OUR BODIES OUR SELVES

A COURSE BY AND FOR WOMEN

NEW PRINTING OF

35¢

WOMEN & THEIR BODIES

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THE FIRST PRINTING SOLD SO FAST WE HAVEN'T HAD TIME TO REVISE THE PRINTED COURSE. WE ARE WORKING ON REVISIONS WHICH WE HOPE WILL BE READY FOR THE 3RD PRINTING. WE WANT TO ADD CHAPTERS ON MENOPAUSE AND GETTING OLDER AND ATTITUDES TO CHILDREN (CHILDREARING ALTERNATIVES, SINGLE WOMEN HAVING CHILDREN, ADOPTING, ALSO NOT HAVING CHILDREN). WE WANT TO EXPAND THE EXISTING CHAPTERS TO INCLUDE MORE ON MONOGAMY, HOMOSEXUALITY, WOMEN'S DISEASES AND HYSTERECTOMIES, THE RELATION BETWEEN MENTAL AND PHYSICAL HEALTH, NUTRITION, ETC., ETC.

WOULD YOU LIKE TO MAKE SUGGESTIONS, WRITE UP YOUR OWN EXPERIENCE, OR OTHERWISE WORK ON THE COURSE? PLEASE WRITE US. THE COURSE IS WHAT ALL OF US MAKE IT.

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Course Introduction

One year ago, a group of us who were then in women's liberation (now most of us consider ourselves members of Bread and Roses) got together to work on a laywoman's course on health, women and our bodies. The impetus for this course grew out of a workshop on "women and their bodies" at a women's conference at Emmanuel College in Boston, May 1969. After that, several of us developed a questionnaire about women's feelings about their bodies and their relationship to doctors. We discovered there were no "good" doctors and we had to learn for ourselves. We talked about our own experiences and we shared our own knowledge. We went to books and to medically trained people for more information. We decided on the topics collectively. (Originally, they included: Patient as Victim; Sexuality; Anatomy; Birth Control; Abortion; Pregnancy; Prepared Childbirth; Postpartum and Childcare; Medical Institutions; Medical Laws; and Organizing for Change.) We picked the one or ones we wanted to do and worked individually and in groups to write the papers. The process that developed in the group became as important as the material we were learning. For the first time, we were doing research and writing papers that were about us and for us. We were excited and our excitement was powerful. We wanted to share both the excitement and the material we were learning with our sisters. We saw ourselves differently and our lives began to change.

As we worked, we met weekly to discuss what we were learning about ourselves, our bodies, health and women. We presented each topic to the group, gave support and helpful criticisms to each other and rewrote the papers. By the fall, we were ready to share our collective knowledge with other sisters. Excited and nervous (we were _just_ women; what authority did we have in matters of medicine and health?), we offered a course to sisters in women's liberation. Singly and in groups, we presented the topics and discussed the material; sometimes in one large group, often in smaller groups. Sisters added their experiences, questions, fears, feelings, excitement. It was dynamic! We all learned together.

One original version of the course was that we as a group would give the course to a group of women who could then go out and give it to other women. To some extent, that is what happened. After the first time around, those of us who had worked out the course originally, plus women who had taken the course, got together in an enlarged group to rewrite the papers so they could be printed and shared, not only with women in Boston, but with women across the country. Other women wanted to learn, other women's health groups wanted to compare and combine our work and theirs.

So after a year and much enthusiasm and hard individual and collective thinking and working, we're publishing these papers. They are not final. They are not static. They are meant to be used by our sisters to increase consciousness about ourselves as women, to build our movement, to begin to struggle collectively for adequate health care, and in many other ways they can be useful to you. One suggestion to those of you who will use the papers to teach others: the papers in and of themselves are not very important. They should be viewed as a tool which stimulates discussion and action, which allows for new ideas and for change. Often, our best presentations of the course were done by a group of women (we could see a collective at work – in harmony, sharing, arguing, disagreeing) with questions throughout, and then splitting the larger group into smaller groups to continue talking about whatever part of the topic that was especially relevant to the women in that group. It was more important that

we talked about our experiences, were challenged by others' experiences (often we came from very different situations), raised our questions, expressed our feelings, were challenged to act, than that we learned any specific body of material.

It was exciting to learn new facts about our bodies, but it was even more exciting to talk about how we felt about our bodies, how we felt about ourselves, how we could become more autonomous human beings, how we could act together on our collective knowledge to change the health care system for women and for all people. We hope this will be true for you, too.

This course should grow and include other topics, such as menopause, divorce, child care, strengthening our bodies (diet, exercise, karate, etc.) – topics important to the group of women giving and taking the course. The material has been and should be used in ways other than a course. A course is only one way of spreading the word.

We want all your ideas, comments, suggestions, criticisms, etc.

Power to our sisters!!

Nancy Hawley, Wilma Diskin, Jane Pincus, Abby Schwarz, Esther Rome, Betsy Sable, Paula Doress, Jane de Long, Ginger Goldner, Nancy London, Barbara Perkins, Ruth Bell, Wendy Sanford, Pam Berger, Wendy Martz, Lucy Candib, Joan Ditzion, Carol Driscoll, Nancy Mann, Hester Butterfield, Marilyn Slotkin, Linda Borenstein, Martha Reudi, and all the other women who took the course and read the papers.

In reading or teaching this course you may need additional information, pictures, or charts and models. There are bibliographies in several papers and most public libraries carry illustrated books in sections like Sex Education and Young Adults. You can probably avoid spending money on them. The following three books, not in most libraries, have some of the best illustrations and information:

A Child is Born: The Drama of Life Before Birth in Unprecedented Photographs, A Practical Guide for the Expectant Mother, Dell Publishing Co., N.Y.
Birth Control Handbook, Box 1000, Station G, Montreal 130, Quebec (25¢); also available (ten or fewer copies only) from New England Free Press, 791 Tremont St., Boston, Mass. 02118 (10¢)
Understanding, Ortho Pharmaceutical Corporation, Raritan, New Jersey

You can get more information, posters or plastic models from:
the nearest Planned Parenthood office
International Planned Parenthood Federation, 111 4th Ave., New York, N.Y.
Ortho Pharmaceutical Corporation, Raritan, New Jersey
Educational Department, Tampax Incorporated, New York, N.Y. 10017
Health–Pac, 17 Murray St., New York, N.Y.
Women's Abortion Project, 36 W. 22nd St., New York, N.Y.

The above are very different kinds of people. Don't forget that Ortho and Tampax are capitalist organizations, pushing their own products for profit; nevertheless, their educational departments put out some excellent stuff. Planned Parenthood pushes population control and birth control pills.

The local Planned Parenthood can give you the name of the local Ortho representative from whom you can try to get birth control kits (with Ortho contraceptive products). It helps to have a physician call for you. P.P. can also give you the names of gynecologists who may give or sell you different IUDs. It is also good to have the names or doctors to whom you can refer women.

It took a long time to put together this course, but we don't consider it a finished product. As more women use, teach, and learn from the course, it must be expanded and revised to meet our needs. We plan to continue our work and want to have a second edition ready to be printed in six months to a year. The course will be best changed by the corrections and additions sent by those who use it. So send them in: Boston Women's Health Course Collective, c/o New England Free Press, 791 Tremont St., Boston, Mass. 02118

Anatomy and Physiology

Our society has traditionally valued the mental over the physical. Those who contribute to this hierarchy calling the mind noble and the body base do humanity a great disservice. It denies our physical selves. The results are particularly damaging to us as women who are defined as more or less mindless and thus stuck with being "base" bodies. A "base" thing is not worth knowing about, striving to feel good about, so we grow up ignorant, misinformed, unprepared. Only when we are very young can we enjoy using our bodies, playing outdoors and running, and throwing tantrums sometimes when we feel like it. As we grow older, every part of our body is used against us. Nearly every physical experience we have as a woman is so alienating that we have been filled with extreme feelings of disgust and loathing for our own bodies. Every part of our body is an area of real or potential disgust to us – armpits, faces, vaginas, buttocks, stomachs, breasts. The slightest so-called "imperfection" is a source of very private anxiety and fear that we dare not communicate to each other because we are taught to think we are the only ones that feel these things. And the objectified disgust we have for ourselves we feel towards other women and we are filled with disgust at the thought of her (our) body under the clothing (armpits, vagina, etc.)

Our society adds insult to injury by demanding that that the truly "womanly" woman be soft, somewhat weak and awkward – in short, physically unfit. We contribute to this by, for example, wearing high heeled shoes which are unhealthy and also keep us in our place (we can't run). Our physical limitations are actually more apparent than real, however, and exist today because we don't have the opportunity to develop ourselves, and men and the pressures exerted by our male-dominated society tell us what is good, what is bad (a strong woman is considered "masculine" and undesirable as a woman). We want to become physically healthy, strong, and enduring through exercise, proper eating and training (like karate) and proud of our bodies. Pride because we feel good ourselves, not because we look good for others.

What are our bodies? First, they <u>are</u> us. We do not inhabit them – we <u>are</u> them (as well as mind). This realization should lead to anger at those people who have subtly persuaded us to look upon our bodies (ourselves) as no more than commodities to be given in return for favors. In fact we feel we are commodities because our bodies, in toto and dismembered, are used to sell products – useless, mind-destroying products that make millions for business<u>men</u>. Our legs, busts, eyes, mouths, fingers, hair, abdomens, and vaginas are used to sell stockings, bras, fashions, cosmetics, hair coloring, a multitude of birth control products that men would not consider using in any form, powders, sprays, perfumes (again to make us smell "nice" for men because our own smells are not good enough), and such obscene things as deodorants for our vaginas. Consequently we view our bodies and those of other women according to how closely they "measure up" to the sexist standards of the society. But our bodies are unique because they - us - will never occur again. Love for ourselves and other women, both of which we have n[illegible] allowed to experience, begins to surface when we refuse to objectify ourselves any longer and [illegible]g on the nowhere identity we have been forced to subsist on for so long.

As women [illegible] r reproductive organs is vital to overcome objectification. We have been ignorant of [illegible]ction and this enables males, particularly professionals, to play upon us for money a[illegible] to intimidate us in doctors' offices and clinics of every kind. Once we have some [illegible]ir bodies work by talking and learning together and spreading the [illegible] at the total mercy of men who are telling us what we feel when we [illegible] we do (it's all in our minds!). (Going together in small groups to doctors [illegible] other is incredibly helpful to us and works wonders of "humility" on the minds of many doctors.)

The purpose of this paper is then to help us learn more about our own anatomy and physiology, to begin to conquer the ignorance that has crippled us in the past when we have felt we don't know what's happening to us. The information is a weapon without which we cannot begin the collective struggle for control over our own bodies and lives.

The body contains four major cavities. (These cavities are actually filled with organs and fluids: they aren't to be thought of as huge holes or hollows.) One is the pericardial cavity (peri=around; cardial=heart), enclosing the heart, located just beneath the breast bone. There are two pleural cavities, each

enclosing a lung and located deeper in the chest towards the back. These three cavities are protected by rib cage and breastbone. Finally there is the peritoneal cavity, containing most of the viscera, enclosed and protected by the bowl-shaped bony pelvis.

The pericardial and pleural cavities are separated from the peritoneal cavity by the diaphragm. This is a sheet of muscle which extends from the solar plexus (wishbone) to an opposite spot near the back. It aids in contraction and expansion of the pleural cavities enabling the lungs to empty and fill.

The viscera include digestive organs (stomach, small intestine, liver and gall bladder, pancreas, large intestine or colon, appendix, and rectum), excretory organs (kidneys, ureters or the tubes leading from kidneys to bladder, the bladder, and part of the urethra or the tube extending from bladder to outside), adrenal glands, and some reproductive organs (ovaries, oviducts, uterus).

The organism (ourselves) is composed of many systems (digestive, reproductive, etc.). Systems are composed of various tissues, and tissues are composed of similar kinds of cells. When you eat steak, for instance, you are eating fat (a type of connective tissue) and meat (muscle tissue). The four main tissues are epithelium, connective tissue, muscle and nerve.

Epithelial tissue is composed of cells which are placed very close together. It may vary in thickness from one to several cell layers. Epithelium gives rise to sweat glands, mucous glands, sebaceous glands (secrete oil; responsible for acne), endocrine glands (adrenals, pituitary, thyroid, etc., all of which secrete hormones), exocrine glands (e.g. part of the pancreas which secretes digestive enzymes), and hair follicles. It also covers and lines structures. As skin, it covers our body, and as mucous membrane it lines our mouths and the rest of the digestive tract. Mucous membrane also lines oviducts, vagina, urethra, blood vessels – any hollow organs or parts of organs. It also covers them (e.g. stomach).

Connective tissue is characterized by few cells spaced widely apart. As the name states, connective tissue connects organs and tissues with each other. These cells secrete various compounds into the spaces around them, forming the tough substance of cartilage, ligament, tendon and bone and the more delicate substance of fat and mesentery. Mesenteries are sheets of varying toughness which not only connect organs to one another but which carry blood vessels and nerve fibers from one place to another.

The cells composing muscle tissue can contract when they receive nervous impulses. We move about by using our voluntary musculature. Involuntary muscle, present in such places as digestive tract and uterus, causes peristalsis and labor contractions.

The cells of nervous tissue can generate, transmit and receive impulses. The autonomic, or independent, division of the nervous system controls involuntary processes such as digestion and heartbeat, and the central division supplies our skeletal musculature and performs other functions not pertinent here.

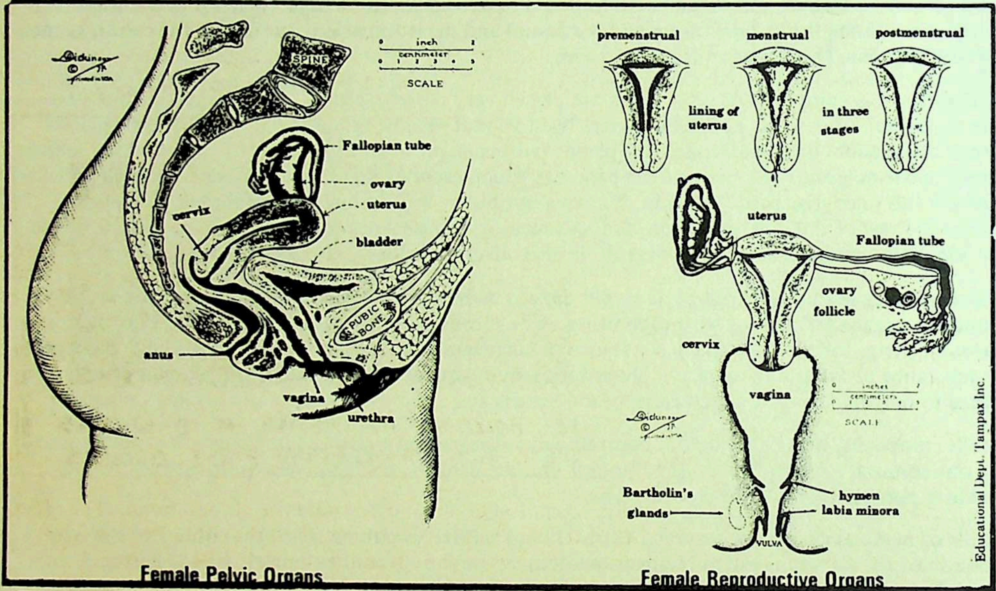
The rest of this chapter will cover the reproductive system. If you wish to study the other systems, they are dealt with in the appendix. The first part of the discussion of the reproductive system will concern anatomy; the second part will deal with ovulation.

Many of the reproductive organs of women and men are similar in origin and in function; they are homologous and analogous to each other. Homologous organs are structures with a common origin, developing from the same embryonic tissue. If they have the same function, they are considered analogous, the implication being that organs with a common ancestry do not always have a similar function. Studies have provided some interesting homologies: ovaries and testes (also analogous), labia majora and scrotum, clitoris and penis (also analogous), bulb of vestibule and bulb and adjoining part of corpus spongiosum penis (also analogous), Bartholin's glands and bulbourethral glands (also analogous). What is more, the embryonic gonad (sex gland, from the Latin "gone" or seed) is "indifferent"; that is, it will become male or female depending on the chromosomes and hormones present at the time.

The gonads have a dual function in both sexes. The ovaries produce female germ cells (eggs) and female sex hormones (estrogen, progesterone). They are about the size and shape of unshelled almonds, located one on either side of the body (see diagram). Each ovary lies in a mass of fat which cushions and protects it. The funnel-like end of an oviduct (Fallopian tube) extends towards the side of the ovary

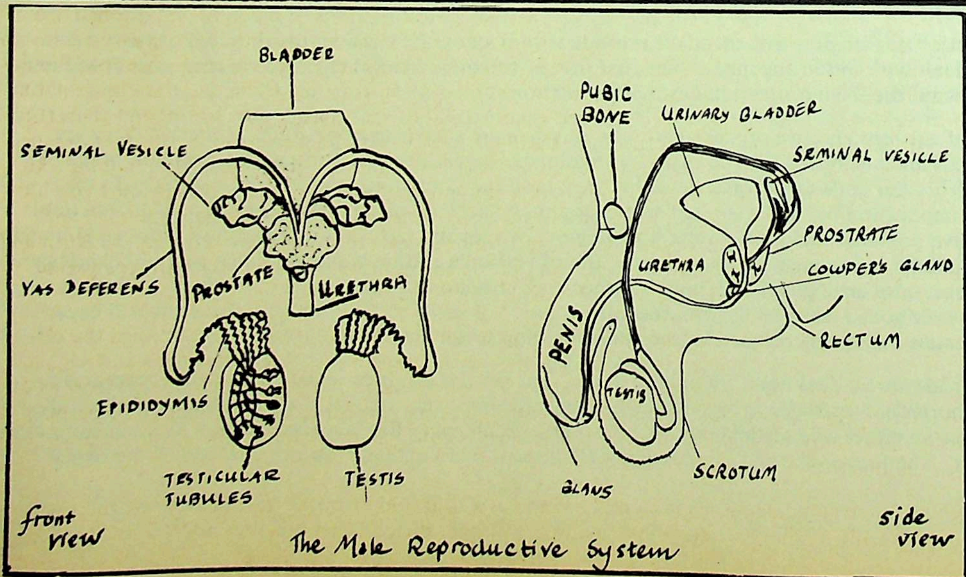
from which the eggs are released (see diagram this page). (It is significant that there is a gap between each tube and the corresponding ovary: very rarely an egg will be fertilized before it can enter the tube, and an abdominal pregnancy will result.) The length of each oviduct is about four inches. Whereas the ovaries are connected to uterus and tubes only by ligaments and mesenteries, the tubes actually open into the uterus. Each opening is so small that only a fine needle can penetrate it.

The uterus (womb) is about the size of a fist. This thick-walled, hollow, muscular organ lies in the lower part of the peritoneal cavity between bladder and rectum (see diagram). The bladder is beneath the abdominal wall, the uterus is behind the bladder, and the rectum is nearest the backbone. The cavity of the uterus is compressed from back to front into a mere slit. The narrowed part of the uterus is called the cervix, and this protrudes into the vaginal canal. You can touch your own cervix; it feels like a large nipple with a small dimple in its center, extending from the top part of the vagina way towards the back. The uterus changes position during the menstrual cycle, so where you feel the cervix one day



Female Pelvic Organs

Female Reproductive Organs

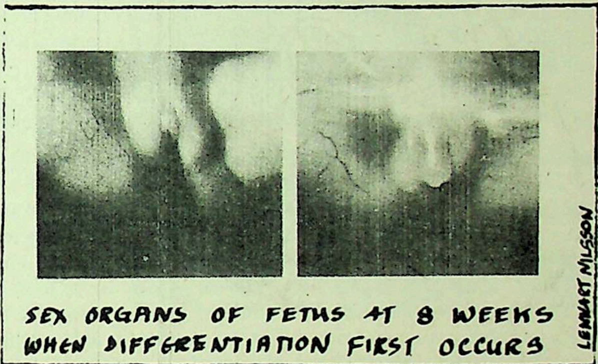


The Male Reproductive System

may be slightly different from where it will be the next! The entrance into the uterus through the cervix is very small, about the diameter of a very thin straw. This is the little dimple that you feel in the middle of the "nipple".

The vagina extends from just behind the cervix (where it ends blindly as the fornix) to the outer genitals, or vulva. Like the uterus and cervix, the vagina is between bladder and rectum (see diagram), and is positioned such that when you are standing or sitting or squatting it extends towards the small of the back (remember your Tampax instructions: "point it towards your waist"). Its walls are ordinarily in contact; i.e. its space is potential, not actual. Its length may average some 3½ inches but it is capable of considerable distension. Its lining is thrown into folds which flatten out as the vagina expands in intercourse or childbirth. Feel your own vagina with your fingers and you may be able to feel the folds. You may also be able to feel some feces in the rectum, through the "bottom" wall of the vagina.

The basic plan of tissue organization is the same in oviducts, uterus and vagina. The innermost lining in each case is mucous epithelium. In the vagina it is quite thick, as this organ undergoes wear and tear in intercourse and childbirth. It is not glandular in the vagina, but is in the uterus. In the tubes, as mentioned, it is ciliated. The next two layers are composed of involuntary muscle, thickest in the uterus, whose muscular contractions must expel the baby at term. The last layer around each organ is a thin sheath of epithelial tissue.



SEX ORGANS OF FETUS AT 8 WEEKS WHEN DIFFERENTIATION FIRST OCCURS

The external genital organs all together are called the vulva (see p. 16). The pubis is a rounded fatty covered mass in front of the pubic symphysis. (The pubic bones are part of the hip girdle; where one meets the other is termed a symphysis. In the diagram, the pubic symphysis is labeled pubis.) Next come the hair-covered labia majora, or major lips. They protect the more delicate inner structures. When they are opened, the labia minor or minor lips are seen, extending from the clitoris back to the sides of the vaginal opening. Each minor lip divides into two portions. One part passes above the clitoris to meet the lip on the other side, forming the clitoral hood. The other part passes beneath the clitoris and attaches to its undersurface, forming (with the other lip) the frenulum or base of the clitoris. You will understand this best if you examine yourself with a mirror.

The clitoris is homologous with the penis, and has analogous functions of erection and orgasm. Erection occurs when blood flows into hollow areas within an organ, causing turgidity and consequent stiffening. The hollow areas in the man's penis and in the woman's clitoris are called corpora cavernosa (literally, hollow bodies). The clitoris has two corpora cavernosa, each surrounded by involuntary musculature and connective tissue. Like the penis, the clitoris is composed of shaft (from root to tip) and glans (the glans clitoridis is the tip of the clitoris, from the Latin glans or acorn; the glans penis is the acorn-shaped tip of the penis). In a woman the shaft is hidden under the hood, but the glans protrudes, looking like a small bump. If you are not sure of the location of your clitoris, feel your outer genitals until you hit upon the most sensitive spot. This is pretty sure to be the clitoris. The clitoris is richly supplied with nerves. For a discussion of the history of society's attitude towards this organ, we refer you to Ruth and Edward Brecher's excellent summary of the Masters and Johnson findings (paperback, **An Analysis of Human Sexual Response**, Signet T3038, pp. 144-145).

The vestibule is the cleft between the minor lips and behind the glans clitoridis. It contains the urinary (urethral) and vaginal openings (orifices). The urinary opening is just between clitoris and vagina, and its position accounts for the occasional irritation felt when one urinates after extremely vigorous or prolonged intercourse. The vaginal opening is beneath the urinary opening. The perineum, or perineal region, is the tissue between vagina and anus; this is what is cut in an episiotomy (the cut to enlarge opening for childbirth).

The hymen (cherry, maidenhead) is seen in a virgin as a thin fold of membrane situated at the vaginal opening. Usually a Tampax can be inserted in the partial opening that remains, and of course men-

strual fluid is shed through that opening. The hymen may be entirely absent even in a virgin, however, and when present may assume many shapes and degrees of thickness. There are little folds of tissue that remain after it has been broken.

The bulb of the vestibule is the name given to two elongated masses of erectile tissue, placed one on either side of the vaginal opening and meeting in front of it. This tissue becomes turgid (swollen) when a woman is sufficiently aroused, contributing to a tightening around the penis.

Bartholin's glands are two small, rounded bodies on either side of the vaginal opening, in contact with the hind end of each mass of erectile tissue (the bulb). They are not easy to see. They contribute very **little** to vaginal lubrication during intercourse.

We emphasize that you take a mirror and examine yourself. Touch yourself, smell yourself, even taste your own secretions. After all, you are your body and you are not obscene.

In intercourse, as the man's penis moves in and out of the vagina, the minor lips are alternately stretched and relaxed. This is most evident when the two masses of tissue composing the bulb of the vestibule are erect (i.e. when the woman is very much aroused and the vagina is tightened around the penis). Since the minor lips form the clitoral hood, they move back and forth over the sensitive glans clitoridis, stimulating it so that - under optimal conditions - orgasm occurs even though the penis does not directly contact the clitoris. Many of us can't have satisfactory orgasm through pentration alone, however; many of us want direct manual or direct oral stimulation of the clitoris. Either indirect or direct stimulation is perfectly normal; if you can't have orgasm through intercourse alone, as many women cannot, you should not feel inadequate or ashamed of demanding direct stimulation.

Ovulation: A follicle, seen in the diagram on page 44, is a hollow ball of several layers of cells. In the case of a Graafian or mature follicle, there is an egg cell in the center. The ovary contains thousands of follicles, but only about 300 will become mature. The others are termed atretic (their development is abortive); yet they perform the essential function of secreting constant low amounts of estrogen. The diagram shows the sequence of development and decline of a Graafian follicle (as well as picturing an atretic type). Each month one follicle (occasionally more than one), under the influence of hormones, starts growing out of its resting immature state. It develops various cell layers, one of which starts secreting estrogen, and matures an egg cell in the center. It also moves towards the surface of the ovary. At some point it breaks through the ovarian surface, ruptures, and expels the egg. Another layer of cells in the ruptured follicle then starts secreting progesterone. The follicle is now called a corpus luteum (literally, yellow body, referring to the yellowish fat in it when it is almost completely degenerated). When it declines, under the influence of other hormones, it leaves a whitish scar on the surface of the ovary; it thus is called corpus albicans (white body). The egg, meanwhile, is ejected towards the funnel-shaped end of the oviduct and trapped by the funnelings. Peristaltic contractions of the oviduct, similar to those of the esophagus which push food into the stomach, help the egg toward the uterus. The journey takes about 6½ days. If the egg has been fertilized, a process which occurs in the **outer third of the tube, not in the uterus**, it sits at the entrance to the uterus for some 12 hours before implanting on the uterine wall. 50% of the eggs implant on the front wall of the uterus, 40% on the back wall, and 10% on the sides (these don't do so well). There is a possibility that the fertilized egg may implant in the tube while en route to the uterus. This is an ectopic or tubal pregnancy and requires surgery as the tube can rupture. If the egg is not fertilized, it does not implant but is discarded in vaginal secretions (usually unnoticeable). Fertilization, incidentally, is encouraged by waving cilia (hairlike processes extending from cells lining the tubes) which sweep constantly in the direction of the ovary, aiding the sperm in their journey up the tube. For some reason the cilia's waving does not hinder the egg's journey in the opposite direction, nor does the peristalsis of the tube hinder the sperm from moving towards the ovary.

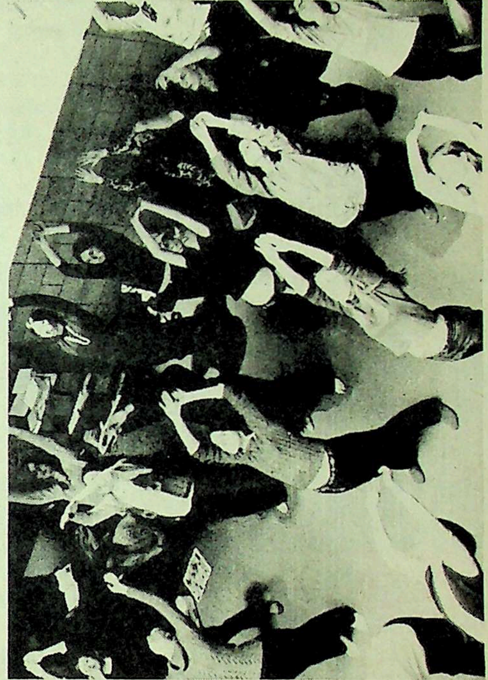
These are just the anatomical facts. But knowing these facts about our bodies is only one way to know them and to begin to get in touch with ourselves. Other things to think about:

1. How do we make our bodies physically strong and healthy?
2. How do we develop our bodies to be physically independent and physically safe, especially from men?
3. How do we feel about our bodies (total body and particular parts)? Are we accepting of our bodies? How do feelings about our bodies relate to our feelings about other things – notion of beauty, men, women, work, control of our lives, self esteem?
4. Does our self concept integrate a sense of our physical and mental selves? (conquering mind-body separation)
5. How can we learn to repair our bodies and those of others in a variety of situations?

Sexuality

This paper was written by a group of us in Women's Liberation anxious to share our thoughts and feelings about sexuality with other women. We are experts only in the sense that we are women, and women talking to women about their range of experience and insights has been more informative to us than all of the How-To-Do-It, What-Is-It-All-About books we have ever read.

The paper includes a lot of personal stories – ours and our friends, because we felt that our own voices, our own histories rang the clearest and truest and helped us reclaim the mysterious topic of sexuality as familiar and ours. There are sections in the paper that deal with specific topics, such as celibacy and orgasms, and an introduction that tries to place sexuality in a larger social context.



We have written about sex because sexual relations between men and women are permeated with myths and preconceptions that put the woman down, and not because sexual relations are an absolutely necessary part of a fulfilled woman's life. If the goal of knowing ourselves sexually were to produce bigger and better spasms in orgasm, it would have been a waste of time to write this paper. Orgasms are not that important in life. What is important are loving, giving, free relationships between people.

I.

We are all so oppressed by sexual images, formulas, goals and rules that it is almost impossible to even think about sex outside the context of success and failure. The sexual revolution - liberated orgastic women, groupies, communal fucking, homosexuality - have all made us feel that we must be able to fuck with impunity, with no anxiety, under any conditions and with anyone, or we're some kind of up-tight freak. These alienating inhuman expectations are no less destructive or degrading than the Victorian puritanism we all so proudly rejected. Robin Morgan, a Women's Liberationist in New York, says "Goodbye to Hip Culture and the so-called Sexual Revolution which has functioned toward women's freedom as did the Reconstruction toward former slaves – reinstituted oppression by another name."

We must destroy the myth that we have to be groovy, free chicks. But it is insidiously embedded in our culture. We are told we must be educated to understand that sex is not bad or dirty, that it can be beautiful, fulfilling, and extremely pleasurable. Playboy, Newsweek, and almost all women's magazines are filled with such analyses of our sexuality. Great pressure is being put on us to be both independent (what modern man wants a clinging vine?) and a sex-kitten at the same time.

Why is it that women still resist so much advertised liberation? Why is the advertising still necessary some 50 years after the propaganda for women to enjoy sex as much as men began? Why do women and men still think sex is dirty? Maybe they're right. When women feel powerless and inferior in a relationship it is not surprising to feel humiliated and unsatisfied in bed. Similarly, a man must feel some contempt for a woman he believes to be not his equal.[1]

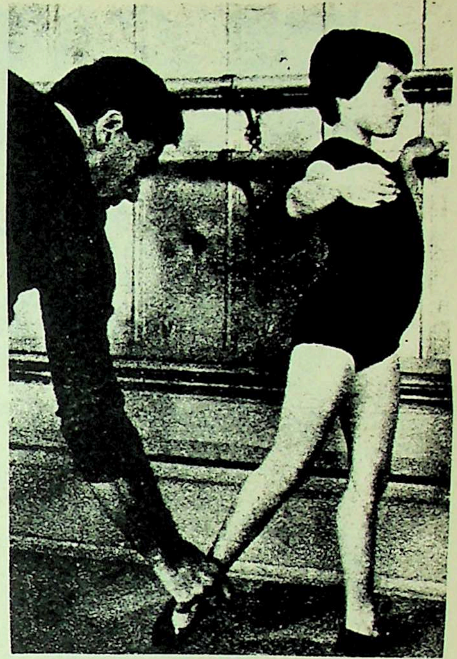
"Frigidity" or inadequacy in bed is not divorced from the social realities we experience all the time. This male dominated culture embues us with a sense of second best status, and there's no reason to expect this sense of inferiority and inadequacy to go away between the sheets.

SEXUAL FEELINGS

Part of the reason so many people have problems about sex is because sexual feelings are considered separate or different from other kinds of feelings we have. Sex has got to do with the body – that alien part of us residing below the neck that has needs and responses that we don't understand. But all our feelings reside in the body. Fear usually makes its presence felt by your heart pounding, your chest feeling caved in, your stomach turning. Joy is tingly – your head feels a little light, fingers and toes sort of shimmer, and the rest of you feels warm and all in one piece. For some people anger feels like a pounding in the head, hands feel tight and clenched and so on. So what's the big to-do about sex? It's all part of the same body that we live in every day, that defines our feelings for us, that moves us around. It can't be mysterious or alien because it's our own familiar house. A good stretch, running fast, breathing deeply – these are all orgasms of a sort. They are as much a part of "sex" as that restricted set of activities that happen in bed and cause us so much trouble.

To make sex special, different, better, more important is to disown our bodies. It is like saying, "you're only good for me", "you're only a part of me" when you perform on command in this usually tense and phony circumstance. But our bodies are us all the time. And if this body, which is us, feels sleepy or scared or cold in certain settings, it has its own good reasons for doing so. And we (our heads) have no right to punish or reject it or let anyone else punish or reject it for not feeling differently.

The problem is that "sex" and all the preparations leading up to it and after it have nothing to do with sex. "Sex" is about being a "real woman" – being that ridiculous caricature of a person that this society tells us we had better become if we are to extract even the smallest amount of security, pleasure and self-esteem from the world. It's a sexual achievement exam. You make love to your judge, and it's pass/fail. And the irony of it is that it's not even our test – they made up the rules and we swallowed the lies and thought that if we "failed" it was our problem. What we need to do is get rid of all the standards we've previously used to measure ourselves, our sexuality. By talking to each other, taking support from each other, we can set our own standards which will bear the mark of sanity and individuality.



GROWING UP

It seems pretty clear to us as women that from the moment we're born, we're treated differently from little boys. Our toys are different. Dolls instead of chemistry sets. Our clothes are different – little dresses to be kept clean instead of sloppy pants. And slowly, over the years, a distinction is made between boys and girls on every dimension. We're emotional; they're intellectual. They're clumsy; we're graceful and dainty. They're going to go on to become doctors and business men. We're going to get married. The most ambitious among us dreamed of nursing. They're athletic. We're domestic. They have an easily wounded ego. We're good at soothing. In short, men were socialized to think of themselves as intellectual, aggressive and creative, while women are molded as passive, gentle, and emotional. OK, you say, that's not so bad. Separate but equal characteristics. We don't think that's true. We think we've suffered by this characterization of us as passive creatures, noticeably in relation to our sexuality. We're not supposed to be interested in sex – that's for men. We're not supposed to admit it if we are – that's dirty. The ideal woman **responds**, she does not initiate. Men will act aggressively towards us sexually, and we must worry about how to set the limits on the sexual encounter. We're always so busy setting the limits and holding off this powerful sexuality coming from him, that we never get a chance to explore our own. Our bodily functions and our own sexuality are always something of a mystery to us.

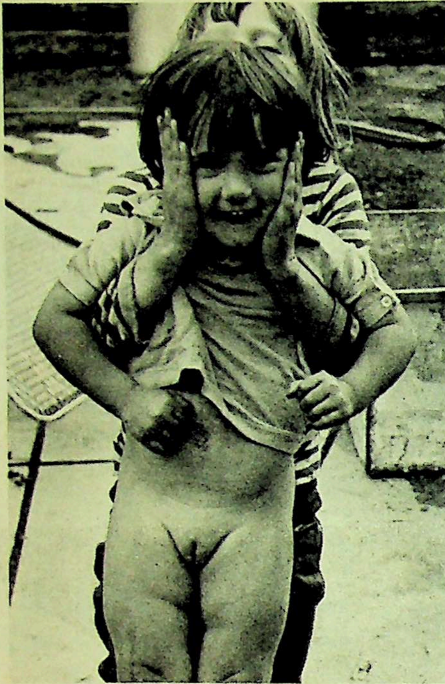
As kids, if we are caught masturbating or exploring a playmate, we're told either to stop immediately, or or questioned carefully as to what exactly we were doing. Certain ideas begin to make themselves felt – like young ladies don't do that sort of thing.

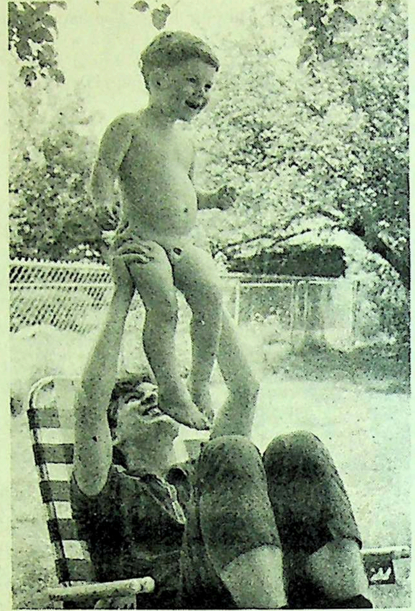
> My three year old daughter and I were visiting my parents. We all sat in the living room. Lisa sat on the carpet holding a paper towel tube to her naked vagina. 'What would happen if I peed in this?' she asked in her heaviest, gurgling, teasing, curious voice. 'Don't do it, the pee will come out on the floor,' was what I told her. My father was extremely upset and told me afterwards that I had handled it all wrong. I should have scolded her and told her not to talk that way. Not, he assured me, because *he* cared, but because there are some pretty small minded people out there who will give her a rude awakening if she's not trained now.

We also learn that physical affection is only acceptable in some relationships, but not in others:

> When I was about seven or eight, I had this best friend Susan. We loved each other and walked around with our arms around each other. Her older sister told us not to do that any more because we looked like Lesbians. So we held hands instead.

> When I was small, five or six, I wanted to lift my dress up and squirm out of my pants while lying on the floor watching TV in front of my father. He sort of caught on and yelled 'Don't do that.'





We also learn that a woman's bodily functions are mysterious and slightly smutty:

> When I first got my period, my mother dragged me into the bathroom and told me to take off my clothes. I stood naked in front of her while she grumbled, "You can have kids now so you better be careful."

> When I first got my period I came and told my mother. She slapped me across the face, and then congratulated me. Later she told me the slap was an old custom.

> The books I sent away for explaining menstruation arrived in plain brown wrapping. My father got to them first, and taunted me by holding them over his head so that they were out of my reach.

The messages go on and on. There's something shameful about our bodies, our sexuality. It shocked and angered our parents, scared us, and added to the growing sense of alienation and mystery we had about our bodies. The messages go on, in different societies, wearing different disguises. In some tribal societies, women are isolated in special huts built outside the community grounds, while they menstruate. They are taboo. Anyone looking at them, caught talking to them, is courting death. The Jews write that a woman is unclean during her period and caution men not to have sexual relations with them during that time.

By the time we're teenagers, we discover that there's only one norm for beauty. A commercial norm that sold products to us as we agonized over breasts, hair, legs, and skin that would not measure up. Again we are left with shame and anxiety. We have body smells and our feet are too big. We lose all respect for our own uniqueness, our own smell and shape and way of doing things. We buy vaginal deodorant, and read Cosmopolitan articles on the Six Ways to be Sexy.

All of this leaves us feeling ashamed and ignorant of our bodies, not wanting to explore them to find out what feels good, what we like and when. All of this leaves us unable to tell the men we sleep with what to do to satisfy us.

They've got us coming and going. First we're supposed to set the sexual limits, deny our responses, and hate our looks. Then, within a few years we're supposed to be experimental and libertine. The more orgasms we have the closer we come to being "real" women. Jump in and enjoy it. That's a lot of confusion, and it's no wonder that so many of us still have serious questions about who we are and what we want.

MASTURBATION

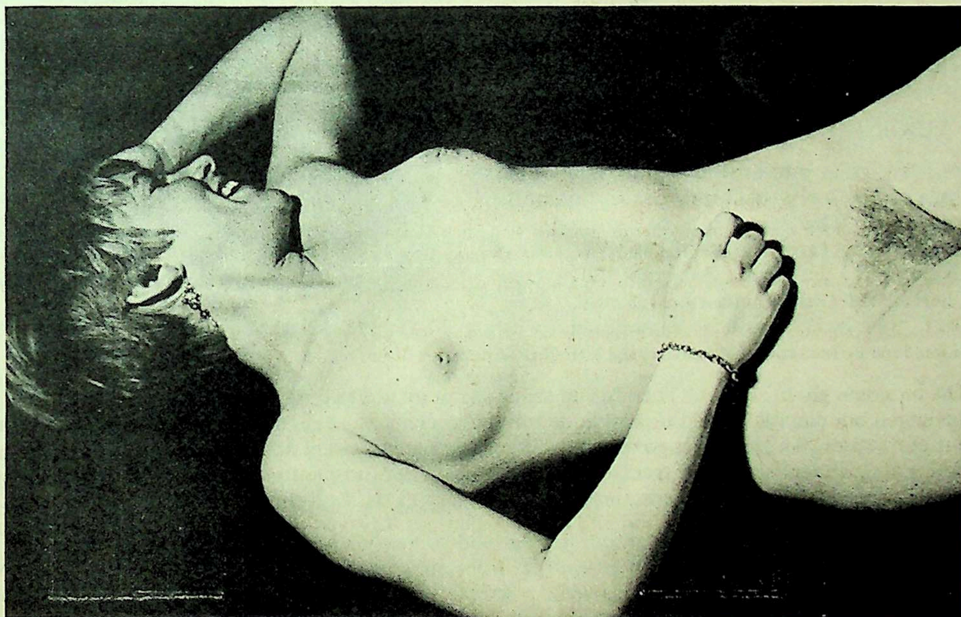
We had a house with old plumbing. The bathtub faucet sprayed a hard stream of water out on an angle. I learned to masturbate with it, had orgasms at 7 or 8 with it. One day, when I was under ten years old, my mother surprised me going at it. She said, "What are you doing?" "Just washing myself." "Oh." I was totally freaked out that she didn't know. I figured it must be something pretty queer if she didn't know. I figured I was part boy and pure queer, and certainly a sinner.

When my father went to the hospital with an infection and there was talk of his having a leg amputation and dying if that didn't work, I got real scared and guilty. I figured it was happening to him because I was masturbating, or at least because I hadn't confessed to my mother. I was sure he would die if I didn't.

We all heard that masturbation was bad and we all felt guilty about doing it. But some of us did do it, which means it must have felt good. Taboos did keep some of us from learning about it until we had sex with men.

I was 14 or 15 years old, and a virgin. I was sitting cross-legged on my bed one day, and became aroused by memories of petting with my boyfriend, and having orgasms. I was also aroused by the sex smell I was exuding. I suddenly realized that *I* could do to my clitoris what *he* had done. I masturbated for the first time, had an orgasm, and wasn't so sure that what I had done was right.

Either way, playing with ourselves didn't feel natural. When we got older, we got sold a myth that masturbating would keep us from enjoying sex with men – it would "fixate" us. But statistics say that women who masturbate are more likely to have orgasms in intercourse than those who didn't.



Masturbation is not something to do just when you don't have a man. It's different from, not inferior to, sex for two. It's also the first, easiest, and most convenient way to experiment with your body. It's a way to find out what feels good, with how much pressure, at what tempo, and how often. You also don't have to worry about someone else's needs or opinions of you. The more you know about your body, the easier it is to show someone else what gives you pleasure.

To masturbate you have to know something about your body, and in particular about your clitoris (klit'-o-ris). This is a small round ball of flesh located above the opening of the vagina, and it is the center of most sexual stimulation. It functions like the penis in the man. When it's rubbed up and down rhythmically, you get excited. The clitoris is where **all** female orgasms happen, whether by masturbation, intercourse, or fantasy.

Some women masturbate by moistening their finger (with either saliva or juice from the vagina) and rubbing it around and over the clitoris. The amount of pressure and timing seems to vary among women. Some women masturbate by crossing their legs and exerting steady and rhythmic pressure on the whole genital area. A smaller number learn by developing muscular tension through their bodies, resembling the tensions developed in the motion of intercourse. Some ways of doing this is by climbing up a pole or a rope or even chinning parallel bars. Other techniques for masturbating include using a pillow instead of a hand, a stream of water, and electric vibrators. Some women find their breasts erotically sensitive, and rub them while rubbing the clitoris. It's nice sometimes to make up sexual fantasies while masturbating. Some women like to insert something in the vagina while masturbating (like a finger or vibrator), but few women get more satisfaction out of vaginal penetration than they do from clitoral stimulation.[2]

If you have never masturbated, don't feel you are confined to these techniques. Finding what you like to do is what it's all about.

VIRGINITY

The "cherry" that is to be every man's prize on taking a virgin symbolizes a traditional conception of the male-female role. The woman is to be nurtured, watered, trimmed and cared for like the most delicate of cherry trees, raised in the anticipation of the moment when the fruit will be juicy and ripe. Then it will be "plucked", "ravished", consumed by the man, for whom all this preparation was actually intended. The more delicate the tree, the more satisfying the deflowering.

Few of us would choose to look at ourselves this way. It would be a sign of great alienation to see ourselves not as people, but as sexual objects, as trees with cherries. Yet the concept is so imbued in our culture that few men can entirely avoid it. We make ourselves pretty for men. We take infinite pains with the curl of our eyelashes, with our hair. In many ways, our daily actions reflect the fact that we have accepted and internalized this conception of ourselves as sexual objects.

Virginity – the constant preoccupation of teenage and college women – has its base in our perception of ourselves as objects for the eventual enjoyment or consumption of another. One asks oneself not "What will be best for me–spiritually and physically?", but "What will they (other people in general, but especially one's future husband) think of me?" To use one's body in this way, as a physical pledge of the appropriateness of one's conduct in the eyes of others, is to deny oneself in the most basic way. Certainly there are many valid reasons for not going to bed with a man, but the preservation of one's hymen is not one of them.

Men traditionally have made a big production of the bursting of the hymen. Marriage manuals spend chapters on it. Pornographers go wild over it:

> At length by my fierce rending and tearing thrusts the first defences gave way, and I got about half-way in. . . as I oiled her torn and bleeding cunt with a perfect flood of virgin sperm. Poor Rose had born it most heroically, keeping the bedclothese between her teeth, in order to repress any cry of pain. . . I now recommenced my eager shoves, my fierce lunges, and I felt myself gaining at every move, till with one tremendous and cunt-rending thrust I buried myself into her up to the hilt. So great was the pain this last shock caused Rose that she could not suppress a sharp shrill scream, but I heeded it not; it was the note of final victory and only added to the delicious piquancy of my enjoyment. . . I drew her to a yet closer embrace, and planting numberless kisses on her rosy lips and blushing face, which was wet with tears of suffering which the brave little darling could not prevent from starting from her lovely eyes, I drew out the head and slowly thrusting it [sic] in again: my fierce desires goaded me to challenge her to a renewal of the combat. A smile

of infinite love crossed her lovely countenance, all signs of past pain seemed to vanish, and I could feel the soft and juicy folds of her cunt. . ."[3]

This episode, with all its ingredients – the man's energetic thrusts, the difficulty of penetrating the barrier, the woman's screams and half-faints, the man's triumph and the woman's blissful acceptance of her new role – are repeated ad nauseum in most pornography. In The Pearl, the scene occurs at least 24 times. This, in perhaps a gentler form, is what men have been brought up to expect in their first sexual relations with a woman.

Even sadder, and much more subtle, is the way we have come to accept the inequality between the sexes as the norm, and are disappointed when we do not live up to it. Most of that passage is a total misstatement of the way it usually is when the hymen is broken. The hymen is a pliable membrance, often perforated, and easily stretched. First intercourse often takes place with no pain at all. The man need not be a battering ram; the woman need not scream and faint. The mythology distorts reality to make women seem more helpless and men more aggressive than they are, even in today's society.

Why are we urged and expected to feel such pain? Marriage manuals give hints on how the husband can reduce the pain of penetration, but when there is no pain at all, a note of apology creeps into the text. The husbands are assured that the hymen might have been stretched or broken accidentally, in horseback or bicycle riding (unlikely, by the way: the hymen is often stretched before intercourse, but rarely broken). These books hardly ever suggest that a man is not due his quotient of pain. For the pain is what keeps the two unequal.

It is the easiest thing in the world for a woman to stretch her own hymen by inserting a finger into the vagina and periodically exerting a little pressure on the sides of the entrance. By the time she can insert two fingers, there is practically no chance of any pain during intercourse. This stretching process also is usually painless. For many women, it happens quite naturally in the course of petting before they ever have full sexual relations. Some women go to a gynecologist and have him stretch the hymen, but this seems less desirable to us because it looks to an "expert" for a "skill", leaving us once again three steps removed from knowledge of our own bodies.

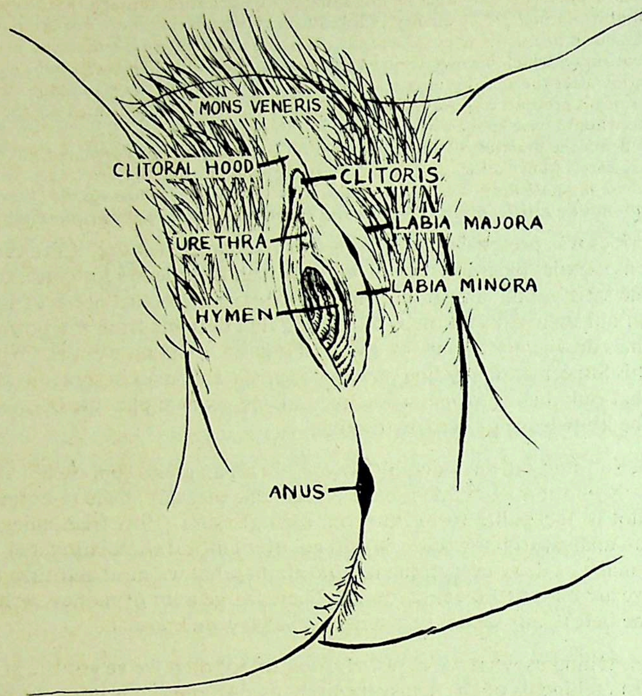
Simple as it is, most of us don't think of stretching our own hymens because we don't have any information, we are uneasy at examining our own bodies, and, most important, we are afraid of depriving men of their drop of blood. We are afraid of having our offering questioned, as not pure enough. The idea of men and women coming together as equals, with neither "offering" greater than the other, rarely occurs to us.

It may seem incredible that most of us are so ignorant on the subject of our hymens, a portion of our anatomy which literature and popular culture makes central to our identities. But this is only one of the ways in which we, by cultivating our ignorance, have set the stage for a relationship with men in which the man sets the terms of the confrontation (by demanding an offering of pain), leads the way from "ignorance" into "knowledge" (thus reinforcing as "teacher" the already inherent inequality) and guides us from our sheltered life into the real world (preserving his own role as the key to that exciting real world). In this process, we often abdicate to the man the definition of our role in the sexual relationship. Because we have no knowledge on which to base our own judgment, he determines the definition of what we should be and feel.

ORGASMS

There has long been a common misconception, still present today, that there are two different kinds of orgasms, one achieved by stimulation of the clitoris, and called a "clitoral orgasm" and the other a "vaginal orgasm" brought on by the penis moving in and out of the vagina. The first was thought to be achieved by masturbation, petting, and intercourse, if the clitoris was stimulated directly. It was considered to be an "immature" kind of orgasm, related to early sexual experiences, while the vaginal orgasm was thought to be more "mature" and to be the ultimate sexual experience for a woman.[4]

There is in fact no difference in the kinds of orgasms women have, either by masturbation, petting, or intercourse. In intercourse, it is the stimulation of the clitoris by the area above the penis which brings on orgasm, along with the pressure on the clitoris that comes from the muscles surrounding it which are moved by the motion of the penis. This does not mean that all orgasms feel alike, and it is probably because intercourse is usually a longer activity and more emotionally intense that many wo-



men thought that the orgasms they had that way were physiologically different.

This false distinction between clitoral and vaginal orgasms was elevated to "scientific truth" by Freud in an early book called Three Essays on the Theory of Sexuality in 1910. Freud was convinced that the pleasure little girls got from playing with their clitorises was of a "wholly masculine character" (whatever that means). Being a man, he assumed that the vagina, into which the man puts his penis, was the true female organ of sexual response. Consequently, he considered stimulation of the clitoris infantile. He proposed that women spend the rest of their lives in the admittedly difficult task of transferring the center of their sexuality from the clitoris to the vagina. The task was difficult, indeed, because it was physiologically impossible. Yet as late as 1951, modern Freudians were still saying that since the mass of women could not afford five sessions of psychoanalysis a week for two years, "female frigidity" (defined as the inability to have that special "vaginal" orgasm) was "a mass problem" which "unfortunately was not to be solved."[5]

Fortunately for women, two scientists, Masters and Johnson, have finally proved Freud wrong. They observed 382 women and 312 men not only during masturbating and intercourse, but also during "artificial coition" – a laboratory procedure that makes accessible to direct vision and to recording on motion picture film, internal changes observable in no other way. What they found was that all orgasms happen in the same way – in the clitoris.

Despite all this scientific evidence, male psychologists persist in treating the orgasm as a subject they can have their own personal theories about. The damaging and degrading images of women that these theories project can best be shown by quoting from one of them. Alexander Lowen, a well-respected psychoanalyst, wrote a book, Love and Orgasm, **after** Masters and Johnson published their results. Here's what he has to say about our sexuality. The comments in parenthese and emphases are ours.

> The *problem* [?!] of orgastic potency in a woman is complicated [??!!] by the fact that *some* women are capable of experiencing a sexual climax through clitoral stimulation. Is a clitoral orgasm satisfying? [Is a penile orgasm satisfying?] Why are some women capable of having *only* a clitoral orgasm? These questions should be answered if we are to understand the *problem* of orgastic impotence in the female.
>
> Most men feel that the *need* to bring a woman to climax through clitoral stimulation is a *burden* [!!†*]. If it is done before intercourse but after the man is excited and ready to penetrate, it *imposes a restraint* upon his natural

desire for closeness and intimacy. Not only does he lose some of his excitation through this *delay*, but the subsequent act of coitus is deprived of its *mutual* [??!!] quality. Clitoral stimulation during the act of intercourse may help the woman to reach a climax but it *distracts* the man from the perception of his genital sensations, and greatly interferes with the pelvic movements upon which his own feeling of satisfaction depends. The *need to bring a woman to climax* through clitoral stimulation after the act of intercourse has been completed and the man has reached his climax is burdensome [oh no!!] since it prevents him from enjoying the relaxation and peace which are the rewards of sexuality [sigh . . .]. Most men to whom I have spoken who engaged in this practice resented it.

I do not mean to condemn the practice of clitoral stimulation [you just did] if a woman finds that this is the way she can obtain a sexual release. Above all she should not feel guilty about using this procedure [after listening to you???]. *However, I advise my patients against this practice since it focusses feelings on the clitoris and prevents the vaginal response. It is not a fully satisfactory experience and cannot be considered the equivalent of a vaginal orgasm.*[6]

The sex Lowen describes was pretty clearly all done for the man's pleasure. Clitoral stimulation gives a woman her most intense sexual pleasure. Yet giving a woman this pleasure is considered a distraction, a burden, a drag on male satisfaction, a restraint. We are to serve the sexual needs of the man we are in bed with and look upon our own satisfaction as something that detracts from the power and intensity of his orgasm. Lowen comes down very strong for a vaginal orgasm. And no wonder. With it, the man can continue to believe in his Superman masculine powers to satisfy a woman in some mysterious inner chamber of her body that only he can reach, while maximizing his own pleasure because he doesn't have to be "burdened" by the knowledge of her frustration.

It is astonishing to be so totally disregarded by Lowen. In a paragraph supposedly about women's orgasms, he talks exclusively about male burden, male pride, male pleasure, male resentment and then has the audacity to tell us not to feel guilty for seeking our own pleasure. How frightening that he can use his moral authority as an analyst to tell women not to go after clitoral stimulation and to write a book whose only effect is to make us deny everything natural about what we need and then make us feel we're frigid or neurotic. There are a lot of Lowens around. They charge a lot of money, write a lot of books, and it will be a long time before our sexuality is written the way we know it.

First we've got Lowen telling us what we're not allowed to do, then we've got the pornographers and a lot of romantic novelists telling us of the ectasy awaiting us. An orgasm is not a mystical experience, it is a physical experience, and here's a description of one.

What happens to the body during orgasm can be divided into four parts. First there is the excitement phase, beginning with the moistening of the vagina. The nipples on the breast become erect, and the breasts increase in size. Other muscles tense, and a rosy glow called a "sex flush" appears on the skin. Excitement is followed by the plateau phase, although it would be hard to say exactly when one phase stops and the next begins. Now the rate of breathing increases. Muscle tension is heightened. Most dramatic is the swelling of the tissues around the outer part of the vagina, which makes the width of the vagina half its normal size, and able to grip the penis. The clitoris elevates like a male erection and the inner lips change in color from pink to bright red. This color change means that the orgasm is going to occur in about a minute if stimulation continues.

Orgasm itself is the third phase. There is a feeling of intense pleasure as the vagina goes into rhythmic muscular contractions until the intensity tapers off. The number of contractions vary with the intensity of the orgasm. The uterus also contracts rhythmically in wave-like motions but this isn't felt.

All the body's muscles respond in some way (even hands and feet contract in a spasm). After the orgasm a kind of final resolution occurs. The swelling of the nipples subsides, sex flush disappears, and the clitoris returns to its normal position. It may be as long as a half hour after orgasm before a woman's entire body returns to the state it was in before she was stimulated. If she has reached the plateau stage without reaching orgasm, it will take much longer.

Orgasm can be a very mild experience, almost as mild as a peaceful sigh, or it can be an extreme state of ecstasy with much thrashing about and momentary loss of awareness. It can last a few seconds, or for half a minute and longer. There is, in brief, no right or wrong way to have one.[7]

It's still possible for some of us to know all of this and still not have orgasms. Here are some of the reasons we think this still happens:

1. We don't notice, or notice and misunderstand, what's happening in our bodies as we get aroused. We don't pay attention to what turns us on. We're too busy thinking about abstractions – how to do it right, why it doesn't go well for us, what he thinks of us, whether he's impatient, whether he can last –

when we might as well be concentrating on the sensations, not thought.

2. We know what we want at a particular moment but we're too embarrassed to indicate what it is. We're especially unwilling to do anything to get our clitorises touched because we buy Freud's line that liking it is proof of emotional underdevelopment. Sometimes we're afraid that the guy will take it as an attack on his manhood. Maybe he won't and we're too tied up to see that. But just suppose he does take it badly and he's upset. Should we play along with his hangup and pretend that what he's afraid of is real?

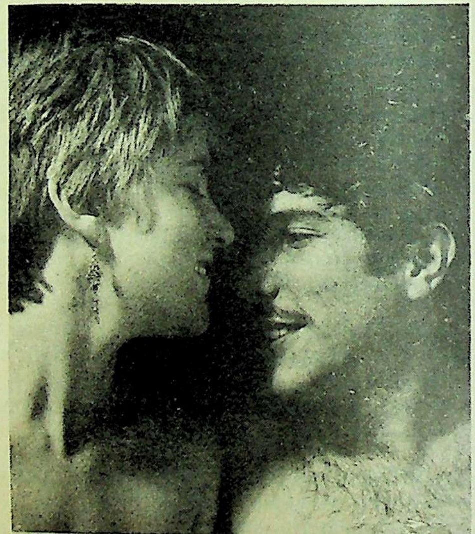
3. We are afraid of asking too much, asking for more than he can give, afraid he won't hold out as long as we want him to.

4. We rush into it. Or let our partners rush us into it. We end up fucking with great intensity, swept off our feet just like in the movies and swept under the rug when it comes to climaxes. If you're getting passed by, it makes sense to slow everything down drastically and never escalate the situation without a clear and pressing physical impulse that tells you to. At this point we tend to get afraid that something is wrong with us – the impulse will never come. At these times it helps to remember that you have your own pacing.

5. You've never had a climax, so you never will. This has no basis in physiology. The only physical feature common to frigid woman is that they don't have a climax. When you've been feeling hurt, sad, or angry about this for too long, you institutionalize it so you won't have to deal with it any more. You give up. You are hope-less.

6. You've been making it with the same guy for a long time and never or practically never been satisfied. You're (naturally) angry at him for this and consequently you don't want him. You continue to make it with him, but you're not involved in it. You feel you're being used. Maybe you're right. More likely he'd like to please you, but he doesn't know any more about it than you do, and if you're willing to forget it, why shouldn't he? After all, he's satisfied.

7. You're putting up with a lot that you don't want in a relationship – an unfair share of the responsibility, a coldness and a distance, or a kind of cruelty. You're angry, but you don't fight for what you want. Or you fight and lose, but don't leave. You sense you're losing, and you don't know how to win. You're resentful or "fucked over", a term which says a lot about sex in these situations.



8. You expect to be instantly free and at ease with guys you don't know very well or feel very close to. Maybe some people are. If you're not, you're not, and you might as well start from there.

9. You get on the right track, but you expect instant results. You don't recognize how many bad experiences you have to overcome. You get tense and you don't give yourself enough time.

It is hard to feel relaxed and loving in bed when there are so many lies to overcome. But getting preoccupied with the search for sexual success is just another way to hurt yourself. If there are times you'd rather just not deal with it, that's cool too.

FANTASIES

I masturbated to this fantasy: an older woman whom I had never met entered a dressing room I was in. After a brief conversation, I placed her against the wall and explored her body with my mouth. First her breasts, then her vagina. As I fantasized this part, I had an orgasm. Afterwards, I felt very disturbed because making love to a woman had been so intensely pleasurable and I was afraid of being "homosexual", and because the woman I created was older and made me think of my mother. I would decide that it was a bad fantasy to have had, and that I was a little abnormal for having had it.

I imagined I was sitting in a room. The walls were all white. There was nothing in it, and I was naked. There was a large window at one end, and anyone who wanted to could look in and see me. There was no place to hide. There was something very arousing about being so exposed. My heart started to pound and my stomach sort of pulsed in a very powerful way. I masturbated while having this fantasy, and afterwards I felt very sad. I thought – I must be so sick, so distorted inside that this image of myself could give me such intense sexual pleasure. It was more satisfying than making love.

It feels terrible to have fantasies when the part we play in them threatens our self-image. We use them to call ourselves names. Which is too bad because those stories are pieces of us wanting to get listened to, and we keep shutting them off because we're afraid of them, afraid that if we accept them as part of us, then we're "abnormal" or unlovable, or worthless. We call these fantasies "immoral" or "perverse" so we don't have to take responsibility for the fact that we liked them. What does it mean to "take responsibility" for our fantasies? It means, for example, if we are aroused by an image of ourselves that is aggressive, we might at first prefer to deny this. But eventually, we might come to feel that aggressive sexuality is acceptable and that only some left-over myths about femininity have kept us from expressing this kind of aggression. Or, if being sexually humiliated is erotic, we might come to question why it is that humiliation which hurts in other situations is pleasurable in bed. What does this say about how we feel about our bodies, or our "rights" in bed?

Fantasies tell us something about the reality we're in – who we'd rather be in bed with, what we'd rather be doing, what we'd rather be feeling. Taking responsibility for them does not mean name calling or self-hate; it merely means accepting our feelings and then trying to understand them.

HOMOSEXUALITY

Between the ages of nine and eleven, my friend Judy and I would sleep over at each other's houses about once a week. We really dug each other. We'd touch each other's breasts and vaginas with a lot of excitement. We looked forward to playing sexually with each other, but knew very clearly that we shouldn't get caught.

A few years later, I was playing with two or three other girls and we decided to play with each other's breasts. I participated, and with some excitement, but in contrast to my experiences with Judy, I was already feeling pretty scared and guilty.

I was riding on a subway in New York and a sudden wind lifted the skirt of a woman seated across from me. She wasn't even young or pretty, but I was suddenly aroused. It scared me and confirmed my fears that my sexual problems with men were due to the fact that I was latently a lesbian.

I started reading Playboy when I was in college. My boyfriend used to buy it. A couple of times when I was alone, I would flip to the centerfold and the other nude pictures and masturbate. Sometimes I would even put my breasts against the pictures. I felt perverted.

Many of us have had some experiences like these – sometimes it's just a vaguely arousing feeling around another woman, or when looking at a picture. Some of us have even had some sexual play with a friend. But for everyone these incidents were filled with tremendous anxiety and self-hate.

In retrospect, we are angry at being made to feel so terrified at such common childhood experiences. Strong feelings toward anyone we care about have some sexual content to them. Besides, why not explore new and exciting territory with a friend?

But look at the difference between the first memory and the two that followed. It's very clear that as we got older, we didn't feel chummy and exploratory any more. Most of us felt perverse and sinful.

In some respects we were right to feel that way. We grew up in a culture that made us feel that the only important aspect of a woman is her body. It made women into all boobs and thighs and holes to penetrate. Masturbating to an image of a Playboy Bunny is as aggressive and predatory as the men who leer at us on the street. The all-American available girl. Play out all your fantasies on her or in her. What a difference from the friendly and genuine sexual contacts we had with each other as little girls.

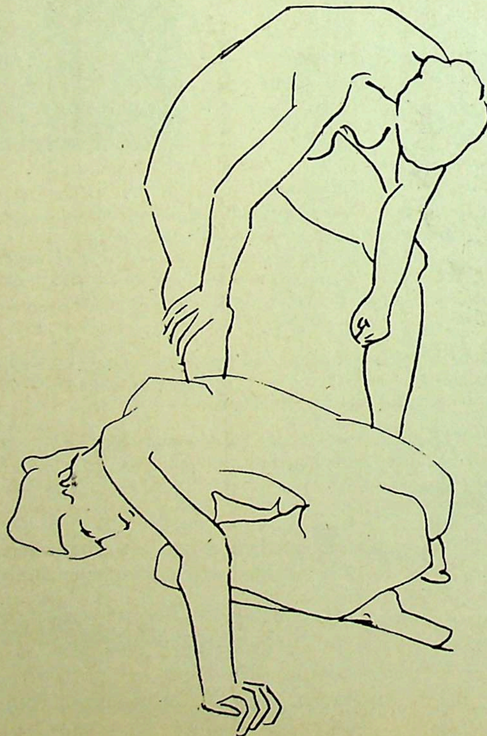
I started reading Women's Liberation literature when I was 25 and happily married with a year-old child. It shattered me. It was the missing link that helped explain the feelings of dependency and unimportance that still remained after many years of therapy and struggle. A few months later, I left my husband. I wanted to be alone and get some strength and identity. I began taking karate and started to get a crush on my female teacher. She was about my age, and was very strong and wise. We never talked much, but I dreamt about her twice. In one dream, I had met her at a party and we just sat next to each other talking and smiling. In the other, I found her badly beaten up and I held her in my lap and nursed her wounds.

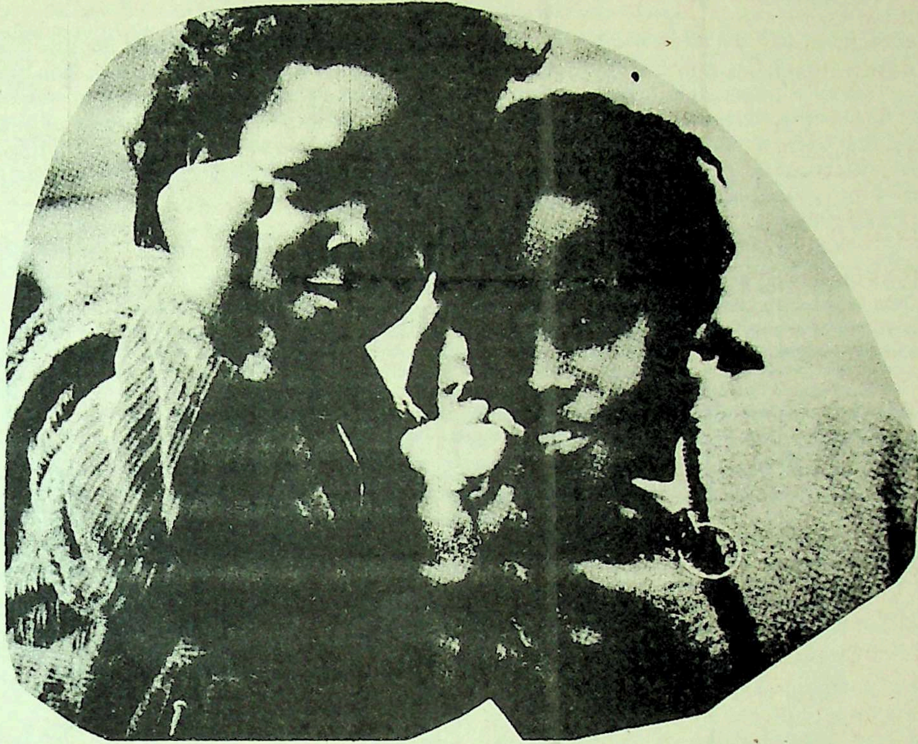
The woman who had this dream said that it had nothing to do with power, nothing to do with rape, nothing to do with pornography, but it was still about sex. Many of us have these strong feelings for each other. A woman we know who recently had a love affair with her friend said that it was the first time she felt like an equal in bed. The roles of submission and aggression disappeared. She never felt like she was giving in, or giving up. She didn't have to pretend to feel things she didn't feel. And the sex was really good because each of them could sense what the other needed, just because they were both women.

AN OPEN LETTER TO MY SISTERS

Why shouldn't we be lovers? I wouldn't suddenly begin to let you take me over and do your bidding. I wouldn't try to model myself after you. I could have loving and independence too. You wouldn't mess me over in bed for lack of empathy with my body. I'd know me better by knowing you. I wouldn't be afraid of being left, or feel jealous if you were with someone else. I'd be more secure in our friendship knowing that we were touching each other because we like each other. There's plenty of loving to be made in the world – no need to fear for where the next good time is coming from. Why shouldn't we? Not because we hate men, but because we love ourselves.

It's very romantic to expect that all those hangups with men will disappear with women. But at least





there isn't that old script to follow. There aren't any ready-made roles to fall into. Whatever happens will arise out of the situation and not out of some phony expectations. There will be times in our lives when we will feel more sexual rapport with women; when we're working with them, or living with them, or loving them. Sometimes that choice springs from fear of men. Fears of rape, of powerlessness, of humiliation are common and in our culture such expectations are realistic. An incredible number of women - including middle class well-protected women - have had horrifying experiences of sexual abuse. Out of fifteen women who discussed the topic recently, four had been raped. But violent attacks by strangers are only a small part of the collective humiliation we all have felt.

> One of my first boyfriends felt that I didn't appreciate his penis enough. He forced me to kneel down so that my face was at eye-level with his penis and then made me caress it so that it would become erect. As it began to rise closer and closer to my face, I was supposed to tell him how beautiful and powerful it was.

> My boyfriend wanted me to suck his penis. I didn't like doing it because it made me gag. But he would keep pushing my face down on it. The only way I was able to do it was to imagine I was standing in a field of carnations so that I could keep my mind off what I was doing. This used to happen a lot.

> I was making out with a guy I had been dating for awhile on a deserted island. I had told him that I didn't want to sleep with him. Suddenly he started taking my underpants off. I told him again, but he wouldn't stop. I suddenly realized that he was much stronger than me and I panicked. I started crying and yelling and he just fought harder. Finally he stopped and said that he thought I was just teasing and that I had really wanted to screw all along.

"Frigidity" with men, or a turn toward female lovers is not surprising when the socially acceptable heterosexual encounters have been so destructive. Psychologists call this abnormal. Fear of men, they say, is abnormal. We say, each of us will have to draw our own conclusions, and deal with our own fears. For some this may mean getting our bodies in shape so that we can fight with men on their own terms. For others, it just means choosing the right male lovers. And some of us may just decide to chuck the whole thing and express our love and sexuality with each other. It may be that what we need to do in order to maintain our integrity as human beings is to move freely through these and other choices given the circumstances of our lives at any particular time, and not be bound by myths and taboos that keep us from doing what is right for us at each moment.

CELIBACY

Celibacy has helped a lot of women we know get closer in touch with themselves because it cleared away the sexual distraction. Sexual relationships quite often produce a lot of anxiety. You question yourself about why you didn't come, or did he like it, or does he really like my body, or wouldn't he rather be in bed with so and so. It's not that it's always inappropriate to ask those kinds of questions; it's just that they take up huge amounts of psychic energy and leave you drained and unfit for other activities and thoughts. Always being into a relationship with a man leaves you defining yourself in terms of the relationship. If there's no man in your life, you must be worthless.

My first reaction to being without a man was frustration and anger. I wanted a man to sleep with. I thought, well, here I am feeling pretty liberated sexually, and there's no one to sleep with. The intensity of that feeling was short lived. I thought less and less about being with a man. I had very relaxed times with my friends during that period. I was never tense and waiting for a phone call. I was not afraid that I would lose someone. I didn't have to think twice about making plans with friends for dinner. I was free. I was not asexual during this time. I was masturbating with much pleasure. I was having different kinds of orgasms, some long and slow and rippley, others short and jerky and tenser. I was exploring my sexuality in a way I had not with men. I had the time and space for a lot of things. It was easier to do the work I wanted to do because of my sense of me being my only obligation. At this point I saw that my initial frustration at not having a man had to do with a judgment I was making of myself. A man meant completion. Without one I could never feel whole. After several months of celibacy, I was feeling pretty whole. I was functioning on approval and good feelings that I supplied from me to me.

We've found this experience to be common among women celibate for a while. A friend of ours was celibate for two and a half years. She didn't masturbate, and she didn't miss sex. A lot of the stories we've heard talk about the growing ease with which it becomes possible to move in and out of sexual relationships. The anxiety of being left by a man diminishes because being alone has been a positive experience. Which is not to say that we're recommending enforced celibacy for everyone. Just that it's not only not the end of the world, some of us have even dug it.

MONOGAMY

So where does all this liberation and independence lead us? Away from the tight, all or nothing kinds of relationships we're used to having with men. Towards thinking of our lives as centered in ourselves and shared in part by others. Towards more love relationships with more kinds of people because we aren't hemmed in and defined by strict roles. Out of the growing list of new options - men, solitude, work, friends - comes less of a need to bank everything on him. It makes it easier to consider having more than one love affair at a time, and easier to allow him the same option. We know a lot of people who are trying to expand their monogamous twosomes to include three, four, or a community of people.

But giving up monogamy is giving up the way we know how to relate to men best. We've all been geared to one man at a time as an Absolute Rule of Relationships. Most of the attempts to break out of that make the people involved pretty anxious.

I was confused about what I wanted from the man I was seeing. I cared about him a lot, and really liked being with him. I was also very much into Women's Liberation and was reveling in feeling creative and independent on my own. I felt some guilt about the times I chose solitude over intimacy. He had a very close relationship with one of my best friends, and one day it seemed that if I allowed them to have an affair, I would have the best of both worlds. I wouldn't feel as troubled about the pitfalls of a tight relationship, while still being able to see the man I really dug. I told them both, separately, that they should sleep with each other if they wanted to. When it pretty quickly looked like they wanted to, I went to pieces. I told them later that I couldn't handle the anxiety, and now wished very strongly that it would not happen. They respected my wishes, but for a long time afterwards, I could not relax when the

three of us were together. I still felt that if he had slept with her, it would have been a rejection of me.

I had been living with a man for a year. We had a pretty loving and open relationship. There was suddenly a lot of withdrawal emotionally and physically, and he wanted to sleep with other women. I felt too weak to leave him, and besides he kept saying that he still loved me but that he didn't want to be owned or to own me and he didn't want to deny his real feelings and impulses towards other women. The problem was I agreed with everything he said. I even believed that sex between us would get better if I gave him some room to move, but I was terrified. He had a short affair with a woman we both knew and it wasn't as bad as I thought it would be. But I was very angry at him. Every time he referred to her I could feel the anger rising and when he wasn't around I was always afraid he was with her. I was afraid he would meet someone else, or a few other people, and I would just be one of many. It all culminated when he told me he wanted to sleep with my closest friend. It was doubly scary because she had been really helpful to me during all the problems he and I were having. It sounded like he had all the answers. We all loved each other. True. We had better times as a threesome than in any pair of two. True. He and she were attracted to each other. True. We all should be lovers. Uh oh. Both she and I were intimidated by the rightness of what he had to say. We found it hard to come up with any reason other than fear of change for not trying it. For the next month we were together most of the time, feeling like three people in love, though they still hadn't slept with each other. Unfortunately, below the surface I was suddenly feeling competitive with her. We had been friends for ten years. She was feeling pressured and angry at him, and he was wondering why we didn't want to share his vision. We finally talked it all out and understood that there was a lot of mistrust of motives and a lot of bad feeling building up. We clearly aren't ready for it.

We have a lot of theories about what we should do to live up to some idealized image of ourselves. But it makes no sense to give up monogamy because that's an impressive achievement, or because we think we have to. Sometimes choices have to be made and getting out may be better than being a weak link in a triangle not of our choosing. We'll be in triangular or communal relationships when we really want to be because they fill more of our needs and make us happy.

CONCLUSION

Accepting the cultural stereotype that has for so long been imposed upon us, we see ourselves primarily as sexual beings. If we look for fulfillment, it is to be fulfilled "as a woman," and by this we mean having children, raising a family, and having an orgasm every time we go to bed. A fulfilled woman, or a "liberated" woman, in the popular mind, is one who radiates sex.

To accept this definition of fulfillment is to be forced into just the straight-jacket society would like to see us in. It means that when we think really deeply (and maybe despairingly) about ourselves and who we want to be, we think mainly about our sexual competence. More women go to psychiatrists asking how to have an orgasm than they do asking how to have fulfilling work.

It takes courage to redefine our priorities. It takes courage just to stop putting on make-up when we think our face is unacceptable, let alone to actually make demands on a hostile world. We shouldn't hate ourselves for not having the courage when we need it – any women who has thought about her own oppression would understand. A lot of us have found that getting together with each other has made it easier.

To any men who happen to read this: This pamphlet was not written for you. Please do not use it as a marriage manual; please do not "try out" the "techniques" you think have been suggested here; please do not suggest to your girl that she read it. If you do want to change your behavior and you are living together, you might start doing half the housework. If you insist on being preoccupied with her as a sex object and want to know specifically what you can do in bed, you might try to become more open to her wants and needs. Listen to what she says, and if you can, do what she asks. In the long run you should try to change your own life, and the society, so that you can be pleased with and proud of yourself without having to exploit her. For either of the sexes to be free, both you and she must be leading worthwhile lives.

But good relationships are difficult, if not impossible, if we don't understand ourselves and our own needs. Asking and being given, telling a need and having it fulfilled, free one to be able to give. This is difficult, if not impossible, when men and women come together not as equals, but as the teacher and the taught, the admired and the admiring, the assertive and the acquiescent. Good relationships must be mutual. They must be built on each partner's feeling as competent and in control as the other.

The goal of this pamphlet, and of the Women's Liberation movement, is to help us move towards a world in which human relationships can be more free, more satisfying. This means freedom from the damaging effects of a traditional sexual caste system; it means freedom from class and racial oppression, and it means freedom for all from want and from alienating work.

No one can ever know the potential of humankind for goodness and for fulfillment until she has explored her own potential. And no one can fully appreciate the possibilities for change in society until she has changed her own life. By looking carefully at our needs, and finding out how to satisfy them in this world, we are fulfilling one part of ourselves and freeing the rest for other satisfying work. We are learning what the world could be like for everyone, in all aspects of their lives.

This pamphlet ought to be more than an experiment in education. It ought to be the beginning, for us, of a revolution.

FOOTNOTES

1. "'Sexual Liberation': More of the Same Thing", by Roxanne Dunbar, in *No More Fun and Games*, Issue Three, was the source of many of these ideas.
2. *Girls and Sex* by Wardell Pomeroy, Delacourt Press, was helpful to read.
3. "La Rose d'Amour", *The Pearl, A Journal of Facetiae and Voluptuous Reading*, New York, Grove Press, 1968, pp. 253-4.
4. Pomeroy, *op. cit.*
5. Edmund Bergler, *Neurotic Counter-feit Sex*, Grune & Stratton, New York, 1951.
6. Alexander Lowen, *Love and Orgasm*, New American Library, New York, 1967.
7. Pomeroy, *op. cit.*

Some Myths About Women

We know there is no universal definition of feminine behavior and character. In some cultures the women are the hard workers and in others the men are. In some cultures pregnancy is resented and children are an imposition; in others pregnancy and children are idealized. To a great extent each culture determines sex roles in its own way and sets up its own mythology which embodies the culture's ideas of sex roles. Common myths about women in our culture are that women are inferior to men, women are sexually passive, females are the beautiful sex, and women are to provide all the nutrient and caring functions in the society. We have learned these myths through institutions of our society, especially the family, schools, and media. We are beginning to challenge these myths and think of ourselves in new ways. We believe that much behavior and feelings that are considered feminine no longer describe us. We are beginning to define ourselves differently, and our new self-definitions embrace a far broader notion about what women are and can be. In this chapter I want to explore some of the prevalent myths that we have outgrown.

What cultural myths concerning feminine sex roles were we taught? How did we learn them? Let's begin with the myth of women's inferiority to men and notice how it's reflected in the following telephone conversation.

Salesman: Hello, Mom.
Mrs. Hunt: Yes, who is this, please?
Salesman: I'm from Prudential Life Insurance Corporation. I understand you just had a new baby.
Mrs. Hunt: Yes.
Salesman: What was it, a boy or girl?
Mrs. Hunt: A boy.
Salesman: So much the better!
Mrs. Hunt is silent. She is into Women's Liberation.
Salesman (giggles nervously): I guess his Dad looks at it that way.
Mrs. Hunt is silent again.
The agent laughs foolishly again and launches into his pitch.

You might think that the male bias reflected in the above conversation is a relic of the past, but the conversation transpired three months ago! In our

culture, primary distinctions between people are made on sex lines. One's genital organs tend to determine the worth and the value of one's behavior. In our culture women are devalued.

With this in mind I'd like to cite two studies. The first is by a psychologist Philip Goldberg. He asked women college students to rate a number of professional articles from each of six fields. Two equal sets of booklets were collated – one attributed to a male author and one to a female. Each student was to read the articles and rate them for value, competence, persuasiveness, and writing style. The identical article received significantly lower ratings when it was attributed to a female author than when it was attributed to a male. This was true for articles from traditionally male fields like law and city planning but also for articles from fields usually considered female, like elementary school teaching and dietetics.[1]

In a second study by Matina Horner, women college students were asked to write a story based on the following sentence. "After first term finals Anne finds herself at the top of her medical school class..." The same sentence is given to men students but the name is changed to John. Most women's stories described Anne as an "unattractive acne-faced girl who is unhappy because nobody likes her". Or they describe Anne as "wise enough not to make this mistake again on the next exam so that the men she likes can do better".[2] These studies do suggest that women have internalized a sense of second rateness, particularly with regard to doing meaningful and competent work in the society.

Most of the important, interesting, and creative work of the society that is recognized is done by men. They are the writers, philosophers, artists, historians, engineers, doctors, politicians, lawyers, architects, and administrators. True, some women enter into these male fields, but most women work in the home as childrearer, and housekeeper or in related fields like teaching, nursing and waitressing. Also open to women is work involving the "sexual sell" such as modeling and prostitution. Our society puts us in contradictory roles, some which we value like child-rearing, teaching and nursing and some which we don't, like "sexually selling" ourselves. What angers us is that all the other capacities of women tend to be underplayed or ignored and consequently women feel inadequate in other areas. And in a sense we don't have a choice. In colonial America this societal division of labor made some sense in that the population had to be maintained and women had to bear many children, so they worked in the home. Work outside the home involved physical strength; men are considered more suited for heavy physical work. But in 1970 most work does not involve physical strength and can be done competently by both men and women. Also women now have more time available for work since they use birth control to limit their family's size. Still, women are told they are not competent in fields outside the home and have internalized this sense.

Since men do most of the innovative work in the society, it is not surprising that women find a male point of view or bias in much of the writing, media, and social institutions that they encounter. A humorous account of how male bias might appear in a biology text is written by Ruth Herschberger in her book Adam's Rib. She writes two accounts of human reproduction. One account is a conglomeration of outpourings from "patriarchal biologists". Here is an excerpt from that section.

> The simple and elementary fact behind human reproduction is that a fertile female egg awaits impregnation in the fallopian tube and the active male sperm must find the egg and penetrate it.
>
> The female sex apparatus is a depression to receive sex cells; the male organs are advanced in order to expel cells.[3]

She then writes a fictitious "matriarchal biologists" account.

> The simple and elementary fact behind human reproduction is that the active female egg must obtain a male sperm before it can create a new life.
>
> The male apparatus is a "tiny factory" which continually manufactures sex cells for the female reproductive system.[3]

In a similar way male bias is written into marriage manuals, sex education literature, and medical texts. When we become aware of this dominant male point of view we begin to see male bias everywhere. Most novels have male as opposed to female sexual fantasies. Movies are directed by men who see women through men's eyes. A friend of mine notes how she was listening to a poetry reading of a love poem from a woman to a man. The poem talks about how the woman desires the man's body in a sensual way. My friend notes how she became slightly embarrassed in that she never publicly heard a love poem from a woman before. It is no wonder that women tend to view themselves through men's eyes since they have had very little experience hearing a woman's point of view. And even when we have heard a woman's point of view, we don't value it as much as a man's.

Not only do women tend to view themselves through men's eyes, but they view other women through men's eyes. An artist friend of mine brought her etchings to an art gallery to enter in an exhibition. The male director told her that her work was fine but refused to exhibit her etchings because he was showing too many women artists. My friend replied that she didn't know there was a sex quota. At this point the director's female secretary replied, "Listen, Miss, didn't you hear. We cannot accept any more women's work."

The vision of a male dominated world is of course reflected in the sexual roles that we were taught. This brings us to our second myth – that women are sexually passive and subordinate to men. Let's look at a few passages from Seventeenth Summer, a teenage novel which nicely illustrates the myth. Angis, the heroine, is a sensitive, serious, acne-faced girl who feels unappreciated and unnoticed. During her seventeenth summer Jack picks her as his girl. With Jack she becomes legitimate as a person. She experiences this transformation.

> It's funny what a boy can do. One day you're nobody and the next day you're the girl that some fellow goes with and the other fellows look at you harder . . . and the girls say hello. . . Going with a boy gives you a new identity.[5]

At another point innocent Angis notices couples parked in cars and expresses to Jack her bewilderment as to what is happening. "He says, 'You're a good kid, Angie,' and looks at her tenderly."[6]

Let's look at some of the attitudes reflected in the above passage. One attitude is that man is active and woman is passive. It is Jack who finds Angie. He wakes up the Sleeping Beauty. Jack is the actor and doer. Jack is the sexual initiator. Angie waits to be found. Angie is sexually asleep and numb. Jack embodies energy and Angie receives of it. These are the sexual roles our culture teaches us. Men are taught at puberty that they'll begin to feel sexual, they're allowed to masturbate (well illustrated by Portnoy in the recent Roth novel) and to be hot for a woman. Overt sexual intiative and aggression is encouraged. Throughout childhood girls have no overt acknowledgement of sexual organs except in relation to urination and future childbearing. Rough physical play like tumbling, wrestling, and chasing is discouraged. Girls are taught that they need sex less than boys. Their role is to restrain men and also to respond to them. Girls tend to have little sense of their own sexuality since they are so preoccupied with how men are acting. If they have a sense of their own sexuality they devalue it – it doesn't count.

Unfortunately the relationship that ensues when boy meets girl is somewhat impossible. In the myth the male has carte blanche to take the unwilling woman. Under his charisma she will yield and love it. The man sets the stage and takes full responsibility for the sexual act and the woman succumbs. What is missing is the notion that to have a sexual relationship both partners must be predisposed, actively participate and have some sense of what their sexual needs and desires are. But women have been taught to deny their sexuality throughout their childhood and adolescence.

What is also implied in this notion of a sexually passive subordinate female is that what satisfies a woman is indistinguishable from what satisfies a man. This leaves no room for women to define their own forms of sexuality. Recently this whole notion has been challenged by Masters and Johnson. Their study reached new conclusions about female orgasms. For the woman the orgasm is centered in the clitoris, whether resulting from manual pressure, or indirect pressure caused by the thrusting of the penis during intercourse. The dichotomy between the vaginal and clitoral orgasm is false.[7] Since female satisfaction depends on some clitoral stimulation a woman must have some sense of her sexual self which is real and different from a man's for her to ask for or want this experience.

Let's return to Seventeenth Summer. A second attitude is that a woman needs a man to feel real and socially acceptable. Through her relationship with Jack, Angie gains recognition by other men and women. A woman is affirmed if she's attractive and approved of by men. Her desirability as a person depends on male approval and not her own. This explains the poignant search girls embark on during adolescence. By locating themselves in strategic places in school and during summers, by befriending popular girls to "cash off of", by devoting much time and money to self-beautification of face and figure, and by devoting all intellectual, emotional and physical energy to manhunting, girls strive for their ultimate status, a man. The woman's need for a man becomes perverted in that she expects him to provide her with an identity and a sense of worth which of course she ultimately has to find for herself.

This myth has tragic implications for the emotional development of women, for relationships amongst women, and relationships between the sexes. Women's Liberation is trying to break down these myths in order to find a more real way of being and relating.

Now we come to the myth that women are the beautiful sex. What is pernicious about this ideal of feminine beauty is how it functions in the society. It seems to work against women in that we all are demanded to be beautiful – an impossible demand that breeds insecurity in women. Not only is it unfair to demand beauty from women as a group, but the standards by which we are judged conform to white anglo-saxon notions of beauty and don't incorporate other ethnic and racial groups' ideals. No wonder women tend to feel inadequate about their appearance.

Let me here quote a dialogue from a therapy session between psychologist Albert Ellis and a patient.

"How do you feel about yourself?" I asked
"What do you mean?"
"You know, your intelligence, ability to get along well with others, looks and things like that."
"Oh, I guess I think I'm intelligent enough. And others like me well enough - I think - if I give them a chance to."
"And your looks?"
"Awful."
"Awful?"
"Yes, why my hips are too high. I don't like them. And my back's too thin and my shoulders, they're not rounded enough and - Oh - just everything, awful."[8]

Ellis talked with 27 women patients, ranging in age from 16 to 50, to investigate the possible relationship between women's emotional disturbance and concerns about beauty. Every woman was concerned about her looks. Ellis feels that half of these women would have fewer psychological problems if they weren't concerned with deficiencies of face and figure. He set up a control group of women who were not in therapy and all but one woman had feelings of inadequacy about her looks. Indeed we have internalized society's demand that we be beautiful and hate ourselves when we don't conform to the impossible standards.

Advertisers of fashion and cosmetics industries play on women's vulnerability because their profit depends on women trying to compensate for their physical inadequacies by purchasing products. Women are bombarded by industries' advertisements in magazines, newspapers and TV advertisements which look at women's looks, judge women's looks, prey on women's insecurities, and then offer beauty aides to compensate for major and minor flaws. Women can buy vaginal deodorants, falsies, make-up, plastic surgery, wigs, hip-flattening or hip curving girdles and weight loss courses, to mention a few. As soon as one "beauty problem" is solved, industries create a new flaw to be compensated for. For example, it wasn't until recently that women felt a need for false eyelashes or colorless lipstick for the Natural Look. Women become so hungup on this search for beauty that will make them loveable, sexual, and acceptable that they fail to realize that they are being manipulated as consumers. This trend continues into the seventies engulfing men as well. And why this frantic search for beauty? Society makes it impossible for us to function if we don't. It gets us a man and a job. Why is this crippling us? Because we are forced to be preoccupied by how we appear to others rather than be concerned by how we feel from within. We would like the reverse to be true.

Now for the last myth that women's work is in the home as homemaker and childrearer or in related nutrient, serving, and maintenance jobs such as nursing, elementary school teaching, or waitressing. This attitude is expressed in a letter written by a professional man which appeared in the Confidential Chat Column of the Boston Globe on March 6, 1970. Here are some excerpts.

"Mom, were you a sexpot?"

> My problem is how to persuade my wife, a junior college graduate, that it is her job to provide her family with clean clothes, decent regular meals, and a reasonably clean home.
>
> Recently she has built one of her hobbies into such a time-engrossing thing that she actually hasn't time for her home or her family. . . I thought hobbies were what you did "in addition" to required work in your spare time, not instead of.
>
> What protection does the modern husband have? Where does he go wrong? Is the modern girl too emancipated? Is sliding into bed between clean sheets every week too lavish to even dream of? Is coming home to a wife who has given of herself during the day for your comfort a Utopia?
>
> *Disillusioned and Disgusted*

We cannot know exactly what psychodynamics are going on between this husband and wife, but it seems that Disillusioned has made a common mistake in that he has equated his wife's loving with housework and child care. Rather than considering housekeeping and 24-hour childrearing as work, and rather menial work at that, and realizing that this work and family income earning work can be divided up between marital partners in a multitude of ways, Disillusioned assumes it's his wife's duty to provide these services and that any

other interest that she has that does not concern the home must be subordinate.

When we begin to examine the role of housewife and mother, we can see why Disillusioned's wife has not found it totally fulfilling. A woman spends her day cooking, shopping, cleaning, laundering, ironing, and house cleaning; a set of fragmented tasks that must be repeated daily. Life is a series of errands. Often for middle class women, this takes place in a suburban setting which can be lonely since families live isolated from each other. Also the urban and suburban environments are so spread out that a woman spends much time in a car in order to accomplish what she has to do.

With modern birth control, we have the possibility to define ourselves as more than mothers. Even though children give us pleasure, the role of mother is confining alone. Child care does not provide women with meaningful life time work. What's incredible is that so many women choose it. Why? Part of the reason might lie in the fact that most jobs open to women, particularly uneducated women, are more demanding and less interesting than being a housewife and mother. Another reason is that middle class women find it hard to do housework and childrearing as well as independent work since the society does not provide childcare centers. But most important is the idea that in our society all women are expected to play this role and their motivation to define themselves differently has been suppressed.

Let's see how women are told to become wives and mothers exclusively. A prime influence is parents. Children emulate parents. Little girls begin to notice that mother is at home and daddy is at work; men and women do different kinds of work. Schools influence sex roles. Educational institutions differentiate the sexes and provide different education for boys and girls within the same classroom. Marked sexual differentiation is made as early as kindergarten through the kind of games they play and the kinds of toys they play with. Girls' playing space is the Doll Corner, an area where motor activity is restricted. Her toys are dolls, household cleaning things, make-up sets, food product sets and ironing boards. She gets the message that taking care of baby dolls and doing housekeeping tasks are appropriate behavior – just like mother. Meanwhile boys have larger space to play in and are encouraged to be active and independent. They have trucks, kites, models, and blocks to play with.

As girls enter elementary school they learn their sex roles from books in addition to toys and games. Jamie Kelem Frisof's article entitled "Textbooks and Channeling" analyzes the sex roles men and women play in America as depicted in five Social Studies texts written for grades 1-3. Here is a summary of some of the findings. In the five texts combined men are shown or described in 100 different jobs and women in less than 30. Women's jobs serve people or help men do important work or do work that was once done at home. On one page the child is to match instruments of work with the worker. There is one woman depicted and she had to be matched with a shopping cart. Men go places, struggle against nature, direct large enterprises, make money, and gain respect and fame. Women have few jobs of interest so they might as well be home. But their work at home as housewife and mother is not considered work or as important as men's work. The books lack interesting and competent female figures. Even though girls do better than boys in elementary schools they are taught in these years that their futures are limited.[9]

Another major influence in defining sex roles is the media: television, magazines and newspapers. In the media the role of housewife and mother has been glamorized and romanticized. Major responsibility for the over-glamorization of the housewife and mother role lies with the household appliance and food industries. They've created the image of the happy housewife and make women feel unfeminine and inadequate if they do not feel fulfilled in this role. Why encourage the woman to be at home? Because women at home tend to be the best consumers and the industries want profit. So women are manipulated by advertisements to believe that they will get a sense of identity, purpose, self-realization

nd joy by buying things for the homes and staying at home. Rather than look for new means of fulfillment women buy the line and look for fulfillment at home.

We can conclude from this discussion that by the time a girl reaches her twenty-first birthday much of er motivation is directed to be wife and mother. Other roles are made to seem inappropriate or unfemiine.

Women today are trying to break down myths concerning feminine sex roles that they were taught nd are beginning to think of themselves in a new way. For this new self definition to be more than just idea we must work for changes in the society. Here are some possible changes in the realms of work, ducation, and culture. (Some of these demands are listed in the Bread and Roses Bill of Rights.)

1. Childcare, by men and women, during working hours, provided by the employer and controlled y the workers and the community.

2. Maternity and paternity leave for men and women with guaranteed return and no loss of pay or niority.

3. Increasing of part-time work and an end of discrimination against part-time workers.

4. Low grade work should be shared by men and women as well as housework. Housework should recognized as legitimate work which deserves pay.

5. Communities should provide free community controlled childcare centers.

6. Living environments must be redesigned to meet the needs of women.

7. Sex discrimination in school curriculum and texts should be wiped out.

8. Facts about sexual inequality should be taught in schools.

9. An end to advertising which manipulates women to buy products.

FOOTNOTES

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Venereal Disease

Most kids in this country have probably heard something about venereal disease, or "VD" as it is often called, by the time they are in high school. You may have seen some scary films in school. Or you hear words like "the clap", "morning drop", "the Whites", "a dose", or "pox", "lucs", "siff", "Old Joe". All of these slang expressions refer to one or the other of the two major venereal diseases: **gonorrhea** and **syphilis**. These diseases are very serious, both because they can hurt you a lot physically, and because they are so common right now in the United States. (More than a million people get VD every year in this country.)

We in women's liberation are writing this paper because we think VD is a dangerous problem that everyone should understand, and because we think that most of the information about it that is generally available to people (especially to teenagers) is inadequate and slanted, with more preaching in it than facts. In this paper we'll first try to talk about the medical aspects of these two diseases: the symptoms, diagnosis, and treatment. Then we will discuss some of the "sociology" of VD: why it seems to be getting worse instead of better.

How Do You Get VD? Syphilis and gonorrhea are two different diseases. The thing that they have in common is that they are both caught in only one way: from having sexual intercourse with someone who already has the disease. The germs for each of these diseases can only live for a matter of seconds outside the human body. If they become dry or too hot or too cold, they die. Therefore, to spread to a new person, these germs must be deposited on warm, moist surfaces (such as the lining of the genitals, or perhaps the mouth, or on a break in the skin). This means that sexual intercourse, with a person of the same or opposite sex, provides ideal conditions for the transfer of VD germs. They go from the sexual parts of one partner to those of the other, and spread to other parts of the body from there.

This also means that the stories you often hear about catching VD from toilet seats, door knobs, towels, dishes, etc., are false. People get VD from other people who have VD, through intimate sexual or physical contact.

Can You Prevent VD? VD is not a disease like mumps or measles that you can only get once, and after that you are immune to it. You can get VD over and over again. Also, there is not yet any shot or vaccine to prevent VD. There is no sure way to prevent the transfer of germs from one partner to the other during intercourse if one of the partners has VD. (Sometimes people wash themselves with soap and water before and after intercourse. Sometimes the man will wear a rubber to prevent transfer. These methods may help, but neither of them is completely reliable.)

However, VD is not difficult to cure once you have it, if you go to a doctor or clinic to get treatment early. That's why it's so important to know the symptoms, and not be too hung-up to go and get help if there's even a slight possibility that you might need it.

SYPHILIS

Symptoms of syphilis

Syphilis is a very infectious disease that invades every system of the body. If treated, it can be cured; if not, it can be disabling and fatal. Syphilis is caused by a small delicate germ of the "spirochete" family (that just means it has a spiral shape). Once these germs have entered the body through intimate sexual or physical contact, the disease goes through four stages:

1. **Primary** – The first sign of syphilis is usually a sore called a "chancre" (pronounced kanker). It may look like a pimple, a blister, or an open sore, and it is usually painless. It probably will show up any time from 9 to 90 days after the germs enter the body. This sore usually appears on or near the genitals (where the germs entered), but it may appear on fingers, lips, breast, anus, or mouth. At this primary stage syphilis is very infectious. The chancre is full of germs which are easily passed on to others.

Sometimes the chancre never develops at all, or it may be hidden inside the body, and the infected person doesn't even know he has syphilis. This is particularly true for women, where the sore frequently

develops inside the vagina, or hidden inside the folds of the labia. In any case, this sore will go away a
by itself, even if the person doesn't do anything about it. But the germs are still in the body, increasir
and spreading.

2. **Secondary** – The next stage occurs anywhere from a few weeks to six months later. By this tim
the germs have spread all through the body, and there are many possible symptoms they may produce
at this stage. A rash may appear on the body (sort of like a food or heat rash, or like hives), or it may
be just on the hands and feet. Sores may appear in the mouth; joints may become swollen or painful,
and bones may hurt. There may be a sore throat, mild fever, or headache. Patches of hair may fall
out. Infectious raised areas may appear around the genitals and rear end.

This is the most infectious stage of the disease. If the person has open syphilitic sores on his body
this stage (in his mouth, for instance), the disease can be spread by contact with these sores, even with
sexual intercourse. This is a stage where syphilis "imitates" other diseases, and so the infected person
may think he has something else. Or the symptoms may be very mild, and the person hardly even no-
tice them. This stage usually lasts three to six months, but sometimes the symptoms of this stage can
come and go for several years. Just like the primary stage, it will disappear all by itself. But the germ
don't go away

3. **Latent** – During this next stage, the outward signs of syphilis disappear, but the germs may be i
vading various inner organs, including the heart and the brain. In the first few years of the latent stag
the disease may still be infectious, but after that it is usually not. The infected person can go along fc
ten or twenty years, feeling perfectly healthy, not knowing a thing.

4. **Late** – This is the stage of the disease when the really serious effects appear. Depending on whi
organs the spirochetes have attacked during the latent stage, a person may have serious heart disease,
crippling, blindness, or mental incapacity. Out of every 100 untreated syphilitics, 23 people will be
killed or incapacitated in this late stage of the disease.

Diagnosis of syphilis

Syphilis can be diagnosed and treated at any time. Early in the primary stages a doctor can look f
subtle secondary symptoms (like swollen lymph glands around the groin), or analyze some of the pus
from the chancre if one has developed. Very soon then (usually by a week or two after the chancre h
formed, though it may take longer), the spirochetes will be in the bloodstream, and they will show up
in a blood test. From then on, through all the stages, a blood test will reveal the infection. It is usual
best to have at least two blood tests several weeks apart, even if the first one didn't show anything, be
cause sometimes the results are not dependable.

This blood test is given regularly just as a check in lots of situations. For instance, people who go t
give blood are always tested for syphilis. The blood tests required before legal marriage are also for th
purpose. (One out of every 90 people who take the marriage blood test is discovered to have syphilis.
However, it could be used a lot more than it is now (at school or jobs, for instance, or whenever anyo
enters the hospital). In communist China, syphilis has been completely eradicated, and one of the ma
ways they did it was by giving the blood test to almost everybody so they could discover who had
syphilis and then treat them.

Treatment for syphilis

The treatment for syphilis is penicillin. It may be one big dose or a series of smaller doses for a sho
period of time. It's just that simple. It is important to have at least two follow-up blood tests to be s
the treatment was complete, since sometimes people have relapses. But the main thing to remember i
that the first three stages of syphilis can be completely cured, and even in late syphilis, the destructive
effects can be stopped from going any further.

Most states have VD clinics where you can get blood tests and penicillin free of charge. At these cl
ics they usually ask you for the names of any people you have had sexual relations with since you got
the disease, so they can contact those people and give them treatment. (This is called "case finding".
They keep your name and the other name or names secret, and it's usually a good thing to cooperate
with them. But if you don't want to tell the clinic people the names, then it's your responsibility to
get in touch with anyone you had sexual contact with yourself. It might mean life or death.

Syphilis and Pregnancy

If a pregnant woman has syphilis, she can pass the germs on to her unborn baby. The germs attack the fetus just like they do an adult, and the child may be born dead or with important tissues deformed or diseased. If the mother's syphilis is treated before the 18th week of pregnancy, the fetus will probably not be infected at all. (Even after the fetus has gotten syphilis, penicillin shots will stop the disease, but it cannot repair damage that has already been done.) Therefore, it is very important that every pregnant woman get a blood test for syphilis as soon as she knows she is pregnant. That way, if she has the disease, she can be treated for it before she gives it to her child.

GONORRHEA

Unlike syphilis, which goes all through your body, gonorrhea is essentially a disease of the genit-urinary organs. (Sometimes gonorrhea travels through the bloodstream and causes infection in the valves of the heart, or acute arthritis, blindness, and even death. However, this is not too common.) It is caused by a germ shaped like a coffee bean called a gonococcus, which works its way gradually along the passageways of the genital organs. This disease can be transmitted to another person at all stages. The symptoms of gonorrhea are different for men and women, even though the germ is the same. It takes about two days to three weeks after gonorrhea germs enter the body for symptoms to show up.

