relief from the problem have been encouraged by development of the oral contraceptives

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[1]Lee Rainwater, "Marital Sexuality in Four Cultures of Poverty," Journal of Marriage and the Family (November, 1964), pp. 459-461. Also in And the Poor Get Children (Chicago: Quadrangle Books, 1960)

[2]Lee Rainwater and Karol Weinstein, "A Qualitative Exploration of Family Planning and Contraception in the Working Class," Marriage and Family Living (August, 1960), pp. 238-242.

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and the intrauterine device which are inexpensive and effective contraceptives.

Of great significance has been the more relaxed position taken by certain quarters within the Roman Catholic Church. The Church now lends passive support to the idea of family planning.[1] The Church has indicated its willingness to no longer protest birth control services made available through public agencies and at public cost on terms acceptable to both Catholic and non-Catholic groups. Such terms provide that no one should be pressured to adopt birth control measures against his will. The rhythm method will be among those offered, and no Catholic in a public position will be required to violate his conscience by participating in a birth control program he does not approve.[2]

F. Policy and Family Planning

The last decade has witnessed vast changes in the expressed policies on family planning of public agencies in the United States.[3] Public fears of encouraging immorality or rewarding vice seem to be fading in the face of new facts and exposed fallacies. There is no evidence that contraceptive practices either encourage or discourage people from having

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[1]Arthur Shostak, "Birth Control and Poverty," New Perspectives on Poverty. (New Jersey: Prentice-Hall, Inc., 1965), pp. 52-55.

[2]Ibid., p. 56.

[3]Need for Subsidized Family Planning Services: United States and Each Country, 1968. Planned Parenthood World Population Report (New York), p. VI.

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sexual relations. This country appears to be on the threshold of a new period in the history of birth control. The current thaw permits public health and welfare agencies to liberalize regulations and sanction discussions of family planning between social workers and clients. Public hospitals have begun to open up clinics offering free birth control information and services. Welfare agencies have begun to report substantial dollar savings resulting from sharp decreases in the fertility of welfare clients. For example, a birth control program operated by the local public health clinic in Mechlenburg County, North Carolina is believed to have saved $250,000 in Aid to Dependent Children grants from 1960-1963.

While advances in knowledge, technology, and rapid expansion of tax supported programs will continue for some time to come, actual adequate and competent birth control services to those Americans who until recently have not had adequate access to them will lag behind. For the rate of change of public policy is often considerably more rapid than the rate of change in public programming, and the extent to which positive policy will be translated into meaningful programs remains to be seen.

Significant differences in fertility exist between various socioeconomic and racial groups. The poor tend to

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have higher fertility rates than the rest of the population.[1] While contraception has been practiced privately by most Americans for many years, significant differences in use exist between various groups. By 1965, 85 per cent of married American women had used some method of contraception. Twenty-six per cent had used oral pills.[2] By 1960, 85 per cent of Protestants had used birth control compared to 70 per cent Catholics; 80 per cent of the whites had used contraception compared to 59 per cent of the blacks. Yet when matched for age and educational status the differences by race disappeared.[3]

G. Differential Access to Modern Contraception

Significant differences in availability of contraception, particularly modern methods such as the pill and intrauterine devices exist between the poor and nonpoor in the U.S. These methods require medical services and the poor receive almost all of their medical services in the public sector which, because of religious and political controversy, rarely includes contraceptive services. In the United States 98 per cent of the births occur in hospitals.

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[1]Frederick Jaffe, "A Strategy for Implementing Family Planning Services in the United States," American Journal of Public Health, Vol. 58, No. 4 (April, 1968), pp. 713-714.

[2]Ibid., p. 715.

[3]Charles Westoff and Norman Ryder, "Recent Trends in Attitudes Toward Fertility Control and in the Practice of Contraception in the U.S." Fertility and Family Planning (University of Michigan Press, 1969), pp. 388-412.

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It appears on the surface a simple matter to provide family planning services by adding them to maternal health services. But in fact maternal health services for the poor are grossly inadequate, fragmented and uncoordinated in most places. In the United States, about four-fifths of the population obtain medical care in the private sector from many private physicians, hospitals and pharmacies whereas the remaining one-fifth, who are poor, receive their medical care in the public sector.

Currently, efforts are being made to improve family planning for the poor through existing public health and welfare programs and such additional means as the War on Poverty by the Office of Economic Opportunity, Maternal and Infant Care projects by the Children's Bureau, and expanded activities of the Planned Parenthood Federation of America. The result is a growing mix of fiscal and service activities.

The question of public policy on birth control is, at bottom, a question of equalizing opportunities for the effective practice of family limitation among the various social classes. For decades middle and upper class Americans have had little difficulty securing competent contraceptive guidance if they desired it. Family planning is and has been part of better quality medical care more or less routinely available in the family building years to those who can afford private medical services. This has not been the case for low income Americans who depend on public or

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charity institutions for medical services. In carrying out their desires in regard to family size, they could, of course have utilized less reliable and unesthetic family limitation methods which do not require medical guidance, and many have - but they certainly have not had equal access to the best, most effective methods known to science.

The conventional explanation for the reluctance of public agencies to provide family planning services is the opposition of the Catholic Church to some methods of birth control. There is, of course, some historical and even current validity to this explanation, as well as to its counterpart that attributes the remarkable recent shift in public policy in large part to the searching re-examination of Church doctrine now underway. While Catholic spokesmen continue to oppose public funds for birth control services, others find no necessity in Catholic doctrine for such opposition. Generally, Planned Parenthood workers have never accepted the Catholic opposition as a sufficient explanation of the timidity of public agencies throughout the country. The feeling persists that the religious problem is sometimes invoked as an excuse, masking other obstacles such as the stereotyped attitudes regarding the poor.[1] There is little interest in initiating a family planning

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[1]Adelaide Hill and Frederick Jaffe, "The Negro American," Planned Parenthood World Population, p. 16.

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program if one believes that the poor do not care how many children they have, which is one of the most common explanations offered by upper class persons in many diverse societies for high lower class fertility.

To think of contraception as a realistic extension of health services means to conceive of the poor as capable of human aspiration, human action, and human growth. Perhaps the truly critical factor is the basic inadequacy in coverage and quality of publicly financed medical care for the impoverished. For their medical care, the poor must still depend either on fragmented public services or on the charity of private doctors and medical institutions where, in both settings, care is largely delivered under such demeaning conditions as to discourage them from seeking it unless it is absolutely necessary.

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CHAPTER II

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

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CHAPTER II

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

A. Theoretical Framework and Related Theory

The major response to the recognition of the population problem in this Country has been the promotion of family planning. In the past fifteen years, there has been a remarkable surge of interest and activity in government sponsored and charity supported family planning programs. Formerly the concern of private, voluntary groups, family planning has moved rapidly into the public domain, with increasing awareness of the socioeconomic implications of population growth.[1]

During the past two centuries there have emerged several theories regarding the implications of population growth with varied influences on policy making. Population theories generally address the causes or consequences of the size, structure, and distribution of a population. Policy which is often influenced by theory is usually

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[1]Robin Elliott, Lynn Landman, Richard Lincoln and Theodore Tsworoka, "U.S. Population Growth and Family Planning: A Review of the Literature," Family Planning Perspectives, Vol. 2, No. 4 (October, 1970), pp. II-XVI.

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concerned with the means to alter or control selected aspects of population, for the purpose of achieving valued goals. National fertility studies indicate that low income families desire less children than they often have. Various researches suggest that the poor have larger families than they desire. This in turn influences a new policy which represents an effort to provide five million indigent women in the United States by 1975 with access to family planning information and services.[1]

Theory as a concept refers to logically interconnected sets of propositions from which one may draw or reject empirical uniformities.[2] Theory endeavors to connect social phenomena. It defines the scope and identifies the predictive value of selected empirical findings by indicating the conditions under which they hold.[3] The theory upon which the present study hinges depicts a more middle range effort than an attempt to develop a grand or total theory such as Malthus' Essay on the Principle of Population.

Before discussing the theory upon which this study is based, it is appropriate to briefly review theories which

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[1]Need for Subsidized Family Planning Services: U.S., Each State and County, 1968. Office of Economic Opportunity/ Family Planning Program, pp. 4-6.

[2]Robert Merton, Social Theory and Social Structure. (New York: The Free Press, 1968), p. 39.

[3]Ibid., pp. 40-45.

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have endeavored to explain the relationship between poverty and population. The most classic of the recent population theoreticians are Thomas Malthus and Karl Marx. Malthus observed that population trends were determined by interaction between two primordial forces: the trend toward population increase resulted from the attraction between the sexes and the positive checks by death and sterility due to hunger, disease and vice.[1]

Malthus argued that the only way a nation can escape from perpetual poverty, due to the pressure of population on finite resources, is to restrict population growth by the exercise of prudential restraint. One of his prudential restraints was to reduce or eliminate welfare programs since the poor reduced limited resources and contributed nothing to the community.[2] Marx rejected Malthus denying, that there was a population problem. He maintained that it was more a problem of how resources in the society were inequitably distributed. He indicated that the unequal distribution of wealth could only be altered through a total reorganization of the society.[3]

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[1]William Petersen, The Politics of Population (New York: Anchor Books, 1965), pp. 26-37.

[2]Ibid., pp. 37-45.

[3]Ibid., pp. 72-91.

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A major modern explanation of population is the theory of demographic transition. This theory is presented by Ansley Coale. The agrarian low income economy is characterized by high birth and high death rates. The birth rates are relatively stable and the death rates fluctuate in response to varying fortunes. As the economy changes to a more interdependent and specialized market economy, the average death rate declines. It continues to decline under the impact of better social organization and improvement in medical knowledge and public health services. Somewhat later the birth rate begins to fall. The two rates pursue a more or less parallel downward course with the decline of birth rate lagging behind. Finally, as further reduction of the death rate becomes harder to attain, the birth rate again approaches equality with the death rate and a more gradual rate of growth is re-established with low risks of mortality and small families as a typical pattern. Mortality rates become relatively stable from year to year and birth rates become responsive to voluntary decisions rather than to deeply held customs.[1]

The above represent theories which offer useful typologies for policy decision making and implementation

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[1]Ansley Coale and Edgar Hoover, Population Growth and Economic Development in Low Income Countries (Princeton, N.J.: Princeton University Press, 1958), pp. 12-13.

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of health and welfare programs. For example, Malthus viewed public welfare as a threat to finite resources and the well-being of the community. Does not the community invest inadequate resources to assist the poor? Marx challenged this theory on the basis of social justice and called for a social revolution which would redistribute economic resources. Is this not partially related to the War on Poverty policy, proposed guaranteed minimum income and ideology of the new Left?

Just as values influence behavior, so too does behavior influence one's value system. For example, a married couple's sense of direction and commitment to their parents, deity, society, etc. influences the number of children they may desire to have. The potential or threat of multiple children may greatly influence one's value system. Policies which are intended to bring about changes in family size are clearly dependent in part on fertility theories. Policies most clearly relevant to social work are those dealing with family planning for the low income family, although policies on migration and population distribution have potential relevance. This dissertation is based on theory which suggests a relationship between family planning and certain health variables. An essential step in developing a successful policy is to determine the relationship between current fertility perceptions and practices. In this study specific health factors which may be related to actual and

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desired family size are analyzed. While there is no limit to the list of possible interactions which may be studied - it is essential to consider relationships upon which intelligent policy may be based.

The theoretical framework for this study provides the opportunity for analyses of the influence of selected health variables on fertility beliefs and behavior among working class urban families. The rationale for endeavoring to analyze the linkage between health variables such as differential use of health services, preventive health orientation, etc. and fertility attitudes and practices is that no previous research has addressed this area.

Family planning services which enable couples not only to limit family size but also to regulate the timing and spacing of children born, are provided by health professionals in health related institutions such as hospitals, well-baby clinics, physicians' offices and other official and voluntary health related agencies. In low income areas, surrounded by affluence for the majority of Americans, the persistence of poverty in the midst of plenty can be a bitter experience for those deprived. Family planning available on a voluntary basis to low income families can constitute one of the major approaches for reducing poverty and enhancing the quality of family life.

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B. Study Assumptions

The overall hypothesis to be tested in this study is that family planning as a function of health related services is perceived and utilized as the consumers differentially participate in the health system. Several assumptions upon which theoretical relationship is based are as follows:

1. Family size limitation is an almost universal practice among all social groups in modern industrial urban societies. Pittsburgh provides such a setting where the urban residents possess varying knowledge and experience with conventional contraceptives, periodic abstinence, the pill, the intrauterine device, etc. Most fertility studies conducted in this country indicate that people regardless of socioeconomic status have at least some knowledge of birth control. It is the intent of this study to advance knowledge in the area of understanding health factors associated with fertility perceptions and performance.

2. The desire for a limited number of children is widespread if not universal among fecund women. While it is not a perfect predictor, it is more reliable than using the "ideal family size" concept which is related to a third party reference group such as a particular norm in a given society.

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3. Women have always responded somewhat negatively to the long vista of recurrent pregnancies and increasing burdens.

4. Neither official nor voluntary agencies have designed and implemented family planning policy which enables the community at large to have immediate free access to information and services as part of comprehensive maternal, child and father health services. A dual system of health services exist, one you pay on a fee for service basis and the other is tax and/or charity supported.

5. Birth control technology continues in its infancy. It is still trial and error. There is almost an inverse relationship between population concern and government investment in the research and development area. This country's total investment in basic reproductive biology, physiological research, contraceptive development, medical assessment of existing methods, behavioral research and training of research scientists remains at a level too low to advance technological development and innovative services required.[1]

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[1]Jeannie Rosoff, "Crisis Thinking: Rhetoric vs. Action." Family Planning Perspectives, Vol. 2, No. 3 (June, 1970), pp. 27-28.

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Sociological medical care research has demonstrated that the utilization of health services varies among different social groups such as religious, social and ethnic groups.[1] Attempts to account for such differences are usually restricted to either a social psychological or a socioeconomic frame of reference. The concept of health orientation can be viewed as a psychological state which provides the individual with a set of beliefs about some relevant health situation and thus influences his response to the situation. For example, a person who is very suspicious toward family planning may have a utilization pattern that is different from another person who is not suspicious. The concept of opportunity can be regarded as conditions which provide the individual with certain access to health services. Health care can be regarded as economic like any other product or service used by people.[2] The amount purchased may depend on such factors as price, income, taste and the alternative use of personal resources. Medical services can be conceptually divided into two components arising out of the demand structure.[3] There are needs where little or no choice is accorded to the individual. The

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[1]Odin Anderson, "The Utilization of Health Services" in Howard Freeman, et. al., Handbook of Medical Sociology (New York: Prentice Hall, Inc., 1963), pp. 349-368.

[2]Grover Wirich, "A Multiple Demand Model for Demand of Health Care," Health Service Research (Winter, 1966), pp. 301-302.

[3]Irving Rosenstock, "What Research and Motivation Suggest for Public Health," American Journal of Public Health (March, 1960), pp. 295-302.

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types of medical services falling into this area are organized around the purposes of episodic and confinement care. Conversely, there are the needs where high discretionary power exists. This component is organized on the principle of providing medical services for minor illnesses or periodic and preventive care such as family planning.[1] Some health needs accord little or no choice to the individual and other needs accord high discretionary power. It is reasonable to assume that the sociocultural and the socioeconomic forces, i.e., orientation and opportunity respectively will be of maximum influence for the needs where high discretionary power is accorded and will be of minimum influence for the needs where there is little or no choice.

Jaffe and Polgar have attacked those who attest to the culture of poverty theory as an explanation for the failure of the poor to use contraceptives effectively and subsequently, as an excuse for not making available additional family planning services.[2] Two approaches to family planning programs can be contrasted: accessibility versus cultural motivation. The accessibility approach

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[1]Eliot Friedson, "The Organization of Medical Practice," in Freeman, et. al., Handbook of Medical Sociology, pp. 299-319.

[2]Frederick Jaffe and Steven Polgar, "Family Planning and Public Policy: Is the Culture of Poverty the New Cop-Out?" Journal of Marriage and the Family, Vol. 30, No. 2 (May, 1968), pp. 228-235.

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attempts to create services where none exist or to remove obstacles which make available services accessible. For example; distance, crowding, eligibility and fee practices, scheduling, lack of information and depersonalized delivery.[1] The cultural-motivational view seems to dominate the thinking of many health and welfare professionals and is often used to rationalize slow progress. This anomaly may be analyzed as an example of the resistance of social institutions to change and in terms of its historical antecedents in upper class biases regarding lower class fertility.[2] Herbert Gans suggests that if a major purpose of research is the elimination of poverty, studies of the poor are not the first order of business but rather studies of the economy, the society, and the persisting cultural patterns among the affluent which combine to keep people in poverty.[3] He finds the cultural approach to poverty deficient because it ignores aspirations of the poor which conflict with behavior and emphasizes obstacles to change; the pure situational view which posits instantaneous and uniform response to opportunities he regards as too simple. The prime issue, he concludes is to discover how soon poor people will change their behavior, given new opportunities and what restraints or obstacles come from that reaction to past situations referred to as culture.

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[1] Ibid., p. 228.

[2] Ibid., p. 229.

[3] Ibid., p. 229.

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Clearly many Americans are cut off from adequate health services. The linkage between excessive fertility and poverty in the U.S. is all too plain.[1] As presently organized and administered it can be stated that preventive and therapeutic medicine are not congenial to the health beliefs and modes of behavior of low income groups.

In essence the use of family planning is not random behavior. The use of family planning services are the result of socioeconomic and sociocultural forces. The explanatory concepts of health orientation and opportunity are of minimum influence for the needs and medical services where there is little or no choice and the concepts are of maximum influence for the needs and medical services where there is high discretionary power. The individual has two sets of alternatives for the needs and services where there is high discretionary power. One set consists of the alternatives of to act or not to act and the other set consists of the alternatives providers of medical services use.

In the Washington Heights Survey an attempt was made to measure health and medical differentials according to social class in terms of the effect of the more ethnocentric and restricted social relationships of the lower income minority groups upon their knowledge of disease, attitudes

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[1]Harold Sheppard, Effects of Family Planning on Poverty in the United States. (New York: Upjohn Institute for Employment Research, 1967), pp. 1-10.

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toward professional medical care and response to illness.[1] The main findings of this study indicate that (1) the lower socioeconomic and minority groups are significantly more socially isolated or ethnocentric; (2) ethnocentrism is, in turn, highly related to a lower level of knowledge about disease, unfavorable attitudes toward medical care, and dependency upon lay support during illness; and (3) the lower socioeconomic and minority groups hold this negative health orientation to a significantly greater degree than the upper socioeconomic and majority groups with the individual's degree of ethnocentrism strengthening or weakening his conformity to the overall medical orientation of his group. The fact that the greater social isolation or ethnocentrism of the lower socioeconomic and minority groups has been found to be related to a negative medical orientation still has many implications for the field of public health. For example, since family planning services tend to be health connected and primarily provided by medical doctors, families that have limited social networks may possess inadequate contraceptive knowledge and/or have unfavorable attitudes toward family planning. It highlights the extent to which health problems among these groups is inextricably intertwined with the many other social problems faced by these

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[1]Edward Suchman, "Social Factors In Medical Deprivation," American Journal of Public Health, Vol. 55, No. 11 (November, 1965), pp. 1725-1733.

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less privileged groups in American society. The narrower health horizons of these groups, adults and children are part and parcel of their generally restricted outlook and lower expectations including such other areas as education, employment and recreation. Basically what Suchman's theory stresses is the need to organize public health and medical programs intended for low income and minority groups in ways that are more congenial to lower class modes of behavior.

C. Literature Review

The general purpose of this literature review is to provide an overview to the research in the population and family planning areas which are relevant to this study and public health social work. A number of related studies are briefly presented.

As the investigator reviewed the literature, a remarkable lack of unanimity became apparent as to whether or not there is a population crisis pending in the United States and who is responsible for it and what should be done. Since this is a question of enormous complexity, it is appropriate to review several of the various strategies proposed for dealing with the population issue and endeavor to point out the potential consequences implied in who should do what for whom. Many observers in the U.S. such as Garrett Hardin, Kingsley Davis and Paul Ehrlich have arrived at the conclusion that continuing population growth in this country, which adversely affects the environment and congests

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the cities, must be halted by a sharp reduction in fertility by whatever means necessary. Such proponents of population control view voluntary family planning, even when it employs the best conceivable array of birth control methods as foredoomed to failure. Cutting across the debate over means is the ethical issue of freedom of choice. The issue is whether choices made by individuals on the basis of personal utility can be compatible, ultimately, with the needs of the society as a whole.[1] Specific proposals for fertility control can be classified as: (1) voluntarism - current family planning ethic, (2) incentive - i.e., symbolic coercion, tax on births after nth child, (3) coercion - compulsory control by the state over the number of children a couple may be allowed to have. The concept of incentive may be viewed as a middle range approach whereby mechanisms such as tax relief for small families may bring about smaller families while using means that preserve some measure of freedom of choice.[2]

It is worth noting the official position held by the United States regarding population and the ideology in

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[1]Garrett Hardin, "The Tragedy of the Commons," Science, 162 (December 13, 1968), pp. 1243-1248.

[2]James Fawcett, Psychology and Population, Behavioral Research Issue in Fertility and Family Planning. The Population Council (New York: 1970), p. 26.

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support of that position. This has primary importance for scholarly research in the fertility area since both ideology and research findings influence the policy paths which dictate national health programs. Family planning as presently understood and accepted means that the married couple freely selects or rejects contraception and decides the number of children they desire. Such decisions may be related to the couples' present and expected future life situation. Whether they elect to have many children or few depends on their own personal choice, their social and economic circumstances, their beliefs about their obligation to their religion, their society and their views of the probable impact of each child on their life situation.[1]

Whether the couple is able to achieve the family size they desire will depend in large part on their knowledge and access to acceptable services which will enable them to avoid undesired pregnancies. While religious beliefs often influence this decision, this factor in itself does not constitute a barrier to the concept of voluntarism, since the family can accept or reject moral prescriptions in deciding upon its desired family size. In November, 1968, The Report of the President's Committee on Population and Family Planning was submitted to President Johnson. The Report closes with the following:

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[1]Abraham Stone and Norman Himes, Planned Parenthood: A Practical Handbook of Birth-Control Methods. (New York: MacMillan and Co., 1965), pp. 75-97.

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> "The Federal Government must undertake a much larger effort if this nation hopes to play its proper role in attaining a better life for its people and for the citizens of the developing countries. In working to avert a population crisis, this nation will at the same time help strengthen the voluntary exercise of a basic human right, the right of the parents to have the number of children they want, when they want them."

This is an expression of the nation's affirmation of freedom of choice for the family in family planning matters.

In his commencement address to the University of Notre Dame in May 1969, Robert McNamara, President of the World Bank made a number of remarks on the subject of family planning and desired family size, which in view of his official position should not go unnoticed:

> "No government can, of course, ultimately succeed in convincing its own population to undertake family planning if parents themselves do not really want it."

> "All of us accept the principle that in a free society, the parents themselves must ultimately decide the size of their own family. We regard it as an intolerable invasion on the family's rights for the State to use coercive measures to implement population policy. We can preserve the right best by assisting families to understand how they can make that decision for themselves. The fact is that millions of children are born without their parents desiring that it happen. Hence a free, rational choice for an additional child is not made in these cases. If we are to keep the right of decision in the hands of the family, where it clearly belongs, then we must give the family the knowledge and assistance it requires to exercise that right."

Particularly relevant to the topic of desired family size is President Nixon's Message on Population, July 18, 1969, to the Congress of the United States.[1] Calling attention to

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[1] President Nixon's Message on Population. Message by Richard M. Nixon, President of the United States, July 18, 1969. Population Crisis Committee, Washington, D. C.

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the urgent need for prompt measures to deal with the problems posed by rapid growth in the U.S. the President points out that:

> "Many parents in developing countries are still victimized by forces, such as poverty and ignorance, which make it difficult for them to exercise control over the size of their families."

Referring to the barriers to voluntary family planning in the U.S., President Nixon further stated in his address to Congress:

> "It is my view that no American woman should be denied access to family planning assistance because of her economic condition. I believe, therefore, that we should establish as a national goal the provision of adequate family planning services within the next five years to all those who want them but cannot afford them. This we have the capacity to do."

Immediately following this statement is an unequivocal enunciation of the United States Government's position about the voluntary nature of family planning activities:

> "Clearly, in no circumstances will the activities associated with our pursuit of this goal be allowed to infringe upon the religious convictions or personal wishes and freedom of any individual, nor will they be allowed to impair the absolute right of all individuals to have such matters of conscience respected by public authorities."

