
Birth Control Handbook
* 30th Anniversary Edition *
Montreal Health Press

Birth Control Handbook

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Introduction

Andrea Brunner

The **Birth Control Handbook** is a guide to current methods of contraception—a handy reference for women and men at all stages of sexual experience. The first part discusses issues which influence your choice of birth control method such as sexuality and health and includes information about your body, pregnancy and health care. The second part describes each method in a way that helps you compare them and make your own decisions.

The **Montreal Health Press** has been distributing information about birth control for 30 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 too often limited to the mechanics of the method—how it works, where to get it. We have tried to pay more attention 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. 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. Some people are comfortable choosing to delay sex with penetration or to be abstinent; others follow a different moral code. But sexual behaviour is not just the result of rational decision-making; it also reflects our complex emotional and physical desires.

Experience shows that 100% effective contraception without side effects is probably an unrealistic goal and that early interruption of pregnancy is quite safe. 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 or promiscuity.

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 child-bearing. We hope it answers the questions you have now; keep it handy for the new questions which arise as your personal situation changes.*

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Sexuality

Ever since human beings figured out that sex leads to pregnancy, they've looked for ways to enjoy sex without making babies. There are only two ways to do this:

1. do something to prevent the egg and sperm from meeting, or
2. have sexual activities without penis-vagina contact (mutual masturbation, oral sex, etc.).

Birth control technology and the values and attitudes learned from family, friends, religion and community influence how people prevent pregnancy.

Popular Culture

Learning about Sex: Most North Americans are not taught about sexuality in the home. But we do get some information about sex as we learn about body parts and through family attitudes toward nudity. The kind of contact we see and experience with family members teaches us about physical and emotional intimacy.

Skjold Photographics

Information about birth control and safer sex may come to us through friends, teachers and health care workers—far removed from the excitement of sexual contact. We may learn how to put on a condom or take the Pill, but not how to introduce birth control in a passionate encounter.

Religion also influences attitudes toward sex and birth control. Some religious leaders preach sexual values that are out of touch with common practices; they are often powerful enough to block sex education and birth control services. Some people see abstinence as the best solution to social problems such as unwanted pregnancy and sexually transmitted diseases; in the USA, more funds are available for programs promoting abstinence than for those encouraging responsible decision-making. People with different values may fear being judged and may hesitate to seek out the information or services they need. Some accept the abstinence message but end up having sex any way; then they panic about a late period or possible infection.

The media sends us a different message about sex, using it to boost ratings and increase sales. Sexual attractiveness and satisfaction are portrayed as essential to success and personal well-being. In the media, good sex is when you are swept away by the passion of the moment. Rarely do we see anyone thinking about safer sex—no discussion about the Pill, no detour to the drugstore for condoms.

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.

The Double Standard: Males and females are raised with different sexual expectations. Males receive approval for showing sexual interest and for being heterosexually active; women are valued for sexual attractiveness but not for sexual experience. Men get little encouragement to be responsible for the consequences of sex and some are still reluctant to use condoms despite the threat of HIV/AIDS. Most men still rely on women to take care of contraception. Though contraception can empower women to choose whether to have sex and under what conditions, it is still a struggle to confidently say yes or no to sex.

Birth control technology also shifts responsibility onto women. Yet if she is not in a serious relationship, a young woman who is ready with birth control risks "getting a reputation". As a result, many girls are unprepared, even when they know that sexual activity is quite likely.

Women are socialized to be responsible for the couple and often put the desires of their partner before their own needs. When men and women both learn to be confident and comfortable with safer sex practices, there are not only fewer unwanted pregnancies but more relationships based on understanding and respect. It takes courage to overcome the double standard.

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

In North America, most heterosexuals start to have sex with penetration 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 pleasuring or see them only as foreplay. "Going all the way" or doing "IT" means having sex that can result in pregnancy. This emphasis on penetration probably has its roots in religions which defined sex as acceptable only for reproduction. Sexual pleasures without penetration were considered second best or unhealthy.

Young people often feel pressured to be sexually active. Many have sex to please their partner and some young women do not get much pleasure from sex with their boyfriends. They need support to explore alternatives which could be safer and more enjoyable.

Sex and Birth Control

Birth control needs and choices depend on a number of things:

Sex Partner(s): Ideally, men and women figure out ways to communicate their concern about birth control to each other. In real life, attitudes toward sharing

responsibility for contraception 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 will likely include coitus in the future. Or a couple plans to marry soon. 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, or if you have many partners, or if your partner(s) have sex with others. The condom is the best choice.

Even with a regular partner, birth control requires communication: Do you always have sex by mutual agreement? Can you agree to avoid penetration or use a condom during the fertile period? Are you sometimes too drunk to bother with contraception?

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 contraception 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?

People are often shy about introducing birth control with a new partner. It's sometimes easier to have sex than to talk about it! You need to let your partner know that you enjoy his or her 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 introduce the topic indirectly. They might mention a magazine article on teen pregnancies or on abortion. Your partner will probably be relieved that you broke the ice. Once you have shared some intimacy, talking about birth control usually becomes easier.

If you have sex with penetration frequently, you may choose a continuous method such as the Pill or the IUD. If coitus occurs less often, you may prefer a method 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 your method is a big hassle, the idea of sex may turn you off. Many people eroticize their method. They may "play doctor" when putting on a condom or inserting foam. The closeness that develops when couples cooperate to use birth control can be surprisingly exciting. Sex and birth control are both ways of showing love and consideration. Many women on the Pill feel freer sexually because of the reduced risk of pregnancy but some complain of less desire.

Doug Aucoin

Sensation: Mechanical methods may affect sexual sensation. Some men complain of a loss of sensation with the condom and some condoms have an unpleasant smell. Thinner and better lubricated condoms permit more feeling. Some people appreciate spermicidal creams for the extra lubrication while others find that they decrease pleasure or make oral sex unpleasant. 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.

Privacy and Living Conditions: 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 unexpected situations than others; condoms are easy to carry discretely.

Interruption: Continuous methods such as the IUD and Depo-Provera are independent of sex. Methods such as the sponge, cap and female condom can be inserted ahead of time. Condoms and spermicides must be used during sex. Some people feel shy about the technical aspects (inserting the sponge, unrolling the condom); some find the interruption distracting. You can find ways to make it more enjoyable and erotic. Some people learn to unroll a condom with their mouths. Music, soft lights and having your birth control nearby can be part of preparing for good sex.

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 then. The Pill makes a woman's periods shorter and lighter, though bleeding may occur at other moments. The IUD often increases blood flow. Long-term methods such as injections often cause irregular periods or no periods at all.

Sexual Problems: Birth control does not create sexual problems. Nor does it solve problems other than reducing 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 cause irritation. 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 create pressure to have sex or be an excuse to limit sexual activity to penetration.

Lifestyle

To use birth control successfully, your method must fit your needs and your lifestyle. What suits someone else may be unacceptable to you. Take an honest look at yourself. Try to imagine using each method. What problems might you expect? Can you do anything to solve them? If you find something wrong with each method, figure out which compromises you can most comfortably make.

Sheryl Ann Medicoff

Gut Reactions: The idea of using chemicals or taking a pill every day turns off some women. Having something in the body such as the IUD upsets others. But many are at ease with these continuous methods. Women who are not used to touching their genitals may avoid barrier methods such as the sponge. Taking one's temperature daily may seem a nuisance to some women but be a source of self-awareness for others. Many men are anxious about getting a vasectomy.

Time investment: Are you willing and able to take the time your method requires? Fertility awareness methods involve daily observations whereas the IUD requires one or two visits to the doctor.

Cost: Can you afford the method you choose? Does it require regular outlays of cash 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 daily activities? Are your hours stable? Are you forgetful? Do you usually make love in your own home? Where else? People with irregular hours might have trouble taking their temperature or remembering the Pill. If you have sex in different places, you must carry your barrier method 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 might be better than something you need to remember.

Disabilities: Do you have any limitations which would make a particular choice inappropriate? If you have difficulty using your hands, using 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. If you have trouble concentrating or remembering things, make sure you get clear written instructions. Put a reminder on your bulletin board and keep your supply in the same place such as your purse or cupboard.

After Giving Birth: Many women become pregnant sooner than they want after having a child. With the tiredness and reorganization that goes with having a baby, sex may not be on your mind. When the opportunity occurs, you need to be prepared. If you are not breastfeeding, you must consider yourself fertile about 4 weeks after the birth. There are few restrictions on your choice of method. You should wait 3 weeks before beginning the Pill to reduce the risk of blood clots. Fertility awareness methods are not reliable until your cycle is re-established; detection of ovulation using your temperature is not reliable if you get less than 6 hours of undisturbed sleep. Complete breastfeeding (no bottles, no other foods) is about 98% effective in the first 6 months; when supplements are used it is much less reliable.

Breastfeeding women have to consider 2 issues: does the method affect milk production? Are chemicals which could harm the baby present in breast milk? Not much research is available to help make decisions. Those concerned about the baby suggest delaying use of the minipill or Depo-Provera for at least 6 weeks. Those concerned that some women will become pregnant before starting contraception prefer to prescribe them right after birth. The Pill reduces the quantity of breast milk and should not be used in the first six months if at all. Female barrier methods such as the cap should be avoided until the bleeding and discharge after birth have stopped. Since breastfeeding decreases vaginal lubrication, spermicides or condoms with spermicide are good choices. IUDs are usually inserted at the 6 week postpartum visit.

Skjold Photographics

Politics and Birth Control Choices

Given how important birth control is to so many people, it is surprising that there are so few safe and effective methods available to us. Many factors determine what methods are available. Governments and foundations which fund research may be interested in population control and concentrate on "high tech" methods such as hormone implants which leave little room for human error. Drug companies must prove that their product is safe and are vulnerable to expensive lawsuits.

Even the methods we have may not be accessible. Religious authorities may block the distribution of emergency contraception in high schools and prohibit abortion services. Ads about birth control for the general public are still uncommon. Health plans may cover hormonal methods or sterilization but not condoms. Laws may block minors from seeing a doctor for birth control without parental consent.

The Women's Movement has fought hard to improve access to birth control both at home and abroad. It has established non-profit clinics and educational projects and promoted interest in methods which have few side effects. Most important, it has made respect for women's autonomy in sexual and reproductive decisions the basis of birth control politics. The Women's Movement also supports social measures such as paid parental leave and subsidized daycare for families wanting to have (more) children. The ***Montreal Health Press*** *is part of this movement.*

Effectiveness

Effectiveness refers to your chance of avoiding pregnancy while using a particular method. Failure rates give the same information from the opposite point of view—the risk of pregnancy. **If 100 women do not use any birth control, 85-90 of them will become pregnant within one year.**

Clear, honest information about effectiveness is difficult to get. Companies that sell contraception tend to exaggerate effectiveness. Health workers sometimes compare the best rates of one method with the worse rates of another, so that their favourite method looks 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 to use the method. Those who get pregnant because they forget or use the method incorrectly are not counted.

Failure Rates

Method	*Lowest Expected*	*Typical Users*
Withdrawal	*4*	*19*
Calendar	*9*	*25*
Symptothermic	*2*	*25*
Condom (male)	*3*	*14*
Condom (female)+	*5*	*21*
Spermicides	*6*	*26*
Sponge+	*14*	
Cervical Cap+*	*9*	*20*
Diaphragm+	*6*	*20*
Lea Contraceptive+	*6*	*20*
IUD	*.6*	*.8*
Mini-Pill	*.5*	*>5*
Pill	*.1*	*5*
Depo-Provera	*.3*	*>.3*
Norplant	*.05*	*.05*
*Sterilization (women)***	*.5*	*.5*
Sterilization (men)	*1*	*.15*

Read as follows: If 100 women use the diaphragm perfectly for 1 year, 6 will get pregnant. Realistically, if 100 women use the diaphragm for 1 year, 18 will get pregnant.

* *failure rates for certain female barrier methods are higher for women who have already given birth.*

\+ *failure rates may be lower with experience*

** *failure rates slightly higher (1.5%) over 10 years.*

Adapted from ***Contraceptive Technology,*** *17th ed., Hatcher et al.*

Suzanne Girard

Typical failure rates mix "good" users with those who use it incorrectly or sometimes have sex without protection.

The difference between these rates is greater for some methods than others. The difference is small for the IUD because your actions don't affect its failure rate. However, improper insertion by the doctor and rejection of the device from the uterus may lead to pregnancy. Though 1 woman in 200 is expected to become pregnant in the first year of IUD use, in reality, about 1 in 100 does.

Human error plays a greater role with the diaphragm. The lowest expected failure rate is 6%; the typical failure rate is about 20%. 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 of use. With experience, people get better at using a method. If you stick with a method for more than a year it probably means that the method has worked, has not made you sick and is compatible with 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).

Rates are also given for specific situations. 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. How do you feel about an accidental pregnancy (p 19)? 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 family size. Today people expect to completely control their fertility—to avoid pregnancy when they want and to be pregnant when they want. But

100% effective methods do not exist. Some people choose less effective methods for health and other reasons.

Using two methods at the same time lowers the risk of pregnancy. For example, many people use condoms for protection from sexually transmitted diseases. If you already use the Pill for contraception, the two combined offer very high protection—close to 100%. However, alternating two different methods does not increase effectiveness; you only have the protection of the method you use at the time. If you are using a fertility awareness method (p 21), you have sex with penetration only on safe days. If you use condoms to be able to have intercourse on *unsafe* days, you are no longer using fertility awareness—you are relying entirely on the condom.

Having two methods available is helpful in case something goes wrong with one or you just don't feel like using it. For example, if you use the Pill and you get the flu (vomiting it up), you continue taking the Pill but use foam or condoms for the next week.

Changing Methods

Accidental pregnancy occurs more often when you first begin using a method. Some women continue their previous method while starting a new one. For example, you could get used to inserting the cap while still taking the Pill.

Diana Shearwood

Women often have unwanted pregnancies when they stop using a method without another to fall back on. For instance, 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.

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, and possibly longer. An IUD can be inserted up to a week afterwards (see p 37). Find out where you can get these "emergency" methods before you actually need them. These methods are widely available in Canada through schools and clinics. A directory of clinics dispensing emergency contraception in the USA is available on the Internet (**//opr.princeton.edu/ec/**) or through a toll-free hotline (**1-888-NOT-2-LATE**).*

Side Effects

A side effect is a change in the body caused by a treatment which has nothing to do with why you take that treatment. For example, antibiotics can cause diarrhea and allergic reactions. Women's awareness and reaction to health hazards of birth control varies. Some change to safer methods; others stop one method out of fear but do not use an alternative method, risking pregnancy. Others choose to live with the health risk of a highly effective method.

This section helps you evaluate side effects for yourself. In general, methods such as hormones and IUDs which provide continuous contraception carry more risks than methods such as the diaphragm which are used during each sex act. We must continue to exert pressure on drug companies and doctors to fully inform people of the risks of each method.

The side effects of each contraceptive method are described in the methods section (p 21- 48).

"Nuisance" Side Effects

These symptoms are unpleasant but are not a sign of serious disease. Often they decrease or disappear with time. For example, you can have more menstrual cramps with an IUD, nausea with the Pill or feel irritated in the crotch when spermicides leak. Men may feel the IUD strings 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, check with friends or health workers for suggestions which might help you.

A method which caused unpleasant symptoms in the past might work better now. For example, an IUD is

Health Benefits

Some birth control methods make us feel better or lower certain health risks. Pill users have lighter periods with less discomfort; they are less likely to become anemic. Condoms block STD transmission. 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 control of their bodies.

Using birth control to space births and reduce the number of pregnancies results in improved health for women around the world. But birth control is no substitute for a more equal sharing of the world's resources, including adequate nutrition and health care.

better tolerated by women who have given birth. Or the 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 may require surgery. Women with IUDs who are at risk for STDs have higher rates of infection of the Fallopian tubes which can cause infertility (difficulty getting pregnant). Some women who use the diaphragm get bladder infections.

Some problems occur while you use the method. You can become anemic if you bleed too heavily with the IUD. Once the IUD is removed, the problem resolves. Other effects may occur after you've stopped the method and may be related to how long you used it. Long-term use of the Pill increases the risk of breast cancer slightly for 10 years after stopping. We can better predict which women might have complications as experience with certain methods increases. We now know that Pill users who smoke are much more likely to get heart disease than those who don't.

Making An Informed Choice

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

Discuss with your doctor how your birth control method affects any health problems you have and vice versa. You should also 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.

You have to decide 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 check-ups 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.

Piera Palucci

Judith Crawley

Sexually Transmitted Diseases

Judith Crawley

Sexually transmitted diseases (STDs) are spread when an infected person has unprotected sexual contact with others. They can cause infertility, serious illness and even death. HIV/AIDS, an STD for which no cure is available, causes suffering and death around the globe. HIV/AIDS has made people more aware that sex has consequences beyond the moment.

You are at risk of getting an STD if you have unprotected sex with more than one person or if your regular partner has unprotected sex with others. For some, celibacy or monogamy is the solution. Others are exploring safer sexual practices.

Many people who need birth control also need protection from STDs. The choice you make for one influences what you do for the other. For example, if you use the Pill, you may not make the extra effort to use a condom to prevent STDs.

Safer Sex

Public health campaigns which promote safer sex to prevent infection with HIV/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 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 oral-genital sex?

Just as you assume that sex with your partner can result in pregnancy, you should also assume that it could lead to an infection. You cannot know everything about a

How Birth Control Affects STDs

Fertility Awareness	*Fewer acts of coitus, therefore fewer chances of infection. Possible increase of female-to-male transmission of HIV during menstruation.*
Withdrawal	*No protection.*
Condom	*Good protection for most STDs including hepatitis and HIV. Condoms for women cover more of the genitals and may offer better protection.*
Spermicides	*Possibly some protection but increased risk if irritation occurs. Advantage 24 may be less irritating and coat the vagina better. Spermicides in the sponge Protectaid (which is also less irritating) kill STD germs in the lab.*
Diaphragm, Cap, Lea Contraceptive	*Some protection from gonorrhea and chlamydia.*
IUD	*Increases likelihood of complications from gonorrhea and chlamydia.*
Pill	*Increases likelihood of getting chlamydia but decreases the risk of complications such as tubal infection.*
Injections, Implants	*No protection.*
Sterilization	*No protection.*

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.

Linda Rutenberg

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 go for treatment 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 low rates of STDs. Sexually active men and heterosexual women need regular STD testing; how often depends on the frequency of unprotected sex by yourself or your partner. If tests are positive you and your partner(s) should receive treatment and avoid sexual intimacy until further tests are negative. 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. Blood tests are used for syphilis, hepatitis and HIV/AIDS.

Bertrand Carrière

Body Parts

You can better understand sex, how to make a baby and how not to, if you know about your body (and your partner's). Many people wonder if their genitals are normal. Genitals vary as much as noses do. They are alike enough to do their jobs but different enough to be uniquely yours. True genital abnormalities are usually found in childhood; abnormalities of internal organs may go unnoticed until puberty or later.

MEN'S BODIES

Testicle: oval-shaped glands held in a thin sac of skin (**scrotum**) which hangs in front of the thighs and behind the penis; kept cooler than the rest of the body (important for producing sperm); produces male hormones (**androgens**) which increase body and facial hair and muscle bulk, and stimulate the production of sperm from puberty on; manufactures sperm which leave each testicle through a long, narrow tube (**epididymis**) which coils up on the back of each testicle.

Spermatic Cord (vas deferens): a tube about 45 cm (18") long which carries sperm from the epididymis; you can feel it at the groin. Each vas passes over the bladder and widens to form a storage place (**ampulla**) for sperm.

Seminal Vesicle: glands which make liquids that mix with sperm in the **ejaculatory duct** just before orgasm; important for the survival of sperm.

Prostate: a chestnut-shaped gland, just under the bladder; produces substances important for sperm survival which mix with sperm seconds before ejaculation. The **semen** ("cum") which is ejaculated is made up mostly of secretions from the prostate and seminal vesicles.

Urethra: tube running from the bladder, through the prostate, pelvic muscles, and the length of the penis, ending at its tip; passage for urine from the bladder (peeing) and for ejaculation (the forceful release of semen during orgasm). A muscle (sphincter) prevents urine from mixing with semen during ejaculation.

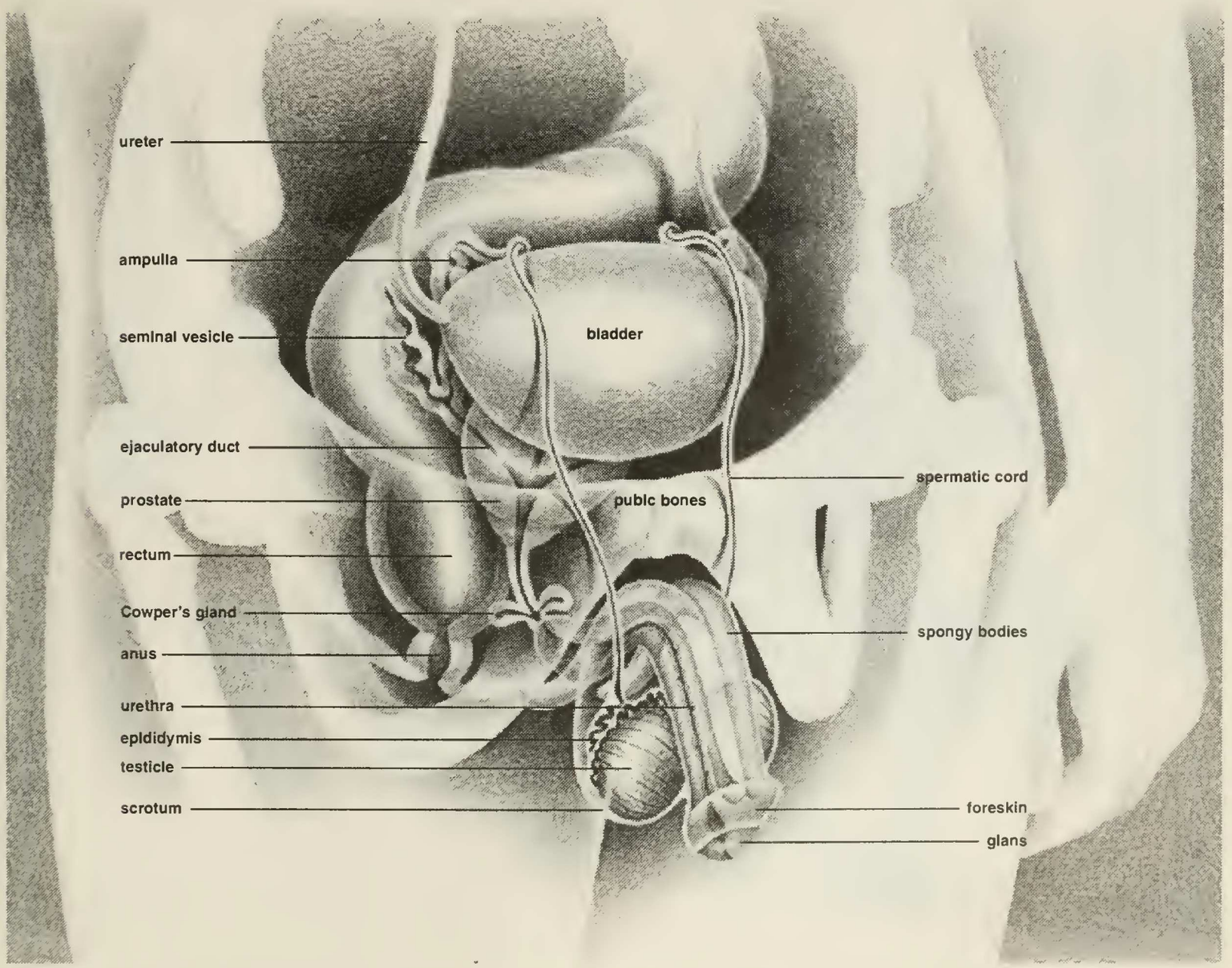
Penis: sexually sensitive organ made up of spongy erectile tissue which swells with blood and hardens when stimulated (erection or hard-on). Two parts lie side by side forming the shaft; they separate and anchor the penis to the pubic bones. A third part, which contains the urethra, lies under the others 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 (**foreskin**) loosely covers the glans. In many cultures, the foreskin is removed by an operation called circumcision, either at birth or later. Circumcision, once common in North America, remains a subject for debate.