Symptoms of gonorrhea in women

The first organs infected by gonorrhea in women are the urethra (the tube through which urine flows out of the body) and the cervical canal (entrance to the womb). Very often, however, a woman may not even know this infection is present. She might feel a little pain when she urinates, or she might have a slight vaginal discharge. Then again, she may have no symptoms at all.

But if the disease goes untreated, various complications can arise:

–The glands in the genital area may become swollen and painful.

–The infection may spread up the urethra into the bladder and cause cystitis. Urination will be more frequent and painful.

–The infection may spread to the rectum and cause proctitis.

–Most serious of all, it may spread and inflame the Fallopian tubes (tubes which the eggs move through on their way from the ovaries to the womb). This is called salpingitis. The woman may feel no symptoms at all at first, and then suddenly have severe pain in her lower abdomen, on one side or both sides. She may also have vomiting and fever. If a woman has a mild case of this, she may feel the same symptoms in much milder form over several months. Her menstrual periods may become irregular. If this disease goes untreated, a lot of scar tissue will develop in the Fallopian tubes. They will become twisted and narrow, so that the eggs can no longer pass through them. If this happens to both tubes, the woman will never be able to have children.

If a pregnant woman has gonorrhea and doesn't get treated before her child is born, the child's eyes can get infected during birth. In the past, this gonorrheal eye infection was a big cause of child blindness. For this reason in the US now, the eyes of every new born baby are treated with drops to kill any gonorrhea germs, just to be sure.

Symptoms of gonorrhea in men

It is much easier for a man to tell that he has gonorrhea. The symptoms for men are early, definite, and obvious. At first he will feel a painful burning sensation during urination, and then a discharge of whitish or yellow pus from the penis appears. This discharge is very infectious, and its germs may be carelessly transferred to the eyes.

If the disease goes untreated, it may spread to the bladder and cause cystitis. Or it may spread to the seminal vesicles or the epididymis (these are organs where the sperm are temporarily stored or where they pass through). In this case it may cause a hard tender swelling in the man's balls. This internal infection will form scar tissue, just as it does in the woman, and it may block the passageway of the man's sperm, making it impossible for him to conceive a child.

Diagnosis of gonorrhea

There is no reliable blood test for gonorrhea. But it is not too hard to diagnose gonorrhea in a man.

There are usually so many germs in the discharge from his penis, that they can be seen and identified under a microscope. If they cannot be seen right away, they can be kept in a laboratory for several days and allowed to multiply. (This is called taking a "culture".) In a woman, though, it is more difficult. The woman is much less likely to think she has gonorrhea in the first place, since she probably doesn't have any symptoms for a while. Also, the germs are spread out in her body more, and much harder to find and identify. If a woman thinks there's even a **chance** she has gonorrhea, or if she knows that someone she has had sexual contact with has a case of gonorrhea, she should go to a doctor or a clinic at once. Usually what the doctor will do is take a sample of secretions from her sexual parts (the cervix or vagina) with a cotton swab. He will look at the sample under a microscope first to see if he can identify any gonorrhea germs. But almost always it will be necessary to allow the germs in the sample to multiply for several days before they can be identified. Sometimes, however, a woman may have the disease, and yet there were so few germs in the sample that they won't show up in the test, even after several days. Therefore, if a first test shows no germs, it is necessary to repeat the test to make sure.

Sometimes, if a woman thinks she may have gonorrhea, doctors will go ahead and treat her for it, even if the tests don't show anything, just because the consequences of the disease are so serious, the tests are so unsure, and the treatment is so easy.

Treatment of gonorrhea

The treatment for gonorrhea, like that for syphilis, is penicillin. It usually involves one or two injections. The size of the dose has been increased over the years because gonorrhea germs have the ability to build up resistance to penicillin. (Syphilis germs do **not** have this ability.) For this reason, doctors are also experimenting with other antibiotics to see if they are effective against the spread of this dangerous disease.

Syphilis and gonorrhea together

A lot of times a person will get syphilis and gonorrhea at the same time. If this happens and a person doesn't know it, he might get treated with penicillin just for the gonorrhea, for instance. The penicillin will cure the gonorrhea, but the dose may only mask the symptoms of syphilis: it probably won't be big enough to **cure** the syphilis. For this reason, anyone about to be treated for gonorrhea should also get a blood test for syphilis **before** he gets the penicillin dose. Also, he should continue to have periodic blood tests for syphilis for about six months afterward just to be sure.

Protect Yourself!!!!!

1. If you notice **any** symptoms of VD in yourself, no matter how mild, you should go to a doctor or a clinic at once. (Turn to the last section of this chapter for a quick check list of VD symptoms.) Don't panic, or feel guilty or embarrassed. For a list of clinics in Boston where you can go for free treatment and tests, see the last section of this paper. Or you can go to a private doctor if you have the bread (probably $20-30). In Massachusetts, if you are a minor, you do **not** have to have your parents' permission to be examined and treated for VD.

2. If you have sexual relations with someone, try and find out if there is any chance they have VD or have been exposed to VD recently. Don't be embarrassed to ask. If two people care about each other they should be looking out for each other anyway.

If you find out you have VD, don't have sexual relations with anyone until you are well. If you had sex with someone when you had VD but didn't know it, you should tell that person right away so they can get treated. It is especially important in cases like this for men to tell women that they might be infected with gonorrhea, because the woman probably won't notice any symptoms in herself until the disease has already done a lot of damage.

3. Don't depend on just **one** test. If the first test for gonorrhea or syphilis doesn't show anything, make sure the doctor takes another one to be safe. Don't just accept whatever he says. Some doctors aren't careful enough, and it's **your** life, not his.

V.D. IS A SOCIAL PROBLEM

Once you know what a serious, even deadly, disease VD can be, and how easy the cure almost always

is, it really seems strange that it has not been brought under control better in this country. We saw before that in China syphilis has been completely ended. What about in the United States?

In this country, well over a million people get VD every year. (That means about 3000 new cases of gonorrhea and 300 new cases of syphilis every day.) Approximately 4000 people each year die in the late stage of untreated syphilis.

Not only are the numbers high. They are getting rapidly bigger. The number of gonorrhea cases went up 35% from 1963 to 1969. That was a six year period. Then in Massachusetts last year, over a one year period, the number of gonorrhea cases went up 15.4%.

About 12 years ago, people were saying that the VD problem in this country was almost solved. The amount of VD had been decreasing since the Civil War, and it reached an all time low in 1957-58. However, ever since 1958, the number of VD cases has been increasing more and more each year.

This is what we call an epidemic. More people now get gonorrhea every year in this country than get measles, tuberculosis, hepatitis, whooping cough, and encephalitis combined. Strep throat is now the only communicable disease that affects more people than gonorrhea.

The other thing about this epidemic is that it is hurting young people worst of all. People 15-19 years old get VD twice as often as other people. A recent study indicated that one out of every 50 kids in that age group gets gonorrhea. Over half of all VD in the US (56%) hits people under 25.

Why is this? Why is it that things are getting worse and worse? In the first place, like most other things, the VD problem is partly a question of money. Most government money right now is being spent on "defense" to fight the war in Vietnam. Medical research money goes to a lot of things like fancy operations for rich people or to develop chemical weapons like Mace. If this weren't true, there might be money available to develop a preventive vaccine for VD, or to figure out a simple screening test for gonorrhea (this would be especially important for women). Also, more VD clinics and casefinders could be paid for.

Another main reason that we see for the uncontrolled spread of VD is the whole set of up-tight attitudes and laws about sex that exist in this country. On the one hand, just about every business in America uses commercial sex to sell its products. (Buy Ultrabrite, etc.) On the other hand, a lot of adults treat sex as if it were something dirty and sinful that should never be talked about – especially in front of kids. This means that a lot of kids - and girls especially - live under a kind of "news blackout" about their own bodies and their own sexuality. They are not told the basic facts about sexual life, reproduction, birth control – or, of course, about venereal disease. All sorts of crazy stories and superstitions get spread. When people are told something, it's usually to preach it and doesn't help. For instance, some of the movies they show about VD in the schools make it look like getting VD is a justified punishment for committing the "sin" of making love with someone before you are married. We know of one high school teacher in Cambridge who once taught a lesson on VD in hygiene class. This was the entire lesson (she didn't say anything else): "God punishes those who sin."

In fact, it turns out that a lot of the people who should supposedly be helping to stamp out venereal disease are really much more interested in stamping out "illegal" sex. Attitudes about sexual participation are changing, particularly among young people, and yet in 36 states of the union, it is still illegal for a minor to be treated for VD without his or her parents' consent. Of course a lot of kids will go untreated because they don't want to blow it with their parents. Even though they know that it is kids who are getting hit the hardest by this epidemic, it seems like the people who make the laws care more about punishing a kid for stepping outside their hypocritical rules than they do about saving his life.

Another example of this kind of attitude can be found in some of the public statements of Dr. Nicholas J. Fiumara, the director of the Division of Communicable and Venereal Diseases of the Massachusetts Department of Public Health. He recently (March 1970) issued a statement saying how serious the increase of gonorrhea in Massachusetts was. Then he said that one of the main reasons for this increase was the existence and use of the birth control pill. He has also listed the Massachusetts anti-"fornication" laws as one good method for preventing VD. (That's about as logical as saying that a good method for preventing food poisoning is to outlaw eating.)

Both of these statements show that Dr. Fiumara is anti-sex before he is anti-VD, and he is especially against the idea of women being free from the fear of unwanted pregnancy and being able to be in con-

trol of their own lives and bodies.

Dr. Fiumara and men like him should be fighting to build more clinics, to educate the public, to break down the barrier of embarrassment and silence that surrounds the subject and prevents kids from being able to take care of themselves as they should. Instead, he is sitting around denouncing the birth control pill.

If we look carefully at the history of venereal disease, we find that its main epidemics aren't so much connected to women having control over their own bodies, like with the birth control pill, or with people who really dig each other making love when they are not married. Instead, it seems to be more tied to times and places where rape and prostitution and very common. As you can figure out if you think about it for a minute, rape and prostitution are usually most common during times of wars and invasions, where a lot of men from one country are taken away from wives and girl friends and sent to another country which they are trying to defeat or conquer. Just plain male chauvinism comes out in the attitudes of the guys toward the women of the other country, and they don't have to worry about the laws and social pressure they would feel back home. Also a lot of times racism enters into this situation. If the women are just "niggers" or "gooks", it's considered even more okay to fuck them over. Outright rape becomes a common occurrence, and prostitution also begins to grow.

Vietnam today is a good example of this situation. The Vietnamese report that rape - and often gang-bangs - of village women and girls are such a frequent thing now in South Vietnam, that they almost consider it as part of the "fighting task" of the American GIs.

Prostitution is also very common in those parts of Vietnam which are occupied by the US troops. The normal life and work of South Vietnam is almost destroyed. Huge numbers of women are widows with children and no means of support. Most of the jobs that people can get in those parts of Vietnam are like maids to GIs or selling stuff on the black market. Everything revolves around the war and the American army, and there are no decent jobs left. So a lot of women are forced to become prostitutes in order to survive. And the corrupt Saigon government encourages them in this. The government itself has actually built and maintained "official" whorehouses at every US base in South Vietnam.

North Vietnam and those parts of the south controlled by the NLF are very different from this. There women are respected, and prostitution has been abolished. Recently in the Boston Globe there was an article comparing Hanoi and Saigon. Here are some of the things it said:

> Hanoi is quiet. . . You can safely leave several hundred dollars worth of local currency in your hotel room. The girls are plainly and modestly dressed in long pants and blouses. . . Even Communist diplomats complain they have to go to Laos to find "feminine companionship"
>
> Saigon is sodden with corruption. . . Bar girls, night clubs, and strip joints give a honky tonk air. . . There is a fancy "house" for high officials and generals to meet their girls.

What all this means about VD is that in the North they have venereal disease now more or less under control. But in the South, it is really terrible. Many many women are suffering from this disease either because they have been raped or have been forced into prostitution. And the GIs themselves, frustrated and lonely, disrespectful of Vietnamese women, also suffer from this disease and spread it to others. In fact, there is a new, penicillin-resistent strain of gonorrhea which has grown up because of the war, which doctors in this country have begun calling "Vietnam Rose!" because it originated in Vietnam. Maybe a better name for it would be "American Invader".

Anyhow, this is just one modern example of how male chauvinism and racism and national expansion can help the spread of VD, because they encourage such sick sexual relations and the sexual exploitation of women by large numbers of men. Syphilis was first taken to China by white "explorers" from Europe. The first big epidemic in Europe was spread from Italy where the French and Italian soldiers were fighting a long drawn-out war and messing over the local women. Why doesn't Dr. Fiumara mention some of these problems and this history instead of blaming it on the pill?

Until our government and big business stop sending American boys overseas and until they stop paying them to kill and rape the people of other countries, the people of our own country are going to be sick in many ways – a continuing epidemic of venereal disease is only one of them.

In the meantime, we should all do everything we can to protect ourselves and our friends. So turn to the next page to remind yourself of the possible symptoms of syphilis and gonorrhea, and how they can be cured in an individual. The social cure is going to be harder.

Syphilis

POSSIBLE SYMPTOMS

Primary state (9-90 days after infection): chancre

Secondary state (few weeks-6 months later):
rash (all over, or on hands and feet) – sores in mouth – sore throat – mild fever – swollen joints – headache – patchy balding

Latent stage (10-20 years): no outward symptoms at all

Late stage: heart disease – crippling – deafness – blindness – paralysis – insanity – death

DIAGNOSIS – Physical examination by doctor
In early primary stage: examination of pus from chancre
After that: blood test

TREATMENT – One or more shots of penicillin or some closely related drug

SLANG NAMES – Pox – Lues – Bad Blood – Siff – Hair-cut – Old Joe

Gonorrhea

POSSIBLE SYMPTOMS

In Women
maybe slight vaginal discharge
maybe some pain when urinating
(later) severe abdominal pains
infected bladder
infected rectum
infected tubes
sterility
arthritis
blindness
death

In Men
discharge from penis
pain during urination
sore, swollen testicles
infected bladder
infected tubes (seminal vasicules or epidedemis)
sterility
arthritis
blindness
death

DIAGNOSIS – Look at discharge under microscope (usually only works for men)
Examination of "cultures" of germs from the discharge (where the germs have been allowed to grow for several days)

TREATMENT – One or more penicillin shots, or some related drug

SLANG NAMES – Clap – Strain – Gleet – Morning drop – A dose – The Whites

Important Information About Penicillin Treatment

Whenever you get a penicillin treatment for *any* disease, don't drink any alcoholic beverages for 48 hours. Alcohol deactivates the white blood cells, which are the agents that actually kill the disease. Even though the penicillin will still work to stop the growth of *new* germs in that time, the treatment will be ineffective if the white blood cells are not active.

Boston Venereal Disease Clinics

These are the names of clinics and hospitals in the Boston area where you can be tested and treated for VD. Most of them have special VD clinics arranged for certain hours during the week. The telephone number listed for each hospital is the number to call to find out exactly when their hours for VD are. The Cambridgeport Clinic is probably the one that is the most sympathetic and helpful to kids, but everybody already knows that so you'll probably have to stand in line a pretty long time. (It's up to you.)

Cambridgeport Free Clinic, 10 Mt. Auburn St., Cambridge – 876-0284
Cambridge City Hospital – 354-2020
Beth Israel Hospital – 734-4400, ext. 187
Boston City Hospital – 424-4082
Boston Dispensary – 542-5600, ext. 326
Massachusetts General Hospital – 726-2748
Peter Bent Brigham Hospital – 734-5000, ext. 2362
University Hospital – 262-4200, ext. 5356

Birth Control

I. Making a Responsible Choice of Birth Control Method–Some Obstacles

All of us ought to have the right to make our own decisions about having children: if we will have children, when we will have children and how many children we will have. The spread of contraception has given some of us more choices in these matters, but we have not yet reached the time when all women can make these decisions with freedom. Religion and economic factors play a large part in keeping women from knowing about and/or using contraception. In this society, the right of a woman to know about and/or use contraception is still controlled by the state, not by the individual. Check both the laws and hospital practice in your state to see how available birth control care is to every woman.

We women have a more personal interest in birth control than men do, for we bear the children, and in large measure we are responsible for raising them. Numerous and frequently spaced pregnancies can have serious ill effects on both mother and children. Until men take an unwanted pregnancy as seriously as women do, they will consider contraception a female problem. However, we women must try to shape a society where men will make this their interest too. Clearly there is no ideal contraceptive today. The rhythm method has a high failure rate, the pills have undesirable side effects, etc. As we move into more sophisticated research in contraception, it is important that women insist on male contraceptive research being given equal consideration.

The Senate hearings on the pill have made it all too clear that it is imperative that we women know more about our own bodies and how they function. We have known for a long time that certain interests are making money off of our ignorance. The birth control pill is no different from any other drug in that the main interest of the drug companies is first and foremost to make a profit. The prescription task force of HEW estimated that in 1968 the drug companies spent $4500 per physician per year on advertising and promotion of all drugs.[1] In 1968 women took $100 million worth of birth control pills. In 1969 the sale of oral contraceptives amounted to $120 million.[2]

With such a lucrative product, it is easy to see why the drug companies might want to cover up "unfortunate results" stemming from the pill. As early as the Senate hearings of 1963, it was learned that the entire basis for the FDA's safety decision on Enovid, one of the pills, was data collected on 132 women who had taken the pill for only one to three years. It has been estimated that 132 is fewer than the number of women who will die in 1970 from the blood clotting caused by the pill.[3]

Another area tied in with the drug companies' cover-up is their failure to solicit doctors' reports of complications arising from the pill. On the contrary, the drug companies actually supported those doctors who were ready to publish reports favorable to the pill. In 1966, Dr. Robert Wilson wrote a book, Forever Feminine, in which he advanced the theory that the pill could prevent menopause and make a woman feel young and "sexy" no matter what her age. In 1964, the Wilson Foundation had received $17,000 from the Searle Foundation (G. D. Searle is a major drug company, the makers of Enovid and Ovulen 21). Searle has also given grants to Dr. U. E. Ayre who has done studies to show that Enovid could not cause and might even inhibit cancer of the cervix.[4]

The "population experts" have been the second major ally of the pill, pushing it because of its high effectiveness and not looking so hard at its side effects and hazards. For years Dr. Alan Guttmacher supported the "fertility rebound" theory – that when a woman went off the pill she would experience an increase in fertility – until a 1966 report indicated that the pill had caused sterility, temporary and permanent, in about 10% of the women studied.

The drug companies' cover-up of the hazards of the pill was evident in the patient pamphlets which distorted or denied known risks. Now, after the pill has been in use for ten years in this country, the FDA is finally urging doctors that they disclose to their patients the warnings, adverse reactions and counterindications. But the obstacles to our learning enough to make reasonable decisions do not end with the drug companies' cover-up and the population experts' down-play of side effects and hazards of various methods of birth control. Our doctors themselves don't learn all they should, particularly about the pill, a hormone-affecting medication that their patients will be taking for years at a time. And what the doctors do know, they usually don't pass on. The doctor, trained to treat us as patients, not

people, has given us reassurance rather than the information we need. We can have no confidence in such individuals who do not inform us of the possible dangers of a drug they are administering to us. Some doctors can only be interested in maintaining a kind of MD-priesthood mystique. Dr. Robert Kistner of Harvard Medical School (one of the most ardent defenders of the pill at the congressional hearings) was one of the main witnesses at the pill hearings for G. D. Searle, the major birth control pill manufacturer. When counsel for the plaintiff asked him why he didn't tell his patients of the potential risks involved in oral contraceptive use, Dr. Kistner replied: "Well, if you tell them they might get headaches, they will get headaches.[5] We can't take the place of doctors, but we have to demand to know what is pertinent to our health and safety; instead of relying solely on doctors we must rely on ourselves, our research, our feelings, our experiences and those of other women. And we must learn about every available method of contraception so that we are not at the mercy of the typical doctor who says, "You got headaches? You got cancer? Okay, here's a prescription for the pill"; or, "I don't like the pill; here, take this I.U.D.

No matter what kind of birth control we choose (except condoms), how do we deal with our feelings of legitimate resentment against the burden of total responsibility for birth control? This is painful because it brings home very sharply our vulnerability; we are the ones who get pregnant. From the male point of view, "the chick got herself knocked up". This kind of attitude fills us with such rage that we often take it out on men. We have to begin to be open with each other and with men about this problem.

If we are going to have sex, we must use contraception. According to United States mortality statistics, 100,000 pregnancies would result in about 25 maternal deahts–eight times the death rate associated with the pill from blood clotting. Of those women who terminate their pregnancies through illegal abortions, about 1 in 100 will die. So if we choose to stop using the pill because we are concerned for our health and safety, we'd better be sure that we are protecting ourselves from the higher health risks of pregnancy and abortions.

The only more or less effective methods of birth control, apart from the pill, are the diaphragm with cream or jelly, the condom, foam and condom, or the I.U.D. Other methods can significantly reduce fertility, but are not effective control methods. The fact that there is no effective, safe, and esthetically pleasing birth control method serves to maintain the dependent-submissive relationship women have vis-a-vis men. A women is the one who risks impregnation and if a man doesn't stand by her and support her, she has to face the social indignation and psychological turmoil alone. She almost has to feel dependent on him, to feel that he will not "let her down". And how humiliating if he does! When a relationship which is supposed to be based on mutual respect and/or love is in actuality based on this kind of fear and dependence, we can understand the source of much female anxiety in sexuality. Is it this dependence which is one of the sources of our feeling compelled to "sell" ourselves to a man, pleasing him through consuming a billion dollars worth of cosmetics a year, changing the fashion of our dress every three months, playing the jolly industrious housewife?

We women demand birth control, not so that we can be used by men in demeaning or inhumane relationships; a liberated woman does not mean a "free fuck". Even as these imperfect methods of birth control become more and more available, men have put pressure on women to fuck, and many of us feel ourselves under an external pressure to do so, but with those terrible feelings of guilt, anxiety and disgust. In a submissive, dependent relationship, where women are afraid to make sexual demands, afraid to demand that men touch us where it feels good; in a culture where women have been so conditioned that we have been afraid to experiment with and explore our bodies so we don't always know what would feel good; in a world-historical situation where women have been inferior and powerless – what will it take for us to have pleasurable, fulfilling, guilt-free sexual relations? Far more than just good birth control methods. But that, at least, is a start.

II. Conception–The Process to be Interrupted (see pp. 4-8 as well)

The ovaries (Latin "ova"=eggs), shown in the diagram on the next page, manufacture eggs and female sex hormones; the oviducts ("egg ducts"), each wide as a telephone cord and also called Fallopian tubes (after Fallopio, a 16th century physician who discovered them), extending from ovaries to uterus (from Latin "womb" or "belly"), and the uterus itself, some four inches long. Also evident is the cervix (from Latin "neck"=neck of uterus), protruding into the upper wall of the vagina (Latin for "sheath"). One end of each oviduct extends towards each ovary, and the other end enters the uterus. When a woman

is standing, the uterus is nearly horizontal so that the small end of it (the cervix) points towards the tip of the spine while the bulbous end projects forward. The cervical os (Latin "os"=mouth, opening) is tiny; no tampax, finger or penis can possibly enter.

The ovaries, located four to five inches below the waist and halfway between sacrum and groin, contain some 3000-4000 follicles, hollow balls composed of many layers of cells. However, only about 300 of these will mature egg cells in their centers and release them in the process of ovulation. The other follicles degenerate before completing development. Each month one follicle begins growing, matures an egg cell in its center, and moves closer to the ovarian surface. At some point in the cycle, it breaks through the surface, ruptures, and expels an egg in the general direction of the oviduct. This is ovulation. The egg, trapped by the funneled end of the oviduct, is helped towards the uterus by peristaltic contractions of the tube (similar to esophageal peristalsis). The journey to the uterus takes about 6½ days, and the egg then has about 12 hours to implant on the uterine wall. If it is not fertilized, it won't implant, and the ruptured follicle (which all this time has been secreting progesterone in preparation for a pregnancy) degenerates; the egg is expelled from the uterus. A scar is left on the surface of the ovary from the degenerated follicle; in a pre-pubescent girl the ovary's surface is smooth.

Fertilization is the process of union of egg and sperm. The sperm are ejaculated into the vagina in seminal fluid. They can move an inch in 8 minutes, so that a sperm may reach an egg (in the outer third of the tube) in 1½ hours. The sperms make their way up the cervix into the uterus, and into the tubes, where they are helped towards the ovary by waving cilia. Cilia are hairs protruding from the cells lining the oviducts, and as the tubal cilia always sweep in the same direction they create a current that helps the sperm up towards the egg. Fertilization takes place in the outer third of the tube, not in the uterus. The cervical mucus is thinnest at ovulation, and thus least hinders the entrance of sperm into the uterus at that time. (See Ib)

III. Hormones of the Menstrual Cycle

The next part of this chapter will concern hormone effects on uterus, ovaries and cervix. This is necessary for an understanding of how birth control pills work.

The main glands involved in the normal menstrual cycle (Latin "mensis"=month) are the ovaries and the pituitary. The ovaries produce eggs (usually one per month), female sex hormones (estrogen and progesterone) and small amounts of male hormones (androgens). The pituitary is called the master gland of the body because its hormones affect almost all other glands and organs in the body. Its interaction with other glands is controlled by various mechanisms. For instance, by secreting Y, it may stimulate another gland to produce X. However, if X inhibits Y, as the level of X rises, the level of Y will fall. Thus, eventually less X will be secreted. This type of control is called "negative feedback mechanism" and is important for our discussion. (See Ia)

The cycle starts with FSH (follicle-stimulating hormone), a pituitary hormone which stimulates an ovarian follicle to grow. FSH is secreted in greatest amounts during menstruation, is lowest at ovulation, and then rises again. This is logical because FSH must be present in greatest amounts to start each follicle's development; a follicle begins developing during menstruation. Then at the time of ovulation, FSH is needed least; the follicle is doing what it was "meant" to do. Then it must rise again, to a level where another resting immature follicle is stimulated to grow. In a diagram, FSH levels would look like the diagram on page **44.**

What makes the FSH level rise and fall? A rising level of FSH causes rising amounts of estrogen to be secreted by the cells in one layer of the follicle. Because of the negative feedback mechanism, however, increasing estrogen causes a decrease in FSH. A word here about atretic follicles. We have mentioned that most of the follicles in the ovary degenerate before completing develop— This is normal, called atresia, but before the follicles die, they are secreting small amounts of es— llicles are constantly degenerating, there is a low constant level of estrogen being secr— the FSH level manageable; only one follicle generally grows each month.

Getting back to the cycle, as the estrogen level rises, not only does i— t eventually stimulates the pituitary to release two other hormones, LH and LT— one, is a

Ia

Pituitary Gland

Pituitary Hormones

Ovary

Uterus

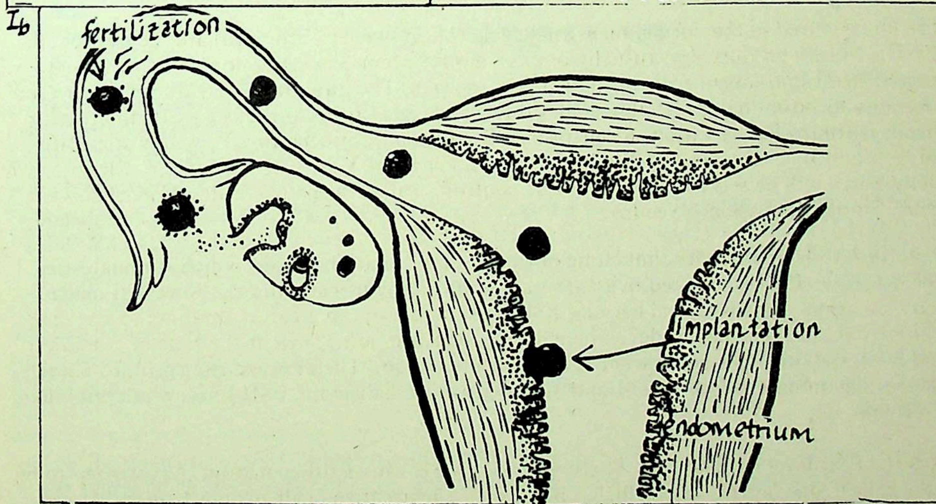
Follicles

Ovarian Hormones

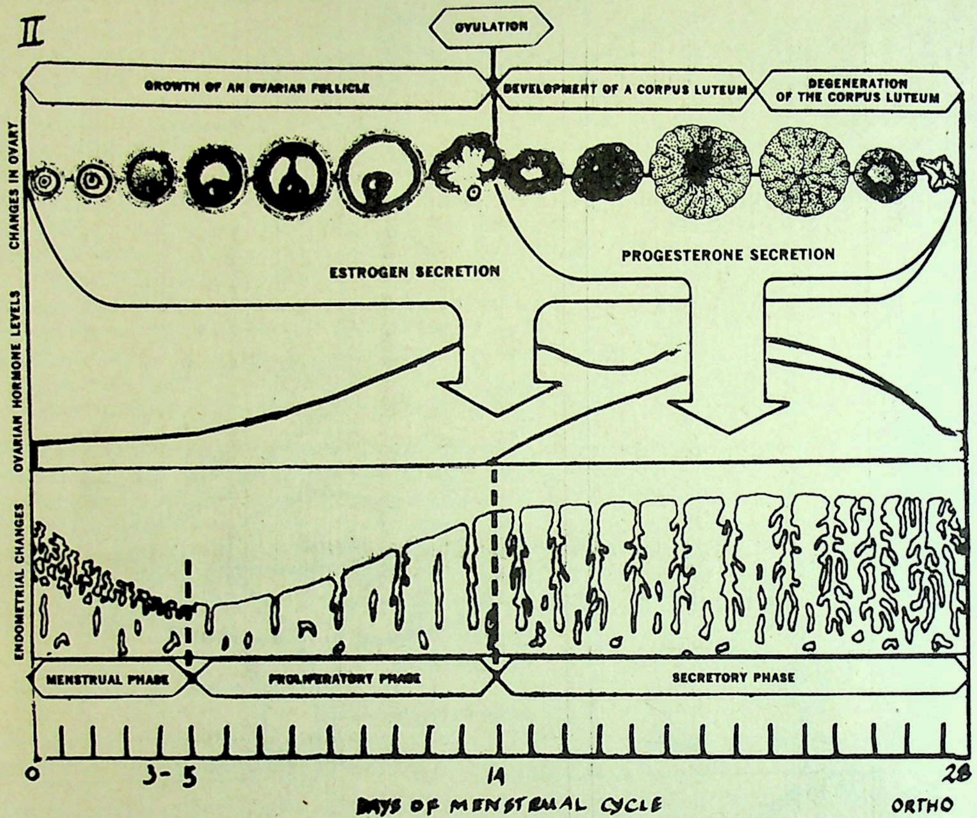
Endometrium

Cervical Mucus

ORTHO



causative factor in ovulation and in formation of the corpus luteum, the outer layer of the egg cell ("luteum" means yellow, and "luteinizing" is thus associated with the yellow body). LTH, or luteotrophic hormone (again, "luteum", or yellow, and "trophic", or growth), is necessary for the cells in another layer of the follicle to produce progesterone. In other words, it causes growth of one layer c cells in the yellow body or corpus luteum. The corpus luteum would last from day 14 to day 22 in : 28-day cycle, but if no pregnancy occurs, it degenerates. It does so because of another negative feec



back mechanism. In this one, the rising progesterone level inhibits pituitary secretion of LH and LTH. In other words, the corpus luteum's own secretions are self-hindering. As the corpus luteum degenerates, and as estrogen and progesterone levels decline, FSH production is stimulated and the cycle starts again.

Summary: FSH leads to follicle growth and estrogen secretion. Estrogen leads to FSH decline and LH, LTH rise. LH, LTH lead to ovulation and progesterone secretion. Progesterone leads to LH, LTH decline. LH, LTH decline leads to corpus luteum degeneration and estrogen and progesterone decline. Estrogen decline leads to FSH rise; new cycle begins. Estrogen and progesterone drops cause menstruation.

This has been the ovarian cycle – from follicle growth to ovulation to follicle degeneration. There is also a uterine cycle and a cervical cycle, both simpler to explain and both essential for an understanding of birth control pills.

Uterine cycle: Estrogen causes the uterine lining to proliferate (to grow, thicken, form glands which will secrete embryo-nourishing substances) and maintains this lining. Progesterone is what makes the uterine glands start secreting the nourishing substances, and it also increases the uterine blood supply. (Estrogen also aids secretion but to a very small extent.) An egg can only implant in a secretory lining, not in a proliferative one. The lining is proliferative, under the influence of estrogen, until the egg is ovulated. At that point, the corpus luteum starts secreting progesterone, which changes the character of the lining to secretory. The egg,which takes normally about 6½ days to get to the uterus, thus finds a well-developed lining.

Cervical cycle: The cervical mucus, under the influence of estrogen, becomes thinner and wetter. Under the influence of progesterone, after ovulation, it becomes thicker and dryer. In addition, the two

sex hormones, estrogen and progesterone, affect the content of the cervical mucus. There is a sharp peak in calcium (Ca) and sodium (Na) concentrations at the time of ovulation, and this is apparently very beneficial to the sperm. (About 24 hours before ovulation, there is a sharp drop in CA, and this is the basis of a new test for telling when a woman ovulates.) The thinness and wetness of the mucus at ovulation aid the sperm's entrance into the uterus at that time. (See diagram)

Finally, a note on menstruation. Menstruation is no more than the shedding of the uterine lining as a result of hormone withdrawal. As the estrogen and progesterone levels drop, the lining cannot be maintained, and it is shed. About 4-6 tablespoonfuls (2-3 oz.) of blood may be discharged. Why does menstruation only last a week or less? Because the FSH level starts rising after ovulation and a new follicle starts growing – and starts secreting estrogen. Estrogen, causing growth of the uterine lining, inhibits further shedding. The timing is such that the whole old lining (except for the bottom layer of cells, which will form a new lining) is shed before a new one grows. Menstrual cramps are uterine contractions caused by the uterus trying to discharge "foreign" material which won't support a baby.

An interesting sidelight on the importance of hormones might be mentioned here. At the time of menopause, when a woman runs out of follicles, she gets an estrogen deficiency. Since there is no more inhibition of FSH, the FSH level goes wild, rising from normal (10-80 units) to as high as 350-500 units. Women who want children but who can't ovulate regularly if at all suffer from too low an FSH level. They are treated by injections of a substance called Pergonal – which is actually FSH from "old lady urine" (from women who have menopausal symptoms and lots of FSH!).

Medical researchers were able to study the hormone levels because these hormones (FSH, LH, LTH) maintain their structural integrity (their identity), are bound to albumins under the influence of estrogen, and are then excreted in the urine. Estrogen and progesterone are metabolized by the liver to various compounds also excreted in the urine, and can be detected by anyone with the proper equipment. For instance, estradiol-17B is the basic estrogen made by the placenta, ovary, testis and adrenal. It is excreted in urine as estriol in pregnant women, and as estrone in non-pregnant women. The conversion of estradiol-17B to estriol or estrone occurs in the liver.

IV. Birth Control Pills

How They Work. Currently used birth control pills prevent pregnancy primarily by inhibiting the development of the egg. On the fifth day of your cycle, when low estrogen level usually triggers the output of FSH, the pill gives you just enough synthetic estrogen to inhibit the FSH. So in a month when you are on the pill your ovaries remain inactive, and there is no egg to be fertilized. This is the same procedure by which a woman's body avoids unnecessary menstrual cycles when she is pregnant: the fetus puts estrogen into her blood, thereby inhibiting FSH. So in a way, using much lower levels of estrogen, the pill simulates pregnancy, and some of the pill's side effects are like those of early pregnancy. If ovulation occurs, it is because you have been given too low a dose of estrogen in your pill to inhibit your own FSH level.

Synthetic progesterone is used differently by the two major kinds of pill. With the **sequential** pill, you take pure estrogen for 15-16 days, then a combination of estrogen and progesterone for 5 days. This schedule is more like that of your regular menstrual hormones, but is less effective in preventing pregnancy because all it does is inhibit ovulation. The **combination** pill combines estrogen and progesterone for the whole 20 or 21 days. The addition of progesterone every day provides two back-up effects: increased thickness of cervical mucous makes a barrier to sperm, and improper development of the uterine lining makes implantation impossible should ovulation occur.

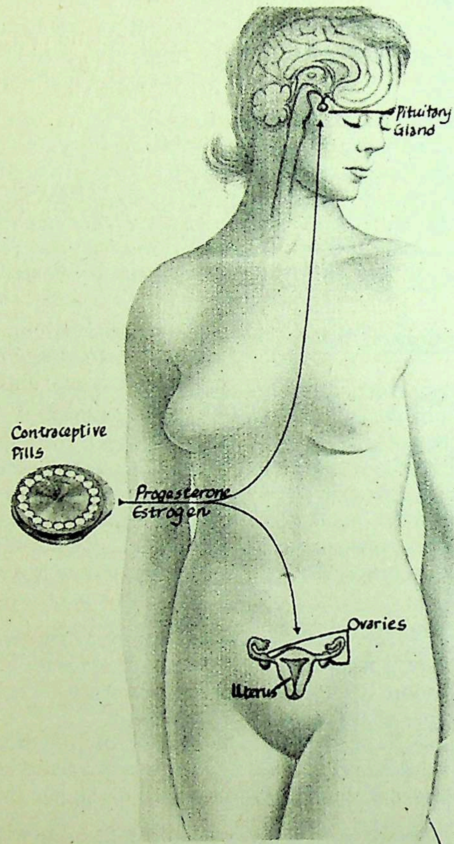
For purposes of birth control, then, **combination pills are best**. Combination pills are better also as regards safety and side effects: they generally need to use less estrogen, and the estrogen they do use is consistently counterbalanced by progesterone. (Estrogen has been linked to most of the major and many of the minor side effects of the pill.)

Combination Pills

Description. Small pills which are taken for 20 or 21 days each month. Synthetic estrogen and progesterone are combined in each pill. You take one pill each day. During the days that you are not taking pills, your period usually comes. The **twenty-eighth day pill** is a combination pill for women who have trouble remembering an on-and-off pill regimen, and would do better taking a pill each day. 21 pills contain hormones, 7 are placebos. (e.g. Norinyl 1 FE has seven iron pills. There is some question as to whether iron is good to use, since the placebos have insufficient iron for women who need it, and women who don't need iron shouldn't be getting it.)

Effectiveness. The combined agent pills have a 0.5% pregnancy rate. Pregnancy can occur if you forget to take your pill for two or more days, if you try to juggle your pill schedule (a couple of days left off at the end of cycle is okay, but no more), if you don't use a back-up method of birth control for the first ten days of your first packet of pills, and occasionally when you switch brands of pill (if you switch to avoid side effects, use another method for ten days to be safe).

Simplicity. You must see a doctor to get the pills. Then you have to follow the 20, 21, or 28 day regimen, taking one pill each day. You should see a doctor every six months when you are on the pill.



Application. Unrelated to sexual act. Take one pill each day, at approximately the same time of day, with a meal or after a snack at bedtime to minimize the possible side effects of nausea. With most pills you start on the fifth day of your period (the day you start your period is day one of your menstrual cycle). **If you forget a pill**, take two pills the next day. If you forget two pills, take two the next day and two the next, then keep taking your pills but use another method of contraception for that cycle. If you forget three pills or more, withdrawal bleeding will probably begin, so act as though you are at the end of a cycle. Start a new cycle according to your pill's regimen, using another method of birth control as well, from the day you realized you forgot the pills through ten days of the next cycle.

Reversibility. If you want to become pregnant, stop the pill, after the cycle is completed. If you ovulated regularly before taking the pill, you will probably resume ovulation and become pregnant two to five months after stopping. In some women, the pill's progesterone oversuppresses the pituitary's production of L.H., and you won't ovulate. Ovulation can be made to start, if there are no additional problems, by use of Clomid. If that doesn't work, you may be given pergonal.

Safety. The FDA first approved the pill in 1960. The longest time the pill has been taken by U.S. women has been 12 years (in other countries, notably third world countries, the women have used it longer). Some doctors have women take it for 3-4 years at a time, with a stop of 3-4 months and another kind of contraception is used during that time. Other women take the pill for nine months or the length of an

actual pregnancy, and then stop for several months while using another kind of contraception. As related in the first part of the chapter, the Senate Hearings (January 1970) connected the pill with certain alleged health hazards: so far blood clotting is the only well-established hazard. Unfortunately, a few weeks after these disclosures, it was possible to predict that up to 100,000 women would be afflicted with unwanted pregnancies in the few months after the hearings. According to U.S. mortality statistics, 100,000 pregnancies would result in about 25 maternal deaths, whereas only about 3 women per 100,000 pill users would die of blood clotting. The issue of safety is clearly related to that of personal mental comfort. If you stop taking the pill, will you be absolutely faithful about using another form of birth control every time you have intercourse? Once women have had the freedom of the pill, it may become psychologically difficult for women to use chemical or mechanical methods. The failure rate is high with chemical and mechanical devices if they are not used regularly.

Infant sexual abnormalities do not seem to be pill-related, but not enough long-term studies have been done.

Advantages of the Pill.

1. Just about complete protection against unwanted pregnancy.
2. Regularity of menstrual cycle.
3. Lighter flow during periods (combination pill). This effect pleases most women, bothers some.
4. Fewer menstrual cramps or none at all.
5. Pill often brings a sense of well-being and a new enjoyment of sex because the fear of pregnancy is gone.
6. Relief of premenstrual tension.

Side Effects. In 1963, one out of five women had side effects. By now, the rate is probably lower because the hormone dosages have been reduced. If you get a bad side effect on one brand of pill, change to a different one.

1. Gastrointestinal disturbances: nausea, bloated feeling; usually goes away after two months; is less if pill is taken with a meal or just before bed; use antacid tablets to relieve.

2. Weight gain: androgenic or progestogen-dominant pills like Ortho Novum or Nove Lestrion can cause appetite increase and permanent weight gain due to build-up of protein in muscular tissue: if you want to gain weight, this is helpful. Estrogenic pills (Enovid, sequentials, Ovulen) can cause fluid retention due to increased sodium. This effect is temporary or cyclic. Watch your salt intake, ask the doctor for a diuretic drug to help stimulate urine production, or change your brand of pill.

3. Headaches and tension from fluid retention. Some women develop bad migraines and have to change or even stop pills.

4. Breakthrough bleeding or vaginal staining between periods: What happens here is that there isn't enough hormone (whether progesterone or estrogen) supporting the lining at a given point in the cycle, and a little of the lining sloughs off. This may also occur if you miss a pill, as a result of the hormone withdrawal. It usually happens a week or so after you start the first month of pills. Often it clears up by the second or third cycle. Some women stop breakthrough bleeding by taking two pills for several days and then returning to the regular dosage for the rest of the month. This works because the initial hormone level was lower than what you were used to and the uterine lining couldn't be supported on it. So you increase the hormone level and it stops. If it doesn't stop after a few months, you may need to switch pills to find ones that more closely correspond to your own hormone levels.

5. Breast changes: tenderness, enlargement and secretion. Breast soreness should last only a couple of cycles.

6. Rise in blood pressure in susceptible individuals.

7. Sexual desire may be affected, or you may begin to feel depressed.

8. Fatigue: May be due to calcium loss related to muscular activity. The effect of progesterone is to retain sodium and potassium and lose calcium. As estrogen magnifies the effects of progesterone, both hormones are responsible. Fatigue, as in early pregnancy, usually lasts only two or three months.

9. Vaginitis: Can occur with any brand of pills. Vaginitis is defined as a vaginal infection, and may be yeast, fungus or bacteria. The pills increase the sugar and water content in the vagina, so that all atmospheric yeasts or bacteria (or fungi) find the vagina excellent to grow in. It does not always occur,

but the point is that any of the pills could make the vagina more susceptible, particularly to monoliasis. The combination pills do this the most. If you get recurrent vaginitis, you may have to go off the pill.

Possible Serious Adverse Reactions. Call doctor immediately if you suspect one of these warning signs: leg pains, blurring vision.

1. Thrombophlebitis and pulmonary embolism, i.e. blood clotting.
2. Neuro-ocular lesions.

Contraindications (conditions which prohibit use of the pill). **This is for pills in general, rather than for combination vs. sequentials.** These contraindications make it absolutely necessary for you to see a doctor for a **careful** examination, pap smear, and taking of your medical history before you go on the pill.

Note: There are some 50 gynecological endocrinologists in the country, and over 25 of them are in New York or Boston. These are the few people studying the side effects and contraindications of the pill. More people are needed!

1. Diabetes: Some doctors feel that none of the pills can be given to people with diabetes or a history of diabetes in the family such that they might be incipient diabetics. This is because the progesterone in the pills tends to bind the body's insulin and keep it out of circulation, just what the diabetic doesn't need. Other doctors reason that since a pregnancy can be fatal to a diabetic, the risk of birth control pills is worth it. These doctors will give pills to a diabetic, and then keep close watch on her blood sugar count.

2. Cystic fibrosis: Definitely no pills.

3. Hepatitis or other liver diseases: These diseases indicate that the liver isn't functioning properly. As the liver metabolizes the sex steroids (progesterones and estrogens), a sick liver should be pill-less.

4. Migraines and epilepsy: Both are aggravated by sodium storage in the cells of the brain. Sodium storage leads to water retention. This effect occurs especially with the estrogenic pills, which are responsible for more water and salt retention than the androgenic ones.

5. Any disease associated with poor circulation, blood clotting, and heart disease or heart defect, such as bad varicose veins in you or members of your immediate family. The estrogen in the pill, like the estrogen in the body during pregnancy, is suspected of causing blood clots (thromboembolism) and bad varicose veins in women with a tendency to poor circulation. Sequential pills, with often a higher estrogen level and always several days of pure estrogen unopposed by a progestogen, seem to aggravate circulation difficulties more than combination pills do.

6. Undiagnosed abnormal genital bleeding.

7. History of cancer: This and blood clotting problems have been most highlighted in material written about the pills. Not enough long-term studies have been done on cancer and the pill. The estrogen component may help existing cancer to grow, but does not appear to induce new cancer. As no one is sure of what is going on, a family history of ovarian or breast cancer is contraindicative. Under the microscope, the cells of a woman on pills have lesions (breaks) resembling cancerous cells, but the same happens in pregnancy and then returns to normal. This is to say that it is something to think about seriously. It is also a major reason for seeing a doctor every six months when you are on pills.

8. When nursing: You should not take the pill when nursing. Your milk will probably dry up if the pill is administered right after giving birth. The reason for this is that pills inhibit LTH, the pituitary hormone responsible for progesterone secretion, and a nursing mother needs a certain level of progesterone in order to produce milk. N.B.: Check on this. Two major source books on the pill say the new low dosage pills won't affect a mother's milk if she starts pills six weeks after delivery. (Kistner's The Pill; Peel and Potts' Textbook of Contraceptive Practice)

Cost. Visit to the doctor, plus $1.50 to $2.50 for a **month's** supply of pills. About $16-33 **plus** MD's visits per year. One thing to remember is that you pay for the prettier package that is marked with days on which to take pills. If you don't have trouble remembering, get the cheaper brand. Until there is a medical revolution, there won't be clearly marked, cheap drugs. This is something we must fight for. There are over 52 different kinds of pills, but only some 40 different compounds. 80% of these compounds are made by the Syntex Corp. (Maidenhead, England and Palo Alto, California).

Sequential Pills

Description. Same as combination pills: small, must be taken at a certain time each day for 20 or 21 days each month. The sequential pills do **not** have a threefold effect. They **only stop ovulation without providing any backup effects.** The ovulation process is inhibited by the high estrogen content which inhibits FSH. Since the progesterone is given later in the cycle, the cervical mucus stays thin and the uterine lining is suitable for implantation at the time ovulation would normally occur. If the level of estrogen is too low to inhibit ovulation (remember that the estrogen and progesterone levels vary among women), there is **no protection** against an unwanted pregnancy. Therefore, one must be **especially careful** not to miss a pill on the sequential regime. Sequentials are, in summary, good for hormone deficiency (estrogen therapy), but not for birth control. Estrogen and progesterone are given **in sequence**: estrogen for 15-16 days and progesterone and estrogen combined for five days.

Effectiveness. Sequentials have a pregnancy rate of 1.5% if no pills are missed. If you are on sequentials, ask the doctor why, and see if you can switch.

Simplicity. Same as combination pills.

Application time. Same as combination pills, except that there is not as much leeway for missing pills or even taking them at different times of the day.

Reversibility. Same as combination pills, but remember that there is even more estrogen in the sequentials than in the combination pills. (See discussion of effect of estrogen on FSH.)

Safety. More cases of thromoembolism have been reported by women on sequentials. (See discussion under contraindications for combination pills.)

Side Effects. See discussion under combination pills. Sequentials emphasize estrogenic effects like nausea, bloating, breast tenderness, hypertension, headaches, heavy periods.

Contraindications. See discussion under combination pills.

Cost. See discussion under combination pills.

Brands of Pills (General)

If you choose to take the birth control pill, how do you determine which pill to take? We should be aware that different pills have different kinds, quantities and strengths of estrogen and progesterone in them. (See Kistner's The Pill for full discussion.) Certain progestogens like Norethindrone produce androgenic (male) effects like hairiness, acne, scanty periods, permanent weight gain. Pills with a less anti-estrogenic progesterone, and pills with more estrogen, have been reported to increase "female" characteristics like bloating, breast swelling, heavier periods. Insist that your doctor discuss with you the composition of the particular brand he is prescribing. Also, see the following partial rundown on the various brands, their contents, dosages, and the specific side effects. The British Committee on Safety of Drugs now advises that only products containing 0.05 mg. or less of estrogen (like Ortho Novum '50) be prescribed because reports of suspected adverse reactions indicate that there is a higher incidence of thromboembolic disorder (blood clotting) with products containing 0.075 mg. or more estrogen than with products containing a smaller dose.

(Brands of Combination Pills (partial listing)

Enovid, Enovid-E. Both contain excessive amounts of progesterone and estrogen. Neither should be used

Norinyl, Ortho-Novum. These pills are the same. They contain one mg. norethindrone and .05 mg. mestranol. As they are extremely anti-estrogenic, they should not be given to women with much body hair, unless those women like more hair. They produce lighter periods because they favor a thin endometrium, not very suitable for an egg to implant upon.

Norlestrin. Norlestrin I contains one mg. norethindrone acetate and 0.05 mg. ethinyl estradiol. Made by Parke Davis & Co., Detroit. The pregnancy rate is about 0.5%. Norlestrin is androgenic.

Provest. Provest contains 10 mg. medroxy-progesterone acetate and 0.5 mg. ethinyl estradiol. It is made

by Upjohn Co., Kalamazoo, Mich., has a pregnancy rate of 0.5%, and is estrogenic in effect, rather than androgenic. Derived from 19-nor testosterone.

Ovulen. Ovulen contains one mg. ethynodrel diacetate and 0.1 mg. mestranol, and is made by G. E. Searle & Co., Chicago. It has a pregnancy rate of 0.5% and is estrogenic in effect. Derived from progesterone.

Demulen. Produced by Searle. Demulen 1 contains one mg. ethynodrel diacetate and 0.05 mg. ethinyl estradiol. Demulen .5 contains 0.5 mg. ethynodrel diacetate and 0.05 mg. ethinyl estradiol. Demulen has not been sufficiently studied.

Ovral. Contains 0.5 mg. norgestrel-D and 0.05 ethinyl estradiol. Best for people with low glucose tolerance. May find excessive breast growth.

Brands of Sequential Pills

Except for estrogen deficiency therapy, you should not be using these pills.

C-Quens. Eli Lilly has stopped producing them. If you have a prescription for them, get it changed.

Oracon. Made by Mead Johnson, Evansville, Ill.; the first 16 tablets contain no progestogen, but 0.1 mg. ethinyl estradiol (an estrogen) each. The last five contain 25 mg. (very high hormone level) dimethisterone (a progestogen) each, and 0.1 mg. ethinyl estradiol. The effect of Oracon is midway between an estrogenic and androgenic pill, and it has a 5% pregnancy rate. Higher breakthrough bleeding is found on these than on other pills, and there are problems of fluid storage and depression (emotional).

Ortho-Novum SQ. Made by Ortho Pharmaceutical Corp., Raritan, N.J. This sequential regimen is androgenic rather than estrogenic, and so the pregnancy rate is less than 5%.

Notes on Pills

The progesterone from which some of the pills are derived comes from Mexican yams (interesting sidelight). Most important, the key to the pills is their biological activity (the compounds they contain), not the dosage of each one.

List of Suggested Pills

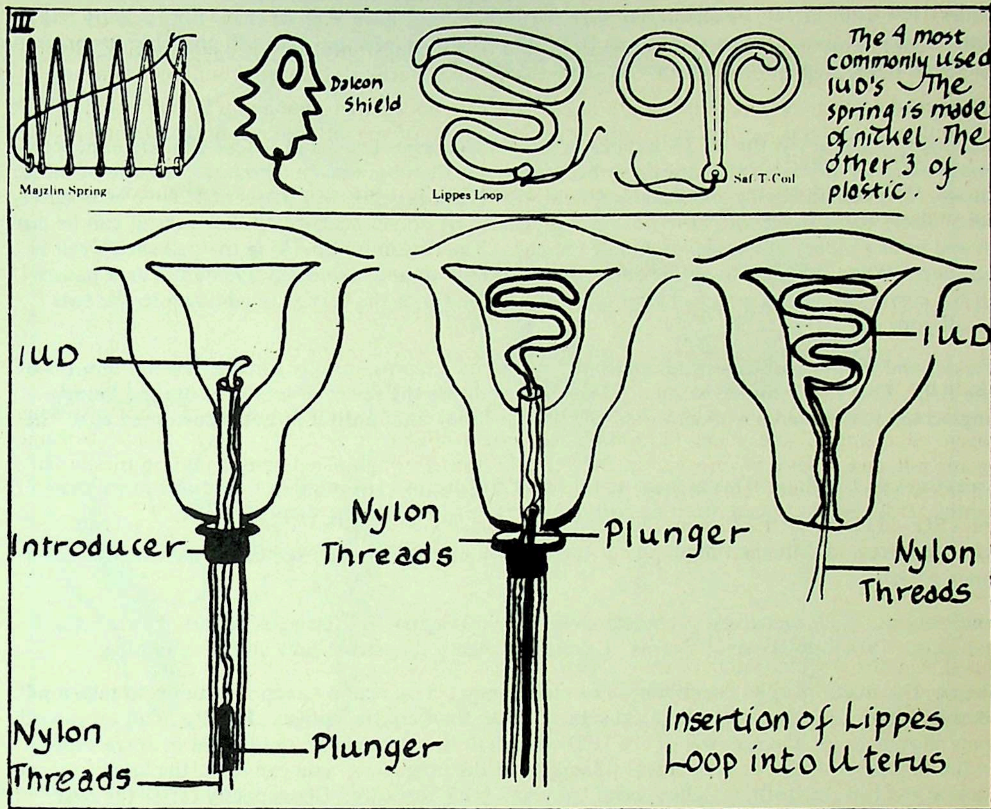
For women with low glucose tolerance and women in general: **Ovral, Norlestrin 1, Demulen 1, Norlestrin 2.5, Demulen .5.** For women in general: The ones above and **Norinyl 1** and **Ortho-Novrim 1.50.**

V. IUD or Intrauterine Device ("coil", "loop")

Description. Gold, stainless steel or, most commonly, radiopaque memory plastic devices in different shapes and sizes. They are placed semi-permanently inside the uterus. One or two strings extend into the upper vagina so you can check weekly that the device is still in place. Once the IUD is inserted by a doctor, nothing needs to be done other than weekly checking, unless there are problems or you want to get pregnant.

How It Works. The IUD is a mechanical foreign body inside the uterus which acts as an irritant to it. Doctors think (rather than know) that irritation of the uterus causes tubal hyperperistalsis (very rapid peristalsis of the oviducts), so that an egg reaches the uterus before maturing, or before a proper secretory lining is ready for it. Another possibility is that the IUD might change the nature of the uterine lining so that it cannot support an egg. But a recent study was not able to prove that such changes in the uterine lining could prevent conception.[6] Other studies are being done to determine if the presence of the IUD causes hormonal changes which cause the suppression of ovulation.[7] In a fairly recent theory the uterine wall responds to the foreign body by sending out macrophages, huge white blood cells which try to get rid of the IUD and, failing that, instead devour egg or sperm or both. Some people find it a little unsettling that no one knows exactly how the IUD works. Others, uneasy with the pill's more generaized effects and the pregnancy rates of other methods, don't mind the IUD. At least the effects of the IUD are local—if something goes wrong, your uterus hurts and you seek medical help.

Effectiveness. Second only to the pill. With Safe-T-Coil, Lippes Loop, Dalkon Shield, Mazlin Spring, pregnancy rate is about 2%. (Drug company representatives tend to give lower failure rate for their de-



vice.) With Hall Inhiband, an older design, rate is 3-5% (get yours changed). Some women use foam with the IUD, all the time if they feel particularly fertile, or for 7-10 days at mid-cycle (see Rhythm).

Application. Needs to be inserted by a competent doctor. Perforation of the uterus, occurring in 1 out of 2000 women, has been found by the AMA to be primarily the result of faulty insertion by the doctor. The process can be somewhat painful because the uterus is stretched a bit by the device. You may have cramps during insertion and for the rest of the day. Take aspirin, a Darvon or Miltown beforehand, or try shallow panting to keep your mind off it. Does not take long, anyhow–just about five minutes. The doctor does a "souding" of the uterus to check the size and shape. The IUD can be put in a tipped uterus. If the uterus is small, as it is if you have had no pregnancies, you'll get a small IUD. (If it is too small you won't be able to have one at all.) Just before insertion, the Safe-T-Coil and Lippes Loop are straightened out in a plastic tube like a straw; remember, the diameter of the cervical opening is the size of a thin straw. The doctor gently (we hope) puts the tube into the vagina and up into the uterus through the cervix. When in place, the IUD is released (except that it's your uterus [not your vagina], it is similar to putting a tampon in place; there's a plunger) and it springs into shape within the uterus. The Dalkon Shield comes at the end of an applicator. No plunger is used: the applicator is twisted and pulled out, the shield remaining in place.

Application Time. After childbirth or during menstruation. Insertion during menstruation is preferred because (1) it is a little easier at that time; (2) insertion can make you bleed; and (3) most important, doctors and clinics want to be sure you aren't pregnant, as an IUD insertion can cause a miscarriage. IUD can remain in place for years, although it should be checked every six months by a doctor.

Reversibility. A doctor must remove it. Chances of becoming pregnant are the same as before using the coil.

Safety. Doctors maintain sterile technique when inserting the IUD so that danger of infection is kept at a minimum. For your safety, be absolutely sure that you do not have V.D. or (have not recently had) pelvic inflammatory disease when you get an IUD. If you are so infected, you will probably become one of the 2-4% of IUD-using women who suffer from P.I.D.

Side Effects.

1. The major drawback is the 8-12% expulsion rate. The Lippes Loop and Safe-T-Coil are expelled much more often by women who have never been pregnant than by women who have had one or more pregnancies. The Mazlin Spring and Dalkon Shield, which are expelled less frequently, have been developed particularly for women who have not been pregnant. If you expel the coil, however, it can be put in again and your chances of expulsion do **not** increase. The reason for checking the coil each week is pertinent here. When it begins to be expelled, it straightens out and cannot always be felt as it passes through the cervix. Hence, if you feel a bit of plastic at the tip of the cervix, in addition to the two strings, call your doctor!

2. Heavier and more irregular periods and more menstrual cramps, usually for the first 3-6 months of using the IUD. This varies among women. Heavier periods are the result of a thicker uterine lining, cramping occurs as the uterus works to shed the thicker lining and, until it grows accustomed to it, the IUD.

3. Breakthrough bleeding. This is from irritation of the uterus. It should not continue more than a few months. If it persists, it can often be corrected by use of a different shape of IUD.

4. Back pain is an occasional side effect. If it persists it can often be corrected by the use of a different shape of IUD.

Contraindications. Endometriosis. Venereal Disease. Any vaginal or uterine infection. Pelvic inflammatory disease. Prohibitively small uterus. Excessively heavy menstrual flow and/or cramping.

Advantages. For many people, psychologically very freeing. You needn't even remember to take a pill. Also good for those who object to chemical substances in their contraceptives. Finally, if an unwanted pregnancy should ensue, the removal of the IUD will result in a miscarriage in two out of three times if done in the first eight weeks of pregnancy. If you want the pregnancy, you can carry the baby to term safely and at the time of birth, expelling both baby and IUD normally. Occasionally (after the first eight weeks), a doctor can remove the IUD without damaging the foetus. You can use tampax with the IUD. Man's penis **cannot** feel IUD or properly trimmed string.

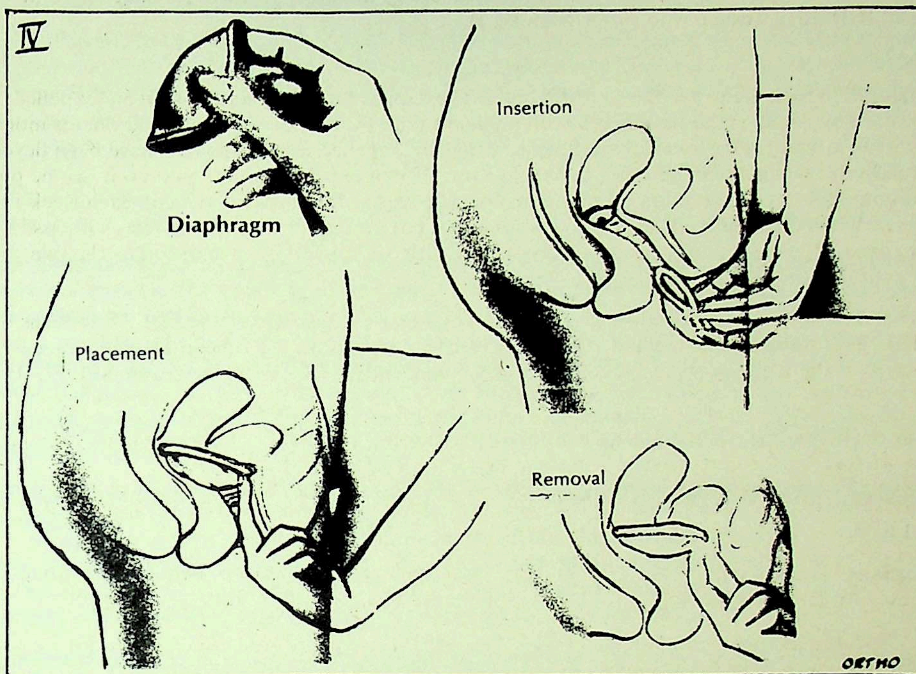
Responsibility. Woman or man must check strings of IUD once a week, feeling tip of cervix to make sure there's no plastic protruding. Be careful not to pull the strings.

Cost. Expensive initially, but nothing afterwards except a doctor visit once every six months. Initially, $35-50 in Boston, $50-100 in New York. Some private doctors in Boston are cheaper than $35. Many clinics are as low as $10, some places free.

VI. Diaphragm

Description. A diaphragm is made of soft rubber in the shape of a shallow cup, with a flexible metal spring forming a circular outer edge. It comes in a variety of sizes measured in millimeters (mm); the range is from 50 to 105 mm. or 2-4 inches. Approximately one teaspoon (¾ inches of cream as it comes out of the tube) or one plunger full of cream or jelly (gel) is put in the shallow cup, around the rim and on the outside as well. Then the cup is pressed together and inserted into the upper third of the vagina over the cervix so that it fits snugly behind the pubic symphysis. For extra protection, insert a little extra cream or jelly after the diaphragm is in place. When it fits properly, you should not be able to feel it, nor should your partner in intercourse, except occasionally. The diaphragm is a mechanical device, although the only protection is the chemical one from the cream or jelly. The diaphragm holds the cream in place and against the cervix.

Effectiveness. From 95-98% effective depending on (1) effectiveness of cream or jelly (some are much stronger spermicidal agents than others) and (2) proper fit and proper care. The diaphragm can move somewhat during intercourse, as the vagina expands. Do not use vasoline on it. This corrodes the rubber. Check it for holes. Wash it carefully after use, blot dry and dust with talc. Do not boil.



Simplicity. You need a medical exam to be fitted and a prescription to buy it. It isn't hard to learn how to use it and one should be positive about handling oneself. It should be put in place one to three hours before intercourse, as one's own body chemicals can destroy the spermicidal effect of the birth control jellies and creams. (The shorter the time, the safer you are.) It should not be removed until at least six hours after intercourse, and can be left in for 24 hours or more. You need to add another teaspoonful of cream with an applicator for each additional intercourse. Application can be made by the man as well as by the woman, or by both of you. Integrate it into your lovemaking.

Advantages. A good method if you have infrequent intercourse. And no side effects! Very effective if you use it right.

Disadvantages. Closely related to sexual act. You must remember to use it every time, be sure not to run out of spermicidal cream or jelly, be sure to have it with you when you need it.

Reversibility. Don't use it if you want to become pregnant.

Comfort. Diaphragm is helpful if you want to have intercourse during your period. It can hold at least 12 hours of menstrual discharge. Discharge of cream or jelly can be a nuisance; try different brands. There is less leakage with foam. Can use a tampon or pad for leakage after intercourse.

Responsibility. Woman is responsible. Even if the man puts it in place, the woman must go to the doctor, be sure it fits right, etc. A woman who always does the whole thing herself (off in the bathroom) can end up resneting the burden and/or pregnant (doesn't bother to put it in).

Cost. Diaphragm costs about $4.50. Medical exam is about $15 at a private office, less at the clinics. Jelly, cream, foam vary in price. 2½ oz. tube has about 12 doses. Total is about $56 yearly.

Life of Product. It should be examined every year for size fitting. It may last a couple of years with proper care; check regularly for holes, tears, etc. (Hold up to bright light or fill with water.) You will

need a new size after a pregnancy, or after gaining or losing 15 pounds.

Popularity. In Guttmacher's book, it is stated that just under 25% of all married couples of childbearing age use it. No statistics about unmarried couples, nor breakdown according to class, race, etc.

Brand Names of Jellies and Creams. In choosing one brand over another, you have to consider factors of: (1) effectiveness of the brand as a spermicidal agent; (2) smell and taste of product (oral-genital play); (3) any allergic reactions on part of man or woman. If you don't like what you are using, change. Feel free to try different creams, jellies, etc., as long as you remember the various pregnancy rates. Preceptin and Koromex are good to use. Other names can be gotten from the Consumer Union Report (available in paperback).

VII. Cervical Caps (no longer made)

This product hasn't been used much since 1950, when diaphragms were generally substituted. It is like a diaphragm only smaller, made to fit securely over your cervix, where it mechanically blocks sperm. It is convenient because it can be left on for days or weeks, must be removed only during menstruation. Spermicidal foam, cream or jelly can be inserted at time of intercourse for additional protection. Unless the woman puts it in every time she has intercourse, there is no chemical protection on the inside of the cap, as spermicides are good for three hours at most. For this reason, and because the cap is harder to put on than a diaphragm, and because it can slip off during intercourse, the cervical cap is not as effective as the diaphragm.

VIII. Condom (rubber or prophylactic or safe)

Description. Thin, strong rubber (or lamb intestinal) membrane shaped like the finger of a glove. Open end (1 3/8 in. diameter) is rubber ring; closed end is plain, or may have a pocket nipple of teat (less likely to burst upon ejaculation). Length is about 7½ in. The lamb membrane condoms are called "skin" condoms – more expensive, but cut down less on sensation.

How to Use. Put on erect penis just before intercourse, not just before ejaculation – the first few drops of the male discharge just prior to ejaculation often contain enough sperm for pregnancy to occur. Remove after intercourse.

Effectiveness. As a mechanical barrier: 5-6% pregnancy rate. Combined with chemical if woman uses foam or cream or jelly: less than 5% pregnancy rate. Foam and condoms are the best method for people before they get to a doctor, if pills are forgotten, if IUD comes out, etc.

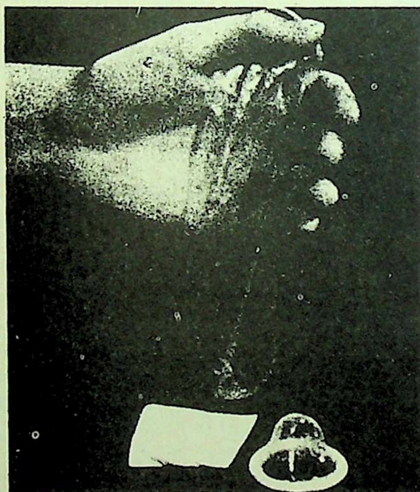
Cautions.

1. ½ in. of space left between penis and condom on plain-ended condoms to collect ejaculate and prevent bursting;

2. Use lubricant to prevent tearing (spermicidal foam, cream or jelly, saliva, of K-Y Jelly);

3. Man must hold rin when he withdraws so condom won't slip off and sperm won't enter vagina.

4. If accident, cream or jelly should be used as quickly as possible. The 1958 FDA findings show that 1 in 350 condoms is defective. Get brand name condoms, not bargain-types. Brand name condoms are checked by the government. Watch out for pre-lubricated condoms–lubrication can get on the inside and they can slip off.



▽ The Condom: Lower left- in store package. Lower right- rolled and ready for use. Top- Unrolled, after use.

Simplicity. Very simple to use; purchase over

counter: no M.D. exam.

Disadvantages. Has to be put in place just before intercourse: may be interference, though can be integrated into sex play and put on man by woman. Can irritate woman, especially during entrance of penis into vagina, if not sufficiently lubricated (either with woman's vaginal juices, or saliva, K-Y Jelly, or, best of all, contraceptive foam, cream or jelly). Many men find that condoms cut down on their sensation.

Reversibility. No problem: don't use if you want to get pregnant.

VD. Only contraceptive that helps prevent VD spread from penis to vagina contact. Also protects partners from infecting and reinfecting each other with an infection like trichomonas.

Responsibility. Man. Male contraceptive, so doesn't interfere with woman's body processes. Man must be willing to use it. If on long-term relationship with man, may alternate this method with others that woman is responsible for.

Cost. Three for $1.00 just as effective as more expensive ones; difference is that the latter ones are thinner and allow for greater sensitivity. $18-60 yearly ($0.35-$1.25 each).

Life of Product. Shelf life of two years. Some can be re-used five to six times if properly cared for (put in bedside tumbler of water, wash, powder and reroll).

Popularity. Used by one out of four couples who practice birth control. Statistics on unmarried couples not available.

IX. Effective Spermicidal Agents

A. Aerosol vaginal foam (the most effective)

Description. Comes in aerosol can with plunger-type applicator. Be sure to get the applicator kit the first time. Foam mechanically blocks entrance to cervix, and chemically kills sperm.

Application. No more than fifteen minutes before intercourse. Shake the can very well (twenty-five times). Put applicator on top. When applicator is tilted (Delfen) or pushed down (Emko), the pressure triggers the release valve and a column of white aerated cream is forced into syringe, forcing plunger out. Insert applicator 3-4 inches into your vagina and push plunger in. Do this lying down, if possible. Use two applicators full.

Effectiveness. Less effective than creams and jellies when they are used with diaphragm; when used alone, it is more effective than the creams or jellies used alone. The reason is the different physical properties. Creams and jellies have a tendency to remain as a lump of material after insertion and are distributed by penis during intercourse. Foam disperses evenly throughout the vagina even before intercourse. Thus, the cervix is more consistently blocked by chemical substances with foam than with creams of jellies alone.

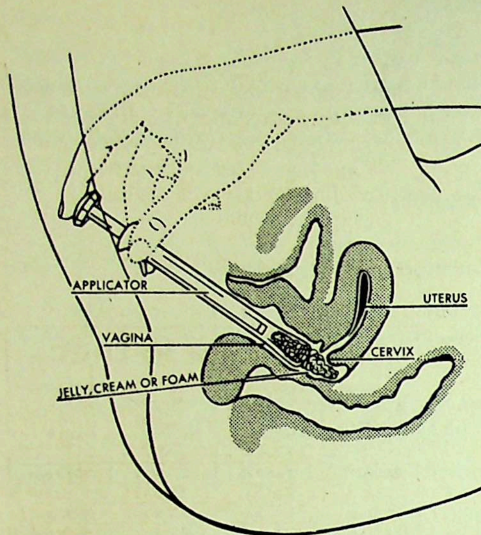
Comfort. More comfortable than creams or jellies because no (or less) leakage; disappears within a few hours after intercourse with no residue. Use tampax if you feel drippy. There is a problem if you get to the end of a bottle and are without additional supply of foam; there is no indication that you're at the end, unless you see the gas without the foam! Keep an extra can on hand. Delfer slows up. Emko—a spring on the cap tells you.

Responsibility. Woman.

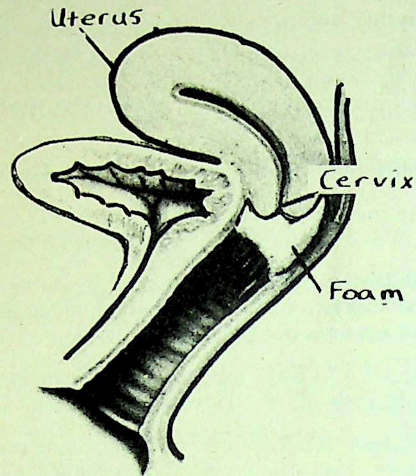
Cost. 1 oz. bottle (25 applications) is about $3.00; also comes in 2 and 4 oz. sizes which are cheaper per ounce. It is less expensive than creams or jellies (compare number of applications).

Popularity. Growing.

Brands. Emko Foam, which is more widely known, is reputed to have a 20% pregnancy rate and is therefore not an effective contraceptive. Delfen Foam – no accurate effectiveness rate, but is considered to be around 90% effective.



Application of spermicidal preparation



Contraceptive action of foam

B. Jellies and Creams for Use Alone (without a diaphragm)

Description. Tube which comes with transparent plastic applicator (plunger). Applicator, for which you must pay more, is easily washed with soap and water. Fill applicator (usually screws onto tube) with 2 doses within an hour before, but preferably closer to, intercourse and insert it 3-4 inches into vagina and release plunger; put in another dose for additional intercourse. Action is chemical; spermicidal agents immobilize the sperm cells and also, when in the vagina, form a film or coating over the cervix, which hinders the sperm from entering.

Effectiveness. Less effective alone than when used in combination with diaphragm, because the mechanical effect of the diaphragm is to keep the cream where it belongs—over the cervix, rather than spread throughout the vagina. If you must use cream or jelly alone, get your partner to use a condom.

Simplicity. No medical exam involved and sold over the counter in drugstores and, in some states, in markets; usually with no questions asked.

Application Time. Needs to be put in place just prior to each and every intercourse. Can be a drag if you do it alone, can be fun if you do it together.

Reversibility. Just don't use it if you want to get pregnant.

Responsibility. As seems to be mostly the case, the woman! Get your partner to help put it in.

Comfort. Problems of leakage, allergy or reaction to smell or taste of product. If your vagina is sensitive to one brand, try another. Jelly is gooier than cream. Use tampax if you feel drippy.

Cost. 2½ oz. tube (12 applications) costs about $3.00.

List of Brands. See Consumers Union Report. Preceptin, Koromex A are good.

C. Jellies and Creams for Use with Diaphragm

Description. Everything more or less the same as under part B; also, see description of how to use diaphragm. These tend to be less effective than the ones to be used alone.

X. Birth Control Methods that Don't Work Very Well

A. Rhythm Method (safe period)

This is the only birth control method approved by the Catholic Church. We mention it in such detail because some Catholic couples are trying to use rhythm without the assistance of a doctor or clinic, and because too many teenagers and college students, unable to get good contraceptive advice and care, try to avoid pregnancy by timing their intercourse according to some vague idea that there is a "dangerous" time around mid-cycle. **You can get pregnant at any time during your cycle**, because in any cycle you might ovulate early or late.

Description. No product involved. Method based on fact that woman usually releases only one egg each menstrual cycle. Egg has active life of 12 hours; sperm about 4-5 days. Therefore, 5-6 days each month that intercourse could lead to pregnancy: 4-5 days before ovulation (egg release) and half day after. Normal woman ovulates 12-16 days before next menstrual period. Formula as follows:

1. Keep written record of your menstrual cycle for 12 consecutive months. Count 1st day of menstruation as day 1 of cycle, and day before next period as last day of cycle. At end of 12 months, figure number of days in shortest and longest cycles.

2. Subtract 18 from shortest cycle's number and this determines first fertile or unsafe day.

3. Subtract 11 from number of days of longest cycle; determines last fertile day or day on which unsafe period ends.

4. Each month, bring list of 12 cycles up to date by adding cycle just counted to bottom of list and crossing off oldest cycle on top.

THE RHYTHM METHOD

HOW TO FIGURE THE "SAFE" AND "UNSAFE" DAYS

LENGTH OF SHORTEST PERIOD	FIRST UNSAFE DAY AFTER START OF ANY PERIOD	LENGTH OF LONGEST PERIOD	LAST UNSAFE DAY AFTER START OF ANY PERIOD
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

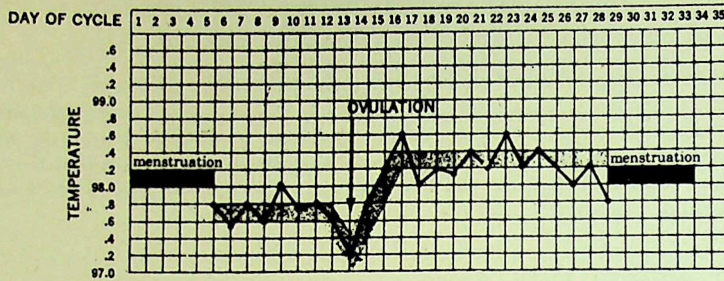
Time-Life

A daily record of basal body temperature (measured on a special thermometer, which only registers a few degrees, from 96-100° in 1/10 degree gradations which are wide apart and easily read) is used in combination with the chart of cycles. The basis of this is that whatever a woman's so-called normal temperature may be, there are characteristic (though slight) daily variations within each month caused by ovulation. The cycle runs like this: After each menstrual period, temperature on awakening low. It may be still lower on the day associated with ovulation, which is assumed to occur just before or just after lowest morning temperature reading. After ovulation, because of action of newly formed hormones, progesterones, termperature rises several tenths of a degree and remains up until a day or two before menstruation begins. If pregnancy occurs, temperature remains consistently high for several months since progesterone continues to be formed. Suspect pregnancy if BBT (basal body temperature) is high for more than 18 days.

Effectiveness. Depends on regularity of menstrual cycles. If variance of more than 10 days between longest and shortest cycles, not effective because safe period is too brief (true for about 15% of women Requires a lot of self-control and cooperation between partners. About a 20% pregnancy rate; lower if diligently use thermometer and calendar and always abstain if chance of ovulation. Not good after pregnancy; need several months to recalculate safe period.

Simplicity. Complicated to keep chart of menstrual cycles if irregular and to always interpret slight variations in BBT with accuracy (fever-producing illness or tension leads to rise in temperature, as well as onset of ovulation).

Application Time. No devices, but have to have figures for menstrual cycle for one year prior to be protected at time of intercourse.



Reversibility. Calculations help tell you period of ovulation, and guide for days for intercourse if you want to get pregnant.

Comfort. Psychological comfort is lousy; calculating safe period cuts down on spontaneity and problem increases, since guilt may be felt if one partner wants to have intercourse during safe period.

Responsibility. Need cooperation from both if to work most effectively. Problems: if relationship is not long-term; if couple are not "practicing" Catholics.

Cost. $0.03 per chart; BBT $2.50-$4.00; M.D. visits if there is variation in cycles and one needs advice.

B. Douche

Some women try to flush out their vagina with water or other special solution **immediately** after intercourse--an effort to remove semen before it enters the uterus. **If** douche works, it keeps sperm level below number needed to **assure** fertilization. (Remember only one sperm is needed, but the trip is complicated so many sperm are needed to support odds.)

But douching does not often work: sperm swim fast, and some will reach your uterus before you've reached the bathroom; and the douche, which is liquid squirted into your vagina under pressure, will push some sperm up into your uterus even as it is washing others away.

Douching is the least effective of all methods, and puts exclusive burden on the woman, who must hop up to the bathroom immediately. **Don't use it!**

C. Vaginal Tablets

Description. Tablets are 2-3 times the weight of aspirin. They are round or arrowhead in shape and come packaged in tinfoil or in wax-sealed glass vials. One tablet is inserted as far as possible into the vagina before each intercourse. The tablet needs time to dissolve -- 15 minutes to one hour. It may need to be moistened with saliva or a drop of water before insertion if the vagina is dry. While the spermicide is incorporated into a cream or jelly base with foams or jellies, in the tablet it dissolves on contact with moisture and delivers spermicide into upper vagina. The foaming kind of tablet also forms film over cervix. Although they are one of the less effective methods, some physicians think that they are one of the most widely used because they advertise. The ads are usually placed in publications which are more frequently bought by the poor and promise a solution to "your most intimate marital problems." The women who read these ads can be sure of two things: that the product is to be inserted into the vagina and that it will take care of "some problem." The product is not sold with the information that these suppositories are to be inserted before coitus or even that they are a contraceptive device. Since pregnancy is one of the biggest "intimate problems" some of these readers have, they buy the suppository and take a chance. The very same suppositories can be bought with a prescription and are a much more effective birth control method because instructions are included which say to insert one before each intercourse to prevent pregnancy. Birth control laws in some states do not allow advertising contraceptive devices. Thus a large segment of the population which could more effectively use this product is kept in the dark as to how to use it most effectively.

Effectiveness. Less protective than creams or jellies and far less than foams because less sure that it will dissolve rapidly and be distributed evenly. **It is not a reliable** method.

Simplicity. Probably the simplest of all current medical contraceptives. No exam or equipment is needed. But you can also get pregnant pretty easily using them.

D. Vaginal suppositories

Description. Instead of being packaged as a tablet, spermicide is incorporated into a base of glycero-gelatin, cocoa butter or soap. In this base, they melt at a little below body termperature. All the rest of the information is just the same as for the tablets. It is interesting that suppositories have been advertised as "feminine hygiene" preparations. Norforms or other "hygienic" preparations **do not** serve as efficient contraceptives.

E. Withdrawal (coitus interruptus or "taking care")

This folk method is practiced without medical initiative and passed on from one generation to another.

Description. Withdrawal of penis far away from vagina just before ejaculation, so that semen is deposited outside vagina and away from lips of vagina as well. No equipment or preparation needed.

Effectiveness. Not highly effective, because fluid released **before** ejaculation may contain sperm as well. But withdrawal is better than nothing!

Simplicity, Application, Comfort. Simple in theory, but hard to apply because of need for discipline by man and split-second withdrawal. Therefore affects psychological aspects of sex—can't relax and lose consciousness. When used over long period, can lead to premature ejaculation by male. Can be hard on woman, also, if she doesn't reach orgasm before the man withdraws.

Reversibility. Don't withdraw to achieve pregnancy!

Responsibility. Man is responsible for withdrawal. He has to feel sure enough of himself so he doesn't feel threatened if sperm lands outside woman. Woman must trust man.

Popularity. World-wide, most used of all methods. 5% of couples in America. Used by a lot of U.S. couples who don't have access to good contraceptive care (teenagers, many college students, poor people).

XI. Post-coital Medication – "The Morning-After Pill"

Some college health services (Yale, for one) and some doctors will give you a series of high-dosage estrogen pills if you come in less than three days after unprotected intercourse in the middle of your menstrual cycle. A lot of estrogen at that point in your cycle will usually affect the uterine lining so as to make it impossible for a fertilized egg to implant. Check the birth control pills section for the side effects of estrogen, and you will see why this is not a method to be used often. The dosage used at Yale is 50 mg. of diethylstilbesterol (two 25 mg. tablets) to be taken together once a day for five days. You might want to get anti-nausea pills at the same time.

XII. When You Are All Done – Sterilization

Sterilization is a 100% effective, absolutely final form of birth control, available for men and for women. It is legal in all states, although many hospitals are conservative about it and require that the person be a certain age, with a certain number of children, etc., and that the person have the spouse's signed consent. (Other hospitals, notably in ghetto areas, tend to do too many and not entirely voluntary sterilizations. Black women in the south are all too familiar with the "Mississippi Appendectomy" in which their fallopian tubes were tied or their uterus removed without their knowing it.)

In the traditional sterilization operation for a woman, a fairly large abdominal incision is made, a piece of each fallopian tube is cut out and the two ends are tied off. A more recent development is the laparoscope technique, in which a tube with mirrors and lights is inserted through a small incision, the tubes visually located, and the tubes cauterized (burned) by a small instrument inserted through another insertion. The traditional tubal ligation is major surgery, unless entrance can be made through the vagina. It requires a 4-5 day hospital stay and is accordingly very expensive. The laparoscopic sterilization requires only a one day hospital stay and is being done on an out-patient basis (much cheaper, and less convalescing time). Sterilization does not affect hormone secretions, ovaries, uterus or vagina.

Sterilization for the man, called a vasectomy, can be done in a doctor's office. The doctor applies a local anaesthetic, locates the two vas deferns (tubes that carry sperm from testis to penis), removes a piece of each and ties the ends off. The man's genital system is basically unchanged: sperm are made, his sexual hormones stay operative, there is no noticeable difference in his ejaculate because sperm make up only a tiny part of the semen.

XIII. Future Methods of Birth Control

Male contraceptive research. At first a birth control pill was developed for men, but it drained a man's ability to have an erection as well as acting as an antidote to the potency of the sperm-producing cells. Now researchers are working on a sperm capacitation pill in Sweden and California. This will stop the sperm's ability to penetrate the egg. It may be available in two to three years. As yet, no compound has reached serious clinical trial because of, as the British Medical Bulletin states it, "apprehension regarding the risks involved from tampering chemically with the **male** germ cells."[8] (our emphasis)

Female contraceptive research involves some of the following: (1) Trying to put progesterone on IUDs. This would change cervical mucus and the uterine lining, thus making conception even less likely. (2) Work on a pure crystalloid which will let a small amount of its contents out into the body each day. The body will absorb an amount directly proportional to the surface area of the crystal (crystalloid), which is a long oval and is inserted under the skin. This will be available in about two years, and will be pure chlormadinone acetate (like the minipill). Now it must be replaced once every six to eight months. Hopefully the time can be reduced to once a year by the time it is released. The crystalloid would release 0.35 mgm. per day continuously into the circulation. You could check on the contraceptive protection from time to time by feeling for a little bump under the skin of your arm or thigh. The problem of the body reacting to the crystalloid as a foreign body may be solved by use of silastic, a silicone. (3) There is an injection almost ready for release. This is pure cma: latex crystals with cma attached. The latex isn't well handled by the body, so problems still exist. (4) Doctors can now tell when a woman will ovulate 12 hours before she does. This is done by measuring the sodium and calcium levels of the cervical mucus, using flame photometry and spectrophotometric radiometry.[9] (5) There is research going on in the use of prostaglandins, chemicals which are known to cause uterine contractions. Prostaglandins might be worked into a pill that could be taken once a month to bring on a period whether the woman is pregnant or not.

Some of this research is frightening and confusing. We don't want contraceptives to become one more area in which we are intimidated and frightened into doing things we're not sure of or don't want to do. Each of us has the right to choose a method that is best for us and to understand that method in terms of application, effectiveness, safety, etc. For we alone best know what our needs are.

FOOTNOTES

1. *Health-Pac Bulletin*, March 1970, p. 12. 2. Ibid. 3. Ibid. 4. Ibid. 5. Ibid., p. 11.
6. W. A. Kelley, *Journal of Reproduction and Fertility*, vol. 19, 1969, p. 338.
7. A. Pakraski and G. G. Ray, *Journal of Reproduction and Fertility*, vol. 19, 1969
8. *British Medical Bulletin*, vol. 26, 1970. 9. Conversation with Dr. Kosasky, 1969.

SUGGESTED BOOKS TO READ ABOUT BIRTH CONTROL

(All are paperbacks except Demarest and Sciarra.)

Demarest and Sciarra, *Conception, Birth and Contraception,* McGraw-Hill, Inc. (New York: 1969), $8.95

Kistner, Robert W., M.D., *The Pill,* Dell Publishing Co., Inc. (New York: 1969).

The McGill University Student Society Birth Control Handbook (available from New England Free Press or from McGill Student Society)

Neubardt, Selig, *Contraception,* Pocket Books (New York: 1968).

Peel and Potts, *Textbook of Contraceptive Practice,* Cambridge University Press (Cambridge: 1969).

Yale University Student Committee on Human Sexuality, *The Student Guide to Sex on Campus,* New American Library (New York: 1971).

Abortion

INTRODUCTION

Abortion is our right – our right as women to control our own bodies. The existence of any abortion laws (however "liberal") denies this right to all women. The abortion laws symbolize the oppression of women in America and the lies that support it: sex is beautiful; motherhood is the ultimate fulfillment of women; children are a full-time joy; and poor black, brown, white women have the same opportunities as rich white women.

We often become pregnant because we are forced to believe that we are only acceptable as sex objects and mothers. We are taught that sex is not quite right (even though we are taught to be sexy and flirt) so we're scared to ask those who may know where to get birth control and which birth control methods are most effective for help. For if we ask/get birth control, then we are admitting we are doing that bad thing – having sex. Or even when we do ask, we can't get birth control, especially the most effective means, legally if we are unmarried and certainly not as teenagers (in Massachusetts).* And even if we can get the most effective method as far as pregnancy prevention, it may not be the best method for individual ones of us (for example, we may have a family history of cancer and perhaps should not take the pill). Birth control is better than nothing, but there is no such thing as an ideal method (i.e. one which is safe, simple, cheap and effective) yet. Birth control does fail because the **methods** are imperfect, not because we are stupid. Nevertheless the blame falls on us.

The risks are indeed great. Although the risk of death for an abortion done under proper medical supervision during the first 12 weeks is less than for a full-term pregnancy, only 1% of American women can get legal abortions; some 1000-5000 die each year of illegal abortions – the most common cause of maternal death in this country. Sterility is another frequent result. The risks to our mental health are enormous too. Either we have to deal with the fear and trauma of getting a "criminal" abortion (even though we know in our heads that we should have the right to control our bodies, we live in a schizophrenic system that separates our minds from our bodies and tells us we shouldn't have that control) or the fear and trauma of having an unwanted child which we may have to raise by ourselves. We're freed from the rat race of the work world to face the "calm" of the home (40% of women have full time jobs as well as full responsibility for children).

If you're white and middle class you're still oppressed as a woman. Our **poor** white sisters are oppressed by class and sex and our **black and brown** sisters by race, class and sex. Some of us suffer more than others. 75% of women who die from abortions are non-white (most of those abortions are done illegally). 90% of all legal abortions are given to white, private patients. All of us want the choice only available to the rich now.

Most important, we want those abortions to be **voluntary** as well as free and safe; genocide of poor and black peoples to keep the most oppressed populations in check is a real fear when abortion laws are repealed. We don't know from our own experiences - since we're white and middle class - whether other women are forcibly made to abort or be sterilized. Whether or not it is true, it is a fear that should be faced. For this reason it's crucial that whenever we talk about abortion, we talk about the implications for **all** women. One woman cannot be liberated without the liberation of all women.

We must fight against those who keep us down: (1) the legislators who use their power to prevent repeal of all abortion laws (don't be fooled by "reforms" – there have been just as many illegal abortions in Colorado after the law as before); (2) the medical profession that uses the laws to maintain its power by defining the legality of each case and by making profits off the legal abortions they choose to do ($350 to $1000); and (3) the racketeers who profit from abortions ($150 to $1000) as they do from prostitution (again women), drugs, etc. We are demanding **free, safe and voluntary** abortions, for all women who want them, to be carried out in properly equipped hospitals or clinics by humane and qualified personnel.

HISTORY

One of the myths that anti-abortionists use to in-

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* There is an exception to this, which was placed in Roxbury (the implications being none too subtle). At the Boston City Hospital Family Planning Clinic in the Ob/Gyn outpatient department, women can get many methods of birth control, including pills, free, regardless of age and marital status. This program is financed by the federal government, but the people working there are fairly nice.

fluence legislators and to harass and scare the woman with an unwanted pregnancy is that abortion violates some age-old and god-given "natural law". One look at history shows that they are lying or terribly misled. Until one hundred years ago almost no one - not even the Catholic Church - punished abortion in the early stages of pregnancy. Lawrence Lader says that "the Greek city states and ancient Rome, the foundations of Western civilization, made abortion the basis of a well-ordered population policy." (Abortion, p. 76) Christianity infused the fetus with a soul, but during eighteen centuries of debate the Church went by the conveniently loose view that the fetus became "animated" by the rational soul and abortion was therefore a serious crime only at forty days after conception for a boy and eighty days for a girl. (No methods of sex determination were specified.) English common law by the thirteenth century settled into a fairly tolerant acceptance of abortion up until "quickening", the unspecific moment usually in the fifth month when the woman feels the fetus move. In the United States for a long time the common law inherited from England protected the right of abortion of early pregnancy.

Suddenly in the nineteenth century things ightened up. In 1869 Pope Pius eliminated the listinction between an animated and non-animated fetus, and since then the Catholic Church has called all abortion murder and punished it severely. Anti-abortion laws were first passed in England in 1803 and became stricter through the century. Connecticut in 1821 punished abortion of a fetus by poison after it had quickened, but as in other states a succession of laws followed which culminated around 1860 in outlawing all abortions except those "necessary to save the life of the woman."

There were three main reasons why abortion suddenly became a "crime". The first was quite decent: abortion until recently was a dangerous operation, methods crude, antiseptics scarce, even hospitals dirty. It was in part the mid-nineteenth century wave of humanitarianism which pressed for abortion laws to protect women. The second motive of the anti-abortionists was less laudable. As biologists in the nineteenth century began to understand conception, women began to practice more effective contraception. Catholic countries like France began "losing" the population race, and the Church wanted to keep its mothers running. So the Church itself turned to biology and used the idea that "life" and therefore soul-infused human life begins at fertilization. This reasoning also spread to England and the U.S. It so happened that English and American industries needed workers, the huge farmable territories of the new world needed farmers, and the Civil War had depleted America's labor crop. Abortion laws saw to it that woman took her place beside the other machines of a developing economy.

The third reason for the sudden emergence of anti-abortion laws is the most dangerous: it is the idea that sex for pleasure is bad, that pregnancy is a punishment for pleasure, and that fear of pregnancy will reinforce "degenerating" modern morals. These ideas had long fought for supremacy in the Catholic Church, and showed in 1869 that they had won. The English and American puritanism which still perverts our minds flourished in the nineteenth century; it is significant that the 1873 U.S. federal law which banned from the mails any literature, medicine or article to do with contraception or abortion, was engineered and executed by Anthony Comstock, fanatical secretary of the New York Society for the Prevention of Vice. Today the idea that sex is bad is worked with cruel sadism on the victim of an unwanted pregnancy by her community and, worse, by her doctors, many of whom underneath it all feel that a little humiliation and a little pain might teach a girl a lesson. It is partly this thinking which slows down development of quick and painless methods of abortion. And in a majority of states, including Massachusetts, puritanism still works to keep abortion laws and practices rigid. The legislators of morality, undaunted by Prohibition, cannot stop sex but do send one million American women a year underground for dangerous and often fatal (3000 a year) criminal abortions.

ABORTION PRACTICES IN SOME OTHER COUNTRIES

Not all countries have stayed with the nineteenth century's obsolete and cruel abortion regulations. Law and practice opened up abortion to both rich and poor in Scandinavia beginning with Iceland in 1934. We should notice that pressure for abortion reform in Scandinavia, as in England, came from not only the general public but also national medical associations and distinguished doctors, whereas in the U.S. the medical profession has been a major obstacle to change. Abortion in Scandinavia is not given on demand, however: there are strictly defined categories of legal abortion, mostly medical categories, but also humanitarian (e.g. victims of rape), "eugenic" (e.g. for cases of predictable fetal deformity), and in Norway and somewhat in Sweden, social (e.g. where poverty, too many children already, alcoholism, etc., would make the birth of the child a misfortune). A Scandinavian woman has to go through a lengthy bureaucratic procedure to "qualify"

under one of these categories; as a result, few foreigners come to Scandinavia for abortions, many Scandinavian women go to Poland instead of waiting around at home, and the women who do get legal abortions are often past the time limit for a simple operation and must undergo more serious surgery and therefore more risk.

In Russia and the Communist Eastern European countries ideology values a woman's independent contribution to society and counts her an equal with the right to control her own reproduction, and the economic conditions have made workers desirable and housing scarce. So despite the Catholic Church, Russia off and on since the 1920s and since the '50s Hungary, Poland and the rest of the Eastern Bloc, have legalized abortion on demand and perform in some cases more abortions than live births. (Abortion rates will go down as contraception spreads.) The results of Eastern European abortion policies have been striking: Hungary's one-child family proves that abortion works as population control; fatality rates are miniscule, far lower than for childbirth or for simple tonsilectomy in the U.S.; and criminal abortion, unlike criminal abortions in Scandinavia, have been greatly reduced. Contraception, however, is spreading at varying speeds and with different amounts of government support in these countries, with, as of 1965 (Lader) the USSR being the most ambivalent and Poland requiring contraceptive classes of all women who have abortions.

Japan, where there are no religious or moral obstacles to abortion, actually arrived at abortion on demand as a matter of national survival. Countless troops were returning home after World War II to a devastated economy and a baby boom resulting from war-time nationalism. The Eugenic Protection Law of 1948 and two later amendments, along with low abortion costs, instituted abortion as the national method of population control. It worked fantastically, cutting the Japanese birthrate to less than half in fifteen years. Japanese experience with abortion demonstrates again that legal abortion is safe, that legal abortion kills criminal abortion, that a woman's body does not suffer from having repeated abortions, and that the psychological consequences of abortion in a society where abortion is legitimate are only good.

Two side issues are worth noticing. First, Japan has had a lot of trouble popularizing contraception because abortion is so effective and so cheap. Second, the 13 February 1970 issue of Science magazine reports that Japanese Prime Minister Sato has reversed his position on population growth because the shifting age of the Japanese population (older) means there are fewer workers for the factories making cars and cameras for America; he urges Japan to strive to bring the birthrate up to the "average" level. This attitude is ominous: profit, short-term economic development, and assiduous exploitation of all available resources are clearly the motives at work. Woman in Japan is still the tool of economics and nationalism, which come also before any consideration of world population growth.

England legalized abortion in 1967. Although there is a statutory list of indications, and the doctors have held on to the final word, in effect abortion in England is on demand. Abortion is given in the cases of threat to the woman's life or physical or (widely interpreted) mental health, in the case of fetal deformity, and in the broadly interpreted social case of a threat to the physical or mental health of existing children in the family. The English were conscious at the time of the passing of the law that their facilities for abortion would need quick and substantial expansion. But the pressure on abortion facilities has turned out to be quite uneven, with London bearing the brunt of demand from out-of-towners from places like Birmingham, where conservative doctors are exercising their right within the present law to refuse to perform abortions. London doctors also enjoy a lively private trade from foreigners, especially American women, who try to keep their numbers secret so the door won't shut.

U.S.A.: ABORTION REFORM OR REPEAL, AND MEDICAL CONSERVATIVISM

Since England, Japan, Eastern Europe are out of the question for all but the richest of American women, we have to move from these topics to face our own abortion situation, which is improving in some states but still does not look good. So far, inertia, the strong Catholic minority, puritanism, an extremely conservative medical profession, sexist legislatures and the American woman's ambivalence towards sex and towards her rights regarding her body, all have kept our abortion rigidities operating, even in the few "enlightened" states where reform along Scandinavian lines has been achieved. As this paper is being written, it looks like a number of states are moving towards either legislative or judicial repeal of their abortion laws. We are including the following discussion of the shortcomings of abortion reform not only for historical interest, but also because we suspect that many of the factors which give women in reform states such a hard time won't be changed merely by repeal of restrictive laws.

By mid-1969 five states (California, Colorado,

Georgia, Maryland, North Carolina) had modified their abortion laws according to the American Law Institute guidelines wherein abortion is permitted for five reasons: if the pregnancy is the result of rape or incest, if the mother has rubella (german measles) or is under fifteen years of age, or if her health is seriously endangered by the pregnancy. The important word there is "health" which can be interpreted as mental health, allowing for abortion on psychiatric grounds. The abortion permitted under these laws is called a "therapeutic abortion", as though none other than a hospital abortion can be considered therapeutic. By the end of 1969, five additional states had reformed their laws (Arkansas, Delaware, Kansas, New Mexico, Oregon), with Kansas and Oregon adding to the ALI statutory list a provision for risk to existing children and environment. A number of states have reform actions under way.

But reformed abortion laws in the hands of the American medical profession are just as bad as the old laws, and often worse. The whole notion that a certain woman "deserves" an abortion is an insult, and opens the woman up to the degrading procedure by which doctors and hospitals judge whether she falls into some category of qualification. And the medical profession hides behind the list of qualifications, using it more to turn women down than to accept them. According to Larry Plagenz (Modern Hospital, July 1969), the number of abortions in some California hospitals has increased six-fold since the law changed, while some have stopped altogether, and meanwhile the statewide rate of 100,000 yearly illegal abortions continues unabated. Dr. George Cunningham, Chief of the Bureau of Maternal and Child Health, stated in the same article that "hospitals that want to can make the procedure for obtaining an abortion complicated, time-consuming and expensive. One method is to require two psychiatrists' statements when the law requires only one." The "abortion committee", rarely required by law, is the shield used by hospitals in many states. After a case has been approved by two or more specialists, it must be passed by a committee of three or more rotating senior staff members, and a unanimous vote is often required. As it is not uncommon even in non-Catholic hospitals for there to be a Catholic or a conservative doctor on the board, most cases are turned down. (We object not to a doctor's refusing on personal grounds to perform abortions, but to his being able to stop other doctors from performing them.)

Even if a case seems "deserving", the hospital has often already filled its weekly, monthly or yearly quota of abortions, set in accordance with the Ob/Gyn profession's unofficial ratio of abortions to live births for a given year. Another obstacle to the approval of this "case" (remember this is a woman) is the availability of a hospital bed. Medical people piously assert that they can't make full use of the existing law for fear of being flooded with abortion requests, which would fill up the beds. But they are likely to see each woman one way or another, either for delivery or for emergency treatment after a botched illegal abortion; and in these cases she'll be taking up a bed for five or more days. Abortions do not have to be so bed-consuming: it is our doctors themselves who say that an abortion patient must be hospitalized for two nights, whereas in England women leave the clinic six hours after the operation and in Rumania they leave after two hours (not to mention the speedy departure some of our same doctors urge on their illegal abortion patients). A further obstacle to moving abortion out of the hospitals into out-patient settings is current medical insurance policy, which does not cover out-patient health care.

The case might also be rejected because the hospital is a teaching hospital, and although teaching hospital staffs tend to be more liberal than most, they want to do only so many abortions because abortions are "dull" and "uninstructive". Clearly the doctors are resisting the notion of themselves as public servants. They resist also the idea that as public servants they might perform on demand – for they are steeped in a professional tradition in which the doctor knows all and the patient nothing. Whereas this might be true with appendectomy, it is not true with abortion. Dr. Lonnie Myers of the National Association for the Repeal of Abortion Laws quotes a poll of all doctors' views on abortion, in which the only group which came out consistently for abortion on demand was the plastic surgeons. Plastic surgeons, the only doctors whose patients decide what is to be done, do not consider operating on demand a threat to their professional sanctity. Women must see to it that Ob/Gyns, who came out on the opposite end of the poll, start to feel this way not only about abortion, but about the whole range of their services to women. (By the way, this is not a plug for plastic surgeons; we abhor both their cosmetic type of work and the fantastic rates they charge.)

Doctors show also by the fees they charge that they do not consider themselves public servants. Women, always the major health consumers, really bear the brunt of abortion costs. For a purely medically indicated D & C, a doctor charges about $200, while he gets $300 and up for the same technique when it happens to be a therapeutic abortion. If he is doing it illegally, he gets upwards of $1000 for the risk he is taking. The cost of a

therapeutic abortion in Washington, D.C. in March 1970 was about $600, half for doctor's fee and half for hospital charges. Medical insurance does not always cover the cost of a T.A., especially employee insurance, university health plans, and almost all plans for the single woman (who can sometimes get the hospital to list her operation as a simple D&C). There has been a suspicion voiced that doctors play down abortion because delivery is more remunerative, but actually there is a lot of money in the abortion business, as some London Ob/Gyns are discovering, and as the underworld has known for a long time.

Medical conservatism will hold out for a long time against both abortion on demand and abortion for low fees. The individual doctor does not break out of the system because he has been forced to work hard for sub-standard pay for many years, and just as he starts to make the money that he has come to think is his due, he doesn't dare risk his job by performing abortions or by urging his hospital to allow more of them. Medical conservatism feeds on itself.

So even in reform states a legal therapeutic abortion is almost impossible to get. The clinic patient without a private doctor and psychiatrist and money to help her over the obstacles gets little benefit from reformed abortion laws. About 80% of hospital abortions last year went to middle and upper middle class white women, while 75% of the deaths from illegal abortions hit poor non-white women. And even for the more wealthy woman, the procedure is lengthy and degrading: as in divorce proceedings where infidelity must be proved or faked, so in obtaining an abortion on the usual psychiatric grounds a woman must feign mental illness and often finds herself labeled psychotic.

