

MODERN BIRTH CONTROL METHODS

‘I have read this book with great interest and am of opinion that it deals with a most important, indeed the most important, factor in our lives in a very clear and simple manner’—*From the Foreword by Sir William Arbuthnot Lane*

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GEORGE RYLEY SCOTT

F.R.A.I., F.Ph.S.(Eng.), F.Z.S.

EIGHTH IMPRESSIO

This practical, informative and authoritative work *describes the technique of every method of birth control known to medical science*; it gives plain directions for the successful carrying out of each of these methods.

It is a common complaint that contraceptive measures often fail. *This book shows why they fail and tells how failure can be avoided.* 'No one method of Birth Control is reliable in all cases; but there is a method, or a combination of methods, applicable to almost every case and circumstance', says the author. The secret of successful birth control lies in the selection of the right method: in this connection an especially valuable and unique feature of the book is a series of tables designed to enable the method most suitable for any particular case or in special circumstances to be selected by the reader.

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MODERN BIRTH CONTROL METHODS

With an Appendix on
THE FACILITATION OF CONCEPTION

by
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With a Foreword by the late
SIR W. ARBUTHNOT LANE, Bart., C.B.

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FOREWORD

I HAVE read this book with great interest and am of opinion that it deals with a most important, indeed the most important, factor in our lives in a very clear and simple manner. The sex instinct is infinitely the most powerful of our appetites, existing in various degrees of intensity in men and women. It would appear that the usefulness of the individual to take part in the struggle for existence depends directly upon it. While its presence in abundance supplies a driving power which enables the person, male or female, to perform tasks of almost super-human character, and demanding great courage and endurance, the possession of a subnormal virility entails almost with certainty an inferiority complex and an unfitness for success in life.

For this reason the work which Mr Ryley Scott has produced will serve as an excellent textbook and medium of education for those engaged in the legal, medical and nursing professions. Just as the study of dietetics has not till very recently been considered of sufficient importance to form any portion of the medical curriculum, so the study of birth control and the innumerable vital issues associated with it have been ignored. Indeed it has been left to the members of the lay public to interest and later to instruct the medical fraternity in this most important subject. Again, as is the habit of the present

day, women pioneers are acting as pace-makers to the world and to the medical profession in this particular subject. All honour is due to Margaret Sanger and Marie Stopes for the courage, intelligence and bravery which they have displayed and their determination to succeed in spite of malicious persecution, abuse and calumny, too often emanating from those from whom the world expected education and guidance. However, changes have taken place rapidly and dietetics and birth control are now engaging the attention not only of the medical profession but also of the public, which has at last decided to think for itself and has not waited to be guided blindly by any body or group of educationalists or politicians.

Mr Ryley Scott is to be congratulated very warmly on the work he has produced, on its excellence, and on the simplicity of the manner in which he describes the troubles and necessities of life and the way in which they can be best met to the advantage of the individual as well as to that of the community. He is not dogmatic but prefers to appeal to the intelligence of his readers. He thoroughly realizes the vast differences which exist between the very various sexual idiosyncrasies so familiar to medical men.

This book will be of infinite service to women, since by employing the various means so clearly described in it, an almost incalculable number of them will be freed from a constantly present dread which does much to deprive them of the pleasure and satisfaction of marriage, too often rendering the lives of many intolerable. Men

rarely recognize the depth of anguish of the woman when she misses a period, and the dread with which she looks forward to a period of increasing discomfort, pain, risk to life and possibly financial disaster, to say nothing of the damage to her structures which so often results from frequent pregnancies.

W. ARBUTHNOT LANE

The Author wishes to express his great indebtedness to DR NORMAN HAIRE for kindly allowing the reproduction of passages from *The Comparative Value of Current Contraceptive Methods*; and for his invaluable help in reading the original edition of this work in manuscript and suggesting certain alterations and improvements in the text.

G. R. S.

INTRODUCTION

I

THE object of this work is to review calmly and without prejudice the known methods of avoiding conception, to present the whole contraceptive armamentarium in cold array, to set out the advantages and disadvantages of each method, and to leave to the individual the final selection of the one most applicable to her or his taste and circumstances.

While I am most thoroughly convinced that, barring sterilization, there is no *absolutely foolproof* method of contraception known, there are indubitably some methods which, intelligently used, decidedly limit, and in certain cases almost eliminate any risk of conception. But no *one* method is suitable in *all cases*, no *one* method is the best *in every circumstance*. To single out one appliance or one method and recommend it ecumenically and blindly is to adopt the tactics of the tub-thumping vendors of a quack remedy that professes to cure every distemper to which the human body is susceptible.

I am not, in this work, concerned with the ethics of birth control. I am not going to attempt to justify birth control from the standpoint of eugenics, or the need for alleviating unemployment, or any other of the varieties

of chicanery that it is customary for exponents of contraception to parade. In a previous work,¹ to which I would refer the curious, I have attempted to explode the fallacies on which these arguments are based, and have stated that birth control is a private matter for the individuals concerned, that married couples have the right to decide whether or not they shall practise birth control, that plainly this decision concerns no one else. Because of this, contraceptive information should not remain the monopoly of the privileged few ; it is nothing to boast of that individuals with exclusive knowledge should be in a position to sneer at those unfortunate women who, owing to numerous pregnancies, are kept in a state of continuous poverty or ill-health.

It is true that I stand almost alone in voicing this viewpoint ; but the reason for this lies, I think, to a very big extent in the hypocrisy and moral cowardice of mankind concerning anything connected with sex. With exceptions which I could count on the digits of one hand, even the most enthusiastic advocates of birth control have attempted to whitewash their propaganda with some one or other social blessing which they claim that birth control will confer upon mankind ; to wit, the alleviation of poverty, the elimination of overcrowding, the prevention of unemployment, the production of finer children, *et al.* No one seems willing to admit the right of the woman or the man to refuse to increase the world's population for the one reason that I affirm,

¹ George Ryley Scott, *The Truth About Birth Control*, Werner Laurie, London

in a majority of cases, leads to the adoption of the bother and expense of contraceptive technique; to wit, the fact that she or he does not want children for purely personal and selfish reasons and cares not one jot for all the arguments that the eugenists and the social improvement crusaders have brought forward.

This apologetic attitude (for I can call it by no other name) on the part of many birth control propagandists, is a pitiable as well as a hypocritical attitude. It looks as if these propagandists were really at root, despite their seeming iconoclasm, Puritans ashamed in the final analysis of the work they are doing, and therefore seeking frantically to justify it on grounds which are calculated to ingratiate them with the public and possibly, on the Day of Resurrection, with God and Jesus Christ. They strongly remind me of the ecclesiastics who interview harlots and peep into night clubs with the avowed objects of studying measures for alleviating vice!

All this is heightened and intensified by the surreptitious manner in which contraceptive devices and manuals on birth control are distributed to the public.

Most of the vendors give the idea that they are ashamed of the things they peddle; one would never imagine from their conduct and from that of some birth control propagandists that in England contraception is a legitimate practice. This is reflected in the reaction of the public generally to birth control propaganda, which in turn apparently provides evidence in support of the arguments of the eugenists and their ilk.

The general attitude, in both its ethical and sociological aspects, towards birth control is a wrong attitude. It has vicious repercussions. It is a terrible thing that, simply because of the existence of a censorious moral viewpoint which brands the subject of sex with obloquy and makes it an obscene matter to be referred to, if at all, in secret and in shame, the woman who desires to avoid a pregnancy which she dreads should experience difficulty in securing the necessary knowledge which will enable her to exercise a choice which is undoubtedly her right in a society which looks upon any interruption of pregnancy as a criminal offence.

II

All this hole-and-corner work, this association of birth control with something unclean, obscene and blasphemous; coupled with the attitude of the Church, the Press and the medical profession, have not only created and extended much of the existing confusion but have retarded progress to a very considerable extent. It has taken courage of a very high order to brave the storms of protest from one section of the public, the sneers from another, the abuse from a third.

There are indications of a change in public opinion. A number of influential medical men and a few prominent theologians have expressed the need for the dissemination of birth control knowledge. Mr Justice McCardie stated that in his opinion "the knowledge of birth control ought to be more widely extended."²

² At Leeds Assizes, November 30, 1931.

Recently, through scientific and medical attention having been directed to the problem, there have been definite improvements in birth control technique.

I have already mentioned that there is no one method applicable to every case and in all circumstances. It is possible that in the future a method universally applicable may be discovered, but at present there is no such indication; and owing to the nature of the problem and the variations in individual physiology and psychology, I think any such development unlikely.

To-day the main problem confronting the individual who desires to practise birth control is the problem of selecting the right method. There is a method or a combination of methods applicable to almost every case. This particular technique, if intelligently carried out, will enable the individual to reduce so thoroughly the possibilities of conception that the risk becomes an infinitesimal one. The heavy incidence of failure is largely due to: (1) The wrong method being chosen; and (2) the failure or inability to carry out properly the instructions. A method, however theoretically perfect it may be, is of no use to the individual who for any reason whatever cannot adopt it or carry out adequately its essential technique.

The importance of this matter of selection cannot be too often reiterated or too strongly emphasized. To enable the individual to select the one method which is specifically applicable to his or her own individual case is one of the main objects of this particular work.

GEORGE RYLEY SCOTT.

CHAPTER ONE

THE PRINCIPLE OF CONTRACEPTION

THE reproductive life of man ranges from the age of 18 to that of 60; of woman from 16 to 45. There are many and marked exceptions to these ages, but they may be taken as approximately correct in relation to the majority of men and women. During this reproductive period the male organs of generation, known as the testes, are producing spermatozoa, while coincidentally the ovaries in the female are producing ova. But while in the female only one ovum or egg matures in a month, in the male the semen normally swarms with millions of spermatozoa.

At every act of intercourse between the sexes millions of these spermatozoa are emitted from the male penis and discharged into the female vagina and uterus. It requires one only of these microscopic tadpole-shaped spermatozoa to unite with the female egg, thrown off by one of the ovaries, for conception to result.

There may of course be no ovum awaiting the coming of the spermatozoa; there may on the other hand be no spermatozoa present in the emitted semen; or again the vaginal conditions may be such as to destroy the vitality of the spermatozoa; or indeed any one of a score of other conditions, physiological or pathological, may render con-

ception unlikely. But sooner or later, unless the sterility of the male is a permanent feature, or the sterility of the female absolute, conception will ensue.

Obviously the aim of anyone wishing to avoid impregnation is to prevent the meeting of a live spermatozoa with an ovum. The methods in vogue to this end are termed contraceptive methods. So long as such a method is employed before, during or immediately after ordinary intercourse, whether it is put into operation by the male or by the female, whether it be mechanical or chemical, matter not at all; it is a contraceptive method.

It is important to distinguish clearly contraception *per se* from abstinence on the one hand and abortion on the other. Most birth control advocates include abstinence in their list of methods; the majority of the clergy admit no other method (apart from restriction of intercourse to what is popularly called the "safe period," which is partial abstinence) as ethically or theologically allowable. But clearly abstinence, strictly speaking, is not a contraceptive method at all. Imagine anyone advertising a perfect and hundred per cent. effective method of birth control for a five-shilling fee and in return for the money sending a slip of paper bearing the words "avoid intercourse!"

The distinction between contraception and abortion in the earliest stages of impregnation is not so exact. Some so-called contraceptive methods are really abortive methods. Thus a certain type of intra-uterine pessary, sold as a contraceptive appliance, is really an abortifacient; unduly vigorous douching, in certain circumstances, may dislodge an impregnated ovum.

CHAPTER TWO

THE CONFUSED POSITION

A GLANCE into the various published manuals and leaflets on birth control suffices to show how the foremost authorities differ in their recommendations of the various methods, how they often contradict each other's findings, how in their fanatical zeal they often overlook damaging evidence and elaborate favourable results which have been obtained from the use of their own approved methods. But the main reason for this confusion is the failure to take sufficiently into consideration the physiological and psychological variations which are so common in both men and women.

Today, however, the consensus of opinion is that few of the contraceptive methods that are available to the bulk of the population are reliable if employed alone; a combination of two or more methods adopted simultaneously represents the mode of procedure which is almost universally recommended.

Mrs Hornibrook contends that if the chemical method and the mechanical method are combined, "*the protection against fertilization may be regarded as almost absolute*"¹ (Mrs Hornibrook's italics). Dr Marie Stopes

¹ Ettie A. Hornibrook, *Practical Birth Control*, Heinemann, London, revised edition, p. 11.

is enthusiastic in favour of a rubber cervical cap known as the "Racial,"² in conjunction with a "Racial" greasy suppository, "for the perfectly normal woman," describing it as "the ideal method"; and for those "who cannot wear the cap, or who cannot get expert advice and examination, the sponge and pure olive oil, have proved invaluable."³ Johann Ferch advocates the silver cap, and in certain circumstances a rubber cap, followed by douching not later than half an hour after intercourse; he describes the "check pessary" as "the only hygienic and good preventative." The American Birth Control League considers the "Ramses" pessary with contraceptive jelly give the most satisfactory results. Lord Dawson stated the condom to be the only reliable method giving "absolute security," a view with which the Cambridge Clinic agrees; Bloch, Kisch, Krafft-Ebing all recommend it as the best available contraceptive; so, too, the Medical Committee of the National Birth Rate Commission.⁴ Dr. Leonhardt advocated the use of an invention of his own known as the "Secura Air-Cushion Pessary" in combination with a chemical contraceptive. Mr Michael Fielding recommends the rubber cervical

² The word "Racial" is the registered descriptive name adopted by the Constructive Birth Control Clinic for the various contraceptives recommended by the Clinic and made according to Dr. Marie Stopes' specifications and formulae.

³ Marie Carmichael Stopes, *Contraception: its Theory, History, and Practice*, Putnam, London. Third edition, 1931, p. 33.

⁴ Referring to this, the most ancient of contraceptive appliances, the Medical Committee says, "This is probably the most certain of contraceptive methods, but as its use necessitates intelligent care, it is unsuitable for the ignorant and for those under the influence of drink, while the cost makes it prohibitive for the poor."

cap or the "Dutch" pessary and a chemical contraceptive.

As a fact there is no 100 per cent. reliable contraceptive method for *all cases*, a point upon which all the above-quoted authorities are apparently in agreement. There are methods which eliminate almost every possible chance of conception in normal women, but there is ever-present the possibility of that fatal slip—it only needs one such slip in twelve months, provided it occurs during a woman's fertile period, to bring about conception. There are women who, through the incidence of physiological, pathological, and even on occasion psychological conditions, can only use methods which are admittedly risky; there are some who cannot use any method at all; there are others who are too careless or too stupid to carry out even the simplest methods correctly.

All things considered the method recommended by Dr Norman Haire, consisting of the employment of the "Dutch" or "Haire" pessary smeared before insertion on both sides with contraceptive lactic-acid jelly, followed next morning by a douche with soapy water while lying down and before removing the pessary, with a similar douche after removal, seems to provide the most satisfactory method for the normal reasonably healthy woman who wishes to avoid conception with or without her husband's approval. A somewhat similar diaphragm pessary ("Ramses" type) is advocated by the American Birth Control League. The late Dr James F. Cooper (Medical Director of the League) says: "*In a word, this combination of the Ramses type of diaphragm pessary with the lactic-acid jelly referred to above, provides at*

least an approach so close to a hundred per cent. contraceptive method as to warrant placing in it a large measure of confidence."⁵ (Dr. Cooper's italics.)

Mrs Florence, who, as Honorary Secretary of the Cambridge Clinic, has had exceptional opportunities for studying contraceptive problems, puts the matter thus:—

"It is a significant indication of the limitations imposed by present-day knowledge of contraceptives when 155 people out of 247 are obliged to admit that they found methods of family limitation either so ineffective or so distressing or so troublesome that they abandoned the attempt to use them."⁶

So! And then the virgin girl presents a problem.

And finally, not to be overlooked is the notorious carelessness of many men and women in carrying out the requisite technique, a carelessness which often follows the successful practice of contraception over a lengthy period.

The psychological aspect is one that birth controllers and their opponents largely overlook. It seems to me that in the future it is an aspect of the problem which is going to receive vastly increased attention, and which will eventually have much to do with the selection of contraceptive methods. As it is, through neglect of this supremely important psychological factor, there is little to guide the individual possessed of any æsthetic ideas or feelings of delicacy, in the choice of a method which in

⁵ James F. Cooper, *Technique of Contraception*, Day-Nichols, New York, p. 145.

⁶ Lella Secor Florence, *Birth Control on Trial*, Allen & Unwin, London

its adoption will arouse in both partners the minimum amount of repulsion.

Most of the available methods, good, bad and indifferent, may be divided into two great classes: the first, where the bother or the unpleasantness or the repugnance on the part of one or other of the partners in the sex act is so manifest that there is danger of an ultimate decision being arrived at that the game is not worth the candle; and the second, where although the necessity for the annoyance or disgust connected with preparation is avoided, periodical visits to a doctor are essential. There are certain men—and I do not blame them—who would rather a thousand times run the risk of adding to the world's population, or who would prefer to abstain from coitus for ever, than be bothered with the disgusting experience connected with the proper fitting of a "French letter"; there are women who would prefer to run the risk of bearing a dozen unwanted children, or preferably perhaps go to their graves virgins, than suffer the trouble, annoyance and humiliation of getting out of a comfortable bed to perform ablutionary measures either in the bathroom or under a man's nose, be he husband or lover. By adopting the more expensive methods, such as the "Gräfenberg" ring or the "wishbone" pessary, all this bother at the time of intercourse, true enough, is avoided, but the relief is a purely temporary one. It is followed by what to many is a far worse and more humiliating ordeal, the inevitable ultimate probing of a physician into an essentially delicate matter. Actually there is no method at present available that is not disliked to some extent by either the man or the woman, and often enough by both. In numerous

cases, this inherent dislike leads to carelessness in the matter of technique or to the abandonment of contraceptive methods altogether.

As every psychologist, and indeed every physician knows, individuals vary tremendously in the matter of their likes and dislikes, and essentially so in the case of something which is of so secret a nature as is a method of contraception. Thus the method which fills one individual with dismay and revulsion will arouse no such feelings in the case of another; what in one set of circumstances will be viewed with disgust, in another set of circumstances will be embraced with joy. The charwoman living in Whitechapel, with half-a-dozen children dragging at her heels, and with the dread big in her of another addition to the flock, will be disposed to view with delight the birth control method that would be repulsive to the childless decorative idler of Mayfair.

There is, too, the often overlooked fact that the contraceptive method in which the woman, or, to a lesser degree, the man, has no faith is, for the individual concerned, definitely a bad method. It is a bad method because it spoils all possibility of sexual pleasure and may induce an anxiety neurosis. Men, in selfish pursuit of their own pleasure, are often guilty of forcing their partners to adopt emergency measures in which there can be little or no reliance.

The heavy percentage of failures in contraceptive methods, therefore, is, I submit, due not to the fact that contraceptive technique is faulty in itself, but to (1) the adoption of methods which are not suitable for the

physiological and psychological features of the person concerned; and (2) carelessness in carrying out the particular method selected.

Despite the confusion to which I have drawn attention, there is therefore no occasion for despair. For those who will adopt the particular method indicated by individual physiological and psychological factors, who will carry out the detailed instructions carefully and thoroughly, the risk of conception occurring may be reduced to a minimum. *Indeed, where the method or combination of methods most suited to the occasion is adopted and carried out intelligently, this risk is so slight as to be almost negligible.*

In this selection of the right methods lies the key to success. Its importance is such that I must give to the consideration of the personal factor in contraception a separate chapter.

CHAPTER THREE

THE PERSONAL FACTOR IN CONTRACEPTION

I

It may be a concomitant of the machine age, or it may be due to other influences, but the fact stands out dismayingly that the average individual living in this decade is becoming increasingly addicted to relying upon methods and practices which call for the minimum output of personal thought, individual attention or intelligent operation. In other words, the mass production of stereotyped products is resulting in a general reliance upon and a call for fool-proof systems and rubber-stamped ideas. Society becomes more and more accustomed to getting its daily mental food pre-digested and tabulated just as analogously it secures its bodily sustenance canned, measured and semi-assimilated.

For many reasons contraceptive technique has not reached anything like that stage of perfection where the individual can rely upon the selected method working with all the precision of automatism. True there are one or two methods which approach this ideal state, but they are definitely limited in their availability. To a greater or lesser degree every known method of birth control calls for care or intelligence or both in its application.

It seems to me that this side of the thing is rarely sufficiently emphasised in birth control literature. In the main unintentionally, through sheer enthusiastic advocacy, an exaggerated simplicity and degree of reliability for this method or for that has been suggested not perhaps in so many words as by implication. On the other hand, opponents of contraception have been led by their misplaced and unwarranted zeal in the cause of a fantastic morality or orthodox religion, to seize upon any failure due to ignorance of technique and any harmful results due to obvious carelessness, and blazon them before the world as indisputable evidence of the worthlessness or the injuriousness of all birth control methods.

