

VOLUNTARY MOTHERHOOD

*A Study of
The Physiology and Hygiene of
Prevention of Conception*

By A Woman Physician
with Twenty Years' Experience



1928

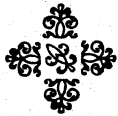
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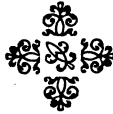
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3	Introduction
5	Anatomy Necessary for this Discussion
8	How to Judge the Value of a Birth Control Method
9	Classification of Birth Control Methods
10	Methods Used by Men
10	Cotus Interruptus
11	Condoms
13	Methods Used by Women
13	Chemical Methods
13	Solution for Douching
15	Suppositories
16	Pastes (Antiseptic)
17	Tablets
18	Mechanical Means
18	Sponges
19	Rubber Pessary
22	Different Types of Pessary
22	Cervical Pessary
22	Vault Pessary
24, 26	French Pessary
24, 28	Daphragmatic Pessary
24, 28	Ramases, Kantos
24, 28	Meninga
26	Devices Inserted into Neck of Womb (Gold Spring Pessary)
32	Summary of Methods
32	Reliable Methods
32	Partially Reliable Methods
33	Unreliable Methods
33	Prevention for Newlyweds
34	Prevention in Relation to Period of Menstruation
34	Biological Method (Spermatoxin)
35	Nursing Mothers
35	Sterilization
35	Delayed Menses
36	Final Word
37	Glossary

VOLUNTARY MOTHERHOOD

BY WAY OF INTRODUCTION

BIRTH CONTROL, Birth Regulation and Voluntary Parenthood are popular terms for prevention of conception. Many people confuse prevention of conception with abortion. This is due to a lack of understanding of what conception really means. To prevent conception means to use methods which will interfere with the fertilization of the ovum (egg) or, in other words with the formation of the embryo, which develops into the baby. Abortion implies the destruction of the embryo already formed. Knowledge of Birth Control is the best method of lowering the number of abortions.

As a physician I consider the study of contraceptive methods and their application a branch of medical science which should be taught in medical colleges. Physicians and nurses who know the anatomy of the sexual organs and the hygiene of sex should be the ones to instruct women and men as to the best methods available. In some cases of kidney trouble and heart disease, serious illness and even death may be prevented by contraceptive means. Nevertheless the majority of physicians of our country are not only indifferent but actually hostile to Birth Control and refuse to give any information concerning it.

The Birth Control movement is not the result of artificial agitation; it is forced upon the minds of women and men by existing conditions and, therefore, neither the prejudices of physicians nor suppression by law will be able to do away with it. While in most practical applications of medicine in the prevention of disease the physician must influence the masses, in Birth Control the masses slowly but surely are influencing the medical profession. More and more physicians are becoming converted to the idea of Birth Control, but the great drawback for many of them consists in the fact that they do not know where to get reliable information on the

problem, which up to date has been left almost entirely in the hands of the laity.

Voluntary parenthood is no panacea for all human evils; it will solve neither the problem of poverty nor of war as claimed by some neo-Malthusian enthusiasts. But it has a wide scope of influence and is especially of momentous significance in the life of woman. Woman can never obtain real independence unless her functions of procreation are under her own control. The woman married to a worker finds in Voluntary Parenthood the same opportunities for leisure and economic relief as are afforded to her husband through his labor union. To her voluntary parenthood means the eight- or six-hour day, instead of the twelve- or sixteen-hour day, which the mother of many children is forced to endure. The professional woman is enabled through voluntary parenthood to combine her professional work with marriage. Ellen Key points out that every professional woman has the serious question before her: marriage or independence. Voluntary parenthood permits her to combine both.

Many more important changes will be brought about by the application of Voluntary Parenthood principles. A few of them can be enumerated without going into detail: Prevention of conception does away with abortions. It permits early marriages. It lightens the burden of motherhood and gives mothers some leisure for self-culture.

It brings about happier sex relations. It preserves woman's health and prevents her aging prematurely.

It leads to an improvement of the race. Having had about twenty years of experience in prevention of conception, I feel it my duty to share this experience with others, especially with the medical profession. The nightmare of undesired parenthood must be destroyed. If this little pamphlet will help to pave the way in that direction my desire will have been attained.

Our laws still mete out the same punishment for birth control as for abortion. The severe prosecution for the practice

of both, however, has not diminished the number of abortions, nor prevented the spread of contraceptive methods. The people of the United States have practically adopted birth control. Physicians can testify to the fact that the overwhelming majority of married couples use one or another of the methods of contraception. It is no longer necessary to prove the need of birth regulation; men and women are now mainly interested in securing reliable and healthful contraceptives, for those methods spread and used at present are the least reliable, the ones most unhealthful.

Legislation cannot prevent birth regulation. All it achieves with its narrow, unscientific attitude is the prevention of the spread of normal and healthful methods, while it leaves the way open to contraceptives detrimental to health.

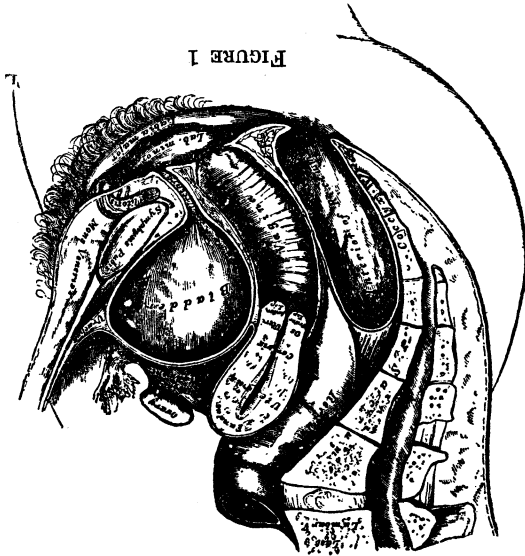
The average woman and man are surprisingly ignorant of the functions of their bodies, especially their sexual organs. They have hardly any idea of what "conception" really means. They have therefore some very curious notions regarding prevention of conception. For example, many of my patients are sure that urinating after coitus is a good method of prevention; others believe that the woman can prevent conception by refusing to respond to the passion of the man. (Perhaps this causes the frigidity of which men complain so bitterly.) Again some imagine that medicines taken by mouth can prevent conception.

The correct application of contraceptive methods presupposes a clear understanding of the nature of conception. I therefore give briefly a description of woman's sexual organs and the process of conception.

THE KNOWLEDGE OF ANATOMY NECESSARY FOR THIS DISCUSSION

The external part of woman's reproductive organs is known as the *vulva*. It surrounds and protects the entrance to the vagina. The *vulva* comprises the large and small *labia* and the *clitoris*, the opening into the bladder and the vagina. (See Figure 1.)

