been expelled; or, if the device has a transcervical appendage, by examining herself periodically.

In the United States the most successful IUDs are associated with a pregnancy rate of from 1.5 to 3.0 per 100 women during the first year of use. These rates tend to decline during the successive years and in general the rates vary inversely with the size of the device and with the age of the patient.

Acceptability

Among clinic patients in the United States the FDA finds that rates of continuation have been much higher for the IUDs than for traditional contraceptive methods. Experience of family planning programs in developing countries has been similar. Fragmentary evidence suggests that in the lowest socioeconomic group with the most minimal education, rates of continuation are higher with IUDs than with the oral compounds. But adequate information comparing rates of continuation of IUDs with oral compounds for non-clinic patients is unavailable.

About 80 per cent of women will continue to use IUDs for the first year after insertion; 70 per cent for the second year and, from limited data available, about 50 per cent of women are still using the IUD at the end of the fifth year. The incidence of involuntary expulsion varies widely among different types of IUDs. The great majority of expulsions occurs in the first year of use; about one half of the total within four months after insertion. More devices seem to be expelled with the menstrual flow than at any other time. If an IUD is re-inserted after an expulsion the chance of re-expulsion is two or three times as high as the chance of expulsion after the first insertion of the same type of IUD. Nevertheless, about one half of all women who experience a first expulsion eventually retain the device after one or more re-insertions. Expulsion rates for all types of IUDs tend to decline steeply with increasing age of the woman and less steeply with parity. Expulsion rates are very high following insertion during the first few days after childbirth. They are lower following insertion five to 12 weeks after childbirth and the lowest following insertion at three months or later. For all IUDs, voluntary removal at either the doctor's or the wearer's initiative, is the most important cause of discontinuation and may exceed the combined effect of pregnancies and expulsions at a ratio of 2 to 1 or more. The most common reasons for removal are bleeding and pelvic pain and account for about 60 per cent of all removals, excluding those for planned pregnancies. Like the expulsion rate, the removal rate is highest in the first month after insertion.

Some 6-8 million of these devices are now in use, perhaps one million in the U.S. As results are confirmed, it is likely that contraception with the intrauterine device will assume even more importance in the future.

Diaphragm with Contraceptive Jelly or Cream

(See attached product list and p. 16 for related readings.) The medical profession has found the diaphragm and jelly/cream method very effective among intelligent and highly motivated patients. However, in many population groups a disturbing proportion of users of the diaphragm is known to abandon this method rapidly. The appropriate size and type of diaphragm (supplied commercially in various types from 60 to 105 mm. in diameter) must be selected by trial fitting during pelvic examination. The diaphragm when properly in place lodges in the posterior vaginal fornix, completely covers the cervix, and fits snugly behind the pubic symphysis. The largest size which can be worn comfortably and is unnoticed by husband and wife should be prescribed. Various types are available, some of which are more effectively held in place in the presence of a cystocoele or mild prolapse. The size and type of diaphragm needed may change following delivery, pelvic surgery, weight gain or loss, and particularly after the honeymoon period. Once the appropriate size has been determined, it is essential that the patient be instructed carefully in the method of insertion and be given an opportunity to demonstrate her proficiency during this instruction period.

Effectiveness

The diaphragm, used in combination with jelly or cream, offers a high level of protection, although occasional method failures may result from improper placement or displacement during coitus. A rate of 2-3 pregnancies per 100 women per year would seem to be a generous estimate for "perfect users." If motivation is poor, much higher pregnancy rates should be expected.

Patient Instructions

Approximately one teaspoonful (5 ml.) of a contraceptive cream or jelly (see attached product list) should be placed on either side of the diaphragm; some is spread around the rim, and the diaphragm inserted with the cream or jelly side uppermost. The diaphragm may be inserted up to six hours prior to intercourse and may be left in place for as long as twenty-four hours. It must remain in place at least six hours following the last ejaculation. Douching should not be permitted during this interval. If intercourse is repeated, the diaphragm should not be removed, but additional cream or jelly should be inserted vaginally prior to each coitus. The patient may go to the toilet at any time. The diaphragm is easily removed by hooking the