Birth Control Handbook

Montreal Health Press

Birth Control Handbook
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We thank all those, too numerous to mention by name, who offered their ideas, criticism and moral support in the revision of this Handbook. Your special contributions bear testimony to the fact that the collective spirit—and the commitment to women's health—is alive and well in North America.

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Introduction

Birth Control Handbook is a guide to current methods of contraception. Issues which influence your choice of birth control method and your ability to use it successfully—such as sexuality and health—are discussed first. Information about the human body, conception and health care follows. In the last section, we describe each method in a way that enables you to compare them and to make your own informed choices. **Birth Control Handbook** is a handy reference for women and men at all stages of sexual experience.

The Montreal Health Press has been distributing information about birth control for more than 25 years. During this time a generation has grown up knowing that pregnancy and parenting can be conscious choices. But unexpected and unwanted pregnancies still occur.

Information about birth control is often limited to the mechanics of the method—how it works, where to get it, etc. Less attention is given to the human aspects—how to talk with a partner about sexual needs and limits, how to share the pleasures and responsibilities of intimacy.

Sexually transmitted diseases, and the AIDS crisis in particular, demand that we confront sexual ethics directly. Though some groups use fear and guilt to suppress sexual activity, we believe that more positive solutions are possible. Safer sex suggestions encourage people to explore their sexuality, to use their imagination for greater pleasure with less risk. Taking the emphasis away from coitus as the basis for heterosexual sex puts birth control in a new perspective.

Experience shows that 100% effective contraception without side effects is probably an unrealistic goal. At the same time, the safety of early interruption of pregnancy is clear. Knowing this does not make people irresponsible; it merely provides them with alternatives. We must stop making people feel guilty for birth control failures which are often the result of imperfect methods, not just carelessness.

For birth control to be truly voluntary, people need to feel able to bring children into the world, confident that they can provide them with food and shelter, hope and love. With present levels of unemployment, cutbacks in health and social services and so little community support for child care, many people feel insecure about beginning a family or having more children.

The Montreal Health Press is part of the movement for reproductive freedom. This handbook aims to promote joyful, responsible sexual expression and childbearing.

Andrea Brunner

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Sexuality

Ever since human beings figured out that sex could lead to pregnancy they've looked for ways to enjoy sex without making babies. There are only two ways to do this: having sexual activities other than penis-vagina contact (mutual masturbation, oral sex, etc.) or using something to prevent the egg and sperm from meeting.

Since most women are fertile until about age 50, a heterosexual woman has to use these 2 strategies for 30 to 35 years if she wants to limit the number of pregnancies she has. How she does this is influenced not only by birth control technology but also by family, friends, religion and her community.

Popular culture

Learning about sex: Most North Americans do not learn directly about sexuality in the home. But we do acquire basic attitudes about sex through the language used for body parts and through family attitudes toward nudity. The physical contact we observe and experience with family members teaches us about physical and emotional intimacy.

Religion also influences sexual values and attitudes toward birth control. Some religious leaders preach sexual values that are out of touch with common practices, but they are often powerful enough to block sex education and birth control services.

Information about birth control and safer sex most often comes to us through friends, in school or in a doctor's office—far removed from the excitement and urgency of sexual contact. We may learn how to put on a condom or take the Pill but not how and when to introduce birth control in a passionate sexual encounter. When sex education is offered in schools, teachers are often obliged to promote celibacy.

At the same time, North Americans are bombarded with sexual images in advertising, movies, television and magazines. Each year we receive thousands of messages that portray sexual attractiveness and satisfaction as essential to individual success and personal well-being.

In the media, good sex is defined as spontaneous, being swept away by the passion of the moment to achieve sexual bliss. Rarely do we see anyone planning ahead—no discussion about the Pill, no detour to the drugstore for condoms.

These mixed messages about sex are confusing. Most of us blunder through individually, isolated from each other's experience. We may not worry about birth control or safer sex until a period is late or signs of infection appear. We may have sex but feel guilt and regret afterward.

We need more positive sex education in the schools. We need to hear more than "Don't do it" from parents, teachers and religious groups. We need our entertainment and advertising industries to provide images of sexuality that are both safe and thrilling, not just cheap ploys to attract viewers and sell products.

The Double Standard: Males and females are raised with different sexual expectations. Males receive approval for showing sexual interest and for being heterosexually active; for women, sexual attractiveness is valued but sexual experience is not. However, men get little encouragement to be responsible for the consequences of sex. Many are still reluctant to use condoms. If they carry one in their wallet it is often just a symbol of sexual interest and readiness.

Most men still rely on women to take care of birth control. Modern developments in birth control technology have also shifted responsibility to women. Yet if she is not married or in a serious relationship, a woman who is prepared with birth control risks "getting a reputation". As a result, many women, especially adolescents, are not prepared with birth control, even when they know that sexual activity is quite likely.

To be prepared in advance and know what to do if birth control fails empowers women to choose whether to have sex and under what conditions. Yet women are still struggling to gain the confidence to say yes or no to sex. It takes courage to overcome the double standard that is so deeply ingrained in our culture.

Men must also learn confidence and comfort with safer sex practices. This would not only lower the rate of teen pregnancies but also contribute to a better understanding between men and women.

Sexual behaviour: Basically one kind of sex leads to pregnancy: penis-vagina sex—also called coitus, penetration or sexual intercourse. (Ejaculation at the vaginal opening sometimes results in pregnancy and is not a substitute for birth control.)

In North America, most heterosexuals start to have sex with penetration some time between the ages of 13 and 21. Once they begin, it usually becomes their main form of sexual activity. They tend to abandon other forms of sexual pleasuring or use them only as foreplay. For most heterosexuals, "going all the way" or doing "IT" involves having sex that can result in pregnancy.

This emphasis on penetration probably has its roots in religions which defined sex as acceptable only for reproductive purposes. But it makes birth control

appear to be the only route to avoiding pregnancy. Sexual pleasures without penetration are rarely explored, even though most women get more orgasmic pleasures from alternative sexual activities.

Young people are particularly vulnerable to pressure from the media and their peers to be sexually active. Many have sex to please their partner and many young women do not get much pleasure from sex with their boyfriends. They need support to explore alternatives which could be more enjoyable and safer.

Sex and birth control

Birth control needs and choices change as we move through the life cycle. Using birth control successfully at each life stage depends on:

Sex partner(s): Ideally, both partners are concerned about birth control and figure out ways to communicate with each other about it. In practice, attitudes toward sharing birth control responsibility vary a lot.

Different situations may require different strategies: some people have not had sex with penetration yet; others may be with a regular partner, recently separated or have several partners. Sometimes partners ask us to trust that they have taken care of birth control.

The first experience of sex with penetration may be predictable—a lot of petting with a partner could likely include coitus in the future. Or a couple has had limited sexual contact but is planning to marry. These situations enable us to discuss birth control ahead of time.

Other situations are not planned. You "go all the way" in a passionate moment. Sadly, rape or incest may be your introduction to vaginal penetration. The "morning after pill" is useful in these situations.

Disease prevention is important if you have a new partner, if you have many partners or if your partner(s) have sex with other people. The condom is the best choice. Other barrier methods—diaphragm, cervical cap, foam—also provide some protection from sexually transmitted diseases.

Even with a regular partner, questions arise: Is it easy to talk about birth control together? Do you always have sex by mutual agreement? Can you agree to avoid penetration or use a condom during the fertile period? Facing these issues not only helps you make birth control choices, but also helps you assess the quality of your relationship.

Sexual Activities and experience: Learning to integrate birth control and sex takes time, experience, a willingness to experiment, and the belief that safer sex is worth the effort.

We can become more comfortable introducing birth control into sexual situations if we share our questions, failures and successes with our friends as well as our lovers. How do your married friends deal with birth control? What does your sexually active single friend do? Have you seen any movies that give you an idea worth trying?

People are often shy about introducing birth control with a new partner. It's sometimes easier to have sex than to talk about it. How can you let your partner

Doug Aucoin

know that you enjoy his company, that you are turned on, but that you are also concerned about birth control and safer sex?

Some people use the direct approach. They ask their partner what they do for birth control. Others try to introduce the topic indirectly. They might mention an interesting magazine article on teen pregnancies or an abortion debate. Your partner will probably be relieved that you broke the ice. Once you have shared some intimacy, talking about birth control may become easier.

If you have sex with penetration frequently, you may choose a continuous method of birth control such as the Pill or the IUD. Otherwise, you may prefer to use a method only during sex, such as the condom or diaphragm.

Sexual pleasures such as kissing, fondling, caressing the genitals and oral-genital sex can be equally enjoyable. For most women, sexual pleasure comes more readily in these ways—and no birth control is needed.

Sexual desire (libido): Feelings about birth control affect sexual desire. If you see your method as a big hassle, the very idea of sex may turn you off. But some people eroticize their birth control. They may "play doctor" when putting on a condom or inserting foam. The increased intimacy that develops when people cooperate to use birth control can be surprisingly exciting. Sex and birth control are both ways of showing love and consideration.

Some women complain of a lack of sexual desire on the Pill, while others feel freer sexually because of the reduced risk of pregnancy.

Christina Sprong

Sensation: Some methods affect sexual sensation. Men complain of a loss of sensation with the condom, and some condoms have an unpleasant smell. Thinner and better lubricated condoms permit more sensation.

Spermicidal creams and jellies are sometimes appreciated for the extra lubrication while some find that they decrease friction. Oral sex may be unpleasant because most spermicides have a chemical taste. Wiping the genitals with a damp cloth usually solves this problem.

Sometimes the IUD strings prick the tip of the penis during penetration. You can have the strings cut differently or pushed to the side.

Interruption: Continuous methods such as the IUD and the Pill don't require care during sex. Methods such as the sponge, cap and diaphragm can be inserted ahead of time. Condoms and spermicides must be used during sex. Some people find the interruption distracting; they may feel tense or clumsy about introducing it.

You can find ways to make the interruption enjoyable. Unrolling the condom over an erect penis can be erotic. Some people learn to do this with their mouths. Setting the tone with music and soft lights, and having your birth control nearby can all be part of preparing for good sex.

Privacy and living conditions: People have sex in many different situations. Women get pregnant in parks, cars, standing up on their lunch hours, etc—not just from sex in bed at night. Some methods are easier to use in spontaneous situations than others; condoms are easy to carry discretely.

Menstruation: Pregnancy is unlikely to occur during the first days of menstruation, except in women with short cycles (26 days or less). Some women find that orgasm relieves menstrual cramps while others prefer to avoid sex during menstruation.

The Pill makes a woman's periods shorter and lighter, though there may be bleeding at other moments in the cycle. The IUD often increases blood flow. Long term methods such as injections often cause irregular periods.

Sexual Problems: Birth control does not solve or create sexual problems unless the problem is fear of pregnancy. But it can complicate how you deal with a sexual problem.

Men with erection problems may not be enthusiastic about condoms. But men who ejaculate more quickly than they would like might find that the condom helps slow them down. If a woman does not lubricate readily, the condom can irritate her vagina. Using saliva, a water-based lubricant or a lubricated condom helps.

Women who use continuous methods may become resentful if their partner is less interested in sex than they are.

Birth control frees people to have coitus without unwanted pregnancy. It should not be a pressure to have sex or an excuse to limit sexual activity to penetration.

Lifestyle

To successfully use birth control, your method must fit your needs; you shouldn't have to change who you are to use it. What suits you may be unacceptable to someone else.

Take an honest look at yourself. Try to imagine using each method. What problems might you expect? Can you do anything to solve or reduce these problems?

Gut reactions

If you find something distasteful about each method, figure out which compromises you can most comfortably make.

The idea of using chemicals or taking a pill every day turns off some people. Having something in the body such as the IUD or hormone implants upsets others. But many people are at ease with these continuous methods.

Some people prefer to use birth control only when they have sex, so they opt for the condom, diaphragm, sponge or foam. Others find them messy and not very erotic.

The biological methods are especially good for people interested in becoming aware of their own fertility.

Time investment

Are you willing and able to take the time your birth control method requires? Or would you rather "have it over with" quickly? Biological methods require daily calculations whereas the IUD requires one or two visits to the doctor.

Cost

Can you afford the method you choose? Does it require regular cash on hand or one large expense? Is your partner sharing the cost? Does your health insurance or government program pay?

Routines

Do you have a regular pattern of activities from day to day? Are your hours stable? Are you forgetful? Do you usually make love in your own home? Where else?

People with irregular hours have trouble calculating their fertile period using their temperature. Taking the Pill at the same time each day might also be a problem. If you have sex in different places, you must carry your birth control with you or have more than one kit (if you use the diaphragm, for example).

Risk taking

Do you throw caution to the wind easily? Do you use drugs (including alcohol) which make you more likely to take risks? Do you act impulsively?

If you are likely to have unplanned sex or to not bother with birth control, a continuous method such as the IUD might be better than something you need to remember.

Suzanne Girard

Disabilities

Do you have any limitations which would make a particular choice inappropriate? If you have difficulty using your hands, spermicides or the diaphragm might be a problem (unless your partner can insert them). Circulation problems related to paralysis may increase the risk of blood clots on the Pill. With appropriate counselling, blind people can use all methods.

Someone with learning difficulties needs extra counselling to ensure that use of the method is understood. Visual images, rhymes and songs are useful learning devices. People with mental health problems also need support to persevere with birth control.

Before puberty

Since ovulation can occur before your first period, a slight risk of pregnancy exists if you have sex before your periods start. Use something other than the Pill until you've had several periods.

Before menopause

You must wait at least a year after your last period before celebrating (or mourning) the end of birth control. During the years before menopause you are less fertile and may be tempted to be less vigilant. As long as you do not want to be pregnant, birth control is necessary.

Because of the risk of side effects, the Pill is usually not prescribed to smokers over 35. Non-smokers over 40 should be followed closely. IUDs are more effective and cause fewer complications in older women. However it is difficult to tell if heavier or irregular bleeding is due to the IUD or pre-menopausal changes. Irregular cycles make biological methods more difficult.

Pregnancy by Choice

If 100 women have sex regularly for one year without any birth control, about 90 of them will be pregnant by the end of the year. But thoughts of an unplanned pregnancy often take second place to sexual explorations. When we start having sex, we are usually caught up in the newness of sexuality—feelings about intimacy, nudity etc. Even when we have more experience, the need for affection and passion may override our better judgment.

For many, worry over a late period is the first real recognition that sex can lead to pregnancy with life long consequences.

How you feel about pregnancy influences your choice of birth control and how well you use it. If you are convinced that you have little to gain from being pregnant now, you are more likely to persevere with birth control.

Is there a right time for pregnancy?

There is no right time to have a child, no recipe for the ideal family. Some people will have many children, others none. Some will have them in their teens, others in their 40s. These are personal decisions which deserve respect and support.

Judith Crawley

Skjold Photographs

For many women, having and raising children is part of their sexual identity. They expect motherhood to be creative and challenging, bringing them joy and respect.

Many women have other plans for their lives. Having a baby may conflict with achieving goals such as getting an education, advancing in a job, etc.

Sometimes when few chances exist for personal achievement (and financial independence), becoming a mother seems like an attractive route to adulthood. It may be a way to get one's own room or apartment, to have someone to love who loves you back. But often the responsibility of a baby is more than expected and the support from friends and family is less.

Some women hope to share parenting with the child's father. Others do not expect him to stick around.

Think about what it would mean to you to have a child now. How would it affect your life? What do you expect from your partner? How committed is your partner to avoiding pregnancy? The clearer the answers are to you, the easier it is to make birth control part of your sex life.

Unplanned pregnancy

Birth control methods are not perfect. Neither are people. An unplanned pregnancy can happen to anyone. How you think you would cope if you became pregnant is a factor in choosing your birth control method.

People's reactions to an unwanted pregnancy are not always predictable or clear. You may assume you would have an abortion but when you are faced with the actual decision you may reconsider. Or the opposite: you thought you were against abortion for yourself but faced with the option of pursuing the pregnancy you reevaluate your personal position.

Politics of family planning

Historically, the family planning movement has been influenced by both progressive and conservative thought.

Progressives saw family planning as a woman's right to control her sexuality and fertility. They wanted women to enjoy their sexuality without suffering the physical and social consequences of unwanted pregnancy.

Conservatives were more concerned with population control, limiting the number of poor or handicapped people and non-white immigrants.

Both influences are still present today. In Western countries, politicians are concerned about the low birth rate of white majorities and the high birth rate of non-whites and immigrants. Middle-class women are accused of having fewer children out of selfishness. Poor and non-white women are considered ignorant and irresponsible when they do have children.

We believe that people should have the right to determine the size of their families. Population control politics must be balanced by an equitable sharing of the world's resources. Women in the labour force will have (more) children when social conditions are supportive, when men do their share of parenting and housework, when paid parental leave and subsidized daycare are available and when women earn decent salaries.

Sometimes an unplanned pregnancy is easily accepted. The woman or couple feel willing and able to make the necessary adjustments for parenting. They can accept the "accident" and look forward to becoming parents.

In these cases, factors other than effectiveness may have greater importance when choosing birth control. Risk of side effects or interference with sexuality may make them choose a less effective but more satisfying method. They make this choice knowing that they can cope if the method fails.

For others, an unplanned pregnancy is completely unacceptable and would create a crisis in their lives. Pursuing the pregnancy and having a child appears impossible. But abortion, for whatever reasons, is not an option. For these people, effectiveness becomes the most important factor in choosing birth control. They need to use it at all times with or without support from their partner.

A woman who has considered and accepts the possibility of abortion can usually cope with an unplanned pregnancy. It may be uncomfortable, costly and inconvenient, but it is not a tragedy. For her, less than perfect birth control makes abortion an unfortunate possibility.

Having the baby and giving it up for adoption is an option for some women. Today, they can be reasonably sure that the baby will be adopted immediately by people anxious to be parents. But many people who decide on adoption are unable to go through with it once the baby is born.

Coping with unplanned pregnancy

- Give yourself some thinking time on your own. Go for a walk, take yourself out for lunch. This is your decision about your future.

- Who is the best person (or people) to share this turning point with you? Do you want someone to help you go through your options — a friend, a counsellor, a religious leader? Does your decision depend in part on someone else (for example, your partner's willingness to take responsibility as a parent)? Is there anyone you should avoid telling — who would try to stop you from making your own choices?

- If abortion is a possibility, you should not delay your decision too long since abortions done earlier are safer. You need to find a clinic or doctor to perform the abortion (see p 45).

- If you decide to continue the pregnancy, you need pre-natal care to ensure good health for you and the baby.

Vincenzo Pietropaolo

Effectiveness

The effectiveness of any particular method describes your chance of avoiding pregnancy while using it. Failure rates give this information from the opposite point of view—the risk of getting pregnant while using it for one year. If 100 women do not use any birth control for one year, 85 will become pregnant.

Clear and honest information about the effectiveness of each birth control method is difficult to get. Companies that sell contraception tend to exaggerate its effectiveness. Doctors and other health workers often compare the best rates of one method with the worst rates of another, making their favourite method look better. You need to know how effective a method will be for you.

Measuring effectiveness

Lowest expected failure rates tell you the best protection you can expect if you use a method correctly all the time. They are based on studies where people get special training and encouragement to use the method. Those who get pregnant because they forget or use the method incorrectly are not included.

Typical failure rates give an average rate, mixing together "good" users with those who use it incorrectly or sometimes have sex without protection. They are based on studies of the general population.

The difference between these rates is greater for some methods than others. For example, the difference is small for the IUD because once it is inserted, your actions don't affect its failure rate. Only 1 woman in 100 should become pregnant in the first year of IUD use. Yet about 6% do. Improper insertion by the doctor and rejection of the device from the uterus may lead to pregnancy.

Human error plays a greater role with the diaphragm. The lowest expected failure rate is 3%; for the typical user, the pregnancy rate is about 18%. The doctor can give you the wrong size, you can forget the diaphragm at home when you go out or you can put it in wrong.

Most failure rates are calculated in the first year a person uses a method. With experience, people get better at using a method. If you continue the same method for more than a year it probably means that the method has worked, has not made you sick and is acceptable for your sex life. Your success makes you a better user.

If you are unhappy with your method, you are likely to stop using it. Probably, more women get pregnant in this situation than from method failures. Studies look at how many people continue each method over time. About 1/3 of Depo-Provera users quit the first year; 3/4 quit after 4 years (some, to get pregnant).

Sometimes rates are given for specific situations. For example, the failure rate of the Pill for girls under 20 is about 6%, double the over-all rate. Diaphragm users have higher failure rates if they have sex more than 3 times a week.

How effective is good enough?

Only you know the answer to this question. How do you feel about an accidental pregnancy (p 8)?

In the past people knew that their methods (withdrawal, sponges soaked in vinegar, etc) were not perfect. Birth control let them space their pregnancies and reduce their family size.

Today people expect to completely control their fertility—to become pregnant only when they want to. But 100% effective methods do not exist. Some people choose less effective methods for health and other reasons. People who experience an unwanted pregnancy are not necessarily irresponsible.

Using two methods at once

Using two methods of birth control at the same time lowers the risk of pregnancy. For example many people use condoms for protection from sexually transmitted diseases. If you are already using the Pill for contraception, the two combined offer very high—close to 100%—protection.

However, alternating two different methods does not increase protection. You only have the protection of the method you use at the time.

For example, if you are using the Billings method (p 24), you have sex with penetration on the safe days only. If you use condoms during the safe days you are using two methods (Billings and condoms) and have added protection. If you use condoms for intercourse on unsafe days, you are no longer following the Billings method and are relying entirely on the condom.

Even if not used together, having two methods available is helpful in case something goes wrong with one or you just don't feel like using it. For

Failure Rates *

Method	Lowest expected	Typical users
Withdrawal	4	19
Calendar	9	>14
Sympto-thermic	2	>11
Condom	3	12
Female condom	5	21
Spermicides	3	21
Cervical cap*	9	18
Diaphragm*	6	18
Sponge*	9	18
IUD	.6	.8
Pill	.1	3
Depo-Provera	.3	.3
Norplant	.09	.09
Sterilization (women)	.4	.4
Sterilization (men)	.1	.15

Read as follows: If 100 women use the diaphragm perfectly for 1 year, 3 will get pregnant. Realistically, if 100 typical women use the diaphragm for 1 year, 18 will get pregnant.

Adapted from ***Contraceptive Technology 1994-96****, Hatcher et al.*

* rates for women who have never been pregnant; failure rates for female barrier methods are higher in women who have given birth.

Birth Control Emergencies

"Emergency" methods, used soon after intercourse, are useful if something goes wrong with your method (condom breaks, cap falls out, etc) or you have not used birth control.

The morning after pill can be used up to 3 days afterwards. An IUD can be inserted up to a week afterwards. See p 33.

Find out where you can get these "emergency" methods before you actually need them.

example, if you use the Pill and you get the flu (vomiting it up two days in a row), you could continue taking the Pill but use foam or condoms for the rest of the cycle.

Changing methods

Accidental pregnancy occurs more often when you first begin using a method. Some women continue their previous method while starting out with a new one. For example, if you begin using the cervical cap, you might stay on the Pill one last cycle while you get some experience with the cap.

Women often have unwanted pregnancies when they stop using a method without another to fall back on. For example, you stop the Pill when you break up with a boyfriend and then have unprotected sex with someone new. Or you may be fed up with the diaphragm but not bother to buy condoms.

Denise Faille

Side Effects

A side effect is a change caused by a treatment which has nothing to do with why you take that treatment. For example, drugs for arthritis can cause upset stomach and ulcers.

Birth control is used by millions of women around the world. Even a small increase in health problems because of side effects means that thousands of women are affected. High dose pills and certain brands of IUDs did cause serious illness and even death. Public pressure has forced drug companies and doctors to better inform people about the risks of each method.

At different moments in their lives, many women become wary of the health hazards of birth control. Some change to safer methods; others stop one method out of fear but do not really commit themselves to an alternative.

This section should help you sort out how to evaluate side effects for yourself. Specific side effects are described in detail in the sections describing each method (pp 24 to 50). In general, methods such as hormones and IUDs which provide continuous contraception are more likely to cause side effects than methods such as the diaphragm which are used during each sex act.

"Nuisance" side effects

These symptoms are unpleasant but they are not a sign of serious disease or damage. Often they decrease or disappear with time. For example, you can have more menstrual cramps with an IUD, nausea with the Pill or mild pelvic pain with the diaphragm. You can feel irritated in the crotch when spermicides leak. Men may feel the strings of the IUD sticking into the penis during intercourse.

Your birth control counsellor should tell you what side effects can occur and how to cope with them. If symptoms persist, you have to decide if you like the method enough to put up with them or prefer to try another method. Before giving up on a method you should check with friends or health workers for suggestions which might help you.

A method which causes unpleasant symptoms once might work better at another time. For example, an IUD is better tolerated by women who have given birth. Or a method might have been improved since you last tried it.