The vagina is the canal that forms the passageway between the external and internal sex organs, between the vulva and the *uterus* (womb). It serves also for the purpose



of copulation (the sexual act). The penis (male organ) enters the vagina during *coitus*, and *ejaculation* of the *seminal fluid* takes place into the vagina. The vagina is directed downward and backward. In virgins the vaginal opening is narrowed (not covered) by a mucous membrane, called the *hymen*. The uterus is a small muscular bag consisting of the *cervix* (neck) and body. It measures three and a half inches including the cervix, which is a quarter of an inch long. In breadth it is about two inches. The cervix is the part of the uterus which enters the vagina and can be easily felt as it projects into it. The opening in the cervix leads into the cavity of the uterus. This opening is very narrow. The uterus is not a closed bag; it has openings at both sides at its upper, broader end. These openings are connected with the tubes, two narrow canals leading to the ovaries. Each tube is about five or six inches long. The outer extremity of the tube is trumpet-shaped and surrounds the ovary. The ovaries are almond-

shaped glands. They are the most important part of the sexual mechanism, for in them is found the *ovum* (egg). The ovum is the microscopically small cell that contains all the physical and spiritual characteristics which the mother contributes to the child.

The ovary discharges the ovum into the tube and from there the ovum is pushed into the uterus. A discussion of the forces bringing about these movements would lead us into too many details. The ovum is one of the two parts necessary for conception. The other part is the *semen* or *spermatozoa* (seeds) of man. The seminal fluid of man, which is created mainly in the *testicles* and ejaculated during the sexual act into the vagina, consists of millions of microscopically small cells (spermatozoa). The spermatozoa are little cells built for motion. The front part of the cell looks like a little head, while the back is formed like a little tail. (See Figure 2.)

The spermatozoon deposited in the vagina moves toward the cervix, enters the opening of the cervix and through the canal of the cervix enters the uterus, and from there enters the tube. (The spermatozoon moves half an inch during one minute.) The uterus probably helps the spermatozoon along by its contractions during sexual excitement. It draws the seminal fluid up into itself by contracting and relaxing its walls like a rubber ball.

The union of these two cells, ovum and spermatozoon, is called *impregnation* or conception. It usually takes place in the tube sometimes in the uterus. The newly formed cell, the product of this union settles down in the uterus and forms the *embryo*, which later develops into the baby. The ovum is the carrier of the mother's hereditary qualities, the spermatozoon, the carrier of the father's characteristics.

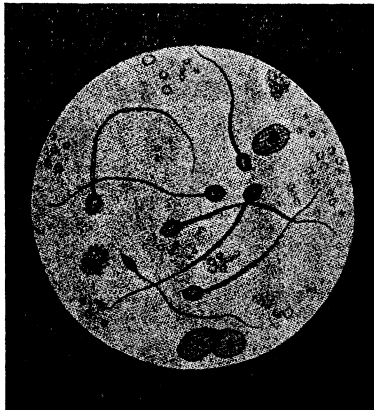


FIGURE 2
SPERMATOZOON (*much enlarged,
as seen under microscope*)

HOW TO JUDGE THE VALUE OF A BIRTH CONTROL

METHOD

The important thing for us to remember is the fact that conception takes place in the uterus or tube. The spermatozoa must enter the uterus for the purpose of conception. To prevent conception, the problem is how to prevent the entrance of the spermatozoon into the uterus.

This prevention of conception, or prevention of the entrance of the spermatozoa into the uterus, must be brought about in such a way that the health of the man and the woman should not suffer. Nor should it interfere with the normal sexual relationship, as such interference is likely to cause nervous disturbances very injurious to health. Naturally, contraceptive measures must be simple enough to be used by a person of average intelligence and should not be so complicated as to necessitate many preparations. Many authorities on sex hygiene think that the seminal fluid is absorbed by the mucous membrane of the vagina and that this absorption stimulates woman's health. Although the evidence for this is not conclusive, it must be considered in the choice of method. I would say then that a good contraceptive method should comply with the following conditions:

1. It must prevent the entrance of the spermatozoon into the uterus—in other words, *it must be safe* (sure).
2. It must not interfere with the course of normal sex relations.
3. It must not affect health detrimentally.
4. It must be simple enough to be used by the average person.
5. It should, if possible, allow for absorption of the seminal fluid by the walls of the vagina.

CLASSIFICATION OF BIRTH CONTROL METHODS

I shall divide these methods into two groups:

1. Methods used by men.
2. Methods used by women.
 - a. Chemical methods.
 - b. Mechanical methods.

In discussing these I shall lay stress on the conditions mentioned above; namely, health, security, simplicity, and normality. And since security is next to health, the most important, I shall review all methods in a summary dividing them into three groups:

1. Reliable.
2. Partially reliable.
3. Unreliable.

An original feature of my discussion is that special stress is placed on certain combinations; in fact it will be seen that *combinations* are the only completely reliable methods.

Description in full of the use of methods which are unreliable or only partially reliable is included in this pamphlet for two reasons. First, if I do not mention these, some readers may consider them reliable methods of which I have not heard. Secondly, it is well to realize that under certain circumstances emotion is more powerful than reason and that on these occasions a poor method of prevention is better than none.

METHODS USED BY MAN

The methods used by most men are *cotus interruptus* (withdrawing of the male organ); and *condoms* (saves).

COITUS INTERRUPTUS

The male organ (*penis*) is withdrawn from the vagina just before ejaculation of the seminal fluid. This method is neither safe nor healthy; it tends to wreck the nervous system of the man and of the woman, and does not give complete satisfaction to either. Investigation has proved that a leakage of seminal fluid containing spermatazoa takes place previous to ejaculation. Thus, even if the man withdraws before ejaculation, impregnation can take place. In addition to this, the majority of men do not have the self-control to interrupt the sexual act at the very height of their passion. The average man unknowingly leaves a part of the seminal fluid near the entrance to the vagina in the vulva. From this point the spermatazoa can make their way deeper into the vagina, up through the cervix into the uterus, since they can move about an inch in two minutes, and also can live for several days. This possibility is easily demonstrated by the fact that *wirgins can conceive*. Women positively pregnant often present an intact hymen. In these cases, since the penis could not enter the vagina, we have evidence of the ability of the sperm to travel from the hymen up into the uterus.

Some physicians assert that men can attain full control of themselves after a certain time. This neglects the fact that there is leakage of seminal fluid and also presents the question: How many children may be born before this ability is reached?

In my practice I have found many cases where *cotus interruptus* seemed effective. Invariably I learned that the seeming efficacy was due to a peculiar construction of the sexual organs of the woman which made conception difficult. Whenever a patient tells me that her husband succeeded in warding off pregnancy for several years by *cotus interruptus*,

I am sure to find either a narrow opening of the cervix or a displaced uterus, or some inflammatory condition of the uterus, if not sterility in the man. The woman in these cases is aided more by her own partial sterility than by this method of birth control. But in cases where woman's sex organs are in normal condition this method is absolutely unreliable.

