15/44.7

THE NURSE

AND

PLANNED PARENTHOOD

THE NURSE AND PLANNED PARENTHOOD

This pamphlet presents briefly the factors in family planning, a medical program of vital concern to the nursing profession. The aims and importance of Planned Parenthood are interpreted from the nurse's point of view.

Outstanding progress has been made during recent years in maternal and child health. Higher standards and improved services would have accomplished even more than they have in this field were it not for the lack of conception control among the vast majority of low-income mothers. Until this service is available in health programs to all the people, the health of mothers and babies cannot be considered as adequately safeguarded. This pamphlet is designed to give nurses the information on the subject so they can take their full share in the program, and to help them carry out their responsibility under appropriate medical supervision.

This booklet was written by

FRANCES BOYLE, R.N., *Supervisor and Instructor,* Women's Clinic, Cornell University Hospital School of Nursing.

HEDWIG COHEN, R.N., *Assistant Director,* National Organization of Public Health Nursing.

MARION HERNANDEZ, R.N., *District Secretary,* Hannah Stone Planned Parenthood Center.

PAULINE STAHLE, R.N., *Executive Secretary,* Planned Parenthood Committee of Mothers Health Centers.

The Nurse's Opportunity

The Planned Parenthood movement in this country was conceived in the mind and heart of a nurse. Ever since, members of her profession have become increasingly aware of its place in preventive medicine and in its encouragement of child bearing for those physically, emotionally and economically prepared for parenthood. But, perhaps because they are so close to the need, nurses are often unaware how they, more than anyone else, hold the key to the well being of those families who most require information and advice on Planned Parenthood.

On private duty, in hospitals and in public health, there are today almost 400,000 nurses in this country. These nurses, both in opportunity and numbers, are vital to the health of American families. The nurse is more than the minister to the sick. She is the teacher of health. She gives instruction in the art and science of protecting and promoting health, and in the treatment and prevention of illness. Of all members of the healing professions, she is the nearest to the patient. Her charges look to her with confidence for help in their most intimate problems.

Among the questions frequently asked are: "What can I do not to have another baby right away?" and "Why can't I have a baby?" These pleas for help are heard at the hospital bedside, in the out-patient department, in the home, in the public health clinic. Every nurse who has contact with women patients hears them. She is letting the patient down when she says "I don't know." Besides, the patient will not believe such a statement; but will be convinced that the nurse simply does not wish to be bothered.

To give a satisfactory answer, the nurse does not have to be an expert in all the manifold aspects of fertility. She does need to know the basic facts about conception control and treatment for infertility so that she can guide her patients toward a healthful family life. That is an important part of the nurse's job — to give spiritual and emotional security through health information is as important as to prevent disease or heal the sick.

The Planned Parenthood Program

The Planned Parenthood Federation of America and its State and local affiliates are especially eager to gain the cooperation of the nursing profession. Patients who have no other source of knowledge about raising a family rely upon the nurse to direct them to the appropriate health service. Planned Parenthood organizations, for their part, seek to help nurses in carrying out their duties by making knowledge available to them.

The Planned Parenthood program is directed toward safeguarding mothers and babies through realization of the slogan: "Every child a wanted child." This does not mean that many unplanned babies are not dear to their parents. But it is a recognition of the fact that in the most important experience of life — parenthood — the utmost use should be made of professional knowledge, skills and techniques. The Planned Parenthood Federation of America, as a voluntary health agency in the field of preventive medicine, has a four-fold program, as follows:

1. Conception control to encourage the birth of children through intelligent planning, and at the same time to help protect the health, well being and stability of the individual family. The instruction of the medical and nursing professions in techniques of conception control is essential to carrying out this aim. The clinics of Federation affiliates, therefore, welcome nurses as observers. Institutes and other forms of in-service education or special courses in planned parenthood can be arranged. The field staff of the Federation is available for consultation or guidance in the development of this (as of other) aspects of the program and welcomes correspondence.

2. Study of infertility to enable the involuntarily childess couples to have families. Nurses see the unhappiness caused by inability to have babies. They know about the despair which comes to those who never learn that there are services which may be able to help them — actually successful in about 20% of all cases.

3. Education for marriage and parenthood, so that families may be strengthened through knowledge. In any such program, whether in teaching engaged couples or in counselling the married, nurses are essential because they have an intimate contact with those who stand most in need of this advice and who will not get it unless the nurse

advises them and refers them to those community agencies which can supply it in more technical detail.

