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Devices and Desires

A HISTORY OF CONTRACEPTIVES IN AMERICA

Andrea Tone

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the common bonds of womanhood. Another layer to Hon's claims of sisterhood was shared ethnicity. Hon's primary customers were Polish, like herself. She advertised her products in Polish newspapers such as *Zgoda*, published in Chicago, home to 125,604 Poland-born immigrants in 1910 and 137,711 in 1920.[67]

In 1917, twelve years after she had begun operations, Antoinette Hon was still in business. Each day she received an average of thirty to forty letters ordering or asking about her wares. At a time when a middle-class, college-educated professional woman earning eighteen hundred dollars a year was thought to be doing well, Hon's annual salary was thirty-six hundred dollars.[68]

Hon's business capitalized on the medical endorsement of certain forms of birth control. But doctors did not appreciate contraceptive entrepreneurs like Halleck or Hon. In the eyes of the medical establishment, Halleck and Hon were dangerous quacks practicing gynecology without a degree. In 1917, Hon was charged with fraud for dispensing medicine without a license.[69]

Of course, doctors who refused to prescribe birth control were partly to blame for the proliferation of contraceptive entrepreneurs in the age of Comstockery. In the absence of medical leadership, women and men turned to the marketplace to acquire what doctors denied them. There they found men such as Julius Schmidt, with skins aplenty, and Joseph Backrach, with womb veils to spare. At the turn of the twentieth century, low production costs, high consumer demand, weakly enforced laws, and the reluctance of reputable manufacturers to specialize in controversial goods bequeathed ordinary folk such as Schmidt and Hon the freedom to participate in and profit from the bootleg birth control trade. From an entrepreneurial standpoint, these were the business's golden years.

FOUR

Black-Market Birth Control

Casanova wore the finest condoms money could buy, but he was hardly enthusiastic about them. It was emasculating and dispiriting, he complained, to have to "shut myself up in a piece of dead skin in order to prove that I am perfectly alive." Casanova's complaint, a familiar refrain among condom-wearing men then and now, did not prevent him from promoting condoms or wearing them during frequent visits to French brothels. The condom, he announced, was a "wonderful preventive" for "shelter[ing] the fair sex from all fear."[1]

Of course, no contraceptive was perfect. The savvy Italian knew that condom quality varied and that the *surest* way of sheltering sexual partners from fear was to inspect each one before use. Prior to intercourse, Casanova blew his condoms up, balloon-style, to see if they would burst or deflate.[2] In the days before condoms were subjected to mechanized air-burst tests, one did what one could.[3]

More than a century later, Americans had similar reactions to condoms and other birth control devices. They complained that rubbers and skins dulled sexual sensation and that postcoital douching was a chore. But they used these methods anyway, believing that to do so was better than doing nothing.

Although obscenity laws in late-nineteenth- and early-twentieth-century America were frequently violated and erratically enforced, they made contraceptives illicit goods to be confiscated, not merchandise to

be regulated and inspected. Without government safeguards to protect consumers from unscrupulous merchants and shoddy wares, America's birth control buyers were on their own.

Refusing to let their procreative destinies be held hostage by absent safeguards, women and men invented strategies to shield themselves from quackery. They shared experiences with family and friends and sought advice from experienced contraceptors. To better the odds of pregnancy prevention, they used multiple contraceptives at once. They inflated condoms, Casanova-style, while yearning for superlative devices that felt and worked better. These precautions did not eliminate heartbreak, pain, or pregnancy. But they helped. National fertility rates dropped steadily after 1880, most sharply among African-Americans. In 1910, only France had a lower birthrate in the Western world.

It is difficult to gauge how safe, effective, and tolerable contraband contraceptives were before the advent of clinical testing in the 1920s and product standardization in the 1930s. Evidence from the period, however, sketches a scenario in which glaring incidents of quackery coexisted with a surprising degree of consumer confidence in bootleg birth control. If Americans stopped short of celebrating contraceptives as aesthetically pleasing or absolutely protective, neither did they denounce the devices as universally useless or prohibitively dangerous.

By modern standards, contraband contraceptives certainly seem to have been wanting. Take the ever-popular condom. Skins could be thick and smelly, especially if they were recycled, a cost-saving but odoriferous practice in which condoms were rinsed, dried, powdered, and then reused.[4] Hand-stitched low-grade skins sported protruding and uneven seams that could irritate genitals during high-friction sex. Chemicals used to create the finer goldbeaters' models left unsuspecting wearers vulnerable to chemically induced skin welts and lesions.[5] Making matters worse, the relative inelasticity of animal-based skins, no matter how well stretched or secured by ribbons or rings, rendered them less watertight and durable than today's formfitting models. By 1900, things had changed little since 1671, when one mother described skins to her daughter as both an "armor against enjoyment and a spider web against danger."[6]

Not the contraceptive panacea for which men and women yearned, the maligned skin was nonetheless bought and even praised, as it was in the anonymous 1744 poem *The Machine—or Love's Preservative:*

> *By this Machine secure, the willing Maid*
> *Can taste Love's Joys, nor is she more afraid*
> *Her swelling Belly should, or squalling Brat,*
> *Betray the luscious Pastime she has been at.*[7]

For all its drawbacks, the skin was most appealing for its potential to be, in Casanova's words, a "wonderful preventive." Lovers took precautions to minimize the risk of condom failure. They examined skins for cracks and structural weaknesses, moistened them to ensure a tight fit (Casanova purportedly dunked his in a canal before use), and incorporated such safety "rituals" into foreplay.