The only commendable point in this method would seem to be its simplicity. The average woman, brought up in aversion to the sex act, does not realize the importance of normal sex relations for herself and husband, and is very much inclined to leave the full care of prevention to the man. The patient who tells me that she does not care for sex relations, says also, "Let him take care; as for me I do not need it anyway." Probably she does not have any sex desire just because of the abnormality of such relations, and no doubt also because of the overpowering fear of undesired motherhood.

I consider coitus interruptus *unsafe, abnormal, and unhealthy* and would advise its use only in exceptional circumstances and then only in combination with other methods, such as douching or the introduction of chemical pastes, of which I will speak later.

CONDOMS

A professor in a German clinic said about condoms, "From the point of view of prevention a condom is as thin as cobweb, but from the point of view of the joy of the sexual act it is as thick as the wall of a fortress." This statement is no an exaggeration. Condoms tear, leak and slip off. Absolute safety can be attained only if the condom is combined with the use of a paste or douching.

Condoms are made of rubber and skin (beetleskin or fish-skin so-called). It is best to use the rubber condom only once. Lubricate with glycerine or vaseline before using. Beetleskins are stronger and can be used again. Wet it from both sides before using. They must be kept in water or still better, diluted alcohol. Before using the condom it should be tested

with air or water to see if it contains a hole. Space should be left at the lower end for the seminal discharge.

Condoms are sold at every drug store and are marked: "For Prevention of Infection." Such is our hypocrisy. The man buying a condom silently admits either that he or his wife is diseased or that he intends to use it with a prostitute. He is not supposed to use it for prevention of conception.

I do not recommend the condom. First, it is highly disagreeable. Few men and women can enjoy sex relations with this foreign body present. Secondly, it is unsafe in the sense that one never can tell when it will fail. As far as simplicity is concerned objections cannot be raised by the woman, but it is neither safe nor normal.

I can hear some readers say at this point, "They have never broken in our experience." My answer is that my practice shows that married women are apt to have as many pregnancies in a given number of years with the use of condoms as without.

Safety is insured only when the condom is supplemented by other methods. Douching is unsatisfactory in this case, for during the time consumed in preparing the douche, the spermatozoa released through a tear in the condom may enter the uterus. In coitus interruptus the woman has the assurance that the spermatozoa are not deep in the vagina, an assurance which she cannot have in the case of a torn condom. The other supplementary means used with the condom must be other than douching. The best supplementary is a chemical paste inserted in the vagina before coitus to destroy any liberated spermatozoa.

Some men, urged by their wives, whose fear of an unwanted baby takes away all sex desire, use even two condoms at once. I know a number of families who have followed this method for years. It is hardly necessary to state that sex relations under such conditions are absolutely abnormal and can satisfy neither husband nor wife.

I draw the conclusion, then, that both methods, coitus interruptus and condoms, are unsatisfactory. If either method is used supplementary precautions must be taken.

METHODS USED BY WOMAN

As I have said, the methods used by women are to be divided into

- (a) Chemicals introduced into the vagina.
- (b) Mechanical appliances.

THE CHEMICAL METHODS

These in turn are to be divided into

1. Douching.
2. Suppositories.
3. Tablets.
4. Paste.

DOUCHING WITH ANTISEPTICS IMMEDIATELY AFTER COITUS

The fountain syringe of two or three quarts capacity is best for this purpose. The bag should be filled with warm water and an antiseptic added and stirred in thoroly.

Douches can be taken in a sitting position. The vaginal nozzle should be introduced into the vagina, and moved around, so that the water reaches all parts. Douching with cold water is not advisable. The advantage that time and work are saved by its use is counterbalanced by the fact that the vagina contracts and may keep in its folds some the semen, which will thus not be exposed to the effects of the solution. Cold douches are also inadvisable in that the sudden cooling off of congested organs can be harmful.

Solutions to be used:

1. Boric Acid—1-2 tablespoons to 2 quarts of water.
2. Lysol—one quarter of a teaspoon to 2 quarts of water.
3. Creolin—one quarter of a teaspoon to 2 quarts of water.
4. Sulpho-Napthol—one quarter of a teaspoon to 2 quarts of water.
5. Vinegar—1 glass to 2 quarts of water. Wash out with one quart of clean water afterwards.

Do not use salt solution. It may support the life of the spermatozoa. For the same reason sodium bicarbonate, and

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Do not use salt solution. It may support the life of the spermatozoa. For the same reason sodium bicarbonate, and

other *alkaline* solutions must not be used. These are very good for other purposes but not for birth control. Plain water can not be relied upon, but in the absence of antiseptics, water is better than nothing. Of all mentioned solutions boric acid is the one to be preferred: it is mild and efficient.

The much advertised whirling spray—a large, heavy rubber ball from which the solution is squeezed by hand through a nozzle into the vagina is not reliable, since it holds an insufficient quantity of solution. It may be effective if strong antiseptics are used for the purpose of destroying the spermatozoa without washing them out, but strong antiseptics are harmful to the vaginal mucous membrane, and may cause poisoning. Besides, the fluid may not reach the spermatozoa hidden in the folds of the vagina as the force of the flow is not as strong as from the regulation douche bag.

Some advise use of douching before coitus. This contradicts the condition of simplicity and normality, for too much preparation interferes with sex relations. It also washes out the normal mucous present in the vagina, thus bringing about an abnormally dry state of the vaginal walls. Finally, the ejaculation may project the seminal fluid directly into the cervix where the thin liquid coat of antiseptic solution could hardly ensure prevention.

Many women claim perfect success with douching, for the same reason that others claim success in preventing conception with coitus interruptus. In these cases obstruction is usually found, such as displacement of the womb, which by itself gives considerable security. In a normal woman, however, douching will not serve the purpose. *This method is absolutely unreliable.* The spermatozoa can enter the womb during coitus or while the douche is being prepared. Douching by itself is, therefore, not to be recommended, but in combination with other means (described later) it is helpful.

SUPPOSITORIES, TABLETS, AND PASTES

The basic idea of this preventive is the introduction of chemicals into the vagina. These chemicals are intended for

the destruction of the spermatozoa without injuring the mucous membrane of the vagina, or affecting the health through absorption.

Chemicals used are:

- Quinine—5 to 15 grains to an ounce of paste or cocoa butter.
- Boric Acid—3 to 4 percent solution.
- Salicylic Acid—1 to 2 percent solution.
- Formaldehyde—1 to 1000 or $\frac{3}{4}$ teaspoon to a quart.
- Chinosol—1 grain to an ounce. ($\frac{1}{4}$ percent)
- Corrosive Sublimate—1 to 5000, 1 tablet to 2 qts. of water.

Corrosive Sublimate ought not to be used, since it is easily absorbed and works as an accumulative poison in the human body.

These chemicals introduced deep into the vagina near the cervix before intercourse, mix with the so-called "seminal lake," the accumulation of the ejaculated semen, and by their chemical action destroy the life of the spermatozoa. They must be introduced before coitus so that the seminal fluid gets in contact with them before reaching the cervix. *Their work is futile if the penis comes directly in contact with the cervix and ejaculation takes place directly into the uterus.*

SUPPOSITORIES

Chemicals mixed with cocoa butter or boro-glycerine are made up in egg shaped or globular form. Suppositories made of cocoa butter require at least 7 minutes to melt in the vagina, those of boro-glycerine at least 20 minutes. Unless they are melted, they are ineffective.