Genital Health Care For Men

Young men do not need an annual check-up with a doctor but they should examine themselves occasionally. A man's external genitals are in full view so sores, lumps or discharge should be obvious. To examine for cancer of the testicle, slide your fingers 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 be tested 2 to 4 weeks after unprotected sex with a new partner.



Male Sexual and Reproductive Parts

WOMEN'S BODIES

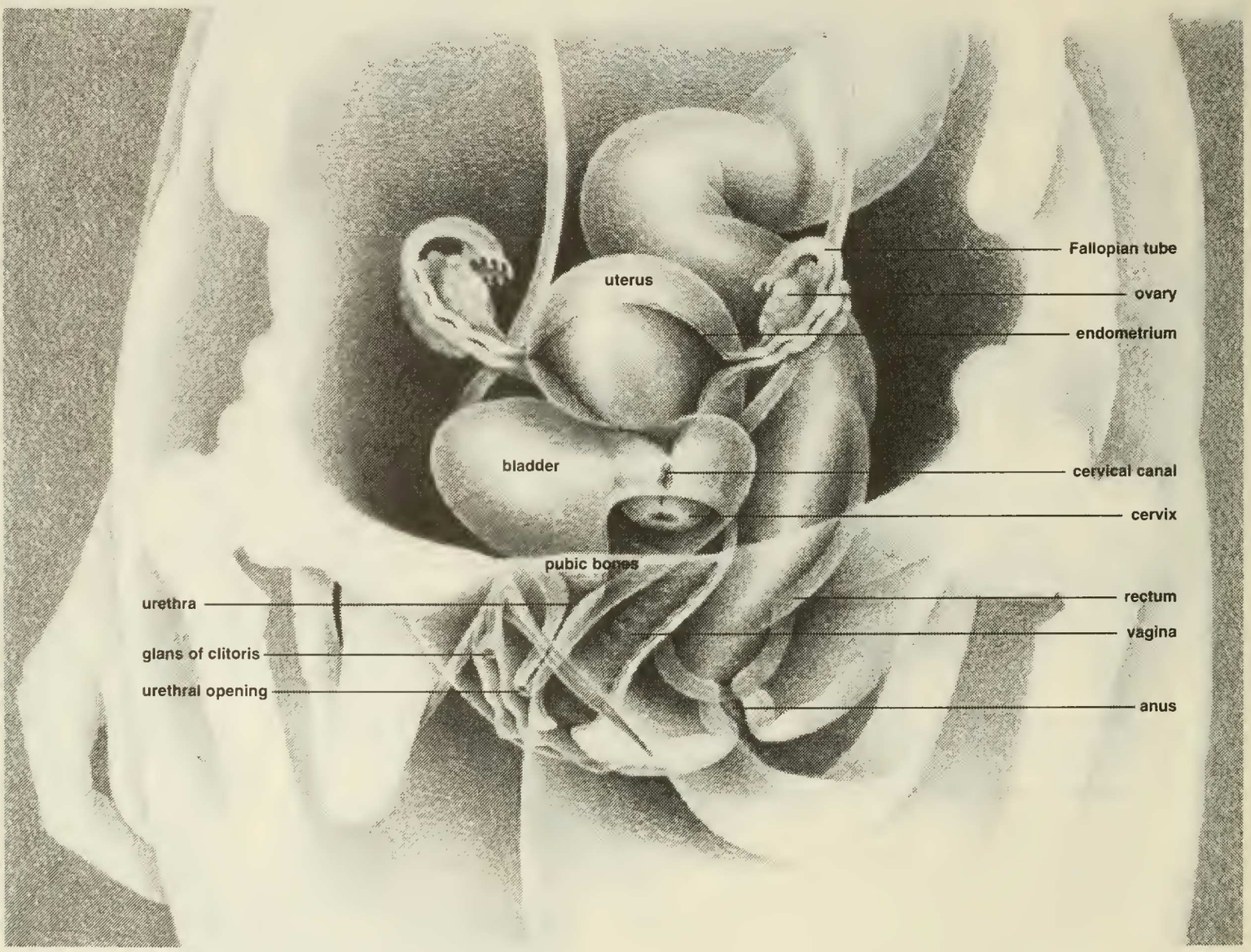
In women, reproductive organs are inside the pelvis, protected by bones and muscles. Sex organs lie outside these muscles. You can look at your own genitals easily by holding a mirror between your legs. These outer structures together are called the **vulva**.

Outer Lips (labia majora): folds of tissue beginning at the fatty cushion over the pubic bones (mons veneris) and joining in front of the anus. In young girls they meet, protecting the vaginal opening; at puberty they move apart and become covered with pubic hair.

Inner Lips (labia minora): delicate folds of moist pink skin lying between the outer lips, surrounding the vaginal opening and forming a hood over the clitoris. When a woman is excited sexually they become engorged with blood which makes them slightly erect.

Clitoris: an exquisitely sensitive organ lying just below the mons. The tip (glans) is covered by a hood formed by the inner lips. 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. During excitement, it engorges with blood, becomes erect and pulls back under the hood.

Urinary Opening: opening of the tube from the bladder (urethra) through which women urinate (pee); lies just under the clitoris and above the vaginal opening.



Female Sexual and Reproductive Parts

Sheryl Ann Medicoff

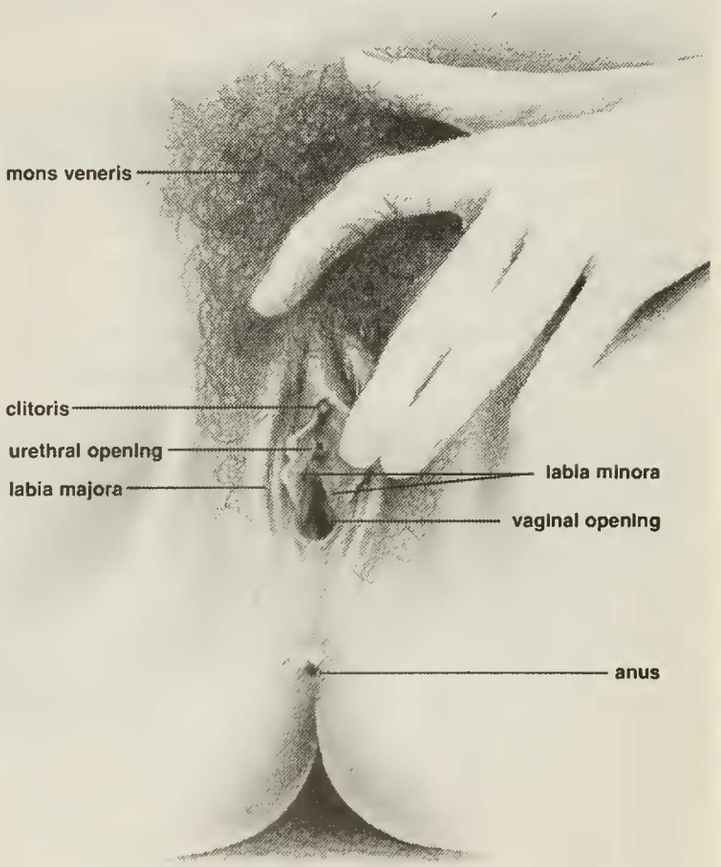
Vaginal Opening: outer part of the vagina located behind the urinary opening. During sexual stimulation it becomes moist and the surrounding erectile tissue becomes engorged with blood. The pelvic muscles around the vaginal and urethral openings contract and relax during orgasm. They can also be contracted voluntarily, for example, to stop urinating. 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 insert a tampon. The hymen stretches and may tear slightly the first time the vagina is penetrated. Afterwards, only its edges are visible.

Vagina: a tube-shaped structure lying between the urethra and rectum. It is made of soft elastic folds and lined with a moist mucous membrane like the inside of the mouth. During sexual stimulation, the vagina expands and lubricating fluids pass through the membrane; the deeper part of the vagina is much less sensitive (except just under the urethra) than the opening.

Uterus: a pear-shaped muscular organ which holds the fetus during pregnancy; about 8 cm (3") long and 5 cm (2") wide (slightly larger after pregnancy). The inside is lined with spongy tissue called the **endometrium** which thickens each cycle in preparation for pregnancy. When pregnancy does not occur, the lining breaks down and bleeds (menstruation). The **cervix,** the bottom part of the uterus, opens into the vagina. Its glands make mucus around ovulation which helps sperm get through. This mucus causes a feeling of wetness which can help you detect when you are fertile. 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 bends backwards or enters the vagina from an angle toward the back. This is not a problem but can affect the use of birth control methods such as the diaphragm.

Fallopian or Egg Tube: delicate tubes about 10 cm (4") long. The open end widens near the ovary and the narrow end attaches to the uterus. The open end picks up the egg released by the ovary; tiny hairs lining the tube move the egg toward the uterus. Conception—when the egg and sperm join—takes place in a tube.

Ovary: almond-shaped glands which contain egg cells and produce hormones. At birth, each ovary contains thousands of immature egg cells. From puberty on, the ovaries get "turned on" by signals from the **pituitary**, a small gland in the brain. They produce **estrogen** and **progesterone**, the hormones which control the menstrual cycle.



Vulva: female genitals

The Menstrual Cycle

Menstruation represents the ability to reproduce. From puberty to menopause, a woman's body prepares for pregnancy each month. When pregnancy does not occur, the lining of the uterus breaks down and flows out through the cervix and the vagina. This bleeding marks the beginning of a new cycle. Many women enjoy their cycles and feel in touch with their bodies and other natural cycles through them.

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) sends them a signal to produce more. When hormone levels rise, the pituitary stops signaling the ovaries which in turn stop producing hormones. When hormone levels fall, the process starts over again (see menstrual chart).

The length of a cycle varies from one woman to another and from one cycle to another. *Cycle length depends on the time it takes to release an egg (ovulate).* Once the egg is released, menstruation follows about 14 days later. The range of cycle length is about 24 to 35 days; ovulation occurs around day 10 in a 24 day cycle and around day 21 in a 35 day cycle.

To calculate the length of each cycle, count the first day of bleeding as day 1 and the last day as the day before bleeding starts again. Having regular periods means that you know about 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 8 to 10 days.

Menstrual Bleeding

Menstrual flow contains blood, white cells 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. Women lose about 30cc of blood (about 2 tablespoons) during each period which lasts between 2 and 8 days. Bleeding may be abundant for several days and then taper off. Some women have no discomfort during their period; others have severe pain. If your cramps are not relieved by simple measures such as a heating pad, exercise or mild pain-killers, or if you miss work or school because of them, you should consider seeing a doctor to find an explanation and relief.

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. If you are infected with the AIDS virus, you may be more likely to transmit it to someone else if you have unprotected sex during your period.

Toxic Shock Syndrome (TSS), *caused by the growth of toxin-producing bacteria, is* linked to *the use of tampons, particularly super absorbent ones.* TSS *causes flu-like symptoms such as fever, nausea, vomiting, and a rash. Since TSS can be fatal, anyone with these symptoms while using a tampon should remove it and take it with her to the emergency room. To reduce the risk of TSS, manufacturers recommend changing tampons regularly and using the high absorbency ones only when necessary. If you use tampons overnight, insert a new one just before going to bed and remove it as soon as you wake up. Women who have had TSS should probably not use barrier methods such as the diaphragm or sponge.*

Premenstrual Syndrome (PMS)

Controversy still exists about emotional changes related to the menstrual cycle. Scientists have not been able to show a direct link between a specific hormone and disturbed emotions or abilities. Nonetheless, PMS has been accepted in popular culture by both women and men. It has even been used as a legal defense to explain violent acts.

There is nothing inherently wrong with emotional variation—it is not a sign of mental illness. A small minority of women suffer severely with PMS and may benefit from anti-depressant medication.

Some studies suggest that many women with PMS have other problems—chronic depression, unhappy relationships, ongoing life stressors such as poverty, responsibility for ill family members etc. Most women would benefit from an improvement in their living conditions and equal opportunities in society. Women are socialized to be nice and to put their needs after those of others. Premenstrual irritability and anger may simply mean that women censor their emotions less at this time.

The Menstrual Cycle And Birth Control

The chapter on fertility awareness methods (p.21) describes how to take advantage of the fertile time in each cycle to become pregnant or avoid a pregnancy. These strategies work well for women with regular menstrual cycles but are less effective for young girls around puberty and midlife women approaching menopause. For a young girl, there is a slight risk of pregnancy before the first period because ovulation can occur before menstruation. Many adolescent girls have irregular periods since it takes awhile before enough hormone is produced with the right timing to cause ovulation each cycle. When young girls have sex without birth control and don't get pregnant, they may continue taking risks, thinking that they can't get pregnant. Young girls do not have to wait to have periods before starting the Pill. Condoms are a good idea for early sexual experiences because they also prevent STDs.

Women approaching menopause have a similar problem. Women in their forties know they are less fertile and may be less vigilant. You must wait at least a year after your last period before celebrating (or mourning) the end of fertility. Until then, midlife women who don't smoke can still use the Pill; many do so to control irregular or heavy bleeding. Smokers can use the minipill. Barrier methods and IUDs are well suited for this age group.

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

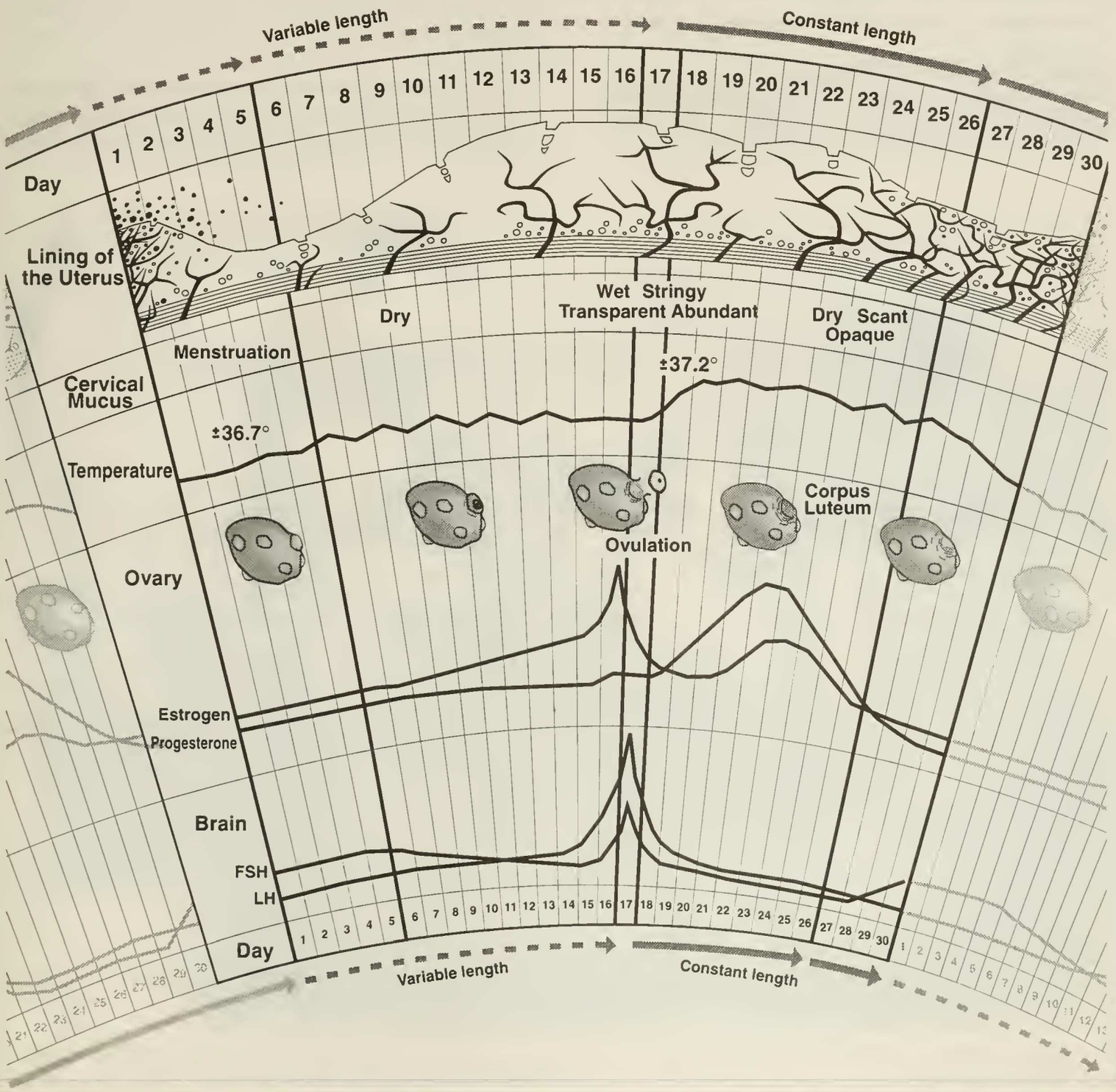
After ovulation

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.



Getting a Check-up

Some birth control methods such as the Pill or IUD require a visit to a doctor. If you use condoms or other methods which do not require a medical visit, you still need an occasional check-up. The frequency depends on your lifestyle and personal health.

To get the most out of your visit, you need to be open about your sexual lifestyle and your concerns. Health workers can share with you successful birth control strategies that other women have used. This chapter will prepare you for your first birth control consultation and set a standard by which you can judge the quality of the services you get.

Whether you go to a family planning clinic, a hospital, a family doctor or a gynecologist, a birth control visit should include:

- **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, screening for sexually transmitted diseases).**

Reviewing Your Situation

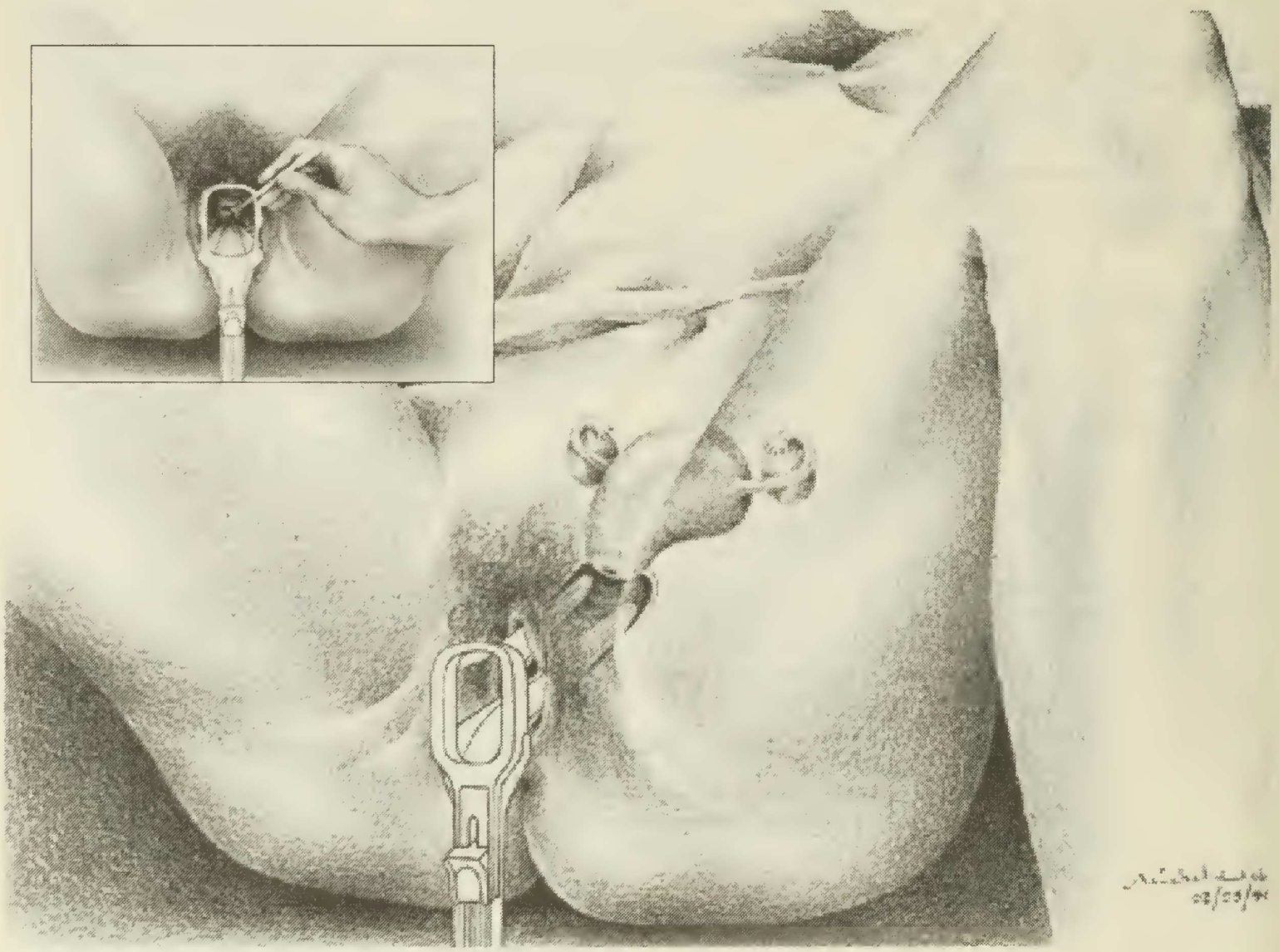
Tell the health worker why you've come: to renew your prescription, to change methods, etc. Describe your experience with birth control. Which methods have you used? What did you like or dislike about each? What are you using now? For how long? Are you having any problems with it? Do you have a back-up 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? What are you doing to avoid sexually transmitted diseases? Have you been vaccinated against hepatitis B?