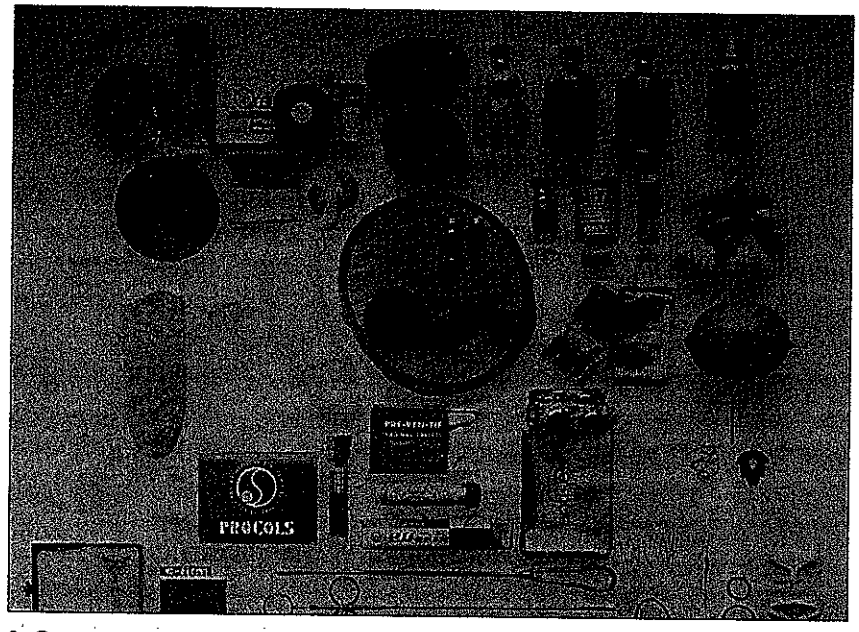
These strategies undoubtedly helped reassure skin users. But what probably eased their minds more was the arrival of rubber condoms in the 1860s. Historians have often discounted the significance of technological upgrades to birth control before the Pill, as if, in the long history of contraception, only a once-a-day oral contraceptive counts as new. In doing so, they have drawn attention to the ancient origins of many modern methods, an important point. But it is equally essential to recognize that technological modifications of traditional contraceptives that today might appear minor were regarded as revolutionary in their time. Such is the case with the invention of diaphragms that contained springs, and IUDs made of malleable plastic. And it was certainly the case with condoms created from rubber. In the nineteenth century, people viewed rubbers as a superior form of condom and contraceptive. George Bernard Shaw thought them the "greatest invention of the nineteenth century"—and this in a century that witnessed the birth of the internal combustion engine and the telephone.[8]

The American freethinker and publisher Gilbert Vale hailed India rubber sheaths as more durable than skins.[9] Rubbers reduced the risk of condom slippage or breakage. And because rubber as a substance is less porous than natural membrane, it is less likely to leak. (This is one reason why gynecologists today counsel against the use of skin sheaths as protection from sexually transmitted diseases such as AIDS.)[10]

Still, the quality of pre-latex rubbers varied. The hand-sewn rubbers described by T. J. B. Buckingham in his 1892 report were as seamed as many skins, making them both uncomfortable and poor retainers of fluid.[11] Seamless condoms were available, created either by working warmed natural rubber around a mold until its edges adhered or by dipping cylindrical molds into dissolved, masticated sheet rubber.[12] How successfully seamlessness fixed hand-stitched sheaths' tendency to leak is unknown, but as late as 1938, one birth control guide urged users of rubbers to inflate them to check for holes.[13] Seam or no seam, all pre-latex rubbers had a short shelf life. Rubbers deteriorated rapidly, especially when they came into contact with moisture. The magnitude of this problem is suggested by one advertisement for India-Rubber Capotes, which promised customers condoms "WARRANTED NOT TO DECAY."[14]

A more telling indicator of condom quality is the results of the first scientific investigations of condoms undertaken before inspections by the Food and Drug Administration (FDA) began in the late 1930s. A 1924 study by the physician and birth control advocate Robert Latou Dickinson found a 50 percent failure rate among couples using skin and rubber condoms at three birth control clinics in New York and London.[15] A contributing factor was likely the condoms themselves, first evaluated by the biochemist Cecil I. B. Voge, best known for his discovery in 1926 of a laboratory test for confirming pregnancy.[16] In 1934 and 1935, Voge assembled more than two thousand American sheaths representing twenty-one brands, a majority of which he purchased on "the open market." After inflating each sheath to a "moderate size . . . 8 inches long and 6 inches in diameter," he sealed the open end and suspended it for observation. Condoms that neither burst nor deflated after twenty minutes were placed against an illuminated background and visually examined for other defects: foreign matter, dirt, creases, thin spots, and weak tips. Only 41 percent of those tested—the strongest, cleanest, and most evenly textured sheaths—passed. Of those that did not, half burst upon inflation, a quarter were found to have pinholes, and the rest were declared otherwise unfit.[17]

Bursting condoms, holey sheaths, smelly skins: this is the material out of which modern sexual nightmares are made. Indeed, compared with today's sheer, odor-free, and resilient condoms—which are routinely subjected to a grueling twenty-five-liter air-burst test before being unleashed



9. Contraceptives, past and present (Courtesy of the History of Contraception Museum, Janssen-Ortho Inc., Toronto, Canada)

on the public—early condoms do not measure up.[18] But that does not mean that men and women in turn-of-the-century America judged them ineffective. Evaluating contraceptive efficacy by the standards of a post-Pill world obscures the way Americans of an earlier era assessed birth control. Pregnancy is not a relative condition. But at the turn of the century, evaluations of contraceptives were informed by available options, which were more limited and less effective than they are today. Government regulation of contraceptives was unknown. Although being at the mercy of manufacturers and merchants was not ideal, it was an existence American consumers knew well. Until the FDA was established in 1906 to combat endemic quackery, most medical products—even legal ones—were sold without consumer protections. In a political and medical environment where the potential for health fraud was high and the unregulated market provided danger almost as often as relief, Americans could not help but evaluate contraband contraceptives for themselves.