Health problems

More serious side effects may threaten your health and even your life. They usually require some kind of treatment. Often you must stop using the method either temporarily or forever.

For example, women who use the Pill are more likely to have gall bladder trouble which often requires

Health Benefits

Some methods make us feel better or decrease certain health risks. For example, Pill users have lighter periods with less discomfort; they are less likely to become anemic. Research shows that the Pill reduces ovarian cancer, a disease often detected late in older women.

Many women who chart the signs of their fertility or who use the cap feel more in touch with their bodies than before.

Using birth control to space births and reduce the total number of pregnancies results in improved health for women around the world. This fact is often used to justify the health risks of certain methods. But birth control is no substitute for a more just sharing of the world's resources including adequate nutrition and pre-natal care.

surgery. Young women with IUDs have higher rates of infection of the Fallopian tubes. Often they must be hospitalized for antibiotic treatment. Sometimes the infection causes infertility (difficulty getting pregnant). Some women who use the diaphragm get bladder infections which require treatment.

Some problems occur while you use the method. If you bleed too heavily with the IUD, you can become anemic; this usually corrects itself once the IUD is removed. Other problems may occur after you've stopped the method, and may be related to how long you used it. Whether or not long-term use of the Pill increases the risk of breast cancer is still not clear.

We can better predict which women might have complications as experience with certain methods increases. For example, we now know that Pill users who smoke are much more likely to get heart disease than those who don't.

Some women are very conscious of health risks and avoid drugs whenever possible. They are willing to use methods which require more effort such as the biological methods (or avoiding penetration) rather than take health risks. Other women prefer the convenience of continuous methods and accept the risks associated with them. For many young healthy women, the risk of possible side effects years from now is more abstract than the risk of an accidental pregnancy.

You have to decide for yourself what risks are acceptable to you. If you are at greater than average risk for a particular problem but still want to use that method, you should have more frequent checkups and be aware of signs of trouble.

In the U.S., fear of lawsuits has affected the way medicine is practised. You may be asked to sign a consent form for certain methods. Make sure you understand what the form says before signing.

Effect on existing illness

You should discuss with your doctor how your birth control method will affect any health problems you have and vice versa. Report any drugs you are taking even if you are only using them for a short time.

People with chronic illness such as diabetes or heart disease are often in a difficult situation. It may be very important to avoid pregnancy but the most effective methods may be unsuitable. Health workers need reminding that sexuality and birth control are also important issues for people with chronic illness or disabilities.

Piera Palucci

Bertrand Carrière

Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) are infections which spread when an infected person has sexual contact with others. They cause serious illness and infertility. You are at risk of getting an STD if you have sex with more than one person or if your regular partner has sex with others.

Today the world is confronted with a new STD—AIDS (Acquired Immunodeficiency Syndrome)—which causes severe illness and death. Since no effective cure or vaccine exists yet, prevention is vital.

For some, celibacy and monogamy are the solution. Others are exploring safer sexual practices. One result is that people have become much more aware that sex can have consequences beyond the moment.

Many people who need birth control also need protection from STDs. The choice you make for one may influence what you do for the other. For example, if you are using the Pill for birth control, will you take the extra effort to use a condom to prevent STDs? Or do you need to take the Pill if you are already using condoms?

Safer sex

Public health campaigns which promote safer sex to prevent AIDS and other STDs also offer good strategies for avoiding unwanted pregnancy:

1. Condoms are effective for both birth control and STD prevention.
2. Fewer and more careful choice of partners means fewer situations to negotiate birth control.
3. Sexual activities such as mutual masturbation are less likely to allow germs to pass and carry no risk of pregnancy.

Many people are seeking ways to protect their health while enjoying sex. You have to figure out which strategy works for you. In a sexual encounter, can you discuss STD prevention? Can you hold off on sexual intimacy with someone who does not cooperate? Do you feel comfortable exploring sexual activities which carry less risk, such as mutual masturbation?

Just as you assume that your partner is fertile, you should assume that s/he might have an infection. It is unrealistic to expect to know everything about a partner's past bed mates (were any of them drug users who shared needles, another way of spreading infection?). Safer sex is a sign of respect, not of distrust.

If your birth control method does not offer STD protection you need to add protection or change methods.

It is tempting to stop worrying about STDs after being with the same partner for a while. If you have not had tests that show neither of you is infected, time is no guarantee. Tests for gonorrhea and chlamydia are reliable within a few weeks after infection. Tests for AIDS may be negative for 3 to 6 months after infection.

Hidden infection

Most STDs do not cause symptoms (make you feel sick) until the infection has spread. As a result, most people infected with an STD do not know it. This creates two serious problems:

An infected person can unknowingly give an STD to his or her sexual partner, who in turn can give it to someone else.

An infected person may not get treated until complications occur. Treatment at this stage stops the infection but does not always undo the damage which has been done (for example, unblock scarred tubes).

Gay women have very low rates of STDs. Sexually active men and heterosexual women need STD testing at regular intervals; how often depends on the frequency of unprotected sex with different partners. In addition to a physical examination, tests should be done for chlamydia and gonorrhea. In women a Pap test for cancer of the cervix will also detect microscopic warts on the cervix.

If tests are positive you and your partner(s) should receive treatment and avoid sexual intimacy until further tests are negative.

People who want to be tested for AIDS should have counselling before and after the test. Confidentiality and (if you wish) anonymity should be guaranteed.

How birth control affects STDs

Pill	Increases likelihood of getting chlamydia but decreases the risk of complications such as tubal infection.
IUD	Increases likelihood of complications from gonor rhea and chlamydia.
Condom	Good protection for most STDs. Possibly better protection from condoms for women which cover more of the genitals.
Diaphragm & cap	Some protection from gonorrhea and chlamydia for both partners.
Spermicides	Probably some protection from most STDs but possible ncreased risk if spermicide causes irritation. *Advantage 24* may be less irritating and may coat the vagina better.
Biological methods	Fewer acts of coitus, therefore fewer chances of infection.
Withdrawal	No protection.
Sterilization	No protection.

The Birth Control Market

The ideal birth control method is 100% effective, inexpensive and without side effects. It is easy to obtain and to use and does not interfere with sex. It does not exist.

Birth control decisions often involve choosing between effectiveness and side effects, between expense and interference with sex. Though many people blame themselves for their problems with contraception, their choices are limited by a number of factors:

Research choices

Most birth control research focuses on «high tech» methods. To minimize human error, researchers prefer methods which are done to people rather than those which people control. For example, methods which stop ovulation are preferred over those which detect ovulation.

Foundations concerned with population growth, particularly in poor countries, give priority to methods such as injections, implants and sterilization because they are long-lasting and require little education. Little research has been done on methods for men or on ways to improve how people use birth control.

Government approval

The Drugs Directorate (Canada) and the Food and Drug Administration (USA) are responsible for approving new drugs and devices. Their effectiveness and safety must be proven with laboratory, animal and human studies. Drug companies often blame government for requiring too many tests before approving new products which increases their costs.

Governments also reduce birth control choices when they refuse to pay for contraceptive services. After a legal challenge, the Quebec government was obliged to pay for IUDs as well as the Pill for people on welfare. It still does not pay for condoms.

Governments make birth control and abortion laws. These laws determine the age when young people can get birth control without their parents' consent. Many state governments deny funding to organizations which perform or refer people for abortions.

In France, despite attacks from conservative groups, the government introduced the abortion pill, RU 486. North Americans still do not have access to it although the U. S. will begin studies soon. Drug companies fear boycotts by anti-choice groups if they undertake such research.

Marketing

The market for birth control is enormous—most women of reproductive age. Companies which produce birth control aim for huge profits by tapping this market.

But law suits for health damages reduce company profits. After many women claimed damages from use of the IUD, all but one manufacturer withdrew the product from the U.S. market. The companies claimed that they could not afford the lawsuits, not that their product was dangerous. Women in the U.S. who would have chosen the IUD were thus limited in their choice. In 1988, a different manufacturer began selling a new IUD which is accompanied by a detailed "informed consent" sheet.

Advertising of birth control to the general public was legally restricted until recently. Television networks still fear audience reaction to such advertising. But pharmaceutical companies have always advertised to doctors and health care workers. This often influences which birth control method they recommend to their patients.

Accessibility

Condoms and spermicides are on public display in drug stores, no longer behind the counter. Other methods require a doctor's visit which can be costly. In Canada, some provincial health programs no longer pay for certain birth control services. In both countries, funding for family planning has been reduced drastically.

Less than 20% of students in the U.S. receive birth control education at home or in the schools. In Canada the rates are slightly higher.

Women's groups

The Women's Movement has fought hard to improve access to birth control, exposing abuse and neglect both at home and abroad. It has established many non profit clinics and educational projects and promoted interest in the cervical cap and menstrual extraction.

Most important, it has made respect for women's autonomy in sexual and reproductive decisions the basis of birth control politics. The Montreal Health Press is part of this movement.

Diane Comley

Body Parts

You can better understand sex, how to make a baby and how not to if you know something about how your body (and your partner's) works.

Many men and women wonder if their genitals are normal. Genitals vary as much as noses do. They are similar enough to perform their functions but different enough to be uniquely yours.

Genital abnormalities are usually discovered in childhood; abnormalities of internal organs may not be discovered until puberty.

Women's bodies

In women, reproductive organs are inside the pelvis, protected by bones and muscles. Sexual organs lie outside these muscles.

You can look at your own genitals easily by holding a mirror between your legs. These outer structures together are called the **vulva**.

Outer lips (labia majora): These folds of tissue begin at the fatty cushion over the pubic bones (mons veneris) and join in front of the anus. In girls they cover and protect the vaginal opening; at puberty they move apart and become covered with pubic hair.

Inner lips (labia minora): These delicate folds of moist pink skin lie between the outer lips, surrounding the vaginal opening. In front they form a hood over the clitoris. When a woman is excited sexually they become engorged with blood which makes them slightly erect. The inner lips vary in size and form in each woman.

Clitoris: This exquisitely sensitive organ lies just under the mons. It is covered by a hood formed by the inner lips which can be gently pulled back to reveal the glans or tip. Its shaft which can be felt under the hood divides and anchors it to the pubic bones.

The only function of the clitoris is sexual pleasure. When it is stimulated, it engorges with blood, becomes erect and pulls back under the hood.

Urinary opening: This opening through which women urinate (pee) lies just under the clitoris and above the vaginal opening. It is the outer part of the urethra, the tube from the bladder.

Vaginal opening: The outer part of the vagina is located behind the urinary opening. During sexual stimulation it becomes moist. Erectile tissue on both sides of it become engorged with blood. The pelvic muscles around the vaginal and urethral openings contract and relax during orgasm. They can also be contracted voluntarily, for example to stop urination.

In girls, the opening is partially covered by an elastic membrane called the **hymen** which is open enough to let menstrual blood pass out and to permit use of tampons. The hymen stretches and may tear slightly the first time the vagina is penetrated. Afterwards, only its edges are visible.

Vagina: The vagina lies between the urethra and the rectum. It is made of soft elastic folds which stretch when a woman is sexually excited. The vagina is lined with a moist mucous membrane much like the inside of the mouth. During sexual stimulation, lubricating fluids pass through this membrane.

The inner part of the vagina (except just under the urethra) has very few nerve endings. The outer structures have many nerve endings and are much more sensitive to sexual stimulation.

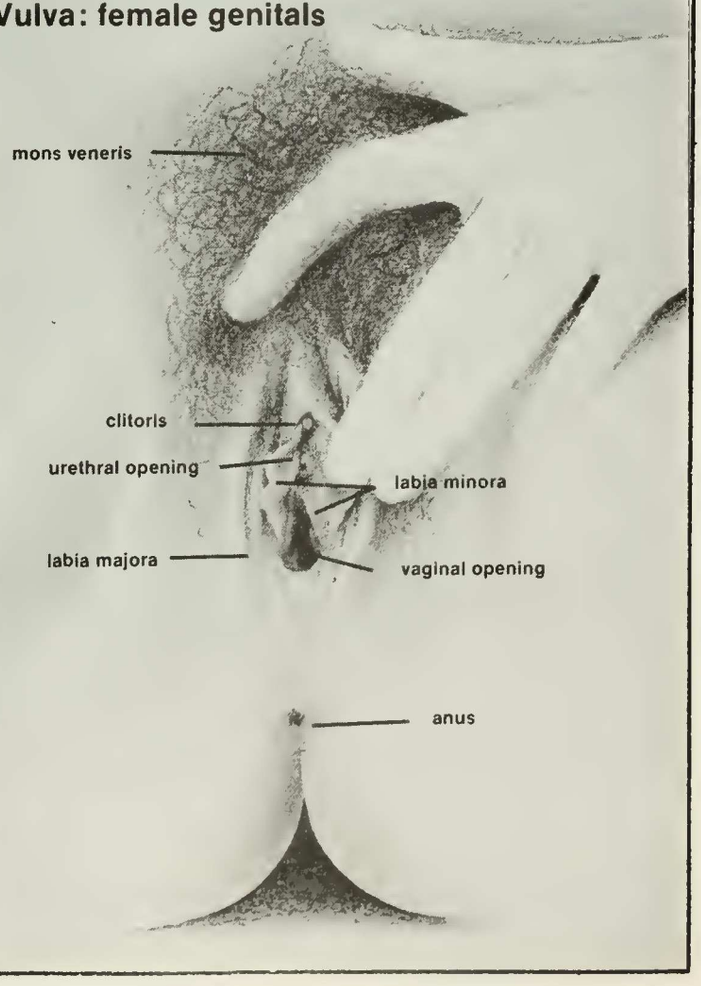
Uterus: The uterus is a pear-shaped muscular organ. During pregnancy it supports the growing fetus. In a woman who has never been pregnant, the uterus is about 8 cm (3") long and 5 cm (2") wide. After pregnancy, it remains slightly larger.

The inside of the uterus is lined with a spongy tissue called the **endometrium**. This lining thickens each cycle in preparation for pregnancy. When pregnancy does not occur, the lining breaks down and menstruation is the result.

The **cervix** is the bottom part of the uterus which opens into the vagina. The glands of the cervix produce mucus which helps sperm get through during ovulation. This mucus causes a feeling of wetness which can help you detect your fertile period.

Usually the top part of the uterus bends forward and the cervix enters the vagina at an angle of about 90 degrees. In about 15% of women, the uterus is bent backwards (retroflexion) or enters the vagina from an angle toward the back (retroversion). This does not affect a woman's sexual or reproductive experience but it can affect the use of birth control methods such as the diaphragm.

Vulva: female genitals



Fallopian or egg tubes: These two delicate tubes are each about 10 cm (4") long. Their open end widens near the ovary and the narrow end attaches to the uterus. The open end picks up the egg after ovulation. Tiny hairs in the tube move it along toward the uterus. Conception—when the egg and sperm join—takes place in the tube.

Ovaries: These two almond-shaped glands are loosely attached to each side of the uterus. They produce hormones and eggs. The ovaries get "turned on" by a signal from the **pituitary**, a small gland in the brain. The ovaries produce estrogen and progesterone—hormones which control the menstrual cycle.

At birth each ovary contains thousands of immature egg cells. From puberty on, one egg is released each cycle. This is called ovulation.

Men's bodies

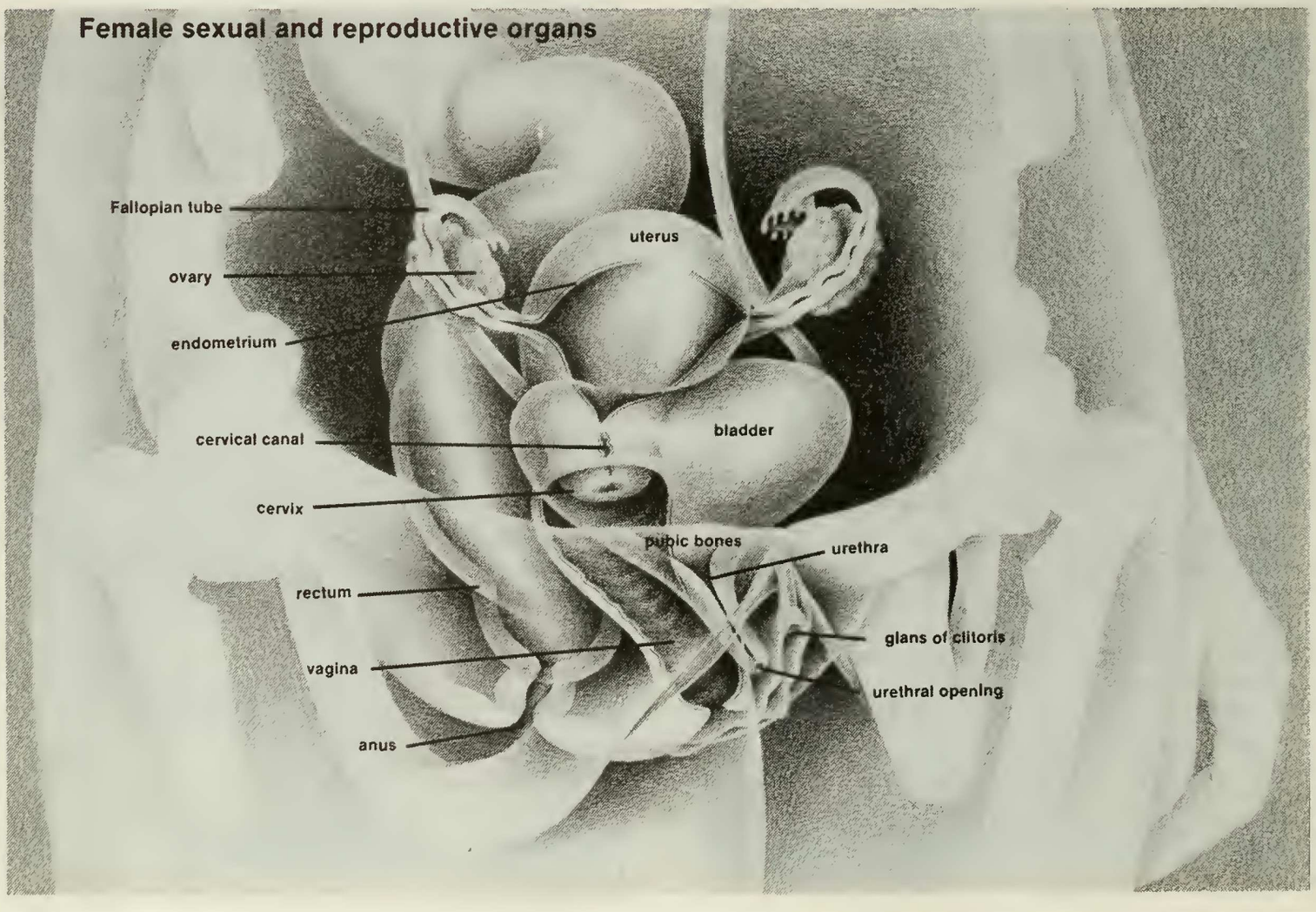
Testicle: The two testicles are oval-shaped glands which produce male hormones (androgens) and sperm. A thin sac of skin (**the scrotum**) which hangs in front of the thighs and behind the penis holds the testicles and keeps them cooler than the rest of the body. This is important for sperm production.

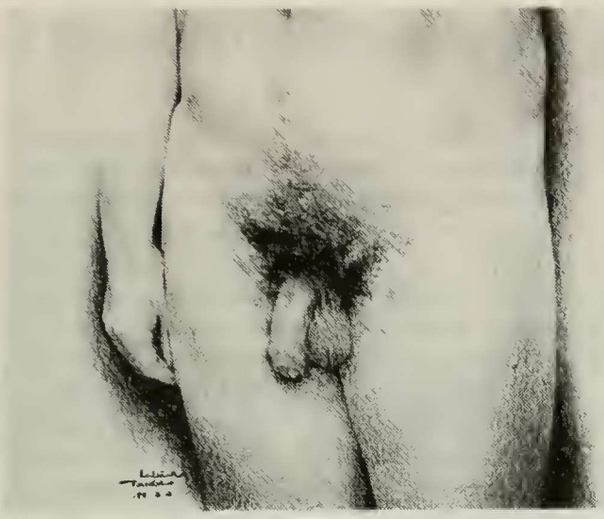
Male hormones from the testicles increase body and facial hair and muscle bulk. They stimulate the production of sperm from puberty on.

Sperm leave the testicle through a long, narrow tube (called **the epididymis**) which coils up on the back of each testicle. They leave the scrotum through the spermatic cord, a tube you can feel in each groin.

Spermatic cord: Each spermatic cord (also called the **vas deferens**) is about 45 cm (18") long. From the groin, they pass over the bladder and widen to form a storage place (**ampulla**) for sperm.

Seminal vesicle: These glands lie next to the ampulla where sperm are stored. They secrete liquids important for the survival of sperm. These secretions mix with the sperm in the **ejaculatory duct** just before orgasm.





Prostate: This chestnut-shaped gland, just under the bladder, produces substances important for sperm survival which mix with sperm seconds before ejaculation.

Urethra: This tube goes from the bladder, through the prostate and pelvic muscles, and runs the length of the penis, ending at its tip. In men the urethra has two functions: urination (peeing) and ejaculation (the forceful release of semen during orgasm). A muscle (sphincter) prevents urine from mixing with semen during ejaculation.

Penis: The penis is made up of spongy erectile tissue which swells with blood and hardens when sexually stimulated. Two parts lie side by side forming the shaft. They separate and anchor the penis to the pubic bones. A third part, which contains the urethra, passes under the others and widens to form the tip (**glans**).

The penis is covered with loose skin which attaches at the edge of the glans. A fold of the skin (the **foreskin**) loosely covers the glans. In many cultures, the foreskin is removed by an operation called circumcision. Jews circumcise boys at birth; in other religions circumcision may be done later. Circumcision of all boys at birth was once common in many North American hospitals.

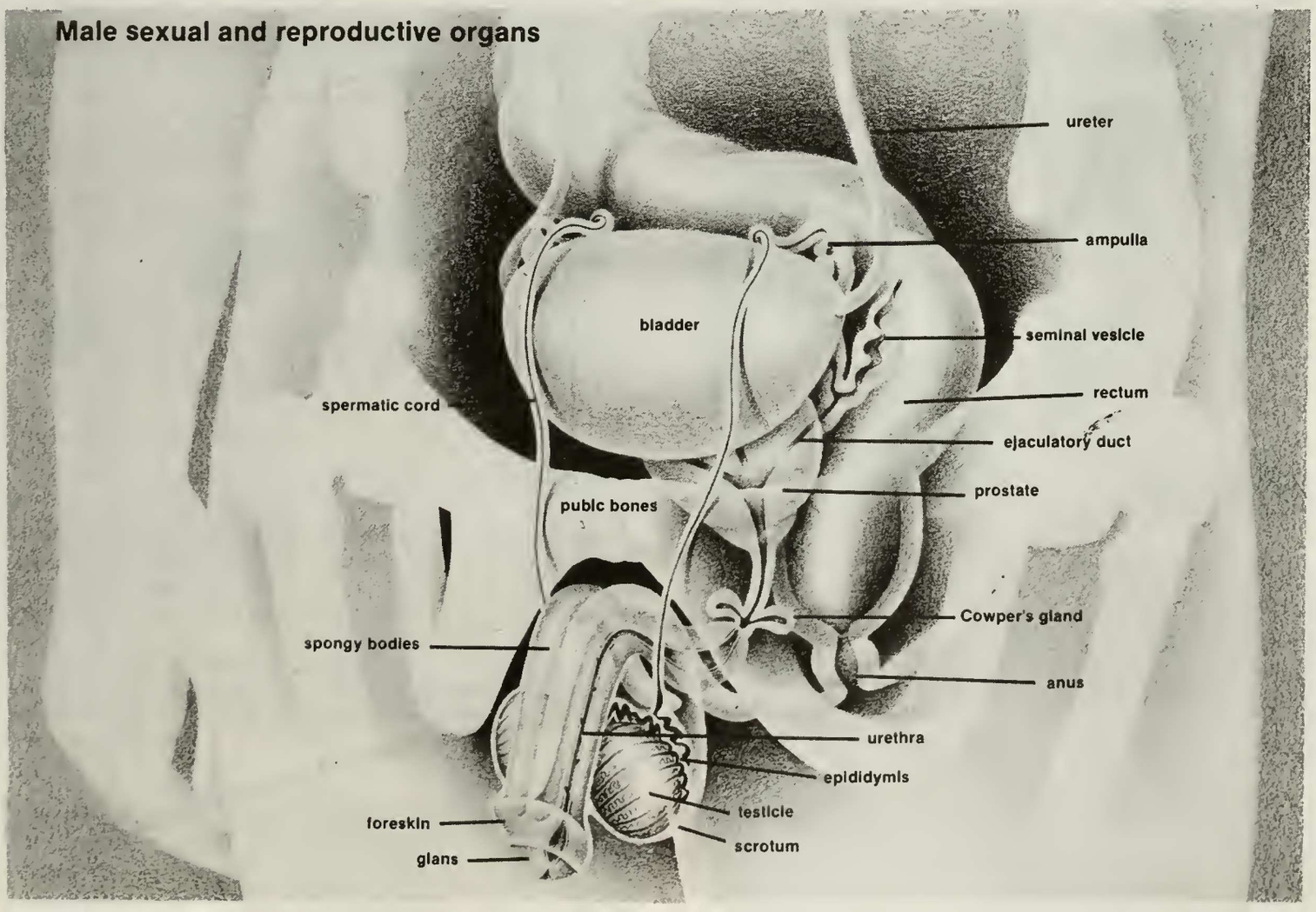
Genital health care for men

Young men do not need an annual check-up with a doctor. However they should examine themselves monthly.