In evaluating the above statements, three fundamental moral assumptions emerge:

1. The integrity and welfare of the family as the basic social unit should be a primary goal of society.
2. Self-determination is a basic right of the individual couple to decide the desired number of children.

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3. All couples should have access to family planning information and expertise to implement their personal desire regarding family size.

Irrespective of the varied allegations that have been charged against family planning, this country has developed a national policy, respecting the integrity of the family and freedom of choice in the determination of family size. This constitutes both a mandate and a constraint. In essence and contrary to the Erhlich approach, citizens of the world may be able to de-fuse the so-called "population bomb" by trusting individuals to act in their own best interest, when they are provided the means to do so and can have a reasonable awareness of the consequences of their actions for themselves and the greater community.

While the majority of public health professionals accept and support this country's national moral position regarding voluntary family planning as a means to control population growth by providing adequate information and fertility services to all Americans, there are eminent scholars who reject family planning as a promising vehicle through which to control population growth. Kingsley Davis is very sure that the United States will not be served even if the American population is able to comprehend the relationship between individual and national fertility.

> "Logically, it does not make sense to use family planning to provide national population control or planning. The 'planning' in family planning is that of each separate couple. The

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> only control they exercise is control over the size of their families. Obviously, couples do not plan the size of the nation's population, anymore than they plan the growth of the national income or the form of the highway network. There is no reason to expect that the millions of decisions about family size made by couples in their own interest will automatically control population for the benefit of society. On the contrary, there are good reasons to think that they will not do so."[1]

Garrett Hardin is even more convinced that the majority of people cannot be expected to act on any rational basis other than their immediate narrow self-interest:

> "People vary. Confronted with appeals to limit breeding, some people will undoubtedly respond to the plea more than others. Those who have more children will produce a larger fraction of the next generation than those with more susceptible consciences. The difference will be accentuated, generation by generation....."
>
> "The argument has been stated here in the context of the population problem, but it applies equally well to any instance in which society appeals to an individual exploiting a commons to restrain himself for the general good -- by means of his conscience. To make such an appeal is to set up the selective system that works toward the elimination of conscience from the race."[2]

Setting aside Hardin's questionable assumptions about the inheritance of acquired characteristics, one finds Hardin, Ehrlich, Davis and others who share the same view, i.e., disbelief in the ordinary man's potential capacity to set rational

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[1]Kingsley Davis, "Population Policy: Will Current Programs Succeed?" Science, 158 (November 10, 1967), p. 732.

[2]Garrett Hardin, op. cit., p. 1346.

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limits to his own behavior without being goaded by some coercive force to do so. Voluntary family planning efforts are intended to insure that each couple have a choice in deciding the number of children they desire. Such services are intended to strengthen the family by assuring that every child born will indeed be a desired one. As desirable as voluntary family planning may be, it is not a guarantee per se. Stycos in a recent article in "Sociological Perspectives" stated:

> "Birth control is not an end in itself. Neither is it a way of avoiding other problems, such as unbalanced distribution of land and wealth, the need for general education, and the exploitation of the nation's natural resources. If programs of family planning were to divert attention from these problems, the programs would not be worth the price: for low birth rates alone can do little for the nation and little more for the family, unless accompanied by efforts to improve other aspects of the social and economic milieu. On the other hand, improvement of social and economic conditions will be immensely facilitated by slowing down the rate of population growth."[1]

The ideology of voluntary family planning best represents the goals and aspirations of both the provider of services and the consumer. The coercive methods of the doomsday advocates who do not trust in man's basic ability, given adequate information and services to voluntarily govern his fertility, will only serve to alienate the greater society and assure charges of genocide and ultimately a police state.

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[1] J. Mayore Stycos, Human Fertility In Latin America Sociological Perspectives (New York: Cornell University Press, 1968), p. 312.

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The earth's population reached its first billion by 1830, its second billion by 1930, its third billion by 1960, is now at the 3.5 billion mark and, if the present rate of population growth continues, may climb to more than 7 billion by the year 2000.[1] Pictorially this change can be represented as two related cable cars - the natural increase car ascending and the mortality car descending. The current rate of population growth in the U.S. (1.0 per cent per year) is the same as that for the U.S.S.R. and is somewhat higher than that for Europe (0.8 per cent) but is significantly lower than that for Latin America (2.9 per cent) and for India (2.6 per cent). The total population in the U.S. was about 205 million in mid-1970, some 25.4 million or 14.1 per cent above the 1960 census figure.[2] The Census Bureau is currently projecting the population in a range of 266 to 321 million by the year 2000, but points out that the population may in fact fall outside this range.

Mortality is decreasing and can go somewhat lower. The partial control in the late 19th century of intestinal diseases was followed by the successful attack on the respiratory infections early in the 20th century.[3] As control has

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[1] Current Population Reports (1970), p. 25.

[2] Ibid., p. 26.

[3] R. Thomlinson, Population Dynamics (New York: Random House, 1965), pp. 109-110.

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been gained over mortality at the threshold of life and people are living longer, death rates have risen from the degenerative diseases, especially heart, cancer and stroke.

From 1900 to 1968, life expectancy for whites increased from 47.6 years to 71.1 years in the U.S. For all other races it increased from 33.0 years to 63.9 years. There has been a major increase in life expectancy for all races, yet the life expectancy for non-whites lags behind that for whites.[1] For example, 63.9 years for all "other races" in 1968 was about the level for whites in the late 1930's. Life expectancy is highest for white females and lowest for males, all other races.[2]

The infant mortality rate is considered to be a sensitive indicator of health status over time. The steady fall in the level of infant mortality from 140 prevailing in 1900 to 24-25 infant deaths per 1000 live births is principally attributable to the reduction in just one disease complex - the pneumonia-diarrhea complex relating to environmental health and sanitation. The decline in infant mortality before the advent of antibiotics is largely attributable to medicine and public health. Tuberculosis, diphtheria, and streptococcal diseases comprise only a small part of total infant deaths.[3]

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[1]Earl Huyck, et. al., "Population Change in the United States and the Development of Family Planning Services." Discussion Paper prepared for presentation at White House Conference on Children and Youth (October 1970).

[2]Ibid.

[3]Ibid.

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Internationally, the U.S. in 1967 ranked 13th in infant mortality. The infant mortality rate in 1968 was 21.8 for the U.S. population, that for the whites was 19.2 and only slightly more than half of that for all other races (34.5). In large U.S. cities high infant mortality is often linked with lower income and minority groups. The 1966 Public Health Service data indicate that male infant mortality rates are highest for blacks 44.0, somewhat less for American Indians 39.0, and substantially less for whites 23.5 (WHCCY, Chart 70). In sum, the U.S. lags behind a number of other nations with respect to life expectancy and infant mortality, and the differential impact within the U.S. represents unfinished business on the social and economic dockets.

One of the more obvious problems associated with population growth in this country is poor control over fertility, which has resulted in unwanted children, who suffer emotional, physical and cultural deprivation. Some couples have more children than they desire, and others report failures in spacing children. A large number of unwanted pregnancies in the U.S. are terminated by abortions, many of which are illegal. The greater incidence of illegal abortions and therefore the greater health risks are among blacks and other minority races. According to 1967 estimates developed from a special survey reported by the National Institute of Child Health and Human Development and appearing

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in Demography, February 1970, some 4.1 per cent of women (1.6% white and 10.3% black) indicated that they had an abortion within their life time. Nearly one-fifth of these abortions were illegal.

Failure to control fertility successfully is found among all socioeconomic groups in the population, but is more prevalent among those with less education and lower income.

Nearly half of the children living in poverty conditions in 1968 were growing up in families with five or more children under 18 years of age; and the risk of poverty increased rapidly from 9 per cent for one-child families to 42 per cent for families with six or more children.[1] In a recent paper presented at the Annual Meeting of Planned Parenthood World Federation in October 1969, Charles Westoff commented on a re-analysis of the 1965 National Fertility Study regarding the extent of unwanted fertility in the U.S.[2] This sample was based on a representative sample of married women in their childbearing years. The term "unwanted fertility" refers to excess fertility or births that would not have occurred had the married couples had access to perfect contraception. The findings of the analysis by Westoff are summarized:[3]

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[1]Mollie Orshansky, "The Shape of Poverty in 1966," Social Security Bulletin (March 1968), p. 13.

[2]Larry Bumpass and Charles Westoff, "Unwanted Births and U. S. Population Growth," Family Planning Perspectives, Vol. 2, No. 4 (October 1970), pp. 9-11.

[3]Ibid.

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1. A substantial proportion of recent births to married couples was unwanted. Twenty-two per cent of all births to married couples were unwanted by at least one spouse. As would be expected, the per cent unwanted increased rapidly by birth order: 5 per cent of first births, 35 per cent of fourth births and more than half of sixth or higher order births were reported unwanted by at least one parent.

2. As would be expected, the incidence of unwanted births varies inversely with education and income. The incidence of unwanted births was very much higher among the poor than non-poor, 62 per cent and 17 per cent respectively.

3. For the six year period from 1960-1965, Westoff estimates that there has been between 4.7 million and 5.9 million unwanted births in all socioeconomic groups or roughly between 3/4 and 1 million births per year. The poor had between 2.2 and 2.7 million unwanted births, while the non-poor had between 2.5 and 3.2 million unwanted births.

The conclusion seems obvious, i.e., the elimination of excess fertility - births that either parent or both originally would have preferred to have avoided, would produce a marked impact upon improving the life situation of millions of American near poor and poor families.

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National and local studies have provided convincing evidence that families having between two and four children are preferred by an overwhelming majority of American parents.[1] Desired family size often does not determine the number of children actually born. As of 1955, a substantial segment of women were found to have experienced excess fertility.[2] Between 15 and 30 per cent of married women reported one or more pregnancies and births beyond the number either they or their husbands really wanted. Among the least educated and poor families unwanted pregnancies were found to occur with much greater frequency. In 1960, the failure rate of this group remained unchanged. In contrast to the rest of the population they expressed doubt as to their ability to forestall additional unwanted pregnancies in the future.

One of the early and outstanding fertility studies is the Indianapolis Study. Two types of situation existed during the late thirties which prompted the household survey of 2,589 native white Protestant couples with wives under 45 years of age. One was the generally low level of birth rate during the 1930's, especially in the urban areas. The other was the existing status of research in differential fertility. The study was conducted in Indianapolis in 1941. Kiser and Whelpton in a critique of their own study indicate that it is

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[1]Arthur Campbell, "The Growth of American Families Studies" Welfare in Review (October, 1965), 3, No. 10, pp. 124-131 and Ronald Freeman, Pascal Whelpton and Arthur Campbell, Family Planning, Sterility and Population Growth (New York: McGraw-Hill Book Co., 1959)

[2]Ibid., p. 126.

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not socioeconomic status per se but rather the underlying attitudes and psychological characteristics of these classes that account for the fertility behavior.[1] The 1955 Growth of American Families Study was based on a sample of 2,713 white women aged 18 to 30, currently married and either living with husbands or temporarily separated because of their husbands being in military service. The results of this study indicated that religious beliefs, education, income and employment of wife were significant factors which influenced the use of birth control. Eighty-four per cent of the women who were college graduates and seventy-four per cent who were high school graduates favored and had used some form of contraceptive whereas only forty-eight per cent who had less education reported using a birth control method.

This study provided the first information on family planning variables for a nationwide sample of couples. This study was limited to white couples for reasons of economy. One of the major findings of the study was that nearly one-third of the couples were below normal in their ability to reproduce. This subfecund segment of the childbearing population reported a wide range of impairments. One in ten of all wives reported that they or their husbands had had an operation that prevented childbearing. Another important

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[1]Clyde Kiser and Pascal Whelpton, Resume of Indianapolis Study of Social and Psychological Factors Affecting Fertility (Glencoe, Ill.: The Free Press, 1956), pp. 256-271.

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finding of The 1955 Growth of American Families Study was that nearly all couples had some limitation on their fertility. The proportion reporting that they had ever used contraception was 70 per cent. An additional 9 per cent expected to use contraception. This left 21 per cent who had never used contraception and did not intend to so so. Most of these couples were below normal in the capacity to reproduce. Only 4 per cent of the couples were able to have more children and said that they had not used contraception and did not intend to do so. In other words, 96 per cent of all the couples had or expected to have some limitation on their fertility.

In spite of the widespread use of contraception, the 1955 study showed that many couples were unable to control fertility to the extent desired. Thirteen per cent of the wives reported that they or their husbands had had more children than they had wanted. The comparable proportion was higher for couples with low incomes and low educational attainment.[1]

In a Chicago fertility survey conducted in 1959 with 758 ever married females under 45 years of age with a racial composition of 349 white and 409 black, the study findings suggested that while practioners are labeling "weak motivation" as the reason for high fertility, an alternative explanation

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[1]Arthur Campbell, "The Role of Family Planning in the Reduction of Poverty," Journal of Marriage and the Family (March 1968), pp. 236-245.

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needs to be researched.[1] Perhaps a more fundamental explanation is the combination of limited or inadequate knowledge of modern contraceptive methods and comparative availability of health services rather than a hostile attitude toward fertility limitation.

Of general relevance to this study is Elizabeth Bott's concept of conjugal role relationship.[2] This involves a pattern whereby husband and wife share many interests and activities in which they interact as a couple among scattered other couples. In contrast families characterized by separated conjugal role relationships engage in few activities and each spouse moves within a relatively closed external social network. In Family Design, Rainwater applies this theory to a sample of 257 families and found a close tie between class position and type of conjugal role organization.[3] The segregated roles typical of so many lower class couples inhibit communication between husband and wife, especially in areas as sensitive as sexual behavior. When communication is inhibited the likelihood of conflict regarding sexual relations is increased. Contraception only further complicates a very touchy matter and using it consistently and effectively depends

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[1]Donald S. Bogue, Sociological Contributions to Family Planning Research (Chicago: University of Chicago Press, 1967), pp. 3-34.

[2]Elizabeth Bott, "Conjugal Roles and Social Networks," The Family (New York: The Free Press, 1968), pp. 272-281.

[3]Lee Rainwater, Family Design (Chicago: Aldine Publishing Co., 1965), p. 144.

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upon a degree of mutuality in attitudes toward sex. There is an apparent decline in interest in sexual relations as one goes down the social class scale. The decline is sharper for women than for men and the largest difference is between lower-lower class men and women and those in higher status. These differences seem to be very much a function of the total conjugal relationship.[1]

Central to effective family planning is a particular world view on the part of the planner. To plan means to look ahead, to orient oneself toward the future and to make commitments both to oneself and to others. To plan is to consciously choose between alternative courses of action and to pursue the course chosen in an energetic and consistent manner. Planning requires an active mastery over one's impulses, energies and capacities and to a considerable extent of one's environment. Many social researchers suggest that such a view is difficult for the lower class person to maintain.[2] It can be argued that the lower classes are less able to defer gratification. This inability to delay action in order to reap future rewards incorporate elements of self-defeatism and like the culture of poverty must be questioned. The culture of poverty theme underestimates the changeability of many of the poor in new circumstances. For example, Jaffe reports that birth control

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[1]Ibid., p. 260-291.

[2]Oscar Lewis, LaVida: A Puerto Rican Family In The Culture of Poverty (New York: Random House, 1966), p. 1-44.

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methods are accepted with surprising rapidity by the poor who were supposed to be highly resistant to this kind of planning.[1] If the culture of poverty is more than an interesting metaphor, it implies an intergenerational transmission of values and practices which inhibit constructive action. Proponents of the culture of poverty concept such as Michael Harrington failed to fully understand Lewis's point; that he is not talking about all the poor. While many patterns and orientations are carried from one generation to the next considerable variation occurs among the working class. Many positive elements of strength of coping exist.[2]

In the United States, poverty, ignorance and a high birth rate are closely related.[3] The proportion of couples in the U.S. who have not used and do not expect to use contraception is presently about 14 per cent. Among white couples in which the wife had no more than a grade school education, the proportion is 28 per cent. Among non-white couples, the proportion is 43 per cent. The highest proportion of couples who never employ contraception or who have children beyond the number they intend is found among non-whites who live

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[1]Frederick Jaffe, "Family Planning, Public Policy and Intervention Strategy" (1965), referred to S.M. Miller, et. al., Social Class and Social Policy, p. 66.

[2]Ibid., p. 58.

[3]The Growth of U.S. Population, Publication 1279, (Washington, D.C.: 1965), National Academy of Sciences - National Research Council, p. 10.

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in the rural South, or who have a rural southern background. Low income families do not want more children than do the families with higher incomes, but they have more because they do not have the resources to plan their families effectively according to their desires.[1]

The basic facts outlining the trend of white and black fertility changes since World War II are hardly in dispute. The post-war baby boom was the result of increased levels of fertility among all Americans, but was more pronounced among black families. Black fertility increased very rapidly in the late 1940's and continued at quite high levels until 1957, when it began to decline along a path parallel to the decline in white fertility. In the past several years there has been a somewhat larger absolute decline in black fertility rates than in white rates.[2] Nevertheless, in 1963 black fertility was still 40 per cent higher than white - 144.8 births per thousand women aged fifteen to forty-four compared to 103.7.[3] This fertility differential has been especially puzzling to demographers, because it occurred at a time when the black population was becoming increasingly urbanized, achieving higher educational levels, and improving on some socioeconomic indices. There are changes of course,

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[1] Ibid., p. 10.

[2] Adelaide Hill and Frederick Jaffe, "The Negro American." Planned Parenthood-World Population (New York: 1966), p. 206.

[3] Ibid., p. 207.

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which in many societies have, in the long run, been associated with declining fertility levels.

If likes are to be compared with likes, it is essential that differential fertility be analyzed among comparable groups. Thorough studies of post-war trends in white-black fertility reveal that when various measures of socioeconomic status are held constant, white-black differences in fertility are either reduced very significantly or eliminated entirely. The 1960 census showed that blacks with four years of high-school education has about the same number of children as whites with the same amount of education, while those with four years of college have fewer than comparable whites.[1]

Hill and Jaffe report that higher fertility levels among the blacks are the result partly of the unusually high fertility of black couples who live in the rural South and partly of the moderately high fertility of many blacks who were born in the South and have since emigrated. When one examines the data regarding blacks who have no previous southern farm residence, one finds average past and expected number of births that do not differ significantly from those of white couples. In other words, by the time black couples are one generation or more removed from the rural South, their fertility is very much like that of the white population.[2]

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[1]A. Hill, F. Jaffe, op. cit., p. 208.

[2]Arthur Campbell, "Fertility and Family Planning Among Non-white Married Couples in the U.S." Eugenics Quarterly, 12, No. 3 (September 1965), pp. 131-132.

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This finding of The 1960 Growth of American Families Study is especially interesting in light of the fact that blacks who are one generation or more removed from the rural South are still subject to continuing discrimination in employment income, housing, health services, etc. which does not affect many of their white counterparts.

The 1960 Growth of American Families Study provided for the first time, a nationwide view of the family size preferences of black families. The study demonstrated that black wives wanted fewer children than white wives. The average number wanted by non-white respondents was 2.9 compared to 3.3 by the white wives. Only a small number of non-white wives currently living on southern farms expressed a desire for more children than their white counterparts. Furthermore, 46 per cent of non-whites said they wanted no more than two children compared to 29 per cent of the whites.[1]

Catherine Chilman has highlighted some of the major family planning research findings regarding the poor in this country.[2] Prior to noting several of these findings it is worth mentioning that most fertility studies are generally limited to married couples only; are not national in scope and tend to focus upon selected urban areas. Such studies

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[1]Pascal Whelpton, Arthur Campbell and James Patterson, Fertility and Family Planning in the United States (Princeton, N.J.: Princeton University Press, 1966).

[2]Catherine Chilman, "Poverty and Family Planning in the United States. Some Social and Psychological Aspects and Implications for Programs and Policy." Welfare in Review, 4, No. 4 (April 1967), pp. 3-15.

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do not make fine enough distinctions between working class and very poor groups. Non-white samples are either not included or are very small and women are the chief respondents for the majority of fertility studies. Despite such gaps and limitations a good deal of information is available which should prove helpful to practitioners, administrators and researchers as they seek to develop effective family planning programs for the poor. Several fertility researches by Kiser, Bogue, Westoff, Beasley, Rainwater, etc., suggest the following information:

- Most people in the U.S. approve of the concept of family planning.
- All socioeconomic levels in this country desire between two and four children.
- Evidence is beginning to emerge that families with more than four children, even when controls are established for differences in socioeconomic level, are less likely to be viewed by the children as happy ones, and are less likely to produce self-reliant, outgoing youngsters who achieve well in school.
- The basic reason for limitation of family size given by couples in the U.S. is an economic one. It is clearly tied to a desire to provide a better quality of life for one's child.

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— The desire for small families and for effective contraception is highly associated with: urbanization, education - more than an eighth grade education and high aspirations for one's children. In this country, however, urbanization has failed to have a sharp distinctive impact on desire for small families and related contraceptive practice that was anticipated by urban sociologists. These anticipations were based on the experience of Western European countries and on theories of urbanization. Urban and rural families in the U.S. are highly similar in generally wanting between two and four children and in having this number of children. The distinctively different group consists of those families living in the rural South and recent urban migrants from that region, especially black families. The relatively greater poverty, isolation and racial segregation of the rural South probably play a large part in the different family planning attitudes, information levels and practices found in this region.

— Large families increase the problems of the poor. A small income has to be divided into even more parts. Children suffer extra amounts of economic, physical, social and psychological deprivations.

— The life styles more typical of the poor include elements that create a variety of problems for

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them and tend to stand in the way of their movement out of poverty. These life styles affect family planning attitudes and practices in a variety of ways. Attitudes of fatalism, magical thinking, apathy, lack of time orientation and hostile alienation from the more advantaged sector of society - especially its social institutions tend to stand in the way of active planning for marriage, child spacing, family size and future goals for one's self and one's children.[1]

Rainwater has investigated other aspects of family life styles which are prevalent among the poor:[2]

1. A larger proportion of middle class families than poor families report happy marriages and mutually satisfying sex relationships.

2. Low income men and women tend to live in quite separate social and psychological worlds with very little communication between husband and wife, whereas communication and shared activities are clearly related to marital happiness and sex satisfaction and communication and marital happiness are closely associated with effective family planning.[3]

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[1] Ibid., pp. 3-15.

[2] Lee Rainwater and Karol Weinstein, "A Qualitative Exploration of Family Planning and Contraception in the Working Class." Marriage and the Family (August 1960), pp. 119-141.

[3] Ibid., pp. 181-191.

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> 3. Hostile and mutually exploitative attitudes are likely to occur between the sexes in low income groups; the male tends to play an authoritarian role in the family, a larger number of marriages are broken by divorce, desertion and separation.[1]

Perhaps Rainwater's most pertinent insights were with regard to conjugal roles. The segregated roles typical of so many lower class couples inhibit communication between the marriage partners, especially in areas as sensitive as sexual behavior. When communication is inhibited, the likelihood of conflicts regarding sexual relations is increased. Contraception only further complicates a very sensitive area, and using it consistently and effectively depends upon a degree of mutuality in attitudes toward sex, a condition which often tends to be absent.[2]

The difficulties which prevent the consistent, effective usage of coitus-related contraceptives may engender what can be conceptualized as a cycle of pessimism surrounding contraception.[3] Lower class women often reach adulthood ignorant and misinformed about the process of procreation, let alone methods of contraception. Medical advice regarding this concern is rare, since the poor do not generally visit

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[1] Ibid., p. 180.

[2] Ibid., pp. 60-122.

[3] Steven Polgar, Human Organization (New York: The Free Press, 1966), pp. 326-327.

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physicians for preventive medicine. Furthermore, many lower class women find it uncomfortable to discuss contraception. Thus a woman often finds herself with several children early in marriage as a result of sporadic use of birth control or neglect of the matter altogether. Such pregnancies tend to undermine the belief not only in the effectiveness of family planning but, also in her own capability to effectively use methods. This detrimental interplay according to Polgar between attitudes and behavior forms a cycle of pessimism.[1]

The contraceptive methods available prior to 1960 were found to be more often used belatedly, sporadically, or inappropriately by the poor than by the population at large.[2] Several factors appeared to account for this differential. Prominent among them were fear and misinformation concerning contraception, lack of funds to purchase supplies, poor communication or disagreement between husbands and wives as to the number of children desired, ambivalence about any interference with sex and reproduction, delay in resorting to contraception, marital instability and a serious disorganization of family life. These conditions were often found to operate simultaneously. Inconvenience and other drawbacks in the use of existing methods provided additional

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[1] Ibid., p. 328.