Clearly the only just alternative is the repeal of all restrictions on doctor-performed abortions (until methods are developed which can be applied by non-doctors). In early 1970 Hawaii removed all restrictions except that abortions be performed by physicians in hospitals on residents of 90 days or more. California courts have struck down the 1967 "reformed" law. Vermont abortion repeal advocates have defeated a strict reform law. The federal court for Washington, D.C. declared the abortion law unconstitutional because it was too vague, going on to say that no doctor should have to bear the burden of proof that the law invaded a woman's liberty and the right of privacy which "extends to family, marriage and sex matters and may well include the right to remove an unwanted child at least in the early stages of pregnancy."

But the doctors remain in control. Current abortion law repeal sentiment, as voiced by the active National Association for the Repeal of Abortion Laws, tends as in the D.C. court and the Hawaiian legislature to lean towards leaving abortion up to "the woman and her doctor." This seems to be a bad idea. The Washington, D.C. situation in March 1970 shows that even total absence of law does not convince or liberate the medical profession. At this writing Senator Robert Packwood of Oregon has had to introduce a bill authorizing D.C. hospitals and doctors to perform abortions because they have been so slow to respond to the court's verdict. (Senator Packwood did, however, slip in one unfortunate clause requiring the husband's approval.) The same recalcitrance that doctors have shown in reform states will operate to hold down abortions in repeal states until women get together and press for abortion clinics, shorter or no hospitalization, low fees, and, most important, for abortion on demand. As long as abortion is up to the doctor, it will be hard to get.

THE ABORTION SITUATION IN MASSACHUSETTS – MARCH 1970

(Courses given elsewhere can substitute local information.)

Although Massachusetts is a Catholic state with the most backward birth control laws in the country, the Mass. law on abortion is vague and therefore quite liberal. It states merely that unlawful abortion is illegal, implying that there is such a thing as "lawful" abortion. Physicians in the state, especially in Boston, have long considered therapeutic abortion lawful under certain circumstances. This interpretation of the law has been approved by the Mass. Supreme Judicial Court in the 1961 case of the Commonwealth vs. Brunelle. In later cases (Commonwealth vs. Wheeler, vs. Nason, vs. Corbett), the court allowed the physician to procure an abortion for a patient in case of a threat to her life or to her mental health. Although the inclusion of mental health as grounds for abortion seems liberal, the problem in Massachusetts rests in the final clause: ". . . if his judgment corresponds with the general opinion of competent practitioners in the community in which he practices." The "general opinion" of Massachusetts doctors has been most conservative, and they have not made full use of the court's interpretation of the law. (See the section on medical conservatism.)

As a result of the doctors' hesitation, only about 2000 hospital abortions were performed last year in Massachusetts, almost all of them in six major Boston hospitals. (The rumor that many private doctors admit patients for a "D & C" which is really an abortion is perhaps truer of out-lying areas than of Boston, where most hospitals are

teaching hospitals with pathology labs which analyze every bit of tissue removed.) At least 90% of the therapeutic abortions are done under the mental health provision of the court. The protocol for establishing eligibility varies from hospital to hospital, the Beth Israel being the least restrictive. In general most require the consent of the woman's gynecologist, two psychiatrists, the chief of gynecology and/or the abortion committee of the hospital. In the middle of August 1969, the Boston Hospital for Women, Lying-In Division, one of the most conservative hospitals, tightened up its abortion policy. BLI now requires that the candidate for an abortion have been diagnosed as schizophrenic prior to becoming pregnant, or that she be undergoing treatment simultaneously with her pregnancy, and strongly advises that she continue with counseling for several months after the abortion. Even in the more liberal hospitals the qualification procedure is long, insulting, expensive, and often leaves a woman two or three weeks more pregnant with the hospital door shut in her face.

The Boston abortion is expensive, about $600 y the time the doctor's and hospital bills are id, even more if a number of psychiatrists were en. Blue Cross/Blue Shield will pay for a thera-eutic abortion for a married woman only. Welfare usually covers its recipients. The Boston City Hospital takes five "charity" cases a week for consideration, which sounds magnanimous until you realize they don't take all the cases they consider, and even if they did it would be only 260 a year.

Groups Counseling Women with Unwanted Pregnancies

The Massachusetts resident or student with an unwanted pregnancy has a few places to turn before she starts on the lonely road underground. She can, of course, first try her doctor, who might surprise her.

A. The Pregnancy Counseling Service, 3 Joy St., Boston. 523-1633

To examine her legal alternatives the woman with an unwanted pregnancy can go to the PCS, where a counselor will help her figure out what she might do if she chooses to continue the pregnancy, or, should she choose to stop the pregnancy, the counselor will help her determine if she can (and is willing to) qualify for a T.A. at a Boston hospital, or if she can qualify in a more liberal state. The PCS will help the woman with whichever alternative she chooses, and will also give her the names of doctors who will give her means of contraception. The PCS will also describe for her the safe and unsafe methods of abortion, in case she has to turn underground. The PCS is working to establish an independent medical facility for abortions, which involves persuading doctors to take advantage of the current vague law. The PCS is, of course, broke and welcomes volunteers and contributions. They have a good fifteen hour training program for counselors.

B. The Clergy Consultation Service. 527-7188

The clergy helps a woman consider all her options, and if she is forced underground they try to help her avoid a bad illegal abortion. The woman calls the central number and is informed by a taped message which clergymen are on duty that week. She then calls and makes an appointment with the one she chooses (various faiths are represented), to whom she brings a doctor's statement of how far along she is in pregnancy. The CCS always has a few weeks' waiting list and so can help only women who are under ten or even nine weeks pregnant. To protect themselves the Clergy sends women out of state, most often out of the country. They try to adjust the fees to the client's ability to pay. Despite some crackdowns and arrests, Clergy Consultation Services operate in many cities and states.

C. The Parents Aid Society, 1575 Commonwealth Ave., Boston. 783-0060

This advisory service is run by Bill Baird, and we do not know exactly what kind of referrals he makes.

THE NEW YORK ABORTION – MARCH 1971

Women in the Boston area who come to Pregnancy Counseling Service (3 Joy St., Boston; 523-1633) are usually directed to clinics or hospitals in the New York City area (unless they qualify for and want a legal Massachusetts hospital abortion, which PCS can advise on too). There is presently no New York residency requirement, though this may change, and New York City costs are lower now than elsewhere in the state. Out-patient clinics take women up to 12 weeks after their last menstrual period (LMP). Besides sound medical care, clinics avoid hassles and extra expense of hospitals, and some also give good, supportive counseling. The whole clinic procedure, including pap smear, blood tests, counseling, abortion, and recovery time, can take as little as 3-4 hours. Women 4-6 months pregnant are directed to hospitals where the saline or hysterotomy procedures are done. (Doctors don't do abortions by any method between 12 and 16 weeks LMP, except very rarely a late D & C.) The saline takes three hospital days, the hysterotomy up to six days. Most hospitals also provide counseling.

Whatever the method, and whether or not counseling is available, **it is a good idea to go to New York with one or two friends. Women friends can be particularly supportive at a time like this.**

Typical costs: **D & C or Suction** (up to 12 weeks LMP) – $150-$200. **Saline** (16-20 weeks LMP) – M.D., $150-$250, plus hospital, $300-$400. **Hysterotomy** (20-24 weeks LMP) – total cost approximately $700-$900.

PCS can arrange free or low-cost abortions for woman with little or no money who are under 12 weeks pregnant. This is harder after 12 weeks: hospital costs are inflexible, though doctors sometimes waive their fees. PCS also tries to arrange rides to New York where needed.

Since the New York abortion law went into effect on July 1, 1970, many exploitative agencies for counseling and referral have cropped up: AIA, Med-Ref, 5th Ave Women's Pavillion, Prestige Placement are a few. They make profits of $25-$150 per woman. Some are now subpoenaed but not yet shut down. Such useless, profiteering agencies aren't just in New York City but in Boston, Philadelphia, Washington, etc., with ads in local papers everywhere.

But there are trustworthy, non-profit services in many areas. In New York City, call Women's Abortion Project (a Women's Liberation group). Outside Boston, check Information for a local Clergy Consultation Service, Planned Parenthood, or Women's Liberation group. Don't rely on ads, however good and reassuring they sound. If you don't know anyone who knows an agency or clinic first-hand, it makes sense to call PCS in Boston.

ABORTION METHODS

When legal resources fail her, the woman with an unwanted pregnancy starts asking friends of friends, nurses, taxi drivers, in a frightened and hysterical nosing around which ends her up on a doctor's table if she is lucky and rich, in the hands of a nurse, or worse, of some semi-medical quack if she is less lucky and less rich, at the mercy of her own mutilating hands if she is desperate, and in the emergency ward of a hospital if the "operation" turns bad.

It is important for a woman to know the whole range of abortion methods, both so she will know what she is talking about with her doctor, and, more important, so she can judge the methods of an illegal abortionist and find the courage to walk out if her life is in danger. (Don't pay in advance if you can help it.)

I. Timing

When the embryo is one month old it is a tiny mass of tissue, with no resemblance to a human being. At the end of the first month the embryo is about the size of a small pea. By the end of the second month, the growing embryo, by this time called a fetus, is a very fragile one inch long mass of differentiated tissue acting as a parasite within the mother's body. When the fetus is three months old, it has attained a length of about five inches. (Birth Control Handbook, Montreal)

The earlier the abortion is done, the safer it is for the woman and the easier it is on the doctor. Even doctors who will perform abortions willingly have some cut-off point, ranging from when the fetus takes clear human shape ("pulling out an arm and then a leg" is deeply disturbing to one local Ob/Gyn), through the time near twenty weeks when the fetus moves (making abortion far more dangerous for the woman), to the time of "viability" around 28 weeks when the fetus could survive if born. Hospital abortions in Boston are almost never done after the fourth month, illegal ones rarely after the third.

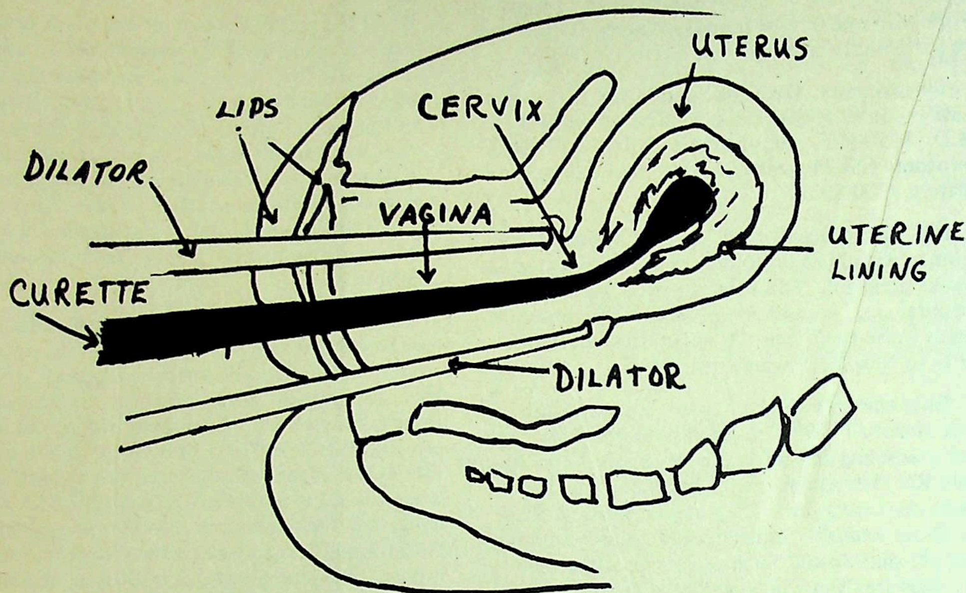
II. Medical Techniques for Abortion

A. Up to three days: **post-coital medication**

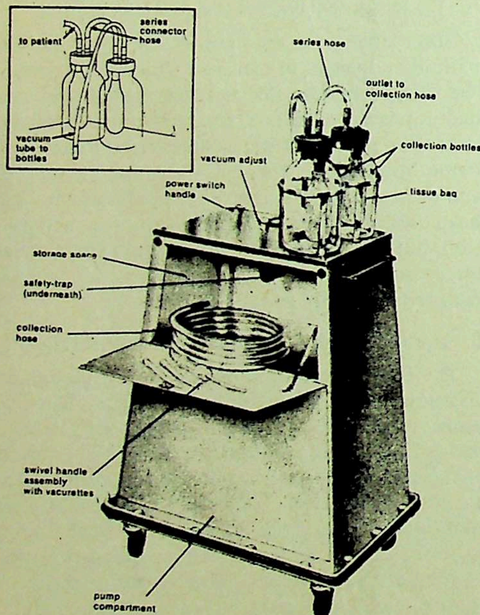
Some doctors in the country are experimenting with high dosages of estrogen which will abort a less than three day old fertilized egg. If you have had unprotected intercourse in the middle of your menstrual cycle, get their names from Planned Parenthood or the Pregnancy Counseling Service and offer yourself as part of the experiment. There have been no reported failures from the medication, but since it must be used within three days of intercourse, no one knows how many of the women were actually pregnant.

B. Up to 12 weeks: 1. **dilation and curettage**

The D & C is the standard method of hospital abortion up to three months in the U.S. The procedure, which is done on women for various reasons including infertility, involves the dilation of the cervix and the scraping of the womb with a curette. The cervix is dilated by means of graduated dilators starting at 2 mm. and proceeding up to about 12 mm. at ten weeks pregnancy and to 14 mm. at twelve weeks. The doctor uses the curette, a metal loop on the end of a long thin handle, to scrape gently the internal uterine wall, removing the fetal tissue with forceps. The patient is totally anaesthetized, and requires from six hours to two days of recuperation, during which time there might be some bleeding.



Operating unit for vacuum curettage.



Berkeley Tonometer Co.

B. Up to 12 weeks: 2. **Vacuum aspiration**

In China, Japan, Russia, England, Eastern Europe, up to twelve weeks the fetus is aborted by means of a sterile metal, glass or plastic tube with a lateral opening near the tip, which is inserted through the dilated cervix into the uterus and moved about to dislodge the fetal tissue from the uterine wall; the fragments are then drawn out by means of a vacuum pump connected to the tube. Although it still requires a highly trained person to pass the tube through the cervix into the uterus without puncture, the vacuum suction method is easier, quicker and less traumatic (physically) than the D & C, and allows abortion to become an inexpensive outpatient procedure. American doctors are resisting the vacuum suction technique; a few Boston hospitals have the equipment, but none use it often.

C. 12-16 weeks.

In England during this period, doctors use a combination of the vacuum aspiration and D & C with forceps methods; the operation is over a hundred dollars more expensive. In the U.S., doctors often make a woman wait until she is 16 weeks pregnant and can have a saline injection (see below). There seems to be a touch of sadism in making a woman, especially a young girl, wait until a more painful and traumatic method must be used.

D. After 16 weeks: 1. **hysterotomy**

In a hysterotomy the fetus is removed through a small abdominal incision, usually below the pubic hair line. This is major surgery, requires several

days' hospitalization and convalescence, is therefore more expensive (at least $1000 here), and in the U.S. often condemns a woman to caesarian births thereafter. Although as major surgery the hysterotomy involves more risk, it does not affect a woman's reproductive system at all (unlike the hysterectomy, or removal of the uterus, with which it is often confused).

D. After 16 weeks: 2. **saline injection**

With this method, a long needle passed through the locally anaesthetized abdomen withdraws some of the amniotic fluid and replaces it with an equal amount of concentrated salt solution. This solution kills the fetus and induces labor and miscarriage in twenty to twenty-five hours. This method is useful only at 16 weeks because the amniotic sac must be big enough to find. The saline injection method is more painful and emotionally harrowing than a hysterotomy, but it is not major surgery, takes less time, and is cheaper. While this procedure may be necessary for some women, if it is not done with extreme caution and precision, it is very dangerous and could be fatal.

III. The Doctor-performed Illegal Abortion

Many illegal abortions up to 12 weeks are performed by doctors who give D & Cs or vacuum aspiration abortions in hidden offices. Many do it for profit but some do it because they believe abortions should be done but are scared to court arrest by doing them in the open. The cost ranges from an occasional humane hundred or so, to the usual $600-$1000. Except for a more hasty departure afterwards and the use of a local instead of a total anaesthetic, the abortion performed by a skilled and conscientious illegal abortionist who keeps his tools clean is just about as safe and comfortable as a hospital abortion. While on the whole the rural woman has a harder time than the city woman in finding an illegal abortion, Lawrence Lader describes the abortion practice of some small town doctors who have some kind of understanding with the local police. Lader also tells of the woman whose unsympathetic gynecologist told her to go elsewhere and then at the end of her long and panicked search turned out behind face mask and gown to be her illegal abortionist.

IV. Methods of the Unskilled Abortionist

The dirty D & C. The D & C in the hands of hurried incompetents with no anaesthetics, no antiseptics and dirty tools is frightening and dangerous.

The catheter method. Catheters are narrow tubes sold at drug stores for drawing off urine. The catheter is inserted into the uterus through the cervix, a dangerous procedure when attempted by an amateur. Germs introduced into the uterus by the catheter cause an infection which the uterus contracts to expel, thereby "spontaneously" aborting the fetus.

The high douche. Forced douche or injection under pressure of over-the-counter chemical agents like soap, turpentine, Lysol, vinegar, lye, will produce an abortion if the solution reaches the fetus or sufficiently irritates the uterus.

Both the catheter method and the high douche work on the theory that an infection or dangerous substance will kill the fetus before it kills the woman. They can result in permanent disability or death.

Air pumped into the uterus. This method causes air embolism (air into the bloodstream) and sudden and violent death.

V. Self-induced Abortion

The most unskilled abortionist of all is the woman herself.

External means. Woman try extremely hot baths, severe or prolonged exercise, violence to the lower abdomen, and various long sharp tools of self-mutilation. Except for the occasional knitting needle abortion we hear about, which may be myth, none of these methods work.

Drug store abortifacients. The woman can also get from her "friendly" druggist a number of abortifacients which, all expensive, endanger her life to varying degrees and almost never work.

1. Soap-base pastes and douche solutions are among the most dangerous. Soap goes directly to the uterine veins to cause blood vessel blockage, **shock and death.**

2. Desperate women douche with almost any liquid they can think of, running the risk of **severe burning of tissues, hemorrhage, shock, death.**

3. Tablets of potassium permanganate, a caustic tissue-destroying agent which damages the vagina walls and can cause **massive hemorrhaging, ulcers, and infection,** are sold despite a FDA prohibition.

4. Among the useless folk remedies sold are quinine pills and Humphrey's Eleven pills, which women take in massive expensive doses (literally hundreds of pills) because once a woman who thought she was pregnant took some around the time when her period was due, and lo and behold her period came.

5. Women also take quantities of birth control pills, which actually support the pregnancy if anything, and are suspected of causing genital deformity in the fetus.

6. Castor oil and other strong purgatives are used to no abortive effect.

Of the million women in the U.S. who yearly get illegal abortions, between two and five thousand actually die. Thousands more spend time in the hospital with sceptic abortions, peritonitis, gangrene, air embolism and other acute repercussions. Unknown numbers of them find themselves infertile later on when they want to plan a pregnancy. (At an Abortion Conference in Boston sponsored by the Unitarian Universalist Women's Federation, it was disclosed that 10% to 20% of a local infertility clinic's patients have had previous sceptic abortions.) And many thousands of women escape from the frightening experience physically whole but with a new cynicism and very rarely any better contraceptive techniques than they were using when they got pregnant.

FUTURE PROSPECTS

"Even when abortions are easily available, middle class women who go to private doctors for their abortions will be made to feel uncomfortable and patronized. When poor and black and brown women go to the hospital OPDs, they will feel despised and degraded. Black and brown women are already afraid that their tubes may be tied without their permission or that an IUD may be inserted after childbirth or during a gynecological exam without their knowledge. (Whether these stories are true or false, they are believed.) With the acceptability of abortion, there may well be pressure put on poor black women, on unmarried high school and college students, to abort rather than to bear the child.

"The first problem is to get the abortion laws repealed. But many women are already looking ahead to the problem they will face even after the laws are repealed. Medical and nursing students, nurses and other health workers are beginning to ask that more abortions be performed immediately and that institutions make plans for dealing with the increased demand after the laws are repealed. Women's liberation groups who already have abortion referral services, are now urging women to go to hospitals for their abortions, to show the institutions that the demand is there and that they must face it. Some women's groups are looking ahead to the obstacles raised by doctors' and hospitals' attitudes towards abortions. 'Abortion law repeal will be meaningless,' said one spokesman for the repeal movement, 'unless women seeking abortions are treated with dignity and respect by doctors and hospitals. No one should think that with legal abortion on demand, or even with free legal abortion, that the women in this country will consider themselves liberated.' "

– Rachel Fructer, A Matter of Choice: Women Demand Abortion Rights, in Health-Pac Bulletin, March 1970

TWO PERSONAL EXPERIENCES

Probably the most insidious mistruth about abortion is that of the so-called post-abortion guilt feelings on the part of the woman. In fact, many women have been taught to expect, and in some perverse way, may welcome, the "cleansing effect" that anticipated post-abortion guilt offers them, as though they have to atone for their crime. For as long as this society fails to recognize and refuses to sanction the right of a woman to have an abortion whenever she chooses to do so, the fear of post-abortion self-recriminations represses her as surely and as effectively as any prohibitive law is capable of doing. The problem then is, how to get women to face the reality of post-abortion feelings while shaking off the shackles of superimposed guilt feelings. Ironically, guilt, the psychologists tell us, grows out of anger – anger at ourselves for feeling inadequate and unwomanly, but also anger at a society which reveres us as mothers and child-raisers, but despises our rights to make the decision not to have a child. Perhaps then sharing my personal experience might in some way show my sisters that guilt and its attendant emotions need not follow an abortion.

"I'm sorry," the voice said to me over the phone; "the test was positive." From that moment on, I was a changed woman. I was going to become a mother. But was I really, in the true sense of the word? Any woman who has ever conceived understands the mixed emotions I was feeling. Understand, then, the thrill I felt in knowing that life was beginning. My body is constructed to bear children, and it was fulfilling that purpose. But then, I was forced to ask myself, is that my purpose as a rational, as well as a biological human being, and was I not reacting to a societal stimulus as well as a biological one in feeling good about being pregnant?

For me, the answers to these questions resulted in my decision to abort my pregnancy. For I realized that these vague biological stirrings inside of me could never justify giving birth to a child I did not want, and was not prepared to raise. Neither was I willing to subject myself to the ordeal of pregnancy and waiting only to relinquish the child at the end of it all. It's all crystal clear to me now, the re-telling of it. At the time, my decision was not so well thought out, but rather grew out of the conviction that I could not, under my circumstances, continue with an unwanted pregnancy. For me the fetus represented an undesirable growth that had to be expelled and with it also any guilt feelings about what I intended to do. Not once then did I ever think of the fetus

as a human being, but rather as an entity that contained some of the properties and carried the potential for human life, in much the same way that a fertilized egg contains the properties and potential for life. If then, the destruction of a fertilized egg is within our power, why not a fetus?

Finding an illegal abortionist was not easy. The few legal avenues that are open did not even occur to me (I had my abortion over two years ago), although I'm sure I would not have qualified for a so-called therapeutic abortion. As millions of desperate women before me, I went underground. My search led to a registered nurse (I was told) who did illegal abortions. My contact was a woman who had recently undergone an abortion by the R.N. and who seemingly had suffered no physical ill effects from it. The negotiating was done entirely through my intermediary and after settling on the price ($400), the date was fixed. All the while I was not able to pry out of my contact many details about the procedure, which really panicked me. There was no one else to ask, so I went into the thing "cold turkey" and all of my dreaded fears about the physical pain were realized. The woman came to my apartment, spread me out on the kitchen table and inserted a cathether tube up my vagina into my uterus. This, I was told, would in time start the contractions in the uterus which would lead to the expulsion of the fetus. When I questioned the abortionist further, she put me off as though I were undeserving of anything more than what she had just done for me for $400. I had to be content with her vague instructions about what to do when the bleeding began while trying to stifle my anxiety about complications. The entire procedure took about 15 minutes and her attitude was one of do the abortion and run. It was apparent that with the exception of my two friends (who were as ignorant of the process as I was) I was strictly on my own. And so began a 48 hour ordeal of pain and anguished waiting for it to be over. At that point I had little regard for myself as a worthwhile human being, I was someone to be scorned and avoided – I was a walking, bleeding catheter tube. On Sunday the contractions began, and by the middle of the afternoon it was over. The force of the uterine contractions had dislodged the catheter tube and it slipped out easily and along with it the fetus. Looking at the fetus was an experience I will never forget. I had been approximately two months pregnant and at that stage the fetus had acquired some of the characteristics of a human being as we know it. It was about an inch long and I am unable to remember its color. I do remember staring at it in a curious, somewhat detached way; it looked so strange, and indeed it was. Its appearance did not shock or repel me, partially due to the fact that by that time I had shut myself down emotionally and was feeling only relief that it was over. It was only much later that I was able to internalize how I felt and continue to feel, and then to verbalize, as I have tried to do here. Even now, my total emotional reaction to it escapes me, except in one vitally important way. At no time, even in the shadow of societal taboos, did I believe that I was doing something "wrong" or committing some "offense against nature". When, in fact, it is my nature and my right to determine my destiny as a woman. Since that time my confidence in the rightness about my decision has grown and along with it a sense of dignity and self-determination about myself as a woman.

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I had my second child in March, stopped nursing him in October and became pregnant in December. Right after making love - too lazy to put in the diaphragm - I realized that I had miscounted and was possibly ovulating. In a panic I remembered from a long time before I filled the sink with water and * washed myself out. Around the time my period was due I began to feel the sensuality I know means for me either pregnancy or some kind of minor cyst (which stimulates pregnancy hormones). My doctor gave me an intensive dose of progesterone to induce bleeding if I wasn't pregnant. I didn't bleed and went back to him; he confirmed the pregnancy. I told him I didn't want to be pregnant and asked him his position on therapeutic abortions. He outlined the procedure – hospital board * approval and recommendation of two hospital psychiatrists (my own wouldn't do). He implied that I would pass the board because he was on it and said he'd contact the psychiatrists he felt would be most sympathetic to me. He added that I would have to pay $700 **in advance** to Peter Bent Brigham.* He also suggested that I consider having a tubal ligation, after all I was 32, had two children, etc., and it would make the doctors more sympathetic to giving me an abortion. I told him that for me a tubal ligation was a major decision, whereas having a D & C seemed relatively minor. His reply: from a medical point of view a tubal ligation was a minor operation, whereas the D & C was something equivalent to major.

So I set my mind toward a therapeutic abortion. Emotionally and intellectually I was for it: (1) I didn't want to bring up a third child, there was too much I wanted to do; (2) I had been writing a paper about women choosing whether or not they wanted to have children and how many they wanted to have, and here I was faced with the necessity of living out these beliefs we have that women

should have the power to choose their own lives; (3) So important, the whole idea of abortion was made easier because I knew from much talking with women and my reading how many women go through abortions; and that knowledge would definitely have sustained me through whatever I was going to have to experience, whether it be therapeutic if I could get one, a trip to England, to Montreal, even an illegal abortion if that became necessary. In spite of this generalized feeling of support, I realized that though some of my close friends had had abortions, I had never really asked them the * specifics and knew very little about what had happened to them; and I began to ask them to talk about their experiences. I also felt for the first time what it meant to be really fertile, and learned that even with birth control methods, there's a fairly high incidence of pregnancy. It seems so obvious that we should have back-up abortions.

Meanwhile I was incredibly depressed. At the same time that I knew in my gut I didn't want to have another child, I felt terrible that I didn't want * this pregnancy. I am used to welcoming and looking forward to pregnancy, and it was unnatural in the deepest way not to want to be pregnant (I had been infertile, gone through three years of trying to get pregnant, had an operation for ovarian cyst removal and became pregnant in three months, had a first beautiful pregnancy, and a few years later a good second one). I found it impossible to stop being depressed.

The day I was supposed to call my doctor to find out if he had made appointments with the two psychiatrists, I began to spot. The world turned over. A miscarriage? I called the doctor, he said "Run around the block a few times" and come see him the next day. I jumped up and down often, happy as the spotting increased, feeling crazy to be hoping so for a miscarriage.

The next day the doctor said: "You're miscarrying. I could try to give you some hormones, but there's a 90% chance you're going to lose it, and under the circumstances, go into the hospital tonight * and I'll give you a D & C." A little later I said to him again, "It's all crazy" and he answered "It sometimes happens like this. I had a girl once who was getting on a plane to go to England (——) when she started to bleed. I had her in the hospital in no time.

I went into the hospital at five, and at eight was taken up to the operating room (same floor as deliveries). For 45 minutes, I, and anesthetist and the nurses waited for my doctor. I asked one of the nurses what the doctors' attitudes were toward D & Cs. She answered that doctors didn't seem to mind doing them because they were medically necessary, but that she had seen doctors' eyes as they * were doing therapeutic abortions (D & Cs) and she felt their distaste. Some nurses refuse to work during therapeutics. It's clearly written on the chart whether it's a therapeutic or a D & C (same thing). She said one doctor came into the operating room * where a woman was waiting to have a therapeutic, took one look on her chart and walked out, not performing the operation.

Since I had eaten lunch and couldn't be completly anesthetized, and since anyway I wanted to be aware during the D & C, I had my first spinal which was clumsily done. Finally I became totally numb from my waist down. Earlier in the hospital room I had felt nauseous at the idea of being scraped out. Here in the operating room I felt nothing physical, but had a lot of other feelings: my doctor seemed cold and distant, I joked trying to make some connection with him but couldn't. I cried because I had miscarried and had to be scraped out and I was very tired. I felt guilty too because I was glad of the miscarriage and felt I was playing the part of someone who was sorry.

I spent three hours in the recovery room, a dull neutral time it felt like, but now, thinking about it, I was probably recovering in all kinds of ways. I had been in that same room after the births of my two babies when I had felt high, joyful and totally relaxed; now was so different, no experience of birth before, a nothingness of feeling.

It took a day or two to recover physically from the D & C. And it was only after talking to many people and thinking very hard about all my ambivalent feelings – the guilt, the anger at my husband that it was I who had to go through all these hassles, the contradictory feelings about the abortion-miscarriage – that my two-month depression disappeared, convincing me even more that though it can be a hellish bitter struggle to get into reasons for depressions, once the reasons are found and talked over, the depression begins to disappear. And women have to look into themselves and talk together to an enormous extent to untangle our feelings which are so wrapped up in body processes that we confuse physical with psychological. We have to talk together too because we are socialized **not** to feel and express deeply negative things concerning our bodies and wills. The wish to do away with a pregnancy was hard for me to cope with and confused me for a long time. After this experience my mind is clearer.

*** I have put stars next to many of the things that happened which I found objectionable, appalling, which should be discussed on a lot of levels.**

Pregnancy

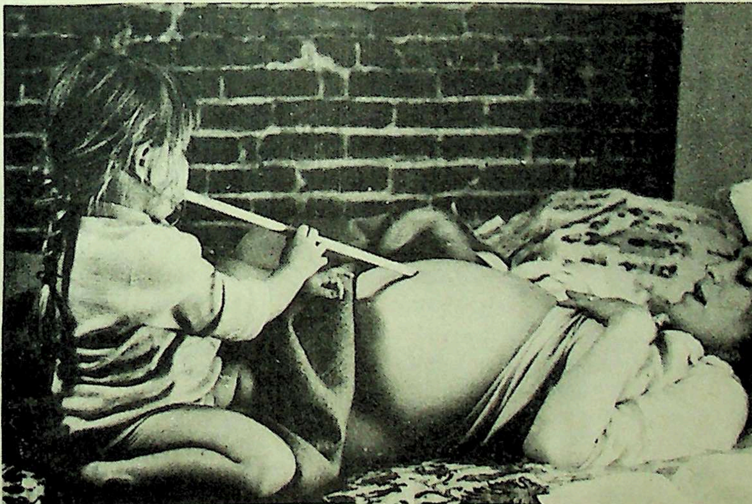
INTRODUCTION

We, as women, grow up in a society that subtly leads us to believe that we will find our ultimate fulfillment by living out our reproductive function and at the same time discourages us from trying to express ourselves in the world of work (often by pointing to our reproductive roles as a reason for doubting our seriousness). Because our opportunities, hence our motivations, are limited we ourselves often begin to believe that in motherhood we will find greater satisfaction than as student, worker, artist, political activist, etc. Often we look forward to pregnancy and motherhood as a time when we can put our identity crises on the shelf and relax, secure in the legitimacy of our maternal roles. Both we and our children fare better when conception is chosen freely out of a desire for a child to love and care for and not as a means to fulfill other important needs for identity, security and social approval.

Instead, more or less haphazardly, we get pregnant, and it's during the pregnancy that we become involved in the struggle to come to terms with who we are. Because often we are not aware there is a struggle; because we don't know what it's about and/or have no language to express it or we may understand our ambivalence and feel guilty, we experience serious depression during pregnancy or after childbirth.

Consequently, when we live through these depressions, nightmares and fantasies, we think we are the only one to have them. As soon as we are able to talk to other women about them we find we're not alone! (At a meeting where a group of us met to discuss our feelings during and after pregnancy four out of five of us there told of fantasies about taking up knives or about people entering our houses to kill our children. We all discussed the various forms of depression we had felt, usually subtler than suicidal wishes and less easily identified as depression.) In our isolation we feel guilty for our "unmotherly unnatural" feelings. When we meet and talk together we discover as a common experience that we have strong negative feelings about having children. Most important of what we are learning is that our feelings are shared, are legitimate. We all have them to some extent, we shouldn't shrink from them (they don't go away), and we must accept them as legitimate as a first step in dealing with them. Having the courage to recognize, express and share these feelings is the beginning of the struggle to understand why we have them.

Often we are not free of our own psychological needs even in "choosing" to stop the pills or whatever and become pregnant. Societal pressures on men as well as women persuade us that we must demonstrate our fertility and immortalize our man's seed by having children. We produce the children, and we see them as extensions of ourselves, as our possessions, not people. Further, our limited opportunities and lack of legitimacy in other areas make the traditional role of mother the



course of least resistance for many of us. For some of us and most of our third world sisters, very real economic pressures make pregnancy and motherhood a nightmarish rat-race for survival. The mentally "healthy" pregnant woman must be secure in knowing that all material needs (adequate housing, food, clothing, toys, etc.) will be provided, either by herself, her family or the society.

We should not have to make the choice that many of us are forced to make today – one of commitment to motherhood or to serious work. If we want to be with children, we should first try out caring for friends' children or helping in a playgroup or preschool. We should have some space to examine our feelings about being with children, including feelings of possessiveness that all of us who grow up in this society are taught. Maybe we'll decide that we don't want the full time responsibility of rearing or adopting children, but decide to be part-time parents. We should talk with friends who have borne children and those who have adopted; both are alternatives which we should examine. In addition, there should be guaranteed income for all individuals in our society, so that women who want to have children alone are not forced to be financially dependent on a man; there should be childcare at the job or in the community that lasts for 24 hours and is community controlled; there should be communes with all members sharing childcare equally; and there should be maternity and paternity leaves until we have our strength back and the baby is sleeping through the night. Further, we believe that half-time jobs should become the norm so both parents can lead fully human lives and participate in the raising of their children and the life of their community.

PREGNANCY

Why become pregnant? Why have a child? We as women are talking about having versus not having children. Some of us feel strongly that there are no good reasons for having children. Some feel it's self-indulgent for us to have our own children but all right to adopt children who need homes. And some believe that giving birth to and rearing our own children can be a creative, even revolutionary act. These are vital questions to ask and try to answer before discussing pregnancy. But I wrote this paper at a different level of consciousness: it gets at the negative reasons we have for wanting children. It talks about how it feels to be pregnant and describes what is happening to and within our bodies. Basically it assumes: (1) that a wanted pregnancy is good, and (2) that it's necessary and exciting to have some control over the process both by learning as much as possible about ourselves and by changing attitudes and institutions to be more responsive to our needs when we decide to have children.

It's essential to realize that we as women can be whole human beings without having children. It's possible for us to be complete both physically and emotionally, just as men are. We should be free to decide whether or not we want to have children, and if we do, how many we want to have. And we should be able to decide how much time we want to spend rearing children. For the first choice to take place, we must become aware of the many factors that hinder our freedom to choose. For the second decision to be possible, we must work together to change many kinds of attitudes and institutions, making them more flexible and responsive to our needs; and we must develop day care centers and new kinds of communities to free us from our traditional roles. Only these kinds of societal support will enable us to live out our choices with confidence and freedom.

As things stand now, a woman as mother is not free, for the bearing and raising of children demands much time and emotional energy. In order for us to fully come to terms with pregnancy, we should thoroughly consider what having a child means to us personally. Once we become aware of societal and religious pressures and expectations weighing on us, and realize to what extent our thoughts and emotions have been grossly and subtly directed, then we can begin to extricate ourselves from binds we don't want and positively choose our own attitudes towards having - or not having - a child.

Some biological pressures: Women are physically different from men in that they are able to bear children. A particular biological process is begun and completed when we become pregnant and give birth. The biological process quickly acquires social significance; it becomes difficult to separate the two. And though we are human beings capable of choice, in many societies women still breed like animals. We are trapped and defined in advance by the biological efficiency of the reproductive process: it is so easy to get pregnant. It is biologically preferable that strong healthy young women in their teens and early twenties be the bearers of children. And when people are young, sexual feelings are surprising and newly intense. As a result, we become pregnant, married and unmarried, before we have a chance to develop fully as autonomous human beings.

As for societal pressures, in this society we are persuaded on many levels that we have no choice, we don't need to have a choice, we don't want to

have a choice. This society has a vested interest in keeping us non-autonomous, and many mechanisms develop which come to determine how we should feel and act. The Catholic Church tells Catholic women they should have as many children as possible. Consumerism and advertising convince all of us from our birth that we must be pretty to attract men so we can get married and have a home and children. Then there are attitudes such as: all women are good for is to bring up children (and be sexual objects on the side), and the ensuing glorification (by men) of Motherhood. Mixed in with these attitudes and best expressed by the Victorian and Puritan traditions, of which we are still victims, is the gut feeling that our physical functions in general are base and unclean. We are not free to be sexual beings, men think, but we must justify our sexuality by becoming pregnant. Women, who menstruate, carry their children in their wombs like animals, give birth with obvious effort and discomfort, are thought to be close to "nature"; but men are threatened by this physicality, and create myths about women which we partially come to believe, though our experience tells us these myths are false. Women are **not** predestined to be mothers.

More specifically, here are some common phrases expressing these "cover-up" attitudes: "Earth mother . . . You're not a whole woman until you've had a child . . . The most intense exciting experience of a woman's life is to give birth . . . The fulfillment of having children." And from a very middle class booklet handed out by a Boston area doctor and written by a man: "A woman is likely to glow and look more beautiful during this period while her body is fulfilling its ultimate physical function. For each woman pregnancy has its own unique mystery, emotional response and contentment. Yet, while every mother-to-be differs in these respects, there are innumerable experiences which are common to all. They bind every woman into that exclusive sorority called Motherhood." And later: "Doctors who devote their practice to the care of pregnant women report again and again how amazing it is to observe a girl become a woman physically and emotionally in nine months. For many, the prospect of motherhood makes them mature. They become poised, proud, confident, and beautiful. Nature, in her own mysterious manner, seems to have devised an intricate balance that prepares the body for a baby and the mind for acceptance of motherhood. A conscientious woman responds to these responsibilities. She uses them to become a better person and a contributor to the growth of society."

These words are loaded in many ways. We find vague emotional words, such as "ultimate", "beautiful", "mystery", and they are used by a man in a biased way. Does our fifth pregnancy have its own 'unique mystery'? Is it 'nature' which prepares our minds for acceptance of continual motherhood? Are we "poised and proud" when bearing an unwanted third child? Most important, the definition of us is biased in traditional ways. To be a woman equals motherhood which equals fulfillment of destiny as preordained by Nature. These are the definitions most ingrained into us and they provide us with socially-backed positive attitudes toward childbearing that are a far cry from more individual thought-out attitudes.

These traditional definitions are often used by us as an excuse not to go out and tackle a world we have been ill-prepared to face up to. Excuses are not autonomous choices. We get pregnant for so many unconscious reasons: to hold onto or possess our man, to keep a marriage together, to prove we are not sterile (a sin), to please our family (and so often because the man insists on having his own children), to produce something of our own, to extend our own ego, to compete (women as products, as tools for producing babies, babies as products). Then there are other reasons which in practice can turn out to be constructive or destructive: we want to relive our own childhood as a parent; to prove to our parents or ourselves that we can do better; we are curious. Often what happens is that we en up exerting our own limited power over our kids, taking out our frustrations and disappointments on our children, expecting and even demanding that our children live out our lives where we feel we have failed. This is especially true of our parents' generation.

Some women, to escape jobs that are unrewarding or difficult, take refuge in repeated pregnancies. Someone suggested that babies provide the only opportunity for tenderness in some people's lives. So we find that under the guise of being "a contributor to the growth of society" we "intentionally" become pregnant because for so many there is little else we feel we can do well (because being out of the house is made dull or difficult for us by the system).

Then too there is the matter of guilt. If you have made your choice, you must constantly keep defending it. If you decide **not** to have children, you must keep making that decision and fight for it, justifying your choice to yourself and others, convincing yourself that you are not physically and emotionally sterile, a non-woman. If your intellectual, political arguments against having children are well thought out, your emotions (and society's judgments as society stands now) will confuse you especially as you get older, and remain at least partially unfulfilled in your chosen work, as you have been persuaded from birth that you will.

Next, the question of childrearing. What choices do we have today as to how and by whom we want our child to be brought up? What facilities do we provide for women in all categories who need free time and time to work as children are growing up? It does not have to be true that the woman who bears and gives birth to the child has to bring her up too; that only she, because she is a Woman, is emotionally equipped to care for children. From our births we are socialized into tender nurturant home roles, and men are encouraged to be tough, to go out into the world. These roles should be changed. Also our society has limited itself to the family as a viable child-rearing unit, a family in which the man is the breadwinner and the woman - super-cheap home labor - raises the next bread-winning breeding generation. It is very important that we question a set up so limited and limiting. Keep in mind too that 15-20% of the babies born at Boston City Hospital and Boston Lying-In have unmarried mothers. What provisions other than debilitating welfare have been made for these mothers and children? What provision do we make for us who autonomously decide to have children and rear them without men?

Finally, we should ask the question: What are the positive reasons for having children? The answer of each of us depends on her goals, principles and history. Each of us must make the choice to conceive a child with a sense of deep responsibility. Having children raises important questions such as: In what ways do we as people become more conservative in order to protect our families? What are the mental effects of being parents (for instance we are often forced to be more authoritarian than we would like to be)? In what ways does the nuclear family put pressures on both parents and children which inhibit our mutual growth, which destroy meaningful communication over a long period of time?

Once these and similar thoughts have been broached, we will begin to think in a clearer way about the necessity of escaping from our roles. We can be partially freed by our knowledge, then by our efforts to change all kinds of institutions. Because pregnancy has enslaved us in the past, that does not mean it must continue to do so. A pregnancy positively chosen can be a deeply joyful experience.

Pregnancy and childbirth have been shrouded by both men and women in mystery and fear. We have been forced into thinking that most physical discomfort and pain resulting from pregnancy is our "lot". So we submit to the experience and don't feel altogether legitimate in expressing questions, hesitations or fears. Or perhaps we never learned how. Society has emphasized the joys and been condescending, unsympathetic, or ignorant about the trials. Surely there are happy simple pregnancies, but even then our bodies change so greatly that we are bound to have questions. During pregnancy the normal functioning of the body as we experience it is called into question as it is during an illness. How irrelevant that doctors tell us it is normal for a woman to be pregnant. What do they mean by normal?

Basically three main things are happening during pregnancy: (1) Something is growing in the body. (2) Our bodies change physically both to make this growing possible and as a result of this growth. (3) We go through all kinds of psychological and emotional changes during this time. We owe it to ourselves to know as precisely as possible all that is happening to us, so that we know what questions to ask, how to pursue demands we might make on doctors and friends in order to lessen any discomforts we might be feeling and to insure that we get humane treatment. There are many things we don't know about this crucial event, and it's difficult to get information as a result of our long-standing inertness, and of doctors' attitudes toward us as we climb on the medical conveyer belt of pregnancy.

In this part of the chapter, pregnancy will be discussed as follows: (1) signs; (2) procedure for detecting pregnancy: tests and the pelvic examination; (3) some thoughts on what it feels like to be pregnant, both physically and emotionally; (4) some common changes taking place in the body and possible complications to be aware of; (5) possible doctors' attitudes and future examination schedule; (6) demands. In an appendix there will be a discussion of (1) the growth of the fetus from week to week, (2) infertility, possible reasons and what to do, and (3) miscarriages, possible reasons and ways of coping.

Most important: Though your pregnancy will have many things in common with other women's experiences, it will also be unique. Experience your own pregnancy. Talk to other women who have been pregnant and who are pregnant at the same time as you, but remember there's no "right" way to be pregnant. Try to learn about everything that happens, everything you don't understand. Remember that when we talk about experiencing signs and emotions, there are many exceptions and many combinations. Each pregnancy will probably be different and the first will be unique, for everything that happens is new.

Signs. You might have none, some, or many of the following early signs of pregnancy: if you have

had regular periods you will miss a period (amenorrhea). You might have nausea or more rarely vomiting, but they will disappear much before or by the 10th or 12th week. Breasts enlarge, tingle, and may hurt. The nipples may darken, and the area around them might become larger and darker. You may feel constantly exhausted. You will probably feel you have to urinate more often (frequency). If you feel this need, either alone or with the signs mentioned above, demand that a urine specimen be taken to be studied, for (1) if you feel the need to urinate more often it's either a sign of pregnancy or you might just have a urinary tract infection, or (2) if you are pregnant you become more susceptible to urinary tract infections. You should specifically demand that you doctor check your urine sometime during the first three months of pregnancy.

If you have irregular periods, you might not realize for 3-4 months that you are pregnant if you have none of these signs. You might or might not gain weight, but generally by the fourth month clothes don't fit too well around the waist. During the fourth or fifth month you can feel the first movements of the fetus, like a fluttering inside.

Procedures for detecting pregnancy: Tests and Pelvic Exam. You will see the doctor when you recognize some of the signs as pregnancy; or you might find you are pregnant while being checked for some other thing.

There are two main kinds of pregnancy tests, biologic and immunologic. Both use a hormone (HCG–human chorionic gonadotropin) secreted by the developing embryo and found in the urine of pregnant women. It can be detected as early as three weeks after conception. Both kinds of tests use urine. In the biologic tests when the urine containing this hormone is injected into laboratory animals - rats, mice, rabbits, frogs - it causes them to ovulate. This process takes a few days, whereas the fastest immunologic test takes only a few seconds. When a drop of urine is mixed on a slide with a drop of serum hostile to it and two drops of another substance, the mixture won't coagulate if the hormone HCG is in it. These tests are 95-98% accurate, but can be false if they are performed too early before there's enough hormone in the urine, if there are technical errors in handling or storing the urine, or if the test animal doesn't respond as it should. Usually the diagnosis of pregnancy can be made without these tests, but they are really useful if your periods have been irregular and you specifically want to know soon. The tests become unreliable after the 16th week of pregnancy because then the amount of HCG goes down as it is not needed any more by the growing fetus.

Then there's the pelvic examination: if you are pregnant, (1) the doctor can feel that the tip of the cervix has become softened, (2) he can see that the cervix has changed from a pale pink to a bluish hue, (3) the uterus feels softer, and (4) the shape of the uterus changes: where the embryo attaches itself to the inside of the uterus it makes a bulge which can sometimes be felt on the outside of the uterus. The doctor will most likely put one gloved lubricated finger into the vagina as you lie on your back on an examining table. If there is pain, say so. During a pelvic, it's most important to be relaxed for tension increases your own discomfort. Relaxation involves trust and that is sometimes difficult to have.

From the 16th to the 18th week the doctor can feel the fetus in the uterus. Its heart tones can be heard around the 18th-20th week, at approximately twice the rate of the mother's.

What pregnancy feels like. What does it feel like to be pregnant? Some pregnancies are comfortable, others are not. Up until the fourth month, except for some possible signs, you don't feel the changes going on within, for the placental system is developing within the uterus as well as the complicated system of the fetus. Then, as the fetus begins its bulkier growth, your waist becomes thicker, your stomach starts to swell below the waist, and occasionally you can feel the slight movements of the fetus from within (4th-5th month: called "quickening"). Very very gradually the bulge becomes larger. It feels hard to the touch, for the uterus is a strong muscular container and is completely filled. Toward the sixth or seventh month you can feel the movements of the fetus both from the inside and the outside as it changes position, turns somersaults, sometimes putting pressure on the bladder, sometimes on the obturator nerves at the top of your legs. You can put your hand on it and feel bumps – the knees, hands, elbows and feet – moving around, like a pillowcase seen from the outside with a cat moving inside. Each baby will lie in a certain position. Occasionally it hiccups, sometimes regularly for a few minutes. All of these movements get stronger and stronger; toward the very end of pregnancy they lessen and stop as the head settles into the pelvis.

As your body gets heavier, you tend to walk differently for balance, often leaning back to counteract the heavy front. Some women become very large, others barely show even at the end of pregnancy (fairly rare); some women really broaden, others remain narrow. Your breasts will become larger, you'll probably have to wear a bra if you don't already, or get a bigger one, for it's a good idea to support the breasts in order that they

go more quickly back into shape after you've had the baby, or later on have stopped breast-feeding. If you plan to breast-feed, massage your nipples to toughen them.

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It seems presumptuous to tell how you will feel individually, but we as woman do have many feelings in common. Feelings during pregnancy are so dependent on how we usually feel about ourselves, how much we want to be pregnant, to have a child, how we feel about the man. Some **positive** feelings: sometimes at the beginning of pregnancy there's an increased sensuality, a kind of sexual opening out toward the world, and heightened perceptions. Expectation. Great excitement, especially when you find out you are pregnant and then feelings of power and elation, when you feel the quickening, the first signs of life you are able to feel, though the fetus has been moving around for several months. And there are many **questions**: what is going to happen? How will the experience change me? What will I learn? Will I be able to cope well? And throughout the pregnancy there will be **negative** feelings and thoughts, during general depression and especially if a woman feels threatened, angered, and upset by it. The depressions are perhaps related to all the underground anxieties we have in relation to our own mothers and our childhoods. Anger about the takeover of our bodies by something tiny, invisible. This anger can be most intense at the beginning if there is nausea, and toward the end when it seems to have gone on too long and we want to be free and light and empty again. Anger that a cycle has begun over which we have no control. Resentment that some part of our freedom might be curtailed, has been curtailed. And there are many **fears**: with a first baby there's very simply fear of the unknown. No matter how much one knows about the physiological changes and events in the body, there's something incomprehensible about the beginning of life. There are fears that the child will be deformed, that one will die, that the child will die, that the whole thing for some reason won't happen at all. The fears might express themselves in nightmares, or in waking violent fantasies. One woman felt that though she had convinced the world she was beautiful, she had been deceiving everyone, and the child by being deformed would reveal to the world how ugly she really was. And then we feel **guilty** that we have these fears, for don't they in some way suggest that as mothers we will be inadequate? We can't allow ourselves these depressions because we are supposed to be strong, maternal, natural, accepting, etc. It is vital that we realize that our fears and depressions are legitimate, and we can and should feel free and right in expressing them. Talking together and sharing these experiences is vital in breaking down our societal isolation as well as the isolation that our fears impose upon us.

You might feel surprised after the first five months that there are still so many more to go, and very impatient. Or maybe glad that the pregnancy is going on so long, so that motherhood and the responsibilities it entails be postponed. If the pregnancy is good there's a completeness in the symbiotic relationship: the mother is glad to carry the child, and the child is protected from the world. And then there's a possible numbness, a kind of self-protectiveness against something happening. Some women don't think of the baby as a person, but as a fruit or vegetable, so that they won't have to begin to think of anything serious happening to something like themselves. Pregnancy makes some women feel dependent on other people.

It's important to know that these fears and doubts can occur during a good pregnancy too, for in a very real sense, your body has been taken over by a thing and a process which is not within your control, and you must come to terms with that, not passively, but actively, by knowing what the fetus looks like as it grows, what is happening to your body, and what your specific fears are. Talk to friends and try to sort out the inevitable old wives tales from the realities.

Some women want to know how they will look,

how they will feel about their changing changed bodies, how a man will feel about them. An important reason for this question is that we are taught that women must be sexually attractive: in this society we must be slim, firm, well-groomed. We are also taught that we are to become mothers: a pregnant woman is fulfilling her expected role, doing her duty though she might not be a creature of traditional sexual beauty in the process. Thus as our bellies become larger, we must make a transition from one role to another, and sometimes our images clash. Again, the way in which the woman feels about herself is important here. She might feel ripe, fertile, filled, beautiful. Or she might think of her body as swollen, distended, deformed, and really hate it. These feelings seem to depend on how much she feels she is in control about what happens to her body and how much she accepts its changes. How the man feels depends partly on the relationship between them: if either has negative feelings it's best if they can talk about them and realize they are legitimate and changeable. Talk can also lead to some deep good questioning about the conventional ideas of beauty that we're all brainwashed with on some level. Some men are turned on by pregnant women. Some men even participate in women's pregnancies by experiencing nausea and other symptoms. Other men are repelled, disgusted, threatened for a lot of reasons, and hostile. Two people will have to work these complex feelings out individually.

What about making love during pregnancy? Traditionally, doctors have asked that women abstain from intercourse four to six weeks before giving birth and up till six weeks after; altogether women had to abstain for three months. According to a recent Siecus Study Guide (No. 6: Sexual Relations During Pregnancy and the Post Delivery Period), this abstention was based on four unproven beliefs: (1) the thrusts of the penis against the cervix induces labor, (2) the uterine contractions of orgasm will induce labor, (3) membranes may rupture, leading to infection and (4) the sex act is physically uncomfortable. Masters and Johnson have some evidence that the contractions of orgasm could set off labor, but the women in their study were close to term anyway. The Siecus pamphlet concludes that intercourse toward the end of pregnancy is not inevitably dangerous! But you shouldn't make love if you have any vaginal or abdominal pain, if there is any uterine bleeding, if the membranes have already ruptured (then there is danger of infection), or if you have been warned that miscarriage might occur. In the latter case you should not masturbate either, as your orgasm might bring on the miscarriage. Also sometimes oral-genital contact isn't good as air blown into the cervix might endanger the baby.

During pregnancy, some women want to make love more often, some less. Masters and Johnson report an increase in sexual desire during the second trimester, and a decrease during the third. Many booklets and manuals mention that new and groovy positions can be tried. When you are pregnant, it is not usually comfortable (sometimes not even possible) to have the man above you; it might be better for you to be on top, for him to be behind you. It's possible that the woman or man might feel that the presence of the fetus is a hindrance and that the act is no longer as private or free as they want it to be. Or maybe you will want to use pregnancy as a time to be free from making love. On the other hand, especially at the beginning of the pregnancy, both women and men might feel freer for there is no worrying about conception, and making love can become more fluid and more natural.

To sum up, when we think of the complex feelings we have during pregnancy, we learn most by accepting and working with them. Then we come to know ourselves. A lot of our negative feelings, fears, and anxieties during pregnancy can be directly linked to specific forms of repression that society has inflicted upon us and our mothers before us. If our mothers were afraid because of ignorance, we will probably have absorbed much of their fear. We must become articulate, and learn together who we are so that we can choose to be the best that is in us, so that we can change traditional attitudes toward motherhood which deny

us knowledge and control over ourselves.

Changes and Precautions. As the pregnancy advances, our bodies change in many ways. The skin over the abdomen can become stretched and lines of stress will appear. By mid-pregnancy the breasts, stimulated by hormones, are functionally complete for nursing purposes. After about the 19th week a substance called colostrum may come out of our nipples, but because of high hormone (estrogen-progesterone) levels, there is no milk. Our breasts are larger and heavier.

There are changes in our circulatory system. Total blood volume increases 30-50% as the bone marrow produces more blood corpuscles and you drink more liquid. Because of the increase in blood production, our bodies need more iron; many doctors prescribe iron pills at this time. The heart changes position and increases slightly in size. Its peak load happens about the 30th week, then blood pressure tends to go down. Any of us who have a history of heart trouble should be aware of this.

The flow of urine is reduced because of hormonal changes, but both early and late in the pregnancy, partly as a result of pressure from the enlarged uterus, and because you drink more liquids, there's a frequent need to urinate. Again, urinary tract infections are more common, as the flow of urine can be slowed down and the functioning of the kidneys changed.

Movements of the bowels and the entire digestive system can be slowed down because of pressure from the uterus, so indigestion and constipation occur sometimes. Also as a result of pressure, the veins in the rectum (hemorrhoidal veins) become dilated. Varicose veins in the legs are common.

Sometimes we salivate more - it is not known why - and our gums tend to bleed more easily than usual. It is a good idea to have teeth checked, if possible, in the early months of pregnancy.

The joints between the pelvic bones widen and are made moveable about the 10th or 11th week, stimulated by a hormone called relaxin. Posture changes because we must lean back. Occasionally the separating bones come together and pinch the sciatic nerve which runs from the buttocks down through the legs. Backaches are common: there's more pressure on the spine.

Some of us get cramps in our legs (calves, feet and thighs). Sometimes in the morning you wake up and have sudden cramps which quickly wear off.

Many of us tend to put on weight greater than the weight of the fetus, uterus, enlarged breasts, amniotic fluid. The body tissues retain more water (edema) and feet, hands, toes and ankles can swell up. This weight gain can strain the heart if it is excessive.

When we go to the doctor for each examination, we are weighed, our blood pressure is taken, and our urine checked. These are preventative measures which guard against a disease of pregnant women called eclampsia. Those of us who tend to retain fluid are most susceptible, but there's no way of determining who will become toxic; that is, some interference occurs within the uterine circulation, causing a decrease of oxygen in the placental area. This may cause toxic substances to appear in the maternal circulation, substances which haven't yet been isolated. Eclampsia is divided into roughly three stages, called toxemia, pre-eclampsia, and eclampsia. Signs of toxemia are a weight gain of five pounds or more in four weeks, suddenly rising blood pressure, albumin in the urine, and swelling ankles. As soon as these are caught, they can be treated by proper salt-free diet and diuretics to get rid of the extra fluids in our kidneys.

Finally, the uterus changes greatly. Its size increases five to six times, its weight increases twenty times, and its capacity increases 1000 times. In the beginning it grows because it is stimulated by hormones. After eight weeks, the growth of the embryo-fetus determines its size. The greater part of the uterine weight is gained before the 20th week. During pregnancy it contracts painlessly (Braxton-Hicks contractions). It's possible for you to feel the hardening caused by the contractions, which last only moments but are repeated often.

This is by no means an exhaustive detailed list of body changes. But it does indicate that drastic processes are going on in our bodies and keeping in mind that we are in some ways adapted to bearing children, we must realize that we've got to be aware of possible difficulties.

Pregnancy examination procedure and possible doctors' attitudes. It's a good idea to see a doctor when you either think or know you are pregnant. During the initial visit he will examine you after (hopefully) taking a careful medical history. Be sure he knows your blood type. After the first visit, you will see him once a month until the 28th week. Then twice a month until the 36th week, and from then till the birth, once every week. During these exams you will have your blood pressure taken, your urine and weight checked. The doctor will measure the growth of the fetus both internally and externally. After the heartbeat becomes audible to him, he will listen to it each time.

During pregnancy we can become emotionally vulnerable and, as a result of all we're experiencing and the often impersonal efficiency of the examination, we may be rendered almost speechless. Often both private and clinic doctors treat us as children who know very little and are capable of learning less. It's a good idea to prepare lists of questions and persist in asking them until the answers are clear and satisfactory. It's much easier to do this and to establish some kind of reasonably good relationship with a private doctor than with clinic doctors who rotate so that we don't see the same doctor twice during a pregnancy. In either case we should demand to be treated as the intelligent and capable human beings that we are. This involves a lot of fighting and persistence, for we'll come up against stereotypical situations (paternalistic, punitive, condescending attitudes) and find ourselves forced into taking roles and playing games we don't want to play.

Demands. When we are pregnant we should be able to meet with other pregnant women to discuss our common anxieties and apprehensions. Doctors and clinics should make addresses and phone numbers of pregnant women available to each other. In each office or clinic we should demand information about pregnancy classes for couples and women alone. We cannot depend on hospital one-time classes or even prepared childbirth classes as they exist today to meet all our needs for information, support and encouragement. We must help each other as much as possible and as women we must demand that society provide us with the rooms, printed materials and group leaders of our choice to make our pregnancies times of learning and growth, and not full of fears.

APPENDIX

Growth of the embryo-fetus from week to week

The word embryo comes from the Greeks and means to swell or to teem within. Fetus comes from Latin and means young one or offspring.

Fertilization and growth of the embryo: The female ovum can be fertilized 12 to 24 hours after leaving the ovary, and the male sperm is effective for about 48 hours. A few dozen reach the vicinity of the egg. There are approximately 400 million sperm to 3.9 cc. of an ejaculation. (Another estimate: 20 to 500 million sperm to an ejaculation.) While many sperm manage to detach the outer layer of the ovum (zona pellucida), only one sperm can fertilize the egg. It must reach the egg's nucleus. The sperm loses its tail: its head - a nucleus containing chromosomes - swells. The 23 chromosomes of one cell meet the 23 of the other to form a single cell. At that precise moment the sex is determined, as well as certain dominant characteristics of the (from the) parents. About 10 hours after the first cells unite, there are four cells. Within the next 30 or so hours, it becomes multicelled, called the morula or mulberry, and is the size of a pinpoint. At about the end of the fourth to fifth day, it has reached the uterus, propelled forward by the movements and the cilia (hairs) of the fallopian tubes. It is now about 150 cells with a kind of hollow space inside (blastocyst). Implantation (attachment to the uterus wall) occurs between 5½ to 7 days. This process is called nesting or nidation. Tiny blood vessels in the wall of the uterus are broken and the growing cells absorb the nutrients from them, grow roots called villi, gather nourishment and the blastocyst implants itself in the uterus.

During the second week, the embryo is plate-shaped, with hundreds of cells, some of which form the embryo itself, the embryonic shield which contains preliminary tissues for a whole body; some form the umbilical cord, the placenta and the amnion (a membrane, a cluster of cells into which fluid flows).

By the third week, the embryo is one-tenth of an inch long, its neural tube formed, a swelling which runs from head to tail; from this tube grows the spinal column, nervous tissue and brain. By the 18th day, the eyes and ears begin to develop. The placenta takes up one-fifth of the uterine surface. By this time the first period will have been missed.

Fourth week: The embryo is ¼ inch long. The heart, looking like a U-shaped tube, starts beating on the 25th day. Proportionate to the fetus it is nine times as large as the human heart. There's a beginning circulatory system. There are simple kidneys, liver and digestive tract. The tongue has begun to form. On the 26th day, limb buds appear. (By now you can be given a birth day about 238 days in the future.) "Relative size increase is never again so great as in this first month. The embryo is now 10,000 times larger than the egg. Also the extent of physical change is never again to be equaled." (Smith, p. 142) By now the embryo has a closed system of circulation independent of the mother's.

Fifth week: The heart is pumping frequently, 65 times a minute. External ears are starting to take shape. About the 31st day, arm buds become hands and shoulders, and a few days later, finger outlines appear. The nose, upper jaw and stomach start to form. The embryo is ½ inch long. On the 33rd day, the eyes are dark for the first time; black pigment has just formed in the retina. The brain is ¼ larger than three days earlier.

During this time the fetus is unnoticed but vulnerable. The mother's diseases can be communicated to the embryo; the part growing most rapidly is most susceptible.

Sixth week: About the 37th day the tip of the nose is visible and eyelids begin to form. Five separate fingers and toe outlines begin to appear. The skeleton is complete and growing, but it is still cartilage rather than bone. Stomach, intestines, reproductive organs, kidneys, bladder, liver, lungs, brain, nerves and circulatory system are developing rapidly. The embryo is ¾ inch long.

Seventh week: Embryo one inch long, weighs 1/30 of an ounce. The stomach produces digestive juices, the liver makes blood cells, and the kidneys have started to extract uric acid from the blood. The ears develop in unison, timing, and form, as do the arms and legs. The upper and lower jaws are clear, the mouth has lips, a sort of tongue and first teeth (buds). The arms are as long as printed exclamation marks!! The thumb is different from the fingers. The first true bone cells develop; there's a working brain and a working circulatory system. There are active muscular reflexes. The body is padded with muscles and covered with thin skin.

Eighth week: Neck visible, head very large. Uterus four inches long. Placental area 1/3 of the uterus.

Embryologists can tell precisely how old an embryo is by seeing the stage of formation of its body during the first 48 days. After the eighth week, the embryo changes mainly in dimension and in refinement of the working parts (perfection of funcion follows perfection of structure).

Ninth week: Its sex can be seen externally. Its footprints and palmprints are indelibly engraved for life. Spontaneous movements occur, eyelids and palms are sensitive to touch (reflex squinting and gripping). Nails begin to grow. Eyelids close for the first time. Amount of HCG reaches maximum level. (The 8th and 9th weeks considered the best time for abortions.)

Tenth week: The quarter stage reached at 66th day, but the fetus will have to multiply its weight over 600 times in the remaining three quarters. The uterus weighs about seven ounces, contains one to three ounces of amniotic fluid. A common time for miscarriages.

Eleventh to fourteenth weeks: Fetus can frown, move thumb to fingers, swallow. Vocal cords completed. Urination begun and urine is removed with renewal of amniotic fluid. Can digest swallowed fluid. Sperm or egg cells exist. The mother's uterus moves up out of the pelvis and can be felt from the outside if the woman is thin. By the 12th week the fetus is about 2¼ inches crown to rump or 2¾ inches crown to heel and weighs ¾ ounce.

This is roughly the end of the development period. The fetus and placenta are about equal in size. The fetus's movements are fluid and graceful. Every baby by now shows distinct individuality in his or her behavior. The amnion tissue surrounding the fetus is transparent, paper-thin, tough, slightly elastic, shimmering; it's an enclosing watertight protective bubble growing with the baby. The fluid within is never stagnant; one-third of its volume is removed and replaced every hour. The baby's lungs and kidneys are thought to be one source of the fluid; and so is the amnion itself. The fetus fills the uterus. Its heart pumps fifty pints a day. The uterus is halfway between the pubic bone and the navel. The placenta produces the hormone progesterone in sufficient amount to maintain pregnancy (formerly done by the defunct corpus luteum).

In its second stage of growth, during the 15th-18th weeks, hair starts to grow on its head. Eyelashes and eyebrows begin, nipples appear, nails become hard. At birth they will be so long they will need to be cut. The heartbeat can be heard externally and you can feel its movements as it moves and hiccups. The skeleton hardens, it sleeps and wakes like a newborn, buds for permanent teeth come in.

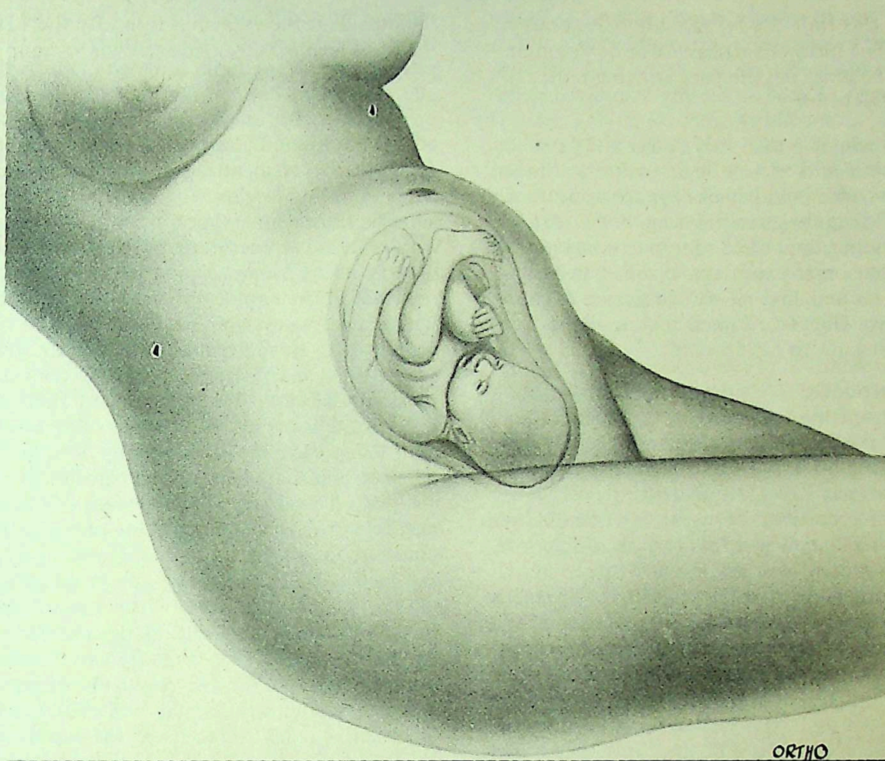
19th-22nd weeks: Premature life is possible. It can grip firmly with hands. A hairy growth called lanugo appears on arms, legs, and back. Now approximately 12 inches crown to heel. Uterus is up to navel.

23rd-26th weeks: Many prematures at this age are able to live. Amniotic fluid perhaps 1½ pints, but after 30th-36th week may not increase or might even decrease to allow fetal growth. Head hair grows long, lanugo disappears. Fetus can and does suck thumb. Umbilical cord reaches maximum length. Uterus a few inches above the navel, fetus about 14 inches long.

The third stage: 27th-30th weeks: by about the 28th week the fetus is "legally viable"; that is, it has organs sufficiently formed to enable it to live if born early. It settles into a head down position, is fatter, with smoother skin. About 16 inches long.

31st-34th weeks: Still growing, about 17 inches long. Premature babies look more like babies as they have more fat on them, and less like little old people.

35th-38th weeks: The fetus's heart pumps 600



pints a day. Growth stops shortly before birth. One cell has become 200 million cells. The weight of the original fertilized egg has been increased five billion times. The uterus is 14 inches long, maximum size, and it weighs 2¼ pounds. The placenta weighs 1½ pounds at term and is seven to nine inches in diameter. The baby is ready to be born.

From the mother's blood, from the placenta and perhaps from the amniotic fluid the baby has been receiving substances which make him immune to a large variety of diseases. It receives disease-combating proteins called antibodies which have been built up from the diseases she has had. These immunities will gradually wear off after the first six months of life. In the last month before birth, the baby will have a level of antibodies and gamma globulin equal to that of its mother.

Infertility

Many woman have difficulty becoming pregnant. Usually if a man and a woman have been trying to conceive over a long period of time, many tensions are built up. Trying to conceive on the mathematically right day, during ovulation, can become a self-conscious mechanical process, eventually destroying good sex. Both the man and the woman might begin to resent each other, to hold unfounded grudges and suspicions, and above all, to feel inadequate.

How long should a woman or a couple wait before seeing a doctor? If you can't conceive a child after trying for two years, or for one year if you can't wait or if you are past thirty (your fertility declines with increasing age), then you should see a doctor interested in infertility who has had obstetric and gynecologic experience, and knows about the physiology of reproduction. He should also definitely know about semen analysis. If he is a good doctor he will be aware of your tensions and hang-ups and he will try to deal with the emotional and psychological conflicts you might have toward each other and maybe towards having a child. A doctor who runs through a series of tests without talking with you will be helping you less than he could.

Often you, the woman, will feel more guilty and responsible for not being able to have children than the man will. Studies show that 10-15% of the couples in the U.S. are infertile, and in more than 40% of these cases the man is responsible. It's possible that some men will resist (1) the idea there's something amiss with them and (2) going

to the doctor with you. It's threatening for him as well as you to think himself on some level impotent, and even more upsetting to find out definitely that his sperm are not "powerful" or numerous enough. But if he's really interested in having a child, he'll consent to be examined first. It's usual to examine a man first because it's a much simpler process. But now it's possible within the span of two menstrual cycles for a woman to get a series of diagnostic studies done if the sequence is treated logically; or she can, in two days in the hospital, have many tests done. Of course these tests cost money, and we should demand that they be made available to all women who need to have them, who want to have a child.

If you decide to see a doctor systematically, then prepare for a first meeting by trying to go over your medical histories. The doctor should take your histories in detail. He'll probably ask you as a woman if you are married. He'll ask about your gynecological history: when did menstruation begin, regularity of periods, discharges, periodic bleeding, spotting, former infections, abortions, possible rape. It's hard to speak factually about difficult events like abortions and rape; but they are facts, possibly medically important, and it can be part of our strength that we speak of them clearly. The doctor will review your circulatory, digestive and excretory systems to find out if you have been or still are ill, and to find out how you have been treated for these illnesses in the past. He'll probably ask about your sexual relations.

The next step for a man will be a physical exam and a sperm analysis, and for the woman a physical exam and a pelvic exam. It might be that just going to see a doctor will relax you enough to conceive, if nothing else is wrong. It might be that the man's sperm might be defective in some way, and you can work with the doctor from that evidence to try and conceive.

Before going into the specific kinds of things the doctor will be looking for, it makes sense to mention the conditions on which fertility in women depends: (1) good general health, (2) desire to give birth to and rear a child, (3) no infection or inflammation in the reproductive tract, (4) good functioning of the reproductive tract – vagina, cervix, uterus, fallopian tubes, ovaries, the anterior pituitary gland and parts of the hypothalmus and cerebral cortex.

For an egg to be fertilized there are roughly twelve conditions: (1) At a time properly related to the developmental stage of the endometrium (lining of the uterus), an egg must be discharged from the ovary. That presupposes that at least one ovary be intact, that it have "responsive" follicles, that its activities be governed by a functioning hormonal-endrocrine apparatus. (2) Near the exact time of ovulation, the hairs (fimbriae) of the fallopian tube must surround the lower half of the ovary and catch the ovum. (3) In the tube the egg must progress at a rate of no more, no less than 5-6 days; otherwise, the fertilized egg will not implant successfully. (4) Healthy sperm must be deposited in a healthy intact vagina. (5) Once in the vagina a sufficient number of sperm must go into the endocervical canal as a result of their efforts or because of "in-sucking" organic contractions of the uterus. (6) Once in the canal there must be a good biochemical environment. The cervix must be in all ways intact. Its secretions must interact well (nontoxically) with the sperm. (7) From the canal the sperm must climb to the uterus. (8) Then into the fallopian tubes. (9) They must be able to swim against the push of the hairs to the farther third of the tube and there meet the egg during its time of viability. This depends on the vigor of the sperm, maybe on the chemical secretion of the tubal secretions. (10) Large numbers of sperm must affect the shell of the egg so that it can be penetrated. (11) As it is swept along the tube toward the uterus the fertilized egg must undergo a series of maturational changes that make it into a blastocyst as it arrives in the uterus. It must be genetically and embryologically normal. (12) The endometrium must be ready to receive it, the secretory changes of the menstrual cycle must be adequately advanced.

Thus, if any of these things are prevented from coming about, the end result can be infertility.

During the second step of the exam, the doctor will then give you a pelvic. He'll look at the distributions of pubic hair, the development of the labia, he'll look for evidence of infection. Next the entrance to the vagina is inspected. Sometimes it's found that the hymen isn't sufficiently open. Two glands (Bartholin's and Skene's) are examined to see if they're closed up, infected or tender. There might be some obstruction in the vagina. The amount, color and odor of vaginal secretions are noted. The doctor inserts a speculum to hold open the vaginal walls, and observes the position, size and shape of the cervix. Then he'll palpate the cervix and uterus with one finger inside and one hand outside to determine the size of the uterus in relation to the cervix, its position, consistency and freedom to be moved. In the same way he'll also check the position, size and consistency of the ovaries.

If he hasn't found anything wrong anatomically, and if the man's semen is normal, then you return for the third step of the investigation, which con-

sists of complete blood tests to check your normal endocrine functioning and basic body health. You will have a complete blood count to check the number of red and white cells that you have; a hematocrit, a count of the percentage of red cells in a specimen of blood to determine anemia; a test to determine by checking white blood cell count if there's any infection and a differential: a check of the kinds of cells involved in the white blood cell count. Your blood will be typed, for it's possible that incompatible blood types may be reflected in the sperm and in the egg. And as abnormal thyroid function affects fertility, you'll have two or three tests to determine how efficiently the thyroid is working. You should have a two-hour post-prandial blood glucose test to determine that there's proper functioning of glucose control mechanisms, a test for diabetes. And finally you will have a urine analysis to determine kidney function, hormones in the urine, infections.

If everything described above gives no clues to what is wrong, the doctor will do a systematic investigation of the bodily systems of reproduction.

First he'll want to find out whether your ovaries produce graafian follicles which upon ripening emit eggs. Two days before menstruation he'll do an endometrial biopsy which consists of taking a small sample of the uterine wall tissue to give information about whether ovulation takes place and how the endometrium develops. He will do a fern test twice, once during mid-cycle, once at the end of the cycle: when estrogen is present and highly concentrated, during ovulation (mid-cycle), the cervical mucus under the microscope shows fern-like designs. At the end of the cycle the fern pattern will no longer be there, for the progesterone of a normally ovulating woman inhibits fern formation. Another way of determining ovulation is to record your basal body temperature rectally on a special thermometer. Your temperature is supposed to rise 1° F at ovulation and stay high during the life span of the corpus luteum. If there's no significant rise, progesterone isn't being provided in effective amounts. The basal body temperature is of greatest value with women who have regular menstrual cycles. All these tests of egg formation shouldn't be counted as conclusive. It might be that they'll have to be done a few times, for you might have an atypical cycle the first time. Any diagnosis of ovulation to be fairly complete should cover at least three cycles.

There are several kinds of menstrual disorders which indicate that something has gone wrong either with ovulation, hormonal levels or some other facet of the menstrual cycle. There are different kinds of bleeding: disfunctional uterine bleeding, possibly caused by persistent corpus luteum cysts, pelvic inflammations or infections, anemia; dysmenorrhea (abnormal menstruation); amenorrhea (no menstruation); anovulatory bleeding (bleeding without ovulation). The doctor needs to follow here a logical sequence of studies. A common cause of lack of menstruation is the Stein-Leventhal syndrome: enlarged ovaries or ovaries with cysts. The cysts can be removed by a simple operation.

If he has to continue the search, the doctor will check the transportation of the cells, by looking for tubal disorders. The fallopian tubes might be blocked, so that he will blow CO_2 through them (the Rubin test, CO_2 insufflation test). This test in itself might correct the blockage.

A hysterosappingram may be taken of the uterus and tubes. A water-soluble opaque medium is injected into the uterine cavity and outlines the uterus so that any obstruction or malformation shows up clearly in an X-ray.

Tubal disorders may be grouped under two categories: (1) mechanical obstruction by organic lesions, caused by pelvic inflammatory disease, ruptured appendix, peritonitis, abdominal or pelvic operations or (2) disturbances of the physiologic function of the tubes – failure of the ovum pick-up mechanism, delayed or too rapid ovum transport, endocrine disturbances and/or psychic stimuli; that is, if you are psychically disturbed, what goes on in your brain might inhibit certain necessary hormones from being released.

If nothing yet has been found to be wrong, the doctor will then look into how sperm are placed on or near the cervix and how they pass through the cervical canal. The most well-known test is the Sims-Huhner or Postcoital test. Often it is the first test to find out how the sperm enters the woman. It should be done six hours after a couple has had intercourse, though there's disagreement about that timing. When cervical mucus is taken from the woman and looked at under the microscope, the number of actively moving sperm is counted. There's also the semen penetration (Miller-Kurzrock) test in which a specimen of the man's semen is placed near a sample of cervical mucus. If the sperm can penetrate the mucus and live, then they are viable, they interact well. Sometimes the semen and cervical mucus are simply hostile, the male immune in some way to the female, or vice versa.

Position of a couple during intercourse becomes important, another kind of test.

Finally there's something called psychogenic

infertility. This means simply that because of conscious or unconscious anxieties or fears a woman will try in all kinds of ways not to have a baby. There's infertility due to no identifiable cause, the cause has not been found. And there is absolute sterility, for instance where both tubes have been seriously damaged.

The whole process of finding causes for infertility can be incredibly wearing and depressing. It takes a lot of strength for a woman to go through some or all of the above tests. But it's helpful to know some of the causes, some of the tests; it's essential to demand of the doctor that he tell you what the procedures he uses consist of, that he describe the tools he will be using if you want him to, that he give you some idea of how the different processes will feel and be responsive to your reactions.

Miscarriage (natural abortion)

Miscarriage is always an emotional event. There are different kinds of miscarriages at different times during pregnancy. If it happens early and the fetus is barely formed, you might be less affected than if t happens after the fourth or fifth month, after ou have felt the fetus move within you and felt t to be real to you. But if you want a baby, even if it happens early and especially if it has occurred once or several times before, it can be occasion for increased anguish and despair and add to the tension involved in trying to conceive again. Many fears are increased, and you become more and more vulnerable and must work on building up defenses. If a miscarriage occurs in the fifth month or later, some women feel incredibly incomplete, and find themselves waiting for something to happen – their time sense gets shaken up. This can happen even earlier. All of this is not to alarm but to make women aware that miscarriage is a possibility during pregnancy (one in ten women miscarry) and can be very difficult to cope with. But anxieties can be lessened by your persistence in both learning reasons for your miscarriage and by being as much as possible aware and constantly in touch with your feelings and fears. It is also vitally helpful that you talk out these feelings, and very important that your friends not gloss over the event, feeling so uncomfortable with it - and it can be hard to deal with - that you are frustrated when you try to communicate your feelings. Often through talking both to the man involved and empathetic friends you can sort out your own strong feelings and begin to know your anxieties.

If a woman is not fertile, the reasons for her infertility might be the reasons for miscarriage. (The man is less responsible for miscarriage than for infertility.) So many of the tests performed for infertility are useful in determining why a woman will habitually abort.

There are four general classes of causes of miscarriage: (1) defective egg or sperm, (2) faulty production of estrogen or progesterone, (3) anatomical illness or functional abnormalities, or general illness or infection, (4) psychological. 30% of women abort and around 50% of the fetuses are found to be abnormal. Some more percentages: after a first miscarriage it's 85-90% sure that the next pregnancy will be all right. After a second, there's a 50% chance, and after a third, a 25% chance. A woman who has miscarried three times or more is called a habitual aborter. She should definitely have preventative (preconceptual) therapy and treatment.

Miscarriages are classified into stages or types. One abortion can pass through many stages.

Threatened abortion. There's a difference between bleeding and abortion bleeding. Some women when pregnant about the time they are supposed to have their periods bleed slightly for a few months. Sometimes as the blastocyst implants into the uterine lining there's slight bleeding. Sometimes the bleeding might be bright red – if it continues for several days, go to the doctor; he'll examine you for lesions. Early bleeding has no effect on fetal development. If bleeding does begin (slight brown staining with little or no abdominal cramps), there is always uncertainty. The pregnancy might or might not continue. You will be advised to go to bed until the bleeding has turned brown and then stopped for 24 hours. Afterwards you should not douche, be too active or make love until the 14th week of the pregnancy. Many women find the fact that there is no treatment hard to accept; and find it so hard to accept the fact that if the bleeding continues for several days, it means almost definite miscarriage.

Inevitable. Severe cramps, cervical effacement and dilation occur with strong bleeding and clots. No way to stop it.

Complete. The uterus empties itself completely of the fetus, membranes and the decidual lining of the uterus. During the first three weeks, spontaneous abortion is almost always complete. Sometimes then and even later it might feel like a really heavy period; sometimes you might not notice it at all as it takes place around the time you expect your period. If the pregnancy is more advanced than three weeks, the doctor would very likely give you a D & C to be sure that every bit of membrane is out of the uterus, for unless it is completely emptied, the uterine muscles won't contract to

compress the bleeding vessels and control the hemorrage.

Incomplete. Varying amounts of tissue remain in the uterus, either attached or free. Mild to severe cramps, perhaps pain in a specific place. Must get a D & C.

Missed. When the fetus has died but remains in the uterus. Symptoms of pregnancy disappear, breasts get smaller, the uterus stops growing and gets smaller. Spontaneous abortion almost always occurs. There's a brown spotting. Doctors usually wait until it begins by itself, and then give a D & C.

For the record there's something called a **septic** abortion. What that means is that a woman has tried to abort herself and has caused either infection or an incomplete abortion. If abortions were free and legal and easily available this "medical" category would completely disappear.

Sometimes a woman's cervix has been injured and can't hold in the fetus. A simple operation can be performed to prevent her from losing her baby.

In general, if you have a history of miscarriage, you should get fully examined along the lines of the infertility investigation. If you have miscarried only once, that usually means that the egg or sperm is defective, and it's paradoxically a healthy thing for your body to get rid of an embryo or fetus which isn't growing well.

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Prepared Childbirth

The purpose of this chapter is to explain to women the experience of childbirth and the ideas and techniques of prepared childbirth from a women's liberation viewpoint. It is important that prepared childbirth be discussed in the context of a course on women and their bodies that includes sections on sexuality, anatomy, medical institutions, etc. My larger aim is to re-unite women's minds and bodies, not just for the brief period of childbirth, but in an overall program of overcoming our mental and physical oppression as woman.

There are two basic assumptions which I think are important to state clearly at the beginning: (1) Every baby born should be wanted (there should be free, legal and safe abortions to any woman upon her request alone). (2) Every woman (married or unmarried, rich or poor, black, brown, yellow, red or white) has the right to childbirth preparation.

Childbirth preparation does not begin or end with childbirth; a more accurate description is preparation for children, which begins with the decision to have a child (hopefully not a casual one), goes through the defined stages of pregnancy, labor, delivery and birth of a child, a short postpartum period (length varied) and a longer (endless?) period of childcare. I will focus on labor, delivery and the birth of the child and will call that preparation for childbirth. This discrete period (average of 14 hours from beginning of true labor to birth of the child for a primipara or first-time woman) compared to the time it may have taken to conceive, the nine months of pregnancy and the 21 years of legal responsibility (years of emotional responsibility are unnumbered) is short and intense. Childbirth is a period of crisis for all women, a time of great physical, emotional and social changes. Childbirth preparation must help the pregnant woman and those close to her understand the changes and her feelings about them; it must identify the range of physical, emotional and social changes, their inter-connections and ramifications and offer support, experience, explanations, partial solutions. This sharing may start at conception of a child but it does not stop at childbirth.

My primary focus is on us as women, on us as people and we neither begin nor end with the birth of a child. The child is a new dimension and can be an exciting dimension as long as it isn't the only dimension. With this introduction we can focus on preparation for childbirth.

WHAT'S IN A NAME: SOME COMMENTS ABOUT HISTORY

Prepared childbirth is often misnamed "natural childbirth". The only thing that is natural is that a woman's body is biologically equipped to bear and give birth to a child. (We have been **taught** to want children and to expect to raise them ourselves.) Although considered normal by most women (reared on the usual myths), it is not natural for us to have our babies in helpless, degrading, ignorant pain and fear. Dr. Grantley Dick-Read, an English obstetrician, believed fear caused tension that inhibited the process of childbirth. If women were educated to understand what was happening to their bodies, he felt pain would be minimized. He certainly was a pioneer (book published in 1942) in preparing women for childbirth; however, his method appealed to religious conviction and mystical beliefs about a woman's role in society.

A French obstetrician, Fernand Lamaze, visited the Soviet Union and saw Pavlovian reflex theories applied to childbirth. All kinds of women gave birth in joy rather than in pain. Excited by what he observed, he returned to France and in 1951 introduced a method called the **psycho-prophylactic** technique in clinics for working women (psycho-prophylaxis of pain in labor means prevention by psychic means).

"Although the goal was the same - childbirth with minimal discomfort and with medication, enabling the mother to see her child coming into the world - the Lamaze method differed from the Read method chiefly in advocating that the mother be very active during a contraction instead of concentrating on relaxing.

"The Lamaze method was introduced to the United States in 1959 with the publication of Thank You, Dr. Lamaze, a book written by Marjorie Karmel, an American whose first child had been delivered by the French physician in Paris.

"The following year, Mrs. Karmel and Elisabeth Bing, a Berlin-born physical therapist, founded the American Society for Psychoprophylaxis in Obstetrics [ASPO], a nonprofit teaching organization of doctors, teachers and parents.

"'We don't call it natural childbirth but educated childbirth,' says Mrs. Bing. . . 'Read says it's a normal physiological process, which shouldn't hurt if you think right. He's very mystical. We say labor is a situation of stress and we try to cope with that situation.'"[1]

As we examine the history of childbirth practices (see Awake and Aware by Dr. Irvin Chabon), we realize that when anesthesia began to be used and children began to be born in hospitals, less of us died in childbirth. However, we paid a price. As we moved from home to the hospital, we became "patients" ("objects", "victims"), were seen as "sick", and thus lost control over the experience. Now that we are taking control of our bodies and evaluating the use of drugs (not only during childbirth!), we are also questioning the hospital as the **only** place to have a baby. We are going forward, not backward. We are not saying no drugs, no hospital. We are learning the reasons for both and feel that they are an advance for some of us; but for others of us they are not necessary. It comes down to us understanding our own bodies, the risks we take, and demanding the right to shape our experiences, whether in the hospital or at home.

Preparation then takes on a new meaning beyond that envisioned by Lamaze and his followers. It is a process of exploring our own feelings and trying to figure out what we need and want during the short period of childbirth (and how that relates to the larger period of preparation for children); of learning what happens during labor and delivery and acquiring skills for coping with our bodies; of understanding the medical situation in America (particularly the hospital and the doctor) and finally of integrating the parts of the process for each of us in a way that enables us to approach childbirth with confidence in our ability to handle all parts of the experience so the experience as a whole is positive and one of growth for us.

HOW YOU GET PREPARED: CLASSES FOR PREPARATION, DETAILS AND DIFFERENCES IN APPROACH

There are two different groups that offer preparation classes in the Boston area. One is a group of trained nurses (RNs) who teach the Lamaze method (they have some LPNs too). The group is called The Lamaze Childbirth Education, Inc. Although not affiliated currently with ASPO, they are known as the official Lamaze group in the area. The other classes are sponsored by the Boston Association for Childbirth Education (BACE). You don't have to be a trained nurse to teach (often the teacher is a nurse and her assistant is not); BACE has its own training course and apprenticeship program for its instructors. The method they teach is eclectic, combining techniques of Dick-Read, Lamaze and Shiela Kitzinger (see bibliography).

The biggest difference between the two groups is their general organization. The Lamaze group is a medical, professional organization, and the BACE group has a parent, para-professional organization. As I mentioned above, this means that only trained nurses teach the Lamaze classes, while parents may teach the BACE classes. The Lamaze group has talked of non-nurses teaching, but has not changed since they feel it's important that the teachers also be **monitrices** (monitor or coach) during labor and delivery (to be a monitrice your credentials have to be approved by the hospitals). I don't know whether BACE has a system of monitrices, but parents do teach courses.

The orientation of the Lamaze classes is on childbirth and that of the BACE classes on parenthood. Both groups give similar physical training for the actual period of childbirth. BACE goes beyond the birth of the child and talks about breast feeding, child development and other topics of relevance to new parents. BACE also talks about family centered maternity care in the beginning, a concept which is a challenge to all medical facilities in the Boston area. The BACE classes will more likely teach you to be properly critical of hospital procedure and the medical profession than the Lamaze classes. The Lamaze classes teach the women (couple) how to cope with the doctors and hospital (responsibility is on the woman), while the BACE classes teach the woman (couple) that she will not be well received and will need a lot of support from her man (hospital's problem which couple has to be aware of). Even though the BACE group is not about to break with the medical profession, the governing body of the BACE organization is a parent board which shapes the classes and changes as the parents change.

From a woman's liberation point of view, both sets of classes fall short. Nevertheless, it is essential to have some kind of training and coaching in exercises and breathing, and they are the only ones doing it now. Both Lamaze and BACE are excellent in physical preparation of a woman for that short period of time called childbirth. BACE goes a little further in recognizing the emotional changes and social changes of becoming parents. However, neither group has adequate preparation for children. The classes do not begin early enough; they should start before conception. People should have an opportunity to talk through a decision to conceive a child before the child is actually conceived (e.g. if you want a child to care for, why not adopt?). From the period of conception to the start of classes in the seventh or eighth month is a long one; unless you happen to have other pregnant friends you are not likely to have a chance to talk out the many feelings and fears you have about having a child. (Even then there is pressure not to talk about negative feelings.) In other countries where midwifery is practiced, women have

contact with the midwife who will deliver her baby from very early in her pregnancy. The midwife is a woman with whom you can share feelings; she is also a source of contacts with other pregnant women (often in the neighborhood since the midwife is assigned to one or two neighborhoods). Clearly one of our demands must be to make the practice of midwifery legal and popular.

The classes never discuss the nuclear family as an institution of oppression (for both children and parents) and means of childcare (playgroups, day care, communal child care, etc.). This could be a time for women and men to split and talk alone and then come back together as a group.

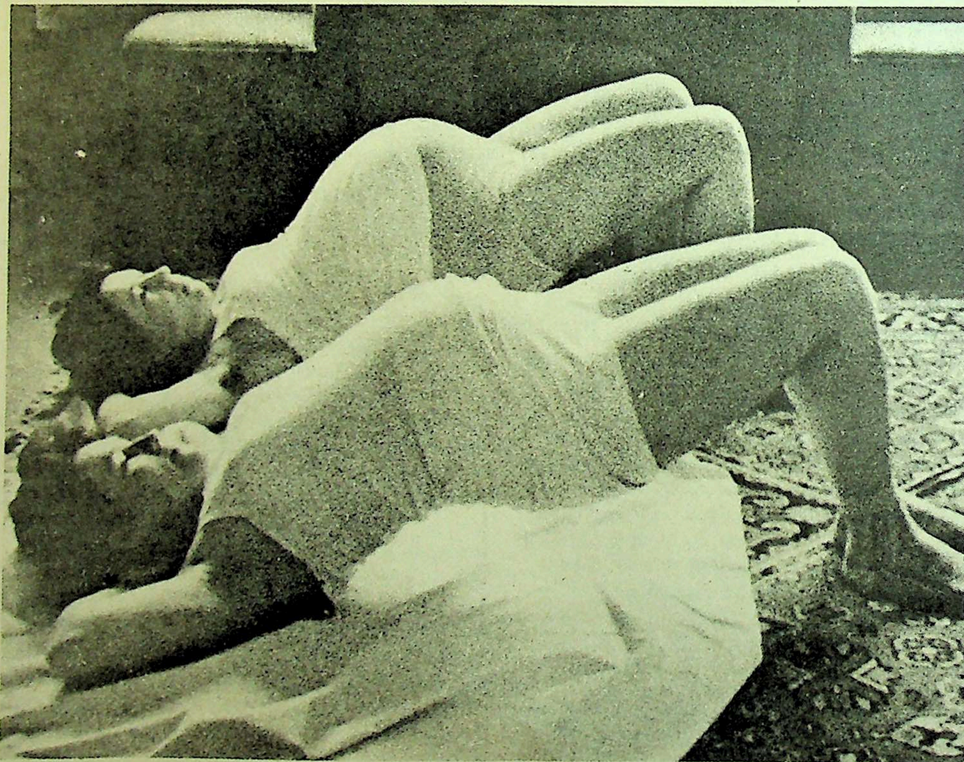
The classes are too large (15 to 20 couples) to have the kind of discussion I'm talking about, too expensive ($30 a couple) and too exclusive (they attract primarily middle class, married couples, highly educated intellectual types). BACE has started one class in a local community center for low income women. But **all** women must have preparation – in their neighborhoods, in clinics, in churches, in schools.

PREPARATION BEFORE LABOR: LEARNING ABOUT YOUR BODY AND HOW TO USE IT – MUSCLES, EXERCISES AND NEUROMUSCULAR CONTROL

The work of labor centers on the pelvis and uterus. In order to approach labor, we have to understand the construction and functions of these parts of our body. Then through physical exercise we will prepare our bodies for the hard work of labor.

Pelvis. The pelvic girdle is formed by the hip bones which create a shape something like a lobster-pot sloping downwards and forwards, through which the baby passes when it is being born. The pelvic outlet is limited by the **sub-pubic area** in front, the **ischial tuberosities** at the sides, and the **sacrum** behind. The **coccyx**, the little bone at the bottom of the spine, although curved forward, is attached to the sacrum by a joint which moves back when the baby is being born, so that it does not get in the way.

Uterus. The internal reproductive organs of a woman are composed of a hollow, thick-walled mus-



cular **uterus** or womb, shaped like a pear with the stalk end pointing downwards and usually slightly backwards. In front and behind are the bladder and the rectum, and the mouth of the uterus, or **cervix**, connects up with the vagina from below.

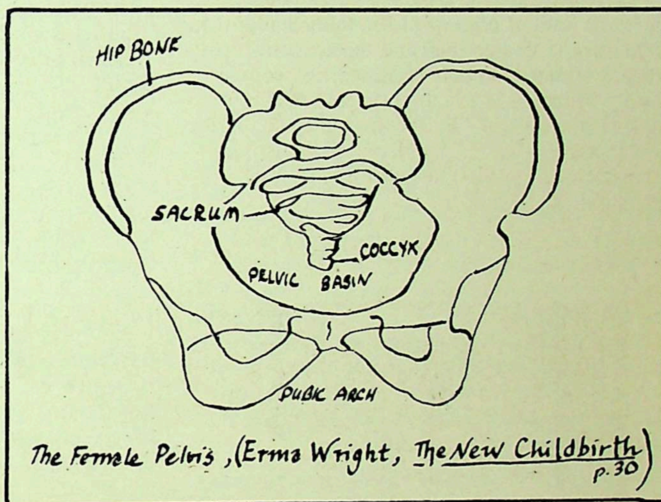
"By the end of pregnancy, the uterus has moved up and out of the pelvis into the abdomen, is narrow-shaped and about 12 inches long. Its **fundus** (top) reaches nearly as high as the **diaphragm**, which is the sheet of muscle which separates the abdomen from the **thorax** (chest). The baby is protected within the walls of the uterus which are about half an inch thick, and is also inside a bag of membranes, where [she] floats in (**amniotic fluid**, or bag of waters), attached by the umbilical cord to [her] placenta through which [she] is nourished.[2]

The open space created by the bony pelvis and which supports the growing muscular uterus is called the **pelvic basin**. Across the bottom of this basin stretch the **pelvic floor muscles**. In their normally firm state, these muscles keep the intestines and other soft organs from falling through the lower opening of the pelvis. During delivery these muscles should be relaxed to permit the baby to pass through.

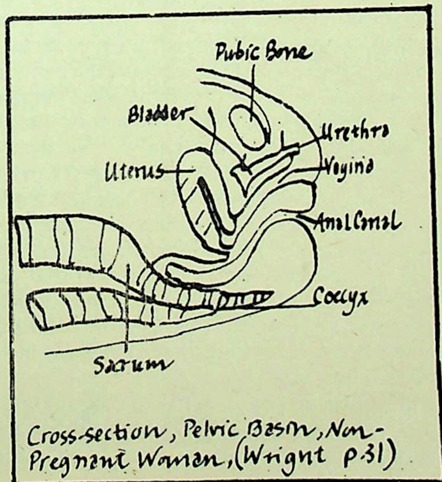
Here are three exercises from Erna Wright that will get your pelvic muscles in shape for labor. As you do them, you will understand your body better and take control of parts of it so it works for you during labor.

"Exercise 1. Sit on the floor 'tailor fashion'. If it feels hard sit on a cushion; but don't lean against anything. Make your back muscles support your body in an upright position. The exercise you are about to learn will help increase the suppleness of the muscles of the pelvic floor. . .

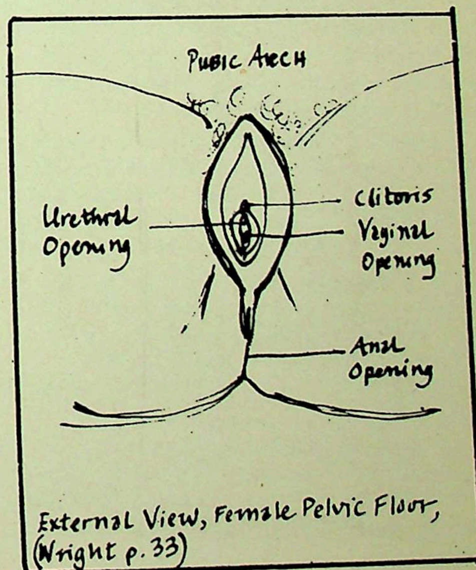
"Put the soles of your feet together with heels as close to your body as possible without losing your balance. Grasp your feet together with one hand and put the other hand **under** one knee. Now push your hand toward the floor with your leg; then bring the leg back to its previous position with your hand. Notice that the muscles on the



The Female Pelvis, (Erna Wright, The New Childbirth p. 30)



Cross-section, Pelvic Basin, Non-Pregnant Woman, (Wright p. 31)



External View, Female Pelvic Floor, (Wright p. 33)

outer side of the thigh are pulling against the muscles on the inner side, called the **adductors**. Repeat, pushing toward the floor in one smooth movement, and bring the knee back once more. After six repeats, change hands and do the exercise six times with the other leg. Then keep your feet together without holding them, and use both hands under both knees simultaneously. Again repeat six times. Don't jerk your knees downward – just push as smoothly as possible each time.

"After a few weeks of doing this whole pattern once daily, you will find that you can bring your heels closer to the body without losing balance – proof that your adductor muscles have lengthened (postnatal exercises will reverse this again).

"Exercise 2: This has become a boon to many expectant mothers who suffer from backache. The exercise is intended to make the muscles covering the back of the pelvis more supple.

"Kneel on the floor, sitting back on your heels. Rest your hands on the floor in front of you, with the elbows turned outward and slightly bent. Put your head down and hump your back. Now, using your thigh muscles like pistons, push your buttocks out backward – like a duck lifting its tail. Feel your thigh muscles doing the work. Then make them pull your buttocks back again, as though you were trying to hide them. Repeat six times. Alternatively you can do this exercise sitting on a hard chair about halfway along the seat. Plant your feet firmly on the floor in front of you. In this position hold your thighs with your hands to feel the muscles at work.

"If you ever find that you back suddenly goes into a spasm, especially after bending down, don't stay in a bent position. Sink onto your knees instead, and do this exercise. After a few minutes the cramplike sensation in your back will ease. This exercise is also often beneficial in early labor if backache is experienced.

"Exercise 3: Kneel on the floor with your knees slightly apart. Put your hands flat on the floor with your arms held straight. Your back should be arched slightly upward so that your body forms a square between knees and hands.

"Do the exercise as follows: Contract the muscles surrounding the back passage [anus]. Decontract. Repeat with muscles surrounding the front passage [urethra, vagina] and then the whole pelvic floor. Repeat the whole pattern three times, once a day.

"A word of comfort: It is almost impossible to do this the first few times. Just get the idea, and then persevere. After a few weeks you will achieve control over the different parts of the pelvic floor."[3]

You will want to do some exercises to strengthen the upper and lower muscles of your abdomen. These muscles are used during delivery when you help push the baby out. It's important that you begin to get these muscles in shape because the better each push is, the fewer pushes will be needed, and the baby will stay in the birth canal for a shorter period of time.

These exercises are very simple. Lie down flat on your back on the floor. With arms at your sides, relax (i.e. decontract) all muscles. Try to think that if the floor was not supporting you, you would float free in space.

Upper abdominal muscles: Slowly lift just your head from the floor (shoulders should come up as little as possible) until your chin touches your chest. Do this to the count of three and lower to count of three with pause in between raising and lowering. Do this three times the first time and work up to ten within a few weeks. Do this exercise once a day.

Lower abdominal muscles: Now lift your feet off the floor, keeping the rest of your body still. You should raise them just high enough so you feel a pulling sensation in your lower abdomen. Do this in the same pattern as for the exercise above.

You may also want to do exercises to strengthen the muscles under your growing breasts. Both of these exercises should be done sitting up straight. For the first, grasp both wrists with the opposite hands and push hard towards the elbows. Hold three counts. Relax. Repeat four times. For the second, place both palms at temples, fingers pointing upwards. Push palms against head while slowly raising elbows as high as possible. Repeat four times. These can be done after the baby is born too.

Not only these specific exercises, but exercise in general is important throughout pregnancy. The better physical shape you are in, the easier it will be for you to cope with the physical demands of labor. That doesn't mean you should start to do physically heavy work if you've never done it before. It's more that you should keep working and living as you had before. Dancing and sex included! (See section in Brecher summary of Masters and Johnson for sex during pregnancy.) For psychological reasons as well it's important that you remain active and not let the pregnancy dominate your life for nine months. Certainly think and talk about fears and feelings, about changes in your body, your head and your life. They are all real and legitimate and essential to talk out with women, with your man. But keep thinking about yourself and who you are/want to be in addition

to the reality of being a pregnant woman. You neither begin nor end with that baby; you are a person apart from the child and need continually to think on that – for your sake and for the child's.

Be as sensible about resting as about exercising. Rest when you need to. It's most important during the last month so you will be ready for the hard work of labor. It's also hardest then; you feel most heavy and it's difficult to find a comfortable position. Relaxation exercises, which I'll get to in a moment, can help.

To make the transition from those exercises which get our bodies in good shape before labor to those breathing exercises we need to learn to manage our labor, we need to talk about the functions of oxygen and of neuromuscular control.

