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# US Fertility Prevention as Poverty Prevention:

## An Empirical Question and Social Justice Issue

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## Abstract

**Purpose—**This paper examines the impact of the United States (US) welfare reform family-cap policy on the childbearing decisions of poor and low-income women by posing two complementary questions, both placed within a broader historical context. Specifically, it raises an empirical question pertaining to the family cap's effectiveness and a social justice question pertaining to the policy's ethical and legal justification in terms of human and reproductive rights.

**Methods—**In order to address the first question, a thorough review of past and current research pertaining to the family cap at both the state and national level is provided. The second question is addressed with an overview of international human and reproductive rights documents of relevance to the family-cap policy, as well as an analysis of the covenants' numerous components with which the family cap is in conflict. Finally, this paper situates the family cap in its historical context by investigating previous governmental attempts to control and regulate the reproductive health and rights of poor women and women of color in the US.

**Main findings—**The majority of empirical analyses of the family cap have found that the policy has not had an impact on poor women's reproductive health behaviors. In addition, the exclusive application of this policy to poor women receiving cash assistance is demonstrated to be in violation of 8 international human and reproductive rights documents, several of which the US is a signatory.

**Conclusion—**These two findings make a strong case that policymakers and social and health researchers alike critically re-examine whether a policy that has not achieved its ostensible goal *and* is applied in a disparate manner—primarily to poor women and families, and women of color—should continue to be implemented by the states.

## Introduction and Background

The 1990s marked the introduction of state and federal policies in the United States (US) that sought to restrict poor women's sexual activity and childbearing as a means of addressing their experience with poverty. This "fertility prevention as poverty prevention" strategy was realized in US states' adoption of the family-cap or child-exclusion policy, as well as federal inclusion



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of the abstinence-only education until marriage policy in the 1996 welfare legislation. The family-cap policy denies *additional* income support to poor women who have a baby while enrolled in Temporary Assistance to Needy Families (TANF), the federal cash assistance program.

In addition to imposing lifetime time limits and work requirements on those receiving cash and some other forms of social assistance, the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), or "welfare reform," permitted states to impose policies pertaining to the sexual and reproductive-related behaviors of poor women. The PRWORA begins with an introduction supporting the institution of marriage and stating that preventing out-of-wedlock pregnancies and births are "very important government interests" that the legislation is intended to address (104$^{th}$ US Congress, 1996). Thus, one would expect that the government would have included an evaluative component of the implementation of specific PRWORA policies, such that potential changes in out-of-wedlock pregnancy and birth rates could be measured. This was not the case. Thus, while women who gave birth while receiving cash assistance in a family-cap state did not receive an increase in their cash grant (despite the increase in the size of their household), neither states nor the federal government had incorporated a way to determine whether the policy was effective. In essence, policymakers both implicitly and explicitly viewed fertility prevention via the family cap as a mechanism for poverty prevention without concern for empirical support.

For over a decade, 24 states have implemented a family-cap policy (Table 1) (Levin-Epstein, 2003). The existence of such a policy as part of welfare legislation implies that policymakers believe that poor women base their child-bearing decisions on the availability of additional income support from the state welfare system. Conversely, it is expected that the *lack* of additional welfare funds will influence poor women to *avoid* giving birth to additional children. Thus, this anti-poverty measure assumes that poor women make reproductive decisions based on the existence of welfare policies and whether they can expect to receive an increase in their cash assistance with the birth of a new child.

Implicit in these policies is the belief that there is a causal association between individual sexual and fertility-related behaviors and poverty. While supporters of such policies have pointed to cross-sectional studies documenting associations between the two, very little research has examined the role played by important pre-existing structural and socio-demographic factors (e.g., the availability of community-level resources). As such, the conclusion, for example, that childbearing among certain groups of women leads to poverty ignores the pre-existing circumstances of women's lives that may already predispose them to economic and other social disadvantage (e.g., dropping out of high school) (Geronimus and Korenman, 1992; Upchurch, Lillard, and Panis, 2002).