In any consideration of modern contraceptive technique, the first point to grasp is that no one method can possibly, as so many people seem to think, reach the degree of simplicity looked for in a penny-in-the-slot machine. One is dealing with human beings where physiological, pathological and psychological factors all enter into the matter and where the actual conditions are rarely exactly duplicated. The patent medicine, despite the volume of testimony in its favour, is inferior to the physician's prescription because it attempts to treat the human sufferer as a rubber-stamped, machine-made product. For a precisely similar reason the birth control method that has proved eminently successful in one instance fails most dismally in another. *The best contraceptive method for the individual is the one selected by an expert in contraceptive technique after careful personal examination.* In

this connection I cannot do better than quote the words of Dr Norman Haire:—

“Where contraceptives are to be used it is desirable that a medical man or woman should advise the best method for the particular case. No nurse or other non-medical person is competent to make the necessary examination and form a decision as to what method is best for a given patient, and then properly instruct the patient in the use of that method. It is desirable that the patient should return to the doctor at intervals for supervision, and this is particularly desirable from the point of view of research. The doctor should endeavour to note the effect of the contraceptive on the physical and mental health of the patient, and so obtain much-needed data. I want to point out here the extreme difficulty of obtaining *exact* data on contraceptives; the patients are frequently unintelligent, and more often unobservant, and are quite unable to give definite answers to some of the questions. They may have used a particular method irregularly, or two or more methods in different combinations at different times. Whatever method they have used they may have used it carelessly. Often they do not tell the truth.”¹

Here we touch upon one of the main reasons for the comparatively large number of failures connected with the practice of birth control. Owing to the fact that contraceptive technique is not included in the curricula of

¹ Norman Haire, *The Comparative Value of Current Contraceptive Methods*, reprinted from *Proceedings of the First International Congress for Sexual Research* (Berlin, October 10 to 16, 1926); London, 1928.

the medical colleges in England, America, and most other countries, comparatively few medical men have the requisite knowledge to select the most suitable appliance or recommend the best method. Thus, in the huge majority of cases, there is much groping in the dark, much experimenting in wrong directions, much reliance being placed upon the recommendations of chemists and of those gentlemen who decorate their shop windows with copies of *Aristotle's Works* and the novels of Paul de Kock !

Second only to the need for the adoption of the method most suitable for the peculiar physiological and psychological make-up, or the degree of intelligence of the individual in question, and the selection of reliable, properly constructed appliances, is there to be kept big in mind the necessity for looking after the state of the bowels. In a later chapter I shall have occasion to draw attention to the fact that certain appliances cannot be successfully employed where the rectum is distended with unvoided excrement. It is therefore of the utmost importance that the woman who wishes to use the most reliable of contraceptive methods open to her must make every endeavour to evacuate the bowels daily. Chronic constipation seriously interferes if it does not altogether preclude the use of any kind of rubber pessary.

The appliances themselves require proper care. A condom is carried about in a wallet or waistcoat pocket and to the consternation and disgust of the owner splits open and lets the semen enter the vagina; a rubber pessary that has been lying in a drawer or cupboard when brought into use fails to prevent conception. In

each case the appliance in question is blamed for an unwanted pregnancy, when actually the individual was entirely at fault. Rubber is easily damaged. The rubber pessary is injured by boiling; it hardens and develops tiny fissures if kept in a warm dry place. When not in use it retains its elasticity if submerged in water, preferably in a wide-mouthed glass bottle or jar; or, perhaps better still, if buried in a box of fuller's earth or precipitated chalk.

II

Keeping well in mind the personal factor and its bearing on the ultimate choice of a contraceptive method, it may be well at this stage to give some indication as to which methods are likely to prove satisfactory, subject to the physiological and psychological factors previously mentioned, in the cases of different individuals. The detailed elaboration of the advantages and defects of these methods will appear in succeeding chapters.

MALE METHODS

(1) *Where the male wishes to prevent conception without consulting his partner.*

(a) The short "letter" or "American tip," smeared with lactic acid jelly

Provided it is properly carried out, this method is an excellent one.

(b) *Coitus interruptus.*

This is only to be advised as an emergency method, or where there are objections to (a).

(2) *Where there are no reasons, æsthetic or otherwise, for the male to refrain from consulting his partner, but where the female is unwilling to, or cannot, adopt a contraceptive method.*

- (a) The condom smeared with contraceptive jelly.
- (b) The short "letter," smeared with contraceptive jelly.
- (c) *Coitus interruptus.*

FEMALE METHODS

(3) *Where the female does not wish to consult her partner or allow him to have any knowledge of her intention.*

- (a) The "Mensinga" style pessary or the cervical cap with lactic acid jelly, followed next morning with a douche.
This is almost a certain method for normal women.
- (b) Sponge or cotton-wool plug, with lactic acid jelly and douche.
Advisable where a rubber pessary is not available or cannot be used.
- (c) "Gräfenberg" ring with lactic acid jelly, a suppository or a tablet.
- (d) Handkerchief rolled into a ball.
(An emergency method.)

(4) *Where the woman has no need or wish to be secretive, but the man cannot or will not adopt a contraceptive method*

- (a) As under 3 (a).
- (b) As under 3 (b).
- (c) As under 3 (c).
- (d) As under 3 (d).
- (e) Female sheath.

A very effectual method: its use is indicated where, at all costs, the female is determined to avoid conception, and where there is any fear of venereal infection.

(5) *For the virgin.*

- (a) Lactic acid jelly or soluble suppository.
- (b) Chemical douche.

Both these methods are slender reeds to lean upon, and unless fitted with a pessary after surgical dilatation, it is preferable to rely upon the male using a sheath or practising *coitus interruptus*.

(6) *Male and female in combination.*

- (a) "Mensinga" style pessary and short "letter."
- (b) "Mensinga" style pessary and condom.
- (c) "Mensinga" style pessary and *coitus interruptus*.
- (d) Sponge or plug and short "letter."
- (e) Sponge or plug and condom.
- (f) Sponge or plug and *coitus interruptus*.
- (g) Rubber cervical cap and short "letter."
- (h) Rubber cervical cap and condom.
- (i) Rubber cervical cap and *coitus interruptus*.

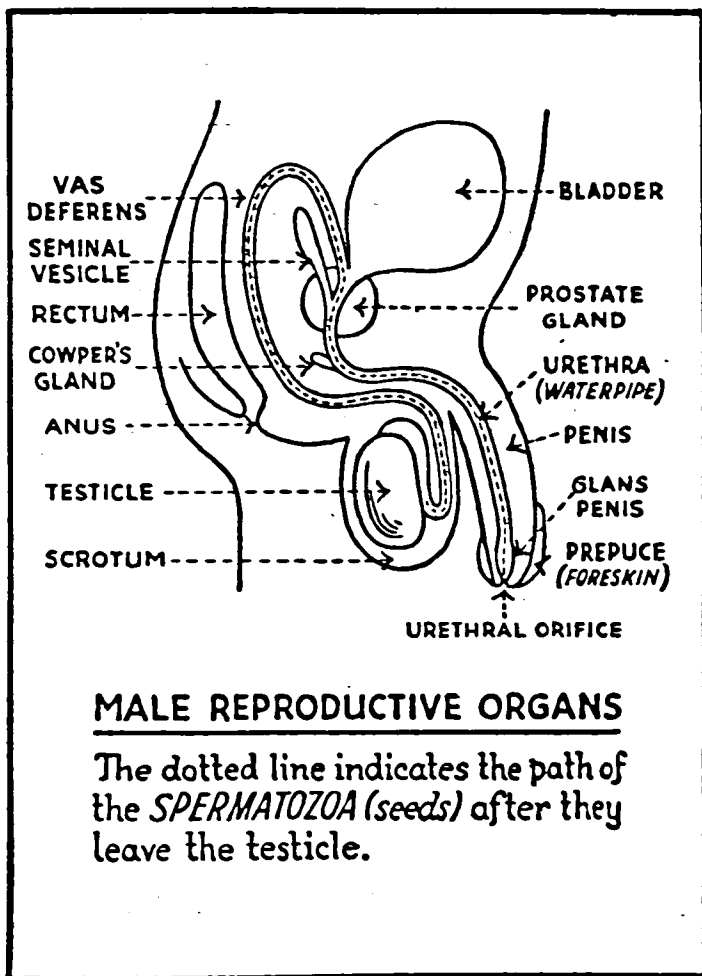
CHAPTER FOUR

METHODS APPLICABLE TO THE MALE

I "WITHDRAWAL"

THE oldest means of avoiding conception is the one employed successfully by Onan, known scientifically as *coitus interruptus*, and popularly as "withdrawal," "being careful" and "coming out." Not only is it the oldest, but despite the widespread advocacy of other methods, despite, too, its wholesale condemnation by doctors, by birth control fanatics and by their opponents, I have little hesitation in saying it yet remains the most widely practised and the most popular of all contraceptive methods. So universal indeed is its practice that a huge proportion of those who regularly employ this method do not even look upon it as coming within the category of contraceptive technique.

The reasons for this universality and popularity require no very diligent search. It is a method that calls for no appliances or preparation, it involves no expense whatever, it can be adopted in any circumstances, and at any time, and it calls for no *consultation* on the part of the man with the wishes or prejudices of his partner. For this reason alone it is widely employed by males during the honeymoon period and even more so in cases of extra-marital intercourse.



MALE REPRODUCTIVE ORGANS

The dotted line indicates the path of the *SPERMATOZOA* (seeds) after they leave the testicle.

Coitus interruptus is simplicity itself in theory; also it is simple enough in practice provided the man retains full control of himself. It consists of the sudden withdrawal of the erected penis from the female vagina immediately before ejaculation takes place, with the result that the semen is emitted outside the vulva. It is strongly advisable that the bladder be emptied before attempting *coitus interruptus*.

The risks of failure are obvious. For although theoretically the method presents no difficulties and in cold blood would be easily enough accomplished, in the throes of sexual passion it takes on an entirely different face. As every sexual act resembles to some extent an epileptic seizure, little wonder that a not inconsiderable number of men, with the best will in the world, miscalculate the moment for withdrawal, allowing a partial emission into the vagina; others forget all about their resolutions; others again change their minds at the last moment, refusing to terminate their spell of passion. Even where *coitus interruptus* is done properly or where, to be absolutely safe, the man withdraws prematurely, there is the risk that a few drops of semen may have been emitted through the gaping os (mouth of the womb) long before the approach of actual orgasm. There is further the slight but not to be overlooked danger that semen emitted into the vulva may later reach the uterus and bring about conception, especially if, without previous micturition by the female, the coital act is repeated. Additionally, in all cases of repeated attempts at intercourse, seeing that, through ignorance of the danger, the male rarely takes the very necessary precaution of

cleansing the penis after the first coital act, there is a distinct risk that semen from the first ejaculation will be transmitted into the vagina at the second intromission.

All things considered, *coitus interruptus*, *per se*, is a most unsafe method, and the statistics available give a very heavy percentage of failures.

The question of its harmful effects or otherwise is a more debatable point. If we are to believe some medical writers it is responsible for a terrible category of diseases, ranging all the way from cancer of the uterus to insanity. Many authorities denounce it as injurious to both the man and the woman.

There is certainly the possibility of the continued practice of "withdrawal" inducing in the male a state of congestion which may in time cause permanent trouble analogous to what occasionally results from excessive masturbation, and it may, too, induce an anxiety-neurosis, but such cases can only be exceptional. The evil results attributed to the practice as regards the woman are those arising from unsatisfied sexual passion and failure to achieve orgasm. But if this is true in the case of *coitus interruptus*, then it happens just as often where other birth control methods are employed and indeed where contraception is not practised at all. For in ninety-nine out of one hundred cases the male reaches orgasm before his partner. Every sexual act should be preceded by courtship, says Havelock Ellis. What in all cases the male should do is to spend some time in caressing the woman, so as to prepare her for intercourse before actual penetration occurs, and delay his orgasm until she has

reached hers. This he can do just as effectively whether he intends to have normal intercourse or to practise *coitus interruptus*. Indeed it is difficult to see what evil effects the method can possibly have on the woman. The anxiety connected with the fear of pregnancy resulting from the failure of her husband to withdraw in time, or at all, though peculiar to *coitus interruptus*, is an anxiety of principle and not of method; the fear of conception resulting is common to every method that can be employed and in addition it is even more pronounced if no preventive measure is adopted.

To sum up, there are no doubt cases where indulgence in *coitus interruptus* develops dormant neuroses or aggravates existing ones, but as regards normal healthy individuals there seems to be no actual evidence that the evil effects attributed to the practice are anything but exceptional and only the results of its excessive and long-continued usage. Indeed it would appear that those who catalogue so terrifying a list of evils resulting from its practice are in error in diagnosing the root cause of these evils. One can imagine the ease with which, when once it has been decided that *coitus interruptus* produces pernicious results, seeming evidence in support of the hypothesis can be unearthed in some profusion—the neurasthenic wreck is questioned as to whether he has ever indulged in *coitus interruptus*, and if, as is extremely likely he admits its practice, the question as to the origin of his malaise is considered settled beyond the faintest dispute. Actually the cause of the trouble in nearly all the cases instanced as evidence of the evil effects of *coitus interruptus* is *excessive sexual indulgence*, and the results

would probably have been precisely the same had normal coitus been practised. The very fact that "withdrawal" has been in use longer by far and is more widely practised than any other known birth control method is sufficient to show that these evil results are grossly exaggerated and founded on the most dubious evidence.

In view of its unreliability the question arises should *coitus interruptus* be employed at all? It must be remembered that there is no perfect method of contraception, all are liable to fail. Moreover, certain methods which give good results in one case fail dismally in others. And a method which, generally speaking, is not to be recommended may in special circumstances, despite its risk, be the best or possibly the only method that can be employed.

Those who advocate the use of pessaries and condoms *in all cases* seem to overwork these facts. They fail to see that to the person in dread fear of pregnancy and who cannot be continent, a poor method is better than no method at all. There are many cases where rubber pessaries cannot be employed. In instance, the virgin (unless the vagina is first dilated); the victim of a fallen womb, of cystocele, of vaginal rectocele, and often a woman with a large and flabby vagina resultant from excessive child-bearing. In all such cases, failing the condom, which may not be available or the man may refuse to use, *coitus interruptus* is advisable, particularly if the woman is able to apply to the vagina a soluble suppository or a smearing of contraceptive jelly immediately *before* intercourse.

II COITUS RESERVATUS

Allied somewhat to *coitus interruptus* is the practice of *coitus reservatus*, sometimes called Karezza, or Zugassent's Discovery, or Male Continence. It consists in the avoidance of orgasm by the male and the consequent failure to ejaculate. It is infinitely more difficult for the man than is withdrawal with ejaculation outside the vulva, as in *coitus reservatus* the essence of the thing is that the act of intercourse should be extended over a prolonged period, and that while both parties to the act should achieve sexual pleasure and satisfaction there should be no orgasm and the penile organ should subside before removal. The practice achieved some notoriety through its advocacy by Dr John Humphrey Noyes, the founder of the Oneida Community in New York State, according to whose published accounts the system worked admirably and produced no evil results. In more recent years it has been warmly advocated by Dr Alice B. Stockham.¹ It may be definitely stated that *coitus reservatus* is only for the few. It calls for strong powers of control, and also it would seem there is need for preliminary training. It is, too, attended with the same risks of unconscious seminal emissions as is *coitus interruptus*, and for this reason the use of a chemical contraceptive by the woman in addition would be strongly advisable. It seems to me there is here definite risk of harmful results to the male following a practice where the avoidance of ejaculation is the paramount feature.

¹ See Alice B. Stockham, *Karezza; Ethics of Marriage*, Chicago.

For instance, the fears expressed by the opponents of *coitus interruptus* are in the case of *coitus reservatus* quite justifiable fears. Apart from the tendency to induce congestion through the avoidance of orgasm, the very fact of there being no ejaculation of the seminal fluid enables the man to repeat the sexual act to an extent that would be quite impossible were normal coitus, with the loss of semen, practised.

There are ample grounds for thinking that in recent years there has been a huge increase, particularly among adolescents indulging in sexual intercourse, in the prevalence of perineal coitus, where no *immissio penis* actually takes place; or in the *demiretrait*, where the penis is withdrawn sufficiently to avoid the discharge of semen in the neighbourhood of the os; or in sedentary coitus *a posteriori*, where ejaculation takes place in the pudendum. Although this decidedly reduces the risk of conception it does not preclude it altogether—there is always a possibility of the spermatozoa deposited in the lower part of the vagina or even in the folds of the labia in some way or other finding their way into the uterus.² It should always be remembered that the entrance into the uterus of a solitary spermatozoon out of the millions that are normally discharged in the coital act *may* be sufficient to cause conception.

² There are, too, certain risks in connection with penile intromission directed against the more delicate and susceptible part of the vagina, that is, the posterior fornix. Especially is this danger indicated where there is serious disproportion between the parts, or where the male is exceptionally passionate and headstrong.

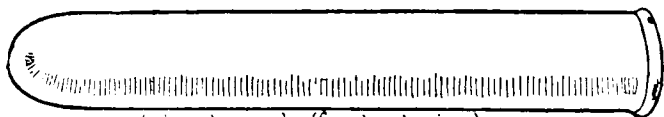
III THE CONDOM

Second only in popularity to the practice of *coitus interruptus* is the use of the condom or sheath, popularly referred to as the "French letter." It is no new discovery, but was sold in London as long ago as 1776,³ and has achieved notoriety as a preventive of venereal infection quite apart from its employment as a contraceptive. It has been praised as a perfect contraceptive; it has been denounced as useless. Bloch, Kisch, Krafft-Ebing, Robie, Havelock Ellis and Lord Dawson all recommend it. Dr Marie Stopes records 75 per cent. of failures following its use; Dr Norman Haire records 51 per cent; the American Birth Control League record 50 per cent. On the other hand, the Cambridge Clinic announce only three failures out of thirty-one cases, and recommend the sheath as the most reliable method providing it is properly used.⁴

In considering the claims of the condom it must be borne in mind that in recent years vast improvements have been made in its manufacture. It is true the market

³The antiquity of the condom is indicated in references to the appliance in the literature of the seventeenth and eighteenth centuries. There is an entry (spelled *cundum*) in Captain Francis Grose's *Classical Dictionary of the Vulgar Tongue* (1785) referring to the use of the "cundum" for the purpose of preventing venereal infection. It was known to Casanova, who refers to it under the name of *redingote anglais*; and Madame de Sévigné, who died in 1696, was aware of the existence of such a device. An earlier reference is to be found in the notorious anonymous pornographic *L'Ecole des Filles, ou la Philosophie des Dames* (1668), of which there is a rare English translation entitled *The School for Girls*.

⁴It should be noted that most failures are due either to defective sheaths, or to carelessness in their use.



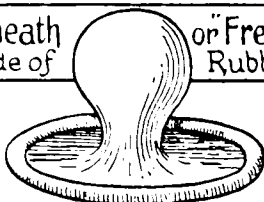
(about one half actual size)

Condom Sheath or "French Letter"

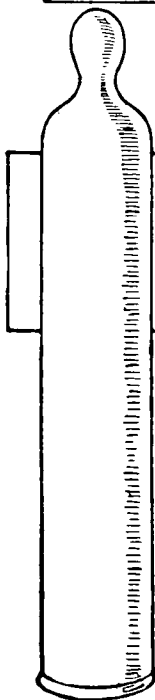
Made of animal membrane.

Condom Sheath
Made of

"French Letter"
Rubber



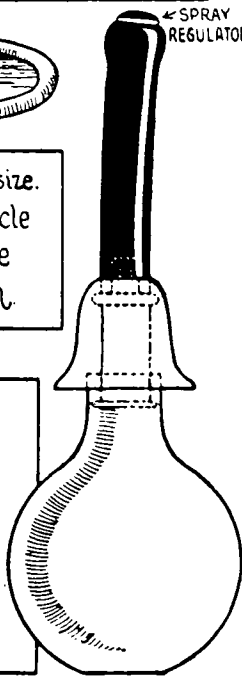
← SPRAY
REGULATOR



about one half actual size.
CONDOM with receptacle
at the end to receive
the emitted semen.

SYRINGE

Used for flushing
the vagina with
antiseptic
solution,
immediately after
intercourse.



is still flooded with inferior goods, but the important point is that high-grade condoms *are being made* by reputable manufacturers and *can be procured* if care is exercised in the selection and purchase of a reliable brand. The new type is made of latex rubber, it is seamless, it is extremely thin, and each sheath is closely examined and air-tested before leaving the manufactory. I have seen this process of testing in operation and was impressed with its thoroughness and efficacy.

Condoms are made of skin and rubber. Both have their disadvantages and drawbacks. The rubber condom is much softer than the skin article. It is "rolled" on to the male organ, to which it clings tightly. This apparent advantage may well prove a drawback. The "clinging" character of the rubber, by the very tightness induced, may interfere with erection. On the other hand, if a condom sufficiently large to lose much of this "clinging" character is used, there is a strong probability that it will slip off during intercourse. Again, to some persons, the characteristic smell of rubber is objectionable and in certain instances may well have an anaphrodisiacal influence: this fact alone causes many men to express a preference for the skin sheath. Then too, rubber of the delicate character used in making condoms is easily damaged, not alone during intercourse, but also by careless handling; moreover, it deteriorates quickly in unfavourable atmospheric or other environmental conditions.