What are your plans for pregnancy? 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? How long and how much do you bleed? Do you have cramps? Do you bleed between periods or after intercourse? When was your last period?

The health worker asks questions about your past health (illnesses, allergies, operations) and that of family members. Are you taking any medication? Do you have any symptoms which worry you?



Pelvic examination: a plastic or metal speculum is placed in the vagina so that the cervix and the folds of the vagina can be seen. Inset: Taking a Pap test.

Physical Examination

Many people are nervous about a physical examination. We are not used to exposing our bodies, particularly our sexual parts, to a stranger. We may worry that the exam will hurt or that a serious problem will be found. The more you relax, the less uncomfortable the examination will be. Taking long slow breaths is helpful. Let the examiner know if you are particularly anxious. A pelvic exam is not necessary at your first visit if you have not had male-female sex with penetration.

A bath, shower or simply washing the genitals is adequate preparation for a pelvic exam. Do not use douches, creams and powders for at least 24 hours before the exam because they hide signs of infection. You will be more comfortable if you urinate (pee) beforehand. To be properly examined, you must undress; a robe or sheet should be provided for you.

The doctor takes your blood pressure and examines your neck, breasts, heart and abdomen, looking for lumps, swellings, painful spots or other signs of disease. For a pelvic exam, you lie on your back with your buttocks at the edge of the table, your feet in supports and legs apart. The outer genitals are examined for sores or irritation.

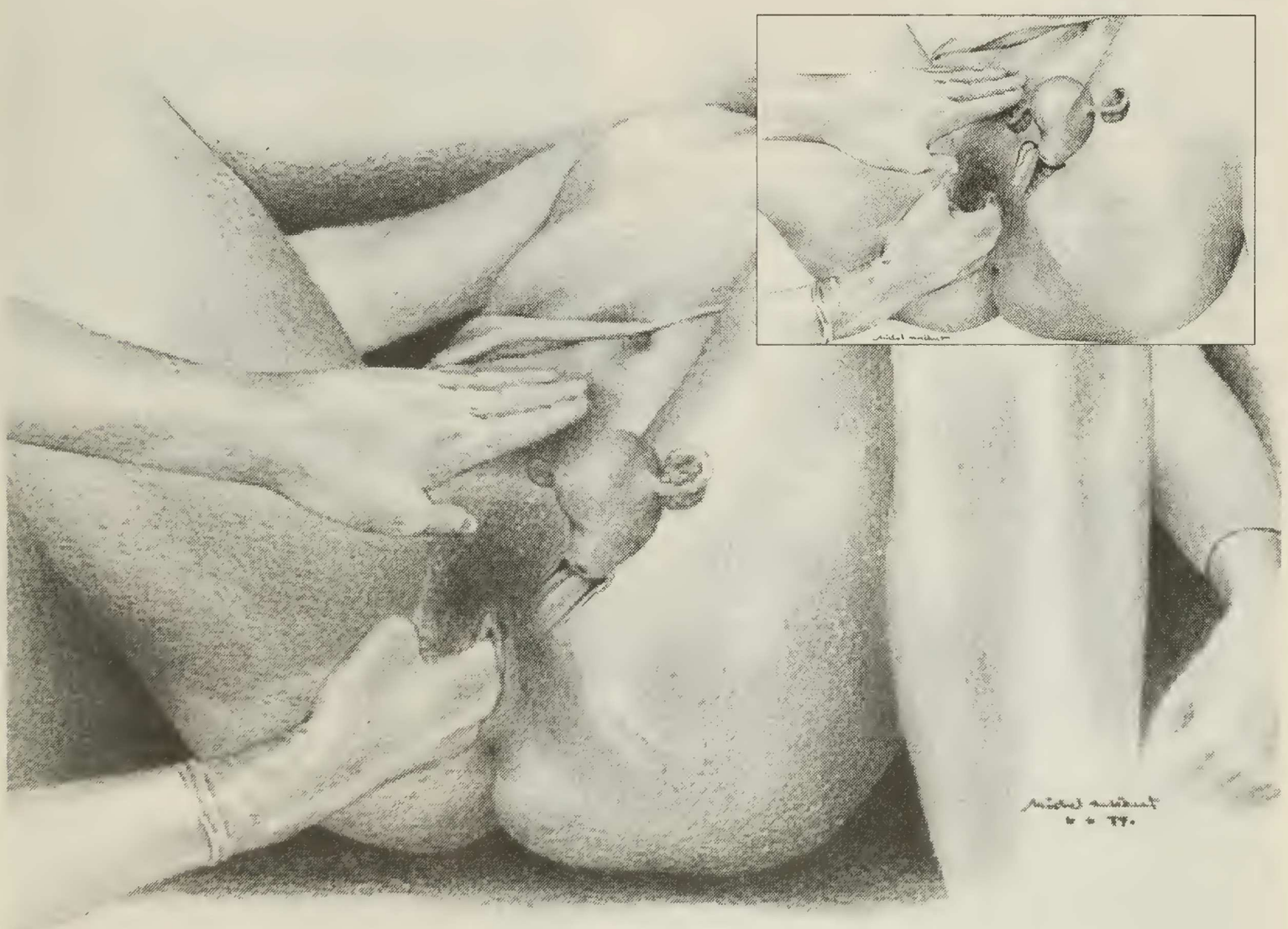
To look inside the vagina, the examiner uses a metal or plastic instrument called a speculum. A metal speculum should be warmed before use. The speculum is inserted into the vagina with its blades closed. The blades are gently opened and adjusted until the cervix is seen. The examiner may do several tests which can be slightly uncomfortable. The Pap test (cytology) for cervical cancer is done every year or two. A flat stick and a Q-tip or fine brush are used to collect cells from the surface of the opening of the cervix; the cells are put on a slide and sent to a lab.

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 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. 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.

Lab Tests

If you are healthy, few tests are necessary. Make sure you understand the purpose (and cost) of any tests. A blood test for antibodies against rubella (German measles) will tell you if you need to be vaccinated to prevent problems in a future pregnancy. Women with a family history of



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

Getting The Most Out of a Consultation

Some 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 jargon. They may be embarrassed or feel judged, especially about sexuality. These suggestions will help you get what you want during your visit:

- *Write down your questions beforehand. 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.*
- *Consider bringing someone with you to help you remember your questions and to go over the visit with you later. Including your boyfriend might help him learn to participate more in using birth control. Make sure you still feel free to talk with the doctor about yourself.*
- *Ask for written instructions: how to use the method, when you should come back, what you should do if you have a problem.*

blood clots can be tested for coagulation problems before starting the Pill. You might discuss whether or not to be tested for HIV/AIDS.

Wrapping Up

Once you choose a method, make sure you understand how to use it and when and why you should come back to the clinic. If any problems are found, the counselor should explain them to you, and arrange further tests or visits. You might want help or information about lifestyle issues such as smoking. Finally, there should be time to review your questions to be sure they have been properly answered.

Judith Crawley

PREGNANCY

How You Get Pregnant

Pregnancy begins with conception (fertilization), when an egg from a woman joins with a sperm from a man. *If 100 women have sex regularly for one year without any birth control, about 90 of them will become pregnant.*

Women's Role: At birth, a girl's ovaries contain many thousands of unripe eggs. Each one contains 23 chromosomes (strands of genes). After puberty, one egg is released (ovulation) each cycle. The egg is drawn into the end of a Fallopian tube and moved toward the uterus by tiny hairs lining the tube. If fertilization does not occur within 24 hours, the egg dissolves. A "nesting place" develops within the uterus for the fetus. The lining thickens and produces substances which will feed the fertilized egg.

Men's Role: From puberty on, men produce millions of sperm cells continuously. Each sperm cell has a large head which carries 23 chromosomes, and a long thin tail which moves back and forth, pushing the sperm along. Sperm are carried from the testicles to a storage place behind the prostate. Just before a man ejaculates, sperm are mixed with fluid from the prostate and other glands. During orgasm, this fluid (semen) spurts out of the urethra. One ejaculation contains about 350 million sperm.

Fertilization: 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.

When one sperm joins with a ripe egg in the Fallopian tube, no other sperm can enter. As the fertilized egg floats down the tube, the chromosomes combine. The fertilized egg divides into a cluster of cells which reaches the uterus in about 3 days. It floats there for 2-3 days before burying itself in the lining of the uterus (implantation). The endometrium does not break down so menstruation does not occur.

The endometrium feeds the cluster of cells which continues 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.

How To Know You Are Pregnant

If you miss a period or if it is much lighter than usual, you should ask yourself if you could be pregnant: did you miss any pills or not use a condom? Do you have other signs of pregnancy such as nausea or swollen breasts?

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 easier the procedure. If you don't know what to do, you've got time to think or get help. If you suspect you are pregnant and do not want to be, continue using birth control until you know for sure.

Pregnancy tests measure a hormone called HCG (Human Chorionic Gonadotrophin). A blood test detects pregnancy within days after fertilization. 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.

Judith Crawley

A pelvic examination (p 17) will confirm that you are pregnant and how advanced the pregnancy is. 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. At 7-8 weeks (3-4 weeks after a missed period) the uterus is big enough for the examiner to feel the difference. At 12 weeks, the uterus can be felt above the pubic bone.

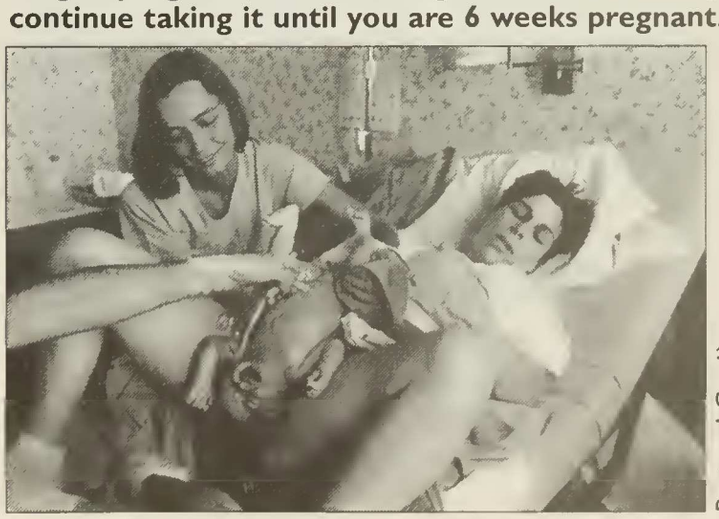
Preparing For Pregnancy

Stopping birth control: When you decide you want to have a baby, stop using your birth control method. Many Pill users wait until they have one period while not on the Pill before trying to get pregnant. This gives you a better idea of when the baby is due. You need only wait until your period to get pregnant after an IUD is removed (no delay if removed during your period). After stopping Depo-Provera, you might wait until getting a period before trying; otherwise you will not know if your period is late because of the injections or because you are pregnant.

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.

If you are not immunized against German measles (rubella), a disease which causes malformations, you should receive the vaccine and wait 3 months before becoming pregnant. Ask a doctor about special tests if someone in either of your families has a genetic problem. Find out about the effect of pregnancy on any chronic disease (diabetes, lupus) you have. 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.

The vitamin, folic acid, reduces the risk of malformations affecting the brain and spinal cord. Folic acid is present in certain beans and green vegetables but it is difficult to get enough in your diet. **If you are trying to get pregnant, take 0.4 mg of folic acid daily; continue taking it until you are 6 weeks pregnant.**



Bertrand Carrière

Unplanned Pregnancy

Birth control methods are not perfect. Neither are people. An unplanned pregnancy can happen to anyone.

People's reactions to an unexpected pregnancy are not always predictable or clear. You may assume you would have an abortion but when faced with the actual decision, you may reconsider. Or the opposite: you thought you were against abortion for yourself, but when you find yourself pregnant, you re-evaluate your position.

Often, an unplanned pregnancy is easily accepted. The woman or couple feel able to make the adjustments for parenting. They accept the "accident" and look forward to the future. Others find an unplanned pregnancy unacceptable and choose abortion, knowing they can have children if they desire at some other time. Having the baby and giving it up for adoption is an option for some women but many are unable to go through with it once the baby is born.

If you find yourself pregnant unexpectedly, give yourself some thinking time on your own. Go for a walk, take yourself out for lunch. This is your decision about your future. Think about who the best person (or people) is to share this turning point with you. Do you want someone to help you look at the options—a friend, a counselor? 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?

Feelings About Pregnancy Affect Birth Control Strategies

Thoughts of pregnancy often take second place to sexual explorations, especially when we first start having sex. Even with more experience, emotions may override better judgment. For many, the first real recognition that sex can lead to pregnancy occurs only when a period is late.

How you feel about becoming pregnant influences your choice of birth control and how well you use it. 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, the easier it is to make birth control part of your sex life.

Skjold Photographics

If pregnancy is unacceptable now and abortion is not an option, you need to use very effective birth control all the time. However, if you feel more comfortable about an unplanned pregnancy (either because you know you would have an abortion or would accept becoming a parent), you might choose your birth control method for its lack of side effects rather than its effectiveness. If you want to be pregnant, even though you've decided it's not the right time, you are likely to be careless with your birth control method.

There is no right time to have a child. Some people will have many children, others none. Some will try to follow a plan—have children at a certain age or when they have a good job; others let nature take its course. Sometimes, even when our situation is not what we'd like it to be, we still want to have a child. We go ahead, knowing we have some challenges ahead. Having a child always changes our lives. Many loving parents say that the responsibility for the welfare of a child is bigger than they expected.

Pregnancy is rarely a good solution for personal problems such as failing at school, not having a job or fear of losing a partner. If you find yourself forgetting the pill or not bothering to use the condom, ask yourself (and your partner) if having a baby now is really what you want.

Vincenzo Pietropaolo

Infertility

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 getting tested for infertility. Finding and treating the problem (if there is one) 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 effects of working conditions and pollution on reproduction are under study. Sexually transmitted diseases can cause infertility when they form scar tissue which blocks the transport of egg or sperm.

Rarely, some birth control methods contribute to infertility. If a woman has an IUD, an STD such as chlamydia is more likely to cause infertility. Hormone injections do not cause infertility but conception may be delayed afterwards. Rarely, over-scraping of the uterus during abortion causes infertility.

Infertility is a complex subject beyond the scope of this book. Information is available from local health care workers, women's groups and on the Internet. Reproductive technologies used to overcome infertility are costly and controversial.

Fertility Awareness Methods

Most women are aware that they are more likely to become pregnant at certain times of the menstrual cycle but few know how to calculate the time correctly. Many women enjoy learning to observe the changes of their own menstrual cycle and use this knowledge as part of their birth control strategy. Fertility awareness methods are the only means of birth control approved by the Catholic church.

The fertile period can be calculated 4 ways:

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

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 events of the menstrual cycle and on sperm survival:

- The egg can live for 24 hours after ovulation.
- Sperm usually live for about 3 days, rarely up to 5 days.
- The time from the start of menstrual bleeding until ovulation varies from 6 to 20 days.
- Ovulation occurs about 14 days before the next period.
- Progesterone released by the ovary after ovulation causes a slight rise in body temperature until the next period.
- Mucus produced by the cervix is scant, thick and milky when a woman is infertile, and abundant, thin and clear when she is fertile.
- Since the exact time of ovulation cannot be predicted, 2 to 3 days are 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 = **91** to **98%** effective; typical users = about **80%**). If calculation of the fertile period is done regularly and both partners co-operate to abstain from intercourse when the woman is fertile, they can effectively avoid pregnancy. Using a second method such as the condom during the "safe" days increases effectiveness. However, using condoms during "unsafe" days means relying solely on the condom.

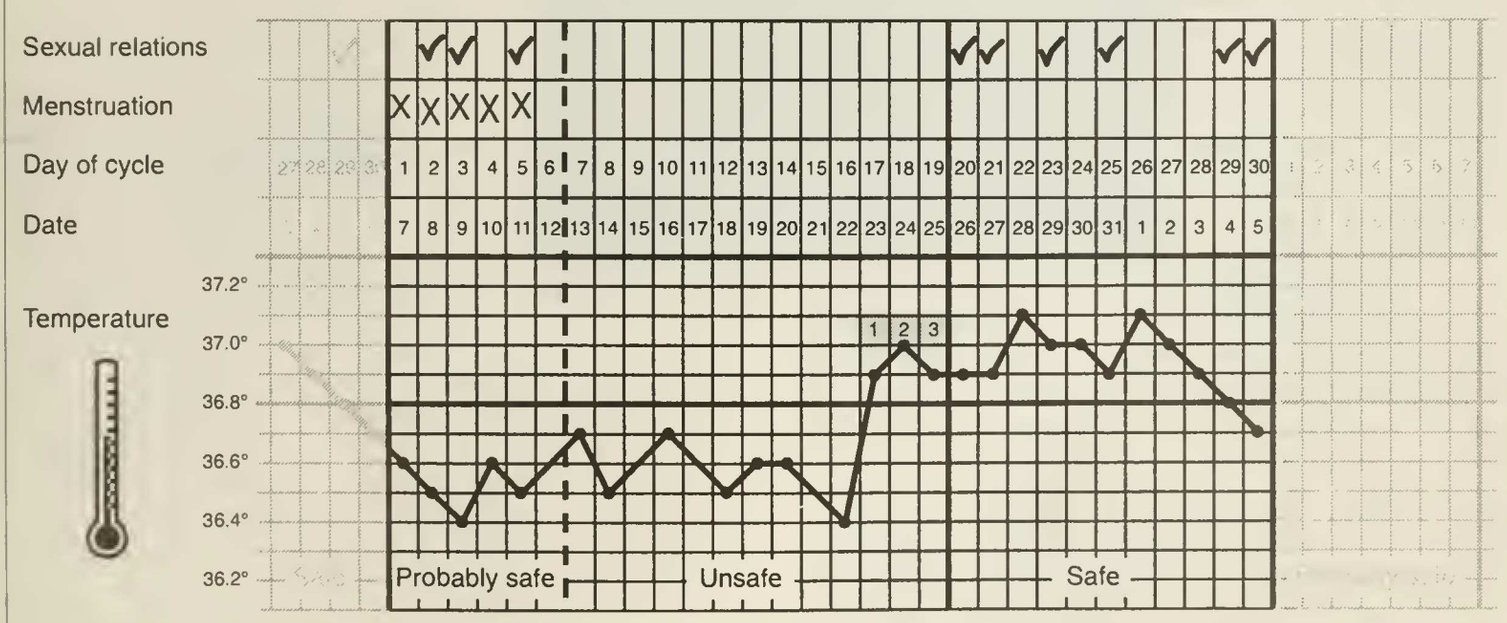
Effect On Sexuality

Fertility awareness methods limit vaginal intercourse to the "safe" times, anywhere from 8 to 15 days each cycle.

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	21st day
33 days	15th day	33 days	22nd day
34 days	16th day	34 days	23rd 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

Temperature Method



Technology & Fertility Awareness

Calculators and computer programs *exist to help determine your fertile period.* ***Ovulation prediction kits*** *which were developed to help women get pregnant, detect a rise in the hormone LH which precedes ovulation. These kits are expensive and have not been adapted for birth control.* ***Enzymes in saliva and urine*** *change around ovulation; an electronic monitor which uses urine tests to calculate the fertile period is available in Britain.*

non-procreative sex can still be enjoyed. Communication is important to successfully use these methods. Usually women do the calculating but men need to know what is expected of them. You can keep the chart at hand and take turns figuring out the "safe" times. You should know about emergency contraception (p 37) in case you have sex at an unsafe time. Partners who see each other infrequently may have trouble accepting the discipline these methods require.

Effect On Fertility

To get pregnant, you can use the same calculations to have intercourse when you are most fertile. Many couples just 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, the fetus will not be affected.

Use

To use these methods, you need to learn the signs of fertility. Some doctors and clinics offer instruction. Training by couples who successfully use these methods is offered by SERENA, Fertility Management Services and the Couple to Couple League. Some of these groups have religious ties which may not be obvious in their publicity. Internet sites with information on fertility awareness are *www.fertilityuk.org* and *familyplanning.net*.

Women with irregular cycles, who have just had an abortion or given birth or who are breastfeeding may have more difficulty determining their fertile period.

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.

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). Record your temperature on a graph and note the days of menstruation, sexual activity and any factors influencing your temperature.

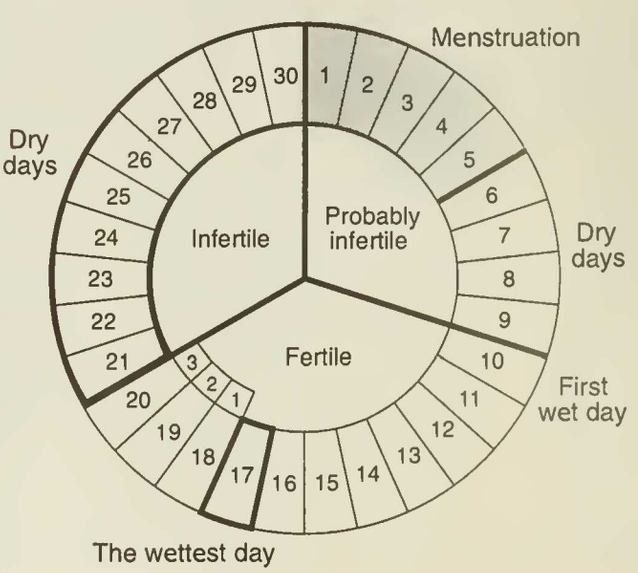
The unsafe time begins on day 3 of the cycle or as calculated by the calendar method. When your temperature starts to rise, draw a line on the graph one tenth of a degree higher than the highest temperature recorded earlier in the cycle. When the temperature remains above this line 3 days in a row, the fertile period is over. You can safely have penis-vagina sex from that evening through to your next period. You must repeat the calculations each cycle.