A social policy such as the family cap can make a powerful statement about the beliefs and principles of a society. In addition, social policies have the power—indeed are designed—to effect changes in the day-to-day lives of members of society. Putting aside the unanswered question of whether or not there is a causal association between childbearing and poverty, this specific anti-poverty policy presents two important questions: one empirical and one ethical (i.e., concerning human rights or social justice). This joint approach is consistent with the position put forth by Beauchamp and Childress (2008), which maintains that "principles and rules provide background moral considerations for policy evaluation, but a policy must also be shaped by empirical data" (p 10). The empirical question pertains to its overall effectiveness —that is, has the family-cap policy had any impact on the sexual and reproductive health behaviors of poor women (e.g., contraceptive use, pregnancy, abortion) resulting in poor women having fewer births? The family cap also raises a social justice question concerning its ethical and legal justification—mainly, how does the existence of the family-cap policy align

with international covenants pertaining to human and reproductive rights? Finally, consideration of both of these questions must be placed in a broader historical context related to past efforts to regulate the reproduction of poor, or otherwise marginalized, women in the US.

## The Empirical Question

### Review of original family cap research

There have been a few empirical evaluations of the policy's impact in states that implemented the family cap, as well as studies examining, at the national level, the effect of welfare policies on fertility. In the past, the few evaluations of the family cap had relied on administrative data (US Government Accountability Office, 2001). We have been involved in a number of research activities examining the potential impact of welfare policy changes on the health of poor women and their children (Romero, Chavkin, and Wise, 2000, 2001; Romero et al., 2002; Wise et al., 2002; Smith et al., 2002). Two recent research projects (conducted by DR) specifically focus on the family-cap policy. The first project was a qualitative study of current and former welfare recipients in New Jersey, while the second project is a national-level analysis of the family cap's effect on the reproductive health behaviors of poor women.

**New Jersey family cap qualitative study—**This study examined whether poor women in a family-cap state base their childbearing decisions on welfare policies and/or economic factors. This study was, to our knowledge, the first examination of this policy from the perspective of women subject to it (Romero et al., 2007). We interviewed 32 current or former welfare recipients at community-based health clinics and welfare offices in northern New Jersey to learn about their knowledge of the policy and their attitudes regarding contraceptive use and fertility-related decision-making. Contraceptive use did not differ between current and former welfare recipients, suggesting that the family-cap policy may not have influenced poor women's reproductive behaviors.

Furthermore, we found that only two of the 32 women had heard of the family-cap policy; however, their knowledge of it was incorrect. After being informed of the policy, over half reported that it would not influence their decision to use contraception, and three-quarters of the women said the policy would have no influence on their decision to have a child while receiving TANF. Instead, they indicated that their fertility-related decisions were more likely to be based on their personal and relationship circumstances rather than on government policies. These findings question the assumed connection between knowledge, behavior change, and poor women's childbearing decisions.

**National analysis of the family cap—**Romero et al. have also examined poor women's fertility at the national level within the context of the family-cap policy. Using the 1995 (pre-welfare reform) and 2002 (post-welfare reform) National Survey of Family Growth (NSFG), individual- and state-level differences in fertility-related behaviors of welfare recipients (poor) and non-recipients (non-poor) were compared. Specifically, the individual-level analysis compared poor and non-poor women with regard to contraceptive use, pregnancy, abortion, sterilization, and births; there were *no* differences except for abortion. In 1995, poor women were more than twice as likely to have had an abortion than non-poor women (2.8 *vs*. 1.3; $p<.05$). In 2002, the difference in the rate of abortion between poor and non-poor women increased (4.3 *vs*. 1.2; $p<.001$), suggesting that poverty policies may have been associated with increased abortion rates among poor women.

The state-level analysis focused on welfare recipients, comparing the reproductive behaviors (e.g., contraception use, abortion, pregnancy, births) of those residing in family-cap states with those in non-family-cap states. Prior to the implementation of the policy (1995 NSFG), there

were no significant differences between poor women in family-cap and non-family cap states. These findings persisted in 2002, providing national-level evidence of a *lack of effect* of this anti-poverty policy.[1]

**State policy analysis: 24 family-cap states—**Given that the family-cap policy has been in place for about a decade in most states that adopted it, we recently undertook a state policy analysis of its implementation, assessment, and status. Through a comprehensive policy status review of the 24 family-cap states, we identified modes of policy implementation, whether the policy is still in effect, any changes or modifications to the policy (e.g., legislative actions, amendments), if any evaluative research had been conducted, quantitative caseload measures (e.g., number of individuals subject to the policy, number of children born under the policy), and similarities and differences with other national policy data on state-specific trends. The study had two complementary components: a comprehensive, web-based review and analysis of existing, publicly available data on the family-cap policy, and qualitative, key-informant interviews of welfare agency officials.

