TABLE 8.—RELATION OF POVERTY TO SIZE OF FAMILY, AS SHOWN BY A 1966 STUDY.[1]

Number of children	All U.S. families (in thousands)	The poor		The poor and near-poor	
		Number of families (in thousands)	Percentage of all U.S. families	Number of families (in thousands)	Percentage of all U.S. families
1	9,081	843	9.3	1,276	14.1
2	8,491	869	10.2	1,323	15.6
3	5,416	694	12.8	1,152	21.3
Total for parity 1–3	22,988	2,406	10.5	3,751	16.3
4	2,923	543	18.6	904	30.9
5	1,396	387	27.7	593	42.5
6 or more	1,286	541	42.1	747	58.1
Total for parity 4+	5,605	1,471	26.2	2,244	40.0

[1] Data from 21, Table 4.

EQUALIZING ACCESS TO EFFECTIVE METHODS

It is precisely the reduction or elimination of this involuntary disparity between the poor and non-poor which has been the objective of publicly supported family planning service programs. Given the essentially similar preferences of the two groups concerning family size, programs which equalize access to modern methods of fertility control should also help to equalize the incidence of unwanted pregnancy for the two groups. Blake can regard this as a "fantastic . . . blanket decision" imposed by the family planners only if she ignores (i) the evidence on the type of birth control methods on which the poor rely, (ii) the evidence on the relative effectiveness of different contraceptive methods, and (iii) the response of poor persons to organized programs which offer them a complete range of methods.

The data on contraceptive practice cited above measure the combined use of all methods, including those methods known to be least effective in preventing conception. The cited studies also show that couples of higher socioeconomic status who can afford private medical care tend to use the more reliable medical methods, while low-income couples depend more on less reliable, nonmedical methods. Among white Protestants in 1960, for example, half as many wives with a grade school education as college graduates used the diaphragm and twice as many relied on withdrawal (12, p. 281). Published and unpublished findings for 1965 on methods employed by whites and nonwhites reveal the same picture. Three times as many nonwhites as whites relied on the douche (16) and on suppositories (23, p. 2), and twice as many relied on foam (23). When the condom is classified among effective methods and rhythm is omitted from the analysis because of the different proportions of whites and nonwhites who are Catholic, we find that half of nonwhite users of contraceptives rely on the least effective methods, as compared to about 30 percent of whites (16).

These findings are significant in two respects: (i) the methods on which the poor rely most heavily have considerably higher failure rates and thus would lead to a higher incidence of unwanted fertility; and (ii) the overwhelming majority of poor persons accept the best methods science has been able to develop when they are given the choice.

The relative rates of failure with the different methods range from 1 to 3 failures per 100 women-years of exposure for pills and IUD's to 35 to 38 failures for rhythm and douche, with the numbers for the condom, the diaphragm, and withdrawal clustering around 15 (24).

RESPONSE TO FAMILY PLANNING PROGRAMS

It is difficult to understand how the greater reliance of the poor on nonmedical methods can be attributed to their personal preferences in view of the considerable research demonstrating that the poor have little access to medical care for preventive services (25). When access to modern family planning services offered with energy and dignity has been provided, the response of