Cervical Mucus: Use your fingers to examine the cervical mucus present at the vaginal opening. 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), days with sticky, cloudy secretions, moist to wet days with slippery clear discharge and back to drier days with sticky, white secretions until the next period.

During menstruation and the first dry days, you can have intercourse every other day; this restriction ensures that you do not miss the first sign of increased secretions. Once you aware of stickiness or wetness, you abstain. 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, *whichever comes last*.

Cervical Mucus Method



Withdrawal

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

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 most people, withdrawal is only moderately effective **(82%)** but it is better than nothing. If done correctly all the time, it is probably quite effective **(96%)**. Effectiveness varies according to a man's culture, age, experience and willingness to take full responsibility for pregnancy prevention. Younger men have difficulty controlling ejaculation. In some cultures, as boys come of age, they learn to delay and control ejaculation. Alcohol and drug use probably reduce effectiveness. A second penetration after the man ejaculates may be another cause of failure as some sperm may be left in the urethra.

Effect On Sexuality

Coitus interruptus is exactly what the name says—an interruption of intercourse. The man must be alert and able to withdraw his penis in time. A woman may doubt her partner's ability or intention to withdraw. Such vigilance can interfere with sexual pleasure. Some couples find the method messy. Experienced couples can adapt their sexual behaviour and use this method satisfactorily; young people with little sexual experience are often less successful.

Skjold Photographics

Effect On Health

Withdrawal has no side effects. Reduced contact with sperm probably decreases HIV risk for women.

Use

Both partners need to agree to use withdrawal as their method. The man must be aware of his level of sexual excitement. When you feel yourself approaching orgasm, you withdraw your penis from the woman's vagina and 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.

If either partner wishes to continue, you can use other forms of sexual stimulation. If penetration is desired after you ejaculate, you must wash or wipe your penis, particularly the tip. Urinating will probably flush out sperm from the urethra.

Condoms

The male 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 only female condom available has a flexible ring at each end, holding the sheath in the vagina. Underwear with a stretchy crotch is another model under study. Condoms have become more popular as public health campaigns promote their use to prevent infection with HIV/AIDS.

Most condoms for men are made of latex. Skin condoms, made from animal intestines, are expensive and may be less effective for disease prevention. *Avanti* is a polyurethane condom which seems to be more resistant and to increase sensation. The female condom, *Reality*, is also made of polyurethane.

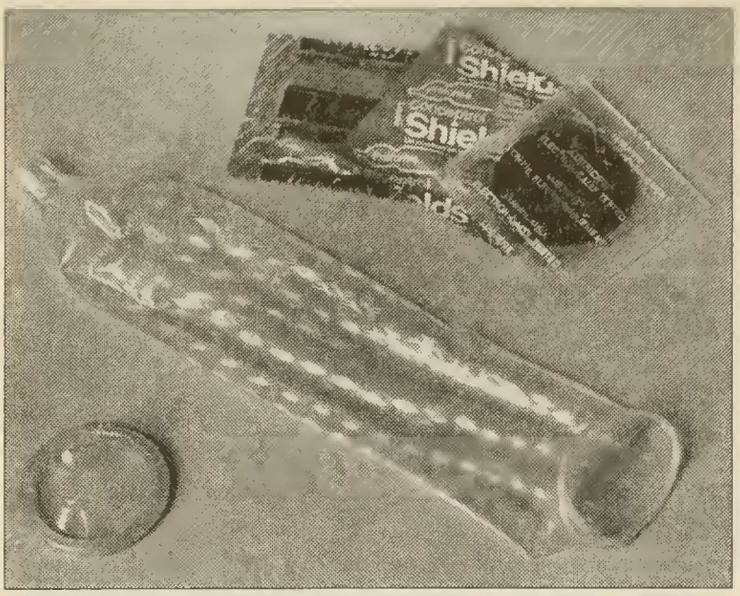
You can buy condoms without a prescription in drugstores and at some birth control clinics or order them from mail-order services on the Internet (*www.condomania.com* or *www.condom.com*). Many brands exist, either dry, lubricated or with spermicide. Most condoms for men are about the same size (19 x 5 cm or 7-8 x 2 inches); some brands are a bit bigger (Beyond Seven, Crown, Kimono, Maxx, Trojan Very Sensitive) and others smaller (SnuggerFit). The female condom is loose-fitting and comes in one size.

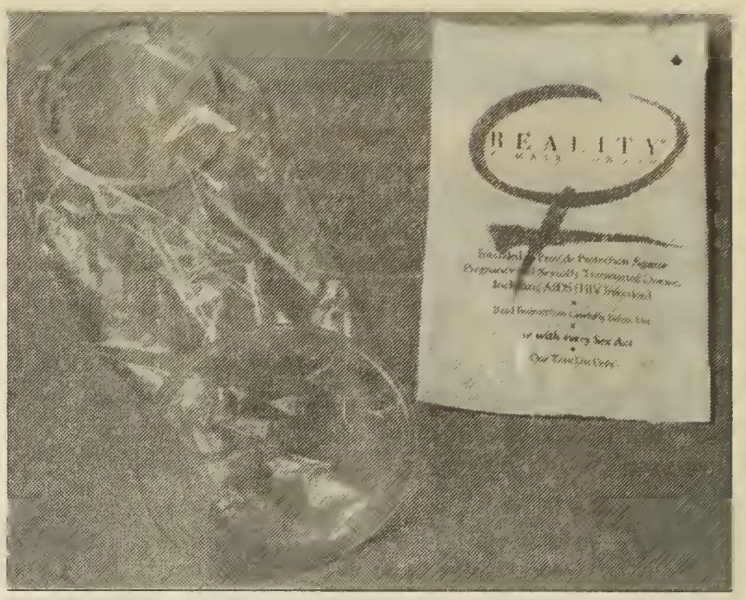
How They Work

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

Effectiveness

Condoms for men are highly reliable (**97%**) if used correctly every time there is the slightest penetration of the woman's vagina. For the typical user, effectiveness is about **86-88%**, with non-use the reason for most failures. Condoms break less than 2% of the time and slip slightly more often. Adding vaginal spermicide increases protection to over 99%. The condom for women is almost as effective (**95%**) but errors in use may be more frequent (typical use = **79%**).



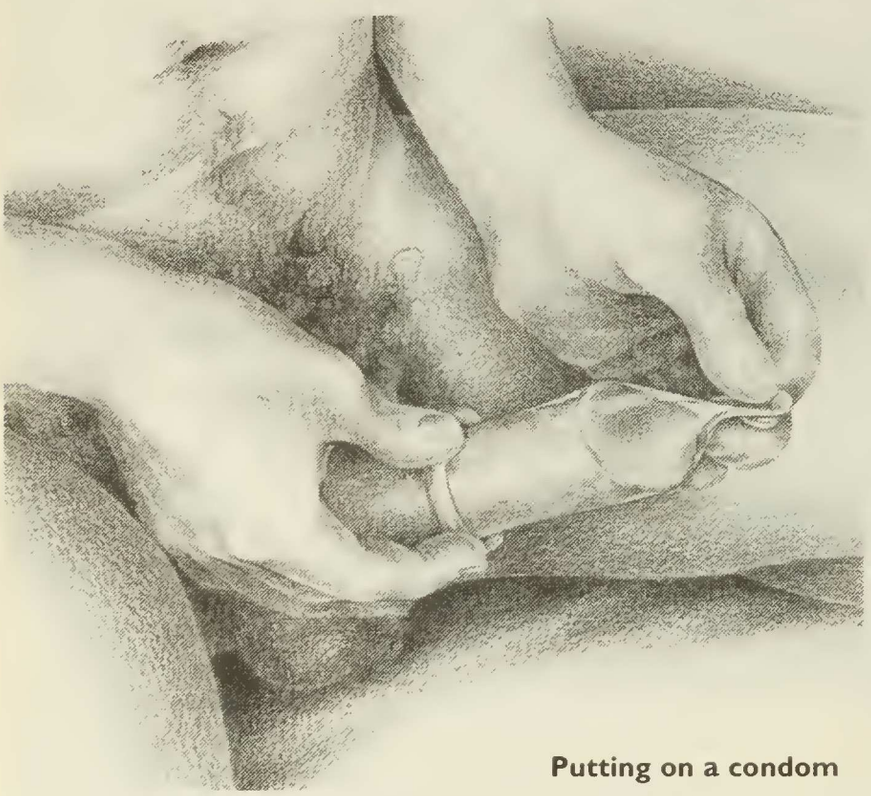


Effect On Sexuality

Though some people dislike interrupting sex to put on the condom, others find ways to make condom use playful and erotic. Either partner can initiate the use of the condom, indicating a desire for penetration. If the rubber smell of one brand bothers you, try another brand.

Products used with condoms for lubrication must be water soluble (spermicides, examining gels, glycerin, saliva & most sexual lubricants). Condoms for men are weakened by oil based products such as Vaseline, edible oils, certain sexual lubricants and vaginal medications (hormones, yeast treatments).

Modern condoms are thinner and affect sensation very little. Try different brands to find a fit you like. Putting a drop of lubricant on the tip of the penis before unrolling the condom may help. 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.



Putting on a condom

Reactions to the female condom vary. Polyurethane allows better heat transmission than rubber. Some like the looser fit. The outer ring may improve stimulation or get in the way. Some couples complain of noise during vigorous sex; adding lubricant may solve this problem. You might need to try it a few times to feel comfortable with it.

Effect On Health

Either partner can be allergic to compounds in the condom or the lubricant. Try changing brands. If you are allergic to latex, try polyurethane condoms, either *Avanti* or the female condom.

Condoms for men offer protection from most sexually transmitted diseases including hepatitis B and HIV/AIDS; few studies of the female condom exist but lab tests support its effectiveness. The female condom may offer better protection from STDs such as syphilis, herpes or warts since it partially covers the outer genitals. Regular condom use decreases a woman's chance of developing precancerous cells on the cervix.

Effect On Fertility

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

Use

Buy condoms ahead of time; keep them in places you are likely to have sex and in your travel case or purse. Let your partner know that you are prepared—your concern should be appreciated. If your partner objects to condom use, try to make it more appealing or suggest sex without penetration. *Do not use male and female condoms at the same time.*

Male condoms: Condoms keep in their packages for about 3-5 years (2 years for those with spermicide) if not exposed to heat. Check the expiry date. Condoms can be carried in your wallet or pocket only for a short time because body heat can harm them.

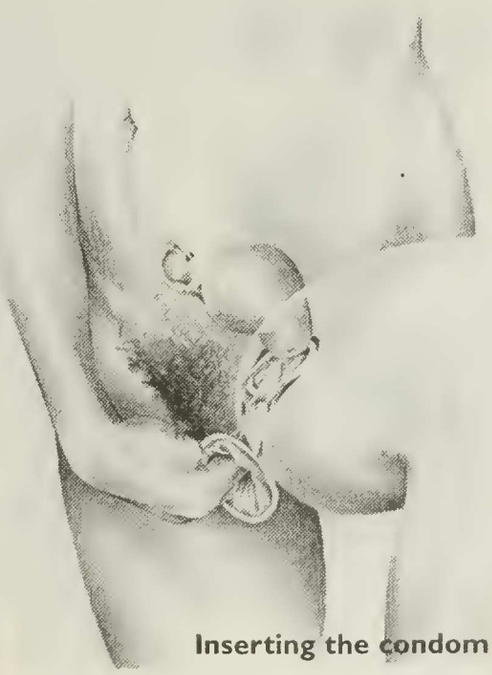
If you have never used a condom, practice putting one on when you are alone. Most condoms are pre-rolled. Uncircumcised men should pull back the foreskin before putting on the condom. Either partner can put the

condom on the man's erect penis. Leave a half inch space at the tip to collect the semen. Squeeze the tip to remove any air and unroll the condom to the base of the penis. A stronger band of latex at the open end keeps the condom from slipping off. Be careful not to tear it with rings or fingernails.

Put on the condom *before* any penetration of the vagina. After ejaculation, you must withdraw your penis before losing your erection. Hold the end of the condom against the base of the penis to prevent semen from leaking out. A new one must be used for another penetration. If the condom breaks or semen spills out, the woman can consider taking the "morning after" pill.

The female condom: Before using it with a partner, practice inserting the condom a few times, following the illustrated package instructions. You can put it in up to 8 hours before sex. Find a comfortable position; squeeze the inner ring with the fingers of one hand and separate your lips with the other. Insert the ring, then use one finger to push it up further. Check that it has lodged behind the pubic bone. Make sure the sheath is straight, not twisted. The outer ring will hang loosely about an inch from the vulva. Guide your partner's penis into the opening; you may want to add lubricant to the inside of the condom or directly onto the penis. Make sure the outer ring does not get pushed inside the vagina. To remove it, twist the outer ring to keep the sperm within the sheath; pull down gently.

Squeezing the condom ring



Inserting the condom

Vaginal Spermicides

A spermicide kills sperm or stops sperm from moving. Throughout history, women have put substances in the vagina to prevent pregnancy. These home-made methods were easily available and somewhat effective. Today, spermicides come in many forms: foams, creams, jellies, sponges, film and suppositories. They can be used alone or to increase effectiveness with other methods such as condoms.

How They Work

The sperm-killing chemical in most spermicides is nonoxynol 9 which destroys the membrane of sperm cells. It is mixed with a base which coats the vagina and, to a certain extent, blocks the cervix. Advantage 24 is a bioadhesive jelly which releases spermicide for 24 hours. The sponge which contains 3 spermicides also traps sperm.

Effectiveness

Spermicides are very effective **(94%)** when used correctly all the time. Failures occur when they are not used properly (for example, not shaking the foam container) or not used at all. For the typical user, spermicides are **74%** effective. The *Protectaid* sponge may be slightly more effective **(80%)**;further studies are needed to see if the rate is the same in all women, whether or not they have given birth. Most pregnancies occur in the first 4 months of use.

Effect On Sexuality

Spermicide use affects spontaneity. You need to wait about 15 minutes after inserting a suppository or film for it to melt. Most spermicides must be inserted not more than 1 hour before intercourse. This means carrying the spermicide and applicator with you if you are away from home. *Advantage 24* gel is good for 24 hours after insertion. You need to reapply the spermicide for each additional act of intercourse for all products except the sponge.

Some couples use spermicides for lubrication; others find them too wet. Spermicides may leak out the vagina and give a chemical taste during oral sex.

Effect On Health

Spermicides cause no serious side effects. An allergic reaction can cause genital irritation, rash or itchiness for the woman or her partner. Changing brands may solve the problem.

Inserting foam

Spermicides also kill germs, offering some protection from STDs such as chlamydia and gonorrhea which in turn could reduce transmission of HIV/AIDS. However, if spermicides are used frequently (more than 15 times per month), they may irritate the genitals, increasing the risk of HIV infection. *Advantage 24* and the sponge are less irritating and are under study for HIV/AIDS prevention.

The risk of Toxic Shock Syndrome (TSS, p 14) with the *Protectaid* sponge is unknown. It should not be used during menstruation or for at least 6 weeks after childbirth.

Effect On Fertility

Only very small amounts of spermicide are absorbed through the vagina; if you become pregnant while using it, the fetus will not be affected.

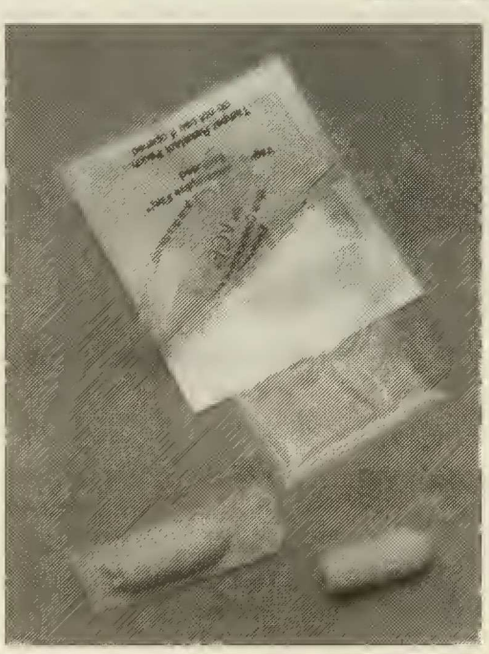
Use

Spermicides are available at drugstores and some birth control clinics without a prescription. Buy two containers since it is difficult to know when you will run out. For foams, jellies and creams, you need to buy an applicator as well. Pre-loaded applicators of foam are expensive for regular use but convenient to carry in a purse. Read the instructions and wash your hands before using a spermicide. Keep spermicides in a cool, dark place.

Load the applicator just before use. For foam (*Emko, Delfen, Koromex*), shake the bottle well (20 times) and gently press the applicator on the nozzle. Foam will enter the applicator, pushing 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, add a second applicator-full. If an hour passes before having sex or if you have a second penetration, add another applicator-full. Afterwards, do not douche. Wash the applicator in soapy water. If foam has dried on it, let it soak in warm water.

To use creams and jellies (*Conceptrol, Gynol II, Shur Seal, KY Plus*), screw the applicator onto the tube to fill it. *Advantage 24* comes in pre-filled applicators.

Protectaid is a small, polyurethane sponge containing F-5 Gel (small amounts of nonoxynol 9, sodium cholate and benzalkonium chloride). You insert it high in the vagina 15 minutes before intercourse and leave it in place 6 hours after the last penetration for a maximum of 12 hours. To remove it, hook your finger around the edge and pull down; you may have to bear down to reach it. *Protectaid* has not been approved in the USA but can be ordered via the Internet (*birthcontrol.com*).



The paper thin *Vaginal Contraceptive Film* (VCF) and suppositories (*Encare, Semicid, Sweet & Fresh*) must be pushed up to the cervix 10-15 minutes before intercourse. Fold the VCF twice before inserting it. These products dissolve completely; a new film or suppository must be used for each penetration.

Reusable Vaginal Barriers
Diaphragm, Cap & Lea Contraceptive

Historically, women have used many different ways to block sperm from entering the uterus. Household objects such as half a lemon worked both mechanically, blocking the cervix, and chemically, stopping or killing sperm. In the late 1800s, European women began using diaphragms and caps for the same purpose. They were also the first to try the *Lea Contraceptive*, the newest barrier device on the market.

These devices can be inserted some time before sexual activity, giving women more control over their fertility. A male partner may not even realize that you are using one.

Since the diaphragm and cap come in different sizes, you need to see a health professional for a fitting. In Canada, you can buy the *Lea Contraceptive* from clinics or pharmacies, although you may have to ask them to order it for you. You can also get it on the Internet (*birthcontrol.com*).

Jeannie Kamins

How They Work

Barrier devices block or immobilize sperm before they can enter the uterus. Sperm cannot reach the protective mucus produced by the cervix; they have trouble surviving in the acid secretions of the vagina. Exactly how long barrier devices can be worn and still be effective and safe is not really known; advice is based on people's experience and intuition rather than on good studies.

The diaphragm is a thin rubber dome with a flexible rim. It fits behind the pubic bone and extends to the inner end of the vagina, holding a sperm-killing jelly against the cervix. The *Prentif Cavity Rim Cervical Cap* is made of rubber and looks like a thimble, with a thick rim which fits snugly over the cervix and a soft cup which protrudes into the vagina. *Lea Contraceptive* is made of soft silicone. It is held in place by suction and covers the cervix and part of the upper vagina (less than the diaphragm). Its one way valve lets air escape to improve suction.

Effectiveness

Barrier methods require discipline to use them every time you have sex. At least half of accidental pregnancies occur due to neglect or incorrect use. To use barrier methods successfully, you need to be comfortable touching your genitals. Failure rates are higher in women who have intercourse 3 times a week or more. Barrier methods are less effective if spermicide is not used with them. For a second act of intercourse, diaphragm users must add more spermicide; leave the diaphragm in place and use an inserter to add foam, cream or jelly. This is optional for cap and *Lea Contraceptive* users. All devices must be left in place 6-8 hours after the last sexual act.

If used correctly all the time, the diaphragm is very effective **(94%)**; however among typical users it is only **80%** effective. Fewer studies have been done with the *Lea Contraceptive* but it appears to offer similar protection. The cap is quite effective (**91%** for perfect use) in women who have never given birth but much less in women who have had a child (**74%**).

To be effective, your device must be in good condition. Check for cracks or holes by holding it up to the light or filling it with water. After use, wash it with unscented soap and pat dry. Avoid contact with talcum powder and oil-based creams (p 24). Check that you have enough spermicide for the next time.

Effect On The Menstrual Cycle

Barrier methods do not change the menstrual cycle. Controversy exists about using barriers during your period because of the risk of toxic shock syndrome (p 14). Menstrual bleeding may make it easier for the device to be dislodged. You can use the diaphragm for an hour or so to prevent menstrual staining during sex but this is not long enough for contraception.

Effect On Sexuality

Barrier methods need not interrupt sexual activity since they can be put in ahead of time. The diaphragm can be inserted up to 6 hours before penetration, the cap and *Lea Contraceptive* up to 40 hours. If you do put it in during sex, wait 10 minutes for suction to develop (30 minutes for the cap). If the presence of spermicide on the vulva interferes with oral-genital sex, washing after insertion should solve the problem.

If the device fits properly, you should barely be aware of it. Sometimes your partner may feel his penis touching the

device. If this is uncomfortable, check with your finger that the device is placed properly. Whether or not vigorous sex or certain positions are more likely to dislodge the device has not been adequately studied. If the device is dislodged, replace it and consider using the morning after pill (p. 37).