The skin condom, which is made of animal gut, combines strength with thinness. It must be moistened with water before use, a procedure which is annoying to the

man; it is difficult to adjust correctly. But in its favour are several important points: it exerts no pressure on the male organ; it has no objectionable smell; it interferes less with sensation than does the rubber article.

The ultimate decision as to whether the rubber or the skin sheath is the better must rest with the individual. Some men find the rubber condom more satisfactory; others prefer the skin condom. It is, however, of the greatest importance that the appliance, whichever type is selected, should be used correctly. The requisite technique, in each case, must be employed if success is to be assured.

The first step is to insert a small amount of non-greasy contraceptive jelly (lactic acid jelly is admirable for this purpose) into the tip of the rolled rubber condom. Next apply the thinnest possible coating of this same spermicidal jelly to the surface of the male organ. Now proceed to "unroll" the condom over the sex organ, taking care to allow the end of the sheath, containing the jelly, to overhang slightly the extremity of the glans penis (where the urine is discharged). Having got the condom affixed properly, anoint the *whole* of its external surface with non-greasy spermicidal jelly, taking care not to overdo the process: the thinnest possible coating is all that is necessary or advisable. After intercourse, the male organ should be withdrawn while still erect. If, by any chance, it is discovered that the condom has split or that seminal fluid has escaped from an overlooked puncture, the female, without the slightest delay, should either use a contraceptive douche (see page 87) or "wipe out" the

vagina with a piece of lint or cotton dipped in a spermicidal solution, or, failing this, in soap and water.

Before leaving the subject of the rubber condom it may be well to mention that, in the opinion of many authorities as well as the writer, the teat-ended sheath offers no advantage over the ordinary type. The object of the teat-end is to provide a receptacle for the emitted semen, thus avoiding any risk of rupture through the condom being drawn on too far. This particular risk is, however, easily obviated by leaving a space at the end of the sheath, as already instructed. The disadvantage of the teat-end lies in the fact that it may easily get caught or fixed in the cervical canal or one of the adjacent pockets, leading to dislodgment, either in the process of coition or when the sex organ is withdrawn from the vagina.

With the skin condom the technique is rather different. A little spermicidal jelly should first be inserted in the tip of the sheath exactly as with the rubber condom, and a thin coating of the same jelly applied to the male organ. The next procedure consists in drawing the sheath over the erect organ, a feat more difficult to accomplish than in the case of the rubber appliance, as here it is not a case of "rolling on" but of pulling. The skin condom lacks elasticity, which makes it impossible to draw on a sheath that is too small. On the other hand, if the condom is too big there is grave risk of dislodgment during or immediately after intercourse. Some skin sheaths have a string attachment for tying the open end to the root of the male organ; in other instances a rubber band is used for the same purpose. Both measures are unsatisfactory, either failing through

the condom not being secured tightly enough, or causing discomfort through being too tight. The real solution of this difficulty lies in the selection of the right size of sheath. Having affixed the condom, its exterior surface must be *moistened with water*. After intercourse the same careful examination as is necessary with the rubber article is indicated; in the event of a split or leak being discovered one of the prophylactic measures already described should be adopted by the female.

It is advisable, wherever possible, to use a new condom each time. From motives of economy, however, it is often necessary to use the same sheath on several occasions. In any such case, a special type should be purchased—it is termed the washable condom. It is made of thicker material than the ordinary type; also it involves additional trouble. The rubber appliance must be washed thoroughly after use, dried carefully, and stored under water in a dark place, or alternatively in powdered chalk. No attempt should be made to re-roll the sheath for storage purposes, but it must be re-rolled when the time comes to use it again. The skin condom should be washed, dried, and greased before being put away in the same flat state in which it was purchased.

Before use a condom should be tested for defects. A hole so minute as to be invisible to the eye may mean all the difference between success and failure as an anti-conception device. Both the rubber and skin condoms may be tested by inflating with air, squeezing gently and passing over the face. Filling with water is another test; in this case a pre-requisite is the drying of the

exterior surface of a condom that has been stored in water. Also the interior must be dried before use.

The cost of the appliance is one of its disadvantages, ruling out its use by the poor. The best quality rubber condoms (seamless and made from rubber latex) cost 2s. or 2s. 6d. each; cheaper grades range from 4d. each. The sheath with a receptacle end is rather more expensive, the cheapest brand costing 6d. each. The more durable washable type costs from 1s. to 7s. 6d. each. Skin condoms range in price from 8d. to 2s. each.⁵ It is false economy to purchase cheap sheaths made from sheet rubber.

While the condom, provided care is taken in its selection and the requisite technique is mastered, ranks as one of the most efficacious contraceptive appliances available, it is not foolproof. There is always a risk of the sheath rupturing.⁶ Also it has other disadvantages. The whole business of its application is, in many cases, a disagreeable affair for both husband and wife. It must be remembered that the sheath cannot be adjusted until the penis is in a state of erection, that is, until that precise moment when neither partner, granted the possession of any æsthetic feelings, can view the procedure of fitting the condom with anything but irritation if not disgust. In many cases this, in itself, is sufficient to drive away

⁵ These prices, and those which appear elsewhere in this book relating to other contraceptives, are approximate only, and are merely included to give some idea of the relative cost of the various birth control methods and appliances. The prices of rubber goods vary from month to month and sometimes from week to week.

⁶ In certain instances so great is the fear of rupture, with resultant conception, that two or even three condoms are sometimes used. Obviously, however, practically all sensation must be deadened by such a procedure even if erection is not destroyed.

tumescence. Then, as already mentioned, the smell of rubber is often objectionable; possibly the sheath is so tight-fitting as to cause discomfort, or, if care has not been taken to purchase one of fine texture, so thick as to interfere with sensation. And so, for one reason or another, many men find it impossible or difficult to perform the act when wearing a condom; in every case is there *some* interference; always is there the risk that through being too slack it will slip off during intercourse or through excessive tightness it will break.

To obviate the risk of failure, the condom should never be relied upon alone. A soluble suppository or contraceptive jelly should coincidentally be employed by the woman.

Its use alone is only indicated where the woman refuses to take any precautions or where other methods are out of the question; and where the man, through delicacy, is averse to suggesting any other measures.

To meet the needs of those who object to the diminution of sensation caused through the condom, and additionally of those who are not coincidentally requiring a venereal prophylactic, an abbreviated sheath designed to cover only the glans or extremity of the penis is available. It is known by a variety of names such as "short letter," "Malthus cap," "American tip," *et al.* Certainly there is much less interference with sensation than where the ordinary condom is used. This abbreviated "letter" can be affixed *before erection*, and as its grip tightens with the swelling of the penile organ, there is little danger of dislodgment either before or during orgasm. There is,

however, some risk of displacement *if the penis is retained in the vagina after erection has subsided*. If this point is carefully noted and due care taken, the "tip" ranks as one of the most reliable and effective methods of contraception available to the male.

There is one drawback. These caps, because of the expense involved, are out of reach so far as the poor are concerned. They cost from 7s. 6d. to 10s. 6d. per dozen.⁷

⁷ See note on page 47.

CHAPTER FIVE

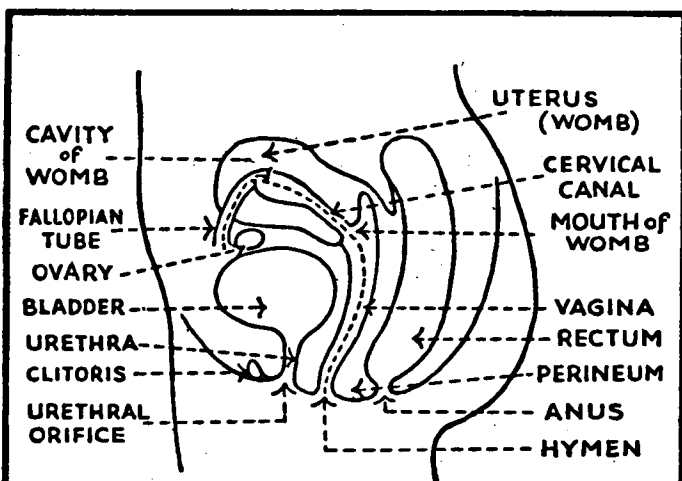
METHODS APPLICABLE TO THE FEMALE

I. THE "SAFE PERIOD"

CHIEF among "natural" methods of birth control is restriction of intercourse to the period in the female's menstrual cycle when there exists a state of biological sterility. This regularly recurring barren state is popularly termed the "safe period," and for many decades the restriction of intercourse to certain specific parts of the menstrual cycle, varying according to the recommendations of different authorities (first the middle part and later the end of the cycle were said to be periods of infertility), was widely practised throughout Great Britain and the United States.

There were several reasons for this popularity. Reliance on the "safe period" was advocated in many popular sexual guides and birth control manuals; the method involved neither the use of appliances nor the mastery of a difficult technique; it cost nothing whatever to put into application; and being actually a form of abstinence it had the approval of clergymen of every denomination and moralists of all types.

Theoretically the method has a perfectly sound foundation, to wit, the fact that a woman is fertile for a brief period only during each cycle of ovulation: the remainder of the cycle she is barren. The *precise*



FEMALE REPRODUCTIVE ORGANS

The dotted line indicates the path of the *OVUM* (Egg) after it leaves the ovary

Note the positions and proximity of the 3 openings: the urethra, vagina and anus indicating the need for cleanliness & the risk of infections being transferred from one to the other.

length of this fertile period has not been established, but there is ground for the assumption that it is of brief duration, probably not longer than twenty-four hours.

Obviously, assuming this hypothesis to be true, here appears to be the contraceptive method *par excellence*, the one-hundred-per-cent. effective method for which the world is searching. All it calls for is careful observation of the calendar in relation to the menstrual periods, and the willingness of husband and wife to restrict intercourse to certain days in each month. The snag is concerned with ascertaining the actual period of infertility. It is this snag which many years ago was responsible for the widespread failure attending its use, and its consequent denunciation as unreliable by a number of medical men and scientists.

One of the first to popularise the idea of a regularly recurring period of infertility was Dr R. T. Trall, who, in the first edition of his *Sexual Physiology* (1868), gave detailed and definite instructions whereby he claimed that every woman could ascertain her "safe period." Again, Dr P. W. Siegel's paper on the subject, published in 1915 in the *Münchener Medizinische Wochenschrift*, where he asserted that from the twenty-second day to the end of the menstrual cycle infertility was absolute, received the widest publicity. Then, in 1917, Siegel admitted that his first published conclusions were restricted in their application to females with a certain type of menstrual cycle and did not, as had at first been thought, apply universally. It was a gracious and wholly admirable concession, on the part of the doctor, to scientific truth, but it had, inevitably, so far as popular opinion

was concerned, a discrediting effect upon the entire basis of this hypothesis relating to the biological sterility of woman.

Evidence of the unreliability of the "safe period" was plentiful in the shape of women who had adopted the method only to find themselves pregnant. As a result, all things considered, the "safe period" remained under a cloud for many years, newer contraceptive methods displacing it. For the most part, its mention in birth control manuals was of a denunciatory nature, readers being warned that the method was unreliable. Indeed for years the "safe period" was thought to be dead and durably buried. And so the matter stood until the year 1929, when entirely new light was thrown upon the phenomenon of ovulation, and at a bound the old hypothesis concerning a regularly recurring period of sterility once again came into prominence.

It appeared that almost coincidentally, in Austria on the one hand, and in Japan on the other, two researchers, to wit, the biologist Dr Hermann Knaus, and the gynæcologist Dr Kyusaka Ogino, working along independent lines, arrived at approximately similar conclusions. It should be remembered that adverse comment by scientific investigators concerning the biological sterility of the female was not a denial of the truth of this hypothesis: it dealt merely with the fact of there being in existence no means of ascertaining at what precise part of the menstrual cycle the woman's period of sterility occurred. It was upon this aspect of the matter that both Knaus and Ogino concentrated their researches.

It is unnecessary to detail here the long series of experi-

ments conducted by these scientists. Suffice it to say that both researchers by these experiments seemed to establish a point of supreme importance, i.e. the existence of a definite relationship in point of time between ovulation on the one hand and menstruation on the other. Their observations pointed to the old idea of a "safe period" being correct. Where previous researchers had failed was in not having discovered any means of ascertaining the time of ovulation. For on this point rested the practicability of the "safe period!" as an anti-conceptive measure.

According to the findings of Ogino, ovulation occurs at some time between the twelfth and the sixteenth days, counted backwards in the cycle, preceding the commencement of menstruation. Knaus narrows down the time of ovulation even more, asserting that it occurs on the fifteenth day preceding menstruation.

Now in view of the fact that the interval between successive menstruations varies considerably in different women it follows that the time of ovulation cannot be predicted without knowledge of the length and regularity of the menstrual cycle.

There were, too, as both Ogino and Knaus fully realized, other factors to take into consideration if this new knowledge was to be of any practical use in the field of contraception. The first of these factors was concerned with the brief nature of the period during which a matured ovum may be fertilized, a period characterized by the time which elapses between leaving the ovary and being discharged, if not previously intercepted by a male spermatozoon, from the uterus (the stage at which

fertilization becomes impossible). The falsity of the old notion that the ovum remained in the womb for days or weeks awaiting fertilization had already been demonstrated. Modern research established the fact that the period of fertilization is probably measured in hours and certainly cannot be longer than a day. The second factor related to the male's part in conception, that is, to the life of the spermatozoon. Here again old theories were exploded. Recent biological research has proved beyond doubt that the male spermatozoa, after leaving the male organ of fecundation, retain their fertilizing powers for a comparatively short period only: there is evidence that this period cannot exceed, even in the most favourable circumstances, three days.

Conception depends therefore upon the occurrence of the sexual act at the time of ovulation or just before or just after its occurrence; this potential time of conception constituting the fertile period of woman. Knaus limits the period to five days, i.e. the day of ovulation "plus three days before it and one day after it."¹ Ogino defines it as eight days, i.e. the period of ovulation, constituting the twelfth to the sixteenth days preceding the commencement of menstruation, plus the three preceding days and the following day.

The whole problem of controlling conception, according to the Ogino-Knaus method, depends upon ascertaining correctly and in advance the period of ovulation. It is here that the difficulty arises; a difficulty caused and intensified by the variations in the length of the menstrual

¹ Hermann Knaus, *Periodic Fertility and Sterility in Woman: A Natural Method of Birth Control*, Maudrich, Vienna, 1934, p. 90.

cycle. In certain females the intervals which elapse between successive menstruations are extremely regular, in others these intervals are irregular, in some they are erratic.

The first thing the woman must do is to establish the length and degree of regularity of her menstrual cycle. To this end she must record carefully the length of each cycle (the interval between the commencing days of two successive menstruations) over a period of at least six months. Such a record will show whether she is regular or irregular, and, if the latter, the extent of the irregularity. Having secured this information it is a simple matter to ascertain the period of sterility. It merely calls for careful reckoning with the aid of a calendar. The procedure is to count backwards in the menstrual cycle so as to arrive at the period of fertility in relation to this cycle.

My own view is that it may be well to err, if at all, on the safe side and allow a potential conception period of eleven days all told. Thus, in my manual dealing specifically and exhaustively with the "safe period,"² I have stated: "It is advisable in practice to allow two other additional days before, and one other additional day after, the ovulation period, to take care of all possible fluctuations. As an example, take the case of a woman who has kept a record of her menstrual periods and finds she has a regular cycle of twenty-seven days. Her next menstruation is due to commence, say, on July 3rd and to end on July 29th. By counting backwards in the

² *Practical Birth Control by Nature's Method*, Cassell

cycle from the twelfth to the sixteenth day we arrive at a period of ovulation covering July 14th to 18th. Now to this period add five days before and one day after, which will give a total 'danger period' from July 9th to July 19th. These days are the ones on which intercourse should be avoided. The case of the female whose menstrual cycle fluctuates is rather different. Suppose, for instance, the lengths vary between twenty-seven and thirty days. In a twenty-seven day cycle, with menstruation commencing on July 3rd, the 'danger period' is, as we have seen, from July 9th to 19th. In a thirty day cycle this 'danger period' is from July 12th to 22nd. Therefore the 'danger period' of any woman whose cycle fluctuates between twenty-seven and thirty days will be July 9th to 22nd, or, ignoring any specific month and date, from the seventh day to the twenty-second day in any menstrual cycle."

In all cases of erratic menstruation, i.e. where the cycles fluctuate to such an extent that there appears to be no systematic variation at all, it is, of course, impossible to predict when the next menstrual period will commence and so calculate the time of ovulation, ergo, no reliance can be placed upon the "safe period." Further, where any variations are observed in cycles which have been regular, until the return to normalcy, a mechanical contraceptive should, wherever possible, be used by either the husband or wife, instead of, or in conjunction with, restriction of intercourse to a calculated "safe period," and as a substitute for, or in addition to, any chemical contraceptive in use. The employment of a mechanical contraceptive (wherever religious principles do not inter-

vene) is also indicated during the months when data concerning the length and regularity of a menstrual cycle are being procured.

Unfortunately menstruation can never be looked upon as a *stable* thing. There are so many factors, physiological, pathological, and environmental, which may conceivably affect the menstrual cycle. Thus serious illness, mental disturbance, pregnancy, parturition, a radical change of climate, or even an alteration in one's way of living may upset its regularity, with the result that the "safe period," as a practical means of controlling conception, becomes temporarily or permanently unreliable. Also the determination of the degree of menstrual regularity, simple as it is, appears to present difficulties to certain women; while in many other cases careless recording leads to errors in calculation. Finally, not to be overlooked is the fact that many husbands may be unwilling in some cases and find it difficult in others to adjust their sexual appetites to the vagaries of menstruation interpreted in calendrical terms.

Summed up, one may safely say that the "safe period" has much to commend it as an additional or auxiliary birth control method. It has also many points in its favour as applicable specifically to the first few weeks of marriage, again preferably in a strictly *supplementary* sense. It is obviously well worth adoption in those cases where the religious principles of either the husband or the wife prevent the use of contraceptives. But in any instance where, at all costs, pregnancy is contra-indicated, *it should never be relied upon alone.*

II FRIGIDITY AND OTHER "NATURAL" METHODS

There is a popular notion that by deliberately avoiding any passionate display of love, and particularly orgasm, the woman can avoid conception. It is true that where the female's orgasm coincides with that of the male the likelihood of conception occurring is increased; it is true that orgasm with the accompanying dilation of the os may facilitate the entry into the uterus of the spermatozoa, but it is false and dangerous reasoning to infer from these premises that the deliberate avoidance of orgasm will actually *prevent conception*. It will do no such thing. Sooner or later where reliance is placed on this method, pregnancy is going to result.

Little more reliable is the practice, at one time widespread but now falling into disuse in all but the peasant class, of prolonged nursing and suckling of a child. It seems to have been successful in some cases, in others it has failed signally. One must not overlook the fact that the failure to conceive during the period of lactation may have been due to some other overlooked cause. At any rate the failures where the prolongation of suckling has been tried are sufficiently numerous to cause anyone wishing to avoid another pregnancy to select some other method.

The region of the cervical opening (which leads directly into the womb) is the danger zone so far as conception is concerned, a fact which has been amply demonstrated by Huehner, Meaker, and other biologists and gynaecologists. The nearer to the cervical os the semen is ejaculated the greater are the possibilities of impregnation following intercourse; conversely the further away from

the os the semen is discharged the less risk is there of conception ensuing. In view of these facts, it is obvious that any position in coitus where the ejaculate is directed toward the anterior section of the vagina, and where, additionally, because of this position, the semen tends by gravitation to drain away from the region of the cervix, lessens very considerably the likelihood of the female being impregnated. In recent years the connexion between coital technique and conception has been given increasing attention, and certain unorthodox positions have received recommendation as being anti-conceptual or the reverse. Much depends, however, upon the position of the womb. In any case of malposition, and, according to Curtis, "at least one woman in every half-dozen has a uterus which is definitely out of its natural position,"³ the adoption of an attitude calculated to favour contraception in a normal woman might easily facilitate conception where the uterus is in an abnormal position. It is therefore advisable for any married couple wishing to practise unorthodox methods of intercourse as anti-conceptual measures to first consult a gynæcologist, especially as, in many instances, owing to physiological abnormalities or pathological conditions of the vagina, there are risks to the woman attending any method which involves the male organ being directed against the lower section of the vaginal wall. Finally, in no case can an unorthodox attitude, in itself, be considered reliable as a contraceptive method—it should, in every instance, be adopted in conjunction with the use of some mechanical or chemical contraceptive.

³ Arthur Hale Curtis, *A Textbook of Gynecology*, Saunders, Philadelphia, p. 211.

The practice among peasant women in many countries of sitting erect in bed immediately after coitus and coughing violently, with or without hand manipulation of the abdomen, though similarly valueless still retains a good deal of popularity. This popularity was and is probably due in large measure to its persistent oral recommendation by one woman to another; and also as a result of its mention in some of the earlier popular books and tracts dealing with birth control, as a contraceptive method widely adopted among the poorer classes.

