3/6

MODERN CONTRACEPTION

A PRACTICAL GUIDE TO SCIENTIFIC BIRTH CONTROL

DR. PHILIP M. BLOOM
M.B., Ch.B., D.G.O., L.M.

DELISLE

2/-

MODERN CONTRACEPTION

A PRACTICAL GUIDE TO SCIENTIFIC BIRTH CONTROL

PHILIP M. BLOOM
M.B., Ch.B., D.G.O., L.M.

DELISLE : LONDON

Published by Delisle Limited
238 Edgware Road, London, W.2

DELISLE is a specialist organization in the field of sex education, marriage and the family. A list of recommended titles will be sent on receipt of a stamped addressed envelope. Requests for guidance concerning literature or any other matter should be addressed to the Director.

First Edition .. .. .. *May*, 1949
Second Edition (Revised) .. *May*, 1950
Third Edition .. .. .. *May*, 1951
Fourth Edition (Revised) .. *October*, 1952
Fifth Edition .. .. .. *July*, 1954
Sixth Edition .. .. .. *May*, 1956
Seventh Edition (Revised) .. *October*, 1957
Completing 60,000 *copies*

PREFACE

This book has been written primarily for the ordinary man and woman who desire to know something about contraception. It does not attempt to go further than the sub-title indicates. Medical terms have been used sparingly and only when it is believed that they should be words in everyday use.

My thanks are due to Mr. Vincent Long for his encouragement and help; to Mrs. L. M. Blackett Jeffries, M.D., for her kind interest and suggestions; and to my wife for drawing diagrams which are not supposed to be accurate in every detail but which give an understandable picture of what I have attempted to describe.

PHILIP M. BLOOM.

79 *Harley Street, London, W.*1.

MADE AND PRINTED IN GREAT BRITAIN BY
STANLEY L. HUNT (PRINTERS) LTD., GEORGE STREET, RUSHDEN, NORTHANTS.

CONTENTS

DIAGRAMS

INTRODUCTION

There is no attempt in this book to argue at length the moral pros and cons of birth control. From the point of view of physical and psychological health, family planning and family spacing has now been accepted by all civilized communities and by all thinking people.

Ignorance, however, about methods of birth control is still far greater than it should be. This lack of knowledge or, more usually, a knowledge of improper and unsatisfactory methods, is probably the largest single factor in aggravating marriage difficulties, and is often an important cause of marital disharmony and of other sexological problems. It is the author's endeavour here to give a simple and non-technical description of the commonest methods used today, and to indicate which are the best and why.

Contraception means what the word implies—the prevention of conception by some means or other. If one carries its meaning to the extreme it would include complete abstinence from sexual intercourse. Obviously, however, this is not meant when one talks about contraceptive methods. Scientific contraception invariably implies the use of an 'artificial' device.

Some people believe that using contraceptives is wrong. Perhaps they consider it right that women should bear children continuously with only the short space which Nature allows between the birth of one child and the conception of the next. We find that the physical and mental health of the mother is affected; the welfare of the children is also affected; and in our present society the economic and domestic results of such large families are often disastrous.

Or they may argue that complete continence is not necessary because, fortunately enough, conception does not occur every time sexual intercourse takes place. In that case they are really advocating contraception, but by accident instead of by design.

Abstinence may be advocated, but the fact remains that the vast majority of normal men and women cannot practise this without severe frustration and bad psychological results.

If the argument assumes that contraceptives are morally wrong because there is an 'artificial' prevention of the sperms reaching the ovum, but that it is permissible to use the 'safe period', it is difficult to see where the moral difference lies. In the latter the sperm is prevented from fertilizing the ovum by means of time rather than by some material barrier.

However, as the method of abstinence at certain times of the month is used by a number of people and, indeed, is advisable for a few, it will be described later. The more common and usual methods of contraception will be described first.

1

THE SHEATH

Other names for this form of contraceptive are the condom, the rubber preventative, and the French letter. The wearing of a sheath by the man is one of the commonest methods in use, and there is a great deal to be said for it. It is well to note that there is absolutely no truth in the persistent belief that the makers include one 'dud' sheath with every dozen issued.

The advantages of the sheath are:

(1) The ease with which it can be applied and used.

(2) If it is from a reliable firm it has a good standard of contraceptive safety. Both the sheath and the non-greasy lubricant should invariably be obtained from a reputable chemist or a recognized clinic.

(3) It is harmless to physical health and future fertility.

The disadvantages are:

(1) It might detract, for one or both of the partners, from the sensation which should be experienced. This is not invariable, and many couples find the use of a sheath most satisfactory.

(2) The love-making, or love-play, has to be interrupted while the sheath is being applied. It is sometimes found that this interruption adversely affects one or both partners.

(3) The danger of the semen escaping. Reference will later be made to the possibility of the sheath breaking. It is also well to remember that after ejaculation the penis soon gets smaller and it sometimes happens when the man withdraws that the sheath may be left in the vagina and some of the semen escape. The sperm may then pass up the vagina into the womb. *It is wise to offset this accident —or the breaking of the sheath—by the woman inserting, before each act of intercourse, a chemical suppository* which will give her added, if not 100%, protection. But should either of these accidents occur, an immediate douche by the woman will wash out most of the semen, and another suppository may be pushed well up into the vagina, thus rendering conception less likely. The suppositories are described in the next chapter and the douche later.

There are two kinds of sheath: (A) the more common type of condom, and (B) the washable sheath.

(A) The condom is made of very thin silky rubber or latex, is used once only and is then discarded. It is supplied already rolled, and is adjusted to the erect penis just before the coital act. The condom is made in two forms: one with a teat at the end, and the other with a plain end.

The teat-end condom has the advantage of collecting the semen after ejaculation, but has the disadvantage of tearing more easily on penetration, especially at the beginning of marriage when the vaginal entrance is still a little tight. In this case, the plain-end condom is preferable. It should not be pulled tightly over the tip of the penis, although it is very rare for the condom to break with the ejaculation of the semen. If it breaks at all it does so usually at penetration, when it should be obvious to the wearer

and he can withdraw and apply a new one. A harmless non-greasy lubricant, applied to the outside surface of the condom or to the vaginal entrance (or to both) makes penetration easier and lessens the danger of tearing the condom.

(B) Washable sheaths are usually made of latex or rubber.

They can be washed and dried after intercourse and used repeatedly. They are necessarily thicker than the ordinary condom; and, because they last a longer period of time, are relatively cheap to use.

Washable sheaths have all the disadvantages (already described) of the ordinary sheath. Because of their added thickness they may detract even more from the pleasure of the sexual act.

After use the sheath should be washed carefully in lukewarm water and dried on a soft towel. It should then be powdered with French chalk or any type of talcum or preserving powder and put away flat.

Mention may be made of a condom, popularly known as the 'American Tip'. It is short and fits over the glans or tip of the penis, but is loosely made to collect the ejaculated semen. An elastic band grips the groove behind the glans and holds the 'Tip' in place. Its only advantage over the other types of condom is that it leaves most of the penis uncovered and enables it to come into direct contact with the vagina. Apart from this, the disadvantages are the same, with possibly a little more trouble in adjusting it to the erect penis, more chance of losing it when withdrawing the penis, and a danger of leakage.

2

CHEMICAL CONTRACEPTIVES

For a large number of years, chemical contraceptives in the form of suppositories and various types of pastes, jellies, creams and ointments were to a great extent used as the only means of contraception. Some of these were irritating to the vagina and therefore harmful; but with research and improvement the majority used today are absolutely harmless.