"Before doing exercises, we must know how to do them properly. Whenever we make our body do any work that is more than the usual amount - and this is what exercise really means - the muscles use more body fuel, stored from our food. To do this efficiently, they need more **oxygen**. Oxygen is a gas present in the air, more so in fresh than in stale air, so always do your exercises in a room with an open window. The amount of oxygen we take in by ordinary automatic breathing is not quite sufficient for doing extra work, and under such circumstances we feel our body demanding more. Think back to the last time you ran after a bus. You will recall that when you reached it and collapsed into the nearest seat you were probably puffing a bit – the body's way of saying, 'More oxygen, and faster please.'

"This is not the best way of doing it. It is far better to recognize the need in advance and provide the extra oxygen by adapting one's breathing to the work the body is doing. We do this by using **consciously controlled breathing**.

"During [childbirth] the group of muscles called the uterus works very hard over several hours to deliver the baby from the mother's body into the outside world . . . The muscles are working far more than usual. And **as we cannot tell the uterus to rest when we choose to, we must prepare for constant work**. This is why it is important for all other physical activity to be reduced as much as possible. If other muscles go into action when the uterus does, they are wasting energy and oxygen that should be in reserve for the uterus. Then the body will tire quickly and prevent the uterus from functioning as efficiently as it should."[4]

We must learn certain skills so we can help the uterus work hard and constantly during labor with minimum diversion of energy to other muscles. If you have the image that you will lie and passively relax during labor you are wrong. Rather you will be very active, you will be working very hard; but **with** your uterus, not against it! Now how do we do that? First we learn how to breath in a conscious and controlled way. Today you may be unaware that you are breathing. During labor you will be aware of each and every breath. In a similar way you may be unaware when you move muscles to lift an arm or extend a leg today; but during labor you must become aware that each contraction of a muscle other than that of the uterus may be a waste of energy which must be conserved for the constant work of the uterus. In other words, you want to use other muscles efficiently, as you want to breath appropriately and efficiently.

Since we have learned to use muscles not singularly, but in combination with one another (we use many more muscles than those in our legs to walk, for instance), we have to learn to dissociate the muscles from one another if we are going to be able to allow the activity of the uterus to be as unhampered as possible.

"When any muscles work, they do so because of a message sent by your brain and prompted by your will. The brain sends the message to the muscles concerned via the nerves; this is called **neuromuscular skill**. The simple ability to reach out and grab something, which you acquire at about five months, is a complex neuromuscular skill.

"There is no harm in the fact that these skills become mechanical. It is perfectly all right for ordinary purposes. But it does mean the brain acquires habits in the way it works. . . We therefore have muscles with a strong habit of working together, regardless of whether or not they are needed for a particular activity.

"But in labor the situation is very different. In labor you have one group of muscles contracting as it wants to, to a particular pattern of its own. And when these muscles begin to contract strongly, then other muscles, quite unconnected with this function, do so too: the muscles of the arms, legs, back, and even face, all try to join in. And this is the typical picture painted so luridly by Victorian fiction writers when they described women in childbirth. 'A terrible groan escaped from her pale lips. Then her hands clutched the bedpost as her whole body was contorted by unendurable agony.' –something like that. But all they are **really** describing is neuromuscular association. Even so, it is rather an uncomfortable endeavor because it consumes so much energy and oxygen. And it's hardly a picture of relaxation, is it?

"Instead we will teach your brain a new neuromuscular skill – the skill of deliberately keeping

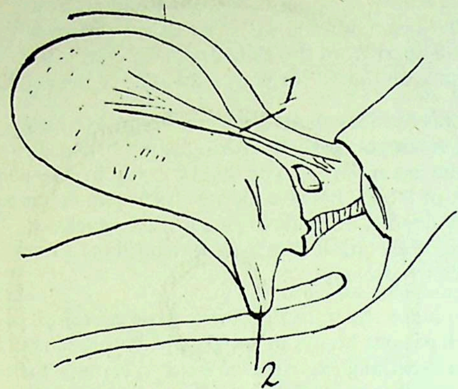
apart muscular activity. This is called **neuromuscular disassociation.**"[5]

LABOR AND DELIVERY

When I talk about labor and delivery, I am assuming a normal, uncomplicated one. It's all important to remember your experience will be similar but also unique.

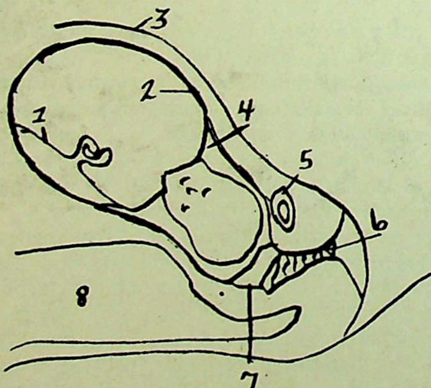
You've gone through a lot from the time you decided to have a baby until now. You are well prepared, both physically and emotionally, and pretty psyched up to have the kid. And then you freak as the prospect of labor gets more real as you get closer to your "due date". You begin to feel scared and lose the confidence that has been building up over the months; you'll never be able to manage. You must have been crazy to want a kid in the first place; you worry about loss of your own independence, the dependence of another person on you. . . And will you be able to tell a true labor contraction from a false one? And what does a contraction feel like anyway??

A contraction during labor feels something like menstrual cramps. You may feel it in the lower abdomen, groin, back depending on your own body construction and on the baby's position. Unlike uterine cramping during menstruation, uterine contractions during labor are not a constant level sensation, but a sensation that rises to a peak and then falls. As seen in the sketch at the top of the page, the uterus is composed of opposing sets of muscles. "The opposing sets of muscles interlace down its upper two-thirds and more circularly around the bottom third. In pregnancy, the lower set keeps the baby from falling out, but during labor they must relax progressively against the pull



Uterus, showing (1) right-hand round ligament which moors it at the vulva and (2) right-hand uterosacral ligament which attaches it to the back of the pelvis. There are also left round and left uterosacral ligaments on the far side not shown in the picture. (from Lester Hazell, Commonsense Childbirth, *p. 85)*

of the upper ones to allow the cervix to open up."[6] So as you feel a contraction beginning you may sort out a pushing sensation at the highest point of your bulge and a pulling sensation in your groin.

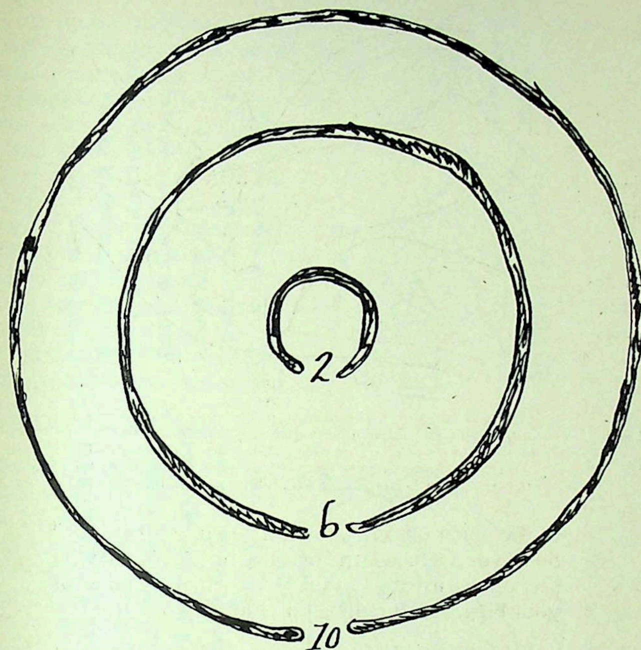


Full-term baby before labor begins; mother on her back with head out of picture, left. (1) placenta and cord. (2) uterus. (3) mother's navel. (4) bag of waters (amniotic fluid) surrounding baby. (5) pubic bone. (6) birth canal. (7) cervix, thick and closed with mucus plug. (8) bony structure of spine, tailbone, and back of pelvis.

"During the three weeks or so prior to the onset of labor, certain changes take place which are useful for determining the approach of labor. These are (1) lightening (engagement of the baby's head); (2) frequency of urination; (3) beginning effacement (thinning) of the cervix; and (4) false labor.

"Lightening is the lowering of the uterus which takes place in first-time mothers (primiparae) several weeks before their due dates. This locks the baby's head down tight in the pelvis so that he can't do much gross moving around. Because the top of the uterus no longer crowds the lungs, breathing is easier, the heart and stomach function more smoothly, and the relief of pressure is the reason for calling this process lightening; though she doesn't look it, the woman feels lighter. In women who have had more than one baby (multiparae), the lightening often does not occur until early in labor itself, perhaps because the abdominal muscles may not be as firm, and the uterus tends to bulge out rather than being pushed down by them. After lightening has occurred, walking becomes more difficult from increased pressure on the hip joints. Frequency of urination may be due to the pressure of the baby's head on the bladder, limiting its capacity and requiring it to be emptied more often.

"Beginning effacement of the cervix and false labor should be discussed together because they will blend from precursors of labor into labor itself. Although there may have been false labor (Braxton Hicks contractions) since the beginning of pregnancy, it may make itself felt more and more in the last weeks before birth. False labor contractions are erratic and irregular; the uterus contracts and



Cervical dilation in centimeters, shown actual size: 2 centimeters in very early labor; 6 centimeters at beginning of transition; and 10 centimeters full dilation at end of first stage. (from Hazell, op. cit., p. 224)

relaxes, whereas in true labor it contracts and **re-tracts.** (By retract we mean that each muscle fiber instead of contracting and relaxing, as is true of most other forms of exercise, contracts and then remains in a shortened state while it rests, thus pushing the baby farther down within the abdominal cavity and closer to [her] birth.) Early effacement of the cervix is probably the result of some of these false labor contractions which do more and more retracting as the due date approaches. . ."[7]

I want to mention the three stages of labor and include pictures before I go on to woman in actual labor. **Stage one** (which is further divided into three parts) is concerned with completing the **effacement** (thinning out of cervix or neck of uterus, measured in percentage from 0% to 100%) and **dilation** (opening of cervix measured in centimeters or fingers from 0 cm to 10 cm or 1 finger to 5 gingers; 1 finger equals 2 centimeters) of the cervix so it is wide enough for the baby's head to move into the birth canal. It begins with the onset of regular contractions and ends with the **crowning** of the baby's head (whole of top of baby's head is visible when lips of vagina are opened). Average time is 12 hours. **Stage two** begins with crowning and ends with delivery of the baby through the birth canal and out of the mother's body. Average time from one-half to two hours. **Stage three** is the separation and delivery of the placenta and attached membranes. Average time is from a few minutes to half an hour.

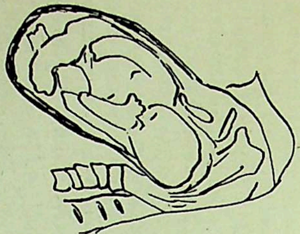
So when are you going to be in true labor? Enough with the preliminaries, you say! There are three signs that the first stage is beginning: (1) bloody show is visible; (2) premature rupture of membranes(from trickle to one cup); and (3) regular uterine contractions. The show is blood-tinged mucous (pinkish, thick vaginal discharge rather than bloody red) that has up until now been a plug in the cervix (like a cork on a bottle) which has served to protect the growing baby from germs that might enter through the vagina. The "cork" falling out shows that the cervix is beginning to open up.

For most women the bag of waters doesn't break until the beginning of the second stage of labor, though it can break before or any time during the first stage. The membranes can also be ruptured by piercing them with a needle (doesn't hurt; sensation like a balloon filled with water bursting). "The intact bag of water has an important function in labor that makes a superb dilator of the cervix by maintaining equal pressure according to the laws of hydrodynamics. If you apply force upon an enclosed liquid, this force will be transmitted equally everywhere throughout the liquid. In the case of the bag of water the part of it known as the forewaters protrudes down through the dilating cervix. As the uterus contracts, the total force of the contraction is transmitted right into that little finger of forewaters, causing it to spread and act as an opening wedge through the cervix. Hence the intact bag of waters makes a better dilator than the contours of the baby's head. . .

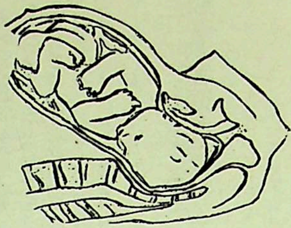
"The membranes often rupture when enough of the cervix is dilated so it no longer supports the membranes."[8]

If your bag of waters is leaking or has broken, call the doctor immediately and get to the hospital or settle in one place at home. The reason is that once the waters are gone, there is a chance that the cord can get wrapped around the baby's head, especially if the head is still high up in the uterus, but more important, there is a real possibility that the baby's head will press against the cord and cut off his own blood supply. If the contractions of your uterus stay regular, get longer, stronger and closer together, you know you are in true labor. If you have questions about whether you're really in labor or not, change position or activity. For

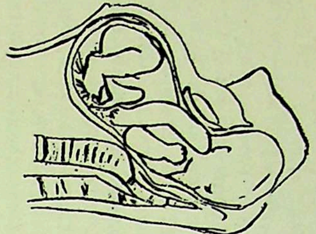
I: Before Labor Begins
This baby has reached full term and is awaiting the start of childbirth



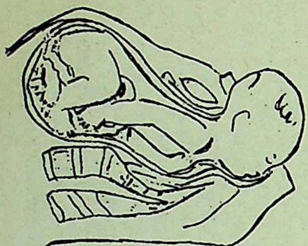
II Early Labor
The pressure of the baby's head has thinned the cervix of the uterus but has not yet started to dilate it.



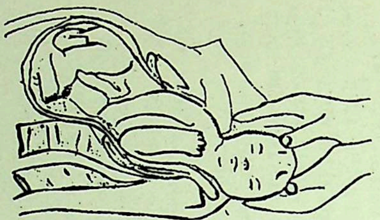
III The cervix is fully dilated and the head is at the entrance to the birth canal. The amniotic sac is still unbroken here. In some cases, it has already broken.



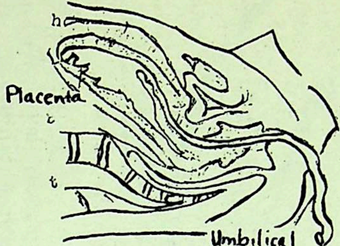
IV. The Baby's Head Begins to Show



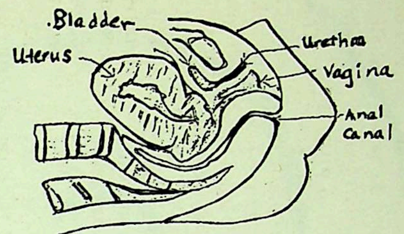
V The "CROWNING" - This is the point at which the crown of the head is fully visible outside the mother's body. On the next contraction the baby's head should slide out as far as the chin.



VI Turning - As the head emerges, it turns sideways, making the emergence of the shoulders and the rest of the body easier.



II Third Stage of Labor
The baby is born. In the next 10-15 minutes the uterus starts to contract, expelling the placenta. With the expulsion of the placenta, labor is over.



VIII Pelvis After Delivery
The various organs in the pelvis now begin to go back to their prepregnancy size, shape, & position. After birth the uterus is now as hard as a rock.

example, if you are lying down, get up and walk around; if you're standing, sit down; or take a shower. I was told that when contractions were five minutes apart with my first baby (ten with my second – time depends on distance from the hospital and what's happening inside your particular body), I was to leave for the hospital. In the reading I've done since then, I discovered it wasn't the time intervals between contractions that were important, but the length and strength of the contractions, for they, rather than the time between, indicate how well your uterus is working (which made me think that doctors don't tell us that possibly because they don't think we can understand/ judge that but assume we can tell time!).

Anyway, you're in labor and off to the hospital!

In addition to your suitcase with stuff for the hospital stay, take the following for labor (don't laugh; I'll explain uses as I go along): stop watch or watch; lollypops; small brown paper bag; tennis balls; powder or cornstarch; hot tea with sugar in thermos; playing cards; books; favorite pictures; posters; camera; tape recorder; candy bars; sandwiches (for your man, coach – they can eat while you labor even though you can't); and anything else that will make you happy in the foreign environment of the hospital.

To eat or not to eat. . . I'll present both viewpoints and you choose. You'll have to take into account when you last ate and when you expect to deliver. Not to eat: If you've just finished a big meal, too much oxygen will have to go to the digestive muscles and less to the uterus, which needs all the oxygen for contractions. You can take lollypops and sips of tea between contractions to give you quick energy. Some doctors say no to even that but I don't know any good reason why not. Even if you do feel nauseous during transition (end of first stage of labor), these foods won't remain in your system that long. To eat: "You must stock up on food before the digestive processes are cut down. Otherwise you will go into labor, the available sugar in your blood will exhaust itself, and you will get very tired, needlessly. In fact you will be starving. But you won't feel hungry, simply weak. So this meal is therapeutic."[9]

As your contractions are about to begin, you want to think about the shape of them – there is a beginning, a middle and an end. They gradually rise to a peak and then descend. It's fascinating to observe the rise and fall of your own contractions, to see the pattern of your body emerge. Also, it keeps your mind active and prepared to respond with appropriate breathing techniques which also have a beginning, a middle and an end. Otherwise, you might be laboring all the time and not relaxing at all. The ability to relax becomes more important as labor gets harder.

The first regular contractions you may have are about **30 seconds** long and 15 minutes apart. These feel like premenstrual cramping only at regular intervals. Usually they are not uncomfortable and don't interfere with whatever you are doing at the time (these gentle contractions are sometimes called effacement contractions since that is their function). By the time the contractions are **45 seconds** long and five minutes apart, you'll probably need to begin breathing consciously (you may have started sooner). What you need is a gentle and relaxed kind of breathing, thus you do **Candle Blowing** (see Appendix, Chart A for instructions). (Also, this kind of breathing because it is so relaxing is helpful in getting to sleep during the last month of pregnancy and also may be useful toward the end of the first stage of labor if the more active breathing tires you out. With all kinds of breathing you can switch back and forth; the only guideline is **your comfort**.)

Three centimeters is an important guidepost: you are about one-third of the way through labor and also your contractions are at their strongest. They will get longer and closer together, but not stronger. This is very encouraging because you are totally on top of the situation at that point and it makes you feel that you really might be able to manage your labor! (I can't document this. The nurse who taught the Lamaze class I went to before the birth of my first child told us this. I can't remember if during either of my two labors I felt this to be true since the contractions of 9 centimeters are clearer in my memory than those of three centimeters. I do remember that it was a morale booster, especially at first birth. Whether you take it as fact or fancy, it's a good thing to remember.) At this point, when you're feeling very confident, I want to stress the importance of taking one contraction at a time – repeat – one contraction at a time. Just think about what you need to do for the one contraction that is upon you, not how many more there will be. I stress this because if you have a difficult contraction and start feeling tense and out of control, you tend to think about the endless numbers of contractions to come (they are finite) and assume that they will be as bad or worse than the one you just went through. Remember you got through it. A success! One at a time. **Count each success**, don't anticipate failure.

If you are not already in the hospital, you have called your doctor and are on your way by 3 centimeters dilation. You can lie down in the car if you're more comfortable that way. At the hospital,

if they are sure you're in labor you will probably be taken to a labor room; if they are not sure, to an examination room. If you are sure and they are not sure (nurse says, "you are so young, how could you know you're in labor"; or, grabbing you by the arm, says, "listen, girl, you think having a baby is fun; well, it's the worst pain you'll have known!" —help like this we can do without!), you and your man/coach can make demands to be taken directly to the labor room. You may still have to deal with a bitchy nurse or an inhuman resident who makes you feel dumb and worthless. It's lousy, but remember it's their problem, not yours. Insist long and hard enough. Don't forget you are paying a lot of money, whether you are a clinic or a private patient.

A note about hospital labor rooms: your social class is revealed by whether you're assigned to a private labor room or not. White, middle class patients go to private rooms, black, poor patients to ward rooms. For example, Boston Hospital for Women, Lying-In Division (BLI) will only give private labor rooms to private patients. Even if there are free single labor rooms, clinic patients go to the wards. When I questioned this policy, the woman who was taking us on the hospital tour told me "you get what you pay for". Other hospitals which have only a few private labor rooms follow the same class based policy only it's described in different terms. At Mt. Auburn Hospital in Cambridge, Lamaze patients get the private rooms, because they are too "noisy" and disturb the other women (a friend was told this by her doctor who is head of obstetrics there). I wanted to be alone with my husband when I had my two children. I can see a time, though, when all women have preparation for childbirth, that we might want to be together with our sisters during labor. But then group labor rooms would be our wishes and not hospital rules.

When you get to the labor room, you are what they call "preped" – you're put in a hospital gown and have your pubic hair shaved. There is a real question about the necessity of this shaving procedure; there are so many antiseptic solutions poured, wiped, etc. over your pubic area that it certainly is not for the sake of cleanliness. Rather, it's custom that most doctors subscribe to. Of course, they're men and don't have to deal with itchiness as pubic hair grows back. If you can avoid being shaved, you should. "The only valid reason for removing the hair that I can see is that it might becloud the doctor's view of the perineum in case he needs to make an incision. No hair grows where the incision should be. Some doctors have solved the problem by having the hair clipped with scissors right around the outlet of the birth canal. While this may be unnecessary, still it avoids the problem of shaving, not the least of which is itching and soreness as the hair grows back."[10] If you are shaved, you can ask the nurse to stop during contractions if the shaving bothers you. Remember about making demands. Think positive, assume success.

Next you will probably get a vaginal exam (maybe rectal too since the rectum is close to the cervix and therefore you can feel the amount of dilation from that point too – refer to pictures of anatomy earlier in this chapter) by a resident. (Doctor may not appear until middle to end of first stage of labor.) Ask any questions you have of anyone. You have to let people know you are a human being and not a piece of meat. The resident or nurse may listen to fetal heart tones (you can ask to hear it too) and check vital signs – temperature, blood pressure, pulse.

Another preparation is the enema. A bag's worth of soapy water is put into your rectum and within minutes you start eliminating everything – water and fecal matter. "As for the enema, it is supposed to insure that no fecal matter will be expelled with the second-stage contractions and contaminate the doctor's sterile field. But does this work? Sometimes, but so frequently does the last of the enema arrive along with the pushing of second stage that a friend of mine who is an obstetrical nurse remarks, 'I don't really believe the baby is coming until I smell feces.' [Does the American idea that childbirth is dirty come from this?]

"The other theoretical purpose of the enema is to make sure that there is no hard fecal matter in the rectum which would compress the adjacent birth canal, making the passage smaller for the baby. Left to her own devices, nature usually takes care of this. The same hormones that start up the contractions of the uterus in early labor often cause the intestines. Many women have a sort of painless diarrhea that persists until first stage is well advanced and the intestines are clear. The laxative action of labor may be lost, however, in the inhibiting atmosphere of the hospital. I have never seen a home delivery that was contaminated by involuntary bowel movements; many hospital labors are."[11]

If you can get to the toilet, it's more comfortable there than on a bedpan. Again, ask to wait until your contraction is over. You will have to do breathing for contractions while you are on the toilet. Contractions will get stronger right after the enema (because of it) and may persist at the strength for several contractions. The enema as well as the breakage of the bag of waters will speed up several contractions. Expect it; don't settle back into a pattern or rhythm which you will be

able to anticipate. But by this point you are ready for another kind of breathing. It is a **slow, shallow panting** where you close the pant by saying either **hut** or **out** (whichever you prefer). You can also do just a regular shallow pant (only your chest should move and ever so slightly), but the closing off of the pant with a sound seems to give you an added crispness and something more on which to concentrate. (See Appendix, Chart B for instructions.)

You know to start this kind of breathing because the candle blowing is no longer working, i.e. it no longer is enough to keep you comfortable. You feel a stronger pulling sensation at this point, pressure and tension building up during a contraction. You are dilated about 4-5 centimeters (2 to 2½ fingers); contractions are lasting about **one minute** and are four minutes apart. You may still be able to read, sing, play cards, talk to people around you if that is relaxing to you between contractions. Medical people need to check dilation, vital signs, fetal heart tones, but if they are just standing around and bothersome ask them to leave. You are having the baby and have the right to shape the kind of experience you have. If someone is annoying you and you lose control in the middle of a contraction, do the following: (1) relax, (2) pant rapidly (let your man/coach know and they should know how to command you to relax and should pant with you), (3) use rest time to relax completely. This is something you can do at any time during your labor. Remember, if you feel tired try candle blowing for a contraction or two. If you feel sleepy, change positions; if you've been lying down, sit up (prop pillows under legs and behind your back to make you comfortable). You need to be alert at all times. Whatever position - whether sitting, on your knees as for pelvic rock exercise, lying - is comfortable for you is the one you should use; disregard comments of nurse, etc. Sometimes a change in position is very helpful. Your coach might suggest it from time to time since you are so busy with breathing and relaxing. Coach should also be aware, because of what you're going through, that you may resent the suggestion (that resentment is normal too). Again, it's you that is having the baby. The Lamaze chart at the end lists feelings for this part of labor under mid-phase, first stage. Some comments on what you can do: if you start feeling tired, suck a lollypop; if you are thirsty - panting does that to you - ask for ice chips to suck or take little sips of water, not big gulps (you will still feel like taking big gulps). Sucking a cold, wet washcloth is also very satisfying.

This **mid-phase** (from 3 or 4 centimeters to 7 or 9 centimeters) can be a low point of labor. You've gotten over the initial excitement of realizing that you are really in labor and are really going to have a baby; you've been able to handle each contraction easily; you've gotten into a pattern. Then the pattern changes. Maybe the bag of waters breaks or is punctured by the doctor and the contractions are longer and closer together (remember they don't get stronger) and you have to concentrate harder. In addition, after working very hard for an hour, two hours or more, the doctor comes and examines you and says you haven't dilated any more. Discouragement sets in, you feel restless and your back begins to hurt since the baby's head has changed position and is pushing against the sacral vertebrae. Erna Wright lists several rules for handling backache labor: (1) all pressure must be taken off the back; (2) the uterus must be tipped forward during contractions; (3) the uterus must be supported during contractions; (4) back massage of back effleurage can be applied during contractions; (5) position should be changed every half hour to keep up the morale; and (6) between contractions a cold compress over the sacrum is a wonderful boon.[12] Don't let yourself be weepy. Remember you've managed each and every contraction so far and here comes another. You take a deep cleansing breath, let it out and start shallow panting in rhythm with your contraction. After the contraction is over is the time for some changes. Change your position and adjust your pillows. Have a lollypop and some water. While you are relaxing let your man/coach give you a gentle back rub which can be continued with greater force during the next contraction. While someone else is putting pressure on your back, you can give yourself an **effleurage**, the light caressing stroking of your abdomen, a very pleasant sensation after the hard work of the uterus (the powder of cornstarch is used when your abdomen gets hot and sweaty). The effleurage can be a circular motion with the fingertips of one or both hands which is slow and gentle; it can be a fairly rapid and heavier back and forth motion with the fingertips or with one hand; you can do it or someone else can do it if you are busy concentrating on your breathing (at one point during my second labor, I was breathing, my husband was putting pressure on my thighs and my monatrice was giving me an effleurage fast, furiously, but lightly). If the back or leg pressure is getting you down after a few contractions (even with all the changes), you can ask for an **analgesic**, a mild medication which relaxes your muscles. Doctors tend to have favorites. You should talk with him during your pregnancy about what kinds he uses and why; you should get the names because you may know that one of the several he uses really makes you dopey and you can request another (remember you want to relax, not go to sleep; you have to keep on top of your contractions, not be driven under by them).

"There are several categories of drugs used in labor. First are the tranquilizers, which have the well-known effect plus that of increasing the effects of other drugs given with them. I feel that tranquilizers have their greatest use in the hospital **after** the baby is born to ease the impact of a strange environment upon a mother who needs rest, and that they are still too new to be evaluated for side effects they may have while the baby is in utero.

"Next there are the sleep-producing drugs, of which seconal and nembutal are the classic examples. These have the effect of reducing the amount of oxygen available to the baby and are rarely used any more during labor if the baby is expected to be born during the time when the drug is having its effect and could interfere with the beginning of breathing. . .

"Next come the analgesics, the pain killers. Demerol is the one most often used in labor. It is like morphine in many ways and can also have a depressant effect on the baby's respiratory center if it is given within a few hours before the baby's birth. You can never be sure how soon the baby will be born. As with other drugs, different women respond in different ways to Demerol. A common side effect is vomiting and some women find that it is not particularly helpful for relieving discomfort. Doctors who regularly conduct minimum drug labors have found that if Demerol is going to be effective, the smallest dose, recommended by drug companies, 50 milligrams intramuscularly, will usually work just as well as the higher dosages with probably less risk to the baby. (It is an interesting aside that an 8-pound baby needing Demerol **after** he/she is born would be given 5 milligrams.)

"Probably the safest analgesic if used correctly is Trilene. This is a volatile liquid that is placed in a special inhaler. The mother holds the inhaler herself and breathes in the vapors as she needs to. If she gets enough of the vapor to make her drowsy her hand falls away, and she will soon have her head clear from breathing fresh air. Trilene used in this manner is an analgesic rather than a general anesthetic. The only problem comes in the mother's learning to time her breathing of the Trilene so that its maximum effect coincides with the height of the contraction. In most women it takes about thirty seconds for the Trilene to take effect. Therefore in order for it to work, they must labor breathe the Trilene from the first inkling of the contraction's coming. Trilene has the definite advantage to the baby that its effects are apparently not residual as they are with any substance that is injected into the mother."[13]

You are working hard and long and your spirits are rising as you handle each new contraction. Doctor comes in and says he has to examine you during a contraction to find out most accurately the extent of the dilation. You pant for all you are worth, but it hurts. Doctor says you've made progress; you've gone from 3 or 4 to 7 or 8 centimeters. Wow, you feel great! But no time, a new contraction, and you have to start the more **rapid panting**, third kind of breathing (see Appendix, Chart C). You've moved very quickly into the third and final phase and hardest phase of the first stage of labor. It's called **transition**. It goes from 7 or 8 centimeters to 10 centimeters and complete dilation. Contractions are **60 seconds** (sometimes as much as 90 seconds) and 3 to 1½ minutes apart. Basically contractions are long and very close together. Be encouraged, baby is almost out! If the labor has been normal up to now and the baby's head is in the normal posterior position (head down, face toward backbone), it should last for only one hour and about 20 contractions if it is a first baby. If you can, try to remember time is short, the end is in sight. You'll have a hard time concentrating and need someone to be very directive and to do the panting with you. Because you are panting so fast, you may get **hyperventilated**. This means that you are taking in too much oxygen and not giving off enough carbon dioxide. As a result you may feel tingling in hands and feet and feel dizzy. Counteract this by breathing into the brown bag you've brought (or into your hands if you forgot the bag). At this point the doctor may become very concerned about fetal heart tones. If your oxygen-carbon dioxide balance is off, so will be the baby's. The doctor has to watch that the baby's breathing rate stays above a certain point; if it goes below that point, the doctor knows he has a definite time period in which the baby must be born and if he doesn't think the baby will naturally be born in that time span he'll have to speed up the delivery himself.

You may have to cope with feelings of nausea (remember you have nothing in your stomach to throw up). You may feel very hot (you don't have time for ice chips but a wet washcloth over your face is great and you can suck it too). You may feel irritable and then will need direction and encouragement, strong and clear, loud and repetitive. You are almost there! You may have to deal with the urge to push. You will feel this urge because of the position of the baby's head. The urge may be weak or so very strong that you're sure you're just about ready to shit the baby out! It feels like you have to have the biggest bowel movement you've ever had and you can't hold it in one second more. But you can't push because you are not completely dilated and will tear yourself and hurt baby's head if you do. So there are three breathing techniques you can use to control the urge to push until you're completely dilated and the doc-

tor gives you the signal:

Whoo-Ha. A rapid, shallow pant done saying the words Whoo-Ha and moving your head side to side (another thing to keep your mind active) at the same time. This can be used earlier in labor during difficult contractions or just for variety. With any of these techniques where words and motions are incorporated into the breathing, they should be done clearly and loudly. It takes lots of concentration and your mind off your uterus which is working for all it's worth at this point.

Pant–Pant–Blow. A couple of shallow rapid pants followed by a huge, loud blowing out of air. You can't blow out and push at the same time, which is true of the other techniques too. You need to pant as well as blow or you'll get hyperventilated (even practicing the technique when not in labor makes you feel a little dizzy).

Slump and rapid shallow panting technique accompanied by saying "one-two-one-two" as you slap your leg and expel air. Sound complicated? It does in fact take a lot of practice to do it on command, but you avoid the problem of hyperventilation if you can do it well. However, you can't use this technique if you are lying down (impossible to slump in that position) and have to use one of the others. Whoo-Ha will work if your urge to push is not too strong. But if it's strong you'll need to use the Pant-Pant-Blow and keep a brown bag handy in case of hyperventilation.

Now we can think about medication. Only now, when the baby's head is crowning and the hardest work of the uterus is done, can we be given **anesthesia** (as opposed to analgesia, tranquilizers). Why not until this point? Medication which deadens the nerves so you don't feel the contractions also slows down the uterus and until this point it's essential that the uterus be working at full force to get the baby's head into place to be delivered and to get the cervix dilated. Remember **you are not a failure** if you take medication. If you've handled each contraction up to this point **and** the baby's head is in a position so the delivery will be normal **and** you are not so tired that you can't go on (fatigue slows down labor), then don't worry about medication now and refuse the **caudal** that the doctor offers. The caudal must be started no later than 7 centimeters because it takes a while to work (don't expect immediate relief; the aim is to get it working best during delivery when you may or may not need it), in contrast to the **spinal** or **saddle block**, which is given later and takes effect immediately.

"Conduction anesthetics is a very popular category today. This consists of saddle blocks, caudals, epidurals and other local anesthetic agents injected somewhere into the back, depending on where the doctor wishes the anesthesia to extend. The caudal and saddle block are the most popular for obstetrics. In a caudal, a large-gauge needle is put up into the low back where the tailbone connects. Through the needle is run a catheter tube which remains in place throughout labor and through which the local anesthetic agent can be injected from time to time. Doctors who use this method usually start at about 4 centimeters dilation and keep injecting the agent as necessary to maintain numbness. The effect is to numb and paralyze everything from that level down. This is a tricky procedure from the standpoint of getting the anesthetic agent in the caudal canal where it belongs, and there are dangers which require a very experienced doctor to handle. For this reason caudal is not the choice of most doctors unless they work in a large well-equipped medical center. There is some dnager of inadvertently putting the needle into the baby's head, but more likely is a misplacing of some of the anesthetic agent with a subsequent drop in blood pressure to the mother and less oxygen to the baby. When the mother's blood pressure drops, so of course does the blood pressure in the placental bed. By far the worst disadvantage to caudal is that the bearing-down reflex is obliterated, and the baby usually must be tugged out by forceps on his head instead of pushed from behind by the gentle force of the contractions.

"Saddle block is a low spinal anesthetic which is a one shot affair. It gets the name from the fact that it blocks the area of the mother that would touch a saddle if she were riding a horse. The effects last about an hour and a half, and it has the blood pressure and forceps disadvantages of the caudal. In addition, about 20% of mothers receiving a saddle block have a spinal headache afterward for days that is far worse than the pain of labor it was supposed to obliterate. Since there are more local, less dangerous ways of blocking nerves, and since the saddle block is given after transition, which is the hardest part of labor, it seems to me to be the poor choice of too much too late.

"Local anesthetics, pudental blocks, and paracervical infiltrations are injections made from below directly into the nerves of the perineum or around the birth canal or the cervix. They don't carry the general risks of caudals and spinals, nor do they stop a mother from bearing down. The main reason locals and pudentals are given is to numb the perineum when an episiotomy will be made and must be repaired. However, the descending head of the baby creates its own anesthesia of the perineum, which lasts about ten or fifteen minutes after the baby is born. I can testify from personal experience and observation that when an

episiotomy is made at a time when the perineum is bulging and the baby's head is clearly visible, there is no pain from it. The sensation is rather like having the sleeve of your coat cut: you are aware that someone is using scissors near you, but there is no pain. However, the episiotomy must be repaired right away or this natural anesthesia wears off. If the doctor is by himself and must see to the baby immediately, often he cannot put the stitches in before the numbness is gone. If he has a helper, he can do the necessary needlework before the placenta comes out and can leave threads loose to allow him extra room to deliver the placenta.

"Paracervical infiltration can be done repeatedly (it wears off in about an hour and a half) from about 3 or 4 centimeters of dilation. It numbs the area around the cervix and is a help in relieving backache. However, in a certain number of cases it causes the babies' heart rates to slow temporarily. Although these babies seem all right at birth, the possible long-term effects have not been evaluated.

"Another class of drugs. . . is the type used to stimulate the uterus to contract. These drugs are called oxytocics. Posterior pituitary extract (Pitocin) is a common one, and it is sometimes used in induced labors to start the contractions as well as in slow labors to speed things along. It is usually given along with intravenous fluids in an arm vein. It can be lifesaving but must be used with care. Because of the unpredictability of the amounts of labor hormones secreted by the mother, Pitocin carries the danger of a possible violent labor with ruptured uterus, or oxygen deprivation in the baby from having the uterus contracted long enough and hard enough to cut placental circulation. As a hangover from the days when mothers were so drugged that their uteri were completely flaccid after birth, a similar drug is given routinely on the delivery table after the baby is born. Sometimes with an awake mother who is producing her own abundant supply of posterior pituitary hormones, this causes the placenta to be trapped, which is an annoyance requiring either patience until the effects of the drug wear off or a strong sedative or general anesthetic to relax the uterus. Oxytocics also duplicate the natural hormones which are secreted and contract the uterus as soon as the baby is put to the breast. The result usually is painful uterine cramps. Also for the purpose of contracting the uterus, Ergotrate, another oxytocic, is often given in pill form for a day or so after the baby is born. I suspect this is necessary for women who don't breast-feed, but for those who do, it may give rise to painful 'after pains'."[14]

You want to take as little anesthesia as necessary. Remember, it's given according to **your** body weight, which is a large dose for the average 7-pound baby. Unless there are problems involving the life of your baby, I see no good reason for a general anesthesia which knocks you out completely (and even in the case of deformity or death it may be more difficult to deal with the pain involved if we're put out and awake to discover the horror). In any case, we should be involved in the decision about whether or not we get general anesthesia.

After that low note let's go on to a high one. It's absolutely fantastic to watch your baby be born and important in your feelings about yourself and your baby in the hours and days that follow the birth. So on to delivery!

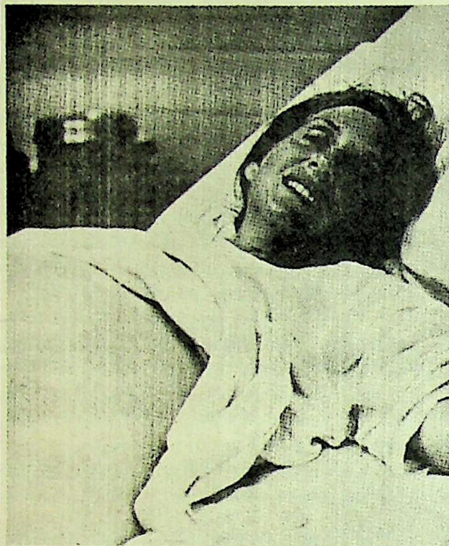
The **second stage of labor** is the delivery. You have been wheeled from the labor room (where you've been for approximately 12 hours if it's been a typical first delivery, shorter time for subsequent deliveries). You are moved to a new table (it's uncomfortable in the middle of a contraction, so ask nurse, etc., to wait). Your legs are put in stirrups; they are like the ones on the examining tables in the doctor's office though wider apart. (There is question whether stirrups are necessary - home deliveries are done without them - or for the doctor's convenience. There is a special chair designed for childbirth that supports our bodies in a sitting, slightly reclined position which certainly seems a more "natural" position for birth (body is in line with the forces of gravity and thus facilitates the delivery) than lying down on a bed. Of course, these chairs are not in use in American hospitals, as I know!) Then they may try to strap your hands down. **Don't let them** – they have no right and you need to use your hands for pushing. Someone (the anesthetist) may try to give you a spinal. Be sure there is a reason for it. In some hospitals it's so routine they don't stop to ask the doctor, let alone you (this happened to me last year at Cambridge City Hospital). (Like the doctor, the anesthetist is concerned about getting his money for his time and he may be required to be on duty whether or not his skills are needed.) Next you'll have sterile solutions poured all over your crotch and your legs and body draped with sterile cloths. If you're lucky, there will be a mirror so you can see what it looks like from below as your baby is born. Mirror or not, be sure your man/coach supports you under your shoulders so you can get as close to the action and see as much as possible. If your membranes haven't ruptured naturally or been broken by the doctor, he will do it now. It's been a long day of probably the most concentrated physical exertion for you, but you're almost at the end; the prize is almost in view!

Lamaze and his followers have falsely given women "the idea of birth as an athletic achievement. . . Under this system the obstetrician may keep up a running commentary on the progress of a woman's labor and although some women like this constant encouragement, some are distressed by the continual flow of words, the reiterated 'Alors! Madame, attention! Poussez! Poussez . . . Poussez . . . Poussez . . . Encore. Encore! Continuez! Continuez! Tres bien. Tres bien. Reposez-vous. Respirez bien.' etc. . . .The better the coordination of uterine contractions, voluntary muscular activity and breathing rhythm, the less effort is required from the woman and a relaxed and natural second stage results."[15]

Contractions are one minute long, 4-5 minutes apart, and of decreasing intensity after transition. This part usually takes about an hour. Now if you get the urge to push, you can push (you may have been pushing in the labor room or on the way to the delivery room). It feels great, you feel exhilerated! It's also a hard time since very probably you're tired and you may feel uncomfortable as the baby's head is pushing on the perineum, causing a burning sensation. Keep your perineum relaxed by pushing it out and the burning will be less. The tiredness and burning continue but in contrast to what many male doctors think, this stage is not as painful as transition might have been. They may gauge pain by the effort you are exerting as you push and the redness of your face, but you may feel tremendous excitement at that time as you know that the baby's coming within minutes! A contraction is about to begin and the doctor signals you to push. You'll use the following technique: Take a cleansing breath and let it out. Then take a deep breath to fill your lungs as completely as you can with air and hold it. As you are taking the breath, get into position to push by putting your hands on the stirrups and by lifting your shoulders and tucking your head on your chest. (The exercises for the various muscles of your abdomen prepared you for this.) And now you push hard with all the muscles of the abdomen against your vagina (in contrast to against your rectum as for a bowel movement). When you run out of air, drop your head back quickly, take another breath and push again. You may need two or three new breaths or three pushes for each contraction. You only push during contractions. In between them you should rest. Probably after a few pushes the doctor will give you a local anesthesia (if you haven't had anesthesia already) into the perineal area (the perineum is the skin that stretches from anus to vagina which you have strengthened by exercise and learned to relax for labor and which you will learn to tighten after delivery so that internal organs won't fall out in later years). Next comes the episiotomy, or cut into the perineum. I question the need for an episiotomy for all women. They are now done routinely but should be done on an individual basis. Some babies need more room to get out (for instance those in breech position with bottom rather than head first), and then it makes sense for the doctor to make a cut than for the woman to be torn. If it's done so that the woman's pelvic floor doesn't get stretched excessively, that has to be weighed against how long it will take stitches to heal and problems in sexual intercourse from too tight stitching or from stitches not dissolving as they are supposed to. Remember the doctor is a man and has his own and other men's interest in mind more than that of woman. To illustrate with a comment from my doctor at my six week checkup after the birth of my last child: Full of male pride he tells me - while doing a pelvic exam - "I did a beautiful job sewing you up. You're tight like a virgin. Your husband should thank me." These same lines were repeated to other women friends who use the same chauvinistic doctor! We must share in making the decision about whether or not we get an episiotomy.

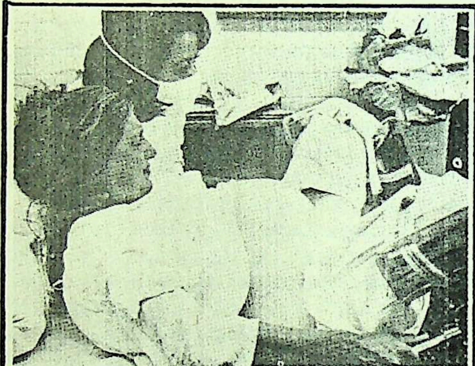
The doctor may need to use certain instruments at this time. "Instruments used in labor include forceps and the newer vacuum extractor. Basically forceps are tongs with two blades that can be separated. The doctor inserts each blade individually before joining them at the hinge and pulling the baby out. Forceps can be lifesaving to the mother and baby, but their use is often abused. While many of the babies who would have been delivered by dangerous 'high' forceps (used before the baby's head is engaged) are delivered by Cesarean section, it is still routine in many parts of the United States to give knock-out amounts of gas or paralyzing conduction anesthetics and deliver babies by 'low' forceps (when the head is visible during contractions). The newest tool, which is still being evaluated, is the vacuum extractor. It is a suction cup which is placed on the baby's head and pulls him out of the birth canal. The method seems to be less damaging to both mother and baby than forceps, but more experience is needed before the best use can be made of this tool."[16]

At delivery the baby needs to tuck her head onto her chest to decrease its diameter to get under mother's pubic bone. The doctor will then turn or rotate the baby internally to get her head through. Rotation usually takes place at the first contraction and pressure is then decreased on sacral vertebrae (this is the cause of low back pain). When the baby's head is coming out, pant, don't push; you don't want to hurt her head. Contractions are pushing the baby's head out with help of your pushing;

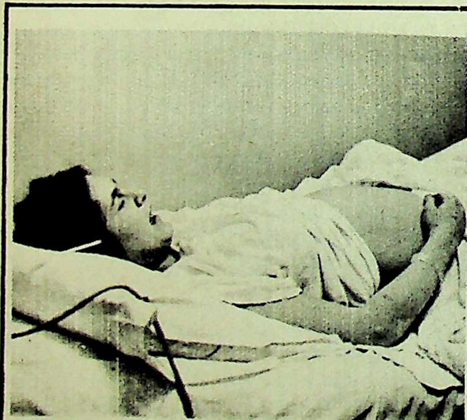


1 Mother in first stages of labor relaxes between contractions.

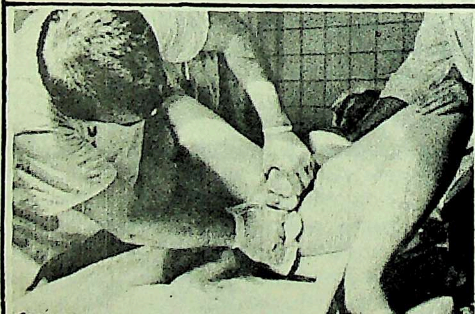
2 Transitional stage: She uses the transitional breathing and effleurage (abdominal massage).



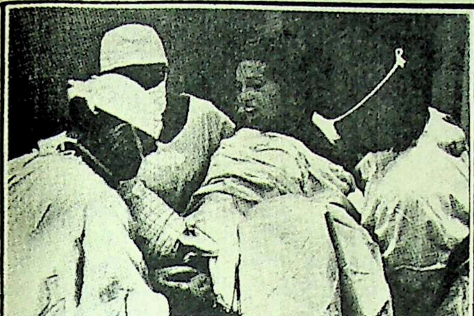
3 Moved into the delivery room, she pushes with 2nd stage contractions.



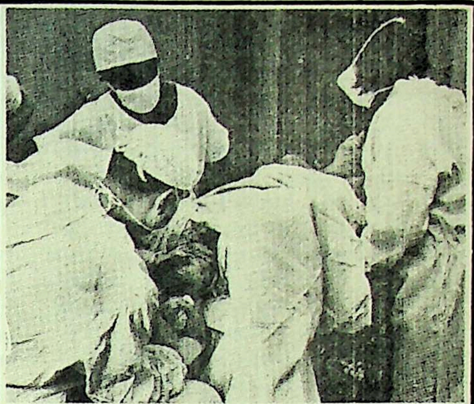
4 Hard labor



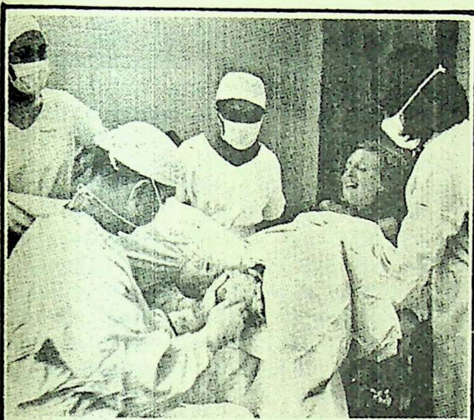
5 Infant's head is born.



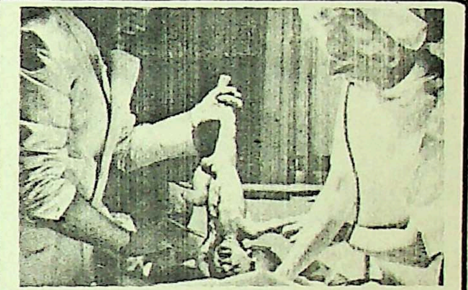
6 Mother sits up to meet her child. Downward pressure applied to effect delivery of upper shoulder.



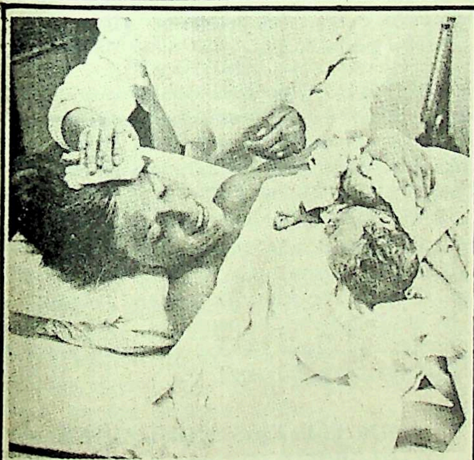
7 Upward pressure now applied to deliver lower shoulder.



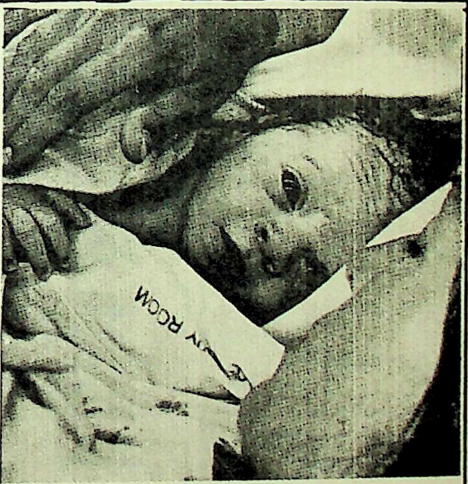
8 Infant has begun to cry



9 With infant's head down to drain mucus from respiratory passages, umbilical cord is cut.



10 The cord has been cut, and mother meets her Child.



11 Minutes after birth.

there is a rocking back and forth motion; a little more progress with each contraction and then your baby's head is born! (Each time I've typed this sentence I've remembered just how excited I felt when my daughter's head was born!) You can't believe it! The baby may begin to cry when only her head is visible and the rest of her body is still inside you. It feels amazing! She is bluish and purple; if she cries before completely born she will look fairly pink by the time her body is out. She is wet looking, her head is shaped or molded from the birth canal, openings full of mucous, very little blood. You may want very much to grab her and deliver her from your body yourself. But you'll be stopped; your hands are not sterile, and of course, it's the doctor's job, his achievement to deliver the baby (while in actuality you've done all the hard work). Lousy but true. I've seen marvelous pictures of women taking their own babies from their bodies (some books on bibliography include such "dirty" pictures), but it will never happen in American hospitals! Your baby will cry now if she hasn't already; rarely are babies spanked or need help in starting to breathe when the mother has not had medication (doctor himself or a machine can force oxygen into the baby's lungs if there are problems in getting the baby to breathe on her own and avoid danger or retardation which comes from a lack of oxygen to the baby's brain). "If the cord is long enough, the mother can hold and nurse [her] even before it is cut. As soon as the blood is emptied from the cord, the doctor will clamp it a few inches from the baby's navel and cut it. After several days the remnant of the cord will drop off, and the baby's navel will look like any other navel. Contrary to some misinformation, the contours of the baby's navel are determined by heredity and not by the doctor's skill in cutting the cord."[17]

The cord struck me as exceedingly strong and beautiful – translucent, blue and in the shape of a telephone cord but thicker. The doctor gave my baby to the nurse to suck out more mucous, wipe and wrap and only then did I get her. I was shaky, chilly, exhausted and happy. I wanted to hold and nurse my baby but had no energy left. So my husband held her close to me. I felt so close to him at that moment and also to the woman who was my monatrice. She had been great, especially during the pushes, and very supportive. I realized later it was very important for me to have a woman there who had been through the same experience as I. I only wish now it had been at home and with my other child and friends around. (See Lester Hazell and Shiela Kitzinger for details about home delivery.)

The placenta is delivered during the **third stage.** Watch for it. I was amazed at how it looked – beef hearts on one side and an intricate series of veins and arteries on the other. Part of the transparent bag was attached. It was so amazing because it was this placenta that kept my baby living in utero for nine months! Several contractions expel the placenta and it slides out; the doctor can push on your abdomen (ouch) and reach in and grab it. If he does, pant to keep comfortable. You can do pushes as you did to help the baby come out for the placenta. When the placenta is taken off the wall of the uterus, the circular muscles close off the blood vessels so massive internal bleeding does not occur. You may be given a drug (shot or drip into your arm) to keep the uterus contracted. Take pain relieving medication (like Darvon) for constant crampiness. Learn to feel if your uterus is hard; if it softens, massage it briskly. Better for you to do the massage than nurse.

After the placenta is out and examined, the doctor will sew you up. That was the only thing that hurt me. (It could have been less painful if he had put in the stitches loosely before the numbness of the area wore off and therefore before the placenta was taken out.) It was a sensation of pin pricks. It was bothersome because by that time I did not want anyone to touch my body. "You will notice that first of all you get a series of small injections around the area to be repaired. Those will numb the area, although they will not take all the sensation out. You should breathe [do what kind makes you comfortable] and decontract the pelvic floor. In fact the trick is to push the pelvic floor forward a little [as you did when the baby's head was born], so that there is no tendency to tighten the muscles. Keep the pelvic floor forward, and don't contract your stomach muscles. . ."[18] (By the way, the stitches don't have to be taken out. They will dissolve by themselves.)

In addition to the possible afterpains or crampiness you'll have a blood loss like a heavy menstrual period that will last for several weeks. It's called **lochia**. Lochia reminds me about sexual relations, because the most liberal of the "experts" say you should wait until lochia ends (discharge of lochia goes from bright red to brown to a yellowish discharge) to have intercourse. Doctors say wait until the six week checkup. Masters and Johnson say six weeks may not be necessary. I say let your mind and body decide for you – see how you feel emotionally and physically.

YOUR FEELINGS RIGHT AFTER CHILDBIRTH

You are wheeled from the delivery room into a room which is your room in the hospital. (You

may be with another, with one, two or many other women. The more privacy, the more you pay. The first time I really enjoyed being with another woman. It was her third child and she was very helpful to me. The second time, since I couldn't be with close friends, I wanted to be alone.) You'll be starved, tired, exhausted to the bone, but probably not ready to sleep (if you haven't been drugged, that is). You'll be happy with yourself and your man/coach, but also feel strange and not at home in the hospital. You'll want to share your excitement with family and friends, but you'll be limited to telephone. (If you don't have a telephone in your room then that is not even a choice right after birth.) You may feel some loss when you look down at your abdomen and also realize they have taken your baby - whom you have just barely seen - to the nursery for a minimum of 12 hours. You may feel sad about that and also guilty that you haven't felt some "gush" of motherhood. Don't feel guilty; it doesn't happen like that! It takes time for you and for the beautiful little creature that has just emerged from your body - amazing, you feel, as you recall what's just happened! - to get to know each other. You may also just want to be alone for a while. You may feel very scared, you may get depressed when you think of what responsibility for another person means. You may need to talk with your man, your coach or someone else. You may have other feelings that I haven't mentioned. Remember those feelings are yours and you have the right to feel whatever you do; don't let anyone tell you otherwise. You also have the right to make demands for your needs to be met. I'll make no promises about what response you'll get, but you never know until you've tried. If you are feeling miserable and being treated like a non-person, make demands to get out of the hospital as soon as you can. (They usually make you stay five days, but I have known women who have left the hospital as little as one day after the birth of their child.)

I'm thinking two sets of thoughts as I'm writing: (1) negative ones about the hospital and (2) positive ones about the experience of childbirth.

More and more I feel that if we want our babies to be born at home it should be possible for every woman — unless there are strong medical or personal reasons against it. We should know all the facts and be the ones that make the final decision. (What if our homes are crawling with rats and roaches and are not fit to live in, let alone give birth in? That means we must demand that every woman have a home where she can give birth and can then actually make the choice of home or hospital. That means our struggle for ourselves must be a struggle for all women (all people) which won't end until we have power over all aspects of our lives, until we take power from those who keep the system running for ourselves. It means a revolution, sister!)

At this time our demands should include: (1) availability of life supporting mobile units to all homes; (2) doctors deliver babies at home until (3) there are enough trained midwives to take the place of doctors. We women want to have our babies in safety and in comfort. And we will not be satisfied until this is a right of all women.

The experience of childbirth is an important one — and should be a positive one as well — for those of us who decide to have children. For some of us it is the first time in our lives we are in touch with all parts of our body. And when we are prepared, it is an experience which demands that our minds and bodies work together and therefore an experience that helps us break out of the mind-body separation that keeps women "in their place". Also the whole range of feelings of giving birth to another being - especially as you see with your own eyes that being emerge from your own body - is so very powerful (thrilling) and other women talk of feeling much more able to allow themselves to experience sexual pleasure (and to demand it once they have felt it) after going through the physical upheaval of labor and childbirth. "Nothing more massive could happen to my body," one women said to a group of women, "so I could let myself get into and enjoy sex more."

And you have a child, a child who will change your life and whose life you will help to shape. With the help of your man, your friends and good childcare arrangements (which you'll have to struggle to get; it seems to me that deciding to have a child today is also a decision to get into that struggle, a struggle of survival for women and for their children), the activity of raising a child, like that of giving birth, is rewarding, unalienated work!

I tried to write this paper so that other women who have not had children and not thought about childbirth could learn enough about childbirth preparation to teach it to others. However, everything can't be included in a paper of this length, nor could I, as one person, even think of all the information and feelings that are relevant. So I caution all who use the paper to talk to other women about their feelings and experiences and ideas and to refer to books on the booklist. Finally, there are several movies of actual births that might be helpful (refer to organizations mentioned on booklist).

Childbirth preparation for all!
Power to women!

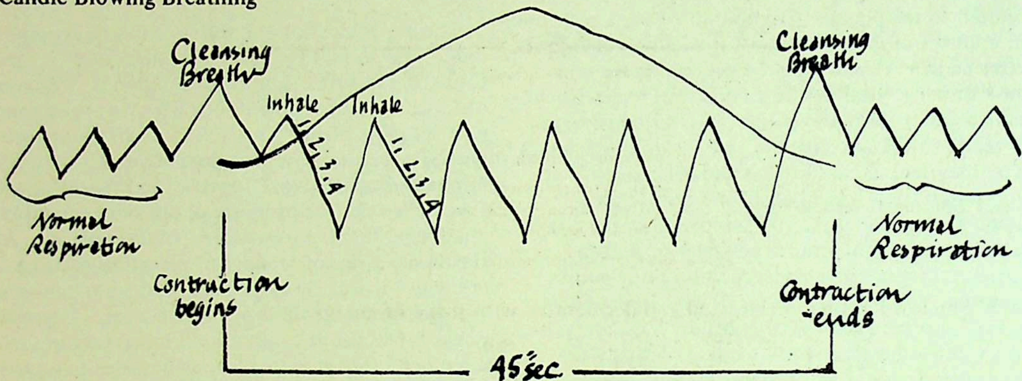
Breathing Techniques – Practice Outline

The instructions that follow are from two different Lamaze classes I took.

Practice for brief periods, frequently during the day. Make use of Braxton-Hicks contractions, for they will give you some sense of what early labor contractions feel like.

During practice, stop if you get dizzy. You do not need the extra oxygen now, as you will in labor. Also, don't get discouraged if it seems hard to master these breathing techniques at first; they are easier to do during actual labor than during practice sessions.

Candle Blowing Breathing



Candle blowing is used most in the early part of the first stage of labor (it may be used in the last months of pregnancy to help you relax and also later in labor for variety for a contraction or two). Use this technique as long as it keeps you comfortable. It usually stops being helpful about three centimeters dilation, but trust your own feelings and don't worry about numbers.

At the start of a contraction take a deep cleansing breath and let it out, making a sound like "whew" loudly and clearly and crisply. It's important that you be clear and noisy and definite in this and all breathing – both in practice and during labor; the patterned nature of the breathing is as crucial for a comfortable labor as is the technique of breathing itself.

Inhale a normal amount of air and breathe out evenly through pursed lips, counting 1, 2, 3, 4 to yourself as you exhale. You should imagine that there is a lit candle a foot from your mouth and with each count you are exhaling to *bend* the flame of the candle evenly and constantly without blowing it out. You can practice with an actual candle or with just a match at first to get the feel of it. The breathing should be very smooth and the transition from one to the next breath should feel easy. This kind of breathing should make you feel relaxed. (Keep your eyes open; you don't want to go to sleep!)

Begin practicing with 10 second pretend contractions. Gradually increase to 30-45 seconds, perhaps five seconds a day until you reach 45.

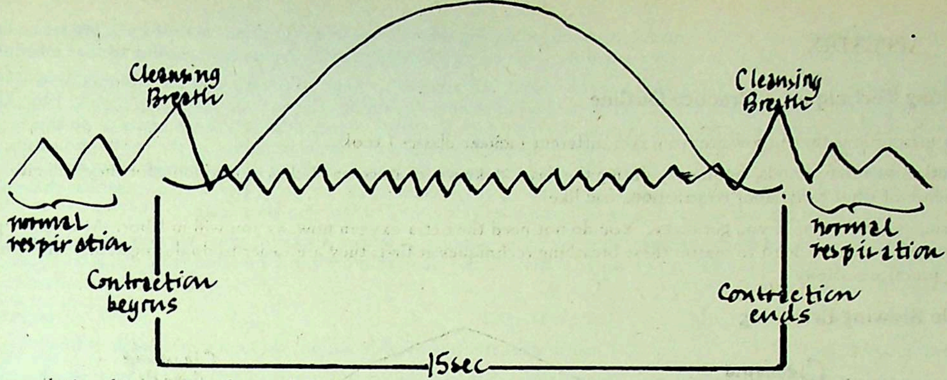
Add neuromuscular release technique when the breathing has been mastered. When you can relax (decontract all muscles) and do the candle blowing, add the effleurage. (Both are described in the body of this chapter.)

COACH OR SELF COMMANDS	*WHAT YOU DO*
"Contraction begins"	Cleansing breath in through nose, out through mouth with "whew"
"Inhale"	Inhale through nose at normal depth
"One-two-three-four"	Exhale steadily through pursed lips to the count of four
Repeat count of four as you time the pretend contractions	Continue through pretend contractions (rate of 8-12 a minute)
"Contraction is over"	Deep breath in through nose, out through mouth with "whew". End contraction just as you began it.
"Rest"	Resume normal respiration, stop conscious control

Slow, shallow panting, closed off by "Hut" or "Out" (chart next page)

This "hut" or "out" panting is used when the candle blowing no longer keeps you comfortable.

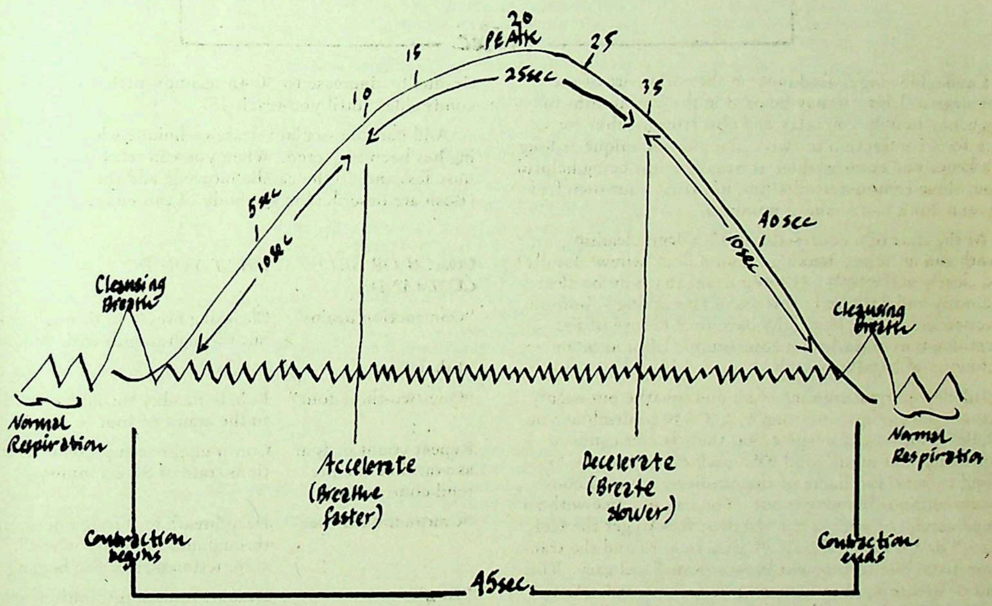
Start with a deep breath in and out. Then begin slow shallow breathing with most of the air exchanged in the upper chest, just below the throat. Use either nose *or* mouth, not both. Mouth is easier for most people. Abdomen and shoulders should remain as motionless as possible. Say the words either "hut" or "out" to close off each breath with a sound. Keep the depth regular and *even*. Think light and bouncy. Keep your tongue behind upper teeth to minimize drying of



your mouth (ice chips or sips of water help between contractions). Finish contraction with a deep breath in and out. Rest between contractions.

COACH OR SELF COMMANDS	*WHAT YOU DO*
"Contraction begins"	Take a deep breath through nose, exhale through mouth, "whew".
Coach paces contraction by calling out when 15, 30 and 45 seconds have elapsed.	Inhale through mouth, less than normal amount, at faster rate. Close off each pant with either "hut" or "out". Exhale through mouth. Continue through pretend contraction (rate of 60 a minute).
"Contraction is over"	Deep breath in and out, "whew". Rest, resume normal respirations.

Rapid Shallow Panting, accelerated and decelerated with shape of contraction



This kind of breathing feels much like the previous kind, only it must be quicker to respond to contractions which are longer, closer together and feel stronger. The more active the uterus, the more active must be the breathing to keep our attention on the breathing, to keep us from tensing muscles and thus interfering with the work of the uterus. The panting is so rapid that we don't have time to close off each pant with a sound as before. We must be sure to exhale as much as we inhale or else get hyperventilated from an imbalance of oxygen-carbon dioxide.

Start with a deep cleansing breath and then begin shallow panting with acceleration of speed as the contraction builds up; fast superficial breathing at the crest of contraction; deceleration of speed as contraction subsides. Finish with deep cleansing breath. Both in practice and during labor you will need to concentrate fully to make the change in rhythm very smooth, and keep the breathing even within each rhythm.

Practice for 2-3 contractions each of 60 second duration a couple of times a day. Don't start this kind until you have mastered the other two kinds of breathing. So you will build up to what is suggested above slowly, at your

own pace. It's important not to become discouraged during practice because you think there is some pre-set endurance test you have to meet. Make your own schedule. Just be sure you do practice regularly according to that schedule.

When you practice, use a watch with a second hand. 15 seconds to go up to the wave of the contraction with the breathing gradually getting quicker; 30 seconds of rapid-shallow breathing at peak (rate may be as high as 140-160 a minute at peak; don't try to practice that amount, for you'll get too dizzy – remember it's much easier to do this breathing during labor than in practice); and 15 seconds for the gradual return of normal breathing as the contraction ends. Vary length of practice contraction occasionally. Add neuromuscular release technique and effleurage when breathing is mastered. It helps if your coach calls out passage of time (i.e. 10 seconds, 15, 20, etc.); gives you a sense that there is movement and the hard work will end and there will be a brief rest period before you start again.

This breathing is used when the slow "hut" or "out" panting no longer works for you. We may use it before then, when there is a change in the pattern of our contractions and we need more active breathing to cope, after enema or breakage of bag of waters.

COACH OR SELF COMMANDS	*WHAT TO DO*
"Contraction begins"	Cleansing breath in through nose, out through mouth with "whew"
Coach paces contraction by calling out passage of seconds and by signalling when to accelerate, decelerate breathing	Inhale through mouth, less than normal amount, at fast pace which gets faster as contraction peaks and becomes slower with decrease in intensity of contraction. Exhale through mouth. Continue through pretend contraction.
"Contraction is over"	Deep breath in and out, "whew". Rest, resume normal respiration.

LABOR SUMMARY (Lamaze)

PHASE OF LABOR	WHAT YOU MIGHT FEEL	WHAT YOU CAN DO
Stage One		
Early Phase 0-2 fingers 0-4 cm.	Backache Diarrhea or constipation Abdominal cramps Show Ruptured membranes Excitement, anticipation Regular contractions	No food Time contractions Call nurse and doctor Pelvic rock for backache Candle-blowing breathing Get accustomed to contractions Conscious relaxation
Mid-Phase 2-4 fingers 4-8 cm.	Stronger, more frequent contractions More serious concentration Dependent on companionship Discouragement, doubts Restlessness Back and/or leg pain Weepy	Slow "hut" or "out" panting or rapid panting Effleurage Ice chips, water sips Relax Vary position bed/pillows Mild medication (analgesic) Back rub Concentrate on one contraction at a time Encouragement from man/coach
Transition 4-5 fingers 8-10 cm.	Leg cramps and shaking Nausea and vomiting Heavy show Hot and perspiring "Sleeping" between contractions Total involvement, detachment Apprehension Inability to concentrate Increased pressure Desire to push Dizziness	Rapid panting mostly but vary with other kinds Techniques for resisting urge to push Remember time is short Wet cloth on face, suck Man/coach tell woman to concentrate Specific commands Lots of encouragement Use brown bag, hand over mouth for tingling from hyperventilation Don't panic!
Stage Two Expulsion of Baby	Contractions may slow down Urge to push Pressure to rectum, perineum Total involvement May feel exhausted and have difficulty concentrating Excitement with actual birth of head, shoulders, etc.	Specific instructions for each contraction Relax, push out perineal muscles Three pushes/contraction (don't be afraid to push hard) Be ready to stop pushing and pant Man/coach support shoulders, give encouragement
Stage Three Expulsion of Placenta	May feel slight contraction	Relax, pant, push out perineal muscles. May ask to stitch loosely before removes placenta.
Nursing (Hazell, p. 232)	Suckling at the breast helps contract the womb to prevent bleeding and satisfies the baby	The baby is offered both breasts right after birth and whenever [she] is hungry.

FOOTNOTES

1. "We Don't Call It Natural Childbirth, but Educated Childbirth", Marilyn Bender, *New York Times*, 16 May 1967, p. 380.
2. Kitzinger, pp. 29-31. 3. Wright, pp. 53-56. 4. Ibid, pp. 33-34, 85. 5. Ibid., pp. 81, 82, 83-84. 6. Hazell, p. 92. 7. Ibid, p. 84,91.
8. Ibid., p. 95. 9. Wright, p. 109. 10. Hazell, p. 9. 11. Ibid., pp. 9-10. 12. Wright, p. 162. 13. Hazell, pp. 132-33.
14. Ibid., pp. 134-36. 15. Kitzinger, p. 143-44. 16. Hazell, p. 136. 17. Ibid., p. 98. 18. Wright, p. 142. (See booklist for references.)

BOOKLIST

Childbirth Without Fear. Dr. Grantley Dick-Read (1942).
Written by English doctor who was one originator of prepared childbirth. Method more mystical than Lamaze method, with more stress on relaxation and less on activity.

Thank You, Dr. Lamaze. Marjorie Karmel (1959), pb.
Lively, personal account of two experiences with prepared childbirth. First child delivered in France by Dr. Lamaze, second in America. (Comparisons of practices in two countries') Fun to read. Little outdated.

Childbirth Without Pain. Dr. Pierre Velley (1961).
Series of lectures, exercises by associate of Lamaze. Good, thorough in Lamaze method though hard to read. Shouldn't be the first book you read. Be sure to look at the pictures of a delivery – very exciting! Velley is practicing in France.

Awake and Aware. Dr. Irvin Chabon (1967), pb.
Book written by American doctor. Good history of childbirth practices (part I liked best was explanation of change from home to hospital deliveries), Lamaze method, short birth records of women, exercises and good pictures. Current, easy to read, recommended.

The New Childbirth. Erna Wright (1966), pb.
Manual to prepare woman for childbirth written by midwife. Excellent preparation in Lamaze method. Written by woman who has children. Pictures! Less critical of medical profession than book by Hazell. Could do all physical preparation necessary with this handbook alone.

The Experience of Childbirth. Shiela Kitzinger (1962).
English woman. Method described combines Read and Lamaze. Strong psychological orientation (I felt it made woman look too much in on herself and not look enough beyond herself, at the society, for origin of some problems). Has chapter on home delivery which is more specific than the one in Hazell.

Commonsense Childbirth. Lester Hazell (1969).
Written by woman. Best overall book for many reasons: good to read, complete and sensible approach to childbirth. She has had kids of her own and conveys what it feels like to give birth. Even more important, she has an understanding of the source of lots of women's problems during childbirth – the medical profession (and is very critical of it). (This is more important since no other books I've seen on the subject of childbirth preparation seem to have that understanding.) Information in book fits right into women's liberation. Excellent section on why to have a baby at home; also good one on breast feeding. If you buy one hardback book, get this one.

A Practical Training Course for the Psychoprophylactic Method of Childbirth. Elisabeth Bing, Marjorie Karmel, Alfred Tanz, M.D. (1961).
Lamaze techniques. Manual officially approved by A.S.P.O.

Pregnancy and Birth. Dr. Allan Guttmacher (1965), pb.
Guttmacher is head of International Planned Parenthood; he practiced obstetrics and gynecology for many years in New York. He has written many books for the general public. This book is okay when you don't expect to understand topics in too great depth.

The First Nine Months of Life. Geraldine Lux Flanagan (1962), pb.
Story of conception and week by week progress of baby in utero. Exciting to follow when pregnant. Terrific pictures, for example of baby sucking thumb in utero!

Life Before Birth. Ashley Montagu (1964), pb.
I haven't read this book. Title covers the content though I can't make any comments on author's point of view.

Husband-Coached Childbirth. Dr. Robert A. Bradley.
I haven't read the book. It's often referred to in childbirth preparation courses, I guess because it's directed toward the man. However, I'm skeptical about a man writing about how men can help women in childbirth; without having read the book, I'd be happier if the author were a woman.

A Child Is Born. Lennart Nilsson and Axel Ingelman-Sundberg and Claes Wirsen (1965), pb.
Beautiful color photographs.

Conception, Pregnancy and Contraception. (1969).
New book with excellent drawings and photographs. I was especially impressed with drawings of female anatomy which gave a sense of the relation of one part of our bodies to another (which is rare in most books I've seen).

The Womanly Art of Breastfeeding. La Leche League (1963), pb.
Some helpful information if you can get past the sickening stuff about a woman's role is to bear and raise kids. Little outdated in comparisons between breast and bottle milk! Does give woman lots of support for breast feeding.

Nursing Your Baby. Karen Pryor.
I haven't read it completely, but I felt it had the same information as *The Womanly Art...* and was less objectionable to read.

Baby and Child Care. Dr. Benjamin Spock (1946; rev. 1968), pb.
Well, what does one say about Spock, anyway? He was reassuring to me at times, but mostly was too general to be of real help (have to always call your own doctor). Revised edition not much different than original. He may be good about Vietnam war, but he's terrible on women (don't expect father to play with the child after a long hard day at the office, let him read his paper, bring him his slippers), sex, and religion. He has a new book out called *Decent and Indecent*, which is more chauvinistic and more rigid than the first. Spock is on his way out as far as I'm concerned. We'll have to write our own book to replace his "classic".

Textbook of Pediatrics. Nelson.
This was recommended by a woman medical student friend. I haven't gotten it since it's expensive ($20.). Several of us have talked about buying it collectively. It's the book pediatricians use to check on illnesses. With a medical dictionary to decipher the jargon, we should be able to check before we call the doctor and have some check on his diagnosis.

Prenatal Care, Infant and Child Care, Your Child from 6 to 17, Adolescence. U.S. Department of Health, Education and Welfare, Children's Bureau Pamphlets.
Have about the same information as Spock, but are free from the government.

The Magic Years. Selma Fraiberg, pb.
Covers years from birth to six. Freudian but not too offensive. (I haven't read it thoroughly since women's liberation and now might find it worse.) Helpful hints and some good stories if you don't take everything too literally.

Gessell Institute's Child Behavior. Ilg and Ames (1956), pb.
Can give some information of what to expect from a child of a given age. Don't take age norms too seriously. Remember it's statement about what children have done in this society over t years ago. Things are changing and need to be pushed more. (instance, children can begin to relate to each other from the ti they are only weeks old. Yet this and other books say not until three, an assumption that the child is in the nuclear family until that age and then goes to nursery school as a first encounter with the outside.)

Love Is Not Enough. Bruno Bettelheim, pb.
Written about children in his special Orthogenic School in Chicago. Although the book is not about "normal" children and Bettelheim is a very authoritarian man, he has some important things to say about all kids. I especially liked his chapter on food, on in-between times and space.

Infants and Mothers and Their Development. Dr. T. Berry Brazelton (1969).
The book is a study of three different children. I haven't read the book but he is the pediatrician I use. He has done work with Jerome Bruner and the book reflects these studies on learning, I'm sure. It probably has some good observations about effect of children on their environment (as well as the environment on them). Beware of his chauvinism (I understand it has a terrible part on working mothers) and tendency to Freudian interpretations.

Analysis of Human Sexual Response. Ruth and Edward Brecher.
Excellent summary of revolutionary (!) studies of sex by Masters and Johnson. Talks about sex during pregnancy and after childbirth and that's why it's on this list.

I did not do a survey of literature to make up this booklist; the list is based on the books I like and was familiar with. I'm sure there are things I have left out. Please feel free to add others (and pass the word on to me).

If you can't get the books from the library or from the bookstores, check with (1) Boston Association for Childbirth Education, (2) Lamaze Education, Inc., (3) La Leche League.

Outside the Boston area, you can check with these groups: International Childbirth Education Association, Box 5852, Milwaukee, Wis. 53220; American Society for Psychoprophylaxis in Obstetrics, 36 W. 96 St., New York, N.Y. 10025; La Leche League International, 9616 Minneapolis Ave., Franklin Park, Ill. 60131

Post Partum

INTRODUCTION

Postpartum emotional disturbances, like most (possibly all) mental disorders, are defined by the social context in which they occur. (Marcuse writes, "Health is a state defined by an elite.") For example, on an Israeli kibbutz the mother who feels that she cannot leave her newborn between nursing times to contribute to the community work is regarded as in need of special counseling for anxiety. In the U.S., the woman who returns promptly to work after childbirth is regarded as cold, neurotic and unresponsive to the needs of her baby.

In fact, a baby's need for stable responsible adults can be met by a group or community of people. We believe it is a myth that the mother must be omnipresent to prevent psychological damage to the infant. The myth is perpetrated to keep us isolated and privatized in keeping with the competitive capitalist ethic.

What little research has been done on postpartum is heavy with male bias and conventional attitudes about motherhood. It shows that over half of all women who bear children have some emotional upsets following childbirth. If we look at the minority of women who cope well during this difficult time, we may find the seeds of the social conditions needed to make both motherhood and childhood a time of satisfaction and growth. Some of these

are: (1) complete choice in becoming pregnant (physically, psychologically, and socially); (2) economic security; (3) child care that can meet the needs of infants and toddlers so that we need not give up our work in order to be mothers.

The psychological postpartum period, the months following childbirth (for some the feeling of helpless lethargy lingers on for years), is for many of us a time of emotional changes. Some of us are high, some mellow, some lethargic and depressed, some have mood swings. We are confused and a little scared because our moods do not resemble the way we are accustomed to feel; we never expected this overwhelming need to sleep, even in the early morning, the inability to concentrate on a book or other activity, the suicidal fantasies (anger turned inward) or the fantasies of leaving the baby and its father (anger turned outward). We are frightened by anger at the baby who is so terribly vulnerable and dependent on us. If you never have had the experience of being responsible for another's care - if you have never cared for small children - it is an awesome responsibility to find yourself totally responsible for the life of another human being. The newborn human infant cannot meet its own needs except by crying to signal discomfort. It depends on us for nourishment, removal of fecal matter, clean clothes and occasionally even a change of position (let alone affection).

For us as first time mothers it begins to seem as though life henceforth will be merely a struggle to meet the personal needs of the baby and ourselves (in that order), with little or no time left for anything meaningful or fun.

It is very important to remember that the time the baby needs so much care is short. In the first year, babies learn to hold their own bottles or cups, sit up, crawl, stand, sometimes walk and begin to say words. Every few months brings a new stage of development (don't worry if your baby is a bit slower than your friends') and some lightening of your load (more messes at first, though).

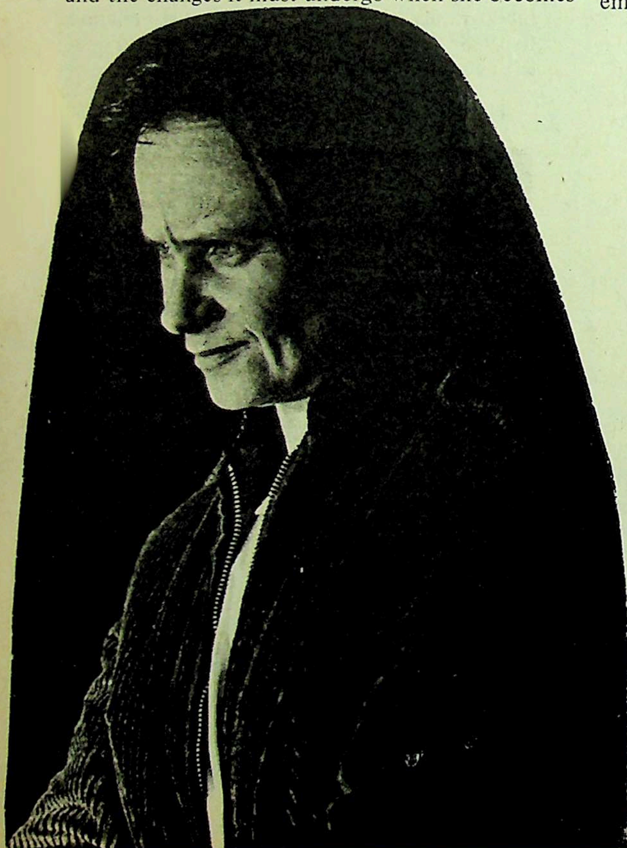
Example: At a recent meeting a woman speaks suddenly about herself: "I have one child and I'm pregnant again. Immediately after the birth of my first baby, I felt high and exhilerated. But that night I got sad. I cried all night long. During the next few days I lay in my bed thinking of how I would kill myself. I looked at how the windows opened and I concentrated on figuring out times when no nurses were on duty. I couldn't sleep at all. I tried to tell them I was depressed, and all they gave me were sleeping pills. I felt like I'd never feel anything again but this incredible despair, that it would never end. I had nightmares. The one I remember best is where I would be feeding the baby. I would fall asleep and the baby would fall off the bed and be killed. I don't know why I had these dreams and impulses. I have had a happy marriage and it was a wanted pregnancy." She talked about meeting another woman and finding that she had gone through the same kind of experience, including a dream that she had slit her new baby's throat with a knife.

The postpartum period, the first few months after childbirth, is treated by most doctors from a purely physiological point of view. They dismiss most of the psychological and emotional feelings as "natural". Postpartum depression in its mild forms is considered so common as to be unworthy of mention, so little research has gone on in this field. However, some 10% of the psychosis in women develops from the reproductive experience (Piker, '38). Women are offered verbal bromicides rather than realistic treatment. After all, society tells us, women should find Motherhood totally fulfilling and should instinctively know how to respond to and care for their babies. Because of the societal pressures surrounding Motherhood - the mystique of the maternal instinct, joys of child care, fulfillment through others - many women are unable to pinpoint their feelings of confusion and inadequacy or are unable to feel legitimate in verbalizing their hesitations and problems. This

chapter will cover the emotional, social, and physical stresses on the postpartum woman, and put forth some proposals for action by women so that pregnancy, birth and the initial phase of motherhood can be a positive experience, perhaps even a time of real psychological growth.

The problems that develop in this period are accentuated by the fact that the obstetrician is often the only supportive professional the woman sees during pregnancy. And he is very rarely supportive of her emotional needs. When a woman becomes pregnant, she is put on an assembly line, whether she goes to a clinic or sees a private doctor. She goes to the doctor and finds that her body is regarded as a machine to be serviced periodically. Pregnant women are always referred to as the patients (the same category as sick people). She is shunted through at predetermined intervals during pregnancy, and then not until six weeks after delivery. If she sees a private doctor, she should object to paying a fee for the cursory treatment she is given. If she goes to a clinic she will see a number of doctors and possibly even be delivered by one she has never met.

Nowhere are the woman's many fears touched upon: her difficulty in coping with her self image and the changes it must undergo when she becomes a mother. The doctor does not usually make a real attempt to deal with her feelings. Even fears of childbirth are rarely dealt with. Concerns about parenthood are almost certain to be dismissed with bland assurances that women simply know these things when they need to. The myths about the unbounding joys of pregnancy, delivery, birth, and motherhood felt by "normal" women are only enhanced. Even most childbirth preparation classes are oriented toward physical control during the birth process and do nothing to prepare the mother for motherhood and babycare. Furthermore, in this society the positive self-esteem gained by motherhood is undercut by the difficulty in continuing one's career because of the extra domestic activities she now has. Although the occupation of motherhood is highly touted, that of housewife (=drudge) is generally considered pretty undesirable. But for most people they are inseparable, with motherhood held out as the reward for cheap household labor.



Yet pregnancy, a life crisis with tremendous growth possibilities, is treated merely as an initiation period to be gotten through, with birth as a climax, while the birth of a child can be a traumatic experience for any couple, or person, and for us to build an entirely new web of relationships. This emphasis on the delivery is useful for the image of the doctor as a specialist, and a performer; a sop to his ego. He is the magician, the "deliverer". Paid up until birth, he sees the woman afterwards only in extreme cases except for the perfunctory six week checkup at the end of the puerperium (Latin; puer – a child, parere – to bring forth). During this time the generative tract usually returns to normal.

After the birth, if the woman should be upset and call her doctor he might refer to the baby blues, a catchall term, used to describe the common symptoms of irritability, crying, and hypersensitivity. Her legitimate complaints might be brushed aside as emotionalism. One woman here in Boston, soon after childbirth complained that fecal matter was coming out of her vagina. The doctor refused to examine her and dismissed this as fantasy. Was he unwilling to acknowledge the possibility that his episiotomy was not done perfectly? In desperation, the woman went to another doctor, who treated her successfully for a ripped vagina. Thus the woman is left mostly on her own. Specialization provides her with one physician up to the birth, another for her newborn child, and a psychiatrist if needed for severe emotional problems. The English midwife system (explained later) eliminates this fragmentation.

Most women go home after a five day enforced rest in the hospital, which is now about five days for paying patients and two days for non-paying. There they have no help and often have other children to care for. For the next few months, they are unable to get more than four hours of sleep at a stretch. In casual conversation, many women report such things as falling asleep in company, no time to fix their hair or take care of their own personal needs, inability to cope with daily household routines, or inability to maintain involvement in outside interests. They often feel that they have lost control of their lives, and a dread that life will always be this way. They often feel guilty because they think their own inadequacies are the cause of their unhappiness. **They do not ask if their roles are realizable.** The casual observations are confirmed by a survey of 137 obstetrical patients postpartum. They showed "subjective evidence of anxiety and/or depressed and cognitive dysfunction in 64%. Symptoms included inability to sustain attention, distractibility, poor recent memory and labile moods resembling clinical signs seen in acute brain syndromes but much milder in degree."

Many household routines can be minimized or streamlined during this period in the interests of efficiency and getting rest but even those activities that are beneficial to the woman's morale are often too much of an effort after a day of crying babies, feeding every three hours, and washing clothes. In earlier times, women had fewer appliances, but more people helped with housework, especially when a new baby arrived. Even the visiting nurse seems to have gone out of style as women become "better educated". That our education rarely touches on baby or child care is taken into account by no existing public or private institution. Although there are many classes which help us to deal better with the physical side of pregnancy and childbirth, there is little readily available instruction for childcare, which is also a **learned** skill, not instinctual. A study of maternal role-taking responses showed consistently higher scores for multiparas (those who have been mothers before) (Reva Rubin, Nursing Research). Another study (Gordon and Gordon) shows that women who attended child care classes during pregnancy had significantly fewer emotional upsets postpartum. All the classes emphasized that the responsibilities of mothers are **learned**, not inborn. This confirms our belief that knowing what to do with a newborn does not necessarily get into our heads by "maternal instinct".

There frequently is a mild depression on or about the second and fourth days, corresponding to engorgement and the beginning of lactation. It is not really known why this connection exists. Some people feel that the separation of the mother and child in the hospital increases the depression. This is true for nursing mothers as well since there is usually an initial mandatory twelve hour separation. Mild postpartum depression is not an item high on the research priority list although nearly half the adult population in the United States (i.e. most of the women) experience this syndrome (probably because mothers are not as important to the efficient functioning of the industrial machine as other members of society). These "blues" in themselves are not indicative of longer term depression. During this time it is a good idea to talk to someone about your feelings. If your doctor has no time for you or is unsympathetic, try to have someone close to you be there to talk to.

Our attempt to research the professional journals produced only a handful of articles over the last two years. Most of these deal with aspects of the postpartum depression. Of course, everyone should not expect to have a depression, but it is common enough to suggest that contributing factors exist in most of our lives. One study done in 1968 by Rita Stein shows the lack of integrated research of the emotional side of pregnancy and postpartum period. (Her study contains a valuable bibliography, showing the gap from Hippocrates to 1928. It provides a good historical overview with a sociological approach.)

The "traditional" and first serious theory (30

years old) was that women suffering from severe postpartum depression had deep-seated mental illness and that the birth of the baby was merely the trigger that brought the pre-existing psychic disturbance to the surface. Women suffering from psychotic postpartum disturbances were diagnosed as schizophrenic, manic depressive, or whatever clinical syndrome their behavior was thought to resemble. Often they were hospitalized for years; in some cases, for life.

Today this attitude is being rejected in favor of stress triggering theories. These can be broken down into two streams of thought: (1) The depression is caused by physical stress, i.e. hormonal imbalance and the bodily shock of labor. (2) The depression is caused by social stress, including one's background and one's current environment. A study in 1962 found postpartum depression analogous to combat fatigue (Hamilton). Women who exhibited severe symptoms were sometimes found to have thyroid difficulties and made dramatic recoveries when treated with thyroid compounds. It is known that there is normally a change in the amounts of 17-hydroxyclorticoids, steroids related to the sex hormones, in the blood level whenever there is a general emotional arousal. Perhaps the hormonal imbalance caused by the end of pregnancy can help to trigger the depressed feelings so often encountered. Those who favor the physical stress theories emphasize hormonal treatments, drugs, such as tranquilizers, anti-depressants, and sometimes hospitalization in severe cases. A study currently being done in Boston attempts to pre-ent recurrences by controlling the hormonal bal-ce, tapering the drug dosage off over a period wo months. Other reports show that the social ors including one's background and one's cur-t environment are larger contributors to depres-ion for most people. This is borne out by reports of depression in fathers (Lunenberg, 1967) and adoptive mothers (Rheingold). Rita Stine's study lists four major role changes for the mother of a newborn: (1) Becoming maternal yet not experienced in coping with the demands of an infant. This dichotomy between expectations and experience is definitely perpetuated by the nuclear family, where there is usually no other adult to help with child care during the day. (2) A change in personal status in the occupational and social scheme. She must choose between **doing** something and **being** a mother, since child care is not available in many cases. (3) A change in ego-ideal. The mother must put the child's needs before her own. A woman is taught to obliterate her personality and live through her children and husband. (4) A change in marriage and family patterns. Her role becomes more rigid and confined. Rita Stein recommends taking life histories emphasizing early childhood and marital adjustment to determine which women are likely to require special help in changing into their new roles. She does not discuss the validity of the role. Another recommendation of the study is to use pre-natal groups to discuss problems.

A questionnaire developed by Richard and Katherine Gordon was successfully used to spot potential problem areas and predict the statistical likelihood of having postpartum difficulties. The findings of this study showed that 78% of the women who showed 7-10 stress factors (explained below) developed postpartum problems. Those with the most stress factors were likely to have the most severe and long-lasting illnesses. Of first-time mothers interviewed, nearly one in three developed difficulties! For one out of ten, the problem persisted for at least six months.

Stress factors for this study are divided into two main categories: (1) "Personal insecurity" or background factors, such as loss of a parent in early childhood, inexperience with babies, first pregnancy, etc., and (2) Current environmental factors, especially role conflict, but including such things as isolation, financial problems, husband working late, and upward social mobility. The Gordons believe that though a woman's history plays some part in her ability to "adjust to motherhood", it is the current factors of isolation, **lack of stimulation** and **role conflict** that deepen the problems and cause them to continue. In The Wretched of the Earth, Franz Fanon similarly finds that mental disorders of childbirth among Algerian refugees were deepened by their living conditions despite appropriate treatment. This has application for all women who must bear their children under traumatic conditions and raise them in poverty.

In making use of information gathered by social scientists we should be careful to distinguish between scientific findings and the underlying assumptions, biases, of the researcher. We should beware of such phrases as "a good adjustment to motherhood" or "female-passive vs. male-aggressive role conflict". In the Gordon study, the stress factors were separated into two categories, personal insecurity and role conflict. As we read the items which make up the personal insecurity factors, we find they refer to such things as early death of the mother or lack of experience with babies. In other words, these are factors of insufficient experience and knowledge in the maternal role. If a man feels insecure the first day of a new job, his masculinity and whole self image are not called into question. Unfortunately, our society encourages a woman to fuse and confuse her role as a person with her role as a mother. She is taught to believe **only** she

can best mold her children. This is reinforced by a society that does not provide her with adequate alternative child care. Role conflict exists because the society makes it so difficult for a woman to pursue other goals while providing good care for her children.

PHYSICAL ASPECTS

The physical changes occurring in the postpartum period are enormous. Although they are considered "natural" they closely resemble the pathological. Nicholson J. Eastman, M.D., who is the author of a textbook for medical students on obstetrics as well as a book for pregnant women called Expectant Motherhood, says that "under no other circumstances does such marked and rapid tissue catabolism (tissue break-down) take place without a departure from a condition of health." A woman should be aware that such changes are taking place and that they will probably affect her physically as well as emotionally. It is important to note here that feelings, particularly of depression, are intensified and are of longer duration if the woman permits herself to get run down physically. Some women have stubborn virus infections which may lead to depressions, or substitute for them (in women who cannot acknowledge depression).

As with pregnancy, some women will experience a number of discomforts while others will have hardly any at all. Some discomforts of this period are sweating, especially at night, loss of appetite, thirst due to loss of fluids and constipation partly due to inactivity but principally due to relaxation of the abdominal walls and their consequent inability to aid in evacuating the intestinal contents. Getting up and walking as soon as possible is thought to prevent severe constipation. A woman may feel that her genitals are looser. As far as sexual relations are concerned, the Masters and Johnson study indicates that if a woman's vaginal area feels okay, there is no reason to avoid intercourse if you desire it. However, proceed slowly at first because if your episiotomy is still tender and starts to hurt under pressure of the penis, the side position is probably best for intercourse. The taboo varies from one country to another, even in the Western world. Many women in the U.S. begin in their third week postpartum. Most women find that their vaginas do not lubricate easily at this time and fear they've become frigid. (If you have this trouble, just use a plain, unscented lubricant, as K-Y Jelly.) Doctors make the six week rule for their convenience so they do not have to be bothered taking each case individually. This rule originated in the days before antibiotics. Remember, too, that if you sleep with someone regularly you probably already share the same germs and have developed a tolerance for them. (See appendix for more on postpartum sex.)

After a normal delivery the patient is out of bed 24 to 72 hours postpartum. Those who get up soon after delivery state that they feel better and stronger sooner and have fewer bladder and bowel difficulties. By getting patients up earlier it has been possible to reduce the recommended hospital stay to four or five days as compared to the customary ten days in the recent past. You might also consider whether the high costs of hospital stays, shortage of beds and the depersonalized treatment the patient gets will affect how healthy you feel. It would be better if women had the choice of delivering at home. (It's safely done now in England.)

However, it should be emphasized that because the woman is able to get up out of bed and move around does not mean she is ready to re-assume her usual responsibilities at home. It is important to get enough sleep and to set aside some time in the afternoon to make up sleep lost due to night feedings. For the entire six weeks, time should be set aside for exercise and rest. Paternity leave, time a father gets off from work when a child is born to help care for it, or daycare for other children would help with this immensely. Housework should be shared by other family members or simply kept to an absolute minimum. If there is no help, the first week home plan on take-outs, frozen dinners, paper plates, etc. No more stair climbing and other exercise should be done than you can do comfortably. You may feel you want to limit stair climbing to once a day for even the first week. Be careful of heavy lifting, which should not be done before you are able. Try to tune in to signs your body gives to tell you it is tired; don't ignore them.

Thanks to prepared childbirth, women feel better after giving birth and are able to resume their customary activities sooner. However, we feel that the common discomforts of this period have been so de-emphasized that "prepared" mothers are often quite distressed when they find themselves not feeling as well or as strong as they had expected. Do not get taken in by the modern equivalent of dropping the baby in the fields – the cliche ending of the natural childbirth films in which the mother hops off the delivery table with the baby at her breast and walks off unsupported into the sunset. You may feel great, you may have few or no discomforts, you may have many; you will not know until the time comes. But when you are aware of the range of possibilities you probably can handle them better if they occur. For a more detailed physical account of the body changes and their effects on you during this time, please turn to the appendix.

WHAT CAN BE DONE

We as a women's liberation group can begin to organize ourselves to fight those aspects of our society which make childrearing a stressful rather than a fulfilling experience. We should recognize the fragmentation of education into subjects not integrated with real experience so that most of us learn nothing about babies until we have them. We should be aware of the isolation of the nuclear family. We need to be aware of the lack of maternity and paternity leave, lack of good child-care facilities forcing women to choose between family and career. We must recognize the mystique of the full-time mother that causes women to feel that they are depriving their children if they have careers or other pursuits and fight the male supremacy which requires the women to come home from a job and take care of the backlog of home and child care.

1. As an immediate step, the Gordon questionnaire could be widely distributed to obs and clinics with follow up provided for women who showed six or more social stress factors. Since it doesn't look as though this is being done, a women's group could leaflet these questionnaires at medical buildings, clinics, childbirth classes and maternity shops inviting women to come to meetings to talk about infant care, women and social stress. Group counseling could be organized for pregnant and postpartum women who are already experiencing difficulties. Crash counseling can help women deal with their problems effectively (Kniebel).

2. Develop pregnant-couples groups to explore feelings, fears, hopes about pregnancy, childbirth, and parenthood. Use the crisis of pregnancy to bring about individual psychological growth and help move the marital relationships (where they exist) to a new stage of development.

3. Make more use of group processes in already existing groups. Humanize childbirth classes so that feelings are dealt with along with the physical facts of pregnancy. Psychologically trained people should train lay people and nurses to deal with feelings in these groups. Psychiatrists should be available to consult with individuals or couples who feel they need it.

4. Set up a pre- and post-natal telephone service. Any woman with a problem could call. Serious problems would be referred to qualified people.

5. New organizations of visiting laywomen to help with post-natal problems.

6. Work on developing, with sympathetic medical people, a nurse-midwife approach like that existing in England. The midwife sees the woman during pregnancy, stays with her during all of the delivery, and helps with child care for the first few months of the child's life. She can handle all routine procedures competently and can recognize complications. Then the obstetricians could be on call for all difficult pregnancies and births, pediatricians could care for all serious infant illnesses, not just for those who could afford to have them.

7. Develop mobile emergency units (again, as in England) to enable women who want to deliver at home to do so as safely as in a hospital. This would remove the implications of emergency, trauma, and disease associated with hospitals from the birth process. With these unnecessary stresses removed, the return to normal activities could be speeded up.

8. Place realistic information in every clinic and doctor's office. (The doctors should pay a little for the printing.)

9. Demand maternity leave for mothers and fathers as provided in Sweden. Then both parents can cement the "love affair with the baby" (Baher) and learn together to meet its needs.

10. Daycare should be provided by all places of employment so both parents can return to productive work with mothers able to nurse the child on the job. This will have the added benefit of breaking down puritanical prejudices against breast feeding, a natural function of a woman's body. It should not have to be done surreptitiously.

We must free ourselves from the equations woman = passive, man = active, woman = child rearer, man = provider. We are all human beings, all one species. Our reproductive organs determine complementary roles in reproduction. They need not and should not determine our roles in society.

APPENDIX

The appendix describes the physical aspects of postpartum in more detail than the chapter.

After Labor

For at least one hour after the completion of labor, the physician or midwife should remain in attendance in case of complications. If at the end of that period the uterus has satisfactorily contracted, the woman may be left alone. If not, contractions should be stimulated and progress carefully watched until all danger of hemorrhage

has passed.

The genitals must be kept clean to prevent infection. The cervix is large after pregnancy, admitting two fingers. It is very important not to introduce anything into the vagina because of the danger of infection. The cervix returns to nearly normal condition in **one week** by proliferation of new cells (unlike the uterus, which first autodigests part of itself and then makes a new lining). The genitals are washed with an antiseptic solution each time after elimination and the sterile pad changed. Dr. H. J. Eastman, the author of our medical text, states that the pad is useful not only to absorb the lochia but because "it makes it difficult for the patient to touch her genitalia, a practice very common among the uneducated classes. . ." The good doctor does not mention whether he has ever tried **telling** these "uneducated" women about the dangers of infection.

An abdominal binder is not necessary, but many women feel more comfortable wearing one (usually a girdle that won't roll up).

Afterpains caused by contractions of the uterus are more common in women who have had more than one child. They are often accentuated while the baby is nursing. When they are severe, codeine or aspirin is prescribed.

The **uterus**, by a process called involution, becomes reduced to 1/20 to 1/25 of its size at delivery. Involution is effected by autolytic (self-breakdown of cells) processes by which the protein material of the uterine wall is broken down, absorbed and cast off through the urine. The endometrium (lining of the uterus) is excreted as lochia (a blood stained vaginal discharge). The discharge is bright red for the first few days; after three or four days it becomes paler and usually after ten days there is merely a whitish or yellowish discharge. Unusually heave or long term bleeding suggests need for more rest. Though the lochia consists of waste material (not longer needed in the body), it is clean and should not have a bad odor. If it does, it may indicate imperfect involution or retention of parts of the afterbirth. By the end of the third week, the entire endometrium has been cast off, including the placental site, so that women who bear many children do not have scar tissue in the uterus.

There is usually a weight loss of about five pounds in addition to the weight loss representing the baby and the contents of the uterus. This represents water loss and other factors.

The **vagina** requires some time to recover from the distention and rarely returns to its pre-pregnant size. If you have used a diaphragm, most likely it won't fit now, so use another method of birth control. If you are nursing and can't take the pill, use your old diaphragm with lots of cream or jelly until you can be fitted with a new size. It is not known if any of the commonly prescribed exercises for the vagina are effective. The vaginal outlet is markedly distended and shows signs of laceration. The labia majora and minora become flabby and atrophic as compared with their condition before childbirth. You can probably see some of the changes of your genitals if you look at yourself with a mirror.

Masters and Johnson examined a limited number of postpartum women during **intercourse** and found marked changes from the normal. The physiologic reactions of most parts of the genitals were reduced in rapidity and intensity. The vaginal walls were quite thin and failed to lubricate as soon or as much as before. "Normal rugal patterns (folds) were flattened or absent and the vagina was light pink in color [usually vivid] and appeared almost senile to direct observation. Particularly was this steroid-starvation true for the three nursing mothers." Orgasm was not as strong or as intense. Interestingly enough, the feelings of sexual tension did not correspond to the physical appearance, as they usually do. "Sexual tensions frequently were described at non-pregnant levels, particularly among the nursing mothers." This may be in part due to pelvic congestion, which can be experienced as sexual arousal. But even more important, the women could not **subjectively** feel the difference between orgasms during this time (3-4 weeks) and those three months later when their orgasms looked physiologically like those of a nonpregnant woman.

The process of involution of the peritoneum (abdominal cavity) and the abdominal wall, requires at least six weeks. Except for the presence of silvery striaie, they gradually return to their original condition provided the abdominal muscles have retained their tonicity. This is why it may be important to exercise during pregnancy and to do the exercises prescribed for the postpartum period.

Between the second and fifth day there is a condition called diureses or lots of **urination**. During pregnancy the body tends to retain water and this diureses of the puerperium is simply a reversal of the process and a return to normal the water metabolism. Urination may amount to over a gallon a day. Occasionally sugar is found in the urine. This is due to the presence of lactose or milk sugar and has no con

with diabetes. If the patient does not urinate within six hours after delivery, she must be catheterized because the bladder may become distended to the point of bursting. Patients who have had analgesics in labor may not be aware that their bladder is full.