Throughout the black-market era, moreover, contraceptives that would be almost 100 percent effective were unfathomable. The only reli-

able method was abstinence, something that has not always been in women's control. Male withdrawal, or coitus interruptus, was another popular technique. (Some physicians, referring to its grassroots practice, condescendingly termed it "the French peasant's withdrawal.") Free and easy to learn, withdrawal had a failure rate of about 20 percent. (Failure rates refer to the percentage of women who become pregnant after a year's use.)[19] Doctors' remonstrations against withdrawal, which linked it to insanity, impotence, blindness, and a host of other ailments, may have persuaded some men not to try it and others to "change their minds" at the last minute. Although modern science has invalidated such prophecies of doom, they may well have had a placebo effect on Americans in an earlier era. In 1895, one woman complained that her husband, a physician, had practiced withdrawal only to complain of being entirely "worn out [the] next day."[20]

The frequent failure of the so-called safe period, the point during the menstrual cycle when intercourse is least likely to cause pregnancy, was disheartening to Americans who practiced it, particularly because many physicians mistakenly insisted on its reliability. Doctors assumed that the reproductive cycles of lower mammals and humans were the same. Knowing from observation that animals ovulated during estrus, they reasoned that women must ovulate during menstruation and be least fertile midway through the menstrual cycle. As one Michigan doctor instructed in 1881, a woman trying to prevent pregnancy should avoid "having connection with her husband just before her menses," for "that is the time that nature evidently intended that conception should take place . . . it is then that all animals are in heat."[21] As early as the 1870s, postmortem examinations of women who died while menstruating without signs of a matured ovum had disputed this assumption. Most physicians nevertheless continued to insist on the simultaneity of menstruation and ovulation until the 1920s, when Japanese and Czechoslovakian studies of the laparotomic retrieval of ova from Fallopian tubes proved them incorrect.[22]

Many women, though, suspected that the doctors were wrong. Emily Fitzgerald had only to witness the world around her to know better. The wife of a western Army doctor, she began to suspect that the safe period was a myth. "I don't believe that there is a safe day in the month for me," she complained in 1875. "Indeed, I know there isn't—15th-16th-17th—

or any other." Emily and some women friends had discussed the problem at length. We have "meetings of horror over the subject," she wrote, "as we all . . . seem to be awfully prolific."[23]

The despair Emily and her contemporaries felt about a method that was supposed to be effective but was not probably shaped the criteria they used to evaluate other contraceptives. Compared with the safe period, condoms seemed a good bet. A failure rate of 50 percent also meant a 50 percent success rate, a significant measure of protection by the standards of an earlier age.

Although it is impossible to know how many couples used condoms in the late nineteenth and early twentieth centuries, a survey conducted by Dr. Clelia Duel Mosher provides clues. Mosher, born in 1863, first became interested in studying women's sexual practices in 1892, when she was a biology student at the University of Wisconsin. In preparation for a talk on marital relations she was to give at a local Mothers Club, she asked married women, most of whom were college educated and middle-class, to discuss their gynecological health. How often did they have intercourse? What contraceptives had they used?[24]

Mosher received an A.B. from Stanford University, and then went to the Johns Hopkins Medical School. After graduating from Hopkins in 1900, she moved to Palo Alto and eventually became assistant professor of personal hygiene at Stanford. Over the years, she continued the survey she had begun in 1892. By the time she completed it in 1920, the bound but never published questionnaires—discovered by accident in 1973—had chronicled the marital relations of forty-five women. Mosher's is the only known survey of its kind of Victorian women in the United States.[25]

Condoms were popular in Mosher's group, ranking second in frequency of use after the douche. Eleven of the twenty-eight contraceptive users had tried condoms, chiefly because they deemed them more trustworthy than other techniques. One woman, a former music teacher, turned to condoms after she and her husband, married in 1889, conceived by "accident" in 1891 during her "so-called 'safety week.' " Her pregnancy was physically and emotionally draining. When Mosher interviewed her in 1892, the new mother had regained her strength and vigor, but the couple had abandoned the safe period for the reliability of a "thin rubber covering for man." Another condom user, born in 1867, had con-

ceived five times before switching to condoms. Two of the pregnancies had ended in miscarriage. When Mosher asked the woman what form of birth control she was currently using, her answer underscored her faith in condom technology: "Cundrum now," she replied. "Must not conceive again." Others shared her confidence. After one woman became pregnant using the safe period and a postcoital douche, her husband switched to condoms. The "French method of prevention," the relieved woman told Mosher, had been "perfectly successful."[26]