(A) The suppository (still often called pessary by many chemists and doctors) is usually small, soft, and easily inserted into the vagina. It should be pushed in as far as possible and allowed to remain there for about 5 minutes before actual penetration. During that time the natural warmth of the vagina will melt the suppository, causing it to spread and form a mechanical barrier (to the ejaculated semen) which will also destroy the sperms coming into contact with it. Another type of suppository produces, when melted, a foam which acts in the same way, but it needs a certain amount of moisture to produce the foam, and as the vaginal secretion varies from woman to woman it is not certain exactly how much time is needed for the tablet to dissolve completely. It may, however, be placed in water immediately before insertion into the vagina.

As with the sheath, the common assertion that the maker includes one ' dud ' with every box of suppositories must be contradicted. It just is not true.

(B) Pastes, jellies, creams, or ointments* are spread on a contraceptive cap before insertion, or are placed in the vagina by an applicator. They obviously need no time lapse, and act immediately.

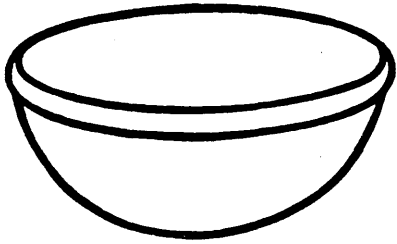
Chemical contraceptives are only relatively reliable, and should always be used, therefore, in conjunction with a contraceptive cap, or condom, or washable sheath.

Soft suppositories, melting as they do at the temperature of the vagina, will always melt in any tropical climate. In this case it is possible to buy a variety of hard suppositories which are affected by the vaginal secretions rather than by temperature. Or, as an alternative to any suppository, there is the applicator. The paste is usually contained in a tube, like toothpaste, and the necessary amount can be squeezed into the applicator. The nozzle of the applicator is then inserted into the vagina and a plunger deposits the paste.

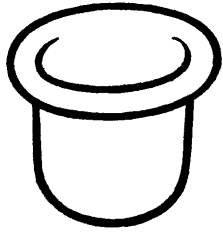
* To avoid repetition of these various kinds of chemical contraceptives we shall in this book use 'pastes' to include creams, jellies, and ointments.

Publisher's Note

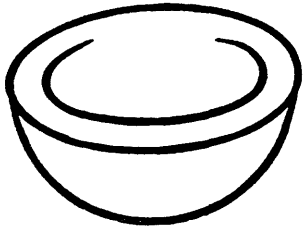
Many requests are received for information regarding supplies of contraceptives, lubricants, etc. A list of approved products will be sent by Delisle, 238 Edgware Road, London, W.2, on receipt of a stamped addressed envelope.



DUTCH CAP



CERVICAL CAP



DUMAS CAP

3

CONTRACEPTIVE CAPS

These are simple mechanical barriers to prevent the semen from entering the mouth of the womb. They are of various and graduated sizes and have many names. For the sake of simplicity the general term of 'cap' will be used here. The consultant will decide which is appropriate in each case.

They are invariably made of rubber, and fall mainly into three types:

Dutch cap, or occlusive diaphragm.

Cervical cap.

Dumas cap.

One or other of these can be used by 99% of women. They are harmless, they are effective, and they are not felt during intercourse by either the husband or the wife, with one exception which is later described.

The cap must be fitted by an experienced doctor, and the woman must be taught how to use it properly. When this is done, the procedure is simple. By itself, the cap is only relatively safe, and must be used in conjunction with a chemical contraceptive.

The combination of cap and chemical contraceptive has many advantages over any other form of birth control:

(1) It is as safe as any other method—and safer than some. There is a failure rate of about 1% to 2%, and that mostly due to carelessness in carrying out the taught routine.

(2) The method is harmless and the good chemical contraceptives are absolutely non-irritant.

(3) Fertility is not impaired.

(4) Once the cap is correctly placed in position neither the woman nor the man should be conscious of its presence. She can forget about it completely until the time comes for removal.

(5) It has an aesthetic quality superior to almost any other form of contraceptive. The cap is best inserted at night before going to bed and is removed in the morning as part of the usual routine toilet. This means that if the cap is inserted every night as a routine (and this is particularly advisable during the first months of marriage) there is no thought or worry of interrupting the love-play to carry out some form of contraception.

(6) The final advantage is that the onus is on the woman; and as she has to bear the brunt of the unplanned pregnancy she is usually much more likely to ensure that the birth control method is efficient.

There are two disadvantages:

(1) The first is the trouble that must be taken in preparing and inserting the cap. But with practice this becomes a very simple routine. If the woman realizes that it is purely a means to an end, and that she is making certain of planning her children and of having them when she wants them this does not become an issue any more.

(2) The second disadvantage is even slighter. The warmth of the vagina liquefies the paste, and a certain small amount oozes away during the course of the night, so that if intercourse occurs more than four hours after insertion of the cap a little more paste

should be applied to maintain the standard of safety. It is not, however, necessary to remove the cap and re-apply the paste. Most of the paste on the inner side of the cap has not been lost. It needs only a little more on the outer side of the cap, and this can be effected by the use of suppositories made of the same substance as the paste. If one of these is inserted about four or five minutes before the act of intercourse the warmth of the vagina will melt it, and it will more than replace any paste lost. Alternatively, the applicator, already described, can be used.

The cap should not be removed until 8 hours have elapsed after coitus. Normally the sperms cannot live for long in the vagina and the presence of the contraceptive paste destroys most of them within a few hours—it has been estimated that 8 hours is more than sufficient time to deal with all the sperms.

Although the cap must be removed every day to give the normal secretions of the uterus and vagina a chance to flow away, there is no harm in leaving the cap in position up to 12 hours or even longer on the occasions when sexual intercourse occurs some hours following the insertion of the cap. This does not interfere in any way with any of the normal movements or daily habits of the woman. She can go about just as usual until the time comes to remove the cap.

After use, the cap should be washed, carefully dried, and dusted with powder. With care, it should last at least a year. The cap and paste are not expensive and are well within the means of the majority of people.

It is most advisable that women should visit their doctors for refitting once a year. There are two exceptions to this rule:

(1) Women who have been fitted with a cap at marriage should be re-examined three to four months later.

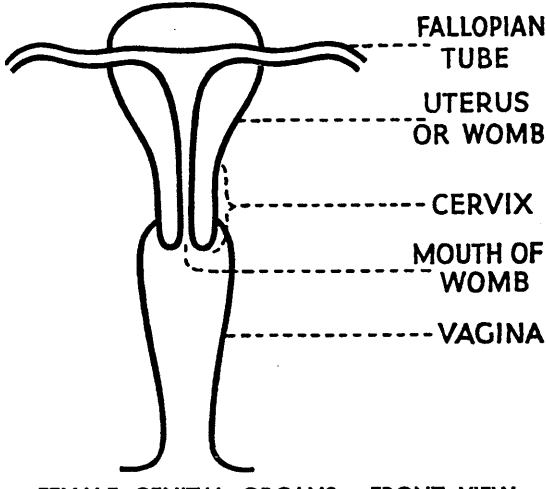
(2) Women who have just had babies should be refitted about six weeks to two months after the birth of the child and before sexual intercourse is resumed.

As the majority of women can be fitted with a Dutch cap, and as it is the simplest to use, this will be described first and in full.

The Dutch Cap

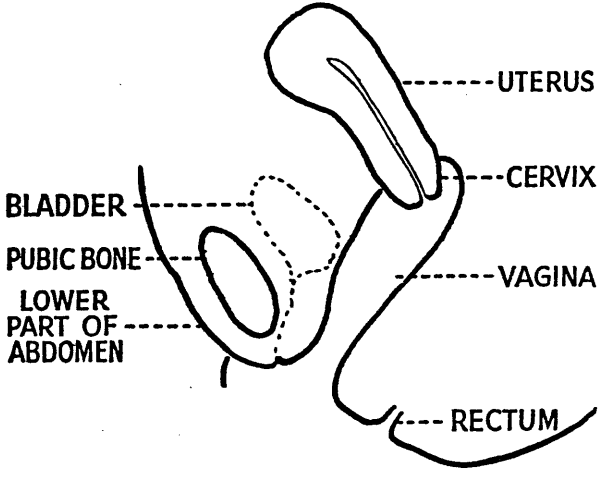
The Dutch cap is composed of a soft rubber dome whose outer rim contains either a coiled or flat watch spring. To understand how it is used it is as well to have a simple picture in one's mind of the genital organs.