Bowels. A mild cathartic may be given on the second or third day to relieve constipation. It is desirable to get the bowels moving during the hospital stay but this is not always possible.

Most of the **blood and metabolic alterations** of pregnancy disappear within the first two weeks of the puerperium. In a study of 1000 deliveries, 20% of patients had anemia on the fourth day postpartum. In 15% it was mild, but in 5% it was severe. If you feel unusually weak or tired during the first two weeks, anemia may be the cause.

Diet. The postpartum woman may eat a normal diet. La Leche League lists foods for nursing mothers which may help to avoid colic. If she is nursing, her diet should be the same as during pregnancy with the addition of a pint of milk, bringing the milk total to a quart and a half a day.

Temperature. The temperature should be carefully watched during the first two weeks because fever is usually the first sign of infection.

Care of the Nipples. Little attention is required beyond simple cleanliness. If the nipples become sore, a nipple shield may be used temporarily.

If your doctor is not helpful with nursing problems, call La Leche League.

Menstruation usually returns in eight weeks in women who do not nurse. In nursing mothers there is ordinarily no menstruation as long as the child is completely fed by nursing, but there is great variation with menstruation occurring sometimes as early as two months but most commonly at four months. Most women do not ovulate while nursing, but a substantial number do, so it is wise to employ reliable birth control precautions.

APPENDIX ON CHILDCARE

An entire paper should be devoted to childcare. But that hasn't been written and your child has arrived and so we're adding a few notes on children, mothers, and childcare.

The full impact of having a child often doesn't hit us until we're home from the hospital and faced with the responsibility for another human being. Many feelings, thoughts, and fears come to mind: I am supposed to be fulfilled because now I am a mother, but this seven pound being that just emerged from my body is not a person – she just sleeps, eats, and shits at first. But I still have to be around most of the time to care for the baby and give up my other interests, my independence. And I feel scared: what if I do something wrong – I'm afraid to even bathe the baby for fear I might drop and kill her.

All these things are common problems. Just because we're women, we don't instinctually know how to care for children – experience is essential. Also, once your child is born, she is a separate being, one that you have to get to know, and who has to get to know you. We have learned from talking with each other that a child has a very strong will to live; there is not much we can do to hurt the child physically. We have also learned that our

independence and emotional well being is as important for our children as for ourselves: we must remain people in spite of the fact that we're now mothers! Therefore, in thinking about childcare we have to talk about our own needs as well as the needs of our child.

And we must talk about our own needs first, because in no other place are they given the consideration we know they warrant.

Even though we have physically borne the children, we know that we cannot for ourselves and must not for our children rear them alone. Depending upon our own living situations, we have to find the easiest way to share the care of our children **from the very first day home**. Sharing means to us joint responsibility, not just a division of tasks. We expect the other constant adults in our children's lives to know how to take care of the child without having to turn to us as "the experts". ("I didn't know how to change a diaper any more than my husband did. In fact, I may have been more nervous about it, since as a woman I was 'expected' to know how. I learned to do it and so can he and others.") Our children need intimate, consistent care from adults, and that care can come from the father of the child, friends with whom we may be living collectively, in childcare centers, and from us as mothers. The important thing to remember is that we must not forget about ourselves as people just because we're now mothers. And if that means we want to be away for a day, a week, or even a month, our children shouldn't suffer. If primary relationships exist between our children and other adults **from the start**, then everyone will be happier. If, on the other hand, we allow ourselves to think that we are the only adults able to care for and love our children, then we will almost always come to think of our children as our possessions.

We don't want to push women out of the home, but we want to leave the door wide open - for both ourselves and our children - to grow and develop as independent people.

Clearly we can't cover all the things we've learned about children. We have learned from talking with the other adults who share the care of our children and from our sisters who have been mothers before us. We have learned that there are no final rules to follow; our children are as different from each other as we are from our friends. The key thing is to try to relax and enjoy your children - they can be great fun - as long as you don't have exclusive responsibility for them twenty-four hours a day.

Here are some random pointers that come to mind:

1. No books are adequate (especially Dr. Spock, even though he can be reassuring at times). None take into account the mother as a person. Talking to friends is more helpful.

2. Time for ourselves alone is essential – awake and asleep. You'd be surprised how much getting enough sleep determines your ability to cope. When you're away from you baby, enjoy being yourself; motherhood is only one part of you.

3. For details about the physical care of yourself and your baby:

– Check Lester Hazell's Commonsense Childbirth (not yet in paperback) and Sheila Kitzinger's The Experience of Childbirth.

– If you're planning to breast feed your baby, read some good, supportive books about it first (Commonsense Childbirth has an excellent section on breastfeeding, as does the Kitzinger book, and Karen Pryor's). Don't let people discourage you, and remember that sleep and lots of liquids are necessary.

– Don't let up on your doctor/clinic until all your questions are answered. If you have a question, it's valid even though the doctor may not think so!

– Check with your friends – their experiences will give you support as well as information.

4. Finally, we're including a list of some products we have found helpful (you may or may not). If you get your baby used to these things from the start, you'll probably have less hassle.

– Disposable diapers (Pampers); diaper service; or if you do your own, use diaper antiseptic in the wash.

– Pacifiers (some babies won't ever take them, and probably don't need them, but it's useful to introduce them during the first week to get your baby accustomed to them).

– Baby carriers, infant seats, portable beds, etc. —anything that increases your mobility. A baby can sleep anywhere and under most circumstances if you teach her early enough. Security shouldn't come from a bed or a place but from adult reassurance, and your expectation that the child can do it.

– Other equipment that gives the child mobility and variety: jump seats, swings, jumpers, Mobiles, etc.

– A food grinder (which you can buy for about $1.00) or a blender (a lot more expensive) will allow you to grind all adult food into baby food. It saves money on canned baby food, and it's also amost invariably better for the baby.

We can't emphasize enough that caring for a baby is a learned skill, and one that we are continually learning. Through experience - the everyday variety of trial and error - you and your

housemates will come to know the baby's needs and learn to meet them in the most direct and uncomplicated way.

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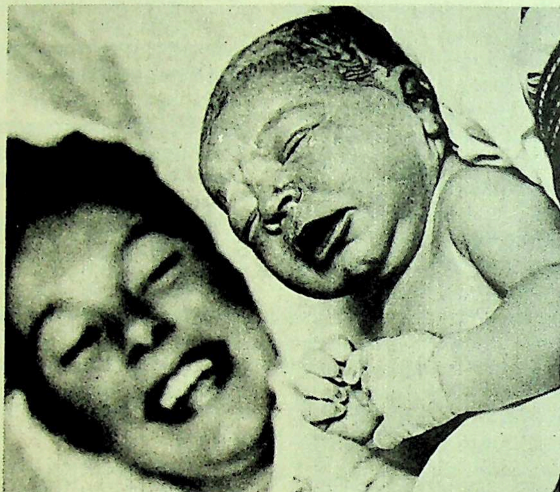

Medical Institutions

In the previous sections to this course, we have discussed the problems women face in their encounter with our medical system. We have been given inadequate and often incorrect information on how our bodies function. We can't get birth control, so thousands of us die each year from illegal abortions. Childbirth is often a terrifying and inhumane experience. These problems are not mistakes, they are results of a system which is designed to make profits, maintain a professional elite, and treat certain sick people, rather than deal with the problems of human beings and their illnesses. The purpose of this paper is to show how our medical institutions work so we can better understand how to restructure them for our own use and health.

Doctors, clinics, hospitals, and medical schools do not take responsibility for the health of the people. Health care in America is not a unified system dedicated to keeping people healthy, measuring the results of treatment, or dealing with health problems in the society. It is a system designed to profit certain groups of individuals or corporations. In one study it was revealed that 60% of therapy reviewed was below acceptable standards (Fortune, January 1970). There are practically no preventitive public health programs in the country. Most of the existing programs study epidemiology and innoculate against communicable diseases. When Federal money is allocated to "more important" expenditures, such as the war in Vietnam, even these programs suffer. The Federal government recently decreased funds for a mass innoculation campaign against a German Measles epidemic predicted for the year of 1970. In contrast, it has reported that communicable diseases have been practically eliminated in North Vietnam.

It is well known that German Measles can be serious for children and devastating to the fetus in early pregnancy. It can be very damaging even when the mother has such a light case that she is unaware of it and before she has discovered that she is pregnant. If you are contemplating getting pregnant, it takes two or three months in Massachusetts to have a simple antibody titer test done on your blood. If you don't have antibodies and want an immunization, you have to wait three months after the shot to be safe, and then have another blood test. You can go out of state and pay $10 (in Massachusetts, it is a free state test only) to have the results in a few days.

The factors in our society which produce a great amount of sickness are not dealt with by the medical establishment. In fact, bad housing, poor nutrition, poor sanitation, pollution, and dangerous working conditions are not dealt with by any establishment. The diseases resulting from these factors are obviously suffered mainly by poor people who have no control over them. Unfortunately for the poor, building low income housing, as has been stated many times by builders, landlords, bankers, and city planners, is not profitable. All of the previously-mentioned disease-producing factors could be eradicated if the effort were made and the money were allocated. Recently, the Mass. Dept. of Health refused to set up stricter levels for pollution in our air, although it was reported that the yearly average of sulfur dioxide in Boston, for example, was double the amount at which adverse health effects have been noted. Boston Edison was the voice they listened to when making their standards. The FDA is supposed to screen drugs before their release, but in a recent study in 19 out of 27 drugs, dangerous contraindications were not reported to or checked by the FDA. The FDA, a regulatory agency, is well regulated by the pharmaceutical ("ethical drugs") industry (see The Therapeutic Nightmare). It commonly approves drugs known by the drug companies, and often by the FDA itself, to be unnecessary and lethal.

Children put things in their mouths. In slum

apartments in every city in the country, they are eating lead-based paint which is flaking off the walls. Lead poisoning is also an industrial disease where lead or compounds of lead are used. The human body has no way of eliminating lead. As it accumulates, the initial signs are intestinal pain, muscular weakness, and anemia; later signs, produced by relatively tiny concentrations, are mental retardation and death. The lead lobby, people who profit by the use of lead, are strong enough to prevent other substances being substituted for lead in certain products, such as gasoline.

In the rural South, hookworms live in the soil and enter the body through bare feet. The multiply, are very debilitating, and can cause death. Hookworm infestation is more prevalent among poor people because of the lack of shoes and because malnutrition increases the likelihood of being sick with hookworm. Malnutrition makes the body more susceptible to any infections and many other diseases. Dr. Jack Geiger of Tufts has said: "If I could do just one thing to improve the health of the people, I would double their per capita income."

In coal mines, the coal dust in the air causes black lung disease (Reader's Digest, from the Washingtonian, April 1969), which shortens life drastically. 125,000 Americans have black lung disease. The coal companies have successfully blocked black lung compensation bills in West Virginia. Because the coal companies have refused to install a $50 device which has cut the incidence of black lung in European mines, some miners die and others have to retire at forty with no compensation, so the companies won't have to dig into their profits. Recently a compensation bill was passed, with the money coming out of tax money instead of company profits.

In Boston, workers who dig tunnels for our gas mains, water mains, and transportation systems suffer 20-30% casualties on every job because of dangerous working conditions. In nearly every industrial shop, workers can tell you about unnecessary conditions that endanger life and limb. In 1968, 2,200,000 industrial injuries were reported, 900,000 leading to permanent disability and 14,500 leading to death (HRN 5-69). The only way for these accidents to be decreased is for management to be more concerned with the health of the workers and less concerned with profit.

The U.S. spent $62 billion for medical care in 1969 –

- $35B to "proprietary" hospitals and nursing homes
- $12B to doctor's services
- $10B to supply companies
- $ 6B to drug companies
- $ 6B to commercial health insurance
- $ 2B on medical research
- $ 2B on construction costs for hospital building

America spends more money per person on health than any other country in the world. It is estimated that by 1975, health care will be the nation's largest "industry" in terms of money spent and people employed: our national health bill is expected to be $94 billion. In the last nine years it has gone from $27 billion to $62 billion. This figure includes everything connected with health: drugs, doctor's bills, hospital bills, private health insurance premiums and so on. Someone is making money off sickness, the money is going to profit, not good medical care. Of the $62 billion spent on health in 1969, at least $3 billion are profits, $600 million going to drug companies, $400 million to supply companies, and $1,400 million to physicians and surgeons. In one supply company, 93% of its income comes from disposable items, thus increasing unemployment (no laundering) and pollution (burning the items).

Stock brokers are recommending the health industry for good investments. Some of the companies expanding into health issues are: Motorola, IBM, Monsanto, Litton, Lockheed, and Philip Morris. In its second year, Healthcare Corp., a Boston-based nursing home and medical supply company, made a net profit of $1 million. (In its third year,

Healthcare Corp. has had an antitrust suit filed against it.) The state of New York has banned for-profit corporations from owning hospitals. Has someone realized that profit making is not compatible with high health standards?

America has the most highly developed medical technology, the most equipment, the most drugs, and just about the worst health record of any industrialized country. We rank 18th in infant mortality and 12th in maternal mortality in the world. Of course, as Fortune magazine points out, if you exclude the poor, the figures go up. The non-poor Americans as a group rank 10th in infant mortality, indicating the poor quality of medical care given even to people who pay for what they think is the best care available. Millions of America's children are born disabled or become disabled through medical and nutritional neglect during their early years. We rank 22nd (World Health Organization) in life expectancy for males. If we figure the statistics separately for blacks and whites, we find that black life expectancy is seven years less than that of whites, and that black maternal mortality rate is four times that of whites; a pathetic example of the unequal distribution of medical care. Harris polls show that over one-third of the nation feels ill-cared for in its medical needs. One-third of this nation also lives in poverty or severe deprivation. For all our technology, we discover hunger in 1968.

Medicine, like other fields, has traditionally discriminated against women. Hysteria comes from the Greek word for uterus and was thought to be caused by the wandering of the uterus to various parts of the body because of its longing for children. Hippocrates recommended marriage as the remedy. Dorland's Medical Dictionary defines hysteria as a psychoneurosis with certain symptoms and does not mention any sex incidence. Medical students, however, learn from their teachers (often by snide remarks) that hysteriacs are bound to be women. It is obvious then that a man presenting identical symptoms is defined differently. The difference isn't in behavior, but in the word used.

Doctors' attitudes toward patients are terribly condescending, especially toward women. You aren't supposed to read the record of your own body, and you are scolded like a child if you do. Doctors withhold information that you are dying. They withhold information that you might have a difficult pregnancy or childbirth. In playing God, their attitude is that you must have complete confidence in them to make all of your decisions for you. Why should they make your decisions?

Doctors see women as patients more frequently, women average 25% more visits to the doctor per year than men, not counting the many times they accompany their children. A standard complaint of doctors is that they are tired of neurotic women with nothing wrong with them who come in because they are lonely or dissatisfied with life. Psychiatrists get more women patients. A study showed recently that conceptions of behavior of normal men and normal adults coincided, but behavior stereotypically feminine was not thought by psychoanalysts to be normal adult behavior. No wonder more women end up on the couch, where they are supposed to learn to adjust.* It is also true that many women have a more difficult time adapting to "their roles" in society.

The system fails to provide basic preventive medicine for people. For example, cancer of the cervix or the uterus can be totally cured by early detection by the Pap smear and early treatment. The Pap smear was developed about thirty years ago, and yet today (1970) only 12% of American women regularly get Pap smears. It would be simple (but boring) to have a mass screening campaign. A great proportion of the 14,000 deaths per year from uterine cancer could have been prevented. A young internist recently remarked that he rarely did pelvic examinations of his women patients because it embarrassed him. How many women die because doctors have hang-ups about their genitals?

On the other hand, unnecessary and cruel surgery is often performed. In a study at Columbia, one-third of the hysterectomies reviewed were judged as having been done without medical justification. The study covered 6,248 operations. 30% of the patients aged 20-29 who had hysterectomies had no disease whatsoever. In individual hospitals, the percentage of unnecessary hysterectomies has been as high as 66%. (Carter, The Doctor Business) In Appalachia, doctors have removed healthy reproductive organs from 11 and 12 year old girls to get the $250 fee. Unnecessary surgery is common in America. We have twice as much surgery, per capita, as England. The unnecessary operations are called "remunerectomies" (done for monetary remuneration). How many remunerative testectomies do you think are done?

The medical system is not responsle to the community. It is controlled by the doctors. Fortune magazine says,

> The doctors created the system. They run it. And they are the most formidable obstacle to

* "The country's number one problem", occupying half of the hospital beds, has been designated to be abnormal behavior, people who can't adjust to life situations. Maybe the "sick" person is the one who can adjust to life situations and the society around him or her. It is often not us, but our society, which is sick.

its improvement. It is the doctor who decides which patients will be treated, where, under what conditions, and for what fee; who will enter the hospital, for what therapy, and for how long; what drugs will be purchased and in what quantities.

We also know they decide how we will have our babies and whether anyone can be with us. A private doctor is responsible only for the patients who walk into his office. He (note sex assumption) has no means of knowing what's going on out there in the community, whether the people are healthy, what the medical problems are, what the causes are. Not many doctors will refuse to see a patient who can't pay them, but most will make all possible efforts to direct people without money to clinics. Few patients are willing to press the point that they should get reduced rates or free care from the doctor. It's good to know that if you ask for a reduction of fees, you can get it. Faced with the reality of your income versus his, the doctor does sometimes give in. Recently, however, Robert K. Funkhouse, M.D., of Cambridge, answered a young couple whose income was $5500/year before taxes and who requested to pay $10 instead of $20 for a 20 minute examination:

> Unfortunately it is completely impossible for me to make a living wage at the rate you have calculated. As it is, from a full-time medical practice I am only able to earn something in the neighborhood of $20,000 a year which is not enough to enable me to put my children through college.
>
> While the system of financing medical care in the United States may leave much to be desired, it is the one that existed at the time you made an appointment to come to see me, and I would very much appreciate it if you would pay my fee.

The fee-for-service system sets the tone of private medical care in the country. The doctor sells a commodity to those who want to buy it and can afford it, and he sells it on his terms. All the private doctors in Charlestown take Wednesday off. Patients complained, and they asked the doctors to rotate days off so there would always be someone there. All the doctors in Charlestown still take Wednesday off. For obvious reasons, most doctors prefer the fee-for-service system. This is the system by which the doctor bills the patient himself, the amount based on what the service was and what he thinks the patient can pay. For example, a family without insurance was charged $150 for an appendectomy. A few months later, another child in the family had the same operation and the family was relieved that in the meantime they had gotten insurance. This time the doctor charged $300, $150 for the family to pay and $150 for the insurance. He argued if they paid it before, they can pay it now. This attitude reflects the attitude that 'if it doesn't hurt, it isn't doing any good'. The doctors feel if it doesn't hurt the pocketbook, you won't appreciate the medical care; also, you might lose respect of the doctor if he loses control of the billing process.

There are two alternate systems of remuneration: one is prepaid group practice where the doctors are salaried. The AMA state and local societies have fought this system by using their power to deny hospital admitting privileges to the physicians in group practice. Group practices have difficulties attracting doctors. One western group has been trying to recruit an orthopedic surgeon at $40,000 per year in vain because they can make $80,000. Another drawback in this system is that it may be set up so that salaried doctors may be exploited by senior partners (often doctors) in the business and keep the profits for themselves. The other system is payment per patient treated (i.e. by the government); this is called capitation.

The AMA (American Medical Association) has been an extremely powerful force in insuring that

CLENCHED FIST SALUTE is given by some of demonstrators leaving Hotel Americana ballroom after interrupting opening of American Medical Assn. meeting. They protested AMA stand on health care measures. (AP)

medicine is practiced for the doctors, not the patients. Although it does not speak for every doctor as an individual, it does write the rules that all doctors must follow. Milford O. Rouse, M.D., last year's AMA president, has asserted that there is a threat to medicine in the concept of health care as a right rather than a privilege. The AMA has the richest lobby in Washington, spending $1.1 million in 1965 (HRN, 8-69). In 1968, AMPAC, the AMA's front for political contributions, gave $680,000 to candidates for national office who think our resources should be allocated to death: wars and guns and ABMs and MIRVs, rather than to clinics and more doctors. It is estimated that five times this amount is spent at the local level.

The N.Y. State Journal of Medicine, the organ of the state medical society, has an interesting definition of illness, although it doesn't look as if the patient would benefit by it (Carter, The Doctor Business).

> . . What does illness mean? Cowardice, malingering, laziness, maladaptation, cussedness, pure worthlessness. . . It is time that someone - everyone - should hoist Mr. Charles Darwin from his grave and blow life into his ashes so that they could proclaim again to the world his tough but practical doctrine of the survival of the fittest. . . The Declaration of Independence said that man was entitled to the "pursuit of happiness". Any man who wishes to pursue happiness had better be able to stand on his own two feet. He will not be successful if he feels that he can afford to be ill.

It has been stated that physicians have a low opinion of humanity.

The AMA has opposed free innoculations against diphtheria and polio, free vaccinations against smallpox, the establishment of Red Cross bloodbanks, federal grants for medical school construction and medical student loans, national health insurance and Medicare. In 1938, federal public health authorities made it known that they were ready to spend millions on polio research. The AMA opposed it: "Until we learn more about it, any program which contemplates prevention of infantile paralysis is a bogus campaign." (Carter, The Doctor Business) In 1955, after Salk developed his vaccine, the AMA House of Delegates passed a resolution demanding "immediate termination" of free distribution of the vaccine. The Federal Government's program to innoculate people was called "a violation of the principles of free enterprise". In New Jersey, the state medical society forbade physicians to participate in the free programs except when the patients were paupers. Half of the vaccine purchased by the Federal Government went unused in the first year of the program, due to doctors' unwillingness to participate in free programs. The doctors charged $5 a shot. They get most vaccines free.

The AMA has fought any form of practice of medicine that promotes preventive measures rather than curative treatment. The AMA's positions on pollution, smoking, car safety, and working conditions all show that they put the freedom of the corporations above the concern of keeping people healthy. 45% (HRN 8-69) of the AMA's operating budget comes from the drug and medical supply industries, so the AMA is interested in laws which bolster the exorbitant profits of these industries. An example of such a law is the ability of the drug companies to obtain a patent on a new drug, thus inhibiting competitive pricing. Dr. Milton Rouse has stated the purpose of the AMA by saying that the AMA should "concentrate [its] attention on the single obligation to protect the American Way of Life. That way can be described in one word: capitalism."

The "usual and customary" fee-for-service clause in Medicare was inserted by the AMA, ensuring that the traditional system of the doctors billing the patients be preserved. Subsequently, in 1966, doctors raised their fees 8%, costing the U.S. public $500 million (HRN 8-69). The AMA has also had a hand in setting up hospital practices.

Instead of having health teams to give continu ous care necessary for the protection of health, the system in this country is that patients are treated only after they become sick enough for admission to a hospital. (When was the last time a doctor came to your house?) Hospitals are centers for dealing with crisis medical problems. Yet only a few hospitals can do this well. The others do not have enough personnel, equipment, experience, or desire. There are several kinds of hospitals. Proprietary hospitals are owned by private investors, usually doctors, and make a profit for their owners. Their annual reports are often confidential. There are mainly small ones in Boston. Most of the big hospitals around here are voluntary hospitals, originally set up by charitable organizations and partially supported by private contributions although now most of their financing comes from governmental and other quasi-public funds. The other kind of hospital is public and is supported by the city or other government. The source of the financing of the public and voluntary hospitals does not differ greatly (eventually, tax money), but they are benefitting different people. Most of the people who can't pay for their care and who don't have insurance

are supposed to go to the publicly-financed public hospitals while private patients go to the publicly-financed "private'. hospitals. But there are many more private and voluntary hospitals than public. The city of Somerville has 88,000 people and no public hospital, one proprietary and one voluntary. Government grants and other monies go mainly to the voluntary hospitals thus insuring that more money is spent on "welfare" to rich and middle class people, rather than poor people.

Most of the hospitals' policies are set up by the doctors who are involved in them. The doctors are in an extremely hierarchical and autocratic pecking order. This pecking order also extends down through nurses, nurses' aides, technicians, orderlies, maintenance, and housekeeping. The decisions are made by the chiefs of each medical department and passed down to each lower person as in the military. This insures that the high people won't be bothered by the low people. There was actually a conference titled "Developing Subordinates" at the New England Hospital Assembly, Spring 1970.

Fortune, January 1970, says that payroll represents 60-70% of hospital costs (which are reaching $100 a day). Fortune cites Mass General statistics of salary increases for blue-collar workers, nurses, interns, and residents which have gone up to $84 and $150 a week, $7,000 and $11,000 a year respectively. These figures fail to mention that senior physicians get around $40,000 in addition to their private patients, and hospital administrators get over $40,000, to one of $75,000 (New York City). 35% of hospital employees are in this upper category and here is where most of the payroll money is going. If a hospital had 100 employees, 35 of them getting $40,000 and 65 averaging $6,000 (which is probably high), then the annual payroll would be $1,400,000 to the doctors and administrators and $390,000 for everyone else. And in their public statements, hospital administrators blame the wage increases of the workers for the increase in cost.

A teaching hospital is any hospital which takes medical students for teaching purposes. The teaching hospitals are run mainly by the medical schools. All of the major hospitals in Boston have relationships with one or more of the three medical schools. Here is one place to look for medical empires. Although the trend is allegedly changing, the medical students practice mainly on "charity" patients, that is, poor people who come in without a private doctor. The hospital is dependent upon the medical school for personnel to do the routine scut work. Taking advantage of medical students and treating them roughly insures they will continue the tradition when they have the power to do so. The medical schools could not teach without patients to work with.

Hospitals are concerned with having the equipment and supplies that allow doctors to practice modern medicine. As it is, they are spending most of their money on equipment and specialists that can meet the most exciting type of medical difficulty. Boston City Hospital recently announced its first open heart surgery case. There are three other places within a ten minute drive (assuming no traffic congestion) where the same operation could have been performed. The hospitals are competing among themselves for prestige. This is why they build another open heart surgery team which costs $500,000 a year to maintain, rather than spend the money on ambulances, community doctors, or local clinics. The Public Health Service reports that in 1967, 776 hospitals had open heart units, but 31% hadn't been used for a year. Not using the equipment and people's skill regularly is very dangerous for the patient. In the Soviet Union, they have centers for such a specialized operation, and the government flies patients thousands of miles to them. Would the community the hospital was supposed to be serving pick open heart surgery over something like 15,000 out-patient visits a year? Prestige is also measured by the "quality" of interns and residents the hospitals get, and they need fancy equipment to get them. Harvard in particular has a number of superlaboratories at hospitals to train people who will be leaders in medical schools all over the country. This helps to maintain Harvard's elitist and highly academic, research-oriented influence on the training of doctors all over the country.

The medical schools are becoming an increasingly dominant force in the way medicine is coming down to people. Doctors are doctor chauvinists as well as male chauvinists. Most women doctors are no exception to this, having taken a role of "honorary men". Although 70% of hospital employees are women, 7-10% of the doctors are women. Two percent of doctors are black (Parade, 11-30-69). Medical schools teach their students very carefully. You learn that you are being trained to occupy an exalted position in the medical world (and society in general), but in the process you must take a lot of shit. Dr. Lewis of Harvard has said: "Doctors go through a greater socializing process than even the priesthood." For at least seven years they spend most of their waking hours not only absorbing medical information, but "learning how to act and think as well". Thus the order in which the doctors dump all over anyone below them is established.

Medical schools are maintained as elitist institutions by their high tuition and the almost total lack of federal aid for scholarships to medical schools (unlike graduate schools). The students are mainly from well-off families. The top 12% of the socio-economic structure in this country provides 50% of the medical students (HRN 8-69). The AMA has fought hard to maintain this status quo. The AMA has also contributed by blocking federal funds to build medical schools, keeping the number of doctors for an expanding population criminally low. In 1900, before medicine was so "advanced", there were 157 doctors per 100,000 population in the U.S. In 1959, there were 132.7. In Massachusetts, the figures were 174, in Mississippi, 69 (EAM, Harris). Somerville has 35 doctors for 88,000 people and their average age is 60.

Medical schools are disease-oriented rather than people-oriented. This leads to the dehumanizing experience of a person being referred to us "a pneumonia in room 222". The medical schools have recently been pushed, largely by students, to reform. A committee of deans and faculty and a few students try to decide what's to be done without asking the people in the community they are supposed to be serving. The community does not represent the same interests as the trustees do: real estate, banking, construction, insurance, drugs, and hospital supply companies. These reports are usually shelved.

The purpose of clinics is to provide care for the patient who can't afford a private doctor. They are run with this in mind. Most of the poor people in Boston go to the clinics at Boston City Hospital, where facilities are so understaffed and undersupplied that a doctor was heard complaining about his inability to find a clean tongue depressor. This concentration of patients is changing a little with the other big hospitals expanding their clinic facilities. BCH serves over 1000 people a day in assembly line fashion. You may see as many as six doctors in the course of your pregnancy. In no case is any effort made that you see the same doctor for any longer than the duration of one particular illness. Disease is regarded as a purely technical matter, the malfunctioning of a machine (the heart is a pump. . .). Work is arranged so that the students, interns, and residents of the teaching hospital can see the maximum number of "cases" in a short period of time. They fail to take the whole person into account, to see that he/she follows as good a diet as possible, to recognize his/her fears and anxieties which may be exaggerating his/her sickness, to see that her/his life is making her/him sick.

In the out-patient department at Boston City, most patients wait two or more hours to see a doctor. Much of the human contact comes in the form of "Alright, numbers one through ten line up and get weighed". There are only two nurses and two aides for sixty patients each morning in the Ob-Gyn clinic. Some new liberal administrators at BCH are concerned that the service is inhuman. They think that the solution is an appointment system, which the Ob-Gyn clinic has had for a long time. Only about half the patients keep their appointment, which messes up the system. The liberal administrator interprets the unkept appointment as a lack of the middle class value of the importance of time, so they plan to give lectures to the waiting patients on the value of keeping their appointments. A few conversations with patients would reveal that when you wake up in the morning, two or three bus trips from the clinic, a household to care for, children to find a babysitter for or lug on the bus with you, not feeling well, and anticipating the bureaucracy and coldness of the clinic, you think twice about going. It takes a lot of will power to go. The appointment system doesn't necessarily decrease the amount of waiting anyway, because patients always come in without appointments.

The Boston hospital system is dimly aware of the fact that they are too far from where the patients live. It is reasonable to have to travel several bus trips to get specialty treatment, involving complicated machinery or specially trained personnel. But basic family services should be available around the corner. The city provides some very fragmented services out in the communities. Mayor Kevin White and hospital administrators give lip service to the need to establish comprehensive care units in neighborhoods. They have vague plans to establish nine such centers in Boston. One has been built in Charlestown, but they have put off any work on the rest of the centers for two years and have given their planning grant to an organization called Hospital Planning for Greater Boston, now Health Planning for Greater Boston. Instead, they announced the construction of a new out-patient facility in an empty lot right across the street from BCH. Again the city and hospital administrators have decided against neighborhood facilities. Perhaps this is because in some places where neighborhood health centers have been established, the community has begun efforts to try to take over their administration and make it serve their needs.

It may be that the city decided to locate the outpatient facility where they did because of the problem of staffing community clinics. Medical personnal clearly prefer the centralized system since it allows efficient concentration of teachers,

students, and teaching material (patients). Out of 1000 people who get sick, 100 go to the doctor, ten go to a hospital, and one goes to a teaching hospital. Our doctors are trained almost exclusively on that one case in 1000. When (and if) they get out and set up a practice and find out that nearly every patient has something minor and/or is neurotic, they are bored. They were trained for more complicated things. The big money is in specialties. The big prestige is an appointment at a teaching hospital.

The need for neighborhood clinics is still desperate. There are only 17 doctors practising in Roxbury, for a community of 70,000 people. Roxbury used to have a hospital called the New England Hospital, which was originally set up as a hospital for women doctors to practice, since they were not allowed into the other hospitals. After the exodus of doctors from Roxbury, the hospital wasn't getting enough patients. A planning firm studied the problem, and concluded that the problem must be an antiquated physical plant, and that they should build a new one (a standard answer). Then some experts from Harvard came along and said the hospital should get federal funds to support certain community services. The hospital's board of directors voted to include the Harvard men on the board. The new board shut down the hospital. They are making plans to put in a maternal and infant care program and a youth program. These programs are extentions of the work of community medicine departments at Harvard teaching hospitals, thus contributing to the increasing fragmentation of medical services and their control by distant institutions who know very little about, and have little concern for, the community.

The Columbia Point Health Center sounded good on the drawing board. It was the first center funded by OEO, the organization consisting mainly of public relations programs to demonstrate to Americans that there really is a Great Society. The grant proposal submitted by Tufts said that the purpose of Columbia Point Center was "to intervene . . . in the cycle of extreme poverty, ill health, unemployment and illiteracy by providing comprehensive health services, based on multi-disciplinary community health centers, oriented toward maximum community participation." Nice language, but it hasn't worked out that way. At Columbia Point, the community has gotten together to fight for its interests and the clinic tries to hold on to its decision-making power. The theory is that it is only the professionals, with all their training, who know

how to run a health center. The reality is that the professionals are isolated, by their backgrounds, their training in elitist institutions, and their positions of authority over the people they treat.

So far, the existing medical institutions have been unable to give proper medical care to all the people. Because of this inability, small groups in a few places have gotten together to form clinics of their own. In the spirit of the idea that health care is a human right, most of these clinics have been free. Our society and the medical world do not take kindly to these clinics, they are not the American Way. The Black Panther Party of Boston has set up a free clinic in Roxbury on the pattern of the Judson Mobile Health unit in New York in which the patients are encouraged to ask questions, and are invited to look through microscopes at their own blood samples, and participate in the decision making. Watch out for harassment. The Free Clinic in Berkeley was attacked by the Berkeley police with cannisters of CS gas during a fight over People's Park. One of the cannisters was shot through the window of the clinic during regular clinic hours. CS is a dangerous substance, especially when used against already sick people. Many medical and scientific personnel in this country spend all their time on research, development, and testing of chemical-bacteriological weapons, yet the Hippocratic Oath says, "I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing."

The drug companies and equipment manufacturers have a clearer position on health care. They admit that they're in the business for the money. Drug companies made over 15% profits on their sales in 1960, it is said to be up over 20% now. This compares with around 9% for the average of the top 500 corporations in the country (EAM). The rise in stockholders' investment in leading drug companies has gone from $287 million in 1947 to $896 million in 1959 and has risen greatly since. In this country there are over 7000 drugs on the market; Sweden, which has a better health record, has only 2000 drugs on the market. The government there limits drugs to the ones it considers useful and safe. Of every dollar we spend on drugs, 6% goes to research and 25% goes to advertising; the cost of the materials was 32%. In tetracycline, a drug known for price fixing, the production cost of a certain amount was $5.03, the sale to wholesalers $24.22, sales to druggists $30.60, the sales to the consumer $51.00 (EAM). Drug companies' expenditures on trying to get doctors to buy their products by means of pamphlets, ads, engraved golf balls, and steak or lobster dinners (at Jimmy's Harborside) amount to $4000 per doctor per year (HRN 8-69). With over 300,000 doctors in the country, think what this money could do if it were spent on medical care. Doctors and hospital administrators also benefit from the high profits of the drug and medical supply companies; often they own stock in these companies and sit on their boards of directors. They are in an excellent position to have their company develop and market what the hospital needs, and to have the hospital buy from the company. The result is higher costs to the sick and a higher standard living for the elite. The major catalog of drugs is Physician's Desk Reference, which is published by drug company interests and distributed free. Needless to say, it lists no price for drugs, so the doctor often has no idea of the costs of drugs (he gets his free).

The medical institutions we have do just exactly what they are intended to do. The drug and supply companies make money, the AMA protects capitalism. The medical schools train a small number of people to fit into the system. The hospitals treat some sick people. The clinics see some people and offer study material to students. None of them is responsible for the health of the people.

Blue Cross was set up during the depression by the hospitals, to insure they would have their bills paid. Blue Cross is non-profit, tax exempt and receives all its funds from its subscribers (and interest from investments). Financial information of Blue Cross is not available, although it accumulates large reserves ($4-5 million in Connecticut alone) which it invests. They have a policy called "experience rating" which evaluates group policies. Those groups who have a higher rate of sickness pay more. Since poorer groups of people are sicker, the poor again pay more. The Board of Trustees of Blue Cross does not have the consumer interest represented unless you count leading businessmen from Con Ed, International Nickel, and Federated Mortgage Investors. Ten out of 23 board members are doctors, hospital administrators, trustees or other medical establishment (HPB, 9-69). When hospitals negotiate reimbursement contracts with Blue Cross, they are often negotiating with themselves.

Medicare and Medicaid were supposed to allow poor people the means to have a private doctor, but the Mass. General still has the White building for poor people, Baker for middle-class, and Phillips for the rich. And the difference is phenominal. The Reader's Digest (8-69) alleges that "the Medicaid program is in deep trouble because a disgracefully large minority of medical professionals have been permitted to cheat both the government and the needy." It is estimated that double-billing,

kickbacks, and overcharging, by our respected medical profession (doctors, nursing homes, druggists and dentists) have amounted to half a billion dollars in the last year alone. Is this what the AMA means when it talks about the American Way of Life? No significant changes can or will be made until an entirely new system of medical care is installed. The present programs like Medicaid and Medicare are designed to protest capitalism and the fee-for-service system and to prevent the coming of the bogeyman, Socialized Medicine. Socialized medicine merely means that medicine is practiced for the people rather than the profession. Many people have advocated a national health insurance. There are three major plans on the drawing boards now: the AMA plan, the Rockefeller plan, and the Reuther plan (HPB, 1-70). These are insurance plans, not socialized medicine. A few people may benefit from them in terms of medical care, but the major beneficiaries as usual will be the doctors, drug companies, the usual. The Reuther plan is the most liberal, but still shares the shortcomings of the others:'

– National health insurance (NHI) will reinforce the fee-for-service system.
– NHI will make the health system dependent on private insurance companies.
– NHI has no aggressive cost control mechanisms built in.
– Most of the proposals for NHI are based on regressive taxing methods.
– NHI makes no provision for consumer/community participation in program planning or budgeting.

The medical establishment is being challenged on all sides. It is changing and being changed. There is some federal money available for local neighborhood clinics run by the community, although the AMA and medical societies have traditionally opposed these clinics because they would take some power out of doctors' hands. Doctors are losing some of their power but unfortunately it is not to the people but to the corporations. January 1970's Fortune shows the trend clearly.

The first of four articles on American Medicine is called "Better Care at Less Cost Without Miracles" and extolls the Kaiser Foundation program of prepaid corporate medicine. The Kaiser plan is an improvement at the moment to Blue Cross, but it is still set up to profit the doctors and hospitals. "Any reduction in operating costs below management's projections swells a bonus fund that is shared by doctors and hospitals." In 1968, the Kaiser doctors in Northern California each collected a bonus of $7,900, on top of their $20,000-$53,000.

The third article is "The Medical Industrial Complex". Johnson and Johnson's earnings went from $15 million in 1959 to $59 million in 1968. General Electric "dominates" the medical X-ray machine market. (Past anti-trust suits have shown how GE "dominates"). "According to Arthur D. Little Inc., the total market for medical technology, including electronic devices, probably exceeds $450 million a year." They are talking big business. A headline to this article is "Costly Machines to Save Lives". This is corporate propaganda: if you are against a hospital's purchase of a costly machine, you are against saving human lives. These articles clearly show the shift that is taking place in medicine. Medicine is converting (or being converted) from entrepreneurial capitalism to corporate capitalism. Before we cheer the loss of power of the medical societies, we'd better take a look at what is replacing them.

We will have a National Health Insurance. It will be run either by insurance companies who will obviously run it in the interests of big business (themselves) or it will be run by the Federal Government. In the latter case it will still be run in the interests of big business, much like the Department of Defense. We will have to spend millions in the War against Death as we do in the War against Communism. And it will be in the form of Costly Machines to Save Lives. The situation, like the Defense Department, will be that the suppliers will create the need for goods, will be assured that the goods will be bought for a long time, plan the obsolescence, and fix the prices. Fortune reports that "a single X-ray unit can cost $100,000 and is subject to rapid obsolescence." Like defense, the government, universities, and medical schools have collaborated to serve industry. Much more money is given in National Institute of Health grants for equipment than personnel. The schools are competing with each other and the measure of success has become the amount of equipment possessed.

The construction industry is also benefitting from the surge in medical spending. Their answer has been to solve human problems by building new buildings such as hospitals. This is known as the "Ediface Complex". Fortune's last chapter in the medical series is "Hospitals Need Management Even More than Money". They advised that new managerial approaches and scientific planning methods which hospitals need, demand computers and perhaps going into sideline business ventures (such as hospital supply?) to boost their incomes.

We believe that health care is a human right and that a society should provide free health care for itself. Health care cannot be adequate as long as it is conceived of as insurance, which is the

business of taking in $100 from 100 people to guarantee them against loss by a contingent event and then paying out $40 to the people the event happened to and pocketing the rest. The profit system guarantees that certain people will benefit and the rest will be exploited. We will gain nothing by pumping more money into our present system. Health care for everyone is possible only outside of the profit system. Elitist attitudes and patients being regarded as "consumers" would not be supported if society and its institutions were run by and for all of the people.

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Women, Medicine, and Capitalism

Marcuse says that "health is a state defined by an elite." A year ago, few of us understood that statement. What does he mean? We believed that all people want to be healthy and that some of us are more fortunate than others because we have more competent doctors. "Now you should go to Dr. A. Man. He's my doctor and he's just great!"

Today we understand the stark truth of Marcuse's statement. We have not only started to look at health differently, but have found that health is one more example of the many problems we as people, especially as women, face in this society. We have not had power to determine medical priorities; they are determined by the corporate medical industry (including drug companies, Blue Cross, the AMA and other profit-making groups) and academic research. We have learned that we are not to blame for choosing a bad doctor or not having the money to even choose. Certainly, some doctors have learned medical skills better than others, but how good are technical skills if they are not practiced in a human way?

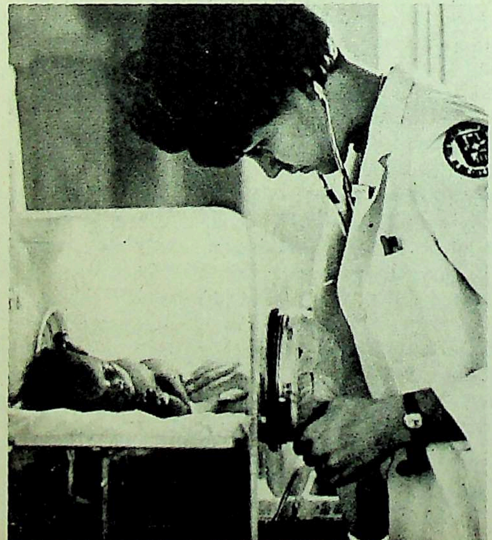
We as women are redefining competence: a doctor who behaves in a male chauvinist way is not competent, even if he has medical skills. We have decided that health can no longer be defined by an elite group of white, upper middle class men. It must be defined by us, the women who need the most health care, in a way that meets the needs of all our sisters and brothers – poor, black, brown, red, yellow and pink.

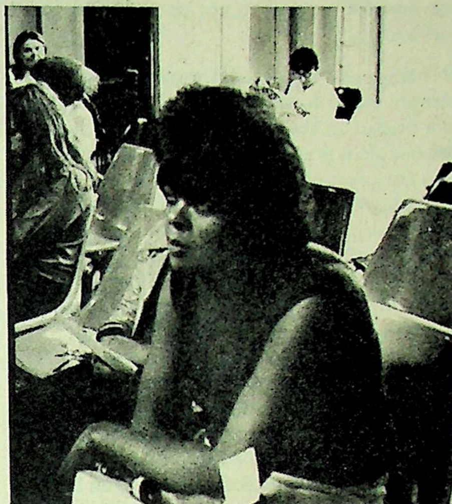
THE IDEOLOGY OF CONTROL AND SUBMISSION

Perhaps the most obvious indication of this ideology is the way that doctors treat us as women patients. We are considered stupid, mindless creatures, unable to follow instructions (known as orders). While men patients may also be treated this way, we fare worse because women are thought to be incapable of understanding or dealing with our own situation. Health is not something which belongs to a person, but is rather a precious item that the doctor doles out from his stores. Thus, the doctor preserves his expertise and powers for himself. He controls the knowledge and thereby controls the patient. He maintains his status in a number of ways: First, he and his colleagues make it very difficult for more people to become doctors. (For instance, for thirty years the AMA opposed the expansion of the existing medical schools, primarily to protect their entrepreneurial economic privilege.) Second, he sets himself off from other people in a number of ways, including dressing in whites. (In fact, in most hospitals there is a rigid hierarchy which is demarcated according to dress: doctors wear whites, nurses wear white with a cap denoting what school they attended, nurses' aides wear another color uniform, and housekeeping women still another color. The implication being, of course, that it is very important not to confuse one group with another.) Another much more important way doctors set themselves off from other people is through their language. Pseudoscientific jargon is the immense wall around that body of information, experience, etc., which they consider as medical knowledge. (epistaxis = nosebleed, thrombosis = blood clot, scleral icterus = yellow eyeballs, etc.)

Thirdly, doctors insulate themselves from the rest of society by making the education process (indoctrination) so long, tedious, and grueling that the public has come to believe that one must be superhuman to survive it. (Actually, it is like one long fraternity "rush" after which you've made it and can do what you like. Only members of the club get to learn the secret, which is that doctors don't know much to begin with and are bluffing a good deal of time.) Thus, a small medical elite preserves its own position through **mystification**, butressed by symbolic dress, language, and education.

It is important for us to understand that mysti-





fication is the primary process here. It is mystification that makes us postpone going to the doctor for "that little pain", since he's such a "busy man". It is mystification that prevents us from demanding a precise explanation of what is the matter and how exactly he is going to treat it. It is mystification that causes us to become passive objects who submit to his control and supposed expertise.

OBJECTIFICATION

We know that we as women are objectified as sex objects in our society. Any woman who has walked alone at night knows the feeling of vulnerability and helplessness that accompanies our awareness that we are being perceived as pure sex objects. The medical setting further objectifies a person. The patient is assumed to be an object on which one can "objectively" and "scientifically" perform certain operations. The patient is merely the vehicle which brings the disease to the interventionist (instrumentalist). The outgrowth of these assumptions is that the best place for a doctor to act on a patient is in the hospital, i.e. when the patient is horizontal, passive, most like an object. Finally, that part of a person which is considered sick is further separated and removed. ("The ulcer in 417." or "We did a gall bladder today.") For us as women, the treatment of any gynecological or obstetrical problem thereby results in the alienation of us from our own body, from our own genitals.

ALIENATION

Naomi Weisstein, in her essay on women, 'Psychology Constructs the Female", has outlined very well how the society has caused the alienation of a woman from her body. Freud's impact cannot be overestimated; we have internalized the notion that woman is incomplete, that something is missing. This alienation leads to a condition which is epitomized by the middle class woman, who, whenever she feels ill, goes to see her gynecologist. The implication: whatever is the matter with her has to do with her sexuality.

Alienation is also what makes it hard for us to talk about sex. Our sexual experience is so privatized that we never find out that other women have the same problems we do. We come to accept not having orgasm as our natural condition. We remain ignorant about our own sexuality and chalk it up to our own inadequacies. And if we should be so bold as to go to a doctor - and if we should summon up the courage to ask him about our common problem - chances are he will know nothing about it, although he will never or rarely admit this and will probably laughingly dismiss our questions. Doctors in general are as ignorant about sexuality as the rest of the men in society.

Doctors' blatant ignorance about sex stands in stark contradiction to the fact that they are considered the only legitimate person to consult about any sexual problem. Thus, we bring all our awkwardness and ignorance about sex to a doctor who cannot understand that his own ignorance and arrogance are the epitome of male chauvinism. (Add any man's standard portion of male chauvinism to the whole mind set and life style of the man who controls knowledge and thereby people

"for their benefit" and we come up with the doctor of our society.)

Which brings us to preventative medicine. We as women are made to feel uncomfortable about going to a doctor in the first place. If we cannot feel comfortable going to our doctors normally, then to go for preventive reasons will be all the more difficult. Thus, while the medical profession has come out in favor of massive screening of women for cancer of the breast and cervix (the cervix is the neck of the uterus, or womb), their practice, their approach, their manner - that is to say, their ideology - all works in the opposite direction. First, our complaints aren't important enough, since we think that we aren't important. (A man is made to feel uncomfortable in a different way; he is made to feel that it isn't masculine to admit to a minor ailment, since he should be tough and not feel it.) The net result is that both men and women postpone seeing a doctor, whom they regard as too important to be bothered. And when the visit involves a pelvic examination, it is even less likely a woman will go through with it. Small wonder that only 12% of the women in this country who ought to have "Pap" tests (short for Papinicolaou, the guy who invented it) for cervical cancer get them. This is one of the very concrete ways that male chauvinist medicine means poorer health care and health protection for us.

We cannot begin to write here about capitalist forms of medicine per se; that is to say, the prohibitive cost of medical care, the racist and inferior treatment of poor people and black people, the profit and prestige-making institutions of the "health industry" (hospitals, medical schools, drug companies, etc.), the total neglect of the public or preventive protection, or the fee-for-service, pay-as-you-die economic base upon which most medical practice is based. This is an important and extensive issue which must be dealt with elsewhere. Suffice it to say that capitalism is incapable of providing good health care, both curative and preventive, for all the people. Cost-benefit analysis trades off the benefit to the people of collective public health in favor of the cost to the people of private, patch-up medical care. The capitalist medical care system can be no more dedicated to improving the people's health than can General Motors become dedicated to improving the people's public transportation. Our difficulty in perceiving the similarity between the health care system and any other corporate capitalist enterprise in the society results from our acceptance of the rhetoric that medicine **helps** people.

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introduction

For the past three years we have been working to provide men and women with the information they need to control their own bodies. The right to this control, to use our own bodies as we desire, is a most basic, essential human right, a right that has long been denied to us. Until recently, the right to have sexual intercourse without the burden of unwanted pregnancy was legally denied to all women. Even today, birth control is more easily obtained by married women of the middle and upper classes, and abortion is only available to those who can pay he cruelly high prices of entrepreneurial doctors. ose who cannot pay find themselves in "charity" spitals, where they are butchered, experimented , and frequently sexually molested.

At this time we are concerned by the rising of a new movement which seeks to destroy and take away what control many men and women have finally obtained. The population control movement presents a new danger to basic human rights, both in North America and in the Third World.

In the U.S., the modern population control movement began as the "eugenics movement", which strove to "purify" the American population by advocating the forced sterilization of people defined as "feeble-minded, insane, epileptic, criminalistic" and "orphans, ne'er-do-wells, the homeless, tramps and paupers". By 1917 sixteen American states passed compulsary sterilization laws applicable to a total of 34 different categories of people. At the time, the only means of male sterilization was castration, and the equivalent operation on the female involved grave risks in the pre-antibiotic era. Between 1907 and 1963, 63,678 unfortunate men and women were sterilized by court order. In the past fifteen years, the states of Delaware, Georgia, Illinois, Maryland, Mississippi, North Carolina and Tennessee have considered implementing new laws to punish "unwed mothers" by various means including sterilization. Judges in many U.S. cities "offer" sterilization to unmarried mothers, threatening to cut them off welfare if they do not accept. With the prospect of starving in a giant city, these women have no choice but to submit to the surgeon's scalpel.

The Zero Population Growth movement, known as ZPG, does not like to admit its heritage of the eugenics movement and forced sterilization laws. Paul Ehrlich, author of **The Population Bomb,** insists that at the moment, governments should only convince or cajole people to maintain a small family size. On the other hand, if people are not willing to voluntarily control their reproduction, eventually, "the Government will have to step in and employ sanctions of some sort." In **The Population Bomb,** Ehrlich speaks of putting chemical sterilants in drinking water, but he admits that this would pose technical problems. For countries other than white America, Ehrlich is less restrained. Discussing a proposed Indian government plan to forcibly sterilize all Indian men who have fathered three or more children, Ehrlich stated, "We (the U.S. Government) should have applied pressure on the Indian government to go ahead with the plan. We should have volunteered logistic support in the form of helicopters, vehicles and surgical instruments. We should have sent doctors to aid in the program by setting up centers for training para-medical personnel to do vasectomies. Coercion? Perhaps, but coercion in a good cause. I am sometimes astonished at the attitudes of Americans who are horified at the prospect of our government insisting on population control as the price of food aid." The world has already seen the results of U.S. coercion "in a good cause" coming in the form of helicopters, vehicles and instruments more deadly than the scalpel.

We are horrified by the possibility that the U.S. would demand sterilization or birth control programs in countries to which it gives food aid, especially given the current American attitude towards food production and distribution. In 1968 the U.S. government paid the huge companies that today control American farming ("agribusiness") $4 billion to take 35 million acres out of production. In 1970 the Canadian government ordered Canadian farmers to grow no wheat at all. Untold millions of tons of grain have rotted in the holds of retired U.S. ships, which have been converted into floating storage bins. Big business actually destroys food, by burning grain, pouring milk into the ground, and shooting pigs. U.S. agribusiness has reason behind this madness. Food production in America has become fairly advanced, and food surpluses are constantly produced. With a surplus of food, prices go down. Since the U.S. population can only consume a certain amount of food, and since companies are not willing

to give away the food to starving nations, surpluses must be destroyed to maintain the high prices that make them so much money.

An advertisement for the Committee to Check the Population Explosion tells us that every day about 10,000 people die of starvation in "underdeveloped" countries. The ad says little of the U.S., where in 1968 the Citizens' Board of Inquiry into Hunger and Malnutrition estimated that 30 million Americans are hungry, and 10 million of them are actually starving. The Committee's ad suggests that the horrible world-wide starvation exists "because world population growth has already out-run world food supply." How can these people dare to suggest that world food supply is insufficient when U.S. companies destroy any existing food surplus, and the U.S. and Canadian governments prevent surplus from appearing in the first place?

Such contradictions are even more obvious in countries of the Third World, nations of Asia, Africa and South America. In Brazil, for example, a high proportion of the population is hungry, and many starve. Brazil has a population of 90 million people, but within the borders of Brazil, which is more than 90% as large as the U.S., there exists as much arable, potentially food-producing land as exists in all of Europe. Brazil cannot feed its 90 million people, but Europe can adequately feed its hundreds of millions. Why? Because of coffee and the coffee's owners. Most of Brazil's cultivated land is used to grow coffee, a cash crop with no food value. American companies "own" most of the cultivated land, and they "own" the coffee. The U.S. companies pay slave wages to plantation workers, and pay hardly any taxes to the Brazilian government. Coffee is shipped out of Brazil, and huge profits go to the companies' vaults in the U.S.

In 1952 the U.S. President's Materials Policy Commission reported on whether or not America has the raw materials necessary to "sustain its civilization". Members of the government commission included men such as Laurence Rockefeller; William S. Paley of CBS; George P. Brown of the First National Bank of Boston and the New England Telephone and Telegraph; Frank Pace of Time-Life, Continental Oil etc. As long ago as 1952, when Paul Ehrlich was still an unknown biologist studying butterflies, the financial rulers of America concluded that population growth in Asia, Africa and South America "presses hard on available natural resources". They meant that rising populations of young, hungry, jobless people might refuse to give up their national riches to foreign American companies. In a speech given at the University of Notre Dame on May 1, 1969, Robert McNamara, president of the World Bank and former secretary of defence, warned that, "The threat of violence is intertwined with the threat of undue population growth. It is clear that population pressures in the underdeveloped societies can lead to economic tensions, and political turbulence... which in the end can bring on conflicts among nations." McNamara was not speaking of wars such as the Second World War; he meant wars of national liberation, such as the one he had so much experience with in Vietnam. Vietnam was once the "rice-basin of the East", but the Vietnamese finally decided to throw out their foreign exploiters and take control of their own resources. In response, America bombed and defoliated Vietnam to the point of ecological disaster. Vietnam has huge resources of tin, which American industry wants and is prepared to do almost anything to get.

Dr. Binay R. Sen, former director-general of the UN Food and Agriculture Organization, has stated: "The ever-mounting tidal wave of humanity now challenges us to control it, or be submerged along with all our civilized values." For the population control movement, this implies that civilized values belong to **us,** white North Americans and Europeans; the tidal wave of humanity is **them,** the black, brown, yellow and the few surviving red people who also populate the earth. Within the population control movement is a high degree of simple racism, a throw-back to the eugenics movement that wanted to "purify" the American population. The fact that ZPG claims to direct its propaganda primarily at white, middle class Americans does nothing to eliminate the factor of racism which is an inevitable, historical aspect of the U.S. population control movement, financed and directed by America's white ruling class.

The population control movement also blames us, individual men and women, for the pollution of our air, water, and earth. Ehrlich has stated that: "Our large polluting population is responsible for air pollution." Newsweek Magazine's environment issue claims that the pollution-causing "villain... is not some profit-hungry industrialist, nor some lax public official who can be replaced. The villains are the consumers who demand (or at least allow themselves be cajoled into demanding) new, faster, bigger, cheaper playthings without counting the cost in a dirtier, smellier, sicklier world." We are the villains because we individually submit to the billion dollar psychological warfare waged against us by Madison Avenue. We are the villains because we drive to work in the only transportation system made available by GM, Ford and Chrysler. We are the villains because America's biggest industry is the war industry, that bleeds taxpayers dry and exists only for death, destruction and ecological tragedy.

Ninety-four people signed the Committee to Control the Population Explosion ads. Included were people such as George Champion of the Chase Manhattan Bank (Rockefeller's bank); Frank W. Abrams of Standard Oil of New Jersey; Lammot du P. Copeland, of DuPont, David E. Lilienthal of TVA; and Mrs. Cordelia Scaife May of the super-rich Mellon Family. Hugh Moore, founder of Dixie Cup, paid for the ads, just as he paid to advertise Paul Ehrlich's **Population Bomb.** The people who signed the ads are, as James Ridgeway states in **Hard Times,** representatives of coal, chemicals and paper, "the industries which have fouled the continent from one end to the other. Their representatives now ask that the masses control the size of their families so that the plunder can continue."

(continued)

Ehrlich and ZPG say that the American middle class consumes and pollutes more than any other people in the world. The solution they propose is not the elimination of unnecessary, wasteful production, exemplified by Detroit's manufacture of dangerous, polluting automobiles that fall apart after three years; nor do they suggest stopping pollution at its major source - the irresponsible, greedy companies which pour filth into our atmosphere in the process of making their huge profits. ZPG suggests that the solution lies in a zero population growth, a stabilization of our numbers. But in America, the annual population growth is already not more than 1%, a rate a few hundred times closer to zero than it is to our potential biological maximum. How can a slight further reduction solve all our domestic problems? And if such low birth rates have accomplished nothing here, how can we expect zero population growth to solve the problems of Third World nations? We cannot. For solutions, we have to turn to new methods of governing ourselves, to new methods of distributing and conserving the riches of the world which in fact belong to all human beings, not only to the Rockefellers, Fords, DuPonts, Mellons, Rothchilds and their like.

One of the few countries in the world where there exists no starvation is China, a country where a short 25 years ago human misery reached incredible levels. E.L. Wheelright, who travelled 5,000 miles in China in 1966 found: "wherever I went, there was no evidence of malnutrition, let alone starvation; food is plentiful and cheap; even in the poorer areas I never saw anyone who looked as though he could do with a square meal". The 700 million Chinese accomplished this by overthrowing their foreign exploiters, by taking control of their own natural riches, by granting equality to women, by providing voluntary birth control, sterilization and abortion programs, by determining their own priorities, such as education and food for all. Nothing short of equally basic social change in America and in the countries it exploits is going to bring solutions for our terrible problems of hunger, pollution, crime in the streets, racism and war.

anatomy

Female reproductive structures

The female external genital organs, which are given the general name, **vulva**, include the following:

Mons veneris: This latin term describes the cushion of fat over the pubic bone which, from puberty on, is covered with pubic hair.

Labia majora: The folds of fat tissue on either side of the vaginal opening are called the labia majora or "major lips". In children, the labia majora completely cover and protect the genital organs; in mature women, the lips remain apart. The skin, covered with pubic hair, becomes moist and delicate closer to the vaginal opening.

Labia minora: The "small lips" or labia minora are folds of sensitive, reddish tissue between the labia majora. When a woman is sexually excited, these small lips become slightly erect. They join in front forming the **prepuce** which covers the clitoris.

Clitoris: The clitoris, the most sexually sensitive of the female genitals, is located in front of (above) the urethral opening, and is partially covered by the prepuce. A homologue of the penis, the clitoris responds to stimulation by becoming slightly enlarged and erect.

Urinary meatus: The meatus, found between the clitoris and the vaginal opening, is the opening of the urethra through which urine is released from the bladder.

Bartholin's glands: The purpose of these two small glands, situated in the labia minora on either side of the vaginal opening, is not clearly understood. They release only a drop or two of mucus when a woman is highly excited sexually.

Hymen: This elastic membrane, also called the "maidenhead", is found at the vaginal entrance projecting from the vaginal wall. In most women, the hymen does not block the vaginal opening completely, allowing the menstrual flow to pass through. Rupturing of the hymen (loss of virginity) can be painless or quite difficult, and slight bleeding often occurs. Many women stretch the hymen themselves before the first act of intercourse. In cases where the tissue is very tough, the hymen can be broken medically.

Vagina: The vagina, located between the bladder and the rectum, is about 4 or 5 inches long. Normally its elastic walls touch each other but they stretch considerably during intercourse and even more during childbirth. When a woman is excited, lubricating mucous secretions pass directly from blood vessels in the vaginal wall into the vagina. Although externally the vagina is highly sensitive, the internal end has little sensitivity. The vagina ends in pockets about the cervix: those in front and back of the cervix are called the **anterior fornix** and **posterior fornix** respectively; those to the sides are called **lateral fornices**.

Uterus: The womb or uterus lies between the bladder and the lower intestine. Before the first pregnancy, it is about 3 inches long and 2 inches across at the widest point, and its thick muscular walls practically touch each other. After each pregnancy, the uterus remains slightly enlarged as does the cavity within it. Normally the top triangular portion bends slightly forward, and the lower portion points down and back toward the spine. When the top bends too far

forward or backward, the condition is known as **anteflexion** or **retroversion** respectively. This can cause problems during pregnancy, abortion and with certain birth control methods. Internally the uterus is lined with a thick spongy tissue called the **endometrium** which is cast off as the menstrual flow once every 28 days if pregnancy does not occur. The lower part of the uterus which extends into the vagina is called the **cervix.** The muscular cervix contains the cervical canal which serves as a passage between the uterus and vagina. The opening of the cervical canal into the vagina, the **external os,** is round before the first pregnancy, and slit-shaped afterwards. The opening into the uterus is called the **internal os.**

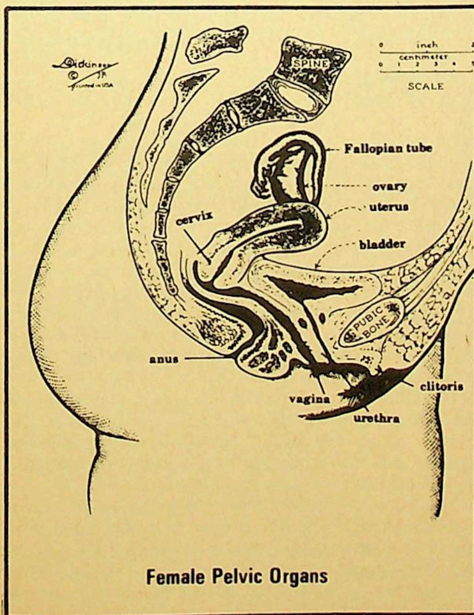
Fallopian tubes: The two Fallopian tubes (oviducts) are attached high on either side of the uterus, and extend about 4 inches toward an ovary. At ovulation, a suction-like mechanism draws the egg toward the tube's fringed end; then rhythmic tubal contractions move the egg toward the uterus. Union of egg and sperm (**conception, fertilization**) occurs within the tube, which is less than half an inch in diameter.

Ovaries: The two ovaries (female **gonads**) lie on either side of the uterus. At birth, 100,000 to 600, 000 immature egg cells (**ova**) each within a follicle are embedded deep within the body of the ovary. After puberty, the follicles move toward the ovarian surface; each cycle, several follicles develop but only one releases an egg ready for fertilization. The oval-shaped ovaries also release hormones which affect ovulation and development of the endometrium.

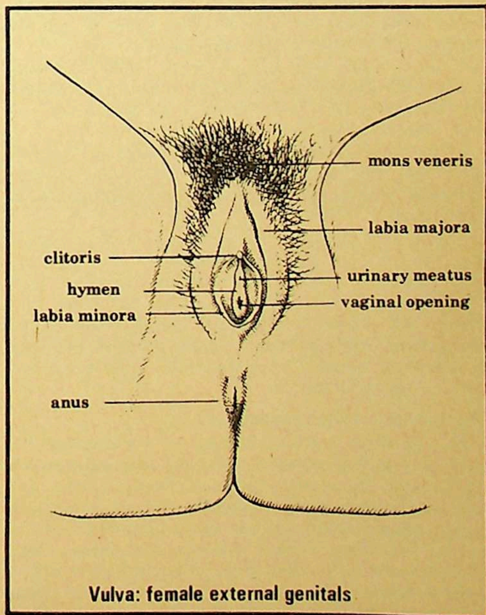
The Gynecological Examination

After puberty, a woman should have an annual gynecological examination. On her first visit, a general medical history is taken, including: past illnesses or operations; allergies or sensitivity to drugs; present medication; and general state of health. This general information is essential for proper gynecological care: for example, women treated with antibiotics often develop a vaginal infection called monilia; a tired feeling may be due to anemia influenced by a heavy menstrual flow; etc. As well, gynecological symptoms can lead to discovery of general problems: for example vaginitis can be a sign of latent diabetes. Any family tendency toward particular disorders, such as breast cancer, are recorded.

The doctor questions the woman on her gynecological history. At what age did she begin menstruating? Are her cycles regular? What is the duration and amount of her menstrual flow? Does she have cramps before, during, or after her period? Does she use external pads or internal tampons? If the woman has been pregnant the doctor should ask for a complete obstetrical report: number of pregnancies; miscarriages; induced abortions; type of delivery (vaginal or ceserean); premature or full term delivery; weight of newborn; complications before, during or after delivery; breastfed or formula; plans for future pregnancies. What method of birth control has she used and with what success? what gynecological problems has she had previously? How long ago? How was it treated? The woman should offer any information she feels will be useful, whether or not she is asked.



Female Pelvic Organs



Vulva: female external genitals

Such thorough questioning is not necessary at each visit. Women attending clinics where the doctor is rarely the same at each visit should ask if her complete chart has been read prior to examination.

The woman is left alone in the examining room to undress, and is given a disposable robe or sheet to wear. A nurse records the woman's height, weight, and blood pressure. A blood sample is taken for analysis of the woman's blood type, haemaglobin count and white blood cell count. The blood sample can also be used to test for syphilis. If the woman complains of burning or pain on urination, a urine sample is taken also.

While the woman sits on the examining table, the doctor examines her head, neck, breasts, lungs, heart and abdomen. With the woman lying on her back, a further check is made of the breasts, abdominal organs (e.g. liver), and groins. The doctor is looking for swelling, unusual growths, or other signs of disease. Women over 30 should be instructed how to examine their own breasts, and encouraged to do so at least once each cycle.

For examination of the genitals, the woman lies on her back with her legs apart in stirrup-like supports. The doctor examines the vulva for inflammation, sores, color changes, or growths.

To inspect the vagina and cervix, the vaginal walls must be held apart. The speculum, a metal or plastic instrument with rounded blades, is warmed and lubricated before it is inserted into the vagina. The blades are opened and the vaginal walls gently separated. In most cases the speculum can be used, even if the hymen is intact.

The Pap test for cervical cancer is done with the speculum in place. With a flat stick or glass tube, cells are gently scraped from the surface of the cervix and placed on a glass slide which is sent to a laboratory for microscopic examination.

If the woman suspects gonorrhea, cells from the cervix and urethra are placed on a culture medium and sent to a lab. The culture is grown for several days and examined microscopically.

If the woman complains of itchiness or vaginal discharge, the doctor examines a sample of the discharge microscopically to determine the cause of the irritation.

The doctor removes the speculum and performs an "internal" or pelvic examination. Two fingers of a surgically gloved hand are inserted deep into the vagina. With the other hand on the lower abdomen, the doctor examines the uterus, checking its size, shape, and mobility. Unless there is swelling or abnormal growth, the ovaries and Fallopian tubes usually can not be felt.

Common gynecological complaints

In a healthy woman, the vaginal walls are moist with transparent secretions. Many different species of bacteria, fungi, and yeasts normally inhabit the vagina. If the balance of the microscopic organisms is disturbed, vaginal disease and inflammation may result. Douching, vaginal sprays, local injury, certain diseases (e.g. diabetes), pregnancy and some contraceptives can upset this balance. Organisms responsible for some vaginal infections are often transmitted sexually although they may exist in the vagina without causing trouble.

Vaginal candidosis (monilia): A fungus, **candida albicans,** causes a thick white cheese-like discharge which irritates the vagina and vulva, inducing itching and inflammation. C. albicans often exists unnoticed in the vagina, but can be stimulated to "overgrow" and cause inflammation by: pregnancy, diabetes, antibiotics, (taken for other infections), steroid therapy, anti-trichomonal drugs, and oral contraceptives. Pregnancy, diabetes and the Pill increase the quantity of a carbohydrate, glycogen, in the vaginal walls. This leads to the growth of bacteria which change glycogen to lactic acid. The acid alters the chemical balance of the vagina promoting the overgrowth of C. albicans.

Treatment with **nystatin** suppositories or cream inserted into the vagina usually cures the woman. If the woman's regular sexual partner is not circumcised, he should insert some nystatin cream under the foreskin. The male should be tested for the presence of C. albicans in the urethra and, if necessary, treated with oral nystatin to avoid re-infecting the woman. When C. albicans infects the mouth and throat, the infection is called thrush. Thrush is also treated with nystatin.

Trichomoniasis: A thin yellowish, foamy, foul-smelling discharge causes intense burning and itching of the vagina and vulva. A one-celled protozoan, the trichomonad, causes these symptoms. Treatment with **metronidazole** (usually "Flagyl") orally for one or two weeks cures most cases. For stubborn cases, vaginal suppositories of metronidazole are used simultaneously. Alcohol should be avoided during treatment, since it reacts with the drug causing nausea and vomiting. The male should be examined for the presence of the parasite in the urethra.

Non-specific vaginitis: A vaginal discharge and irritated vulva may result from a foreign object (such as a forgotten tampon) in the vagina. Its removal clears up the condition. Microscopic organisms other than trichomonads or C. albicans may be responsible for infection. Antibiotic vaginal suppositories are usually effective treatment.

Urethritis, cystitis: Infections of the urethra and bladder are caused by various bacteria (usually E. coli) and other micro-organisms. Pain and burning on urination and a need to urinate frequently and urgently are common symptoms. Sulpha drugs and antibiotics relieve the symptoms immediately but should be continued for two weeks in order to destroy the organisms completely.

Syphilis and **gonorrhea** must be absolutely ruled out when a diagnosis of vaginitis, urethritis or cystitis is made. Antibiotic treatment for vaginal and urinary diseases may mask symptoms of gonorrhea or syphilis, without curing the woman.

When antibiotics are prescribed, the woman must take them at the required time intervals, maintaining a constant drug level in the body. Should the drug level drop below a critical point, the possibility of treatment failure is increased, and resistant strains of the infecting organism may develop.

Male reproductive structures

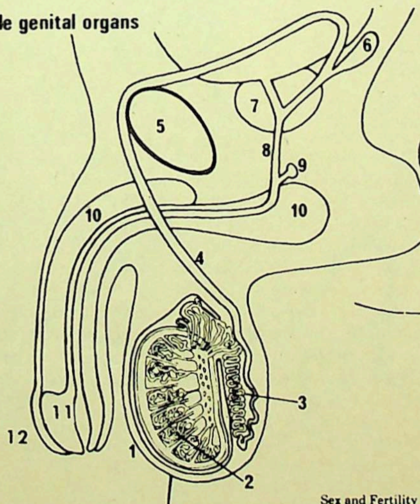
The penis and scrotum are the only parts of the male reproductive system which are external; the other structures rest within the lower pelvic area. **Scrotum:** The scrotum, a two-chambered sac lying behind the penis and between the legs, carries and protects the two testicles or testes. In sexually mature males the skin of the scrotal sac is wrinkled and covered with pubic hair. The scrotum normally hangs loosely away from the body so that a temperature below normal body temperature is maintained in the testicles. This lower temperature is necessary for the production of sperm cells. In cold weather muscles in the scrotal wall contract to bring the testicles closer to the warmth of the body.

Testicles (testes): The two testicles are made up of tiny sperm-producing tubes called **seminiferous tubules,** and male hormone-producing cells called **interstitial cells,** lying between the tubules. At puberty, the tubules begin to produce millions of sperm cells continuously. Sperm production can continue until a man is eighty or ninety years old.

Epididymis: The seminiferous tubules lead into an oval cushion of tissue called the epididymis which is connected to the upper part of each testicle.

Vas deferens: The tubules making up the epididymis carry sperm cells into a single tube called the vas deferens (spermatic or seminal duct). The **spermatic cord** which consists of the vas tube intertwined with nerve and muscle fibers and blood vessels, can contract to pull the testes into the safety of the body.

Male genital organs



1 scrotum, 2 seminiferous tubules, 3 epididymis, 4 vas deferens, 5 pubic bone, 6 seminal vesicles, 7 prostate gland, 8 urethra, 9 Cowper's glands, 10 erectile tissue, 11 glans, 12 foreskin.

Ampulla (seed reservoir): Each vas deferens leads upward from a testicle into the pelvis, passes around the urinary bladder and enlarges just before the prostate gland to form the ampulla. Contractions of muscles in the walls of the vas deferens push sperm cells into the ampulla. Each ampulla is about an inch long and less than an inch wide.

Seminal vesicles: Attached to the bottom of each ampulla is a gland called the seminal vesicle. These glands secrete a thick yellowish substance necessary for the survival of sperm cells and important in the composition of the final seminal fluid.

Prostate gland and urethra: The two vas tubes join within the prostate gland and enter the urethra. The urethra is a tube which carries urine from the bladder to the opening of the penis. The prostate gland produces a white alkaline fluid which mixes with sperm cells and the secretions of the seminal vesicles during ejaculation. This prostate gland secretion makes up the majority of the final seminal fluid, also called the ejaculate. Muscle tissue covering the prostate gland contracts during ejaculation forcing semen through the urethra and out the penis. The number of sperm in each ejaculation varies greatly in different men. An average ejaculation contains 350 million sperm cells.

Cowper's glands: These two small glands join the urethra as it leaves the prostate gland. Cowper's glands secrete a few drops of colorless alkaline mucus during sexual excitement.

Penis: The penis is a tubular organ made up of three bodies of erectile tissue which stiffen or "erect" when filled with blood. Physical or mental sexual stimulation causes the penis to engorge with blood and to become erect. The adult male penis is normally about 3¼ to 4¼ inches long; however, when erect it is usually 6 to 7½ inches long and about 1½ inches wide. Since the female clitoris and not the vaginal barrel is the center of female sexual sensitivity the length or width of the erect penis has little effect on the amount of pleasure a woman receives during sexual intercourse.

The skin covering the penis is loose and can move back and forth. At the base of the penis, this skin is covered with pubic hair. One body of erectile tissue expands at the top of the penis to form the glans. At birth, the glans is covered with the foreskin, which is routinely removed in many North American hospitals. The removal of the foreskin of male babies which is a Jewish and Moslem ritual, is called circumcision. Circumcision prevents the accumulation of smegma, a waxy secretion which forms below the foreskin. Uncircumcised men must pull back the foreskin and wash away accumulated smegma regularly. The glans of the penis, whether or not it is covered by the foreskin, is highly sensitive to sexual stimulation.

The urethra, which carries urine and, during ejaculation, semen, ends at the tip of the penis at the slit-like opening called the meatus.

hormones and the menstrual cycle

The **endocrine system** consists of various ductless glands and tissues, which release chemical substances called **hormones** directly into the blood stream. Because all hormones are interrelated, it is necessary to consider them in terms of hormonal interactions and balances, rather then individual substances. Hormones significantly affect all body functions; in fact, the endocrine system is considered a control mechanism for the entire body.

The **pituitary gland,** located at the base of the brain, is the most important endocrine gland. The pituitary apparently regulates action of all other en-'ocrine glands. **Follicle Stimulating Hormone (FSH)** ıd **Luteinizing Hormone (LH)** released by the pi-ıitary, affect the ovaries (female gonads) and thus .re known as **pituitary gonadotropins.**

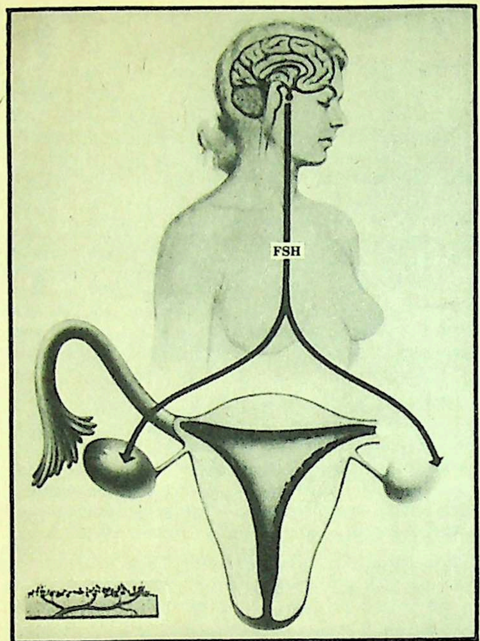
The gonads of each sex are also considered endocrine glands. The ovaries release sex hormones called **estrogen** and **progesterone** which play a major role in ovulation and in the cyclical development of the uterine lining.

Puberty is the general term for all the physical and psychological changes a girl undergoes between the ages of 11 and 17, including the appearance of pubic hair, breast development, and distribution of fat tissue, especially about the thighs and hips. The first menstruation or **menarche** is only one of these many changes, stimulated by the production of pituitary gonadotropins.

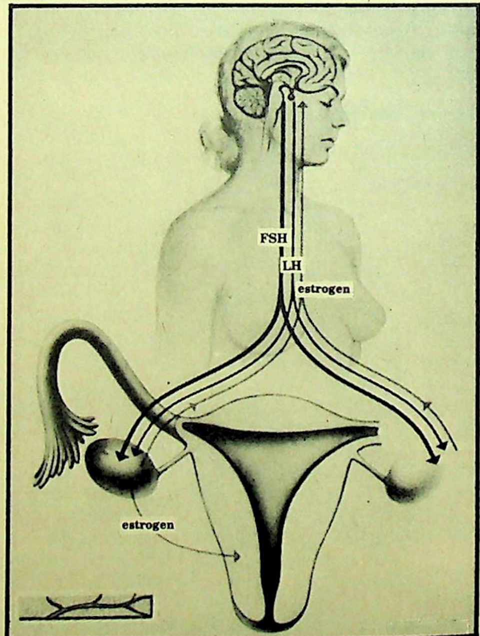
The average menstrual cycle lasts approximately 28 days. Some women have consistently longer or shorter cycles; others, especially young women, have cycles which vary in length. The menstrual cycle can be influenced by a change in climate or emotional stress. The first day of the menstrual flow is considered the beginning or day 1 of the menstrual cycle.

Day 1 - day 5: menstrual phase

The cycle begins with the shedding of the developed endometrium as the menstrual flow. Total blood loss during menstruation is about 2 to 4 ounces; most of the flow is fluid but occasional blood clots appear when the flow is heavy. The "period" lasts 3 to 7 days, usually heavy at first and tapering off at the end.

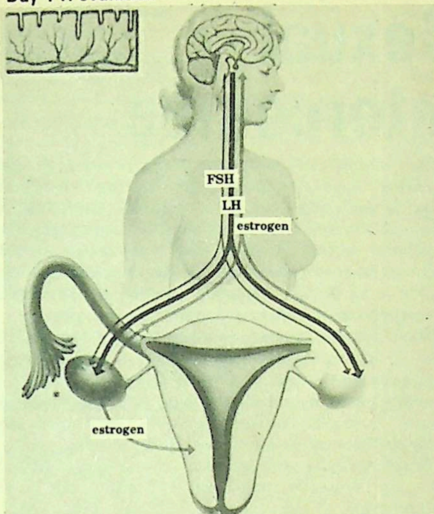


Days 1-5: menstrual phase — Ortho



Days 6-13: proliferatory phase — Ortho

Day 14: ovulation



Ortho

Women use either external sanitary napkins or internal tampons to absorb the flow. A napkin (pad) is attached to a belt which holds it in place against the vulva. Napkins should be changed regularly since blood gives off an unpleasant odor when exposed to air. Internal tampons are held in the vagina by muscles at the vaginal opening. When inserted correctly, tampons cannot be felt. Tampons should be changed as often as the flow necessitates. Women with the hymen intact (virgins) can use tampons without difficulty. When the flow is extremely heavy, two tampons can be used at once. The second is inserted beside the first, and the strings should be tied together. Some women prefer to use a tampon and sanitary napkin to absorb a very heavy flow.

There is no reason whatsoever to prohibit sexual intercourse during menstruation.

During menstruation, the hypothalamus (brain structure which controls involuntary body functions) stimulates the pituitary gland to release **Follicle Stimulating Hormone**. FSH stimulates the growth of several ovarian follicles, each containing one egg, on the surface of the ovary. FSH also stimulates the developing follicles to secrete estrogen.

Day 6 - day 13: proliferatory phase

Estrogen released by the follicles causes the endometrium to proliferate and induces changes in the cervical mucus which permit easier movement of sperm into the uterus. Estrogen also suppresses the pituitary's secretion of FSH. At about the 12th day, the pituitary begins to secrete Luteinizing Hormone (LH). One follicle develops more extensively than the others, protruding from the surface of the ovary.

Day 14: ovulation

Ovulation is the release of one ovum (egg) from the protruding follicle. When the pituitary gonadotropins, FSH and LH, are in a particular ratio, the tip of the follicle becomes transparent and thin. A sudden increase in the amount of circulating LH causes the thinnest area on the follicle's surface to rupture, releasing the egg. The fringed end of the Fallopian tube draws the egg into the tube.

Movement of sperm through the cervical mucus is easiest at this time, due to estrogen-induced nutrient and alkaline levels.

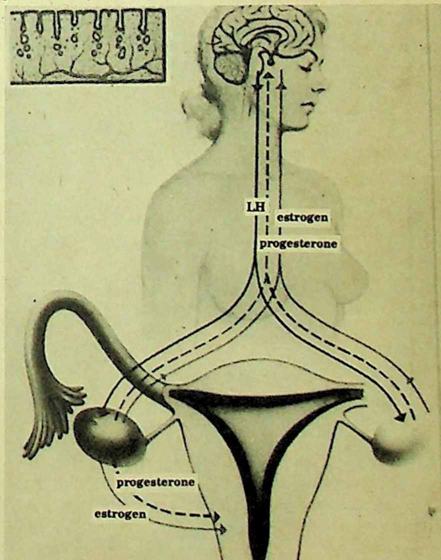
Once the egg has been released, LH stimulates the ruptured follicle to become a hormone-secreting gland called the **corpus luteum.**

Day 15 - day 25: secretory phase

Immediately after ovulation, the corpus luteum (yellow body) secretes progesterone which, along with estrogen released by the ovaries, stimulates further development of the endometrium. The endometrium becomes a rich bed of blood vessels and tissues in preparation for implantation of a fertilized egg. Estrogen and progesterone also affect the pituitary gland: both hormones block its production of FSH, and progesterone alone blocks the production of LH.

If the egg is fertilized, the placenta takes over the production of progesterone, blocking the release of pituitary gonadotropins, which in turn prevents the release of another egg throughout pregnancy.

If fertilization does not occur, the corpus luteum starts to degenerate about day 25. Its cells are reabsorbed and replaced with normal ovarian tissue. As a woman gets older, reabsorption is not complete and scar tissue from the corpus luteum remains on the ovarian surface. Follicles which began to develop but did not rupture are also reabsorbed by the ovary.



Ortho

Days 15-25: secretory phase

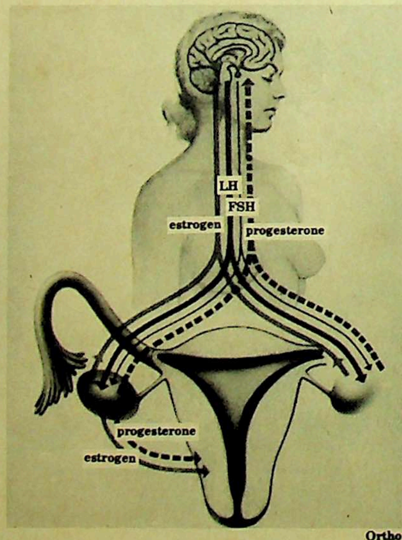
Day 26 - day 28: secretory phase (premenstrual)

Degeneration of the corpus luteum reduces the secretion of estrogen and progesterone. This low hormonal level causes the contraction of blood vessels leading to the endometrium, thus reducing the flow of blood to the tissue. The tiny veins and arteries of the endometrium break down, releasing blood, thus marking the beginning of the menstrual flow. The low hormonal level also stimulates the secretion of FSH by the pituitary gland, causing the whole cycle to begin again.

The climacteric (change of life)

The cycle described above continues, except during pregnancy and breastfeeding until the climacteric when the ovaries begin to fail. **Menopause** or the end of menstruation, the most noticeable event of the "change of life", occurs between the ages of 45 and 50. The process is gradual as ovulation becomes more irregular and infrequent. Once ovulation stops, progesterone is no longer released. Estrogen production is greatly reduced. Women under the care of a gynecologist usually receive hormonal "replacement therapy" for the rest of their lives.

Many women suffer from minor to severe depression and irritability during the change of life. Because western women are forced to compete as sexual objects, and are allowed no meaningful function within society, such problems take on an exaggeated importance. There is no reason why the climacteric should affect a woman's ability to function fully both mentally and physically or to enjoy sexual intercourse.



Days 26-28: secretory phase: (premenstrual)

Sexual intercourse

The ability to enjoy sexual intercourse (coitus, "making love", copulation, "having relations", "having sex", etc.) develops with knowledge of the human body and with experience in social and sexual relations with others. The pleasure of sex without fear of pregnancy or moral sinfulness continues to be denied, especially to women, because of the repression of such knowledge and experience.

Most couples engage in some form of sexual foreplay - kissing, caressing, teasing, - before beginning sexual intercourse. Almost any part of the body is sensitive to sexual stimulation, but especially the thighs, buttocks, breasts, nipples, neck and ears. Both partners can enjoy oral-genital contact.

When sexually aroused, the man's penis and the woman's clitoris become hard and erect, due to the engorgement of the tissue with blood. The woman's vaginal walls separate, expand, and become moist with mucus. To begin coitus, either partner guides the man's erect penis into the vaginal opening. Saliva is always available as a lubricant if the vagina is too dry for comfortable intromission. Together, the man and woman move their bodies in such a way that the clitoris and the penis are stimulated, not necessarily simultaneously.

Female orgasm

Whether a woman comes to orgasm (the climax) through masturbation, manipulation, or coitus, the physiologic response is the same. Sexual sensitivity is centered in the vulva, specifically the clitoris, and not the vaginal barrel which contains many times fewer nerve endings. Stimulation of the clitoris causes engorgement of blood vessels in the genitals, and a general neuro-muscular tension. Other body changes in this **excitement phase** include: increased rate of breathing and of heart beat, breast enlargement, erection of nipples, upward movement of the uterus, and expansion of the vaginal walls. Sometimes a sexual flush (temporary skin rash) appears.

At the **plateau phase** of excitement, these changes are accelerated, and, without distraction, the woman soon reaches orgasm - the pleasurable release of tension in the genitals and throughout the entire body. The vaginal walls especially near the opening, contract rhythmically. The uterus contracts pushing the cervix further into the vagina.

As the tension is released, the body begins to return to its normal condition **(resolution phase)**; but, if stimulation continues before sexual tension drops below the plateau level, the woman can "come" again almost indefinitely. Women can experience long orgasms or a rapid series of orgasms without a return to the plateau phase.

Male orgasm

Male orgasm also involves the release of neuro-

muscular tension throughout the body. In the plateau phase when orgasm seems inevitable, the contents of the ampulla, seminal vesicles, and prostate gland combine to form the final seminal fluid. Muscles surrounding the urethra as it leaves the bladder contract so that urine cannot be released.

During orgasm, the semen is forced out the tip of the penis through the urethra. The first muscular contractions are strong and their rhythm is the same as the woman's vaginal contractions. The amount of ejaculate released influences the strength (but not necessarily the pleasure) of the orgasm. Other body changes are similar to those in women including muscles spasms, sexual flush, and a light film of perspiration.

During the resolution phase after orgasm, the body changes disappear, at first suddenly, and then slowly taking up to several hours. The penis loses much of its erection, and a short time span (the **refractory period**) must pass before a man can have another orgasm.

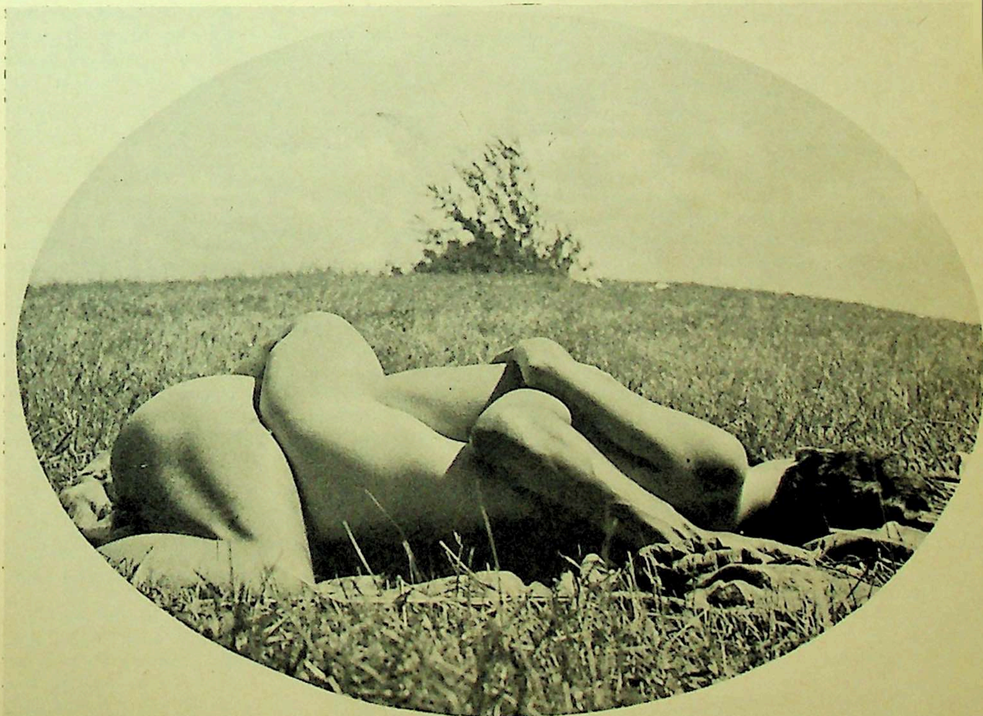
Positions

The many imaginative positions for making love fall into one of two classifications: face to face, and intromission from behind. In face to face positions (to mention only a few), either partner can lie on top of the other, both can lie on their sides, one can sit over the other who is lying down, or both can stand or sit. When intromission occurs from behind, the man can lie on top of the woman, the woman can sit back on the man's lap, the woman can crouch while the man kneels behind her, etc. Each position has its advantages and disadvantages such as: freedom of movement, depth of penetration of the penis, and stimulation of the clitoris.

Rupturing the hymen (loss of virginity) should be done in a position in which both partners can easily control their movements. The hymen should be stretched gradually with gentle but constant penetration of the penis. Slight bleeding and some pain is common; however, some women feel no discomfort at all. Many women prefer to stretch the hymen gradually themselves before attempting sexual intercourse. Over a period of several days, the woman inserts one finger into the vagina, then two, and then three, until the tissue is stretched sufficiently.

There is no reason for prohibiting sexual intercourse during menstruation. The erect penis blocks the flow during intercourse, and a disposable cloth placed on the sheets can prevent possible staining when the man withdraws his penis. Some women have a slightly heavier flow after intercourse due to contractions of the uterus during orgasm.

In keeping with the **Handbook's** *emphasis on contraception, those means of human sexual expression, such as homosexuality, masturbation, oral-genital intercourse, and anal intercourse, which do not lead to conception have been omitted. A comprehensive discussion of human sexuality is beyond the scope of the* **Birth Control Handbook**



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conception

Sperm

Sperm cells, produced in the seminiferous tubules of the testes, are moved by muscular contractions through the vas deferens for about three weeks until the mature cells reach the ampulla. Secretions from the prostate gland and seminal vesicles add both bulk and energy to the sperm cells, creating the final seminal fluid.

Each sperm cell consists of a head, mid-piece, and tail. The head contains 23 chromosomes responsible for the hereditary characteristics from the father. The mid-piece and tail are made up of coiled fibers which contract and expand to move the sperm cell along.

An average of 350 million microscopic sperm cells are released in one ejaculation. The life span of sperm within the female genital tract is approximately 48 hours.

The egg

Follicle Stimulating Hormone (FSH) released by the pituitary gland at the beginning of a woman's cycle, stimulates several ovarian follicles to grow. About the 12th day, the pituitary begins to release Luteinizing Hormone (LH) as well. When FSH and LH are in proper balance, one of the follicles ruptures, releasing an egg which is soon picked up by the fringed end f the Fallopian tube.

The nucleus of the egg cell contains 23 pairs of hromosomes; as the egg matures, 1 chromosome from each pair is retained, and the other is discarded in a cluster called the polar body. The nucleus and the nourishing cytoplasm are surrounded by a thicker membrane, the zona pellicuda. Smaller cells from the ruptured follicle cling to its surface. Some of these cells are brushed off by hair-like cilia within the Fallopian tube as muscular contractions move the egg toward the uterus. If the egg is not fertilized within 24 hours of ovulation, it degenerates and passes out the body unnoticed.

Changes of the uterus

As the ovarian follicles develop, estrogen is released by the ovaries. After ovulation, progesterone is released by the corpus luteum, the scar tissue on one ruptured follicle. Both hormones stimulate the endometrium (uterine lining) to "proliferate", preparing the lining to nourish a fertilized egg after implantation. If implantation does not occur the lining is shed as the menstrual flow.

At the time of ovulation, mucus in the cervical canal becomes more plentiful, thinner, and richer in nutrients, so that sperm cells can pass easily into the uterus.

Fertilization

During sexual intercourse, millions of sperm cells are ejaculated high into the woman's vagina, near the alkaline environment of the cervix. Many sperm "swim" in the wrong direction; others are killed by the acid condition of the vagina, and still others are trapped in the folds of the vaginal walls. Those that pass through the cervical canal are moved toward the Fallopian tubes primarily by muscular activity of the uterus. Some sperm enter each Fallopian tube, only one of which holds an egg.

Fertilization occurs in the Fallopian tube. The first sperm cells to reach the egg release a chemical which dissolves cells adhering to the zona pellicuda. Once the egg is exposed, one sperm cell bores through the cell membrane to the center of the cell. A second chemical reaction prevents any other sperm from entering the egg.

As the fertilized egg (gamete) is moved down the Fallopian tube, the nuclei of the sperm and egg fuse together to form one nucleus with 46 chromosomes. These chromosomes reproduce themselves and the cell divides in two. This division process continues until the gamete is a cluster of tiny cells, each with 46 chromosomes. Fats and other substances of the egg cell provide it with nourishment for 3 days as it travels down the tube to the uterus.

Nidation

For several days the egg cluster or **blastocyst** floats freely in the uterine cavity. About six days after fertilization, the blastocyst attaches itself to the endometrium, and buries itself by chemically dissolving a bit of endometrial tissue. Blood surrounds the cluster and nourishes it. Nidation **(implantation)** is complete by the 12th day after fertilization. One mass of cells from the blastocyst soon develops as the growing embryo; others become nutritive structures such as the placenta.

Implantation often does not occur at all, and the fertilized egg degenerates.

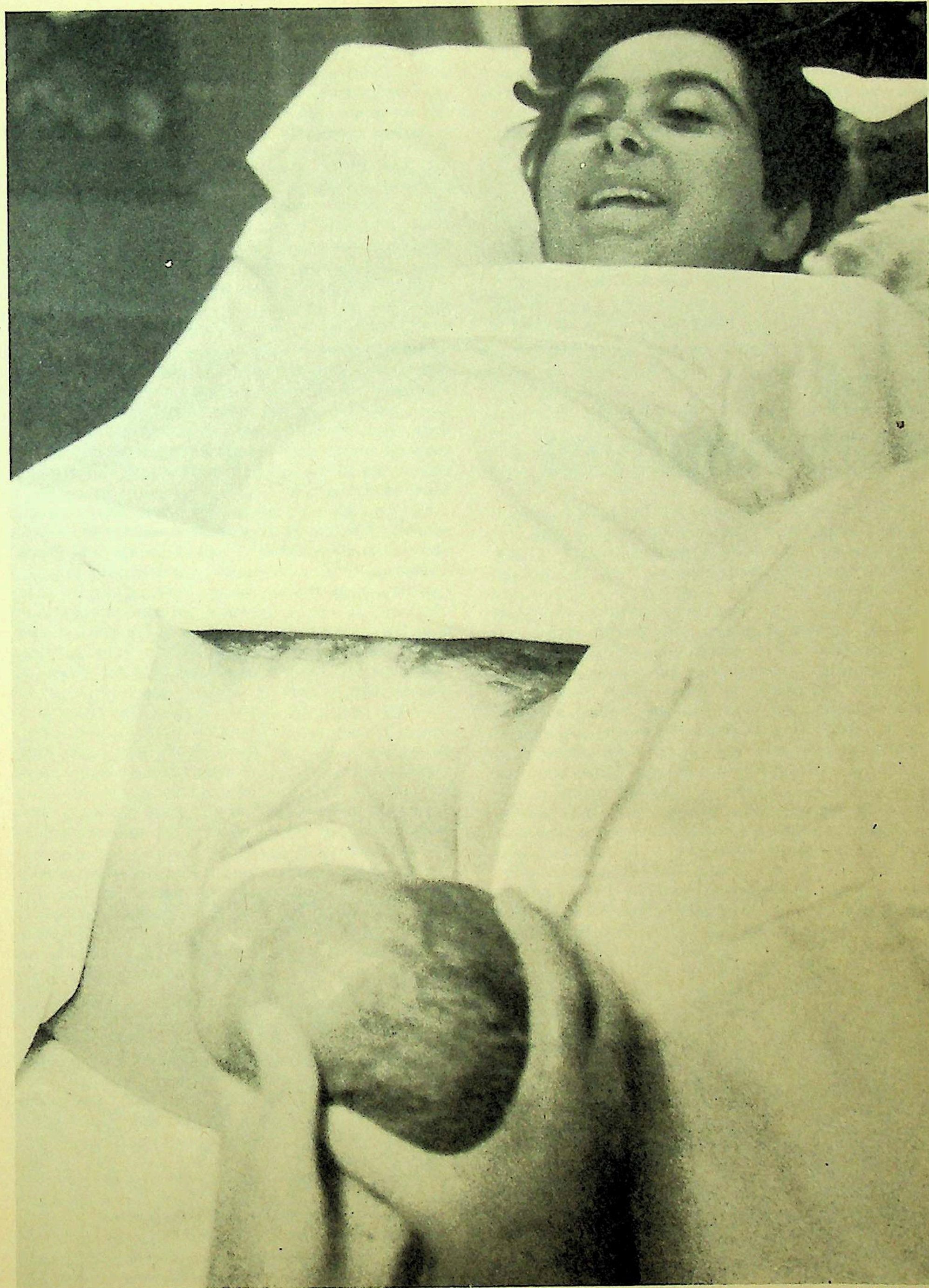
Determination of pregnancy

Usually, a woman first suspects that she is pregnant when her menstrual period is overdue. The length of pregnancy is always calculated from the first, day of her **last** menstrual flow; thus, if a woman is ten days late, and normally has her period every 28 days, she is considered 38 days or 5½ weeks pregnant.

A woman whose period is late but who does not wish to be pregnant should continue to use some kind of contraception until pregnancy has been confirmed by a doctor.

Pregnancy tests work by detecting the presence, within urine, of a hormone called Human Chorionic Gonadotropin (HCG). The placenta releases increasing amounts of HCG so that, by the 6th week of pregnancy, some HCG appears in the pregnant woman's urine.

In the "biological test", some of the woman's urine is injected into a laboratory animal such as a rat or toad. If HCG is present, it causes a particular reaction (such as ovulation) in the animal. Such a reaction is defined as a positive result, meaning that the woman is pregnant. This test takes at least six



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hours.

"Chemical tests" take from 2 minutes to several hours. When a chemical is added to a sample of urine, the presence or absence of a chemical reaction determines if the test is negative or positive.

Although both tests are highly accurate, false reports do occur. Pregnancy tests are not accurate for pre-menopausal women. Hospital laboratory tests are often more accurate and less expensive than drugstore tests.

For a positive confirmation of pregnancy, a woman should see a gynecologist for an internal examination. Private doctors are expensive, but family planning centers, university health services, and hospital gynecological clinics are more reasonable. Women under 18 can often get cooperation at the adolescent clinic of a children's hospital.

Several signs of early pregnancy which a doctor or paramedical specialist can detect during an internal examination are: darker color of the vulva and vagina, softness of the uterine isthmus (area between the cervix and uterine body), softness of the cervix, and size of the uterus.

If the doctor is not positive of the diagnosis or suspects that the woman is not pregnant, the woman can be given synthetic progesterone, either orally or by injection, which raises the hormone level in the woman's blood stream. If the woman is not pregnant, the following drop in the hormonal level causes withdrawal bleeding. **Such pills cannot abort a fetus:** they can only bring on a late period. These pills cost approximately $3 at reputable pharmacies.

oral contraceptives

Few scientific achievements have had greater social impact than the development of the oral contraceptive. The Pill is presently used by approximately 18.5 million women, about 8.5 million of whom live in North America. The Pill is the closest thing to the "ideal contraceptive" available, and its popularity reflects a changing social and political mood of a whole generation of women.

The oral contraceptive is 100% effective when taken as instructed, relatively "safe", easily reversible, and in the control of the woman; however, use of the Pill does present certain difficulties. Taking one pill every day is a nuisance, appreciated by few not taking oral contraceptives. Minor annoying side effects are common, although transient, in the first three months of use. Most importantly, the oral contraceptive constitutes an endocrinological insult to the female body which in rare instances can lead to serious disease and even death. Nevertheless, on the basis of available scientific findings, the editors of this publication are convinced that the benefits of oral contraception outweigh its dangers. Accepted human activities such as pregnancy and childbirth, or even travel in automobiles carry much greater risks to health and life. Many drugs used more commonly than oral contraceptives, such as aspirin or penicillin, are potentially more dangerous than the Pill; however, relief of pain and combatting infection are accepted as important in our society. Until recently, contraception, with its gifts of sexual freedom and physical health for women, has not been appreciated as an important medical achievement.

Margaret Sanger, renowned anarchist and fighter for the liberation of women, was probably the first to write : "No woman can consider herself free until she can determine the number of children she will have". In the winter of 1950 Margaret Sanger convinced Dr. Gregory Pincus to accept a grant of $2,100 from the fledgling Planned Parenthood Federation which she had founded. Millions of dollars of corporation money soon followed the original Federation grant, but credit for initiating the first research project which eventually produced the Pill goes to one of the most noble women of this century, Margaret Sanger.

Pincus and a colleague, Dr. John Rock, experimented with synthetic estrogens and progesterones and eventually produced "Enovid" for the G.D. Searle Company. Originally, Enovid contained 10 mg. of a synthetic progesterone called norethynodrel and as much as .22 mg. of synthetic estrogen called ethinyl estradiol. In 1956, Rock, Pincus and a third doctor, Celso Garcia, selected 265 Puerto Rican women "from the low income population living in a housing development project in a slum clearance area" for the first significant human trials. Officially, Puerto Rican women were chosen because of their "high pregnancy rate"; in fact, these poor, non-white women were used as Guinea pigs since G.D. Searle hesitated to test such potent medication on white American women. Ironically, during the tests these women received better medical attention than they had ever had.

The Puerto Rican tests revealed that Enovid prevents pregnancy, and that women do not drop dead after ingesting norethynodrel and ethinyl estradiol. By 1960, on the basis of scanty scientific information, the United States Food and Drug Administration (FDA) authorized the G.D. Searle Co. to market Enovid.

Description

There are two kinds of oral contraceptives: the **combination pill** and the **sequential pill**. A series of the combination oral contraceptive consists of 21 (20 in some brands) identical pills each containing synthetic estrogen and progesterone. A sequential oral contraceptive series is made up of two different kinds of pills. The first 11, 14, 15 or 16 pills (depending on the brand) contain only synthetic estrogen, and the next 10, 6, 5, or 4 pills contain a combination of estrogen and progesterone.