One of Mosher's respondents used a "woman's shield—pessary cap"—prescribed by a doctor because "she must not have more children."[27] Notwithstanding the doctor's confidence, it is unclear how effective womb veils were at the turn of the century. If the pessary was constructed to fit like a diaphragm, odds of its reliability were poor. Today diaphragms are prescribed only after the cervix has been measured, a technique that enables a medical practitioner to select the best-fitting size. Sizes are standardized—ranging from fifty to ninety-five millimeters—and manufacturers supply doctors with "fitting" models to ensure accuracy. Unfortunately, medical schools at the turn of the century did not train physicians to fit women with diaphragms or to rule out physiological contraindications such as cervical lacerations, erosion, or displaced uteri. In lieu of standardized sizing, womb veils were sold over the counter in ambiguous dimensions that varied by producer: "big" and "small," "one-size-fits-all," "mothers' size." Too large a shield could cause abdominal pain, cramping, vaginal ulceration, and recurrent urinary tract infections; too small, dislodgement and pregnancy. If the pessary had been designed to function as a cervical cap, the odds of pregnancy prevention were better. The cap works by forming around the cervix a seal whose suction prevents sperm from moving past its edges. (In contrast, the diaphragm works by suspending a spermicidal agent within the vagina.) Although today a doctor's fitting is recommended before a cervical cap is used, caps are currently manufactured in only four sizes (ranging from twenty-two to thirty-one millimeters). An exact match between the inner diameter of the cap rim and the base of the cervix is not required for the method to work. This made cervical caps usually more reliable than diaphragms at the turn of the century. Still, in a pre-latex age, even the best-fitting caps and diaphragms suffered from some of the same shortcomings as any contraceptive made of India rubber, including rapid deterioration. But if the fit was right and the material resilient, diaphragms and cervical caps had a high potential for success. Two early studies of the methods found failure rates ranging from 1 to 24 percent.[28]

Another of Mosher's respondents used an intrauterine device, a "Good-year rubber ring," as birth control. IUDs were the most painful and medically dangerous birth control method at the turn of the century. Compared with today's quarter-sized malleable plastic models, intrauterine stem pessaries were bulky and large, making them difficult and painful to insert. IUD use increased a woman's risk of cramping, dysmenorrhea, uterine perforation, and pelvic inflammatory disease—a potentially life-threatening infection of the Fallopian tubes, uterus, or ovaries, incurable in the days before antibiotics.[29] Still, women able to endure the discomfort of insertion and use often found them beneficial. Although the specific antifertility mechanism of IUDs is unknown, scientists agree that the presence of an object in the uterus prevents pregnancy most of the time. There are several theories on how IUDs work. One is that the IUD immobilizes sperm by interfering with its migration from the vagina. Another holds that IUDs expedite the transport of the ovum through the Fallopian tube, causing the egg to arrive at the uterus too soon. The most widely accepted theory is that the introduction of an IUD causes a local inflammation or chronic, low-grade infection that makes fertilization and egg implantation impossible.[30]

The douche was the most popular contraceptive in Mosher's study, although its failure rate was higher than that of the IUD. For excellent reasons, doctors today do not recommend douching. As a hygienic practice, it is unnecessary and potentially harmful, because the vagina is self-cleansing. Water and chemical solutions wash away beneficial bacteria, increasing chances of infection. In addition, forceful douching may remove the mucous plug protecting the cervix, uterus, and Fallopian tubes from disease, providing a biological expressway for pathogens. Studies have linked douching to a higher incidence of pelvic inflammatory disease, sexually transmitted diseases, and ectopic pregnancy.[31]

As a contraceptive, douching is equally unsound. Sperm move fast. By the time a douching solution is introduced, seminal fluid that has already penetrated the cervix and surrounding tissues is difficult, even impossible, to remove. In addition, douching, while flushing away some sperm, pushes others into the uterus, placing a woman on a fast track to

pregnancy. Many douching solutions are either spermicidally benign or so toxic that they chemically inflame, irritate, or burn the vagina and cervix. Doctors and family planning counselors today consider douching the least effective contraceptive, and some refuse to classify it as birth control.[32]

Still, it would be a mistake to assume that couples who repeatedly used this method at the turn of the century were stupid. In an era when sperm motility and the spermicidal properties of chemicals were not well understood, douching seemed intellectually logical, presenting women with a technique to wash away sperm and devitalize persistent leftovers. Compared with the safe period, douching must have seemed particularly reliable. Before clinical investigations in the 1920s and 1930s revealed failure rates as high as 90 percent (about the same as using no birth control at all), many doctors endorsed its contraceptive efficacy in medical journals and to patients for these reasons.[33] One 1924 study found that, after condoms, douching was the form of birth control most frequently recommended by doctors, more popular among medical professionals than diaphragms and suppositories combined.[34]

Moreover, although douching failure rates could be alarmingly high, they varied enough (one study found a 42 percent failure rate) to suggest that the method provided some women with a modicum of protection. The shape of a woman's body, the solution she used, and when she douched were important variables. Dorothy Bocker, a physician at Margaret Sanger's Birth Control Clinical Research Bureau, found in her yearlong investigation of contraceptive methods that douching was less likely to work in women with wide cervical canals and prolapsed uteri.[35] The chemical makeup of douching solutions also influenced the method's success. An effective spermicide kills "very vigorous human sperms" within a minute without injury to the vagina. But many commercial preparations were too inert or caustic to qualify. Zinc sulfate douches, for instance, were frequently used to prevent pregnancy at this time. But because zinc sulfate acts slowly on sperm, it is not an effective spermicide. This might explain a comment made by one of Mosher's subjects: "Sulphate of zinc . . . is not infallible." Citric acid was a better bet, but only in the right concentration. At 1:1,000 parts, it immobilizes sperm instantly, but a more diluted concentration takes longer, increasing the likelihood of conception.[36]