Abstinence, despite its endorsement by the theologians and moralists generally, is rarely practicable in the married state, whatever arguments are brought forward in its favour as applicable to celibates. Then, too, where the married *are* willing to abstain from intercourse—such an *unnatural* procedure in the early and most fertile years of married life is definitely injurious, often inducing an anxiety-neurosis with its concomitant physical ills. Celibacy, where one can avoid the other sex is one thing; where one is in continual personal contact with someone who arouses voluptuous desire it is distinctly another, and the continuance of such a state must be physiologically harmful. The only indications for abstinence would be where the woman was a subject for Cæsarean operation, or the victim of pernicious vomiting in pregnancy; though here again a more sensible method would be therapeutic abortion followed by salpingectomy.

A Japanese method known as *Shimoyu* consists in removing the semen from the vagina digitally *immediately* after intercourse, employing for this purpose a thin paper "serviette," or a strip of absorbent cotton, wrapped around

the finger. Sometimes, as an additional preventive, the "wrapped" finger is dipped into an antiseptic solution. Manifestly, such a method is unreliable, as it is quite impossible to be certain that the vagina is thoroughly emptied. Moreover, where there has been ejaculation through the os into the cervical canal or uterus, the failure of any such attempt at removal of the semen is obvious. Actually, this method was originated by Japanese prostitutes, not for any contraceptive purpose, but as a means of avoiding the contraction of venereal disease.

Analogous to this Japanese method is the "washing-out" process, in which soap-suds are applied thoroughly to the vagina and cervix with the fingers; a procedure sometimes employed as an emergency method where a condom has burst, or where *coitus interruptus* has failed and a douche is not practicable.

III MECHANICAL METHODS

Of all mechanical methods used by women the most widely employed is the plug or sponge. It is the oldest form of contraception used by the female, being advocated by Place in 1823 in his "scandalous handbills."

Modern sponges are made of rubber in various sizes and shapes with strings attached to facilitate removal: these rubber sponges are less expensive than the natural marine article and can be sterilized and kept cleaner. The sponge is first soaked in a solution of boric acid or medicated oil and then pushed into the vagina until it completely covers the os. Other materials can be used instead of sponge: a plug of cotton-wool or silk or even a handkerchief rolled into a ball. In the booklet issued

by the Malthusian League is advocated the employment of a cotton-wool plug dipped into a mixture consisting of half an ounce of boric acid powder incorporated with half a pound of vaseline. The sponge or plug should be left in position *until the following morning*, and as an additional safe-guard a douche may be used before removal.

Vinegar is often recommended for soaking the sponge, but its irritant effect on the male organ is sometimes unpleasant for both parties.

The cost of this method, if an old handkerchief or a plug of cotton-wool is used, is infinitesimal. Even if a sponge is preferred the cost is still small.

The virtues of the sponge or plug lie in its cheapness, in the fact that it is always available at a moment's notice, and that its insertion can be successfully accomplished by anyone. On the other hand it is important that the sponge or plug should be big enough, and yet not too big, a matter of some niceness. Often it is not bulky enough completely to occlude the vagina, in which case it fails; or it is so large as to be uncomfortable, or to interfere with sexual pleasure. Dr Marie Stopes recommends "a sponge soaked in cooking oil," as "a fool-proof method if the sponge is the right size and shape"⁴

All things considered, the sponge or plug (1) soaked in olive oil or a spermicidal solution, or (2) anointed with contraceptive jelly, is perhaps the best of all methods

⁴ See Marie Carmichael Stopes, *Contraception: Its Theory, History and Practice: A Manual for the Medical and Legal Professions*. Third edition, London

available when a rubber pessary is inadmissible, as where the cervix is abnormal or damaged. But it is always unreliable and very often useless in any case of retroverted uterus, as the plug or sponge is almost certain to be pushed into the posterior fornix.

The so-called paper pessary used in Japan by prostitutes of all classes, is allied to the plug, but is not nearly so satisfactory. Soft toilet paper is used. A piece sufficiently large to cover the external os is pushed into the vagina. If the paper is too thick or too much of it is used, sexual satisfaction is seriously interfered with; if the paper used is insufficient in quantity or of *too thin* a texture, it will surely fail to prevent the emitted semen entering the uterus. The method really ranks as an emergency one. It is most unreliable even in cases where indications would appear to be favourable: for any woman with a gaping os through childbirth, it affords the smallest possible degree of protection.

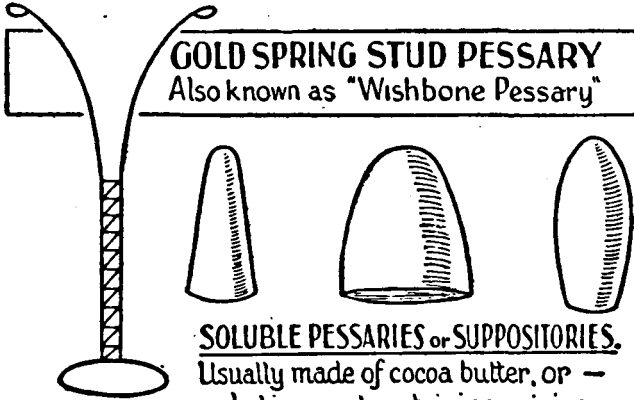
In recent years rubber pessaries have achieved increasing popularity, mainly through their recommendation in various books and by the clinics. There is the vaginal occlusive diaphragm, or true pessary, which stretches from side to side of the vagina, thus shutting off completely the external os; and the smaller cervical cap, which sits snugly on the cervix itself. Both types have their enthusiastic devotees, both have been claimed to reach the acme of efficiency.

The original diaphragm is the "Mensinga" or "Dutch" pessary, first introduced by Dr Mensinga in 1883. At that time it consisted of a piece of soft sheet rubber stretched over a hard rubber ring, but later a piece of



RUBBER SPONGES

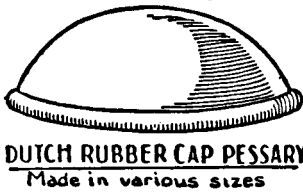
with strings attached for removal.



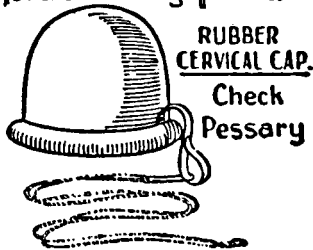
GOLD SPRING STUD PESSARY
Also known as "Wishbone Pessary"

SOLUBLE PESSARIES or SUPPOSITORIES.

Usually made of cocoa butter, or — gelatine, and containing quinine.



DUTCH RUBBER CAP PESSARY
Made in various sizes



RUBBER CERVICAL CAP.

Check Pessary

spring steel was substituted for the rubber ring to give greater flexion and adjustability. This vaginal pessary has been used in Holland for many years and has received Dr Aletta Jacobs's enthusiastic recommendation. In recent years various modifications of the original "Mensinga" pessary have been used, though all depend for their success on shutting off from the danger zone the upper part of the vaginal passage. The "Ramses" pessary differs from the "Mensinga" in having a coiled or spiral spring in place of the flat watch-spring, and is made of amber-coloured virgin rubber with a rather high dome which can be "rolled" round the base before the pessary is actually inserted. This modification of the "Mensinga" pessary was introduced to meet the demand for a spring that would retain its circular position. It is, however, a debatable point whether the slight advantage secured compensates for its disadvantages. Its greater pliability renders it more difficult to insert correctly, and when inserted, unless extreme care is taken, it is highly probable that the cervix will not be completely segregated. Dr Norman Haire says "it is unreliable." On the other hand the American Birth Control League use it extensively and highly recommend it.

Another well-known and highly recommended diaphragm is the "Dumas" pessary, made of one piece of thick firm solid rubber devoid of springs or metal of any kind. Its employment is indicated where vaginal conditions preclude the use of the "Dutch" pessary or the cervical cap, and it is perhaps the most suitable pessary for use in cases of constipation.

All these pessaries are made in different sizes to suit the variations in the vagina, the "Haire" pessary for instance, being made in eighteen sizes. There are, too, specially modified forms of the "Matrisalus" type, which resemble somewhat the hard rubber pessaries used in gynæcology, for cases of cervical displacements or abnormalities, in certain cases of *prolapsus uteri* (falling of the womb) and where the perineum is badly torn, but these can only be of interest to and be selected by a medical man.

The cost of the diaphragm pessary ranges from 3s. to 7s. 6d.,⁵ which is really very low when one considers that it will prove an effective contraceptive over a period of at least a year and possibly two or three years. But to ensure long life it must be properly cared for. After removal from the vagina, and washing and drying with talc powder, the pessary should be stored in a small box and kept away from heat, until again required. Before use it should always be carefully examined. When the wire begins to show or the rubber develops cracks or fissures the pessary should be discarded and a new one substituted.

The consensus of evidence is in favour of the hemispherical diaphragm with the flat watch-spring of the type recommended by Dr Norman Haire. This pessary, or one of a very similar type, is recommended by Mrs Hornibrook and by Mr Michael Fielding, as preferable to any other. It is in use at many clinics. Both the "Mensinga" and the "Ramsey" pessaries are used by

⁵ See note on page 47.

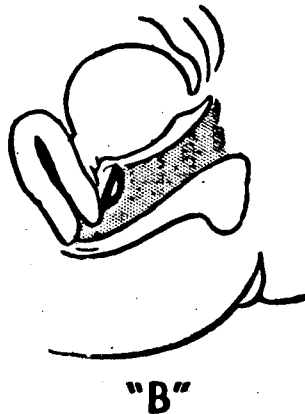
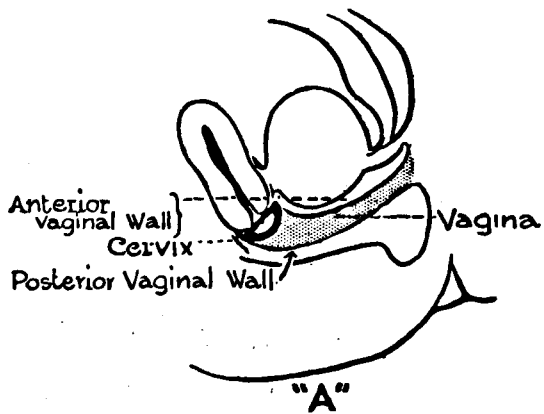
the Clinical Research Department of the American Birth Control League. In all cases the rubber pessary is used in conjunction with the chemical contraceptive, but to this I shall refer at length in another section.

The pessary in the first instance must be fitted by a doctor, or otherwise by someone with medical knowledge and skill. Only as a result of an examination can the doctor decide whether or not the pessary is likely to give good results. Where there is a retroverted uterus, or *prolapsus uteri*, conditions by no means rare, the pessary will prove but a poor security, even if it can be used at all.

By actual test the most suitable size is decided upon, in all cases this being the largest pessary that can be worn without discomfort and which does not unduly dilate the vaginal wall. The next step is to teach the patient to insert the pessary herself, for obviously she cannot be running to the clinic or to a doctor every time she wishes to use it.

No woman should ever attempt to place the pessary in position while standing or sitting. She should either crouch down on her heels with the knees well bent, or lie flat on her back, face upward, thighs opened to the widest possible extent, legs bent from the hips, and the knees also bent. Then, taking the pessary, previously smeared with non-greasy⁶ contraceptive jelly, between the thumb and first finger of the right hand, convex side

⁶ Grease rots the rubber and therefore any greasy jelly, cocoa-butter, boracic ointment or vaseline should be avoided.



IN DIAGRAM "A" IS SHOWN THE CORRECT POSITION WHICH THE RUBBER DIAPHRAGM PESSARY SHOULD ASSUME IN THE VAGINA. IT WILL BE SEEN THAT THE CERVIX IS COMPLETELY COVERED AND PROTECTED BY THE PESSARY, THE BACK RIM OF WHICH PASSES AGAINST THE POSTERIOR VAGINAL WALL. IN "B" THE PESSARY IS WRONGLY INSERTED IN THE ANTERIOR FORNIX, LEAVING THE CERVIX UNCOVERED AND THE ENTRANCE TO THE WOMB ENTIRELY UNPROTECTED.

uppermost,⁷ and squeezing the rim gently, push the appliance into the vagina; releasing the rim, continue with the forefinger the pushing process downwards and backwards to the extremity of the vaginal canal, finally gently forcing the anterior rim upward until it presses against the vaginal wall behind the symphysis pubis. It is essential that the rim of the pessary should pass behind the cervix, otherwise it may lodge in the anterior fornix, leaving the os entirely unprotected; in this position the pessary is useless. The test as to correctness of position is in being able to feel the cervix through the soft rubber dome of the pessary. As it is difficult if not impossible to feel the cervix while in the supine position, the woman should raise her back from its horizontal posture and resting on one hand so that the trunk assumes an angle of 45°, perform the necessary exploration with the index finger of the other hand, feeling well down and backwards, when the cervix should be easily located. This procedure is exceedingly important, as in no other way can the wearer be *certain that the cervix is covered*. If the pessary is correctly placed and is the right size it should cause no discomfort whatever; in fact the wearer should be quite unconscious of its presence.

The removal of the pessary is not a difficult matter. In a crouching position, the forefinger is inserted in the vagina, hooked over the rim of the pessary and the

⁷ Actually, so far as its contraceptive value is concerned, it is of little moment which side of the pessary is uppermost, but its removal is facilitated when the convex side is uppermost. There is a risk, particularly where the woman is inexperienced, of the pessary being accidentally turned in the process of insertion, hence the advisability of using the jelly on both sides of the pessary.

appliance pulled out. Before removal it is well to douche and, as an additional safeguard, again after removal. In most cases it is more convenient to leave the pessary in position until the following morning; but there is no reason why douching and removal should not take place at once. The desirability of early removal of a pessary is one of those instances where a douche immediately after coitus is necessary; other cases are where a condom has been employed and has slipped off or burst; where *coitus interruptus*, without any additional safeguard, has been relied upon.

In consequence of the many recent improvements both in the construction and in the technique of fitting and using, most of the objections to and disadvantages of the diaphragm pessary have been overcome. No longer is it necessary for the woman to wear a pessary too large for her vagina; no longer does the rigidity of the pessary or its clumsiness interfere in any way with the sex act.

Theoretically the occlusive diaphragm pessary is perfect. It has been asserted by several authorities that the average woman finds the insertion and removal of this pessary can be accomplished with ease; that the technique peculiar to the rubber diaphragm involves no difficulties whatever. These optimistic opinions, however, are by no means borne out by Mrs Florence, the Honorary Secretary of the Cambridge Women's Welfare Association, who as a result of the experience gained at the Clinic run by the Association says that, "in most cases not only the patient but the doctor found difficulty in adjusting it,"

and that women are "never certain when it is properly placed." *

One can well understand why this is so. Apart from the fact that many women are exceedingly difficult to fit properly, one is up against the fallibility of the average human being. I have indicated in another chapter the fact that the failure of birth control methods is due not so much to the actual deficiencies of the methods themselves as to the errors or omissions on the part of the persons employing them. Thus despite the fact that this diaphragm pessary is probably the most reliable contraceptive available to the average woman; despite too its seeming simplicity, it is by no means fool-proof. Many women seem quite unable to master the technique of insertion; many are too careless or too indolent to carry out the method in all its details continuously—sooner or later at one point or another they boggle the thing.

Then again there is always the possibility of that *bête noire*, constipation intervening. It is undeniable that any woman suffering from constipation will find difficulty in using an occlusive pessary of any kind, the rectum in its distended state protruding into the vagina to such an extent that it is often quite impossible to get the pessary in place, and even in the event of this difficulty being surmounted, quite impossible to retain it in the correct position. When one considers that by far the bigger percentage of women do most certainly suffer from this

* Lella Secor Florence, *Birth Control on Trial*, Allen & Unwin, London

affliction, it will be realized in what an enormous number of cases either is the use of the pessary impossible or attended with difficulties and risks. There are, too, other conditions, common enough in women, where its effectiveness is seriously impaired. For instance, in all uterine displacements, in cystocele and rectocele, in cases where the perineum is torn, or in *prolapsus uteri* (falling of the womb), it is difficult if not impossible to fit the patient successfully. It is for this reason that women who have brought into the world a plurality of children are likely to continue their propagation—it is almost impossible, owing to the torn perineum, to adopt any contraceptive measure; they must perforce rely upon such steps as the male can or will adopt.

I have already mentioned the necessity of obtaining the correct size of pessary. If it is too small there is risk of failure; if it is too large there may be some slight discomfort and possibly some stretching of the vaginal opening. This stretching has been made much of by opponents of the occlusive type of diaphragm pessary, but the risk has, I think, been greatly exaggerated. Dr Norman Haire, in a letter to the writer, says in reference to the "Mensinga" pessary: "*This method is the best one we have at present.* If it is properly fitted, it should not stretch the vagina sufficiently to have any harmful effects. Some of the doctors who use it use sizes which are much too large, but if one chooses the right size it does not stretch the vagina unduly at all."

It is further necessary, even when the woman has completely mastered the technique of insertion, that she

should occasionally submit to re-examination in order to ensure the continued correct fitting of the pessary. The size that fits perfectly at one time may be too small at a later period: thus after the first few months of married life the pessary may become slack and insecure; after the first parturition the probability is that it will not fit at all.

Dr Leonhardt's "Secura" pessary, a balloon of thin rubber which occludes the vaginal canal, used in conjunction with a greasy chemical contraceptive containing boric acid and quinine acts in very much the same way as the diaphragm pessaries; its insertion and subsequent inflation call for the use of a special instrument. Somewhat, though rather crudely, analogous to this method is the old and simple idea of using a child's ordinary rubber playing ball.

The rubber occlusive cervical cap, often called the "French" cap, in recent years has been strongly recommended by Dr Marie Stopes⁹ and other English and American authorities. It is a dome-shaped cap of thin rubber with a thick rim, and is shaped something like a man's miniature bowler hat. Provided the right size is selected—it is made in several sizes—it should fit snugly on the cervix, being supposed to be held in position mainly by

⁹ Dr Marie Stopes says: "I have no hesitation in confirming my 1918 statement that the right type of occlusive cap, if properly fitted and used correctly, is the best available method of contraception for *normal and healthy* women." (Dr. Stopes' italics.) Marie Carmichael Stopes, *Contraception: Its Theory, History and Practice*. Third edition, London

suction¹⁰ and partly by the rubber rim, and in this position it is claimed to prevent any seminal fluid from entering the uterus. It is also said to cause the minimum amount of interference with sexual intercourse. There are several varieties on the market: they differ mainly in the height of the dome. One type known as the "Mizpah" is in two sections, the thin rubber cap being detachable from the rim.

Most of the occlusive cervical caps are obtainable with or without a string attachment for the facilitation of removal. This string or tag is quite unnecessary and is apt to become a nuisance—it is advisable to select a cap without any attachment or to remove this attachment before use. I have already mentioned that these cervical caps are made in different sizes. Women vary in cervical dimensions, not only as regards race (e.g., negroes have exceptionally large cervixes) but also individually within the same race. To ensure the correct size being chosen the fitting must be done by someone

¹⁰ There are the strongest grounds for supposing that Dr. Norman Haire, in ridiculing this idea of the cap being held in position by suction, is sound in his argument. He says: "A great deal has been written about the action of suction with regard to cervical pessaries, but I believe that it is all erroneous. You probably played in childhood with a leather sucker to which you attached a string. If this was moistened and pressed fast to a stone or any other heavy object, but forming a vacuum between the sucker and that object, you could lift the latter. You can do the same with a leather sucker on the palm of your hand as long as you hold your hand stiff. But now flex your hand, the vacuum is destroyed, and the sucker falls off. So with the cervix. If ever the cap is attached to the cervix by suction, the movements of coitus almost invariably destroy the vacuum so that the small cap is extremely likely to fall off or be knocked off into the vagina." Norman Haire in *The Comparative Value of Current Contraceptive Methods*.

with medical knowledge. The method of insertion, when once the correct size has been secured, is to squat on the heels and holding the cap (smeared with contraceptive jelly or other suitable lubricant¹¹) in a horizontal position, the rim being grasped in the fingers of the right hand with the dome downwards, place it into the vagina, pushing it gently downward and backward until it fits snugly on the cervix, which can be felt through the thin rubber dome. The cap may be inserted any time before intercourse and should be left in position until the following morning, when its removal must be preceded by douching. Now, reading these instructions, the thing sounds simple enough in all conscience, but those who have used this particular contraceptive have a different story to tell. In the first place a perfect fit is essential and this in itself is difficult to secure. The cervix, composed of mucous membrane, is normally moist and slimy and given these conditions it is impossible to get any appliance to fit tightly like "a glove on a finger." Consequently the cap is extremely likely to slip even after the most careful and expert fitting, and it is easily dislodged by the penis in the act of copulation. Again, with few exceptions, its placing in position even after a demonstration by a nurse, is a matter of some difficulty; in many cases, it is not only difficult, it is impossible. For instance, where the cervix is torn, scarred or enlarged through parturition, or is of an abnormal shape or size, no cervical cap can be properly fitted, or if fitted can be retained in the requisite position. Then too, as with the

¹¹ Care must be taken not to use too much lubricant or it will not be possible to retain the cap in position.