A man's external genitals are in full view so sores, lumps or discharge should be obvious. To examine for cancer of the testicles, you slide the fingers of one hand over the surface of each testicle. Any lump, whether painful or not, should be reported to a doctor.

Many sexually transmitted diseases cause few or no symptoms. If you have more than one sex partner, you should have STD tests regularly (the more partners, the more often). Even if you don't have symptoms you should have the tests 2 to 4 weeks after unprotected sex with a new partner.

Male sexual and reproductive organs



An Average Menstrual Cycle

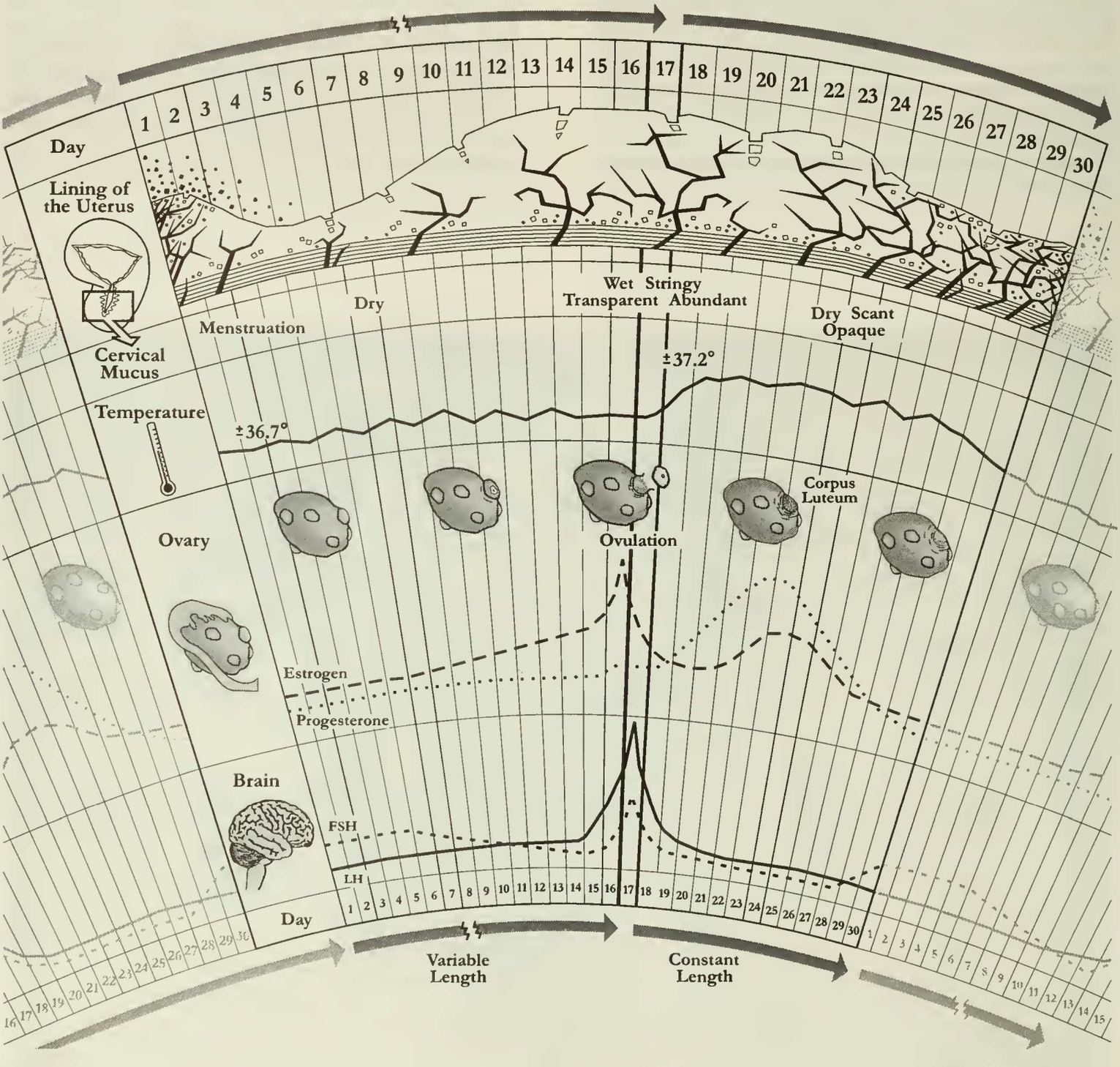
Days 1 to 5, menstruation
The pituitary produces FSH (Follicle Stimulating Hormone). Ovarian hormones are low. The lining of the uterus (endometrium) breaks down, causing menstrual bleeding.

Days 6 to 16, before ovulation
The pituitary continues producing more FSH and begins to release LH (Luteinizing Hormone). The ovaries respond by producing estrogen which makes the egg sacs (follicles) grow. One sac gets very big and sticks out. Estrogen stimulates the growth of the lining of the uterus and the production of fertile mucus in the glands of the cervix.

Day 17, ovulation
Suddenly the pituitary releases lots of FSH and LH and the ovaries secrete a spurt of estrogen. The egg sac bursts open, releasing its egg. Some women feel a twinge when ovulation occurs.The glands of the cervix produce lots of very thin, stringy mucus which is easily penetrated by sperm.

Days 18 to 26, after ovulation
FSH and LH fall rapidly. The ovaries release less estrogen. The ruptured sac turns yellow forming the corpus luteum which produces progesterone. This hormone affects the uterine lining and raises body temperature. The glands of the endometrium grow and produce nutrients in preparation for pregnancy. The cervical glands make less mucus.

Days 27 to 30, premenstrual
If conception does not occur, the yellow egg sac breaks down, producing less progesterone. This makes the lining of the uterus more fragile. When it starts to break down on the 31st day, the next period starts. This is day 1 of the next cycle and the entire process begins again.



The Menstrual Cycle

For half of her life, a monthly cycle prepares a woman's body for pregnancy. Menstrual bleeding (the shedding of the lining of the uterus) marks the end of one cycle and the beginning of the next.

Most girls begin to menstruate between the ages of 10 and 16. Women usually stop having periods around age 50 after which pregnancy is not possible.

Hormones control the menstrual cycle much like temperature controls a heating system. When hormones from the ovaries are low, a gland in the brain (the pituitary) signals them to produce more. When hormone levels rise, the pituitary stops signalling the ovaries which in turn stop producing hormones. When hormone levels fall, the process starts all over again.

The length of a cycle is determined by the time it takes to release an egg (ovulate). This varies from one woman to another and from one cycle to another. Once the egg is released, menstruation follows about 14 days later. The normal range of cycle length is about 20 to 40 days.

Having regular periods means that you know when your next period is due, whether it is every 25 or every 33 days. Your cycles are irregular if they vary by more than 10 days.

To calculate the length of each cycle, count the first day of bleeding as day 1 and the day before the next period as the last day.

Menstrual bleeding

Menstrual flow contains white blood cells, blood and cells of the uterine lining which is breaking down. Natural chemicals either prevent the blood from clotting or break up clots. Clotting occurs when heavy bleeding uses up all the chemicals. The uterine muscles contract to help the flow along.

Women lose about 20 to 80 cc (1 to 3 ounces) of blood during each period which lasts between 2 and 8 days. Bleeding may be abundant for several days and then taper off.

You can have sexual activity of any kind during your period. Orgasm causes the muscles of the uterus to relax and contract. Some women find this relieves menstrual cramps. Most women find that the flow is heavier for several hours after orgasm.

***Toxic shock syndrome (TSS)**, caused by the growth of toxin-producing bacteria, is associated with the use of tampons, particularly super absorbent ones. It causes flu-like symptoms such as fever, nausea, vomiting, and a rash. Since TSS can be fatal, anyone who has these symptoms while using a tampon should remove it and take it with her to the hospital emergency room. To reduce the risk of toxic shock syndrome, manufacturers recommend changing tampons regularly and not using them overnight.*

Politics of the menstrual cycle

Menstrual bleeding, a normal event for adult women, is often treated as dirty and shameful. Women learn not to talk about their periods except in intimate circles. Finding a blood stain on one's clothes in public is seen as a social disaster. A woman who complains about menstrual cramps may be accused of rejecting her femininity. Imagine accusing a person who is constipated of rejecting his identity.

Sometimes the menstrual cycle is used as an excuse to discriminate against women — to discredit their intellectual and emotional abilities. Studies showing that women commit more violent acts just before or during menstruation fail to say that women commit fewer criminal acts just before ovulation. Men who neither menstruate nor ovulate are far more violent than women. To say that women are inferior because they menstruate means that men's bodies are the norm for human beings.

Menstruation represents the ability to reproduce. Many women enjoy their cycles and feel in touch with their bodies and other natural cycles through them.

Skjold Photographs

Fertility

Conception, also called fertilization, occurs when an egg from a female joins with a sperm from a male.

Women's role

When a girl is born, her ovaries contain thousands of unripe eggs. Each one contains 23 chromosomes made up of many genes. After puberty, one egg is released (ovulation) each cycle. It lives for about 24 hours.

The egg is drawn into the end of a Fallopian tube and moved toward the uterus by tiny hairs lining the tube.

Since the fetus will grow in the uterus, a "nesting place" is prepared for it. The lining of the uterus thickens and its glands produce substances which will feed the fertilized egg.

Men's role

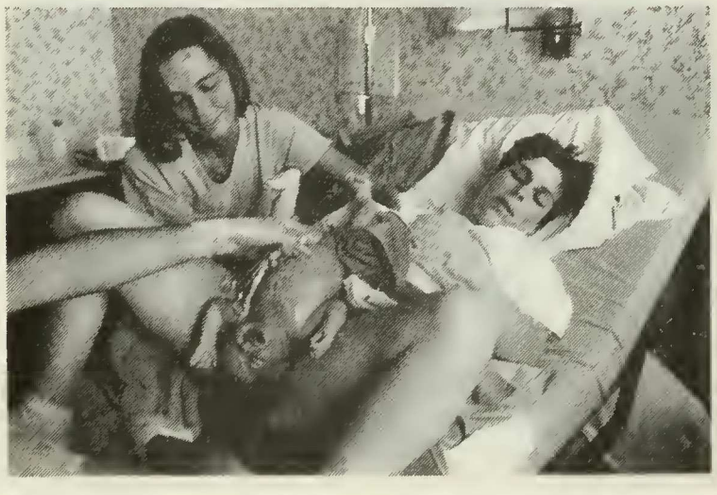
From puberty on, men produce millions of sperm cells continuously. Sperm look like microscopic tadpoles with a large head and a long thin tail. The head contains 23 chromosomes. The tail moves back and forth, pushing the sperm along.

Sperm flow from the testicles to a storage place at the end of the spermatic cord. Just before a man ejaculates, sperm are activated by fluid from the prostate and other glands. During orgasm this fluid spurts out of the urethra. One ejaculation contains about 350 million sperm.

In the vagina, sperm move quickly in all directions. They can survive for 48 to 72 hours. Many die in the folds of the vagina. Others are blocked by the mucus of the cervix. Once in the uterus, some sperm go into each Fallopian tube, one of which may contain an egg.

Fertilization

When one sperm joins with a ripe egg in the Fallopian tube, no other sperm can enter. The fertilized egg floats down the tube toward the uterus. As it moves, the chromosomes combine; they contain the genes which determine the sex of the fetus and many other features.



Bertrand Carrière

Taking hold in the uterus

The fertilized egg divides into a cluster of cells which reaches the uterus about 3 days after fertilization. It floats there for several days before burying itself in the lining of the uterus. This is called implantation. The endometrium does not break down so menstruation does not occur.

The endometrium feeds the cluster of cells which continue to divide. Some cells form the embryo (tiny fetus). Others become the placenta which provides nutrients and hormones. These hormones prevent a woman from releasing another egg once she is pregnant.

How to know you are pregnant

If you miss a period, you should evaluate the likelihood of pregnancy: did you miss any pills, did you not use a condom, is your IUD still in place? Do you have other signs of pregnancy such as nausea and swollen breasts? A period which is much lighter and shorter than usual can occur even if you are pregnant.

The sooner you find out you are pregnant the better. If you want to be pregnant, you can begin pre-natal care early. If you want an abortion, the sooner it is done, the safer the procedure. If you don't know what to do, you've got time to think or get some help.

If you suspect you are pregnant and do not want to be, continue using birth control until the pregnancy is confirmed. Many women become pregnant because they stop contraception when they think they are already pregnant.

The length of pregnancy is calculated from the date of your last period, **not** from conception. If you are 3 weeks late and have periods every 4 weeks, you are 7 weeks pregnant.

Pregnancy tests measure a hormone from the placenta called HCG (Human Chorionic Gonadotrophin). A blood test detects pregnancy within days after fertilization. New urine tests are reliable as soon as your period is late, some even earlier. A fresh morning sample in a clean bottle gives most accurate results. You can buy pregnancy test kits in drugstores for home use for $10 - $20.

Urine tests are not 100% accurate. If your test is negative and you don't get your period within a week, repeat the test. If you miss two periods, go for an examination. If your test is positive, have the pregnancy confirmed by a pelvic examination.

A pelvic examination (p 22) will confirm that you are pregnant and how advanced the pregnancy is. At 6 weeks (2 weeks after a missed period) the uterus is big enough for the examiner to feel the difference. After 12 weeks, the uterus can be felt by pressing above the pubic bone.

Preparing for pregnancy

Stopping birth control: When you decide you want to have a baby, stop using your birth control method. Pill users should wait until they have at least one period while not on the Pill before getting

Judith Crawley

pregnant. This will give you a better idea of when the baby is due (which is important for your prenatal care). To get pregnant after an IUD is removed, wait until you have a period (no delay if removed during your period).

Protecting fetal health: The embryo begins to develop even before you miss your period (and suspect a pregnancy). It can be harmed easily so it's important to avoid hazards such as X-rays and drugs while you are trying to get pregnant.

Find out if you are immunized against german measles (rubella), a disease which causes malformations. If not, you should receive the vaccine and wait 3 months before becoming pregnant.

If you or your partner has had other sexual partners in the past year, you should both be tested for sexually transmitted diseases, even if you have no symptoms.

Ask a doctor about special tests before trying to get pregnant if someone in either of your families has a genetic problem. Ask about the effect of pregnancy on any chronic disease (diabetes, lupus) you have.

The vitamin, folic acid, reduces the risk of certain malformations affecting the brain and spinal cord. Folic acid is present in certain beans and green vegetables but it is difficult to be sure how much you are getting. ***If you are trying to get pregnant, you should take 0.4 mg of folic acid daily; continue taking it until you are 6 weeks pregnant.*** Women who have already had a fetus with this kind of deformity (or have a close family member who has) should discuss the dosage of folic acid with their doctor.

Protecting your fertility

After a year of regular sex about 10% of women will not yet be pregnant; some will get pregnant in the second year.

Unless you have a health problem which interferes with getting pregnant or have untreated symptoms such as pelvic pain, give yourself at least a year or so before going for tests. Treatment of infertility is a major undertaking physically, emotionally and financially.

Infertility has many causes. Either the man, the woman or both may have a problem. You may be born with the problem (a woman with no uterus) or you may develop it (as the result of an infection). The effect of working conditions and pollution on reproduction is under study.

Sexually transmitted diseases are a major cause of infertility since they form scar tissue which blocks the transport of egg and sperm. STDs are preventable (see p 13).

Some contraceptive methods can cause infertility. The IUD carries a high risk of infertility in young, childless women who have more than one sexual partner.

Long acting methods such as implants and injections do not cause infertility. However the time it takes for fertility to return once you stop the method varies from one woman to the next.

Whether abortion, especially multiple abortions, creates problems for future pregnancies is not clear. Countries where women have many abortions do not have higher rates of miscarriage or prematurity. Nonetheless, finding ways to dilate the cervix more gently, particularly in late abortion, is important.

In rare cases, over-scraping of the uterus during an abortion can cause infertility. Self-induced abortions or those done by unskilled people are a definite cause of infertility.

Diana Sherwood

Infertility is a complex subject beyond the scope of this book. Information is usually available from local health care workers and women's groups.

New reproductive technologies used to overcome infertility artificial insemination, embryo transfer, etc—have received a lot of publicity. They are fascinating, but they are far more costly and less effective than taking simple measures to protect fertility. STD prevention and the development of safe birth control methods could reduce the need for such "high-tech" solutions.

Getting a Checkup

While many birth control methods are readily available, others require a visit to a doctor. Whether you go to a family planning clinic, a hospital, a family doctor or a gynecologist, a birth control visit should include:

- general information about the different methods available;
- help in making the best choice for you;
- clear instructions about the method you choose;
- general health care measures (Pap test, breast exam, screening for sexually transmitted diseases).

If you don't see a doctor for birth control, you still need an occasional visit for general health care. Women who have sex with men should have an annual Pap test; others can go less often.

Health workers can help you gain insight into your use of birth control. They are up to date on the technical aspects of birth control and they know how other women face these choices that affect our intimate lives.

The following description of a birth control consultation will prepare you for your first experience and set a standard by which you can judge the quality of the services you get.

Reviewing your situation

Tell the health worker why you've come: to renew your prescription, to change methods, etc.

Describe your contraceptive experience from the time you started using birth control to the present. Which methods have you used? What did you like or dislike about each? What are you using now? For how long? Are you having any problems with it? Would you like more information about other methods? Do you have a back-up method if something goes wrong with your usual method?

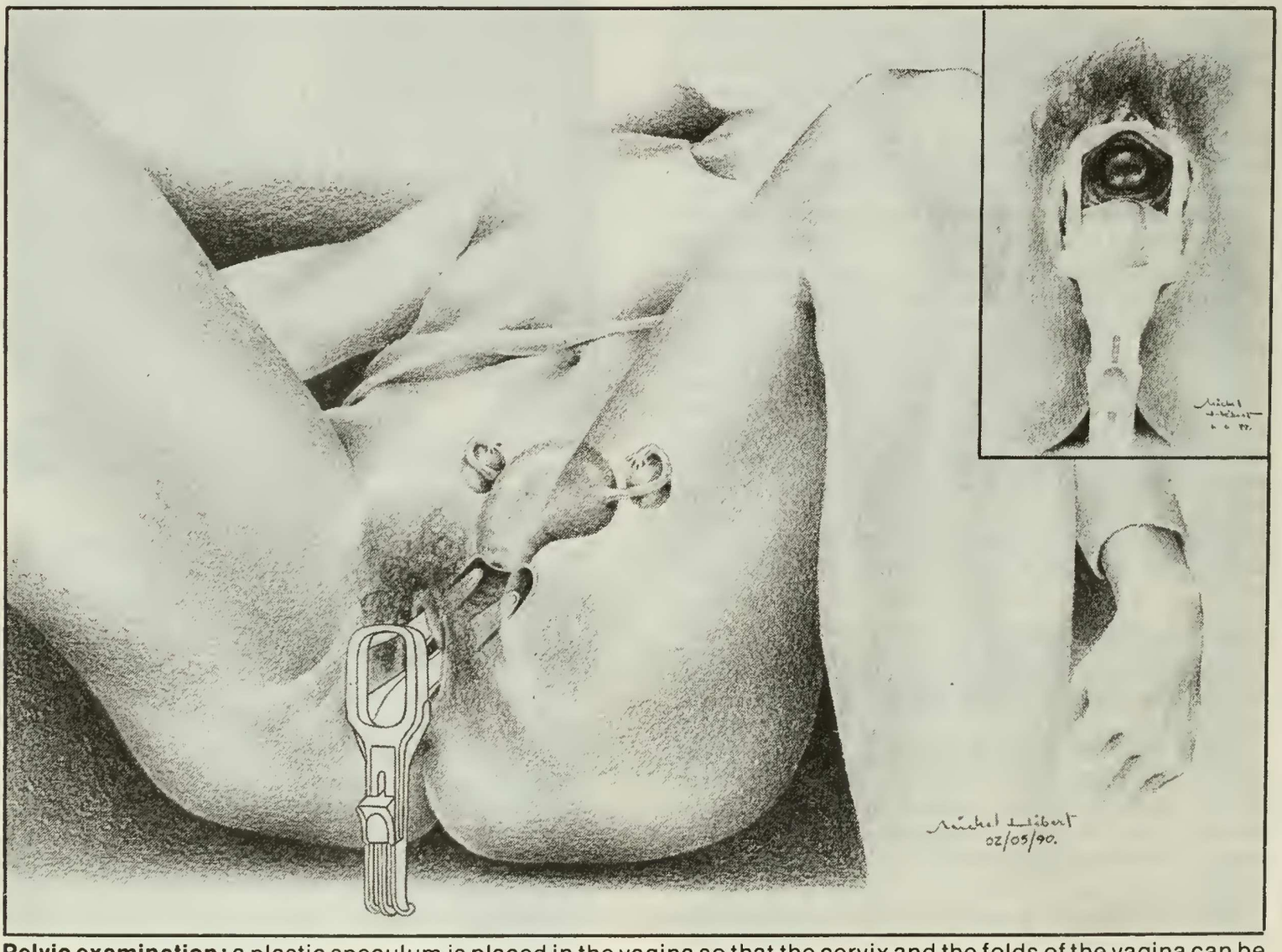
You may want to discuss how your birth control method affects your sex life. Does your partner cooperate? If you have more than one partner, what are you doing to avoid sexually transmitted diseases?

What are your plans for pregnancy? Are you delaying another pregnancy or are you trying to avoid pregnancy at all cost? What would you do if your method failed and you became pregnant? Have you ever had an abortion?

Are your periods regular or not? How long and how heavy do you bleed? Do you have cramps or feel bloated? Do you have any bleeding between periods or after intercourse? When was your last period?

The health worker asks questions about your past health (major illnesses, allergies, hospitalizations and operations) and that of family members. Are you taking any medication now? Do you have any symptoms which worry you? Information about lifestyle such as smoking or special diets is important.

If you are considering a method such as the IUD or cap which needs to be inserted or measured during an examination, now is the time to make up your mind.



Pelvic examination: a plastic speculum is placed in the vagina so that the cervix and the folds of the vagina can be seen. Inset: view of the cervix.

Physical examination

Most people are nervous about a physical examination. The pelvic examination can cause anxiety if you are unprepared or have been examined roughly in the past. The more you can relax, the more useful and the less uncomfortable this examination is. Taking long slow breaths is helpful. Let the examiner know if you are particularly nervous so that you can be put at ease.

A bath, shower or simply washing the genitals with soap and warm water is adequate preparation. Douches, creams and powders hide signs of infection and should not be used for at least 24 hours prior to a pelvic examination. You will be more comfortable if you urinate (pee) beforehand.

To be properly examined, you must get undressed. You can use a robe, sheet or your own clothes to cover yourself.

You should be weighed and your height and blood pressure recorded. The doctor examines your skin, neck, breasts, heart, abdomen, groin and legs. The examiner is looking for lumps, swellings, painful spots or other signs of disease. If you do not know how to examine your own breasts you should be shown how.