Synthetic hormones stimulate the same body reactions as do natural hormones. There are 2 kinds of synthetic estrogen and 9 different synthetic pro-

gesterones. The two estrogens, **mestranol** and **ethinyl estradiol,** have almost identical properties; however the effects of ethinyl estradiol are more highly localized at the reproductive system. For example, ethinyl estradiol has less effect on glucose tolerance than does mestranol. Although ethinyl estradiol is probably the better estrogen, mestranol is used more commonly. Mestranol is used in: Enovid, Ortho Novum, Norinyl (including Norquen and Noriday), C-Quens, and Ovulen. Ethinyl estradiol is used in: Norlestrin, Provest, Oracon, Ovral, and Demulen.

The quantity of estrogen in each pill is more important than the kind. Several years ago it was discovered that not more than .05 mg. of estrogen in each pill is necessary to ensure 100% contraceptive effectiveness. Also, when such "low dose estrogen pills" are used, risks of serious complications are significantly reduced. In December 1969 the British Committee on Safety of Drugs officially recommended that brands of oral contraceptives containing more than .05 mg. of estrogen should not be used. In the words of the British Medical Journal, British pharmaceutical companies "were quick to take the hint", and withdrew from the market all combination pills containing more than .05 mg. of estrogen. American pharmaceutical companies have produced low dose brands, but have refused to withdraw high dose pills from the market.

Most synthetic progesterones are produced by chemically changing the synthetic male sexual hormone, testosterone. Depending on the chemical process used, the resulting progesterone is either **estrogenic** or **anti-estrogenic**. With estrogenic progesterones, at least some of the hormone is changed by the body into estrogen. Norethynodrel, the progesterone component of Enovid, is the only commonly used estrogenic progesterone. Estrogenic progesterones should not be used since they introduce unnecessary estrogen. On the other hand, anti-estrogenic synthetic progesterones, like natural progesterones, counter the effects of estrogen. The anti-estrogenic qualities of synthetic progesterones add to the contraceptive effectiveness of the Pill.

Depending on the kind and quantity of synthetic hormones used, a particular brand of combination pills can be estrogenic or anti-estrogenic. All low dose combination pills are distinctly anti-estrogenic, which counteracts side effects and complications related to estrogen (most side effects are estrogen-related). In contrast, sequential pills are distinctly estrogenic; because the sequential series does not provide progesterone for most of the 21 pill cycle, more than .05 mg of estrogen must be delivered by the sequential pill to ensure contraceptive effectiveness, and even so, sequentials are not 100% effective, with annual failure rates of 1% to 2%. Not only do sequentials deliver more estrogen per day, but the lack of progesterone's anti-estrogenic effect further extends the effects of estrogen. Since sequential pills provide excessive estrogen, they should be ordered off the market. (The Eli Lilly Co recently discontinued production of C-Quens, but pharmacists still have large supplies). **Women taking sequential pills such as : C-Quens, Estalor, Lyndiol SQ, Miniquen, Norquen, Ortho-Novum SQ, Oracon SQ, Ovex SQ and Secrovin SQ should see a gynecologist and ask for a change of prescription**

How the Pill works

A healthy woman who is not pregnant or breast feeding menstruates approximately once every 28 days. Soon after menstruation begins, the hypothalamus (part of the brain) stimulates the pituitary gland to secrete a hormone called Follicle Stimulating Hormone (FSH) into the blood stream. FSH stimulates the growth of several ovarian follicles, and the secretion of estrogen by these follicles. A few days after the first release of FSH, the pituitary also begins secretion of Luteinizing Hormone (LH). Around the 14th day of the menstrual cycle, a sudden increase of LH secretion causes one follicle to rupture and release an egg. After ovulation, the ruptured follicle changes into a gland called the corpus luteum which begins to secrete progesterone. As the quantity of estrogen and progesterone increases in the blood stream, the pituitary secretes less FSH and LH.

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If the egg is fertilized, the corpus luteum as well as the placenta secrete large quantities of progesterone throughout pregnancy. Estrogen and progesterone block the pituitary's secretion of FSH and LH, and ovulation cannot occur during the nine months of pregnancy. Overlapping pregnancies are thus prevented.

The oral contraceptive mimics the body's defences against pregnancy by creating a hormonal "pseudo-pregnancy" within a woman's body. Each pill of a series contains enough estrogen and progesterone to block secretion of FSH and LH, thus preventing ovulation.

In addition, progesterone causes secondary changes which make pregnancy unlikely even if the pituitary "escapes" the effects of the synthetic hormones. Progesterone causes the cervical mucus to become thick and impenetrable, preventing sperm cells from entering the uterus. Progesterone also disrupts the cyclic growth of the uterine lining, making it unreceptive to a fertilized egg. Since sequential oral contraceptives are primarily estrogenic, secondary progesterone-dependent effects are not produced, resulting in the 1% to 2% failure rate of sequential pills.

Medical examination and prescription

Oral contraceptives, like all potent medication, must not be used by certain women. Proper medical screening can spot women for whom oral contraception would pose unacceptable risks.

A complete medical history must be taken before prescribing an oral contraceptive. Questions which must be asked include:

1. Does the woman have, or has she ever had: a blood clotting disease such as thromboembolism, thrombophlebitis, pulmonary embolism, "stroke", retinal thrombosis; migraine headaches; heart disease or defect; endocrinological disease or disorder such as thyroid dysfunction or diabetes; liver disease such as jaundice; kidney disease; asthma; epilepsy; or any significant psychiatric problem such as severe depression?
2. Is there any inheritable disease in the woman's family? Has the woman's mother ever had any form of cancer, migraine headaches, high blood pressure, or varicose veins? If the woman has any sisters, similar information about their medical histories can be relevant.
3. Has the woman ever been pregnant? How many times? How many live babies, abortions or miscarriages has she had? Has the woman had complications during pregnancy, such as toxemia, varicose veins, or liver disease?
4. At what age did the woman have her first menstrual flow? What is the average length of her menstrual cycle and of the flow itself? Does she experience cramps, fluid retention, breast swelling and tenderness, or mood changes before, during and/or after menstruation?

Women who have or who have had: thromboembolism, thrombophlebitis, pulmonary embolism, a "stroke", retinal thrombosis, heart disease or defect, severe endocrine disorder, recurrent jaundice of pregnancy, or any form of cancer must not take oral contraceptives. The synthetic estrogen delivered by the Pill can worsen existing conditions of these diseases or increase a woman's susceptability to a relapse.

Women who have had: mild endocrine disorder, liver disease such as jaundice, or kidney disease can take the oral contraceptive if: (a) an endocrine disorder is well under control, (b) kidney or liver disease is completely cured.

Women who have or who have had: migraine headaches, high blood pressure, varicose veins, asthma, epilepsy, any significant psychiatric problem, or diabetes can take an oral contraceptive, provided that they are closely supervised medically, and that periodic tests are taken to ensure that the Pill's estrogen is not worsening their condition. If the Pill causes migraine headaches to become more severe or more frequent, the woman must stop taking the medication. If high blood pressure or varicose veins are adversely affected by oral contraception, the woman must stop taking the medication. If fluid retention occurs as a side effect to the Pill, asthma or epilepsy can be adversely affected. For women with asthma or epilepsy, diuretics can be prescribed, and only anti-estrogenic pills should be used. Women with existing psychiatric problems must be followed by a psychiatrist while taking oral contraception. Women with minor depression before menstruation often find their symptoms relieved while taking the Pill. Pre-diabetic women, or women with active diabetes should have an annual or semi-annual glucose tolerance test, and should use an oral contraceptive containing ethinyl estradiol as its estrogenic component.

Once the medical history is taken, the doctor performs a general and a gynecological physical examination. The woman's blood pressure and weight must be recorded, samples of blood and urine must be taken, and a careful breast examination and a Pap test (for cervical cancer) must be performed.

A doctor has a variety of brands to choose from when prescribing oral contraceptives. Only "low dose" brands which contain not more than .05 mg of estrogen per pill should be used. **The low dose brands are : Demulen 1, Demulen .5, Norlestrin 1, Norlestrin 2.5, Norinyl 1, Ortho-Novum 1/50** (Norinyl 1 and O-N 1/50 are exactly the same), and **Ovral.** The use of Norlestrin 2.5 should be reserved for women who require a larger quantity of progesterone to counter extreme estrogen-excess symptoms (such as nausea, vomiting, fluid retention and breast tenderness).

All women taking the Pill should have an annual gynecological examination, including breast examination and a Pap test.

Personal use of the Pill

Most oral contraceptives are taken in a series of 21 pills. This produces a convenient "three weeks on, one week off" cycle of medication.

To begin taking the Pill, a woman must wait for a menstrual flow. Counting the first day of her flow as day 1, the woman takes the first pill

of a series on day 5. One pill is taken at about the same time daily for 21 days. The woman counts 7 days after taking the last pill. On the 8th day, she takes the first pill of her next series. Thus, if a woman takes the first pill of her first series on a Tuesday, she takes her last pill of that series on a Monday, and takes the first pill of the next series on the Tuesday of the following week. The "starting day" (i.e. the day that the first pill is taken) is the same day of the week for every series.

Some oral contraceptives come in 28 day series. The first 21 pills contain the synthetic hormones. The last 7 pills are placebos - pills that contain nothing other than sugar. A woman taking a 28 pill series takes one pill every day, beginning a new package the day after taking the last (28th) pill.

Most brands of the Pill are now available in a 28 day series in which the placebos contain iron. It is argued that since all women lose some blood due to withdrawal bleeding, they should receive "replacement iron" (iron is necessary in the formation of new red blood cells). However most women are not anemic and do not require replacement iron; those women who do need iron added to their diet usually require more than is provided by the iron placebos.

In general, combining different drugs into the same pill or pill series is bad medicine, which serves only to maintain high drug prices and increase drug sales.

If one pill is forgotten it should be taken as soon as it is remembered, even if this means taking two pills on the same day. If taking the pill is incorporated into routine daily activities (e.g. "waking up", "supper", "going to bed") a woman is less likely to forget a pill. If a combination pill is forgotten for not more than 24 hours, the chances of pregnancy are close to zero. If more than one combination pill is forgotten, or if one sequential pill is forgotten, the forgotten pills should be taken when remembered and another contraceptive method should be used for the rest of the cycle.

The combination Pill provides 100% contraceptive protection from the first pill of the first series. **If a woman is changing her brand of pill from a higher dose of estrogen to a lower dose, another birth control method should be used for the first 2 weeks of the first low dose series.**

Reversibility of contraceptive action

The oral contraceptive is easily reversible. When pregnancy is desired, the woman finishes a pill-series, and does not start another series. Sixty to 75% of women who stop taking the Pill to become pregnant achieve their aim within three cycles of the last pill, and 90% become pregnant within one year. The pregnancy rate is the same in women who have never taken oral contraceptives and who are attempting to become pregnant.

Babies born to women who have used oral contraceptives are not affected by the medication.

In a small, undetermined percentage of women who stop taking the Pill, ovulation and menstruation are delayed for a month or two, and in some reported cases, for as long as a year. This condition of post-Pill amenorrhea (lack of menstruation) has been named the "oversuppression syndrome". Amenorrhea following discontinuation of the Pill is more likely to occur in women who have irregular menstrual cycles before using oral contraception. The probable cause of post-Pill amenorrhea is a lingering, oversuppression of the hypothalamus by the Pill's synthetic progesterone. Almost all cases of oversuppression disappear by themselves without medication. If amenorrhea continues for more than 6 months, cortisone acetate or clomiphene citrate (brand name: Clomid) is used to bring on ovulation and menstruation. Clomid is highly effective if there is enough natural estrogen in the bloodstream. If the level of estrogen is low, skull X-rays are taken to make sure that a coincidental tumor does not exist, and supplementary human gonadotropins are then given to induce ovulation.

Prolonged post-Pill amenorrhea responds quickly and easily to treatment with Clomid, or, if necessary, human gonadotropins. It is unlikely that the incidence of oversuppression increases in women taking oral contraceptives for prolonged periods. The practice of discontinuing oral contraception every 2 years to determine if ovulation occurs spontaneously is medically useless and often results in unwanted pregnancy.

Side effects

Oral contraceptives are potent medication and induce many body changes other than the suppression of ovulation.

Nuisance effects

Most nuisance effects induced by oral contraception are related to estrogen. Such effects are common during the first 3 cycles of medication while the body is adjusting to the new hormonal levels, and they usually disappear by the 4th cycle. If any side effect persists for longer than 3 cycles, or becomes severe, the prescribing doctor should be consulted.

The majority of women taking low-dose oral contraceptives do not experience any side effects, or are bothered only by minor, transient effects. Psychological factors play a large part in the incidence of minor effects. If a side effect is expected, it may very well occur.

Nausea sometimes accompanied by vomiting or stomach cramps is the Pill's most common side effect. If it occurs, nausea appears within a day or two of the first pill taken, and recurs at the beginning of the following cycle. Such side effects can be avoided by: a. taking the daily pill after a full meal; b. taking the pill just before going to sleep; or c. taking the pill with a glass of milk or a mild antacid.

Fluid retention can occur as a result of estrogen's effects on the body's retention of salts. A general "bloated feeling", cramping or swelling of the legs, breast discomfort, rapid weight gain,

Estimates of risk of death to women in England 1966

	AGE 20-34	35-44
Annual death rate per 100,000 healthy, married, non-pregnant women from pulmonary cerebral thromboembolism:		
Users of oral contraceptives	1.5	3.9
Non-users of oral contraceptives	0.2	0.5
Annual death rate per 100,000 total female population from:		
Cancer	13.7	70.1
Motor accidents	4.9	3.9
All causes	60.1	170.5
Death rate per 100,000 maternities from:		
Complications of pregnancy	7.5	13.8
Abortion	5.6	10.4
Complications of delivery	7.1	26.5
Complications of the post-birth period from:		
Thromboembolic disease	1.3	4.6
Other complications	1.3	4.6
All risks of pregnancy, and post-birth period	22.8	57.6

and generalized itching are minor symptoms of fluid retention. Fluid retention can adversely affect migraine headaches. If a woman experiences severe headache, dizziness, and blurry or double vision shortly after starting the Pill, she should immediately consult the prescribing doctor, and stop taking the medication.

Fluid retention is harmless except to women with migraine headaches, epilepsy, high blood pressure, vascular disease, or heart defect or disease. Fluid retention can be alleviated by a low salt diet, restricted water intake and, if necessary, a diuretic.

Chloasma is the rarest of estrogen-related nuisance effects. Chloasma, also called the "mask of pregnancy" appears as "giant freckles" on the face. Pill related chloasma is more common in women who experience chloasma during pregnancy, and in women frequently exposed to strong sunlight.

Leukorrhea is an estrogen-related, harmless, white or clear, excessive vaginal discharge. If vaginal discharge becomes bothersome, a gynecologist should be consulted.

Estrogen deficiency and progesterone excess side effects occur if a Pill is too highly anti-estrogenic for a particular woman. Such side effects include: mood changes, including depression and changes in sexual desire; increased appetite and weight gain; fatigue; decrease in amount and duration of menstrual flow; oily scalp and skin (sometimes leading to acne); changes in facial or body hair distribution; and breast enlargement. Progesterone related side effects, although usually minor, either remain constant or become worse with each successive cycle. A doctor should therefore be consulted Breast enlargement is the most common progesterone-related side effect. After an initial size increase, breast size remains constant until the Pill is discontinued, at which point the breasts return to normal size.

If a woman is taking a Pill that delivers more than 1 mg. of progesterone daily, progesterone-related side effects can usually be eliminated by switching to an oral contraceptive with less progesterone (not to a Pill with more estrogen).

Breakthrough bleeding and spotting (bleeding between periods) are the only common progesterone-deficiency side effects. If they occur, such bleeding episodes usually disappear by the fourth cycle. In persistent cases a pill with a higher dose of progesterone can be prescribed.

Vaginitis: Estrogen affects glycogen content of vaginal walls, making the vagina more susceptible to infestation by microscopic yeast or fungus organisms (a common problem for all women). Discharge, itchiness and general vaginal discomfort are symptoms of vaginitis. Vaginitis is not serious, but can be extremely uncomfortable, and deserves immediate medical treatment. Treatment is usually simple (topical creams etc.).

Metabolic effects

The biochemical activities which keep organisms alive are collectively called metabolism. The Pill causes more than 50 undesirable biochemical changes in the female body, most of which are induced by estrogen. It is reasonable to suspect and has been proven in some cases, that reducing the quantity of estrogen reduces the extent of the metabolic changes.

Pregnancy induces similar metabolic changes but pregnancy-related changes are more extensive and in some cases more dangerous. Much more estrogen and progesterone are present in the blood of a pregnant woman than in one who is taking oral contraceptives.

Oral contraceptives containing .1 mg of estrogen per pill cause an increase in the amount of **cortisol** in the bloodstream, but low dose pills (.05 mg estrogen) do not cause a similar observable cortisol excess. Cortisol is produced by the adrenal glands and is an extremely important hormone.

Excessive cortisol slows **insulin production** and reduces its effectiveness. Insulin, a hormone produced by special cells of the pancreas, is essential to the body's use of sugars. A low level of insulin in the bloodstream leads to a disease called diabetes mellitus, characterized by "low glucose tolerance" - the body's inability to transport and use sugars. The Pill does not cause diabetes, but even low dose pills reduce glucose tolerance in most women. Glucose tolerance usually returns to normal when the woman stops using oral contraception; however, long-maintained reduction of glucose tolerance may have permanent effects, especially in women susceptible to diabetes because of heredity or obesity. Women whose blood relatives have diabetes should have a glucose tolerance test before starting the Pill, and an annual test while taking the medication.

Like pregnancy, the Pill increases the amount of

circulating fats and fatty proteins. This may also be the result of cortisol excess. An increase in circulating fats heightens a woman's susceptibility to atherosclerosis, a vascular disease in which arteries are clogged with fat, and it makes particles in the blood, the **platelets,** "stickier". Greater platelet stickiness increases coagulability of the Pill-user's blood, and contributes to the development of thrombosis in some women.

Cortisol may also affect the **liver** which is highly sensitive to circulating hormones. If the liver's excretion of certain wastes into the bile is impaired, jaundice develops. Pregnancy affects liver excretion and some women become jaundiced late in each pregnancy. This disorder is called "recurrent jaundice of pregnancy" and usually disappears promptly after the pregnancy. About 1 women in 10,000 Pill-users develops a similar jaundice. Symptoms include loss of appetite, nausea, general itchiness, dark urine and yellow discoloration of skin, fingernails and eyes. Pill-related jaundice usually begins within 4 weeks of starting oral contraception. The jaundice usually disappears once the woman stops taking the Pill.

Most women taking the Pill excrete higher than normal levels of an amino acid called **tryptophan.** The Pill's estrogen seems to cause a deficiency of vitamin B6 (pyridoxine), which is necessary for the body's use of tryptophan. Such a situation also exists in depressive illness, and pyridoxine deficiency may be the cause of mild to severe depression experienced by some women taking the Pill. Twenty-five to 30 mg of pyridoxine daily significantly improves certain cases of Pill-related depression. Pyridoxine in these quantities is a harmless, water-soluble vitamin.

Since the quantity and nutritive value of breast milk is reduced by the Pill, women who intend to **breast-feed** should not use oral contraception immediately after child-birth.

Serious complications

Thromboembolism : The various kinds of thromboembolism are diseases in which an unnecessary clot forms within a blood vessel, obstructing the flow of blood and starving body tissues. Thromboembolism can have serious and even fatal consequences. During pregnancy, estrogen causes an increased level of blood clotting chemicals (called "factors") within the blood serum, creating a condition of hypercoagulability. Blood loss during and after childbirth is greatly reduced by the blood's increased capacity to coagulate.

Hypercoagulability also increases a woman's susceptibility to thromboembolism during and immediately after pregnancy. Estrogen delivered by the Pill causes increased susceptibility of approximately the same degree.

In 1968 three British scientists, M.P. Vessey, R. Doll and H.W.H. Inman presented carefully collected statistics evaluating risks of fatal and non-fatal thromboembolism to women taking oral contraceptives. The excess death rate from thromboembolism was estimated to be 1.3 per 100,000 users aged 20 to 34 and 3.4 per 100,000 users aged 35 to 44. It was also estimated that 47 women in 100,000 users are admitted to hospital every year for non-fatal thromboembolic disease. Among non-users of the Pill, only 5 in 100,000 are admitted every year. When corrected for error, this reveals a nine times greater risk of non-fatal thromboembolism for Pill-users.

A more recent paper presented by the same scientists reveals that the excess death rate is reduced in women using pills containing not more than .05 mg of estrogen, and another recent study revealed the unexplainable finding that the risk of thromboembolism for Pill-users with blood type O is only about one-third as great as the risk to Pill-using women of other blood types.

An American study organized by Philip Sartwell for the U.S. Food and Drug Administration and presented in the 1969 FDA report on the Pill, reveals findings which are approximately the same as the British ones. The Sartwell study also indicates that high dose and sequential pills provide additional risk.

The Pill and cancer: Massive doses of estrogen have been used in gynecology for more than 30 years. No increase in any form of cancer as a result of this medication has been observed.

Estrogen of pregnancy produces cellular changes in the cervix, which look very much like cellular changes of early cervical cancer. After pregnancy, the cervical cells regain their normal appearance. The Pill induces similar cellular changes, and some scientists believe that the oral contraceptive increases the risk of cervical cancer. On the other

RISK OF DEATH WITH VARIOUS CONTRACEPTIVE METHODS

		Women age 20-34 years (1,000,000 users/year)			Women age 35-44 years (1,000,000 users/year)		
Method	Pregnancies	Deaths due to pregnancy	Deaths due to method	Total	Deaths due to pregnancy	Deaths due to method	Total
IUD	30,000	7	unknown	-	17	unknown	
Oral contraceptives	5,000	1	13	14	3	34	37
Diaphragm	120,000	27	0	27	69	0	69
Safe period	240,000	55	0	55	135	0	135
Pregnancy	1,000,000	228		228	576		576

hand, the Pill might provide a protective effect against uterine and breast cancer.

On the basis of presently existing information, no definite conclusions can be reached as to the effects of oral contraception on the incidence of cancer.

The Pill and vascular disease: Estrogen causes blood pressure increase in susceptible women.

There are several recorded cases of "stroke" in women taking the Pill. A stroke is the rupture of a blood vessel leading to or from the brain. High blood pressure increases the chance of stroke. Severe, debilitating headache is a stroke symptom. If severe headache is experienced while taking the Pill, a doctor should be consulted to rule out the possibility of stroke.

Although a significant relationship has not yet been demonstrated, it is believed that risk of stroke is increased, probably only slightly, in women taking the Pill.

The real risks of oral contraception, proven and suspected, must be compared to other health hazards. In Britain, of one million young, pregnant women, 228 die because of pregnancy and post-delivery complications. Maternal mortality is higher in the U.S., especially among non-white, poor people who are butchered in "charity" hospitals. Among one million young Pill-users, 15 die of thromboembolism each year, meaning that the Pill involves an annual risk about 1/15th the risk of one pregnancy. Since there are other birth control methods, not all women become pregnant once a year, but no other method is as effective or as widely acceptable. The diaphragm, for example, carries a 10% to 12% annual failure rate, which means that of one million diaphragm-users, 100,000 to 120,000 become pregnant annually, leading to 23-27 deaths. Contrary to what manufacturers and their paid-off scientists tell us, the IUD has a failure rate of at least 3% per year, and young, never-pregnant women may experience higher rates. Infection and death are not unknown complications of IUD use, although exact statistics have not been determined. Risks of illness or death associated with IUD use or IUD failure (i.e. pregnancy) are probably the same or greater than risks of the Pill.

Most active drugs are dangerous, but it is not the danger of oral contraception that makes it the subject of such special consideration by the media and society in general. The Pill is the first 100% effective contraceptive, the first drug to weaken male society's control over women. Women with control over their own bodies are in a better position to demand and obtain control over their own lives. Male chauvinism can not tolerate such a possibility and searches to introduce a new fear into women.

The dangers of other widely used drugs rarely stimulate as much attention. Everybody uses aspirin, but aspirin is harmful, and should only be used when absolutely necessary. Penicillin is a life-saving antibiotic, but it is also deadly poison for sensitized people. Millions smoke cigarettes, the most advertised, most dangerous and most widely used drug available. Food consumed in North America is contaminated with cancer-producing pesticides and with at least one of the hundred of dangerous food additives, which, by law, need not appear on package labels.

The fact that the Pill is far from the most dangerous of U.S. industry's products reflects no credit on the pharmaceutical corporations. The drug industry, the most profitable business in America, spends on advertisement three times what it spends on research. Research means finding new drugs to patent and make money on, and to get them "past" the FDA. Even though Searle did little research on the Pill before getting FDA approval, oral contraception did not turn out to be the killer it might have been.

All of the long range, and even the short range dangers of oral contraception have not yet been determined; however, deaths from Pill-use will never begin to compare to deaths resulting from inadequate health care, poisonous industrial pollution, dangerous transportation and hundreds of unnecessary, harmful food additives. Use of the Pill should be considered in the light of existing health realities.

Photocell - Clara Gutsche

intrauterine devices

The effectiveness of an intrauterine (within the uterus) device to prevent conception has been known for over 2000 years. Hippocrates, the ancient Greek doctor described a device which was inserted into a woman's uterus through a hollow lead tube passed through the cervix (entrance to the womb). For centuries Arabian and Turkish camel drivers inserted small round pebbles into the uteri of their camels before going into the desert to prevent the camels from becoming pregnant during the long journey.

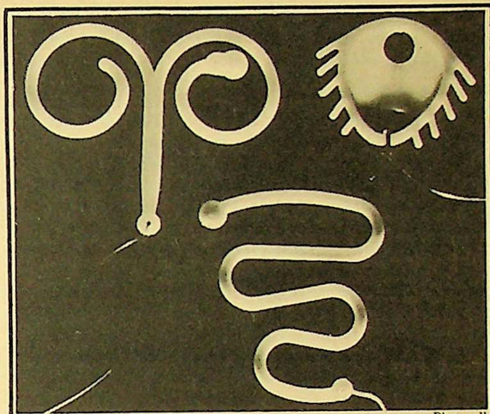
In this century, Grafenberg, a German doctor, reported in 1930 of his use of an intrauterine contraceptive device made of silkworm gut, wound into a ring and inserted into the uterus. Grafenberg's major contribution was the development of a device with a structure such that it remained only in the uterus and was not continuous with the cervical canal or vagina. Similar devices used in the beginning of the 20th century had structures which led into the uterus from the cervical canal. Grafenberg claimed that such structures served as ladders for the upward movement of bacteria from the vagina into the uterus. Devices with such "bacterial ladders" caused a great deal of infection and discomfort for many women.

Because of complications with devices other than the Grafenberg ring, intrauterine contraception was neglected, until in 1959, two doctors working independently reported considerable success with modifications of the original Grafenberg device. Only recently have doctors begun to devote serious attention to IUD's (or IUCD's). It took many years for the medical profession to forget its prejudice against anything lying within the uterus even though reports on the Grafenberg ring made it clear that infection was not a common complication.

Description

Today there are three basic kinds of IUDs: closed devices such as the Hall-Stone ring, the Ota ring, the Zipper ring, the Birnberg bow, and other modifications of Grafenberg's original design; more recently developed open devices such as the Lippes loop, the Margulies coil and the Saf-t-coil; and closed-plane devices such as the Dalkon shield. The open devices and the closed-plane IUDs are safer and easier to insert. Closed IUDs should no longer be used.

Most of the modern, safer devices are made of flexible plastic. The new synthetic plastics are being used for various kinds of human surgery and repair as well as for IUDs since the body does not react to their presence. The malleability of plastics provides an additional advantage - IUDs made of such materials can be straightened out



Photocell

Left: Saf-t-coil; right: Dalkon Shield; bottom: Lippes loop

and threaded into very thin **introducers** (inserters) which can then be inserted into the uterus through the cervix with little or no pain. The malleability of plastic also allows for great latitude in design and may prove very useful in evolving the "ideal design". The plastic tube molded into the IUD design usually has a core of metal salts so that if the position of the device must be determined exactly, an X-ray will reveal the IUD (X-rays only show the presence of dense structures such as bone, metal, or metal salts, but not plastic itself).

The Dalkon shield also contains copper embedded in the plastic for pliability. Whether or not any of the copper escapes into the blood stream is unknown. This question assumes greater significance with the recent announcement of a new IUD, the "copper T" or "copper 7", which has 200 square mm of copper wire wound around the outside of the device. Copper itself has an anti-fertility effect but large quantities in the bloodstream can be harmful. Although G.D. Searle announced the coming of its new IUD with much fanfare and publicity, its public relations department has had little to say since the copper 7 was reclassified by the FDA from a "device" to a "drug" (due to its release of copper). The FDA's reasonable insistence on further study will delay the marketing of this IUD for some time.

Although there is much disagreement as to which is the best IUD available, the Lippes loop (size D, a little more than 1 inch across) is the most widely used. The Lippes loop is preferred because of low expulsion, pregnancy and side effect rates associated with its use. The more recently developed Saf-T-coil is about as safe and as effective as the loop. The Dalkon shield may prove to be the best IUD of all, especially for women who have never had children, but its use has not been sufficiently widespread for accurate comparison. Calcium deposits and endometrial inflammation related to use of the Majzlin spring have caused many

family planning clinics to stop using the device, and to recall all women using the device for a change to another IUD.

Insertion of the device

The insertion of an IUD is usually a simple, rapid, and more or less painless procedure. Before insertion, the woman should be given a complete general and gynecological examination to ensure that no infection is present and that any anatomical abnormalities will not hinder insertion. With a speculum in place, a sterile uterine probe is carefully passed into the uterus to ensure that the cervical canal is not obstructed and to recheck the uterine position. As the diagram shows, the IUD is threaded into a sterile plastic introducer (if it has not already been "loaded"). The loaded introducer is inserted through the cervical canal and is advanced to the lowermost portion of the uterus, just beyond the entrance of the triangular slit-like cavity. Sometimes it is necessary to grasp the cervix with an instrument to steady it before inserting either the probe or introducer. As the cervix is grasped the woman feels a pin-prick sensation, however pain is rarely experienced. Pressure is put on the plunger of the introducer and the IUD is pushed into the uterine cavity where it regains its original shape. The introducer is withdrawn leaving two nylon threads which are connected to the device, protruding nto the upper vagina. The threads are trimmed ɔ that only an inch or two remains beyond the ervix.

An IUD can be inserted at any time during the menstrual cycle, but it is best introduced on the first day of a menstrual period. This has several advantages: the most important is that insertion at that time can not interfere with an early or unsuspected pregnancy since if the woman is still menstruating, she has not yet ovulated that month and cannot be pregnant. Also insertion of the IUD may cause a slight amount of bleeding from the uterus, and this spotting is not an additional problem during menstruation. In addition the cervical canal is open wider during menstruation than during other parts of the woman's cycle.

As soon as the IUD is inserted, it begins to prevent conception. If a woman is changing from birth control pills to an IUD, she may be advised to take the pills for one month longer, since most accidental pregnancies which occur with the IUD, begin during the first month of use. Also, continued use of oral contraceptives reduces the amount of menstrual bleeding or spotting which may be increased during the first month of IUD use.

If the nylon appendage connected to the IUD is properly trimmed, neither the male nor the female is at all aware of the device during coitus.

Insertion of IUDs for women who have not had children

After a woman has a child, miscarriage or abortion, her uterus remains slightly enlarged and her cervix slightly dilated permanently. Many doctors refuse to insert an IUD into the smaller, tighter uterus of a **nulliparous woman** (never been pregnant) because of severe pain which often occurs during and immediately after insertion. Some research is presently being done with various drugs meant to reduce the pain of insertion for nulliparous women. Many if not most women who have never been pregnant also experience some pain from cramps for the first few days after IUD insertion. This pain is sometimes not more severe than that experienced from normal menstrual cramps; in some other cases it can be accompanied by fainting or be so severe that removal of the device is necessary. All nulliparous women have a greater tendency to expel the device spontaneously from their uterus. Failure rates of the IUD are also significantly higher for nulliparous women.

Removal

Removal of devices with nylon "tails" is simple. The doctor pulls gently on the threads extending into the vagina, and the device usually slips out easily. Women should not attempt to do this themselves since occasionally the cervical canal is obstructed or the IUD is lodged in the uterine wall, and an unskilled tug could cause injury. For devices without an appendage, the doctor inserts a small blunt hook into the uterus, catches the IUD, and pulls it out.

Expulsion and required removal of IUDs

The muscles of the uterus run in two different ways (diagonally and transversely) and when the uterus contracts it does so in a rhythmical way. These contractions cause the IUD to be pushed out of the uterus of certain women. At present there is no sure way of knowing which women are likely to expel the device.

Between 10 and 12 percent of all women who receive IUDs spontaneously expel the device in the first year of use. Most expulsions occur in the first 3 months that the device is in the uterus. Expulsions of the IUD usually occur, if at all, during menstrual bleeding. Women using IUDs should check the surface of their menstrual tampons or pads to ensure that the device has not been passed out with menstrual blood. If the IUD has a nylon appendage, the woman should check for its presence after each period and at least once a week. If the nylon thread or beads cannot be felt, the doctor should be consulted and another method of contraception should be used until a new device can be inserted.

If a woman expels an IUD from her uterus she can have another one inserted. The chances that this same woman will expel the device again are very high - 50% of women who receive a second IUD expel it from their uterus.

The Lippes loop, because of its design compresses easily and is least likely to be pushed out of the uterus by a single muscular contraction.

Beyond the 10%-12% of women who spontaneously expel the IUD, another 8% to 10% of women have the device removed because of troublesome side effects which are described below.

Side effects

Minor side effects to the IUD are common but not serious. Usually, these side effects disappear after the first month or two of use, however all side effects

should be reported to the doctor who inserted the IUD.

Side effects include: minor or severe pain similar to pain from menstrual cramps; irregular bleeding during the month (spotting); and very heavy menstrual bleeding for the first few cycles after insertion. The extra heavy bleeding for the first few menstrual cycles following insertion seems to be a common experience. It should be reported to the doctor but it is not serious. Sometimes drugs are prescribed to lessen the bleeding. Pelvic pain and irregular or extra-heavy bleeding account for most of the 8% to 10% of IUDs which are removed either as a result of the doctor's decision or the insistence of the patient. Severe cramps and heavy irregular bleeding seem to be more common in women who do heavy physical work. Should this factor be significant, the widespread "encouragement" of the IUD in Third World countries where women commonly do heavy work may be called into question from the perspective of personal acceptability besides its racist implications.

Serious complications

Pelvic Inflammatory Disease PID - (any infection of the pelvic organs) occurs as a complication to the IUD in 2% to 4% of women wearing a device. Usually, an incident of IUD - related PID is a relapse of some previously existing infection, such as gonorrhea. In such cases, the insertion of an IUD is enough to weaken the natural defences of the uterus, and bacteria which had been kept in check multiply and cause clinical signs of infection. Commonly used IUDs are sterilized before distribution, and sterile techniques are maintained by most doctors during insertion, to reduce the risk of PID. If PID occurs in a woman wearing an IUD, it can usually be treated without removing the device. Women who have had a pelvic infection previous to IUD insertion can safely use a device but must make sure that the infection has been totally eliminated.

Once in approximately 2,500 IUD insertions, the device does not remain in the uterus, but goes through the uterine wall into the abdominal cavity. Such **uterine perforation** is usually the result of error on the part of the inserting doctor or technician; however, some IUDs are pushed through the uterine wall by contractions of the uterine muscles themselves. Whatever the cause, complete perforation of an open device, with the IUD itself floating freely in the abdominal cavity, is not dangerous. Since the body does not react to the IUD, it is usually left where it is. If however, a closed device perforates, there is a risk that it will catch a loop of one of the intestines and obstruct the passage of food or waste material. (This is why closed devices are no longer used). Surgery is always performed to retrieve a closed IUD, should it perforate. Similar surgery must be performed if an open device perforates only half-way, leaving a dangerous, rigid "hook" protruding through the uterine wall.

There have not been any cases reported of cervical or uterine cancer occuring as a result of IUD use. On the basis of presently available information, it can be said that IUDs do not cause cancer.

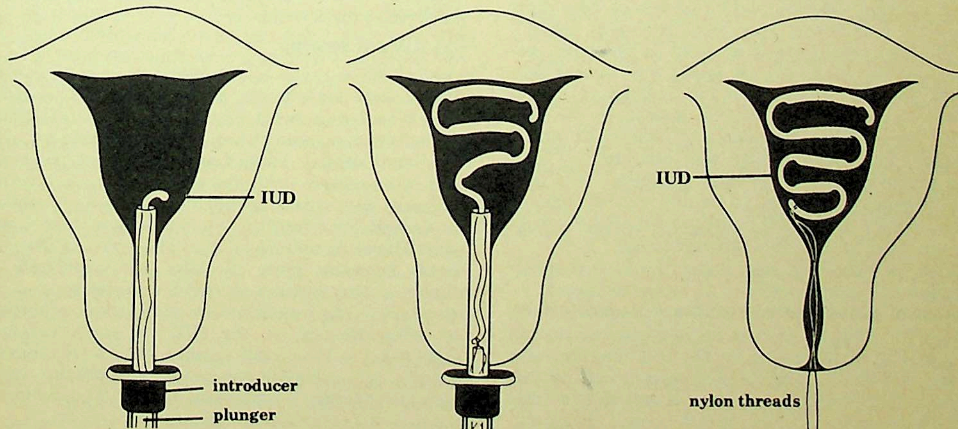
Should an IUD fail and a woman become pregnant with a device still in place, there is no danger to the baby. Usually the device is left in the uterus and is only removed when the baby is delivered. There are no reports of abnormalities in babies born to women with IUDs in place.

How the IUD works

Many conflicting theories have been suggested in attempts to explain the contraceptive action of the IUD. The exact mode of action is still not understood.

One widely accepted theory suggests that the IUD interferes with the dynamic muscular balance of the cervix, uterus and Fallopian tubes. It is suggested that sperm transport up into the tubes and ovum transport down toward the uterus are disrupted by the IUD's effects on uterine and tubal muscles.

Another group of explanatory theories concentrates on cellular changes in the uterine lining, the endometrium. If the cyclic development of endometrial cells is disrupted, implantation of a fertilized egg



is impossible.

One group of theories is primarily biochemical, and suggests that when an IUD is present, the uterine environment is chemically hostile to a fertilized egg.

A recently presented theory suggests that abnormally high concentrations of **macrophages** develop within the uterus when an IUD is present. Macrophages are normal body cells which attack "invading" cells such as bacteria, by **phagocytosis.** (A phagocyte is a cell, such as a white blood cell, that can "swallow" another cell, and thus destroy it). Macrophages normally do not exist within the uterine cavity, and their presence might destroy a fertilized egg.

IUDs do not cause early abortion nor do they prevent pregnancy by creating a low-grade infection in the uterus.

Effectiveness

The efficiency of the IUD is considerably less than the oral contraceptive pill. At best, only 1.5 to 3 women out of 100 become pregnant during the first year after insertion of the IUD. Failure rates tend to decline with further years of use. Many doctors report a contraceptive failure rate of much higher than 3.0. With some devices, up to 8 or 9 women out of 100 become pregnant during the first year after the IUD is inserted.

IUDs are most effective for women who have had several children, and are older than 30 years of age. Age is the more important factor. For example, in one study on the Lippes loop, 5.7% of women 15-24 years old at time of insertion became pregnant within the first year. In the same study, only 4.7% of the women 25-29 years old, and 2.9% of women 30-34 years old became pregnant in the same time period.

Women who must not become pregnant should not rely on the IUD unless abortion is an acceptable and available option.

Acceptability

Considering the 10% to 12% of women who expel the IUD within one year after insertion, the 8% to 10% who must have it removed in that same period, and the 2% to 3% (at least) who become pregnant, the IUD is an acceptable method of contraception for only about 75% of women in the first year. Acceptability goes down to about 50% within 5 years. For those women who can use the IUD, it is probably the best method available - it is safe, easy to use, cheap, does not require repeated action (like taking a pill daily) and does not interfere with the act or enjoyment of sexual intercourse.

With the advent of statistically significant reports linking oral contraceptives with an increased incidence of death and disease from thromboembolic illness, some women have strongly advocated the use of the IUD in preference to the Pill. Failure rates for the IUD of 1% to 2%, and a naive belief that the IUD is "harmless" have been repeated over and over again.

It is absurd to believe that the pharmaceutical and plastic corporations producing IUDs have any more concern for the lives of individual women, than do the pharmaceutical corporations producing the Pill. The IUD is neither harmless nor as effective as the manufacturing companies claim. It is not possible at this point to determine exactly how many women die as a direct result of IUD use (possibly from perforation); it is known however, that many women die during or after normal pregnancy (about 300 per million pregnancies), and that some women using an IUD become pregnant. As a result of contraceptive failure, 30,000 to 80,000 pregnancies occur every year in 1,000,000 IUD users. Thus, in 1,000,000 women using the IUD for one year, 9 to 24 women die as a result of pregnancy, and beyond these deaths, an undetermined number of women die as a result of criminal abortion.

Reversibility

The contraceptive effect of an IUD is completely reversible. When the device is removed the woman can have children again.

The IUD and genocide

The IUD is cheap to manufacture, easy to insert, and in large scale terms is very effective. Not more than 8 to 9 women out of 100 will become pregnant during the first year of use. Women who do not use any contraceptive method usually do get pregnant within one year - 90 women in 100 will become pregnant in one year if they do not try any method to control their fertility. Since the growth of large populations in nations of the Third World (Africa, Latin America, parts of Asia, etc) represents a threat to the power and world dominance of such countries as the United States, considerable attention is being directed at the IUD by these nations. Scientists, working with grants from such organizations as the Population Council, a "private American foundation", supported by the Ford Founda-

tion, John D. Rockefeller III, and other private donors, are attempting to develop more effective IUDs which can be inserted by only semi-skilled personnel. By advocating "voluntary sterilization" and use of the IUD, the governments of the United States, Britain and other western powers are attempting to control by contraception the numbers of non-white people, just as white people from Europe eliminated large numbers of red Indians by importing European diseases for which the Indian had no antibody (immunity) resistance. One important characteristic that the IUD shares with sterilization is that the effectiveness of the method cannot be controlled directly by the individual woman who carries the IUD in her uterus. Both sterilization and IUDs are used much more extensively in countries other than the western nations. Of the 8 million IUDs used, only 1 million are carried by U.S. women. In contrast, of the 18.5 million pill users in the world, at least 8.5 million live in the U.S. and an additional .5 to 1 million in the United Kingdom.

Large scale use of contraceptive measures, applied to women who may not want to control their fertility, approaches genocide and ceases to be birth control.

condom

The condom, a sheath worn on the penis during sexual intercourse, is a widely used, effective, mechanical contraceptive. The condom is also known as: "prophylactic", "rubber", "safe", "French letter", or simply "contraceptive".

Most condoms manufactured today are made of thin, strong latex rubber; condoms made from animal membrane are also available. Rubber condoms are approximately 0.0025 inches thick, 1 inch wide and 7 inches long. At the open end of the sheath the rubber is thicker, forming an elastic ring which keeps the condom from slipping off the penis. The condom is either plain-ended or tipped with a "teat" meant to receive and hold ejaculated semen. There are no "sizes" for condoms, since all are considerably elastic.

Skin condoms, produced from sterile animal membrane, first appeared in England during the eighteenth century. Since the development of the latex rubber process in the 1930's, skin condoms have been largely replaced by the cheaper and equally effective rubber sheaths. The principal advantage of skin condoms is that natural membrane is a better conductor of heat than a film of rubber, and therefore interferes less with sensation.

Skin condoms are packaged in plastic or aluminum capsules containing water, glycerine and a preservative. Rubber condoms are packaged in paper envelopes, cardboard boxes or aluminum foil. Most rubber condoms are sold dry and powdered; but at least one company distributes lubricated rubber condoms sealed between strips of aluminum foil.

Association of the condom with prostitution and prevention of veneral disease has resulted in a reluctance on the part of many men and women to use this birth control method. In addition there exists a widespread misconception that the condom is an unreliable contraceptive when compared to other methods. In fact, statistics reveal that when properly used, the condom is as effective as the diaphragm and jelly method.

The condom method of birth control does have an important inherent disadvantage - it is a contraceptive used by the male partner alone. If the male sexual partner is reliable, and both man and woman accept this contraceptive method, there is no problem; however, not all men are trustworthy, and certainly not at all times. Since it is the woman who bears the consequence of unwanted pregnancy, women are more likely to appreciate the importance of using some form of contraception during all acts of sexual intercourse.

The mechanical nature of the condom also provides potential problems. Some men and women do not like using a "device" during sexual intercourse, claiming it disrupts spontaneity. If this is the sincere feeling of either partner the condom should be avoided. On the other hand, many men and women incorporate unrolling of the condom into the enjoyable routine of sexual foreplay.

Many men claim that the condom dulls sexual pleasure. Physiologically, this claim is highly questionable. Modern condoms are extremely thin and transmit sensation very well. Men who insist that the condom interferes significantly with sexual sensation are usually refusing to accept responsibility for birth control.

The condom does have several important advantages: it is harmless, very simple to use, and easily available. If the male sexual partner is willing to take on the responsibility of contraception seriously, the condom is the best birth control method for occasional or unexpected sexual intercourse.

Aside from contraception, the condom does provide some protection against venereal diseases such as syphilis or gonorrhea.

The condom is probably the most commonly used mechanical contraceptive in North America. Eight hundred million to one billion condoms are sold every year in Canada and the U.S.

Since 1938 the United States Food and Drug Administration (FDA) has supervised the manufacture of condoms. FDA enforcement and automated manufacturing and testing techniques contribute to the maintenance of very high quality levels.

Use

The condom must be worn throughout sexual intercourse since pregnancy can result from an early, unexpected ejaculation. If the condom is not prerolled, it should be rolled just before use. The condom should not be completely rolled up - a half an inch should be left at the closed end to receive ejaculated semen. If the condom being used is al-

ready rolled when purchased (most rubber condoms are pre-rolled), it should be unrolled half an inch. The condom is then unrolled over the erect penis. The half inch space left at the end of the condom (or the "teat", if the condom has one) should be squeezed while unrolling, so that air is not trapped in the closed end. It the man it not circumcised, he must pull back the foreskin before unrolling the condom. Properly unrolled, the condom covers the whole penis, with the half inch extension (or "teat") hanging limply at the end. Care must be taken not to tear the condom with finger nails, rings or any rough object.

When inserting the penis the male should avoid catching the extension or teat on the outside of the vagina, since it is possible to thrust a hole through the side of the sheath if the tip becomes caught.

Occasionally there is insufficient moisture in the vagina to allow for easy entry of the penis, especially if it is covered by a dry rubber condom. Forcing the penis into a relatively dry vagina can be uncomfortable and irritating for the woman. Such problems can be avoided by the use of an artificial lubricant or a pre-lubricated condom. A commercial spermicidal preparation (contraceptive foam, cream or jelly) is a good lubricant to use, since it also provides contraceptive protection. Other non-greasy jellies, such as surgical jelly, can also be used. Of course, saliva is the most readily available and cheapest ubricant of all. **Vaseline or any kind of petroleum elly or oil should never be applied to rubber condoms,** since these materials destroy rubber. Unless a pre-lubricated condom is used, the lubricant is applied to the outside of the sheath after it has been unrolled onto the penis.

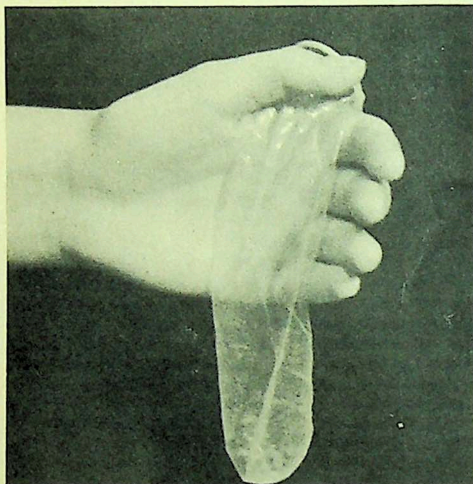
Following male orgasm and ejaculation, there is always a partial or significant loss of erection. As long as the upper open end of the condom remains tight against the penis, sexual intercourse can continue; however, if loss of erection is significant and the condom does not fit firmly against the penis, semen can leak out of the open end, or the condom can slip off the penis, into the vagina. In such cases, the male partner should hold the upper part of the condom tight against the base of his penis, and withdraw from the vagina.

If the condoms slips off the penis, it should be removed from the vagina immediately, with the open end held tightly closed.

The condom is removed by stretching the ring at the open end and pulling down. The condom should be checked immediately after removal. If for some reason the condom has burst, the woman should immediately insert an applicator-full of vaginal spermicide into her vagina, or, if that is not available, douche with water. In such clear-cut cases of contraceptive failure, pregnancy can be avoided if the woman takes a large dose of the female hormone estrogen shortly after intercourse. Such an after-the-fact contraceptive is commonly used for special cases - such as women who have been raped. Although not all gynecologists are familiar with this use of estrogen, many emergency clinics in large city hospitals have estrogen available for this purpose. Estrogen in high doses is a potent drug and cannot be administered casually.

Some doctors suggest that the condom should always be used in combination with a vaginal contraceptive foam, cream or jelly. This extra precaution reduces the chances of conception should the condom break; however, condoms bought from drug stores or pharmaceutical companies can be assumed to be reliable.

Years ago doctors suggested that all condoms be tested before use. Blowing the condom up like a balloon was the most commonly suggested test. Considering present-day quality control maintained by reliable manufacturers, such testing by the user is likely to do more harm than good. With modern condoms, the number of sheaths damaged during testing is usually greater than the number of defective condoms found.



Good quality condoms can be used several times. If the condom is to be reused, it should be dropped into a bedside glass of water after removal from the penis. As soon as is convenient, the condom should be carefully washed in warm soapy water. Rubber condoms should be dried and powdered with cornstarch. Skin condoms can be kept in a mild solution of household boric acid and water. A condom that is reused should be tested for leaks before each use.

If the condom is not to be reused it can be flushed down the toilet.

Condoms should never be kept in a wallet or pocket since the combination of moisture and heat provided by contact with the body deteriorates and eventually rots the condom. Condoms are best kept in the small cardboard containers in which they are usually sold. Without excessive heat or moisture condoms can be stored for up to two years.

Both rubber and skin condoms are meant to cover the entire penis. Another kind of condom, called the "tip condom" or condom cap, covers only the glans of the penis. Tip condoms should never be used since they are likely to slip off after male orgasm.

Cost

Condoms should be bought only from drug stores, pharmaceutical companies or family planning agencies. Those sold in men's washrooms, gas stations or from peddlers are likely to be of inferior quality. Condoms can be bought by anyone, without a prescription.

The most common drug store price is $1.25 for 3 rubber condoms. Lubricated rubber condoms cost about $1.50 for 3. Skin condoms can cost $1.00 or more each. Rubber condoms bought in quantity from manufacturing companies or family planning associations cost 25 to 35 cents for 3.

diaphragm and jelly

The diaphragm and spermicidal jelly method is a relatively popular and effective mechanical form of contraception.

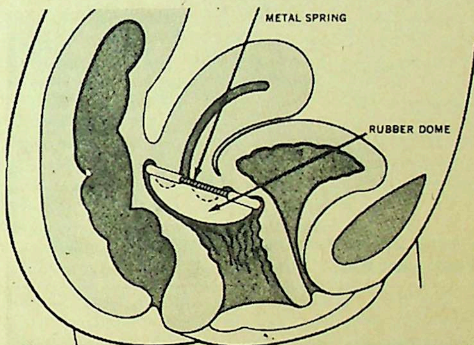
The soft rubber diaphragm with a spring rim is fitted as a mechanical barrier to the cervix, preventing sperm from entering the cervical canal; the front end fits snugly behind the pubic bone, the dome covers the cervix and the back end rises into the posterior fornix, a small pocket beind the cervix. A spermicidal preparation (cream or jelly) smeared on the surface of the device acts as a chemical contraceptive; it kills sperm which pass the diaphragm rim or remain in the folds of the vaginal wall. Some doctors question whether the device actually blocks the cervix or merely serves as a platform for the spermicide. Even so, it is always fitted as a barrier to the cervix.

Medical examination and prescription

Each woman must be individually fitted for the diaphragm by a gynecologist or a family planning clinician. Non-prescription, "one size fits all" diaphragms should not be trusted. A virgin (woman with hymen intact) can be fitted for a diaphragm; however, sexual intercourse stretches the vagina slightly, and she should be refitted shortly after her first act of intercourse. Fitting should be checked at least every two years and after any of the following circumstances: childbirth, miscarriage, any operation (surgery), and a gain or loss of more than ten pounds.

The doctor must perform an internal pelvic examination to choose the size and type of diaphragm most suited for an individual woman. The woman is asked to examine herself internally so that she learns to recognize the edge of the pubic bone and the cervix, important for proper fitting. Then, the doctor inserts a sample diaphragm and asks the woman to examine it in place. She should be able to recognize the cervix through the rubber and the position of the front rim. The woman removes the device by hooking her finger under the front rim, and pulling down and out.

The woman then learns to insert the device herself. A teaspoonful of spermicidal jelly or cream is smeared on the upper surface of the diaphragm (dome up or down, depending on the woman's anatomy). Spermicide must not be placed on the rim since this increases the possibility of displacing the diaphragm during coitus. With one hand, the woman squeezes the diaphragm into a long narrow shape. With the other hand holding the vaginal lips apart, she inserts the compressed device into the vagina until the far rim passes the cervix. She then pushes the front rim up behind the pubic bone and checks that the cervix is completely covered.



Mechanical action of diaphragm

Plastic or metal inserters facilitate insertion, especially for women who have short fingers or dislike handling themselves. The diaphragm is hooked to notches on a rod which the woman inserts into the vagina. When she twists the rod, the device is released. Most inserters have a blunt hook at one end for removal. The rod is hooked to the front rim of the device which is then pulled down and out.

Use

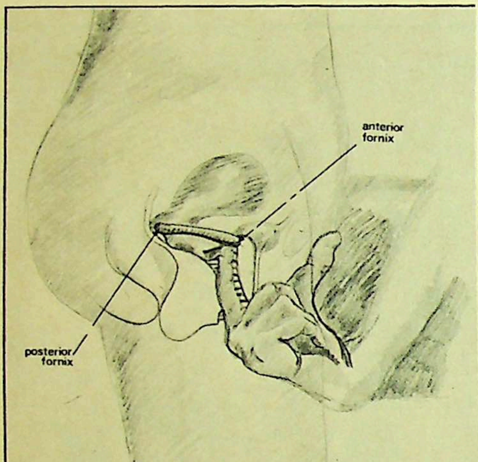
The diaphragm is most easily inserted while crouching, squatting, lying down, or standing with one foot raised.

The diaphragm may be inserted not more than two hours before sexual intercourse. If more than two hours goes by before coitus, an applicator full of spermicide should be inserted into the vagina, or the device should be removed to place more spermicide on the diaphragm's surface. A woman can walk around, bathe, or urinate with a diaphragm in place but she should recheck its position after a bowel movement.

After an act of sexual intercourse, an additional application of cream or jelly must be inserted into the vagina by means of an applicator before each additional coitus.

To ensure that all sperm are destroyed by the

jelly, the diaphragm must remain in place for at least six hours after the last act of intercourse. A facial tissue or towel can be used to absorb any fluid leakage from the vagina. Spermicidal creams and jellies do not stain. After removal, the device should be washed with mild soap and water, dried and powdered with corn starch.



Correct position with rim behind cervix and caught under pubic bone

Douching is unneccessary but if desired must be postponed at least six hours after intercourse.

Occasionally the woman should examine the diaphragm for holes and cracks, especially near the rim. Filling the device with water and checking for leaks, or holding the device to the light are two good tests.

The diaphragm can be used during menstruation; however, conception is highly unlikely at that time.

If positioned correctly the diaphragm cannot be felt by either sexual partner during coitus. Diaphragms made of plastic are available in case of an allergic reaction to rubber. Also, the brand of spermicide should be changed if either partner is allergic to the kind being used.

The diaphragm is ineffective if left in a dresser drawer or purse. However, human frailty is not the only reason for its potential failure. The device can slip out of position for a number of reasons: improper fit, cream on the rim, expansion of the vaginal walls during sexual stimulation, and frequent insertions of the penis. The diaphragm is much more easily displaced in coital positions where the woman is above the man.

Cost

The cost of fitting a diaphragm by a private doctor is about $15 to $25, and considerably less at a hospital or family planning clinic. The device itself, which is obtainable only by prescription costs about $4. A tube which contains about 20 applications costs approximately $3.

vaginal spermicides

The insertion of a sperm-killing chemical into the vagina before sexual intercourse is an ancient contraceptive practice. More than 3.500 years ago an unknown Egyptian writer suggested a mixture of honey and acacia tips (a vegetable gum) as a vaginal spermicide. Through the ages different preparations of harmless substances have been used as vaginal contraceptives.

Today, several simple-to-use vaginal contraceptives are available. These contraceptive preparations are made up of two components: a spermicidal (sperm-killing) chemical and a harmless, bulky base. The spermicide kills sperm cells deposited in the vagina and the base mechanically blocks the cervix, so that even if some sperm cells are not killed, they cannot enter the cervical canal.

In Canada and the United States only three forms of vaginal spermicides are readily available: foams, creams and jellies. Spermicidal foaming tablets and spermicidal suppositories are also marketed but are more difficult to obtain, especially in Canada. Neither foaming tablets nor spermicidal suppositories are as effective as the least effective of the foams, creams or jellies, and therefore should not be used.

The spermicidal foams are more effective in preventing pregnancy than either the creams or jellies. Once inserted into the vagina, the foam spreads quickly and evenly over the cervix, and forms an effective barrier. The creams, and especially the jellies, often fail to spread properly over the cervix and are therefore more likely to fail as contraceptives.

"Messiness" is another problem more often associated with the creams and jellies than with the foams. Many women complain of leakage or dripping from the vagina during or after sexual intercourse while using cream or jelly.

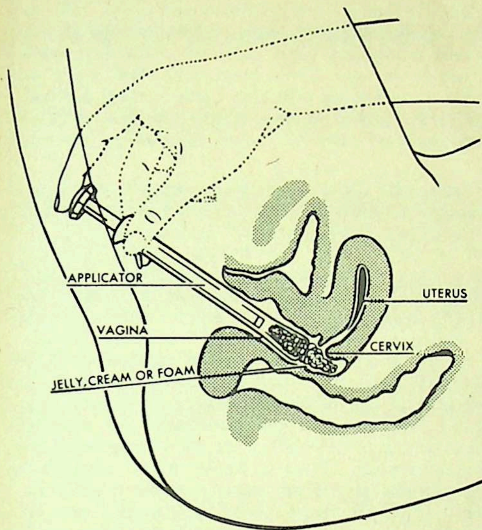
The contraceptive foams are packaged under pressure in aerosol cans or vials while the creams and jellies come in tubes. A special applicator is sold with the can or tube of spermicide.

Two brands of vaginal foam are marketed in North America, and their brand names, "Delfen" and "Emko", have become synonymous with "contraceptive foam". Since vaginal foams are both easier to use and more effective, there is no reason why creams or jellies should be used at all.

All vaginal spermicides have a high failure rate and should not be used by women who must not become pregnant. The vaginal spermicide contraceptive method is not as effective as the diaphragm and jelly or the condom.

Application of spermicidal preparation

On the other hand, vaginal spermicides have sev-



eral advantages. The preparations are harmless, can be obtained from almost any drug store without prescription, do not involve a "device" such as a diaphragm or condom and are easy to use properly. Some couples effectively combine the use of foams with other contraceptive methods such as the condom or rhythm method.

Use

To use the contraceptive foam, a woman first shakes the can or vial and then fills the applicator by pushing the open end of the applicator tube down onto the nozzle of the container. As the foam rises in the tube of the applicator the plunger is pushed up. When the plunger has risen to the top of the tube, the applicator is full. The woman lies down and gently pushes the applicator into her vagina as far as it will go. The woman then pulls the applicator back (out) half an inch and pushes down on the plunger. As can be seen in the diagram, withdrawing the applicator half an inch from the end of the vagina positions the open end of the applicator close to the cervix. When the plunger is pushed, the foam flows out of the applicator next to the cervix.

Applicators which come with creams or jellies can be screwed onto the mouth of the tube. The applicator is filled by squeezing the tube. Otherwise, creams and jellies are used in the same way as foams.

Foams, creams or jellies must be inserted not more than one hour before sexual intercourse. If more than one hour elapses between the insertion of a vaginal spermicide and sexual intercourse, another applicator-full of spermicide must be inserted.

If the woman gets up from bed or goes to the toilet after insertion of a vaginal spermicide but before sexual intercourse, another applicator-full of spermicide must be inserted.

Leaking from the vagina before, during or after sexual intercourse can be controlled by pressing a facial tissue or clean towel against the vaginal opening. Vaginal spermicides do not permanently stain clothing or sheets.

If a douche is desired, it must be delayed for at least 6 hours. Not all sperm cells deposited during sexual intercourse come into contact with the spermicide immediately, and many sperm can live on in the vagina for several hours after the male's ejaculation. Douching cannot remove all the sperm cells from the vagina, but it does dilute and remove most of the spermicidal preparation.

After sexual intercourse, the woman can get up or go to the toilet without affecting the contraceptive action of the spermicide.

After use, the plastic applicator should be dropped into a bed-side glass of water and should be washed eventually in warm soapy water. If the spermicide dries within the applicator, it hardens and sticks to the sides. If this happens, the applicator can be soaked until the spermicide softens. Since the applicator is made of soft plastic, it cannot be boiled.

Side effects

Some men and women are allergic to one or several brands of vaginal spermicides. If allergic irritation occurs a doctor should be consulted and the brand of spermicide changed.

Vaginal spermicides cannot cause cancer or an other diseases.

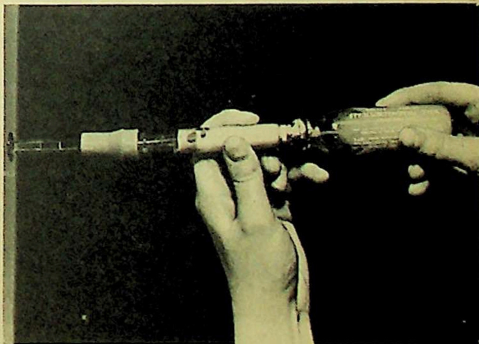
Should a vaginal contraceptive fail, the baby is in no way affected by the spermicide.

Cost

In Canadian and U.S. drug stores contraceptive foam "kits" (including applicator) are sold for $4.00 to $4.50. Refills of the foam alone sell for about 50 or 60 cents less than the complete kit. A can or vial of contraceptive foam contains about 20 applications of the preparation.

Vaginal creams and jellies are less expensive - selling for about $2.50 for a complete kit. There are about 25 applications in a tube of cream or jelly.

Contraceptive foams, creams and jellies can be obtained at lower prices from discount drug stores, hospital pharmacies and family planning centers.



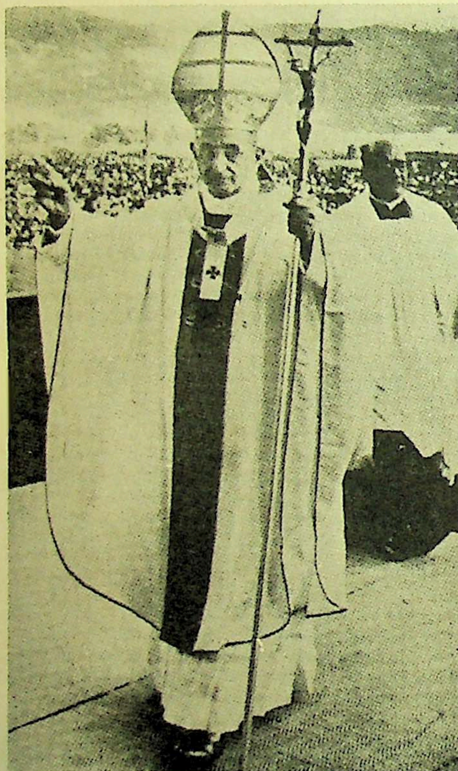
Foam and applicator

rhythm

The rhythm method (periodic continence, safe period, Ogino method) is simply the abstinence from sexual intercourse each cycle on those days when a woman is most likely to become pregnant. Used alone, it is **not an effective birth control method,** but it is helpful in determining the possibility of pregnancy in case of failure of another method.

Women who must not become pregnant should not rely on this method. Also, it should not be used by women who have irregular cycles, especially for any of the following reasons: age (under 22 or approaching menopause), recent miscarriage or childbirth, breastfeeding, or emotional problems. The rhythm method should be attempted only under the guidance of a doctor or family planning advisor.

To be successful, the rhythm method must be accepted by both the woman and her regular sexual partner, if she has one. Otherwise resulting frustration can threaten the relationship, or a sexual encounter may be imposed on the woman when she should abstain. Women whose sexual experiences are sporadic should not depend on the rhythm method, since the fertile period and a particular unexpected opportunity may frequently coincide.



If, then, there are serious motives to space out births, which derive from the physical or psychological conditions of husband and wife, or from external conditions, the Church teaches that it is then licit to take into account the natural rhythms immanent in the generative functions, for the use of marriage in the infecund periods only, and in this way to regulate birth without offending the moral principles which have been recalled earlier.

— From Encyclical Letter of Pope Paul VI Humanae Vitae

Use

To calculate the **fertile period** when pregnancy is most likely, a woman must consider several factors: approximate time of ovulation, life span of sperm cells, and life span of the egg. Ovulation occurs at the middle of the cycle, usually about 14 days before the onset of the next menstrual flow. Therefore conception is least likely at the beginning and end of a woman's cycle, and most likely at mid-cycle. Sperm can survive in a woman's body for about 48 hours after ejaculation; the egg lives only about 24 hours after ovulation. Therefore, a woman using the rhythm method must not have sexual intercourse from 2 days before the earliest chance of ovulation until one day after the latest possible chance. This fertile or "unsafe" period can be calculated in several ways.

The calendar method

This method of calculation assumes that ovulation occurs approximately 12 to 16 days before a woman's next menstrual flow. Also, intercourse must be prohibited 2 days before this 5 day span and 1 day afterwards to account for sperm and egg survival. For a woman with a regular menstrual cycle, the total period of abstinence **(theoretical fertile period)** is always 8 days long.

Most women are not always regular; the length of the cycle varies one or several days in either direction. In order to use the rhythm method without error, a woman must first keep a record of her menstrual cycle for 8 months, using some other birth control method at this time. Marking the first day of the menstrual flow as day 1, a woman records the length of each cycle. After doing so for 8 cycles, she calculates the unsafe period for the 9th cycle as

THE RHYTHM METHOD

HOW TO FIGURE THE "SAFE" AND "UNSAFE" DAYS

LENGTH OF SHORTEST PERIOD	FIRST UNSAFE DAY AFTER START OF ANY PERIOD	LENGTH OF LONGEST PERIOD	LAST UNSAFE DAY AFTER START OF ANY PERIOD
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

Time-Life

follows: subtract 18 from the length of the shortest cycle to find the first unsafe day; and subtract 11 from the longest cycle for the last unsafe day. A woman must not have intercourse from the first to the last unsafe day. The chart above calculates the fertile period for cycles of varying lengths.

A woman must continue to record the length of each cycle and base her calculations on the **most recent** 8 cycles. Thus, the unsafe period for the 10th cycle is based on the shortest and longest cycles between the 2nd and 9th cycles; for the 11th, it is based on those between the 3rd and 10th cycles; and so on.

The temperature method

A woman's body temperature is higher during the second part of her menstrual cycle. Progesterone, released by the corpus luteum after ovulation, causes a rise in body temperature. Also, a temperature drop occurs about 48 hours before ovulation, although this drop is not always as noticeable as the following rise. Thus temperature change as an indicator of ovulation can be used to determine the unsafe period.

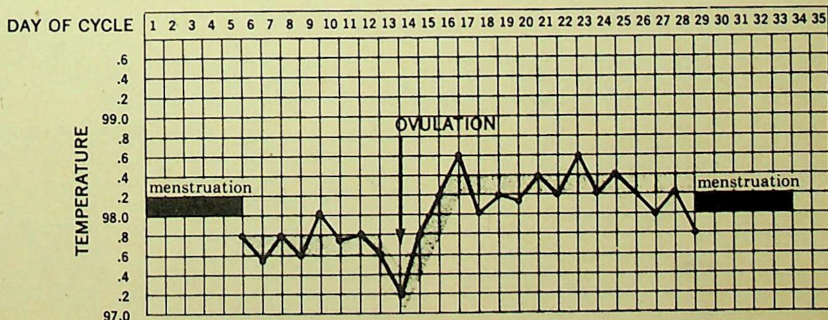
Since body temperature also varies with daily activity, a woman takes her temperature before getting out of bed or beginning any activity each morning. This is known as the **basal body temperature** (BBT). Special thermometers with fine gradations are available for this purpose.

To familiarize herself with her typical cycle, a woman records her basal body temperature daily as shown in the chart for at least six months beforehand. She notes any other factors, such as a cold or restless night, which might affect the morning's temperature. She continues recording the BBT as long as she uses this method.

The **absolute fertile period** is calculated from day 5 of the cycle (onset of menstruation is day 1) until 3 days after the rise in basal body temperature. This is the unsafe period when sexual intercourse is prohibited, according to the temperature method.

Calendar-temperature method

The absolute fertile period calculated by the temperature method can be quite long, depending on a woman's cycle. The combination of the calendar and temperature methods often shortens this unsafe period. Also, if the basal body temperature is affected by other factors such as illness, a woman can rely on the calendar method for that cycle if she has kept an accurate menstrual history. In the combined method, the first unsafe day is calculated from the shortest cycle (using the chart provided); and the last unsafe day is the third day after a noticeable rise in the basal body temperature.



coitus interruptus

Coitus interruptus, also known as "withdrawal" or "being careful" is the oldest method of birth control still commonly used today. Withdrawal is mentioned in Genesis, the first book of the Old Testament, written about 3,000 years ago.

Coitus interruptus is difficult to use properly and has a very high failure rate. Women who must not become pregnant should not rely on their partner's use of this contraceptive technique.

Use

"Coitus interruptus" means interrupted sexual intercourse - a good description of this contraceptive technique. When coitus interruptus is used, sexual intercourse continues until just before the male orgasm. When the male feels his ejaculation coming on, he withdraws his penis from his partner's vagina and external genitalia before ejaculating.

It is important that the male withdraws his penis completely and ejaculates **away** from his partner's vagina. Sperm cells can move on their own, and if deposited anywhere between the labia majora (external vaginal lips) they may be able to continue up the vagina and into the uterus. Contrary to common belief, more than just one particular woman has become pregnant while still virginal. The hymen need not be broken before pregnancy can occur.

Sexual intercourse can be resumed after the male's ejaculation, if the male can maintain an erection. The tip of the penis should be carefully wiped, and if the man is not circumcised, the foreskin should be withdrawn and the penis wiped again.

As a contraceptive technique, coitus interruptus has several inherent defects. Most importantly, it is the male partner alone who determines the contraceptive effectiveness of the method. Not all men are trustworthy, and few can be depended upon at all times. The assurance, "I'll be careful" means nothing to a woman who knows that her partner will not physically suffer the consequences should a "mistake" occur.

Not all men are physically able to use coitus interruptus successfully. Effective coitus interruptus, involving withdrawal before ejaculation, requires the man to be aware of when ejaculation will occur; however, complete ejaculation in a single emission (one powerful gush) is the ejaculatory pattern in not more than 50% of men. The other half of the male population usually expels semen sporadically or in a slow stream. Whether such men are aware of the exact moment when semen first begins to escape, or whether they feel only the last portion of the ejaculation is not known.

Aside from ejaculatory pattern, men differ as to timing of ejaculation. About 50% of all men ejaculate within 2 to 5 minutes after the beginning of sexual intercourse, while the other 50% can continue coitus for 5 to 20 minutes before reaching orgasm. Men who ejaculate within 5 minutes of the beginning of coitus have more difficulty withdrawing from the vagina properly.

Both men and women face still another physiological obstacle when attempting to use withdrawal. As orgasm approaches, men and women experience mild to extensive loss of consciousness during which coital movements lose their voluntary character. This condition can last several seconds, and a conscious action such as withdrawing the penis can be impossible. If intercourse continues uninterrupted for too long, one or both of the sexual partners may slip into this semi-conscious stage, and forget about withdrawal.

Side effects

For many years some doctors, especially those who opposed birth control in general, warned of possible ill effects of coitus interruptus. Modern medical and statistical research has revealed that coitus interruptus is physically harmless.

Psychologically, on the other hand, withdrawal can lead to problems, especially for women. In Western societies most women take longer to reach orgasm during sexual intercourse than their male partners. Therefore, coitus interruptus often involves interruption before a woman can reach orgasm. If the male partner can maintain an erection after ejaculation, sexual intercourse can be resumed; however, not all men can or want to continue coitus. Withdrawal thus often means frustration for the woman unless masturbation or clitoral manipulation brings the woman to orgasm.

Aside from the simple factor of timing, the woman may fear, often justifiably, that the male will not withdraw his penis before ejaculating. Concentrating on the possibility of an unwanted pregnancy is not conducive to sexual enjoyment and orgasm.

Men can also experience psychological or sexual problems related to coitus interruptus. If the man sincerely wants to protect his sexual partner from pregnancy he may find himself in a constant state of fear throughout the sexual act, afraid that withdrawal at the right time will not be possible.

For all the problems associated with coitus interruptus, this contraceptive technique is not without its advantages. Withdrawal costs nothing and is always available. The consistent use of coitus interruptus does reduce the frequency of pregnancy. Even so, given the existence of cheap, easily available mechanical, chemical and hormonal contraceptives, coitus interruptus should no longer be considered a valuable birth control alternative.

other methods

So-called contraceptive methods which are, for all practical purposes, ineffective need not be considered extensively by this handbook. These methods include: immediate post-coital douching, total self-restriction of female orgasm known as "holding back", prolonged nursing, and coitus reservatus.

There are serious drawbacks to use of the douche as a contraceptive method. If there is to be any possibility of effectiveness for conception control, the douche must be used immediately after intercourse – an unpleasant interruption for the woman. More significantly, at that time, the pressure of the douche might easily force concentrated sperm into the cervical orifice; sperm could very well continue and effect fertilization. On the other hand, if the pressure of the douche is inadequate to distend the vagina, sperm remain untouched in the vaginal crevices. For these reasons the douche should not be considered a contraceptive method, and must not be used for conception control.

It should be noted that too frequent douching is harmful since it destroys protective bacteria in the vagina.

The strong coal tar "feminine hygiene" disinfectants should never be used. If not mixed properly, they will burn the tissues.

It is a relatively common belief that if the female partner "holds back" and does not permit herself to achieve orgasm during coitus, pregnancy is impossible. This belief is based on the misconception that women, like men, ejaculate in orgasm a substance that is necessary for fertilization. While it is true that there is a release of fluids when a woman reaches sexual climax, these fluids simply facilitate the swimming movement of sperm. In the partial absence of these secretions (absence is never complete), sperm can still reach the Fallopian tubes and fertilize an egg. There have been many pregnancies in women who have never had orgasm.

There is no truth to the belief that as long as a woman is nursing a baby she cannot conceive. Because of hormonal balances, during early months of breast feeding ovulation may be delayed, but this protection does not last long, nor is it reliable.

The practice of coitus reservatus is similar to coitus interruptus (withdrawal). The essential difference is that whereas in coitus interruptus the male partner does not allow himself to achieve orgasm and ejaculate within the woman's body, in coitus reservatus there is no ejaculation. The male does not withdraw, but remains in sexual contact during the female partner's orgasm and gradually his erection subsides. Such control for an hour or longer, it has been reported, requires training; further it is highly probable that some sperm will escape through the erected penis even though the male partner does not ejaculate. The control that is necessary for utilization of coitus reservatus as a contraceptive method cannot be maintained by many men. The same psychological and physiological arguments against coitus interruptus are directed against coitus reservatus.

Photocell: Clara Gutsche

sterilization

Sterilization, a surgical procedure for the permanent prevention of conception, is usually advised in the following situations: when pregnancy could endanger a woman's life or health; when the parents have already produced a child with an inherited nervous or physical disease, such as hemophilia; where physical, mental or emotional factors prevent the couple from caring for another child properly; when a couple considers their family complete and wishes absolute protection from pregnancy. Although hospital policy varies, most regulations assume childbearing is essential to every woman's life. It is often difficult for women with few or no children to obtain permission for sterilization.

Female sterilization

A woman can be sterilized by the surgical removal of any of the reproductive organs: ovaries (oophorectomy), uterus (hysterectomy), or Fallopian tubes (salpingectomy). Since simpler methods of sterilization exist, these methods are not used unless the tissue is damaged or diseased.

The most common method of female sterilization, **tubal ligation,** which involves tying off the Fallopian tubes, effectively prevents an egg from reaching the uterus, and the sperm from travelling into the tube. The woman continues to ovulate and have menstrual bleeding each cycle.

To perform the operation, an incision is made in the abdominal wall and the tubes brought into view one at a time. The tubes are cut, usually close to the uterus, and the separated ends are tied or stapled closed.

The operation may be performed within 12 hours after normal delivery, when the uterus is enlarged and the tubes are easily reached. After cesarean section the operation is done after repairing the uterine incision. In either case, the procedure hardly lengthens the hospital stay.

When a woman has not been pregnant for several months, sterilization may be performed abdominally, as discussed above, or by making an incision in the vagina through which either tubal ligation or hysterectomy can be done. The operation is done under general anesthesia.

Tubal ligation has a failure rate of about 1 in 250 cases (somewhat higher after ceserean section). Less than 50% of the attempts at reversibility have been successful.

Tubal ligation under "laparoscopic control" is a more modern sterilization technique. A tube containing a tiny electric bulb is passed through a small incision in the abdominal wall. Carbon dioxide gas is pumped into the abdominal cavity. With the cavity bloated, the pelvic organs can be easily seen. The surgeon passes special instruments through the lighted tube, grasps the Fallopian tubes, "burns" them with an electric current, and cuts through them once they are hardened. This procedure is less traumatic than major abdominal surgery, and some hospitals discharge women the same day of laparoscopic sterilization.

Male Sterilization

Sterilization may be performed on the male in two ways. **Castration,** removal of both testicles, is never done on normal individuals because it produces impotence and eliminates sexual desire, as well as affects secondary masculine traits. It is considered only in the case of serious diseases such as cancer or tuberculosis.

The most common method of male sterilization, an operation known as a **vasectomy,** has no effects on a man's sexual desire or virility, except perhaps to enhance it by relieving him from fears of having another child. The operation involves severing the vas deferens, thereby preventing the passage of sperm from the testicles to the penis. Since the contribution of the testes accounts for only about 1/10 of the volume of the total ejaculate, the actual quantity of seminal fluid is not appreciably diminished.

A small incision is made in the upper and lateral region of the scrotum, directly over the spermatic cord. The cord itself is cut and the vas deferens is separated from the blood vessels and nerves. Two ligatures are put a small distance apart around the vas deferens and the portion between them is cut out. The incision is closed with sutures and a temporary dressing applied. The entire operation done either in a hospital or doctor's office takes approximately 20 minutes. Men are sometimes advised to wear a suspensory for a few days to hold the testicles up so that traction on the wound is not painful.

Male sterilization cannot be depended on for contraception for the first three weeks after vasectomy, during which time sperm produced before the operation may still be present in the semen. After this time a semen specimen is examined under a microscope to check for the complete absence of sperm. In about 1% of the cases the severed ends of the vas deferens grow together and continue to transport sperm. Therefore it is advisable to have a semen specimen examined about every six weeks for the first six months after which such precautions are no longer necessary.

Attempts to restore fertility after a vasectomy have been successful in only about 50% of cases. Reversible methods are being sought such as use of a silicon injection which hardens to form a removable plug.

Sterilization operations were performed by Nazi doctors on Jews in World War II. Today, the United States legal system manages to sterilize "welfare mothers" (usually black people) who have had illegitimate children. In Delaware a Senate committee recommended that welfare mothers with 2 or more illegitimate children should be sterilized. In New York, judges offer women the choice - either be sterilized or receive no more welfare.

Like the IUD, sterilization is used more extensively in Third World nations. Since male vasectomy is a quick, simple operation, it is considered invaluable in the control of Third World populations. In India where vasectomies are performed in train stations, 5,500,000 have been "voluntarily sterilized". Pakistan is initiating a program to sterilize 50,000 men a month.

André Giguère

i see soul pain eyes
hidden in blue shadow
fur lashes deny the real
hair / acceptable above the brow
not below the knee
  i see your eyes, sister
  i see your soul
you call your breasts wrinkled lemons,
hide them under 1/2 inch foam, learn
to like your thighs only to hear
you have ugly feet.
how long will we listen to men
who tell us they love us?
who call us frigid or maniac & turn away?
how long will we stand as dolls on a shelf
  buy me   buy me
  one house & i'm yours.

  i'm *mine,* sister.
  how about you?

alta
Letters to Women

effectiveness

The pregnancy rate for any period of time during which a particular birth control method is used is an expression of the failure rate of that method. The **Pearl formula** is a standardization of contraceptive failure rate.

$$1300 \times \frac{\text{total number of conceptions}}{\text{total months of exposure}} = \text{failure rate per 100 woman years of exposure}$$

The above formula assumes that ovulation occurs 13 times a year, thus providing 13 chances for conception. Thirteen is multiplied by 100 to provide an easily definable "per cent" figure - thus 1300. "One hundred woman years" standardizes the pregnancy rate in terms of the number of times conception is possible during a year's period of exposure. The formula assumes regular heterosexual contacts, no intervening pregnancies or periods of breast feeding, and ovulation during each menstrual cycle. Thus, if 60 women use one contraceptive method for 10 months, and five conceptions occur, the formula would reveal a failure rate of:

$$0 \times \frac{5}{600} = \text{almost } 11\%$$

Two different failure rates are often provided for each contraceptive method, "theoretical failure rates" and "clinical failure rates". The theoretical failure rate reveals the effectiveness of a method if it is used absolutely consistently and according to instructions. The clinical failure rate states the effectiveness of a method used under average conditions by average people. The theoretical rate can be accurately determined for only two contraceptive methods - the Pill and the IUD. With the Pill, it is possible to objectively determine if a woman has taken one pill every day for 21 days in a cycle; and with the IUD it is similarily possible to objectively determine if the device is in place in the uterus. Since all other contraceptive techniques are not totally divorced from the sexual act, it is not possible to make objective observations as to the consistency or accuracy of personal use.

In the chart, theoretical failure rates and clinical failure rates are presented only for the oral contraceptive and the IUD. For all other methods, only clinical rates are provided. Listings are approximations, and are subject to great variation. A listing should be read:

". . . . . pregnancies in 100 women using the . . . . method for 1 year".

When considering the meaning of effectiveness statistics it should be remembered that the most important variable is "individual failure". Oral contraceptives can be 100% effective; however this is meaningless if a woman forgets to take 1 or more pills. Similarly, the condom theoretically provides

Method	Theoretical failure rate	Clinical failure rate
Oral contraceptive (combination pill)	0	.05
IUD	1.5 - 8	1.5 - 8
Condom		10 - 15
Diaphragm and jelly		10 - 20
Vaginal spermicides		15 - 25
Rhythm method		15 - 30
Coitus interruptus		20 - 30

100% protection against conception. The chart above reveals, however, that an average failure rate for the condom is 10 to 15 per year. In terms of effectiveness, the main difference between the oral contraceptive and the condom is that the former provides many fewer opportunities for individual failure than does the latter.

When choosing a contraceptive method, personal beliefs, preferences and hang-ups must be considered, since they affect "individual failure". If a woman is afraid of the oral contraceptive, it is likely that she will "forget" a pill every so often. If a man believes that a condom dulls sexual sensation, or if he really does not care whether or not his partner becomes pregnant, he may occasionally "forget" to wear the sheath.

C. David Gutsche

new methods

The continuous progesterone pill ("mini-pill")

Estrogen is responsible for most side effects associated with the Pill. Experiments are being performed with an oral contraceptive which contains only .05 mg of a potent synthetic progesterone in the daily pill. One pill of a progesterone oral contraceptive series is taken every day, in contrast to the 3 weeks on, 1 week off regimen of the estrogen-progesterone pill. The "minipill" eliminates side effects and endocrine changes caused by estrogen. Unfortunately it is associated with another set of side effects resulting from the absence of estrogen. Estrogen as a component of the combination Pill regulates the user's cycle, and helps prevent ovulation. When progesterone is used alone as an oral contraceptive, menstrual cycles are disrupted, and ovulation still occurs.

Chlormadinone acetate (CA) is the most commonly used progesterone in minipill preparations. CA is highly anti-estrogenic, and causes localized changes in the genital tract making conception unlikely. When a woman is taking a continuous progesterone contraceptive, mucus in the cervical canal becomes thick and impenetrable to sperm. Progesterone also disrupts the cyclical development of endometrial cells, making the whole endometrium unreceptive to a fertilized egg. Even so, pregnancies do occur in women taking the progesterone-only pill. Although scientists working for pharmaceutical companies claim otherwise, the minipill's failure rate is at least 5 to 6 a year.

To be effective, the minipill must be taken at the same time every single day without fail. To forget even one pill can expose a woman to pregnancy.

The minipill is unacceptable to many women because of its high failure rate and high incidence of extremely irregular menstruation. If these problems can be eliminated, the minipill might replace the estrogen-progesterone preparations.

Several chlormadinone acetate preparations have already been on the market in England and Canada. These pills were withdrawn in England because longterm tests revealed the development of breast nodules (tumors) in female dogs given CA for several years. The significance of these findings is questionable, since dogs metabolize sex hormones differently than do humans or monkeys. Breast nodules have not been observed in monkeys treated with CA, nor are the breast nodules discovered in bitches clearly cancerous. Further experiments will probably result in the return of CA products to the general market.

The "morning-after" pill series

An effective, after-the fact oral contraceptive has been available for several years. To prevent pregnancy resulting from an unprotected act of sexual intercourse, 25 mg of a natural estrogen, "stilbestrol" is taken by the woman for 5 days. To be effective, this series must be started no later than

André Giguère

24 hours after intercourse. Stilbestrol works by interfering with the action of progesterone at the uterine lining: apparently stilbestrol causes a reduction of a progesterone-dependant enzyme called carbonic anhydrase, which is essential for implantation of the fertilized egg.

Large doses of stilbestrol often cause severe vomiting and nausea. Such side effects are easier to tolerate than an abortion, even one performed under ideal conditions. Since large doses of estrogen cause many undesirable metabolic changes, use of the morning-after pill should be restricted to special cases such as rape victims and victims of observable contraceptive failure (e.g. a burst condom). Stilbestrol has been used in gynecology for about 40 years, and most gynecologists have supplies on hand.

Progesterone injections

Injections of 150 mg. of a potent, long acting progesterone have been used as a contraceptive technique for several years. Unlike the progesterone only pill, the injection method is usually 100% effective. The synthetic progesterone used probably causes an oversuppression of the hypothalamus, blocking the secretion of LH. It can take 12 to 21 months after a progesterone injection for the hypothalamic suppression to wear off, although 100% protection against conception is only provided for 3 months. Many scientists believe that in some cases hypothalamic suppression induced by progesterone injection may never wear off, leaving a woman sterile.

Progesterone injections have not been widely used in Canada and the U.S. The majority of experiments have been performed on non-white, poor women, living in Third World nations. Since the possibility of permanent infertility is rarely explained to such women, experiments with progesterone injections often constitute non-voluntary chemical sterilization programs.

The progesterone injection technique is associated with a high incidence of extremely irregular menstruation. If this side effect, and the possibility of sterilization can be eliminated, the injection technique would be a good contraceptive.

Silastic implantations

Another progesterone-only contraceptive technique being experimented with widely on Third World women involves the implantation, under the skin, of a tiny plastic "pillow" filled with progesterone. Silastic, used in making the pillow, releases progesterone at a slow continuous rate. To implant the plastic capsule, which is about as big as a pencil tip, a small area of skin on the inside of a woman's arm is locally anesthesized. A large bore needle carrying the capsule is then injected leaving the capsule under the skin. The capsule can be removed in a similar way.

Side effects associated with this method are similar to those complicating use of progesterone injections.

Silastic intravaginal-ring

This is a highly promising method. A silastic ring, of about the same diameter as a diaphragm, and filled with a synthetic progesterone, is inserted into the vagina on the first day of menstruation. When properly placed, the ring cannot be felt by the woman or her sexual partner. The ring is left in the vagina for 21 days and the progesterone which is absorbed into the blood stream through the vaginal walls, has a localized effect on the genital tract. After 21 days, the woman removes the ring, and menstrual-like bleeding begins a few days later. Preliminary reports on this method indicate low side effect levels and regular menstruation.

The once-a-month pill

A more convenient form of the combination oral contraceptive is under investigation. A form of ethinyl estradiol (estrogen), which is picked up from the digestive system and stored in fat cells, is used in combination with a long acting synthetic progesterone. Effectiveness of this pill appears to be high and side effect levels low; however, the hormonal balance of this pill is estrogenic. Anti-estrogenic oral contraceptives are associated with a lower incidence of metabolic changes and serious complications, and so the future of this method is questionable.

Pill for men

Experiments with several non-hormonal drugs used to prevent sperm production have not yet been very fruitful.

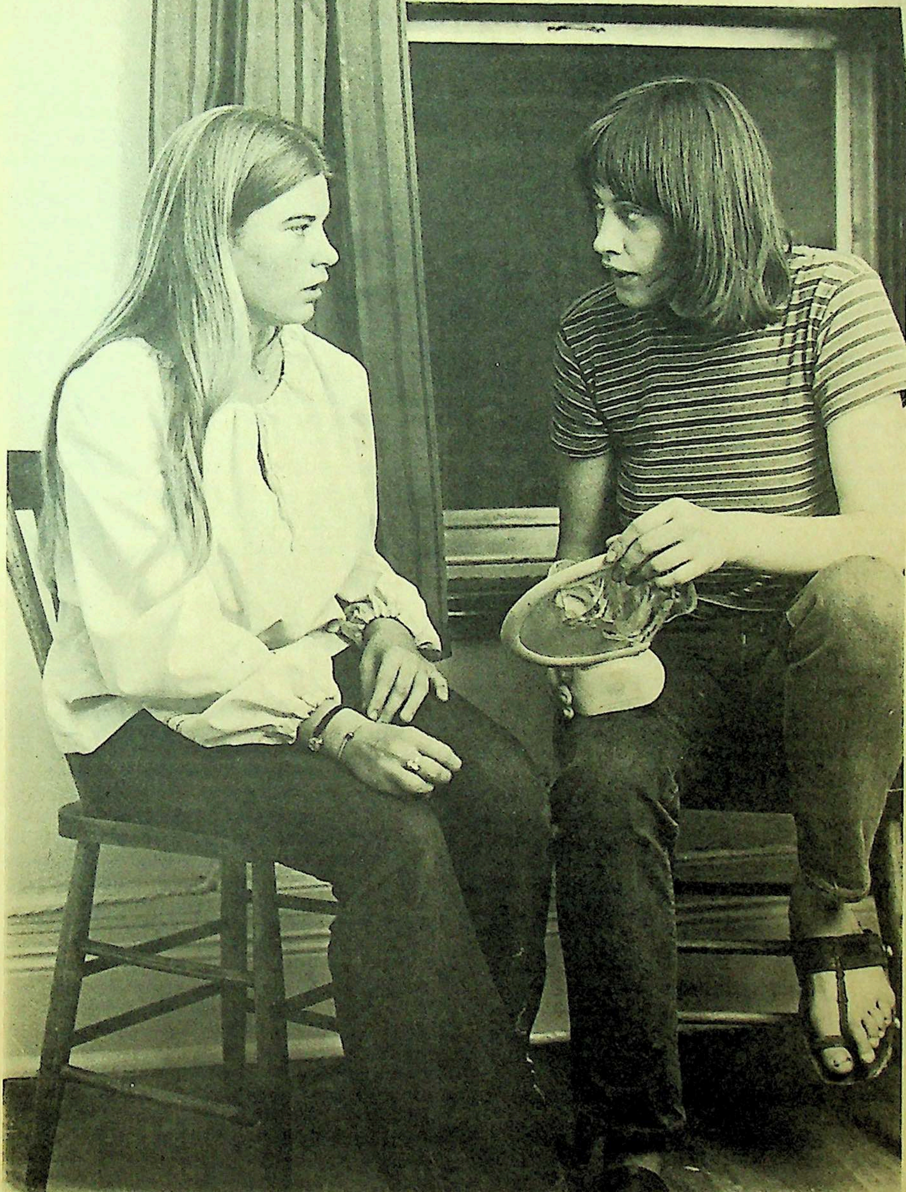
Vaccinations

When the body is "invaded" by a toxic chemical or disease organism (e.g. bacteria) white blood cells and specialized blood serum chemicals attack the invader. In the course of the subsequent biological battle, the body's defences become specialized against the particular invading chemical or organism. This specialization process, called the development of immunity, is highly complex and hardly understood. If the same chemical or organism attacks again, specialized "antibodies" carried by the blood serum, destroy the invader without exhibiting disease symptoms.

It may be possible to immunize ("vaccinate") a woman against a particular man's sperm. Sperm cells are actually invading bodies; however, they are not normally attacked within the female body since they do not, under normal circumstances, induce immunization. If a woman could be immunized against sperm, antibodies would attack and destroy sperm cells when they enter the Fallopian tubes.

Not all antibodies are maintained for the whole life of the organism. For example, smallpox antibodies "wear out" in a few years, and booster shots are needed to redevelop immunity. Vaccination against sperm need not be permanent, and various techniques could be used to determine when re-immunization is necessary. If the vaccination method can be perfected, it would be preferable to hormonal contraception.

abortion



Photocell - Clara Gutsche/David Miller

Vacuum Curettage

This modern method of abortion, also called **uterine aspiration,** was first developed in China. It has become the method of choice for abortions up to the 12th week of pregnancy since it can be done quickly, with little blood loss, minimal anesthetic and a low risk of complications. It can easily be performed in a doctor's office or in an outpatient clinic.

In preparation for a vacuum curettage, the woman should not eat for three hours before the operation to avoid vomiting and the dangers of choking. She should bathe the day of the operation. Shaving of the pubic hair is not necessary.

To begin the procedure, the doctor (or paramedical specialist) conducts an internal examination to verify the pregnancy and check the angle of the uterus. A speculum holds the walls of the vagina apart throughout the operation. A uterine sound is passed through the cervical canal into the uterus to ensure that the canal is not blocked, and to estimate the measurements of the uterus.

A local anesthetic is sufficient to block pain occurring during the operation. The most commonly used form, the **paracervical block** is also used frequently during childbirth. The chemical (xylocaine or carbocaine) is delivered by injection at the back of the vagina behind the cervix. The injection itself is not painful. Nerves leading from the cervix are numbed by the anesthetic, and sensation from the uterus and especially the cervix is "blocked" before it reaches the spine.

The cervical canal must be dilated (widened) to permit the introduction of surgical instruments. This can be done in a number of ways. In the traditional method, the doctor passes a series of increasingly larger polished metal rods (Hegar's dilators) into the cervical opening. The first is about the width of a thin soda straw, and the last is about the width of a finger. The cervical tissue stretches more easily in women who have had children. Although the anesthetic blocks severe pain during cervical dilation, women sometimes feel cramps similar to menstrual cramps. Dilation of the cervical canal can also be accomplished by an instrument with two rounded tips which are inserted into the canal; by applying pressure to the handle, the tips separate, causing the tissue to stretch. This expansion technique takes only several seconds but occasionally it is more uncomfortable than Hegar's dilation.

Some doctors prefer to dilate the cervix with a "vibrodilator" which attaches to some vacuum operating units. Vibration of a soft metal cone held in the cervical canal dilates the canal almost instantly to an exact size; however, many doctors continue to use one of the older methods of dilation since the vibrodilator makes a loud noise which can be upsetting to the patient.

Once the canal is dilated, the doctor inserts a hollow tube called the **vacurette** into the uterus until it touches the amniotic sac. The vacurette is connected by transparent plastic tubing to a collection bottle. The vacuum pressure is turned on for 20 to 40 seconds, and the doctor observes the passage of fetal and placental tissue into the collection bottle. When the uterus is emptied, the doctor feels a slight tug on the vacurette. In order to ensure that no placental tissue is left in the uterus, the doctor goes over the uterine lining with a curette as in a D. & C. This is especially important in pregnancies close to the 12 week limit, and when the uterus is positioned abnormally. The entire operation takes about 5 to 10 minutes.

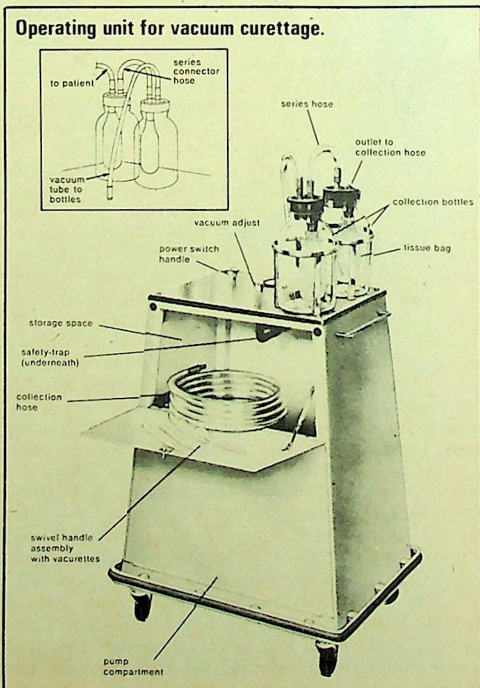
Recuperation from vacuum curettage is almost immediate. Some women want to lie down for a few minutes, others have cramps similar to menstrual cramps, and still others feel perfectly normal. Women who get up from the operating table too quickly sometimes faint.

A woman will have menstrual-like bleeding for a day to a week after an abortion. She may use either pads or tampons, whichever she prefers.

The first real menstrual flow begins 3 to 6 weeks after the abortion. Since it is difficult to tell exactly when she becomes fertile again, a woman must consider herself subject to another pregnancy immediately, and begin to use some form of birth control. A woman who wishes to use oral contraceptives must take the first pill of a series within 5 days after the abortion; otherwise she must wait until her next menstrual flow.

A woman must not douche after an abortion. The cervix remains slightly dilated and a douche can force fluid into the uterine cavity.

Operating unit for vacuum curettage.



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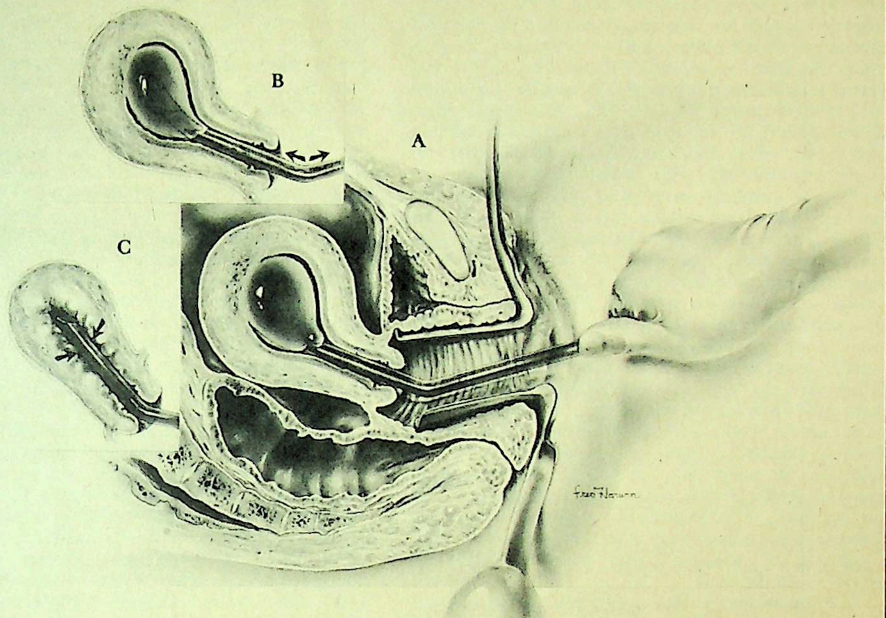

Berkeley Tonometer Co.

Vacuum curettage: A. vacurette inserted through cervical canal; B. suction turned on, material flows through tubing; C. empty uterus "tugs" on vacurette.

Other than the restriction on douching, there is nothing that a woman cannot do after an abortion. Some women wish to rest for an hour or two; others go about their everyday business without interruption. There is no restriction on sexual activity so long as birth control measures are taken.

Some doctors automatically prescribe antibiotics such as penicillin after an abortion; others who do not believe in such prophylactic treatment give antibiotics only if a woman shows signs of infection, since it is more difficult to cure infection which develops despite antibiotics. Fever, and pain in the pelvic area are symptoms of infection. Infection after a properly performed abortion is fairly simple to cure; however, it is serious. If fever, pain, or uncontrollable bleeding occurs after an abortion, a woman must see a doctor or go to a hospital emergency clinic immediately.

Although the probability of Rh immunization after early abortion is slight, Rh negative women who wish to have another child should receive "Rhogam" injection within 72 hours of the abortion. If Rh positive blood cells from the fetal blood stream enter the woman's blood stream, the woman becomes immunized (develops antibodies) against Rh positive blood cells. These antibodies will attack blood cells of an Rh positive fetus in future pregnancies. Future babies, if not stillborn, would be born with "hemolytic disease of the newborn" which produces severe, often fatal anemia. Rhogam prevents the development of Rh positive antibodies in the woman's blood stream.

Dilatation and Curettage

This method has been widely replaced by the vacuum curettage. It is still used where aspiration equipment is not available and, with a general anesthetic, for cases between the 12th and 15th week of pregnancy. Both uterine aspiration and "D & C" are used as diagnostic procedures for gynecological problems such as endometrial growths or cancer.

Preparation for a D & C is the same as that for vacuum curettage, including pelvic examination, paracervical block and cervical dilation. Once the canal is dilated the doctor inserts a **curette** (surgical instrument with spoon-like tip) into the cavity of the uterus to scrape loose the embryo and placenta. Loosened portions of embryonic material are removed from the uterus with a long surgical grasping instrument called an ovum forceps. The entire operation takes about 10 to 15 minutes.

Recuperation is slightly longer than that for uterine aspiration, due in part to greater blood loss. Post-abortion instructions (no douching, etc) for vacuum curettage are applicable after a D & C as well.

Intra-amniotic hypertonic saline

This method of inducing abortion is used after the 15th week of pregnancy. Before 15 weeks, the uterus and amniotic sac are too small and the procedure is difficult to perform.

A local anesthetic is injected into a small area of

skin several inches below the navel. A long needle is inserted through the abdominal wall and uterine wall into the amniotic cavity. Sinc the amniotic fluid is under pressure, some should flow out freely if the needle is positioned properly. The needle is replaced with a more flexible catheter and the amniotic fluid is drained out. An equal amount (maximum 200 ml) of 20% salt solution is injected through the same catheter into the sac. This procedure must be done slowly and carefully since an injection of salt solution into the blood stream can be fatal. Since the woman is not asleep, she can report any sensations such as headache, numbness, pain or faintness which may indicate a misdirected injection.

The saline solution kills the fetus and stops the placenta's production of pregnancy supporting hormones such as progesterone. Uterine contractions usually begin within 48 hours and the cervix dilates. Eventually the amniotic sac ruptures releasing the salty fluid (breaking of the waters). Contractions become harder and closer together until finally the fetus is expelled, usually within three days of the injection. In about 50% of cases, the placenta is expelled within half an hour. If parts of the placenta are retained, a curettage is performed to remove them to reduce chances of infection or haemorrhage. Curettage is necessary after saline abortion in about 10% of the cases.

The woman may or may not be kept in the hospital between the time of the injection and expulsion of the fetus. The deciding factor is usually economic: with hospital beds costing $100 a day, poor women often have to wait the interval at home, many of them not returning to the hospital at all. Some institutions are encouraging women to abort at home, saving hospital beds for "more important" cases. Liberal rhetoric about "aborting in the privacy of one's home" can not hide the realities: overcrowded and understaffed hospitals, practically non-existent home care programs, etc. - realities which hit the poor and non-white first and hardest.

Care after saline abortion is similar to that after vacuum curettage, although greater caution is the rule. Douching is forbidden. Any symptoms of retained placental tissue or infection (severe bleeding, fever) should be reported to a doctor immediately. Sexual intercourse may be resumed when the woman so desires; some suggest waiting until the menstrual-like bleeding has stopped.

The saline method of abortion should be avoided for women with kidney disease, heart disease, or previous delivery by caesarean section. In general, the woman should be in a state of good health before undergoing saline abortion. In the interval between the injection and delivery, she should drink a lot of fluids and avoid eating salts.

The risks of saline abortion, although higher than those of vacuum curettage are still lower than those for continued pregnancy. The degree of safety is closely related to the competence of the doctor who determines the eligibility of the woman for saline abortion and who injects the solution into the amniotic sac. It is hoped that the number of women seeking abortions after the 16th week will be reduced when "free abortion on demand" is realized.