"Dutch" pessary, it is impracticable for any woman when suffering from constipation, which rules out its use for the majority of women most of the time and for all on occasion. Finally, even where the shape and condition of the cervix are favourable, the woman may experience great difficulty in placing the cap in position. Her fingers may be too short, either through their own diminutiveness or through the abnormal length of the vaginal canal; or she may be so corpulent that its correct insertion is quite impossible. Apropos of the difficulty which is experienced, even in normal circumstances, by so many women in correctly inserting the cap, I am informed by a nurse in charge of a clinic that although all the women who come for advice are shown how to insert the appliance, *many of these women visit the clinic every time they require their cervical caps re-inserting.*

In any case where the cervix is well-shaped and in a healthy state, thus ensuring a satisfactory fit, and the woman can master the technique of insertion, the cervical cap undoubtedly proves an efficient contraceptive appliance. Its use is particularly indicated in cases where a diaphragm cannot be worn successfully, i.e., cystocele, rectocele, or any flabby or pathological state of the vaginal walls.

Whenever a rubber contraceptive is used, whether it be a vaginal pessary or a cervical cap, it should be removed every day, washed in an antiseptic solution, dried and re-inserted, or stored away until again required. Apart from the need for this attention purely as a means of avoiding local inflammation, there is, where a pessary or cap is worn continuously, the risk of its

displacement, particularly in the case of the working woman who spends a good deal of time on her feet. The cervical cap is much more likely to be dislodged than is the "Haire" or "Mensinga" vaginal pessary. Indeed, any cervical cap should, *in every circumstance*, be removed, or at least re-adjusted, daily.

These caps, considering their long life, are inexpensive. They cost from 3s. to 5s. each.¹² They are made in four sizes; sizes 1 and 2 being in most general use.

In employing a rubber contraceptive, whether it be a vaginal pessary or a cervical cap, a safe rule to follow is not to use the appliance if pain or discomfort is experienced.

It is advisable that the removal of the vaginal pessary or the cervical cap should be preceded by a douche or the insertion of an antiseptic jelly or ointment. Many failures are due to neglect of this precaution. In most cases the douche is to be recommended; but there are occasions when it is inconvenient or impossible, and here lactic-acid jelly or some other spermicide should be inserted *a few hours before removing* the pessary or cap, preferably as soon as possible after intercourse. In cases of emergency a piece of soap may be inserted.

Allied to the rubber cap is the metal or celluloid cervical cap, which is made in various forms, and each particular variety in a large number of sizes. This type of cap is more widely in use on the Continent than in England or America, and is greatly favoured by prostitutes in Germany, not only for contraceptive purposes, but also as a preventive of cervical gonorrhœa.

¹² See note on page 47.

These metal caps, usually constructed of very thin silver, silver alloy or aluminium, are available in a large number of sizes. An *exact* fit is essential, and the selection and fitting can only be done by a medical man. Once fitted, the cap is usually left in position until the commencement of menstruation, when it can be removed by the woman herself. But for its replacement she must again visit her physician. This one point is in itself sufficient to restrict the use of the appliance considerably. Apart from the fact that it is only indicated where the cervix is perfectly normal and well-shaped, the method is obviously a most unsatisfactory one. Unless the fit is of the correctness of a kid glove, the tiny spermatozoa will enter the canal; and even where a perfect fit is secured the cap is easily dislodgable, not only by the movements of coitus, but by the woman herself during the day. There is the risk, too, common to all metal appliances, of inflammation and possibly septic conditions resulting from its use.

One of the difficulties in connection with all metal caps (and it applies in a lesser degree to thick, hard, rubber caps) is caused, not through any inherent fault of the cap itself, but owing to the fact that cervical conditions are not always the same in the same woman, with the result that there is no guarantee that the perfectly fitting cap of to-day will not be the badly fitting cap of next week or even of tomorrow. It is because of these variations in cervical and vaginal conditions that metal caps so often cause abrasions and soreness; and, where they are retained in position for any length of time, induce cervical or vaginal discharges.

Then there is the question of expense. The prime cost of the cap is small, but there is the fee for fitting and insertion (as in no circumstance can the woman fit herself or insert the cap), and there are continual return visits for examination and re-insertion.

What is claimed to be a huge improvement on the metal cap is the stud pessary. These stud pessaries, too, are constructed of metal for the most part—some are made of solid rubber. Mostly, however, they are of gold or silver, and are pretty expensive. The simpler form, which is designed to cover the cervix in the manner of the metal cap and to block the cervical canal, is shaped like a man's collar-stud. It can be fixed only, and is usually removed, by a medical man. Like the simpler metal cap it remains, or is supposed to remain, in position during the intervals between the catamenial flow. Obviously so exact must be the fit that only a perfectly shaped, small and healthy cervix will take this appliance. Obviously, too, however perfect the fit it is liable to displacement; it is extremely doubtful if complete occlusion is possible; it is liable to induce inflammatory conditions or irritations, with copious discharges and probably dysmenorrhœa (painful menstruation). It is not to be recommended.

A more satisfactory appliance is an extension of this type of pessary, generally known as the intra-uterine pessary. There are on the market various types of this appliance—they have been much used in Germany, and I believe in America. The most popular, the most praised, the most blamed, and incidentally the most expensive is the "wishbone" type of pessary (so-named

from its shape, which resembles that of the forked bone or merrythought of a fowl's breast), of which there are several varieties. This is usually made of gold and platinum. It consists of a disc or stud mounted on a central hollow stem and terminating in two diverging arms. The stud covers the cervical os, the stem, some two inches long, goes through the cervical canal, and the two arms penetrate the uterus where they spring apart and hold the apparatus in position. It overcomes the main defect connected with all other intra-uterine and intra-cervical studs in that it can be left in position for long periods, not only because of its non-liability to be dislodged, but also because the hollow stem allows the menstrual or other discharge to escape. Admittedly it may and often does allow spermatozoa to enter the uterus; but in the event of impregnation the presence of the pessary often induces early or immediate abortion. It would appear that the appliance was originally used by its introducer as a means of facilitating conception in cases of difficulty. Its use as a contraceptive, or, strictly speaking, as an abortifacient, came later. Opinions as to its value vary greatly. Dr May Halton of New York, who reported 720 cases without any bad results occurring, considered the appliance should not be left in position for more than two months at a stretch if pregnancy or other undesirable results were to be avoided. Dr R. H. Vercoe advocates its use "in cases where temporary sterilization is advisable." On the other hand, Dr Norman Haire considers it "a very dangerous instrument" and "quite unreliable as a contraceptive." It has caused, he says, "pyometra, pyosalpinx, and even fatal peritonitis."

The experience of the American Birth Control League bears out Dr Norman Haire's views. In many cases where this type of pessary was used pregnancy resulted; in others, infections and early (often septic) abortions were evident. It would appear to be definitely insecure and hazardous.

In any case its use is necessarily restricted to the ranks of the well-to-do: the cost of a pessary of the "wishbone" type and its inserting ranging from two to five guineas according to the quality of the apparatus, and the fee charged by the doctor. And the expense attached to its use is a continual one. It can only be inserted by a medical man with the aid of a speculum. Its removal, too, and its re-insertion, call for the same skilled attention, and through its liability to cause pathological conditions frequent examinations and attention are necessary. Its one virtue, which has commended it to so many wealthy women of leisure, is that its adoption does away with the continual bother of insertion and removal which cause so much annoyance in the case of the ordinary rubber pessary.

The objection to the employment of intra-uterine pessaries, apart from dangers connected with such appliances as the "wishbone" type of pessary, are that they all form a means of communication between the vagina and the womb, thus facilitating the entry into the uterus of infective organisms, with consequent liability to endometritis, peritonitis and inflammation of the ovaries. Dr Ernst Gräfenberg, aware of these difficulties and dangers, sought to devise a means whereby this communication with the cervical canal and the vagina

could be avoided. First, he experimented with a silkworm-gut ring, but the difficulties experienced in locating the gut ring when its removal became necessary proving an obstacle, he eventually substituted for the silkworm-gut a coiled flexible ring of fine silver or gold wire. This ring is made in a number of different sizes, and it is of great importance that the correct size should be used—those instances of expulsion from the uterus have occurred when a ring has been inserted either of a size so small that it has slipped into the cervical canal or so large that uterine contractions induced by irritation have caused its expulsion. Owing to the extreme pliability of the spiral ring it can be bent into oval form while it is passed through the cervical canal, regaining its correct shape when it reaches the uterine cavity.

The presence of the ring in the uterus is believed to act either by preventing fertilization of the ovum or preventing the embedding of the ovum if fertilized; and thus is an effective means of preventing impregnation. Many experiments on the part of the inventor and others are claimed to have proved most successful.

The "Gräfenberg" ring has its disadvantages. Many have been cited: some real, some doubtful, some fictitious. One objection is that the ring may be lost without the wearer's knowledge: this, it is admitted, has occurred in many cases, due probably to the use of a ring of unsuitable size. The cancer bogey has been dragged out in its disfavour, but it is probably without foundation. Perhaps the most serious drawback is the fact that only a medical man skilled in gynæcology can insert the ring. The woman is placed in the

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It is of vital importance that the "Gräfenberg" ring should not be inserted into a pregnant uterus, as this would probably necessitate the pregnancy being ter-

minated—a proceeding which in some countries might involve legal difficulties. To avoid any such possibility Dr Norman Haire recommends that insertion should only take place during the menstrual period.

The need for examination of the vagina and cervix for signs of disease has been mentioned. The ring should never be used until any unhealthy conditions have been removed. In cases of gonorrhœa, the presence of the ring would serve to aggravate the disease; where menorrhagia (excessive menstruation) or metrorrhagia (hæmorrhage due to some cause other than menstruation) is present it *may* cause a similar aggravation. Thus not only is the ring unavailable for the considerable number of women suffering from pathological conditions of the uterus, cervix and vagina; but the outbreak of vaginal discharge *after* insertion of the ring will probably necessitate its immediate removal.

For these reasons it would appear that this method is not one that is likely to be widely adopted. Moreover, early enthusiastic reports concerning the ring's reliability when used alone have not been confirmed by later experience, and it now seems advisable that a chemical method, such as a suppository, lactic acid jelly, or a tablet should be used by the female or a condom by the male as an auxiliary contraceptive measure when the ring is in position. Provided some such supplementary method is employed, the combination of ring and chemical would seem to afford a high degree of protection against impregnation.

In a great many cases of painful periods insertion of the "Gräfenberg" ring relieves the pain or even cures it altogether.

IV CHEMICAL METHODS

All chemical methods have for their object the destruction or removal of the spermatozoa after entry into the vagina.

The difficulty in connexion with a chemical contraceptive—it applies whatever the form—is to provide something which is sufficiently potent to kill the spermatozoa without at the same time injuring the cells of the vaginal and uterine walls.

There is, too, another point which is very generally overlooked; a point which Dr Somerville of Oxford discussed in the Contraceptive Session of the Fifth International Neo-Malthusian and Birth Control Conference: the presence in the genital tract of dead organic matter destroys the germicidal effects of any chemical antiseptic of a strength that can be safely introduced into the vagina. Dr Somerville definitely stated that as a result of his investigations “disinfection, so far as spermatozoa are concerned, of the vaginal tract, is not to be done by chemicals.”

Actually the virtue of most chemical contraceptives rests almost entirely in their mechanical action in washing-out the spermatozoa in the case of douches, and in hindering or destroying their motility in the case of suppositories or ointments or jellies. The only exception is where a sufficiently acid condition of the vagina can be induced.

The most common of all chemical methods and the one which has been in use for the longest period, is the

douche. It is, as I have already indicated, widely recommended as an additional safeguard *after* using a rubber or metal pessary, or a plug or sponge, but many women rely upon the douche alone. The avowed object of this syringing with a chemical contraceptive is twofold: to kill the spermatozoa by means of the chemical employed, and to wash them away from the vagina by the mechanical process of douching itself. The supposedly double chance of preventing conception thus afforded finds favour with a considerable number of women. Additionally it is a method which has been widely advocated in books and pamphlets giving contraceptive information. It was recommended as an efficient and a reliable method as long ago as 1833 by Knowlton in his *Fruits of Philosophy*.

The chemicals employed are many. Vinegar is popular, so is boric acid, so too potassium permanganate, chinosol, lysol, citric acid, tartaric acid, sulphate of zinc, common salt, and ordinary soapy water. Cold, luke-warm and hot douches are all used. Actually water itself, if it reaches the spermatozoa, will destroy their motility; hot water will coagulate the semen. Of the chemicals, acids are the most effective, as an excessively acid condition in the vagina is often a contraceptive condition. Lactic acid, in a one-per-cent. solution; or vinegar (one dram in a pint of water) are most suitable. The douching may be accomplished with the aid of a fountain-syringe, well elevated so as to give a good pressure of water: the popular small hand bulb syringe is much less effective. Usually douching is done while in the sitting posture, but *the lying-down position is the*

better method. In the sitting or squatting posture so often adopted by women when douching, through the pressing together of the muscles, it is quite impossible for the water to penetrate completely the vagina.

Now if by this syringing process every nook and cranny of the vagina could be reached the method would be eminently successful in clearing out all the spermatozoa deposited there. But unfortunately it is quite impossible to do this. The spermatozoa, during coitus, become embedded in the folds of the vagina and when the sex act is completed and the vagina resumes normal conditions nothing that can be applied *afterwards* can possibly reach *all* the spermatozoa. Moreover, some may, and probably will, have already reached the cervical canal or possibly the uterus itself before the syringing can be attempted. And on occasion, where the semen is ejaculated through a gaping os directly into the uterus no douching of any kind will have the slightest effect.

For these reasons the douche is one of the most unreliable of popular contraceptive methods. In addition it has other disadvantages. In the first place it is a method which has many annoying features. To be in any way effective, douching must be done *immediately after intercourse, and it must be repeated after each coital act.* No woman wishes to get out of bed and start this business at a time when she is desirous of sleeping. Then again warm water, as often as not and particularly in the dwellings of the poor, is not available, causing the woman to rely on the cold douche,

which applied to the congested genital passages is not only decidedly unpleasant but may induce metritis (inflammation of the womb), peritonitis (inflammation of the membranous lining of the abdominal cavity) or oöphoritis (inflammation of one ovary or both ovaries).¹³

Regular douching tends to wash away the Doederlein's bacilli ordinarily present in the vagina which act protectively against infective organisms; even if it does not actually cause vaginal inflammation or cervicitis (inflammation of the cervix) through the employment of unsuitable or too powerful solutions (e.g. corrosive sublimate, carbolic acid).

Alone the douche cannot be recommended as a contraceptive method possessing any degree of reliability for the woman whose uterus is normal, or where orthodox methods of coitus are adopted. Where the semen, through deficiencies on the part of the male, through so-called abnormal coitus, or through retroversion or anteflexion of the uterus, is deposited some distance away from the external os, the douche will probably prove effective without any other method being employed, and doubtless its success in just such cases has contributed to its repute. It is valuable in combination with the use of vaginal pessaries and cervical caps, as already indicated, and in certain other cases.

¹³ There is one other reason why I am against the douche; a reason which I fear is almost universally overlooked. In country districts where the poorer people have to rely exclusively on shallow and often polluted wells for their water, and where sanitary conditions are still, even in these enlightened days, of the most primitive kind, *unboiled* water is unsuitable for use as a douche and rubber utensils cannot be kept free from the presence of pathogenic organisms.

The expense attached to this method is the primary cost of the syringe. There is no need to purchase an expensive and elaborate affair: various efficient types are available at prices ranging from 3s. 6d. to 12s. 6d.¹⁴

Next in popularity to the chemical douche is the soluble suppository (often erroneously described as soluble pessary); a form of contraceptive of which, I believe, enormous quantities are sold. Because its melting-point is that of the temperature of the human body cocoa-butter is almost universally employed as a medium through which the selected spermicide is conveyed into the vagina. The chemical favoured is usually quinine bisulphate, often in conjunction with salicylic acid. Chinosol, too, is widely used. More recently gelatine has been employed as a base for the quinine suppository with a view to doing away with the more objectionable features of cocoa-butter. But this form of suppository must be used while freshly made, and the melting-point of the gelatine is most uncertain. All these soluble suppositories are usually made in the form of cones and are easily inserted lying on the back and raising the knees or by squatting on the hocks. The cone should be pushed into the vagina as far as it will go. The next morning a douche is advisable.

The objects of the chemical suppository are primarily to cover the upper part of the vagina, and particularly the external os, with grease, and so present an effectual barrier to the entrance of semen into the cervical canal; and secondarily, according to the statements of its

¹⁴ See note on page 47.

advocates, to kill the spermatozoa with the quinine or other chemical content of the suppository. For years it has been supposed that quinine in itself is an efficient spermicide, but recent research has established the fact that this belief rests upon the most dubious foundation. There are strong grounds for assuming that it is the greasy base of the quinine suppository that renders the spermatozoa immobile and not any specific chemical action of the quinine itself.

The soluble suppository is rarely satisfactory, and for many reasons. Firstly and mainly it is not reliable when used *alone*—there is a very considerable proportion of failures, and this risk applies in all circumstances. It matters little what is the chemical content, if there is during coitus ejaculation directly into the uterus or into the cervical canal (which often occurs) the suppository is useless. For this one reason alone it is quite unsafe for all multiparæ, and for those with abnormally large cervixes; for all others it is a slender reed to lean upon. There are other disadvantages. To prove effective it has to be inserted so as to allow a certain definite interval between insertion and coitus; a procedure which bristles with obvious difficulties. Even when this difficulty has been overcome the suppository does not always melt, in which case it is useless; when it does melt it makes a mess of the bedclothes; it is sticky and oily and the cocoa-butter has an odour that fills both man and woman with disgust; it adheres to the sides of the vagina and is not easily removed; in many instances it is of too small a size and does not, in liquid form, provide sufficient covering for the upper part of the vagina and

the cervix. In some cases the quinine content has an irritating effect on the penis, and on occasion, through excessive lubrication, it interferes with the sex act itself. In warm weather and in hot countries it is often in semi-liquid form when its use is called for. But it is not expensive, the quinine, chinisol, and other types costing 2s. 6d. per dozen, and there is one famous brand obtainable at 1s. per dozen;¹⁵ it can be used by anyone above the level of a moron, and it is indisputably better than nothing.

Alone, no antiseptic ointment, whether quinine, boric acid or salicylic acid is reliable as a contraceptive. Its use is indicated only as an auxiliary where the condom, the rubber pessary or the plug is used.

Alum, because of its astringent properties, has long been used as a contraceptive;¹⁶ but apart from any other drawback, its regular use is not to be recommended. Boric acid and lactic acid in powder form are similarly used. Finely powdered the chemical selected is introduced to the vagina. It is, however, impossible to do this properly without the aid of a "blower," and even then, unless the powder is thickly deposited on the cervix it will prove of little avail. It is bound to fail a good deal oftener than it succeeds.

¹⁵ See note on page 47

¹⁶ There is a curious reference to the use of alum in the East in Sheikh Nefzawi's *Perfumed Garden: A Manual of Arabian Erotology*. The passage reads: "I will now deal with alum. This substance in powder, introduced into the vagina and sprinkled on the penis, is a contraceptive. It acts by drying and contracting the vagina. However, the frequent use of this substance should be avoided as it is apt to make the woman sterile."

Foam or effervescent tablets have been praised by, among others, Dr Robinson, the American writer on birth control and kindred topics. The idea of these tablets, made of tartaric acid, soda perborate or other effervescent base, in which is incorporated boric acid or chinosol, is that when introduced to the moistened vagina *immediately before intercourse* the sperm-killing gas which is given off will penetrate every chink and cranny of the vagina. But unfortunately this result is by no means assured. In many cases, through insufficient vaginal secretion, there is no effervescence at all; and through the enormous variation, not only as regards different women but in the same woman in different circumstances, the tablet dissolves on one occasion and not on another. And in all cases the protection is definitely limited as regards time: after an hour at the outside the "tablet" is useless—a point this of some importance to the woman who has no control over the time when intercourse takes place. Here again we have a contraceptive that to place such implicit faith in it as to rely upon its action alone would be foolish in the extreme.