4. Research so that all the other three phases of the program may be strengthened and improved. At present the Planned Parenthood Federation is collaborating in the first comprehensive, coordinated research program in this field, which is being developed by the National Research Council's Committee on Human Reproduction under contract with the National Committee on Maternal Health. Grants are being made to established institutions and individuals for specific projects with the primary objectives the discovery of simpler and more acceptable methods of conception control, improved treatment for infertility and a reduction in the great waste in human reproduction, especially spontaneous abortions, miscarriages, stillbirths, premature births, congenital malformations, maternal deaths, etc.

In the first three of these phases of Planned Parenthood, it is plain, the nurse is the key to successful functioning of the program. These three phases, therefore, are discussed in somewhat more detail.

Methods of Controlling Conception

In considering the first point, the nurse should be familiar with the various methods of conception control, the advantages and drawbacks of each, their availability and acceptability among the patients she serves. The most successful nurse will be the one who knows the patient as well as she knows the techniques.

The methods of controlling conception most generally recommended because of their reliability are based on the principles of mechanical barrier and of chemical spermicidal action, or both. The sperm is mechanically prevented from entering the cervix, that is passing from the vagina into the uterus; also it is chemically rendered immobile upon its emission into the vagina. Contraceptive methods can be classified in two groups or categories:

I. Those requiring individual fitting or instructions by a qualified physician after a pelvic examination. These methods are designed to give the greatest possible protection to a select group; those women who have the initiative and the money to obtain this service

from a private physician, or those individuals who are fortunate enough to live in sections of the country where this same service can be obtained from Planned Parenthood Clinics where voluntary contributions underwrite the cost of service to each patient. These methods are:

1. *The Vaginal Diaphragm:* of saucer shape with a spring rim provides a thin rubber partition across the vagina, thus separating the lower from the upper vagina. Through this mechanism insemination occurs in the lower vagina, but no sperm reaches the upper portion. The protection given by this barrier, partly held by suction, is strengthened by the addition of a spermicidal jelly held in the cup and placed against the opening of the cervix. The jelly also acts as a lubricant, facilitating insertion and placement. The diaphragm is fitted by the physician after pelvic examination, and the woman is then taught by demonstration to insert and remove it herself. She is also instructed in regard to how long she is to wear it, how to clean and dry it after use, and how to test it for defects. Periodic examination and refitting are required because measurements are likely to change, particularly in the newly married and after childbirth or pelvic surgery.

2. *The Cervical Cap:* made either of a rigid material such as metal, celluloid, or plastic, or of soft rubber, is fitted over the part of the cervix which projects into the vagina, the portio vaginalis. The cap is fitted after medical examination, and the plastic or metal cap may be left in place for longer periods than the diaphragm, described above. As an additional safeguard and also as an aid to application, spermicidal jelly is put into the cap.

II. Those less complicated methods which may be taught either by the physician or by the nurse under standing orders from the doctor. These methods are designed to give a relatively high degree of protection to the greatest number of individuals at the least cost. At present they are the best available methods for mass use in Public Health or in the hospital Out-Patient Department where the clinician does not have time to fit and instruct the patient in the use of the diaphragm.

1. *Contraceptive Jellies or Creams:* Contraceptive jelly is the general term for the semi-fluid preparations made for deposit in the upper

vagina to prevent the sperms from entering the uterus. This jelly has a dual purpose: First, effectively to *block the opening* into the cervical canal; and, second, swiftly to *paralyze the sperms.*

The average amount used is an ample teaspoonful (about 5 cc.) injected through a nozzle. This either attaches to the collapsible tube which constitutes the reservoir for the material, or else, in another form, is emptied by means of plunger, bulb or syringe. An excessive amount may diminish willingness to use the method because of messiness due to overflow and undue lubrication. These objections apply less to creams. The elaborate instructions for placing the jelly are unnecessary as the act of coitus is adequate for spreading the material.

Dr. Robert E. Seibels reports as follows on the use of jelly alone by the Health Department in South Carolina (Journal of Human Fertility, Volume 9, March 1944, Page 47): Conclusion:

"1. On a mass basis the simple contraceptive method, syringe and jelly or creme, is acceptable to 85 per cent of the patients in a rural clinic.

"2. A public health nurse can provide this service adequately.