Findings from the web-based document review indicate that most state agencies do not provide current or potential welfare recipients with information about the family-cap policy. When information about the policy is available, it is usually provided in the state's TANF plan, which is not easily accessible to clients. The findings from key informant interviews with state welfare administrators included the following: the policy was still in place in the majority of states that had adopted it (21 of 24); very few formal state-level evaluations of the policy had been conducted; most administrators did not believe that the policy was effective, although most who believed that it was effective did so in the absence of empirical support; related state polices were inconsistent with the ostensible goals of the family cap (e.g., lack of a Medicaid family planning waiver); and differences in application of and exceptions to the family cap existed by state (e.g., some states extended the policy beyond the TANF head of household [i.e., mother] to a pregnant teenage daughter). (Complete results from this research are being reported elsewhere.)[2]

## Other family cap and related research

The following is a summary of research conducted by other investigators pertaining to the family-cap policy or the reproductive-related behaviors of poor women. First, there are the findings from evaluations that accompanied the family-cap waivers implemented in New Jersey and Arkansas, which were among the first states to implement the policy. In Arkansas, an experimental study did not find a difference in birth rates between welfare recipients subject to the family cap (experimental group) and recipients *not* subject to it (control group) (Turturro, Benda, and Turney, 1997). In New Jersey, two methods were used: an experimental design similar to the Arkansas model and a pre-post analysis of the welfare caseload over a 6-year period. The results supported a negative effect of the family cap on pregnancies and births, while the number of abortions increased (Camasso et al., 1998; Camasso, 2004). Reviews of the findings from these studies have suggested potential methodological weaknesses (e.g., carryover of the treatment to the control group, or contamination), thus raising questions about the validity of the results (Kearney, 2002). However, a subsequent analysis by Camasso et al. (2003), taking into account the potential effect of contamination, revealed that their overall findings of the family cap's effects on increased abortion persisted.

[1]Unpublished manuscript in preparation for publication. (Romero, D. et al. Poor women's fertility and reproductive-related behaviors: An analysis of welfare reform using the NSFG.)

[2]Unpublished manuscript in preparation for publication. (Romero, D. & Agenor, M. State family caps or child exclusion: An overdue assessment of welfare reform policy.)

Other non-experimental studies have provided mixed results. Horvath-Rose and Peters (2001) were among the few to find the desired effect of the family-cap policy. Using vital statistics birth data and state-level panel data from 1984 to 1996, they examined the impact of welfare policies on non-marital birth ratios for all women. Their analysis revealed negative correlations between each stage of the welfare waiver process ("any waiver requested," "any waiver approved," and "any waiver implemented") and non-marital birth ratios (Horvath-Rose and Peters, 2001). Kearney (2002) also used vital statistics data from 1989 to 1998, limiting her sample to those on or at risk of being on welfare in the 15- to 34-year old age group, to examine if denial of incremental benefits with the birth of a child had any impact on aggregate-level birth rates. She analyzed changes in birth rates across states, comparing states with and without the family cap, and did not find evidence of an effect of the policy on fertility.

A different analysis was conducted using state-level data on births from vital statistics, data on abortions, and individual-level data on contraception and sexual activity from the 1988 and 1995 NSFG. Arguing against the narrow focus on birth outcomes, Levine (2002) introduced the concept of the "fertility decision tree," stating that a woman's fertility behavior and final birth outcome depend upon several preceding stages (sexual activity, contraception, pregnancy, abortion, and birth). He proposed a method that examines the impact of abortion and welfare policies, along with economic conditions from 1985 to1996, on all of these stages simultaneously. This analysis did not find a systematic effect of welfare waivers on fertility-related behavior; however, it showed that the family cap was associated with an *increase* in births and pregnancies (Levine, 2002).

Results from other analyses conducted over the last couple of years also continue to be negative. One analysis used 1989-1996 data from the Panel Study of Income Dynamics (PSID), a longitudinal survey of US residents, to examine the association between state-level welfare policies implemented before the PRWORA (pre-1996) and the risk of a subsequent non-marital birth among low-income mothers on or at risk of receiving welfare (Ryan, Manlove, and Hofferth, 2006). Using this national sample of Aid to Families with Dependent Children (AFDC, now TANF) recipients, the authors concluded that state-established welfare policies did not have the desired influence on women's childbearing behaviors, and that the family-cap policy had no significant effect on subsequent non-marital childbearing. Instead, their research suggested that characteristics such as parity, gender of the previous child, and marital and cohabiting status were more likely to influence women's childbearing decisions (Ryan, Manlove, and Hofferth, 2006).