[2] Gitta Meier, "Research and Action Programs in Human Fertility Control," Social Work (1966), p. 42.

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deterrents. Moreover, the most reliable contraceptives, mainly those requiring medical prescription, were found to be at least known and used by poor couples.[1]

Contrary to a widely held belief, poverty - i.e., the cycle of poverty does not necessarily breed poverty. If it did, there would be more poor Americans today than in the past. Instead there are fewer poor persons than 10 to 20 years ago. The proposition that poverty breeds poverty is actually based on the reality that in any given period, a high proportion of poor adults had poor parents than did non-poor adults. But this observation neglects the fact that many nonpoor adults were born into poor families.[2] Any society dedicated to the faith that poverty can be prevented or reduced cannot accept the belief that poverty necessarily breeds poverty. While the latter part of this statement is perhaps true to the extent that high birth rates persist among the poor, the vicious circle of large family size among the poor, coupled with inadequate education, low job skills and high unemployment can be broken. One of the means at society's disposal by which to intervene is an effective mass program aimed at assisting impoverished Americans to control their family size.[3]

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[1] Ibid., p. 42.

[2] H. Sheppard, op. cit., p. 2.

[3] A. Campbell, op. cit., p. 236.

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Apart from monetary resources, a child with fewer brothers and sisters is able to reveive greater attention from his parents. Children from smaller families tend to have greater mental development and can take better advantage of learning situations: they have more years of formal schooling. Needless to say, greater education is associated with higher occupational status, higher income and lower unemployment. Dr. John Clausen in a summary of research on "Family Structure, Socialization, and Personality" has written that:

> Children from small families tend to make higher scores on intelligence tests than children from large families, even when social class is held constant. Most impressive is the evidence provided by a longitudinal study of a stratified sample of all children born in Britain in one week in March 1946. Data on intelligence and school performance at ages 8 and 11 years were secured from more than 97 per cent of the designated children remaining alive in England or Wales - a population of more than 4000. Intelligence test scores at both 8 and 11 years showed a decline with increasing family size, a decline that was most marked in families of manual laborers. The poor performance of children from larger families was as pronounced by age 8 as by 11. Although less great at the higher status levels, the differences in favor of children from smaller families were found even among the children of professionals.[1]

An analysis of educational achievements of 45 million men (age 20-64) in the country shows that the rate of completion of high school is related to the number of brothers and sisters they had. Seventy-three per cent of those with

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[1] H. Sheppard, op. cit., p. 14.

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no siblings completed high school as compared with 60 per cent with one to three siblings and 39 per cent with four or more.[1]

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[1]Peter Blau and Otis Duncan, The American Occupation Structure (New York: John Wiley and Sons, Inc., 1967), p. 391.

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CHAPTER III

METHODOLOGY: DESIGN, SAMPLE SELECTION, ANALYSIS PROCEDURE AND STUDY LIMITATIONS

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CHAPTER III

METHODOLOGY: DESIGN, SAMPLE SELECTION, ANALYSIS PROCEDURE AND STUDY LIMITATIONS[1]

A. Design

The data for this study have been taken from a larger research project titled Pittsburgh Health and Family Project,[2] which was conducted during the summer and fall of 1969. The study was financed and conducted by the Population Division, Graduate School of Public Health. The project cost was slightly less than $5,000. The overall project was intended to be an exploratory study with about equal concentration on the following two general areas of public health concern:

1. Health needs and utilization by the poor, use of existing health facilities and reasons for non-use or under-utilization of existing health services.
2. Factors influencing the management of their life situations with specific reference to their ability to plan and limit family size.

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[1]The University of California, Santa Barbara Department of Education X-TAB Program developed in Jan. 1968 was used for the cross-tabulations (Contingency Tables) presented in this study. This is a general purpose cross-tab program written entirely in Fortran IV for the IBM 360-50.

[2]Professor Arthur Conning, Ph.D., Assistant Research Professor, Population Division, Graduate School of Public Health, University of Pittsburgh was the principal Coordinator of the project.

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The specific purpose of this dissertation is to explore some underlying dimensions of the relationship between use of health resources and family planning in two neighborhoods in an urban designated poverty area.[1] The study objective was to interview a representative sample of women of childbearing age in two Pittsburgh census tract areas. The initial study intent was to interview 100 white females and an equal number of black. A total of 212 women participated in the household interviews with resultant subtotals of 98 blacks and 100 whites completing questionnaires which were used for analysis in this presentation. The actual field work during which the data were collected lasted approximately five months, August through December 1969. Since there were fewer black interviewers at the beginning of the study, it took a longer period to complete the interviews.

Participation in the study was based upon the following criteria:

1. Each eligible respondent was female
2. She was 20 to 45 years old
3. All Spring Hill area (Census Tract 24A) respondents were white and all Manchester respondents (Census Tract 21D) were black
4. Each respondent had at least one child of her own living at home with her
5. Each respondent was either a household head or spouse of same.

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[1]This investigator joined the faculty of the Population Division in the summer of 1969 and assisted with the research design and implementation. To date, only a portion of the data have been analyzed and none of the findings have been published.

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All interviews were conducted in the respondents' homes by six female graduate students attending the University of Pittsburgh Graduate School of Public Health and the Graduate School of Social Work. In order to reduce racial bias in the responses to the questions, white interviewers interviewed white respondents and black interviewed black respondents. All completed interviews were routinely reviewed by the project coordinator to assure high quality and to verify that all questionnaire items were answered.

No contacts were attempted with potential respondents prior to the actual face to face pre-screening interview. Before administering the questionnaire, each respondent was read the following and asked several questions to determine if she would be eligible for participation in the study:

> I am from the University of Pittsburgh Graduate School of Public Health and we are concerned with things which affect health and the family. We would find it very helpful if we could speak with you. To find out whether I may speak in detail, however, I must first know something about those living in your home.

Several questions were then asked to determine if the interviewee was the lady of the house, her relationship to the household head, number of children living with her and her age.

Prior to the actual implementation of the data collection phase, several weeks were devoted to pretesting and improving the quality of the questionnaire. Initially the questions were pretested by members of the research group and this was done by first administering the questionnaire

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to one another. Next each of the interviewers tested the questionnaire by administering it to two female respondents selected from lower income families who did not reside in the study area. Appropriate questionnaire revisions were made which facilitated its implementation and response reliability. A minimum of six orientation-training sessions were provided for the interviewers to familiarize them with the questionnaire prior to their going into the field.

Before discussing the analysis procedure, it seems important to consider the related concepts of validity and reliability which are essential for judging the quality of the data.[1] Since these criteria are related, they cannot properly be considered in isolation. The poor often are used for purposes of research and have recently expressed considerable frustration regarding the limited payoffs from extensive and expensive health surveys. Community leadership in Pittsburgh had indicated that lower income blacks have been giving incorrect information to surveys conducted in their neighborhoods. Given the limiting restraints of budget and manpower, it was nevertheless felt to be important to conduct a reliability test-retest in the Manchester area. A sub-sample of the black study population was selected. The choice of an appropriate interval between the test and retest is important in considering the reliability. It serves to

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[1]Richard Linderman, Educational Measurement (N.J.: Scott, Foreman and Co., 1967), pp. 35-54.

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indicate the performance stability of the study population over a period of time, however, due to the nature of this study, it was impossible to control for this. The sample size is small and the female interviewers were not available to participate in the retest. A male Negro social work student volunteered his time to conduct the retest on a subsample of eleven cases. There was an average of eight weeks between the initial administration of the questionnaire and the followup retest on certain randomly selected knowledge and attitudinal items from the original questionnaire. The questions asked on the retest were equivalent in form to those stated on the original questionnaire.

A total of thirty items were selected from the original questionnaire for the reliability retest. These questions were equally distributed among the attitudinal and knowledge areas concerning health, family planning and general family information. For the purpose of this dissertation, only sixteen items were selected from the test-retest reliability format. Eight items related to attitudinal type questions, and the remainder dealt with information or knowledge variables. A total of sixteen crosstabulations, eight for attitudinal and an equal number for knowledge information were conducted. The correlation coefficient for the attitudinal data ranged from .545 on the item, "I doubt that doctors can do all the things they say they can do." 1) Agree - 2) Disagree, to an R of .818 for the item "Almost everyone

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worries at one time or another. Would you please tell me whether you worry about the following (family finances) a lot, a little, not at all?" The average reliability correlation coefficient for the attitudinal items is .727. For the knowledge or more exact type information items which are not as subject to variance as are the attitude factors, the range is .818 for the question "Do you and your family have a regular family doctor in private practice?" 1) Yes - 2) No, to a reliability correlation coefficient of 1.00 for the question "What was the highest grade of school that you have completed?" The average correlation coefficient for the total of sixteen attitude and knowledge items is .776. See Appendix for the individual R, per item for the sixteen variables used in the reliability test-retest. Since only one item fell below a coefficient of .7 and the overall coefficient of stability is .776, this researcher has accepted that the questionnaire is indeed reliable.

While the test-retest method of determining reliability provides information concerning the particular sample of test items used, another investigator might obtain considerably different reliability results if the test had consisted of a different sample of items. It is altogether possible that the test-retest procedure may result in an overestimate as well as underestimate of reliability because of a possible failure to account for fluctuation or differences in item characteristics among the universe of test items.

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There are often problems in interpreting responses to attitudinal questions. Verbal and non-verbal behavior often are not closely related. The critic may ask "in a sensitive area such as fertility, will people tell the truth about their beliefs and behavior?" Even with reference to the simple statistic as to how many births a woman has had, there may be difficulty in obtaining correct information. For people from various social backgrounds are neither time nor number conscious and tend to forget numbers of children born, even number of children they may now have.

In the area of fertility attitudes and behavior it would be surprising if accurate data could always be obtained. Certainly it has been possible to interview persons about many aspects of their beliefs and behavior. Some investigators say that the American public is more sensitive to answering questions about income than about sexual behavior.[1]

About fifteen years ago, questions about number of children desired, number expected, knowledge about contraceptive methods, use of contraception, etc. were seldom asked. The first representative national study in the United States was undertaken in 1955 by Freedman, Whelpton and Campbell. This study in many ways formed a model for future studies focused upon reproduction behavior. Earlier studies such as Kinsey's and the 1941 Indianapolis Study were not

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[1]W. Parker Mauldin, "Fertility Studies: Knowledge, Attitude and Practice," Studies in Family Planning, The Population Council, No. 7 (June 1965), p. 9.

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designed to be representative of U.S. women. In the middle 1930's Kelly began a study of marital compatibility among 300 engaged couples. He asked how many children they expected to have. Approximately 20 years later, these same couples were again interviewed and asked how many children they actually had. For the purpose of testing the predictability of desired family size as compared with future actual family size, only couples who remained married to their original partners were included in the followup study. No problems of sterility were reported by the couples and no children had been adopted. The resultant correlation between desired and actual family size is quite low, only 0.30. Recall of originally stated preferences revealed considerable error, associated with success in planning and actual size of family following the procreative period.[1]

B. Sample Selection

The communities from which the sample was drawn, are located in two nonadjacent census tracts on the Northside of Pittsburgh. The Manchester residents are predominantly black and those of Springhill are white.[2] It was not possible to

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[1]Charles Westoff, E. Mishler and L. Kelly, "Preference in Size of Family and Eventual Fertility Twenty Years After." American Journal of Sociology, Vol. 62 (1957), pp. 491-497.

[2]In contrasting the Manchester and Spring Hill neighborhoods the researcher's primary concern is the analyses of selected health characteristics and their relationship to key fertility variables. It is not the primary intent of this research to conduct a comparative analyses between whites and blacks, however, interesting differences do arise and are presented. The rationale for this consideration is that the two communities' social patterns, history of urban blacks and whites are sufficiently dissimilar and do not permit treating the data as representative of one study population.

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secure in advance a list of families satisfying the research selection criteria. Therefore, a list of occupied dwellings had to be compiled for both the Spring Hill and Manchester census tracts. The project staff walked on every street in the defined areas and sequentially recorded the address of each dwelling believed to be occupied. In the Spring Hill area, a total of 1344 addresses were recorded and a total of 665 were listed for Manchester. Most of the dwellings were occupied by at least one family. Several Manchester dwellings had multiple families. This was not discovered until during the actual data collection.

When the list of housing structures was completed, each unit was assigned a number. Since an equal probability model was used to select the sample, each dwelling had the same chance of being selected. Housing structures that were selected by a random process from the list of all Spring Hill and Manchester housing structures in the survey areas were assigned a case number. These were the dwellings that had to be visited by the interviewers in order to determine eligibility for participation in the study. Several housing structures had more than one household. Each household within a housing structure was identified by the case identification number. Each case number is a three digit number, e.g. 001, 661, etc. Each household within a case was assigned a two digit number, e.g. 01, 02, etc. If only one household exists within a case, it always had a household

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number of 01. The eligibility interview, which was applied to each and every household within a case determined whether the respondent or lady of the household was eligible for the main female interview.[1]

The sampling fraction for the study was based on the following:

1. The number of families wanted for the study sample - 100 white and 100 black. A total of 440 housing structures in Spring Hill and 430 in Manchester were randomly selected from the compiled lists and visited by the assigned interviwers.
2. Estimate of the number of households within a single housing structure.
3. The proportion of households with the desired characteristics - female respondent born between the years 1924 and 1949, having at least one of her own children living with her.
4. The anticipated response rate - once an eligible respondent was identified and consented to the interview, the main questionnaire was then administered.

There were relatively few refusals in both the Spring Hill and Manchester areas (9 white and 1 black). The overall response rate taking into account refusals, absentees, ineligible persons, etc. was 85 per cent for the white census area

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[1]For the purpose of this study the lady of the house was defined as being the wife of the household head or a female household head who had not yet reached her 45th birthday.

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and 81 per cent for the black. The housing units were selected from compiled lists for each census tract using a random sample table. Every household within each dwelling selected, was considered to have been selected once the housing structure itself was randomly identified as a possible component of the sample. Once the dwelling was selected by the random number process, it had to be visited.[1] It was not permissible to substitute an eligible family not on the list of randomly selected houses. A household with no one home was revisited. If following three attempts, no one was contacted the household was listed as absentee.

C. The Analysis Procedure

The technique employed for data analysis is to cross-classify the two samples of women according to their fertility attitudes and behavior (dependent variables) according to, for example, use of public and private health resources (the independent variables). For purposes of analysis, the samples are always controlled on race. In many studies dealing with fertility where data on religion have been available the white study sample is usually divided into Catholic and Protestant. For several of the crosstabulations in this study Catholic and Protestants among whites only are separately treated.

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[1]Leslie Kish, Survey Sampling (New York: John Wiley and Sons, Inc., 1965), pp. 385-386.

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The data presentation is divided into three chapters. The first is devoted to presenting a general description of the poverty area and the study population families. The second part addresses the first hypothesis concerning the relationship and direction between use of health services and resultant family planning attitudes. The final analysis chapter represents an effort to explain the influence of health services use on selected fertility behavior.

The data analysis was aided by the 360 computer which is available at the University of Pittsburgh for unsponsored research to doctoral candidates and others involved in unfunded research. Given the sample sizes of 100 whites and 98 blacks the critical question evolved as to how many control variables could be simultaneously crosstabulated and how many cells the tables could have before the crosstabulations became meaningless due to insufficient frequencies. While several of the tables are not statistically significant at the .05 or .01 levels using the chi square or Fisher's Exact Probability, the importance of the analysis is to determine if a relationship in the hypotheses exists and its direction. Socioeconomic status,[1] religion, age, socialization and marital status are used as test variables in the tables.

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[1]See Chapter V for explanation of procedures for defining socioeconomic status, preventive health orientation and health worry cluster. While it may have been preferable to have used additional categories for these component variables, this was not possible due to the size of the study sample.

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All tables are controlled on race. For the purpose of analyzing the hypotheses and describing the community, contingency tables based upon the following outlines are constructed depicting fertility beliefs and behavior patterns (Table 3.1 and Table 3.2).

TABLE 3.1

HEALTH BEHAVIOR AND FERTILITY ATTITUDES

Independent Variable	Dependent Variable	Major Control Variable Race: White/ Black	Selected Test Variables: Age, SES, Rel., Socialization Marital Status
Use of public/ private health care	Desired family size	"	"
Preventive health orientation	"	"	"
Health worry cluster	"	"	"
All of above	Importance of having children desired	"	"
Where appropriate i.e., intact family, all of above	Husband/s desired family size	"	"
All of above	Ideal child spacing	"	"
All of above	Importance of child spacing	"	"

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TABLE 3.2

HEALTH BEHAVIOR AND FERTILITY PERFORMANCE

Independent Variable	Dependent Variable	Major Control Variable Race: White/ Black	Selected Test Variables: Age, SES, Rel., Socialization Marital Status
Use of public/ private health care	Number of children born	"	"
Preventive health orientation	"	"	"
Health worry cluster	"	"	"
"	Present contra-ceptive methods	"	"
"	Confidence in present methods	"	"
For intact families all of above	Husband's attitude toward present method	"	"
All of above	Parity when used family planning	"	"
All of above	Status of last or current	"	"

D. Community Description and Study Sample: Response to Family Planning

Descriptive statistics have been used to outline some of the study sample's social characteristics. This also includes a description of Manchester and Spring Hill areas.

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Parameters such as age, annual income, education and marital status have been presented for both the white and black study groups. Additional descriptive tables are provided in order to present the following information regarding the study population's beliefs and use of the local Planned Parenthood and other health agencies which offer birth control information and services:

1. Attitudes regarding who should provide family planning services.
2. Family planning services currently used by study population.
3. Reasons for not using such services.
4. Respondents currently using Pittsburgh Planned Parenthood.
5. Reasons for not using the Pittsburgh Planned Parenthood.

E. Study Limitations

A criticism which can be directed at survey research is that the interviewee often responds to attitudinal questions that do not represent his considered judgment. The same question posed to the respondent at a different time may elicit an entirely different response. This type of criticism may be even more relevant for questions which relate to the sensitive area of human fertility.

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The female of the household is the sole respondent. Although attitudes and utilization of health services and family planning are analyzed in terms of the family, the orientations are those of one member. The data which this study has received regarding the male's attitude to family size limitation have been derived through interviews with female respondents. While an adequate analysis of the male's beliefs and behavior with respect to human fertility is incomplete, there are some studies which indicate that the mother is the significant decision maker in health related matters for the family.[1] Finally, the study sample is small and generalizations regarding the findings should be interpreted with caution and only relative to the two selected census tracts and similar urban areas.

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[1]Ray Elling, et. al., "Patient Participation in a Pediatric Program." Journal of Health and Human Behavior (Fall 1960), pp. 183-191.

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CHAPTER IV

COMMUNITY DESCRIPTION, STUDY SAMPLE PROFILE AND PITTSBURGH FAMILY PLANNING CRISES IN RETROSPECT

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CHAPTER IV

COMMUNITY DESCRIPTION, STUDY SAMPLE PROFILE AND PITTSBURGH FAMILY PLANNING CRISES IN RETROSPECT

A. General Description

Pittsburgh is the industrial and population center of southwestern Pennsylvania. It is the second largest city in the Commonwealth of the State, having a population density of 2,237 people per square mile. Ninety-three per cent of the people are regarded as urban residents.[1] In 1967 the total County population was slightly more than 1.5 million people which totaled approximately 419,000 families with a median income of $6,173 per year. It is estimated that roughly 14 per cent of the total families in Allegheny County earn $3,000 or less per year.[2] In 1966, Allegheny County had a 9.4 per cent non-white population which was 99.2 per cent black. The Pennsylvania Department of Health, Bureau of Planning estimates that the 1970 non-white population in Allegheny to be 160,152. Slightly more than 20 per cent of the Pittsburgh population was non-white in 1967.[3]

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[1] A Population Profile with Implications for Health Planning, Human Service Region V - Series 11, Pennsylvania Department of Health, Issues March 1968, p. 16.

[2] The Pittsburgh Standard Metropolitan Statistical Area, A Preliminary Plan for a County-Wide Family Planning Program, June 1970, p. 14.

[3] "Statistical Bulletin," February 1970, Vol. 51 Metropolitan Life, p. 6.

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It is difficult to get reliable census information on the number of Catholics residing in Pittsburgh. According to the Pittsburgh Plan For A Community Wide Family Planning Program, data on a parish by parish basis are not available. For the Diocese of Pittsburgh which includes several Counties with a total population in excess of three million people, approximately 30 per cent are Catholic.

Both the Manchester and Spring Hill census tracts are located in an Office of Economic Opportunity designated poverty area. Most of this territory is very hilly and transportation is a particular problem, especially in the winter. Like many Pittsburgh communities the closer residents are to the river the higher the incidence of poverty. With the exception of the Planned Parenthood mobile unit which provides services once per week other public planning services are located across the river. It has been reported that a neighborhood health center will be built under the Model Cities Program in the Manchester area. When this occurs, consideration may be given to moving the Manchester Planned Parenthood operation to that site. Allegheny General Hospital which provides family planning services to both the Manchester and Spring Hill residents is located about equidistant from the two census areas selected for the study. The hospital has operated a family planning clinic for two years and serves only low income families. Again, transportation is a particular problem for those coming from the other

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side of the river. Allegheny General has recently opened a satellite center in Northview Heights, however, residents in the Spring Hill area have limited access due to distance from the facility.

The census areas from which the black and white samples were selected are located on the northside of Pittsburgh. The black study group was drawn from one of the three census tracts that encompass the Manchester area. As a result of considerable urban renewal in the area, the construction of Three Rivers Stadium and Interstate Highway #79, many of the black families have begun to move to the fringe area of the neighborhood.

The Spring Hill area from which the white sample was chosen has not had to face such extensive transitional problems. This neighborhood is encompassed by two census tracts and is located above the East Street area. The Pennsylvania State Highway Department currently is widening Route 8 which runs through this neighborhood. The area also is experiencing the influx of many white families who have fled the fringe areas of Manchester.

In order to more adequately present the research findings of this study, this Chapter describes selected social and demographic characteristics of the study population. It will be noted that this study uses variables often employed in surveys dealing with differential fertility attitudes and practices between whites and blacks. This Chapter presents

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several descriptive variables which are used in subsequent Chapters in crosstabulations for purposes of analyzing the study hypotheses. Several variables which are presented in this Chapter controlled on race for the purposes of presenting and comparing the study population are: migration, age of respondents, number of children ever born, distribution by religious affiliation, approval or disapproval of family planning, desired or preferred number of children, distribution of reasons for approval or disapproval of family planning, socioeconomic status and general attitudes toward Pittsburgh Planned Parenthood Association.

B. Summary Profile

There are no studies which have considered the relationship between the differential use of health services and fertility attitudes and practice regarding family size. It is appropriate to summarily describe the social characteristics of the study population prior to analyzing the direction of the hypotheses in this study:

1. There is a total of 198 female respondents, 100 white and 98 black in the study sample.
2. The average age for both the white and black respondents is 32 years.
3. Twenty-seven of the black respondents had experienced their primary period of socialization in the South and did not migrate to Pittsburgh until after their sixteenth birthdate. Ninety-eight

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per cent of the whites were raised in Pittsburgh or other areas in Pennsylvania.

4. Seventy-five per cent of both groups believed family planning to be very important and beneficial to the families economic and health well-being.

5. The median desired family size was 4 for whites and 3 for blacks.

6. While most families prefer a small family size, 25 per cent of both whites and blacks have five or more children.

7. Sixty per cent of the black respondents and 30 per cent of the whites gave birth to at least one child before reaching their twentieth birthdate.

8. An average of three children were living with at least one natural parent at the time of the study.

9. There were no single white respondents in the study sample and only twelve black. For 88 per cent of the white group this was their first marriage as compared to 75 per cent for the blacks.

10. The median educational level achieved by both groups was 10 years. There were no college graduates in the entire study population.

11. The average annual gross incomes for whites was $5000 and $4000 for blacks.

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TABLE 4.1

SELECTED CHARACTERISTICS OF THE STUDY POPULATION CONTROLLED ON RACE, PITTSBURGH POVERTY AREA, 1969

Characteristics	White	Black
Average annual household income	$5000	$4000
Per cent with income under $3000	7%	25%
Per cent with Public Assistance as income source	21%	59%
Median education level for respondents	10 yrs.	10 yrs.
Average age for respondents	32 "	32 "
Mean number of persons in household	5.0	5.9
Per cent of households with no male adult	16.0%	52.04%

Data are presented on both white and black respondents by migration status since region of origin was viewed to be a significant factor associated with use of medical resources and fertility attitudes and behavior. This assumption is later analyzed in the Chapters dealing with the differential use of health services and fertility beliefs and practices. A respondent was considered to be a nonmigrant if she could be assigned to one of the following categories:

1. Born in Pittsburgh, has always lived there.
2. Born in Pittsburgh and lived there up through the age of 16 years.
3. Not born in Pittsburgh but lived there from age 5 years through 16 years.