The uterus, or womb, is roughly pear-shaped, and



FEMALE GENITAL ORGANS — FRONT VIEW

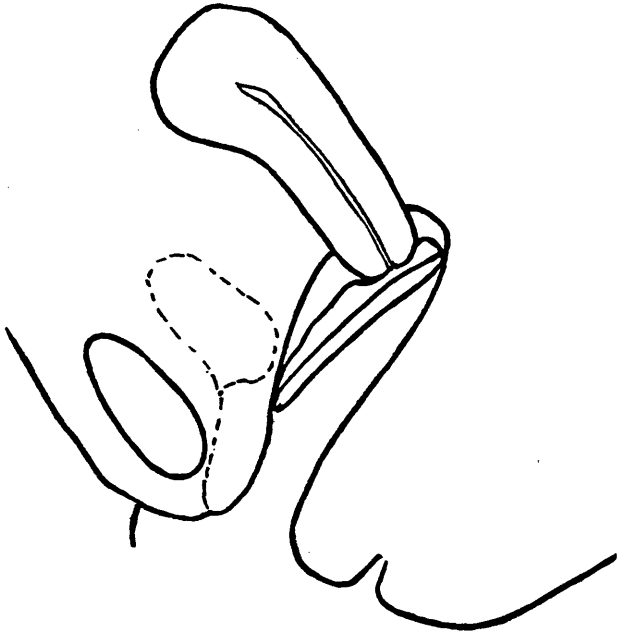
altogether about 3 inches long. It is situated in the lowest part of the abdomen and is usually tilted forwards. The narrow portion (or neck) of the womb is about 1 inch in length; it is known as the cervix, and projects into the vagina. The vaginal walls are loosely opposed to each other, but are very elastic and easily distended. They are attached to the cervix, and the lining of the vagina becomes continuous with that of the cervix. It will be understood, then, that if an internal examination of the vagina is made the cervix can be felt as a small projection of a half to two-thirds of an inch, about the thickness of one's finger, and usually pointing backwards. It is smooth to the touch and has the consistency of india-rubber. The vagina itself is 3 to 4 inches long, and the cervix can be felt about 2 to 3 inches from the entrance.



FEMALE GENITAL ORGANS — SIDE VIEW

At the lower end of the abdomen a bone can be felt which is part of the pelvis, or 'hip bones', and is called the pubic bone. This pubic bone is about 2 inches deep, and the under-part of it can be felt through the tissues at the vaginal entrance. These, then, are the important landmarks.

The cap is placed in the vagina with the dome up against the cervix; although some consultants insert it the reverse way round. It is not really very important which side of the dome faces the cervix,



DUTCH CAP IN POSITION

and in fact some caps are made where the soft rubber centre gives only a slight impression of a dome at all. One reason for inserting the cap with the dome uppermost is that it is easier to grip when taking it out.

Before inserting the cap, it is covered by a contraceptive paste* (the choice usually being made by the doctor for each individual woman).

(1) The paste is applied to the cap, a ribbon of about 5 inches in all being squeezed out of the tube. Approximately 2 inches are applied to that side of the cap which will face the cervix, 2 inches to the other side, and a little round that half of the rim which is going to be inserted first. The paste on the rim automatically acts as a lubricant and, as the cap is inserted, spreads round the whole rim. Some of it is usually scraped off as the cap is inserted but not sufficient to interfere with the necessary contraceptive quantity. The strips of paste may be left as such or, more conveniently, roughly spread. This is not important as the paste liquefies at body temperature and automatically covers every part of the cap. The recommended pastes are non-greasy and water-soluble but, as already stated, act as lubricants. The cap is usually placed on the outstretched left hand with the dome uppermost. It is then taken gently but firmly between the fingers of the right hand. If held too tightly there is tendency for the cap to slip between the fingers.

(2) The most common type of cap has a flat spring in the rim and if held too tightly, especially at one or other end, the rim is likely to kink and make the cap lose its shape. A little manœuvering of the flexible spring can restore the round shape to a

* See footnote p. 17.

greater or lesser extent at first but soon, with persistent tight gripping, all shape will be completely lost and the spring eventually snap. The grip, therefore, should be a comfortable control of the cap exerted by thumb and index finger at centre of rim.

(3) The cap is then pointed towards the entrance of the vagina and inserted as far as the thumb and index finger will allow. Being held symmetrically on either side by these two digits, the other three fingers can exert pressure on the outer and free end of the cap to push it gently into the vagina.

The cap eventually fits in the vagina diagonally. The first part of the rim to be inserted fits right behind the cervix in the hollow made by the vaginal walls joining the cervix. The last part of the rim is pushed up by the index finger to fit in the soft tissue behind and against the pubic bone. Once the cap is in position it opens out and distends to a slight extent the elastic vaginal walls with which the rim comes into close contact, thus shutting off the cervix and womb completely. Examination by the finger will then show that the cervix is covered by the soft rubber of the cap.

Removing the cap should be simple. The index or middle finger is inserted into the vagina and hooked round that part of the rim which lies up against the pubic bone. The grip is firm and the cap is pulled out easily.

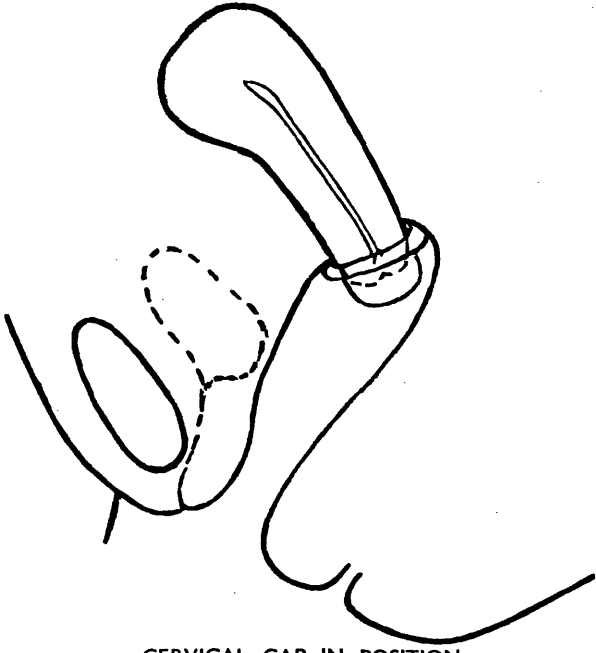
This description may seem complicated and difficult; but in practice, with expert instruction, the routine is quickly and easily learned.

The Cervical Cap

This cap is shaped rather like a thimble and has been popular in a few clinics throughout the country.

Like the Dutch cap, it is used in conjunction with a chemical contraceptive, and has the same action in preventing the sperms from reaching the womb. It differs from it, however, in the way it is inserted and adjusted. The cap is made to fit comfortably over the neck of the womb and is left there overnight to be removed in the morning.

The main difficulty met with in fitting this cap is the inability of many women to reach the cervix comfortably with their fingers and actually adjust the cap in position. Removing it is also a far more tedious



CERVICAL CAP IN POSITION

affair than the simple procedure of taking out the Dutch cap. With long fingers any intelligent woman can soon master the technique, but with short fingers it is almost impossible.

Many types of cervix are unsuitable for the wearing of this cap. The very short cervix, for example, will not hold it, and most doctors would not recommend its use if the cervix has been injured at the birth of a child, and where there might be some chronic inflammation.