Efficacy also depended on quick thinking and immediate action after intercourse, a disruption not all women would tolerate. As Bocker observed, douching is "psychologically bad because the woman, after normal intercourse, is relaxed and fatigued; and using a douche is an act of will as devastating to the woman as coitus interruptus to the man."[37] Moreover, only affluent women had access to running water, a bathroom, and the privacy that facilitated douching as a practice.[38]

Vaginal suppositories and tablets were easier to use, but their effectiveness varied. Many turn-of-the-century suppositories and tablets contained boric acid or quinine, ingredients not considered effective spermicides. Others contained lactic acid, so effective that in the 1940s some birth control advocates suggested that it be used alone for contraception. In theory, suppositories were double-acting: they mechanically paralyzed and chemically neutralized sperm. Usually based in cocoa butter or gelatin, they were intended to dissolve at room temperature. In practice, weather extremes in a pre-air-conditioning age and corresponding fluctuations in vaginal temperature made suppositories' diffusion, homogeneity, and contraceptive attributes unpredictable. Foaming tablets were also unreliable. Composed of an effervescent, moisture-activated mixture such as tartaric acid and sodium bicarbonate (which, when triggered, produced a protective foam), tablets often remained inert until *after* ejaculation.[39]

Without a doubt, black-market birth control carried significant risks, especially by today's standards. But these risks did not just victimize contraceptive consumers. They incited women and men to action. Inventing strategies to shield themselves from product failure and commercial exploitation, women and men at the turn of the century did their best to convert awareness of birth control hazards into techniques for self-protection.

One strategy was to employ several birth control methods at once. Today's contraceptives, used as directed, rarely have failure rates exceeding 9 percent, and most Americans feel confident employing one method at a time.[40] Sexually active Americans in a less certain world doubled, tripled, even quadrupled up. Amassing contraceptives as if they were battle weapons, they stocked their birth control arsenals well. To buck the

odds, one woman in Mosher's survey used a vaginal suppository and a douche, another a four-pronged regimen of a suppository, pre- and post-coital douches, and the "mid month period." Yet another used "cundrums" and a diaphragm, reserving the safe period for when the couple "could afford chance."[41] A 1941 investigation of contraceptive practices revealed that 66 percent of those surveyed had "previously used various and often multiple contraceptive methods."[42]

Another way women and men limited their vulnerability to contraceptive failure was by sharing their experiences with different methods and brands. In an era when the only way of discerning an article's safety and efficacy was through trial and error, recommendations passed along from mother to daughter, friend to friend, and husband to wife guided worried birth control users through the turgid and sometimes treacherous waters of the contraceptive marketplace. Women in Mosher's study cited as sources of reproductive knowledge "some very frank talks" with mothers, physicians, friends, and relatives. One respondent appreciatively recalled, "[A] few months before my marriage a wise woman friend told me about the various ways of 'regulating conception.' "[43] Bocker's 1923 investigation of preclinical birth control practices identified a similar network of local and informal instruction, whereby women learned about contraceptives "from neighbors, relatives, and friends." Bocker spoke with one woman from a small Midwestern town whose determination led her to the doorsteps of the community member she believed possessed the most expertise: the "keeper of a brothel."[44]

So entrenched was this tradition of grassroots discussion that once birth control became legal, contraceptive manufacturers endeavored to discredit it through advertising campaigns designed to bolster consumer support of products that were "scientifically tested" instead of "just" recommended by friends. Convincing contraceptive users to forgo what manufacturers disparagingly labeled "back-fence gossip" was difficult, for during an era when scientific evaluation of commercial birth control was denied them, women and men had turned to each other for the very information manufacturers were now claiming to monopolize. Writing in 1888, the Boston physician H. S. Pomeroy found informal discussions of fertility control disdainful but common. "Many of those who have become adept in the art of avoiding parenthood," he railed, "have . . . learned their lessons of some kind friend or neighbor."[45]

Mindful of the dangers of contraband contraceptives, Americans used them anyway. Their potential benefits outweighed their risks. Frustrated by the high failure rate of "natural" methods such as the safe period, drawn to advertised assurances of reliability, turn-of-the-century Americans looked to the market for pregnancy prevention. In Mosher's study, a majority of women (70.3 percent) practicing contraception forsook natural methods for the "safety" of commercial contraception.[46]

How universal was birth control use? Measuring use of contraceptives is inherently difficult, especially for an age when birth control was criminal, few people recorded their experiences with contraceptives, and medical, marketing, and opinion surveys of national practices did not exist. The women interviewed in Mosher's study used black-market birth control frequently. But their affluence and education set them apart from American women as a whole.