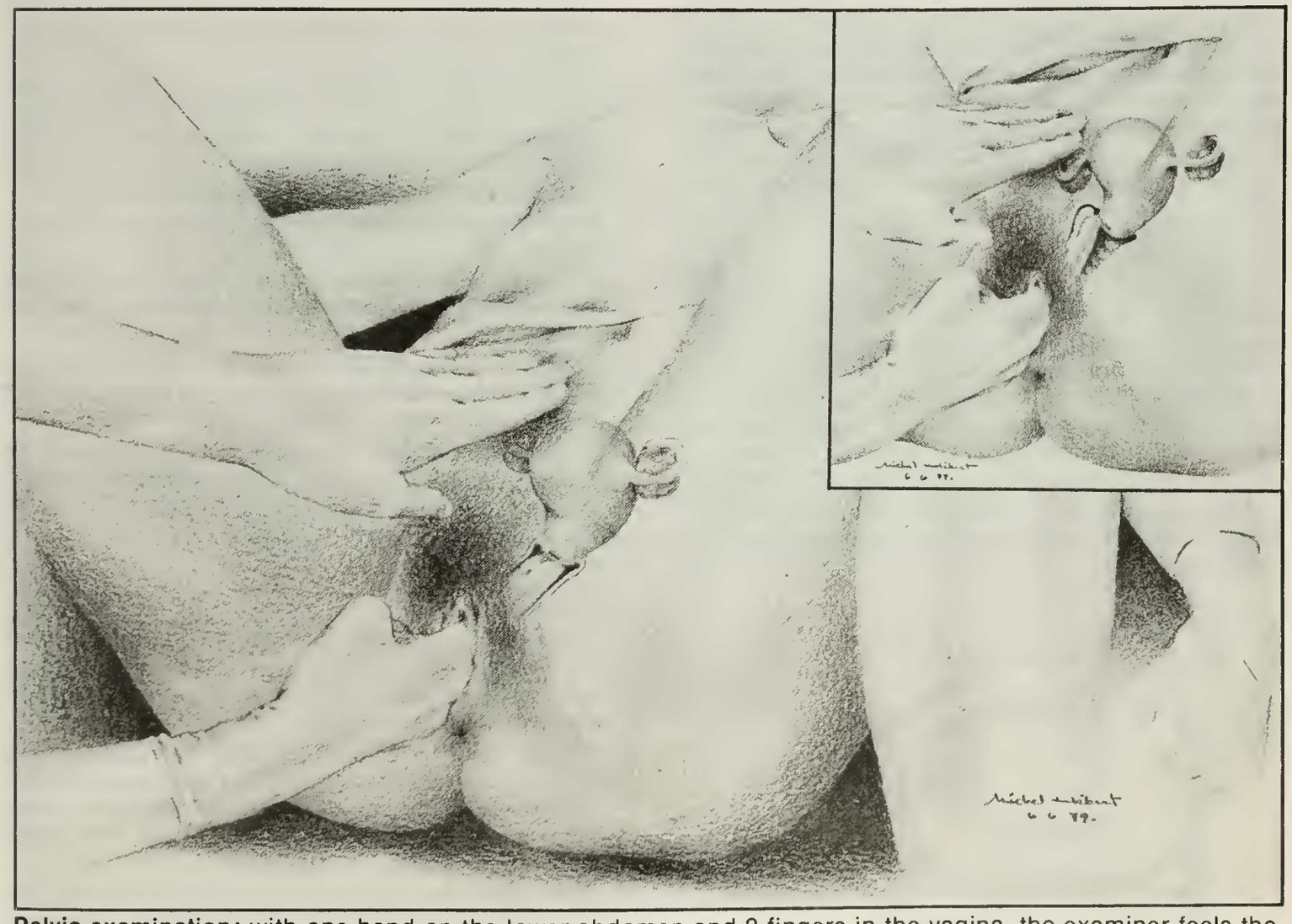
For a pelvic examination, you lie on your back with your buttocks at the edge of the table, your feet in supports and legs spread apart. The outer genitals are examined for sores or signs of irritation.

To look at the inside of the vagina and the cervix, the examiner uses a metal or plastic instrument called a vaginal speculum. A metal speculum should be warmed before use. The speculum is inserted into the vagina with its blades closed. The blades are gently opened and adjusted until the cervix can be clearly seen.

The examiner may do several tests which can be slightly uncomfortable but rarely painful. The Pap test (cytology) for cervical cancer should be done once a year, and more often in women who have had a previous abnormal test. A flat stick is used to collect cells from the surface of the cervix; these cells are examined in a laboratory for signs of cancer.

Women who have more than one sexual partner or whose regular partner may have other lovers should have tests done for gonorrhea and chlamydia (two STDs which affect the cervix). When the tests are done, the examiner closes the blades of the speculum and removes it.

To examine your internal organs (uterus, ovaries, and Fallopian tubes), the doctor puts two fingers of a gloved hand into the vagina and places the other hand on the lower abdomen. The size, shape and position of the internal organs can be felt between the two hands. If you are relaxed this examination should not be painful; pain is caused either by tension, rough handling or disease. Sometimes the uterus is felt better with one finger in the rectum instead of the vagina.



Pelvic examination: with one hand on the lower abdomen and 2 fingers in the vagina, the examiner feels the uterus—its size, shape and position. Inset: examining each ovary and tube.

Getting the most out of a consultation

Many women dislike going to a doctor because they or their friends have had unpleasant experiences. They may feel that doctors talk down to them or use too much jargon. They may be embarrassed or feel judged, especially about sexuality.

To get what you want out of a consultation, consider the following suggestions:

** Think about why you are going. Do you just need a prescription or do you want to talk about changing methods?

** Where is the best place for you to go? Ask friends where they go and why they like it. Would you prefer a woman doctor?

** Prepare your questions ahead of time.

** Consider bringing someone with you to help you remember your questions and to review the visit with you later.

** Ask for written instructions: how to use the method, when you should come back, what you should do if you have a problem.

** Call back for test results.

Lab tests

Unless a problem is found, few tests are necessary. Make sure you understand the purpose (and cost) of any tests.

A simple urine test for kidney function can be done at the clinic. Blood may be taken for several tests. A test for anemia (low blood count) should be done in women who have very heavy menstrual periods. A test for antibodies against rubella (German measles) should be done to determine the need for the rubella vaccine in women who want to have children. A cholesterol measurement may be useful for women on the Pill. Special counselling is important for women considering the test for antibodies to the AIDS virus.

Wrapping up

Once the decisions are made, make sure you understand how to use the method, when and why you should come back to the clinic. If any problems were found during the examination, the counsellor should explain them to you and arrange further tests.

The health worker may discuss health care and hygiene such as advantages of cotton underpants or the harmful effects of "feminine hygiene" products.

Finally, there should be time to review your questions and make sure they have been answered to your satisfaction.

Biological Methods

Fertility awareness

Biological birth control methods are based on a woman knowing when she is likely to get pregnant and when she is not. They are the only means of birth control approved by the Catholic Church. Many women delight in the self-knowledge which these methods encourage.

The fertile period can be calculated 4 ways:

1. **Calendar Method:** the length of past menstrual cycles predicts the probable fertile period.
2. **Temperature Method:** daily temperature recordings detect ovulation.
3. **Cervical Mucus Method (Billings):** changes in cervical mucus show signs of fertility.
4. **Combined Method (Sympto-thermic):** both the increase in temperature and the changes in cervical mucus determine the fertile period.

How they work

Pregnancy is prevented by not having coitus (penis-vagina sex) during the fertile time of the cycle.

Calculation of this "unsafe" time is based on the normal events of the menstrual cycle and on sperm survival:

1. The egg can live for 24 hours after ovulation.

2. Sperm can live for 48 to 72 hours.

3. The time from the beginning of menstrual bleeding until ovulation varies from 6 to 20 days.

4. Ovulation occurs about 14 days before the next period.

5. Progesterone released by the ovary after ovulation causes a slight rise in body temperature until the next period.

6. Mucus produced by the cervix is scant, thick and milky when a woman is infertile and abundant, thin and clear when she is fertile.

7. Since the exact time of ovulation cannot be predicted, 2 to 3 days must be added to the beginning and end of the fertile or "unsafe" period.

Effectiveness

The calendar method is the least effective. The other three methods are quite effective after adequate training. **Best users = 94% effective; typical users = less than 89%.**

In practice, if a woman does her calculations regularly and abstains from coitus when she is fertile, she can avoid pregnancy. But if she becomes lax or has coitus during the unsafe period, she risks pregnancy.

Using a second method such as the condom during the "safe" days increases effectiveness. However using condoms during the "unsafe" days only replaces one method with another.

The calendar method

Length of shortest cycle	First unsafe day	Length of longest cycle	Last unsafe day
21 days	3rd day	21 days	10th day
22 days	4th day	22 days	11th day
23 days	5th day	23 days	12th day
24 days	6th day	24 days	13th day
25 days	7th day	25 days	14th day
26 days	8th day	26 days	15th day
27 days	9th day	27 days	16th day
28 days	10th day	28 days	17th day
29 days	11th day	29 days	18th day
30 days	12th day	30 days	19th day
31 days	13th day	31 days	20th day
32 days	14th day	32 days	21th day
33 days	15th day	33 days	22th day
34 days	16th day	34 days	23th day
35 days	17th day	35 days	24th day
36 days	18th day	36 days	25th day
37 days	19th day	37 days	26th day
38 days	20th day	38 days	27th day

Effect on sexuality

Biological methods affect spontaneity by limiting vaginal intercourse to the "safe" periods. But they do not limit hugging, kissing, mutual masturbation, oral-genital sex or orgasm.

Communication is important to successfully use these methods. Usually women do the calculating. Men need to know what is expected of them. You can keep your chart at hand and take turns figuring out the "safe" times.

Effect on fertility

When you want to conceive, you can use the same calculations to have intercourse when you are most fertile. Many couples simply stop calculating and let nature take its course. You can be sure you are pregnant if your temperature stays high after a missed period.

If you become pregnant accidentally even though you did not have sex during the "unsafe" time, there may be a very slight risk of miscarriage or fetal malformation due to conception with an over-ripe egg or sperm. This can happen to anyone using no birth control.

Use

To use biological methods, you need to learn the signs of fertility. Some doctors and clinics offer instruction. In Canada, SERENA gives courses where couples who use these methods train other couples. Similar groups such as the Couple to Couple League exist in the U.S.A.. Some of these groups have religious ties so some people may feel out of place. Fertility Management Services also offers training.

Calendar method: Keep a record of the length of your cycles for at least 6 months. You cannot use the Pill or other hormones during this time. Count the first day of bleeding as day 1 ; the last day of the cycle is the one just before the next period starts.

Subtract 18 from your shortest cycle to get the first fertile (unsafe) day. Subtract 11 from the longest cycle to get the last fertile day. Avoid vaginal intercourse from the first unsafe day up to and including the last unsafe day.

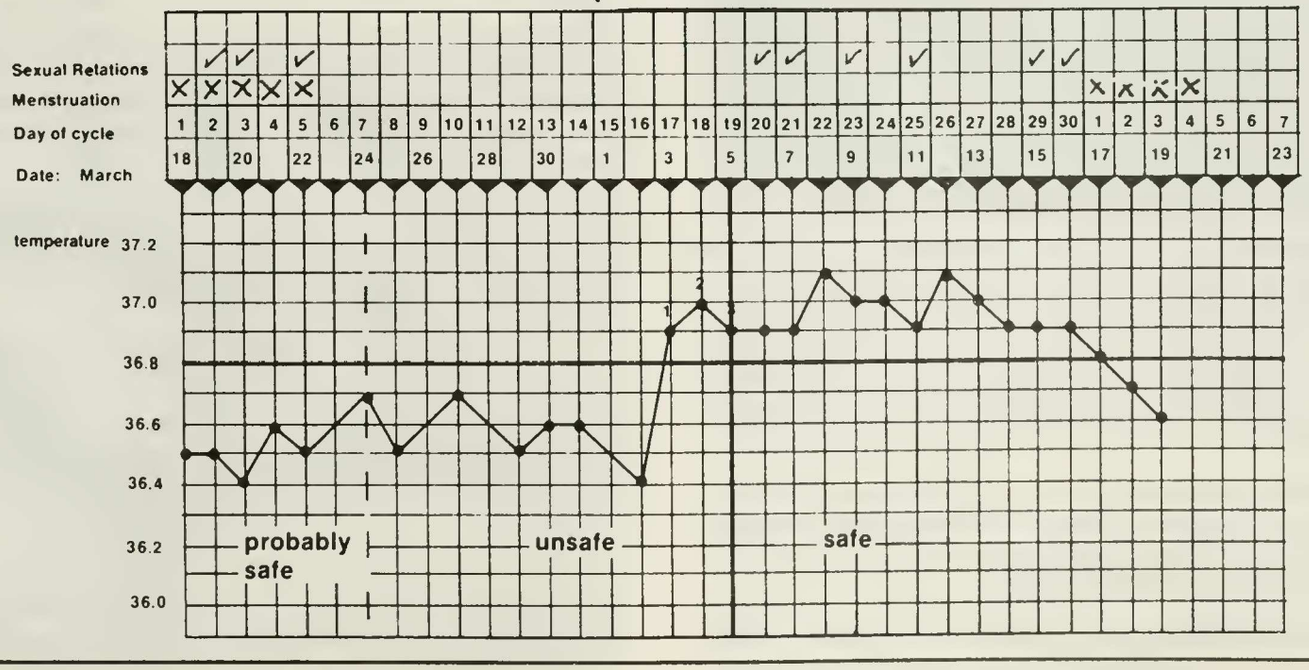
Continue recording the length of your cycles and use the shortest and longest of the 6 most recent cycles for your calculations.

This method should not be used by women with irregular cycles, a recent abortion or birth or while breast-feeding.

Basal body temperature (BBT): Take your temperature with a special thermometer (available in drug stores) each morning immediately upon waking, before any other activity (getting up, smoking, eating). Take it for 4 minutes each day the same way (in the mouth, vagina or rectum). New ear thermometers (shaped like the tool used to examine ears) give precise readings in less time. Record your temperature on a graph and note the days of menstruation, sexual activity and any factors influencing your temperature.

The unsafe time begins on day 3 of the cycle or as calculated by the calendar method. When your temperature starts to rise, draw a line on the graph one tenth of a degree higher than the highest temperature recorded earlier in the cycle. When the temperature

Temperature method



remains above this line 3 days in a row, the fertile period is over. You can safely have penis-vagina sex from that evening and for the rest of the cycle.

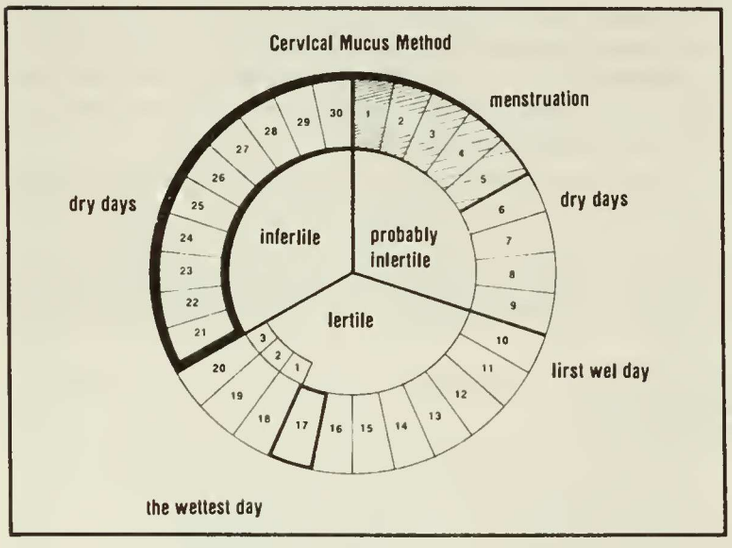
Cervical mucus: Use your fingers to examine the cervical mucus present at the vaginal opening. It is not necessary to touch the cervix. Each day you note:
1. the sensation at the vulva — dry, moist or wet;
2. colour of the secretions — yellow, white or clear; and
3. their consistency — thick, thin or stringy.

A regular cycle has several days of menstrual bleeding, a few dry days (except in short cycles), moist to wet days, followed by dry days until the next period.

The first sign of wetness indicates the first unsafe day. Because this change occurs without warning, you should limit intercourse to every 2nd day during menstruation and the first dry days.

The last wet day called the peak indicates ovulation. The last unsafe day is the 3rd dry day in a row after the peak. You can safely resume coitus the following day until the next period.

Sympto-thermic method: Use the strictest calculations of the methods above. The first unsafe day is either the first wet day or the day calculated by the calendar method, *whichever comes first*. The end of the unsafe period is based on either the basal body temperature or the cervical mucus methods, *whichever comes last*.



Technology & fertility awareness

Calculators exist to help determine your fertile period. The BBT thermometer is incorporated into a hand-held computer. One brand (Bioself) has coloured lights to indicate safe and unsafe times; you can also take it to a dealer to get a print-out of your most recent cycles. Another brand (Rabbit) does a graph which you interpret.

Ovulation prediction kits were developed to help women get pregnant. They detect a rise in LH which precedes ovulation. The kits are expensive and are not approved for birth control.

Enzymes in saliva change around ovulation. Tests to measure and use these changes are under study.

Withdrawal

Coitus interruptus is probably the most widely used form of birth control because it is free and always available. It is also known as withdrawal or "being careful".

How it works

The man withdraws his penis from the woman's vagina before he ejaculates. When no sperm are released in or near the vagina, the woman cannot get pregnant.

Effectiveness

For the typical couple, withdrawal is not very effective (**82%**) but it is better than nothing. Some men fail to withdraw or are not careful about withdrawing in time. Younger men have difficulty controlling ejaculation. Sometimes a small amount of sperm is found in the clear liquid which comes out during sexual excitement. When this liquid (pre-ejaculate or "pre-cum") leaks out before the man withdraws, pregnancy can occur.

Effect on sexuality

Coitus interruptus is exactly what the name says — an interruption of intercourse. The man must be alert to withdraw his penis in time. A woman who doubts her partner's ability or intention to withdraw in time will be understandably tense.

Experienced couples can adapt their sexual behaviour and use this method to their own satisfaction. Unfortunately young people with little sexual experience often rely on withdrawal.

Some couples find the method messy.

Use

The man must be aware of his level of sexual excitement. When you feel yourself approaching a level which could lead to orgasm, you withdraw your penis from the woman's vagina. Make sure to ejaculate away from her genitals.

Withdrawal might be easier in positions in which you cannot penetrate deeply; for example the "spoons" position with the woman's back against your chest.

To improve control, some couples use the "squeeze technique" which was developed to treat premature ejaculation. When the man feels orgasm approaching, he withdraws and his partner squeezes the penis around the ridge of the tip until his excitement diminishes.

If either partner is not yet satiated, they can satisfy themselves by using other forms of sexual stimulation. If penetration is desired after you ejaculate, you must wash or wipe your penis, particularly the tip.

Henri Robideau

Condom

The condom (safe, rubber, prophylactic) looks like a deflated balloon and is worn on the erect penis during sexual intercourse. It is the only effective, reversible birth control method for men.

The condom has become more popular recently as public health campaigns promote its use to prevent infection with the AIDS virus.

Most condoms are made of latex. Skin condoms, made from animal intestines, are expensive and may be less effective for STD prevention. A polyurethane condom called Avanti is available in certain states; it seems to increase sensation and be more resistant to tears.

Men and women can buy condoms without a prescription in drugstores and at some birth control clinics. Many brands are available, either dry, lubricated or with spermicide. Most condoms are about the same size (19 x 5 cm or 7-8 x 2 inches) but some brands are a bit bigger (Beyond Seven, Crown, Kimono, Maxx, Trojan Very Sensitive) and others smaller (SnuggerFit).

How it works

When a man wears a condom during intercourse, the semen ("cum") is collected in it and does not enter the vagina.

Putting on a condom

Effectiveness

The condom is highly reliable (**97%**) if used correctly each time a couple has sex whenever there is the slightest penetration of the woman's vagina. For the typical user, effectiveness is about **88%**. Condoms with sperm-killing lubricants are slightly more effective. Adding more lubricant reduces the risk of tearing the condom.

Effect on sexuality

Some men and women dislike interrupting sex play to put on the condom. Others find ways to make the moment playful and erotic. Either partner can initiate the use of the condom, indicating a desire for penetration.

For additional lubrication, use products which are water soluble (spermicides, examining gels, glycerin etc). Condoms can be weakened by oil based products such as vaseline, edible oils, certain sexual lubricants and certain medications (hormones, yeast treatments). The spermicidal suppository, Pharmatex, also weakens condoms.

Skjold Photographs

Modern condoms are thin and change sensation very little. Try different brands to find a fit you like. Some men with problems delaying orgasm find that the condom permits them to enjoy a slower sexual rhythm. Men with difficulty maintaining an erection are less enthusiastic.

Effect on health

Either partner can be allergic to a compound in the condom or the lubricant. Try changing brands. People allergic to latex should try the polyurethane condom, Avanti.

The condom offers protection from most sexually transmitted diseases including hepatitis B and AIDS. If there are sores on parts of the genitals not covered by the condom, transmission of syphilis, herpes or warts can occur. Regular condom use by male partner(s) decreases a woman's chances of getting precancerous cells on the cervix.

Effect on fertility

If a woman becomes pregnant when using a condom, the fetus will not be affected.

Use

Condoms keep in their packages for about 3 years if not exposed to heat. Check the expiry date. Condoms can be carried in your wallet or pocket for a short time only; otherwise your body heat could harm them.

If you have never used a condom before, practice putting one on when you are alone.

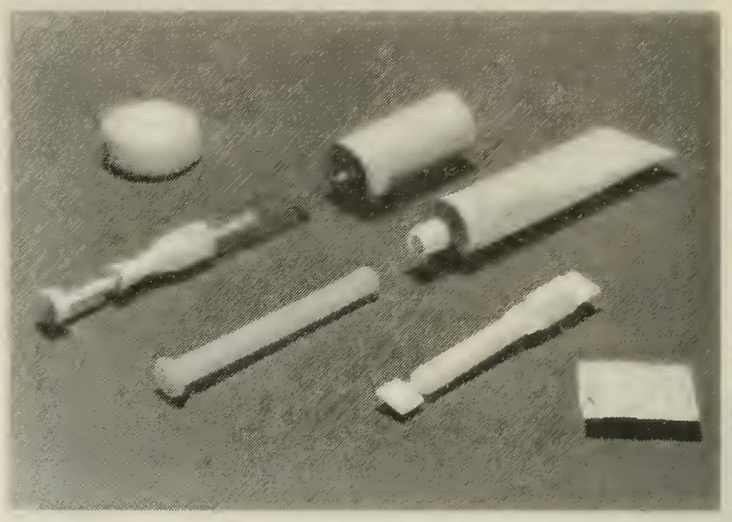
Most condoms are pre-rolled. Uncircumcised men should pull back the foreskin before putting on the condom. Leave a half inch space at the tip to collect the semen. Squeeze the tip to expel the air and unroll the condom to the base of the penis. A stronger ring of latex at the open end keeps the condom from slipping off. Be careful not to tear the condom with rings or fingernails.

Put the condom on *before* any penetration of the vagina. After ejaculation, the man must withdraw his penis before losing his erection. Hold the end of the condom against the base of the penis to prevent semen from leaking out. A new condom must be used for another penetration.

If the condom breaks or semen spills out, the woman can insert spermicide into the vagina immediately or use the "morning after" pill.

Condoms for Women

Condoms for women (called an intra-vaginal pouch) may be slightly less effective than those for men. Two brands (*Reality, Women's Choice*) are sheaths with a ring at one end to hold it in the vagina and a larger ring end which remains outside protecting the vulva. The *Bikini Condom* fits like bikini underwear with a rolled up pouch at the crotch. Condoms for women cover more of the genitals providing further STD protection.



Chuck Samuels

Vaginal Spermicides

A spermicide kills sperm or stops them from moving. Throughout history, women experimented with substances which they put in the vagina to prevent pregnancy. These homemade methods were easily available and somewhat effective.

Today, spermicides come in many forms: foams, creams, gels, suppositories and sponges. *VCF*, a paper-thin film coated with spermicide, is available in the USA.

How they work

The sperm-killing chemical in most spermicides is nonoxynol 9. Another substance called a base is mixed with the spermicide to keep it from spilling out of the vagina. The base coats the vagina and, to a certain extent, blocks the cervix.

Effectiveness

Spermicides rapidly kill or immobilize sperm. Since the spermicide must be well distributed in the vagina, the base, in which it is mixed, influences its effectiveness. *Advantage 24* gel and foams are better distributed than creams and suppositories and are the best choice when a vaginal spermicide is used alone. The sponge acts as a physical barrier to sperm but may get pushed aside by the penis, especially in women who have had babies.

Foam is very effective **(95%)** when used correctly all the time. The major reasons for failures are not bothering to use the foam or not using it properly (for example, not shaking the container). For the typical user, foam is **(79%)** effective.

Effect on sexuality

Spermicide use affects spontaneity. Most must be inserted not more than 20 minutes before intercourse. This means carrying the foam and applicator with you if you are away from home.

Suppositories take 15 minutes to melt after insertion; film takes 5 minutes. The sponge is less of an interruption since it is good for at least 12 hours after insertion and can be relied on for more than one act of penetration.

Some couples use spermicides for lubrication; others find them too wet. *Advantage 24* gel may be more pleasing than other spermicides which leak out the vagina and give a chemical taste.

Effect on health

Spermicides cause no serious side effects. An allergic reaction can cause genital irritation, rash or itchiness. Changing brands usually solves the problem.

Spermicides kill germs as well as sperm, offering some protection from STDs. However, if spermicides irritate the genitals, they could increase the risk of infection with HIV.