Hysterotomy (miniature caesarean section)

Hysterotomy involves major surgery with a hospital stay of about one week. An incision is made in the abdominal wall just above the pubic bone. A second incision is made in the uterine wall, and

DANGER

Competent, medically trained abortionists, whether they are acting legally or not, never use methods described below. These methods involve extreme pain and can lead to permanent disability, infection, or death:

Oral means:

- **Ergot compounds - overdose is poison**
- **Quinine Sulphate - can cause deformities in fetus or death to mother**

Nothing that is swallowed can cause abortion without also causing death or severe disability to the mother

Solids inserted into uterus:

- **Knitting Needles**
- **Coat Hangers**
- **Slippery Elm Bark**
- **Chopsticks**
- **Ballpoint Pen**
- **Pastes**
- **Catheters**
- **Gauze (packing)**
- **Artists Paintbrushes**
- **Curtain Rods**
- **Telephone Wire**

Common danger of perforation of womb and bladder - death from infection or haemorrhage.

Fluids inserted into uterus:

- **Soap suds**
- **Alcohol**
- **Potassium Permanganate**
- **Lye**
- **Lysol**
- **Pine Oil**

Severe burning of tissues - haemorrhage - shock and possible death.

Air pumped into uterus: gas emboli in the blood stream. Immediately fatal.

Injections into Uterine Wall:

- **Ergot**
- **Pitocin**
- **Sodium Pentothal**

Overdose is poison.

Vacuum Cleaner

Connected to uterus - not to be confused with vacuum aspiration - is fatal almost immediately - rips uterus from pelvic cavity.

Physical exertion

Such as lifting heavy objects, running etc is useless.

Falling down stairs

Severe injury to mother but no abortion.

the fetus and placenta are removed. Both incisions are carefully repaired. Some doctors insist on delivery by caesarean section for all pregnancies after a hysterotomy, since the uterine wound can rupture due to labor contractions. Hysterotomy is quickly being replaced by the simpler "salting out" method.

Prostaglandins

Prostaglandins are a group of naturally occurring fatty acids which contribute to the normal functioning and contractions of "smooth muscle" organs, such as the uterus and intestines. Prostaglandins have been found in many parts of the human body and the full range of their effects remains a mystery.

Three kinds of prostaglandins, El, E2 and F2-alpha, are being used experimentally to stimulate abortion. The prostaglandin is administered to the pregnant woman intravenously, by injection into the amniotic sac, or by insertion through the cervical canal into the uterine cavity. (Oral administration requires large dosages and frequently results in side effects).

Both intravenous and direct application into the uterus have been successful, causing abortion in more than 90% of women tested. Side effects result from stimulation of smooth muscles of the digestive system, causing nausea, vomiting and diarrhea. Side effects are more common with high dosages. Since local administration (i.e. not intravenous) affects uterine muscles more efficiently, lower dosages can be used. The interval between first application of prostaglandin and complete expulsion of the fetus is about 18 hours.

Prostaglandins stimulate delivery at any stage of pregnancy. When perfected, these chemicals will probably replace the saline method for abortion past the 12th week of pregnancy. For pregnancies between the 5th and 12th weeks, vacuum curettage is preferred, as it affects an immediate, complete abortion, and hospital stay can be as little as half an hour. Prostaglandins for abortion at a very early stage, before 5 weeks, is another possibility. The insertion of a prostaglandin-tampon if a period is missed could bring on an unnoticeable abortion. Many such early abortions occur naturally, felt as "heavy periods".

The morning-after-pill

Abortion immediately after fertilization but before implantation can be achieved if the woman takes 25 mg of a natural estrogen, stilbestrol, for 5 days beginning within 24 hours of sexual intercourse. (see new methods, page 37). The stilbestrol series is often given to victims of rape, and can also be obtained in other cases of unprotected sexual intercourse.

NOTE:

Women seeking abortion must not confuse the experimental techniques involving prostaglandins or stilbestrol with claims of quacks or other unscrupulous doctors who offer an "injection" or "pills" for exorbitant fees. These injections or pills usually contain progesterone which can bring on a missed period, **if the woman is not pregnant.** Progesterone can not induce abortion. Prostaglandins are not yet commercially available, either legally or on the black market, and stilbestrol is available from gynecologists or hospital clinics at low cost.

Statistics

Statistics for illegal abortion are developed on the basis of population, hospital records, total number of births, death from post-abortive complications, questionnaires etc. Some of the most carefully developed and most widely accepted figures are listed below. Statistics for legal abortion, such as performed in Communist countries and in Japan are from hospital records.

General:
In the world: at least 30,000,000 abortions every year.
At least 4/5 of all abortions are performed on married women.

Canada:
At least 100,000 illegal abortions every year.
At least 20,000 admissions to hospital for post abortive complications - at least 1,000 of these cases result in severe disability or death.

United States:
At least 1,000,000 illegal abortions every year. Four out of five legal abortions are performed on private patients, not clinic patients. Nine out of ten legal abortions are performed on whites, not Blacks.

Where abortion is legal:
Bulgaria: between 1962 and 1964, 67,000 legal abortions without a single death.
Czechoslovakia: between 1962 and 1964, 140,000 legal abortions without a single death.
Hungary: between 1962 and 1964, 358,000 legal abortions with 2 deaths.
Japan: 1,500,000 legal abortions every year performed by more than 20,000 specially licensed technicians.

Availability of abortion

The battle for change in the abortion situation in North America over the past several years has had some results. In Canada the "liberalized" law allows for abortion when continued pregnancy would threaten the life or health (undefined) of the woman. Of those states in the U.S. with reformed laws, New York is the only one which leaves the decision between the woman and the doctor, with no hospitilization and no residence requirement. Even a quick look at the realities in these areas shows that we are still a long way from abortion on demand.

Male chauvinism and conservatism on the part of the doctors are exemplified in the Canadian situation. The law is worded such that a group of hospital doctors could define the condition, "unwanted pregnancy", as a threat to women's health; applications could be rubber stamped and abortions done immediately on an outpatient basis. This has occurred only rarely. Doctors still believe they

have a right to participate in a woman's decision whether or not to have a baby, beyond offering her the use of medical technology to prevent or terminate a pregnancy. So long as male doctors see women as breeders with no other useful function within society, women will continue to be denied control of their own bodies. So long as doctors, administrators, boards of directors, and the church set the priorities of the hospitals and are not responsible to the demands of the community they serve, the real health needs of the people will not be satisfied.

The New York abortion fiasco best illustrates what happens when the health system is directed by the profit motive. No sooner was the law passed, when referral agencies, with all the style of Madison Avenue, were established to direct "ladies in distress" to cooperative doctors. These agencies have been taking from $10 to $75 for each referral (in addition to the doctor and hospital fee of $200 to $1000) while groups such as Planned Parenthood and Women's Liberation have offered the same services without charge. The agencies have placed advertisements in campus newspapers and sent introductory letters to doctors all over the country. Some agencies offer to arrange reduced fees on occasion for "hardship cases", thus ensuring that the out-of-state doctors send them a regular clientele at the full fee.

These problems are not accidental, nor can we expect them to be solved without a radical restructuring of the entire medical profession, indeed, of the whole society. The number of doctors trained each year is controlled by the American Medical Association; thus a shortage of doctors maintains the high income of the members of the profession. Para-medical staff who could easily be trained to do abortions and many other routine medical procedures would tend to demystify the god-like image of the doctor. To date, there is no program for the training of para-medical staff in the numbers required to meet the needs of the people. The prohibitive costs of all medical procedures determine the quality and amount of medical attention a person will receive, regardless of that person's needs. The emphasis on curative rather than preventative medicine ensures business for the medical profession but does little to improve the quality of life for all people.

Poor women, especially black women, suffer the worst humiliation at the hands of male doctors and their hospital boards. These woman are commonly "offered" abortion - with the stipulation that they must accept sterilization as well. The rationale that such measures are necessary to alleviate the population crisis is merely a cover for racist genocide. The children of the rich exploit and pollute the resources of the earth, not the children of the poor.

The struggle for justice on the abortion issue will not be complete until abortion becomes just another medical procedure available free to all women whenever necessary.

venereal disease

Venereal disease, the "diseases of love" (from Venus, goddess of love) are traditonally defined as syphilis, gonorrhea, chancroid and lymphogranuloma venereum.

Symptoms of most **sexually transmitted diseases (STD)** are more obvious in the male than in the female. The infected male with obvious symptoms is in a position of heavy responsibility; it is his immediate duty to inform his sexual partner(s) of what is usually their common infection.

Gonorrhea and non-gonococcal urethritis

Throughout the western world there is an epidemic of gonorrhea. Its principal cause is the increasing resistance of the gonococcus (gonorrhea bacteria) to penicillin. Penicillin-resistant strains of gonorrhea have developed mainly in Asia. U.S. troops, sent to Korea and Vietnam to "crush communism" also crushed the social structure, culture and livelihood of the people. Foreign armies create large numbers of prostitutes, women who have no other way to survive and support their children. In Vietnam black market trade is the principal form of commerce, and penicillin is sold to prostitutes by the same kind of people who push heroin. Vietnamese prostitutes, as their Korean sisters before them, are self-treating themselves with inadequate, low-quality penicillin, creating an ideal breeding ground for penicillin-resistant gonorrhea. Soldiers returning to the U.S. often bring back a "Vietnam Rose" for their wives and girlfriends.

In the male, acute urethritis usually develops 2 to 5 days after sexual intercourse with an infected person. There is pain and burning during urination, frequent urination, and a thin discharge escaping from the meatus at the tip of the penis. The discharge soon becomes thick, yellow or yellow-green. The lips of the meatus become red and protrude from the tip of the penis. The first half of urine that is passed is hazy. A slight painful swelling of the lymph glands in the groin sometimes occurs.

If the infected male is not treated, complications develop. Glands in the urethra can become severely infected, causing abscesses and swelling of the penis. The disease can spread back to Cowper's glands, prostate gland, bladder, seminal vesicles, vas deferens and epididymis.

When gonorrhea is suspected in the male, a sample of discharge is examined microscopically. The characteristic gonococcus is usually obvious. Standard treatment for the male is one injection of 2.4 million units of procaine penicillin G. For resistant cases, more penicillin is used, or probenecid is given at the same time. Probenecid slows the kidney's removal of penicillin from the blood stream. Ampicillin, tetracycline, erythromycin and a new antibiotic, spectinomycin have all been used successfully to treat gonorrhea.

In women, gonorrhea is usually symptomless. The bacteria lodge in the cervix and urethral opening and

slowly spread into the reproductive system and bladder. Unless informed of her infection by a male partner, the woman usually goes without treatment until complications develop. Salpingitis, infection of one or both Fallopian tubes, is a common complication, causing disruption in menstrual cycles, severe pain in the lower abdomen, nausea, vomiting and fever. Unless treated, salpingitis twists the Fallopian tubes with scar tissue, leaving the woman sterile. Diagnosis of gonorrhea in women is difficult, since direct microscopic examination of cervical or urethral discharge is usually inconclusive. In women, gonorrhea is usually diagnosed on the basis of medical history (i.e. an infected partner) and a culture: samples taken from cervix and urethra are put onto a special medium that supports bacterial growth. After a few days the cultures are examined for presence of gonococcus. Since infection in the woman is usually of longer duration, larger doses of penicillin, as much as 4.8 million units, are needed to accomplish a cure.

There is a rapidly increasing incidence of a less serious urethral disease, or group of diseases in men called non-gonococcal or non-specific urethritis (NGU or NSU). Symptoms are similar to early male gonorrhea, although the discharge usually remains thin and watery. The cause(s) of NGU/NSU can not always be determined, although certain viruses are suspected. Only broad spectrum antibiotics, such as tetracycline, are effective treatment. Complications are rare, the disease being mainly a nuisance and not a danger. A corresponding disease in women has not been discovered.

Syphilis

Syphilis, caused by a microorganism called T. pallidum, is the most dangerous STD. The disease usually goes through 4 stages: primary, secondary, latent and late. Primary stage symptoms are more obvious in the male. About 2 to 4 weeks after sexual intercourse with an infected person, a single, small, oval, red spot appears on the penis. This spot rises, becoming a chancre, a painless swelling that eventually ulcerates (opens). Painless swelling of the lymph glands in the groin often occurs. In 50% of uncircumcised men, the chancre develops under the foreskin, making retraction impossible. In women, the chancre usually develops on the cervix and is not obvious except during speculum examination. Microscopic examination of fluid squeezed from the chancre usually reveals T. pallidum.

Even if the disease is not treated, the chancre soon disappears. Within a few days or months the rash of secondary syphilis appears on the chest, shoulders, abdomen and around the anus. At first, the rash consists of smooth, reddish or colorless areas; soon the spots become raised and copper or brownish, spreading to the face, palms and soles. Definite diagnosis in the secondary stage is made on the basis of various blood tests, such as the Wasserman, VDRL, TPI, FTA-ABS etc.

If secondary syphilis is not treated, the symptoms usually disappear in 3 to 9 months. The disease enters the latent stage, which can continue for a few years to 50 years. During this time T. pallidum insidiously attacks one or more of several susceptible body tissues. When results of this prolonged, steady destruction become obvious (e.g. heart attacks, paralysis, insanity etc.) the person is said to have late syphilis.

Treatment for all stages of syphilis is penicillin. T. pallidum is extremely sensitive to this antibiotic. Tetracycline is also effective. Antibiotics completely cure primary and secondary syphilis, and can stop the destructive processes of the latent disease.

For further information on sexually transmitted disease, contact the Birth Control Handbook for **Diseases of Love - VD Handbook** (available October 1971, individual copies 25c, bulk orders $40.00 per 1,000 copies).

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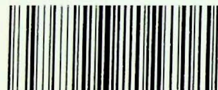
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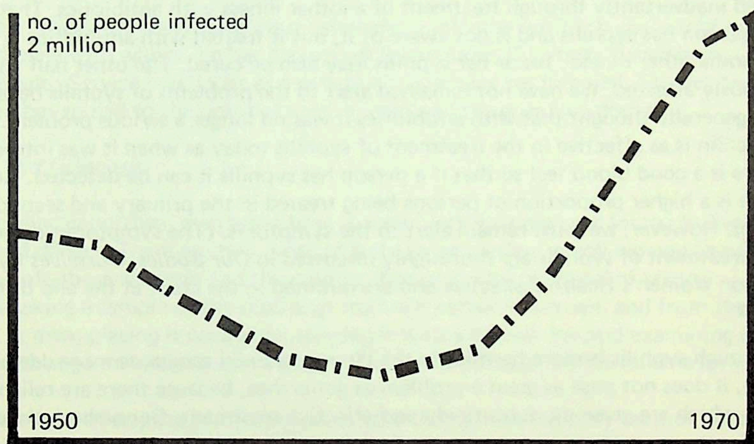
Venereal Disease



It is a woman's right to control her body and to determine for herself when she would like to bear children. But if she cannot get adequate health care for her body, she cannot make these choices. Venereal disease is the main disease which takes away a woman's right to choose. It can make her sterile, less fertile, miscarry, have stillbirths or diseased children.

In spite of the severe consequences, VD tests are not yet a routine part of the health check-up. AND when you do get a VD test, it is very often not accurate.

More women are being exposed to VD today than in the past. This is probably because women have more sexual freedom today. But as long as VD is a threat, women cannot have sex without fear, and this is limiting our sexual freedom.

VD was on the decline in the 1950's, but today it is the most widespread serious communicable disease in the country. It infects perhaps one American in every 100, and young people are the largest group infected. If any other disease that is passed from one person to another so easily were that widespread, it would be considered an epidemic and would receive urgent national attention.

One reason VD has been neglected seems to be because of the moralistic attitude toward sex in this country—sex outside of marriage is "bad." If you have sex outside of marriage, you deserve to suffer the consequences. Instead of treating the disease, the authorities tell people not to have sex. Other reasons that VD has been neglected are discussed at the end of this paper.

There are two types of VD, syphilis and gonorrhea. There has been a recent increase in syphilis, but gonorrhea is out of control and is a greater danger to women. For this reason, this information is mostly about gonorrhea.

SYPHILIS

At least 500,000 Americans have syphilis and don't know it. Half of them will be cured inadvertently through treatment of another illness with antibiotics. That is, if a person has syphilis and is not aware of it, but is treated with antibiotics for some other illness , his or her syphilis may also be cured. The other half will be seriously affected. We have not remained alert to the problems of syphilis because it was generally thought that with antibiotics it was no longer a serious problem. Penicillin is as effective in the treatment of syphilis today as when it was introduced. There is a good blood test so that if a person has syphilis it can be detected. And there is a higher proportion of persons being treated in the primary and secondary stages. However, we must remain alert to the symptoms. (The symptoms, diagnosis and treatment of syphilis are thoroughly discussed in *Our Bodies, Ourselves* by the Boston Women's Health Collective and are outlined in the chart at the end of this paper.

Although syphilis is more harmful in the later stages and can cause more damage then, it does not pose as great a problem as gonorrhea, because there are reliable tests which are given more routinely and effective treatment. Gonorrhea seldom produces symptoms in women (or produces symptoms that are more readily attributed to other women's problems), has no reliable diagnostic tests and no reliable test to assure a woman that she is cured. The high dosage of penicillin needed for treatment may cause complications or future resistance to this drug. Thus, we can see that gonorrhea is a great problem for women, and we intend to stress the aspects that we feel are not discussed elsewhere.

GONORRHEA

Although syphilis and gonorrhea are two different diseases, they have one thing in common and that is that they are both caught in only one way: from having sexual intercourse with someone who already has the disease. The germs for each of these diseases can only live for a matter of seconds outside the human body. If they become dry or too hot or too cold, they die. Therefore, to spread to a new person, these germs must be deposited on warm, moist surfaces (such as the lining of the genitals, or perhaps the mouth). This means that sexual intercourse, with a person of the same or opposite sex, provides ideal conditions for the transfer of VD germs.

Gonorrhea is caused by a germ shaped like a coffee bean called a *gonococcus*, which works its way gradually along the passageways of the genital organs. This disease can

be passed on to another person at all stages. The symptoms of gonorrhea are different for men and women, even though the germ is the same.

Symptoms or Lack of Symptoms

To start with, gonorrhea is often without symptoms in women. About 90% of the women infected with gonorrhea are not aware of their infection. This is in contrast to men who usually become aware of the infection within a matter of days because of a pus discharge from the penis and a burning sensation while urinating. Even in the minority of women who do develop symptoms—a vaginal discharge and pain during urination—the symptoms are thought to be a sign of common gynecological problems or the side effect of a birth control method, such as the pill.

Because of this, a woman doesn't learn that she is infected until (1) she is told by an infected male with whom she has had sexual intercourse; (2) she is traced by a Public Health Service casefinder as a person someone else has infected; (3) her own infection has spread to the point of causing pain and she goes to a doctor.

Testing and Diagnosis

In diagnosing gonorrhea, men again have it easier, while women are forced to live in doubt and danger. There are two types of tests for gonorrhea which women should be aware of—the *gram stain* and the *culture*. The *gram stain* method of testing involves taking a sample of the discharge from the cervix in women, and from the urethra in men, placing it on a slide, staining it with a special dye and examining it for gonorrhea germs under a microscope. This method is about 99% reliable for men.

For women, however, the gram stain method, although still the only method used in many places, is highly unreliable and should never be used without also doing the culture test. The *culture* test also involves taking a sample of the discharge, putting it on a special plate, and letting the sample grow under special laboratory conditions for several days in an attempt to let the gonorrhea germs (if there are any) multiply. This allows the germs to be detected more easily. The culture method can also be used as a test for men, but it is hardly ever necessary as the gram stain in males is so reliable.

However, it is important to emphasize that even the culture test can be inaccurate for women. Accuracy depends greatly on which places are chosen to take the culture from. Ideally, the four places of possible infection—the cervix, urethra, vagina, and rectum—should be cultured, but this is very expensive. If a single place is chosen for culture, it should be the cervix since a single cervical culture will detect approximately 82% of infected women. In some studies, about 50% of infected women showed an infection in the rectum. The urethra is another place where germs are likely to spread easily. Therefore, at least two places should be cultured—cervix and urethra or cervix and rectum. Even if more than one place is cultured, 6-9% of infected women will not be diagnosed in a single visit. One explanation for why the culture method doesn't work is that the gonococcus organism often dies on the way from the clinic or doctor's office to the laboratory, thereby resulting in a false

negative result for a woman who is in fact infected. Also, there is some evidence that there is a greater chance of detecting gonorrhea during menstruation.

Test for Cure

Since most women have no symptoms of gonorrhea, the only way they can tell they are cured is by being tested. And since the tests are not reliable, a woman should have at least two negative tests before being discharged as cured. Yet, many women are treated and discharged without ever being tested for diagnosis or cure. They tell a doctor they think they are infected, and the doctor gives them penicillin. This can happen when the doctor does not have the complicated laboratory facilities needed to do the tests. But it is very unsafe for women.

Treatment without testing is very unsafe for women for two reasons. First, she may *not* have been infected and received a large dose of antibiotics needlessly. (Too many large doses of antibiotics can make the body build up a resistance to this medicine.) Second, she can never know if she was cured.

It is obvious that our greatest need is for a cheap, accurate test to diagnose gonorrhea and test for cure. Until we have such a test, many women will discover they have gonorrhea only when it has reached the painful stages, and by then, serious damage may already be done.

Results of Gonorrhea

Unlike syphilis which goes all through a person's body, gonorrhea is essentially a disease of the genital and urinary organs. (Sometimes gonorrhea travels through the bloodstream and causes infection in the valves of the heart, or acute arthritis, blindness and even death. However, this is not at all common.) The disease is more likely to persist and spread in women than in men because the cervix becomes inflamed and the germs get into the glands and do not pass out of the bodily easily. In men, on the other hand, the germs stay at the initial source of infection, usually the urethra, where they can be more easily washed out of the body. Men who are not treated can suffer from narrowing of the urethra and sometimes get chronic inflammation of the testes (the balls).

One of the most severe consequences of untreated gonorrhea in women is salpingitis (a very painful infection of the tubes which may lead to abcesses or scarring of the fallopian tubes). If this happens several times, it can result in sterility. In 1948, a study showed that salpingitis was present in 2.6% of women diagnosed as having gonorrhea. A study carried out in 1963-66 showed that the percentage had risen to 10.6%. Early recognition and treatment is essential if subfertility and sterility are to be prevented. In addition, a pregnant woman with untreated gonorrhea can infect her baby as it passes through the birth canal. The baby's disease is called gonococcal conjunctivitis and causes blindness if not treated. Gonococcal conjunctivitis is usually prevented by placing a few drops of silver nitrate solution in the baby's eyes at birth. However, in the past ten years, gonococcal conjunctivitis has increased just as gonorrhea has spread. This epidemic must be stopped!

Treatment

The normal treatment for gonorrhea is high-dosage injections of penicillin. If the

first treatment does not cure, the dosage is doubled for a second treatment or other antibiotics are tried. However, treatment is often not as safe or easy as it sounds. Gonorrhea germs, as well as the body's systems, seem to have the ability to build up resistance to penicillin. Strains of gonorrhea are developing which do not respond to the normal high dosage of penicillin treatment. One way these resistant strains seem to develop is when a low dosage of antibiotics is taken for protection against the disease. This low dosage may not be strong enough to kill the gonococcus germs, so instead they adapt to the presence of antibiotics and become resistant to them. As a result of the development of these strains, the Public Health Service (PHS) in 1965 increased its recommended dosage of penicillin for the treatment of gonorrhea to 2.4 million units in men and to 4.8 units in women (4.8 units is the maximum injectable at one time). If dosage requirements increase, future patients may have to be hospitalized for intravenous treatment.

However, some doctors maintain that penicillin impotency is not yet a "major problem nationally" as there are oral antibiotics such as the tetracyclin group and other mycins for difficult cases. And for the few cases that don't respond to this treatment, there is another antibiotic, Loridine, whose cure record is perfect so far. Another treatment is to give oral probenecid along with penicillin. This drug makes you urinate less often and by keeping the water in your body also keeps the penicillin in your body and at a high level for a longer time so it can kill the germs. This does not reduce the danger of taking such high powered drugs, nor does it reduce the need for accurate diagnostic tests and tests for cure.

Funding

The absence of laboratory diagnostic tests for gonorrhea which are comparable to the simple, reliable blood test for syphilis, and the lack of adequate and safe treatment for the disease reflects the priorities of a health care system that severely neglects many of the basic health care needs of women.

One big reason for the neglect of gonorrhea is that the severe effects of gonorrhea were much more widespread among poor (white, brown and black) women who could not get adequate health care. Syphilis, on the other hand, has received much more attention because it killed middle class whites. Our capitalist, racist, and sexist society is not willing to spend money to liberate poor people, Blacks or women.

Millions of dollars are spent each year by the government and private institutions to do research on and educate the public about other diseases like cancer, heart disease, polio, etc. So far, there is no private group doing the same for VD. And the government gives much less money for VD than for other diseases.

The total Public Health Service's VD budget for 1969 was 12 million dollars. Only $500,000 of this was for gonorrhea control. Most of the gonorrhea money was not for research, but for carrying on the traditional casefinding method which was already proven to be a very limited and ineffective approach to the control of gonorrhea. Although research is presently going on at the VD research laboratory in Atlanta for a blood test for gonorrhea, there is little hope that there will be enough money to produce a cheap routine test in the near future.

The gross inadequacy of federal funds is also the reason that there are no preventive

vaccines for syphilis or gonorrhea.

There is also a severe shortage of clinics which will treat VD patients. While some clinics have made the blood test for syphilis a routine part of an OB-GYN exam, almost no health facility gives gonorrhea tests routinely, or even makes the test available.

Prevention

As mentioned before, the Public Health Service is charged with the control program for VD. This involves testing for VD and follow-up investigations to locate sex partners and those that a person might have infected. This is not a very reliable way to control VD since a person can refuse to name sex partners. In half of the states, the law *requires* that positive results of lab tests for VD be sent to the Health Commissioner who contacts the doctor or clinic of the person to determine if the disease actually exists. Many private doctors, however, do not report VD cases to the PHS for follow-up. One of the reasons for this is that the PHS has a very moralistic attitude towards sex. When they investigate reported cases of VD, they ask the persons to name all sexual contacts and other persons with whom he has had contact and knows to be *'promiscuous'*. In fact, it turns out that a lot of the people who should supposedly be helping to stamp out VD are really much more interested in stamping out "illegal" sex. The people to be most harrassed by these techniques are poor and low-income people since they often have little choice but to use public clinics which must report to PHS. Attitudes about sexual participation are changing, particularly among young people, and yet in 36 states, it is still illegal for a minor to be treated for VD without his or her parent's consent.

The United States is known for its hypocrisy when it comes to sex (as well as many other things). On the one hand, just about every business in this country uses commercial sex to sell its products. On the other hand, a lot of adults treat sex as if it were something dirty and sinful that should never be talked about—especially in front of young people. And when sex is talked about, it must be moralized about. For instance, some of the movies shown about VD in the schools make it look like getting VD is a justified punishment for committing the "sin" of having sex with someone before being married.

It is clear that the present casefinding and investigation methods of PHS have not worked in wiping out VD, and instead of concentrating on these ineffective techniques, other ways of approaching this problem must be found.

NEW PERSPECTIVES ON V.D. or HEALTH CARE WITHOUT RACISM, SEXISM or CAPITALISM

1) Up to now, gonorrhea has not been treated as a dangerous epidemic because its severest consequences were found mostly in poor (white, black and brown) communities where there is still no adequate health care available. Sterility from gonorrhea is a type of population control which the ruling class always wants for poor people. No one in authority was ready to put money into researching and eliminating a disease which most severely affected poor (white, black and brown)people. (Non-poor white people who get this disease could secretly go to their private doctors and spend money on expensive treatment.)

As long as the worst effects are felt by women, it is women who will have to struggle to end VD. AS WE EDUCATE OURSELVES ABOUT VD; WE MUST TALK ABOUT THE RACIST AND SEXIST WAY HEALTH CARE IS SET UP.

2) We must demand research for a preventive vaccine and accurate diagnostic tests which are not expensive.

3) Tests must become a routine part of every health check-up—*without* morality attached.

4) Clinics should provide *total* health care, not be separated into VD or social hygiene clinics, gynecological clinics, and birth control clinics.

There should be separate teenage clinics, just as there are pediatric clinics. Teenagers should be able to get total health care at these clinics *without* parental consent.

5) Every institution (clinics, schools, churches, community agencies, etc.) must talk about VD as an epidemic disease and spread the facts. Nursing and medical schools have not even done this for their own students nor have they encouraged VD research.

6) We must help each other by freely discussing VD and telling our sex partners if we think we have been infected. In our present health system with its moralistic attitudes, we cannot depend on clinics, schools, etc. to do this work for us. Since there is no foolproof protection against contracting gonorrhea, and anyone can get it, we have only our feelings of responsibility to each other to protect us.

As long as we have racism, sexism, a profit-making health care system, and an uninformed, moralistic public, we will continue to have terrible health problems such as uncontrolled gonorrhea.

Even if women get the very best health care presently available:

There is no prevention.
There is no good diagnosis.
There is no foolproof treatment
for any woman's gonorrhea.

IMPORTANT FACTS ON V.D.

• SYPHILIS:

POSSIBLE SYMPTOMS:

1) Primary stage: (9-90 days after infection) chancre
2) Secondary stage: (few weeks-6 months later)
   rash—all over, or on hands and feet
   sores in mouth
   sore throat
   mild fever
   swollen joints
   headache
   patchy balding
3) Latent stage: (10-20 years) no outward symptoms at all
4) Late stage:
   heart disease
   crippling
   deafness
   blindness
   paralysis
   insanity
   death

DIAGNOSIS:

1) Physical examination by doctor
2) In early stage: examination of pus from chancre
3) After that: blood test called VDRL.

TREATMENT:
High dosages of long acting penicillin.

• GONORRHEA:

POSSIBLE SYMPTOMS:

1) In Women:
   maybe slight vaginal discharge
   maybe some pain when urinating
   (later) severe abdominal pains
   infected bladder
   infected rectum
   infected tubes
   sterility
   arthritis
   blindness
   death
2) In Men:
   discharge from penis
   pain during urination
   sore, swollen testicles
   infected bladder
   infected tubes (seminal vesicles or epididymis)
   sterility
   arthritis
   blindness
   death

DIAGNOSIS: 1) "gram stain" method (very *un*reliable in women): taking a smear of the urethral or vaginal discharge, placing it on a slide, staining it with a special dye, and examining it under a microscope for germs.
2) "culture" method (about 82% reliable for women): taking a smear of the discharge (in men, a urethral smear; in women a smear from at least the cervix and the rectum), innoculating it on a special medium or culture plate and incubating the culture under special laboratory condition for several days. This is to let the gonorrhea germs multiply for greater chance of detection.

TREATMENT: a high dosage of penicillin or related antibiotic.

HEALTH ORGANIZING COLLECTIVE OF
N.Y. Women's Health & Abortion Project
36 West 22nd Street N.Y.C. 10010
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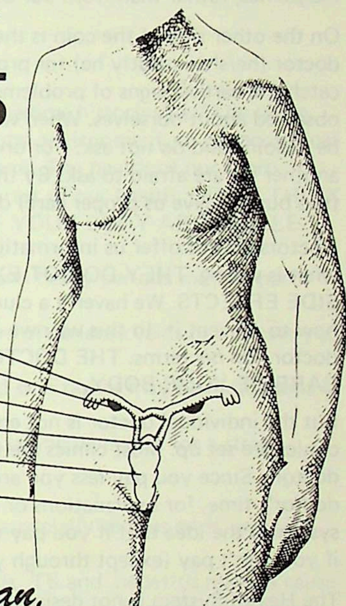
THE GYNECOLOGICAL CHECK-UP



I am a woman. You are a woman.

We know that we need healthy bodies to live, love and work in the best ways. So we try to take care of our bodies—we try to stay healthy. BUT, our health does not depend on us alone. We have some personal choices that fundamentally affect our health, but primarily we are affected by the environment we live in and by the health care available to us.

In working for better health care we must struggle on three levels.
One, we must struggle to improve the environment. Poverty, inadequate housing, bad working conditions, pollution of food, air and water, and inadequate health facilities directly affect our bodies.

Two, we must struggle to get preventive health care—to have adequate, thorough and regular physical examinations, effective and *safe* birth control, good prenatal care and adequate tests for detecting such destructive diseases as gonorrhea and cancer. We must also struggle to educate ourselves about our bodies, and what doctors and drugs are doing to us.

Third, we must struggle to get free, quality care for our specific medical problems, like abortions, childbirth, infections and operations.

In working for better health care, and in particular for better gynecological care, it is important to accept the responsibility we have for our own education: to know and

understand how our bodies function, how to try and keep in good condition, the factors that may affect us, problems that may arise, and the symptoms that we should look out for. Most of us get this information from friends or women's magazines, rather than from our doctors or clinics.

On the other side of the coin is the responsibility of the health system and the doctor (he/she—mostly he) for providing us with regular and thorough check ups to catch the earliest signs of problems and answer our questions about what we have observed about ourselves. When we are examined by a doctor, we are not told what he is doing and do not ask. For one thing we don't know what to ask and for another we are afraid to ask. By the time we have gotten up the courage, the 'busy' (too busy to give us proper care) doctor is gone.

Doctors do not offer us information about our bodies, how to care for ourselves or what is wrong. THEY DO NOT EXPLAIN MEDICATIONS OR THEIR POSSIBLE SIDE EFFECTS. We haven't a clue how to tell when something is really wrong or how to prevent it. In this way we are kept dependent on the powerful and busy doctor—on *his* terms. THE DOCTOR SHOULD BE THERE TO HELP YOU TAKE CARE OF *YOUR* BODY.

But the individual doctor is not entirely to blame. Part of the problem is the way clinics are set up. Most clinics are for people who cannot afford to go to private doctors. Since you pay less you are not supposed to make demands for more of the doctor's time, for explanations or for more personal treatment. Built into the health system is the idea that if you pay for each visit and each service you have rights, and if you don't pay (except through your taxes), you should take what you get.

The Health System is not designed to help us, nor is it designed for preventive care which yields no profit—it is instead, part of the profit-making apparatus of the whole country: profits for doctors, hospitals, drug and insurance companies.

We women must teach ourselves and learn what is necessary for the health of our bodies. With our new knowledge we can demand that doctors, clinics and hospitals give us the care we need. We can also demand more research in gynecology and pediatrics—the two lowest categories on the research scale. But we realize that until health care is seen AS A RIGHT, NOT A PRIVILEGE, we cannot have FREE, quality health care.

The following description of what a good gynecological examination should include is put forth to provide us with the information we need to begin our struggle. It is a beginning step in developing awareness of our bodies, ourselves, and the kind of health care we must demand—for all of us women.

WHAT A GOOD GYNECOLOGICAL EXAMINATION SHOULD INCLUDE

Wash before you go to the doctor but do not douche because the secretions inside your vagina are important signs of health and/or disease.

WEIGHT AND BLOOD PRESSURE

These are frequently measured by a nurse or aide before you see the doctor. Long

term records are useful to have. A sudden change in your normal weight or rise in blood pressure may be an indication of disease, and may affect the kind of birth control you can use. Some doctors and clinics also measure your temperature at this point, but others only do it if you are sick.

GENERAL MEDICAL HISTORY

When you first visit a doctor or clinic a complete medical history *should be* taken. Just as health care cannot be isolated from your total environment, so gynecological (GYN) care may be affected by other health problems. The health of our reproductive and sexual organs is not separate from the rest of our health. DON'T THINK THAT CURRENT PROBLEMS IN THE REST OF YOUR BODY ARE IRRELEVANT just because you've come for a GYN exam:

If you're tired all the time you may be anemic and heavy periods may be part of the problem.

Tired feet and aching legs may be the forerunners of varicose veins or indicate you shouldn't take the Pill.

Frequent colds, feeling run-down, backaches and skin rashes may be indications of a GYN related problem.

Your vaginal infection may be the side effect of taking penicillin for a strep throat.

The doctor should also know about past diseases, especially serious ones, even if you've been completely cured:

Rheumatic fever, blood clots, gonorrhea, syphilis, TB and hepatitis may all cause major or minor damage that will relate to your GYN care. They may determine the sort of birth control or medicine that is recommended.

Also, be sure to tell the doctor about diseases that run in your family. Present diseases such as diabetes or heart disease should also be reported.

If you are allergic to any drugs, or if you have a history of allergy in your family, be sure to mention it.

It is important to know your blood type and if you are Rh positive or negative

GYNECOLOGICAL HISTORY

This should be taken in detail. These are the questions you should be asked. If you are not asked, try to bring them up. When you go back for a second visit, remind the doctor of the things which are a problem for you. Even a private doctor may not read your record, and in a clinic you may have a different doctor.

1. Is your period regular?
2. How long is your cycle?
3. Has it been changing?
4. Is your period heavy, medium, light?
5. Has that been changing?
6. Do you have cramps? are they severe or slight?

7. Have you ever been pregnant?
8. Did the pregnancies end in miscarriage/abortion/childbirth?
9. If a pregnancy ended in miscarriage, at what month were there problems?
10. If a pregnancy ended in abortion—at what month—what method—under what circumstances (illegal-legal—you have the right to refuse to answer questions about illegal abortion, but if there were complications it would be wise to explain them).
11. If a pregnancy ended in childbirth, at what month, how heavy was the baby, were there any complications during pregnancy or delivery?
12. What methods, if any, of birth control have you used?
13. With what effect?
14. What method, if any, of birth control are you presently using?
15. Have you had any infections, diseases—especially gonorrhea or syphilis —or operations?

The medical history may be taken by someone other than the doctor, by a nurse or a trained aide. Don't assume that because you've told her that the information will necessarily get through to the doctor or that he will read the aide's notes thoroughly before he examines you. You may find it much easier to talk to the nurse because she's usually a woman and often seems more willing to answer you so try out your questions before you go in to see the doctor. MAKE SURE THAT ALL OF THESE QUESTIONS ARE ASKED, BECAUSE IF THEY AREN'T YOUR EXAMINATION HAS NOT BEEN COMPLETE.

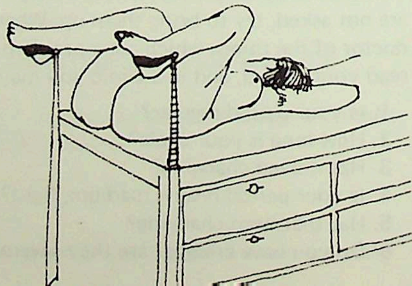
Most clinics and most doctors do not take good, complete medical histories AND IT IS HARD WHEN YOU ARE ALONE IN A DOCTOR'S OFFICE OR CLINIC TO CRITICIZE THE KIND OF CARE YOU ARE RECEIVING.

THE PHYSICAL EXAMINATION

The exam will be more comfortable if you urinate. If you are asked to undress, you should be given something to cover yourself with. You have the right to have a woman in the room with you during the exam.

At an initial examination with the doctor you should have a general check-up, i.e. he should listen to your heart and chest, check your eyes, ears and throat. If you've had this done recently by another doctor, especially one at the same clinic, this general check up isn't necessary, but if you've not seen a doctor for a while don't hesitate to ask a gynecologist to do these simple tests. However we know that this is NOT common practice.

You will then be asked to lie down on the examining table and put your feet in the stirrups.



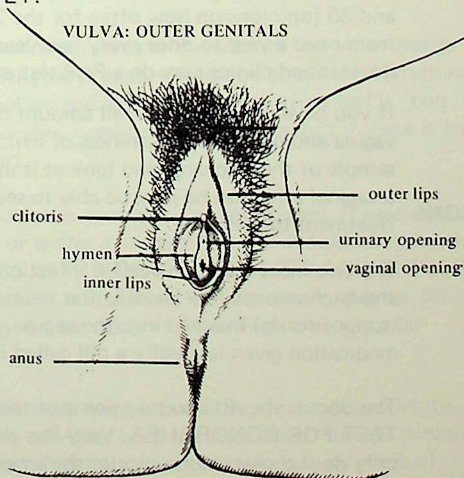
MOST OF WHAT WE'VE LEARNED ABOUT OUR SEXUAL ORGANS HAS BEEN SECRET, WHISPERED, OR PRIVATE. Many a woman has never explored herself with her fingers. It is therefore very hard to feel relaxed about being exposed and examined by a stranger, especially a man. So instead of relaxing we tense up, which means it's much harder for the doctor to feel the organs inside our abdomen and harder to examine the vaginal muscles at the entrance, which are tight, and it's also more uncomfortable for us. That is why it is important to TRY and relax.

EXTERNAL EXAMINATION:

While you're lying on your back the doctor should press and poke your upper abdomen feeling for your liver, spleen and kidneys. If they are enlarged this could be a sign of pregnancy or disease. These organs are important in general and especially when you're pregnant when they have to work for you and the fetus, too.

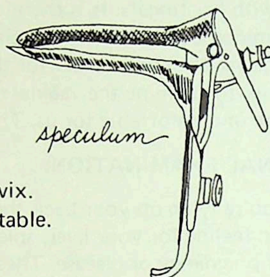
The doctor will *examine your breasts*, feeling each part for any unusual lumps or growths. If you feel any pain or tenderness you should tell the doctor.

You should examine your own breasts regularly especially if you are over 30 when the chance of getting breast cancer increases. If the doctor doesn't tell you how to do this, ask him or the nurse. Booklets about breast self examination should be available, so ask for one. If not, probably the American Cancer Society in your area can send you one. This examination of yourself is especially important if you use a clinic or outpatient department where you see a different doctor each time or where the doctors are fresh out of medical school and inexperienced. You can detect changes that occur slowly and will probably be able to feel small lumps long before any stranger. DON'T FORGET, MORE THAN ONE FIFTH OF CANCER IN ADULT WOMEN IS CANCER OF THE BREAST AND IN MOST CASES CAN BE CURED IF IT'S TREATED EARLY.



Next, the doctor *examines your outer genitals*. First he checks the vulva and the anus. The vulva includes the outer and inner lips of the vagina, the entrance to the vagina, the hymen if present, the clitoris and the urinary opening. He's looking for

signs of infections, such as inflammation, swelling or sores, and for infected glands and for growths (such as warts, cysts, tumors or polyps) and *also for signs of damage.*



INTERNAL EXAMINATION

After checking the outside, the doctor places an instrument called a SPECULUM inside you—this holds the wall of the vagina open so that the doctor can see the walls of the vagina and the cervix. This usually is not painful, but may be uncomfortable. Again, try to relax.

He looks at the color of the mucous membrane lining the vagina and to see whether there's a discharge or signs of infection, damage or growths.

He also notes the position of the cervix in relation to the vagina. In some women the uterus is tipped or tilted. If so, he should tell you—there is nothing unhealthy about having a tipped uterus, but some people think it can cause extra problems in pregnancy or abortion, so it is important for you to know about it.

NEXT, the doctor may perform some tests.

First: PAP TEST

Using a Q-tip, wooden spatula, a flattened metal stick or a glass tube, he'll remove some cells from your cervix. This is painless. These will be sent to a lab and studied to see if there are any signs of cancer developing. This is called a PAP TEST and should probably be done approximately once a year if a woman is over 30 and once every two years between 20 and 30 (opinions on how often for the 20-30 year old age group vary from once a year to once every few years). If you are on the Pill some doctors and clinics may do a PAP test every six months.

Second: TEST FOR INFECTIONS

If you have more than a small amount of a yellowish discharge from the vagina and complain of soreness or irritation, or itching, he'll remove a sample of the discharge and look at it under a microscope. If you've got a vaginal infection he may be able to see the organisms and know what treatment to prescribe.

The two most common vaginal infections are monilia (yeast or fungus) and trichomonas. For monilia the treatment usually is a nystatin tablet (suppositories) inserted into the vagina. For trichomonas, 'trich', the medication given is usually a pill called Flagyl.

Third: TESTS FOR VD

The doctor should also take some of the discharge from the cervix TO TEST FOR GONORRHEA. Very few doctors do this routinely, others only do if the woman indicates she's worried about it and suspects that the man or woman she relates to, may have it.

Don't be uptight about asking for a gonorrhea test. Gonorrhea is very

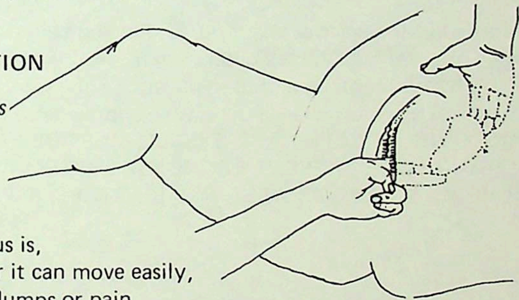
common—it is now the NUMBER ONE SERIOUS INFECTIOUS DISEASE—and it can be very serious for women—you can end up sterile . A woman can carry it for months without knowing it, while a man usually knows he has it—he will probably have a discharge and severe pain when urinating—within three weeks after he has been exposed to it. A woman often has no symptoms.

If the doctor should test for gonorrhea—ask him whether he's doing a simple gram stain or whether it's a 'culture'. The culture is a much better test because it's more accurate: especially when the discharge is from several places (such as cervix and urethra or cervix and anus).

A blood test should be done for syphilis. This is usually an accurate test when done 4-6 weeks after exposure.

After doing the tests the doctor puts on a sterile rubber glove and with two fingers feels inside the vagina for lumps and tumors.

THE BI-MANUAL OR
TWO HANDED EXAMINATION



The doctor *places two fingers against the cervix and with his other hand feels the top of the uterus through the lower abdomen wall.* He can feel how big the uterus is, whether it's soft and whether it can move easily, and if there are any obvious lumps or pain.

Finally the doctor presses your abdomen walls at the sides to feel your ovaries and tubes. If they're fine and healthy he probably won't be able to feel anything, but if there are lumps or inflammation and infection, he can often feel it. You may feel a little twinge when he presses your ovaries. This is normal but if there is serious pain it is usually a sign of infection.

At this point the physical examination is over and you get dressed. *If medication is needed the doctor gives it to you or writes a prescription.* He should tell you what the drug is and SHOULD DISCUSS WITH YOU SIDE EFFECTS AND THINGS TO AVOID—but often he won't bother. It is important to take the drug at the times prescribed so the level of the drug in your body will stay high enough to be effective.

Try and ask questions—even if they seem minor. But if the doctor is one of the cold, aloof sort don't wait till the end to ask—just keep asking through the examination. After the examination many women feel they shouldn't take up any more of 'busy' doctor's time, and feel stupid asking questions—so they get nervous and leave with unanswered questions. Unfortunately, the medical profession and clinics and hospitals are now set up so that it is difficult for a patient, and especially a woman,

to feel comfortable asking questions.

When you come out of the doctor's room with unanswered questions, you might try and talk with the nurse. Nurses often know a great deal about all the medical problems but we seldom realize it because we're generally told just to talk to the doctors. Moreover in clinics the nurses are often more sympathetic and more in touch with the needs and problems of the community than the doctors.

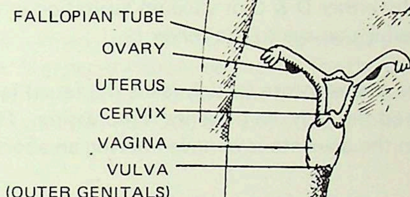
THE BIGGEST HEALTH PROBLEM WE HAVE

The biggest health problem we have is how to get good health care for all of us. This will be a long struggle. Meanwhile, it is also a problem to figure out where to go for the best (presently) available care. Unless you live in a really small town it's very difficult to find out what clinics, doctors, and hospitals exist, and where the best services are available–and how much they cost. It is obvious that all of us should start developing lists of good doctors and clinics for women in our communities.

We must educate ourselves about our bodies and take the mystery out of the doctor's role. We must force doctors and medical institutions to do more research on women's health problems and to share with us the secrets they have learned about our bodies. They must change the way they provide care. OUR WORK TO CHANGE THE HEALTH CARE SYSTEM MUST BE PART OF THE STRUGGLE TO CHANGE OUR PRESENT ECONOMIC SYSTEM–WHICH OPPRESSES US IN OUR HEALTH CARE AS WELL AS ALL OTHER ASPECTS OF OUR LIVES.

HEALTH ORGANIZING COLLECTIVE OF
N.Y. Women's Health & Abortion Project
36 West 22nd Street N.Y.C. 10010
1st revision: 10/71

SALINE ABORTIONS



COMMON METHODS OF ABORTION

Length of Pregnancy (from 1st day of last period)	Method	
Up to 12 weeks	1) D&C: Dilation &Curettage Uterine contents scraped out. Performed in hospital, clinic, or Dr.'s office Local or general anesthesia.	2)ASPIRATION: (or suction curettage) Uterine contents sucked out by vacuum apparatus Performed in hospital, clinic, or Dr.'s office. Local or general anesthesia.
12 to 14 weeks	D&C and ASPIRATION occasionally performed but risks are higher than earlier in pregnancy. Preferably performed in hospital. General anesthesia.	
14 to 16 weeks	No generally accepted safe method in use in U.S.	
16 weeks and over	1) SALINE INJECTION (salting out) Some Amniotic fluid replaced by salt solution causing uterus to expel contents. Hospitalization preferable. Local anesthesia.	2)HYSTEROTOMY (mini-cesarean) Uterine contents removed by major abdominal surgery. Performed only in hospital. General anesthesia.

Up to the 12th week of pregnancy, abortions are usually performed by the safe, quick, simple methods of vacuum aspiration (suction curettage) or dilation and curettage (D and C).

As the fetus grows the walls of the uterus stretch. After the 12th or 13th week of pregnancy these walls are quite thin and soft. There is a risk that when the curette (used in a D & C) or the aspirator tip (used in vacuum aspiration) is passed thru the cervix into the uterus it will damage or perforate (poke a hole in) the uterine wall.

About this time, the fetus becomes too large to be removed from the uterus by either D & C or vacuum aspiration without causing great pain and/or possible damage to the cervix.

At this time, the placenta (which feeds the fetus) is getting quite large, and the flow of blood through the placenta is increasing. This means that, after the 12th week, when the placenta is removed during an abortion, there is a risk of serious bleeding.

The following table shows how the complications from abortion increase with the length of pregnancy.

Complication	**Method of Abortion**	**Number of complications per 1000 Abortions**	
		under 12 weeks	**over 12 weeks**
hemorrhage (loss of more than about 1 pt. blood)	**D & C**	**2**	**7**
	Uterine aspiration	**1**	**10**
perforation of the uterus	**D & C**	**3**	**7**
	Uterine aspiration	**2**	**7**

New York City Department of Health--Report on Abortions–July-Dec 1970

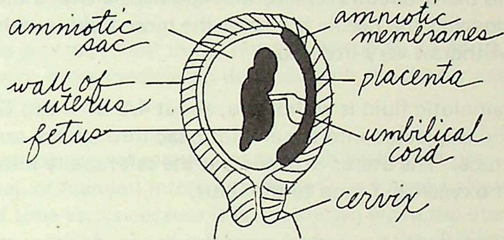
It is because of the risks involved in D & C's and aspirations over 12 weeks that they should be performed in hospitals or clinics equipped with bloodbanks and facilities for surgery. A few skilled doctors will perform abortions by D & C and aspiration between the 12th and 14th week of pregnancy, but many prefer the woman wait until she is 16 weeks pregnant and then perform a saline abortion.

THE SALINE ABORTION

The fetus grows attached to the wall of the uterus by the umbilical cord and the placenta. It is surrounded by a bag made of thin layers of tissue or membrane called the amniotic membranes.

Inside this bag is a watery liquid called the amniotic fluid. This 'bag of waters' or amniotic sac acts as a cushion for the fetus.

When a saline abortion is performed some of the amniotic fluid is replaced by a strong salt (or saline) solution. Between 5 and 50 hours later the uterus starts contracting. After several hours of contractions, the fetal and placental tissue is eventually pushed out.

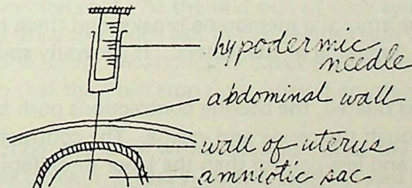


A saline abortion is not generally performed until the woman is 16 weeks pregnant. Before this the 'bag of waters' is generally not large enough for the doctor to locate easily with the hypodermic needle. The amount of fluid in the amniotic sac at 14 weeks is about 2/3 of a cup (150-200 cc) and at 20 weeks it is about 1½ cups (400 cc).

PRE-PROCEDURAL EXAMINATION

Before the procedure the woman should be examined thoroughly and a medical history taken. There are several blood and urine tests that are frequently done to make sure that the woman is healthy. Some institutions require that an X-ray be done to show possible heart and lung problems, but many doctors consider this unnecessary.

One of the most crucial tests is that which shows if a woman has Rh-negative or Rh-positive blood. If a woman is Rh-negative, and the man involved in the pregnancy is Rh-positive, then the woman may develop antibodies against the blood of the fetus. These antibodies could possibly cause her trouble in future pregnancies. An Rh-negative woman should have a shot of a substance called *Rhogam* within 72 hours of a saline abortion. If the man involved is Rh-negative too, there is no problem.



THE PROCEDURE

A patch on the surface of the woman's belly about 3-6 inches below her navel is numbed with a local anesthetic. A hypodermic needle 6-8 inches long is passed through the skin, muscle, and uterine wall and into the amniotic sac. The amniotic fluid is under pressure inside the uterus and begins to flow out through the tube of the needle. The first few drops of fluid may be slightly tinged with blood from the passage of the needle through the uterine wall, but the amniotic fluid is clear or slightly cloudy.

Some doctors remove about 4/5 of a cup (200 cc) of the amniotic fluid. Others remove smaller volumes or simply wait until no more fluid spontaneously flows out.

As the fluid is withdrawn from the amniotic sac, the walls of the uterus contract and the tip of the needle may get dislodged, so that it is no longer in the sac. To prevent this many doctors replace the rigid needle with a fine plastic tube. The risk of dislodging the needle is greater the more fluid is withdrawn. Some doctors prefer to withdraw very little fluid.

After the amniotic fluid is withdrawn, about 4/5 of a cup (200 cc) of a strong salt solution is injected into the amniotic sac through the same hypodermic needle or plastic tube. The uterus expands and the salt rapidly kills the placenta thereby cutting off oxygen and food to the fetus.

It is not known exactly why the uterus begins to contract. The placenta normally manufactures hormones including estrogen and progesterone. One theory is that when the placenta stops functioning the progesterone level goes down and this decrease may cause the uterus to start contracting. Another theory is that the increase in the size of the uterus that occurs as the strong salt solution in the amniotic sac attracts water from the rest of the body starts the contractions. Or, the salt solution damages the amniotic membrane and irritates the uterine wall which may cause the uterus to contract and expel the fetus and placenta.

After the injection the needle or plastic tube is withdrawn. The small holes in the uterus and belly seal up by themselves. The woman may not feel anything for several hours except a great thirst that results from the presence of the salt. She should drink lots of liquids - juice, water, tea, etc., and not eat anything salty.

Between 5 and 50 hours after the saline injection the uterus starts contracting. If the woman puts her hand on her belly, she can feel the uterus hardening and then relaxing, she may also feel cramps, pain or just discomfort. The contractions gradually become stronger and closer together. These contractions dilate (or open up) the cervix.

At some point the amniotic membrane breaks, and there is a gush of salty liquid. This is called the 'breaking of the waters'. It generally speeds up the contractions.

When the cervix is dilated, the uterine contractions push the fetus and then the placenta out through the cervix and vagina. The contractions and expulsion are generally shorter and less painful than the labor of childbirth, but the amount of pain is dependent on whether the woman is relaxed.

On an average the abortion is completed 28 hours after the saline injection.

Some hospitals give the woman a hormone (pitocin or oxytocin) to make the uterus contract faster. In such cases the whole procedure may be over in 10 to 12 hours. However, in some cases this hormone cause the body to retain water so many doctors do not give it routinely. It may be given if the membranes have broken and the contractions are slow.

Some doctors and hospitals prefer to give a woman anesthesia during the contractions so she feels nothing at all. This involves an added cost for an anesthesiologist and the anesthetic as well as the added risks of general anesthesia.

After the woman aborts she is generally kept in the hospital for up to 24 hours. She may be given antibiotics or other medication depending on the doctor and hospital.

A woman should *not* douch or use vaginal sprays, not take tub baths, not use tampax, not have (oral, genital, or manual) intercourse from 2 to 4 weeks after the procedure. The length of time varies because it is not known when the uterus is healed and when there is no more chance of infection from any of these activities.

There may be bleeding (similar but not the same as a normal period) for several weeks after the procedure. A woman will have her next normal menstrual period from 4 to 8 weeks after the abortion. It is best not to have intercourse until some form of birth control is being used (the diaphragm with jelly, the pill, or an IUD (loop) are the most effective forms of birth control.)

SIDE EFFECTS AND COMPLICATIONS

Complications that require medical attention usually occur either at the time the salt solution is injected or at the time that the fetus and placenta are expelled. Hence, it is fairly safe for a woman to be without medical attention in the interim.

Complications during the injection- - The injection is performed with local anesthetic because if anything goes wrong the woman feels the symptoms and is able to warn the doctor before serious problems arise. For example, if the tip of the needle is lodged in the uterine wall instead of in the amniotic sac, the woman feels acute pain when the salt is injected.

If salt should be injected into a blood vessel the woman would feel pains in her lower back and begin to feel faint and cold. At the first sign of such symptoms the doctor would stop immediately since too much salt in the bloodstream would result ultimately in heart failure and death. Most doctors inject the salt solution very slowly taking up to one hour so that they can stop right away if anything goes wrong.

In a few cases a woman does not go into labor within 50 hours after the saline injection. One reason for this may be twin fetuses with two separate sacs and placentas. In such a case an X-ray will reveal the presence of two fetuses and a second saline injection will induce contractions. In other cases where the woman does not start contractions, a second saline injection may also bring on contractions.

Complications after the fetus is expelled- Sometimes after the fetus is expelled the placenta or part of it is retained in the uterus. According to a survey by the NYC Department of Health, this complication is found in 14 out of every 1,000 women. If material is retained in the uterus, it can generally be removed simply by a D & C.

Hemorrhage (heavy bleeding) also occurs occasionally after the placenta is expelled. By the time the dead placenta peels off the uterine wall following a saline injection, the flow of blood through the wall has been cut down, and there is less risk of bleeding than in a D & C. A Department of Health survey reports that hemorrhage occurred in only 2 out of every 1,000 saline abortions performed over 12 weeks but in 7 out of every 1,000 D & C's and in 10 out of every 1,000 vacuum aspirations performed over 12 weeks.

The risk of infection is higher after a saline abortion than after a D & C or a vacuum aspiration performed before the 12th week of pregnancy.

ARE SALINE ABORTIONS SAFE?

It must be stressed that the medical complications of saline abortions are very dependent on the experience of the doctors performing the procedures. Complication rates may be expected to decrease over the next few years.

Saline abortions are definitely not as safe as abortions performed in the first 12 weeks of pregnancy. In New York City there were complications in 6 out of every 1,000 women having abortions under 12 weeks. 34 women out of every 1,000 women that had abortions over 12 weeks had complications.

If you have to have an abortion after the 12th week of pregnancy then a saline is safer than a D & C. A saline abortion is safer than a hysterotomy. In this procedure the uterine contents are removed after cutting open the uterus. This procedure has all the risks of major surgery. Usually all future pregnancies would then have to be delivered by cesarean section.

The risk from having an abortion by any of the techniques mentioned here is never greater than the risk involved in continuing a pregnancy to full term.

The long term effects on a woman's health of saline abortions have not yet been estimated. In the U.S. this method has been used for too short a time for effective studies to have been made. It is noteworthy that the Japanese stopped using this method because the complication rate was too high. The U.S. experience does not bear this out.

It is important that safer methods of early and late abortions be researched and that these methods be taught to all doctors and be available to all women.

WHO SHOULD HAVE A SALINE ABORTION?

Women who have previously had babies by Cesarean section should not have saline abortions. There is a danger that when such a woman goes into labor the pressure of the contractions will tear the earlier scar. Such a woman should be aborted by a D & C in a hospital or by a hysterotomy.

Women who have had rheumatic heart diseases, heart failure, or severe kidney diseases should have special care because of the risks of heart or kidney failure resulting from the extra load of salt. Some doctors recommend using a concentrated

solution of sugar instead of salt in such cases, but others might prefer to perform a hysterotomy.

HOW DOES IT FEEL FOR A WOMAN?

A saline abortion is a very hard, emotionally draining procedure for a woman to go through. First, the very fact that she was not able to have an early abortion probably means that she had a struggle beforehand. She may have had a hard time getting information about where to get an abortion. She may have had trouble getting a pregnancy test. She may have been unable to get enough money together soon enough. She may have been very frightened and tried to hide the pregnancy from her family, boy-friend, or husband and even herself. (At a municipal hospital in Brooklyn 40% of saline abortions were done for women under 20). She may have been deserted by the man. She may have decided to separate from him. She may have really wanted a baby but found the economic and social pressures overwhelming. Certainly it is the woman who cannot get an abortion in the first 12 weeks of pregnancy who needs help the most. Yet, saline abortions are the most expensive and prolonged procedures. Especially after the 20th week, abortions are almost impossible to obtain.

The saline procedure itself is unpleasant because it requires waiting so long and because of the pain of the contractions. The waiting does not hurt physically. If a woman is alone, if she is in a strange city for the first time, and, like most people, is easily intimidated by institutions, it can be a miserable experience.

The pain of labor (contractions) itself is to some degree dependent on how tense the woman is. Relaxation and breathing such as is used in prepared childbirth can be very helpful in minimizing pain. This requires nurses or other personnel instructing the woman in the techniques which is often not possible in crowded hospital situations. At the end of the procedure the overwhelming feeling of relief and release from months of worry can make a woman positively happy.

HOSPITAL PROCEDURES

In New York State most saline abortions are performed in hospitals. Generally the woman stays in the hospital for the whole procedure, and her experience may depend on the hospital she is in, how much she is paying, the attitudes of the staff towards abortion, etc.

Some hospitals are excellent in attitude but poor in physical set-up. In some cases the woman is allowed to go home after the saline injection and is told to come back to the hospital when she goes into labor. This is fine if she is confident and if she has someone reliable with her. The main advantage is that she can save a lot of money since she is not occupying a hospital bed at $100 per day. It also would allow the hospital to use the available space to perform more abortions rather than fill the beds with waiting women. However, for women it can be very traumatic to sit at home awaiting the unknown.

Some hospitals arrange for a woman to go to a nearby house or hotel where there is a trained attendant on call. This is much cheaper than being in a hospital, but more reassuring than being on your own. A solution to the high cost of salines

that results from the high cost of hospital beds might be saline 'clinics,' but these have not yet been developed.

A few hospitals allow the woman to abort at home after receiving the saline injection in the hospital. The medical risks in this for a healthy woman can be slight if she lives close to a hospital and has received adequate instruction. It is an extremely unpleasant and often dangerous experience especially in a context still fraught with fear and guilt. It would probably be feasible if a trained nurse, midwife, or other attendant was present at the final stage in the woman's home. This sort of home care is not available under the present health care system in the U.S.

COSTS, COSTS, COSTS

New York City municipal hospitals start at $270 for a saline abortion. Voluntary hospital clinics (also generally available only to NYC residents) charge from $300 and up. Saline abortions through private hospitals and private doctors cost between $250 and $1500.

Health insurance covers only a very small part of this cost, generally paying the same as it would for a full term birth. Under the Blue Cross 21-day plan only $100 of the hospital costs would be paid for - provided the woman subscribes through a group.

Figures from New York on late abortions show that as abortion and information about abortion becomes available, more and more women are getting their abortions early. In July and August, 1970, 69% of the reported abortions were done before the 12th week of pregnancy, whereas in January and February of 1971, 77% were done in the first 12 weeks. This number will probably continue to increase.

There are many reasons why some women will always need abortions in the later stages of pregnancy. For example, birth defects are often not discovered until about the 20th week of pregnancy. The desperate need of such women means that there should be no time limit set on abortion. It should be left up to the woman to decide.

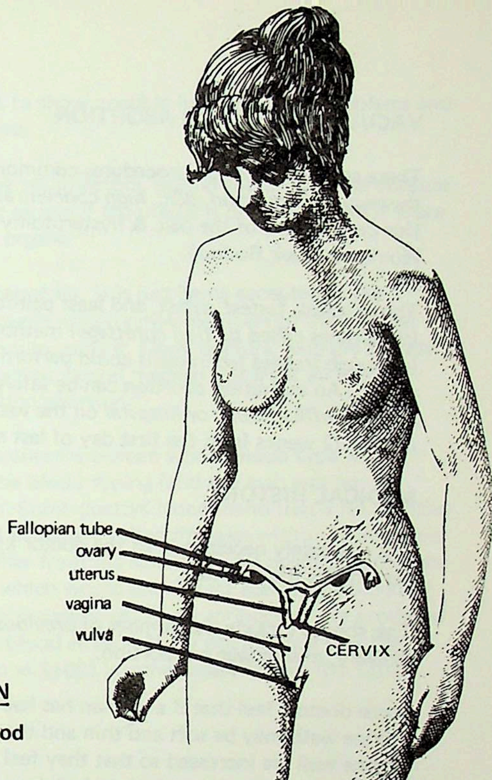
However, it is clear that the present situation prevents women from getting late abortions because of the high cost. We know that many women from outside New York City are forced to bear unwanted children, because they cannot raise $350 plus their travel expenses. Others are still turning to illegal abortionists in other states. There have always been other unsafe methods of inducing abortion after the third month of pregnancy. Women are still dosing themselves with quinine and having their uteruses stuffed with foreign, often unsanitary, material to induce contractions. Women are still having the 'bag of waters' broken in the hope that they will go into labor even though this may take more than a week and leave them vulnerable to serious infection.

The only way to minimize late abortions without sending women back to illegal abortionists or forcing them to bear unwanted children is to make abortion available all over the country. This means working to change the restrictive abortion laws in all states. It means working to make abortion (as well as all other forms of health care) available to women free, when and where they need it.

WORK ON IT SISTERS!

HEALTH ORGANIZING COLLECTIVE OF
N.Y. Women's Health & Abortion Project
36 West 22nd Street, N.Y.C. 10010
1st revision 10/71

VACUUM ASPIRATION ABORTION



COMMON METHODS OF ABORTION

Length of Pregnancy (from 1st day of last period)	Method	
	D&C: Dilation & Curettage	ASPIRATION (or suction curettage)
Up to 12 Weeks	Uterine contents scraped out Performed in hospital, clinic or Dr.'s office Local or general anesthesia	Uterine contents sucked out by vacuum apparatus Performed in hospital, clinic, or Dr.'s office Local or general anesthesia
12 to 14 weeks	D&C and ASPIRATION occasionally performed but risks are higher than earlier in pregnancy, generally should be performed in hospital. General anesthesia.	
14 to 16 weeks	No safe method in use in United States	
16 weeks and over	SALINE INJECTION (or 'salting out.) Some amniotic fluid replaced by salt solution causing uterus to expel contents Hospitalization preferable Local anesthesia	HYSTEROTOMY (or 'mini-cesarean') Uterine contents removed by major abdominal surgery Performed only in hospital General Anesthesia

VACUUM ASPIRATION ABORTION

There are four abortion procedures commonly in use in the United States: they are the *vacuum aspiration, d&c, high concentration saline installation,* and *hysterotomy* (for descriptions of the d&c & hysterotomy see The Birth Control Handbook and Women & Their Bodies).

The simplest, fastest, safest, and least painful method is the *vacuum aspiration* (sometimes called *suction curettage*) method generally performed by gynecologists (although trained technicians could perform the procedure under medical supervision). An aspiration abortion can be safely performed in a properly equipped *doctor's office, clinic or hospital* on the vast majority of women up to approximately 12 weeks from the first day of last menstrual period.

MEDICAL HISTORY

It is absolutely necessary that the doctor know a woman's *medical history* before performing the abortion.

This should include the number of *previous pregnancies* and whether they ended in delivery, miscarriage or abortion.

Some doctors feel that if a woman has had more than 5 previous pregnancies the uterine walls may be soft and thin and the chance of perforating (poking thru) the uterine wall are increased so that they feel it would be safer to perform the procedure in a hospital. Some doctors feel, however, that if the last delivery or termination was more than six months earlier it is still very safe.

A woman who has had one or more deliveries by caesarean sections generally should not have an in-office, in-clinic abortion. The chances of perforating (poking thru) the scar tissue are greater than if the uterus has never been opened by surgery.

Because aspiration abortion is a relatively new method in the U.S., doctors have many theories but do not know what is safe and unsafe.

A past history of asthma, heart disease, kidney failure disease, bleeding or clotting problems, epilepsy or major operations (especially on the intestinal or pelvic areas within 6 months prior to the abortion) *may* possibly make an in-office, out-patient abortion dangerous, and a doctor may recommend the abortion be performed in a hospital.

It is also important that the doctor and staff are aware of previous bad reactions to local or general anaesthetics or to medication.

PRE-PROCEDURAL TESTING

Some doctors feel the need of tests before performing an abortion. These may include a blood clotting time test, hemoglobin and a hematocrit (the last two show if a woman is anemic—loss of blood in a woman with severe anemia is dangerous.)

A few doctors also take x-rays or ekg's to show possible lung and heart problems and urine tests which show kidney infections.

The *blood pressure* of a woman may be taken before, during and after the procedure which may point out internal bleeding caused *if* the uterus is perforated and *if* there has been damage done to surrounding organs.

Aspiration has had wide use in other countries. It is just being accepted in the United States. For this reason, many overly conservative members of the medical profession have been extremely cautious in using it. Many doctors, who are already experienced with this procedure, think that a good medical history is all that is necessary before performing an aspiration abortion.

Another question under some debate concerns women whose blood type is Rh negative. If a woman has an *Rh negative* blood typing (and the man was not Rh negative), the fetus will be Rh positive. Some doctors recommend that a Rh negative woman receive an injection of a blood derivative called *Rhogam* within 72-96 hours after the procedure. This will prevent her from the small but real possibility that she may build up antibodies in her blood which would counteract against the blood of the fetus in possible *future Rh positive* pregnancies. These antibodies are produced if fetal blood passes into the woman's blood stream. Many doctors feel that the expensive injection (it may run as high as $100) is unnecessary before the 12th week of pregnancy.

PROCEDURE

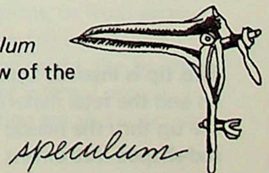
After taking the medical history and explaining the procedure to the woman, she is asked to empty her bladder. It is usually better to eat little or nothing before the procedure because it minimizes discomfort and possible nausea from any drugs she may be given.

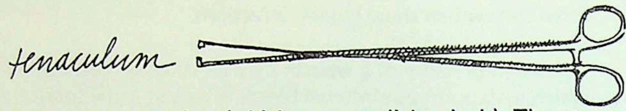
The procedure begins when the woman lies down on a gynecological (or operating-room) table with a sheet draped across her and her feet in stirrups or her legs supported by knee pads.

The doctor will then perform a *bi-manual* exam, inserting 2 fingers of one hand into the vaginal canal, holding the cervix with his/her fingers, and placing the other hand on top of the abdomen, to determine the size of the uterus.

At this point, a woman may receive an injection or an intra-venus (iv) drip into her bloodstream. This may contain a glucose mixture, a tranquilizer, such as valium, and/or pitocin, a uterine contractant which helps the uterus to contract to pre-pregnant size after the fetal material is removed. However, some doctors feel that any or all of the above are unnecessary.

The doctor will then insert an instrument called the *speculum* which keeps the vaginal canal open and allows a good view of the cervix (the mouth or opening of the uterus). This usually does not hurt.





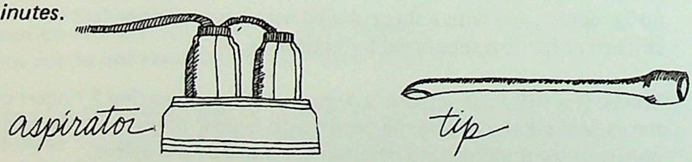
The cervix is then grasped with a *tenaculum* (which causes a slight pinch). The cervix will be held steady throughout the rest of the procedure.

A *paracervical block* (or local anaesthetic) usually xylocaine or novacaine (a substance similar to that used in a dentist's office) is injected into the cervix at 2 points. This numbs the cervix and uterus. The injection is relatively painless as the cervix is a muscle and has few nerve endings in it.

A local, rather than general (or total) anaesthesia is both safer and less expensive. Recovery time is also shorter. A general anaesthetic can worsen lung infections (including bronchitus or colds). It puts a strain on kidneys (especially if the woman has a history of kidney disease and failure). It increases the chances of heart failure. Also, with local anaesthetic there is no added cost of anaesthesiologist.

The cervix is then dilated (opened) slowly with sterile, generally stainless steel, instruments called *dilators*. They are from 6 to 12 inches long and vary in diameter from the size of a matchstick to the width of a piece of chalk and are slightly curved on the ends. The *cervix is dilated* with the smallest dilator first and then with larger and larger dilators until it is opened wide enough for the tip of the aspirator to enter the uterus.

Because the cervix is a muscle, and muscles cramp when they change size, a woman may experience what feels like very heavy menstrual cramping while the cervix is being dilated. If the cervix has been dilated previously (e.g., during miscarriage, delivery, or previous abortions), the cramping is usually less. Dilation usually takes less than *2 minutes*.



The *aspirator* is a machine which consists of a vacuum-producing motor connected to two bottles to which is attached a hollow tube perhaps several feet long. At the end of the tube is a handle into which a variety of different sized sterile hollow tips can fit. These are either stainless steel or disposable plastic and are approximately 6 inches long. The diameter of this tip varies with the length of pregnancy.

This tip is inserted through the open cervix into the uterus. The machine is turned on and the fetal material is removed by gentle vacuuming of the uterine walls, into the tip thru the plastic tube and into the bottle. The abortionist may use a *curette* (a rod-shaped instrument with a triangular or spoon shaped end) to make sure all fetal material has been removed by gently scraping the uterine walls.

The aspiration generally takes *5 to 7 minutes* and is a *painless* procedure. However, as the uterus is emptied of fetal material, it begins to contract back to pre-pregnant size. Since it is a mucsle, these contractions generally cause *cramping*. The cramping, often less severe that that felt during dilation, generally lasts *15 to 30 minutes* after the procedure is completed.

Recovery time with local anaesthetic is usually about *half an hour*, after which most women may return home and resume normal activity.

The amount of pain a woman feels depends not only on physical factors but also and perhaps primarily on her psychological frame of mind. Women who have been told frightening stories about the dangers of illegal abortions done by butcher techniques, who have been made to feel guilty over exercising their *right* to have or not have children, or who would like to carry the fetus to term, but are financially or otherwise unable to do so, often find the procedure more painful.

It is very important to help a woman relax. Of greatest importance is a doctor who has a *non-moralizing, reassuring attitude*. Also, if the woman has the support of *another woman by her side* throughout the entire procedure who is speaking to her, explaining the procedure as it progresses, or even just holding her hand, the whole procedure will go much more easily.

POSSIBLE COMPLICATIONS

The chance of complications from an aspirator abortion is very low. Based on New York City Board of Health figures of abortions performed on 69,000 women, complications resulting from vacuum aspirations were less than 6 out of every 1,000 women.

Possible complications include *hemorrhage* which may occur in about one out of every 1,000 women. It may be caused by laceration (scratching) of the uterine wall or may occur at the point where the placenta is attached to the wall of the uterus. Perforation (poking thru) of the wall of the uterus with dilator, aspirator tip or currette might cause hemorrhage (sometimes internally). Heavy bleeding (approximately, more than twice the flow of the woman's normal period) often accompanied by heavy clotting might indicate that not all the fetal material was removed or that the uterus had not contracted down to normal size. Hemorrhage can occur during or after the procedure. It should not be confused with the normal spotting or flow (similar to a normal period) which follows the abortion and which may be present for 2 to 3 weeks after the abortion.

Another complication is *infection* which may result from unsterile instruments, from a lowered resistance after the abortion which allows already present infecting agents to spread, from tissue left in the uterus which breeds germs, or from germs entering thru the vaginal canal on tampax, thru douching or having intercourse before the uterus has had a chance to heal totally. An infection might also be started if the uterus is perforated allowing infection to spread to other internal organs. A temperature of over 100.5°, heavy cramping, nausea or vomiting are all danger signs which can warn of infection.

Perforations of the uterine wall are generally slight and given time will often heal by themselves. However, a large perforation can damage the uterus and sometimes other internal organs and can lead to infection, hemorrhage or other complications.

The doctor may also fail to remove all the fetal material in which case a woman may need to be admitted to a hospital for a d&c (dilation of the cervix and curettage (scraping) of the uterus) to complete the abortion. A foul smelling vaginal discharge, cramping, nausea, vomitting, prolonged heavy bleeding and infection may indicate a possible *incomplete* abortion.

Infection accounts for complications in one out of every 1,000 women, perforation in 2.3 of every 1,000 women and retained tissue (incompletes) occur in about one of every 1,000 women having aspirations.

Complication rates would go down if medical schools became less conservative and trained old and new doctors, midwives and technicians how to perform safe aspiration abortions.

AFTERCARE

–MEDICATION–Some doctors prescribe *ergotrate* or other smiliar drugs which help assure that the uterus contracts back to pre-pregnant size (in this way helping to prevent infection and possible hemorrhage). Doctors prescribe ergotrate when the uterus was fairly large or there was a good deal of bleeding or as a matter of course.

Ampicillin, Tetracycline or some other *antibiotic* is often prescribed. Many doctors feel that this helps to prevent possible infection while others feel the antibiotic may mask symptoms of infection.

–INSTRUCTIONS for after the abortion–

If infection or heavy bleeding should occur a woman should refrain from any strenuous activity and contact a doctor immediately. Normally a woman can go back to her normal pattern of activities as soon as she feels well enough to leave the doctor's office or clinic.

If there were no complications, it is generally not a good idea to see a gynecologist until the post-abortion bleeding has stopped, as he may give her an infection if he does an internal exam.

To prevent infection:

A woman should *not* douch or use vaginal deodorants
A woman should *not* take tub baths
A woman should *not* use tampax, and
A woman should *not* have intercourse (oral, manual or genital) until all bleeding has stopped or appr. from 2-4 weeks after the abortion.

There is a difference of opinion about the length of time a woman should not do these things, because doctors do not know how long it takes any one woman's uterus to heal completely.

It is best not to have intercourse until some form of birth control is being used. The diaphragm with spermicidal jelly, birth control pills, or an IUD (inter-uterine device, or loop) are the most effective.

If an antibiotic is prescribed, women should be sure to take it at the times specified to keep the level of the medicine in her body high enough to fight any possible infection.

If tetracycline is prescribed, the woman should not drink milk as it lowers the potency of the drug.

COST

In most states abortion is still illegal. An aspiration abortion in New York State, where early abortion is legal, can cost up to $1,000 especially for in-hospital abortions. One hospital estimated that an in-hospital aspiration abortion would cost $250, but if done in a special out-patient clinic associated with the hospital, the estimated cost would go down to $140. In the New York City area to date the lowest price for an in-office, out-patient abortion is $100. It is very difficult to get free abortions.

Until oppressive abortion laws in all states are overturned, until women's bodies are no longer exploited by profiteers, the chances of free, safe abortions for all women are bleak.

It is powerful and revolutionary for us to learn about and become at ease with our bodies, but until we gain control of our inalienable rights to free abortion and health care, we will continue to be oppressed.

unite in sisterhood!

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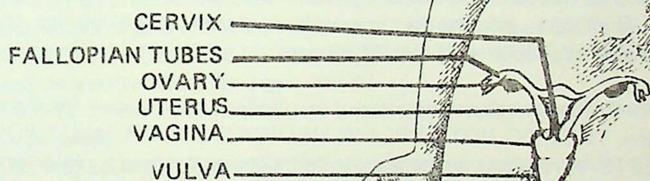
36 West 22nd Street, N.Y.C. 10011

THE GYNECOLOGICAL CHECK-UP



I am a woman. You are a woman.

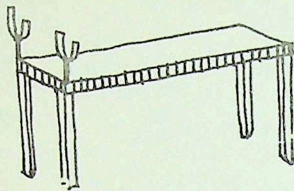
We know that we need healthy bodies to live, love and work in the best ways. So we try to take care of our bodies—we try to stay healthy. BUT, our health does not depend on us alone. We have some personal choices that fundamentally affect our health, but primarily we are affected by the environment we live in and by the health care available to us.

In working for better health care we must struggle on three levels.
One, we must struggle to improve the environment. Poverty, inadequate housing, bad working conditions, pollution of food, air and water, and inadequate health facilities directly affect our bodies.

Two, we must struggle to get preventive health care—to have adequate, thorough and regular physical examinations, effective and *safe* birth control, good prenatal care and adequate tests for detecting such destructive diseases as gonorrhea and cancer. We must also struggle to educate ourselves about our bodies, and what doctors and drugs are doing to us.

Third, we must struggle to get tree, quality care for our specific medical problems, like abortions, childbirth, infections and operations.

In working for better health care, and in particular for better gynecological care, it is important to accept the responsibility we have for our own education: to know and



understand how our bodies function, now to try and keep in good condition, the factors that may affect us, problems that may arise, and the symptoms that we should look out for. Most of us get this information from friends or women's magazines, rather than from our doctors or clinics.

On the other side of the coin is the responsibility of the health system and the doctor (he/she—mostly he) for providing us with regular and thorough check ups to catch the earliest signs of problems and answer our questions about what we have observed about ourselves. When we are examined by a doctor, we are not told what he is doing and do not ask. For one thing we don't know what to ask and for another we are afraid to ask. By the time we have gotten up the courage, the 'busy' (too busy to give us proper care) doctor is gone.

Doctors do not offer us information about our bodies, how to care for ourselves or what is wrong. THEY DO NOT EXPLAIN MEDICATIONS OR THEIR POSSIBLE SIDE EFFECTS. We haven't a clue how to tell when something is really wrong or how to prevent it. In this way we are kept dependent on the powerful and busy doctor—on *his* terms. THE DOCTOR SHOULD BE THERE TO HELP YOU TAKE CARE OF *YOUR* BODY.

But the individual doctor is not entirely to blame. Part of the problem is the way clinics are set up. Most clinics are for people who cannot afford to go to private doctors. Since you pay less you are not supposed to make demands for more of the doctor's time, for explanations or for more personal treatment. Built into the health system is the idea that if you pay for each visit and each service you have rights, and if you don't pay (except through your taxes), you should take what you get.

The Health System is not designed to help us, nor is it designed for preventive care which yields no profit—it is instead, part of the profit-making apparatus of the whole country: profits for doctors, hospitals, drug and insurance companies.

We women must teach ourselves and learn what is necessary for the health of our bodies. With our new knowledge we can demand that doctors, clinics and hospitals give us the care we need. We can also demand more research in gynecology and pediatrics—the two lowest categories on the research scale. But we realize that until health care is seen AS A RIGHT, NOT A PRIVILEGE, we cannot have FREE, quality health care.

The following description of what a good gynecological examination should include is put forth to provide us with the information we need to begin our struggle. A lot of this information will be new to us and it is difficult to remember and learn it all at once. However, it is a beginning step in developing awareness of our bodies, our-selves, and the kind of health care we must demand—for all of us women.

WHAT A GOOD GYNECOLOGICAL EXAMINATION SHOULD INCLUDE

Wash before you go to the doctor but do not douche because the secretions inside your vagina are important signs of health and/or disease.

Weight and Blood Pressure.

These are frequently measured by a nurse or aide before you see the doctor. Long term records are useful to have. A sudden change in your normal weight or rise in blood pressure may be an indication of disease, and may affect the kind of birth control you can use. Some doctors and clinics also measure your temperature at this point, but others only do it if the woman is sick.

General Medical History.

When you first visit a doctor or clinic a complete medical history *should be* taken. Just as health care cannot be isolated from your total environment, so gynecological (gyn.) care may be affected by other health problems. The health of our reproductive and sexual organs is not separate from the rest of our health. DON'T THINK THAT CURRENT PROBLEMS IN THE REST OF YOUR BODY ARE IRRELEVANT because you've come for a gyn. exam:

If you're tired all the time you may be anemic or too heavy periods may be part of the problem.

Tired feet and aching legs may be the forerunners of varicose veins or indicate you shouldn't take the Pill.

Frequent colds, feeling run-down, backaches and skin rashes may be indications of a gyn. related problem.

Your vaginal infection may be the side effect of taking penicillin for a strep throat.

The doctor should also know about past diseases, especially serious ones, even if you've been completely cured:

Rheumatic fever, blood clots, gonorrhea, syphillis, TB and hepatitis may all cause major or minor damage that will relate to your gyn. care. They may determine the sort of birth control or medicine that is recommended.

Also, be sure to tell the doctor about diseases that run in your family. Present diseases such as diabetes or heart disease should also be reported.

If you are allergic to any drugs, or if you have a history of allergy in your family, be sure to mention it.

It is important to know your blood type and if you are Rh positive or negative

Gynecological History

This should be taken in detail. These are the questions you should be asked. If you are not asked, try to bring them up. When you go back for a second visit, remind the doctor of the things which are a problem for you. Even a private doctor may not read your record, and in a clinic you may have a different doctor.

1. Is your period regular?
2. How long is your cycle?
3. Has it been changing?
4. Is your period heavy, medium, light?
5. Has that been changing?
6. Do you have cramps? are they severe or slight?
7. Have you ever been pregnant?
8. Did the pregnancies end in miscarriage/abortion/childbirth?
9. If a pregnancy ended in miscarriage, at what month were there problems?
10. If a pregnancy ended in abortion—at what month—what method—under what circumstances (illegal-legal—you have the right to refuse to answer questions about illegal abortion, but if there were complications it would be wise to explain them).
11. If a pregnancy ended in childbirth, at what month, how heavy was the baby, were there any complications during pregnancy or delivery?
12. What methods, if any, of birth control have you used?
13. With what effect?
14. What method, if any, of birth control are you presently using?
15. Have you had any infections, diseases—especially gonorrhea or syphillis—or operations?

The medical history may be taken by someone other than the doctor, by a nurse or a trained aide. Don't assume that because you've told her that the information will necessarily get through to the doctor or that he will read the aide's notes thoroughly before he examines you. You may find it much easier to talk to the nurse because she's usually a woman and often seems more willing to answer you so try out your questions before you go in to see the doctor. MAKE SURE THAT ALL OF THESE QUESTIONS ARE ASKED, BECAUSE IF THEY AREN'T YOUR EXAMINATION HAS NOT BEEN COMPLETE.

Most clinics and most doctors do not take good, complete medical histories AND IT IS HARD WHEN YOU ARE ALONE IN A DOCTOR'S OFFICE OR CLINIC TO CRITICIZE THE KIND OF CARE YOU ARE RECEIVING.

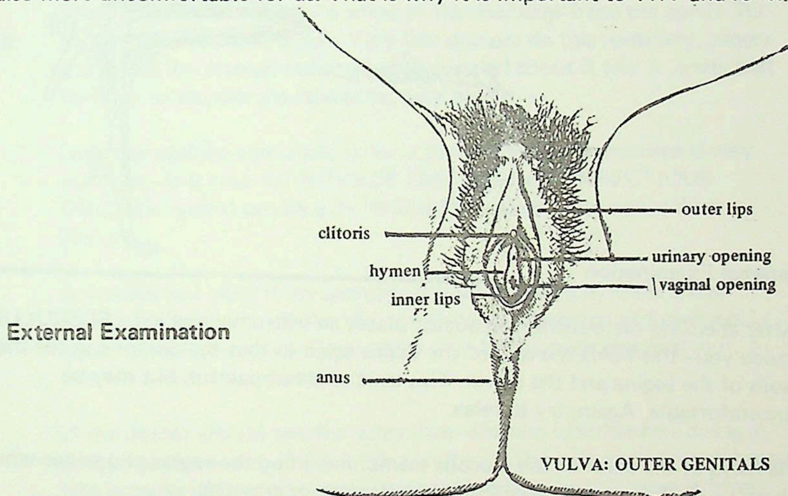
The Physical Examination

The exam will be more comfortable if you urinate. If you are asked to undress, you should be given something to cover yourself with. You have the right to have a woman in the room with you during the exam.

At an initial examination with the doctor you should have a general check-up, i.e. he should listen to your heart and chest, check your eyes, ears and throat. If you've had this done recently by another doctor, especially one at the same clinic, this general check up isn't necessary, but if you've not seen a doctor for a while don't hesitate to ask a gynecologist to do these simple tests. However we know that this is NOT common practice.

After examining the upper part of your body—if necessary—you will then be asked to lie down on the examining table and put your feet in the stirrups.

MOST OF WHAT WE'VE LEARNED ABOUT OUR SEXUAL ORGANS HAS BEEN SECRET, WHISPERED, OR PRIVATE. Many a woman has never explored herself with her fingers. It is therefore very hard to feel relaxed about being exposed and examined by a stranger, especially a man. So instead of relaxing we tense up, which means it's much harder for the doctor to feel the organs inside our abdomen and harder to examine the vaginal muscles at the entrance, which are tight, and it's also more uncomfortable for us. That is why it is important to TRY and relax.



VULVA: OUTER GENITALS

External Examination

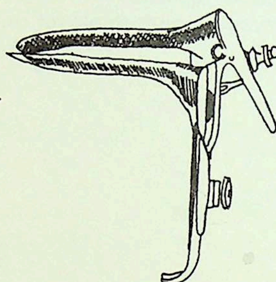
While you're lying on your back the doctor should press and poke your upper abdomen feeling for your liver, spleen and kidneys. If they are enlarged this could be a sign of pregnancy or disease. These organs are important in general and especially when you're pregnant when they have to work for you and the fetus, too.

The doctor will *examine your breasts*, feeling each part for any unusual lumps or growths. If you feel any pain or tenderness you should tell the doctor, also describe to him swelling or tenderness you feel just before or during your period. This will give him the opportunity to discuss with you what the various changes mean. He'll probably just say, "Oh, don't worry", but it's still worth trying.

You should examine your own breasts regularly especially if you are over 30 when the chance of getting breast cancer increases. If the doctor doesn't tell you how to do this, ask him or the nurse. Booklets about breast self examination should be available, so ask for one. If not, probably the American Cancer Society in your area can send you one. This examination of yourself is especially important if you use a clinic or outpatient department where you see a different doctor each time or where the doctors are fresh out of medical school and inexperienced. You can detect changes that occur slowly and will probably be able to feel small lumps long before any stranger. DON'T FORGET, MORE THAN ONE FIFTH OF CANCER IN ADULT WOMEN IS CANCER OF THE BREAST AND IN MOST CASES CAN BE CURED IF IT'S TREATED EARLY.

Next, the doctor *examines your outer genitals*. First he checks the vulva and the anus. The vulva includes the outer and inner lips of the vagina, the entrance to the vagina, the hymen if present, the clitoris and the urinary opening. He's looking for:

signs of infections, such as inflammation, swelling or sores, and for infected glands and for growths (such as warts, cysts, tumors or polyps) and *also for signs of damage.*



Internal Examination

After checking the outside, the doctor places an instrument called a SPECULUM inside you—this holds the wall of the vagina open so that the doctor can see the walls of the vagina and the cervix. This usually is not painful, but may be uncomfortable. Again, try to relax.

He looks at the color of the mucous membrane lining the vagina and to see whether there's a discharge or signs of infection, damage or growths.

He also notes the position of the cervix in relation to the vagina. In some women the uterus is tipped or tilted. If so, he should tell you—there is nothing unhealthy about having a tipped uterus, but some people think it can cause extra problems in pregnancy or abortion, so it is important for you to know about it.

NEXT, the doctor may perform some tests.

First: **PAP TEST** — using a tip, wooden spatula, a flattened metal stick or a glass tube, he'll remove some cells from your cervix. This is painless. These will be sent to a lab and studied to see if there are any signs of cancer developing. This is called a PAP TEST and should probably be done approximately once a year if a woman is over 30 and once every two years between 20 and 30 (opinions on how often for the 20-30 year old age group vary from once a year to once every few years). If you are on the Pill some doctors and clinics may do a PAP test every six months.

Second: **TEST FOR FOR INFECT TIONS** — If you have more than a small amount of a yellowish discharge from the vagina and complain of soreness or irritation, or itching, he'll remove a sample of the discharge and look at it under a microscope. If you've got a vaginal infection he may be able to see the organisms and know what treatment to prescribe.

The two most common vaginal infections are monilia (yeast or fungus) and trichomonas. For monilia the treatment usually is a nystatin tablet (suppositories) inserted into the vagina—for trichomonas, 'trich', the medication given is usually a pill called Flagyl.

Third: TESTS FOR VD

The doctor should also take some of the discharge from the cervix TO TEST FOR GONORRHEA. Very few doctors do this routinely, others only do if the woman indicates she's worried about it and suspects that the man or woman she relates to, may have it.

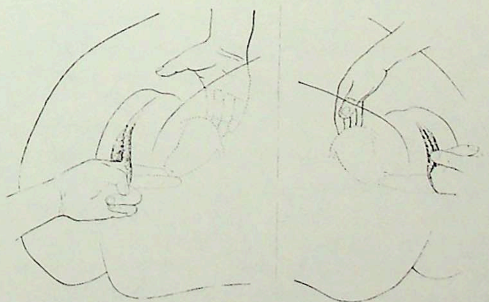
Don't be uptight about asking for a gonorrhea test (gonorrhea is very common—it is now the NUMBER ONE SERIOUS INFECTIOUS DISEASE—and it can be very serious for women—you can end up sterile).

A woman can carry it for months without knowing it, while a man usually knows he has it—he has symptoms of discharge and severe pain when urinating—within three weeks after he has been exposed to it. A woman often has no symptoms.

If the doctor should test for gonorrhea—aks him whether he's doing a simple gram stain or whether it's a 'culture'. The culture is a much better test because it's more accurate: especially when the discharge is from several places (such as cervix and urethra or cervix and anus).

A blood test should be done for syphillis. This is usually an accurate test when done 4-6 weeks after exposure.

After doing the tests the doctor puts on a sterile rubber glove and with two fingers feels inside the vagina for lumps and tumors.



The BiManual or Two Handed Examination

The doctor *places two fingers against the cervix and with his other hand feels the top of the uterus through the lower abdomen wall.* He can feel how big the uterus is, whether it's soft and whether it can move easily, and if there are any obvious lumps or pain.

Finally the doctor feels through your abdomen walls at the sides to feel your ovaries and tubes. If they're fine and healthy he probably won't be able to feel anything, but if there are lumps or inflammation and infection, he can often feel it. You may feel a little twinge when he presses your ovaries. This is normal but if there is serious pain it is usually a sign of infection.

At this point the physical examination is over and you get dressed. *If medication is needed the doctor gives it to you or writes a prescription.* He should tell you what the drug is and SHOULD DISCUSS WITH YOU SIDE EFFECTS AND THINGS TO AVOID—but often he won't bother. It is important to take the drug at the times prescribed so the level of the drug in your body will stay high enough to be effective.

Try and ask questions—even if they seem minor. But if the doctor is one of the cold, aloof sort don't wait till the end to ask—just keep asking through the examination. After the examination many women feel they shouldn't take up any more of 'busy' doctor's time, and feel stupid asking questions—so they get nervous and leave with unanswered questions. Unfortunately, the medical profession and clinics and hospitals are now set up so that it is difficult for a patient, and especially a woman, to feel comfortable asking questions.

When you come out of the doctor's room with unanswered questions, you might try and talk with the nurse. Nurses often know a great deal about all the medical problems but we seldom realize it because we're generally told just to talk to the doctors. Moreover in clinics the nurses are often more sympathetic and more in touch with the needs and problems of the community than the doctors.

THE BIGGEST HEALTH PROBLEM WE HAVE

The biggest health problem we have is how to get good health care for all of us. This will be a long struggle. Meanwhile, it is also a problem to figure out where to go for the best (presently) available care. Unless you live in a really small town it's very difficult to find out what clinics, doctors, and hospitals exist, and where the best services are available—and how much they cost. It is obvious that all of us should start developing lists of good doctors and clinics for women in our communities.

We must educate ourselves about our bodies and take the mystery out of the doctor's role. We must force doctors and medical institutions to do more research on women's health problems and to share with us the secrets they have learned about our bodies. They must change the way they provide care. OUR WORK TO CHANGE THE HEALTH CARE SYSTEM MUST BE PART OF THE STRUGGLE TO CHANGE OUR PRESENT ECONOMIC SYSTEM—WHICH OPPRESSES US IN OUR HEALTH CARE AS WELL AS ALL OTHER ASPECTS OF OUR LIVES.

HEALTH ORGANIZING COLLECTIVE OF
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COMMON INFECTIONS OF THE VAGINAL AREA

TRODUCTION: NORMAL CONDITION OF THE VAGINA

all women the membranes that line the vagina secrete moisture and mucus. This charge is transparent or slightly milky and may be somewhat slimy. When dry it y look yellow. This secretion increases in a woman who is sexually aroused. It is a rmal discharge—and causes no irritation or inflamation of the vagina or the vulva. y woman who wants to examine her discharge should scrape a sample from inside e vagina (with a washed finger of course). It's easiest to see when smeared on glass.

normal healthy woman of child-bearing age has bacteria inside her vagina. These p keep the vagina acid which kills off yeasts, fungus and harmful organisms. Prove yourself it's acid by tasting some of your secretion, it's rather reminiscent of egar. Constant douching or the use of vaginal sprays and deodorants can destroy s bacteria and actually help the growth of unpleasant organisms.

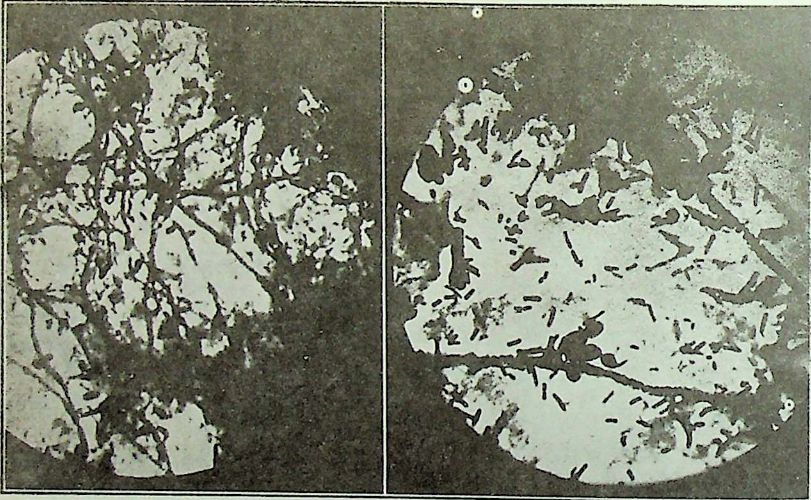
FECTIONS OF THE VAGINA

YEAST, FUNGUS, MONILIA, OR CANDIDA. (These names all refer to the ne infection of the vagina. (Vaginal infection is called vaginitis.)

mptoms: Itching and inflammation of the vulva and outer vagina. A white dis-

charge which may be light or quite heavy and thick, like cottage cheese. This is produced inside the vagina and around the cervix and contains substances that irritate and inflame the vagina and vulva as they are discharged.

Cause: A fungus called Monilia or Candida, is around everywhere, as tiny spores or seeds. As it grows in the vagina it produces a network of threads which produce more spores.



Treatment: The painful outside itching and inflammation may be helped quickly by painting the whole area with gentioan violet. This is messy but helpful when the pain is great. Usual treatment is with tablets of Mycostatin or nystatin. These are put deep into the vagina night and morning and with the moisture of the vagina they disintegrate and spread over the surface of the vagina and cervix killing the yeast.

Circumstances when Monilia infect easily:

1. Women with diabetes or who are prediabetic have sugar in their urine which is deposited on the tissues of the vulva. This provides good food for the yeast and allows them to infect the vulva and vagina.

2. When antibiotics are taken to combat a bacterial infection anywhere in the body, they kill off the normal bacteria which keeps the fungus under control. This allows the fungus spores (Monilia) to invade the vagina.

3. The level of acids in the vagina depends partly on the changes in the level of the hormones released by the ovaries, therefore it may vary during the menstrual cycle. When a woman is taking combination contraceptive pills, the hormone level stays the same for three weeks, this may cause women on the pill to develop vaginal infections more often than women not on the pill.

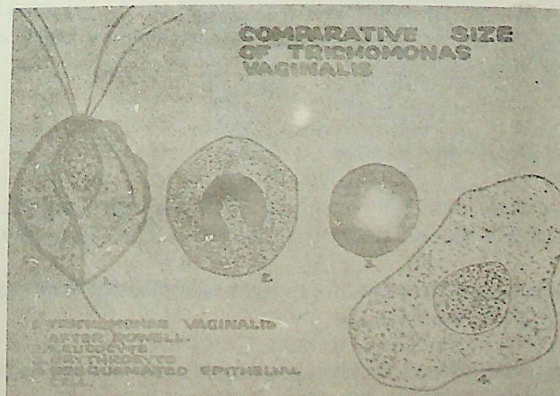
4. During pregnancy hormonal levels change and the vagina is more likely to become infected.

5. Yeast grows in moist warm places. Swimsuits worn frequently may have spores in th: crotch. This is especially true of closely woven nylon and latex suits. You should wash your suit after use with a mild detergent or soap.

2. 'TRICH' OR TRICHOMONAS: (Another type of vagina infection, don't confuse this with trichinosis which is a serious disease you get from eating uncooked pork.)

Symptoms: Itching and inflamed vulva and vagina, discharge of varying amounts which is a greenish-yellowish and slimy or foamy, possibly containing streaks of mucus. This is produced inside the vagina on and around the cervix, and as with the yeast infections it is the product of growth of the Trich that irritates and inflames the walls of the vagina and the vulva.

Causes: A tiny one-celled animal called Trichomonas vaginalis (a protozoan) with tiny whip-like tenacles with which it swims around. To be sure that the Trichomonas is there the doctor or nurse may take a smear from the cervix, mix it with a salt solution and look at it under a microscope. He should see them swimming around especially if the slide is warmed a little.



Treatment: The commonest treatment is a drug called Flagyl or metronidazole. The woman takes 250 mg three times a day for ten days, which cures 90% of the cases. If she has a 'regular sexual partner' he is often treated too since he can be infected inside his penis and reinfect the woman. When taking this drug you shouldn't drink alcohol because it can lead to nausea and vomiting. Very occasionally a woman may have a bad reaction to the drug (stomach cramps, nausea or constipation). For the 10% of the women who are not cured by Flagyl, the doctor will probably first try another 10 days of the same drug, possibly also prescribing vaginal suppositories. Flagyl is made by a single drug company which has a monopoly and manages to keep the price up. The cost of the standard 10-day treatment is from $6 to $12.

There is some disagreement among doctors about whether Trich is found in the normal vagina. In one study 50% of the women tested were found to carry Trich in their vaginas but many of them had no symptoms.Therefore, some doctors do not treat Trich unless the woman complains.

Flagyl (just like antibiotics) may kill off the normal bacteria in the vagina and allow the fungus spores (Monilia) to infect. For this reason some doctors recommend that medicine called Mycostatin or mystatin be used for a few days after the 10-day Flagyl treatment.

3. OTHER INFECTIONS OF THE VAGINA: (Non-Specific vaginitis)

Symptoms include a discharge and itchy vulva and vagina. These are generally treated with sulfanamide drugs or antibiotics. (In some cases the normal vaginal bacteria may multiply profusely and get out of hand.) Such cases are often related to being in poor health generally.

GONORRHEA DISCHARGE: (Gonorrhea is not going to be discussed in detail here, it is discussed in greater detail in other places. It is only mentioned here because its symptoms are sometimes confused with other vaginal area infections.)

Gonorrhea is a veneral disease, it is transmitted *only by sexual contact.* The gon-orrhea bacteria infects the cervix rather than the vaginal wall. This infection results in a discharge that is yellow or yellow green and may be irritating to the vulva. It is easy to confuse with any other vaginitis, though when the vagina is examined it can be seen that it is not infected.

PREVENTION OF INFECTION

1. Routine cleanliness—daily washing of the vulval area with mild soap. Baths may be preferred over showers since the vulva area may be thoroughly cleansed.

2. Likewise routine cleanliness by the man will minimize chance of infection during intercourse. Soap kills Trich fast.

3. Wiping yourself front to back prevents the spread of bacteria and Trich from rectum to vagina.

4. Changing underpants everyday and wearing cotton instead of nylon underwear helps to prevent infection.

5. Avoidance of irritating soaps or sprays, or pressure from clothes, like tight pants. (One vaginal spray—Mesengil, also kills roaches.)

6. Some women, after trying every remedy for constantly recurring infections say that douching once a week with white vinegar (3 Tbls. vinegar/2 qts. water) is the only thing that keeps them itch free.