On the other hand, in women who have prolapse—that is, a looseness of the vaginal tissues due almost invariably to childbirth—and where the Dutch cap cannot fit comfortably, the cervical cap is very often the contraceptive of choice.

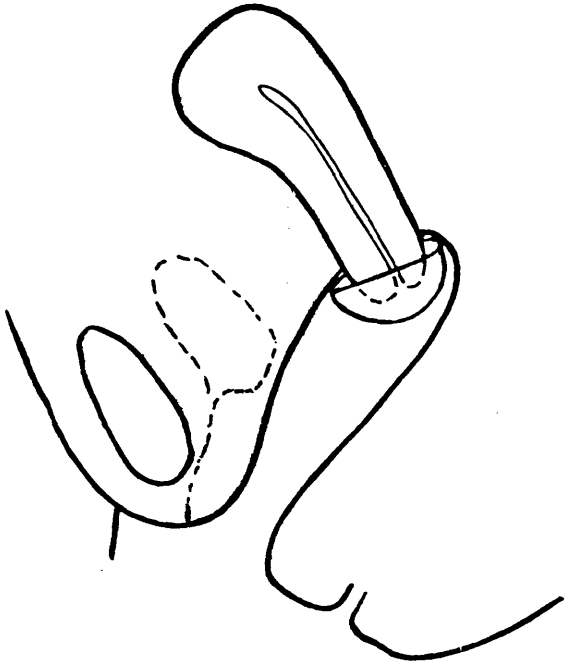
The Dumas Cap

This cap has an appearance somewhat like a tennis ball cut in half. When used, it fits squarely into the vagina, shutting off the cervix and the vault (or roof) of the vagina. It is popular with a few doctors, and again there are occasions when it might be the best of the three caps to use. It is smaller but has a stiffer dome than the Dutch cap, and the rubber at the edges is much thicker than at the centre. For this reason, it has a better chance of being retained in position when the vaginal tissues are too loose to hold the Dutch cap in position. It is used with a chemical contraceptive, and the routine times of inserting it and taking it out are the same as with the Dutch cap.

The disadvantages are:

(1) It is not so easy to manipulate as the Dutch cap.

(2) The thickness of the rubber at the centre may prevent the woman from feeling the cervix through it.



DUMAS CAP IN POSITION

(3) It is said there is a slight chance of it being dislodged during coitus. But a correctly fitted cap is held in place with the aid of a certain amount of suction; dislodgement therefore is improbable.

(4) The husband is occasionally conscious of its presence.

4

THE DOUCHE

A great deal of argument has gone on about the merits and demerits of douching. Some doctors say that regular douching is harmful because it continually washes out of the vagina certain bacteria which are normally present and necessary for its health. Others say that douching should be practised regularly for cleanliness and aesthetic reasons; and that it is harmless.

The truth of the matter is probably that both douching and non-douching are harmless provided that certain points are remembered. They are:

(1) Very hot douches can scald the vagina.

(2) Strong antiseptics are harmful and are a frequent cause of inflammation.

(3) Regular douching is not really necessary because the vagina is automatically cleansed by the normal flow of secretions from the womb and vagina.

(4) Ordinary cleansing habits can easily be observed during normal bathing.

Douching, then, is not necessary, except when specifically ordered by a doctor for some particular condition.

Douching as a contraceptive is used by a number of women, especially on the Continent; but it is an unsatisfactory method because some of the sperms are liable to enter the cervix at the time of ejaculation and therefore would not be affected by douching. Also, it is not always possible to wash out every sperm

which has crept into one or other of the natural fissures and folds of the vagina.

If a woman has been taught the proper use of cap and paste, douching is unnecessary; except when, for some reason or other, the cap has to be removed within a few hours of intercourse.

The only other time a douche is needed is when a sheath tears during sexual intercourse (see page 14).

Many substances kill sperms, but it is important to realize that the main effect achieved by the douche is not that of killing the sperms chemically, but of washing them out of the vagina. Luke-warm water by itself is as good as, and less harmful than, most chemically prepared douches. It is true, however, that a little salt, or even vinegar, added to the water is harmless and does destroy the sperms with which it comes into contact. If a chemical is used, the type and amount should always be prescribed by a doctor.

5

COITUS INTERRUPTUS

Coitus Interruptus, or withdrawal, is still probably one of the commonest forms of contraception practised today. It will be mentioned only briefly—then to be condemned altogether.

By the withdrawal of the penis from the vagina at the moment of the climax, and ejaculation of the semen outside the vagina, contraception is supposedly achieved.

The advantages of this method are very limited, and the disadvantages are legion:

(1) During the course of love-making and sexual intercourse a number of tiny glands within the penis secrete a fluid which acts as a natural lubricant for the end of the penis and, in a certain proportion of cases, sperms can be found in this secretion. Conception can thus happen despite the fact that the actual ejaculation occurs outside the vagina.

(2) Often enough the time of withdrawal is not exact and some of the semen is ejaculated into the vagina.

(3) Even when the semen is deposited on the outside of the vagina it is still possible, though rare, for healthy sperms to find their way into the womb and along one of the tubes, there to fertilize an egg.

(4) It is a very common cause of dissatisfaction and frustration in both men and women. Women especially very rarely achieve a climax with this method. They cannot always be certain that their husbands will withdraw in time, and this often makes

them mentally tense and unable to give themselves fully in the sexual act. At the same time the husband is so intent on withdrawing before ejaculation that he tends to forget his wife and her emotions and, in attaining his own quick satisfaction, makes of coitus a selfish thing.

Many women take some consolation in the thought that by not achieving a climax conception can be prevented. Unfortunately for them, this is not true; 'holding back' is no contraceptive. It is also important to emphasize that coitus interruptus, with all its frustrations, is one of the most important factors in causing anxiety.

6

THE SAFE PERIOD

This method of family planning is known as the 'safe period' because it is based on the now accepted fact that only at a certain time of a woman's monthly cycle is her egg-cell, or ovum, capable of being fertilized. It is usually assumed that only one ovum ripens fully each month, although two ova might ripen within a few hours of each other and perhaps result in fraternal twins being conceived. The ovum passes into one of the Fallopian tubes and is there fertilized if a sperm is present. The periods of time before and after this happening become 'safe'.

With intelligence and care, a fair degree of accuracy can be reached. It may be used as a substitute for more scientific methods of contraception or as an alternative by couples who desire at certain times of the month to dispense with the more practical methods they have been using.

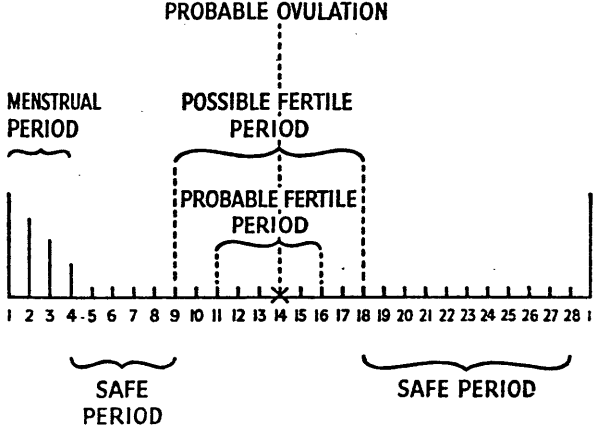
The ovum remains alive for approximately only 24 hours, but sperms, once they have passed the cervix, may live for two days and lie in wait for the ripening of the ovum. The longevity of sperms is dependent on certain favourable conditions such as prevail in a healthy womb and tube. Sperms live only a few hours in the vagina as the normal vaginal secretion is too acid for their survival.

If we were absolutely certain that only one ovum was going to ripen each month, and we knew the exact time when it did ripen; if we knew exactly how long it kept alive, and how long the sperms lived;

then the use of the 'safe period' would probably give perfect control of conception. Unfortunately, we are not certain about all these facts.