Dyer and Fairlie (2004) also found no association between the family cap and fertility. Using the 1989 to 1999 Current Population Survey (CPS), they compared trends in out-of-wedlock birth rates among unmarried and less-educated women with at least one child in the first five states to implement the family cap with similar women in states that did not implement the family cap or any other waivers during that time period (Dyer and Fairlie, 2004). The results from this comparison were mixed and far from systematic. The researchers also conducted a within-state comparison looking at trends in birth rates for single mothers compared to married mothers in family-cap states. This analysis showed some evidence that the family cap reduced out-of-wedlock birth rates. However, when they compared changes over time in the birth rates of single and married women in the five family-cap states to changes over time in the birth rates of single and married women from non-family-cap states, there was no evidence that family-cap policies reduce out-of-wedlock births (Dyer and Fairlie, 2004).

Another study by Joyce et al. (2004) takes the analyses one level further and examines the effect of the family cap on both birth and abortion rates among women at risk of receiving welfare. Drawing from three data sources, they collected birth and abortion records from 24 states and New York City for the period from 1992 to 1999. They used parity to create two

groups of women (at risk of being on welfare vs. not at risk of being on welfare) and compared the within- and across-state differences in birth and abortion rates between the two groups. The researchers found that trends in birth rate differentials between women "at risk" and those "not at risk" in states implementing the family cap were similar to the trends in states that did not implement the policy. They observed a similar pattern with abortion rates: a relative increase in abortion rates among women of higher parity in states with and without a family cap. Thus, they concluded that the family-cap policy had no effect on declining birth rates and increased abortion rates (Joyce et al., 2004).

Last, an analysis by Harris et al. (2003) that attempted to examine the impact of the family cap also reported negative findings. The researchers used the National Longitudinal Study of Adolescent Health, which follows young adults in1994-1995 through their transition to adulthood in 2001-2002, to investigate the impact of welfare-reform policies, including the family cap, on non-marital childbearing among adolescents. From their analysis, Harris and her colleagues concluded that "consistent with other research, the effects of welfare policies on family formation behaviors are weak or non-existent" (Harris et al., 2003).

These studies provide varying results, most often contradicting family-cap policy expectations. The lack of an impact of the family cap was the reason for repealing the policy by at least one state (Pollack, 2008). Ultimately, the nature of the association between income support and childbearing behavior remains ambiguous, with very little evidence that women subject to the family cap exhibit decreased childbearing.

## The Social Justice Issue

Although various scholars have highlighted the importance of considering the family cap within a human rights framework, there is no evidence that policymakers or state welfare administrators have done so (Mink, 1998; Albisa, 1999; Burnham, 2002; Davis, 2005). Since the passage of welfare reform, very few presentations at major national welfare and public policy conferences have been devoted to analyses of the family cap. Moreover, we have not come across any documentation of discourse among policymakers or welfare officials concerning the appropriateness of applying the family cap solely to women in need of economic assistance from the state.

The notion of "rights" brings together *legal* rights, which are claims that would be supported by legal principles, and *moral* rights, which would be justified by moral principles (Beauchamp & Childress, 2008). The family-cap policy, which relates to reproductive rights or procreative freedom, would be considered a *negative* right, that is, pertaining to an individual's right to procreate without outside interference. The next issue to be addressed is, if a right exists, should it be exercised, or, specifically, should a poor woman have a child that she may not be able to "afford?" We suggest that policymakers concluded that poor women should not procreate without first considering the larger issue of procreative freedom, that is, the freedom to decide whether or not to have offspring and to control the use of one's reproductive capacity (Robertson, 1994). The following review of relevant human rights documents provides that analysis.

### Overview of relevant international human and reproductive rights documents (Table 2)

The United Nations Universal Declaration of Human Rights (UDHR, 1948) was among the first of several contemporary international human rights documents. The US figured prominently in its development and adoption by United Nations (UN) member states, including having Eleanor Roosevelt serve as chair of the UDHR drafting committee. The four articles pertaining to the imposition of the family-cap policy are: that all are born free and equal in dignity and rights (Art. 1), deserve protection from interference with privacy, family, and home

(Art. 12), and have the right to marry and found a family, entered into with free and full consent (Art. 16); that motherhood and childhood are entitled to special care and assistance (Art.25); and that all children, whether born in or out of wedlock, shall enjoy the same social protection (Art. 25) (United Nations, 1948).