Effect On Health

Barrier methods offer some protection from STDs such as chlamydia and gonorrhea, but probably not from HIV/AIDS (see p. 9). Diaphragm users have a lower rate of cancerous changes of the cervix. The FDA (USA) suggests a Pap smear before and 3 months after beginning to use the cap.

Some people are sensitive or allergic to substances in the spermicide or the device itself. People who are allergic to latex should not use the diaphragm or cap.

Diaphragm users are more likely to get bladder infections. This may be due to pressure from the rim or to the spermicide. Regular use of barrier methods may change the normal balance of bacteria in the vagina, possibly causing bacterial vaginosis. This infection, often detected because of an unpleasant smell, may be linked to infection of the Fallopian tubes and infection during pregnancy.

Some women feel pressure or cramps when using a barrier method, especially if they leave it in a long time. A forgotten device will cause a foul-smelling discharge which clears up when the device is removed.

Rarely, women using the diaphragm or cap develop toxic shock syndrome (p 14)—about 2-3 cases per 100,000 users. Women who have already had TSS should not use barrier methods. Those who develop symptoms of TSS (sudden high fever, diarrhea, vomiting or a rash) while using a barrier method should remove the device and seek medical care.

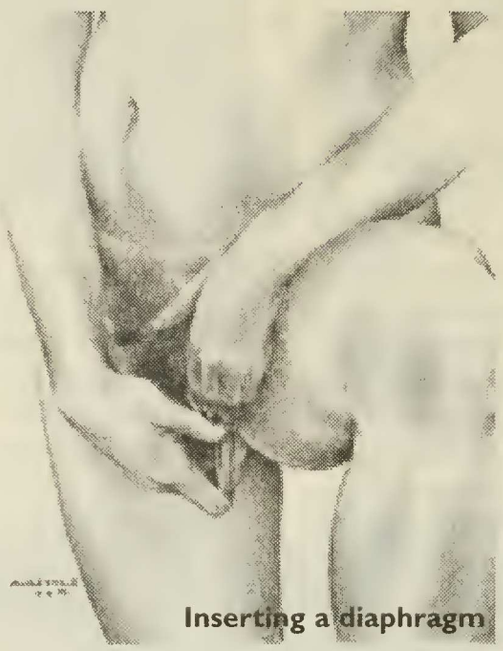
Effect On Fertility

If you become pregnant while using a barrier method, the fetus will not be affected.

Use

Diaphragm: Since the diaphragm comes in different sizes and types, you need to see a health professional who knows how to do fittings. S/he will do an examination to evaluate your pelvic muscle tone and any other conditions which would make it difficult for you to use the diaphragm. The examiner inserts a fitting ring into the vagina and verifies the fit. The largest ring which fits comfortably is the best choice.

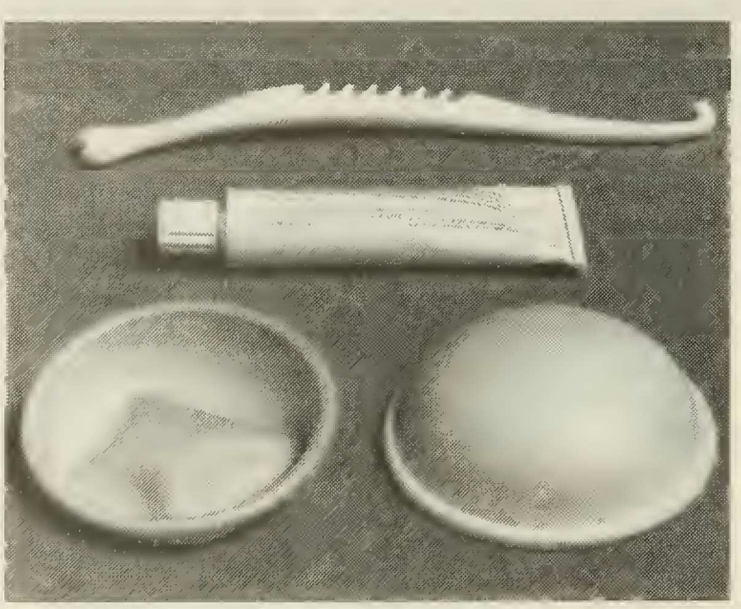
Then it's your turn to insert and remove the ring, checking that the cervix is in the middle. The examiner will confirm that you have put it in properly. A sense of humour is helpful since it may take several attempts to get it right. The examiner decides which type of diaphragm is best for you (coil, flat or arcing spring), depending on your muscle tone and the angle of the uterus.



Inserting a diaphragm

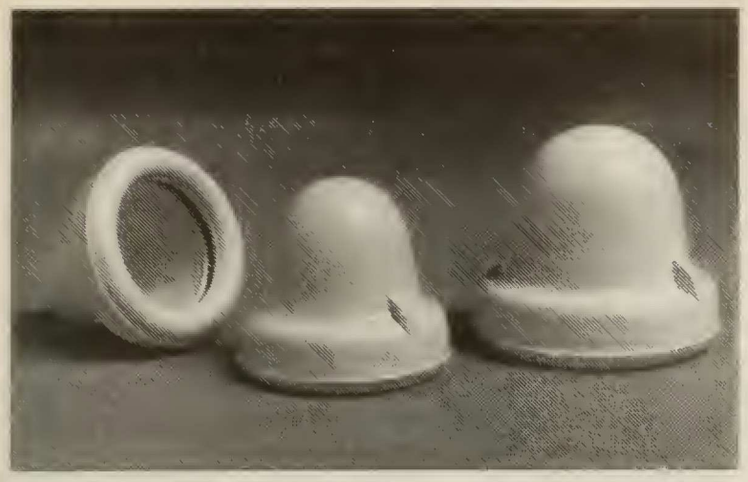
Checking diaphragm's position

You buy the diaphragm at a pharmacy or from the clinic. When you have practiced inserting it, put it in at home and return to the clinic to check you have done it right before relying on it for birth control. The fitting should be rechecked after giving birth, surgery or weight change; otherwise replace it every 1-2 several years. You get a small tube of spermicide with the diaphragm; afterwards you need only purchase the spermicide.

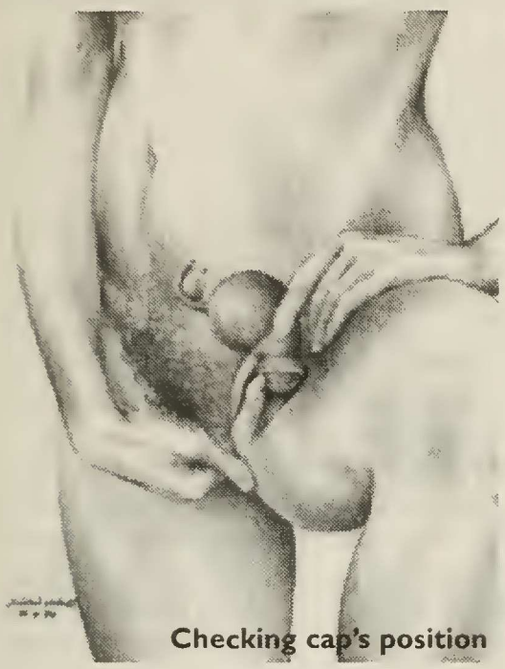


To use the diaphragm, wash your hands and put a teaspoon of spermicidal cream or jelly on the inside cup-like part, spreading a bit on the rim. Squeeze the diaphragm in one hand, spread your lips with the other and slide it into the vagina. Some women do this lying down, others find it easier while squatting or with one foot on a chair. You can also use an inserter which looks like a crochet hook; stretch the diaphragm onto it and insert both into the vagina. Twist the inserter to release the diaphragm. Check that it is in place by feeling your cervix through the rubber dome.

Remove the diaphragm 6-8 hours after the last act of coitus by hooking your finger around the front rim and pulling down and out.



Cervical cap: Only a few practitioners offer cap fittings, so check before making an appointment. Since the cap only comes in 4 sizes, some women may not be able to get a proper fit. The examiner uses a speculum (p 16) to look at the cervix to ensure there are no problems which interfere with a good fit. Then, s/he tries a few different sizes to find the one that fits snugly without turning easily or slipping off. For a good fit, the cup should face the vaginal opening so that during penetration, the penis touches the cup and not the rim.



Checking cap's position

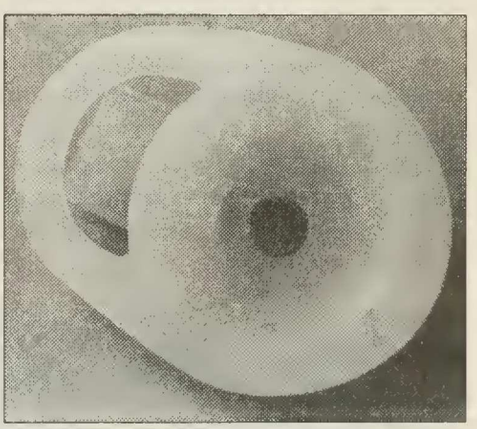
Once the right size is chosen, you practice inserting and removing it. Squeeze the cup and fold the rim with one hand and separate your lips with the other. Push the cap towards the cervix as far as you can and release it. Check its position by passing your finger around the top of the rim, making sure the cervix is completely covered. When it has been in place for a few minutes, gently test the suction by pinching the cup and pulling gently. You should feel some resistance and the cup should remain collapsed. To remove it, use one finger to break the suction at the rim and pull the cap out. Insert and remove the cap a few times; both you and the examiner should check the fit. Usually, clinics which offer fittings also sell caps but you still have to buy spermicidal cream or jelly at the drugstore. Once at home, practice a few times before relying on the cap for contraception (use condoms at the same time, for example).

To use the cap, wash your hands and fill the cup about 1/3 full with spermicidal cream or jelly. To insert it, use the same technique as you did during the fitting. You can leave the cap in place for 48 hours (some authorities suggest 24) with no limit on additional acts of coitus. If you choose to add spermicide, use an applicator but leave the cap in place.

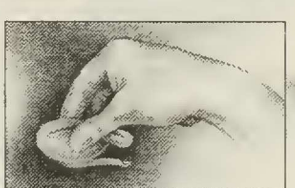
Remove the cap as described above. If odour is a problem, soak it in diluted lemon juice or alcohol. Replace it every year.

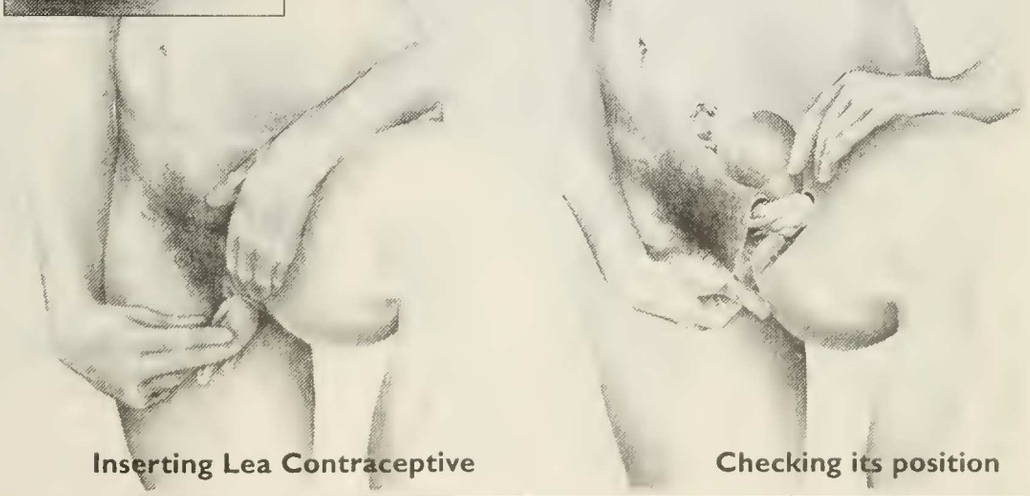
Lea Contraceptive: This device is one size fits all; you purchase it directly from the pharmacy. It costs about $60 and must be replaced every year. It appears bulky, but is more comfortable than it looks. If you aren't sure you are inserting it properly, take it to a clinic to have the position checked.

Wash your hands. Apply a small amount of spermicide to the inside of the cup and to the thick part of the rim, and add a bit on the valve. Squeeze the edges and insert it, cup side up, into the vagina. You may need to push it further with your finger. Check with your finger that the cervix is completely covered; pushing up on the valve may help release any trapped air. You can have intercourse any time in the next 40 hours (some suggest a maximum of 24 hours to reduce the risk of TSS); leave it in place for 8 hours after the last penetration.



To remove the device, hook your finger on the loop and twist until the suction is broken. Then pull down. When washing it, you may need to use a Q-tip to clean the valve.





Inserting Lea Contraceptive

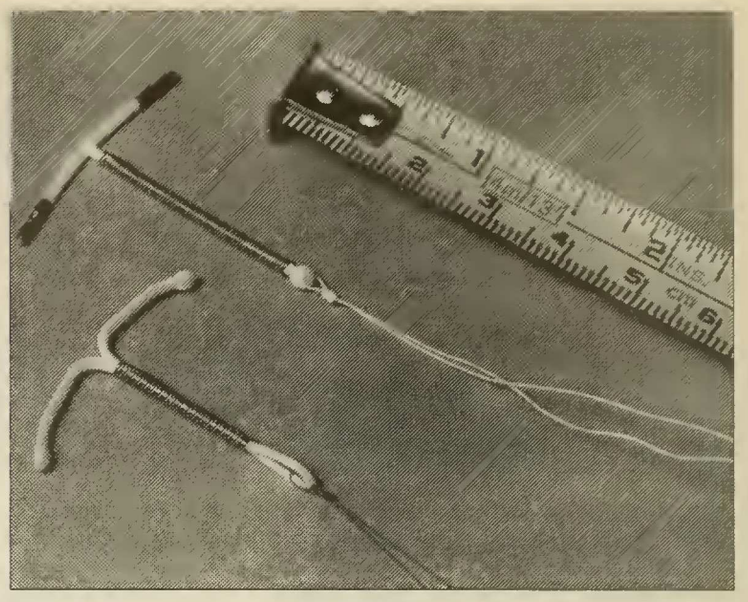
Checking its position

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 1950's. Today's IUDs have either a band of copper or release the hormone, progesterone, which increases its effectiveness and reduces side effects.

The IUD has a complicated history. At a time when the media was publicizing the side effects of the early birth control pill, the IUD was hailed as a simple and safe method. Women of different ages switched to the IUD. Some developed serious pelvic infections which sometimes made them infertile. Women won lawsuits to gain compensation from the makers of one brand, the Dalkon Shield, which caused more illness and deaths than other brands. Fearing similar lawsuits, other companies stopped distributing IUDs and American women could no longer get one (other than the Progestasert). In countries such as Canada where IUDs were still offered to women who had already been pregnant and who were not at risk of STDs, complications dropped drastically. In 1988, a new IUD became available in the USA but it's popularity is still limited.

Today, family planning specialists regard the IUD as a highly effective, safe, inexpensive method. Since its approval for long-term use, it has become an alternative to sterilization as well as an option between pregnancies.



Linda Rutenberg

How It Works

No one knows exactly how the IUD prevents pregnancy. It causes inflammation of the lining of the uterus (endometrium) which prevents egg and sperm cells from moving and joining together. Copper also affects sperm, increasing the IUDs effectiveness. Progesterone IUDs interfere with ovulation, change cervical mucus and the endometrium and affect movement of the egg and sperm.

Effectiveness

In theory, IUDs are very effective **(with copper, about 99%; Progestasert 98%)**. The Lng20, a progesterone-releasing IUD (not yet available in North America) is even more effective. Since there is nothing to do or forget, actual use effectiveness in the first year is almost as high.

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

Effect On The Menstrual Cycle

The copper IUD can cause longer and heavier menstrual flow, usually 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 heavy bleeding persists, you may need a blood test for anemia. Progesterone IUDs decrease 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 could be a sign of infection. If spotting persists in an older woman, she should have tests to rule out cancer.

Effect on Sexuality

The IUD is attractive to many people because it interferes so little with sexuality. Some women feel a change in the rhythmic contractions of the uterus during orgasm. Sometimes your male partner can feel the IUD strings during intercourse. If the strings cannot be pushed out of the way, they can be cut shorter.

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: recent or repeated pelvic infection, undiagnosed abnormal bleeding or a malformation of the uterus. Seriously consider another method if you have a lifestyle which puts you at risk for infection, if your immune system is suppressed by disease such as HIV/AIDS or by drugs such as steroids or if you have fibroids (benign tumours of the uterus) which could interfere with the IUD's position. Women with Wilson's disease or who are allergic to copper cannot use a copper IUD. You will need to be followed more closely or take special precautions if you have problems with the valves in your heart or an artificial joint, a history of pelvic infection or ectopic pregnancy or difficulties with your period. Women who have never borne a child have more problems with the IUD.

Perforation: During insertion, the IUD or the instrument used to measure the uterus may pierce the uterus (once in 1000 insertions). You may or may not feel pain, 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. Copper IUDs must be removed because the copper reacts with the internal organs. The IUD is removed by laparoscopy(p 46) or abdominal surgery.

Pelvic Inflammatory Disease (PID): The uterus and Fallopian tubes become infected. 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 since scarring after severe infection can reduce your fertility (see below). Sometimes, hospitalization is necessary. Most cases of PID happen within a few months after insertion, possibly by bacteria carried into the uterus. After 4 months, IUD users have the same risk of PID as other women. However, if you get an STD such as chlamydia while using an IUD, you are more likely to get PID. The Lng20 IUD reduces the risk of PID. You still need to protect yourself from infection with HIV/AIDS.

Rarely, women with IUDs develop an infection with actinomycosis, a germ which normally does not cause problems. Authorities differ on what to do if this germ is detected on a Pap test. Some suggest removing the IUD immediately; others repeat the test, with or without antibiotic treatment.

Ectopic pregnancy: A fertilized egg sometimes attaches itself within the tube or in the abdomen, not in the uterus. This can be life-threatening, and requires emergency treatment, usually surgery. Because the IUD prevents conception, it also reduces the number of ectopic pregnancies. However if you become pregnant with an IUD, you need to be sure it is not ectopic. If you have had a pelvic infection, with or without an IUD, you have a greater risk of ectopic pregnancy.

Effect On Fertility

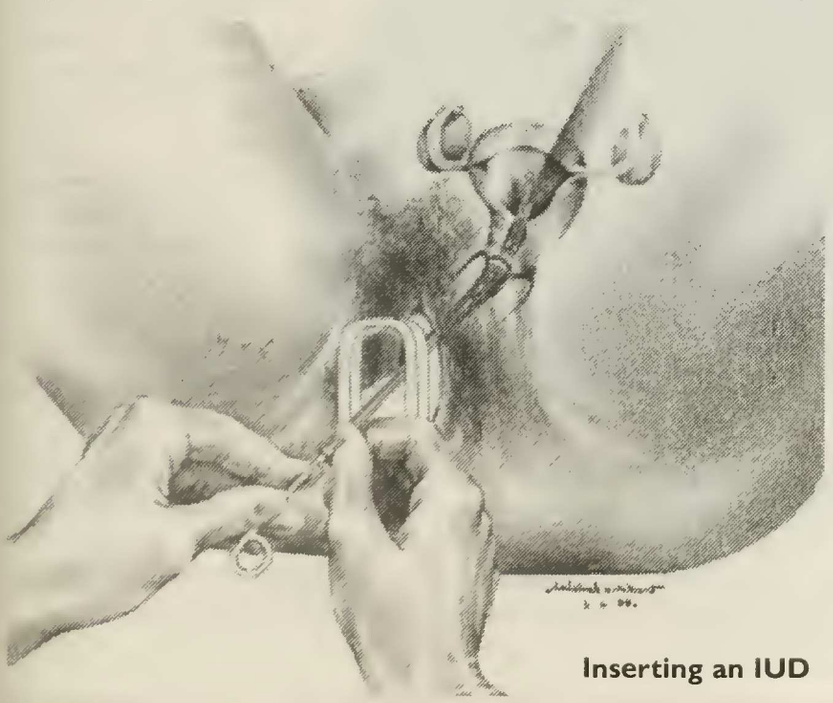
Method failure: If you become pregnant with an IUD, you should be examined to rule out ectopic pregnancy. The IUD does not cause fetal malformations, but if left in place, it increases the risk of miscarriage and premature birth. It should be removed as soon as possible.

Stopping the method: If you want to become pregnant, have the IUD removed by a doctor. There is no reason to delay conception. Women who have used IUDs get pregnant at the same rate as those who have not. If you had a pelvic infection, with or without an IUD, your Fallopian tubes may be scarred. This makes it more difficult to become pregnant and increases the risk of ectopic pregnancy. Past use of an IUD will not affect the fetus.

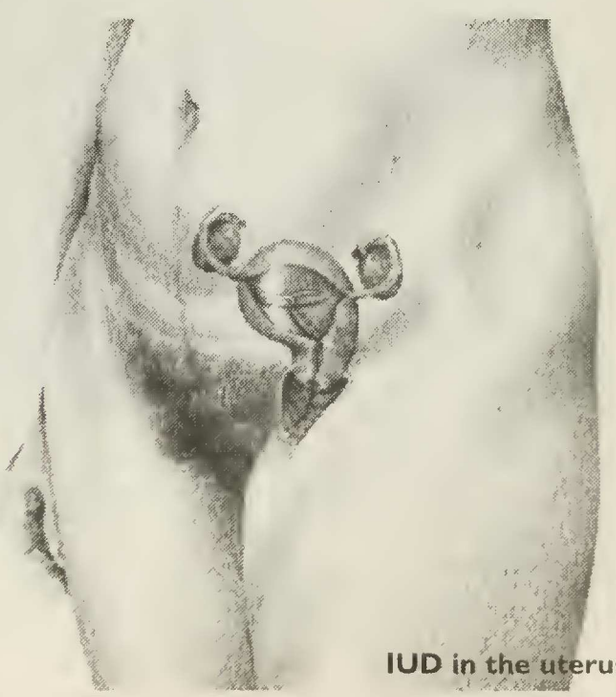
Use

Before insertion: When you consider using an IUD you should have a pre-insertion check-up to learn more about it and to be sure you are a good candidate to use it. A pelvic examination ensures that your reproductive organs are normal. Tests should be done for STDs, particularly chlamydia and bacterial vaginosis.