Margaret Sanger was firmly convinced that elitism kept contraceptives out of the hands of those who needed them most: the working class. Sanger, the twentieth century's greatest champion of birth control, knew plenty about the sufferings of the poor. As a young bride in New York, she immersed herself in the world of radical politics, organizing strikes, pickets, and rallies for the Socialist Party and the Industrial Workers of the World. In 1912, she began work as a part-time visiting obstetrical nurse in Manhattan's Lower East Side, the poorest immigrant district of the city and home to New Israel and Little Italy. Tenements there were crowded, sanitation poor. The resilient spirit that triumphed within this urban squalor—captured in perpetuity by the photographer Jacob Riis—was lost on Sanger. What she saw was only misery, poverty, and degradation, a state of human suffering exacerbated by inadequate fertility control. Mothers exhausted by relentless childbearing, parents struggling to support families of ten, dozens of immigrant women "with their shawls over their heads waiting outside the office of the five-dollar abortionist": these were the images that haunted Sanger. When she launched *The Woman Rebel* in 1914, Sanger articulated the problem of birth control as a class issue:

> The woman of the upper middle class has all available knowledge and implements to prevent conception. The woman of the lower middle class tries various methods of

> contraception and after a few years of experience plus medical advice succeeds in discovering some method suitable to her individual self. The woman of the people is the only one left in ignorance of this information. Her neighbors, relatives and friends tell her stories of special devices and the success of them all. . . . But the working woman's purse is thin.[47]

What should we make of Sanger's insistence that trustworthy contraceptives were known only to the rich? Certainly, the poverty she observed was as genuine as her desire to alleviate it. But Sanger was prone to exaggeration; even sympathetic biographers have noted her tendency to overstate her case to bolster political support.[48] Her observations, moreover, are frequently at odds with the conclusions she draws from them. If income alone determined contraceptive access, why would a woman able to afford a five-dollar abortion not be able to afford a twenty-five-cent reusable condom? One of Sanger's most frequently recounted stories, that of Sadie Sachs, contains a similar inconsistency. As Sanger told it, Sachs was the young immigrant wife of a truck driver named Jake and the mother of three children. Struggling to raise a family in their overcrowded dwelling, Sachs consulted a doctor for effective birth control. The doctor's reply was callous and succinct: "Tell Jake to sleep on the roof." Soon after, Sachs became pregnant and died from septicemia following a self-induced abortion. Sanger repeated this tragic tale often both to elucidate the special reproductive burdens of the poor and to explain her decision to give up nursing for full-time birth control advocacy. If we set aside the possibility raised by one biographer that Sanger embellished the story for dramatic effect, the tale illustrates less the economic barriers to effective contraception than the medical profession's opposition to it.[49] Sadie Sachs lived in slum conditions, yet she managed to see a doctor, which was more costly than buying condoms or suppositories. Presumably, had the doctor recommended contraceptives, Sachs would have been only too happy to buy them, though this would have cost more money still. But all Sachs got for her efforts was bad medical advice. In the end, it was not poverty alone that condemned her to a premature death but an unfeeling physician unwilling to help.

Not all doctors were as dismissive as Sachs's. Many approved of and

recommended contraceptives to their patients. Medical journals of the era frequently published debates on contraception, indicating that professional discussion of the matter had not been foreclosed. Still, the prevailing attitude of the medical fraternity was one of opposition. Only a handful of late-nineteenth- and early-twentieth-century schools trained medical students in contraception, and until 1937 the American Medical Association (AMA) rejected birth control as a legitimate facet of medical practice. The weight of apathy and ignorance made it hard for even the most sympathetic doctor to practice good medicine. As late as 1930 (seven years after Sanger's first permanent birth control clinic opened under medical supervision), the *Journal of the American Medical Association* advised doctors seeking birth control information, "We do not know of any method of preventing conception that is absolutely dependable except total abstinence."[50] In the absence of medical leadership and scientific testing of contraceptives, physicians, like their patients, were on their own.

Doctors disagreed about the reliability of different techniques. Many endorsed the misnamed safe period. One proclaimed douching injections "an absolute protection," another, recalling a case where the syringe had failed, advocated the " 'skin covering' worn by the male." The condom, he insisted, was the only "absolute protection."[51] David Matteson, a doctor from Warsaw, New York, favored the sponge, "preferably a silk sponge . . . with a strong silk thread passed through it." Another doctor cautioned against such devices, warning attendees of an 1888 Washington Obstetrical and Gynecology Society meeting that articles that "occlu[de] the uterine orifice" had "failed too frequently to gain the stamp of certainty." Abstinence was the only method he could recommend with confidence.[52]

Diverse opinions reflected medical uncertainty about birth control in late-nineteenth- and early-twentieth-century America. Not only did doctors not have a monopoly of knowledge about effective birth control; in some cases, as with the safe period, they were wrong. In subsequent decades, as medical discussion, endorsement, and evaluation of contraceptives increased, the credibility of doctors' claims to expertise in this area grew. But at the turn of the century, it is unclear whether women and men were any worse off if they eschewed medical counsel. In any event, most did. Until the FDA approved prescription-only oral contra-

ceptives in 1960, a majority of Americans, including the most affluent, acquired birth control over the counter, not from doctors.

A deterministic view of affordability such as Sanger's, moreover, masks the complexities of consumer behavior. Although household incomes may be fixed, perceptions of what constitutes a luxury and what a necessity are not.[53] The thousands of letters working-class Americans sent to Sanger and other birth control proponents reflect their view that contraceptives were not a prohibitively costly luxury but a commodity few working people could afford to be without. Not just a pregnancy preventive, contraceptives promised families barely making do a prophylactic against economic ruin. Ironically, poor Americans may have felt the lure of the contraceptive market most strongly of all.