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All other persons were considered migrants. The researcher believed that by the age of 16 years most people have experienced a large proportion of their socialization and influence of their environment. The following table depicts responses to the question - When you were growing up (6 to 16 years) in what place did you live most of the time?

TABLE 4.2

RACE AND MIGRATION STATUS OF FEMALE RESPONDENTS AGED 20-45 YEARS, PITTSBURGH POVERTY AREA, 1969

	Migration Status					
Race	Migrant		Non-migrant		Total	
	No.	%	No.	%	No.	%
White	14	14.00	86	86.00	100	100.00
Black	36	36.73	62	63.27	98	100.00

Approximately one-quarter of the blacks had been reared in the South and moved to Pittsburgh after their sixteenth birthday. Almost all of the whites with the exception of two per cent were raised in Pittsburgh or other areas in Pennsylvania. There were no respondents in the study sample born outside of the United States. In all, approximately 75 per cent of the entire study population lived during their growth and development years in Pittsburgh while the remainder grew up in other areas of Pennsylvania and the deep South.

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Ninety-four per cent of the whites as compared to 81 per cent of the blacks have lived in Pittsburgh for 10 or more years. Of those blacks reared in the South about 90 per cent were raised on farms or in country-like areas. Whites were raised in predominantly urban-like areas.

The mean age for both white and black respondents was 32 years. This also was the median age for the whites as compared to 31.5 for the blacks. In 1966, the median age for the population of Allegheny County was 31.6.[1] As initially defined in the selection criteria all female respondents were between the ages of 20-45 years. While families in the study sample were not always intact with a male household head present, it was not always possible to determine the ages of the male partners. The mean age for the male spouses was considerably higher for both the white and black groups 36 years and 45 years respectively. Whites ranged from 20 to 55 years and blacks from 19 to 54 years.

White females in the study were also grouped according to Catholic and non-Catholic status, since previous researches have shown significant differences in fertility beliefs and practices among these two religious groups.

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[1] Op. cit., The Pittsburgh S.M.S.A., p. 14.

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TABLE 4.3

DISTRIBUTION OF WHITE RESPONDENTS' RELIGIOUS AFFILIATION, PITTSBURGH POVERTY AREA, 1969

Religious Affiliation			
White Catholic		White Protestant	
No.	%	No.	%
64	64.00	36	36.00

The black females were not controlled on religious affiliation since only four were Catholic and the vast majority were Protestant. Nearly two-thirds of the white respondents were Catholic. Fifty-nine of them were married to Catholic husbands. The original study design was to have the white respondents evenly divided between Catholics and non-Catholics, however, it was not possible to determine prior to the interview the religious composition of the Spring Hill area.

In response to a question on family limitation, the data showed an overwhelming majority of the respondents approved the general idea of family planning. Each respondent was asked the question - Do you think that it is very important or very unimportant that a couple not have any more children than they really want?

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TABLE 4.4

ATTITUDE TOWARD FAMILY PLANNING BY RACE,
PITTSBURGH POVERTY AREA, 1969

Attitudes	White		Black	
	No.	%	No.	%
Very important	74	74.00	74	76.29
Uncertain	9	9.00	9	9.28
Very unimportant	17	17.00	14	14.43
TOTAL	100	100.00	97*	100.00

TABLE 4.5

ATTITUDE TOWARD FAMILY PLANNING
REGARDING APPROVAL OR DISAPPROVAL BY RACE,
PITTSBURGH POVERTY AREA, 1969

Attitudes	White		Black	
	No.	%	No.	%
Strongly approve	74	74.00	74	76.29
Uncertain	9	9.00	9	9.28
Strongly disapprove	17	17.00	14	14.43
TOTAL	100	100.00	97*	100.00

*Please note that totals for whites and blacks do not always equal 100 and 98 respectively. This is due to a non-response to an item by respondents.

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The same totals both for whites and blacks, 74 each, strongly approved of family planning. Similarly, the data in Table 4.6 indicate that four-fifths of the whites and almost 85 per cent of the blacks prefer a family size of not more than four children.

TABLE 4.6

DISTRIBUTION OF DESIRED FAMILY SIZE FOR WHITE AND BLACK RESPONDENTS, PITTSBURGH POVERTY AREA, 1969

Desired Family Size	White		Black	
	No.	%	No.	%
1 - 2	30	30.30	42	46.67
3 - 4	52	52.52	34	38.00
5 plus	17	17.27	14	15.50
TOTAL	99	100.00	90	100.00

$X^2 = 5.60$, $P < .10$

While the overall X^2 test did not attain statistical significance, the distributions of black and white respondents with respect to what they consider desired family size show discrepancies that approach this level. (Computed $X^2 = 5.60$, which falls just a little bit shy of the critical value of 5.99 at 2 degrees of freedom.) It is felt that significance should be attached to at least

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one aspect of the data, namely that a larger proportion of the black respondents prefer 1 to 2 children while slightly more than one-half of the white study group prefers 3 to 4 children. Less than 20 per cent of either racial group prefer five or more children. There are some indications that black respondents preferred smaller family sizes than the white. No respondent in either group aspired to be childless. The median preferred number of children for both blacks and whites was 3.0, while the mean was 3.8 for whites and slightly less at 3.4 for blacks.

The 1960 Growth of American Families Study was based on a study of 2,713 white women aged 18 to 30, currently married and either living with their husbands or temporarily separated because of their husbands being in military service, reported that 94 per cent of the wives in the sample preferred two to four children in the family.

Each respondent was asked to give a reason for selecting a family size preference. The prime reason for selecting a limited family size was economic and/or to provide an educational opportunity for the children. This held true for both the white and black study groups.

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TABLE 4.7

REASONS FOR DESIRED FAMILY SIZE BY RACE, PITTSBURGH POVERTY AREA, 1969

Reasons	White[1] No.	White[1] %	Black[2] No.	Black[2] %
Economic and/or education	45	51.72	38	55.07
Health of mother or other family member	3	3.45	5	7.25
Other reasons	39	44.83	26	37.68
TOTAL	87	100.00	69	100.00

$X^2 = 1.715$, $P>0.250$

Both whites and blacks tended to cite similar reasons for selecting limited family size and to identify an economic and/or desire to provide an adequate educational opportunity for the children as the reasons for desiring small families.

Table 4.8 shows the percentage distribution of the number of respondents' children. It is important to keep in mind that one-half of these women were aged 32 years or less. All respondents still had potential reproductive years in which to bear additional children.

[1] 13 White respondents gave no reason for preferring a desired family size.

[2] 29 Black respondents gave no reason for preferring a desired family size.

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TABLE 4.8

ACTUAL NUMBER OF LIVE BIRTHS
BORN TO WHITE AND BLACK WOMEN,
PITTSBURGH POVERTY AREA, 1969

Number of Live Births	White		Black	
	No.	%	No.	%
1 - 2	39	39.00	36	36.73
3 - 4	37	37.00	37	37.76
5 or more	24	24.00	25	25.51
TOTAL	100	100.00	98	100.00

While 30 per cent of the whites and 46 per cent of the blacks respectively identify two or less children as the ideal number, actually 39 per cent of the whites and 36 per cent of the blacks have given birth to this number. Approximately one-quarter of both groups have in excess of five children; while less than 20 per cent desired families with five or more children. It should be noted that all respondents are in their reproductive years and therefore may not have completed the actual number of children they will have. Approximately 8 per cent of the white and 5 per cent of the blacks were pregnant. Ten per cent of the blacks were pregnant. Ten per cent of the blacks as compared to 5 per cent of the whites had eight or more children. The largest number of children born to a black respondent was thirteen was compared to ten for one white mother. The mean

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number of children born alive to white and black respondents was 3.4 and 3.9 respectively. While these women are still in their reproductive years, it is interesting to compare them with the number of children born by their mothers. The respondents' white mothers had an average of 7.3 children as compared to 6.5 for the black mothers. These differences may reflect the limited technological development of contraceptive methods and perhaps the desire for larger families at the time of their mothers' procreative years.

Sixty per cent of the black respondents as compared to 30 per cent of the whites had given birth to at least one child prior to reaching their twentieth birthdate. Table 4.9 provides a descriptive presentation of the ages of the respondents at the time they had their first child. A chi square test performed on these data gave highly significant results. Thus confirming the hypothesis that blacks as a group have earlier childbearing experience than whites.

TABLE 4.9

AGES OF WHITE AND BLACK MOTHERS WHEN THEY GAVE BIRTH TO FIRST CHILD, PITTSBURGH POVERTY AREA, 1969

Age Intervals	White		Black	
	No.	%	No.	%
15 - 19	31	31.00	58	59.18
20 - 24	59	59.00	32	32.66
25 plus	10	10.00	8	8.16
TOTAL	100	100.00	98	100.00

$X^2 = 16.45 > X^{2*}.05 = 5.99$ ($P<.001$)

*Critical value of chi square with 2 degrees of freedom and 5% significance level.

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Between the ages of 20 and 24 years, almost twice as many whites, 59 per cent as compared to 32 per cent of the blacks gave birth to their first child.

TABLE 4.10

NUMBER OF CHILDREN LIVING AT HOME WITH RESPONDENTS AT TIME OF INTERVIEW, PITTSBURGH POVERTY AREA, 1969

Number of Children	White		Black	
	No.	%	No.	%
1 - 2	44	44.00	46	46.94
3 - 4	40	40.00	33	30.67
5 or more	16	16.00	19	19.39
TOTAL	100	100.00	98	100.00

An average of three children for both groups were living at home with their parents at the time of the interview. Seventy per cent of the black children compared to 80 per cent of the white children were 16 years or younger. Of the children who had reached their twentieth birthdate, slightly more blacks than whites, 8 per cent and 3 per cent respectively, were still living at home with a parent. It is interesting to note that Table 4.8 indicated where both white and black respondents had given birth to two or less children; Table 4.10 indicates that larger proportions of both groups have less than two children living at home.

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This is primarily due to other children growing up and leaving their parents' homes. This also is true for whites but not for blacks in the three to four children category.

Black families had slightly more members per dwelling unit than white families, 5.9 and 5.0 respectively. A considerably larger proportion of white respondents, 84 per cent compared to 47 per cent of the blacks were married and living with their husbands. Table 4.11 presents the marital status of the study population.

TABLE 4.11

MARITAL STATUS OF THE WHITE AND BLACK MOTHERS, PITTSBURGH POVERTY AREA, 1969

Marital Status	White		Black	
	No.	%	No.	%
Single	-	-	12	12.24
Married	84	84.00	47	47.96
Divorced - Widowed	4	4.00	9	9.18
Separated	12	12.00	30	30.61
TOTAL	100	100.00	98	100.00

There were no single white women in the study population. For 88 per cent of this group, this was their first marriage as compared to 75 per cent of the blacks, however, there were twelve non-responses by the blacks regarding the

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question of more than one marriage. Twelve persons in each group reported that they had been married more than once.

Regarding several of the social demographic characteristics the white and black samples are rather similar. In respect to the number of years of school completed, the median educational level for the white and black respondents was ten years. Their husbands (those living at home) also had equal medians of eleven years of schooling completed. Table 4.12 presents the highest level of education completed by the respondents.

TABLE 4.12

HIGHEST LEVEL OF EDUCATION ACHIEVED BY MOTHERS PITTSBURGH POVERTY AREA, 1969

Educational Level	White		Black	
	No.	%	No.	%
Less than grammar school	5	5.00	2	2.04
Grammar school - some high school	58	58.00	67	67.37
High school - some college	37	37.00	29	29.59
TOTAL	100	100.00	98	100.00

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There were no college graduates in the entire study sample. A larger proportion of blacks - 67.37 per cent, as compared to 58 per cent of the whites completed eight years of grammar school plus some high school. However, more whites than blacks completed high school.

The mean annual gross incomes for whites was $5000 and for blacks it was $4000. The median incomes for whites and blacks were $5000 and $4500 respectively. The median educational level achieved by respondents and the median incomes for both groups are used to form the component variable, socioeconomic status. The median income for both white and black groups combined was $4500 and the median level of years of schooling completed by both groups was 10 years.

Since contingency analysis has the advantage of reporting percentages, direction and some measure of strength of the association between variables, it was decided that the analysis would require controlling on one or more test factors. The critical problem in the later analysis of the hypotheses became how many tables could be simultaneously examined before the tables became meaningless, due primarily to insufficient frequencies in the tables. This was the primary consideration for how many classes the socioeconomic status index could have. Therefore, with a sample size of 198, the decision strategy called for dichotomizing the education and income variables at the median value of their respective distributions. The

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analytical distinctions between social groups and social categories is of prime importance. To conceptually express this differential is one thing but to empirically examine or observe it is another matter. Table 4.13 indicates a high relationship between socioeconomic status and race ($X^2 = 13.90$, $P<.005$) and the coefficient of the association is rather high. All subsequent analysis of the hypotheses while controlling on race for the purposes of comparatively presenting the data also include socioeconomic status as a test factor. This component variable has been dichotomized according to high and low socioeconomic status.

TABLE 4.13

SOCIOECONOMIC STATUS BY RACE, PITTSBURGH POVERTY AREA, 1969

Socioeconomic Status	White		Black	
	No.	%	No.	%
High SES	58	58.00	32	32.7
Low SES	42	42.00	66	67.3
TOTAL	100	100.00	98	100.0

$X^2 = 13.90$, $P<.005$

C. Family Planning Crisis in Retrospect

In 1968, a serious conflict erupted regarding the existence of an Office of Economic Opportunity (OEO) funded neighborhood Planned Parenthood program in the predominantly

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black Homewood-Brushton area of Pittsburgh. Black genocide was charged by several militant leaders and residents of the area. In 1967, Community Action for Pittsburgh (CAP) the local funding agency for OEO proposed the establishment of several neighborhood Planned Parenthood clinics in poverty areas where low income families would have ready access to the services. This local agency provides contraceptive services, marital counselling, fertility and medical services to women. Strong opposition emerged in the Homewood-Brushton area regarding its satellite center, headed by a militant leader of the United Movement for Progress and a medical advisor to the Pittsburgh NAACP. By February 6, 1969 opposition had peaked and the Homewood-Brushton Center was suspended. Almost immediately, a strong counter response evolved led by black women from the area and the program was reinstated. The medical advisor claimed: "Their one service is birth control. What about the data offered on infertility studies, marriage counselling, and pre-marital counselling?"[1] This militant leader claimed that the clinics which predominately served blacks were dirty, overcrowded and understaffed.

The issue of black power was also raised. "How are you going to build black pride," was asked by the militant leader, "if you are never going to be a father?" What he

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[1] Pittsburgh Courier, December 23, 1967.
[2] Ibid., August 24, 1968.

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is arguing is that many black men consider siring large numbers of children to be a sign of virility. There is documented evidence to refute the "machismo theory" of resistance to family planning.[1]

This study is an effort to aprise a segment of the lower income community which had been officially identified as a poverty area presented several questions regarding Planned Parenthood to the respondents. While the militant black leadership tended to oppose Planned Parenthood, this was not the case among the sample respondents. There was considerable support for both the idea of family planning and for Planned Parenthood. Ninety-five per cent of the whites and eighty-six per cent of the blacks were familiar with Planned Parenthood and approved of its services. Twenty-seven per cent of the whites and fifty-three per cent of the blacks had used the local Planned Parenthood services. Only seven per cent of the blacks and one per cent of the whites felt that Planned Parenthood should not provide family planning services. It would seem from an analysis of the study population's attitudes that considerable polarization exists between these recipients of Planned Parenthood services and the more militant representatives or spokesmen for residents in designated poverty areas.

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[1]R. Hill and J. Mayone Stycos, The Family and Population Control. (Chapel Hill, North Carolina: University of North Carolina Press, 1958), p. 100-107.

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Not long ago a family planning center in Cleveland was burned to the ground by militant blacks who had labeled its activities "black genocide".[1] The more recent Pittsburgh incident became the first in the nation where OEO approrriations to support Planned Parenthood clinics in six of the City's eight poverty neighborhoods were turned down. It also is interesting to note that this decision to cut back clinic operations resulted from rather intense pressures and threats of violence by blacks - all of whom were male, who have kept the genocide issue boiling since one of the clinics was threatened with fire bombing in the fall of 1968.

Although concerted opposition to Planned Parenthood had centered in Pittsburgh, the issue has gained national recognition through articles published in Muhammed Speaks, the newspaper of the Black Muslims. The author of the articles is a highly respected black medical Doctor in Pittsburgh who is the medical advisor to the NAACP. He was the man who first raised the issue in 1967 and he contends that the birth control information and propaganda of Federally funded family planning programs are carried into the homes of indigent blacks by home visitors and public assistance workers, who symbolically coerce poor black women into visiting the clinics. He further states that welfare officials deny that the intimidation takes

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[1]Ronald Hallow, "The Blacks Cry Genocide," Nation, Vol. 208, No. 17 (April 28, 1969), pp. 535-537.

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the form of implicit or explicit threats that welfare payments will be cut off if the recipient has more children. Thus it has been argued that free family planning services constitute "genocide." This Doctor's formula for leading his people out of white America's cul de-sac is: black babies equal black votes equal Black Power.[1]

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[1] Ibid., p. 536.

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CHAPTER V

INFLUENCE OF SELECTED HEALTH FACTORS ON FERTILITY ATTITUDES

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CHAPTER V

INFLUENCE OF SELECTED HEALTH FACTORS ON FERTILITY ATTITUDES

The general hypothesis tested in this Chapter focuses upon the relationship between differential use of health services and the acceptance or rejection of family planning as a means by which working class couples space and limit the size of their families. The hypothesis is conceptualized as follows:

> There are attitudinal differences toward family planning between families who use private health services and families who rely primarily on tax supported public health services.

This hypothesis controlling on race is tested on several selected variables such as age, marital status, socioeconomic status, religion and socialization. Approximately four-fifths of both the white and black study population favored doing something to space and/or limit their number of children.

To conduct the analyses, an operational framework has been defined to include additional related variables which measure some aspect of the original hypothesis. The generic dependent variable attitude toward family planning has been

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defined to include desired family size, its relative importance; and ideal child spacing and its importance. The independent variables addressing the health component have been defined to include differential use of medical services; preventive health orientation and a health worry cluster variable which includes specific family health concerns. In Chapter Six, the research tests the relationships between the above independent factors and selected fertility practice variables such as current practice of coitus independent/dependent contraceptive methods, parity first used family planning, actual family size and status of actual family size relevant to desired family size.

A. Summary Analysis

The data analysis conducted in this chapter does not suggest a significant relationship exists between selected health practices and attitudes regarding desired family size and ideal child spacing. Several of the more salient findings resulting from an analysis of the data are:

1. A substantially larger proportion of whites, 71 per cent compared to 40 per cent of the blacks, use private medical care on a fee for service basis. This was significant at the .001 level.
2. Without controlling the differential use of medical services - desired family size relationship on selected test factors, there does not appear to be a significant difference between actual use of

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medical services - desired family size relationship on selected test factors. There does not appear to be a significant difference between actual use of medical services and desired family size for the white study population, however, blacks do differ with 60 per cent of the users of private medical care preferring three or less children.

a. Controlling on age the younger female respondents ages 20-29 years prefer smaller families.

b. Younger whites using private medical care tend to desire smaller families.

c. Younger blacks regardless of medical services used, prefer smaller families.

d. Older whites regardless of health services used tend to desire larger families.

e. Older blacks using private medical care prefer smaller families.

3. A substantially large proportion of Catholics in the study population demonstrate evidence of preferring three or less children, however, the greater majority of Catholics prefer in excess of three children. Less than one-half of the Catholics compared to two-thirds of the Protestant users of private medical care prefer three or less children.

4. While the number is small, private medical care black users reared in the South and currently living in Pittsburgh prefer smaller families, while blacks from the South using public medical care prefer larger families.

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5. Blacks tend to indicate a direction for the hypothesis while the white study group does not.

6. For both study groups less than 20 per cent indicated that having the number of children desired is unimportant. In essence the greater majority of whites and blacks believed desired family size to be important and had previously thought about it and discussed it with their husbands.

7. More blacks, 75 per cent, than whites, 52 per cent were highly worried about health matters within the family. A high health worry rating for both blacks and whites indicates that they prefer smaller families; while respondents who worry very little about health tend to desire slightly larger families.

8. A greater proportion of blacks, 62 per cent as compared to 43 per cent of the whites have a high preventive health orientation. Since a greater proportion of blacks than whites use the public financed medical care system, this may enable those on a non-fee for service basis to establish greater access to preventive health services than those who have to secure such services on a fee basis.

The specific hypotheses to be tested in this chapter are the following:

1. There are quantitative differences in desired family size between families who use private medical services and families who don't and tend to rely on public or tax sponsored medical care.

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2. There are differences regarding the importance of having the children desired between families who use private medical services and families who don't and tend to rely on public or tax sponsored medical care.

3. There are quantitative differences in desired family size between families who worry much about health problems and families who worry little.

4. There are differences in desired family size between families who have a high preventive health orientation and families who do not.

5. There are differences in attitude toward ideal child spacing between families who use private medical services and families who don't and tend to rely on public or tax sponsored medical care.

In order to determine if a general theme or direction exists in the hypothesized relationships, several key variables which may influence the hypotheses are included in the operational analysis. These variables are referred to as test factors and include the following: age, marital status, socioeconomic status, a component variable including annual income and the respondent's education, religion and regional location of early socialization period in respondent's life. The following operational definitions are provided in order to limit the interpretation of the variables which are used throughout this presentation:

Subcultural groups - are defined as race and the variable has two classes; white and black. All crosstabulations are controlled on this variable. This is held constant for both descriptive and for comparative analyses.

Social categories - are defined as socioeconomic status (SES) and have two classes; high and low. This is a

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component variable which includes two subvariables; education and annual income. To formulate the SES variable, education and income are divided at the median. The median years of education completed by both study groups is 10. The median annual income for the white study sample is $5000 and $4500 for the black. $4750 is used as the dividing point for both groups. Respondents with more than 10 years of education and being members of families who have an annual income above $4750 are regarded as high SES. Those who fall below these two items are low SES. In cases where the respondent had low income and high education, her current employment status, type of work or that of her spouse were used to determine whether the particular family should be classified as high or low SES.

Socialization - is defined in terms of where the respondent spent her initial sixteen years. The marginals for this particular item show that 98 per cent of the whites were raised in Pittsburgh or some other area in Pennsylvania while 27 per cent of the blacks were reared in the South and 63 per cent were reared in Pittsburgh. The test factor, socialization is applied only to blacks in the crosstabulations.

Religion - is divided into two classes: Roman Catholic and Protestant. Since there were only four Catholics among the blacks, religion as a test factor applies only to whites.

Age - the respondents for both study groups ranged in age from 20 to 45 years. Both mean and median ages for

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whites and blacks are quite similar. The median age for whites is 32.0 and for blacks 31.5. Age is dichotomized into two categories: 20-29 years and 30-45 years.

Marital Status - is separated into two classes; married and not married. Not married includes single, widowed, divorced, or separated. Married includes common-law union and legally married.

Because of the limited sample size of 100 whites and 98 blacks all independent and dependent variables as well as the test factors have been dichotomized into two categories. Briefly, the independent - dependent variables are defined as follows. Where indicated, they are further explained in the body of the chapter as they are incorporated in the analysis.

Differential use of health services - is defined under two classes. Use of private medical services means that the family has their own family doctor. They pay for his services on a fee basis. They can identify their doctor by name and one or more members of the family have received professional services from him at least twice during the twelve month period preceding the interview.

Use of public medical services - refers to families who primarily rely on tax supported services such as charity, welfare, public clinics and Medicaid.