Other human rights covenants and conventions that are relevant to the family cap and have been ratified by the US include the International Convention on the Elimination of all Forms of Racial Discrimination (ICERD, 1965) and the International Covenant on Civil and Political Rights (ICCPR, 1966) (138th Congress, 1992; 140th Congress, 1994). One legal scholar has clearly documented the specific components of these covenants that make the family cap a direct violation of reproductive rights and welfare reform a violation of monitoring requirements, as well as the family-cap policy's violation of the prohibition on retrogression in the realization of economic and social rights and the right to be free of gender discrimination (Albisa, 1999).

The International Covenant on Economic, Social, and Cultural Rights (ICESCR, 1966), the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW, 1979), and the Convention on the Rights of the Child (CRC, 1989) have not been endorsed or ratified by the US, despite strong support from countries around the world (Working Group on Ratification of the U.N. Convention on the Elimination of all Forms of Discrimination Against Women, 2004; Schopp-Schilling, 2007). These three documents clearly attest to the rights violations presented by the family-cap policy by virtue of its differential treatment of women based on their economic and social standing (ICESCR), discrimination against poor women who have children (CEDAW), and differential treatment of children born to poor mothers (CRC) (Ventura, 2003). Other legal scholars have shown how US states and municipalities have proved it possible to adopt components of these human rights documents despite a lack of federal ratification (Kaufman, 2001; Hon. Kenney and Hon. Curry, 2004; Davis, 2005).

Two world conferences, which took place in the mid-1990s and specifically addressed population issues and the status of women, affirmed that universal human rights include reproductive rights. The Action Plan of the World Conference on Population and Development (UN General Assembly, Cairo, 1994) introduced a new paradigm for population issues, which shifted from a demographic focus to a rights-based framework. It defined the basis for population and development programs as: the promotion of equality between the sexes, promotion of women's rights, and elimination of violence against women to ensure that they could control their fertility *without coercion.* Similarly, the Action Platform of the Fourth World Conference on Women (UN General Assembly, Beijing, 1995) featured a chapter on sexual and reproductive rights, including the need to review state-level legislation concerning the criminalization of abortion (considered a serious public health problem). In addition, it emphasized the need to guarantee self-determination, equality, and sexual and reproductive security to all women. The US signed on to both of these documents. Yet, the family cap penalty that poor women are subject to is an explicit state action that (1) differentially treats poor and non-poor women; (2) presents an economically coercive environment for women's reproductive decision-making, which has been shown in some circumstances to be associated with increased abortion; and (3) jeopardizes women's self-determination in the process. One could argue that although this policy is implemented at the US state level, the 1996 federal welfare legislation permitted it, effectively making it national policy.

## Reproductive regulation of women of color

Currently, Black and Latina women are disproportionately represented among women enrolled in TANF. Thus, US policies that seek to restrict the sexual and reproductive rights and freedom of welfare recipients, such as the family cap, can have a greater impact on them and their

families compared to other women. In addition, an analysis of various welfare policies indicated that the *racial* makeup of a state played a role in the implementation of the family cap in individual states. Specifically, the researchers found that family caps and stringent time limits were significantly more likely in states with higher percentages of African Americans and Latinos in their welfare caseloads (Soss et al., 2001; Schram, 2002). The evidence of a racial factor in state adoption of such a policy, as well as the disproportionate representation of women of color in current TANF caseloads, adds to the importance of assessing its effect on fertility, and ultimately, poverty.

Attempts to control the reproduction of women of color in the US are not new (Nsiah-Jefferson, 1989; Roberts, 1990-91; Roberts, 1997). In the early 20$^{th}$ century, the rise of the eugenics movement extended reproductive control to all of society's "unfit" and "feebleminded" members, such as the mentally disabled, immigrants, and the poor. As a result, birth control became a means of limiting the growth of "undesirable" populations, including African-Americans, Native Americans, and Latinos (Roberts, 1997).