The price of suppositories is from \$1.00 to \$1.50 per dozen. They can be ordered in almost any drug store.

I have used the following forms:

- Quinine Sulph. grain two.
- Boric Acid grain two.
- Cocoa Butter drachm one.

This makes one vaginal suppository.

- Chinosol, grain one sixth.
- Boric Acid, grain two.
- Cocoa Butter, drachm one.

This makes one vaginal suppository.

Screw nozzle on tube, then turn key until nozzle is full to tip; insert amount necessary for treatment. Then withdraw nozzle and plug it with stopper. The tube contains about twenty applications. The application is best made at night before retiring, followed by a syringing with warm water the next morning.

DIRECTIONS FOR USE

PHOTOGRAPH OF TUBE, ONE FOURTH ACTUAL SIZE



Since it is water soluble, the chemical action of the anti-septics upon the spermatozoa takes place at once, whereas, in the case of the cocoa-butter, the fatty consistency interferes with the action of the chemicals, allowing only part of the chemical to act, and then only slowly.

It has many advantages over the suppositories. It is soft and melts at once. It is introduced easier and deeper, because the majority of women can manage a vaginal nozzle better than their finger. It consists mainly of glycerine and some vegetable gelatin and is therefore less disagreeable than cocoa butter suppositories, which form a fatty mixture.

Antiseptic paste is squeezed from the tube into the vaginal nozzle and from there into the vagina by the turn of the key at the end of the tube.

ANTISEPTIC PASTE

The few available reliable statistics show indifferent results following the use of suppositories. One explanation of this is that the chemical contained in the cocoa butter is coated with this fat to such an extent that very little actually comes in contact with the spermatozoa.

The suppository is inserted deep into the vagina so that the finger can hardly feel it. The body heat melts it, and the chemicals destroy the spermatozoa. Also the cocoa butter acts as a mechanical barrier, blocking the opening into the womb. Unfortunately considerable time must elapse before melting takes place, and the woman can never be certain that it has completely melted.

Antiseptic paste in tubes supplied with nozzles are at present sold in the United States for the treatment of leucorrhœa. These pastes incidentally contain all the ingredients necessary for a good preventive. There are many preparations on the market, which retail for from \$2.00 to \$3.00 a tube.

The tubes contain about one-half a glassful of paste, each turn of the key injects about three-quarters of a teaspoonful. Thus each tube contains about twenty applications. You can insist that your druggist obtain these tubes for you.

Among the pastes at present on the market are Prekonsol, Leucorrhol, Patentex, Laktikol and Koromex. These pastes are by no means equivalent, since they differ in composition. Prekonsol, Leucorrhol and Patentex are said to contain, in addition to Boric Acid, oxyquinoline sulphate, which is a powerful and mild antiseptic. On the other hand Laktikol and Koromex are said to rely for their action on Lactic or Boric Acid only. Mere acidity without a strong antiseptic agent is not enough to assure safety, since the vaginal secretion has a buffer nature and tends to maintain a constant hydrogen-ion concentration; in other words the vaginal secretions neutralize the acidity and the spermatozoa are not affected.

Such figures as are available through clinical experience support this view. Two per cent lactic acid paste when used on rabbits produced no effect on the rate of pregnancies. The Illinois Birth Control League reports (1924-1927) better than 96.5% success in 2274 cases where pessaries and Prekonsol paste were used in combination. From 1925 report of the Chemical Research Department, The American Birth Control League, we conclude that in cases where pastes alone were used best results were obtained with a paste similar in composition to Prekonsol, Leucorrhol and Patentex, whereas pastes containing acids only proved least effective. [Owing to the limited number of cases (186) final judgment must be deferred.]

Oxyquinoline Sulphate is a powerful antiseptic but is harmless to tissues. A very small percentage of women are sensitive to this chemical and for them lactic acid pastes are recommended.

The first suggestion that would come to one's mind is a sponge or piece of cotton placed into the vagina in front of the cervix. Pieces of cotton, sponges, or gauze soaked in an anti-septic solution are used for this purpose. If one looks at the picture presenting the relation of the uterus and vagina, one can see how easily the erect penis can push such a sponge away from the cervix into the back part of the vagina. This leaves the entrance into the cervix unprotected with consequent possibility of impregnation. Therefore this method is entirely unsatisfactory.

Sponges

1. Sponges
2. Rubber pessaries covering the cervix.
3. Devices (pessaries) inserted into the cervix.

I divide the mechanical means into

vagina.
The main aim of the mechanical means is to close the opening of the uterus, in other words the spermatozoa are not killed but are prevented from going deeper than the

MECHANICAL APPLIANCES

them.
fact that if the male organ is directly in contact with the entrance of the uterus the spermatozoa may be thrown into the uterus without giving the chemicals a chance to act on them.
A general objection to the use of chemicals alone is the upon.

strong enough to do the work, and can therefore not be relied upon. Some tablets, largely advertised do not contain chemicals. This pain is the main objection against the use of tablets. part of the vagina they cause a distinct pain or smarting. when inserted and coming in touch with the lower sensitive tablets contain the chemicals in condensed form and therefore chemicals more thoroughly into all parts of the vagina. The vescent chemicals are added for the purpose of spreading the Tablets are chemicals compressed in tablet form. Effert-

TABLETS

RUBBER PESSARIES

The use of rubber pessaries is considered the most reliable method of prevention if combined with an antiseptic douche or paste.

The main purpose of every pessary is to cover the cervix, the entrance into the womb. Thus the spermatozoa cannot enter the womb during coitus. (See figure 3, French pessary in place.) The spermatozoa remain in the vagina and must be washed out or destroyed before the pessary is removed, otherwise they may enter the uterus, for the spermatozoa live for many hours, even days. The use of the pessary must always be combined with douching before its removal. Instead of a douche an antiseptic paste can be used. The paste (as explained under "chemical methods") is introduced into the vagina through a glass nozzle attached to the paste-tube. A small amount suffices to destroy the semen. The paste is introduced before the pessary is removed. As it spreads about slowly, the pessary should not be taken out until at least three hours have passed since the use of the paste.

Important Rule:

A pessary should never be removed (if coitus has taken place) unless an antiseptic douche has been used. (See details on douching under "Chemical Methods.") An antiseptic paste can be used instead of the douche, but in this case the pessary cannot be removed at once but must remain in place at least three hours.

A rubber pessary with the use of an antiseptic douche or paste is a reliable method of prevention because all conditions of a good contraceptive method are complied with. (The type of pessary to be used is discussed below.)

It Is Safe

The spermatozoa cannot enter the uterus since the neck of the uterus is covered during coitus and they are removed by an antiseptic douche or destroyed by a paste before the pessary is taken out. For greater safety, some put a

little paste around the rim of the pessary to stop any spermatozoa which might get under the edge.

