poor and near-poor persons has been considerable. The number of low-income patients enrolled in organized family planning services under both public and private auspices has increased from about 175,000 in 1960 to 850,000 in 1968, as hospitals and public health departments have increasingly offered services which provide the new methods not associated with the act of coitus (22). In virtually all known programs offering a variety of methods, 85 to 90 percent of low-income patients voluntarily choose either pills or intrauterine devices (IUD's), the most effective methods currently known.

In 1965, a Chicago study found that three-fourths of patients continued to use the pills regularly 30 months after first coming to the clinic an astonishingly high retention rate for any procedure requiring continuous self-medication (26).

A carefully planned program which introduced the first subsidized services in New Orleans, begun in 1967, has already enrolled nearly two-thirds of the target population, three-fourths of whom had not practiced birth control or had used nonprescription methods before attending the clinic. When given a genuine choice, 82 percent chose either pills, or IUD's, while only 17 percent selected a nonprescription method (27). In the rural Louisiana parish where this program was first tested the birth rate among the indigent decreased by 32 percent in the first year after the clinic was opened, as compared to a decrease of only 6 percent in four surrounding control counties where no organized family planning services were available. The illegitimacy ratio in the county in question dropped from 172 per 1000 live births in 1966 to 121 in 1967, as compared to an increase in the control counties from 162 to 184 (28).

FIVE MILLION WOMEN

Judith Blake challenges the estimate that there are 5 million poor and near-poor women who comprise the approximate population in need of subsidized family planning services. This estimate has been arrived at independently by Campbell (20) and the Planned Parenthood Federation Research Department (19), on the basis of Census Bureau tabulations of the characteristics of the poor and near-poor (17). Campbell estimated a total of 4.6 million, while Planned Parenthood estimated 5.3 million. The difference stems from the use of slightly different assumptions in analyzing the data available for obtaining a "need" figure which defines all women who are (i) poor or near-poor; (ii) not currently pregnant or wanting to become pregnant; (iii) fecund; and (iv) exposed to risk of pregnancy. The differences in the assumptions and results are not regarded as significant at this point, when fewer than 1 million low-income patients are reportedly receiving family planning services.

There exists, of course, no data base from which to define precisely women who have the characteristics listed above. Both estimates have been presented as approximations which reasonably interpret available information. It is important to note that 5 million represents a residual number of potential patients at any given time, after subtraction, from the total of about 8 million poor and near-poor women aged 15 to 44, of an estimated number of those who are sterile, those who are pregnant or seeking to become pregnant (allowance being made for the fact that poor couples say they want three children, on the average), and those who are not exposed to the risk of pregnancy (20) (Table 3). The estimate does involve the policy assumption that all others should have available competent medical advice on regulating fertility—even if they choose to practice the rhythm method, or if they are less than normally fecund, or if they have sexual relations infrequently—since such advice will tend to make their family planning practice more effective. Whether or not all 5 million women would avail themselves of the opportunity remains to be seen. Until the poor are offered a genuine choice, there is no way to determine how many would actually prefer nonmedical methods. Nor is there any way to judge whether low-income Catholics will voluntarily choose methods officially proscribed by their Church to a degree equaling or possibly exceeding the 53 percent of all Catholics who reported in 1965 that they have already used methods other than the rhythm method (23, Table 3).

It is interesting to note that Judith Blake does *not* cite the one factor which might be a significant limitation on these estimates—namely, the proportion of low-income women who have been able to secure competent guidance in fertility control from private physicians. There exists no adequate information on