The IUD can be inserted at any time in your cycle, *as long as you are sure you are not pregnant.* Expulsion rates may be slightly higher when the IUD is inserted during your period. An IUD can be inserted immediately after an



Inserting an IUD



IUD in the uterus

abortion by aspiration and 4-6 weeks after a vaginal delivery. If you had stitches you may still be too sore for an IUD insertion. Inserting the IUD at birth immediately after the placenta comes out is safe but it is more easily expelled.

Choosing an IUD: The most important factor in choosing a brand is the doctor's experience with inserting it. Copper IUDs are made of plastic with a wire or band of copper partially covering them. The Gyne-T 380 can be worn for 10 years and the Nova-T for 7. The Progestasert which releases progesterone must be changed yearly. The LNg20 which releases progesterone for 5 years should be marketed soon.

IUD insertion: The degree of discomfort during and after an IUD insertion varies. Have someone accompany you and consider taking the rest of the day off. Some doctors suggest taking an anti-inflammatory drug such as ibuprophen an hour before your appointment.

You position yourself on the examining table and try to relax. The doctor does a pelvic exam (p 17) to confirm the position of the uterus. A speculum is put in the vagina which is washed with antiseptic. Local anesthesia (freezing) can be used but it prolongs the procedure and increases its risks (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 not relieve the cramps once the IUD is in place.

The doctor steadies the cervix with a clamp and measures the uterus, passing a thin instrument through the cervical canal to the top of the uterus. This often causes cramping and can make you feel faint; let the doctor know how you are feeling. The IUD is loaded into its inserter and passed into the uterus. A plunger mechanism releases the IUD;. the inserter is removed leaving the IUD in place with its strings coming out the cervix. The strings are trimmed to about 2 inches long. You relax on the table until you feel ready to get up. You may have a bit of bleeding so you will need a pad.

Georgia Anastasopoulos

Post insertion instructions: Expect some cramps which will diminish gradually; they can be relieved with anti-inflammatory drugs such as ibuprophen, acetaminophen or aspirin. If you have severe pain and/or fever, contact the clinic. Your periods may be heavier and longer, so your diet should be adequate in iron and vitamin C.

Check for the IUD strings by putting your finger into your vagina. At first, check once a week; later on check after each period. 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 or expulsions occur at the beginning, some women use a second method 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.

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

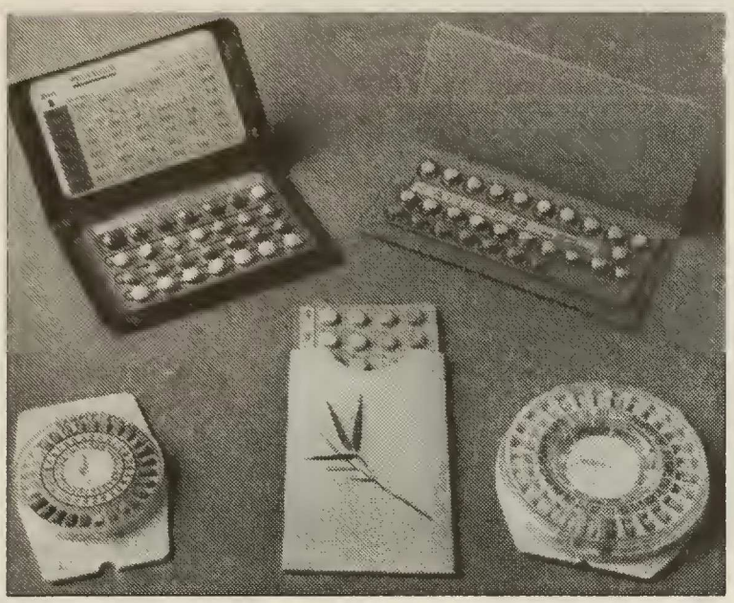
If you miss your period while using an IUD, take a pregnancy test. If you are pregnant or if you miss two periods, call the clinic or doctor's office.

Abdominal or low back pain, vaginal discharge, irregular bleeding or fever are symptoms requiring a doctor's visit to check if the device is being expelled or if you have an infection. If infection is present, antibiotics are started before the IUD is removed. You should be followed closely until you are better.

Even if you have no problems, you should have a check-up 3 months after insertion. Tell the health worker about your experience. Mention any change in your periods, any pain during intercourse and if you can feel the strings. A pelvic examination verifies the IUDs position and should not cause pain. If all is well, you need not return for one year.

Removal: An IUD can be removed at any time. If it is removed at mid-cycle, pregnancy from recent intercourse could still occur. IUD removal is quicker and less painful than insertion. The doctor uses a clamp to pull gently on the strings. If you still want to use an IUD, another can be inserted immediately.

The Pill



The Pill was the first reversible method to be almost 100% effective, a turning point in modern contraception. It was developed at the same time as women were making educational and political advances and challenging restrictive sexual standards. Doing so without fear of pregnancy was liberating.

Much of the early research on the Pill was done in developing countries. At first, its side effects received little publicity but they made headlines when women in North America and Europe began having problems. Many became frightened and stopped using it.

Today's oral contraceptives contain much lower doses. Studies show that women who use the Pill have many health benefits, even years after stopping. Still, minor and serious side effects do occur. Many women are delighted with the Pill's effectiveness; others prefer not to interfere with their natural cycle.

How it Works

The birth control pill consists of synthetic estrogen and progesterone, the same hormones which control the menstrual cycle. These hormones block the natural ones and prevent release of an egg (ovulation) so pregnancy cannot occur. Progesterone also changes the mucus of the cervix, making it more difficult for sperm to get through. The lining of the uterus develops differently so a fertilized egg is less likely to take hold.

Effectiveness

The Pill's effectiveness rate is very high **(best use = 99.9%)**. However, the typical effectiveness rate is about **95%**. Pharmaceutical companies claim similar effectiveness for the very low dose pills (20 mcg of estrogen) but they have not been used widely enough to really know. After one year, more than 25% of women stop the Pill. Many become pregnant accidentally before adopting another method.

Effectiveness is reduced by certain drugs: barbiturates, griseofulvin, rifampicin (used to treat tuberculosis) and anticonvulsive drugs (phenytoin, carbamazepine, primidone, ethosuximide). Use a higher dose pill or reduce the number of days between packs (or take fewer of the last "sugar" pills). **The antibiotics, ampicillin and tetracycline may have a similar albeit smaller effect.** Consider using a back-up method while taking them and for 1 week afterwards. If you take antibiotics for several months, use a back-up method for the first few weeks.

If you previously got pregnant on the Pill despite *perfect* use, you can reduce the risk of it happening again by starting each pack 5 days after the last pill rather than 7 (or take only 5 sugar pills).

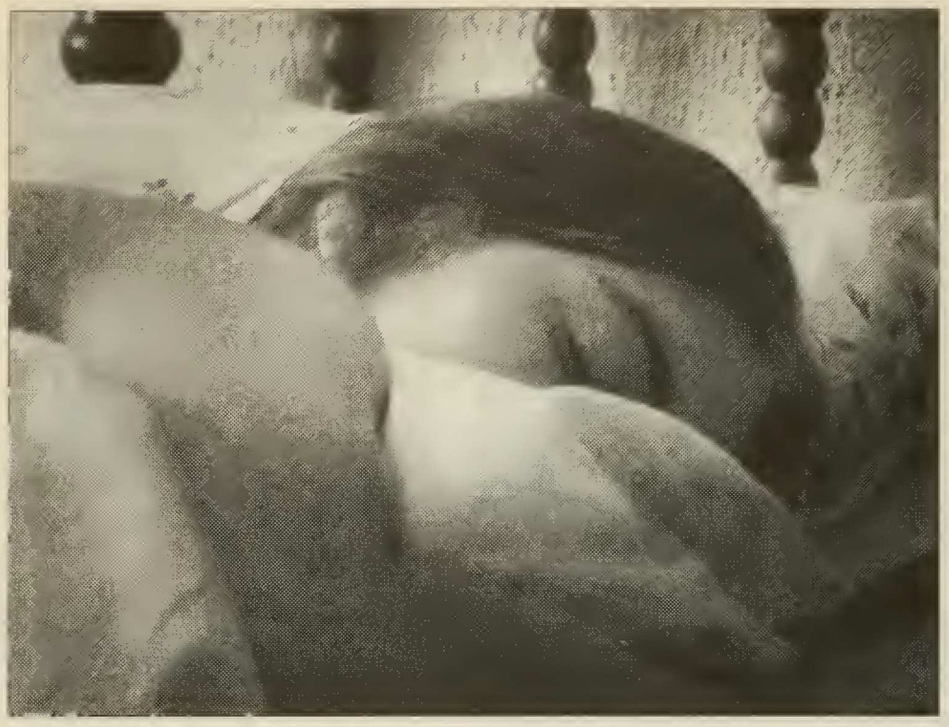
Effects on the Menstrual Cycle

For 3 weeks, the Pill maintains a steady level of both estrogen and progesterone. Ovulation does not occur. The drop in hormones after the last pill causes menstruation which is usually lighter, shorter and less painful.

The Pill gives you a very regular menstrual cycle. If you want to delay your period, start another pack as soon as you finish the first. Or if you want to have it a few days earlier, don't take the last few pills. *Never delay beginning a new package.*

Common Brands of the Pill

Brand	Estrogen (mcg)	Progesterone (mg)
Alesse	20	Levo-norgestrel .1
Minestrin, Loestrin 1/20	*20*	*Norethindrone acetate 1*
Levlen-Lite	20	Levonergestrel .15
Mircette	*20 x 21 days* *10 x 5 days*	*Desogestrel .15 x 21 days*
Loestrin 1.5/30	30	Norethindrone acetate 1.5
Demulen 30	*30*	*Ethynodiol diacetate 2.*
MinOvral, Nordette, Levlen	30	Levonergestrel .15
Marvelon, Desogest, Ortho-Cept	*30*	*Desogestrel .1*
Ortho-Cyclen	35	Norgestimate .25
Diane	*35*	*Cyproterone acetate 2*
OrthoNovum, Brevicon, Genora, Nelova .5/35, Modicon	35	Norethindrone .5
OrthoNovum, Brevicon, Norinyl, Genora, NEE, Norethin 1/35	*35*	*Norethisterone 1*
Ovcon 35	35	Norethindrone
Ortho-Novum 10/11	*35*	*Norethisterone* *.5 x 10 days, 1. x 11 days*
Ortho-Novum 777	35	Norethisterone .5, .75, 1. (7 days each)
Tri-Norinyl, Synphasic	*35*	*Norethisterone* *.5 x 7days, 1. x 9 days,* *.5 x 5days*
Triphasil, Triquilar, TriLevlen	30 x 5 days 40 x 5 days 30 x 10 days	Levonorgestrel .05 x 6 days .075 x 5 days 125 x 10 days
Ortho Tricyclen	*35*	*Norgestimate .18, .215, .25* *(7 days each)*



Pierre Brault

Effect on Health

The Pill has been studied more than most drugs on the market. The hormones in it affect the body in many ways. High doses of hormones in the brands used in the 60s and 70s were linked to serious health problems and some deaths. As the dose has been reduced, the health risks have also gone down.

The Pill has important health benefits. It reduces by about 50% the risk of cancer of the uterus and ovaries; this protection continues for years after stopping the Pill. Women on the Pill are less likely to be anemic (because periods are lighter) or to have pelvic inflammatory disease. The Pill helps problems such as cysts of the breasts and ovaries, acne, irregular bleeding and endometriosis.

Spotting: Sometimes a woman has some bleeding between periods. This is a nuisance but not a sign of disease. It usually stops after a few cycles. Make sure you are taking the pill at the same time each day. If spotting continues or begins again after many cycles, see your doctor to make sure there is no other problem. S/he will suggest changing brands or give you additional estrogen until the spotting stops. Smokers may be more likely to have spotting.

Premenstrual tension: Women who feel irritable and bloated just before or during menstruation sometimes get relief with the Pill.

Missed periods: Some women skip periods while on the Pill. This is not dangerous but makes you wonder about a possible pregnancy. If you miss more than one period, take a pregnancy test. If you miss 3 periods, consult a doctor.

Some women do not get a period 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.

Warning Signs

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*

The most serious complications of the Pill occur while you are using it. Length of time on the Pill affects some complications but not all. With several exceptions, the risk of complications does not continue once you stop the Pill. Although doctors try to predict which women are more likely to have problems, rare complications can still occur in healthy women.

Cardiovascular disease: Venous thromboembolism (blood clots which can break and spread) which is rare in women under 30 is increased in Pill users from 4 in 100,000 per year to 12-16; the risk is greatest for new starters. Heart attacks rise from 2 per 100,000 to 6 in young women but brands with the newer progesterones (desogestrel and norgestimate) may reduce them. Stroke is also rare (3 in 100,000 per year). Low dose brands may increase this rate slightly. Factors such as smoking increase cardiovascular disease much more.

Lipids: Pills with the newer progesterones (see above) may improve the balance between "good" and "bad" cholesterol (HDL versus LDL).

High Blood Pressure: Rarely, the Pill increases blood pressure.

Cancer: Studies suggest that women taking oral contraceptives have up to 50% greater risk of breast cancer. This small increase in risk disappears 10 years after stopping the Pill and is not affected by family history or duration of pill use. Cervical cancer is also linked to the Pill (50% increase), possibly because women using it have more unprotected sex. High dose pills increased the

Effect on Sexuality

The Pill permits a woman to have sexual intercourse at any time without fear of pregnancy. Some find this a great freedom; others feel they have lost an excuse to say no. Some women resent taking the Pill when their sex life is slow. Whether the Pill alters a woman's sexual desire and experience is not clear. If you suspect this, you can change brands or stop the Pill to see if you notice a change.

Skjold Photographics

rate of a very rare liver cancer; it is not clear if this is still true of lower dose pills. A benign liver tumour (adenoma) is linked to pill use. The Pill reduces the rate of ovarian and uterine cancer by half; this protection persists after stopping.

Gall bladder disease: After 5 years of use, the Pill increases the risk of gall stones by about 50% in susceptible women.

Depression: Women taking the Pill may notice a change in their mood for better or for worse.

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

Water retention: Some women retain fluids when taking the Pill. Water retention can cause nausea, leg cramps, bloating, headaches, changes in vision, changes in the fit of contact lenses, irritability and breast tenderness.

The Mini-pill

The mini-pill (Micronor, Ovrette, Nor-Q.D.) contains progesterone only. It does not always block ovulation but is almost as effective (99.5%) as the combined pill. Pregnancy is prevented by changing cervical mucus so that sperm cannot get through. Transport of the egg in the Fallopian tube is also affected. It is a good alternative for women who are breastfeeding and those who cannot take estrogen (see the list of women who should not use the Pill or who require special supervision).

Take one tablet each day without stopping at the end of a package. Forgetting a mini-pill increases the risk of pregnancy more than forgetting a combined pill. If you forget a pill, take it as soon as possible and use a back-up method for 48 hours. If you forget 2 or more pills, continue the package but use a back-up method for a week. If pregnancy occurs, you should be checked to see that it is not ectopic (outside the uterus).

Irregular bleeding is the most common side effect of the mini-pill. In fact, women who continue to have regular periods may still be ovulating and at greater risk for pregnancy. Drugs which lower the efficacy of the Pill have the same effect with the mini-pill.

Headaches: Headaches may get better or worse. Unusual and one-sided headaches should be reported to the doctor. If headaches occur when you are between packages (or taking sugar pills), discuss with your doctor the possibility of taking 2 or 3 packs in a row, thus avoiding menstruation.

Skin changes: Estrogen can cause darkening of the skin around the eyes and mouth. 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.

Some brands increase acne, hairiness, and oily hair and skin; others make them better. In Canada, the brand, Diane, uses a progesterone with anti-androgenic (male) affects and is marketed specifically to treat acne while also providing contraception. Other brands may also be used with good results.

Weight gain: If this occurs after first starting the Pill, it may be due to water retention and usually goes away. Increased appetite occurs in a few women.

Vagina and cervix: Estrogen may increase normal vaginal discharge. The cervix may look red because of changes in the cells at the opening, which may make it easier to be infected with chlamydia. Yeast infections may increase but trichomonas vaginitis decreases.

Breast-feeding: The Pill decreases the amount of breast milk and should only be used once breast-feeding is going well. Very little hormone is passed in the milk and its quality is only slightly changed. The babies seem to be unaffected.

Forgotten Pills—What To Do

If you forget 1 pill, *take it as soon as you remember, even if that means taking two pills at once. Although the chance of pregnancy is small, you may want to use a back-up method for 1 week.*

If you forget 2 pills during the first 2 weeks, *take 2 immediately and 2 the next day. Finish your pack but use a back-up method until you have taken 7 pills in a row.*

If you forget 2 pills in the 3rd week or 3 or more pills at any time, *discard your pack and start a new one immediately. Use a second method for the first week.*

If you have unprotected sex after missing 2 or more pills, *you can use the morning after pill (p 37). Discard the missed pills and finish the pack. Use a back-up method for 7 days.*

Effect On Fertility

Method failure: If you become pregnant while taking the Pill, the risk of fetal malformation is extremely small; rarely, the kidneys or bladder of the fetus are affected.

Stopping the Pill: When you want to have a baby, stop the Pill at the end of a package. The Pill does not reduce fertility but it can take a few months after stopping to have regular periods. It might be easier to predict when the baby is due if you have 1 or 2 periods off the Pill before trying to get pregnant. See p 19 for suggestions for preparing for a healthy pregnancy.

Use

You have to visit a doctor to get a prescription for the Pill. The doctor or nurse asks questions to rule out factors which may make the Pill unsafe for you or require closer supervision. Your blood pressure should be taken; some doctors will listen to your heart and examine your breasts and abdomen. You should have a pelvic examination with a Pap test and STD screening; this is not necessary if you have not yet had sex with penetration and have no problems. For most women, lab tests are not necessary unless you or family members have particular problems (see health section).

You should not use the Pill if you have: *had serious heart and blood vessel diseases such as a heart attack, stroke,*

deep vein thrombosis or pulmonary embolism; conditions which put you at risk for the above problems (uncontrolled high blood pressure, diabetes with organ damage, heart rhythm problems, infection of the heart, migraines accompanied by visual or other problems, polycythemia vera or you are over 35 and smoke cigarettes); active liver problems; recent breast cancer; just given birth (2-3 weeks) or are breastfeeding (at least first 6 weeks, preferably longer). If you have a family history of blood clots, you should have special coagulation tests before deciding to take the Pill.

You should be followed more closely if you have: *gall bladder disease, diabetes, sickle cell disease, high blood pressure, migraines without neurological symptoms, precancerous changes of the cervix, high cholesterol or triglycerides, systemic lupus erythematosis. The pill does not worsen bowel diseases but you may not absorb the hormones enough for it to be effective. Some drugs for epilepsy also reduce effectiveness.*

No special care is needed if you have: *varicose veins, STDs including HIV/AIDS, chronic hepatitis B without liver damage, thyroid problems, obesity or cysts of the breasts or ovaries.*

The clinician suggests a brand of the Pill for you. Except for the minipill (see inset), all brands contain both estrogen and progesterone; there is little difference between them. Several different progesterones are used, possibly causing different side effects (see section on health). Progesterones also have estrogen-like effects and androgen-like (male) effects. These differences are used to reduce side effects. Many side effects such as nausea and spotting stop after the first few months.

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 help you remember to take a pill each day. Some packages are easier to follow than others; make sure you like and understand the pack you get. You should be told what to do if you forget a pill or if you have symptoms (see insets).

Starting the Pill: Depending on the brand, the Pill is started differently. *Always wait for your period.* Some brands start on day 5 of your period (whether or not you are still bleeding). Others start on the Sunday following the first day of bleeding—the same day if it starts on Sunday. You will get your period during the week rather than the week-end with a Sunday start. Still other brands start the day your period begins. Take one pill each day, at about the same hour. To help you remember, link it to something you always do—brushing your teeth, eating a meal, removing make-up, etc.

After giving birth, if you are breastfeeding, wait at least 6 weeks (see above); if not, wait 2 to 3 weeks because of the risk of blood clots. *After an abortion or miscarriage*, you may start the Pill immediately.

If your package has 21 pills, wait for 7 days after the last one; you should get your period during this time. Begin your new package the same day of the week as you began the first one. 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. One brand (Mircette) has only two sugar pills followed by 5 days of estrogen.

You are protected from pregnancy after taking 7 pills from the first package (unless you forget one). Since forgetting is common the first cycle, use another method as well. If you begin the next pack as directed, you will be protected right away.

Taking the Pill with a meal or at bedtime 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 Pill affects the metabolism of other medications. You may need to decrease the dose of steroids, certain sedatives, theophylline and caffeine. You may need a higher dose of aspirin and acetaminophen.

If you see a physician for other health problems, mention that you take the Pill. Certain lab tests are affected by the Pill. It should be stopped one month before major surgery to avoid blood clots.

Follow-up: Return to the same doctor or clinic within 3 to 6 months to go over your experience with the Pill. Your blood pressure is taken; the examination will depend on your symptoms. If everything is normal, you need not return for 6 to 12 months. Women at risk for complications should have more frequent check-ups.

There is no need to stop the Pill for a "rest" and no limit to the number of years you can take it. Your clinician can help you reevaluate your choice of birth control as your circumstances change.

If you go through menopause while on the Pill, you may not know it because the Pill makes you bleed each

Denise Faille

Emergency Methods

Birth control used *after* unprotected intercourse (post-coital methods) plays an important role in reducing unplanned pregnancies. These methods should be easily available becauses they are most effective when used soon after unprotected sex. Taking high doses of the birth control pill (usually *Ovral*) or having an IUD inserted are two effective strategies which have been used for many years. *Danazol*, used to treat endometriosis causes less nausea but is also less effective. *RU 486* (the abortion pill) is effective as a post-coital method but is not yet available in North America.

Post-coital methods are usually recommended for emergencies—when a condom breaks, when several pills are forgotten or when a woman is raped—and not as a regular birth control strategy. If you rarely have sex with penetration, a post-coital method is an alternative, though it will not protect you from STDs.


Jeannie Kamins

Using emergency birth control is often the first step toward responsible sex. **Find out where you can get it before you need it!** In Canada, nurses in many schools and community clinics provide the "morning after" pill and most doctors will prescribe it. A list of U.S. providers is available at *http://opr.princeton.edu/ec/* on the Internet or toll-free at 1-888-NOT-2-LATE.