In the South, Black women were subject to involuntary, coercive, and medically unnecessary sterilizations in teaching and state-run hospitals. Informed consent was often omitted or solicited during times when women were least able to provide it, namely prior to, during, or directly after childbirth. Moreover, women were given misleading information about the nature or purpose of the sterilization, which was often portrayed as medically necessary. A range of strategies, to which women on Medicaid or welfare were particularly vulnerable, were used to coerce women into agreeing to the procedure. For example, sterilization was often presented as a prerequisite for women to receive their desired medical procedure (e.g., abortion). Furthermore, some service providers threatened to rescind poor and low-income women's public benefits if they did not "consent" to being sterilized (Neubeck and Cazenave, 2001; Schram, 2002; Finegold and Staveteig, 2002).

Similarly, since the Indian Health Service (IHS) began providing family planning services in 1965, a number of Native American women have been subject to involuntary and coerced sterilizations at the hands of government-hired physicians. In a 1976 report, the Government Accountability Office (GAO) found that the consent forms provided to Native American women undergoing sterilization failed to inform them about the nature, purpose, risks, and consequences of the procedure, as well as their right to withdraw their consent at any time without being penalized by the loss of benefits. Other IHS infractions included not presenting women with alternative procedures, failing to uphold the 72-hour waiting period mandated by the government prior to performing a sterilization, soliciting consent from women directly after birth, and obtaining consent from women *after* performing the procedure. In total, various studies have found that, during the 1970s, the IHS sterilized at least 25% of all Native American women between 15 and 44 years of age (Brave Heart-Jordan, 1995; Lawrence, 2000; Amnesty International, 2007),

The Latino experience is similar. During the 1950s and 1960s, sterilization increased sharply among Puerto Rican women on the island and mainland. In Puerto Rico, the prevalence of sterilization reached its peak in 1965, with one third of ever-married women between the ages of 20 and 49 having been sterilized. Researchers have linked the high proportion of sterilized Puerto Rican women to the lack of other available forms of contraception and a relatively favorable government attitude toward the utilization of the procedure within this population (Presser, 1980; Kingdom, 1985; Lopez, 1997; Lopez, 2009). Furthermore, the birth control pill, which was developed during the late 1950s and early 1960s, was primarily tested on Puerto Rican and Mexican women (as well as Haitian women) under troubling conditions with regard to informed consent and the protection of human subjects (Asbell, 1995).

## Conclusions and Discussion

Returning to the first question addressing the empirical evidence related to the impact of the family-cap policy, it appears that the findings are mixed but mostly indicative of a lack of an effect on poor women's fertility. Most studies—whether specifically measuring the family cap or proxies for childbearing among welfare recipients—did not find an effect. In addition, an experimental design (NJ) reported an increase in abortions among welfare recipients subject to the family cap, particularly among recent enrollees. Thus, we are confronted with what it means to have a widespread social policy in place that does not appear to work. The public health literature has consistently shown that childbearing decision-making is a process influenced by myriad individual, interpersonal, and structural factors. Notions about the importance and timing of motherhood relative to individual economic circumstances vary (Edin and Kafalas, 2005). Moreover, the strong positive association between women's educational attainment, economic development, and reduced fertility would suggest that approaches other than the family-cap policy—for example, advanced education, childcare that enables women to maintain employment, and family-friendly work-based policies—might be more in line with factors that affect both fertility and the potential need for governmental cash assistance (Abma et al., 1997).

The second issue pertains to the social justice concern of whether the family-cap policy aligns with international covenants pertaining to human and reproductive rights. A review of relevant documents ratified or otherwise endorsed by the US that address universal human, political, economic, racial, and reproductive rights reveals how the family cap violates fundamental principles contained within them (i.e., UDHR, ICERD, ICCPR, Cairo and Beijing conferences). Moreover, other international human rights covenants agreed to by many countries reiterate the rights of women not to be discriminated against, including on the basis of social or economic standing, as well as the rights of children (i.e., CEDAW, ICESCR, CRC). The discriminatory treatment of poor women and children inherent in the family-cap policy is clearly in conflict with internationally accepted tenets of human rights and procreative freedom. While some may continue to express concern for children born into poor families and/or their "cost" to the state as justification for supporting problematic policies, such as the family cap, Robertson (1994) succinctly presents where the emphasis should be placed:

> ...recognition of procreative liberty will not eliminate the dilemmas of personal choice and responsibility that reproductive choice entails. The freedom to act does not mean that we will act wisely, yet denying that freedom may be even more unwise, for it denies individuals' respect in the most fundamental choices of their lives (p 42).