"3. An effectiveness of more than 90 per cent reduction in fertility by regular users has been observed.

"4. The materials studied were free from harmful or irritating qualities."

2. *Suppositories.* For simplicity, no means of protection compares with the suppository. It is unequalled for quickness, compactness and freedom from nuisance on completion of intercourse. The suppository is a small solid cone designed to melt at body temperature or slightly below.

It entails no apparatus as jelly does, no place of discard as the condom does, none of the cleaning as for the diaphragm or the re-used condom.

At present a heavy wrapping of tinfoil makes it possible to keep suppositories even in hot climates. They can be solidified before use by dipping in a glass of cool water for a few minutes. Dr. Eastman and Dr. Seibels have completed an extensive study on the use of the suppository, and will shortly publish an article indicating that the suppository is just as effective as the contraceptive jellies or creams.

3. *Condom.* The condom, or sheath, is worn by the man to prevent sperm from entering the vagina or cervix. It is the most simple and most generally available of any of the more effective conception control measures, mechanical or chemical. Among commercial articles, it is by far the most popular. It is relied upon to furnish about a fifth to a fourth of the desired immunity against pregnancy in the United States. Good quality condoms provide protection as efficient as any method, and, skillfully used, *furnishes security.*

It is imperative that the *vulva be lubricated,* either by self secretion or by a contraceptive jelly or creme.

With all condoms, lubrication within is also desirable. This is preferably by means of a contraceptive jelly. Rubber should not be lubricated with oil or grease-containing substances.

4. *Withdrawal; "Taking-Care".* Withdrawal of the penis just before emission is probably the most primitive method of birth control and one that is most extensively employed all over the world. Its advantages are simplicity and availability at any time or place, and the fullest local contacts between the man and woman.

As with all conception control methods, withdrawal involves some surrender of gratification for the sake of security. In general it is suited to men with complete capacity for holding back until the wife has had full orgasm (or repeated orgasm) yet without any undue restriction on activity during the coitus and without sequel of nerve strain on either partner. — (*"Techniques of Conception Control,"* R. L. Dickinson.)

Many patients instructed in the use of other methods also return to withdrawal. For couples able to employ it successfully and with no ill effects, withdrawal deserves more serious consideration, especially for patients who reject other methods. In several contraceptive studies the protection patients received from withdrawal has appeared surprisingly high. — (*"Contraception and Fertility in the Southern Appalachians,"* Gilbert W. Beebe, M.D.)

Questioning of frank and honest couples will convince any physician that the vast majority of copulating males repeatedly modify their act in this way during one period or another and that this method is the chief cause of our controlled birth-rate. — (*"Medical and Biological Aspects of Contraception,"* John Rock M.D.)

5. *Rhythm. The Rhythm or "Safe Period".* This method is based on the knowledge that women are sterile some days of the month.

By avoidance of intercourse during the very few days in her monthly cycle in which a woman can become pregnant, control of conception is feasible.

According to "The Rhythm" by Leo J. Latz, the simplest form of direction which can be given to a patient is here summarized:

"By keeping . . . records . . . preferably a year . . . of the exact dates and the hour when menstruation began . . . the cycle is determined." "She finds variation from month to month." . . . If she is one woman in five with whom the variation does not exceed 3 to 4 days, 26 to 30, she "is ready to figure when the next period is due . . . She marks the 30th day on the calendar and then counts back 11 days, then crosses off the 8 days preceding . . . These 8 days she is fertile . . . Thus the first 9 days are sterile, the next 8 fertile, the last 11 sterile . . . Next she figures on a 26 day possibility, counts back 11 days, then 8, and finds another figure by which she is 7 days safe and 12 days fertile, and she avoids (exposure) those 12 days. She will continue to mark date and hour from month to month thereafter, and "keep a written record to discover variations." "This is of very great importance, as cycles may vary."

Effectiveness

The following table of effectiveness is taken from *"Techniques of Conception Control"* (page 10).

Effectiveness of Contraceptive Methods as Reported by the Patient

	Effectiveness (Per Cent After Clinic Instruction)
Pessary — Jelly	90 (85-95)*
Condom	90 (85-95)
Jelly alone	80 (63-90)
Withdrawal	70 (50-90)
Foam-Sponge	75 (55-95)
Douche	65 (60-70)

* Means 90 per cent less risk of conception than if no contraceptives were used, or 90 per cent of the users completely protected.
Recent work indicates that suppositories are as effective as jellies alone.