This was certainly the case for one working-class man in Michigan who sought birth control advice from Sanger in 1923. He wrote that he and his wife had "a family of six children to provide for from a laborer's income." He asked Sanger to "impart to us that which will relieve the despair of our lives." Cost, to him, was irrelevant. "Price and money will not stand in the way," he told her, "as we both realize something has to be done."[54] Significantly, in the first large-scale clinical study of birth control methods in use in the United States, more of the predominantly working-class women and men surveyed had relied on purchased contraceptives—the condom, douche, cervical cap, or suppository—than on natural methods.[55]

In addition, the turn-of-the-century birth control trade was highly stratified, accommodating a broad spectrum of budgets. Contraceptive prices varied widely, from $.11 condoms to the $.35 generic one-ounce douching syringe to the $1.25 eight-ounce "Tyrian" Female Syringe.[56] A New York worker making, on average, $1.75 a day in 1890 would have spent a significant portion of a day's wages to acquire a fancy syringe. Yet he might have considered it a good investment, for, unlike cheaper suppositories, syringes were reusable.[57]

Cheap did not automatically mean less reliable. Almost all contraceptives in this era, including the doctor-endorsed safe period or the Vaseline method, had a high potential for failure. As the historian Linda Gordon has argued, class differentials in contraceptive practice at the turn of the century "were not so great as they are today, because the best available methods were not so good as they are today."[58] Before birth

control production was standardized and devices were inspected for reliability, retailers were free to make outlandish claims and charge exorbitant prices. A high price could signify nothing more than one entrepreneur's scheme for getting rich. Although sites of birth control buying varied by class, the safety and efficacy of products typically did not. Whether they acquired bootleg condoms from doctors or "first-class druggists" or by mail order through the *National Police Gazette*, consumers assumed similar risks, for the production technologies, absence of regulation, and economics of patent medicine blurred class distinctions.

Significantly, non-elite Americans were most likely to encounter advertisements for birth control devices. Contraceptive advertisements appeared most consistently in "spicy periodicals" and "penny miscellanies," working-class and immigrant newspapers, "sensationalist tabloids specializing in sports, theatrical news, murders, police reports, and courtroom dramas," and "newspapers aimed at an urban class of stable boys, maids, day laborers, upwardly mobile young clerks and salespeople."[59] The *National Police Gazette* was the nation's largest repository of contraceptive ads. It promised its readers—mainly urban, working men and women—a good time, not a trenchant analysis of the day's political events. Stories on sex scandals, murders, dogfights, rat-killing contests, boxing matches, and other amusements filled its pages, interspersed with ads for impotence devices, gonorrhea cures, pornographic photos, and contraceptives.[60] In contrast, ads for birth control were conspicuously absent in highbrow publications. Editors and publishers, mindful of the law but also of the association of contraceptives with smut, excluded ads that might sully their publications' reputations. Literary respectability was partly defined by honoring the boundary between what was "fit" and "unfit" for print. The efforts of contraceptive peddlers to reach an elite audience through the periodical press usually failed. The E. C. Allen Company, a prominent publisher of literary and agricultural journals in the late nineteenth century, kept a scrapbook of medical advertisements it deemed "unfit" for print between 1880 and 1890. About a quarter of the 182 advertisements it rejected were for contraceptives, including ads for "Dr. Dix's Celebrated Female Powders," "gents' supplies," and the Eureka Medical Company's "vaginal tablets and pocket syringe."[61] The impact of exclusionary advertising practices was twofold. First, it underscored the unseemly nature of contraception. Second, it concentrated

contraceptive advertising in publications most likely to be read by non-elites.

Identifying birth control as an issue that crossed class and ethnic lines, contraceptive entrepreneurs aggressively courted working-class and immigrant dollars. The success of Antoinette Hon is instructive. In an era when small-business failures were as common as the cold, Hon's lasted twelve years, sustained by immigrant women and closed only by government decree. Hon knew that working women had little money or time. She promised goods tailored for the budget-conscious that could be purchased "very cheap[ly]" and taken without having "to disturb your daily work." Her success attracted unwanted scrutiny, but it also demonstrated ongoing working-class and immigrant support of the contraceptive trade. Hon's dispensing medical advice without a license made her a "quack" in prosecutors' eyes, but in the 1917 case against her, chemists and doctors hired by the government begrudgingly conceded that the chemicals in her products were "very injurious to the spermatozoa."[62]

Whereas Hon found support from Poles, the Septigyn Company courted Czech immigrants. The Chicago-based firm sold Septigyn tablets, vaginal suppositories designed to "prevent conception" without "injury to the delicate tissues of the female generative tract." Septigyn advertised its tablets, a hundred of which cost five dollars, in circulars printed in Czech and English. Preferring a marketing scheme more personal than the anonymity of mail-order commerce, the company hired sales agents to distribute flyers and sell products door-to-door in targeted neighborhoods. How well the company did is unknown, but it was enough to irk the AMA, which launched a formal investigation of Septigyn in 1913.[63]

Demographic evidence supports the view that contraceptives were used successfully by Americans from different backgrounds. In the absence of other factors such as a higher incidence of abortion, malnutrition, or disease, low fertility rates suggest a conscious effort among a specified population to restrict childbearing through contraception (although they do not reveal which birth control methods people used). Because of the way information was collected, the U.S. Census (the data set demographers use to determine fertility rates) does not permit calculations of national fertility patterns by class in the late nineteenth and early twentieth centuries. What demographers *have* succeeded in doing is

determining this information for individual communities and towns through household enumerations.[64] Although the local character of this approach makes demographers' findings specific to the communities studied,[65] the findings are nonetheless important, for they challenge claims made by Sanger and historians since that "the most reliable methods of contraception were known only spottily by working-class women in the late 19th and early 20th century."[66]