It Is Harmless

The pessary, if well fitted, does not rub or irritate any part of the uterus or vagina. It remains in the vagina only over night or for a short time, and cannot interfere with the normal discharge of the uterus. Many of my patients have used pessaries for fifteen or twenty years. I have seen and examined them many times during that period, and found no harmful consequences.

It Permits Normal Conditions of Coitus

The majority of men and women, as I have ascertained through a questionnaire, are not conscious of its presence. In a few cases, the man was aware of the presence of the pessary, but found it less annoying than the use of other mechanical devices. Out of two hundred and fifteen cases answering my questionnaire which I circulated this year, only three women reported that the pessary interfered with their sex pleasure. Preparations for coitus are always a disadvantage. To avoid this, the pessary can be introduced hours before coitus takes place. Douching can be delayed until morning, or for many hours: repetition of coitus is possible without new preparations.

The Use of a Pessary Is Simple

Any woman can learn its use within ten or twenty minutes. After having practiced its application, the introduction should not take more than a minute's time. I am often asked whether the pessary can be worn steadily. I do not advise it, because the pessary covers the cervix and prevents the escape of the normal discharge of the uterus. Again, the pessary may slip during exercise or bowel movement. As the pessary is so easily adjusted by the average woman it should be inserted whenever needed. If the pessary is inserted every night before retiring, as a regular part of woman's toilette, whether intercourse is expected or not, there

is no disagreeable interruption either physically or mentally in the love embrace.

There are various types of pessaries, since women are very differently built. Even the same woman needs a change in size at different periods of her life, for instance, before and after

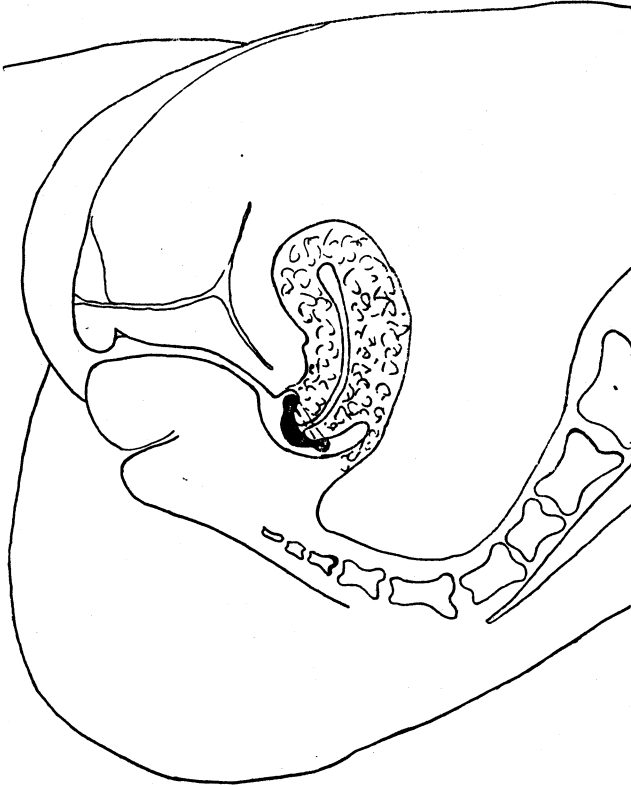


FIGURE 3 — FRENCH PESSARY IN PLACE

child birth. Such pessaries should, therefore, be fitted by physicians or nurses.

Pessaries are made of durable rubber. They do not tear suddenly while in the vagina, but deteriorate slowly. The wearing out of the rubber can be easily noticed. The rubber becomes hard and brittle. In the French pessary the rim flat-

A vault pessary covers the cervix with a cap like the cervical pessary, but it also fills, with its large rim, the vaginal vault around the cervix (the anterior and posterior fornices). The round rim, usually one-quarter of an inch thick, is made of either solid or soft rubber, or of rubber tubing filled with air. The pessary does not hang on the cervix; it keeps in place by means of its large rim which fits in between the upper part of the cervix and the walls of the surrounding vagina.

VAULT PESSARY

This pessary is built like a thimble, only larger. It is made of aluminum, silver, hard or soft rubber. It must fit the cervix snugly, if it is to stay on. In many cases this pessary can be pushed off during coitus. The use of this pessary should be limited to a very few selected cases. It is undeservedly in great vogue in Germany and Russia.

CERVICAL PESSARY

The diaphragmatic and vault pessaries are the only ones recommended by authorities on birth control. The description and evaluation of others are given to warn against their use. The detailed description of the use of the diaphragmatic and vault pessaries are given below.

Some other forms are mentioned in exhaustive treatises, but as they are not in general use, or advisable, we can omit them.

- 1) Cervical pessary
- 2) Vault pessary
- 3) Diaphragmatic pessary.
- 4) Block shaped pessary

DIFFERENT TYPES OF RUBBER PESSARIES

tens after long use; in the Ramses the rubber deteriorates around the rim. Never use vaseline or ointments on rubber. These soften and distend it. The antiseptic pastes recommended contain no fatty substances and therefore do not spoil the rubber.

It cannot be easily displaced. In cases of antiversion of the uterus, however, where the anterior vault (fornix) is very small, this pessary should not be used, for under such circumstances it can be easily displaced during coitus. (See Figure 6)

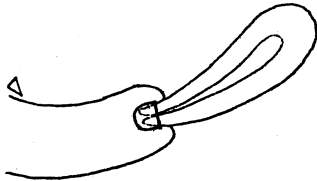


FIGURE 4
CERVICAL PESSARY

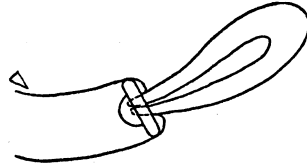


FIGURE 5
VAULT PESSARY

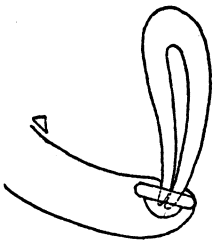


FIGURE 6
VAULT PESSARY
In Anterior Position of Uterus

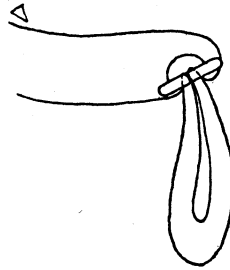


FIGURE 7
VAULT PESSARY
In Posterior Position of Uterus

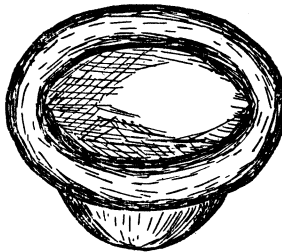


FIGURE 8
FRENCH PESSARY (VAULT PESSARY)

Some physicians persist in calling this type a cervical pessary. In my opinion the presence of the large rim gives a decided advantage to this form over the rimless cervical type, and is sufficiently important for a separate classification.

The following vault pessaries are in use.

The French pessary, which is the characteristic vault pessary, as described above.