The risk of Toxic Shock Syndrome (TSS) is the same for sponge users as for tampon users (p.19). Therefore the sponge should not be used during menstruation or for at least 6 weeks after childbirth.

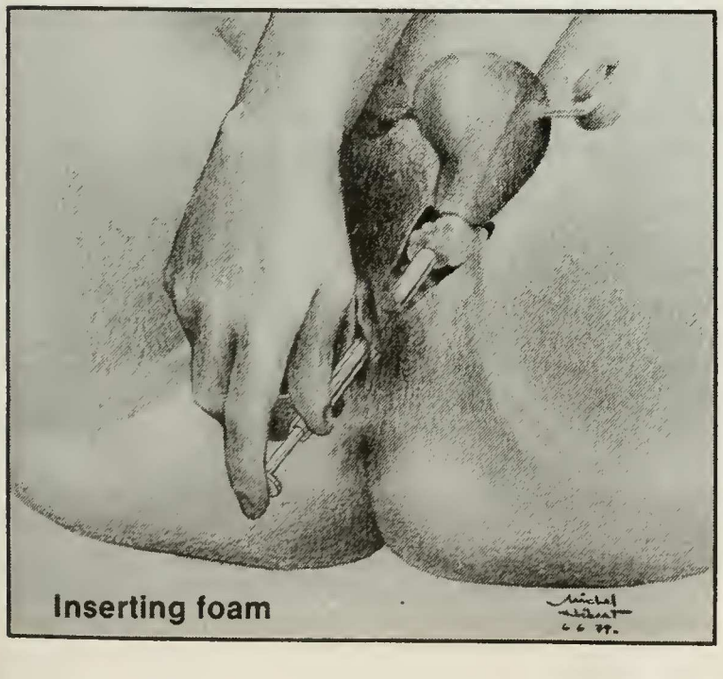
Effect on fertility

There is no proof that spermicides cause birth defects. However since spermicides are absorbed through the vagina you should stop using them if you miss a period.

Use

You can buy foam at drugstores and at some birth control clinics without a prescription. Buy two containers since it is difficult to tell when the bottle is empty. Foam is sold with or without an applicator. The same applicator can be used many times but it's a good idea to buy a second one. Pre-loaded applicators are expensive for regular use but convenient for holidays. Some brands of foam sold in North America are: *Because, Delfen, Emko and Koromex*.

Foam can be inserted up to 20 minutes before penetration. Load the applicator just before use. Shake the bottle of foam very well and gently press the applicator on the nozzle. Foam will enter the applicator and push up the plunger. (Some brands load differently.) Insert the applicator into the vagina as far as possible or until it reaches the cervix. Withdraw the applicator half an inch and push in the plunger to release the foam. If the applicator holds less than 10 cc of foam, add a second applicator-full.



Inserting foam

Suzanne Girard

If more than 20 minutes passes after insertion of foam, add more before penetration. An additional application of foam is necessary for each act of coitus. Douching must be delayed for at least 6 hours after.

Wash the applicator in soapy water. If foam has dried on the applicator, let it soak in warm but not boiling water.

To use creams and jellies *(Conceptrol, Delfen, Koromex, Ramses)*, screw the applicator onto the tube to fill it.

Unwrap suppositories and use your fingers to insert them deep into the vagina. Wait at least 15 minutes to allow them to melt.

Advantage 24 gel is different from other spermicides; its special base attaches to the vaginal walls and releases the spermicide for 24 hours. For this reason, it can be inserted up to 24 hours before intercourse. You must use another applicator-full for each penetration. *Advantage 24* comes in pre-filled applicators which cost about $2 each.

Protectaid is a small, polyurethane sponge soaked with F-5 Gel (small amounts of nonoxynol 9, sodium cholate and benzalkonium chloride). You insert it at least 15 minutes before intercourse (maximum of 12 hours beforehand) and leave it in place at least 6 hours after the last penetration (maximum of 24 hours total use). F-5 Gel is less irritating than other spermicides and may offer some protection against STDs. Four sponges cost about $9.

The paper thin film (VCF) is about the size of a large postage stamp; it must be inserted at least 5 minutes before intercourse but not more than 2 hours before. Fold it in half and push it up to the cervix with your finger. The film dissolves so does not have to be removed. Another film must be inserted for each act of intercourse.

Henri Robideau

Diaphragm and Jelly

The diaphragm is a rubber dome which is worn inside the vagina during sexual intercourse. A woman must see a doctor or a health care worker for a personal fitting.

The modern diaphragm, developed in the late 1800s, was widely used by the European upper classes. Much of what we know about it is based on tradition. Today it is popular because it has few side effects. Studies are still needed to refine its use (for example, how far in advance it can be inserted).

How it works

The diaphragm fits snugly in the vagina and prevents sperm from entering the cervix. It holds spermicidal jelly in place at the cervical opening. Sperm are killed or immobilized before they can enter the uterus. The diaphragm also prevents cervical mucus from reaching the vagina. Without this mucus, the acid secretions of the vagina kill the sperm.

Effectiveness

Used correctly all the time, the diaphragm is very effective **(94%)**. Pregnancy occurs when the diaphragm is not used each time a woman has intercourse or if it does not fit properly. Young women and those who have intercourse 3 times a week or more have higher failure rates.

Effect on the menstrual cycle

The diaphragm can be used during menstruation both for contraception and prevention of blood staining during intercourse, although a slight risk of Toxic Shock Syndrome may exist (p 19).

Effect on sexuality

The diaphragm must be inserted before vaginal penetration, so its use must become an integral part of a woman's sexual behaviour. You must think ahead about whether or not you will need it and be ready to interrupt unexpected sexual play to insert it. Sometimes you may be disappointed if you insert the diaphragm and end up not having sex.

Some women teach their lover to insert the diaphragm for them, and/or to verify that it is properly in place. Some women buy condoms and alternate methods.

During insertion some jelly remains on the vaginal lips. If this interferes with oral sex, you can wash after inserting the diaphragm.

Displacement of the diaphragm may be more common in positions with the woman on top or when the penis is withdrawn and reinserted repeatedly.

Effect on health

A few people are allergic to rubber or to the spermicide.

A diaphragm that is too large may press on the urethra, causing discomfort and difficulty urinating. Women who use the diaphragm sometimes get bladder infections which must be treated with antibiotics. A smaller diaphragm usually solves the problem.

A forgotten diaphragm causes a foul-smelling discharge, low back pain and general pelvic discomfort. Removing the diaphragm provides relief. You can douche if you wish afterwards. You should soak the diaphragm in alcohol for 15 minutes and rinse it afterwards. The diaphragm offers some protection from STDs and from precancerous changes of the cervix.

Effect on fertility

If you become pregnant while using the diaphragm, the fetus is not affected.

Diaphragm fitting

You must be fitted for a diaphragm by someone with experience. If your doctor does not fit diaphragms, ask to be referred.

A pelvic examination is done to evaluate the position of the uterus and cervix, the depth of the angle behind the pubic bone, and the vaginal muscle tone. Any major abnormality (such as prolapse or descent of the uterus, common in some women who have given birth) makes diaphragm use difficult. A sense of humour helps during the fitting since you and the counsellor will be trying and checking the rings many times.

The counsellor uses her fingers to estimate the length of the vagina which she compares with fitting rings of different sizes. The counsellor squeezes the ring and inserts it into the vagina. She checks that the front rim is snug behind the pubic bone and the back rim is beyond the cervix. The ring is removed, the next largest size is inserted and the fit is checked again. The largest size which is comfortable and does not slip out is chosen. It should be left in for 10 minutes and the fit rechecked before making a final choice.

You examine yourself so that you can recognize your cervix which feels like the tip of one's nose. You feel the ring in place and learn to remove it by hooking a finger around the front rim and pulling down and

out. To insert the ring, squeeze it with one hand, separate the vaginal lips with the other and slide it into the vagina. To check if it is in place, feel for your cervix. The counsellor then checks that you have inserted it properly.

You may find it easier to insert the diaphragm while squatting or standing with one foot raised on a chair. Remove the ring and reinsert it several times until you are confident that you can do it correctly. You may also try a plastic inserter which looks like a crochet hook with several notches. Stretch the diaphragm onto the inserter and put the inserter into the vagina with the diaphragm toward the cervix. Twist the inserter to release the diaphragm.

Three types of diaphragms are available. The **coil spring diaphragm** is prescribed to women with strong vaginal tone and no genital abnormality. The **flat spring diaphragm** is for women with a shallow pubic arch or moderate descent of bladder or rectum. The **arcing spring diaphragm** is for women with weak vaginal tone, moderate descent of the pelvic organs or with the uterus bent far forward or backward (anteversion or retroversion).

You receive a prescription, noting the type and size of diaphragm. Buy it and practice with it but do not depend on it for birth control. Go back a week later with the diaphragm in place to have its position checked again.

A tube of spermicidal jelly is sold with the diaphragm. Afterwards you need only buy the jelly.

Use

The diaphragm is used with spermicidal cream or jelly. Smear a tablespoon on the inside cup-like part. Insert the diaphragm as you did the fitting ring in the position most comfortable for you. Squeezing the diaphragm in one hand, spread your lips with the other and slide the diaphragm into the vagina. Use a finger to check that the cervix is covered.

Until recently, you needed to remove the diaphragm and apply more jelly if more than 2 hours went by after insertion. Some researchers suggest that the diaphragm can be inserted 6 hours or more ahead of time, which makes the diaphragm a more attractive method.

Diana Sherwood

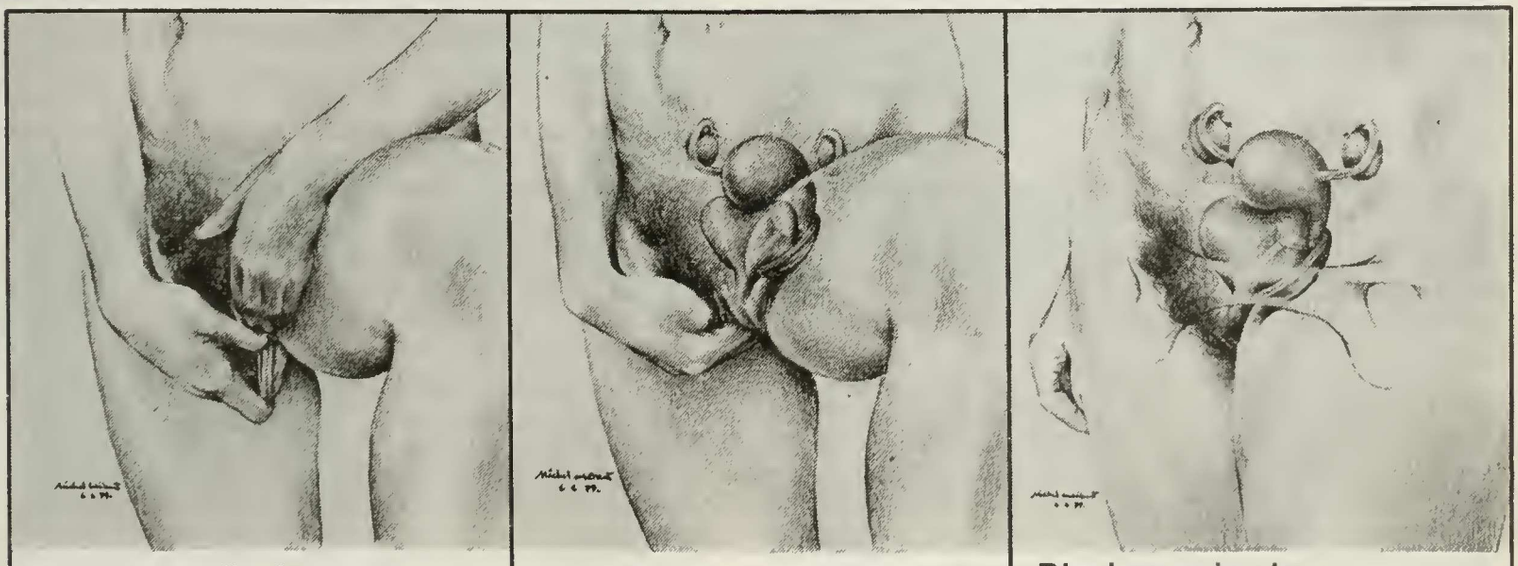
The diaphragm must be left in place for 6 hours after intercourse. Add an applicator of spermicide if you have sex again within 6 hours. Wait 6 hours after the last act of coitus before removing it.

If the diaphragm is properly placed, neither partner should be disturbed by its presence.

A diaphragm should not restrict your activity. After a bowel movement, check that the diaphragm has not been displaced.

When you remove the diaphragm, wash it with mild soap and water, pat dry, powder with cornstarch and keep in its container. Talcum powder must not be used because it destroys rubber. Before re-using, check it for cracks or holes by holding it up to the light or filling it with water.

You should be refitted for a diaphragm after giving birth, after abdominal or pelvic surgery, and after several years.



Inserting a diaphragm

Diaphragm in place

Henri Robideau

Cervical Cap

The cervical cap is a rubber device shaped like a thimble which fits snugly on the cervix. Used by European women at the turn of the century, the cervical cap has been revived by women's health centres. They imported the caps and pressured the government to approve their use.

How it works

The cervical cap fits over the cervix and blocks the entry of sperm into the cervical canal. There is still debate about whether spermicides are necessary to improve the cap's effectiveness or if, on the contrary, they interfere with the suction.

Effectiveness

In theory, the cervical cap is quite effective **(91-94%)**. Some failures are due to difficulties fitting the cap and lack of experience inserting it. Failure to use it each time lowers its effectiveness **(typical user = 82%)**. Failure rates are higher in women who have given birth.

Effect on the menstrual cycle

Caps are not used during menstruation because the flow interferes with the suction holding the cap in place. Also, there may be a slight risk of toxic shock syndrome (p.19).

Effect on sexuality

The cap interferes less with sexuality than the diaphragm or condom since it can be inserted many hours or even days before having sex. As little spermicide is used, it is cheaper, less messy and detracts less from oral sex. Male partners occasionally feel the cap during coitus.

Women who wear the cap for several days sometimes complain of unpleasant odour. This may be caused by the spermicide.

Effect on health

Early studies raised concerns about pre-cancerous changes of the cervix but recent research has not shown an increased risk. Nonetheless, you should have a normal Pap test (p.23) before using the cap and a second Pap test after 3 to 6 months of cap use.

The cap offers some protection from sexually transmitted diseases.

Effect on fertility

In case of failure, the fetus is not affected by use of the cervical cap.

Cap fitting

Many women's organizations have lists of clinics which offer cervical cap fittings. The description below is a summary and not a substitute for personalized instruction.

The examiner checks for problems which may interfere with use of the cap: very short or long cervix; abnormalities due to childbirth injuries, surgery or congenital defects; history of toxic shock syndrome; etc. Cysts on the sides of the cervix and genital infections may delay rather than prevent cap use.

Many women's groups encourage self-examination of the cervix as part of cap use; a woman can learn how to insert a speculum and to identify any problems that might interfere with the cap.

The cap most commonly used in North America is the Prentif Cavity-Rim Cervical Cap. It is shaped like a thimble and fits snugly over the cervix. Its rim is thick and firm but the deep dome is thin and supple; it is available in 4 sizes.

Several sizes of the cap are tried until the best fit is found. A good fit means the entire cervix is covered with little space between the inside of the rim and the cervix; the dome is facing the vaginal opening and

Lea's Shield®, a new barrier method, is a cup-shaped device made of soft, medical grade silicone. It creates suction, fitting snugly over the cervix like the cap but covering more surface like the diaphragm. A one-way valve allows secretions to flow out without letting sperm up. Since "one size fits all", a fitting is not needed; it is sold without prescription for about $60. Lea's shield appears to be effective (slightly less in women who have had children) but further studies are needed.

To use a Lea's Shield, line the inside of the cup with a small amount of spermicidal gel and add a bit on the valve. Squeeze the sides together and insert it, cup side up. You can insert it any time before penetration; you must leave it in place for 8 hours afterwards. It can be worn for up to 48 hours. To remove it, hook your finger on the loop and twist slightly before pulling down. Wash the device with soap and water. After about 6 months, it will discolour and should be replaced.

can be squeezed without pinching the cervix; and the cap does not slip off even when pulled on gently. With few cap sizes available, some women cannot get a proper fit.

Once a proper fit is found, practice inserting and removing the cap. The examiner verifies the fit and shows you how to do so. At home, practice putting on and taking off the cap. Use another birth control method the first 10 times you use it.

The fitting should be checked after birth, abortion or any surgery involving the cervix.

Checking cap's position

Use

The cap can be worn for up to 48 hours. This means you can insert it long before you have sex or have sex repeatedly without adding spermicide. If you insert it just before sex, you must wait at least a few minutes to permit an adequate seal to form.

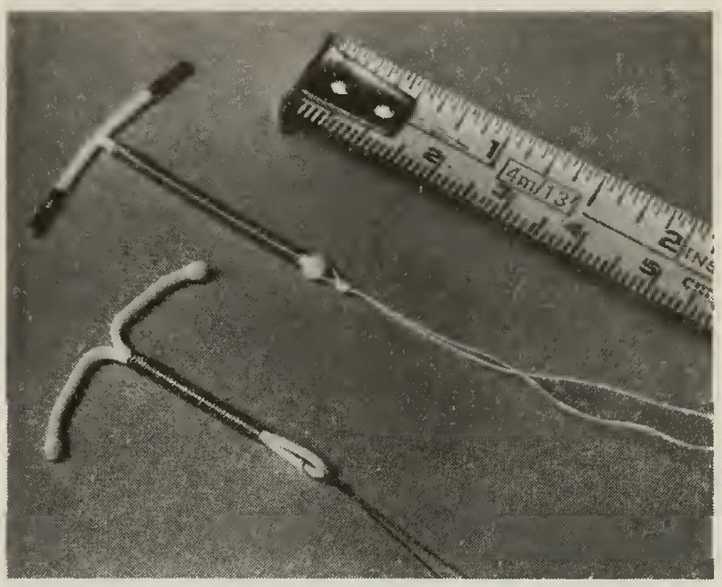
Fill the dome about 1/3 full of spermicidal jelly. Do not put any on the inside rim which could interfere with suction.

Find a comfortable position. With one hand, separate the vaginal lips. With the other squeeze the rim of the cap and insert it, rim first, along the back wall of the vagina as far as possible. Use 2 fingers to guide the cap onto the cervix. Run a finger along the rim to check that the cervix is covered. Squeeze the dome to increase the seal. Pull slightly to check the seal and push it up again. If the cap is not in position try to push it onto the cervix or remove it and start over.

After coitus, check that the cap is still in place. If dislodged, slip it back on and add an applicator of spermicidal cream or jelly (not foam or suppositories which contain chemicals that affect the cap). Always leave the cap in place for 8 hours after coitus.

To remove the cap, hook a finger over the edge to release the seal and pull it out upside down. Wash the cap with mild soap and water; a soft toothbrush is useful for removing secretions. Examine it for cracks or holes. Dry it well and dust it lightly with cornstarch.

If odour is a problem soak the cap in diluted lemon juice or in alcohol. Change it every 6 to 24 months.



Henri Robideau

Intra-uterine Device

An intra-uterine device (IUD) is an object inserted into the uterus to prevent pregnancy. Plastic IUDs were marketed in the late 1950s. Later, the addition of copper or the hormone, progesterone, increased effectiveness and reduced side effects.

The history of the IUD is one of hope, tragedy and conflict. At first, the IUD looked like a simple, safe method of birth control. Women appreciated not having to remember to take a pill or interrupting sex with other methods. But the high rate of pelvic inflammatory disease in IUD users created doubts. A crisis occurred when one brand, the Dalkon Shield, caused very high rates of infection, sterility and even death.

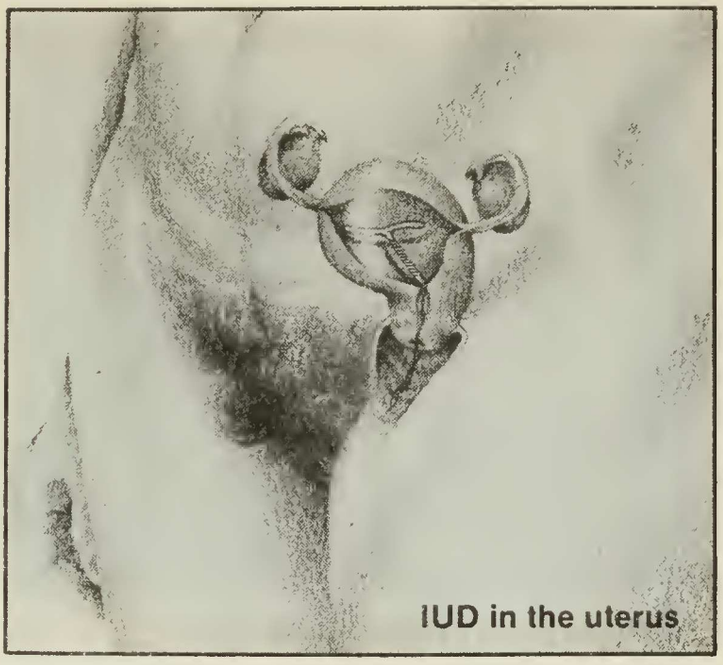
Public pressure and collective lawsuits forced the company to take the Dalkon Shield off the market and to pay compensation to women who suffered serious health problems. Other companies withdrew their IUD from the market to avoid law suits. American women were forced to leave the country to get an IUD (other than the Progestasert). In 1988 a new company began to market an IUD, but under conditions which protect it legally. These legal battles highlight the difficulties in developing safe reliable birth control.

The IUD is still the method of choice for many women around the world. With proper care, complications can be reduced.

How it works

No one knows exactly how the IUD prevents pregnancy. The IUD causes an inflammation of the lining of the uterus (endometrium). This may cause white blood cells to attack sperm or the fertilized egg, or prevent the egg from attaching itself in the uterus. The IUD speeds up the passage of the egg in the Fallopian tube, reducing the chances of fertilization.

The bigger an IUD is, the more effective, but the more likely it is to cause complications. When copper is added, effectiveness is increased (possibly by affecting chemicals in the lining of the uterus) so a smaller size can be used. A smaller size is also used when progesterone is added; it alters the mucus at the cervix, preventing sperm from entering the uterus.



IUD in the uterus

Effectiveness

In theory, IUDs are very effective **(about 99%)**; plastic IUDs are slightly less effective than those with copper or progesterone. In actual use, the effectiveness rate in the first year is almost the same **(98%)** since there is nothing to do or forget. The IUD is most effective in older women and women who have been pregnant.

Once inserted, the IUD works immediately. Most pregnancies occur during the first 3 to 6 months after insertion which is also when most spontaneous expulsions of the IUD occur.

Effect on the menstrual cycle

The IUD can cause a longer and heavier menstrual flow, often just for a few months following insertion. Extremely abundant, persistent bleeding, accompanied by cramps may be a sign that the IUD is not in the right position. If you have very heavy bleeding, you should have a blood test for anemia. The progesterone releasing IUD decreases menstrual flow.

Pain during menstruation often increases, especially in the first cycles. A heating pad or mild painkiller usually provides relief. If the pain is intolerable or occurs between periods, the device should be removed and tests done for infection.

The IUD can cause bleeding between periods. This spotting is often just a nuisance but may be a sign of infection. If spotting persists in an older woman, the IUD should be removed to rule out the possibility of cancer of the uterus.

Effect on sexuality

The IUD is particularly attractive to many women and men because it interferes so little with sexuality. It's always in place.

Some women feel a change in the rhythmic contractions of the uterus during orgasm. Sometimes a male partner can feel the IUD strings during intercourse. If the strings cannot be pushed out of the way, they can be cut shorter during an examination.

If pain occurs during penetration, you should be tested for infection. Sometimes scar tissue caused by infection continues to cause pain even after treatment and removal of the IUD.

Effect on health

Do not use an IUD if you have had: ectopic pregnancy, pelvic inflammatory disease, a positive test for the AIDS virus, undiagnosed abnormal bleeding or a malformation of the uterus.

Consider another method if you are under age 25, have intercourse with several partners, have untreated anemia, have never been pregnant, have severe cramps or very heavy bleeding during menstruation. Proper screening on this basis decreases the risk of serious side effects.

Perforation: During insertion, the IUD or the instrument used to measure the uterus may pierce the uterus. You may or may not feel pain if this happens, but the doctor will realize that the instrument has gone too far. IUD insertion should be delayed until the next menstrual cycle.

Rarely the IUD perforates the uterus later on. A plastic IUD which perforates usually causes no trouble. Copper IUDs must be removed from the abdomen because the copper reacts with the internal organs. The IUD is removed by laparoscopy (p 49) or abdominal surgery.