One study of marital fertility in five Massachusetts towns in 1880, for instance, found that married women in households with a high occupational status did not always have the fewest children. In three of the five towns they did, but in the remaining two, the smallest families belonged to either the lowest- or the middle-occupation group. Such findings should make us wary of generalizing about the class-specific nature of birth control, for as the authors of the study conclude, the "relationship between fertility and the occupational status of the husband may not be clear-cut."[67]

Demographic evidence also suggests that African-Americans used birth control at the turn of the century. National fertility rates for both white and black women declined after 1880, reaching an all-time low in 1940. Between 1880 and 1940, the average fertility rate of whites dropped from 4.4 children per woman to 2.1, for blacks from 7.5 children to 3. Whites were having fewer children on average, but the *rate* of decline was higher among African-Americans, dropping 53 percent between 1880 and 1940, compared with 47 percent among whites.[68]

Racist demographers in the early twentieth century ignored birth control as an explanation for rising black childlessness. Instead, they ascribed fertility decline to malnutrition, infection, tuberculosis, and infertility caused by venereal diseases resulting from sexual promiscuity. Foreclosing the possibility of black self-determination, demographers emphasized the "pathology" of African-American culture, characterizing blacks as morally deficient and medically diseased. One demographer went so far as to suggest that blacks' lack of self-control rendered them constitutionally unfit for the responsibility of contraception. "The negro," he asserted, "generally exercises less prudence and foresight than white people do in all sexual matters."[69]

But conscious use of birth control was definitely a factor. Far from being novices at contraception, African-Americans at the turn of the

century had a long history of fertility control. Anthropologists have documented the use of coitus interruptus, periodic abstinence, botanical contraceptives, and intra-vaginal plugs made of crushed roots or grass among early Africans, and it is likely that they imported many of these traditions when they came to North America as slaves.[70] In the antebellum South, slaves proved extremely adept at using birth control and abortion to thwart their masters' plans to increase slave ranks through procreation. Slaveholders, in turn, accused black women of possessing "secret knowledge" that kept them childless. There is no reason to think that these traditions and this knowledge died with slavery. A black women's newspaper, *The Woman's Era*, seemed to support women's right to reproductive self-determination when it printed in 1894 that "not all women are intended for mothers. Some of us have not the temperament for family life."[71]

Birth control advertisements in black newspapers point to a mail-order and drugstore contraceptive trade within the African-American community. The June 6, 1896, edition of Omaha's *Afro-American Sentinel*, for example, a weekly journal "devoted to the elevation of Negro character in the United States," couched an ad for rubber condoms between one for binder twine and another for elixirs for opium addiction.[72] In 1904, the *Atlanta Independent*, boasting a circulation of fifty thousand blacks, advertised "Paxtine Toilet Antiseptic," a "vaginal wash" unrivaled "for thoroughness."[73] Cultivating an image of African-American propriety within a culture that portrayed black men as hypersexual and then punished them for it, black newspapers would not publish advertisements for sex devices. But they printed some contraceptive ads, and as birth control became more respectable, they printed more. From the mid-1920s on, ads for douching solutions, vaginal suppositories, and diaphragms in the black press were commonplace. So, too, were their purchase and use. In 1932, George Schuyler, editor of the *National News*, observed, "If anyone should doubt the desire on the part of Negro women and men to limit their families it is only necessary to note the large sale of preventive devices sold in every drug store in various Black Belts."[74]

African-American use of contraceptives did not erase demographic distinctions. Black families continued to be larger than white, but we cannot assume that ignorance about contraception "explains" this difference. Occupational and residential status also factored into decisions

about contraception. Most African-Americans, working as tenant farmers, lived in the rural South, where the benefit of children to the household economy may have dissuaded parents from restricting family size. Among whites, those in rural areas also had higher fertility rates than those in urban areas, but because a higher proportion of the white population resided in cities, average white fertility rates were lower.[75]

Political considerations also affected African-American decisions. Just as fertility control had protected slaves from some of the cruelties of slavery, the growth of the African-American population after emancipation seemed to some leaders critical to black cultural autonomy. The separatist leader Marcus Garvey encouraged unfettered black reproduction, believing that racial solidarity came with strength in numbers. Birth control, he feared, would lead to the enfeeblement, if not outright extinction, of the black population. In 1934, Garvey's nationalist Universal Negro Improvement Association unanimously adopted a resolution condemning contraception.[76] The African-American historian, sociologist, and founder of the National Association for the Advancement of Colored People, W. E. B. DuBois, felt differently. He favored contraceptive use among African-Americans to promote the dignity and uplift of black womanhood but admitted that his was often a minority view in the African-American community. "They are quite led away by the fallacy of numbers," he lamented. "They want the black race to survive."[77]

The race consciousness DuBois identified hints at the complexities of contraceptive practice at the turn of the century. American attitudes toward and access to contraceptives were affected by a range of circumstances that frequently transgressed boundaries of color, ethnicity, and class. Above all, the decision to use contraceptives was personal, dictated not by legal codes but by individual wants and needs. Criminal statutes against birth control enabled quackery to thrive, and yet, despite the risks, Americans used birth control devices, relying on a range of strategies to maximize pregnancy prevention and health.

Long before Margaret Sanger made the fight for birth control a political movement, Americans from all walks of life had turned to the contraceptive market, seeking control over their fertility and their lives. And so it was that in the age of Comstockery the birth control business continued, changed but not subdued.