Desired family size - is dichotomized into two classes; small family size desired which is defined as three or less children and large family size which is defined as four or more children. The range of desired number of children in this study population is 1 to 12 children for

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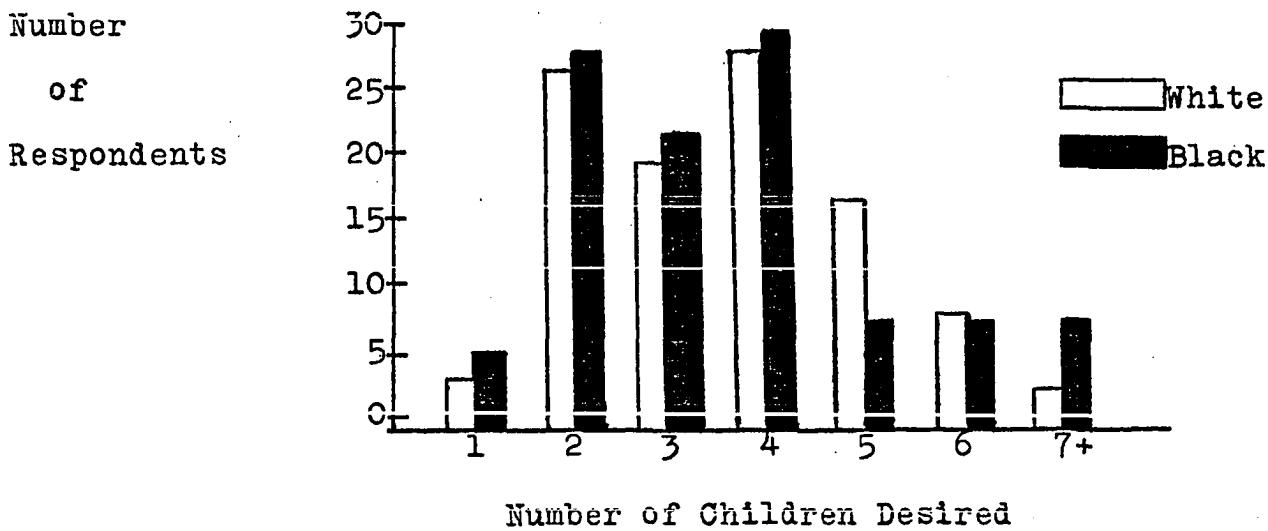
whites and 1 to 10 children for blacks. The means for whites and blacks are 3.66 and 3.60 respectively. The following graph depicts how the desired family size preferences are distributed among the study sample.

CHART 5-1

DISTRIBUTION OF RESPONDENTS
BY DESIRED FAMILY SIZE
PITTSBURGH POVERTY AREA, 1969



Importance of desired family size - refers to whether or not the respondents felt having only the number of children that they wanted was important to the present and future welfare of the family.

Ideal child spacing - reflects how long the respondents feel would be an appropriate time interval between pregnancies. Approximately 25 per cent of both study groups indicated that there should be at least a

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minimum of twelve months between pregnancies. Twenty per cent of the whites compared to 30 per cent of the blacks indicated that there should be two years or longer between pregnancies.

Importance of ideal child spacing - refers to whether or not the respondents supported or rejected the concept of ideal child spacing.

The health worry and preventive health orientation component variables - have been designed by collapsing several items on the questionnaire and are presented later in this chapter.

There is a limited body of systematic knowledge in the area tested by the hypotheses in this study. Only predicted differences rather than directions for the hypotheses have been suggested. The overall objective of this research is to discern whether there is validity and a practical application in using the systematic scheme presented in the conceptual framework for suggesting ways family planning services may be improved either within the private or public health delivery sectors. If the hypotheses suggest meaningful relationships via the subsequent analyses, then future studies may be more definitive with respect to direction and intensity.

Compared to less developed areas in the world, U.S. married couples during the past twenty years who live in urban environments have achieved a relatively large measure of

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control over family size.[1] This has been primarily due to the technological advances and availability of birth control information and services. The study of attitudes toward desired family size rests on the assumption that fertility beliefs relate to contraceptive behavior which is treated in the next chapter. Attitudes of married couples regarding the desired number of children have a crucial impact on levels of fertility. In evaluating the relationships between use of health services and actual reproduction, it is important to know how women of reproductive age respond to questions relating to desired family size and the relative importance of same. In order to determine the respondent's desired family size a series of several questions were asked:

1. Have you had all the children that you want?
   1. Yes 2. Don't know 3. No
2. If yes, would you just as soon have had fewer?
   1. Yes 2. Don't know 3. No
3. If yes, what number of children would you really want?
4. If no, if you could have exactly the number of children you want, what number would that be?

While attitudes regarding desired family size may be viewed as predictors for behavior, one must keep in perspective that attitudes are a reflection of the state of the respondent's

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[1]Charles Westoff and Norman Ryder, "Recent Trends in Attitudes Toward Fertility Control and in the Practice of Contraception in the U.S." in S.J. Behrman, et al., Fertility and Family Planning: A World View (Michigan: University of Michigan Press, 1969), pp. 388-412.

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mind with regard to possible future childbearing rather than an exact prediction of her final fertility. In order to determine whether the respondents had ever thought about desired family size prior to the study interview several additional questions were asked to support asking the above questions. These additional questions are:

1. Do you think it is very important or very unimportant that a couple not have any more children than they really want?

   1. Very important 2. Uncertain 3. Very unimportant

2. Have you ever thought about this before?

   1. Yes 2. No

3. Have you discussed this with your husband?

   1. Yes 2. No

Again, the rationale for asking these questions is to determine whether the respondent had seriously thought previously about what would constitute a desirable number of children.

The following tables controlling on race briefly depict the responses to the above three questions.

TABLE 5.1

IMPORTANCE OF HAVING THE NUMBER OF CHILDREN DESIRED BY RACE, PITTSBURGH POVERTY AREA, 1969

Race	Very Important	Uncertain	Very Unimportant
White	74.0%	9.0%	17.0%
Black	76.3%	9.3%	14.4%

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For both whites and blacks it was very important, for approximately three-fourths of the women to have the number of children desired. About 9 per cent for both groups were uncertain which could be interpreted to mean that they considered desired family size at least to be somewhat important. If these figures are added to the number of women who view this item as being very important, this results in more than 80 per cent of each group who consider desired family size as important.

TABLE 5.2

PERCENTAGE OF WOMEN WHO HAD PREVIOUSLY THOUGHT ABOUT DESIRED FAMILY SIZE BY RACE, PITTSBURGH POVERTY AREA, 1969

Race	Yes	No
White	60.0%	40.0%
Black	70.4%	29.6%

The majority of both groups can recall having thought about this item before. Seventy per cent of the white females had discussed the number of children they would like to have with their husbands. Of the black women who were married, the greater majority had spoken with their husbands about the number of children that the couple felt would be most appropriate. In summary, desired family size seemed to be a more

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valid item to use to evaluate a measure of family planning intent rather than for example "ideal family size" which is dependent upon an external reference group or situation. A question dealing with "ideal family size" would be phrased as "What do you think is the ideal number of children for the average American family?" Such a question has limited usefulnes. The question can be interpreted as the respondent's opinion as to what she considers to be ideal for the average American family or what the average American family considers ideal for themselves. Also, the ideal family size question calls for a statistical judgment on the characteristics of the average American family, a judgment probably beyond the reach of most respondents in this study and varying in relation to their own characteristics.[1]

Several types of questions have been used in fertility studies to determine the married female's orientation to family size. The 1965 National Fertility Study permits a comparative analysis of four orientations toward the number of children per couple. These are classified as "ideal family size," "desired family size," "intended" and "expected" family size.[2] While the overall averages for these concepts are quite similar; the patterns of responses by socioeconomic status reveal important differences in the ability of lower

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[1]Norman Ryder and Charles Westoff, "Relationships Among Intended, Expected Desired and Ideal Family Size: United States." Published as a report by the Center for Population Research, National Institute of Child Health and Human Development (March 1969), pp. 1-10.

[2]Ibid., p. 1.

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income couples to control their fertility to the extent desired. An analysis of the Westoff-Ryder data reveals that the number reported as "intended" and "expected" are virtually the same. Their analysis suggests that future studies should not separate these two items but regard them as equivalent and use only the item, "intended." In The 1965 National Fertility Study which sampled 4,617 married women under 45 years old, the mean numbers of children "intended," "desired" and considered "ideal" were 3.25, 3.29 and 3.29 respectively. This apparent identity did not persist under more detailed investigation. The distribution varied on these three factors among subgroups of the population controlled on race, religion and education. It is interesting to note that women who reported they intended to have specific additional children, 80 per cent gave the same responses to the question dealing with desired family size.[1]

Initially the Pittsburgh study was to include for the purpose of analysis differential access to health resources as an independent variable influencing fertility beliefs and performances. However, based upon examination of the data it became immediately apparent that there was no significant difference between those having access to and actually using private or tax supported health services. Of the 73 white families which had access to private medical care 69 had

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[1] Ibid., p. 7.

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used such services two or more times during the twelve month period immediately preceding the study. For black families there were 49 families having access and 40 using the services.

Table 5.3 depicts the distribution by race of public and private medical users. A significantly larger proportion of whites, 71.1 per cent, used private medical care as compared to only 40.8 per cent of the blacks. Since the proportion of white and black users of private and public medical services are disproportionately distributed several of the table cells within the crosstabulations are quite small and difficult to interpret. Only where cells within the tables have ten or more cases is an analysis attempted.

TABLE 5.3

PERCENTAGES OF USERS OF PUBLIC AND PRIVATE HEALTH SERVICES BY RACE, PITTSBURGH POVERTY AREA, 1969

Race	Private Health Service	Public Health Services	Total
White	71.1% (69)[1]	28.9% (28)	100% (97)[2]
Black	40.8% (40)	59.2% (58)	100% (98)

$X^2 = 1697$, $P<.001$

[1]Numbers in parenthesis indicate total number of cases represented by percentages directly above.

[2]There were three white non-responses to the item.

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Table 5.4 indicates that virtually no differences exist between the white families who use private health care and their preferences for small or large families; while a slightly larger proportion of blacks, 60 per cent, using private health services prefer smaller families.

Among intact families, where a male household head was present, there was little difference between the black and white families who used private health care and their preferences for small or large families. However, among the white intact families using tax supported health care a larger proportion of the husbands preferred four or more children while there was proportionally no difference for the black males in this group.

It should be emphasized again that the two study groups did not equally participate in the use of private and public medical services. Sixty-nine per cent of the white families compared to approximately 40 per cent of the blacks use private medical care. Among the whites using public medical care, a larger proportion, 57.1 per cent prefer larger families, while among the blacks they are equally distributed; 29 female respondents desiring three or less children and an equal number desiring four or more children. Based on an initial analysis of Table 5.4 one might hypothesize that use of private health care by the white respondents has no relationship to their desired number of children, however among the blacks there does seem to be a preference for smaller families.

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TABLE 5.4

PERCENTAGES OF USERS OF PUBLIC AND PRIVATE HEALTH SERVICES AND DESIRED FAMILY SIZE CONTROLLED ON RACE, PITTSBURGH POVERTY AREA, 1969

Health Services	White		Black	
	1-3 Children	4 or More	1-3 Children	4 or More
Private	49.3% (34)	50.7% (35)	60.0% (24)	40.0% (16)
Public	42.9% (12)	57.1% (16)	50.0% (29)	50.0% (29)

The information in Table 5.4 requires additional partitioning of the data to determine if a direction for the hypothesis actually suggests that a relationship exists between differential use of health services and desired family size. When the hypothesis is controlled on both race and age in Table 5.5, it becomes apparent that the younger respondents from both sample groups prefer smaller families, however, an examination of differential use of health services and desired family size revealed a non-significant association. Perhaps preference among the older groups for larger families is more a reflection of their actual family size rather than what they would really desire.

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TABLE 5.5

PERCENTAGES OF USERS OF PUBLIC AND PRIVATE HEALTH SERVICES DESIRING THREE OR LESS CHILDREN BY RACE AND AGE PITTSBURGH POVERTY AREA, 1969[1]

Race	Age	Type Of Health Serv.	Number Of Children Desired 1 - 3	4+	Total	% Desiring 3 or Less	Observed O_i	Expected E_i	Variance Of $(O_i - E_i)$
White	20 to 29	Private	20	10	30	66.7	20	19.0	1.9140
		Public	6	5	11	54.5			
		Total	26	15	41				
	30 to 45	Private	14	25	39	35.9	14	13.9	2.7676
		Public	6	11	17	35.3			
		Total	20	36	56				
Black	20 to 29	Private	10	6	16	62.5	10	10.7	2.2547
		Public	18	8	26	66.7			
		Total	28	14	42				
	30 to 45	Private	14	10	24	58.3	14	10.9	3.4160
		Public	11	20	31	35.5			
		Total	25	30	55				

$$\left(X^2 = \frac{([58-54.5]-\frac{1}{2})^2}{10.3523} = 0.932 < X^2_{>,.05=384} \right)$$

[1]To determine the proportions desiring four or more children merely subtract the given percentages from 100%.

With the introduction of additional controlling variables, the delineation of association becomes more meaningful. Comparisons are more crisp and neat and the reseacher generally sees the patterns in the data more clearly. However, additional difficulties come up, since this means finer breakdown of the data and hence smaller frequencies in the individual cells of the table. Of a less serious nature is the burden of added arithmetical complexities. Such extended analysis can be made by an obvious modification of the method discussed above. For example, if there are three 2 x 2 tables giving the chi square values X_1^2, X_2^2, and X_3^2, a pooled chi square would be computed as:

$$X^2 = \frac{(X_1^2 + X_2^2 + X_3^2)^2}{3}$$

Statistical significance would then be assessed by comparing this with the critical value of chi square with one degree of freedom. This is generally adequate for large samples. With small or even moderately-sized samples spread rather thinly over many cells, certain basic questions on validity of the above methodology arise. Fortunately, several researchers have considered these problems. A notable piece of work is that of Cochran in 1954.[1] Of more recent vintage is that of Mantel and Haenszel which is particularly appropriate for these

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[1]William G. Cochran, Biometrics (1964), p. 417.

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data, since these statisticians introduced improvements that are appropriate when the frequencies are quite small.[1] Application of this procedure is presented in detail using the Data Of Table 5.5. The problem centers on whether the data show any evidence of a relationship between age of respondent and the number of children desired, with adjustments for race and type of medical service used. A convenient arrangement would be that as shown in the following Data of Table 5.5:

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[1]Nathan Mantel and William Haenszel, "Statistical Aspects of the Analysis of Data from Retrospective Studies of Disease." Journal of National Cancer Institute, Vol. 22 (1959), p. 719.

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(DATA OF TABLE 5.5)

Race	Type Of Health Serv.	Age	Number Of Children Desired 1 - 3	4+	Total	% Desiring 3 or Less	Observed O_i	Expected** E_i	Variance Of* $(O_i - E_i)$
White	Private	20-29	20	10	30	66.7	20	14.78	4.3006
		30-45	14	25	39	35.9			
		Total	34	35	69	49.3			
	Public	20-29	6	5	11	54.5	6	4.71	1.696
		30-45	6	11	17	35.3			
		Total	12	16	28	42.9			
Black	Private	20-29	10	6	16	62.5	10	9.60	2.3631
		30-45	14	10	24	58.3			
		Total	24	16	40	60.0			
	Public	20-29	18	8	26	66.7	18	13.23	3.5971
		30-45	11	20	31	35.5			
		Total	29	28	57	50.9			

*For a 2 x 2 table with frequencies $\frac{a|b}{c|d}$, this is equal to

$$\frac{(a+b)\ (c+d)\ (a+c)(b+d)}{(a+b+c+d)^2(a+b+c+d-1)}$$

For the first table this is: $\frac{(30)(39)(34)(35)}{69^2(68)} = 4.3006$

**This is computed in the usual way exemplified by $E_1 = \frac{34(30)}{69} = 14.78$

The Test Statistic (Mantel-Haenszel 1 D.F. X^2) is

$$X^2 = \frac{(154-42.32-\frac{1}{2})^2}{11.9569} = 10.43$$

This is a highly significant statistic. The data show a significant association between age of respondent and desired family size. There is a marked preference among the younger respondents for smaller families. This can be gleaned from an inspection of the above Table, since the proportion desiring less children shows a consistent pattern throughout.

In Table 5.4, there appears to be little difference among white users of the private health services and desired family size, however, one immediately sees a difference when controlling on age for the younger white users of private health services and a preference for smaller families. Differences for both white and black users of the public medical services within the older age group shows that approximately 64 per cent prefer larger families. This may

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be explained by the instability and inconsistency which pervade the socioeconomic environment of the poor. This may often preclude any likelihood that they will orient themselves toward the future. Unlike the middle class person who lives in a matrix of commitments toward the future, the poor individual often lacks any basis for believing that he has some control over his future family size.

Among the users of private health care there is little difference between the whites' socioeconomic levels (SES) and desired family size while among the blacks a slightly larger proportion of the low SES group prefer smaller families. Among the low SES users of public health services 63.2 per cent of the whites and 52.5 per cent of the blacks prefer large families. For the most part this particular cluster of low SES Families are intact, having a male household head living at home. They either are or have recently received aid from the Allegheny County Board of Assistance and the female respondents for both groups tend to be slightly older than the means for the two samples. Vertical economic mobility for this group seems indeed limited. Again it is appropriate to speculate that the interpretation of desired family size may be meaningless for these particular respondents who must eke out an existence on an inadequate income and be dependent upon tax supported programs for health services.

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TABLE 5.6

PERCENTAGES OF USERS OF PUBLIC AND PRIVATE HEALTH SERVICES DESIRING THREE OR LESS CHILDREN CONTROLLED BY RACE AND SOCIOECONOMIC STATUS (SES), PITTSBURGH POVERTY AREA, 1969

Health Services	White		Black	
	High SES	Low SES	High SES	Low SES
Private	48.9% (23)	50.0% (11)	56.0% (14)	61.5% (16)
Public	55.6% (5)	36.8% (7)	57.1% (4)	47.5% (15)

Poverty can become a dynamic factor which influences one's participation in the larger society. The health and welfare literature often refers to the culture of poverty, for it occasionally can have its own distinctive social and psychological consequences for its members. In this study, it may be a resignation to accept whatever number of children come, due to an inadequate capacity to control or determine this specific aspect of one's future.[1]

Sixty-two per cent of the white study sample had household heads who were Roman Catholic and the remaining 38 per cent were Protestant. Religion is an important variable since the Catholic Church has consistently held the same view

[1]S. M. Miller and Frank Riessman, Social Class and Social Policy (New York: Basic Books, Inc., 1968), pp. 56-58.

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regarding birth control.[1] One cannot find a period of history or document of the Church which has not denied that contraception was always seriously evil. Contraception is defined by the Church as any physical interruption or intervention of the generative process (opus naturae) which before or after the proper placing of generative acts (opus hominis) causes these acts to be deprived of their natural power for the procreation of life.[2] The Roman Catholic Church which does in fact endorse responsible parenthood accepts only the rhythm method as the legitimate method for determining the number of children. Most other Christian churches endorse birth control and take the position that the means of spacing and determining numbers of children is in large measure, a matter of clinical and aesthetic choice.[3]

The 1960 and 1965 National Fertility Studies provide a unique opportunity to assess trends in fertility attitudes among Catholic women. There has been a substantial increase in the proportion of women during the past ten years who endorse limiting family size. This increase is due primarily to changes in the attitudes of Catholic women. There has been

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[1]John Noonan, Contraception: A History of Its Treatment by the Catholic Theologians and Canonists (New York: Mentor Books, 1967), pp. 16-32.

[2]Robert Hoyt, The Birth Control Debate (1968), Kansas City National Catholic Reporter, p. 25.

[3]Ronald Weinberg, Laws Governing Family Planning (New York: Oceana Publishing, Inc., 1968), pp. 82-93.

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a shift among Catholic women away from restricting endorsement of the rhythm method toward approval of fertility control in general.[1]

By 1960 Protestant women were overwhelmingly in favor of family planning. Religious preference seems to make little difference with the exception of fundamentalist sects which are slightly less favorable. For Protestant women between 1960 and 1965 there is very little variation in percentages favoring birth control while among the Catholics, the proportional increase of women supporting fertility control is quite large.[2] This pattern may reflect antitraditionalism for some Catholics as well as for others an attitude shaped by negative experience with the rhythm method. Table 5.7 depicts white Catholics' and Protestants' perceptions regarding desired family size.

TABLE 5.7

PERCENTAGES OF WHITE CATHOLICS AND PROTESTANTS WHO USE PUBLIC AND PRIVATE HEALTH SERVICES AND DESIRE SMALL FAMILIES, PITTSBURGH POVERTY AREA, 1969

Health Services	Roman Catholic 1-3 Children	Protestant 1-3 Children
Private	40.0% (18)	66.7% (16)
Public	47.1% (8)	36.4% (4)

[1]Op. Cit., Westoff and Ryder, pp. 388-399.

[2]Pascal Whelpton, Arthur Campbell and John Patterson, Fertility and Family Planning in the United States (Princeton, N.J.: Princeton University Press, 1966), p. 180.

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The majority of Catholics regardless of medical services used, tend to desire larger families, while Protestant families using private health services predominantly desire smaller families. Most Catholics who were high SES also had access to private health services. Thus religion for this group seems to be a reason for preferring a larger family.

Twenty-seven black respondents spent their early socialization period in the rural South. As previously noted none of the whites were raised in this section of the United States. Controlling on health service variable, a larger proportion of blacks raised in the South, 66.7 per cent, who use public medical services preferred larger families while a larger proportion, 80 per cent, of those using private health care prefer small families. While these percentages represent small numbers, there does appear to be a direction for the hypothesis which suggests that blacks reared in the South who later migrated to the North and use private medical care prefer small families while those dependent upon tax supported health care prefer large families. Since the cells would be quite small regarding the socialization data a table presenting this information is not warranted.

Approximately four-fifths of the white study group were married and living with their husbands at the time of the study as compared to slightly less than half of the blacks.

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TABLE 5.8

PERCENTAGES OF USERS OF PUBLIC AND PRIVATE HEALTH SERVICES DESIRING THREE OR LESS CHILDREN BY RACE AND MARITAL STATUS, PITTSBURGH POVERTY AREA, 1969

Health Services	White		Black	
	Married	Not Married	Married	Not Married
Private	49.2% (31)	50.0% (3)	66.7% (16)	50.0% (8)
Public	55.6% (10)	20.0% (2)	34.8% (8)	60.0% (21)

A larger proportion of married blacks using private health care preferred small families. For whites as a whole, irrespective of marital status, they appear to be evenly split on the question of family size.

In addition to the questions regarding differential use of health services, a set of questions relating to concern over family health matters was asked. Using selected health items a health worry cluster was formulated and introduced into the analysis as an independent component variable.[1] One problem noted by Merton is the presence of propositions which are often general and true, but non-specific.[2] Some propositions are on such a broad level of generality that they do

[1]Morris Rosenberg in his book The Logic of Survey Analysis discusses in Chapter Two the meaning of component variable which includes more than one related item to form a single cluster variable.

[2]Robert Merton, Social Theory and Social Structure. (New York: The Free Press, 1968), pp. 147-153).

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little to advance understanding. Thus one could hypothesize that worry plays an important part in attitude formation regarding desired family size. While it may be difficult to deny this proposition, it also does not substantially advance knowledge. It is important to go beyond the stage of propositions so broad that they have no - or only the vaguest empirical referents. The questions dealing with selected health items are summarized in the following way:

> Almost everyone worries at one time or another. Would you please tell me whether you worry about the following a lot, a little, or not at all?
>
> 1. Your health.
> 2. Having more children.
> 3. Health of your family.

The component variable was dichotomized into classes of high health worry and low health worry. A score of one was assigned to each item where the respondent indicated that he worried a lot. The total possible score for all three items answered as worried a lot is three. A score of three was assigned to each item answered as worry "a little" and "not worry at all." The possible range in scores for all three items is three to nine. All cases which had a total score of six or less were identified as belonging to the high health worry cluster and those having a total score per case above six were assigned to the low health worry cluster. The item for which the respondents expressed the most concern was worry concerning the health of the family; 61 per cent for the whites and 60 per cent for the blacks.

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The least health worry item was having more children, 23 per cent and 14 per cent respectively for the whites and blacks. Table 5.9 presents the health worry cluster by race for both study groups.

TABLE 5.9

PERCENTAGES OF WOMEN WITH HIGH AND LOW HEALTH WORRY CONTROLLED ON RACE, PITTSBURGH POVERTY AREA, 1969

Race	High Health Worry	Low Health Worry	Total
White	52.0% (51)	48.0% (47)	100.0 98[1]
Black	74.5% (73)	25.5% (25)	100.0 98

$X^2 = 10.32$ $P < .005$

In Table 5.9 the white respondents are evenly distributed while three-fourths of the blacks (significantly higher $P<.05$) express considerable concern for health issues dealing with the health of the respondent herself and/or other member(s) of the family. As previously indicated 58.2 per cent of the blacks tend to rely on tax supported health care while 71.1 per cent of the whites primarily used private medical care. Of those blacks belonging to the high health

[1]There were two white non-responses to the item.