The Pro-Race, or Dr. Stopes' pessary (much used in England). This pessary has a thinner rim than the French, and a much longer cap. It is supplied with a rubber loop near the rim into which a finger can be hooked to help its removal. It is not an improvement on the French pessary. Its thin rim and long cap give more chances for displacement.

The Mizpah Pessary has a heavy, solid rim, with a slit in the rim, into which a thin detachable rubber cap is adjusted, tied on by a string. This string also serves for the removal of the pessary. The heavy, clumsy rim, the ease with which the cap can come off the rim, make the use of this pessary inadvisable. Women who have no possibility of getting a physician's advice may find the Mizpah helpful, for they can remove it easily, whereas the removal of the French pessary often presents difficulties to a novice.

The small sizes of the so-called Diphragmatic Pessary: Ramses, Kantos or Mensinga (Numbers 45, 55 and 60 m.m.) The pessary is adjusted like a cervical one, but, having a much wider rim than the cervical, it enters deeper between the vaginal wall and the cervix and covers part of the walls. This type is useful in cases where the rim of the French pessary is too large to fit in the fornices and the rim of the cervical pessary is too small.

The Flat Pessary has the shape of a shallow saucer, the rim and cap being made of a single piece of heavy rubber. This pessary can last for years, but it fits only in special cases and cannot therefore be recommended for general use.

My own experience with the French pessary proved it very efficient, except in cases of antiversion of the uterus, (anterior position of the uterus). (See Figure 8)

The Diphragmatic Pessary, Ramses, Kantos and Mensinga (large sizes 60 and up), divide the vagina into two sections, blocking off the upper section which leads to the cervix and leaving the lower part free for normal intercourse. (See Figure 11.)

The larger sizes are used because they are intended to cover a larger surface of the vaginal wall. (This is accomplished without materially diminishing the space left free for intercourse.) They resemble in size and appearance half of a tennis ball. A coiled or plain wire spring runs around the inside of the rim of the cup and preserves the shape. The sizes vary, the average being 60 to 75 mm. in diameter. The largest possible size that fits the woman should be selected.

BLOCK SHAPED PESSARY

A block of rubber or other material, with cup shaped faces on every side is now on the market. The idea of the device

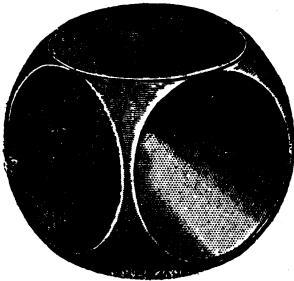


FIGURE 9
BLOCK SHAPED PESSARY

is that it can be inserted in any manner, without the possibility of failing to cover the cervix by one of its cup shaped sides. In actual practice this apparatus is by no means certain to cover the cervix; its bulk and shape can cause irritation to the female and male organs. It is rather an instrument of torture than a preventive. An article has appeared in *The Journal of the American Medical Association* reporting a case, in which this cubical pessary caused an opening between the bladder, rectum, and vagina.

GENERAL DIRECTIONS TO WOMEN FOR USE OF PESSARIES

To understand how to insert the pessary a woman must first get acquainted with her own body. The average woman thinks with disgust of her sexual organs; she has been brought up with such ideas. Such aversion, based on the old, wrong conception that everything connected with sex is low and vile must be overcome. The normal vagina is as clean as the mouth. (If you look at the diagram you will note that the bladder empties through a separate opening.) A woman can best ex-

amine herself in a squatting position by inserting the first finger of her right hand frontwise into the vagina. The finger must be inserted full length, directed downward, inward and backward. Then it will strike (way back and down) the cervix, a round, smooth little body, the size of a thumb, with an open-



FIGURE 10
(Self examination in squatting position)

ing in the middle (entrance into the uterus). In normal cases the cervix points backward and the woman will feel only the smooth surface of its front part. This is the only projection in the vagina, which is otherwise like a soft bag, the walls closing tightly over the finger. (See Figure 10.)

FRENCH PESSARY

(More detailed description)

The French pessary is a small cap made of rubber. It is adjusted over the neck of the uterus. The neck enters into the

deep opening of the cap in such a way that it is wholly covered by the pessary (see Figure 3). The border or rim must fit firmly around the neck of the uterus, while the cap may hang loosely. The rim of the pessary fills out the space between the cervix and the walls of the vagina. The cap does not fit like a glove, as many imagine. I speak of this because women seem to pay attention to the fact that the thin part of the pessary is wrinkled after being placed over the neck. If the upper rim of the pessary fits well, the pessary is in place.

This cap can be adjusted some time before coitus. It must fit firmly between the cervix and surrounding walls so that it cannot be displaced by pressure.

The pessary, folded with the rim upward, is introduced into the vagina. After it is pushed through the narrow entrance of the vagina, it opens; then it is pushed back, in, and down. One must push firmly for the walls of the vagina close tightly and the pressure of the walls must be overcome. The pessary must be pushed as far back as it goes, about a finger's length from the entrance. It slips over the neck of the womb. It is necessary to feel the bulging cervix through the thin rubber tissue of the dome. If the vagina is dry it is desirable to lubricate it with a touch of K-Y jelly, glycerine, vaseline or paste. Do not put any lubricant upon the pessary itself; it is difficult to handle when slippery.

After coitus, douching may be postponed until morning, unless the woman has to move her bowels. If an antiseptic paste is used immediately after coitus, the douching can be postponed until morning, or if one does not object to the presence of the paste douching can be dispensed with.

After coitus, never remove the pessary before douching or applying paste. Douche first, then remove the pessary and use part of the douche after the removal. Always wash the vulva and external genitals while douching. If paste is used instead of douching do not remove the pessary for three hours.

The removal of the pessary does not present difficulties if one learns to hook the finger onto the front rim of the pessary. For this purpose the finger must be introduced sideways. If

the removal is difficult the woman can use a pessary with a *string* (Mizpah). Women often express fear of pushing the pessary too deep or losing it. The diagram of the uterus and vagina shows clearly that the vagina is a closed bag and that the only opening leading from it has the size of a pinhole. Sometimes women think that their fingers are too short to reach the cervix. This is the usual complaint. But this is only lack of experience.

The best procedure with pessaries is as follows: Put a small amount of paste about the size of a bean around the rim of the pessary before placing it in position. This prevents any spermatozoa from getting in around the edges and working their way up into the cervix. Then, as convenience dictates, paste can be placed in the vagina after intercourse to destroy the spermatozoa there, or a douche can be taken the next morning. The paste placed within the pessary is effective particularly in cases where the pessary works loose.

After removing the pessary wash it in warm or cold water, dry well and powder it before placing into a box. Any baby powder can be used for this purpose. Do not boil it if it has a rim inflated with air because the rim will collapse. Boiling is not necessary as the antiseptic fluid or paste keeps it clean. The average pessary ought to keep from one to two years.