All the above methods used intelligently will give protection approximately 90 per cent for those who find them acceptable and use them carefully. This means that women who would ordinarily have eight to twenty-four children, if they use no protection at all, would, if they applied the method after the birth of their first child, have two to six children.

Any nurse who will take time to understand these five common methods of conception control (more detailed instructions can be found in Dickinson's *"Techniques of Conception Control"*) can teach them to those women who wish to plan their families, after they have been prescribed by a physician. Simple understanding and careful explanation of these methods to patients will be more helpful than superficial instructions or hurried fitting with Diaphragm and Jelly.

After nine years of intensive work and study in the field of Conception Control, Dr. Stix makes this recommendation: "Teach the patients the best method of using a contraceptive that they find most acceptable, or are using at the present time."

Her studies reveal that none of the methods described above were used by more than 50 per cent of the patients two years after admission to the clinic, but together these methods give a wide selection to satisfy almost all who sincerely desire to control their own fertility.

Management of Infertility

It has been authoritatively estimated that about one in ten American couples are unable to have children. The experience of a number of clinics over a period of several years shows that one out of every five can be treated with success — success being a pregnancy. However, it is the general belief of the specialists that if more of these infertile couples could be directed to a competent physician in this field early, a greater percentage of successes could be recorded.

It is here that nurses can be of great service to their patients. While treatment for infertility is not as widely available in many areas as conception control, there are an increasing number of clinics and specialists. The Planned Parenthood Federation can refer inquiries to these clinics, some maintained by its affiliates, or to qualified physicians.

Education for Marriage

Frequently patients who already are married are in need of this education quite as much as engaged couples. The very close relationship of fertility and its control to the total problem of sexual adjustment indicates an area that is intimately connected with basic planned parenthood services. The growing understanding of the psychological values inherent in planning a family have given impetus to this new educational approach. Trained guidance is frequently needed to help couples achieve the emotional security essential to successful marriage and parenthood.

Nurses supply part of that trained guidance. Their relation to patients is such that their advice must carry great weight with those who need outside help. Therefore, in addition to the advice which the nurse herself can furnish, she should be aware of the various community services which are available to supplement the help which she can give. Planned Parenthood is one of those services. It should be emphasized, however, that it is only one of them and that it should be used in collaboration with others when desirable.

HISTORY

Planned Parenthood began as a nurse's movement. In 1912 Margaret Sanger, who was working as a district nurse in the slum areas of New York, first sought a method that would spare women from the terrors of death or invalidism brought on by too frequent childbearing. She investigated possible sources of help and drew together other women and men who felt as she did. Many of these early crusaders were nurses, similarly touched by the tragedy of the mothers they attended. Their movement was launched on the belief that parents had the right to plan their own families. Although there is evidence that conception control has been the concern of people throughout human history (the earliest recipe for a contraceptive is dated 1850 B.C.) their ideas seemed radical to most Americans.

Typical of the early days of the movement were arrests, exonerations and more arrests. These failed to shake the will or courage of Mrs. Sanger and her followers. Even as late as 1921, police broke up a public meeting in New York's Town Hall. But on the eve of that meeting a national organization was formed. This was the American Birth Control League, Inc. Its program consisted of forming public opinion, assembling scientific data and promoting favorable legislation so that physicians could include child spacing methods as a part of medical technique.

Two years later the first permanent clinic was opened. It was called the Birth Control Clinical Research Bureau and it offered contraceptive service under medical direction. Dr. Robert Latou Dickinson served as Medical Secretary and as a result of his affiliation with the new organization began his series of contributions to medical literature in this field. They have become standard texts on contraceptive techniques and maternal hygiene.

Professional Support

Religious endorsement of child spacing by a national group was first given in 1929 by the Central Conference of American Rabbis. A year later approval was expressed by the Eastern Conference of the Methodist Episcopal Church, the American Unitarian Association and

almost one hundred other groups in religious, educational and medical fields, among whom was the New York Academy of Medicine. In 1931 the Committee on Marriage and the Home of the Federal Council of Churches of Christ in America issued a majority report stating that the careful use of contraceptive materials by married people was both valid and moral. Major groups, such as the General Convention of the Protestant Episcopal Church and the YWCA's National Board, added their endorsement by 1934.