The cost of these effervescent tablets ranges from 2s. 6d. to 5s. per dozen.¹⁷

The contraceptive jelly is a comparatively new introduction. It was designed to meet the objection lodged against soluble suppositories and effervescent tablets in that they often fail to dissolve and are therefore inert. Moreover, as it has been admitted that the action of the

¹⁷ See note on page 47.

soluble suppository usually depends more upon the thorough blocking of the cervical os with the grease or oil content than in the actual activity of the chemical incorporated, the jelly provides this obliteration more efficiently and ensures also a more thorough penetration of the vagina by the spermicide employed. Glycerine of starch, gelatine, tragacanth, or combinations of these are all used as bases for different jellies. A special, though quite inexpensive, apparatus is required for ensuring the proper introduction of the jelly into the vagina; the jelly itself usually being supplied in a collapsible tube to which, after removal of the screw-cap, a glass nozzle is attached, and a little of the jelly squeezed through the glass pipe into the vagina. Insertion is best accomplished in the lying-flat-on-back posture, and great care should be taken to ensure that the hands and the glass tube are perfectly clean. Insertion of the jelly should be done immediately before intercourse; a douche next morning is advisable to cleanse the vagina. The chemicals used are boric acid, quinine, chinisol and lactic acid. Dr Norman Haire considers lactic acid jelly (1 per cent.) made to his own formula¹⁸ and known as "Contraceptaline," to

¹⁸ The actual formula recommended by Dr Norman Haire (see *The Comparative Value of Current Contraceptive Methods*) is:—

Lactic acid 1 per cent.
Boric acid
Glycerine
Starch,

while that recommended by the Clinical Research Department of the American Birth Control League (see Dr James F. Cooper's *Technique of Contraception*) is:—

Glycerine
Starch

as glycerite of starch

Boric acid 4 per cent.
Lactic acid 1 per cent.

be the best chemical contraceptive of which he has had experience; and the Clinical Research Department of the American Birth Control League uses mostly this same jelly with the same proportion of lactic acid as in Dr Haire's formula.^{18a} It is, however, in combination with other methods, notably the rubber diaphragm pessary, that this lactic acid jelly is to be strongly recommended, and not as a measure to apply by itself.

The cost of contraceptive (lactic acid jelly), complete with apparatus for insertion, is about five shillings, and further supplies of the jelly cost half-a-crown per tube.¹⁹ The method is really an economical one, as, provided the jelly is used as directed, a tube lasts a considerable time. Many jellies, through lack of care in their preparation, or the inclusion of too big a proportion of glycerine, are unsatisfactory, and care should be taken to purchase a lactic acid jelly manufactured by a reliable firm. It is never advisable for anyone to attempt to mix the jelly at home, or to have it made up locally from a formula; jellies, soluble suppositories and foam tablets all call for scientific skill and special apparatus in their manufacture and mixing.

The injection of tincture of iodine into the uterus immediately after the cessation of menstruation is claimed to have proved successful as a contraceptive measure. It is, however, a dangerous method, as any liquid injected into the uterus is liable to go through the Fallopian tubes into the peritoneal cavity and cause peritonitis.

^{18a} See note 18, page 94.

¹⁹ See note on page 47.

To sum up, the chemical contraceptive, whatever precise form it takes, *so far as any spermaticidal effect is concerned*, may be (1) definitely dangerous, or (2) almost entirely ineffective, or (3) extremely uncertain owing to the vagaries of vaginal conditions. Home-made antiseptic douching solutions mostly come under class (1), and the majority of suppositories, jellies and ointments under class (2). For these reasons, in considering the value of any chemical method, one must rely largely upon its mechanical action.

There is, too, another grave disadvantage peculiar to chemical contraceptives. The buyer or the user has no means of testing them beforehand—one must rely absolutely upon the statement of the vendor or manufacturer as to their content, purity and potency. Jellies, ointments, and suppositories may be adulterated; they may have been in stock so long as to be inert. It is important therefore that reliable brands should be purchased from shops specializing in the sale of contraceptives or from reputable chemists (see Appendix Three).

CHAPTER SIX

COMBINATIONS OF METHODS

At the present stage in birth control technique it is undeniable that the most efficient, reliable and foolproof contraceptive is not any one single measure, but a combination of two or more methods. Even a combined method is not *absolutely safe, in all circumstances*, despite the optimistic assurances of certain enthusiasts. Theoretically it should be safe; in practice often enough it is no such thing. *In the hands of the intelligent the combination of methods may be represented as almost one hundred per cent. certain*; in the hands of morons no combination of methods is safe, nothing short of sterilization suffices.

Dr Norman Haire, whose unique practical knowledge of the subject renders his opinion of the very highest authoritative value, recommends a combination of the vaginal occlusive pessary with contraceptive jelly. The particular pessary advocated is the type of rubber diaphragm variously referred to as the "Haire," "Mensinga" and "Dutch" pessary, which has already been fully described (cf. p. 66). There are, as already noted, various forms of contraceptive jelly, but a lactic acid jelly gives the best results. The correct size of pessary having been obtained, it is liberally smeared with the lactic acid jelly before insertion. The following morning, and *before the pessary is removed*, the vagina should be douched with ordinary warm soapy water, or

with a solution of boric acid and water, if soap is found to be unpleasant or irritating.

Mrs Hornibrook advocates the use in combination of a soluble suppository and a rubber pessary. After washing, the soluble suppository is pushed into the vagina, then a proper sized rubber watch-spring pessary (soaped) is inserted. To make safety assured, an hour or two after intercourse, or next morning, a douche is used *before* removing the rubber pessary.

At the Walworth and at the East London Women's Welfare Centres¹ the procedure usually adopted is to use a "Dutch" pessary in conjunction with a spermaticidal ointment, followed within twelve hours by a soapy douche. In certain cases where pelvic conditions are against the employment of the "Dutch" pessary, the "Dumas" type is advised with spermicide and douche, or a contraceptive jelly and the condom.

At the North Kensington Clinic the "Dutch" pessary, the "Pro-Race" cap and the "Dumas" pessary are all used in combination with a spermicide. The spermicide most favoured, especially where douching presents difficulties, is the quinine and urea hydrochloride tablet. In other cases lactic acid ointment is advised, but here a soapy douche must follow. Where a pessary cannot be used, the condom in conjunction with a soluble suppository is recommended.

The Los Angeles Mothers' Clinic advocates the use of a diaphragm pessary called the "Protex," which is

¹ Full details respecting the procedure at these clinics are given in an excellent booklet, *Birth Control and Public Health*, published by the Society for the Provision of Birth Control Clinics.

very similar in principle to the "Ramses," in conjunction with a contraceptive jelly. This method has proved most successful.

The American Birth Control League recommends a combination of rubber pessary and lactic acid jelly, almost identical with that recommended by Dr Haire, except that they seem partial, in most cases, to the type of pessary known as the "Ramses." Out of 5,000 cases where this combination was employed, 96 per cent. proved successful, the comparatively few failures being attributed to carelessness in carrying out the technique.

In considering these figures given by the American Birth Control League it is important to bear in mind that they refer to cases where the wearing of the "Mensinga" or "Ramses" pessary was *favourably indicated and where the pessary had been selected and fitted by experts*. So that the 4 per cent. of failures applies to cases where the method has been adopted in accordance with medical advice under medical supervision. Any wider application or the dispensing with competent advice would undoubtedly enormously extend the percentage of failures.

Even when the proper size of pessary has been obtained and the knack of its insertion has been acquired, it will be sufficiently obvious that there will be liability to slips, and as time goes on and no pregnancy results there will, with increased confidence, be a tendency to carelessness. The douching becomes a nuisance and the woman is inclined to dispense with it. Or she runs out of soluble suppositories and is compelled to rely solely on the rubber pessary. Or the same thing happens with

the contraceptive jelly. Or she is taken unawares and has no time or opportunity to make her preparations. Once, twice or even thrice she runs each or all of these risks and sweats fear. But with no unfortunate results occurring she loses much of this fear; she gets careless and then the inevitable happens.

It cannot be too strongly stressed or too often reiterated that *the failure of contraceptives is very often due not to any defect in the method or appliance itself but to ignorance or carelessness in its application or use.*

Many women have a decided objection to the use of any contraceptive jelly. To some it is definitely irritating; to others its messiness is distasteful.

But despite all drawbacks, in all cases where the rubber pessary can be employed, the advisability of using the lactic acid jelly in conjunction is established: this combination making, all things considered, *the best and most satisfactory method available for the average individual possessed of ordinary common sense.*

There are others who cannot use the rubber pessary; the not inconsiderable number afflicted with torn perineum, *prolapsus uteri*, cystocele, rectocele, marked obesity and chronic constipation. Also a woman with an unduly long vaginal canal or short stodgy fingers cannot insert the pessary correctly. Additionally there are morons and others too stupid or too clumsy to acquire or to carry out the necessary technique. What are they to do, these unfortunates? For the majority chastity is impossible; they are married and they are compelled in some cases and prefer in others to have intercourse.

Well, there are alternative combined methods, but their achievement does not rest solely with the woman; a drawback this of large dimensions. There is, for instance, the combination of soluble suppository or cotton-wool plug, or sponge, with the use of the condom by the male. Alternatively the male may practise *coitus interruptus*—a method not to be advocated where any other combined method is available.

Where the man will not, or cannot, adopt either of these methods, the woman must perforce rely upon the best of whatever measures are available to her. The soluble suppository should never be employed by itself, nor indeed any other chemical contraceptive—except of course as a last desperate effort. *The most reliable method in all such cases is a plug made of cotton-wool or clean white linen, soaked in a 1 per cent. solution of lactic acid and smeared with contraceptive jelly* left in position until morning and removed *after douching*. In the case of the victim of *prolapsus uteri*, if pregnancy is greatly dreaded, it would be well to avoid intercourse altogether. For, I fear, whatever method is adopted, the chances of a *fertile* woman avoiding conception are small. Where the uterus is supported in something approaching its normal position it may be possible to wear a diaphragm pessary, or an oil-soaked plug or sponge could perhaps be inserted. But where, as very often happens, the cervix, through *prolapsus* or other causes, is very low, or where it is badly displaced, the prospects of success attending either of these methods, even where they can be practised, are slender. The only thing to do is to leave it to the husband; or where this is impossible,

doubtful or risky, for the woman herself to use a sheath.

In closing this chapter a description of the methods of examination and instruction adopted at the Cromer Street Welfare Clinic, given below in Dr Haire's own words, may prove of value and interest:—

“On coming to the Clinic for the first time, the patient who asks for contraceptive advice is interviewed by our woman secretary, who fills up the first part of the history card.

“An appointment is made for her to see the doctor, either the same day or later. She is instructed to see that her bowels have moved well before she comes up for examination. This is an important point, as constipation renders a vaginal examination and the fitting of the pessary very difficult.

“When the patient comes to see me in the consulting room, I ask her if her bladder and bowels are empty (if not, she must empty them). I read through the first part of the history which has been filled in by the secretary, and ask any additional questions which I consider necessary. Then I take a brief general medical history, and a careful and exhaustive gynæcological history, examine the woman per vaginam, either with or without a speculum according to the indications of the case, and give her instructions in contraception.

“For this purpose the patient is taken by the nurse into one of the cubicles for examination. There are three cubicles, so as to save waste of time while the women are dressing or undressing. In many cases we find the woman is already pregnant, and has really come to see if we will produce an abortion. This we always refuse

to do, not on moral grounds, but because it is against the law.¹ If the woman is not already pregnant we usually fit her with a particular type of rubber occlusive pessary, which is used in conjunction with a contraceptive jelly containing lactic acid, as eight years' experience has taught us that this is by far the best contraceptive method at present known. In cases of severe perineal tears, prolapse of the uterus, &c., this method may be unsuitable, and we may have to advise some other method, though so far we have not been able to discover any other method which is really equally reliable and harmless.

"If we use the pessary mentioned above, I choose the correct size, and show the woman how to insert it and remove it herself. I leave her for a few moments to practise putting it in and taking it out, and when she has done this once or twice the nurse calls me to examine the patient to see if she has inserted it properly. I then explain to her carefully all the details of its use, give her the pessary and the chemical contraceptive jelly which is used with it, and finally give her a printed slip containing the instructions in detail.

"The patient is requested to return after four weeks so that we may examine her to see if she is using the pessary correctly, and so that she can report whether it is comfortable both for herself and her husband."

¹ This is no longer strictly accurate. In certain circumstances, i.e. where the pregnancy could cause the woman's death or there is serious danger to her physical or mental health, termination of pregnancy can be legally performed by a medical man.

CHAPTER SEVEN

THE VIRGIN AND CONTRACEPTION

THE virgin calls for special consideration. How is she to avoid impregnation during the early weeks of married life?

There are no methods open to her, without surgical attention, that are *reliable*.

The use of the rubber pessary, in all but very exceptional cases, is impossible. Owing to the narrowness of the vaginal canal and the presence of the hymen, ordinarily no such appliance can possibly be inserted. True, a medical man can dilate the vagina, destroying the hymen if necessary, and fit a rubber pessary.

All things considered, where pregnancy is greatly dreaded or its avoidance is essential, and in all cases where the female wishes to have the control of conception in her own hands from the start, surgical dilatation immediately before marriage is advisable. It has, too, other advantages apart from its contraceptive significance, for in this way are avoided much of the pain and discomfort for the woman, and the embarrassment for both parties, which are so often accompaniments of defloration.

She might, of course, perform the dilatation herself digitally. Provided there is no abnormality present, the procedure is simple. It consists in gradually stretching the opening, first with one oiled finger and then as it

gradually widens with two fingers, finally with three. When three fingers bunched together can pass through without difficulty dilatation may be said to be accomplished. This widening process should be spread over about a fortnight's time.

Where the male partner is a willing party and where, too, there are no æsthetic or psychological obstacles to the discussion of the subject between husband and wife, the use of a condom or the practice of *coitus interruptus* is indicated, with in either case, as an additional safeguard, the use of contraceptive jelly or, where possible, of a soluble suppository or a cotton-wool plug, followed next morning by a chemical douche.

There are, especially to-day, a very considerable proportion of women who are either temporarily or permanently sterile; there are others who have physiological or pathological conditions which render them unlikely to conceive. Many of these women go to the trouble and expense of employing elaborate contraceptive methods which are either superfluous or could be replaced by simpler but, in their case, equally effective measures. Where circumstances permit, therefore, it is definitely advisable that the virgin who is about to marry should consult a gynæcologist and ascertain (1) whether any contraceptive measure is necessary and if so (2) which particular method is best adapted to her particular case.

CHAPTER EIGHT

OTHER ASPECTS OF THE PREVENTION OF PREGNANCY

I MODERN SURGICAL METHODS

WITH the passing of savagery, in civilized races for hundreds of years the methods of effecting sterilization were castration¹ in the case of men and ovariectomy in the case of women. Both operations, apart from the pain and danger attached to them, induced morphological changes. As a result, in no case, apart from pathological conditions rendering them essential, or in the case of eunuchs in semi-civilized races, through force, or in certain religious sects, were or are these operations performed.

Modern methods are designed to produce absolute sterility without interfering with sexual desire, appetite or capacity for coitus, and without inducing those distressing metabolic changes associated with the older and clumsier methods of castration and ovariectomy.

Of surgical methods the most effective are vasectomy in the male and salpingectomy in the female; both opera-

¹ The libidinous Roman ladies of the days of Caesarean debauchery were so afraid of conception that they selected eunuchs for their husbands. The following passage from Juvenal is revealing: "There are women who prize the infertile embrace of base eunuchs: thus they may be able to dispense with the use of abortifacients."

tions have neither any retarding effects on sexual potency, appetite or pleasure, nor do they disfigure or have any observable effects on the man or the woman.

Vasectomy consists of cutting the vas deferens in two places, the incision being made either in the scrotum or over the external inguinal ring, taking out a couple of inches of duct and tying the ends with a silk ligature. It can be carried out under a local anæsthetic. Double vasectomy is necessary.² It is worthy of mention that the idea that vasectomy, once performed, renders the male permanently and irrevocably sterile is erroneous. According to the *Journal of the American Medical Association* (quoted by Dr James F. Cooper in his *Technique of Contraception*, pp. 130-31), the fecundity of a man sterilized by ligating and severing the *vasa deferentia* has been re-established on many occasions by resection of the vas.

Salpingectomy is a more difficult operation, entailing confinement in bed for a fortnight, and it is rather expensive. A portion, or better still, all of each of the Fallopian tubes is removed, and the openings made up by turning in and suturing the peritoneal surfaces. The older method, where the tubes are tightly tied to prevent ova passing through them, is not to be relied on. The more dangerous operation *per vaginam* is now superseded wherever possible, by the abdominal transverse incision.

² It has been contended that surgical sterilization might be held to come within the scope of the mayhem clause in the Offences Against the Person Act, but the possibilities of such an action being brought and, if brought, of its success, seem small. No such operation could, however, be legally performed on a mental defective, an insane individual, or one who is not able or in a state to give proper consent.

It is true, there have been many cases of pregnancy following salpingectomy; cases where, despite ligation and removal of the tubes, ova have found their way into the uterus. But any such failure of the operation is only possible with defective surgical technique. There is, of course, always the remote possibility of ovarian pregnancy.

A newer method, devised by Dickinson of New York, which is yet in an experimental stage, is cauterization of the Fallopian tubes where they enter the uterus, the openings being completely closed by the scars resulting from the cauterization. While, theoretically, this method appears to have much to commend it, in practice, the location of the exact points for cauterization is a matter of some difficulty.

Sterilization by means of the X-ray, the Roentgen ray and radium, are all methods which as yet are too uncertain to deserve serious attention in a book of this nature, being only of interest because of their possibilities in the future. So far as present indications go sterility produced by these means is purely temporary, extremely uncertain and attended with the risk of dangerous consequences.

Sterility of the female by immunization seems to offer some prospects of success. Dr Norman Haire says:—

“I made some investigations into the possibility of immunization of the female against spermatozoa by the hypodermic or intramuscular injection of graduated doses of semen. This has been carried out in animals without any ill-effects, so I tried it on myself and then

on twenty women volunteers. The semen was obtained in most cases from the husband, but in some cases where the husband was unhealthy the semen was that of a healthy man, produced by masturbation, and received in a sterile glass basin at blood-heat. It was covered and allowed to stand until the turbidity had disappeared and the semen had become clear. It was then diluted with 100 times its volume of sterile water, and in a water bath it was brought to boiling point and kept at that temperature for five minutes. One drop of this diluted solution was injected and the dose repeated at weekly intervals, increasing by one drop each time. The course consisted of twelve injections. None of the women became pregnant while receiving these weekly injections, but three conceived within a few weeks of ceasing the injections. It would therefore appear that, at least with my technique, this treatment has only a temporary effect. It is possible that some other investigator with a greater knowledge of laboratory methods might have better results. The injections are attended with no ill-effects and scarcely even any local discomfort. Some women seem to experience an improvement in general health after these injections. This is possibly due to the absorption of some element of the semen, and analogous to the improvement noted by Sir Arbuthnot Lane, Stoddart and others, following the administration of extracts of male sexual glands to women."¹

¹ Norman Haire, *The Comparative Value of Current Contraceptive Methods*, London, pp. 11-12.