Briefly, the ovum ripens about 14 days before the start of the next menstrual period. When this occurs, and the ovum passes out of the ovary, the character of the ovarian secretions alters and enables the womb to prepare itself for the fertilized ovum. The womb can then receive the fertilized ovum and grow with it; or, if no fertilization has occurred, cast off its excess tissue in the menstrual flow.

In a woman who has regular 28-day cycles, the 14th day from the first day of her period is the most likely day for conception. If the ovum lives one day, and if the sperm has been lying in wait for it for two days, the fertile period then becomes the 12th to the



SAFE PERIOD CHART

This chart holds good only when the menstrual cycle is invariably 28 days.

15th day. An extra day for safety is added on each side, giving the 11th to the 16th day as the fertile period. It is always possible that the ovum might not ripen on the 14th day; it might ripen two days earlier or later. If we add these days, the fertile period becomes the 9th to the 18th days.

Very few women, however, have a normal 28-day cycle. If a diary is kept they will be surprised how often this 28-day cycle becomes 27 or 29 days, sometimes 26 or 30 days. All this has to be taken into consideration when working out the 'safe period', and has to be included with each menstrual cycle because any given month might be a 28-day, a 30-day, or a 26-day cycle.

The chart is drawn on the presumption that we are not absolutely certain that the womb needs 14 days for preparation. The time may be 16 days or only 12, and this the diagram shows. The 11th-16th days should be looked upon as probably the most fertile, but from the point of view of controlling conception this time should be extended to include the 9th and 18th days. With an occasional menstrual cycle of 26 days, the fertile period is brought back to the 7th day, and with an occasional cycle of 30 days, the fertile period becomes the 7th-20th days.

There are, however, further ways of estimating the time of ovulation, such as the daily bodily temperature. This temperature varies during the menstrual cycle. If taken at the same time every day it remains at a fairly constant level until ovulation is imminent. At ovulation it invariably falls and within 24 hours there is a rise to a height of anything up to 1 degree above the pre-ovulatory temperature. This high level of temperature is maintained until the menstrual period is due. If conception has not occurred it again falls. The post-ovulatory 'safe period' can be estimated

as starting 3 days following the rise of temperature. A great deal of intelligence and care is needed for this routine and as it is probably of more value to the woman seeking pregnancy, and carried out with more enthusiasm by her, a detailed account will not be given here.

The 'safe period' method can often be relatively satisfactory but it has the great disadvantage of relegating sexual intercourse to very definite periods of the month, thus denying spontaneity. Furthermore, it must be remembered that the rhythm of the menstrual cycle is likely to be upset by many physical and emotional factors. Lastly, the 'safe period' cannot be used following pregnancy until it is certain that the menstrual cycle has settled down into a satisfactory rhythm.

7

THE GRÄFENBERG RING

There are certain types of contraceptives which require the insertion of some metal pessary into the womb or the neck of the womb. These have been recommended and used at various times, only to be discarded by the majority of specialists.

They are usually made of gold or silver. The only one which is used to any extent today is the Gräfenberg Ring. This Ring of silver coiled wire is made in various sizes, the most common being about two centimetres in diameter. A general anaesthetic is usually but not always necessary; the neck of the womb is dilated, and the Ring is then inserted completely within the womb and left there for approximately a year, when another anaesthetic is necessary to remove and change it.

The exact means of contraception is not certain. It is possible that the Ring causes the death of the sperms either by its actual presence interfering with the sperms moving up, or by causing some sort of change in the nature of the womb's secretions which is inimical to the sperms. Most authorities hold that it is not a real form of contraception but that the presence of the Ring does not allow the fertilized ovum to embed itself in the wall of the womb, thus causing a very early abortion.

The obvious advantage that it appears to offer over any other type of contraception is that once the Ring is in position there is nothing further to be done until the time comes for changing it.

The disadvantages are:

(1) The insertion of the Ring under a general anaesthetic is a minor operation and involves the danger and risks, however small, of such operations.

(2) The cost is more than most people can afford.

(3) The presence of the Ring sometimes causes discomfort, and increased or prolonged flow of the menstrual period. On occasions this is so severe that the Ring must be removed.

(4) Any slight infection present in the womb is likely to be aggravated by the Ring; and it may also be possible for an inflammation to be set up in a previously healthy womb.

(5) The Ring may become displaced and fall out.

(6) In a very small percentage of cases pregnancies have occurred even with the Ring undisturbed and in position.

The disadvantages therefore overwhelm the advantages.

8

BREAST-FEEDING AS A CONTRACEPTIVE

It is commonly believed that conception cannot occur while the mother is feeding her child.

This is usually true, for while feeding her infant the mother's glands work in such a way as to prevent the ovum from ripening; but many mothers know that the menstrual periods sometimes start before actual weaning, and no mother can be absolutely certain that her first period will wait until she has ceased breast-feeding her baby.

When a pregnancy does occur in these cases, surprise is caused by the fact that there has as yet been no period. But there is no need for surprise as the first period must start at some time, and be preceded by the ripening of an egg. It is this egg which may become fertilized, and then no period starts. Sometimes for two, three or four months the mother is unaware of the fact that she is pregnant.

Because spacing the family is the aim, it is important that all mothers should renew their contraceptive methods as soon as sexual intercourse is resumed.

9

CONTRACEPTION AT THE 'CHANGE OF LIFE'

The menopause, or 'change of life', in women usually occurs in the middle and late forties. It varies quite a lot from woman to woman; some reaching it as early as 40, others as late as 55.*

It is the time in life when women cease to bear babies. The process is one in which the ova stop ripening, and the womb does not undergo its normal monthly preparation for pregnancy. This, however, does not always happen suddenly, and occasional ova manage to ripen at irregular intervals while the change is occurring. Obviously, any one of these ova is capable of being fertilized; and therefore, to be absolutely certain, contraceptive methods should not be discarded until *at least* a year after the last menstrual period.

The change of life is often associated by women with growing old, and the loss of fertility with a loss of sexual desire. Both these associations give rise to much needless anxiety.

Many women, indeed, relieved of the burden of continuous menstrual cycles and the fear of becoming pregnant, take on a new lease of vigorous life.

There is also very little association between fertility and sexual desire; and the latter may continue undiminished for many years.

* This subject is dealt with more fully in *Change of Life* by Dr. Joan Malleson—'Medica'—(Delisle 7/6).

10

NEWLY MARRIED COUPLES AND CONTRACEPTION

When young couples are undergoing preparation and examination for marriage, two questions invariably arise:

(1) When should the first pregnancy occur ?

(2) What is the best form of contraceptive for the newly-married ?

There are many issues which complicate the first question, such as housing problems, economic factors, etc. When a couple, having discussed the matter frankly and honestly with each other, have decided not to use any contraceptive until the first child has been born, the decision is for them the right one. It would be wrong to dissuade them from carrying out their intention. Generally speaking, for the doctor or specialist to be too dogmatic on any question is almost worse than giving no advice at all.

When a couple have decided to wait somewhile before starting their family, and there are no conflicting considerations such as marrying comparatively late in life, contraceptive advice should be given.

Generally, when couples are young they have to start their married life in a very limited home—such as a one or two roomed flat, or sharing a house with in-laws. Economic factors may necessitate both of them working for a short while after marriage. One or both may still be studying. Under these circumstances it is probably advisable to postpone the first

child until economic and environmental conditions are more suitable. Furthermore, it usually takes some time for a couple to become adjusted to each other, physically and otherwise. A pregnancy before this occurs may make an adjustment more difficult to achieve.