The American Medical Association in 1937 recommended the teaching of conception control techniques in medical schools as an integral part of medical practice. In 1941 a committee of the AMA prepared a list of criteria for the evaluation of contraceptives. The report of this committee was the first scientific analysis of the quality and value of contraceptives.

It was in 1937 that North Carolina pioneered as the first state to provide planned parenthood services to mothers as part of its public health program. At the present time six states offer this service in their health department clinics. The U. S. Public Health Service will assist states to establish and maintain child spacing services on the same basis as any part of their health program.

In 1941 the American Birth Control League became the Planned Parenthood Federation of America, Inc. This name represents more clearly the broadening program and the more complete service offered by the Federation to meet the needs of contemporary family life.

Today the Federation's affiliated local committees have under their direct auspices more than 200 planned parenthood clinics in the United States. Nearly one-fourth of the 58 infertility clinics listed with the Federation are administered by local Planned Parenthood committees. Education for Marriage and Parenthood and Marriage Counseling are being given in many centers, and new research efforts have been instigated largely through Federation initiative.

In the evolution of health programs, the planned parenthood movement has followed the pattern of most health agencies. It began as a service to meet specific needs and has developed into a broad, preventive and educational service to the community.

LEGISLATION AFFECTING PLANNED PARENTHOOD

"The Anthony Comstock Era" has left its mark on federal and on some state legislation in the field of conception control. The Comstock Law of 1873 classified contraception with obscenity and made the interstate dissemination of contraceptive information or contraceptive supplies a Federal offense. This act was responsible for a legal fashion that was imitated by a number of states which enacted their own "little Comstock" laws. The chief result was to increase production of inferior contraceptives. Since physicians were in danger of prosecution, inferior products flooded the market unhampered by any medical supervision.

The first important legal victory for the planned parenthood movement was won in 1918. The highest court of the State of New York confirmed a conviction of Mrs. Sanger for opening a clinic but noted that the law exempted physicians. This enabled doctors to prescribe contraceptives when indicated "for the prevention or cure of disease," because the Court took the very broad Webster International Dictionary definition of disease: "An alteration in the state of the body, or some of its organs, interrupting the performance of the vital functions and causing *or threatening* pain and sickness; illness, disorder."

A series of court decisions since then have established the legal right of physicians to prescribe contraceptives for their patients. Only two states, Connecticut and Massachusetts still have statutes which have been interpreted as prohibiting physicians from advising patients on contraception. The Constitutionality of these interpretations has been questioned.

In the 46 other states the situation regarding statutes that govern the control of conception is as follows:

All reference to prevention of conception is omitted from the statutes of 19 states. This permits acceptance of planned parenthood services. These states are Alabama, Florida, Georgia, Illinois, Kentucky, Maryland, New Hampshire, New Mexico, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia and West Virginia.

The statutes restrict the distribution and dissemination of information about prevention of conception, *but specifically exempt medical*

practice in 14 states: Arkansas, Colorado, Delaware, Idaho, Indiana, Iowa, Minnesota, Montana, Nevada, New York, Ohio, Oregon, Wisconsin and Wyoming.

The statutes in 13 states are designed to prevent the indiscriminate advertisement and distribution of information on conception control but *exempt medical practice by "implication or construction":* Arizona, California, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Nebraska, New Jersey, North Carolina, Pennsylvania and Washington.

THE NURSE'S ROLE

The nursing profession, which has been an integral part of the planned parenthood program since its inception, has a vital role in interpreting its values to husbands and wives. The nurses' patients include many potential mothers and fathers, before they have babies, while the babies are on the way and while they are growing up. This close contact with families comes through associations made in homes, hospitals, nursing conferences, schools and in physicians' offices.

The nurse has a practical and extremely valuable contribution to make to planned parenthood, as she has to other essential maternal and child health services. Her contribution consists chiefly in helping husbands and wives to know of the resources available to them for obtaining scientific medical advice in regard to child spacing, in helping them make use of these resources as needed and desired, and in aiding them to utilize the medical advice received. Complete or ideal maternal care has been described as having six phases: premarital examination, preconceptional examination, prenatal medical supervision, delivery care, postnatal care and voluntary intervals between pregnancies. The nursing profession is in one way or another involved in each of these six phases.

Nurses are accustomed to being consulted in regard to family health problems, particularly those related to childbearing, pregnancy and child rearing. Husbands and wives who desire children but have none, talk to the nurse about their disappointment, as do husbands and wives, particularly wives, who want children but only when physically, economically and emotionally ready to care for them.