Pelvic Inflammatory Disease (P.I.D.): Infection is the most serious side effect of the IUD and occurs more often in women who are young, have several partners and have never been pregnant. It happens most often in the months following insertion.

The uterus and Fallopian tubes become infected (called endometritis and salpingitis). Symptoms may be vague: abdominal or low back pain, irregular bleeding, low fever, vaginal discharge or a general feeling of ill health. Early treatment with antibiotics and IUD removal are important. Many cases require hospitalization so that antibiotics can be given intravenously. Rarely, removal of one or both tubes and even the uterus may be necessary. Death from infection has occurred in 1 out of 100,000 IUD users.

Ectopic pregnancy: This is a pregnancy outside the uterus, for example, inside a Fallopian tube or on the ovary. Surgery to remove the embryo is always necessary since severe internal bleeding can occur. The IUD itself does not appear to cause ectopic pregnancy (nor does it prevent it). However infection of the tubes related to IUD use does increase the risk of ectopic pregnancy even after the IUD is removed.

Infection in pregnancy: Infection is possible if the IUD is left in the uterus during pregnancy.

Effect on fertility

Method failure: If you become pregnant with an IUD, you should be examined to rule out ectopic pregnancy. Have the IUD removed to prevent infection. If you continue the pregnancy, the chance of miscarriage is slightly less if the IUD is removed. The IUD does not cause fetal malformations.

Stopping the method: To become pregnant, have the IUD removed by a doctor, preferably during your period. There is no reason to delay conception. Past use of an IUD will not affect the fetus.

Past IUD users should be alert to the risk of ectopic pregnancy. Because of its association with infection, infertility caused by blocked tubes is higher in past

IUD users. This is true even in women who never had symptoms of PID.

Use

Before insertion: When you consider using an IUD you should have a pre-insertion check-up to learn more about it and whether there is any reason why you should not use it. A pelvic examination ensures that your reproductive organs are normal. Tests should be done for gonorrhea and chlamydia.

The IUD can be inserted at any time in your cycle, as long as you are sure you are not pregnant. Some studies suggest that insertion may be less painful in the first half of the cycle.

An IUD can be inserted immediately after an abortion by aspiration and 6 weeks after a vaginal delivery. If you had stitches you may still be too tender for an IUD insertion. After birth by cesarean, you should wait 3 months.

Choosing an IUD: The most important factor in choosing a brand is the doctor's experience with inserting it. Plastic IUDs come in different sizes and can be left in place for at least 5 years. They are no longer available in North America. Copper IUDs, also made of plastic but with a wire or band of copper partially covering them, must be changed every 8-10 years. The Progestasert which releases progesterone is expensive and must be changed yearly. The LNg IUD which releases progesterone for 5 years should be marketed soon. Progesterone IUDs reduce menstrual flow.

IUD insertion: Some women have greater discomfort during and after an IUD insertion than others. You might feel like taking off the rest of the day and having someone accompany you home.

You undress and position yourself on the examining table. A pelvic examination confirms the position of the uterus. A speculum is put in the vagina exposing the cervix which is washed with an antiseptic solution.

Local anesthesia (freezing) can be used. Freezing prolongs the procedure and increases its risks (for example, possible allergy to anesthetic). However if the cervix is tight, freezing is useful. Anesthetic is injected into the cervix and takes effect in a few minutes. Freezing does little to relieve the cramps once the IUD is in place. Fear and tension increase the pain; freezing is no substitute for reassurance and patience. Tell someone if you feel faint.

The doctor steadies the cervix with a clamp. To measure the uterus, a long thin instrument is passed through the cervical canal to the top of the uterus and then removed. This often causes cramping.

The doctor loads the IUD into its inserter which is passed into the uterus. A plunger mechanism releases the IUD within the uterus. The inserter is removed leaving the IUD in place with the attached strings coming out the cervical opening. The strings are trimmed to about 2 inches long and the speculum is removed. Afterwards, you put on a sanitary pad and relax on the table until you feel ready to get up.

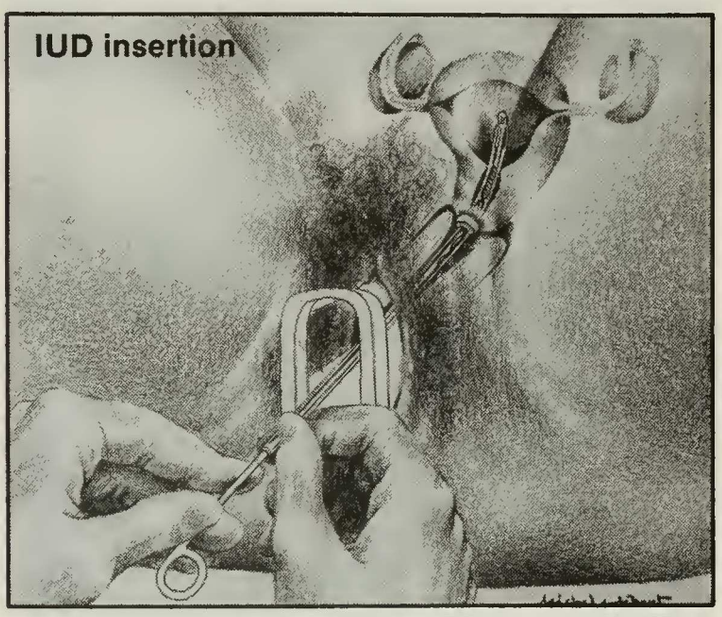
Post insertion instructions: Expect some cramps which will diminish gradually; they can be relieved with anti-inflammatory drugs such as aspirin or acetaminophen (Tylenol, Tempra, etc). If you have severe pain and/or fever, contact the clinic.

Your periods may be heavier and longer. To replace the iron lost, your diet should be adequate in iron and vitamin C.

Once a week, put your finger into your vagina to check for the IUD strings. If you feel something hard, the IUD is no longer in place and should be removed. If you can't find the strings, return to the clinic.

Since most IUD failures occur in the first 3 cycles, some women use a second method (for example, foam) during this time. If you already are on the Pill you can continue it for several cycles both for its contraceptive effect and to counteract the heavy periods of the IUD.

You should have a follow-up examination within 3 months.



Follow-up: Tell the health worker about your experience with the IUD. Mention any change in your periods, any pain during intercourse, and if you can find the strings. A pelvic examination verifies the position of the IUD. You need not return for one year unless there is a problem.

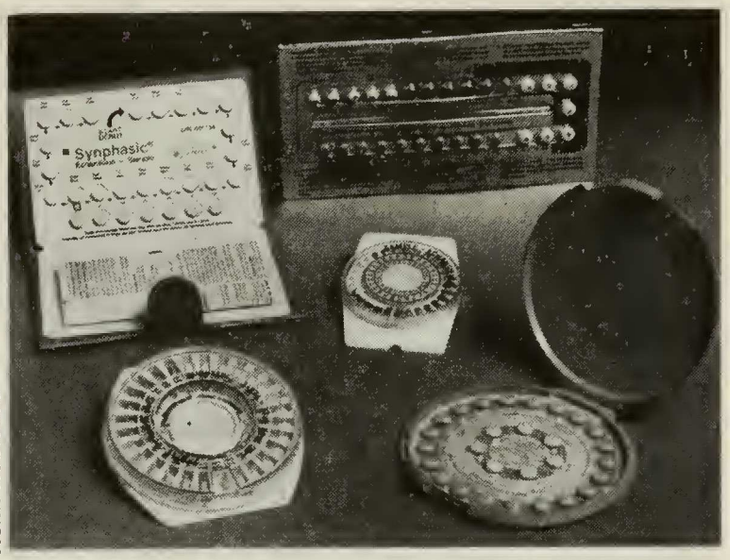
If you miss your period while using an IUD, have a pregnancy test. If the test is negative, repeat it in 1 week. If you are pregnant, the IUD must be removed. If you miss 2 periods, consult the clinic.

If you and your doctor cannot find the strings, an X-ray or ultrasound test will show where the IUD is. If it is proplerly placed in the uterus, it is still effective. When you are ready to remove it, special forceps are used to reach it.

Pelvic infection is usually accompanied by abdominal or low back pain, vaginal discharge, irregular bleeding and slight fever. A woman with these symptoms should see a doctor quickly. It is hard to distinguish between a badly placed IUD and a serious infection. The IUD should be removed after antibiotics are begun. Regular visits are necessary to evaluate the treatment.

Removal: An IUD may be removed at any time. If an IUD is removed at mid-cycle, pregnancy from a recent coitus could still occur.

IUD removal is quicker and less painful than insertion. The doctor uses a clamp to pull on the strings along the axis of the cervical canal. Rarely the doctor must probe into the uterus to find the IUD itself. If you still want to use an IUD, another can be inserted immediately.



Henri Robideau

The Pill

The Pill is the first method to approach 100% effectiveness, a turning point in modern contraception. Its development coincided with major social changes as women began to make educational and political advances and to challenge restrictive sexual standards. Doing so without fear of pregnancy was liberating.

Disillusionment with the Pill began as women experienced side effects. Though no other medication has been so thoroughly investigated, debate on the safety of the Pill continues.

How it works

The birth control pill is made up of synthetic estrogen and progesterone, the same hormones which control the menstrual cycle. Hormones in the Pill block the natural ones and prevent release of an egg (ovulation). If no egg is available, pregnancy cannot occur. As well, progesterone changes the mucus of the cervix, making it more difficult for sperm to get through. The lining of the uterus becomes less prepared to receive a fertilized egg.

Effectiveness

The Pill's effectiveness rate is very high **(best use = 99.65%)**. However in the first year of use, the typical effectiveness rate is about **97%** (about **95%** for women under 22). Pregnancy is more likely if you forget pills containing less than 30 mcg of estrogen such as Minestrin 1/20 (Loestrin 1/20).

The effectiveness of the Pill is reduced by certain drugs: barbiturates, Rifampicin (used to treat tuberculosis) and Dilantin (for epilepsy). Ampicillin, tetracycline, griseofulvin, certain anti-histamines and certain tranquilizers may also have a similar effect.

After one year of use, more than 25% of women stop using the Pill. Many become accidentally pregnant before using another method.

If you do get pregnant despite *perfect* use of the Pill, and want to continue using it for contraception, use a stronger brand (MinOvral, Norinyl, Ovcon 50, Ortho-Novum 1/50) or reduce to 5 (from 7) the number of days when you don't take a pill.

Effect on the menstrual cycle

The Pill replaces the hormonal pattern of the menstrual cycle with a steady level of both estrogen and progesterone. Ovulation does not occur. Hormones are taken for 3 weeks and stopped for one. The drop in hormones in the 4th week causes menstruation which is usually lighter, shorter and with fewer cramps.

The Pill gives you a very regular menstrual cycle so you can accurately predict when your period will start. If you want to change the day your period starts, you can stop before the end of the package or add a few pills at the end. You should not delay beginning a new package.

Spotting: Sometimes a woman has spotting or breakthrough bleeding between periods. Spotting early in the cycle is due to a lack of estrogen; later on, it is due to lack of progesterone. Spotting can be a nuisance but it does not mean that the Pill is not working.

Spotting often occurs when you first start using the Pill; it usually stops without treatment. Women who smoke cigarettes are more likely to continue spotting than those who don't. If spotting doesn't stop, your doctor will suggest changing brands to one with more progesterone or give you additional estrogen until it does stop .

If spotting occurs when you have been on the Pill for a long time, see a doctor to check for other causes such as an STD.

Premenstrual tension: Women who experience premenstrual tension (irritability and/or depression accompanied by bloating just before or during menstruation) sometimes get relief with the Pill.

Missed periods: Some women get no periods while on the Pill. This is not dangerous but leaves you in doubt about a possible pregnancy. If you miss more than one period you should have a pregnancy test. If you miss 3 periods, consult a doctor.

Some women do not get any periods for several months after stopping the Pill. Take a pregnancy test and use contraception if you do not want to be pregnant. If you still don't have periods after 6 months, see a doctor.

Effect on sexuality

The Pill permits a woman to have sexual intercourse at any time in the cycle without fear of pregnancy. Some women find this great freedom; others feel they have lost an excuse to say no. Some women who take the Pill when their sex life is slow resent the risks they are taking for so little benefit.

Whether the Pill alters a woman's sexual desire and experience is not clear. Some women may experience a very gradual change in desire. If you suspect this, you can change brands or stop the Pill to see whether you notice a change.

Effect on health

The safety of the Pill is controversial. While some would distribute the Pill in coin machines, others want to take it off the market. The Pill can cause serious

illness and death as well as inconvenience and discomfort. We still do not know all its longterm effects.

Important health benefits of the Pill include decreases in anemia (from less menstrual bleeding), pelvic inflammatory disease and cancer of the uterus and ovaries. The Pill helps problems such as cysts of the breasts or ovaries, acne, irregular bleeding and endometriosis.

The most serious problems caused by the Pill occur while you are using it. Length of time on the Pill affects some complications but not all. With several exceptions, these risks do not continue once you stop the Pill. Serious complications can be decreased by better screening of women who take the Pill.

The following description of side effects, like the one which comes with each package, is a reference guide to the difficulties a woman can experience on the Pill. Its purpose is not to frighten you, but to help you make choices and to alert you to possible danger signs.

Much research on the Pill was done with higher doses than are used today. The risks today appear to be less.

Blood vessel and blood clotting problems These serious diseases, normally uncommon in women of reproductive age, occur 3 times more often in high dose Pill users. These include: blood clots in the leg or pelvis; pulmonary embolism (the blood clot breaks up and floats to the lungs); heart attack or stroke (blocked or bleeding artery in the brain). The risk of circulatory disease appears much less with low dose pills, though they have not been on the market long enough to know their long-term effects.

Age, smoking, high blood pressure, obesity, diabetes and high cholesterol increase the risk of blood vessel and blood clotting problems much more than the Pill does.

Women should probably not use the Pill if they have had any complications of circulatory disease (blood clot, angina, stroke, kidney failure) or if they are over 35 and smoke or have high blood pressure.

Women who have sickle cell anemia, heart valve problems or a strong family history of circulatory disease may use the Pill but require regular evaluation.

Migraines: Migraines are intense headaches caused by spasms of blood vessels. A woman who has migraines can use the Pill, unless the headaches worsen. Women who begin migraines on the Pill should probably stop, particularly if other symptoms such as visual changes occur.

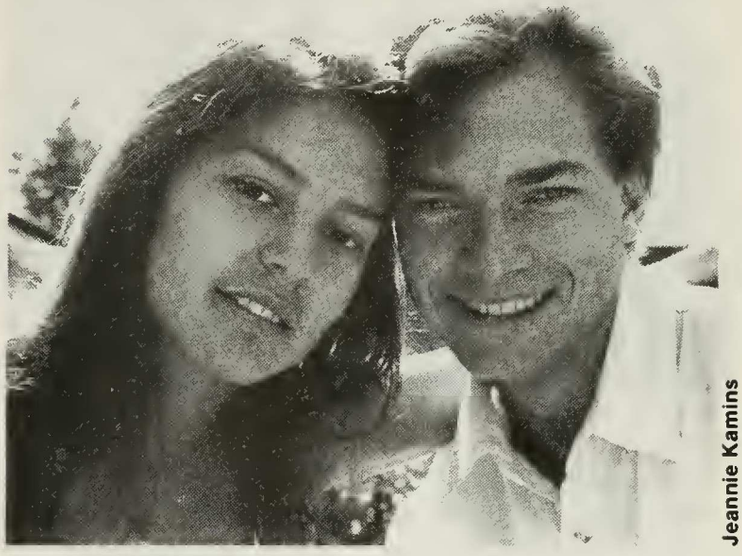
High blood pressure: Blood pressure does not seem to be affected in women using low-dose Pills. Rarely, the Pill increases a woman's blood pressure dramatically and must be stopped immediately. If blood pressure increases moderately, it should be monitored closely. The Pill should be stopped if blood pressure is not satisfactorily lowered after 3 cycles. Young women treated for high blood pressure can use the Pill.

Cancer: Since female hormones make certain tumours grow faster, anyone with a known or suspected cancer should not take the Pill.

Depending on the kind of cancer, the Pill appears to increase or decrease the risk. Most studies on **breast cancer** do not show an increased risk for women taking the Pill. However, girls who start the Pill in adolescence, before their first pregnancy, probably have a slightly increased risk of developing breast cancer before menopause, especially if they stay on the Pill for many years.

Risk of **cancer of the cervix** increases with early sexual experience and with the number of sexual partners. This makes it difficult to determine the role of the Pill which may increase the growth of precancerous cells on the cervix.

The Pill decreases by half the risk of **cancer of the ovaries and of the endometrium.** This benefit lasts many years after stopping the Pill.



Jeannie Kamins

Benign breast disease: Breast size increases temporarily in some women taking the Pill. Many women who already have tender or lumpy breasts feel better; others feel worse. The Pill can cause a milk-like discharge; report this to a doctor to be sure there is no other more serious cause.

Breast-feeding: The Pill should only be used during breast-feeding when other options are not possible. Very little hormone is passed in the milk and babies do not seem affected. However, you may produce less milk so breast-feeding should be going well before starting the Pill.

Liver and gall bladder disease: The Pill causes a slightly increased risk of a rare but benign liver tumour. If the tumour grows very large or bleeds, surgery may be necessary.

Women who have liver damage should not take the Pill. Those who have had liver disease should wait at least 6 months after their liver tests become normal before starting the Pill.

Women on the Pill have an increased risk of gall bladder disease which could require surgery.

Diabetes: The Pill does not cause diabetes. Because both the Pill and diabetes are linked to circulatory disease, diabetic women should either not use the Pill or be closely monitored. Use of the Pill may change insulin needs.

The Pill changes the results of a glucose tolerance test (for diabetes) which return to normal when the Pill is stopped. If a woman has had diabetes of pregnancy or has a family history of diabetes, she

Jeannie Kamins

should probably use a pill with a weak progesterone and have her sugar monitored.

Depression: The Pill can cause depression, irritability and fatigue in some women. These symptoms may be related to fluid retention or to decreased vitamin B6. It is not clear if treatment with vitamins is successful. Sometimes changing to a Pill with less progesterone relieves the depression. Depression comes on gradually so that some women only become aware of the problem when they stop the Pill and feel better.

Puberty: If a girl has had periods for 6 months, the Pill will not affect her growth. Even for younger girls, risks associated with pregnancy are greater than the risks of the Pill.

Nutrition: The Pill alters the absorption of certain nutrients. If you have an adequate diet, you do not need supplements.

Interaction with other drugs: The Pill decreases the effect of anti-clotting drugs, pain-killers and certain blood pressure drugs. It may increase the effects of theophylline, alcohol and some anti-depressants. Sedatives such as valium may have more or less effect.

Lab tests: Many laboratory tests (for example tests for thyroid disease and tuberculosis) are altered by the Pill.

Signs of serious complications

Seek immediate medical attention if you have these symptoms:

- **pain in the leg, abdomen or chest**
- **shortness of breath**
- **severe or unusual headaches**
- **changes in vision**

Water retention: Water retention can cause the following symptoms: nausea, leg cramps, bloating, headaches, changes in vision, changes in the fit of contact lenses, irritability and breast tenderness. If these symptoms do not decrease after 3 packages, change brands.

Skin changes: Darkening of the skin around the eyes and mouth is due to estrogen. Women who have had these changes during pregnancy are likely to have them on the Pill. If they occur, stop the Pill or try a weaker brand as these changes are not always reversible.

Acne, oily hair and skin and increased hairiness can occur; changing to a weaker progesterone sometimes solves the problem.

Weight gain: Bloating at the same time each cycle is due to water retention. Greater appetite and weight gain occur in a few women and may be controlled by switching to a pill with a weaker progesterone.

Vagina and cervix: Estrogen may increase normal vaginal discharge. The Pill changes the place where the tall cells inside the cervix meet the flat cells on the outside. This change is visible with a speculum and needs no treatment. Repeated yeast infection of the vagina may be caused by excess progesterone.

The Mini-pill

The mini-pill (Micronor, Ovrette, Nor-Q.D.) contains only the hormone progesterone. Developed to avoid the side effects of estrogen, it does not always block ovulation and is slightly less effective than the combined pill. Pregnancy is prevented by changing the cervical mucus so that sperm cannot get through. Transport of the egg in the Fallopian tube is also affected.

Take one tablet each day without stopping at the end of a package. Forgetting a pill increases the risk of pregnancy more than with the combined pill.

Irregular bleeding, a common problem, is more a nuisance than a danger. Some studies suggest that the mini-pill increases the risk of ectopic pregnancy (pregnancy outside the uterus).

Breast-feeding women can use the mini-pill since it has less effect on breast milk.

Effect on fertility

Method failure: If you become pregnant while taking the Pill, the risk of serious fetal malformation is extremely small.

Stopping the Pill: When you want to have a baby, stop the Pill at the end of a package. Wait until you have had at least one period without the pill to help you calculate the dates of your pregnancy.

The Pill does not reduce fertility. Sometimes it takes a few months for regular cycles to be reestablished after stopping. After 6 months more than 97% of Pill users have regular cycles.

Use

When you decide to use the Pill, see a doctor to get a prescription. The doctor asks specific questions to rule out factors which may make the Pill unsafe for you or that require closer supervision.

You should have a physical examination which includes: weight, blood pressure, breast examination, listening to the heart, feeling the abdomen for lumps or tenderness, and a gynecological examination. A

Kinds of Pills

All "combined" pills contain both estrogen and progesterone. In some brands, all 21 pills are the same colour and contain the same amount of hormone. Other brands have pills of 2 or 3 different colours, each colour containing different amounts of hormone (see chart). This should not be confused with the sugar pills in 28 day packages which have no hormones but help you remember to take a Pill each day.

There is very little difference between most low-dose brands. Several different progesterones are used, some stronger than others. Progesterones also have estrogen-like effects and androgen-like (male) effects. These differences are used to reduce certain side effects.

Some pill packages are confusing or difficult to handle. Make sure you feel comfortable with the package.

Many side effects such as nausea and spotting go away after the first few months of use. Try to wait at least 3 cycles before changing brands.

blood test for cholesterol should be done. Black women should be tested for sickle cell anemia. Additional tests for glucose tolerance and liver function may be suggested.

Starting the Pill: Depending on your brand, the Pill is started differently. Always wait for your period.

Some brands start on the 5th day of your period (whether or not you are still bleeding). Others start on the Sunday following the beginning of your period (the same day if your period starts on Sunday). Still others start the day your period begins.

Take one pill each day, at about the same hour. If your package contains 21 pills, stop for 7 days after the last one. You begin your new package the same day of the week as you began the first one. You should get your period during the week without the Pill. Repeat the pattern of "21 days on, 7 days off".

With 28 day packages, take a pill every day. When you finish one package, start another the next day. You will get your period while you take the «sugar» pills (without hormones). Make sure you know which ones they are.

You are protected from pregnancy as soon as you begin the first package (unless you forget to take one or more pills). Since forgetting is common during the first cycle, use another method as well.

After giving birth, wait 2 to 3 weeks to start the Pill because of the risk of blood clots. After an abortion or miscarriage, the Pill may be started immediately.

If you forget a pill, take it as soon as you remember, even if that means taking two pills in one day. The chance of pregnancy is still very small. Don't take more than 2 pills a day. The risk increases if you forget more than one pill in a cycle. Use a second method of birth control until the end of that cycle.

If you forget three or more pills in a row, throw out the package and start a new one. Use a second method for the first week. If you don't get your period when you finish the new pack, or if it is very light, take a pregnancy test.

Taking the Pill with a meal or just before going to bed lessens nausea. If you have repeated vomiting or diarrhea for more than one day, continue the Pill but use a second method for the rest of the cycle.

The PIII should be stopped one month before major surgery to avoid circulatory complications.

Follow-up: Return to the same doctor or clinic within 3 to 6 months to review your experience with the Pill. Your blood pressure is taken, as well as any other examination your symptoms might indicate. If everything is normal, you need not return for 6 to 12 months when a complete examination should be repeated. There is no need to stop the Pill for a «rest».

People at risk for complications linked with the Pill should return to the clinic more frequently.