It is also well to remember that the converse sometimes holds true: the pregnancy brings the couple closer together and a woman may reach an orgasm only after becoming pregnant or bearing a child. There are psychological reasons for this, a discussion of which is not necessary here. There is no doubt, however, that there can be no greater happiness than that brought by a desired pregnancy to a well adjusted couple. Moreover, the earlier in life pregnancy occurs the easier it usually is for the woman to bear her child. Fertility also slowly declines as the woman grows older. The early and middle twenties are the most fertile and best child-bearing periods of a woman's life. Contraception has sometimes been blamed for a woman's later infertility when, in fact, it is much more likely to be due to the lessening fertility which comes with increasing age, or to a subfertile state which existed before contraception was ever started. Again, the mother and father are far happier when they are young with their children, and usually the children are better off with young parents. Generally speaking, at least 18 months should elapse between the birth of babies.

The author's advice to young couples who come for marriage preparation, and who have decided to use contraceptives at the beginning of their marriage, is that they should make an appointment with each other exactly one year from the day they get married, to discuss and consider the pros and cons of starting

a family. If they decide against starting one at that date, then they should make a further appointment six months later, and so on. Incidentally, it is surprising how often the difficulties envisaged when thinking of having a baby are solved when the baby actually comes.

When contraceptive advice is to be given the whole question is bound up with emotional attitudes, and involves the problem of hymen dilatation. The hymen (or maidenhead), a vestigial tissue serving no useful purpose in the human being, is a ring of thin skin round the entrance to the vagina, and is present, to a greater or a lesser extent, in practically all women. It varies in size and type just as much as the colour of a woman's hair or the shape of any other feature of her body. In some cases it is thick and tough, stretching almost across the entrance of the vagina. In other cases, it is so thin and elastic that it is not even ruptured by the initial act of sexual intercourse. Quite often, of course, and for a variety of reasons, such as the use of internal tampons, the hymen is already dilated before marriage. Its absence, therefore, is not necessarily the result of sexual experience.

Most women, however, have a hymen somewhere between these two extremes, and this has to be broken during the first attempts at sexual intercourse, causing a certain amount of bleeding and pain. The thought of bleeding and pain on the first night of marriage has caused many a wife to resist the husband's approach, often involuntarily. The pain of the first penetration may set up in her an antagonism towards the sex act; and, in a few cases, a more subtle antagonism is created towards the husband who caused the pain. It is a very important precipitating cause of frigidity. The results may be serious and perhaps disastrous to the ultimate success

of marriage. On the husband's side, there is often apprehension and fear of hurting his wife, and this nervousness in itself can have unfortunate psychological results.

There are a large number of couples who have no trouble at all; and many of those who experience difficulties manage to overcome them. But there are some who come up against very real problems, and a small percentage find it impossible to consummate their marriage without medical help. Why hope for the best instead of making certain of the best ? It is far wiser to have the dilatation completed before marriage, allowing the couple to start the most important undertaking of their lives without fear or worry.

The dilatation can, in fact, be done by the woman herself, by means of her own fingers and the use of a lubricant. After having examined and found the entrance to her vagina she should insert, first, her index finger, and stretch the hymen as much as possible. If she succeeds in doing this and carries on with the dilatation she might soon be able to insert two fingers. Gradually the hymen can be completely stretched.

Most women, however, do not find this an easy procedure, especially when the hymen is a little tough and difficult to stretch. Some women are nervous and afraid of harming themselves. It is often far simpler, quicker and easier to have the dilatation done by the specialist who, if necessary, will use a local anaesthetic. A general anaesthetic is only occasionally necessary.

With the dilatation complete, there is no reason why the woman should not be fitted with a cap. In fact, with the advantages outlined earlier in the

book (Chapter 3) this method is the obvious choice for the newly-married. Refitting in these cases should be carried out from three to six months after marriage, the time depending on the relaxation of the vaginal tissue and the ease with which the cap is fitted in the first place.

Where the hymen has not been dilated, the use of a sheath and a suppository or paste is probably the best choice. When the sheath has been drawn on the penis, a little lubricant applied to it will help in effecting penetration. The woman can be fitted with a cap at a later date.

With adequate marriage preparation, the couple will have obtained an understanding of sexual approach to each other.* They will know that there is no physical barrier to consummation. There will be no fear or embarrassment about pain or bleeding. Instruction in family spacing and the use of contraceptives will have relieved them of the anxiety of an unplanned pregnancy.

Sexual adjustment should then be achieved with relatively little difficulty, preparing the way for the construction of a successful marriage.

* See *The Art of Marriage*, by Dr. Mary Macaulay (Delisle 7/6; Penguin 2/6).

APPENDIX I

FAMILY PLANNING ASSOCIATION

At most clinics, but not all, patients are examined by a doctor. Addresses given here (correct in August, 1957) may be checked with the Secretary, Family Planning Association, 64 Sloane Street, London, S.W.1.

LONDON AND DISTRICT

ACTON: Trinity Way Clinic, Old Oak Road, W.3.
BARNET: Barnet Health Centre, Vale Drive.
BATTERSEA: 102 Earlsfield Road, S.W.18.
BOREHAM WOOD: Principal Health Centre.
BRENTFORD: Health Centre, Albany Road, High Street.
CAMBERWELL: Infant Welfare Centre, Consort Road, S.E.15.
Sumner Road Infant Welfare Centre, Basingstoke House, Sumner Road, S.E.15.
CARPENDERS PARK: Oxhey Place.
CARSHALTON: Welfare Centre, Wrythe Lane.
St. Helier County Hospital.
CHINGFORD: Marmian Avenue Clinic, Hall Lane, E.4.
CROYDON: 33 St. James's Road.
DAGENHAM: The Clinic, Ashton Gardens, High Road, Chadwell Heath.
Five Elms Clinic, Five Elms Road.
DARTFORD: West Hill Hospital.
EDGWARE: Maternity and Child Welfare Centre, Cressingham Road.
ENFIELD: Welfare Centre, Lincoln Road (off Cambridge Road).
EPSOM: Ante-natal Clinic, Epsom District Hospital, Dorking Road.
FARNBOROUGH (Kent): Farnborough Hospital.
GREENWICH: Charlton Lane Welfare Centre, Charlton Lane, S.E.7.
HACKNEY: 28 Lower Clapton Road, E.5.
HAMPTON WICK: 20 Seymour Road.
HAYES (Middx): Minet Clinic, Coldharbour Lane.
HORNSEY: School Clinic, Town Hall, Weston Park, N.8.
HOUNSLOW: Ante-natal Unit, 92 Bath Road.
ILFORD: Maternity Hospital, Eastern Avenue.
ISLINGTON: 39 Spencer Street, Goswell Road, E.C.1.
KENSINGTON: 12 Telford Road, Ladbroke Grove, W.10.
KENTON: Maternity and Child Welfare Centre, Elmwood Avenue.
KILBURN: 60 West End Lane, N.W.6.
LEWISHAM: Welfare Centre, 1-2 Winnet House, Beckenham Hill Road, S.E.6.
MARYLEBONE: 217 Lisson Grove, N.W.8.
POPLAR: Maternity and Child Welfare Centre, Wellington Way, E.3.
Ruston Street Welfare Centre.
PUTNEY: 2 Clarendon Drive, S.W.15.
RICHMOND: Health Centre, Windham Road.
ROMFORD: Maternity and Child Welfare Centre, Marks Road.
STAINES: The Grange, Gresham Road.
STEPNEY: East London Women's Welfare Centre, 6 Burdett Road, E.3.
Mary Hughes Welfare Centre, Underwood Road.
STREATHAM: 37 Riggindale Road, S.W.16.
SUTTON (Surrey): General Hospital, Cotswold Road.
TOTTENHAM: Medical Centre, Lordship Lane, N.17.
TULSE HILL: Purser House, Tulse Hill Estate, S.W.2.
UXBRIDGE: The Clinic, Local County Offices, High Street.
WALWORTH: 153a East Street, S.E.17.
WATFORD: Women's Clinic, The Avenue.