How It Works

How the "morning after" pill works depends on when it is taken in a woman's cycle. It changes hormone levels, possibly blocking ovulation; it may also affect the lining of the uterus, interfering with implantation of a fertilized egg. The "morning after" pill does not abort an existing pregnancy and does not prevent pregnancy later on in the cycle.

Effectiveness

As a "one time only" method, its effectiveness is not easily compared to other methods. Most women using an emergency method would not get pregnant anyway (only a 1 in 4 chance). For those who would have, the "morning after" pill works more than 80% of the time. In other words, **98%** of women who take it within 72 hours of unprotected sex will not get pregnant. Although failures are greater the longer the delay, it may still be worth taking up to 5 days later. Progesterone only pills (levonorgestrel) appear to be equally, if not more, effective.

The IUD as a Post-coital Method

Inserting a copper 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 you want to use the IUD (p 30) afterwards.

Effect On The Menstrual Cycle

You should get your period 1 to 3 weeks after taking the "morning after" pill. The next menstrual cycle should be normal.

Effect On Sexuality

Access to the "morning after" pill means a woman can have unexpected or unplanned sex with less risk of pregnancy. It offers back-up protection for other methods.

Effect On Health

In high doses, *Ovral* can cause mild to severe nausea and vomiting; progesterone only pills may be better for women who are easily nauseated. Women who have conditions which prevent them from taking the Pill (p. 36) may still be candidates for the "morning after" pill. Women with porphoryia or who are breast feeding should not use *Danazol*.

Effect On Fertility

In large studies, the babies of women who became pregnant after taking the morning after pill were unaffected. *Danazol* is more likely to affect the fetus, particularly if you are already pregnant when you take it. If you decide you want to get pregnant, wait until you have a period before trying to conceive. It will be easier to calculate when the baby is due.

Use

Take the "morning after" pill as soon as possible after unprotected intercourse. You do not need to run to the emergency in the middle of the night; the next morning will do. Some doctors will give a prescription by phone to a regular patient. If you don't have intercourse often, try to get a prescription in advance so you can use it at your own discretion.

Take 2 tablets of *Ovral* right away and 2 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* or *Dramamine* at the same time. If *Ovral* is unavailable, take 4 pills of *Nordette*, *Minovral*, *LoOvral* or *Levlen* or 5 of *Alesse*, and repeat the same dose 12 hours later. For the progesterone only option, take 20 pills of *Ovrette* all at once (unavailable in Canada).

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. If you do not get it within 3 weeks, have a pregnancy test. Take some time to think about whether your birth control method is still the best choice for you or if you want to try something else.

Long-acting Hormones: Injections & Implants

With these methods, hormones are given by injection or implants (capsules placed under the skin). Small amounts of hormone enter the blood for months or years. Hormone-releasing rings placed in the vagina are under study. Long-acting methods are a good choice for women who need very effective contraception, who have difficulty remembering to take a Pill or who need to hide their method from others. They do not offer protection from STDs.

Depo-Provera and Norplant use progesterone which prevents pregnancy by a combination of effects—blocking ovulation and changing both cervical mucus and the uterine lining. Like the mini-pill (p 34), they are a good choice for women who cannot use estrogen—for example, women who are breastfeeding, have migraines or have a history of blood clots.

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 wait until the hormone wears out or find a doctor to remove the implant. The potential for abuse is great. Practitioners must make sure that women understand the method and consent to it before administering it and should never refuse to remove implants when a woman wants them out.

Diane Comley

DEPO-PROVERA

Depo-Provera, a long-acting progesterone (medroxy-progesterone acetate), has been used around the world for almost 20 years. Since Its approval for contraception in the USA in 1992 and in Canada in 1997, it has become quite popular.

Effectiveness Depo-Provera is **99.7%** effective if shots are given on time (not more than 1 week late).

Effect on the menstrual cycle Most women using this method have menstrual cycle changes: breakthrough bleeding or, more commonly, no periods at all. Taking estrogen for a short time or reducing the interval between shots may stop irregular bleeding. Some women bleed for a few days just before the next shot. The longer a woman takes Depo-Provera, the more likely her periods will stop completely. After 2 years of use, 70% of women have no more periods. Regular periods may not return for 6-9 months after the last shot.

Effect on health Common side effects include headaches, nervousness or depression, bloating, hot flashes and decreased interest in sex. Breast tenderness and weight gain can also occur. Women who use Depo-Provera may have a decrease in bone density, possibly increasing their risk for osteoporosis. (However studies suggest bone density returns to what it was once the injections are stopped). To protect their bones, women on "Depo" should exercise and get plenty of calcium either in their diet or with supplements. Depo-Provera also reduces HDL cholesterol (the good cholesterol) which may be a problem for women at risk for heart disease. Depo-Provera does not appear to cause breast cancer but may speed its growth. Severe allergic reactions are rare but have happened.

Depo-Provera also has health benefits: it reduces the risk of cancer of the uterus and ovaries as well as the risk of pelvic inflammatory disease. It decreases the frequency of seizures and the severity of symptoms due to endometriosis.

Effect on fertility If Depo-Provera fails, the baby is not at greater risk for malformations. Fertility is often delayed 6-12 months so it is not the best choice for women who want a baby soon. Within 2 years of stopping, 90% of ex-users will conceive.

Use After a health evaluation, you can have your first shot (in the arm or buttock) during the 5 days after your period starts. You are protected from pregnancy after 24 hours. You receive the same dose (150 mg) every 12 weeks. If you are more than a week late for your shot and have had sex without protection since the time the shot was due, you should use another method for two weeks and take a pregnancy test before receiving the next dose. Depo-Provera can be used right after giving birth, although less irregular bleeding occurs if the first injection is delayed for a month. Once breastfeeding is established, Depo-Provera

Claire Beaugrand-Champagne

does not affect the quality or quantity of milk. Although some clinicians give breastfeeding women the first injection in the first week after birth, others suggest waiting for 6 weeks.

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. Problems with removing the implants have made Norplant less popular.

Effectiveness Norplant is highly effective (**more than 99.5%** in the first year, slightly lower afterwards); it is slightly less effective (97.6%) in women weighing more than 154 lb. Anti-seizure drugs and rifampicin reduce effectiveness slightly so back-up contraception may be necessary.

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

Effect on health Headaches, breast tenderness, nervousness, dizziness and ovarian cysts are the most common side effects. Weight gain (less than with Depo), acne and hair loss are less common. Irritation, infection and scarring of the skin may occur after insertion or removal; in the USA, consumers have taken legal action related to problems with implant removal. Norplant probably has the same health benefits as Depo-Provera.

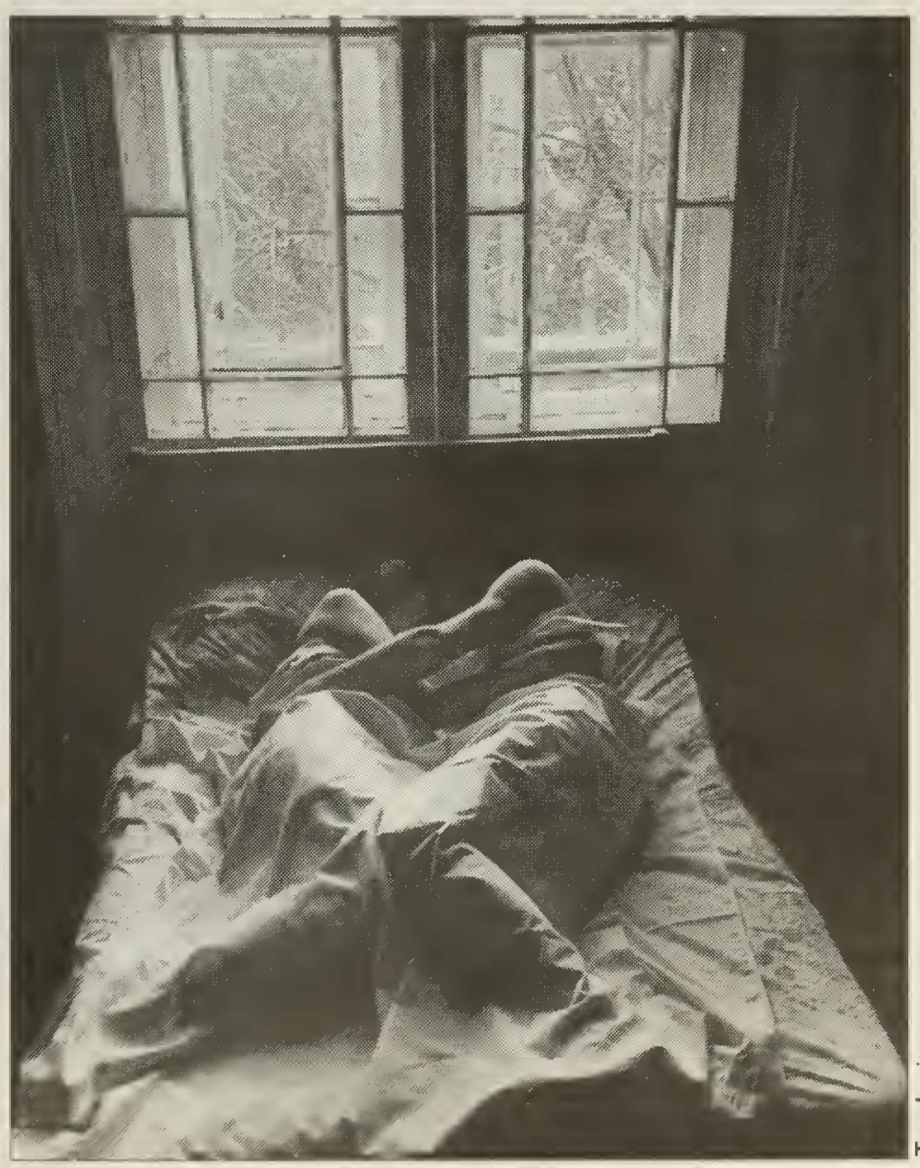
Effect on Fertility There is no delay in the return of fertility once the capsules are removed. Norplant can be used during breastfeeding, preferably after 6 weeks.

Use You have to find a doctor experienced at inserting and removing Norplant. Ask whether the fee includes both insertion and removal. Cost ($500-$700) may be a problem if you have to pay the full amount at once; however, If you use Norplant for the full 5 years, the cost per month is less than the Pill. Medicaid covers the cost in most states and the Norplant foundation (1-800-760-9030) will pay for the implants for poor American women who do not qualify for state assistance.

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. Return to the clinic if the cut continues to hurt or shows signs of infection (redness, swelling or pus).

Women who are bothered by irregular bleeding with Norplant can take estrogen or the Pill for a few cycles to try to solve the problem.

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.



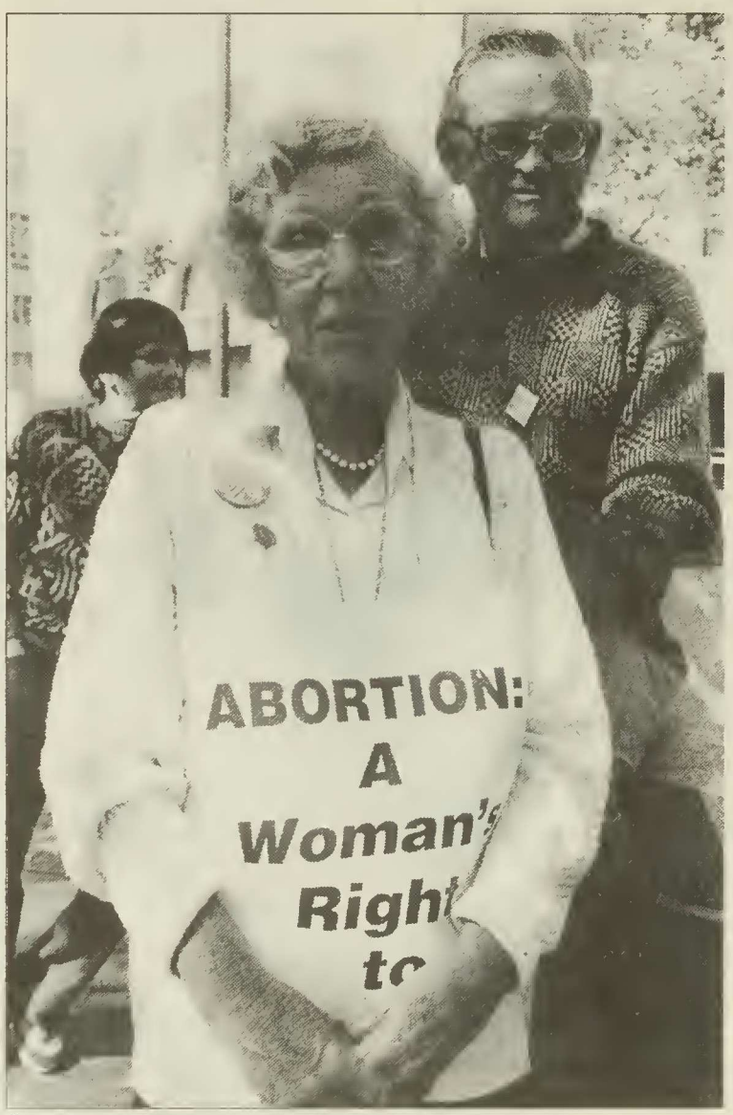
Tom Levitt

Abortion

Abortion is the deliberate interruption of pregnancy. It has always been part of women's experience. During the past 30 years, the legal status of abortion around the world has changed. In some countries, the right to decide to terminate a pregnancy is the result of women's improved status and greater control over their lives. In others, legal abortion is a result of economic and population pressures. But many women are still denied access to safe, legal abortion. Over 125,000 women die each year from complications of unsafe 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 some Western democracies.

Reproductive Choices

Most North Americans support a woman's right to choose. Pro-choice groups are concerned with the quality of life for both women and children and consider parenting too great a responsibility to be undertaken unwillingly. They believe that sex is for pleasure as well as reproduction and birth control sometimes fails. The rights of individuals to make decisions about sexuality and reproduction are central to the pro-choice position. Many pro-choice 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 daycare, 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.



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 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 care. Anti-choice groups defend a traditional world view and see abortion as part of an immoral sexual permissiveness. They often oppose premarital sex, alternative family structures and gender equality 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, and have gone as far as bombings and murder.

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 disobey. Criminalizing some abortions casts doubt on everything to do with abortion—those who have them and those who practice them.

When governments make abortion laws, they define women's reproductive choices. They imply that women cannot make wise decisions for themselves. Ironically, they are considered capable of having and raising children without approval of the state.

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 be sterilized before they are really ready. Sometimes women are forced to continue a pregnancy that carries dangerous health risks.

The only useful abortion law is one which prevents forced 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. Occasionally, laws protect services by providing funds and training for health professionals.

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. Technology such as ultrasound which provides an image of the early embryo makes us more aware of its potential for development.

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 anti-abortion 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 can be dangerous for pregnant women who may feel great guilt if they refuse. There is no law forcing a parent to donate an organ for a living child. Why then, should women be forced to give their bodies for a fetus?

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 are spent to save premature babies yet funds for child health and social services are drastically reduced. Are parents who choose to abort a malformed fetus to be blamed for a society which is so uncaring about the needs of people with disabilities? 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. Others connect to the fetus only when they feel it move. Women who have difficulty becoming pregnant feel a loss with each menstruation. This is very different from how a woman feels when an unwanted pregnancy threatens her future and that of her family. If pregnancy is out of the question, she may see it simply as a problem requiring medical attention. If she would like to have the child but circumstances appear too unfavorable, she may feel some sadness for choosing abortion but also a sense of mastery for having made such an important decision about her future. *The issues are so complex and personal, that no one is better placed than she is to make the decision.*

The Montreal Health Press supports equal access to safe abortion. We encourage you to support your local and national pro-choice groups.

An Abortion Pill

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

The drug, RU 486 or mifepristone, which causes abortion in early pregnancy (first 7 weeks), is available in France, England, Sweden and China. RU 486, an anti-progesterone, affects both the lining and the muscle of the uterus. Methotrexate, a drug used to treat cancer, works by stopping fetal cells from dividing. Several days after taking either drug, women are given misoprostol (a prostaglandin) which is taken vaginally; this drug causes contractions which eventually expel the embryo, like an early miscarriage. A follow-up visit is important to make sure the treatment worked since about 1 in 20 women will need an aspiration afterwards.

Over 200,000 women have used this method to their general satisfaction, pleased with their active involvement in the abortion process; others still prefer the efficiency of suction abortion. Disadvantages of this method include the need for several medical visits, the uncertainty of how long it will take and the solitude of aborting on one's own. Bleeding is greater than with surgical abortion.

Anti-choice groups have lobbied against RU 486, blocking its use not only for abortion but for contraception and other medical uses. Pharmaceutical companies hesitate to bring such a controversial medication to the North American market. Some feminist groups feel we don't know enough about its long-term side effects. The strict control of RU 486 and the many doctor's visits required are a far cry from the "de-medicalized, private" experience described by some promoters.

We support research and distribution of RU 486 and other drugs for abortion as a way of increasing women's options. A safe medical technique could increase the privacy of women having abortions; they would simply consult their own doctor as they do for contraception. Its potential for saving lives is enormous; even black market distribution would reduce the ravages of amateur and illegal abortions around the world.

How It Works

The fetus and placenta are removed from the uterus either by suction or with forceps, depending on the stage of pregnancy. In some 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.

Effect on the Menstrual Cycle

Abortion has no lasting effect on the menstrual cycle. After an abortion, the next period 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 long-term effect on sexual desire or experience unless the circumstances surrounding it were particularly unpleasant.

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. Conservative appointees to the Supreme Court have upheld state laws requiring minors (under 18) to have one or both parents' consent for an abortion. They have imposed waiting periods after abortion is requested and obliged health professionals to use a biased predefined text for counselling women.

Fanatic anti-choice groups have held clinics in siege, harassing clients and staff alike. Violence has escalated to include arson and bombings, and murder. Doctors and other clinic personnel have been shot and killed by extremists whose actions have been applauded by some "pro-life" organizations. Many doctors have stopped providing abortions and young medical graduates are unlikely to begin, leaving most of the country, particularly rural areas, without services.

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.

Effect on Health

Under proper conditions, abortion is a very safe procedure. The death rate for abortion is about 1 per 200,000 abortions, about the same as for a shot of penicillin. Late abortions used to cause more complications but improved technique and more experienced staff have made them safer. Major complications which occur in less than 1 in 1000 abortions are:

Blood loss: Bleeding during vacuum aspiration is minimal (approximately 50-75 ml or 1/4 of a cup). In late abortions blood loss is greater. Bleeding can occur during the procedure and be controlled with medications. Rarely, the uterus fills up with blood right afterwards; repeating the aspiration solves the problem. If heavy bleeding occurs in the weeks following, it may be a sign that not all of the placenta was removed. The uterus may need to be emptied again.

Sheryl Ann Medicoff

Infection: Infection after abortion has several causes: improper sterile technique, pre-existing infection of the cervix and bits of placenta left in the uterus. Most infections can be treated with antibiotics; occasionally a curettage (scraping the lining of the uterus) is necessary.

Perforation: Any instrument used in an 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. Usually the uterus heals; if other organs are damaged or bleeding continues, an operation is required.

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 self-confident.

Some women feel a sense of loss and need to mourn. This is common in women who have mixed feelings; 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 choose abortion 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. Rarely, the lining of the uterus forms scar tissue, making pregnancy impossible. Women who have had several abortions do not have more miscarriages or premature deliveries. Fear of sterility comes from people's experience with self-induced or butcher abortions.

If your blood group is Rh negative, you should receive an injection of antibodies (Rhogam or WinRho) 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 page 18) 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. The National Abortion Federation hotline (1-800-772-9100) can refer you to qualified professionals in North America.

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 certain medical problems.

Many clinics ask you to go for a visit before the procedure. You can discuss your decision if you want to and get information on what to expect during the abortion. Tests for STDs and for your blood group are done; you may need an ultrasound if the age of the pregnancy is uncertain.

Skjold Photographics

Early Abortions (Up To 13 Weeks)

At home, 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. Bring a friend and arrange to take it easy for the rest of the day. Take any medications you usually take unless you are told otherwise.

A clinician will discuss the possibilities for pain relief with you. Some women have very little pain, others quite a lot. Clinic staff are usually helpful; spouses and friends can be comforting or make you more anxious. Many clinics offer "laughing gas" to help you relax or a fast-acting narcotic given intravenously to dull the pain. Freezing of the cervix is always done; this reduces the sensation of the instruments but does not relieve pain from cramps.

You empty your bladder and put on a gown or drape. 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.

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. After injecting a bit of anesthetic, the doctor puts a clamp on the cervix and then finishes freezing it. Some women find this painful and others are hardly aware of it.

A thin rod is passed through the cervical canal to measure the uterus. To dilate the cervix, a series of metal rods each thicker than the last are passed through the canal. Dilation often causes cramping. A hollow tube with holes near the tip is passed into the uterus. The later the pregnancy, the larger the tube. The suction is turned on and the doctor moves the tube back and forth. When the uterus is empty, the suction is stopped and the tube removed. During the aspiration, you may feel tugging, cramps or pain. The vibrating sound of the suction machine may bother you. 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. If you want, the staff will show you the tissue that was removed. You should be allowed to stretch out on the table until you feel ready to sit up and walk to the recovery room. You can have something light to eat or drink. You can take a mild pain-killer for the cramps. You go home when you feel ready, usually in about an hour.

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

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 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. 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. 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 lack of services.

Menstrual Extraction

In the early 70s a group of feminists experimented with menstrual extraction—a gentle 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 encouraged groups of women to develop skills and to acquire the necessary equipment for abortion. For women used to relying on doctors for 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.

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.

Your next period will occur in 4 to 8 weeks. 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.