THE DIAPHRAGMATIC PESSARY (*More detailed description*)

Since the last printing of this pamphlet the use of a large diaphragmatic pessary, such as the Ramases, Rantos or Mensinga, has been definitely demonstrated to be effective. The use of pessaries of this type (either Ramases or Mensinga) is recommended in the following cases especially:

- 1) Where the cervix (neck of the womb) points toward the back. (Antiverted uterus.)
- 2) Where the cervix is lacerated, distended, or otherwise distorted so as to prevent its being covered snugly.
- 3) Where the fornices (the part of the vagina surround-

ing the cervix) do not afford the proper surface for retaining the rim of the vaulted pessary firmly in place.

4) And finally where the woman is unable to learn the use of the vaulted pessary, for the Ramses and Mensinga are very easily inserted and removed.

Several manufacturers of rubber appliances are at present supplying physicians with pessaries of the Ramses type, and are charging reasonable prices.

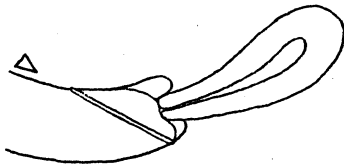


FIGURE 11
DIAPHRAGMATIC PESSARY
Ramses, Mensinga



FIGURE 12
DIAPHRAGMATIC PESSARY
Uterus In Back Position

USE OF THE DIAPHRAGMATIC PESSARY

[*Directions for physicians:* Insert like a pessary used for retroversion uteri: the back part of the rim is behind the cervix, the front rests upon the pubic arch.]

To insert the pessary the woman places herself in a squatting position, the pessary must be held with the cup downward (the dome up), the rim containing the spring is squeezed together and the pessary is inserted into the vagina by being pushed downward, backward and inward. It is preferable to point the dome of the pessary towards the cervix, just the reverse of the manner in which the French pessary is inserted, for the cup of the diaphragmatic pessary should face the opening of the vagina. This makes removal of the pessary easier. The finger can be hooked into the rim, without slipping.

The pessary is pushed as far in as it will go. Then, the front of the rim (now situated above the entrance of the vagina) is pushed *upward*, out of the way of the entrance. In its final position the front rim rests upon the symphysis pubis

(the bony arch which can be felt above the entrance of the vagina). The back part of the spring (the rim) is behind the neck of the womb and cannot be felt; the cervix is felt usually far back, through the thin covering of rubber. After the pessary is inserted, as directed, its correct position should be tested by looking for two landmarks: (1) the front portion of the rim should be back of the pubic arch, (2) the cervix should be felt, covered with the rubber of the pessary.

It is advisable to place a small amount of antiseptic paste all around the rim before insertion.

The pessary may be left over night in its position. Before removing, an antiseptic douche, or an antiseptic paste, should be used in this case as with any other pessary. The pessary is removed, after the douche, by hooking the index finger around the rim and then pulling it out.

This pessary must not be used when the body of the uterus is displaced backwards. (See Figure 2.) The neck is then often pulled back and the rim of the diaphragmatic pessary slips in front of it, instead of covering it.

The care of the Ramses or Mensinga pessary is the same as that of the French (described before). Do not boil it; wash it, dry it, and dust with any body or baby powder. The Ramses pessary usually lasts about eight months, the Mensinga, last- ing longer. The Mensinga is not yet easily obtainable in the United States. The price of the Ramses or Mensinga is three dollars.

The Ramses and Rantos can be obtained in the United States; the Mensinga is imported from England in small numbers. It is at present used in New York hospitals where patients legally receive birth control information if their lives are endangered by pregnancy. The Mensinga pessary has been used for many years in Holland and is very popular in England. It has several advantages over the Ramses (Rantos) pessary. Its spring is flatter, and the rubber keeps much longer. Manufacturers have promised to produce it here in the near future.

DEVICES INSERTED INTO THE NECK OF THE UTERUS

1. Gold or aluminum button.
2. Wire pessary.
3. Gold spring pessary (wishbone). (See Figure 13.)

The gold or aluminum button and the wire pessary are not used now as much as formerly. This is because they were made so short that they could slip out of the neck of the uterus without the woman being aware of it. Therefore they have gradually been displaced by the gold spring pessary (see figure).

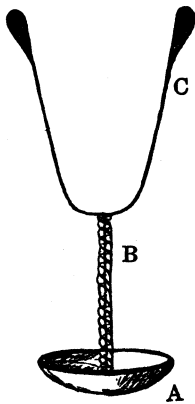


FIGURE 13
GOLD SPRING PESSARY

The latter consists of a circular cap (A) with perforations, attached to a wire spring (B), which is about an inch long and ends in two prongs in the shape of a wishbone. Physicians charge from twenty-five dollars up for the pessary and its insertion. Some people have been known to pay as high as one hundred dollars.

To insert this pessary the prongs are covered (and thus kept tight together) by a gelatinous capsule. After insertion into the neck of the uterus the capsule is dissolved by the body heat and the prongs of the wishbone are released. They spread out and press into the flesh of the inner part of the neck of the uterus. This pressure keeps the apparatus in position, but it brings about irritation likely to lead to inflammatory conditions and possibly cancer. Several cases of cancer following the use of this pessary are now on record.

How this method prevents conception is not quite clear, possibly it is due to the continual irritation of the uterus. Facts prove that this apparatus is not as safe as is claimed. Many cases are on record where pregnancy took place in spite of the spring pessary. It must be inserted by a physician, and remains in position until a physician removes it. Many women claim no annoyance with this method; others suffer

agony. Some cases are known in which the husband complained.

If not removed for about four to five months the spring wire works itself deep into the flesh of the womb. The lining covering the inner part of the cervix grows around and in between the coils of the spring. When this happens the device loses its effectiveness. To prevent such assimilation it becomes necessary to remove the pessary at least every few months. If it is retained for about one year, its removal brings on quite a discharge of blood and tissue.

To prevent serious consequences this apparatus must be removed and re-inserted at intervals of at least every two months.

This device is popular. Its high price seems to impress women. They think at such a cost they are surely getting "the best." The fact that neither man nor woman participates in any preparation is of course in its favor.

The use of this pessary is highly undesirable. *It is quite dangerous and is effective only through its harmful action.* If it irritates, it gives prevention; if it does not irritate, it does not work.

SUMMARY OF METHODS

Reviewing the many methods in use, we find that only a few are reliable. My experience convinces me that *absolute* safety can be obtained only by the use of combinations of methods. Single methods by themselves are not reliable.

Reliable Methods.

1. Rubber pessary combined with paste.
2. Rubber pessary combined with douching.
3. Rubber pessary combined with paste and douching.
4. Condoms combined with paste.
5. Coitus interruptus combined with paste or douching.

Partially Reliable Methods.

1. Sponges (large), especially when soaked in antiseptics.
2. Condoms.
3. Chemicals (suppositories, pastes, tablets, etc.).
4. Gold spring wire pessary (wishbone).

Unreliable Methods.

1. Coitus interruptus.
2. Douching.

(Whenever paste cannot be obtained, suppositories may be substituted.)