Common Brands of the Pill

Name	Estrogen/ethinyl estradiol (mcg)	Progesterone (mg)
Demulen 30	30	Ethynodiol diacetate 2.0
Loestrin 1.5/30	30	Norethindrone acetate 1.5
MinEstrin 1/20	20	Norenthindrone acetate 1.0
MinOvral, Nordette, Levlen	30	Levo-norgestrel 0.15
Lo/Ovral	30	Norgestrel 0.3
Brevicon .5/35, Ortho-Novum .5/35, Modicon	35	Norethindrone 0.5
Ortho-Novum 1/35, Brevicon 1/35, Norinyl 1/35, Genora 1/35, N.E.E. 1/35	35	Norethindrone 1.0
Ovcon 35	35	Norethindrone 0.4
Cyclen, Ortho-Cyclen	35	Norgestimate 0.25
OrthoCept, Marvelon, Desogest	30	Desogestrel 0.15
Ortho-Novum 10/11	35	Norethindrone 0.5 x 10 days, 1.0 x 11 days
Ortho-Novum 7/7/7	35	Norethindrone 0.5 x 7 days, 0.75 x 7 days, 1.0 x 7 days
Tri-Norinyl, Synphasic	35	Norethindrone 0.5 x 7 days, 1.0 x 9 days, 0.5 x 5 days
Triphasil, Triquilar, Tri-Levlen	30 x 6 days, 40 x 5 days, 30 x 10 days	levo-norgestrel 0.05 x 6 days, 0.075 x 5 days, 0.125 x 10 days
Ortho Tri-Cyclen	35	Norgestimate 0.18 x 7 days, 0.215 x 7 days, 0.25 x7 days

Bertrand Carrière

The "Morning After" Pill

Post-coital methods—birth control used after unprotected intercourse—are usually promoted as emergency measures (when a condom breaks or women are raped). They offer an alternative for women who don't have sex with penetration very often, although they do not offer any protection from STDs.

Ovral, one of the stronger birth control pills, is used most often. Danazol (Cyclomen), a hormone used to block menstruation in women with endometriosis, causes less nausea than Ovral. The anti-progesterone RU 486 (known as the "abortion pill") is also effective as a post-coital method but is not yet available in North America.

Resistance to post-coital methods comes from those who think it encourages irresponsible sex or those who compare it morally to abortion. In fact, a request for emergency birth control is often the first step toward responsible contraceptive behaviour. In an attempt to reduce teenage pregnancies, certain schools permit nurses to give the morning after pill to students.

How it works

The "morning after" pill blocks the release of progesterone and affects the lining of the uterus. Even if an egg is fertilized, it won't be able to implant in the uterus. Taken early in the cycle, it may prevent ovulation.

Doug Aucoin

The "morning after" pill will not abort a pregnancy from an earlier sexual experience nor will it prevent pregnancy later on in the cycle.

Effectiveness

Ovral used as a morning after pill is **98%** effective. Its effectiveness decreases the longer the delay; little is known about it use after 72 hours. Its effectiveness also decreases if it is used repeatedly in one cycle.

Effect on the menstrual cycle

The "morning after" pill can make your period come earlier or later. The following menstrual cycle should be normal.

Effect on sexuality

Postcoital contraception permits a woman to engage in an unexpected sexual encounter with less risk of pregnancy. It offers back-up protection when there are problems with other methods.

The IUD as a Post-coital Method

Inserting an IUD within a week of unprotected intercourse also prevents pregnancy. It is an alternative to the "morning after" pill if more than 72 hours has passed and if you want to continue using the IUD afterwards. See page 33 for further information on IUDs

Effect on health

Ovral in high doses can cause mild to severe nausea and repeated vomiting. Women who have conditions which prevent them from taking the Pill (p. 36) regularly may still be candidates for the morning after pill. Women with porphoryia or who are breast feeding should not use Danazol.

Effect on fertility

If Ovral fails, the fetus will be not be affected. If you have taken the "morning after" pill and decide you want to get pregnant, wait until you have a regular period before trying to conceive. It will be easier to calculate when the baby is due. Danazol may be more likely to affect the fetus, particularly if you are already pregnant when you take it.

Use

Take the "morning after" pill as soon as is reasonably possible after unprotected intercourse. You do not need to run to the emergency in the middle of the night; the next day will do. Some doctors will give a prescription by phone to a regular patient. If you have not had a check-up for a long time, check with a doctor to see if you can take this dose safely.

Take 2 tablets of Ovral right away and two tablets 12 hours later. If you vomit within an hour or so after taking them, take 2 more. If you are easily nauseated, use an anti-nausea drug such as Gravol at the same time.

Danazol (400mg-600mg) is taken the same way: the first dose as soon as possible and the second 12 hours later. Some studies added a third dose 12 hours later.

Use another method such as the condom until you get your period. Take some time to think about whether your birth control method is still the best choice for you.

If you do not get your period within 3 weeks, have a pregnancy test.

Long-acting Hormones
Injections & Implants

These methods rely on the release of small amounts of the hormone progesterone into the blood for months or years. The mucus of the cervix and the lining of the uterus are changed, making pregnancy unlikely. Often, ovulation is blocked. Hormones are given by injection or with implants (capsules placed under the skin). Hormone-releasing rings placed in the vagina are also under study.

Women requesting this method need very effective birth control; some can't take estrogen, often forget the Pill or want to hide their method. Women using long-acting hormones who are at risk for STDs need to use other protection.

Groups concerned with overpopulation promote long-acting methods because they are cost-effective: few medical visits are required; nothing can be forgotten or taken incorrectly. If a woman has side effects, she must either wait until the hormone runs out or find a doctor to remove the implant. The potential for abuse is great; U.S. judges have ordered women guilty of child abuse to use Norplant. Women in many countries have had doctors refuse to remove the implants.

Depo-Provera

Depo-Provera, a long-acting progesterone (medroxy-progesterone acetate), is taken by injection. Although it has been used around the world for many years, it was approved for contraception in the USA only in 1992. Since then, its use has increased in Canada, even though it has not been approved.

Effectiveness Depo-Provera is more than **99.5%** effective if taken on schedule.

Effect on the menstrual cycle Most women using this method have irregular menstrual cycles: they can have breakthrough bleeding or no periods at all. This can continue for 6-9 months after the last shot. Irregular bleeding is the main reason women give up this method.

Effect on health Common side effects include breast tenderness and weight gain. Depression can also occur. There is some concern about possible effects on bone density—that it could make women more vulnerable to osteoporosis later in life. The link with breast cancer is controversial: it may speed the growth of tumors, increasing the incidence in younger women but not increasing lifetime risk. Depo-Provera reduces the risk of cancer of the uterus and ovaries. Although reports of mild allergic reactions have increased, severe reactions are rare.

Effect on fertility If Depo-Provera fails, the baby is more likely to weigh less at birth but is not at greater risk for malformations. Fertility is often delayed 6 months or more after the last injection. Within 2 years, 90% of ex-users will conceive. Depo-Provera can be used during breast-feeding, preferably after 6 weeks.

Use After a health evaluation, you must wait until your period to get your first shot. The same dose (150 mg) is repeated every 3 months. You should have a chance to discuss how you feel with this method. If you are more than a week late for your shot and have not had a period, you should have a pregnancy test first.

Linda Rutenberg

Norplant

Implants are small capsules filled with hormones which are placed under the skin. The capsules release hormones very slowly. Norplant, the brand of implant marketed in North America, releases the progesterone, levonorgestrel for 5 years. Women using it have about half the hormone level in the blood as those using the Pill.

Effectiveness Norplant is highly effective (**more than 99.5%** in the first year, slightly lower afterwards); it is slightly less effective in women weighing more than 154 lb. Anti-seizure drugs and rifampicin reduce effectiveness; women using these drugs should probably use a different method.

Effect on the menstrual cycle Norplant can cause irregular periods and a heavier or lighter flow.

Effect on health. Headaches, breast tenderness, weight gain, nervousness, acne or hair loss can occur. Irritation, infection and scarring of the skin may occur after insertion or removal; in the USA, consumers have begun a class action suit dealing with problems with implant removal. One death occurred when a general anaesthetic was used for removing the implants.

Effect on fertility There is no delay in the return of fertility once the capsules are removed. Norplant can be used during breast-feeding, preferably after 6 weeks.

Use You have to find a doctor experienced at inserting and removing Norplant. Ask about whether the fee includes both insertion and removal. To ensure you are not pregnant, Norplant should be inserted during or just after your period. Six capsules are inserted under the skin of the inner arm about 3 inches above the elbow. The skin is frozen and a tiny cut made. The capsules are passed through the opening and placed side by side (like a fan) under the skin. Keep a dressing on while the cut heals. Local anaesthetic is also used for removal which may be difficult because of scar tissue. General anaesthetic, which carries greater health risks, should rarely be necessary.

Abortion

Abortion, the voluntary interruption of pregnancy has been part of women's experience in most cultures throughout history.

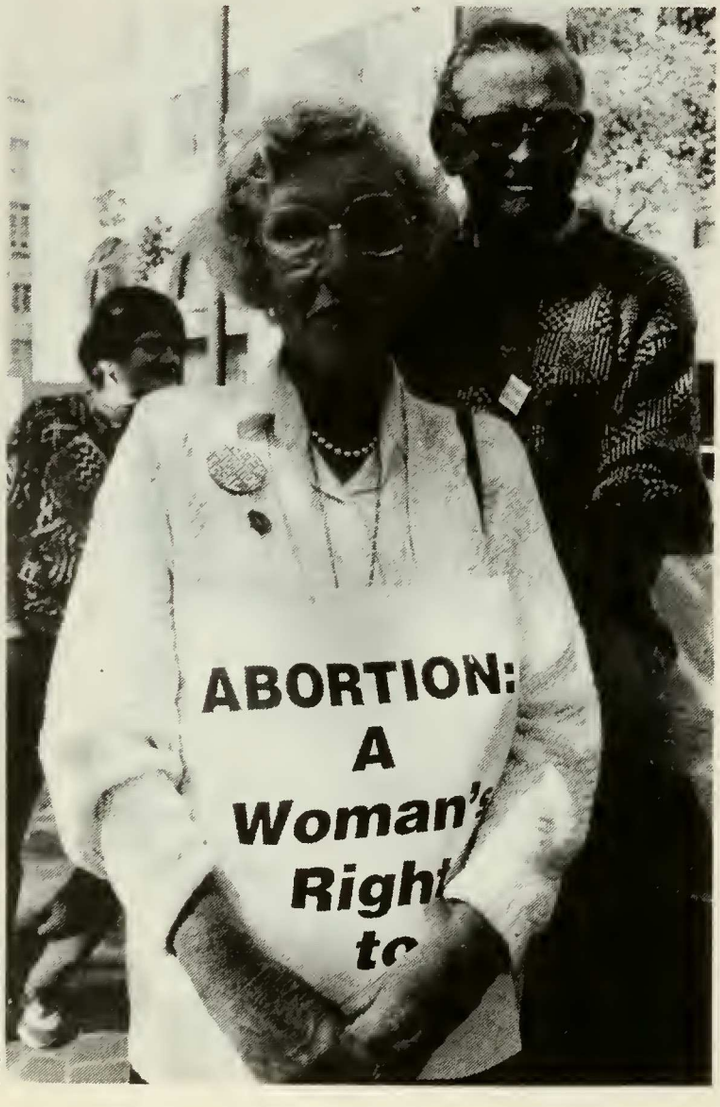
During the past 25 years, the legal status of abortion around the world has changed. In some countries, the right to decide when to have a child is the result of women's struggles to control their lives. In others, access to safe, legal abortion is a result of economic and population problems.

Still today, over 100,000 women die each year from complications of illegal abortions. Others survive with permanent damage to their health, their fertility and their dignity.

In the past decade, groups opposed to reproductive choice have succeeded in limiting women's access to safe abortion services even in Western democracies.

Reproductive choices

Most North Americans believe that a woman should have the right to decide whether or not to have an abortion. Even so, reproductive issues create controversy and conflict.



Piera Palucci

For religious or moral reasons, some women choose to accept an unwanted pregnancy rather than have an abortion under any circumstances. This personal decision must be respected. Many of these women feel that abortion is a trap for women—that it further diminishes the value of parenting in a society where money is more important than people.

A small but vocal group of people opposes abortion not only for themselves but for everyone. They impose their moral and religious beliefs on women who do not share them. This is profoundly anti-democratic.

Though anti-choice groups claim to be defenders of life, many ignore the suffering of women who undergo butcher abortions and the plight of children deprived of basic material and spiritual welfare.

Anti-choice groups defend a traditional world view. They see abortion as part of a sexual permissiveness which they oppose. They often oppose premarital sex, alternative family structures, equality among women and men and try to impose these views on others.

Many of their tactics are dishonest and violent. They advertise fake abortion counselling services and frighten those who call with lies about the risks of abortion. They intimidate and harass clients and staff of abortion clinics.

Pro-choice groups are part of a larger movement concerned with sexual and reproductive freedom. Though no less in awe of human conception, pro-choice people are more concerned about the quality of life after birth. Sexuality need not be limited to the times when people wish to have a child, and birth control is not perfect. Parenting is too great a responsibility to be undertaken unwillingly.

The rights of individuals to make decisions about sexuality and reproduction are central to the pro-choice position. Many prochoice activists would not choose abortion themselves but recognize the need to make abortion available for those who would.

Creating better conditions for parenting—quality prenatal care, paid maternity leave, subsidized day-care, job sharing, etc—is another objective of those concerned with reproductive freedom. Often women have an abortion for economic reasons; under different circumstances many would choose otherwise.

Should there be abortion laws?

Most abortion laws limit access to abortion. They control which women can have them, for what reasons, at what stage in pregnancy and who can perform them. Laws also specify punishment for those who do not conform.

When governments make abortion laws they define women's reproductive choices. They imply that women are too immoral, too selfish, too emotional, too vulnerable to decide wisely for themselves. Yet women who carry the pregnancy and more often than not, raise the child are the ones most affected by abortion.

Poor women always suffer more from restrictive laws. Women with money and connections can either

make the law work for them or they can travel to a place where safe abortion is available.

When abortion is not available, women are forced to use more dangerous birth control methods rather than safer but possibly less effective methods. Or they are sterilized before they are really ready. Sometimes women are forced to continue a pregnancy that carries dangerous health risks.

Laws rarely guarantee services. They do not oblige the medical profession to offer abortions. They do not support research into safer and less painful techniques. Criminalizing some abortions casts doubt on everything to do with abortion — those who have them and those who practice them.

The only useful abortion law is one which prevents someone from forcing another person to have an abortion. Health codes and professional standards of practice are all we need to ensure safe abortions and to protect the public, as is the case for other medical procedures.

What about the fetus?

Religious and medical specialists argue about when life begins as though the answer would solve the abortion debate. Pro-choice groups are accused of denying the human potential of the fetus while anti-abortion groups exaggerate it.

Anti-choice groups dramatize their case with blown-up pictures of fetuses from late abortions. In fact, less than 5% of abortions are done after 16 weeks. The vast majority of abortions are done before 8 weeks when the fetus is only 1 inch long. Many late abortions could be done earlier if obstacles created by antiabortion groups were eliminated.

The issue of fetal rights goes beyond the question of abortion. Technological developments make it possible for doctors to treat an ill or malformed fetus. These treatments may be dangerous for pregnant women who, vulnerable to the image of the selfless, nurturing mother, feel great guilt if they refuse.

Some issues regarding fetal rights merit serious thought. When a fetus is malformed, is the decision to abort motivated by the desire for a perfect child or the lack of social support for the responsibility of a handicapped child? Should abortion be permitted when parents want a child of a different sex?

As reproductive technology progresses, we are faced with many moral issues. Children are born from laboratory conceptions; women receive payment to bear a child for others. Millions of dollars are spent to save premature babies yet funds for child health and social services are drastically reduced. As individuals we have a right and a responsibility to participate in how our society deals with these issues.

Part of the humanity of the fetus is the place it takes in our hearts, our lives and our families. Many women, aware of the risk of miscarriage, wait at least 3 months before sharing their joyful news. Many women begin to relate to the fetus only when they feel it move within them. Women who have difficulty becoming pregnant feel a loss with each menstruation.

Abortion in Canada

The Canadian Criminal Code was amended in 1969 to permit abortions in hospitals when pregnancy threatened a woman's life or health. While a few hospitals set up committees and defined health in a broad way, many hospitals blocked abortions by refusing to create the approval committees which the law required.

In 1973, Henry Morgentaler, a private doctor who did abortions in his office, was arrested. Despite two acquittals he was sent to jail. When he was acquitted in a retrial, the Quebec government stopped prosecuting doctors and created abortion services in hospitals.

In the early 80s, free-standing women's clinics and several government clinics (CLSCs) in Quebec defied the law by offering abortions outside of hospitals and without approval committees. Quebec still has the most functional abortion network in the country.

In collaboration with pro-choice groups, Dr. Morgentaler opened clinics across Canada where both staff and users have been harassed by anti-abortion demonstrators and by the law.

In 1988, the Supreme Court declared the abortion law unconstitutional because it obstructed access to abortion, endangering the lives and health of women. Pro-choice groups began concentrating on making services available.

The following year two men got court injunctions blocking their ex-girlfriends from getting abortions. Public outcry was immediate and massive. One of the women courageously defied the injunction and left the country to get an abortion while the Supreme Court considered her case. After the fact, the Supreme Court ruled in her favour.

Violence against health personnel doing abortions has increased in Canada and may affect the accessibility of abortion services.

The status quo: no legal restrictions on abortion; access limited by poverty, geography and the health care system.

This is very different from how a woman feels when she sees her unwanted pregnancy threatening her future and that of her family.

The Montreal Health Press supports equal access to safe abortion and the removal of abortion from criminal laws. We encourage you to support your local pro-choice groups.

How it works

The fetus and placenta are removed via the cervix either by suction or with forceps, depending on the stage of pregnancy. Any symptoms of pregnancy such as morning sickness rapidly disappear. In late abortions, hormones or chemicals are used to induce labour and delivery.

Effectiveness

Abortion techniques are usually 100% effective. A failure may occur because of inadequate vacuum pressure, inexperience of the doctor, an abnormally shaped uterus or a very early pregnancy. Some clinics will not perform abortions before 7 weeks for this reason.

Abortion in the United States

In 1973, the US Supreme Court ruled (Roe vs Wade) that abortion was a medical matter for a woman and her doctor to decide with minimal government interference. Restrictive state laws became invalid and many abortion clinics opened.

The victory was short-lived. Although the Human Life Amendment (giving the fetus rights as a person) was blocked, other laws limit access to abortion. For example, the Hyde amendment blocked the use of federal Medicaid funds for abortion.

Since 1973, conservative appointees to the Supreme Court have upheld state laws requiring minors (under 18) to have both parents' consent for an abortion. The Webster decision in 1989 permitted state laws such as those requiring tests of fetal viability or further restricting the use of public funds for abortion.

Even health care reform is threatened as anti-choice groups withhold their support for any proposal which includes financial support for women undergoing abortion.

Fanatic anti-choice groups have held clinics in seige, harassing clients and staff alike. Violence has escalated to include arson and bombings. And now murder; doctors and other clinic personnel have been shot and killed by extremists whose actions have been applauded by certain "pro-life" organizations.

The women's movement has been courageously protecting clinic workers and patients from harassment and abuse. Young women who grew up taking the right to abortion for granted are joining older pro-choice militants in the struggle for control over reproduction.

The status quo: fragile constitutional protection, restrictive state laws, lack of services, hardest impact on poor, rural and minority women.

Aspiration will not remove an ectopic pregnancy (outside the uterus). Special surgery which requires hospitalization must be done.

Effect on the menstrual cycle

Abortion has no lasting effect on the menstrual cycle. After an abortion the next period usually begins within 4 to 8 weeks. You can ovulate and become pregnant before having a period.

Effect on sexuality

You should avoid vaginal penetration for one week following early abortion and until the discharge stops following late abortion.

Usually abortion has no effect on sexual desire or experience unless the circumstances surrounding it were particularly unpleasant.

Effect on health

Under proper conditions, abortion is a very safe procedure. Complications occur more often with late abortions. The death rate for abortions done under 12 weeks is about 1 per 100,000 abortions and about 8 per 100,000 when done between 16 and 20 weeks. (By comparison, tonsillectomy carries a risk of 3 deaths per 100,000 cases and appendectomy of 352 per 100,000 cases.) Rules which delay abortions are dangerous to women.

The major complications of abortion are:

Blood loss: Bleeding during vacuum aspiration is minimal (approximately 100 ml or less than half a cup). In late abortions blood loss approaches that after a birth. Hemorrhage during abortion occurs more in late than early abortions. Drugs are given to make the uterus contract and you are kept under observation until the bleeding is controlled.

Heavy bleeding in the weeks after the abortion is usually caused by incomplete removal of the placenta. Treatment with antibiotics and drugs to help the uterus contract is usually adequate. Occasionally aspiration must be repeated.

If you bleed heavily following an abortion, you should be tested for anemia.

Infection: Infection after abortion has several causes: improper sterile technique, pre-existing infection of the cervix and bits of placenta left in the uterus. You may have chills, pain and smelly discharge. Most infections can be treated with antibiotics; occasionally a curettage is necessary. Some centers give antibiotics automatically at the time of the abortion and for several days after.

Perforation: Any instrument used in early abortion can be accidentally passed through the muscle of the uterus. If this happens, you may feel pain. The doctor should notice that the instrument has gone too far and withdraw it. The uterus heals; rarely an operation is required to repair internal damage.

Damage to the cervix: The clamp holding the cervix can slip off, tearing the cervix. The tear is repaired with sutures and heals without problem.

Psychological: How you react after an abortion is influenced by the circumstances leading to it and the support and kindness of family, friends and health personnel.

Most women are relieved afterwards. For many young women this is one of the first major decisions they have had to face. Coping with its many aspects makes them feel more mature and selfconfident.

Some women feel a sense of loss and need to mourn. This is common in women who have mixed feelings about the abortion; for example, a woman may want to have a child but not have the money or she may feel that her marriage isn't strong enough. Women who want to be pregnant but abort because of illness or malformations feel a great loss.

Effect on fertility

Properly performed abortion has little effect on a woman's ability to conceive and carry another pregnancy. Fear of sterility comes from people's experience with self-induced or butcher abortions.

There is debate about whether or not the dilation of the cervix, particularly in late abortions, damages it so that it cannot support a pregnancy in the future. Women who have had several abortions do not have more miscarriages or premature deliveries. New techniques which dilate the cervix more slowly cause less worry.

If your blood group is Rh negative, you should receive an injection of antibodies (Rhogam or WinRho)

Skjold Photographs

within 72 hours after the abortion. This protects the fetus in future pregnancies from blood group problems.

Facing an unexpected pregnancy

Once you know you are pregnant (see p 20) you have decisions to make. You may have already made up your mind or you may need more time. Talking to a friend or a counsellor may be helpful.

Even if you are not sure you want an abortion, make an appointment. It is easier to cancel it than to try to find one as the weeks advance. Ask your doctor to refer you or call a local women's group. Most feminist groups do abortion referral. The National Abortion Federation hot line (1-800-772-9100) can refer you to qualified professionals in the USA.

Early abortions are usually done in a clinic or private office. When you call, ask about which method and anesthetic are used, the price, and what health insurance is accepted. An early abortion need be performed in hospital only if you have a medical problem which requires greater supervision.

Vacuum aspiration

Try to relax and get a good night's sleep. Have a bath or shower or merely wash well; some clinics suggest a douche. Have a snack if your appointment is early or a regular breakfast if it is later. If possible bring a friend and arrange to take it easy for the rest of the day. Unless you are extremely anxious, do not take a tranquillizer which can make you feel worse afterwards.

A nurse or paramedic will ask you questions about your health and should explain the abortion procedure to you. A blood test to check your blood group and a basic physical examination are done.

You empty your bladder and put on a gown or sheet. Then you lie on the table with your feet in supports. Try to relax; take long deep breaths, calm your mind and relax each group of muscles. It is important not to move once the procedure starts.

If the clinic has gas for pain relief, you will be given a small mask to breathe in. There should be someone at your side to hold your hand and comfort you.

The doctor does a pelvic examination to check the size and position of the uterus. A speculum is placed in the vagina. The cervix and vagina are washed with antiseptic solution which may feel cool.

A clamp is placed on the cervix. You may feel a sharp pinch which goes away quickly. The doctor injects local anesthetic into the cervix and the nerves around them. Some women find the injection painful and others are hardly aware of it. The anesthetic begins to work quickly; it relieves pain caused by the instruments but not discomfort caused by contractions of the uterus.

A sound is passed through the cervical canal to measure the length of the uterus. This may cause cramping. To dilate the cervix, a series of metal rods each thicker than the last are passed through the cervical canal. Dilation is often uncomfortable.

A hollow tube with holes near the tip (a vacurette) is passed into the uterus. The later the pregnancy, the larger the tube. The suction is turned on and the doctor moves the vacurette back and forth for several minutes. When the uterus is empty, the suction is stopped and the vacurette removed. During the aspiration, you may feel tugging, cramps or pain. The vibrating sound of the suction machine may be annoying.

In some cases the doctor gently scrapes the inside of the uterus with a curette (a spoon-like instrument with sharp edges) to make sure it is empty.

After the instruments are removed, you are given a sanitary napkin. You should be allowed to stretch out on the table until you feel ready to sit up and walk to the recovery room.