Although aware of the social and psychological aspects of maternal and child health, including the emotional conflicts which may some-

times constitute a barrier to the full use of medical knowledge and service, nurses are basically concerned with the health aspects of planned parenthood. When deep-seated inner conflicts stand in the way of seeking and utilizing medical and nursing assistance, nurses will know to what medical resource to direct the wife and husband for psychiatric aid, including marriage and family counseling.

Published by the

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.
501 Madison Avenue, New York 22, N. Y.

State Planned Parenthood Organizations

Maternal Welfare Association of Alabama
702 County Health Building, 1912 South Eighth Avenue, Birmingham, Ala.

Planned Parenthood League of Conn., Inc.
119 Ann Street, Room 408, Hartford 3, Conn.

Delaware League for Planned Parenthood, Inc.
110 East 16 Street, Wilmington 33, Delaware

Planned Parenthood Assn. of the District of Columbia, Inc.
715 E. Street S.W., Washington 4, D.C.

Planned Parenthood League of Illinois
203 North Wabash Avenue, Chicago 1, Ill.

Iowa League for Planned Parenthood, Inc.
201-202 Davidson Bldg., Des Moines 9, Iowa

Maine League for Planned Parenthood
53 Exchange Street, Portland, Maine

Planned Parenthood League of Massachusetts
229 Berkeley Street, Boston 16, Mass.

Michigan League for Planned Parenthood
625 East Liberty Street, Ann Arbor, Mich.

Minnesota League for Planned Parenthood, Inc.
803 Hennepin Avenue, Minneapolis 3, Minn.

Planned Parenthood Association of Missouri
1127 E. 31 Street, Kansas City, Mo.

Planned Parenthood Committee of Nebraska, Inc.
YWCA Bldg., 560 S. 17 St., Omaha 2, Nebr.

New Jersey League for Planned Parenthood, Inc.
71 Lincoln Park, Newark 2, N. J.

New York State League for Planned Parenthood
501 Madison Avenue, New York 22, N. Y.

Planned Parenthood League of Ohio
5 West Broad Street, Columbus 15, Ohio

Pennsylvania League for Planned Parenthood
253 South 15 Street, Philadelphia 2, Pa.

Rhode Island Maternal Health Assn., Inc.
433 Westminster Street, Providence 3, R.I.

Planned Parenthood League of Texas
2520 Shelby Avenue, Dallas 4, Texas

The Virginia League for Planned Parenthood, Inc.
4050 Forest Hill Avenue, Richmond 24, Va.

West Virginia League for Planned Parenthood
c/o W. W. Point, M. D., Suite 510 Medical Arts Building, Charlestown, W. Va.

Pamphlets available from the
PLANNED PARENTHOOD FEDERATION OF AMERICA

Techniques of Conception Control, by ROBERT L. DICKINSON, M.D.
Directory of Planned Parenthood Clinic Services
Planning Your Family, by HERBERT YAHRAES, published by the Public Affairs Committee
The Doctor Talks With the Bride, by LENA LEVINE, M.D.
To Those Denied A Child, a guide for husbands and wives seeking treatment for infertility
Literature List

Representative Books on Planned Parenthood

Preventive Medicine, by MILTON J. ROSENAU, Appleton, New York, 1935

Preventive Medicine and Public Health, by WILSON G. SMILLIE, Macmillan Co., New York, 1946

Medical History of Contraception, by NORMAN F. HIMES, Williams and Wilkins, Baltimore, 1936

The Rhythm of Sterility and Fertility in Women, by LEO J. LATZ, M.D., Latz Foundation, Chicago, 1939

Marriage and Sexual Harmony by OLIVER M. BUTTERFIELD, Emerson Books, Inc., New York, 1938

Autobiography, by MARGARET SANGER, W. W. Norton & Co., New York, 1938

My Fight for Birth Control, by MARGARET SANGER, Farrar and Rinehart, Inc., New York, 1931

Control of Conception, by ROBERT L. DICKINSON, M.D., Williams and Wilkins, Baltimore, 1938

Ethics for Modern Nurses, by KATHERINE J. DENSFORD and MILLARD S. EVERETT, W. B. Saunders Co., Philadelphia, 1947

The Abortion Problem, A Symposium, National Committee on Maternal Health, 1942