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worry cluster it is worth noting that the greater majority use public medical services. Even among a lower socioeconomic population which this study addresses the majority of whites with slightly higher incomes are able to secure guidance and treatment from their private physicians, while the majority of blacks depend on public medical facilities. Hill and Jaffe suggest that such a dual system provides the poor with medical services which often are piecemeal, inadequate, underfinanced, uncoordinated and offered without compassion or concern for the dignity of the individual.[1]

TABLE 5.10

PERCENTAGES OF WOMEN WITH HIGH AND LOW HEALTH WORRY AND PREFERENCES FOR DESIRED FAMILY SIZE BY RACE, PITTSBURGH POVERTY AREA, 1969

	White		Black	
Health Worry	1-3 Children	4 or More	1-3 Children	4 or More
High	51.0% (26)	49.0% (25)	54.8% (40)	45.2% (33)
Low	42.6% (20)	57.4% (27)	52.0% (13)	48.0% (12)

[1]Adelaide Hill and Frederick Jaffe, "The Negro American," Planned Parenthood-World Population (New York, 1966), pp. 215-216.

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Table 5.10 suggests a direction for the hypothesis. Families with high health worry, both whites 51 per cent and blacks 54.8 per cent, prefer smaller families. These differences regarding family size are slight and require additional research. It is worth noting that respondents expressing low health worry among the whites prefer larger families while the direction of preferring smaller families among the black, 52 per cent remains the same. Controlling the above relationship on age, younger families who worry a great deal about health, preferring smaller families; while older families who fit the high worry cluster prefer larger families. This also holds true for the older group which belongs to the low worry cluster. As previously stated, the older age groups have larger families. The health worry cluster does show that high health worry may be related to desiring a smaller family.

TABLE 5.11

PERCENTAGES OF WOMEN WITH HIGH AND LOW HEALTH WORRY AND PREFERENCES FOR DESIRED FAMILY SIZE, BY AGE AND RACE, PITTSBURGH POVERTY AREA, 1969

Health Worry	White		Black	
	1-3 Children	4 or More	1-3 Children	4 or More
	20-29	30-45	20-29	30-45
High	60.0% (15)	57.7% (15)	62.2% (23)	52.8% (19)
Low	68.8% (11)	71.0% (22)	83.3% (5)	57.9% (11)

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Controlling the health worry cluster - desired family size relationship on socioeconomic status, religion and socialization provides no meaningful additional information. Catholics regardless of health worry continued to prefer larger families while Protestants prefer smaller families. Where there is low health worry among the Catholics, a larger proportion, 64.5 per cent, prefer four or more children.

TABLE 5.12

PERCENTAGES OF WOMEN WITH HIGH AND LOW HEALTH WORRY AND PREFERENCES FOR DESIRED FAMILY SIZE BY RELIGION, PITTSBURGH POVERTY AREA, 1969

Health Worry	White Catholic (4 or More Children)	White Protestant (1-3 Children)
High	51.6% (16)	55.0% (11)
Low	64.5% (20)	56.3% (9)

Blacks who were raised in the South are equally distributed between high and low health worry. Socioeconomic status is more difficult to interpret relevant to the hypothesis since 56.6 per cent low SES blacks who have a high health worry cluster prefer smaller families while 55.2 per cent of the whites in this same category prefer larger families. High SES whites who have a low worry cluster also prefer larger families while blacks, 66.7 per cent in this same category prefer small

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families. Other than controlling on age there does not appear to be a relationship between health worry and desired family size.

How an individual reacts to the immediate, or long range threat of illness and takes advantage of available preventive health services are basic questions in the public health field. Suchman suggests that illness is a social phenomenon.[1] Different societies have developed characteristic ways of dealing with illness. The values and customs of a particular social group strongly influence its perception of preventive health measures as well as interpretation of illness and treatment.[2]

Hollingshead and Redlich found that members of the lower socioeconomic groups are less likely to utilize preventive health programs.[3] Health may be expressed as a degree of conformity to accepted standards of given criteria in terms of basic conditions of age, sex, and community within normal limits of variation. Use of primary prevention as well as treatment of illness are subject to social interpretation which in turn influence the way people respond to participation in the health system.

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[1]Edward Suchman, Sociology and the Field of Public Health (New York: Russell Sage Foundation, 1963), p. 47.

[2]Ibid., pp. 48-70.

[3]August Hollingshead and Frederick Redlich, Social Class and Mental Illness (New York: John Wiley and Sons, 1958).

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In this study a series of preventive health questions were asked. The questions were collapsed into a preventive health component variable using the median scores for both study groups. The questions and distribution of responses for each item are as follows:

During the past twelve months has anyone in the family had any of the following?

1. Physical examination even though nothing was wrong.

White		Black	
Yes	No	Yes	No
68	32	77	21

2. A chest x-ray.

55	45	65	33

3. Eye examination.

65	35	71	26

4. Any tests or examination to detect cancer.

42	58	54	44

Scores of one and three were assigned per item for yes and no responses respectively. The total score range for all four items was four to twelve. The median scores for whites was 8.0 and for blacks 6.0. Thirty-one per cent of the blacks had a total score of four, a high preventive health orientation, compared to only 17 per cent of the whites. Also 22 per cent of the whites as compared to 16 per cent of the blacks had a total score of ten or more.

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According to Table 5.13 the black families have a more positive orientation to preventive health practices than does the white study group. The fact, that the majority of blacks depend on tax supported health services could mean that they have greater access to such services as cancer examinations, eye tests, etc. and are more accustomed to using such public health services than families who pay a fee for similar services.

TABLE 5.13

PERCENTAGES OF WOMEN WITH HIGH AND LOW PREVENTIVE HEALTH ORIENTATIONS BY RACE, PITTSBURGH POVERTY AREA, 1969

Race	High Preventive Health	Low Preventive Health	Total
White	42.9% (42)	57.1% (56)	100.0% (98)[1]
Black	61.9% (60)	38.1% (37)	100.0 (98)

Other than controlling for race, both groups with high preventive health orientations prefer four or more children while families with low preventive health orientations prefer small families. This seems inconsistent with what would be expected and should again be examined in a similar type study.

[1]There were two white respondents who did not complete these items on the questionnaire.

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For the younger black and white age groups there were little differences between high and low preventive health orientation and desired family size. The older age groups with the exception of blacks having a low preventive health orientation prefer large families. One's preventive health orientation and perception of desired family size controlled on age appears to be unrelated.

TABLE 5.14

PERCENTAGES OF FAMILIES WITH HIGH AND LOW PREVENTIVE HEALTH ORIENTATION AND DESIRED FAMILY SIZE BY AGE AND RACE, PITTSBURGH POVERTY AREA, 1969

	White		Black	
Preventive Health	1-3 Children 20-29	4 or More 30-45	1-3 Children 20-29	4 or More 30-45
High	66.7% (10)	70.4% (19)	65.4% (17)	67.6% (23)
Low	61.5% (16)	60.0% (18)	62.5% (10)	33.3% (7)

The preventive health orientation desired family size hypothesis examined on socioeconomic status indicates that low SES, high preventive health oriented families prefer larger families. Approximately the same proportions within the two samples as well as between the samples for blacks and whites with high as well as low SES are fairly equally distributed with respect to small and large families desired. About 50 per cent of the Catholics have a low preventive health

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orientation and are evenly distributed with regard to desired family size. Seventy per cent (18 cases) of the Catholics with a high preventive health orientation preferred four or more children. Non-Catholic whites regardless of health orientation preferred smaller families. Among the twenty-seven blacks raised in the South there were little differences for families with differential health orientation and preferences for small or large families.

A crucial aspect of successful family planning is having the capacity not only to limit the size of one's family but to determine and control at what time intervals it would be most suitable for the family to augment its numbers. In this study two basic questions relating to ideal child spacing interval were asked as follows:

1. When a couple has just had a baby and would like another, about how much later would it be best to have the next baby born?

2. Do you think that it is very important or not very important that the next baby come when the couple wants it?

Fifty-five per cent of the whites and 81 per cent of the blacks indicated that it was very important that the next child be born when the couple believes that they are ready to handle an additional member to the family. Almost equal proportions of whites and blacks, 17 per cent and 15 per cent respectively, felt there should be at least a period of one year between births. Only 6 per cent in the black study group felt that there should be more than a three year

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interval and the vast majority, 63 whites and 54 blacks, felt that one to two years was an ideal interval.

The respondents tend to cluster around the 13 to 24 month period as an ideal spacing interval. Even when further categorizing the interval to 13 to 18 months, there are only an additional six white and 10 black cases that could be added to a new interval period of 12 to 18 months. Therefore, a limited descriptive analysis of ideal child spacing as a dependent variable does not lend itself to a meaningful analysis of the hypothesis. The Indianapolis Study reported that opinions as to the spacing of children were quite uniform. Between 68 and 76 per cent of the couples reported that the most desirable time for the first child is two or three years after marriage. Between 81 and 89 per cent said the most desirable time between subsequent children is two years.[1]

In this chapter, the investigator has presented data on a randomly selected number of white and black families residing in a Pittsburgh officially designated poverty area. The general theme was to determine if a relationship between differential health practices influenced the desire for small or large families. There does not appear to be a statistically significant relationship between these factors and desired

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[1]Pascal Whelpton and Clyde Kiser, "Resume of the Indianapolis Study of Social and Psychological Factors Affecting Fertility." Demographic Analysis: Selected Readings Glencoe, Illinois: The Free Press, 1959), p. 255.

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family size. Of course, it must be kept in mind that the sample is small and a larger study population may produce significant results.

The preventive health attitudinal hypothesis tested neither supports nor rejects that a linkage exists between one's general health orientation and specified components of the family planning, namely desired family size, and ideal child spacing.

Perhaps families residing in low income urban areas are not fully informed about the adverse health effects for both mother and children associated with frequent or multiple pregnancies. Maternal and/or infant mortality is generally higher for very young mothers and for older mothers.[1] Postponing the initial pregnancy until the woman is 20 to 25 years of age and preventing any further pregnancies after she reaches 30 to 35 years of age increases the likelihood that her babies will be healthy. Spacing children two or three years apart, avoiding having more than three or four children and not having children beyond age 35, reduces the likelihood of chronic disease or early death for the mother. Such information is likely to be important and comprehensible to most young couples and perhaps as their health understanding and

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[1]Frederick Jaffe, A Strategy for Implementing Family Planning Services in the United States." American Journal of Public Health, Vol. 58 (April 1968), pp. 713-714.

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aspirations rise so will their fertility preferences in terms of desired family size decrease. For families living near the poverty level, the prospective cost of rearing each additional child may be illuminating information. An accurate projection of probable costs for each prospective child, especially those costs borne directly by the family should be part of the health education made available to all young couples.

Beyond the economic considerations, the effects of large and small families on the emotional, intellectual and physical development of children is another topic which couples should be informed about and encouraged to consider in planning their family size. Providing couples with this type of prevention information is no simple matter. Based on limited analysis of the data in this chapter there still remains an awesome challenge for public healthers.

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CHAPTER VI

INFLUENCE OF SELECTED HEALTH FACTORS ON FERTILITY BEHAVIOR

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CHAPTER VI

INFLUENCE OF SELECTED HEALTH FACTORS ON FERTILITY BEHAVIOR

Various fertility research studies have confirmed that among married couples there is variation in willingness to use contraception. Various factors which affect method acceptability have been identified. Such factors include religion, ignorance, interference with pleasure, etc. Technological efforts are continually being made to develop more effective and acceptable methods for overcoming these objections.

The purpose of this chapter is to analyze the study respondents' various contraceptive practices and their use of health resources, orientation to preventive health measures and concern over selected family health issues. In Chapter Five several of these factors were used as independent variables relating to specific dependent variables such as desired family size, its importance; child spacing and its importance. This chapter uses the same independent variables. The analysis tests the relationships between certain selected fertility performance factors such as parity at which couples began to use contraception, current contraceptive methods, and planning

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status of the family. In order to identify any spurious findings, all relationships are examined using the same test factors employed in Chapter V.

Among the more significant data in the 1965 National Fertility Study was the overall increase in the use of oral contraceptives by women of all religions. The pattern of increasing usage has occurred steadily since the Growth of American Families Study measured this practice on a national basis in 1960. Approximately ten years ago 81 per cent of all Catholics, 90 per cent of all Protestants and 77 per cent of all non-whites were reported as having ever used some form of contraception.[1] For the respondents in the Pittsburgh study the proportions are somewhat higher. This comparison is presented to indicate how much the two census tract areas reflect a national pattern. It is fully recognized that there is a ten year difference in time between the two studies. The differences in use of contraceptives between the two studies may be quite valid since the Growth of American Families Study included douches and suppositories as contraceptives whereas this study does not. Also, the interviewees in the Pittsburgh study came from almost exclusively lower income blue-collar type families, which are generally viewed as being less disposed toward birth control than those of the upper income groups.

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[1]Pascal Whelpton and Arthur Campbell, Fertility and Family Planning in the United States (Princeton, N.J., 1966), pp. 180-190.

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Respondents in the study sample, who have never used any contraceptive method, 8 per cent of the white and 19 per cent of the blacks are regarded as being outside the parameter of the analysis. For the most part, women who did not use contraception, refrained because of lack of fecundity, low parity, sexual inactivity and a desire to have children during the initial years following marriage.

A. Summary Statement of Analysis

Slightly more than half of the white respondents and approximately two-fifths of the blacks were practicing a coitus-independent method at the time the data were collected. Two-thirds of the women age 30 years or less in both study groups had used oral contraceptives or the IUD at some time during their marital years. Women of different age groups reflected different orientations toward the pill, although most attested to its reliability. The greater majority of women whose "actual family size" exceeded their "desired family size" had used the pill and/or IUD. There was a tendency for both blacks and whites not to use a coitus-independent contraceptive method where the actual family size was less than the desired family size.

The mean parity for Protestant women over 30 years of age is greater for those having used the pill (4.38) than for those having not used the pill (3.57). There was no significant difference for Catholics.

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Only coitus-independent contraceptive practices are treated in the analysis since such methods are directly linked to medical practice and have to be either prescribed or applied by a physician. Substantially large proportions of white public medical users (61.5 per cent) and private medical users (57.4 per cent) practice a coitus-independent method. Approximately one-third of the black private health users employ the pill or IUD, while a substantially larger proportion of black public health users (52.9 per cent) rely on contraceptive independent methods. In essence, there does not appear to be a significant relationship between use of health services and contraceptive practice. Controlling on age, the younger respondents in both groups preferred and used either the pill or IUD.

High SES white users of private medical care tend to prefer and use the pill or IUD while the inverse is true for high SES blacks. Again blacks in the study population may be more acquainted with non-private medical care and this probably accounts for the differences between the two study populations.

Of the 90 per cent Catholic women who reported that they had practiced some form of birth control, only 19 per cent (8 cases) had restricted themselves to the rhythm method.

For the 30 to 45 age group, a fairly large differential exists for blacks regarding "desired family size" 3.90 and "actual family size" 5.07. For this same age group desired

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family size for whites was somewhat greater than the actual or achieved family size. This is primarily due to the many Catholic respondents who indicated a desire for larger families.

Approximately 80 per cent of all respondents claimed that they had confidence in their current birth control method. Women in both groups using the pill or IUD expressed considerably more trust and confidence in this method than did women who tended to rely on more traditional methods such as rhythm, condoms, foams, etc.

In order to determine the present contraceptive method used by the study sample each respondent who was fertile and not pregnant was asked to identify their present method of contraception.

TABLE 6.1

CONTRACEPTIVE METHOD CURRENTLY BEING USED BY RACE, PITTSBURGH POVERTY AREA, 1969

Method	White	Black
None	18	33
Rhythm	8	1
Condom	5	0
Withdrawal	4	1
Diaphragm	4	8
Pill	40	27
IUD	11	13
Jelly, foam, etc.	10	15
TOTAL	100	98

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Of those women who were not using a method and were fecund, four whites and ten blacks reported that they expected to use contraception in the near future. Ten per cent of the whites and 15 per cent of the blacks had been sterilized for either medical or birth control reasons. Eleven blacks and eight whites had been sterilized after reaching their thirtieth birthdate. Thirteen blacks reported limitation of family size as the primary reason for this type of surgical intervention while all eight whites indicated medical reasons.

For the purpose of analysis the item current contraceptive methods has been dichotomized into coitus-independent and coitus-dependent. Coitus-independent methods were defined as using the pill or intrauterine device, IUD. Of the respondents who currently were using a coitus-independent method, only 11 per cent of the whites and 13 per cent of the blacks were using the IUD. Moreover, 95 per cent of the IUD users in the black sample had ever used the pill and approximately 50 per cent of the whites in this same group had ever used the pill. In effect the analysis relating to coitus-independent contraception is primarily presented in terms of the pill. Coitus-dependent methods is not treated in the analysis since condoms, creams, jellies, and foams can be purchased over the counter without medical approval or prescription.

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Table 6.2 shows that a greater proportion of whites, 57.4 per cent than blacks, 34.2 per cent, who were users of private medical care prefer and use coitus-independent contraceptive methods. It also suggests that there is an inverse relationship between white and black users of contraceptive independent methods controlling on type of health service used. As previously reported blacks tend to rely more on public or tax supported medical care. Usage of coitus-independent methods does not seem to be linked with type of health services used. In both racial groups, particularly among blacks, there is an apparent tendency to favor coitus-independent methods among public health service users compared to those using private medical care, however, the differences are not significant as shown in Table 6.2A.

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TABLE 6.2

PERCENTAGE OF WOMEN USING COITUS-INDEPENDENT CONTRACEPTIVE METHODS ACCORDING TO PUBLIC AND PRIVATE HEALTH SERVICE USE BY RACE, PITTSBURGH POVERTY AREA, 1969

Type Of Health Serv.	Race	Contraceptive Methods: Coitus-Indep. Methods	Others	Total	% Using Coitus-Indep. Methods	Observed O_i	Expected E_i	Variance Of $(O_i - E_i)$
Private	White	35	26	61	57.4	35	29.6	6.28
	Black	13	25	38	34.2			
	Total	48	51	99				
Public	White	16	10	26	61.5	16	14.5	4.31
	Black	27	24	51	52.9			
	Total	43	34	77				

$$X_2 = \frac{(\,[51-44.1]\,-\frac{1}{2})^2}{10.59} = 3.87,\ P>.05$$

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TABLE 6.2A

ASSOCIATION BETWEEN TYPE OF HEALTH SERVICE AND USE OF COITUS-INDEPENDENT METHODS, PITTSBURGH POVERTY AREA, 1969

Race	Type Of Health Serv.	Contraceptive Methods: Coitus-Indep. Methods	Contraceptive Methods: Others	Total	% Using Coitus-Indep. Methods	Observed O_1	Expected E_1	Variance Of $(O_1 - E_1)$
White	Private	35	26	61	57.4	35	35.8	4.46
	Public	16	10	26	61.5			
	Total	51	36	87				
Black	Private	13	25	38	34.2	13	17.1	5.45
	Public	27	24	51	52.9			
	Total	40	49	89				

$$X^2 = \frac{([48-52.9]-\frac{1}{2})^2}{9.91} = 1.40,\ P < .05$$

Examining the above hypothesis on age, one sees that in general, the younger subjects tend to favor coitus-independent methods to a significant degree ($X^2=6.40$; $P<.025$). Apparent exceptions are the white users of public medical care, where the trend seems to be reversed, with only 54.5 per cent of the younger respondents expressing preference for coitus-independent methods as against 66.7 per cent in the 30 to 44 age range. But the situation for this particular group of public health service users is far from being clearcut. It is easily seen that these respondents are only 26 in all and gave the least contribution to the overall chi-square value, the difference (O-E) being 0.8. From these indications, the researcher concludes that a larger number of subjects would be necessary to clarify the issue.

No evidence of a significant association between type of medical service and contraceptive practices or preferences was seen in the data when controlled for race and age. The trend is there in terms of a greater proportion of public medical service users expressing preference for coitus-independent methods, but not to a degree that could be picked up with the number of subjects used.

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TABLE 6.3

PERCENTAGES OF WOMEN USING COITUS-INDEPENDENT CONTRACEPTIVE METHODS ACCORDING TO PUBLIC AND PRIVATE MEDICAL SERVICE USE BY AGE AND RACE, PITTSBURGH POVERTY AREA, 1969

Type Of Health Serv.	Race	Age	Contraceptive Methods: Coitus-Indep. Methods	Others	Total	% Using Coitus-Indep. Methods	Observed O_i	Expected E_i	Variance Of $(O_i - E_i$
Private	White	20-29	20	9	29	69.0	20	16.7	3.79
		30-44	15	17	32	46.9			
		Total	35	26	61				
	Black	20-29	10	8	18	56.3	10	6.2	2.19
		30-44	3	17	20	15.0			
		Total	13	25	38				
Public	White	20-29	6	5	11	54.5	6	6.8	1.56
		30-44	10	5	15	66.7			
		Total	16	10	26				
	Black	20-29	16	10	26	61.5	16	13.8	3.24
		30-44	11	14	25	44.0			
		Total	27	24	51				

$$X^2 = \frac{([52-43.5]-\frac{1}{2})^2}{10.78} = \frac{64.0}{10.78} = 6.40, > .05$$

TABLE 6.4

PERCENTAGES OF WOMEN USING COITUS-INDEPENDENT CONTRACEPTIVE METHODS ACCORDING TO PUBLIC AND PRIVATE MEDICAL SERVICE BY SOCIOECONOMIC STATUS AND RACE, PITTSBURGH POVERTY AREA, 1969

Medical Services Used	White		Black	
	High SES	Low SES	High SES	Low SES
Private	61.9% (26)	47.4% (9)	37.5% (6)	31.8% (7)
Public	38.1% (16)	61.1% (11)	78.6% (11)	43.2% (16)

The data in Table 6.4 suggest that private medical care is a function of socioeconomic status. Families having high SES in the white group tend to use private medical care while the opposite is true for the black. High SES white users of private medical care prefer and use coitus-independent methods. The inverse is true for blacks. There is no evidence in this study and in other related researches that blacks are successful in spacing and controlling family size through the use of non-medically prescribed coitus-dependent contraceptive methods. Actually studies such as those conduced by Rainwater, Bogue, etc. indicate just the opposite.[1]

[1]Donald Bogue, Sociological Contributions to Family Planning Research (Chicago: Univ. of Chicago Press, 1967). Lee Rainwater, "Family Planning In Cross-Cultural Perspective: An Overview" The Journal of Social Issues, No. 4 (October, 1967), pp. 1-12.

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Forty-one per cent of the white respondents in this study were Catholic women aged 30 years and older. This represents a group which would have the least propensity controlling on religion and age to use the pill or IUD, however, 63 per cent of the Catholics as compared to 50 per cent of the Protestants use a coitus-independent method. This study supports the trend that Catholic women have been continuing their gradually increasing nonconformity with traditional teachings of the Church. Of the 90 per cent Catholic women who reported that they had practiced some form of birth control, only 19 per cent had restricted themselves to the rhythm method.

Prior to the development of the pill, it had been a demographic axiom that a couple's contraceptive efficiency increased as they approached their desired family size.[1] Couples tend to be more highly motivated to regularly practice birth control when they desire to terminate pregnancies altogether, as opposed to spacing them. Stated differently, when a couple's actual family size reaches its desired size the couple become more efficient in contraception use. The widespread adoption of coitus-independent methods among the younger females in this study seems to reject the pattern of haphazard birth control in the early marital years. The mean parity at which couples began to use coitus-independent methods was approximately two.

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[1]Charles Westoff, R. Potter and P. Sagi. The Third Child (N.J.: The Princeton Univ. Press, 1963), p. 292.

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Fertility researches have demonstrated that lower income families have long been plagued by a family size far in excess of what they actually have desired. Table 6.5 suggests that respondents participating in the Pittsburgh study were no exception.

TABLE 6.5

MEAN ACTUAL AND DESIRED FAMILY SIZE
BY RELIGION, AGE AND RACE,
PITTSBURGH POVERTY AREA, 1969

Age in Years	White Average Family Size		Black Average Family Size	
	Actual	Desired	Actual	Desired
20-29	2.61 [1] (42)	3.01 (40)	2.55 (43)	3.04 (42)
30-44	4.10 (58)	4.10 (57)	5.07 (54)	3.90 (56)
TOTAL	3.48 (100)	3.66 (97)	3.95 (97)	3.53 (98)

	Catholic Average Family Size		Protestant Average Family Size	
20-29	2.56 (23)	3.23 (21)	2.68 (19)	2.78 (19)
30-44	4.00 (41)	4.17 (40)	4.35 (17)	3.94 (17)
TOTAL	3.48 (64)	3.85 (61)	3.47 (36)	3.33 (36)

[1] Numerical values not in parentheses represent average actual and desired number of children controlling on age, race, and religion.