WEST HAM: Queen Mary's Hospital, Stratford, E.15.
WESTMINSTER: 1 Bessborough Street.
WILLESDEN: 379 High Road, N.W.10.
WOODBURY DOWN: Health Centre, Spring Park Road, N.16.

PROVINCES

ALDERSHOT: Manor House, Manor Park.
ALTRINCHAM: " Mountlands," The Mount, Church Street.
AMESBURY: Youth Club Hall, Kitchener Road.
AYLESBURY: Royal Buckinghamshire Hospital.
ASHINGTON: School Clinic, Bolsover Street.
BARNSLEY: Ante-Natal Clinic, St. Helen's Hospital.
BARNSTAPLE: North Devon Dispensary, Boutport Street.
BASILDON: Timberlog Lane.
BASINGSTOKE: Brambly Grange, Winchester Road Health Centre.
BATH: Blue Coat House, Health Office, Sawclose.
BERWICK-ON-TWEED: Community Centre, Palace Street East.
BEVERLEY: Clinic, Lord Robert's Road.
BILSTON: Health Clinic, Wellington Road.
BIRKENHEAD: 11a Oxton Road.
BIRMINGHAM: 14 Frederick Road, Edgbaston.
BISHOP'S STORTFORD: Haymeads Hospital, Dunmow Road.
BLACKBURN: Friends' Meeting House, King Street.
BLACKPOOL: Memorial Hall, Dean Street.
BLYTH: Maternity and Child Welfare Centre, Waterloo Road.
BOGNOR REGIS: Health Centre, Westloats Lane.
BOLTON: Public Health Department, Civic Centre.
BOSTON: Ferry House Clinic, London Road.
BOURNEMOUTH: Avebury Clinic, 10 Maderia Road.
Pelham's Clinic, Kinson Community Centre.
BRIDGWATER: General Hospital, Salmon Parade.
BRIDLINGTON: Clinic, Oxford Street.
BRISTOL: Central Health Clinic, Tower Hill.
BURNLEY: Clinic, Elizabeth Street.
BURTON-ON-TRENT: Infant Welfare Centre, Cross Street.
CAMBRIDGE: 22 Parsonage Street.
CANNOCK: Medical Offices, Church Street.
CANTERBURY: Central Clinic, Stour Street.
CARLISLE: Eildon Lodge, 50 Victoria Place.
CASTLEFORD: Castledene Public Health Office, Pontefract Road.
CHATHAM: Cambridge House, 4 Mansion Row, Gillingham.
CHELMSFORD: County Health Service Clinic, Coral Lanes.
CHELTENHAM: School Clinic, Royal Well Road.
CHESTER: 2 Kings Buildings, King Street.
13a Lower Bridge Street.
CHESTERFIELD: County Council Clinic, Brimington Road.
CLECKHEATON: The Valley Road Clinic, Liversedge.
COSHAM: The Health Centre, Northern Road.
CRAWLEY: Clinic, Langley Green.
CREWE: Ludford Street School Clinic.
DARLINGTON: Memorial Hospital.
Clarence Hall, Finchale Road, Newton Aycliffe.
DERBY: Maternity and Child Welfare Clinic, Green Street.
DONCASTER: Richmond Hill School Clinic, Sprotborough Road.
DORCHESTER: Glyde Path Road Clinic.
DORKING: General Hospital, Horsham Road.
EASTBOURNE: 357 Seaside.
EASTLEIGH: The Red House, 6 Romsey Road.
EXETER: Out-Patient Department, West of England Eye Infirmary, Magdalen Street.

FALMOUTH: Welfare Centre, Killigrew Road.
FAREHAM: The Health Centre, West Street.
FARNHAM: Farnham Hospital, Hale Road.
GILLINGHAM: 4 Mansion Row, Brompton.
GLOUCESTER: School Clinic, 9 Brunswick Road.
GRAYS: Park Clinic, Bridge Road.
GRIMSBY: Maternity and Child Welfare Centre, Watkin Street.
GUILDFORD: St. Luke's Hospital, Warren Road.
HALIFAX: Halifax District Nursing Association, Kirby Leas, Savile Road.
HARLOW: Nuffield House, The Stow.
Sydenham House, Long Ley.
HARTLEPOOL: Cameron Hospital, West Hartlepool.
HAYLE: Bodriggey Clinic.
HAYWARDS HEATH: Maternity and Child Welfare Centre, Paddockhall Road.
HEMEL HEMPSTEAD: Churchill, Heath Park.
HEREFORD: 1 Carlton Flats, All Saints Street.
HITCHIN: 107 Bancroft.
HOLBEACH: The Clinic, Park Road.
HOVE: Infant Welfare Centre, Clarendon Villas Mission Hall, Godstone Road.
HUDDERSFIELD: Day Nursery, Greenhead Road.
HULL: 21 Percy Street.
KENDAL: Stramongate Clinic.
KIDDERMINSTER: Coventry Street Clinic.
LANCASTER: The Friends' Hall, Fenton Street.
LAUNCESTON: The Health Centre.
LEAMINGTON: Welfare Centre, Hamilton House, 4 Holly Walk.
LEEDS: Health Department, Park Square.
Leafield Clinic, King Lane.
LEEK: The Clinic, Salisbury Street.
LEICESTER: West End Adult School, Western Road.
LINCOLN: Maternity and Child Welfare Centre, 34 Newland.
LIVERPOOL: 9 Gambler Terrace.
294 Netherfield Road.
Maxwell Fyffe Hall, Back Broadway, Norris Green.
Linacre Methodist Mission, Linacre Road, Litherland.
Congregational Hall, Eastern Avenue, Speke.
MACCLESFIELD: Welfare Centre, 52 Bridge Street.
MAIDENHEAD: The Wilderness Health Centre, Cookham Road.
MAIDSTONE: West Kent General Hospital.
MANCHESTER: 70 Upper Brook Street, Chorlton-on-Medlock.
MARGATE: General Hospital.
MERSTHAM: Red Cross Rooms, 18 Albury Road.
MEXBOROUGH: Child Welfare Centre, Adwick Road.
MIDDLESBROUGH: 63 King's Road, North Ormesby.
MIDHURST: Welfare Hall, Petersfield Road.
NELSON: 64 Carr Road.
NEWBURY: Greenham House.
NEWCASTLE-ON-TYNE: 24 Shieldfield Green.
NORTHALLERTON: Zetland Street Clinic.
NORTHAMPTON: Infant Welfare Centre, 67 St. Giles' Street.
NORTH SHIELDS: 1 Cleveland Road.
NORWICH: 4 Ber Street.
NOTTINGHAM: General Dispensary, Broad Street.
NUNEATON: Riversley Park Clinic.
OLDBURY: Warley Clinic, Bleakhouse Road, Warley.
OLDHAM: Greenacres Congregational Church (Oberlin Street Entrance).
OXFORD: Maternity Out-Patients' Department, Radcliffe Infirmary.
PAIGNTON: 14 Midvale Road.