Later Abortions (14 Weeks Or More)

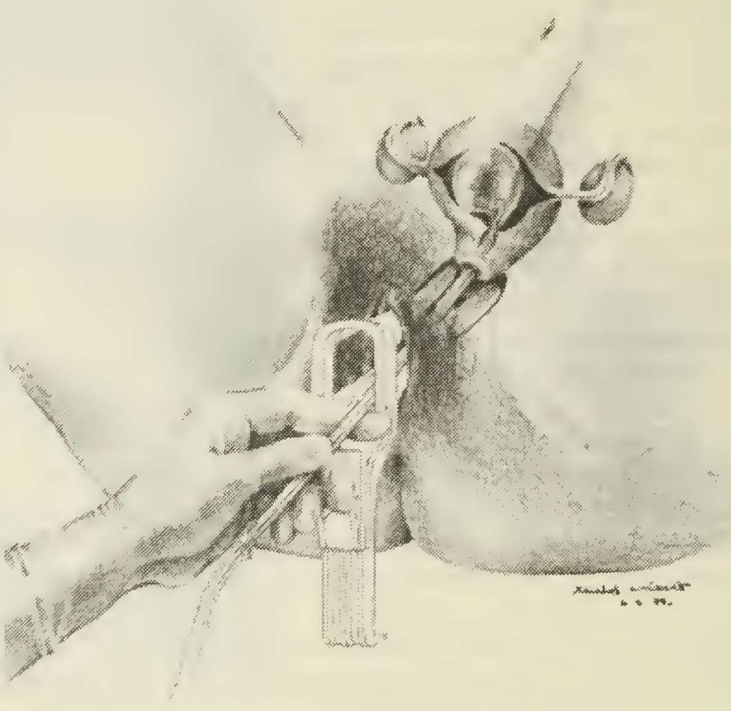
Dilatation-evacuation-curettage (DEC) is the most common and safest technique up to 20 weeks. It should only be done by experienced doctors in a hospital or clinic with emergency facilities.

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 (laminaria) made of seaweed or synthetic material into the cervix. They absorb mucus and swell, gently dilating your cervix; you may feel some cramping; rarely you may begin to miscarry.

You should not eat before the abortion. Sedation, local anesthetic or light general anesthesia is used. An intravenous drip is installed. The laminaria are removed and the cervix is dilated further. Aspiration is begun and forceps are used to remove tissue too large to pass in the tube. Aspiration and curettage complete the procedure. If ultrasound is used to help the doctor direct the instruments, the screen should be turned away from you.

Dilating the cervix

Suction removes fetus and placenta



Afterwards, you are kept under observation for several hours. Many doctors prescribe antibiotics during and after the abortion. Precautions after the procedure are similar to an earlier abortion. You may have symptoms similar to after a birth; if your breasts produce milk, it will stop after a few days. You may need a bit longer to recuperate. Wait 2 weeks before starting the Pill.

Induction of labour is an alternative for late abortions and must be done in hospital. A substance is injected into the uterus which eventually causes contractions and delivery of the fetus and placenta. It can take a while to be completed and is emotionally difficult. Complications such as retained placenta are more common. As evacuation procedures have improved, induction has become a less frequently used abortion method.

Judith Crawley

Cost

In Canada, the doctor's fees and hospital bills are covered by government health insurance. In some provinces, costs in private clinics are also paid; otherwise the woman must pay fees up to $350 (more for late abortions). 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.

STERILIZATION

Permanent birth control, called sterilization, is the most common method of contraception in North America. Women are twice as likely as men to have sterilizing surgery.

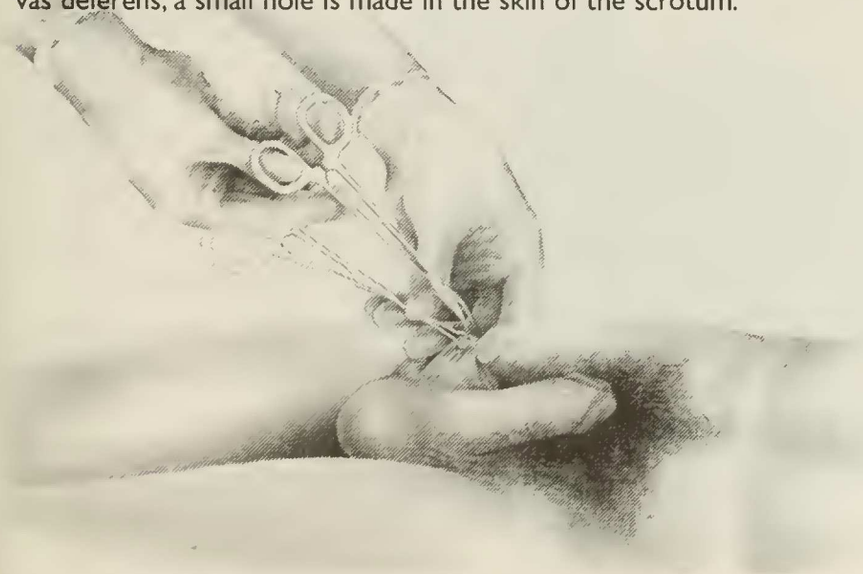
The decision to be sterilized is a positive one if you are certain about it and have the operation willingly. You will no longer have to bother with birth control or worry about an unwanted pregnancy. But many people rush into sterilization, often because of bad experiences with other methods. About 5% regret their decision, particularly those who were sterilized under the age of 30 or immediately after giving birth and those who had young children or relationship problems at the time. Only some of those who feel regret have surgery to try to restore their fertility.

Though it's hard to see into the future, try to think about what situations would change how you now feel about having a child. If you are in a couple, have you explored each other's feelings? If either partner feels pressured, consider one of the long-acting but reversible methods such as the IUD. Let time pass after any crisis—new baby, new job, misunderstandings—before making your decision. If you are already thinking about the success rates of surgery to restore fertility, you are probably not ready.

VASECTOMY

Vasectomy is the sterilization operation for men. This simple procedure takes about 15 minutes and can be done in a doctor's office.

Vasectomy using "no scalpel" technique. While holding the vas deferens, a small hole is made in the skin of the scrotum.



After vasectomy

How It Works

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

Linda Rutenberg

Effectiveness

Vasectomy is **almost 100%** effective. Rarely, the cut ends rejoin and sperm are carried into the semen again. This can occur within a few months or even years later.

A vasectomy is not effective right away. It takes about a month (about 10 to 30 ejaculations) for the sperm beyond the cut to be cleared. Your semen is examined for sperm 8 weeks after surgery. Unprotected sex before this can cause pregnancy.

Effect On Sexuality

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

Effect On Health

About 1/3 of men feel faint during surgery. Afterwards, bruising and swelling of the scrotum are common. Bleeding within the scrotum or infection occur in under 5% of cases, less with the "no scalpel" technique. Treatment with drainage and antibiotics is usually effective. Rarely, leakage of sperm causes a tender lump (granuloma) to form; it generally shrinks without surgery.

Few long-term complications occur. New sperm cells dissolve. The body may produce antibodies against them but this does not appear to cause illness. There appears to be no link between vasectomy and prostate cancer.

Effect On Future Fertility

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

If you wish to father a child, reversal surgery joins the vas again. Sperm are present in semen afterwards in more than 70% of cases, but pregnancy occurs less frequently. The best rates occur when less than 3 years has passed since you were sterilized.

Use

Vasectomies are performed in doctors' 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 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 and around each vas; this may sting 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. In the new, "no-scalpel" technique, the skin of the scrotum is pierced in the middle about an inch below the base of the penis. Each vas is brought through the small hole and cut as described above. The opening shrinks down so stitches are not needed.

You should rest in the clinic until you feel ready to leave. Once home, you can apply an ice pack to reduce swelling and discomfort and take painkillers such as acetaminophen (Tylenol) if needed. For 2 days, wear a scrotal support or jockey shorts and do not bathe or shower. Do not do strenuous exercise or lifting for at least a week. Sexual activity can be resumed in 2 to 3 days or when comfortable. Call the doctor if you have bleeding or symptoms of infection: increased swelling, pain, fever or chills.

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. *Continue using contraception until you've had two negative sperm counts.*

Sterilization Abuse

Sterilization has a long history of abuse. Compulsory sterilization of people with handicaps was once common. Poor women and women of colour have been refused abortions unless they agreed to be sterilized. Forced sterilization has been proposed for women 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, many women do not have access to sterilization.

Democratic solutions about "population problems" 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 a violation of human rights.

TUBAL LIGATION

Sterilization of women involves cutting the Fallopian (egg) tubes. It is more complex surgery than vasectomy and is usually done with general anesthesia. It should be performed only in hospitals or specially equipped clinics.

How It Works

When the Fallopian tubes are cut and tied, sperm cannot reach an egg to fertilize it. Early techniques involved cutting the tubes and tying the cut ends. Now, the tubes can be cut, burned with electricity or blocked using rings, elastic bands or clips.

Methods to reach the tubes also vary. In a *mini-laparotomy*, a small incision is made in the abdomen; this is the technique used when sterilization is performed after giving birth. In *laparoscopy*, the most common technique, a telescope-like instrument is passed through a tiny incision; the doctor uses instruments to reach the Fallopian tubes. 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 **over 98%** 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.

Rarely, pregnancy can occur many years later, particularly in women who were sterilized before the age of 30. If you miss a period and have no explanation, consider taking a pregnancy test.

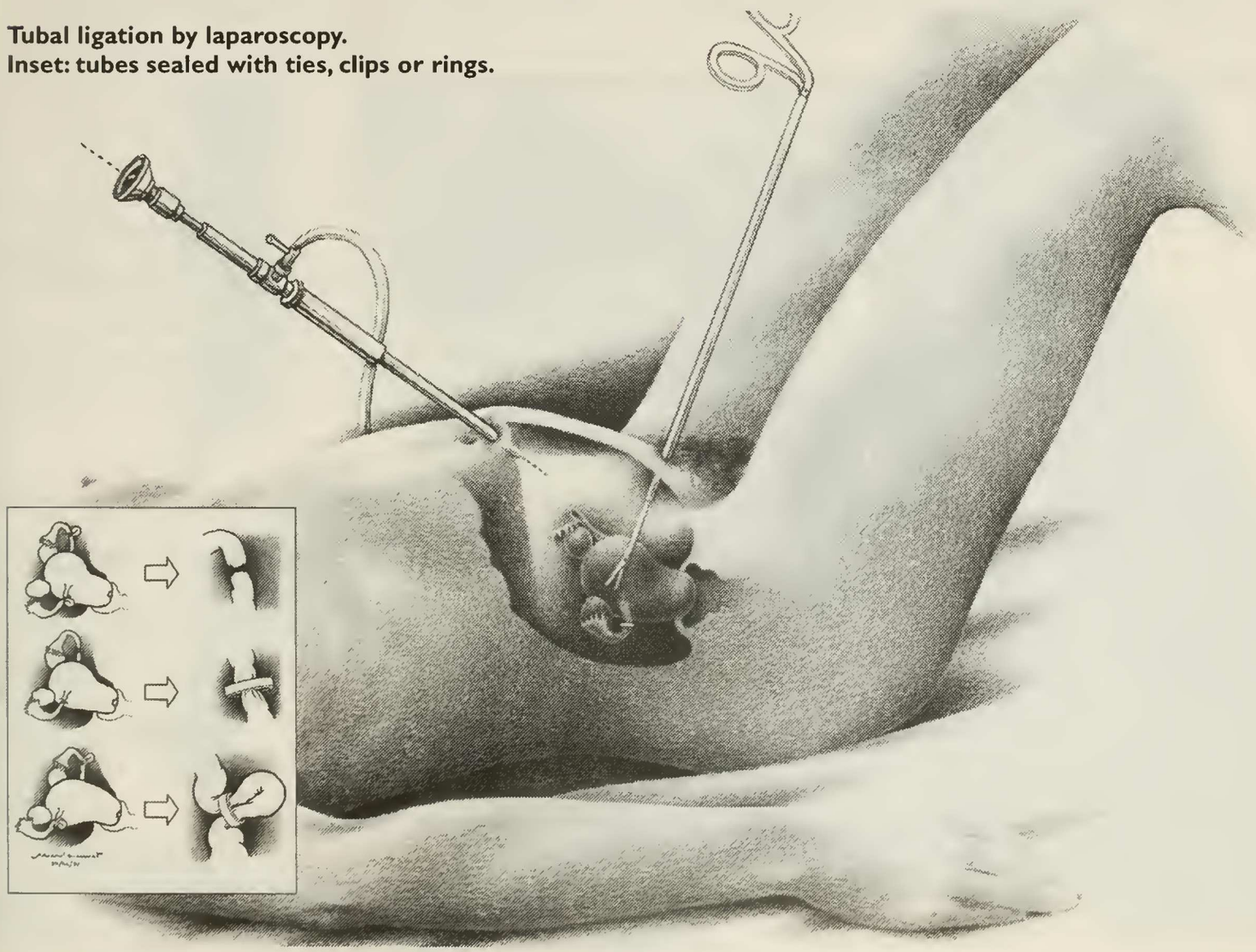
Effect On Health

Sterilization is usually performed under general anesthesia which carries a slight risk of death, especially for women who have heart or lung disease. Some physicians will operate using only sedation and local anesthesia which carries less risk.

Injury to internal organs 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. Abnormal bleeding is a risk of any surgery. Infection of the bladder can occur after any procedure in which the bladder is catheterized. These complications occur during or soon after surgery.

Sterilization does not seem to cause any long-term health problems although women who have been sterilized seem to have more gynecological surgery later on than other women. Some women notice changes in their menstrual cycle but we do not know if these changes are due to the surgery or to age. Most hormone levels do not change but progesterone may decrease slightly.

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



Effect On Fertility

If you become pregnant after tubal ligation, the fetus is not affected. However, the risk of ectopic pregnancy (outside the uterus) which requires emergency surgery is much higher than if you were not sterilized.

Surgery to reconnect the tubes is difficult and expensive. Success is over 75% when clips or rings were used and lower for other techniques. Ectopic pregnancy occurs in about 5% of women who have had reversal surgery.

Use

Your doctor should examine you, discuss the risks of surgery and general anesthesia as well as which sterilization method is best for you. If you have had gynecological problems which caused scarring, you may not be a good candidate for laparoscopy or for vaginal surgery. If you prefer a certain method, find a doctor who has experience with that method. Otherwise, the doctor's choice of method is best since experience is important in reducing side effects.

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

Prior to surgery, you are given a sedative to help you relax. The anesthetist puts you to sleep by an injection in the intravenous solution and puts a tube down your throat 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 each tube is brought in front of the incision. The tubes are 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 which is inflated with gas. The tube is replaced with the laparoscope (a telescope-like instrument). Surgical instruments are 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 may 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 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. You may resume sexual activity in a week or later. After vaginal sterilization, penetration should be postponed for about 2 weeks. Shower or bathe as desired. Use a mild pain-killer other than aspirin for abdominal pain. The stitches will dissolve by themselves.

If you have increasing pain, fever or bleeding from the incision, fainting spells or pain on urination, call the doctor. Otherwise, have a follow-up examination in a month.

Judith Crawley

World March of Women 2000

We are Marching for the Elimination of Poverty and Violence Against Women

The idea to hold a world march of women in the year 2000 was born out of the experience of the Women's March Against Poverty, which took place in Québec in 1995. This march, initiated by the Fédération des femmes dn Québec, was hugely successfnl. Three contingents of 850 women marched for ten days to win nine demands related to economic justice. Fifteen thousand people greeted them at the end of their ten-day walk.

The World March of Women 2000 is an international project, organized by local and national women's groups, bringing together women from all walsk of life. Organizers hope to see many activities dealing with women's issues, beginning on International Women's Day, March 8th, 2000 and culminating in an international action on October 17th 2000.

Goals of the world march of women

- To stimulate a vast movement of grassroots women's groups so that the march becomes a gesture of affirmation by the women of the world.
- To promote equality between men and women.
- To highlight the common demands and inititiatives issuing from the global women's movement relating to the issues of poverty and violence against women.
- To force governments, decision-makers and individuals the world over to institute the changes necessary for improving the status of women and women's quality of life.
- To enter the new millenium by demonstrating women's ongoing determinationa to change the world.

If you would like to become involved in the Women's March or simply want more information, check the website of the Fédération des femmes du Québec (www.ffq.qc.ca) or contact them at 110 rue Ste-Thérèse, #307, Montréal, Québec, CANADA H2Y 1E6, Tel.: (1) 514-395-1196, Fax: (1) 514-395-1224

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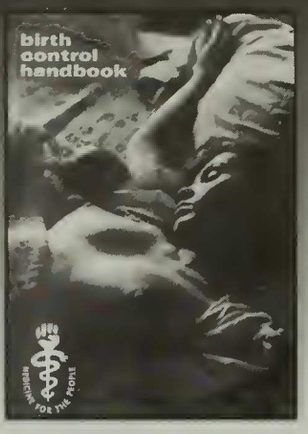

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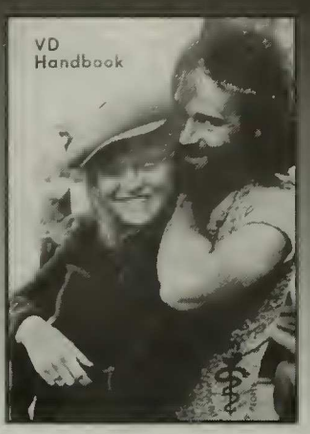

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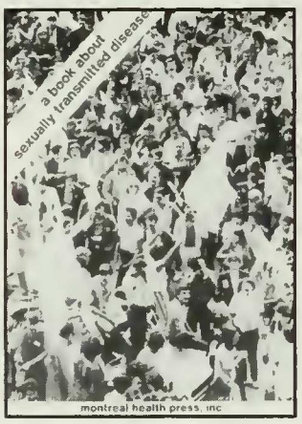

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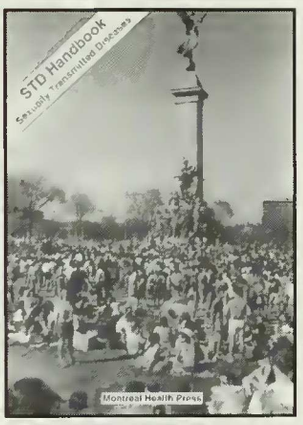

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also available in French

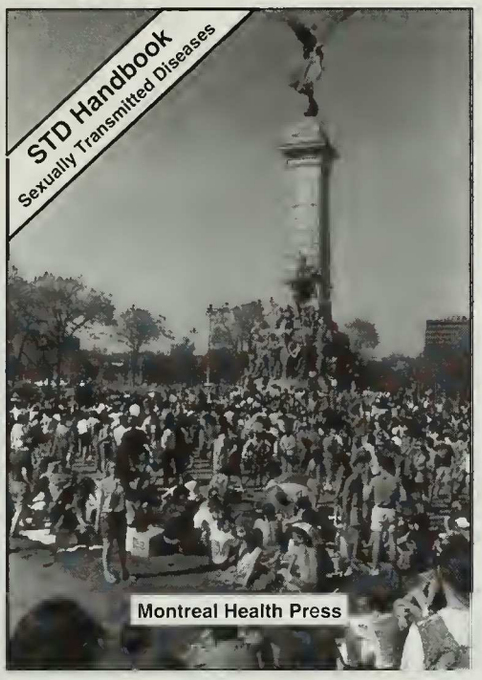
consult our web page for further information: http://www.worldsfinest.com/mhp

Menopause Handbook

"**Menopause Handbook** is a very comprehensive publication, presenting women with a broad scope of information about menopause in a clear, yet not simplistic manner. Your information is presented with objectivity, and your coverage of the information related to the benefits and risks of long term hormone replacement therapy is evidence-based."

M.J. Jacobsen
Ottawa Civic Hospital Loeb Research Institute

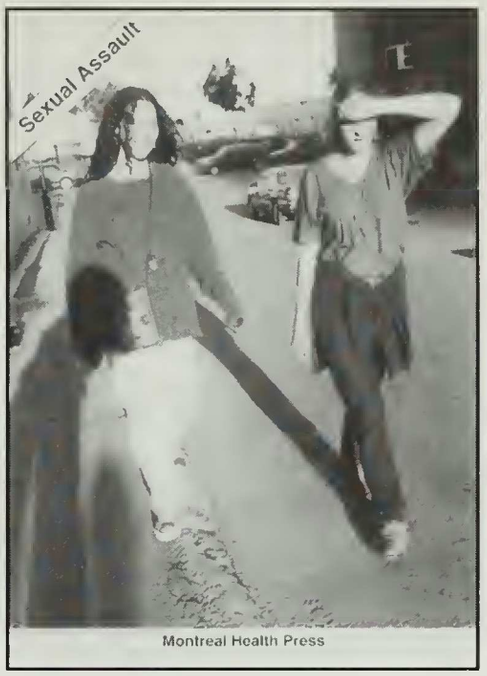
STD Handbook



The **STD Handbook** stands without equal in the US... The book speaks with clarity, in an explicit language, with modern relevance to young sexually active persons regardless of ethnicity and background."

Michael Ritchey, Director
Cincinnati Health Department

Sexual Assault



"No other resource offers the combination of personal and practical information, an understanding of why sexual assault happens and ways to work for positive social change."

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Resources

Contraceptive Technology, 17th rev. ed., R. A. Hatcher *et al*, Ardent Media Inc., NY 1998..

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Promoting Effective Contraceptive Use D J Lethbridge & KM Hanna, Springer Publishing Co., NY, 1997.

Contraceptive Technology Update, American Health Consultants, 3525 Piedmont Rd, bldg 6, #400, Atlanta, GA 30305; www.ahcpub.com.

Herizons—Women's News & Feminist Views, PO Box 128, Winnipeg, Manitoba R3C 2G1 Canada.

On the Issues—The Progressive Woman's Quarterly, www.echonyc.com/onissues

Canadian Abortion Rights Action League 1-800-642-2725; www.caral.ca

Canadian Women's Health Network www.cwhn.ca/

National Abortion Federation www.prochoice.org

Ann Rose's Ultimate Birth Control Links Page gynpages.com/ultimate/

Population Council www.popcouncil.org

Reproductive Health Online www.reproline.jhu.edu/

The Montreal Health Press

We are a collective of women who produce and distribute handbooks on health and sexuality. Our approach is non-judgmental and comprehensive—empowering people to make their own informed decisions on these important issues.

The Montreal Health Press made history in 1968 by publishing the **Birth Control Handbook** at a time when the distribution of birth control information was still illegal in Canada.

Since then we've produced handbooks on sexually transmitted diseases, sexual assault and menopause. Millions of copies in both French and English have been provided to people through clinics, community centres, women's groups and schools throughout North America.

Our publications are regularly revised to include current technical developments as well as social and political changes. We are proud to continue our contribution to health education with this edition of the **Birth Control Handbook.**