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A fairly large differential exists in the black study group with regard to desired and actual family size. Westoff and Ryder in the National Fertility Study showed that blacks were less likely to use the pill for spacing early births.[1] This study indicates evidence that the trend may be changing. A substantially large proportion, 81 per cent (22 cases), of the blacks in this study aged 20 to 24 years had used the pill. The likelihood that these younger women will experience similar high fertility currently experienced by the women in the 30 to 44 age group may be questioned.

The data analysis does not indicate a significant relationship between differential use of health services and practice of coitus-independent contraceptive methods. The data do suggest, however, that the younger families tend to use coitus-independent methods to space and limit family size, while the older couples tend to rely on coitus-dependent devices. The rationales which seem to surface from the data analyses are: 1. There is a decline in fecundity as actual family size reaches or surpasses desired family size. 2. There is a greater willingness on the part of younger people to desire smaller families.

An analysis of the hypothesis that differential preventive health orientation as practiced by the study population influences methods of contraceptive practice indicates

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[1]Charles Westoff and Norman Ryder, National Fertility Study (1966), p. 1202.

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that the proportions of white and black respondents who have a high preventive health orientation go in opposite directions with regard to use of coitus-independent methods. The most interesting data in Table 6.6 is that approximately 66 per cent (16) of the high preventive health oriented whites who practiced coitus-independent contraception use private medical care. Several of the low preventive health oriented black users of coitus-independent methods tend to rely on public medical care.

TABLE 6.6

PERCENTAGES OF WOMEN USING COITUS-INDEPENDENT CONTRACEPTIVE METHODS AND HAVING DIFFERENTIAL PREVENTIVE HEALTH ORIENTATIONS BY RACE, PITTSBURGH POVERTY AREA, 1969

Preventive Health Orientation	White	Black
High	60.5% (23)	40.0% (22)
Low	57.1% (28)	51.5% (17)

Again, the greater proportions of younger respondents regardless of preventive health orientation prefer coitus-independent methods. One noticeable difference among the 30 to 44 age group of whites having a high preventive health orientation is that 65.2 per cent (15 cases) from this group prefer and practice a coitus-independent method.

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For high prevention health oriented blacks, 70 per cent (21 cases), the opposite is true. Testing the hypothesis on socioeconomic status the investigator found that among the high socioeconomic status groups, both for whites and blacks regardless of preventive health orientation, a preference for the practice of coitus-independent methods. For low socioeconomic status whites and blacks regardless of preventive health orientation there exists a practice of coitus-dependent contraception. Based on the limited analysis of the hypotheses there does not appear to be a significant relationship between preventive health orientation and contraceptive practice.

Approximately four-fifths of all respondents claimed to have confidence in their current contraceptive method. Women using the pill or IUD expressed a greater degree of confidence than did women who relied on the more traditional methods such as rhythm, foams and condoms.

Sixty-four per cent (25 women) of the white respondents who belonged to the low health worry cluster practiced coitus-independent contraception as compared to only 43 per cent (9 women) of the blacks. Of those women using a coitus-independent method, only one white female respondent and four black indicated that they both lacked confidence in their method and worried a great deal about pregnancy. The reason for their expressing a lack of confidence and high health worry may be due to the fact that each respondent had four

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or more children and potentially could have additional births due to inefficient contraceptive practice. As parity increases, the probability that a pregnancy may have been ill-timed if not undesired also increases. Table 6.7 indicates that there is not a substantial differential in the white study group concerning confidence in contraceptive practice and current mean parity, however, for the blacks the mean parity for those with confidence in their current contraceptive practice is higher than the whites. There exists a substantial difference among with blacks with respect to mean parity and condifence in method. This may reflect a greater resignation to higher parity on the part of the blacks. The very high parity of the nonconfident black women may indicate pessimism or resignation to accept any number of children.

TABLE 6.7

NUMBER OF WOMEN EXPRESSING CONFIDENCE IN PRESENT CONTRACEPTIVE METHOD BY MEAN PARITY CONTROLLING ON RACE, PITTSBURGH POVERTY AREA, 1969

	White	Black
Confident	3.2 [1] (54)	3.6 (45)
Not Confident	3.4 (17)	5.8 (17)

[1]Represents mean parity.

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Respondents using coitus-independent methods were asked why they preferred the pill or intrauterine device. Belief that the pill or IUD would protect them against pregnancy rather than convenience was the primary reason given for using a coitus-independent method by both white and blacks. Twenty-two coitus-independent users in each study group attested to the belief that the pill was safe and reliable. This is interesting to note in that Tietze suggests that other methods such as the condom and diaphragm are also reliable in terms of laboratory effectiveness when properly used.[1] Coitus dependent users of contraception were less inclined to regard the pill as a better method. They noted its side-effects as a negative factor. It indeed is logical for those women not using the pill to look upon it less favorably. While the data in this study are quite limited, there is an indication that women refrain from the pill because of mistrust and apprehension.[2] Younger women viewed the pill in a positive way and begin to use it on their own initiative rather than on the recommendation of a third party, such as their family doctor.

In Chapter Five, the analysis addressed desired family size relevant to the independent health variables. The comparison of desired number of children with actual family size

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[1]Christopher Tietze, "Statistical Evaluation of Contraceptive Methods: Use Effectiveness and Extended Use Effectiveness." Demography, Vol. 5 (1968), pp. 931-940.

[2]It should be noted that the data for the study were collected shortly before Senate subcommittee hearings on the pill in the Winter of 1970.

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provides another way of examining contraceptive behavior. Respondents whose actual family size exceeds their desired family size, may have less control and certainty of their capacity to handle their fertility than those whose actual family size is less or equal to their desired family size. Again, age must be considered in this analysis. Younger women are more likely to express a difference between actual and desired family size. Since the younger female respondents aged 20 to 25 years for both study groups have not achieved desired family size, Table 6.8 includes only respondents in this age range and compares actual and desired family size controlling on race. The Table excludes sterilized respondents and those who have never used any contraceptive method.

TABLE 6.8

TOTAL NUMBER OF WOMEN AGES 25-44 YEARS WHO HAVE EVER USED THE PILL OR IUD ACCORDING TO DIFFERENTIAL BETWEEN DESIRED AND ACTUAL FAMILY SIZE BY RACE, PITTSBURGH POVERTY AREA, 1969

	White	Black
Actual >Desired Family Size	11	19
Actual <Or Same As Desired Family Size	49	28

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Almost twice as many whites are in the process of achieving or have achieved a family size corresponding to their desired family size. Nearly twice as many blacks indicated that their actual family size is greater than their desired. Women who indicated that their actual family size exceeds that which they desired may be more inclined to prevent additional pregnancies than those for whom the converse is true. Since this is not a longitudinal study, additional followup research at selected intervals would be necessary to pursue this item. The mean parity for the Protestant women over 30 years of age is greater for those ever having used the pill (4.38) than for those never having used the pill (3.57). It is the same for Catholics in each group (3.90).

All female respondents in the study samples were categorized according to planning status. This is not to be confused with the concept "desired family size." Planning status refers to whether or not all of the respondent's children were completely, partially, or not planned at all. This concept is adapted from Whelpton, Campbell and Patterson, Fertility and Family Planning in the United States.[1]

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[1]Pascal Whelpton, Arthur Campbell and John Patterson, Fertility and Family Planning in the United States (Princeton, N.J.: Princeton Univ. Press, 1966), p. 325.

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The concepts used in the analysis are defined as follows:

1. Completely planned - The respondent had no unwanted or sooner than desired children and implies that the respondent always used contraceptives successfully.
2. Partly planned - The respondent had at least one sooner birth than planned and/or undesired birth together with other planned or desired births.
3. Completely unplanned - All unwanted or sooner born babies.

TABLE 6.9

PERCENTAGE OF WOMENS' PLANNING STATUS WITH RESPECT TO FAMILY SIZE BY RACE, PITTSBURGH POVERTY AREA, 1969

Planning Status	White	Black
Completely Planned	10.1% (10)	6.1% (6)
Partially Planned	84.8% (84)	81.6% (80)
Completely Unplanned	5.1% (5)	12.2% (12)

As would be expected the greater majority, more than four-fifths of each study group indicated that several of their children were planned and others were not. Fewer whites

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than blacks indicated that none of their children were planned while more whites, all of whom were Catholic, indicated that their families were completely planned. Use of public and private medical care showed no significant direction for any of the planning status categories. Other than religion, the test variables did not provide any additional information. The independent health variables, preventive health orientation and the health worry cluster did not provide any meaningful direction or interpretation in the analysis.

It is reasonable to conclude that this study has demonstrated very little relationship between health and fertility performance in this lower income urban population. The directions of the hypotheses are inconsistent. Further research employing a larger sample may provide additional information which may more clearly depict any significance in the study hypotheses. It is interesting to note that 58 per cent of the whites compared to 62 per cent of the blacks began to practice some form of contraception either prior to or immediately following the birth of their first child. Table 6.10 presents information controlling on race and age of respondents ever using birth control methods relevant to parity.

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TABLE 6.10

PARITY AT WHICH WOMEN BEGAN TO EVER USE CONTRACEPTIVE PRACTICE BY DIFFERENTIAL USE OF MEDICAL SERVICES BY AGE AND RACE, PITTSBURGH POVERTY AREA, 1969

	White				Black			
	Private Med.		Public Med.		Private Med.		Public Med.	
Parity	20-29	30-45	20-29	30-45	20-29	30-45	20-29	30-45
One Child	65.5% (19)	57.6% (19)	50.0% (5)	46.7% (5)	66.7% (8)	66.7% (12)	66.7% (16)	50.0% (10)
Two or More	34.5% (10)	42.4% (14)	50.0% (5)	53.3% (8)	33.3% (4)	33.3% (6)	33.3% (8)	50.0% (10)

The greater proportion of whites regardless of age, who use private medical care began using contraception following the birth of their first child. For blacks neither age nor medical services used seems to influence contraceptive behavior. Most black females indicate that they began using contraception following the birth of their first child. As reported earlier in this chapter, blacks tend to rely on more traditional contraceptive methods and have been less successful in having only the number of children desired. The data suggest that black women are less effective users of birth control regardless of whether they use public or private health care.

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CHAPTER VII

SUMMARY AND CONCLUSION, DISCUSSION AND RELATED FUTURE RESEARCH

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CHAPTER VII

SUMMARY AND CONCLUSION, DISCUSSION AND RELATED FUTURE RESEARCH

A. Summary and Conclusion

The purpose of this study was to investigate the association between utilization of selected health services and fertility beliefs and contraceptive practices among low-income urban women. The study focused on the following two general hypotheses:

1. Attitudinal differences toward family planning exist between families who use private health services and families who primarily rely on tax supported public medical services.

2. Behavioral differences in utilization of contraception methods exist between families who use private health services and families who primarily rely on tax supported public medical services.

The dependent attitudinal family planning variables included such items as desired family size, its importance, ideal child spacing and its importance. The dependent family planning behavioral variable complex included current contraceptive method, parity when first used birth control and planning status. The independent variable complex included current use of private or public medical care, preventive health

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orientation and degree of worry regarding family's general health. The hypotheses in the study were controlled on race, socioeconomic status, age, socialization and religion.

Study samples of 100 white and 98 black women, ages 20 to 45 years were randomly selected from two non-adjacent O.E.O. designated poverty Pittsburgh census tracts. All respondents were either household heads or married to same and each had at least one dependent minor child living with them at the time of the study. Six female graduate students, attending the University of Pittsburgh conducted the interviews during the 1969 summer and fall. The survey questionnaire was pre-tested, standardized and administered in the respondents' homes. To assure success of the study, only white interviewers were used with white respondents and black with black respondents. The actual interview took approximately 45 minutes to conduct.

The principal hypotheses tested in this study did not demonstrate any statistically significant associations. With the introduction of age as a control variable, the delineation of association became more meaningful. There is a highly significant association between age of the respondents and their desired family size. Among the younger women, age 20 to 29 years, there is a marked preference for small families of three or less children. The prime reasons stated by both study groups for preferring small families were economic and/or to provide an educational opportunity for the children.

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While blacks tended to prefer smaller families, their actual family size was greater than their desired family size. A chi square test performed on the data depicting at what age the respondents first child was born produced highly significant results. Blacks as a group had earlier child bearing experience than the whites (chi square = 16.45, $P<.001$). This, in part, may account for why their actual number of children exceeded their desired or preferred family size. Also, many of the black respondents may not have had access to birth control information and services. A large proportion of blacks had their initial children while still in their early teens. Most state laws do not permit teenagers to receive family planning counseling and service without their parents' written approval.

Usage of coitus-independent contraceptive methods such as the pill and intrauterine devices does not appear to be linked with a specific type of health care used by the respondent and her family. It is possible to glean from the data in both racial groups, particularly among blacks, a tendency to favor using the pill. This was true for public health service users compared to private medical care users; however, the differences were not significant. The younger women not only favored a medically prescribed contraceptive method, but they also adopted use of the pill or IUD to a significant degree (chi square = 6.40, $P<.025$) compared to the older respondents. These same women expressed both

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satisfaction and considerably more confidence in their current contraceptive method than the older women who relied more on non-medically prescribed methods.

Other general findings and observations extracted from this study and relevant to the implementation of family planning programs are summarized as follows:

1. More than 80 per cent of the entire study sample approved of family planning and three-fourths of all respondents indicated that having access to such services was very important.
2. While nearly all women expressed a desire for families of two to four children, approximately 25 per cent had given birth to five or more children.
3. Nearly twice as many blacks ages 25 to 44 years compared to whites indicated that their actual family size exceeded their desired family size. These same blacks desired slightly smaller families than did the whites.
4. More than four out of five women in the sample had ever employed a contraceptive method in an effort to control family size. This includes very ineffective methods such as jellies, foams, etc.
5. Confidence in contraceptive methods tended to decrease for both groups as parity increased beyond desired family size.

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6. Slightly more than 80 per cent of both study groups indicated that one or more of their children were unplanned.

7. Black women tended to worry more about the family's health and general welfare than did the whites. Blacks, who worried more about the family's health tended to prefer smaller families.

Since the study focused upon a rather sensitive issue and it had been rumored prior to implementing the study that blacks were no longer cooperating in health related survey research, the investigator conducted a brief reliability test-retest. A subsample of twelve cases was randomly selected from the original sample of black women. A total of thirty knowledge and attitude items were randomly selected from the original questionnaire and administered again in identical form to the same respondents. This resulted in a mean .776 coefficient of stability. The average reliability coefficient for the attitudinal items was .727 and for the knowledge items .776. The investigator accepted the responses to the questionnaire as being reliable and valid.

There were very few refusals in both census areas. The overall response rate, taking into account refusals, absentees and ineligible persons was 85 per cent and 81 per cent for whites and blacks respectively.

Until quite recently, the only resources available to meet the family planning needs of the poor were the scattered

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centers operated by Planned Parenthood and the occasional service provided by some private physician. This study clearly shows that lower income families both desire small families and endorse family planning as a legitimate means by which to achieve this goal. To serve the low income population on a national basis which includes approximately 5.4 million poor women by 1975 is too great a task for the private agency and physician in private practice alone.[1] As with other primary health services, it can only be accomplished by the joint efforts of all health and welfare agencies which are responsible for providing medical services to the poor. Family planning services, accessible to the poor, must be developed by public and voluntary hospitals and health departments, as well as by private physicians. Similarly, educational and referral efforts by welfare departments, which often are responsible for funding medical services for recipients, must also be augmented. The social work professionals, who have little experience in the delivery of family planning to the poor and are themselves beset with considerable misinformation about the poor's sexual and childbearing patterns, need at least a minimum educational component regarding the value of family planning. Certainly a more positive attitude on the part of the professional caseworker would facilitate restructuring the delivery system to accommodate the poor and near-poor who have expressed a desire for smaller families.

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[1]"Need for Subsidized Family Planning Services: United States, Each State and County, 1968." Planned Parenthood-World Population, p. 4.

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The poor have clearly established their desire for family planning information and services. The health establishment must bend and adapt to this need. Modern family planning services must be made available at low or no cost at convenient times and in locations geographically accessible to the population most in need.

B. Discussion and Related Future Research

The United States has had a population policy from a relatively early date. Governmental policies included the provision of free or cheap land, the advocacy and later restriction of immigration and very recently the evolution of a categorical public policy regarding making available birth control information and services to approximately five million indigent women by 1975.[1]

During the early history of this country, the government encouraged population to migrate westward. The government has influenced economic development and population settlement through such legislative acts as FHA and VA mortgage insurance, the interstate highway system, the awarding of defense contracts, all of which collectively have an impact which may not always be in the best interest of the country from the standpoint of population distribution.

It is interesting to note that the White House Conference on Children and Youth in 1960 met shortly after President Eisenhower contended that birth control was not the business

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[1] Ibid., p. 4.

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of Government. Since that time, there has been almost an 180 degree position change. President Nixon has come out strongly in favor of family planning, citing the staggering magnitude of the population problem throughout the world and the need to provide family planning services to several million poor and near poor women in the United States by the three-quarter mark of the present century.

There often evolve two principal sources of ambiguity in social research. Many purely research efforts which have been for the purpose of building knowledge may in time influence health policy and services. Thus, such research may take on functional equivalent. It may be difficult to draw a sharp line between knowledge-building research and research for use or immediate application. The intent of this study was to add to the present limited body of knowledge by investigating the association between certain health factors and fertility practices. While the study sample is small, certain findings do emerge and suggest areas for additional research using more varied study populations which might include male household heads.

Recent studies, both national and local in scope have revealed a great deal of information depicting variations in fertility attitudes and behavior among different socioeconomic groups. Prior to this research undertaking there had been virtually nothing written to document the extent to which differential use of medical services and preventive health

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orientation may influence desired and actual family size and use of various contraceptive methods.

Previous fertility surveys have largely been directed to the female. The family planning literature is almost devoid of any attention given to the role played by the male in the final determination of family size. One of the limitations of the present study, which became obvious to the researcher was the one-sided approach of only interviewing females. While no effort should be made to negate the importance of the female in family planning, it seems appropriate and timely to place the male in his proper perspective and to examine his role.

Among the more notable national and local fertility studies conducted in the United States are the Growth of American Families Study, The Indianapolis Study and National Fertility Studies. Without exception, these studies have focused their attention on the average American family. While these studies have provided invaluable data concerning family planning patterns, they have revealed comparatively little information on the low income family and particularly on the role of the male household head.

An obvious characteristic of families receiving partial or total welfare assistance is that they are very much in the limelight, targets of intense criticism and objects of considerable concern. This attention reflects some deep and persistent value conflicts in the society of this country.

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The community at large tends to reject public assistance and its recipients and at the same time confronts official health and welfare agencies with increasing demands to rehabilitate such persons. The professionals who are directly involved in treatment, as well as governmental and political officials, the medical fraternity, the news media, the business community and particularly the welfare mothers themselves are genuinely concerned not only with becoming independent of welfare, but with the plight of children, often undesired. But what is known about the welfare father's contraception beliefs and practices?

A successful male household head is largely known by his paycheck. The family receiving welfare support often suffers from handicaps associated with social, economic, and health disabilities of the father. Often, there are problems of low income, inadequate housing, insufficient medical care, etc. Many fathers of families on relief are limited by lack of education and underemployment which tend to isolate them from constructive participation in community life. They view the world as hostile or arbitrary and feel powerless to control it. There is little doubt about the need for more comprehensive health services, and certainly family planning services should be available to the male. However, this will require a clearer definition of the male's current knowledge and predisposition toward his role in family size limitation.

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If family planning programs are to significantly contribute to alleviating the effects of poverty, the male household head of the poor family must be involved. This may eventually prove to be particularly true since the recent congressional hearings of the ill effects of the pill. The New York Times reported on February 22, 1970 that as a result of the Senate subcommittee hearings challenging the safety of the pill, roughly 18 per cent of all women using the pill and a minimum of 15 per cent of those served by family planning clinics have discontinued using the pill.

Fertility research to date tends to assume that the male is of little importance or that he is adequately represented by his wife. There is little evidence to assume either. Suggested research to add to the present limited body of useful knowledge concerning lower class male fertility patterns by interviewing male household heads represents a new frontier in fertility research. Without studies of this type we shall continue to lack meaningful theoretical formulation to explain why the poor family tends to maintain relatively high birth rates even in the presence of increasing availability of family planning information and service.

Since so little information is available regarding the male in this area, additional basic data relevant to his position and role in family size determination may enhance the welfare workers' effort to counsel the male as well as the female in matters relevant to family planning - something

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the worker may not now feel at ease to do, due to an inadequate or incorrect perception of the male's attitude regarding family planning. Fertility information concerning the male, similar to that which is currently available on the female could also influence agency policy which would serve to strengthen efforts to assist the family, once the direction and intensity with which the male regards his role in determining family size is better understood.

It is generally accepted that family planning in the United States is but one of the number of related efforts to provide the poor with the means to escape from poverty. Hence, no research which attempts to make a meaningful contribution to this endeavor can concentrate simply on the female's fertility attitudes and behavior in isolation. It must consider the situation of the husband within the impoverished family and within the larger society in order to understand how poverty affects his relationship with other members of his family and how the effect of these relationships affects the couple's ability or inability to achieve a family size consistent with their desires.

Such a study could endeavor to ascertain from the male's perspective concerning problems of economic insecurity, future expectations, child rearing and health, communication with his wife and, of course, his fertility attitudes and behavior. This would involve the exploration from the male point of view of why, on average, the poor tend to have larger families than

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they may desire. Studies based on female informants have consistently reported a completed family size higher than the desired family size. The reason for this is not primarily due to lack of knowledge of contraception, per se, but perhaps due to lack of accessibility to contraceptive information and services. On the assumption that there often exists a lack of communication between husband and wife, the male's perception of the problem could be examined and related to other possible difficulties stemming from his position within the family. The male's opinions concerning provision of contraceptive services to his spouse usually without involving him, should be sought to see whether this may be an important negative factor in the provision of family planning services. This, in essence, represent in this investigator's judgment an important area for future research.

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(DATA OF TABLE 5.5)

Race	Type Of Health Serv.	Age	Number Of Children Desired 1 - 3	4+	Total	% Desiring 3 or Less	Observed O_i	Expected** E_i	Variance Of* $(O_i - E_i)$
White	Private	20-29	20	10	30	66.7	20	14.78	4.3006
		30-45	14	25	39	35.9			
		Total	34	35	69	49.3			
	Public	20-29	6	5	11	54.5	6	4.71	1.696
		30-45	6	11	17	35.3			
		Total	12	16	28	42.9			
Black	Private	20-29	10	6	16	62.5	10	9.60	2.3631
		30-45	14	10	24	58.3			
		Total	24	16	40	60.0			
	Public	20-29	18	8	26	66.7	18	13.23	3.5971
		30-45	11	20	31	35.5			
		Total	29	28	57	50.9			

APPENDICES

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APPENDIX A

THE CONCEPT OF "LOWER CLASS FAMILIES"

The concept of "lower class families" will be defined for the purpose of this dissertation as those families who occupy a particular social position which is the product of a particular economic and occupational status of particular educational attainments, of living in particular kinds of neighborhoods. Lee Rainwater refers to the working class as consisting of the upper-lower class and the lower-lower class. The former is characterized by greater prosperity and stability. Upper-lower class workers generally are in semiskilled and medium-skilled work; they are in manual occupations or in responsible but not highly regarded service jobs such as policemen, firemen or bus drivers. They have generally had at least some high school education. Their families live in neighborhoods composed mainly of other manual and lower-level service workers. Although people in this group tend to regard themselves as living the good life of average Americans, they are still aware that they do not have as much social status or prestige as the middle class white-collar worker or the highly-skilled technicians.

The lower-lower class represents a group who are very much aware that they do not participate fully in the good life of the average American. They feel at the bottom of the heap and consider themselves at a disadvantage in seeking the goods

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that the society has to offer. They generally work at unskilled jobs, and often they work only intermittently or are chronically unemployed. Few people in this group are graduates of high school and a great many go no further than grammar school. They live in slum and near-slum neighborhoods and their housing tends to be cramped and deteriorated (Rainwater, 1960:4-5). While the distinction between these two levels of the working class is important, due to the limited size of the study population this distinction will not be made in the analysis of the data. The lower class family for the purpose of this dissertation will be defined as to include both upper-lower and lower-lower class families.