PENZANCE: Bellair Alverton Clinic.
PETERBOROUGH: Infant Welfare Centre, Town Hall.
PLYMOUTH: Beaumont Hut, Beaumont Park.
The Health Centre, St. Budeaux.
PORTSMOUTH: Trafalgar Place, Clive Road, Fratton.
PRESTON: Lancaster Road, Congregational School.
READING: Maternity and Child Welfare Centre, Star Lane.
Whitley Clinic, Northumberland Avenue.
REDDITCH: The Old Vicarage, Bromsgrove Road.
REDHILL: County Hospital, Earlswood Common.
RICHMOND (YORKS): Welfare Clinic, Quaker Lane.
ROCHDALE: Baillie Street Council School.
ROTHERHAM: Ferham House, Kimberworth Road.
RUGBY: Ante-Natal Clinic, Temple Street.
RUNCORN: Health Centre, Halton Road.
ST. ALBANS: Wellington Court Clinic, Bricket Road.
ST. AUSTELL: Moorland Road Clinic.
SALFORD: 10 Encombe Place.
SALISBURY: Exeter House, 113 Exeter Street.
SALTBURN-BY-SEA: Infant Welfare Clinic, Bath Street.
SAXMUNDHAM: Health Centre.
SCARBOROUGH: Roscoe Street Clinic.
SCUNTHORPE: Ashby Welfare Centre, Collum Lane.
SHEFFIELD: Attercliffe Vestry Hall, Attercliffe Common.
St. Mary's Community Centre, Bramall Lane.
SHIPLEY: Somerset House Clinic, Manor Lane.
SLOUGH: Social Centre, Farnham Road.
Burlington Road Health Centre.
SOLIHULL: Drury Lane Infant Welfare Centre.
SOUTHAMPTON: Oatlands House Health Centre, Winchester Road.
Sydney House, Peartree Avenue.
SOUTHEND: St. John Ambulance Headquarters, 74 Queen's Road.
SOUTHMEAD: Health Centre, Monks Park Avenue.
SOUTHPORT: West End Congregational Church Hall.
SOUTHSHIELDS: General Hospital, Harton Lane.
STAFFORD: North Walls Infant Welfare Centre.
STAINES: The Grange, Gresham Road.
STEVENAGE: The Clinic, 27 High Street.
STOCKPORT: Clinic, 96 Churchgate.
STOKE-ON-TRENT: 12 Wellesley Street, Hanley.
STOWMARKET: Violet Hall Clinic.
SUNDERLAND: General Hospital, Chester Road.
SUTTON COLDFIELD: Infant Welfare Clinic, 49 Holland Street.
Clinic, Boldmere Road.
SWINDON: Child Welfare Clinic, 61 Eastcott Hill.
THORNABY: Health Centre, Francis Street (entrance George Street).
TOTNES: Adult Education Centre, Shinners Bridge, Dartington.
TOTTON: Welfare Centre, Rumbridge Street.
TROWBRIDGE: Halve Clinic.
TUNBRIDGE WELLS: Homœopathic Hospital, Church Road.
WAKEFIELD: Child Welfare Clinic, Margaret Street.
WALSALL: Bradford Street Clinic.
WALTHAM CROSS: Health Centre, High Street.
WARRINGTON: Christ Church Schoolroom, Wash Lane, Latchford.
WELWYN: Gooseacre Health Centre, Cole Green Lane.
WEST BROMWICH: Highfields Infant Welfare Centre, Bratt Street.
WIGAN: Millgate.
WINCHESTER: The Hut, Trafalgar Street.
WINSFORD: 98 Weaver Street.
WOKING: 77a Chertsey Road.

WORKINGTON: Park Lane Clinic.
WYTHENSHAWE: St. Martin's Parish Hall, Altrincham Road, Baguley.
YEOVIL: General Hospital, Higher Kingston.
YORK: County Hospital.
Health Service Centre, Cornlands Road, Acomb.

SCOTLAND

ABERDEEN: City Residents: 6 Castle Terrace.
County Residents: Gynaecological Department, Woolmanhill.
BRIDGEND DUNS: Public Health Dept., Lanark Lodge.
COWDENBEATH: Blamey Clinic.
DUMBARTON: Hartfield School Clinic, Latta Street.
DUNDEE: Kilcraig Clinic, 99 Broughty Ferry Road.
EDINBURGH: 90 East Crosscauseway, off Nicholson Street.
FALKIRK: Public Health Clinic, Meadow Street.
GALASHIELS: Welfare Centre, Sime Place.
GLASGOW: 123 Montrose Street.
GREENOCK: Hillend Clinic, Border Street.
KILMARNOCK: Clinic, Green Street.
PAISLEY: Russell Institute, Causeyside Street.
PERTH: 80 South Street.
STIRLING: Public Health Department, Springbank.
STRANRAER: Health Centre, Edinburgh Road.

WALES

BANGOR: The Clinic, Sackville Road.
CARDIFF: Ely Clinic Premises, Redhouse Crescent.
CARMARTHEN: Pont Street Clinic.
CHEPSTOW: Old Folks' Club.
COLWYN BAY: Clinic, Nant-y-Glyn Road.
EBBW VALE: Ebbw Vale Hospital.
DOLGELLEY: Dolgelley Hospital.
HAVERFORDWEST: 23 Hill Street.
NEATH: Physiotherapy Clinic, Metal Box Co. Ltd., Canal Side.
NEWPORT: County Clinic, 1 Stanley Road.
PONTYPOOL: Education Settlement, Rockhill Road.
SWANSEA: 36 Walters Road.
WREXHAM: 1 Grosvenor Road.

ISLE OF MAN

DOUGLAS: Friends' Hall, Well Road Hill.
MALEW: Balthane Road, Ballasalla.

ISLE OF WIGHT

FRESHWATER: Nurses Institute, Princes Road.
NEWPORT: The Clinic, County Hall.
RYDE: Well Street Church Hall.

NORTHERN IRELAND

BELFAST: 31 Malone Place.

APPENDIX II

MARRIAGE GUIDANCE COUNCIL

The National Marriage Guidance Council, and the local Councils which are its constituent members, offer general education for marriage, courses in marriage preparation, and a marriage counselling service dealing with individual problems of those about to marry or experiencing any difficulties in marriage. The names and addresses of local secretaries, and of any new

centres (the information here was correct in August, 1957) can be obtained from the General Secretary, National Marriage Guidance Council, 78 Duke Street, London, W.1.

AYLESBURY
BATH
BEDDINGTON, WALLINGTON & [CARSHALTON
BEDFORD
BELFAST
BIRMINGHAM
BLACKBURN
BOLTON
BOURNEMOUTH
BRADFORD
BRIGHTON
BRISTOL
BROMLEY
CAMBRIDGE
CARDIFF
CHELTENHAM & COTSWOLD
CHICHESTER & BOGNOR REGIS
COVENTRY
CROYDON
DARLINGTON
DARTFORD
DERBY
DONCASTER
DUDLEY & STOURBRIDGE
EAST HAM & WEST HAM
EASTBOURNE
EPSOM & EWELL
EXETER
FYLDE
GLOUCESTER
GUERNSEY
GUILDFORD
HARROW
HASTINGS
HUDDERSFIELD
HULL
IPSWICH
KEIGHLEY
LANCASTER
LEEDS
LEICESTER
LONDON (Metropolitan Boroughs)
LUTON
MAIDSTONE
MANCHESTER
MEDWAY TOWNS
MERSEYSIDE
MID-HERTS
MITCHAM
NEWCASTLE-ON-TYNE
NORTH-HERTS
NORTH-MIDDLESEX
NORTH-STAFFS
NORWICH
NOTTINGHAM
OXFORD
PURLEY
READING
REDDITCH
REIGATE & REDHILL
RICHMOND
ROMFORD
ST. HELENS
SHEFFIELD
SLOUGH
SOUTHGATE
SOUTHAMPTON
SOUTHEND
SUTTON & CHEAM
SWINDON
TORBAY
TRURO
UXBRIDGE
WATFORD
WESTON-SUPER-MARE
WIDNES
WIMBLEDON
WOKING
WOLVERHAMPTON
WORCESTER

SCOTLAND

Apply to the Secretary, The Scottish Marriage Guidance Council, 44 Queen Street, Edinburgh. This Council co-ordinates the Marriage Guidance Councils in Scotland.

APPENDIX III

THE ALLIANCE

Founded in 1903, this Society is concerned with Sex Education, Marriage Guidance, and Family Welfare. The Alliance provides lecturers; arranges consultations; and supplies literature on personal relationships, marriage preparation, family planning, marital difficulties, and social problems.

A recommended book list will be sent on receipt of a stamped addressed envelope. All correspondence should be addressed to: The Secretary, Alliance Centre, 238 Edgware Road, London, W.2.