The best method of prevention is the pessary combined with paste or with douching or both. It satisfies all the conditions named earlier in the book: namely safety, health, normal relation and simplicity. It also allows of the absorption of the spermatic fluid.

Only if a pessary cannot be obtained should a condom with paste be used. (In case paste is unobtainable a suppository may be used.) The condom is objectionable for the reason given before (see page 11). Its use should be only temporary. Coitus interruptus with paste and douching is reliable but because of its harmful influence upon health should be used only temporarily until a pessary is obtained.

Paste ought to be considered as a supplementary aid in every case.

A combination of two methods seems at first quite cumbersome. In reality it is not. A pessary with paste in its cup is introduced a few hours before coitus, and its presence is not noticed. The paste is again used immediately after coitus, and its use is simplicity itself. The douche is a little more bothersome, but can either be replaced by the paste, or postponed to a convenient time.

FOR NEWLYWEDS

The case of newlyweds must be considered separately. The hymen prevents the use of a pessary. The paste applied through a vaginal nozzle is the best method. It is much better than suppositories, for the young woman can more easily get used to handling a vaginal nozzle than a suppository. Complete safety requires that the paste be combined with condoms or coitus interruptus. This method should be changed to a well-fitting rubber pessary as soon as the vagina is sufficiently dilated, usually one or two months after marriage.

PREVENTION OF CONCEPTION IN RELATION TO THE

TIME OF MENSTRUATION

Is there a certain time of the month when conception is impossible? Investigations made on ten thousand German soldiers and their wives during the war revealed that fewer conceptions take place in the ten days previous to menstruation, and that more take place in the ten days after menstruation, but that at no time is there absolute safety from conception.

BIOLOGICAL METHODS OF PREVENTION

(Spermatoxins)

Investigations are being made at present in Soviet Russia, Germany, and in our own country as to the possibility of causing temporary sterility by intramuscular or subcutaneous (under the skin) injections of the male spermal fluid (spermatoxin). It seems that the injection of this spermatic preparation gives the blood the power of furnishing to the ovum (egg of woman) some chemical substance which stops in it the tendency to unite with the spermatozoon when it meets it in the uterus or tube. Experiments have been conducted on animals in many countries, and in Soviet Russia on human beings also.

The Russian physicians claim that sterility of five to six months' duration can be obtained by four or five injections of the spermatoxin preparation. They state that the health of women who voluntarily went through the experimentation was not impaired, but on the contrary was much improved. It will, no doubt, take many years before this method finds practical application. I mention it only to show that science can open new ways, if the problem is taken up by specialists and unrestricted by law. The method described above would prove a boon to humanity. All clumsy mechanical methods could be discarded—a few visits to a physician every year would provide the desired sterility. But, alas, we have to wait, and be grateful for the few reliable contraceptives at our disposal.

NURSING MOTHERS AND STERILITY

Nursing mothers show a smaller percentage of conceptions but conception often takes place even in the second month after delivery. Women should, therefore, use protective methods during the nursing period also.

STERILIZATION

I have not considered this method of birth control, because I am writing for those who desire fewer children, not for those desiring none. This method, by the use of surgical or other means, renders the person incapable of being a parent. This is only advisable in cases of hereditary or congenital diseases, or in cases where pregnancy would endanger the life of the woman, as in repeated Cesarean deliveries.

DELAYED MENSES

The question of delayed menses does not come within the province of this pamphlet, but it is important to state that many women are occasionally irregular and have their menstruation delayed for five or six days. Delayed menses does not always mean pregnancy, but may be due to a cold, worry, anemia, loss of flesh, congestion or other causes. The majority of women who try to avoid pregnancy after a few days' delay begin to fill themselves with ergot and all kinds of emmenagogues; they torture themselves with hot douches and baths, and not infrequently suffer dire results. In such cases, it is best to use remedies which regulate menstruation. I have found that plain Viburnum or Helonin (both obtainable at drug stores) bring on the menses within a few days. A good cathartic, and a small dose of sodium bromide to relieve the nervous tension is often helpful. Ergot emmenagogues, and hot baths will quite often delay the menses instead of bringing them on. In cases of pregnancy the above drugs will be of no avail.

We have not yet attained the ideal method. Perhaps some day the "magic potion" that will place birth control in the hands of the parents will be discovered. Many investigations are now being made by physicians and biologists, despite government stupidity.

The methods at hand are a bit troublesome and they give some discomfort, but if methodically and faithfully used, they assure safety with little expenditure of energy, certainly with less work and responsibility than is inflicted by undesired motherhood.

FINAL WORD

GLOSSARY

Anus, outlet of the back passage.

Cervix, the lower part of the uterus, which contains the opening into the uterus.

Clitoris, the undeveloped penis in women. It is situated above the entrance to the bladder. It consists of erectile tissue, and is supposed to be sexually the most sensitive part of woman's sex organs.

Coitus, the sex act; copulation.

Coitus Interruptus, coitus that is interrupted. The male organ is withdrawn from the vagina before the ejaculation of the seminal fluid.

Copulation, the sex act; coitus.

Embryo, the undeveloped baby in its first stages.

Ejaculation, the discharge of the seminal fluid.

Hymen, a thin mucous membrane almost covering the entrance into the vagina in virgins.

Impregnation, union of the two cells, the spermatozoa and the ovum.

Labia, folds of skin.

Mucous membrane, the moist, glandular lining of the cavities of the human body (lining of the mouth for example). This membrane absorbs chemicals much more quickly than the skin of the body.

Ovaries, almond shaped glands situated at the ends of the tubes. They produce the ovum (egg).

Ovum, the microscopically small cell formed in the ovary, which contains all the physical and spiritual characteristics of the mother. This cell uniting with the spermatozoa forms the embryo which develops into the baby.

Penis, male organ of copulation (the sex act).

Seminal Fluid, the fluid man discharges during coitus. It contains millions of spermatozoa.

Spermatozoa, the microscopically small cells found in the seminal discharge of the male. These impregnate the ovum of the female to form the child. They contain all the characteristics of the father.

Sterility of Man, barrenness in man, where the seminal fluid contains no active spermatozoa. This may be due to a diseased condition of the testicles, or to the clogging or tying of canal through which the semen is propelled into the penis.

Sterility of Woman, a condition where no ovum comes into the tube or uterus. This may be the result of a diseased condition of the ovaries or the clogging or tying up of the tubes.

Testicles, the male glands that produce the spermatozoa.

Tubes (Fallopian Tubes), two narrow canals leading from the uterus to the ovaries.

Uterus (Womb), a small muscular bag where the impregnated ovum develops into an embryo and then into a baby. During pregnancy the muscular bag grows along with the baby and serves as its cover and protection.

Vagina, the canal that forms the passageway between the external and internal sex organs, the vulva and the uterus. It serves for copulation (the sex act).

Vulva, the external part of woman's sex organs. It surrounds and protects the entrance to the vagina. It comprises the small and large labia and the clitoris, the openings into the bladder and vagina.