CHAPTER NINE

TABLE GIVING INDICATIONS FOR THE DIFFERENT METHODS

SECTION I

METHODS CONFINED TO THE MALE

MECHANICAL METHODS	Method	Indication	Contra-indication	Reliability	Remarks
	Condom ("French letter," sheath, "French Safe")	In case of a virgin, an old or obese woman, or multipara with gaping vagina. In <i>prolapsus uteri</i> , excessive vaginal sensitiveness. Where woman refuses to take precautions or man is averse to suggesting any	In cases where the man cannot use a sheath. In certain instances causes pain to the woman	Fairly safe when used alone, if technique properly carried out	The fitting of the condom on the erected penis is a disgusting business and in many cases destroys tumescence. Diminishes sensation. Good sheaths relatively expensive. Liable to break. Rubbersheaths perishable
	Short "letter" (American tip, Malthus cap)	As above	—	Reliable if there is no retention of penis in vagina after erection has subsided	Not so liable to interfere with sensation as condom; much easier to adjust

	Condom and contraceptive jelly	Same as condom	Same as condom	Much more reliable than condom alone	Condom not so liable to rupture when smeared with jelly
OTHER METHODS	<i>Coitus interruptus</i> (withdrawal, <i>onanismus conjugalis</i> , "coming out")	In case of a virgin, and where no other method is available. Where the woman refuses to take precautions or the man is averse to suggesting any. <i>Pro-lapsus uteri</i> , obesity	Passionate, excitable men. When under influence of alcohol	Unsafe	Involves no expense whatever. No apparatus required. Always available. Secrecy
	<i>Coitus reservatus</i> (Karezza, male continence, Zugassent's discovery)	As above	Not a practical method for the majority of men	Decidedly unsafe	A difficult method calling for special practice
	Perineal coitus (<i>Coitus sine immissio penis</i>)	None	Inadvisable in all cases	Very unsafe	

SECTION II

METHODS CONFINED TO THE FEMALE

Method	Indication	Contra-indication	Reliability	Remarks
Plug or tampon (cotton-wool, sponge, etc.)	Where a pessary cannot be used or is unavailable	Displacements of uterus, lacerated cervix, <i>prolapsus</i>	Moderately safe	Cheap. Always available. Can be used by anyone
Rubber diaphragm ("Mensinga," "Dutch" or "Haire" pessary, "Ramses" pessary)	In all cases where there are no abnormalities to prevent correct fitting	Retroverted uterus, <i>prolapsus</i> . All pathological vaginal discharges. Cystocele, rectocele, torn perineum. Chronic constipation. Very obese women. Women with short fingers or long vaginal canal	Fairly safe when used alone, reliability enormously increased when used in conjunction with contraceptive jelly	Must be fitted by a doctor or a nurse with medical knowledge, and should be removed daily

MECHANICAL METHODS

"Dumas" pessary	Injured vaginal walls	Unhealthy cervical condition	As above	Must be fitted by a doctor or nurse and should be removed daily
"Matrisplus" pessary	Cervical displacements and abnormalities	Normal conditions	As above	As above
Rubber cap	Where cervix is normal	Torn, enlarged or abnormally shaped cervix. All cases of pathological vaginal or cervical discharge. Chronic constipation.	Fairly safe if used alone, provided the cap fits correctly. Reliability greatly increased if used in conjunction with contraceptive jelly	Difficult to fix in position and to retain in position when fixed. Must be fitted by a doctor or nurse with medical knowledge. Should be removed daily
Metal cervical caps	Only in a nullipara or primipara with perfectly shaped normal cervix	Any abnormality in shape of cervix. Unhealthy secretion from cervix or vagina. Chronic constipation	Most unsafe	Can only be fitted and fixed in position by a doctor. Easily dislodged. Should be removed daily

METHODS CONTINUED TO THE FEMALE—*Continued*

	Method	Indication	Contra-indication	Reliability	Remarks
MECHANICAL METHODS	Intra-cervical pessary. (Stud pessary)	As above	All cases where cervix is abnormally shaped. Multiparæ	Very unsafe	As above. Liable to induce inflammatory conditions
	Intra-uterine pessary.	In cases where the use of other methods have psychic inhibitory influences	As above	Unreliable	Expensive. Must be fitted and removed by a medical man. Causes irritation and liable to induce inflammatory conditions
	Sheath (rubber or membrane) " <i>Capote anglaise</i> "	In venereal infections. Where other methods cannot be employed	—	Safe	Diminishes sensation in both sexes, and often destroys erection in the male

MECHANICAL METHODS	"Grafenberg" ring	Where temporary sterility without bother of appliances is desirable, where use of other methods have psychic inhibitory influences	Gonorrhoea or any infection of the genital passages	Reliable if used in conjunction with a chemical contraception	Must be inserted and removed by a gynaecologist. Admits coitus unhindered and is free from dislike occasioned by other methods. Can be left in position for a year or more
CHEMICAL METHODS	Douche (syringing, irrigation)	Only where no other method is available, or where it is feared the method employed may have failed	—	Most unreliable	Continual douching with chemicals liable to induce vaginal inflammation. Often inconvenient and psychically disturbing
	Soluble suppositories (soluble pessaries)	In cases of emergency. Constipation. Virgins, infantile cervix	All multiparæ. Torn or enlarged cervix. <i>Prolapsus</i> . Short vagina. Highly sensitive vagina	Decidedly uncertain. Not advisable for use alone	Cheapness. Anyone can use it. Objectionable odour. Messy. Causes irritation in some cases if used often. Liability to melt in warm temperatures

METHODS CONFINED TO THE FEMALE—*Continued*

	Method	Indication	Contra-Indication	Reliability	Remarks
CHEMICAL METHODS	Ointments	Only where cervix is healthy, and the os minute, have chemical methods any prospects of success	As above	Should be used with a pessary or cap	Messy and in some cases irritating
	Powders		As above	As above	Requires a "blower" for proper use. Difficult to "place" on os uteri
	Foam tablets		As above	As above	Easy to use. Must be kept dry
	Contraceptive jelly		As above	As above	Easy to use. Keeps better than tablets or suppositories
	Quinine and olive oil		As above	As above	Needs special appliance for insertion
	Sponge or plug with boric acid or olive oil	In cases where rubber pessary cannot be used	Lacerated cervix, anterior cervix	Moderately safe	Cheap. Can be used by anyone

Sponge and vinegar	As above	In some cases vinegar has stimulating effect on penile organ, causing premature ejaculation	Fairly safe	As above
Sponge and douche	As above	Where there is lack of facilities for douching	As above	As above
Rubber diaphragm and jelly, followed morning after by douche	All cases where cervix and vagina are normal	Torn perineum, <i>prolapsus</i> , cystocele, rectocele, chronic constipation, obesity	Safe in 99 per cent. of cases	—
Rubber diaphragm with soluble suppository and douche	As above	As above	As above	—
Rubber cap and jelly, followed morning after by douche	Where cervix is perfectly normal	As above	Safe <i>if perfect fitting</i>	—
Rubber cap with soluble suppository and douche	As above	As above	As above	—

METHODS CONFINED TO THE FEMALE—*Continued*

	Method	Indication	Contra-indication	Reliability	Remarks
COMBINATIONS OF METHODS	Rubber diaphragm and quinine and urea hydrochloride tablet	All cases where cervix and vagina are normal and where there are no facilities for douching	As above	Fairly safe	—
	Rubber cap and quinine and urea hydrochloride tablet	Where cervix is perfectly normal and where there are no facilities for douching	As above	Fairly safe if perfect fitting	—
OTHER METHODS	"Safe period" (Intermenstrual coitus, <i>tempus agensius</i>)	In cases where religious taboos or prejudices preclude any other method	—	Varies greatly in regard to different females. Not to be relied on when used alone, its value being mainly as an auxiliary method	Inapplicable in many cases through male's refusal to adjust sexual appetite to the calendar; especially does this apply to the early years of married life. Permitted by the Church

Avoidance of orgasm (holding back)	As above	—	Decidedly unsafe	Bad effects on the woman
<i>Shimoyu</i> ("wiping out")	—	—	Unsafe	Repulsive to most women
Abstinence	—	—	—	This, in the opinion of most Church dig- natories, is the only method dignified with God's blessing, and is therefore the ideal method, though strict- ly speaking it does not come within the category of contra- ceptives at all
Sitting upright in bed and coughing	—	—	None	—
Prolonged suckling	—	—	Usually fails	—

SECTION III

METHODS FOR MALE AND FEMALE IN COMBINATION

Method	Indication	Contra-indication	Reliability	Remarks
Condom (male) and Plug or Sponge (female)	In cases where rubber pessary cannot be used	Where man cannot use a sheath	Very safe	Reduces sensibility and often precludes orgasm
Condom and soluble suppository	Where rubber pessary cannot be used	As above	Much more reliable than the condom alone	As above
Condom and douche	As above	As above	As above	As above
Condom and foam tablet	As above	As above	As above	As above
Condom and rubber diaphragm	Where there are no abnormalities to prevent correct fitting	As above	Very safe	As above

Condom and rubber cap pessary	As above	As above	Very safe	As above
<i>Coitus interruptus</i> and plug	Where rubber pessary is unavailable or cannot be used	Excitable passionate men	Safe in most cases	Availability in cases of emergency
<i>Coitus interruptus</i> and soluble suppository	As above	As above	Less likely to fail than <i>coitus interruptus</i> alone	—
<i>Coitus interruptus</i> and foam tablet	As above	As above	As above	—
<i>Coitus interruptus</i> and douche	Where other methods are unavailable	As above	As above	—
<i>Coitus interruptus</i> and contraceptive jelly	Virgins, <i>prolapsus</i> , Damaged perineum, obesity	As above	As above	—
<i>Demiretrait</i>	—	—	Decidedly unsafe	—

APPENDIX ONE

THE FACILITATION OF CONCEPTION

WHERE the failure to conceive is due to the husband's sterility or impotence,¹ and the number of such cases is considerable, nothing whatever can be done to remedy things. Where, however, the fault lies with the female partner, or where through ignorance the sexual act is wrongly performed, the story is a different one.

Contrary to popular opinion few women actually conceive at the very first act of coitus, the dyspareunia and the hæmorrhage usually resulting from defloration often preventing this. Nor does the orgy of the honeymoon period facilitate conception.

It is highly probable that one of the major reasons for so many acts of intercourse failing to result in conception lies in the fact that they occur during the female's biological periods of sterility. When it is remembered that the conception period of the most fertile woman is limited to a relatively short period in her ovular cycle, it will readily be understood that the chances of conception following intercourse are by no

¹ Impotence in man may be purely temporary, and this must not be confounded with permanent impotence. At one time or another most men suffer from temporary impotence; the causes are many, ranging from fatigue and mental anxiety or pre-occupation to sexual excesses. In such cases aphrodisiacs should never be used unless they are prescribed by a medical man. Permanent impotence is usually due to disease or to chronic obesity.

means so great as is popularly imagined. Now just as the biological period of sterility can be used as a contributive factor, at any rate, in the prevention of childbirth, so, also, has it distinct possibilities in helping to bring about conception. All that is called for is the adoption of a technique precisely opposite to that indicated in the practice of birth control (see page 57); that is to say, the procedure in the case of facilitating childbirth is the limitation of intercourse to the potential period of conception, i.e. to the period of ovulation.

If the male and female orgasm can be timed to occur together the likelihood of conception resulting, provided neither partner is actually sterile, is considerably increased. In many cases they do *not* coincide, the male reaching orgasm long before the female. It is here that circumcision of the male proves decidedly beneficial, the exposed and consequently less sensitive glans delaying the male orgasm.

Stimulation of the clitoris may in certain cases have some beneficial effect. In this connection the advice of the famous Dutch physician, Van Swieten, to the Empress Maria Theresa, who was concerned about her failure to conceive, is noteworthy: "*Præterea censeo, vulvam sacratissimæ Majestatis ante coitum, diutius esse titillandam*" ("Further, I advise that the external genitals of Her Most Sacred Majesty should be stimulated for a rather long time before intercourse"). And Vicar-General Craisson gave his approval of analogous pre-coital stimulation in his celebrated guide to Father confessors.

In all normal cases the prospects of conception resulting

are considerably increased where the semen is deposited *into* the external os or directly against the cervix. To ensure this there must be deep penetration on the part of the male and a retention of the supine attitude by the woman for some time after coitus.

Among the commonest causes of sterility are the various displacements of the uterus to which women are so prone. Any such displacement prevents the os uteri and the meatus of the glans penis from being in apposition during coitus and thus lessens considerably the chances of the semen finding its way into the uterus. Usually the glans penis enters a *cul de sac* and the semen flows from the vagina into the vulva. To prevent this and to give the semen an opportunity to enter the cervical canal and find its way into the uterus many gynæcologists recommend the adoption of an unorthodox position during the coital act.² There are other practices designed to the same end: thus prolongation of intercourse by the man holding the penis in the vagina for some time so that it prevents any outflow of semen; or the woman crossing one thigh over the other at the conclusion of coitus; or coitus in the position immortalized by Martial, with a *resumption of the normal posture immediately after ejaculation*; or, in certain instances, notably where there is a tendency to vaginismus, coitus in the seated *vis-à-vis* position. Pajot

²The compilers of the *Talmud* had evidently somehow or other stumbled on the fact that the position of the partners in the sex act had some influence on conception, seeing that coitus in the erect position was forbidden as unfruitful. It should, too, be noted that intercourse in this standing position should *never be practised in any circumstances*—it is dangerous.

advised, in cases of retroversion, the retention of faecal matter for three or four days before intercourse; and similarly in cases of anteversion the avoidance of micturition for some hours before the coital act. The same authority advised coitus on the side in cases of lateral version. Where obesity in either the male or the female is the cause of the trouble, Kisch recommends coitus *a posteriori*.³

Ring pessaries, employed in cases of retroflexion and for distending the vagina, are sometimes successful in inducing conception. There is one drawback, however. Any such appliance is likely to interfere with the performance of the coital act.

In numerous cases the vaginal secretion is the root of the trouble. This secretion may be too profuse or it may be insufficient; it may be too acid or too alkaline; and yet again it may be too viscid. And it may vary one way or the other at different times. If the vaginal secretion is very profuse and watery the motility of any emitted spermatozoa will be destroyed; or again the spermatozoa may be completely flushed from the vagina with the discharge. Or the spermatozoa may find entry into the uterus impossible through the canal being

³ It must be distinctly understood that coitus *a posteriori*, coitus in the seated *vis-à-vis* position, and in other abnormal attitudes, are not recommended, except where *uterine displacements* and the urgent desire for children indicate the need for their trial after the exhaustion of all other possible efforts to bring about conception. In all *normal* cases these attitudes favour the avoidance of conception. This warning is not in any way connected with religious taboos or orthodox morality but is necessary owing to the dangers which are invariably involved when a method of copulation is employed to which either the man or the woman is unaccustomed.

blocked by thick sticky mucus. Or yet again any excessive acidity of the vaginal discharge may render the spermatozoa inert.

The secretions of the vagina in all conditions of normality are definitely acid, as a result of the lactic acid produced by Doederlein's bacillus. Ordinarily this acid condition is not sufficient to kill the spermatozoa unless they are subjected to its influence for long periods of time, but in many women there is either permanently or sporadically vaginal acidity of a degree sufficient to kill or injure most sperms, in an hour or less. Contrary to this, the secretions of the cervix are alkaline, and during coitus, and particularly during orgasm, these alkaline secretions are considerably increased. It is for these reasons that where during coitus the semen is ejaculated directly into the cervical canal or the uterus, the chance of conception occurring, whether or not any contraceptive measures are being used, is hugely increased. In contradistinction to the aim of the chemical contraceptive, which is to increase the degree of acidity in the vagina and around the cervix, if the alkaline reaction can be heightened by the use of an alkaline douche immediately before intercourse, the possibilities of conception resulting may be increased, a point noted by Dr Marie Stopes,⁴ who suggests the use of sodium bicarbonate in cases of sterility arising through excessive acid vaginal secretion. Another suitable alkali, and one which gives excellent results, is basic sodium phosphate.

⁴ Marie Carmichael Stopes, *Contraception: Its Theory, History and Practice*. Third edition, London

It is claimed that the "Gräfenberg" ring, though primarily a contraceptive device, in certain instances will facilitate conception. Where sterility is the result of antelexion or under-development of the uterus, the wearing of the ring for six months or so will prove beneficial, and on its removal conception will probably result.

There is one other possible method of promoting conception where the man is impotent but not sterile, and where in the woman there are no uterine or ovarian obstacles to conception. The method is that of artificial insemination.

Obviously it is not a method which will commend itself, except where conception is almost fanatically desired, or as a last desperate attempt after everything else has failed. Where emission is possible, but the male is afflicted with hypospadias or *ejaculatio præcox*, a crude form of insemination may be attempted. A sponge or a plug of cotton-wool or other absorbent material may be saturated with the emitted semen and pushed into the vagina as far as it will go, or a rubber pessary may be filled with seminal fluid and inserted in the region of the external os. At best, however, this is a "hit or miss" method, and though it is quite possible for semen introduced into the vagina in this way to invade the uterus (especially if the woman before insertion uses an alkaline douche) and cause conception, the procedure, with all its unæsthetic concomitants, may have to be repeated so often before it is successful that both parties will give it up in disgust and despair.

A much surer way is to inject the seminal fluid directly

into the uterus,⁵ but here the aid of a third party in the shape of a medical man creates difficulties, especially as to enhance the success of the injection it should be made at a moment when the woman is in a state of sexual excitement induced either through the act of coitus itself or, failing this, through stimulation of the clitoris or the vagina. The operation itself presents little in the way of difficulty to the gynæcologist; there are many successful cases recorded by Sims, Heape and Iwanhoff. It is indicated where, in the male, hypospadias, epispadias, or *ejaculatio præcox*, prevents full penetration, and where in the female, the semen cannot be retained in the vagina after coitus, or the vaginal secretion is abnormally acid and alkaline douches have failed, or in constriction of the cervical canal, occlusion or hypertrophy of the os. The method adopted is analogous to that which is so successfully employed in impregnating mares and bitches.

A small quantity of semen is collected in a syringe and introduced into the uterus after the woman has been sexually stimulated; the syringe being passed through the external os, previously dilated by means of a speculum, along the cervical canal and so into the uterus itself. The semen is obtained from the vulva where there is emission without penetration; by masturbation into a condom or other receptacle where coitus is impossible; or by extraction from the testicles where stricture or gonorrhœal inflammation prevents the passage of semen into the anterior urethra.

⁵ The first recorded case of artificial insemination was that performed by Hunter in 1799, where the male suffered from hypospadias. Hunter, however, merely injected the semen into the vagina.

APPENDIX TWO

THE LAW IN RELATION TO BIRTH CONTROL

THERE is still, among the British public, much confusion respecting the legality of birth control. Many persons believe that it is illegal, not only to practise contraceptive methods but to purchase appliances and books dealing with the subject. These notions are largely the result of the surreptitious manner in which birth control appliances and literature are sold and advertised; the attitude of the Church and, until recently, of the medical profession; and the fact that publishers and vendors of birth control literature in the past have been prosecuted.

In Great Britain contraception is legal. There is no law on the statute book prohibiting the practice of birth control, the sale of contraceptives or the dissemination of information respecting their use. In each case where there has been a prosecution the law was invoked not to deal with birth control *per se*, but on the grounds of obscenity. True this danger still exists, for after all there is in existence no definition of obscenity, but it is quite certain that to-day there is the faintest likelihood of any repetition of the Bradlaugh prosecution of 1887, or the Aldred case of 1923. The pamphlet, *Fruits of Philosophy*, by one Knowlton, a Boston physician, for the publication of which Charles Bradlaugh was prosecuted, in comparison with modern birth control works,

was a singularly tame affair. Since 1923, when Margaret Sanger's *Family Limitation*¹ was ordered to be destroyed, Mrs Aldred, in defiance of the authorities, re-issued the booklet and it is still on sale, no further attempts having been made to suppress it.² To-day the attitude of the Government is one of non-interference.

The Church, having failed in every effort to get the sale of contraceptives and birth control literature made illegal, realizing the widespread practice of methods for spacing births or avoiding children altogether, and recognizing, too, the change in public opinion, has in turn begun to withdraw a good deal of its opposition. Indications of the adoption of this different attitude are observable in the resolution passed at the 1930 Lambeth Conference of Bishops:—

“Where there is a clearly felt moral obligation to limit or avoid parenthood the method must be decided on Christian principles. The primary or obvious method is complete abstinence from intercourse (as far as may be necessary) in a life of discipline and self-control lived in the power of the Holy Spirit.

“Nevertheless in those cases where there is such a clearly felt moral obligation and where there is a morally sound reason for avoiding complete abstinence the conference agrees that other methods may be used, provided that

¹ This booklet was also the subject of a prosecution in America, in 1915. William Sanger was arrested and imprisoned (he refused to pay a fine) for distributing copies of his wife's pamphlet; this prosecution was one of the last in which Anthony Comstock personally figured.

² There have been other English prosecutions. In 1878, for selling Robert Dale Owen's *Moral Physiology*, originally published in America, Edward Truelove, a London publisher, was prosecuted, fined £50 and sentenced to four months' imprisonment.

this is done in the light of the same Christian principles.

"The conference records its strong condemnation of the use of any methods of conception control from motives of selfishness, luxury, or mere convenience."

It is a concession brimming with significance.

The attitude of the medical profession to contraception has, too, quite recently undergone a big change. For many decades the viewpoint of the Church, of the Press, and of the people (publicly expressed) that birth control was a vulgar, if not obscene, subject, unfit for anyone of respectability to be associated with; the memory of the fate which befell the first doctor to publish a birth control brochure,³ and the fact that contraception was not (and is not) included in the curriculum of the medical colleges, have all had their effects. But there is a continually increasing number of leading medical men who are publicly proclaiming their belief in the necessity for birth control for other than purely health reasons.

Any doctor may give contraceptive information if asked for it by a *private* patient. The only prohibition is that respecting medical officers in attendance at Public Maternity and Child Welfare Centres; here, except in cases conforming to the Ministry of Health's regulations, no birth control information can be given.

In 1930, truly a fateful year in the history of the birth control movement, the Government recognized the need for granting opportunities for poor people to secure

³ The General Medical Council, in 1887, struck off the register, Dr. H. A. Allbutt, for a breach of professional etiquette in publishing a sixpenny pamphlet, entitled *The Wife's Handbook*, giving practical birth control information.

contraceptive information. In the Memorandum 153 M.C.W., issued by the Ministry of Health, local Public Health Authorities are empowered to establish clinics for the dissemination of free birth control information to married women, with the proviso that these permitted clinics must be definitely restricted to "*cases where further pregnancy would be detrimental to health.*" Further it should be noted that there is no compulsion expressed or implied, the Local Authorities being perfectly free to incorporate such additional service in connection with existing Maternity and Child Welfare Centres, to form new clinics within the provisions of the Memorandum, or to take no steps in the matter, as they think fit. Since July, 1930, in England, Scotland and Wales, about a hundred Public Health Authorities have approved the principle embodied in the Memorandum, and have already taken action along the lines indicated.

But even so, to the majority of women who require birth control advice these clinics, even when and where established, will be useless. The importance of the Memorandum lies in its sociological significance and not in its practical value, which at present, owing to the limitations imposed by the Ministry of Health, is small. In the main, women are dependent—and are likely to be so dependent for some time—on the private clinics.

Private societies or individuals may run birth control clinics without breaking any law or regulation so long as they restrict their clientèle to married women and are careful not to advise anything likely to terminate an existing pregnancy. It is these privately run and financed societies and clinics that have been instrumental in pro-

viding thousands of women in England with birth control advice and information.