Menstrual Extraction

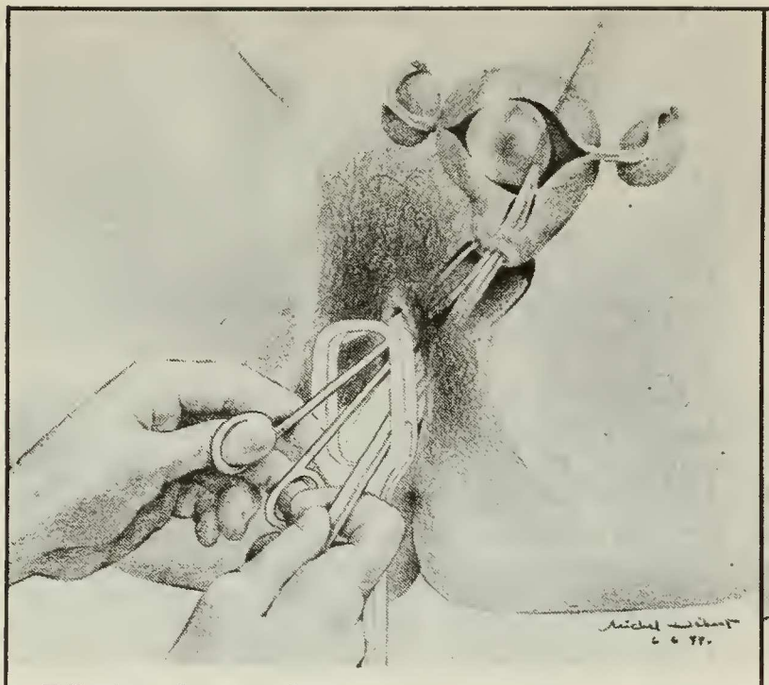
In the early 70s, a group of feminists experimented with menstrual extraction - a mild suction procedure that empties the uterus when a period is due or shortly after. They knew that some women would prefer to deal with a late period by having a menstrual extraction rather than waiting for confirmation of pregnancy. Women can do this simple procedure for each other with minimal training.

Population control experts developed a similar procedure for para-medics to use in developing countries. They hoped to get around strict anti-abortion laws by doing the procedure before pregnancy was confirmed.

Today's pregnancy tests are accurate even before you miss your period. Although no one is forced to have a pregnancy test, you can avoid unnecessary procedures by having one.

As abortion becomes more restricted in certain parts of the US, the same women who developed menstrual extraction have begun to publicize early abortion techniques. They encourage groups of women to develop skills and to acquire the necessary equipment for abortion. They have put into practice the slogan of the pro-choice movement—"NEVER AGAIN"—which refers to the maiming of women through unskilled abortions.

For women used to trusting doctors and relying on them for their health care, this may sound unprofessional and dangerous. For women who could never afford quality health care, a skilled lay woman able to solve their problem is better than a coat hanger.



Dilating the cervix

Suction removes fetus and placenta

You can have something light to eat or drink. You can take a mild pain-killer for the cramps. You can go home when you feel ready, usually in about half an hour. Before you leave you should receive the following information:

Menstrual-like bleeding continues for about a week after an abortion. If heavy bleeding continues longer than 1 week, if it becomes extremely heavy (soaks through more than 1 pad in an hour) or is accompanied by severe pain or fever, call the clinic.

Cramping for several days is normal. A heating pad or mild pain-killer usually helps.

To avoid infection do not put anything into the vagina for one week afterwards or until bleeding stops. This includes a tampon, finger, penis or douche.

Take your temperature twice a day for 2 days. Continue taking it if your cramps get worse or you feel feverish. If your temperature is above 38° C (100° F) twice in a row, call the clinic.

You should have a check-up 2 to 4 weeks afterwards.

If you were less than 8 weeks pregnant at the time of the abortion, have a pregnancy test 2 weeks after.

The next period occurs 4 to 8 weeks after the abortion. You can become pregnant again before that. You can start the Pill right away. An IUD can be inserted immediately after the abortion or in the following weeks. The condom, foam or diaphragm can be used after one week. Biological methods are less dependable until after the next period. Tubal ligation can be done any time afterwards.

Dilatation and evacuation

This method is similar to aspiration but takes longer. It is used for pregnancies between 13 and 16 weeks. Beyond 16 weeks this procedure should only be done by experienced doctors in a hospital or clinic with emergency facilities.

Preparation is similar to that for early abortion. The doctor will see you either a few hours or the day before to insert small rods (called laminaria) into your cervix to help it dilate. These rods are made of seaweed or synthetic material; they absorb mucus from your cervix which makes them swell. The larger they get, the more your cervix opens. You will notice cramping.

You should not eat before the abortion as drugs which sometimes cause vomiting may be used. Sedation, local anesthetic or light general anesthesia is used. An intravenous drip is attached in the vein of one arm and oxytocin, a hormone which causes contractions, is added to it.

The laminaria are removed and the cervix is dilated further. Forceps are used to remove the fetus. To ensure that the uterus is empty, an aspirator or curette is used. If ultrasound is used to help the doctor direct the instruments, the screen should be turned away from you.

Recovery is slightly longer. You should be kept under observation for several hours, and overnight if there are any problems. Some doctors prescribe antibiotics during and after abortion.

Instructions after the abortion are the same as for vacuum aspiration. Because the risk of complications is greater, you should be more alert to signs of trouble. You need to rest and it is better not to be alone.

Induction of labour

Several substances such as salt and urea kill the fetus and cause labour when injected into the uterus. The hormone, prostaglandin can be injected into the uterus, given intravenously or in a vaginal suppository. These procedures should only be done in a hospital.

Local anesthetic is injected into the skin of the abdomen. A long needle is passed through the muscles into the uterus. Some amniotic fluid is removed with a syringe and replaced with salt solution or hormone.

Oxytocin is given to stimulate contractions which do not become painful until about 2 hours before the fetus is aborted. You can be given sedatives and

An abortion pill

The idea of a drug to cause abortion is not new. Women have tried many substances, some of which were effective. Privacy is one benefit of such a drug; only the woman and her provider need know.

RU 486 (mifepristone, an anti-progesterone), which causes abortion in early pregnancy, affects both the lining and the muscle of the uterus. Several days after taking RU 486, women are given a second drug (a prostaglandin). The embryo is gradually expelled, like an early miscarriage. Other studies with methotrexate (an anti-cancer drug already used for ectopic pregnancy) and an anti-ulcer drug are under way; both drugs are inexpensive and available in North America.

More than 200,000 European women have used RU 486 to their satisfaction; others prefer suction abortion.

Anti-choice groups lobby against RU 486. Some pro-choice groups also raise questions. The strict control of RU 486 and the many doctor's visits required are a far cry from the "de-medicalized, private" experience promoted by supporters. Side effects (diarrhea, incomplete abortion, heavy bleeding) are not rare. Criticism of drug marketing is valid, but so are women's needs for a variety of birth control options. We support the use of RU 486 as part of the process of understanding these options. Research must include short and long-term health effects, as well as women's subjective views of the experience.

painkillers as necessary. Usually you abort within 12 hours. You may have to push to expel the fetus.

Recovery after this type of abortion is similar to recovery after a delivery. You should be under supervision at least until the next day and longer if there are complications. You may be given a prescription for antibiotics and ergot (to control bleeding).

Your breasts can be tender and produce milk. A good bra, ice and mild painkillers will help.

Vaginal discharge will change from bloody to pink to white. If it becomes bloody again, foul smelling or is accompanied by fever, you should see a doctor.

The next period begins approximately 6 to 8 weeks later. You can get pregnant before the next period. You should not have vaginal intercourse until the discharge is no longer bloody. You can start the Pill 14 days after this abortion. You should wait until your period to have an IUD inserted. Diaphragm fit should be checked before using it.

If bleeding was heavy, have a blood test for anemia. You should have a check-up within 6 weeks.

Because of its similarity to giving birth, a late abortion can be stressful and emotional. You may have some depression afterwards.

Cost

In Canada, the doctor's fees and hospital bills are covered by government health insurance. Women who get abortions in private clinics are charged fees up to $350 (more for late abortions) for clinic costs.

In the USA the cost of abortion varies considerably. In many states, federal programs which pay for health care for the poor cannot be used to pay for an abortion. Lower fees are available in non-profit clinics; some private clinics have sliding scales.

Sterilization

Permanent birth control is called sterilization. In North America, it is the most common method of birth control. Women are twice as likely as men to choose sterilization.

The decision to be sterilized can be a positive one if you are certain about it and you have the operation willingly. It means that you no longer have to bother with birth control or worry about an unwanted pregnancy.

But many people rush into sterilization, often because of bad experiences with other methods. Some change their minds and undergo further surgery to undo the first which can be complicated and not always successful. Young women and those who begin a new relationship are more likely to regret their decision.

Take some time to think about your life 5 or 10 years from now. What situations would change how you feel now about having a child? If you are in a couple, have you explored each other's feelings enough? Is the one to be sterilized doing so under pressure? Let time pass after any crisis — new baby, new job, misunderstandings — before making your decision.

Vasectomy

Vasectomy is the sterilization operation performed on men. It is a simple procedure that takes about 15 minutes and can be done in a doctor's office.

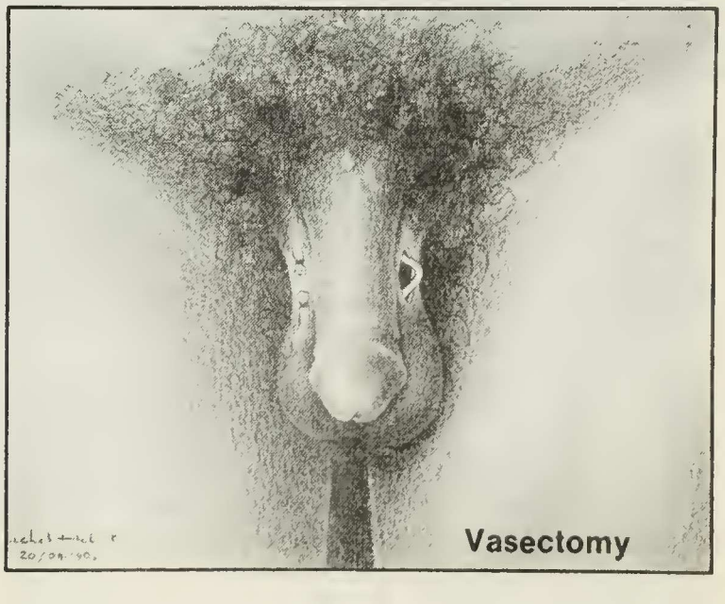
How it works

The tube which carries sperm from each testicle (the vas deferens) is cut and tied. The sperm are blocked and dissolve. If there are no sperm in the semen, your partner cannot get pregnant.

Effectiveness

A vasectomy is not effective right away. It takes a month or so (about 15 ejaculations) for the sperm which were already present to be cleared out. Your semen must be examined for sperm 8 weeks after surgery.

Vasectomy is **almost 100%** effective. In rare cases, the cut ends rejoin and sperm are carried into the semen again. You will only know this if a partner becomes pregnant.



Vasectomy

Linda Rutenberg

Effect on sexuality

A vasectomy has no direct effect on a man's sexuality. Sperm make up only 10% of seminal fluid. The amount of liquid you ejaculate and the sensation of orgasm do not change. Hormone levels do not change after vasectomy.

Effect on health

After surgery, expect some uncomfortable swelling of the scrotum. Bleeding within the scrotum or infection occur in under 5% of cases, less with the "no scalpel" technique. Treatment with drainage and antibiotics is effective. Rarely, leakage of sperm causes a tender lump (granuloma) to form; it usually shrinks without surgery.

Few long-term complications are known. Sperm cells which are produced dissolve. Sometimes the body produces antibodies against sperm but they do not appear to cause illness. A possible weak link between vasectomy and prostate cancer is under study; so far, evidence is lacking.

Effect on future fertility

If you impregnate a woman because you did not wait long enough after the operation or if the ends of the vas rejoin, the baby will not be affected.

If you wish to father a child, specialized surgery joins the vas again. In 60% of vasectomy reversals, sperm are present in semen afterwards. However pregnancy occurs less frequently, possibly because of antibodies against sperm.

Use

Vasectomies are performed in private offices, clinics and hospitals.

Plan to take 2 days off work. The doctor should give instructions for the day of surgery regarding bathing and trimming or shaving the pubic hair.

During the operation, you lie on your back. The genitals are washed with antiseptic. The doctor injects local anesthetic into the skin of the scrotum just over each vas or in the middle. This stings but the freezing works right away. The doctor makes an incision in the scrotum and locates the vas. Each vas is cut and the ends are tied, clipped, burned or plugged. The incision is closed with absorbable stitches. You should rest in the clinic until you feel ready to leave.

In the new "no-scalpel" technique perfected in China, the scrotum is pierced (rather than cut) and the opening stretched to find the vas. Stitches are not needed.

Applying an ice pack for several hours after surgery reduces swelling and discomfort. If painkillers are needed, take something other than aspirin. Wear a scrotal support for as long as it gives relief. Do not bathe or shower for 2 days; afterwards a warm bath may be comforting.

Do not do strenuous exercise or lifting for at least a week. Call the doctor if you have symptoms of infection or bleeding: increased swelling, pain, fever, chills. Sexual activity can be resumed in 2 to 3 days or when comfortable. Continue using contraception until you've had two negative sperm counts, usually about 8 weeks after the operation.

At the follow-up appointment, you will be asked to ejaculate into a container so that the semen can be examined under the microscope for sperm. When there are no sperm in two consecutive tests, you can depend on the vasectomy for permanent contraception.

Tubal ligation

Sterilization of women involves cutting the Fallopian or egg tubes. It is a more complex surgical procedure than vasectomy and should be performed only in hospitals or specially equipped clinics. New research is looking at blocking the opening of the tubes via the uterus; such techniques could be simpler and require less anesthesia.

How it works

When the Fallopian (egg) tubes are cut and tied, sperm cannot reach an egg to fertilize it. The early technique for sterilization involved cutting the tubes and tying the cut ends. Today new methods accomplish the same thing. The tubes can be cut, burned with electricity or blocked using rings, elastic bands or clips.

Sterilization abuse

Sterilization has a long history of abuse. Compulsory sterilization of people with a variety of handicaps was common until recently. Poor women and women of colour have been refused abortions unless they agreed to be sterilized. Forced sterilization has been proposed for women who are infected with the AIDS virus.

In some developing countries, sterilization is promoted as a solution to poverty and starvation. Large families are blamed for poor economic conditions created by dictators and greedy industries.

In other parts of the world, access to sterilization is limited. Sterilization laws in Latin America require that a woman be over 40 and have many children. In North America single women without children are often refused.

Some countries do have a "population problem" Democratic solutions require the participation of the people affected, an equal distribution of wealth and equal rights for women. When sterilization is denied or when it is not totally voluntary, it is an infringement of human rights.

Methods also vary according to how the tubes are reached. In a **mini-laparotomy**, a small incision is made in the abdomen. In **laparoscopy**, a telescope-like instrument is passed through a tiny incision; the doctor uses instruments to reach the tubes inside the pelvis. The tubes can also be brought down through an **incision in the vagina**.

Hysterectomy — removal of the uterus — also makes a woman sterile. Unless there are serious medical reasons for removing the uterus, sterilization should be done with simpler methods.

Effectiveness

Tubal ligation is immediately effective. When you resume sexual activity, you can depend on it for permanent birth control.

Tubal ligation is about **99%** effective. Clips and rings have slightly higher failure rates than methods which are more destructive such as cutting and burning. However ectopic pregnancy (outside the uterus) is higher with the latter methods.

Long-term effectiveness rates (after 10 years) seem to decrease slightly, particularly in women who were sterilized before the age of 30. If you miss a period, even many years after sterilization, you should consider a pregnancy test.

Effect on health

Sterilization is usually performed under general anesthesia which carries a slight risk of death, especially for women who have heart or lung disease.

Injury to organs other than the Fallopian tube occurs more often with the laparoscope; it is sometimes necessary to open the abdomen to repair the damage. Rarely the gas used to inflate the abdomen is accidentally injected into a blood vessel which can be fatal.

Infection is a greater problem when sterilization is done through the vagina. Bleeding can be a problem in any operation. Infection of the bladder can occur after any procedure in which the bladder is catheterized.

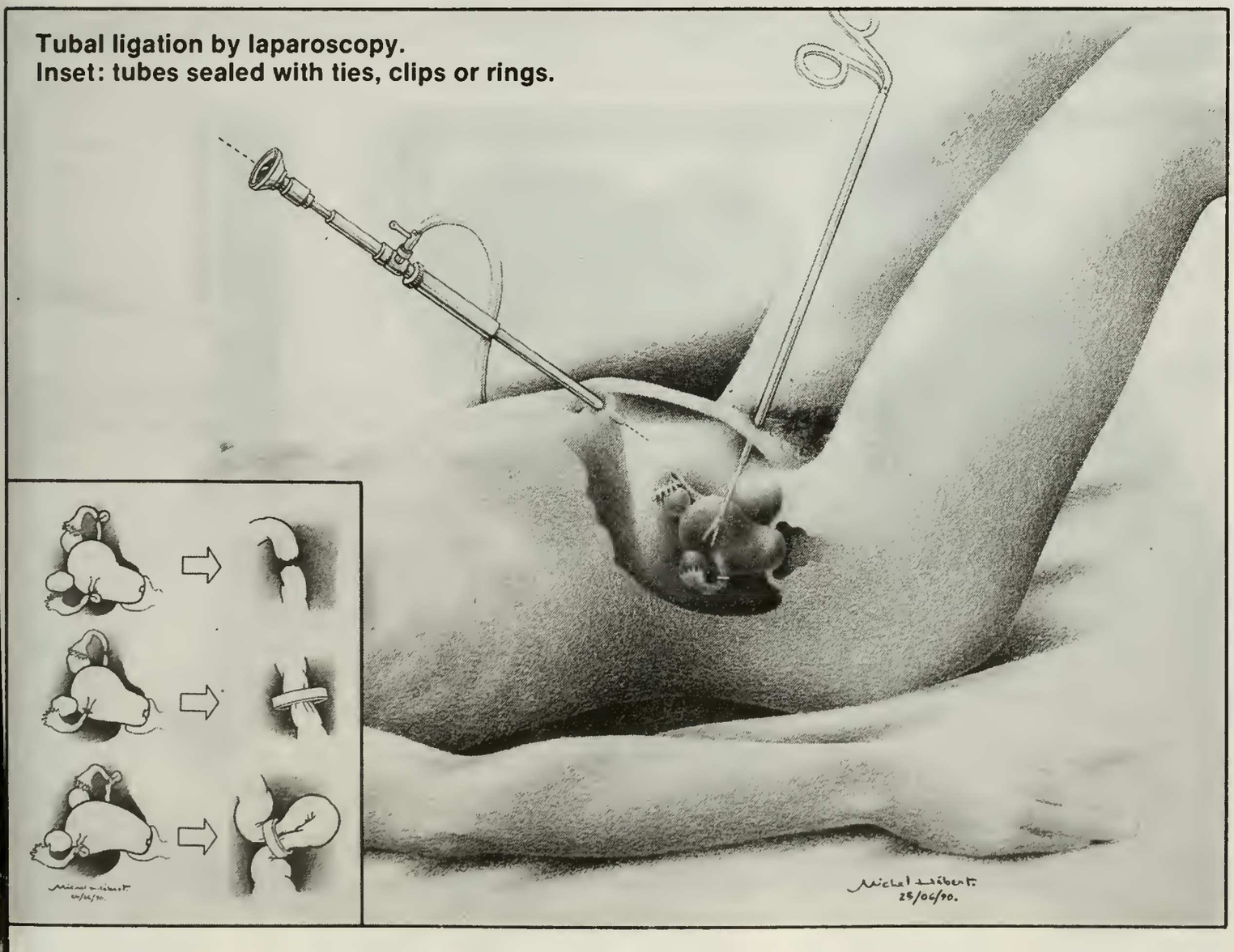
These complications occur during or soon after surgery. It is not clear if sterilization causes any long-term health problems. Some women notice changes in their menstrual cycle. Hormone levels do not change.

Effect on fertility

If you become pregnant after tubal ligation, the fetus is not affected.

Surgery to reconnect the tubes is expensive and works only 30 to 50% of the time. Success is greatest when clips or rings are used.

Tubal ligation by laparoscopy.
Inset: tubes sealed with ties, clips or rings.



Ectopic pregnancy is more frequent in women who have had surgery to reconnect their tubes.

Use

Have a complete examination to check your risks for a general anesthetic and to decide which sterilization method is best for you. If you have had gynecological problems which cause scarring, you are not a good candidate for the laparoscope or for vaginal surgery.

If you prefer a certain method, find a doctor who has experience with that method. Otherwise, you should respect the doctor's choice of method since experience is important in reducing side effects.

You should arrange to take a few days to a week off work and to have some help around the house.

You will be sent for tests such as a chest X-ray, cardiogram and blood tests. You will be admitted either the night before or the day of surgery.

Prior to surgery, you are given a sedative to help you relax. The anesthetist will put you to sleep by an injection in the intravenous solution. The anesthetist puts a tube down your throat which is attached to a machine to control your breathing.

In a mini-laparotomy an incision of less than 3 cm is made in the abdomen. A rod placed in the uterus from the vagina permits movement of the uterus so that the tubes are brought in front of the incision. Each tube is cut, tied, burned or clipped. The incision is closed with stitches or clips.

In a laparoscopy, a small incision is made just below the belly button. A tube is inserted into the abdomen and a gas is pumped in to inflate the abdomen. The tube is replaced with the laparoscope (a telescope-like instrument). Surgical instruments can be passed through the laparoscope or through another incision. Each tube is brought into view and burned, cut or clipped. The instruments are removed and the gas allowed to escape. The small incisions require a few stitches.

For surgery through the vagina, an incision is made deep in the vagina. Each tube is brought into view, cut and tied. The incision is repaired with absorbable sutures.

You wake up in a recovery room. Your throat may be sore from the breathing tube. You may have some abdominal pain, particularly if rings were used. If you had a laparoscopy, you may have some shoulder or chest pain caused by the gas.

Instructions after surgery vary depending on the method. Rest at home for at least 2 or 3 days. Avoid strenuous work for at least a week. Resume sexual activity within about a week or later if desired. Penetration should be postponed longer following vaginal sterilization. Shower or bathe as desired. Use a mild pain-killer other than aspirin for abdominal pain. The stitches will dissolve by themselves. Have a follow-up examination in a month.

If you have increasing pain, fever or bleeding from the incision, fainting spells or pain on urination, call the doctor.

Judith Crawley

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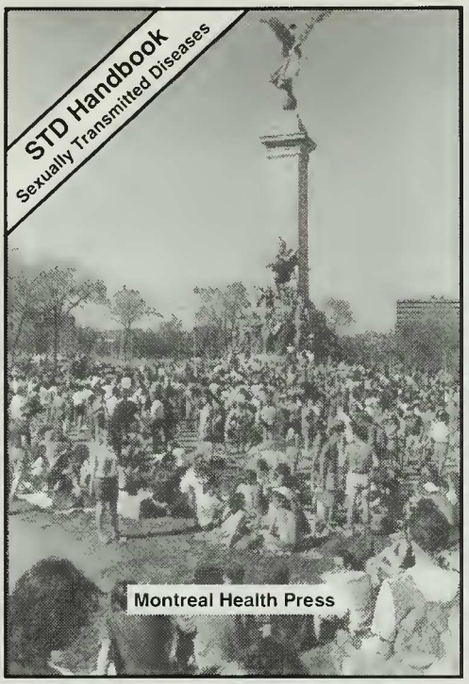

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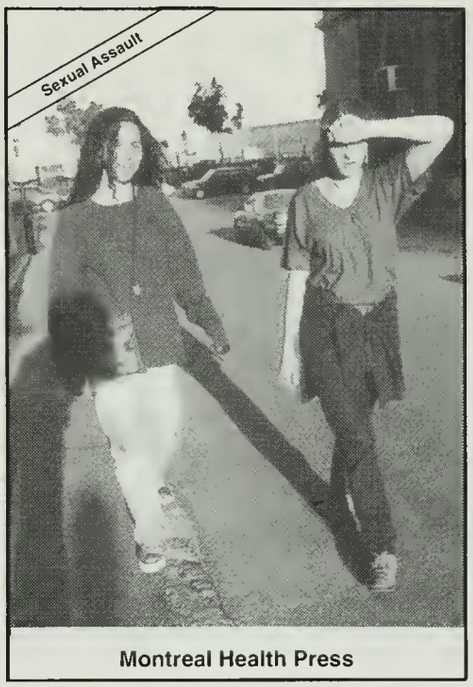

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Other Reading

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Network News National Women's Health Network. 1325 G St NW, Washington DC 20005 USA.

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