This all began with Section 1115 waivers granted to states in the early 1990s, continued with the passage of federal welfare reform in 1996 (which eliminated the need for waivers to implement a family-cap policy), and failed to be reconsidered a decade later (despite the *lack* of evidence supporting its effectiveness) with the passage of the Deficit Reduction Act of 2005 (109$^{th}$ US Congress, 2006). Thus, we are currently confronted with whether US society, including policymakers who supported the policy, will continue to consider reproductive regulation of a select segment of the population (i.e., poor women and women of color) acceptable.

As US welfare policy currently stands, policymakers in almost half of the country have deemed childbearing unacceptable among poor women. In effect, they have taken the approach of fertility prevention as poverty prevention. Yet, fertility among poor women has not decreased and poverty rates have increased in the past several years (US Department of Health and Human Services, 2006 and 2007). One can also envision the "slippery slope" possibilities extending from reproductive regulation of poor women to low-income people who, for example, do not own a home, cannot provide academic enrichment programs to their children, have not accrued

adequate savings (e.g., for college), do not have advanced education themselves, do not have health insurance, and/or are employed in industries not deemed able to provide an adequate income for families with children.

To date, most official reports concerning welfare reform state that it has been a successful policy on the basis of a greater than 50% reduction in caseloads and increased work activity since its inception. The absence of comprehensive, state-based evaluations of other policies, such as the family cap, make it very uncertain what individuals' experiences have been. Our review of analyses conducted by researchers mostly outside of administrative (i.e., state agency) environments indicates that the policy has not influenced poor women's fertility in the desired direction. What we do *not* know is how the thousands of women and children subjected to the family cap over the past decade have fared with regard to their overall health and well-being (Romero, 2006). This seems to be a concern that policymakers and social program administrators would share and insist on exploring. However, to paraphrase a recent comment by a state welfare director explaining the lack of past or planned evaluations of their family-cap policy, it is an old policy that is just not on the radar anymore.

As social scientists and public health professionals, we would suggest that the US family-cap policy make it back onto the "radar" of state policymakers and welfare agency administrators —both in light of research findings regarding its lack of effectiveness and the human rights violations inherent in it. It is time for government to undertake a critical analysis of the assumptions under which the policy was passed, as well as assess its effects on relevant reproductive health outcomes (i.e., contraceptive use, pregnancy, abortion, births), maternal and child health and well-being, racial/ethnic health disparities, and poverty.

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## Table 1
## U.S. States that Implemented the Family-Cap Policy

| State | Year of Family Cap Implementation |
|---|---|
| Arizona | 1995 |
| Arkansas | 1994 |
| California | 1997 |
| Connecticut | 1996 |
| Delaware | 1997 |
| Florida | 1996 |
| Georgia | 1994 |
| Idaho | 1997 |
| Illinois | 1995* |
| Indiana | 1995 |
| Maryland | 1996† |
| Massachusetts | 1995 |
| Minnesota | 2003 |
| Mississippi | 1995 |
| Nebraska | 1996‡ |
| New Jersey | 1992 |
| North Carolina | 1996 |
| North Dakota | 1999 |
| Oklahoma | 1997 |
| South Carolina | 1996 |
| Tennessee | 1997 |
| Virginia | 1995 |
| Wisconsin | 1996 |
| Wyoming | 1997 |

*Family cap repealed by state legislature in 2004.

†All counties used the state “opt out” provision since 2002 in order to not implement the family cap; the state legislature repealed the policy in 2008.

‡Family cap repealed in 2007.

## Table 2

**U.S. Status of International Human and Reproductive Rights Documents Relevant to the Family-Cap Policy**

| Treaty/Covenant | Date Drafted | Ratified or Endorsed by the U.S.? | Date Ratified or Endorsed |
|---|---|---|---|
| U.N. Universal Declaration of Human Rights (UDHR) | 1948 | Yes | 1948 |
| International Convention on the Elimination of all Forms of Racial Discrimination (ICERD) | 1965 | Yes | 1994 |
| International Covenant on Civil and Political Rights (ICCPR) | 1966 | Yes | 1992 |
| International Covenant on Economic, Social, and Cultural Rights (ICESCR) | 1966 | No | N/A |
| Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) | 1979 | No* | N/A |
| Convention on the Rights of the Child (CRC) | 1989 | No | N/A |
| Action Plan of the World Conference on Population and Development, Cairo | 1994 | Yes | 1994 |
| Action Platform of the Fourth World Conference on Women, Beijing | 1995 | Yes | 1995 |

* The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) was signed by President Carter in 1979 but was never ratified.