In only two countries do the Governments definitely favour contraceptive advice for *all* married people. Soviet Russia is one; Mexico is the other. In Russia there are State clinics where contraceptive information is given. So far as I know there are no clinics in Mexico, but the Government is in favour of the dissemination of birth control knowledge—in Yucatan, according to Margaret Sanger, a copy of her booklet *Family Limitation* "was given with the marriage licence to each couple."

On the other hand France is uncompromisingly against birth control. After the first world-war she became alarmed at the shrinkage in her population, and on July 31, 1920, an Act was passed whereby the sale of birth control literature and appliances became a criminal offence.

Eire, too, will have none of it. All literature in favour of birth control or giving practical information is definitely banned.

Almost as stringent is the American law. Contraceptives and literature⁴ relating to the same come under the ban of the notorious Comstock Law,⁵ in which it

⁴ Books which deal with birth control merely in its ethical, sociological, eugenical and religious aspects and avoid mentioning or dealing with the practical side of contraception are allowed to circulate freely in the U.S.A.

⁵ It should be noted that before the passing of the Comstock Bill of 1873 there was no law in the United States of America against the circulation of birth control literature. Owen's *Moral Physiology* (1830), and Knowlton's *Fruits of Philosophy* (1833), both of which gave practical contraceptive information, and both of which were prosecuted in England on the grounds of "obscenity," were circulating freely for forty years before they became "obscene and illegal publications" in America.

is stated:—

“Every obscene, lewd or lascivious and every filthy book, pamphlet, picture, paper, letter, writing, print, or other publication of an indecent character, and every article or thing designed, adapted or intended for preventing conception or producing abortion or for any indecent or immoral use; and every article, instrument, substance, drug, medicine, or thing which is advertised or described in a manner calculated to lead another to use or apply it for preventing conception or producing abortion, or for any indecent or immoral purpose; and every written or printed card, letter, circular, book, pamphlet, advertisement or notice of any kind giving information directly or indirectly, where, or how, or from whom, or by what means any of the herein-before-mentioned matters, articles or things may be obtained or made, or where or by whom any act or operation of any kind for the procuring or producing of abortion will be done or performed, or how or by what means conception may be prevented or abortion produced, whether sealed or unsealed; and every letter, packet or package, or other mail matter containing any filthy, vile, or indecent thing, device, or substance; and every paper, writing, advertisement, or representation that any article, instrument, substance, drug, medicine, or thing, may, or can be, used or applied for preventing conception or producing abortion, or for any indecent or immoral purpose; and every description calculated to induce or incite a person to so use or apply any such article, instrument, substance, drug, medicine, or thing, is hereby declared to be nonmailable matter and shall

not be conveyed in the mails or delivered from any post-office or by any letter carrier."

It will be noted that the law does not prohibit any person from *practising*⁶ contraception; it merely prohibits the sale and distribution of birth control literature and appliances⁷ through the mails.

In many American States physicians are allowed to give contraceptive information to their patients where there are medical indications for same, and this policy is extending. Similarly medical books dealing with practical birth control are allowed to be published so long as they are not sent through the mails, and their circulation is rigidly restricted to members of the medical profession.

Birth control centres have been provided in the States of New York, Illinois, Minnesota, Virginia, Ohio, Michigan, Maryland, Colorado, California and Georgia. These Centres (they are called "centres" to comply with a peculiarity in American law whereby clinics must conform to specific regulations and have formal licences) are all under the supervision of physicians. There is no uniform procedure in accepting cases for treatment. The procedure varies in different States in accordance with the laws of these States, and also the interpretations that

⁶ There is one exception to this. The State Law of Connecticut which supplements the Federal Law, *expressly prohibits the employment of contraceptives.*

⁷ Despite the rigidity of the law, the condom is sold as a venereal prophylactic at drug stores in the majority of cities and towns in the United States of America, and similarly in France. Further it is obviously quite impossible to prohibit the sale of chemical antiseptics which advertised under euphemistic descriptions are widely employed as contraceptives.

are put upon these laws by those running the Centres. For instance, in New York State the law definitely restricts the giving of contraceptive information to "the cure and prevention of disease"; in New Jersey "due cause" is a sufficient indication. In some cases, where the interpretation is a broad one, the spacing of children is considered to be a "health reason." But, generally speaking, the Centres refuse to give information where it is sought for economic reasons only.

The State laws of Alabama, Arkansas, Delaware, Colorado, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Maryland, Missouri, Nevada, New Hampshire, New Mexico, North Carolina, South Carolina, North Dakota, South Dakota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin and Wyoming either explicitly exempt physicians from prohibition or have no specific ruling on birth control practices or the giving of information. On the other hand in Alaska, Arizona, Connecticut, Idaho, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, New Jersey, New York, Pennsylvania, and Washington there are either State prohibitions supplementary to or special concessions in modification of the existing Federal law.

Turning to other countries, in Italy, Greece, Norway, Sweden, Belgium, Poland, Portugal, Colombia, Chile, Costa Rica, Australia, Lithuania, Canada, the sale of contraceptives and the circulation of birth control literature are expressly prohibited.

Many foreign countries are in a similar position to that of England; that is, there are no laws prohibiting birth control and presumably it is only a question of time before clinics are established in all or most of them; there are already clinics or advisory centres in South Africa (Johannesburg), India (Bombay), Germany⁸ (Berlin, Frankfurt, Chemnitz and Breslau), Poland (Warsaw), China (Peking and Shanghai), and Japan (Tokio and Osaka).

THE WORK OF THE CLINICS

The present position of birth control in England, as indicated in the preceding pages, is due in large measure to the efforts of that small and courageous body of pioneer workers who, in the face of much opposition from State and Church, and despite the apathetic attitude of the public generally, fought long and steadfastly to bring contraceptive information to the notice of those most in need of it.

No one can but admire the great struggle for freedom of expression in relation to what at that time was virtually a tabooed subject, which some sixty years ago was waged by Charles Bradlaugh and Mrs Annie Besant. This marked the beginning of a great movement with which the names of Dr Drysdale and other co-workers in the Malthusian League were associated. Then Dr Marie C. Stopes, whose excellent pioneer work along scientific lines constitutes a landmark in the history and

⁸ It is illegal to *advertise* contraceptive appliances in Germany. In the German Penal Code they are included under "articles for immoral purposes."

evolution of modern contraception, made her valuable and admirable contributions to the literature of the subject.

It was, however, with the establishment of clinics for the dissemination of birth control advice and information among married women of the poorer classes that the first real step forward can be said to have occurred. First and foremost in the field stands Dr Marie Stopes, who, in 1921, founded the Society for Constructive Birth Control and Racial Progress, and started the first birth control clinic in the British Empire. It is, too, worthy of note that this Society's clinic was the first in the world to initiate the keeping of careful records with a view to scientific research into contraceptives and investigation of methods in use. In the winter of 1931, in conjunction with the Royal Institute of Public Health, the first course of practical lectures and technical demonstrations were given to members of the medical profession. Other clinics in provincial cities have since been started, and in addition to these fixed centres, the Society provides two travelling caravan clinics for carrying information to women residing in districts where there are no birth control centres. Undoubtedly the birth control movement owes much to Dr Stopes's courage and efforts in inaugurating and extending a movement which is now making considerable progress in many countries of the civilized world.

In 1923 the Committee of the Walworth Women's Centre (the second clinic to be opened in Great Britain) formed an organization called the Society for the Provision of Birth Control Clinics. Its primary object

was to establish and support clinics in which instruction in the most satisfactory methods of contraception could be given to married women in poor circumstances by registered medical practitioners assisted when necessary by qualified nurses. This Society, which, in 1938, was incorporated (along with the National Birth Control Association, and the Birth Control Investigation Committee) in The Family Planning Association, has been successful in establishing more than sixty clinics in London and various provincial towns throughout Great Britain.

On the other side of the Atlantic Dr William J. Robinson, Dr Abraham Jacobi, and Mrs Margaret Sanger fought energetically through the years for the right of married women to have access to birth control information. Here, in addition to religious intolerance, they had against them the Comstock law. As a result of this opposition, Mrs Sanger's initial effort to found a clinic in New York City, in 1916, met with no success. It is, however, largely through her persistent efforts that the birth control movement in the United States is steadily gathering weight and that, although the dissemination of practical contraceptive information and the sale of appliances are still prohibited by the Comstock Act, the tendency is towards a more intelligent interpretation of the law.

APPENDIX THREE

WHERE TO OBTAIN BIRTH CONTROL APPLIANCES

DESPITE the so-called sexual emancipation of this twentieth century and the sophistication of the age in which we live, birth control remains virtually a tabooed subject. Those persons claiming the virtue of respectability think it is not a "nice" subject to discuss; that a manual on contraception is something to keep in a locked drawer for secret consultation; that to be seen gazing in a window displaying birth control requisites or entering the shop is equivalent to an admission of engaging in fornication; that the purchase of any such appliance is something to be undertaken surreptitiously, ashamedly and hurriedly.

One result of such an attitude is the lack of any discrimination in securing supplies of contraceptives, whether from a birth control emporium or a chemist's shop. The goods are not examined, they are accepted and paid for without quibble or question, the purchaser being in too great a hurry to get outside with such purchases before being seen or overheard by a third party. For these and other reasons the majority prefer to purchase contraceptives by hole-and-corner methods, largely through dealers or agents who themselves have no knowledge of the virtues or otherwise of the goods they peddle.

Now this reaction of the public towards the subject of birth control and all its correlations plays into the hands of unscrupulous manufacturers, distributors and dealers. Appliances of poor quality and in a defective state can easily be sold to the public at high prices. Rubber goods which have deteriorated through age or storage in harmful conditions; chemical contraceptives which have been in stock so long that they are inert, can be and are sold.

If the truth could be got at I believe that a considerable proportion of the failures to prevent conception attributed to contraceptive methods are due to the inferior or defective quality of the particular appliances or chemicals employed. In this way many methods get a degree of blame or condemnation which is wholly or largely unmerited.

Now contraceptives may be divided roughly into two classes: (1) those which may be purchased and used without medical or expert advice (condoms, sponges, suppositories, jellies, etc.); and (2) those which call for medical advice in their selection (diaphragm pessaries, cervical caps, etc.).

So far as those belonging to class 1 are concerned, they may be purchased from a shop specializing in birth control requisites; a chemist who sells contraceptives; or direct from the manufacturer. Direct purchase is specially indicated in the case of anyone who is disinclined to enter a shop for the purpose of buying contraceptives, or who lives in a country district. There are reliable manufacturers who have special departments which deal with mail orders, in some cases giving advice

as well as supplying the requisites. Catalogues of their products can be secured and studied at leisure.

Turning to class 2 the procedure here is not so simple. It has already been stated that in the case of a vaginal occlusive pessary or a cervical cap a correct fit is of the greatest importance. For this reason any woman who wishes to use one of these appliances (or who is doubtful as to which contraceptive method is best suited for her particular case), should consult a doctor¹ for the purpose of being fitted with a pessary or a cap of the correct size and instruction in its insertion and removal.

Where the question of expense rules out such a consultation, the best course to pursue is to visit the nearest birth control clinic. Many of these clinics supply all requisites at the lowest possible prices; in some cases at actual cost. They also offer to poor women special facilities for purchasing any necessary equipment, and at some clinics those who are not in a position to pay anything at all are supplied free.

Also, in accordance with the Memorandum issued by the Ministry of Health, all Public Health Authorities *may* now give advice on birth control. Those women who wish to avail themselves of this service should apply for help at the nearest Child Welfare Centre, the address of which can be obtained at the local Town Hall. It

¹ There seems to be a fairly generally diffused belief among both men and women that a doctor cannot give contraceptive advice or information. This is quite an erroneous idea (cf. page 131). If he refuses, and he may, either because he has old-fashioned prejudices against birth control or because he does not know anything about it, the only thing to do is to consult another doctor who has no such prejudices and who is acquainted with modern contraceptive technique.

should, however, be noted that such advice is not available to *all* married women, but *only to cases where further pregnancy would be detrimental to health.*

If anyone requiring birth control information or advice, whether for health, economic or other reasons, finds there is no clinic in the district, the best course to adopt is to write to THE FAMILY PLANNING ASSOCIATION, 69, Eccleston Square, London, S.W.1, who will provide any applicants with the address of the nearest Clinic where such information can be given them.

It may be mentioned here that the male partner rarely finds it necessary to secure medical advice.

APPENDIX FOUR

GLOSSARY OF TECHNICAL TERMS

- ABDOMEN (Belly):** The section of the body between the thorax and the pelvic cavity.
- ABORTIFACIENT:** Any means, chemical or mechanical, intended to empty a pregnant womb.
- ABORTION (Miscarriage):** Technically expulsion of the fertilized ovum at any period before the eighth month of pregnancy. From then on to the termination of pregnancy, expulsion of the foetus is termed "premature labour." In law, no distinction is made between abortion and premature labour where the expulsion has been criminally induced.
- ANAESTHETIC:** A drug or vapour which produces insensibility to pain, either local as with cocaine, or general as with ether or chloroform.
- ANTEFLEXION:** A displacement of the womb, where its axis bends forward upon itself.
- ANUS (Back passage):** The opening in the body through which excrementary products are expelled.
- APHRODISIAC:** A drug or other means, either chemical, mechanical, or psychical, for stimulating or increasing sexual desire or capacity.
- CAESAREAN SECTION:** An operation in which the child is removed from the womb through an incision in the walls of the abdomen and womb.

- CATAMENIAL PERIODS (Monthlies):** The periodical bloody discharges from the womb.
- CERVICAL CANAL:** The passage leading from the cavity of the womb to the vagina.
- CERVICITIS:** Inflammation of the cervical canal—the canal between the womb and the vagina.
- CERVIX:** The neck of the womb where it enters the vagina.
- CIRCUMCISION:** The cutting away of the prepuce or foreskin of the penis in males, as practised by the Jews and the Mohammedans.
- CLITORIS:** The small erectile sensitive organ situated in the vulva. It is homologous to the male penis and is capable of intense stimulation in coitus and masturbation.
- COITUS:** Sexual intercourse.
- COITUS A POSTERIORI:** The sex act performed in the position where the man is behind the woman.
- COPULATION:** The sex act.
- CYSTOCELE:** Protrusion of the bladder into the vagina.
- DECIDUA VERA:** The spongy membrane formed during pregnancy which is part of the placenta and comes away after parturition.
- DEFLORATION:** The rupturing of the hymen; a virgin's first complete experience of the sexual act.
- DYSPAREUNIA:** Painful or difficult intercourse.
- ECBOLIC:** A drug for inducing violent contractions of the womb with a view to expelling its contents.

ECTOPIC PREGNANCY: Where the embryo is formed outside the womb.

EJACULATION: The emission of seminal fluid from the penis.

EJACULATIO PRÆCOX: Ejaculation of the seminal fluid at the beginning of the sex act.

EMBRYO: The child in the womb up to the age of 4 months.

EMMENOGOGUE: A drug for restoring the menstrual discharge in case of suspension.

ENDOMETRITIS: Inflammation of the endometrium or mucous membrane which lines the interior of the womb.

EPISPADIAS: A malformation of the penis in which the urethra discharges through the upper surface of the penis.

FALLOPIAN TUBES (Oviducts): The tubes through which the ovum passes on its way from the ovary to the womb. The name is derived from their discoverer, Fallopius, an Italian physician.

FOETUS: The child in the womb after the first four months of pregnancy.

GLANS: The extremity of the penis.

GONORRHOEA (Clap): A venereal contagious infection of the urethra in the male and of the vagina in the female caused by a specific germ, the gonococcus, and indicated by a purulent discharge from the urethra and pain in micturition.

- GYNAECOLOGIST:** One versed in the diseases and physiology of the female generative organs.
- HYMEN (Maidenhead):** The membrane which in the virgin woman partially occludes the vaginal opening, and which at the first sex act is ruptured, with resultant bleeding.
- HYPOSPADIAS:** The malformation of the penis where the semen is discharged from an opening in the under side of the penis.
- IMMISSIO PENIS:** The penetration of the female vagina by the male member.
- IMPOTENCE:** Inability to perform the sexual act properly.
- LABIA MAJORA:** The large outer lips of the pudendum, constituting the external orifice.
- LABIA MINORA:** The two smaller and inner lips of the pudendum, enclosed within the labia majora.
- MASTURBATION (Self-abuse, self-pollution):** Manipulation of the genitals: in the male, of the penis; in the female, of the clitoris or the vagina. Often wrongly termed onanism, particularly by theological writers.
- MEATUS URINARIUS:** The external orifice of the urethra through which the urine passes in the act of making water.
- MENORRHAGIA (Flooding; haemorrhage):** An excessive and prolonged discharge of menstrual fluid.
- MENSTRUAL CYCLE:** The period between the onset of one monthly discharge and another.

MENSTRUATION (Monthlies): The bloody discharge from the female genitals which occurs at regular intervals, usually once every month.

METRITIS: Inflammation of the womb.

METRORRHAGIA: A bloody discharge from the womb unconnected with menstruation, indicating uterine disease.

MICTURITION (making water): The act of urination.

MULTIPARA: A woman who has given birth to more than one child.

NEUROSES: Nervous diseases or affections.

NULLIPARA: A woman who has not given birth to a child.

NYMPHOMANIAC: A woman who has an excessive desire or appetite for sexual intercourse.

OOPHORITIS: Ovarian inflammation; one or both of the ovaries may be affected.

ORGASM: The supreme moment of pleasure or excitement in the sex act.

Os: Literally mouth. The entrance to the womb.

OVA (Singular, ovum): The eggs produced by the ovaries.

OVARIES: The two oval bodies in the female which produce ova or eggs.

OVARIOTOMY: The surgical removal of the ovaries.

PARTURITION (Childbirth): The act of delivering a child.

- PELVIC CAVITY:** The part of the body which contains the urinary and the generative organs.
- PENIS:** The male member; the copulatory organ.
- PERINEAL COITUS:** The act of copulation where there is no penetration and the seminal fluid is ejaculated between the woman's thighs.
- PERINEUM:** The part of the body containing the excretory organs.
- PERITONITIS:** Inflammation of the membrane which lines the abdominal and pelvic cavities.
- PLACENTA (Afterbirth):** The connecting appendage between the foetus and the mother, which is thrown off with the true afterbirth.
- PREPUCE (Foreskin):** The loose skin which covers the end of the penis, and which is removed surgically in the case of circumcision.
- PRIMIPARA:** A woman who bears a child for the first time.
- PROLAPSUS UTERI:** Falling of the womb.
- PROPHYLACTIC (Preventive):** A precautionary mode of treatment to avoid disease; often specifically applied to the mechanical or chemical prevention of venereal infection.
- PROTOPLASMIC POISON:** Any chemical or other agent which has a destructive or injurious effect on living cells.
- PUDENDUM:** The external female genital organs; the vulva.

- PYOSALPINX:** An abscess formed in one of the Fallopian tubes.
- RECTOCELE:** Protrusion of the rectum into the vagina.
- RECTUM:** The terminal portion of the bowel.
- RETROVERSION:** The displacement of the womb where it falls or bends backwards.
- SALPINGECTOMY:** Surgical removal (partial or complete) of the Fallopian tubes (oviducts).
- SALPINGITIS:** Inflammation of the Fallopian tubes (oviducts).
- SCROTUM:** The bag which contains the testicles.
- SEATED VIS-A-VIS POSITION:** Where the man is seated and the woman sits across his thighs, facing him.
- SEMEN:** The fluid which is discharged by the penis as a result of the sex act or of masturbation.
- SEPSIS:** Blood-poisoning.
- SPECULUM:** An instrument which by dilating passages in the body, notably the vagina or cervix, facilitates examination or operation.
- SPERMATICIDE:** A chemical which destroys the life or motility of the spermatozoa.
- SPERMATOZOA (Seeds):** The tadpole-shaped fertilizing germs in the semen, produced in the testicles and emitted from the penis during copulation.
- STERILITY:** In man, inability to fertilize; in woman, inability to conceive.
- STRICTURE:** A contraction or plugging of the urethra; often a sequel to gonorrhœa.

SYPHILIS (Pox): A contagious venereal disease which usually begins as a hard, painless ulcer on the exterior genitals, and spreads rapidly through the system.

TESTES (Testicles): The two glandular bodies contained in the bag or scrotum which secrete the spermatozoa (seeds)

TUMESCENCE: The arising or development of sexual passion previous to actual coitus.

URETHRA: The connecting canal or tube between the bladder and the meatus urinus.

UTERUS: The womb.

VAGINA: The passage between the entrance to the womb and the vulva (external opening).

VAGINISMUS: A sensitive condition of the vagina which leads to the spasmodic closure of the vulvular entrance, usually preventing any penetration of the male organ. Vaginismus is the main cause of impotence in women.

VAS DEFERENS: The spermatic duct leading from the testes to the penis.

VASECTOMY: Surgical sterilization of the male by ligature and removal of a portion of the sperm-duct.

VULVA: The external female genital opening.

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