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APPENDIX B

RELIABILITY TEST - RETEST

A sub-sample of eleven cases was randomly selected from the completed interview schedules of the ninety-eight black respondents. A series of sixteen questions were taken from the original questionnaire, eight relating to attitude type information and the remaining dealing with knowledge-behavior data. On the re-test, the sixteen questions were administered in their original form to the same respondents. The only difference in the re-test procedure was that a black male social worker administered the reliability questionnaire, the reason being that the black female interviewers had left the research team. The mean reliability for all sixteen questions was .776. The mean reliability score for the eight knowledge-behavior items was .845 and for the attitude items, it was .727.

The following test-retest items are presented with their individual reliability scores:

Now I am going to read to you a number of statements. Please tell me whether you agree or disagree with each:

1. Very few people can be trusted.

   1. Agree 2. Uncertain 3. Disagree R = .818

2. The secret of happiness is not expecting too much out of life.

   1. Agree 2. Uncertain 3. Disagree R = .636

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3. I doubt that doctors can do all the things they say then can do.

1. Agree 2. Uncertain 3. Disagree R = .545

4. Things turn out the way they do because God wills it that way.

1. Agree 2. Uncertain 3. Disagree R = .717

5. Do you believe that the situation of you and your family will be better or worse in five years?

1. Worse 2. Same 3. Better R = .727

6. Almost everyone worries at one time or another. Would you please tell me whether you worry about the following:

1. A lot 2. A little 3. Not at all

A. Family Finances R = .818

B. Your Health R = .727

C. Having More Children R = .727

7. Some people say that, in general the number of children that a couple has depends on their luck. Others say it depends on the parents. What do you think?

1. Luck 2. Luck and Parents 3. Parents R = .818

8. If you could have exactly the number of children you want, what number would that be? R = .600* (*There was one missing observation.)

9. Now, I would like to ask you what you might do if the following happened to you:

What if you had trouble sleeping several nights and had no desire for food? (Open-ended type of question)

	1.	2.
A.	Seek medical attention	Care for self

3. Nothing R = .818

B. What if you had a high fever? R = .909

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10. Do you and your family have a regular family doctor in private practice only?

    1. Yes 2. No R = .818

11. During the past year has anyone in the family visited the dentist?

    1. Yes 2. No R = .727

12. How many children (born alive) did your mother have, including yourself? R = .818

13. What was the highest grade of school that you have completed? R = 1.00

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APPENDIX C

F-7/31/69 (PIHF)

**********STRICTLY CONFIDENTIAL**********

PITTSBURGH HEALTH AND FAMILY PROJECT

CDI 1-3 4-5 6

Case	HH	S
___	__	1

11 ☐

Name:_____ Address:_____ Interviewer:_____

Visit	Date	Arr. Time	If no interview, why?	Appointment for next visit		
				Date	Time	Comments
1						
2						
3						

12 ☐

ELIGIBILITY SHOULD BE DETERMINED FROM THE LADY OF THE HOUSE. IF UNAVAILABLE, OBTAIN INFORMATION FROM ANY KNOWLEDGEABLE PERSON.

I am from the University of Pittsburgh (Graduate School of Public Health) and we are concerned with things which affect health and the family. We would find it very helpful if we could speak with you. To find out whether I may speak in detail, however, I must first know something about those living in your home.

E1. Could you tell me about the persons who regularly live in this home? Please start with the head of the household ... ☐ 13

First name	Date of birth	Rel. to HH head	
		Head	14 15
		Spouse of head	16 17

E1a. Could you tell me how many of your (LADY OF THE HOUSE) children now are living with you? (INDICATE IF "NONE") 18 19

_____ children in HH now

E1b. How many other persons live in this household? (INDICATE IF "NONE") 20

_____ No. of other person in HH 21 22

E2. INTERVIEWER: DETERMINE ELIGIBILITY:

Lady of house born 1924 to 1949 and any of own children in HH. ☐ Other TERMINATE 23

CONTINUE INTERVIEW WITH THE LADY OF THE HOUSE ONLY

I would like to hear your opinions on many things about health and the family, but before beginning it would be helpful to know a little about, for example, how long you have lived here ... (CONTINUE INTERVIEW USING FEMALE QUESTIONNAIRE)

	By	Date	Comments
Revision			
Coded			

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APPENDIX D

PITTSBURGH POVERTY AREA
FEMALE QUESTIONNAIRE

1. How many years have you lived in Pittsburgh (for last time, if more than once)?

_____ years

2. Where did you live before coming to Pittsburgh?

_____ and _____
place state

3. In what place was your mother living when you were born?

_____ and _____
place state

4. When you were growing up (6 to 16), in what place did you live most of the time?

_____ and _____
place state

5. Was this place mostly city-like or mostly country-like?

1. City-like 3. Country-like

6. IF COUNTRY-LIKE: Did you live on a farm when you were growing up?

1. Yes 3. No

7. What is your present marital status?

1. Single, never married
2. Now married
3. Common-law union
4. Widowed
5. Divorced
6. Separated
7. _____

8. Do you have a job now?

1. Yes 3. No

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9. What type of work are you doing now (were you doing when you last worked)?

_____ and _____
duties establishment

10. IF PRESENTLY MARRIED: Is your husband now employed, unemployed, or what?

1. Employed 2. Retired
3. Unemployed 4. _____

11. What is (was) his main job?

_____ and _____
duties establishment

12. What was the highest grade of school that was completed?

_____
grade level

13. What was the highest grade that your husband completed?

_____
grade level

14. Would you tell me your religious preference?

1. Protestant 2. Catholic 3. Other

15. DO NOT ASK: Race?

1. White 2. Black 3. Other

Now I am going to read to you a number of statements. Please tell me whether you agree or disagree with each.

16. Very few people can be trusted.

1. Agree 2. Uncertain 3. Disagree

17. The secret of happiness is not expecting too much out of life.

1. Agree 2. Uncertain 3. Disagree

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18. Some people say that, in general, the number of children that a couple has depends on their luck. Others say it depends on the parents. What do you think?

1. Luck 2. Luck and parents 3. Parents

19. Have you had all the children that you <u>want</u>?

1. Yes 2. DK 3. No

20. IF YES: Would you just as soon have had fewer?

1. Yes 2. DK 3. No

21. IF YES: What number of children would you really want? PROBE FOR SPECIFIC NUMBER ANSWER.

_____
children

22. <u>IF NO</u>: If you could have exactly the number of children you want, what number would that be? PROBE FOR SPECIFIC NUMBER ANSWER.

_____
children

23. Do you think it is very important or very unimportant that a couple not have any more children than they really want?

3. Very important 1. Very unimportant
2. Uncertain

24. Have you ever thought about this before?

1. Yes 3. No

25. (IF NO HUSBAND, SKIP TO 28)
Have you discussed this with your husband?

1. Yes 3. No

26. Do you think that your husband wants more or fewer children than you want?

3. More 2. Same 1. Fewer
7. He doesn't care

27. How many children do you think he wants?

_____
children

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28. How many children do you think is the best number for people in your situation? PROBE FOR SPECIFIC NUMBER.

_____
children

29. IF DON'T KNOW: Well, what would be your best guess?

9. DK

_____
children

30. Why do you think that is the best family size for people in your situation?

31. When a couple has just had a baby and would like to have another, about how much later would it be best to have the next baby born?

_____

32. Do you think it is very important or not very important that the next baby come when the couple wants it?

1. Very Important 2. Depends 3. Not very important

33. How many children (born alive) did your mother have, including yourself?

_____
children born alive

34. How many babies have you had in all? Please include all who were born alive at any time (including any in previous marriages)?

_____
children ever born alive

35. Are you expecting a baby now?

1. Yes (PREGNANT) 3. No

36. Do you believe that the situation of you and your family <u>is</u> better, or worse, than it was five years ago?

3. Better 2. Same 1. Worse

37. Do you believe that the situation of you and your family <u>will be</u> better or worse in five years than it is now?

3. Better 2. Same 1. Worse

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38. I doubt that doctors can do all the things they say they can do.

1. Agree 2. Uncertain 3. Disagree

39. Things turn out the way they do because God wills it that way.

1. Agree 2. Uncertain 3. Disagree

40. Almost everyone worries at one time or other. Would you please tell me whether you worry about the following a lot, a little, or not at all?

	a lot	a little	not at all
A. Family Finances	1	2	3
B. Your health	1	2	3
C. Having more children	1	2	3
D. Health of your family	1	2	3

Now I would like to ask you what you might do if the following happened to you? (RECORD RESPONDENT'S ACTUAL ANSWER)

41. What if you had trouble sleeping several nights and had no desire for food?

_____

42. What if you had a high fever?

_____

43. What if you found your mind wandering all the time and that you started talking to yourself?

_____

44. During the past twelve months has anyone in the family had any one of the following?

A. Physical examination even though nothing was felt to be wrong.

1. Yes 3. No 9. DK

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B. A chest x-ray.

1. Yes 3. No 9. DK

C. Shots for polio.

1. Yes 3. No 9. DK

D. Eye examinations.

1. Yes 3. No 9. DK

E. Any test or examination to detect cancer.

1. Yes 3. No 9. DK

45. Do you and your family have a regular family doctor in private practice only?

1. Yes 3. No

46. How long has he been your family doctor?

_____

47. In your opinion, would you say that your doctor, himself, gives poorer or better care to lower income individuals than he does to other individuals?

1. Better 2. Same 3. Poorer

48. Do you and your family use a hospital clinic or a children's clinic for regular medical care?

1. Yes 3. No

49. IF YES: How long have you been using this clinic?

_____

50. IF NO REGULAR FAMILY DOCTOR: What does the family use for regular medical care and why?

_____

51. During the past year has anyone in the family visited the dentist?

1. Yes 3. No

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52. Within the past twelve months has anyone in your family seen a private doctor at his office or in your home?

1. Yes 3. No

A. Who? MAY BE MORE THAN ONE - Wife Husband Children

B. How many visits? Wife Husband Children

53. During the past twelve months has anyone visited a hospital clinic or children's clinic for some kind of health need?

1. Yes 3. No

A. Who? MAY BE MORE THAN ONE - Wife Husband Children

B. How many visits? Wife Husband Children

54. Did your family pay for all, part or none of the clinic expense?

1. All 2. Part 3. None

55. IF PART OR NONE: Who paid the clinic expense?

---

56. Some couples cannot have any more children. As far as you know, is it physically possible for you (and your husband) to have any more children, if you want them?

1. Physically possible 3. Physically impossible

57. IF PHYSICALLY IMPOSSIBLE: Did you or your (present/last) husband ever have an operation that made it impossible to have any more children?

1. Yes 3. No

58. IF YES: Who?

1. Wife 2. Husband 3. Both

59. Was the operation done, at least in part, so that you would not have any more children?

1. Yes 3. No

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60. Many couples do something to limit the number of pregnancies they will have. In general, would you say you are for or against this?

3. For 2. Uncertain 1. Against

61. Some couples use a natural method, for example rhythm or the safe period, to keep from having too many pregnancies. Would you say you are for or against this?

1. For 2. Uncertain 3. Against

62. Here is a card with the names of methods couples use to delay or prevent having a baby. (SHOW CARD II) Which method or methods have you (or your husband) ever used? PROBE: Any others?

0. Nothing
1. Rhythm
2. Condom
3. Withdrawal
4. Diaphragm
5. Pill
6. IUD
7. Jelly, foam, etc.
8. Douche
9. Sterilization

Other:_____

63. IF NOW FERTILE AND NOT PREGNANT: What is the method that you are now using?

OR, IF PREGNANT: What method were you using before you became pregnant?

_____ 0. None
method

64. IF NONE: What is the main reason why you are not using a method?

_____

65. Do you intend to use a method sometime later?

1. Yes 2. DK 3. No

66. IF "YES": Which method?

_____

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67. Do you seldom or often worry about getting pregnant when you don't want to be?

1. Seldom
2. Sometimes
3. Often

68. Do you talk with your friends or relatives about ways of not having babies when you don't want them?

1. Yes
3. No

69. IF YES: Do a few or do most of your married friends use a method?

1. None
2. Few
3. Most
4. All

70. What do you see as the biggest problem in using a family planning method? (MAY HAVE TO PROBE)

---

71. People often worry about accidentally having a baby. Do you feel very confident or not so confident that your present method will prevent having a baby when you don't want it?

1. Confident
2. Uncertain
3. Not confident

72. What are some of the things that are good about the pill compared to other methods?

---

73. Have you ever thought about these differences before?

1. Yes
3. No

74. Do you feel that using the pill would make sexual relations more or less enjoyable?

1. More enjoyable
2. No difference
3. Less enjoyable

75. We also hear a lot about the so-called "loop" or IUD. In your opinion, what are some of the things that are <u>not</u> so good about the loop compared to other methods?

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76. What are some of the things that are good about the loop (IUD-coil) compared to other methods?

_____

77. How does your husband feel about your most recent method? Does he approve or disapprove?

1. Approve 2. Not care 3. Disapprove

78. When using the pill (loop-IUD), do (did) you feel very confident or not so confident that you can (could) prevent having a baby when you don't want it?

1. Very confident 3. Not very confident
2. Uncertain

79. Do you think that any groups should provide services for the purpose of planning a family?

1. Yes 3. No

80. IF YES: Who would be best to provide the services?

_____

81. Do you know of any particular places that now provide information and services for the purpose of planning a family?

1. Yes 3. No

A. IF YES: What places?

_____ _____ 9. DK

B. Have you ever used any of these places?

1. Yes 3. No

C. IF YES: Which places?

_____ _____

82. IF DID NOT MENTION PLANNED PARENTHOOD: Have you heard of the Planned Parenthood Clinics?

1. Yes 3. No

83. Have you ever used a Planned Parenthood clinic?

1. Yes 3. No

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84. IF NO: Are there any reasons why you have not used the Planned Parenthood clinic services?

_____

85. In general, what do you think is the purpose of the Planned Parenthood Organization? What are they trying to accomplish?

_____

86. Here is a card showing weekly and yearly incomes. Next to each amount is a letter. Please tell me the letter that represents the approximate amount of money that your family had to live on during the past twelve months.

_____
letter or amount

87. Has your family received any financial help from the Department of Public Assistance in the past twelve months?

1. Yes 3. No

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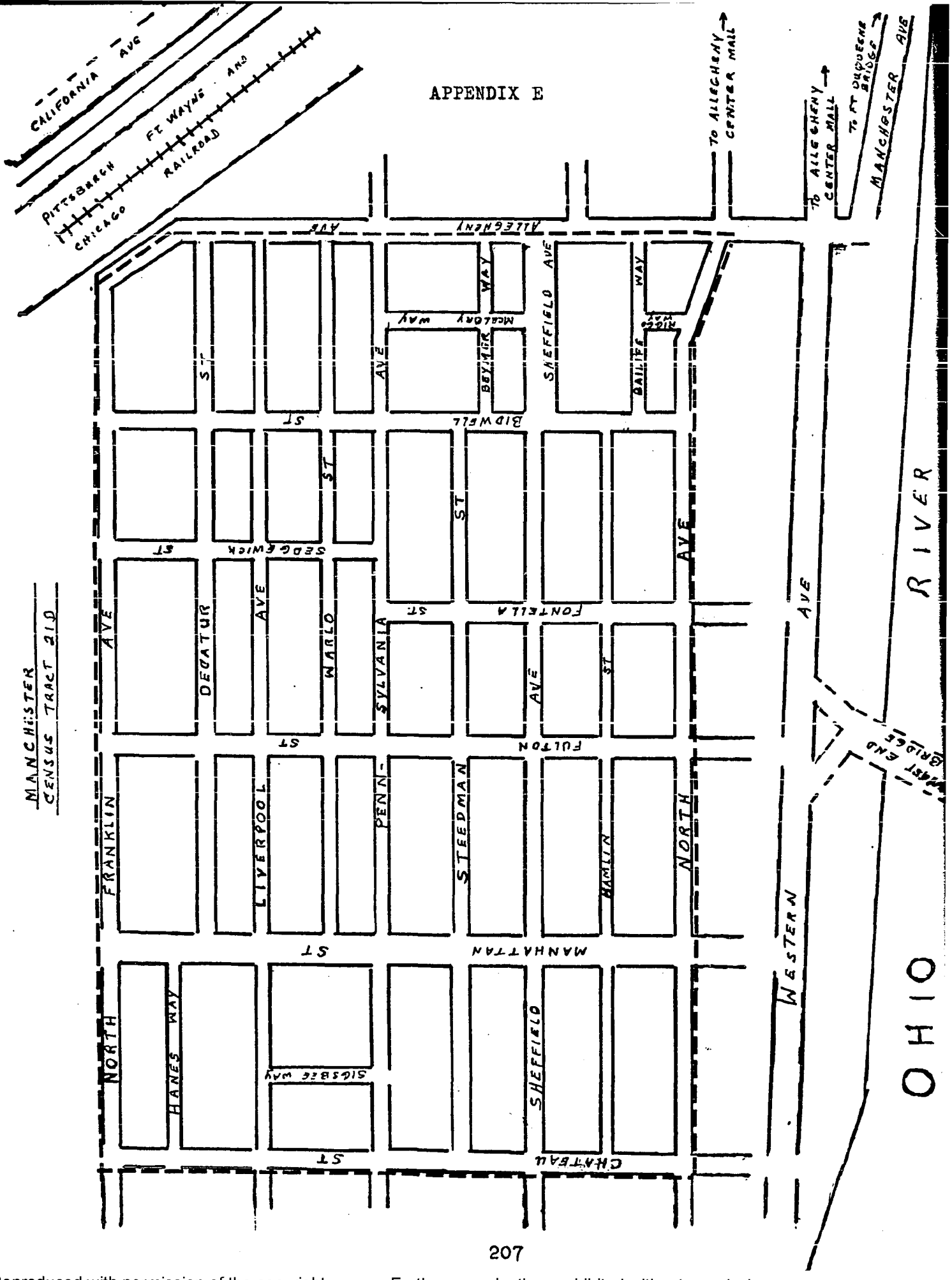
APPENDIX E



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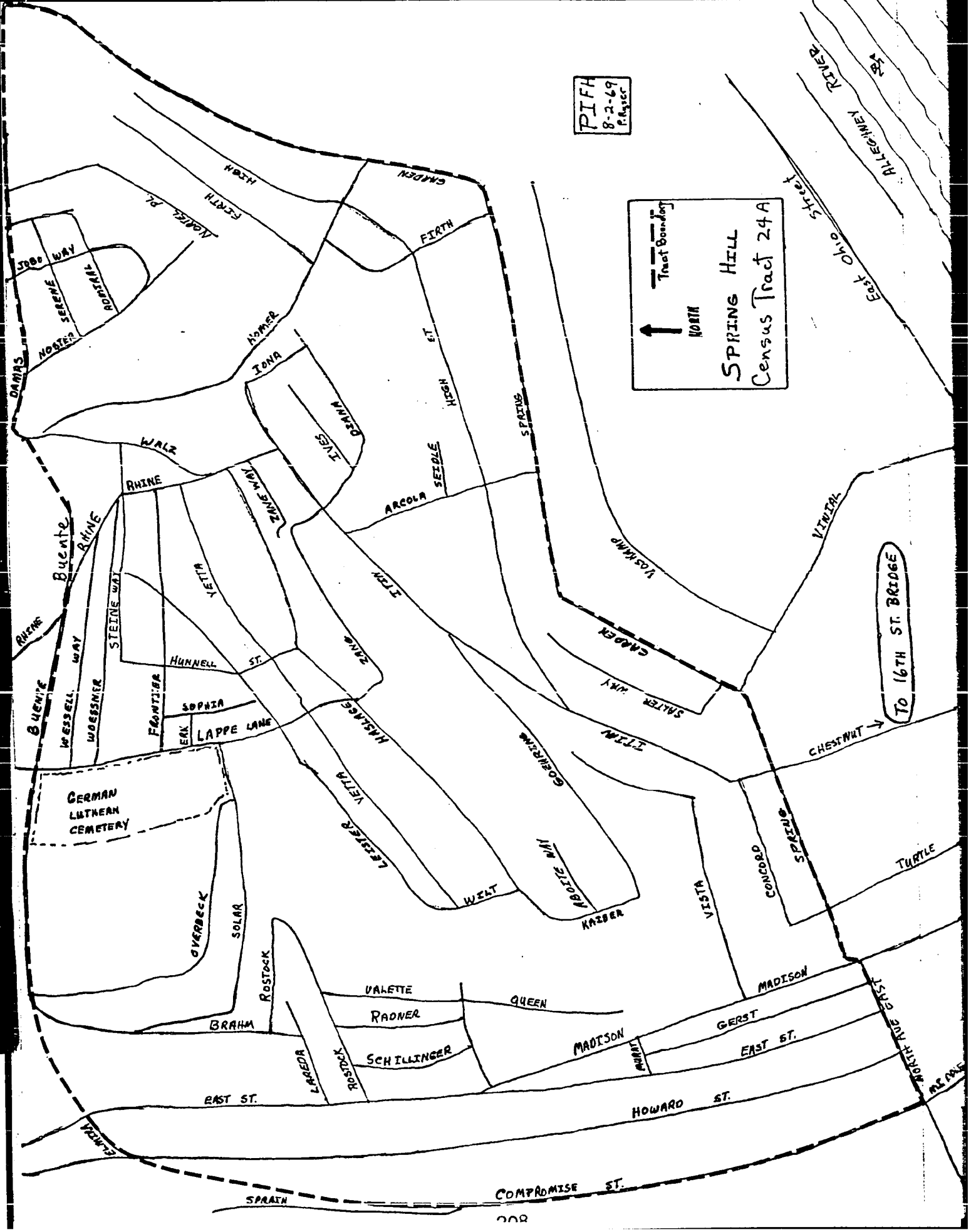

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APPENDIX F

STATISTICAL METHOD OF ANALYSES

The evidence for or against a given hypothesis of association may not all be in one contingency table; oftentimes, it may be gleaned from a number of tables which taken individually does not tell much by way of statistical significance. When combined in some meaningful and valid way, the evidence may pile up in a convincing manner. To illustrate the arithmetic which was attempted in this study, the data in Table 5.4 on the frequency of users of public and private medical services and their desired family sizes controlled on race are used to illustrate the effort put forth to identify the statistical value of the tables. The discussion describing Table 5.4 suggests racial comparisons in which case the controlling variable is the type of medical service used. That this is the main effect of interest is further expressed in Chapter V which calls attention to a differential in the extent of participation in the use of public and private medical services. If such a differential is to be taken into account in the analysis, the precautionary measure is to use type of medical service as the controlling variable. The data and statistical procedure are therefore presented in the following form:

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Health Services

	Public			Private		
	No.Child.1-3	4+	Total	No.Child.1-3	4+	Total
Sample	A	B	A+B	A	B	A+B
White	34	35	69	12	16	28
	C	D	C+D	C	D	C+D
Black	24	16	40	29	29	58
TOTAL	58	51	109	41	45	86

Note that in both fourfold tables (2 x 2 tables), there are relatively more blacks who expressed preference for smaller families than whites. The test statistics for comparing proportions is chi square and for a 2 x 2 table with frequencies equal to A, B, C, D, the formula is:

$$X^2 = \frac{(AD - BC)^2 \, n}{(A+C)(B+D)(A+B)(C+D)} \qquad n = A + B + C + D$$

For Public Users $X^2_{PU} = \frac{(34x16-24x35)^2}{58x51x69x40} \times 109 = \frac{(-296)^2 \times 109}{58x51x69x40} = 1.17$

For Private Users $X^2_{PV} = \frac{(12x29-29x16)^2}{41x45x28x58} \times 86 = \frac{(-116)^2 \times 86}{41x45x28x58} = .386$

The individual X^2 values are both below 3.86, the critical value for significance at the 5% level. However it is noted that there is consistency in the observed patterns for desired family size in both of the above tables in that relatively more blacks want smaller number of children. The question becomes will

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these show more clearly when the two bits of evidence are combined?

From these two chi squares, a single X^2 test statistic may be computed, which might represent the evidence necessary for or against association between health service use and desired family size in both tables. The algebra is as follows:

$$X^2 = \frac{\left(\sqrt{X^2_{PU}} + \sqrt{X^2_{PV}}\right)^2}{\text{Number of tables}} =$$

$$\frac{\left(\sqrt{1.17} + \sqrt{.386}\right)^2}{2} = 1.45$$

Note that a higher value of X^2 results, but again, this is still below the critical value of 3.86. This same procedure was used for most of the tables in the study which relate to the hypotheses with similar results of non-significance at .05 level.

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