RELIEVING THE ITCH

The itch and soreness can be relieved by:

a) Keeping the area clean

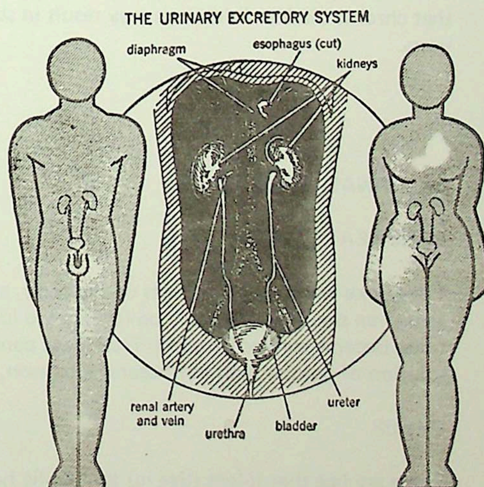
b) Soaking in a bath several times a day

c) Keeping the area dry: dab it dry with cotton—this is softer than a towel and can be thrown away. If you dry yourself with a towel the spores of the fungus will stay on the towel and you'll reinfect yourself and possibly other people.

d) A bland ointment like destin (used for diaper rash) can soothe the itching.

e) Don't wear pants

f) If the itch is uncontrollable, dab on a little witch hazel or an ointment or jelly containing a local anasthetic



BLADDER INFECTIONS OR CYSTITIS

Another infection which many women suffer from secretly is cystitis which is a medical term for a bladder infection. Urine is clean and sterile, normally there are no bacteria in the bladder. The openings of the vagina, urethra, and rectum are close together; this area is moist so it is easy for germs to spread from the rectum or

vagina to the urethra and bladder. Bladder infections occur in children and celibate women, but like vaginal infections they occur more often among women who make love with men. (In the days when women were virgins at marriage, cystitis was often called 'honeymoon disease').

Symtoms: There is pain and a burning feeling when you pass urine. You may want to pee frequently, yet when you do there is very little urine in your bladder. In a bad case there may be blood in the urine.

Cause: Several different germs can infect the bladder including those that are normally present in the rectum. If a woman is diabetic and there is sugar in her urine, bacteria will grow and spread easier.

Treatment: Gantrisin is a sulfa drug and is widely used. In some cases the bacteria may be resistant to gantrisin and an antibiotic like tetracycline is used. This medication should bring almost immediate relief of the symptoms. However, the infection is not immediately cured, so the medication should be continued for about two weeks.

Some women have side effects when they take Gantrisin including headaches, in such cases tetracycline is used.

Women who have a history of bladder or kidney infections should drink a lot of fluids because this dilutes the urine and flushes the kidneys.

It is very important to be completely cured of bladder infections. Many people think that chronic bladder infections may result in serious kidney diseases after many years.

EXTERNAL PROBLEMS:

VENEREAL WARTS

These, like warts on other parts of the body, are caused by viruses and appear to be passed on sexually. They can be felt as hard lumps on the skin surface, and can at times become sore or irritated. Treatment consists of a weekly painting with a solution of polophyllon in tincture of benson, or burning them off.

CRABS

These are lice that infect (live in) the public hair but maybe found on any other hair. They suck the blood from the infested area. Lice are easily passed on sexually but may also be acquired from bedmates, sharing bedlinen and towels. They have occurred recently in commune situations. Treatment is (A) Through cleansing with Kwell in cream, lotion, or shampoo form and (b) using freshly washed underwear and bedding.

A series of minor infections over many years may

(a) cause us terrible discomfort

(b) be a sign of a more serious problem

(c) lead to serious disease in the future.

We need health care that helps us discover and treat these infections as soon as they appear, and we need to get that care in the same place and from the same doctor that treats us for other health problems and especially other gynecological problems.

At the present time there are separate clinics for birth control, Venereal Disease, for vaginal infections, and for bladder infections. Even at the same clinic the chances are that we will see different doctors each time. There are other barriers that prevent us from going for health care till our symptoms are too bad to ignore: barriers of money, red-tape, hours of waiting and the arrogant and racist attitudes of doctors towards women (especially third-world women).

Women must get together to demand that we get free, comprehensive health care in one place, from a single doctor and nurse who know us and are fully responsible to us.

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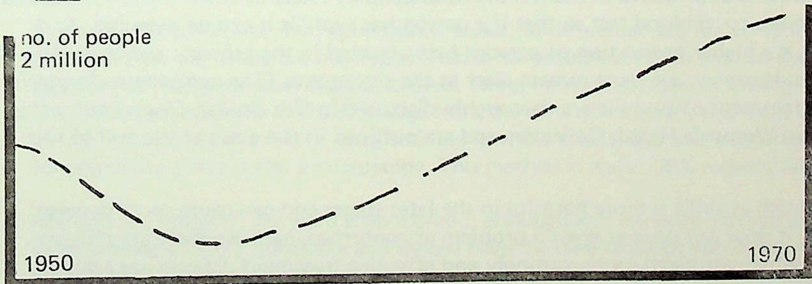

VENEREAL DISEASE

It is a woman's right to control her body and to determine for herself when she would like to bear children. But if she cannot get adequate health care for her body, she cannot make these choices. Venereal disease is the main disease which takes away a woman's right to choose. It can make her sterile, less fertile, miscarry, have stillbirths or diseased children.

In spite of the severe consequences, VD tests are not yet a routine part of the health check-up. AND when you do get a VD test, it is very often not accurate.

More women are being exposed to VD today than in the past. This is probably because women have more sexual freedom today. But as long as VD is a threat, women cannot have sex without fear, and this is limiting our sexual freedom.

VD was on the decline in the 1950's, but today it is the most widespread serious communicable disease in the country. It infects perhaps one American in every 100, and young people are the largest group infected. If any other disease that is passed from one person to another so easily were that widespread, it would be considered an epidemic and would receive urgent national attention.

One reason VD has been neglected seems to be because of the moralistic attitude toward sex in this country—sex outside of marriage is "bad." If you have sex outside of marriage, you deserve to suffer the consequences. Instead of treating the disease, the authorities tell people not to have sex. Other reasons that VD has been neglected are discussed at the end of this paper.

There are two types of VD, syphilis and gonorrhea. There has been a recent increase in syphilis, but gonorrhea is out of control and is a greater danger to women. For this reason, this information is mostly about gonorrhea.

SYPHILIS

At least 500,000 Americans have syphilis and don't know it. Half of them will be cured inadvertently through treatment of another illness with antibiotics. For example, if a person has syphilis and is not aware of it, but is treated with antibiotics for some illness or other, his or her syphilis may also be cured. The other half will be seriously affected. We have not remained alert to the problems of syphilis because it was generally thought that with antibiotics it was no longer a serious problem. Penicillin is as effective in the treatment of syhpilis today as when it was introduced. There is a good blood test so that if a person has syphilis it can be detected. And there is a higher proportion of persons being treated in the primary and secondary stages. However, we must remain alert to the symptoms. (The symptoms, diagnosis and treatment of syphilis are thoroughly discussed in *Our Bodies, Ourselves* by the Boston Women's Health Collective and are outlined in the chart at the end of this paper.

Although syphilis is more harmful in the later stages and can cause more damage then, it does not pose as great a problem as gonorrhea, because there are reliable tests which are given more routinely and effective treatment. Gonorrhea seldom produces symptoms in women (or produces symptoms that are more readily attributed to other women's problems), has no reliable diagnostic tests and no reliable test to assure a woman that she is cured. The high dosage of penicillin needed for treatment may cause complications or future resistance to this drug. Thus, we can see that gonorrhea is a great problem for women, and we intend to stress the aspects that we feel are not discussed elsewhere.

GONORRHEA

Although syphilis and gonorrhea are two different diseases, they have one thing in common and that is that they are both caught in only one way: from having sexual intercourse with someone who already has the disease. The germs for each of these diseases can only live for a matter of seconds outside the human

body. If they become dry or too hot or too cold, they die. Therefore, to spread to a new person, these germs must be deposited on warm, moist surfaces (such as the lining of the genitals, or perhaps the mouth). This means that sexual intercourse, with a person of the same or opposite sex, provides ideal conditions for the transfer of VD germs.

Gonorrhea is caused by a germ shaped like a coffee bean called a *gonococcus*, which works its way gradually along the passageways of the genital organs. This disease can be passed on to another person at all stages. The symptoms of gonorrhea are different for men and women, even though the germ is the same.

Symptoms or Lack of Symptoms

To start with, gonorrhea is often without symptoms in women. About 90% of the women infected with gonorrhea are not aware of their infection. This is in contrast to men who usually become aware of the infection within a matter of days because of a pus discharge from the penis and a burning sensation while urinating. Even in the minority of women who do develop symptoms—a vaginal discharge and pain during urination—the symptoms are thought to be a sign of common gynecological problems or the side effect of a birth control method, such as the pill.

Because of this, a woman doesn't learn that she is infected until (1) she is told by an infected male with whom she has had sexual intercourse; (2) she is traced by a Public Health Service casefinder as a person soneone else has infected; (3) her own infection has spread to the point of causing pain and she goes to a doctor.

Testing and Diagnosis

In diagnosing gonorrhea, men again have it easier, while women are forced to live in doubt and danger. There are two types of tests for gonorrhea which women should be aware of—the *gram stain* and the *culture*. The *gram stain* method of testing involves taking a sample of the discharge from the cervix in women, and from the urethra in men, placing it on a slide, staining it with a special dye and examining it for gonorrhea germs under a microscope. This method is about 99% reliable for men.

For women, however, the gram stain method, although still the only method used in many places, is highly unreliable and should never be used without also doing the culture test. The *culture* test also involves taking a sample of the discharge, putting it on a special plate, and letting the sample grow under special laboratory conditions for several days in an attempt to let the gonorrhea germs (if there are any) multiply. This allows the germs to be detected more easily. The culture method can also be used as a test for men, but it is hardly ever necessary as the gram stain in males is so reliable.

However, it is important to emphasize that even the culture test can be inaccurate for women. Accuracy depends greatly on which places are chosen to take the culture from. Ideally, the four places of possible infection—the cervix, urethra, vagina, and rectum—should be cultured, but this is very expensive. If a single place is chosen for culture, it should be the cervix since a single cervical culture will detect approximately 82% of infected women. In some studies, about 50% of infected women showed an infection in the rectum. The urethra is another place where germs are

likely to spread easily. Therefore, at least two places should be cultured—cervix and urethra or cervix and rectum. Even if more than one place is cultured, 6-9% of infected women will not be diagnosed in a single visit. One explanation for why the culture method doesn't work is that the gonococcus organism often dies on the way from the clinic or doctor's office to the laboratory, thereby resulting in a false negative result for a woman who is in fact infected. Also, there is some evidence that there is a greater chance of detecting gonorrhea during menstruation.

Test for Cure

Since most women have no symptoms of gonorrhea, the only way they can tell they are cured is by being tested. And since the tests are not reliable, a woman should have at least two negative tests before being discharged as cured. Yet, many women are treated and discharged without ever being tested for diagnosis or cure. They tell a doctor they think they are infected, and the doctor gives them penicillin. This can happen when the doctor does not have the complicated laboratory facilities needed to do the tests. But it is very unsafe for women.

Treatment without testing is very unsafe for women for two reasons. First, she may *not* have been infected and received a large dose of antibiotics needlessly. (Too many large doses of antibiotics can make the body build up a resistance to this medicine.) Second, she can never know if she was cured.

It is obvious that our greatest need is for a cheap, accurate test to diagnose gonorrhea and test for cure. Until we have such a test, many women will discover they have gonorrhea only when it has reached the painful stages, and by then, serious damage may already be done.

Results of Gonorrhea

Unlike syphilis which goes all through a person's body, gonorrhea is essentially a disease of the genital and urinary organs. (Sometimes gonorrhea travels through the bloodstream and causes infection in the valves of the heart, or acute arthritis, blindness and even death. However, this is not at all common.) The disease is more likely to persist and spread in women than in men because the cervix becomes inflamed and the germs get into the glands and do not pass out of the bodily easily. In men, on the other hand, the germs stay at the initial source of infection, usually the urethra, where they can be more easily washed out of the body. Men who are not treated can suffer from narrowing of the urethra and sometimes get chronic inflammation of the testes (the balls).

One of the most severe consequences of untreated gonorrhea in women is salpingitis (a very painful infection of the tubes which may lead to abcesses or scarring of the fallopian tubes). If this happens several times, it can result in sterility. In 1948, a study showed that salpingitis was present in 2.6% of women diagnosed as having gonorrhea. A study carried out in 1963-66 showed that the percentage had risen to 10.6%. Early recognition and treatment is essential if subfertility and sterility are to be prevented. In addition, a pregnant woman with untreated gonorrhea can infect her baby as it passes through the birth canal. The baby's disease is called gonococcal conjunctivitis and causes blindness if not treated. Gonococcal conjunctivitis is

usually prevented by placing a few drops of silver nitrate solution in the baby's eyes at birth. However, in the past ten years, gonococcal conjunctivitis has increased just as gonorrhea has spread. This epidemic must be stopped!

Treatment

The normal treatment for gonorrhea is high-dosage injections of penicillin. If the first treatment does not cure, the dosage is doubled for a second treatment or other antibiotics are tried. Hwoever, treatment is often not as safe or easy as it sounds. Gonorrhea germs, as well as the body's systems, seem to have the ability to build up resistance to penicillin. Strains of gonorrhea are developing which do not respond to the normal high dosage of penicillin treatment. One way these resistant strains seem to develop is when a low dosage of antibiotics is taken for protection against the disease. This low dosage may not be strong enough to kill the gonococcus germs, so instead they adapt to the presence of antibiotics and become resistant to them. As a result of the development of these strains, the Public Health Service (PHS) in 1965 increased its recommended dosage of penicillin for the treatment of gonorrhea to 2.4 million units in men and to 4.8 units in women (4.8 units is the maximum injectable at one time). If dosage requirements increase, future patients may have to be hospitalized for intravenous treatment.

However, some doctors maintain that penicillin impotency is not yet a "major problem nationally" as there are oral antibiotics such as the tetracyclin group and other mycins for difficult cases. And for the few cases that don't respond to this treatment, there is another antibiotic, Loridine, whose cure record is perfect so far. Another treatment is to give oral probenecid along with penicillin. This drug makes you urinate less often and by keeping the water in your body also keeps the penicillin in your body and at a high level for a longer time so it can kill the germs. This does not reduce the danger of taking such high powered drugs, nor does it reduce the need for accurate diagnostic tests and tests for cure.

Funding

The absence of laboratory diagnostic tests for gonorrhea which are comparable to the simple, reliable blood test for syphilis, and the lack of adequate and safe treatment for the disease reflects the priorities of a health care system that severely neglects many of the basic health care needs of women.

One big reason for the neglect of gonorrhea is that the severe effects of gonorrhea were much more widespread among poor (black, brown and white) women who could not get adequate health care. Syphilis, on the other hand, has received much more attention because it killed middle class whites. Our racist, sexist and capitalistic society is not willing to spend money to liberate Blacks, women or poor people.

Millions of dollars are spent each year by the government and private institutions to do research on and educate the public about other diseases like cancer, heart disease, polio, etc. So far, there is no private group doing the same for VD. And the government gives much less money for VD than for other diseases.

The total Public Health Service's VD budget for 1969 was 12 million dollars. Only

$500,000 of this was for gonorrhea control. Most of the gonorrhea money was not for research, but for carrying on the traditional casefinding method which was already proven to be a very limited and ineffective approach to the control of gonorrhea. Although research is presently going on at the VD research laboratory in Atlanta for a blood test for gonorrhea, there is little hope that there will be enough money to produce a cheap routine test in the near future.

The gross inadequacy of federal funds is also the reason that there are no preventive vaccines for syphilis or gonorrhea.

There is also a severe shortage of clinics which will treat VD patients. While some clinics have made the blood test for syphilis a routine part of an OB-GYN exam, almost no health facility gives gonorrhea tests routinely, or even makes the test available.

Prevention

As mentioned before, the Public Health Service is charged with the control program for VD. This involves testing for VD and follow-up investigations to locate sex partners and those that a person might have infected. This is not a very reliable way to control VD since a person can refuse to name sex partners. In half of the states, the law *requires* that positive results of lab tests for VD be sent to the Health Commissioner who contacts the doctor or clinic of the person to determine if the disease actually exists. Many private doctors, however, do not report VD cases to the PHS for follow-up. One of the reasons for this is that the PHS has a very moralistic attitude towards sex. When they investigate reported cases of VD, they ask the persons to name all sexual contacts and other persons with whom he has had contact and knows to be *'promiscuous'*. In fact, it turns out that a lot of the people who should supposedly be helping to stamp out VD are really much more interested in stamping out "illegal" sex. The people to be most harrassed by these techniques are poor and low-income people since they often have little choice but to use public clinics which must report to PHS. Attitudes about sexual participation are changing, particularly among young people, and yet in 36 states, it is still illegal for a minor to be treated for VD without his or her parent's consent.

The United States is known for its hypocrisy when it comes to sex (as well as many other things). On the one hand, just about every business in this country uses commercial sex to sell its products. On the other hand, a lot of adults treat sex as if it were something dirty and sinful that should never be talked about—especially in front of young people. And when sex is talked about, it must be moralized about. For instance, some of the movies shown about VD in the schools make it look like getting VD is a justified punishment for committing the "sin" of having sex with someone before being married.

It is clear that the present casefinding and investigation methods of PHS have not worked in wiping out VD, and instead of concentrating on these ineffective techniques, other ways of approaching this problem must be found.

NEW PERSPECTIVES ON V.D. or Health Care without Racism, Sexism or Capitalism

1) Up to now, gonorrhea has not been treated as a dangerous epidemic because its

severest consequences were found mostly in poor (black, brown, and white) communities where there is still no adequate health care available. Sterility from gonorrhea is a type of population control which whites always want for third world people. No one in authority was ready to put money into researching and eliminating a disease which most severely affected poor (black, brown, and white people). (Non-poor white people who get this disease could secretly go to their private doctors and spend money on expensive treatment.)

As long as the worst effects are felt by women, it is women who will have to struggle to end VD. AS WE EDUCATE OURSELVES ABOUT VD; WE MUST TALK ABOUT THE RACIST AND SEXIST WAY HEALTH CARE IS SET UP.

2) We must demand research for a preventive vaccine and accurate diagnostic tests which are not expensive.

3) Tests must become a routine part of every health check-up—*without* morality attached.

4) Clinics should provide *total* health care, not be separated into VD or social hygiene clinics, gynecological clinics, and birth control clinics.

There should be separate teenage clinics, just as there are pediatric clinics. Teenagers should be able to get total health care at these clinics *without* parental consent.

5) Every institution (clinics, schools, churches, community agencies, etc.) must talk about VD as an epidemic disease and spread the facts. Nursing and medical schools have not even done this for their own students nor have they encouraged VD research.

6) We must help each other by freely discussing VD and telling our sex partners if we think we have been infected. In our present health system with its moralistic attitudes, we cannot depend on clinics, schools, etc. to do this work for us.

As long as we have racism, sexism, a profit-making health care system, and an uninformed, moralistic public, we will continue to have terrible health problems such as uncontrolled gonorrhea.

Since there is no foolproof protection against contracting gonorrhea, and anyone can get it, we have only our feelings of responsibility to each other to protect us.

Even if women get the very best health care presently available:

There is no prevention. There is no good diagnosis.

THERE IS NO FOOLPROOF TREATMENT FOR ANY WOMAN'S GONORRHEA

Important Facts on V.D.

SYPHILIS:

POSSIBLE SYMPTOMS:

1) Primary state: (9-90 days after infection) chancre
2) Secondary state: (few weeks-6 months later)
   rash—all over, or on hands and feet
   sores in mouth
   sore throat
   mild fever
   swollen joints
   headache
   patchy balding
3) Latent stage: (10-20 years) no outward symptoms at all
4) Late stage:
   heart disease
   crippling
   deafness
   blindness
   paralysis
   insanity
   death

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DIAGNOSIS:

1) Physical examination by doctor
2) In early stage: examination of pus from chancre
3) After that: blood test called VDRL.

TREATMENT:

High dosages of long acting penicillin.

GONORRHEA:

Possible symptoms:

1) In Women:
   maybe slight vaginal discharge
   maybe some pain when urinating
   (later) severe abdominal pains
   infected bladder
   infected rectum
   infected tubes
   sterility
   arthritis
   blindness
   death
2) In men:
   discharge from penis
   pain during urination
   sore, swollen testicles
   infected bladder
   infected tubes (seminal vasicules or epidedemis)
   sterility
   arthritis
   blindness
   death

DIAGNOSIS: 1) "gram stain" method (very *un*reliable in women): taking a smear of the urethral or vaginal discharge, placing it on a slide, staining it with a special dye, and examining it under a microscope for germs.
2) "culture" method (about 82% relaible for women): taking a smear of the discharge (in men, a urethral smear; in women a smear from at least the cervix and the rectum), innoculating it on a special medium or culture plate and incubating the culture under special laboratory condition for several days. This is to let the gonorrhea germs multiply for greater chance of detection.

TREATMENT: a high dosage of penicillin or related antibiotic.

women's national abortion coalition
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GENERAL AND SUPPLEMENTAL PROPOSALS ADOPTED BY THE WOMEN'S NATIONAL ABORTION CONFERENCE JULY 16-18 1971

GENERAL ACTION PROPOSAL

That the conference call for a nationally coordinated abortion repeal campaign including legislation, legal actions, women's speakouts etc., and demonstrations in Washington D.C. and San Francisco on November 20 for the repeal of all abortion laws, against forced sterilization, and for the repeal of all contraceptive laws. Abortion: a woman's right to choose.

LEGISLATIVE ACTION WORKSHOP PROPOSAL

1. That the Women's National Abortion Action Coalition establish a national information coordination service to keep constituent groups informed on legislative developments on state and federal levels.

2. That the Women's National Abortion Action Coalition (WNAAC) establish a national legal committee to research possibilities of national legislation for total repeal of all abortion laws and contraceptive laws and for no forced sterilization.

3. That WNAAC go on record for the repeal of the Washington D.C. abortion laws and the repeal of sections of the Comstock law regarding abortion and contraception.

4. That WNAAC not support laws that restrict access to the termination of pregnancy, voluntary sterilization, or contraception.

LITIGATIVE ACTION WORKSHOP PROPOSAL

1. That at the November 20 demonstrations there be contingents of plaintiffs in abortion suits around the country.

2. That this conference support Shirley Wheeler, the Florida woman who is being prosecuted for obtaining an abortion, and oppose any prosecution of women having abortions.

3. That the WNAAC national office be a clearing house for information on all court cases, class action suits, and state laws on abortion and sterilization, and for addresses of abortion coalitions involved in court suits.

4. That the conference encourage women to file class action suits against the abortion laws in all areas where this has not yet been done, and to hold send-off rallies or actions around these court cases to build the November 20 demonstrations.

more

GENERAL AND SUPPLEMENTAL PROPOSALS ADOPTED AT THE WOMEN'S NATIONAL ABORTION CONFERENCE

MASS ACTION PROPOSAL

That WNAAC sponsor a massive amicus curiae brief in support of the Texas and Georgia suits which will be heard by the Supreme Court this fall.

That WNAAC support attorney Sarah Weddington in the case before the Supreme Court (she is the attorney in the Texas suit).

MILITARY AND ABORTION LAW WORKSHOP PROPOSAL

That WNAAC support the bill introduced by Congresswoman Bella. Abzug that would guarantee military women and dependents of military personnel the right to abortion on demand in military hospitals.

THIRD WORLD WOMEN WORKSHOP PROPOSAL

That there be Third World women speakers and contingents in the demonstrations in San Francisco and Washington D.C. on November 20. That the conference send a telegram to Angela Davis supporting her in her fight to win bail.

That all literature from WNAAC be translated into Spanish.

PROPOSAL ON GAY WOMEN ADOPTED BY CONFERENCE

That there be gay women's contingents at the massive marches for the repeal of all abortion laws. That WNAAC put out literature on why lesbians support abortion law repeal.

That gay speakers by included in all meetings that take place during the course of this national campaign, and that they ae available to speak in the name of the campaign for abortion law repeal when speakers are requested for other meetings.

CHURCH WOMEN PROPOSAL

That women involved in the Catholic Church and other churches participate in the abortion campaign in a visible Catholic or other church contingent.

That the Catholic contingent make an effort to address women in the Catholic Church through written material, public speaking, and counseling services.

That on November 20 we ask Catholic women, and other church women to demonstrate as separate and visible contingents. The Catholic contingent can help show that the Church is not representative of Catholic women and the daughters of the Church have become sisters in liberation.

WORKING WOMEN WORKSHOP PROPOSAL

That in each area, where possible, there be a task force organized to reach out to working women and draw them into the activities of WNAAC.

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FREE AND LEGAL ABORTION

ABORTION - A WOMEN'S RIGHT

The right to abortion, to decide whether or not to have a child, is central to the liberation of women. Unless we have the ability to control reproduction, we will be unable to make many other fundamental decisions about our lives. Pregnancy has been used throughout history to justify the exclusion of women from decision making and the relegation of women to the socially "unimportant role of homemaker: before we can hope to assume an equal place in society, we must be able to control our bodies. We must have access to abortion on demand. Repeal is not enough, abortions must be free so they are available to all who want them.

FREE AND LEGAL ABORTION ON DEMAND

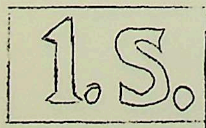
Limiting the campaign to legalization of abortion does not confront the fact that the availability of abortions is determined as much by economics as by law. In states where abortion is legal there is a severe shortage of facilities, making abortions expensive, and difficult to get for most women. A small number of clinics have been permitted to open only in a few large cities, and many hospitals maintain quotas or refuse to perform abortions at all. Poor women in most of these states can get abortions only in overcrowded, degrading city clinics. The abortion campaign must demand a system of publically funded abortion clinics available to all women free and on a voluntary basis.

One argument being raised against the demand of free abortion is that it excludes women who do not support "socialized medicine". We cannot sacrifice the principle of free health care which is essential if we are to win abortion on demand for the majority of wome n, to the low consciousness of the minority. In fact, it is not the demand for free abortions that excludes women, fighting only for legalization severely limits the campaigns ability to involve millions of women - working women, third world, and white - who will not be attracted to a campaign which calls for abortions only for those who can afford them. They will also not be attracted to a campaign which claims to be fighting for the right to control our bodies when that right will be subject to husbands or father's pocketbooks and/or permission.

STRATEGY FOR THE ABORTION CAMPAIGN

We must devise a strategy to involve working women. Not only because of the added strength they will bring but because working women as part of the working class have the social weight to provide the basis of building independent movement which can win concessions from legislatures and the courts because of its power, not because of its reliance on the good will of politicians and judges. In order to involve working women we must have leafletting campaigns at factories urging women workers to join our actions and to get their unions to support our campaign, and also short rallies at factory shift changes. We must develop local actions, rather than concentrating only on a national demonstration, in order to involve women who work, or have children and could not go to Washington or San Francisco.

Those women who are interested in building a Free and Legal Abortion Caucus with a perspective of reaching working women should meet with us after the meeting or call us at: 869-3137.



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Women's Medical Center

80 Irving Place, New York, N.Y. 10003 tel: (212) 533-1100

Women's Medical Center was founded in 1970 to insure a woman's right to abortion. We sponsor the lowest cost abortion service with a strong emphasis on supportive counseling. An information and referral service is available for women's health care, specifically methods of contraception (birth control), abortion procedures and facilities, and gynecological services. Check-up exams are provided for abortion patients.

Our pregnancy test program is free. The results of the test are available directly to the patient, eliminating the run-around, the doctor's fee, and offering a chance for the woman to talk about her plans regarding her pregnancy.

We offer educational courses such as Know Your Body, a series of informal lectures and discussions on sexuality, health, etc.

Women are the largest body of health consumers, but we have no organization to be our "Naider Raider" to monitor medical facilities. Women's Medical Center is planning a medical monitoring service, sort of a consumer's association through which we can all voice our demands and force changes for better, personal, less mystifying health care. A volunteer program is being developed to help make this a reality.

The Center is here for all of us. If we can help you, your friends, or co-workers, tell us about it, and/or come on over and help us do it.

BY WOMEN FOR WOMEN
a non-profit organization

Women's Medical Center

80 Irving Place, New York, N.Y. 10003 tel: (212) 533-1100

A non profit center for women, by women, dedicated to sponsoring quality health services with respect and understanding.

pregnancy tests

A woman can drop off or mail in specimens and call for results the same day.

abortion

A low cost early abortion procedure is provided at a neighboring clinic. We place strong emphasis on counseling and emotional support. Referrals are made for late abortion.

post abortion

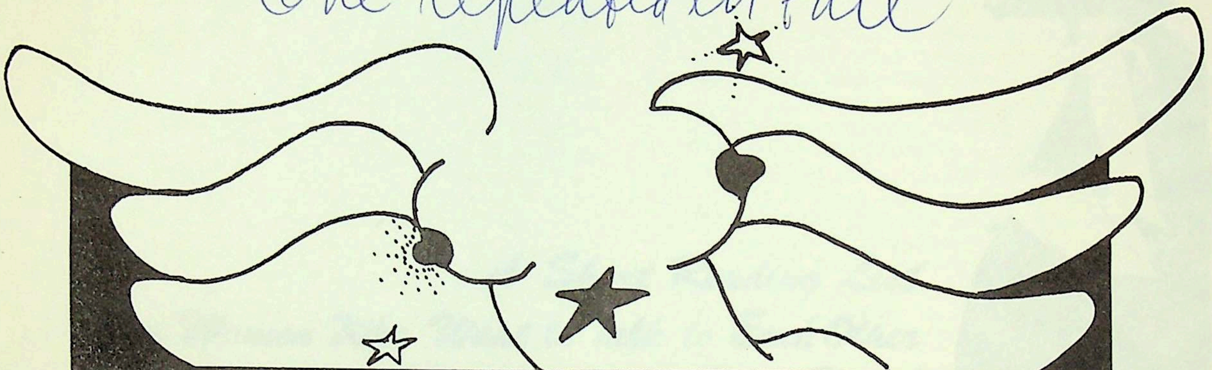
"Rap" sessions bi-monthly
Check-ups and contraception

education

Birth control information
Informal discussions and courses:
Our Bodies, Ourselves
Human Sexuality

KNOW YOUR BODY

to be repeated in full



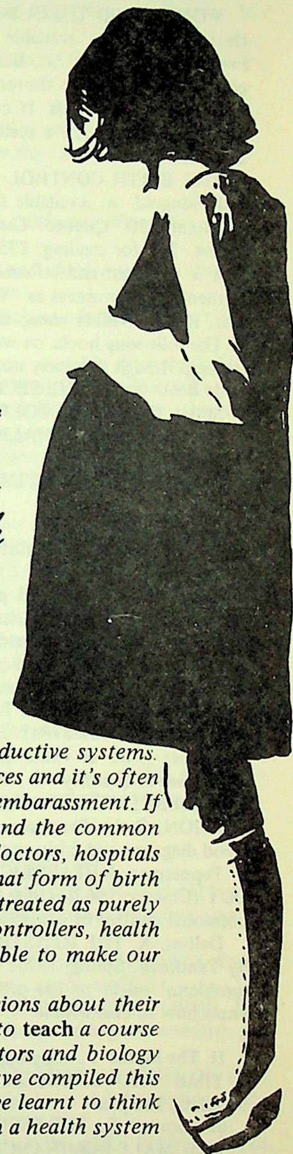
WOMEN'S MEDICAL CENTER
80 Irving Place at 19th Street~

an 8 week course BY & FOR WOMEN starts Thursday May 4th 7:30 P.M.

Date	Topic
Thurs. May 4	ANATOMY, VENEREAL DISEASE, VAGINAL INFECTIONS
Thurs. May 11	MENSTRUATION, PUBERTY THROUGH MENOPAUSE
Thurs. May 18	BIRTH CONTROL & ABORTION advantages and disadvantages of various methods of contraception; methods of abortion
Thurs. May 25	PREGNANCY fertility, development of child, birth, medication, nursing, care of self
Thurs. June 1	SEXUAL RESPONSE orgasm, masturbation, stimulation, fantasy
Thurs. June 8	SEXUAL PREFERENCES & ATTITUDES sex roles, myths
Thurs. June 15	WOMEN AND DOCTORS the gynecological exam, doctors' attitudes towards women; medical services to expect
Thurs. June 22	HEALTHY WOMEN food, cosmetics, exercise, medicine, psychology

minimum donation $1.00 per session

A Short Reading List for Women Who Want to Talk to Each Other About Their Bodies and Their Health



Any woman can organize a series of discussions about women's sexual and reproductive systems. We already know a lot, but it is buried in a haphazard collection of private experiences and it's often confused because we've not been able to talk about these things openly and without embarassment. If we just get together and pool knowledge and experience we will begin to understand the common patterns of health and disease, of sexuality, of pregnancy and of our dealings with doctors, hospitals and the health system. Furthermore, it's important that we do this; choices such as what form of birth control to use, how to choose a doctor, where to get an abortion can no longer be treated as purely personal matters, there are too many other interests—drug companies, population controllers, health planners— that are already making decisions about us and our lives. We have to be able to make our own decisions based on our knowledge of what we need and what we want.

This reading list is designed for women who want to start having group discussions about their sexual and reproductive systems and lives. It could also be used by women who want to teach *a course but we want to stress that we don't need lectures from specialists. Nurses and doctors and biology majors are very helpful, but they are not essential. The women in New York who have compiled this did not start out as medical specialists, but by our discussions and our reading, we have learnt to think clearly about our bodies and our sexuality and have learnt how to begin to deal with a health system that hides any humanity behind barriers of bureaucracy, professionalism and money.*

N.Y. Women's Health & Abortion Project
March 1971

Most basic information is in two books:

WOMEN AND THEIR BODIES, by the Boston Women's Health Collective, available from the New England Free Press, 791 Tremont St., Boston, Mass. 02118. Price is 75¢ plus postage. This is thorough, warm and has a profound women's consciousness. It covers most aspects of women's sexual and reproductive systems, and could be used without any other books.

THE BIRTH CONTROL HANDBOOK, ed. Cherniak, D. and Feingold, A. Available from P.O. Box 1000, Station G, Montreal 130, Quebec Canada. Price: free for individual copies, 25¢ for mailing; $35 per 1000 plus shipping costs. This is excellent and informative but doesn't have the same women's consciousness as "Women and their Bodies". However, it is incredibly cheap and can be distributed en masse.

The following books on women are important background readings though they may not deal directly with biology.

de Beauvoir, S., THE SECOND SEX, paperback

Millet, K., SEXUAL POLITICS

Firestone, S., THE DIALECTIC OF SEX, paperback available, after April 1971

Morgan, R., ed., SISTERHOOD IS POWERFUL, paperback

ANATOMY AND PHYSIOLOGY

I. The Facts

Books on anatomy and physiology are available in most town and all college libraries. It's very educational to read the books written for medical students and doctors. Although they are too technical for most women, they reveal much about professional attitudes.

EDUCATIONAL KITS; Tampax, Inc., 161 East 42nd St., NY (Tel: 212-682-3784) Excellent charts and diagrams which are good as visual aids. They supply them free and sometimes in quantity.

UNDERSTANDING: CONCEPTION AND CONTRACEPTION; Ortho Pharmaceutical Co., Raritan, New Jersey. Good diagrams and fairly good text.

Tepperman, METABOLIC AND ENDOCRINE PHYSIOLOGY (Chicago 1962). Quite technical, but a good section on hormonal control of ovulation, menstruation and pregnancy.

Dalton, K. THE MENSTRUAL CYCLE. To be published by Pantheon, Spring, 1971. Contains data on how women's 'problems' relate to her periods. Insidious but we have to know how to deal with it.

II. The Myths . . oppressive use of female physiology

TIME YOU KNEW, ACCENT ON YOU; educational booklets, Tampax

de Beauvoir, S., THE SECOND SEX

Tigar, MALE DOMINANCE? YES. ALAS. SEXIST PLOT? NO, New York Times Magazine, Oct. 25, 1970, how women's biology makes her unable to function in 'responsible roles'

Millet, SEXUAL POLITICS—among other things a reply to Tigar.

SOVIET WOMAN ASTRONAUT FINDS THE SEXES ARE EQUAL IN SPACE, NY Times, April 5, 1970

DOCTORS DENY WOMAN'S HORMONES AFFECT HER AS EXECUTIVE, NY Times, July 31, 1970

GYNECOLOGICAL CARE AND DISEASE

Try a medical textbook for a discussion of what preventive gynecological care *should* be. e.g., GYNECOLOGY by Taylor

Leaflets on Pap tests, uterine cancer, breast cancer and breast self-examination are available from the American Cancer Society, National Office, 219 East 42 St., NY, NY 10017

Leaflets on V.D. symptoms, treatment centers, etc. can be obtained from your local Department of Health or Planned Parenthood. Information about non-venereal infections can be obtained from those family medical encyclopedias under headings like Candidiasis, Trichomoniasis, vaginitis, Thrush, Moniliasis, Female troubles, etc. The NY Women's Health and Abortion Project is preparing some materials on these infections, which should be available in April 1971.

Morton, R.S., VENEREAL DISEASES, paperback, good and comprehensive covering infections other than gonorrhea and syphilis. Most social details are relevant to England.

SEXUALITY

Masters and Johnson, HUMAN SEXUAL RESPONSE

Masters and Johnson, HUMAN SEXUAL INADEQUACY

THE BOOKS, even though somewhat heavy going .

Brecher, AN ANALYSIS OF HUMAN SEXUAL RESPONSE, very good summary—and much more readable—form of Masters and Johnson.

Belliveau and Richter, UNDERSTANDING HUMAN SEXUAL INADEQUACY, Simpler version of the Masters and Johnson book.

Siecus, HUMAN SEXUALITY, a compliation of their various pamphlets.

Morgan, ed., SISTERHOOD IS POWERFUL, selected essays dealing with sexuality:

Sherfey, A Theory of Female Sexuality

Lyndon, The Politics of Orgasm

Ingrid Bengis, HEAVY COMBAT IN THE EROGENOUS ZONE, Village Voice, Aug. 31, 1970

de Beauvoir, S., THE SECOND SEX

WOMEN'S CONSCOUSNESS AND PSYCHOLOGY

I. Psychiatric Attitudes

Health-PAC Bulletin, May 1970. Special issue on community mental health, especially who it serves in New York.

Laing, THE POLITICS OF EXPERIENCE, 1967 Ballantine paperback. Society not people is schizophrenic.

Radical Therapist, Volume I, No. 3, 1970. Special issue on Women. Particularly relevant articles are 'Kinder, Kirche, Kuche' by Weisstein (also found in SISTERHOOD IS POWERFUL), 'Marriage and Psychotherapy' by Chesler, 'Is Women's Liberation a Therapy Group', by Zwedy. The magazine may be obtained by writing to Radical Therapist, Box 1215, Minot, N.D. 58701

Szasz, THE MYTH OF MENTAL ILLNESS, 1961, Delta paperback. Incisive critique of the medical model of psychiatry.

Weisstein, Naomi. Women as nigger, Psychology Today, Oct. 1969 Volume 20. What's wrong with psychology, especially in its treatment of women.

II. The Traditional Analytical Approach to Women

Freud, S. Femininity, NEW INTRODUCTORY LECTURES ON PSYCHOANALYSIS, 1964, Norton, N.Y. Women are innately inferior because they don't have penises.

Millet, Kate. SEXUAL POLITICS, 1970, Doubleday, Garden City, NY. Critical examination of Freudian theory and the work of Neo-Freudians, such as Erikson.

Reich, Wilhelm. THE SEXUAL REVOLUTION, 1969, Farrar, Straus & Giroux, NY. Philosophical and political discussion of sexuality by a Marxist analyst.

Thompson, Clara. INTERPERSONAL PSYCHOANALYSIS, 1964, NY. Basic Books. A traditional analyst answers Freud.

III. Socialization

Bettelheim, Bruno. THE CHILDREN OF THE DREAM, 1969. Avon, NY. A traditional analyst describes and generally approves of communal child rearing on an Israeli kibbutz.

Goldberg, Philip 'Are Women Prejudiced Against Women?' Transaction, April, 1968, 5, 28-30. Unfortunately, yes.

Horner, Matina. 'Fail: Bright Women,' Psychology Today, Nov., 1969, 36. Women's need to fail, instead of succeed.

Maccoby, Eleanor. DEVELOPMENT OF SEX DIFFERENCES. Stanford University Press, 1966. Discussion of most of the research on sex differences with a complete annotated bibliography.

WOMEN: A JOURNAL OF LIBERATION. Inherent Nature or Cultural Conditioning, Fall, 1969, 3011 Guilford Ave., Baltimore, Md. 21218. $1.25. Especially Bems, 'Training the woman to know her place'; Barry, 'A view from the Doll Corner.'

CONTRACEPTION

Mintz, M. THE PILL, 1969. Information on how the Pill was (wasn't) researched and how possible side-effects were covered up. Some of the information is in WOMEN AND THEIR BODIES and some in 'Another Bitter Pill', Health-PAC Bulletin, March 1970.

D.C., Women's Liberation, P.O. Box 13098, "T" Station, NW, Washington, D.C. 20009. Compilation of excerpts of testimony given at Gaylord Nelson's Senate Hearings on the Pill in Jan. 1970.

Seaman, B., THE DOCTOR'S CASE AGAINST THE PILL.

Rainwater, L., and Weinstein, K.K., AND THE POOR GET CHILDREN. Account of working class attitudes to sex and contraception (pre-pill).

The Population Council, 245 Park Ave., New York, NY. Does a great deal of research on birth control especially the IUD. They have many pamphlets and reports which are free but technical; some are dated. The Council is Rockefeller funded.

Planned Parenthood (Family Planning Resources Center, 44 Court St., Brooklyn, NY) and Ortho Pharmaceuticals give out pamphlets with the expected bias.

ABORTION

Written material on Saline abortions is weak because experience is limited. A report is being prepared by the Women's Health and Abortion Project, Women's Center, 36 W. 22 St., NY, NY 10010

Lader, L., ABORTION, Beacon. Comprehensive background up to 1965.

ABORTION FACTS and an ABORTION BIBLIOGRAPHY may be obtained for 25¢ and 5¢ respectively from New Yorkers for Abortion Law Repeal, P.O. Box 240, Planetarium Stn., NY 10024.

Leaflets on

(a) Specific legal suits in California, Wisconsin, Wash., D.C., NY

(b) Medical, demographic and social aspects of abortion in other countries

(c) Data on therapuetic abortions in U.S. before reform laws came into effect.

These and a bibliography are available from Association for the Study of Abortion, 120 West 57 St., NY 10019

Kennedy and Schulder, ABORTION RAP. An account of women's struggle to change the law in New York State.

Cisler, L., 'Unfinished Business: Birth Control and Women's Liberation,' in SISTERHOOD IS POWERFUL, ed. Morgan, R.

The status of abortion in this country is rapidly changing. For information on your own state law contact a local Women's Liberation group, or a local abortion reform group.

Up to date information and materials may also be obtained from the following organizations:

Women's Health and Abortion Project. c/o Women's Liberation Center, 36 West 22 St., NY 10010

New Yorkers for Abortion Law Repeal, Box 240, Planetarium Stn, NY 10023

National Association for the Repeal of Abortion Laws, 250 West 57 St., NY 10019

Abortion Rights Association, 250 West 57 St., NY 10019

Society for Humane Abortion, P.O. Box 1862 San Francisco, Cal 94101

PREGNANCY AND CHILDBIRTH

Chabon, I., AWAKE AND AWARE (1967). Good history of childbirth practices. Lamaze Method with case illustrations.

Wright, Erna, THE NEW CHILDBIRTH (1966). Paperback. Excellent preparation for Lamaze method.

Hazel, L., COMMONSENSE CHILDBIRTH (1969). Best all over preparation for childbirth with good woman's perspective.

Flanagan, G.L., THE FIRST NINE MONTHS OF LIFE (1962), Paperback. Exciting pictures and description of the developing fetus.

Guttmacher, A., PREGNANCY AND BIRTH (1956). Paperback. Best book for general information about pregnancy, but has male and class bias.

La Leche League. THE WOMANLY ART OF BREAST FEEDING (1963). Information and support for nursing mothers. Extremely oppressed position on motherhood limits usefulness.

Pryor, K. NURSING YOUR BABY (1963). More information and less biased than La Leche League but hard back.

POPULATION CONTROL—THE DEBATE

The Earth Belongs to the People—Ecology and Power,

People's Press, 968 Valencia St., San Francisco, 75¢. Simple but well reasoned analysis of the flaws in the Population Bomb argument.

NACLA Newsletter, Vol. IV, No. 8, 'Population Control in the Third World' from NACLA, P.O. Box. 57, Cathedral Park Station, NY, NY, 50¢. Heavy account of U.S. involvement in promoting population control, especially in Latin America. Outlines involvement of Rockefeller, Fords, Planned Parenthood, etc.

Phillips, BIRTH CONTROL AND ABORTION: SOME THINGS TO WORRY ABOUT, from St. Louis Women's Collective, 4372 Westminster Place, St. Louis Mo., 25¢. A perspective on the abortion and birth control work of the Women's Movement. Written to help discussion within the Movement.

Ehrlich, P.R., THE POPULATION BOMB. The book that lays it on the individual.

Borgstrom, G., THE HUNGRY PLANET "A powerful statement of 20th century Malthusianism"

Zero Population Growth puts out literature that may be well intentioned but is limited. There are local chapters in many states or try the NY office at 30 Charles St., NY 10014.

MEDICAL INSTITUTIONS

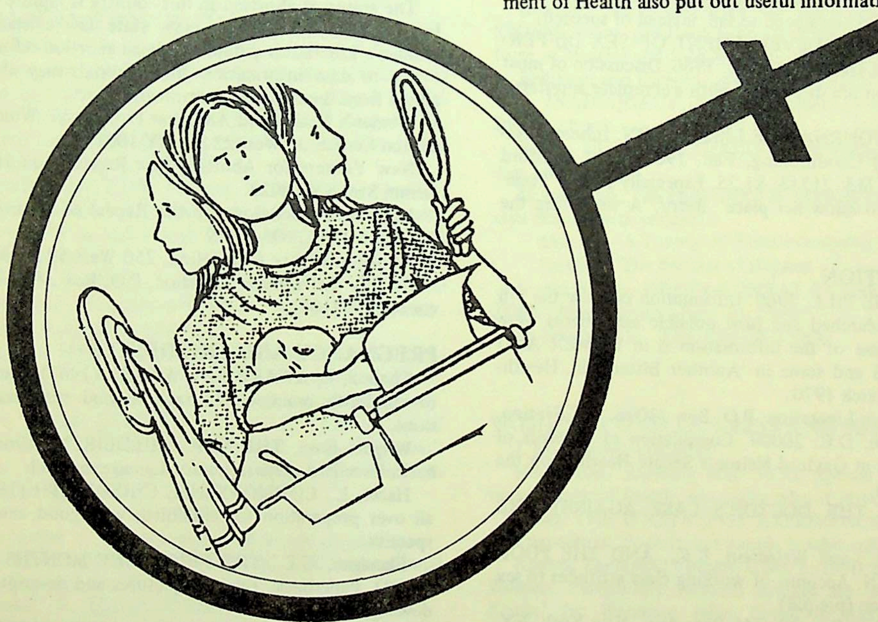
An extensive list of relevant books and literature sources is included in Health Research Guide of Health-PAC, Health-PAC Bulletin, No. 28, Feb. 1971.

Health-PAC, THE AMERICAN HEALTH EMPIRE (1971). Paperback. How the health system really works and who it works for. Basic reading.

Ongoing discussions on the health system are found in the monthly Health-PAC Bulletins available from Health-PAC, 17 Murray St., NY, NY 10007. Annual subscription: Students $5, Regular $7.

Duff & Hollingshead.SICKNESS AND SOCIETY.The story of how a major medical center damaged the community it was supposed to serve.

Information about the number of doctors, hospital beds, and other services in your region as well as infant mortality rates, birth rates, visits to doctors, etc. may be obtained from various government statisticians. One book which is available in many libraries (or should be) is the Statistical Abstract of the United States (1970 edition) put out by the U.S. Dept. of Commerce. The World Health Organization, the Department of Health also put out useful information. ■



A NEWBORN BABY IS A BEAUTIFUL SIGHT, especially when every pregnancy is a wanted pregnancy. And that means :-

That the child was really wanted and will be loved
That the woman has not decided her family is big enough
That her housing conditions are fit for humans to live in, and don't make having a baby a crisis
That, above,all, adequate, efficient and safe birth control was freely available to her.

If all these things were true, few women would want an abortion. So this is the first necessity, that all women must be able to choose when to have a child and when not to.

Birth control must be efficient
Birth control must be safe
Birth control must be as easy to get as a loaf of bread.

But if a woman does get pregnant by mistake and does not want to have the child, what can she do? We are told that abortion is available on the National Health. If this is true, why do so many women have to have dangerous illegal abortions or private abortions costing hundreds of pounds? Relatively few of the abortions now done are performed on the National Health. And besides, under present law, someone else - a doctor, a psychiatrist or both - decide for you whether or not you should have a child. This is intolerable.

Abortion must be free

Abortion must be safe

Abortion must be available to a woman when she needs it.

Many pregnancies are unwanted because having a child in this society can be such a crisis. For most women it means that whatever she is doing out of the home she must stop. It means even more overcrowded h housing. It may even mean deprving yourself or your other children of their basic needs. Abortion will never make those tolerable.

But every woman is entitled to choose whether to have or not to have a child. We therefore call for

FREE BIRTH CONTROL AND ABORTION ON DEMAND

WOMEN'S LIBERATION WORKSHOP, c/o Kate Bruder, 27 Albany Mansions,
Albert Bridge Road, London, S.W. 11
Wednesdays & Thursdays 10-6 : 734-9541

HOW YOU CAN HELP

1) Any Michigan woman who believes that Michigan's abortion law should be repealed--for whatever reasons--can be a plaintiff in the suit. Whether or not you have had an abortion, or even wanted one, your voice is important to us. Women doctors, psychologists, psychiatrists, theologians, nurses and social workers can also give much needed testimony.

Even after the suit is filed on August 31, we will need additional plaintiffs. The suit can be ammended to add these.

2) Sympathetic women, men and organizations can contribute money to help defray the costs of the suit. While our lawyers are donating their services, there are enormous other expenses in research, transcripts, preparation of legal documents, etc. We also need money to expand the publicity and organizational work of the suit.

Remember: Unlike the opponents of abortion, we have no rich and powerful organizational backing. We need your financial support!

MY BODY . . . MY CHOICE

REPEAL ABORTION LAWS

NO FORCED STERILIZATION

FOR INDIVIDUALS:

___ I want to be a plaintiff.

___ Enclosed is a donation of $__________ for the work of the suit.

___ I would like to help work on the suit.

I am interested in:

___ fund-raising

___ publicity

___ speaking

___ getting plaintiffs

FOR ORGANIZATIONS:

Name of Organization __________

____

___ We would like ___ plaintiff forms for our women members.

___ We would like a speaker on the suit.

___ Enclosed is a donation of $__________ for the work of the suit.

- - - - - - - - - - - -

NAME ______________________

ADDRESS ______________________

CITY ______________________

ZIP __________ PHONE __________

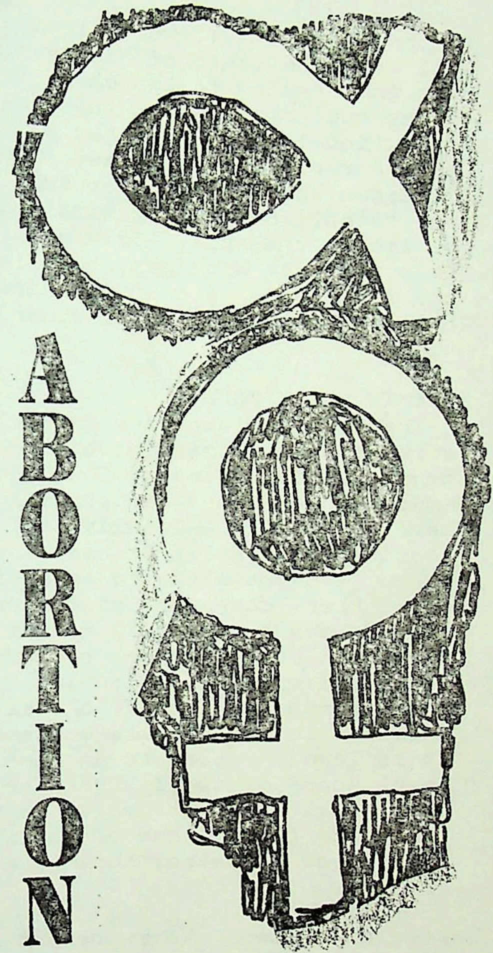
SCHOOL, ORGANIZATION, OCCUPATION

____

Clip and mail to:

Michigan Women's Abortion Suit
Box 26 UCB
Wayne State University
Detroit, Michigan 48202

Phone: 577-3409



a woman's right to choose

On May 22, 1971, women from all over the state of Michigan met and decided to launch a class suit challenging the constitutionality of Michigan's 125-year-old abortion law. The Michigan Women's Abortion Suit was established to organize and publicize the suit. This suit is a first in Michigan, both in the legal sense and in the history of the movement for women's rights.

ONE IN EVERY FOUR

The issue of abortion directly effects every woman in this country. One of every four American women has had or will have an abortion--legally if possible, illegally if necessary. Someone close to each of us--mother, daughter, sister or friend--has needed this medical service. Nevertheless, because of the Michigan abortion law, these women are forced to seek this aid in another state where it is legal, resort to an illegal abortion in Michigan, or, in a final desperate move, attempt the painful and often fatal process of self-abortion.

WHO WE ARE

We are women. We represent a cross-section of Michigan women who oppose the existing abortion law. We cover a span of more than 60 years in age. We have varied incomes, occupations, political affiliations and religious beliefs. We are from the Black, Chicana, Native American and white communities. We are students, working women, professional women and housewives. We are Michigan women, representing tens of thousands as well as ourselves.

WHAT WE BELIEVE

We believe that the right to control one's own body is a basic human and democratic right. The state has no constitutional right to force pregnancy on any woman. We defend the individual woman's right to decide whether or not she will bear a child; therefore we oppose compulsory abortion and forced sterilization without the knowledge and consent of the woman. No individual or group in society has the right to impose its own particular moral beliefs on other people through the laws of the state.

We are also concerned about the lives of the children which this law forces us to bring into the world unwanted. Every child has the right to be wanted, to live a full, happy and meaningful life. We want to determine the number of children we have on the basis of our ability to care for them.

It is women's bodies, health and psycholotical well-being that are at stake in the abortion issue. We as women are the most intimately involved. We must organize as women to fight for our right to decide--because no one will do it for us.

The Michigan Women's Abortion Suit is women, organizing and taking action against the existing abortion law. Since there has been no legislative action guaranteeing women the right to choose, we are taking the state of Michigan to court. We maintain that the law restricting abortion deprives us of the democratic right to control our own bodies.

WHAT IS A CLASS SUIT?

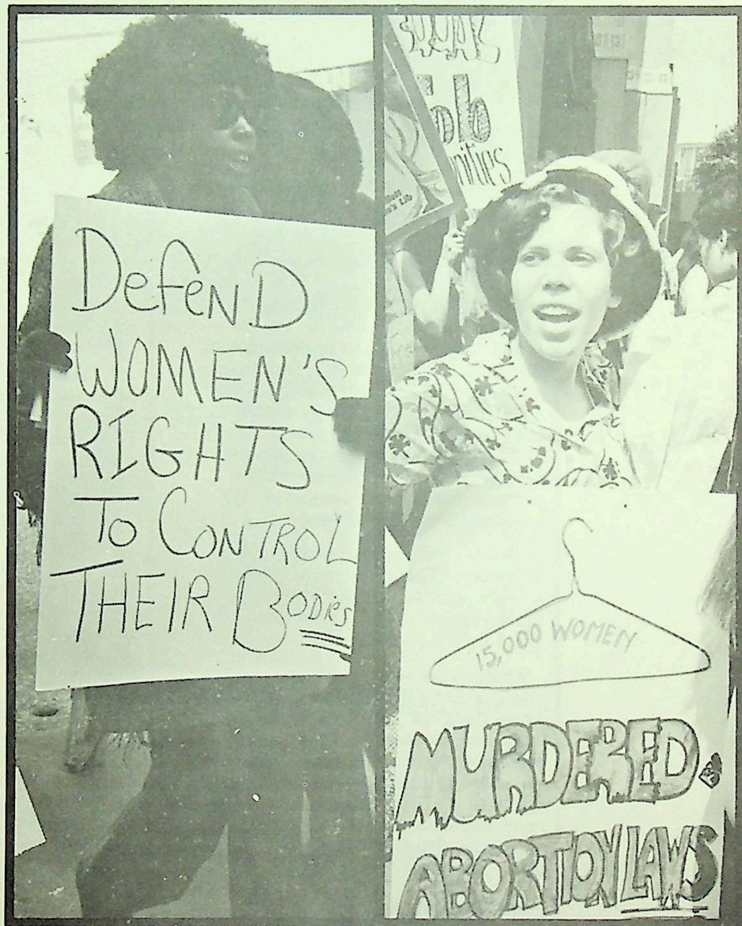
A class suit is a law suit in which a limited number of people (plaintiffs) represent a larger body of people (class). The plaintiffs in this case represent the class of Michigan women who believe with us that the present abortion law is unconstitutional.

WHAT WILL IT DO?

If the court rules in our favor and declares the law unconstitutional, the present Michigan law would be wiped off the books and abortion would be legal in Michigan. Abortion would be considered like any other medical procedure, subject to the laws of safe medical practice which govern the medical profession as a whole.

This suit is not solely a legal measure. It is a tool for educating and organizing women and men about the issue of abortion and the necessity of the repeal of restrictive abortion laws. It will help get publicity for the repeal movement. Finally, it will add Michigan women to the national movement for repeal.

ABORTION IS A WOMAN'S RIGHT



MARCH ON
WASHINGTON DC & SF
NOVEMBER 20

Over 1,000 women from across the country planned a national abortion law repeal campaign at the Women's National Abortion Conference.

A sister has been convicted of manslaughter for having an abortion.

us. At this point one of the means we are stuck with is the courts. The Supreme Court is going to be dealing with the abortion cases this fall. Our drive is now to educate them that this is not a doctors issue. That is why we went to court with women. Up until then, by and large, the legislatures, and the judges and the men who control us believed that is is a doctors issue. We were pretty much irrelevant.

We have now decided what is going to happen. That is the issue. We are going to have abortions if we want them. Basically, that is what the court fight is all about.

What I really want to tell you about now is about a sister. A sister in Florida where there has not' been any organizing around abortion. There have been no abortion court cases. There have been no massive moves in the legislatures. There hasn't even been much discussion. As a result of that one of our sisters is in very great pain.

About a year and a half ago she needed an abortion. She went through what New Yorkers no longer have to deal with: the phone call, the blind folding, being switched from car to car. She ended up in Jacksonville, Florida. She got an abortion, so to speak. Nothing happened.

A little while after that she started hemmoraging and had to go to her own doctor. Her doctor completed the abortion. Somehow some super-sleuth health examiner found out about it, found the fetus, found the catheter left in the fetus and had her arrested.

She was put in jail and stayed in there for three or four days. During the time she was in jail, the cops came into her cell, showed her pictures of the fetus, and asked her whether she had had an abortion.

They said, "How can you deny having had an abortion. Here is your baby. Look at it. This is your baby." She was pretty near hysterical at this point. She finally was bailed out and was set for trial. In Florida you get tried under the manslaughter statute.

Nothing happened for a while because as a result of all this she underwent severe, very severe emotional strain, and had to have the trial put off. Somewhere along the way I found out about it. Last week I got another letter from her saying "My trial has been set for July 12".

Still there were not sufficient women lawyers in Florida. We could not get someone down there who had criminal experience and could move immediately. Because she could not get a delay, because of the rules of the Florida state court, she had a two-day trial last Tuesday. She was found guilty of manslaughter by a jury of three men and three women.

Manslaughter carries up to a twenty-year penalty. She hasn't been sentenced yet. Her name is Shirley Wheeler. I am hoping that before the conference is over, we will have petitions drafted to go to the governor, to go to the judge, and mostly to go to Shirley to express our support for her and to express our anger at the state of Florida and, of course, every other. state.

Because what we do here, from this weekend on, is going to make a critical difference as far as what happens to Shirley. We are responsible for Shirley's freedom. And we are responsible for our own freedom. That is what we've got to be here about. That is what we've got to fight about.

"Abortion laws murder women..."

BY BARBARA H. ROBERTS, M.D.

I always feel a little selfconscious at feminist gatherings when I am introduced as a doctor, because the woman's movement is rightfully very down on the medical profession, but I want to assure you that I am a sister first and a doctor second....

A popular medical dictionary defines "disease" as "literally, the lack of ease," venereal disease as "one usually transmitted through sexual intercourse." It's obvious, therefore, that unwanted pregnancy is the most common venereal disease. When I said that in front of the legislature in Harftord, I was almost lynched.

This disease is associated with immense physical, mental, social and economic suffering. Seeking to be cured of this disease, women from time immemorial have risked pain, mutilation, and death in numbers that really stagger the imagination. Today, when the cure for this disease is statistically safer than carrying that pregnancy to term, abortion is still widely withheld by antiquated laws and religious tenets which are not shared by the majority of people. As a physician, I am tired of having to call a woman mentally unstable in order to abort them. I am tired of seeing battered children in morgues, emergency rooms and hospital wards.

I am tired of seeing women in septic shock, with perforated wombs, even disembowled by incompetent butchers because their own physicans were prohibited by law from helping them. I have seen these atrocities and others with my own eyes and I am tired of them. They are a direct result of inhuman, unconstitutional abortion laws. Laws that murder women.

Because these laws have been around so long, you are taught in medical school and in residency that abortion is a complex operation, fraught with danger and technical hazards. I was highly doubtful of that line so I arranged to be trained in the performance of saline and suction abortions at a nearby medical center. My experience directly refuted what I had been taught. Every woman in this room could become a competent abortionist with about one month's training.

So why is there a complication rate, even for legal abortions, and why do male physicians complain that they do not like to perform them? I think the answer to this is fairly simple.

The reason so many uteruses get perforated is that men are rough. They are trained to be rough when they are little boys. As adolescents and adults they are taught that "he-men" are rough on women. You know, "chicks" are all masochists and the more you beat them, the more they like it. So, they fuck you rough, if they are a gynocologist they examine you rough, and they abort you rough....

We must free ourselves from the chains of unwanted pregnancies. Never again will we stand on a street corner and watch a sister get in a car with a man who may or may not rape her, who may or may not murder her, who may or may not abort her. As Camus has said, no army can withstand the force of an idea whose time has come. The time for abortion law repeal has come, and we shall triumph.

"Every available means..."

BY NANCY STEARNS, ATTORNEY

A couple of years ago, a group of women in New York decided that the means that had been attempted up until then——of going to the legislature and writing letters and all that sort of thing to get rid of the abortion laws —— weren't sufficient. And at that point they finally decided that they would get together and try a new avenue, and that would be the courts.

Now not for a minute did they think the courts would be any different. They did not believe the judges would rule in their favor..:. In fact, they thought that that was just a joke. But what they would do would be to use those courts as a vehicle to organize....They would try to get as many women to join together to sign their names to one piece of paper and to bring them to the judge to say, "We've had it! We're not going to stand for it anymore. We have rights, and you're going to have to deal with those rights...."

And what the New York women did ended up being a model for women in a number of other states. In New York, no court ever ruled. In fact, what ended up happening, as everyone knows, is the legislature moved, not...completely to our satisfaction, but they moved. My own guess is that one of the reasons they moved is that they just did not want the courts doing their own job.

Perhaps even more because there were four or five thousand women out in the street in Union Square around the campaign that was going on, demanding that there be a change. And I frankly think it scared the shit out of them, because they had never seen four or five thousand women together before. That's our role, I guess.

Anyway, after New York, the same kind of thing was tried in New Jersey and in Connecticut and Pennsylvania and Rhode Island, and now the most recent thing I've heard is that 45-50 women in Oklahoma are joining together to do the same thing. I guess you all have the same feeling I do, that 45-50 women in Oklahoma is the same as four or five thousand in New York, and that is how they feel and they are very, very proud....

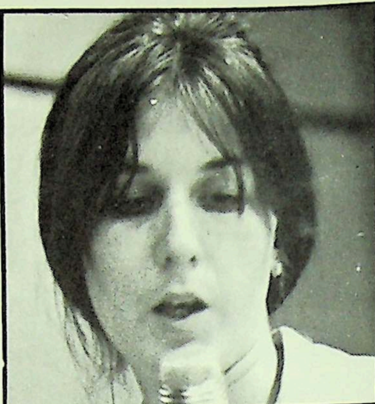
No one really believes that the courts will be different than anything else. We have won some things from them, but we haven't got all that we wanted. One fact which appears unalterable is that, in almost every case, the courts are controlled by men, basically the same people that are controlling the legislature. And that is a severe problem. By and large they have no understanding of what we are talking about and because they have no understanding of our struggle, you get classic comments like the one I got from a judge in a case where I was trying to get a woman out of jail so that she could get an abortion. I tried to urge him to move quickly since speed was of the essence. He looked at me and shook his head and said, "Yes dear, I understand. I am a grandfather."

She didn't get out of jail with his help. She finally did, despite him. She got out of jail because so many people heard about her plight, about the run around by the judges, and we were able to create enough motion and enough anger that we were able to raise enough money to bail her out and get an abortion.

This is the way all these things fit together. It is not a one front struggle. We have to use every means available to

continued inside

The speeches by Barbara Roberts and Nancy Stearns were given at the opening session of the July, 1971 Women's National Abortion Conference. BARBARA H. ROBERTS, M.D., a former co-ordinator of Women vs. Connecticut class action suit and in New Haven Women's Liberation is now working at the National Heart and Lung Institute in Washington, D.C. and spends one day per week performing free abortions at a clinic. NANCY STEARNS, an attorney at the Center for Constitutional Rights in New York City, has worked on several women's class action suits challenging state abortion laws.



WHAT IS WONAAC?

The Women's National Abortion Action Coalition was formed by the national conference of more than 1000 woman held in New York City in July, 1971. At that conference women from 29 states and 253 organizations came together to unite their efforts in the national fight for the repeal of all abortion laws and for the corollary demands of no forced sterilization and repeal of contraception laws. The conference called for a massive show of force for these goals in a march on Washington, D.C. and San Francisco November 20. WONAAC is based on a program of legislative, judicial and mass demonstration activities, on a local and national level, and seeks to unite all women in the fight for the right to abortion.

Clip & Mail to: WOMEN'S NATIONAL ABORTION ACTION COALITION
P.O. Box 685, Old Chelsea, New York, N.Y. 10011
(212) 675-9150

___I (my organization) endorses the Women's National Abortion Action Coalition.

___Send more information on WONAAC and the November 20 demonstration.

___Put me on your mailing list. Enclosed is $2 to cover costs.

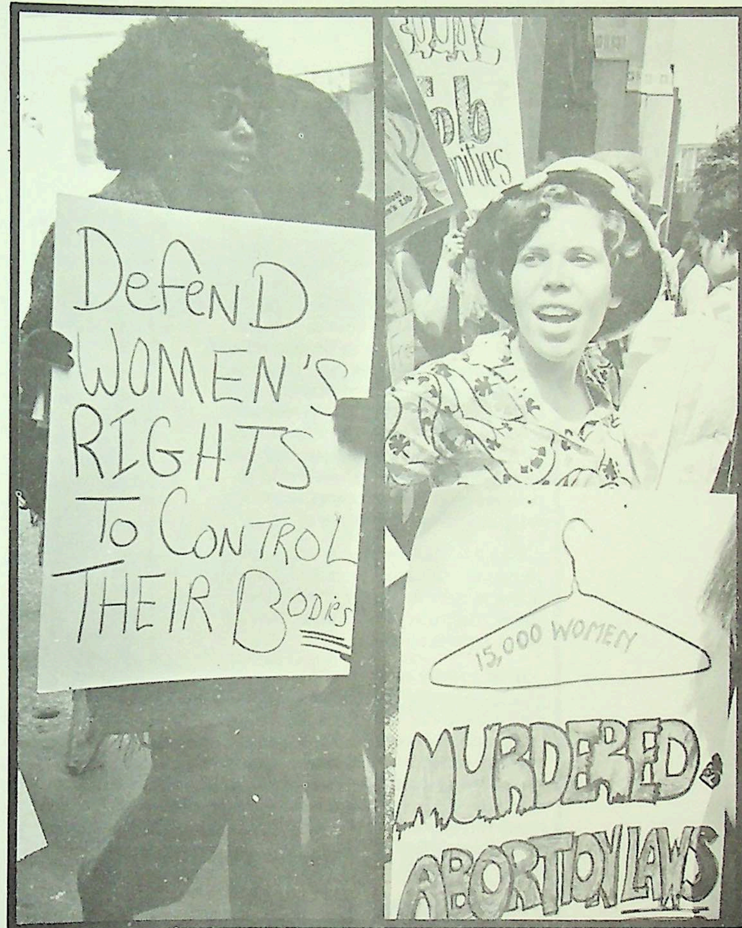
___Enclosed is a contribution of $_____to help the national abortion law repeal campaign.

NAME______________________ADDRESS__________________

CITY____________STATE_________ZIP_______PHONE_________

ORG./SCHOOL/UNION____

ABORTION IS A WOMAN'S RIGHT



MARCH ON WASHINGTON DC & SF NOVEMBER 20

MICHIGAN WOMEN FOR MEDICAL CONTROL OF ABORTION
TRI-COUNTY CHAPTER
5625 Forman Drive, Birmingham, Michigan 48010

Here is my contribution to this campaign to secure the right for every woman to receive the best medical care available and control her own body.

__$3__$5__$7__$10__$15__$20__$25 - I will____write letters to legislators, newspapers
____circulate petitions
____type___make speeches___address
____ask my friends to send money to MWMCA

NAME ______________________________ TELEPHONE __________________

ADDRESS _____________________________ CITY ______________ ZIP ______

For additional copies - Contact M. Landen - 5142 Cobbler's Ct. - Bloomfield Hills, Mich. 48013

o IS ABORTION SAFE?

In countries where abortions are legal on request, information indicates there are 2 to 3 deaths per 100,000 due to abortions, 24 deaths per 100,000 due to childbirth, and 14 deaths per 100,000 due to tonsillectomies. Medical literature reveals that for the healthy woman requesting it, abortion is therapeutic and not psychologically traumatic.

o WHY DO WOMEN SEEK ABORTIONS?

Unfortunately, attention focuses on the dramatic but least frequent situations leading to abortion - conception through rape or incest, and threats to pregnancies from disease or drugs. The overwhelming number of women seek abortions because they do not want to give birth to an unwelcome or unexpected child.

o WHY IS ABORTION LAW REPEAL NECESSARY IF CONTRACEPTION IS AVAILABLE?

Completely foolproof contraception has not yet been developed, and not all women have access to contraceptive information and devices. There are 25 million married women in the U.S. between the ages of 15 and 44; only about 3 million want to conceive in any given year, leaving 22 million women exposed to the risk of an unwanted pregnancy. Even if all these women used the pill, the failure rate could still result in 220,000 unwanted pregnancies each year.

o WHAT NEW MEDICAL TECHNIQUES ARE CURRENTLY USED?

In addition to the D. & C. there are two new successful techniques - the uterine aspiration method and the saline induction method. The latter two are quicker, safer and less expensive. In the next year or two at least one large drug company expects to have a marketable product in the area of medicinal abortion.

o WHAT ARE THE EFFECTS ON SOCIETY OF THE UNWANTED CHILD?

Psychological and sociological studies in this country and Sweden leave no doubt that unwanted children are a social danger. They are more likely to grow up in psychologically unhealthy homes, to become delinquents, and to be poor parents and create still another generation of unwanted children.

o WHAT HAS BEEN THE HISTORIC WESTERN ATTITUDE TOWARD ABORTION?

Aristotle provided the basis of Western attitudes toward abortion. He believed that a male embryo was ensouled 40 days after conception and a female embryo 80 days after conception. Thus, abortion was permissible up to the 40-80 day limit. Through the centuries both canon and civil laws did not prohibit abortion up to the 80 day limit.

Even St. Thomas Aquinas, whose writings are an important source of Roman Catholic doctrine, wrote "At the moment of conception there originates a vegetative organism which will slowly evolve into a sentient organism, to become at a moment I cannot determine, a rational organism, a real human being." With the exception of the years 1588-1591 and until 1869, the Catholic Church held to the position that abortions were permissible if done before the 80 day limit.

ABORTION FACTS

***

ONE DOZEN AND ONE QUESTIONS AND ANSWERS OF PRESENT CONCERN TO MICHIGAN RESIDENTS

o WHAT CAUSED A CHANGE IN THE ATTITUDE TOWARD ABORTION IN THE 1800's?

In the 1800's many methods were tried to induce abortions. Poisonous substances were used, in themselves so dangerous as to make abortions more likely to be fatal than pregnancy and childbirth. The subject attracted many quacks. In order to protect women's lives, England prohibited the use of poisons for abortions in 1803. During the 1800's, France was intent on developing a worldwide empire. It was in the interest of both the church and state to have huge numbers of Frenchmen in order to fight the wars, sustain the home economy, and to colonize. There were social pressures: extra pensions for extra children, public ridicule of couples with few children, sermons about one's duty to be fruitful, and so on, to promote larger and larger families. With the discovery of how and when conception takes place was reported in the early 1860's, the ingenious French people strongly desired to limit family size, developed enough birth controls to cut their birthrate in half within 10 years. Outraged at this threat to France's glory and the Church's income, Pope Pius LX in 1869 decreed that any abortion was murder. Thus, abortion which had been practiced for centuries among Roman Catholics and others was suddenly unnatural and ungodly for the simple reasons that abortion was limiting the population growth of France.

o SHOULD RELIGION PLAY A PART IN ABORTION LAW?

Should one religion be permitted to impose its views on other people who may have opposing views? A religious group is free to characterize abortion as a sin if it sees fit, and to punish its members for this if it wishes. People of other beliefs should have the right to limit reproduction through abortion if it is in accordance with their conception of morality and human dignity.

o HOW DOES MICHIGAN LAW DEAL WITH ABORTION?

Michigan's 125 year old abortion law prohibits abortion except as a last resort to save the life of a dying pregnant woman. There is no other situation where any citizen must put his or her life in jeopardy because a safe medical procedure is denied them by the State.

o HOW WILL ABORTION BE HANDLED WHEN ABORTION LAWS ARE REPEALED?

The decision to abort will be a private one by the woman with the medical advice of her physician.

o DO INDIVIDUAL ROMAN CATHOLICS DIFFER WITH THEIR CHURCH?

In recent polls, over half of the Roman Catholics replying where in favor of liberalizing current abortion laws. Statistics on women requesting and obtaining abortions indicate that the same percentage of Catholic women obtain abortions as there are Catholic women in the general population.

o WHO WILL HELP A MICHIGAN WOMAN WITH AN UNWANTED PREGNANCY?

Michigan Clergy Counseling Service for Problem Pregnancies. Phone: 313-964-0838. This is a service offered by clergymen from many denominations, counseling women with unwanted pregnancies as to the various alternatives.

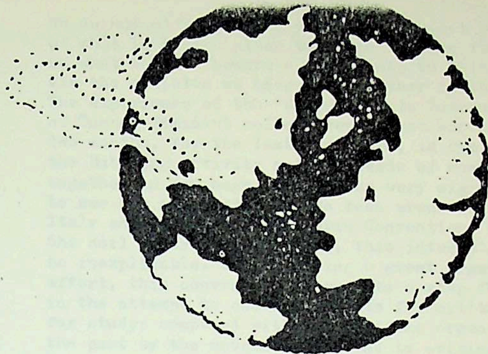
WOMEN'S NEWS

FRAUENINFORMATION

INFORMAZIONE DONNA

INFORMATION DES FEMMES

INFORMACION MUJER



The idea of an international feminist News-letter has come into being rather hastily in these few months just before the international convention on Women and Work to be held in Turin on April 23rd, 24th, 25th, organized by the women's movement there. The proposal to publish an international bullettin was made at a meeting about the press and distribution of women's movement news, held in Florence on January 30th this year, when those present included the Free Press Cooperative with Noi Donne, the Collective of the Bollettino delle Donne di Torino, women from the Network of Tuscan feminist Collectives with Filodonna, the Women's Documentation center of Ferrara with Leggere Donna and some women who are trying to get together a lesbian magazine/journal.
The idea has got under way as a project of collaboration between those present at the Florence meeting, and the articles to be publish in this, we hope the first of many, international news-sheet, were decided on then. The articles published here are in large part a direct contribution from those women present at the meeting.
The technical work (translation and printing) has been undertaken by a group of women from the Network of Tuscan feminist Collectives (Coordinamento Toscano) and by some women friends.
This issue is self-financed. The "technical" work (including translation) has been done free. The self-run counseling center (Consultorio) in Prato (Florence) has advanced the money for the printing.

AIMS
We thought this news-sheet could be a means of communication between diverse national situations, that an exchange of information and experiences might help deepen and extend the work of analysis, reflection and research which is being carried out nowadays. Recent debates and discussions, whether published or not, show how much questioning is going on amongst women about the state of the movement today. Although there is some confusion and uncertainty, there are also signs of a new more "confident" creativity expressed through initiatives and activities that "dare" to project themselves into the future.
As far as it will be possible, we would like the international news-letter to reflect what is going on in the various countries. It should seek to understand and give resonance to new needs - and to the old unfulfilled ones.

As we write, we still don't know how many languages we'll manage to have in the news-letter. Though we're sure we'll arrive at the convention with English and Italian, we can't guarantee it will be printed in German, French or Spanish, owing to the very little time we have at our disposal. Anyway, we've decided to translate the articles into these languages and at least bring photocopies along to distribute at the convention.
Though this news-letter has been produced as a monographic issue on Italy, for obvious reasons relating to the actual practical work of getting it out, we should like to see the formation of editorial groups in other countries in the very near future. These groups should keep in contact with one another, and exchange news and articles at regular dates agreed on amongst themselves. Obviously, each "national" group would undertake the printing and distribution of the news-letter in their own country. Looked at in this way the technical work involved in producing an international news-letter would not be excessive, nor impose too heavy a workload, seeing that translation , when it is needed, would only be from other languages into the mother-tongue. In fact, for this number, the longest and hardest piece of work has been the translation of the articles from the Italian into other languages. We beleve, therefore, that if the interest for this type of project is there, we should be able to lay the foundations for carrying it out, at Turin.

"INTERNATIONAL "NEWS-LETTER" GROUP, PRATO COLLECTIVE

IL FEMMINISMO É INTERNAZIONALE
PERCHÉ OGNI GOVERNO É PATRIARCALE

Feminism is international,
because all governments are patriarcal

Le feminisme est international
parce-que tout gouvernement est
patriarcal

DER FEMINISMUS IST INTERNATIONAL, DENN
JEDE REGIERUNG IST PATRIARCHAL

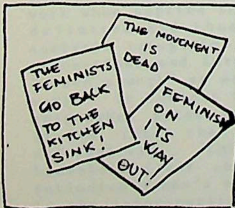
El feminismo es
internacional por que

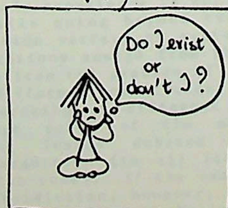
INTRODUCTION

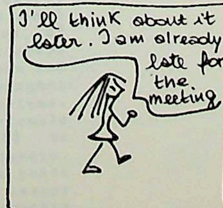
It is significant that the proposal to publish an international feminist news-sheet should come from the so-called grass-roots of the movement just at a time when this movement has been given up for dead or at best in its death throes, by many people. Obviously the mass media and the political parties "measure" the women's movement and its strength and vitality, by its "visibility", a visibility that has certainly decreased in these last years. But it is as well to remember that in this regard, women have come and do come on to the streets when "historical occasions" demand it. Don't let us forget that our "public appearances" have been and still are reactions to wicked provocation by the law-makers. The ardent years of public demonstrations coincided with the big struggles for women's rights: historic moments when parliament could no longer put off the confrontation with women about the big legislative problems of divorce, abortion, women's status within the family, equal opportunities and pay for working women.
Every time, these occasions bring out women on to the streets to remember and confirm their existence as political and social subjects, something gained which legislators can never now ignore. As for instance on the 5th of February this year, when the movement was supposed to be at a low ebb, fifty thousand women, may be more, came to Rome to demonstrate against the shameful parliamentary vote on the sexual violence act.
Without in any way wishing to hide the fact that militant feminism is feeling the general atmosphere of depression and crisis in politics and that many groups and collectives have split up, nevertheless it seems to us that when people talk generically of the "crisis" of feminism, they are doing it without having any objective analysis or critique to hand. What is certain is that the vitality and the strength of the movement cannot be measured solely (nor even mainly) by the frequency of demonstrations or by the number of women participating. The movement is primarily one of conscience raising and the development of women's identity, and the mode and rhythm of these things cannot be measured by our "public" appearances. It can be seen therefore that women's relationship with feminism can be understood in various ways: it is also made up of pauses, re-thinking, reflection. In the last few years, although less "visible", women have gone on meeting each other, working together and, most important have continued THINKING. In any case, it seems to us that against this grey background of political depression the women's movement still represents the most vital social force- and this is not just our opinion, as the new projects and facts of this last year go to prove, from the lesbian women's conventions to the transformation underway in the UDI, the Turin Convention on Women and Work, the initiatives taken by the Network of Tuscan feminist collectives.
We have to look for the signs of change in the movement in the quality of recent events and proceedings.
We do not claim to give you a full exact photograph of what is taking place today in Italian feminism, but we want to put forward a few points to think about via the articles we have put together in this issue. The experience of the "Coordinamento Toscano" (Network of Tuscan feminist collectives), that has met every two months, for the last two years, is symbolic of the bubbling activity and the needs of women to work together in new ways. It is also very significant to see how much interest has been aroused, both in Italy and abroad, by the Turin Convention. Without the soil ready to receive it, this interest would be inexplicable. Besides being a great organisational effort, this convention represents a step forward in the attempt to combine moments for militancy and for study; compared with the meetings organized in the past by the movement this one is original, not to mention those conferences organized by academic or para-academic groups, to which are invited to speak the women expert in their subjects.
And if we are talking about new things, we must not forget the process of transformation of the UDI ratified by the 11th Congress in May 1982, and how this fact changes the panorama of the women's movement in Italy.
We must also underline the growing importance and influence of the lesbian movement within Italian feminism, both because of the exploration of women's "specificity" carried forward by this section of the movement, and because of its vitality, shown by the three national conventions they have held, in June 1982 (Turin), December 82 (Rome), January 83 (Bologna).
Finally we must not ignore the changes which are taking, or which have taken place in the movement's press. This month (March 1983) it was announced in the supplement No.3 of Noi Donne that "Effe is finishing sothat other things can start".
Perhaps the most important event in the development of the feminist press during the last few years has been the appearance of news-sheets from documentation/ research centers and local news-letters. Editorial projects, though in the experimental stage as in the case of Filodonna, the news-letter of Tuscan feminist collectives, are fulfilling this desire that women, all women have to participate in the creation of their own instruments and their own culture. Surely this is consistent with the feminist idea of a cultural revolution as the "personal" product of every woman.
The other factor of the last few years, which if not new is much more explicit than in the past, has been this desire amongst groups and women - with different histories and experiences in the movement - to do things together. This desire should not be confused with a vague wish for overall unification; it is rather the recognition of common aims and characteristics alongside differentiated identities which a priori are not always the same for all women. The differences in feminism can and should continue to exist; these too are our history, our richness as long as they are not distorted into sectarianism because dispersion into antagonistic groups and trends takes away the politcal and social "force" that the movement needs to carry out our system-transformative strategies.

GROUP "International News-letter"
of the PRATO FEMINIST COLLECTIVE

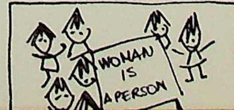
FEMINISM EBBING (?)

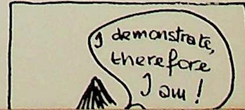






5th February 1983
ROMA
DEMONSTRATION
ON





PREPARING THE INTERNATIONAL MEETING IN TURIN, 23rd /25th April 1983

The purpose of holding such a conference is to draw up a balance sheet of the past 10-15 years of feminism. The visibility of the movement has noticeably decreased since the termination of the "hot" phase of struggles around health issues (underground abortion and the abortion legislation campaign, promotion of health-care counseling centers, etc.). After a "pause" in the movement, the idea for such a conference began to be discussed in Turin feminist circles.

Several themes were suggested for such a meeting but only one met with sufficient enthusiasm: the problem of work. The conference is the joint effort of the major components of the Turin women's movement: the feminist collectives, the "Intercategoriale" [trade union women's caucus], and UDI [Union of Italian Women]. "Women and Work" is an issue that, in different ways, concerns all of us since the vast majority of women now have a job. This issue has particular salience in Turin. The social life of Turin is strongly influenced by the industrial setting, as the huge Fiat complex dominates the labor market and work conditions of the city and its outlying areas. Hence, here class struggle is more than a slogan but is rather reflected in the nature of the women's movement: that the CGIL-CISL-UIL Intercategoriale is an important and active component of the Turin movement is not accidental. The issue of work could also bring together those women who have made feminist militancy the center of their lives through self-managed, sometimes unpaid, work activities, such as self-managed health centers, feminist newsletters or journals, etc.

From 1975 to 1978 the movement of health-care counseling centers served to coordinate the activities of feminist collectives and help coalesce energies and struggles around health-related issues. This phase can be considered as coming to an end with the passage of the abortion legislation in 1978. The presence of a strong Intercategoriale has helped maintain continuity and coordination between the different components of the Turin feminist movement. Thus the Turin movement has its own women's center, jointly run by the feminist collectives, the Intercategoriale, and UDI. Although the different components collaborate on different undertakings, each is totally autonomous, carries out its own initiatives, and may even have its own "headquarters" (as is the practice elsewhere in Italy).

This history of the Turin women's movement explains why three different groups have been able to organize this conference collectively. Yet the fact that we come from different experiences within the feminist universe also explains certain contradictions and difficulties encountered during the preparation for the conference. This conference seeks to bring together the different "souls" of the movement for a debate on their at times divergent "ways of being," viewpoints, and priorities. A coming together of heterogeneous groups is bound to bring out not only elements of unity but also real differences among the various currents.

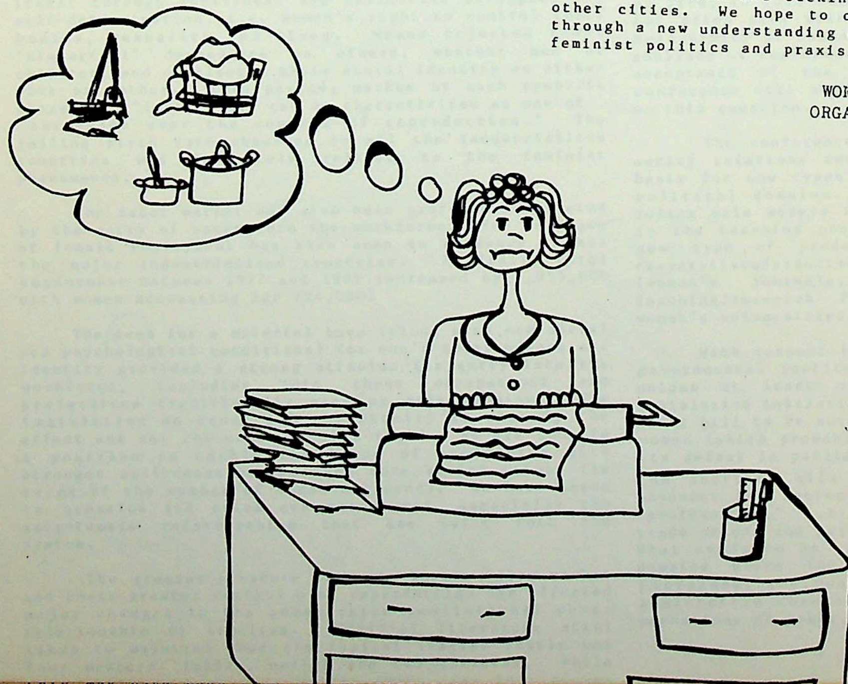
At first sight, the issue of women and work would seem to impose boundaries on a women's conference organized by feminist circles. However, the concept of work when applied to women's experience is not so easily delimited and thus entails going beyond traditional analytic categories. A wide variety of activities, of perceptions and interpretations emerge from the concept "women's work" as well as from the problem of "woman and work." It follows that different and at times divergent approaches arise from focusing on different problems. If we take the vantage point of the male-female contradiction, then the issues debated would be household labor and reproduction (in all its aspects, including women's affective role). If the vantage point is the labor-capital contradiction, however, the issues focused on would be women's position in the labor market and workforce. Similarly, if in looking at the problem of women and work we have emancipatory aims, then the stress would be on struggles and measures that would foster equal opportunities and pay for working women; if we have liberatory aims, then the stress would be on alternative forms of work that women have experimented

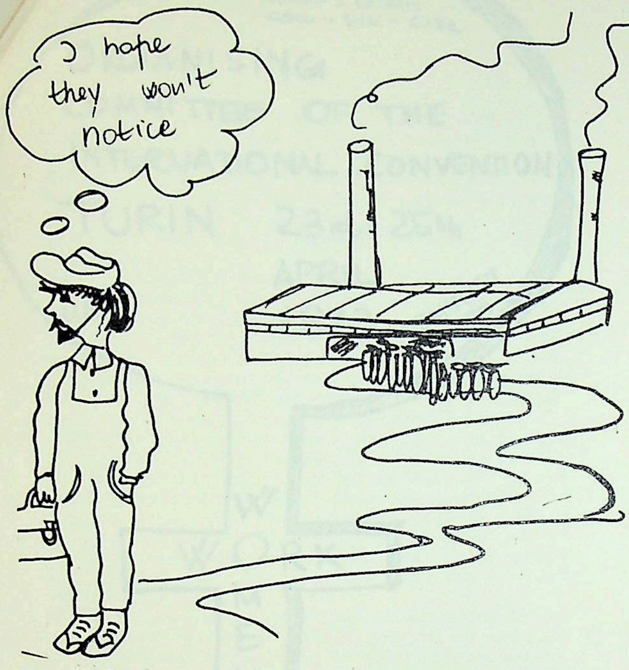
These various perspectives and interpretations have intermingled during the preparation for this conference. Due in part to the inadequacy of our vocabulary for expressing the concept of work, those holding different standpoints could not always formulate their positions with sufficient clarity to insure a real synthesis or balance. There has been some tension and occasional misunderstandings. Nevertheless, these problems have been contained through reminders that each had a role to play. In this preparatory phase, we have learned from one other and from the experiences of the different currents.

Another set of problems emerged from the decision to hold a meeting combining grass-roots organizing and research objectives. This dual character of the conference has created a tension as to the size of the meeting: the research aims dictate a smaller gathering while the organizing goals call for bringing in as many women as are interested (consistent with traditional feminist practice of opening meetings to all women who wish to participate). This cannot be simply solved by "opening up" the conference due to the costs involved in lodging, simultaneous translation, etc. These objective difficulties mean that we cannot invite all who might have liked to attend nor even all those who worked in the preparation of the conference. When the conference was in its initial stages of preparation, the situation within the movement as well as the level of participation in initial preparatory meetings did not indicate any problems of over-registration. We have decided to keep to our original projections despite the political implications that have since become clear.

The contradictions that we have had to confront in organizing this conference point to a series of "knots" that have not been sufficiently reflected upon in recent years. Our political practice has evolved, and we have taken a certain distance from the practices of the early years when all women considered initiatives taken by the various groups as their collective property and responsibility. Similarly, as we have come to acknowledge and view as natural the variety within the "planet" women, we have had to grant even greater autonomy to the various groups. We do not feel that we have the right and duty to scrutinize the activities of other feminist groups and women. However, though there is this recognition of the reciprocal position of the different groups, the relationship between this newly legitimized autonomy and the "perogatives" of the movement as a whole is still largely undefined. For example, there has been a contradiction between presenting this conference as an initiative of the Turin women's movement and seeking "consensus" from women in other cities. We hope to overcome such contradictions through a new understanding of what is emerging today as feminist politics and praxis.

WOMEN OF THE TURIN
ORGANIZING COMMITTEE





"PRODUCTION AND REPRODUCTION": ISSUES OF AN INTERNATIONAL WOMEN'S CONVENTION

In the course of the year-long preparation for this conference, we have become ever more aware of how the women's movement, in its various expressions, has brought about major changes in individual consciousness, behavioral patterns, institutions and culture. However, we also recognize that the movement has been affected by the reactionary onslaught of business and government forces and by the reflux in popular consciousness.

During the 1970s, feminist radicalism manifested itself through individual and collective struggles for self-determination, i.e. women's right to control their bodies, sexuality and lives. Women rejected their "historical" dependence on others, whether men or children, and challenged their social identity as either wife or mother. This period, marked by such symbolic slogans as "I am mine," can be characterized as one of "struggles over the control of reproduction." The falling birth rate observed in all the industrialized countries was intimately related to the feminist phenomenon.

The labor market has also been profoundly affected by the entry of women into the workforce. The increase of female employment has also been in evidence in all the major industrialized countries. In Italy, total employment between 1977 and 1981 increased by 1,055,000 with women accounting for 704,000.

The need for a material base (along with new social and psychological conditions) for one's independence and identity provided a strong stimulus for entry into the workforce, including into those occupations and professions traditionally seen as male domains. The legislation on equal job opportunity is clearly the effect and not the cause of this trend. We are thus in a position to tackle the issue of production with stronger self-consciousness and more social weight (in terms of the number of women employed). We have begun to question its rules and structures, especially the male-female relationships that are built into the system.

The greater presence of women in the labor market and their greater control over reproduction has effected major changes in the composition and internal power relationship of families. Official literature still likes to maintain that the typical Italian family has four members: father, mother and two children. While this may have been true in the 1950s, the 1981 census

usually a single woman (accounting for about 30% of households in Turin).

All our preparatory discussions, as well as materials received from abroad, lead to one conclusion: there has been a change in the concept of work brought about through the questionning and demystification of its sexual bias. Historically, men have been perceived as "producers" and consequently agents of social change while women have been seen as "reproducers" and therefore agents of social/political conservation and biological continuity. The new women's culture, which assigned new significance to work in shaping a woman's identity but rejected its all-consuming character, grew in parallel with new opportunities for self-expression generated by a more advanced society.

To label as "work" what has traditionally been seen as within the sphere of reproduction (from giving birth to household labor) challenges the foundation of trade unionism. In trade union culture, work was only wage labor (the man's eight-hour day); women's labor in the home was only considered accessory.

Another change in the concept of work has come about as a result of the multiformity of women's work. Women's work varies considerably in the different stages of life; in this sense women are mobile because they do not often stay with the same job for 30 years. This muliformity of women's work has usually been ignored in analyses of employment or simply regarded as the passive acceptance of the sexual division of labor. The conference will seek to redress the analytical balance on this question.

The conference will also analyze the network of social relations among women that have served as the basis for new types of production in the cultural and political domains. In the past women "reproduced" ruling male models in various ways (through their role in the teaching professions, for example). Among the new type of production then we can cite women's cooperatives/associations whether in the information (women's journals, publishing houses, etc.) or teaching/research fields (women's studies programs, women's universities, etc.).

With respect to politics, feminism has penetrated governmental institutions, political parties and trade unions at least at the level of discourse. The legislative initiative to combat sexual violence was the first bill to be autonomously elaborated and proposed by women (which probably goes a long way toward explaining its defeat in parliament, analogous to what happened to the abortion bill in 1976). Further, the women's movement has increased female access to the political "professions," i.e. careers with political parties, trade unions and governmental administrations.
What needs to be asked is whether here, as in other domains where the number of women job-holders has increased, the quantitative change has engendered a qualitative change in the rules of the game and the mechanisms of power.

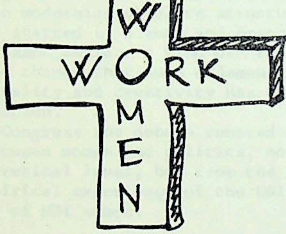
TRADE UNION
WOMEN'S CAUCUS
CGIL - UIL - CISL

ORGANISING COMMITTEE OF THE INTERNATIONAL CONVENTION

TURIN 23rd-25th APRIL 1983

U.D.I.

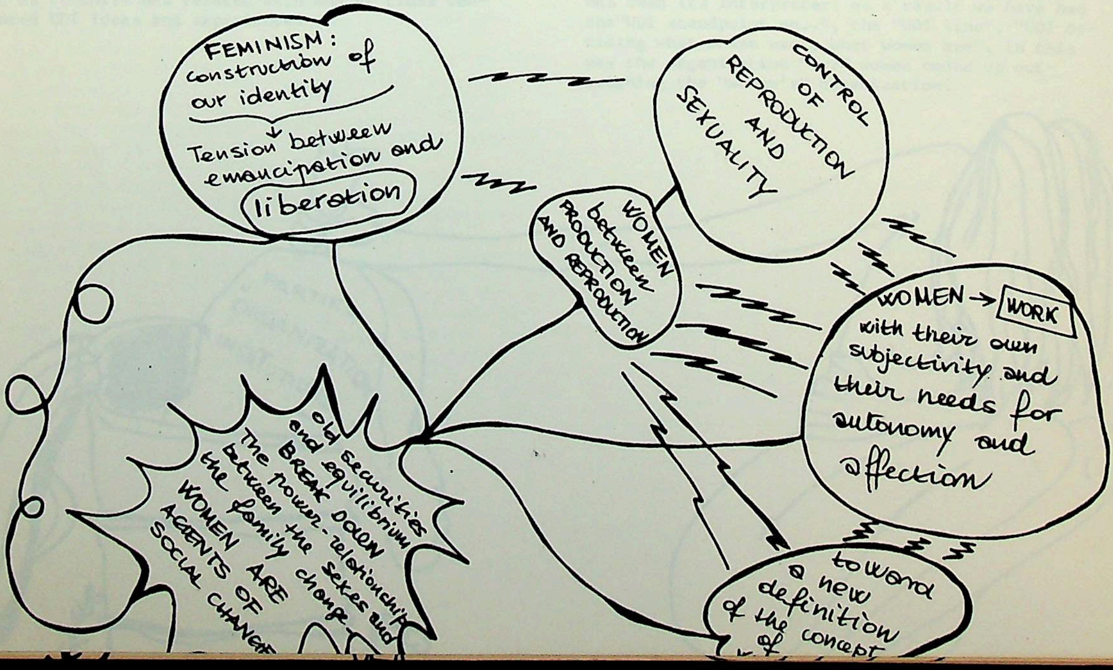
FEMINIST GROUPS



This latter problematic needs to be addressed all the more in the current period when, in Italy as in the other industrialized countries, governmental and business policy is re-establishing "male" economic and cultural modes, i.e. where the dependence of individuals on others is once again being made the foundation of society. This occurs through limitations imposed on the material basis of individual autonomy, through over-emphasis on the family, through stress on public morality and conformism, etc. We can thus place in comparison the failure of the Equal Rights Amendment [ERA] in the United States and the serpentine re-introduction of patronage in job allocation in Italy. While the French and Greek socialist governments have attempted to introduce legislation on equal opportunity and equal rights, the US government has cutback social benefits for female-headed households.

Analogies and differences, parallel and opposing trends will surely be brought out at the conference. It will probably become evident that we live in a world in a rapid state of flux where "models" no longer exist. Women's struggles are in many ways the instruments of change, and perhaps women's work is in some sense the image of the changes to come. Will the conference provide some indication as to a strategy to adopt or direction in which to proceed?

WOMEN OF THE TURIN ORGANIZING COMMITTEE

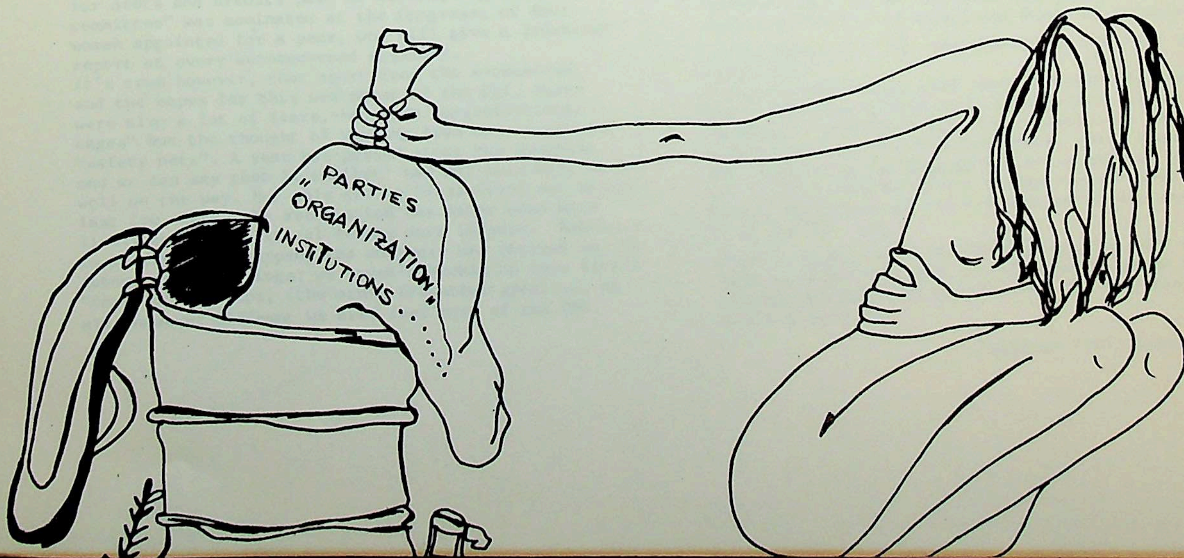


In May 1982, almost a year ago, the 11th UDI congress was held in Rome. UDI is an association which has been going for almost forty years, the first Congress having been held in Florence in 1945, when the 'Gruppi di difesa della donna', which had come into existence in the occupied territories during the Resistance, and the founding Committee of the UDI united.
The 11th Congress is a milestone in the history of this association: it has been described as a challenge, a bet, a congress of 'paradoxes', without a safety net. The very identity of the UDI , its organisation, its political practice, have come under discussion. In our country this is a unique political event because all our organisations, even when they are in crisis, tend to perpetuate themselves rather than raise questions about their own identity or legitimacy. The discussion that took place at the Congress was not simply "adjusting aim", an attempt to modernize obsolete structures: what the UDI has started is a root and branch transformation of the association: a kind of "re-founding",and it is no chance that such a demonstration of political vitality and creativity has come from a women's organization.
At the Congress the debate centred on the relationship between women and politics, not at an abstract or theoretical level, but from the vantage point of the empirical experience of the UDI, its reality, the reality of UDI women.

Autonomy, separatism, opposition to men and male values, civil disobedience: these are the instruments specific to women's politics.

According to one criticism the congress has retraced, and rather late, the steps of feminism and has adopted its key words which are now out of date. This criticism reveals how little attention has been paid to the political discourse and practice of the women's movement in the last few years. Because UDI is a women's organization, it has faced and adopted the contents and the practice of the new feminism just as feminism has related with and at times confronted UDI ideas and experience.

This has been a most creative political exchange which has rendered the Italian women's movemnt unique in Europe; one only has to think of the bill on sexual violence worked out and proposed to Parliament by women, springing from the ground-swell of women's opinion.
A political practice that is based on the individual woman's personal experience, demands, when applied to the overall realm of politics, the redefinition of all political categories and the world itself. Once UDI as a women's organization with a historical heritage has adopted this practice, the issue of such a redefinition cannot be avoided. Because, given its history and identity UDI cannot tackle these issues in terms of 'political theory'. It has to do it in concrete, empirical terms: experimenting with new organizational and political "forms" and getting rid of older forms that are no longer useful.
The most crucial dilemma the 11th Congress had to solve was the one to do with the "forms" of women's politics. The debate preceding the congress originated in the personal and collective unease felt by UDI women, amongst whom had already ripened , at the 10th Congress, the choice of a politics of liberation based on sexual antagonism. The organizational structures of the UDI had been created for different aims, different political objectives and had been inevitably modelled on the only existing forms of organization, the masculine.
At the 10th Congress, many ideas, (notably the issue of autonomy ratified later by the 11th Congress) were already present. But after the grand opening and great communication between women of all sorts, the UDI as organization/institution took over.
At the same time we have to acknowledge that "tested" organizational forms for the politics of liberation do not exist. On the other hand, alongside the UDI organization/institution which has mediated between women and the institutions of the State, there has always existed the UDI as a women's association, a place where women could communicate directly. But it is true that very often, instead of making this communication between women more possible, the organization has been its interpreter: as a result we have had the"UDI standpoint on..", the "UDI line", "UDI deciding what women want, what women are". In this way the organization "for" women ended up outweighing the "women's" organization.



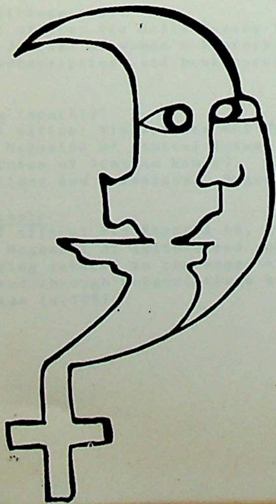
With the 11th Congress UDI as institution has finally been put aside and channels of communication have been opened. The preparation for the Congress and the Congress itself have taken as their point of reference for the development of an analysis and a political practice the "collective/personal" experience of all UDI women.
We can see now what led to the majority decision of the Congress to "dissolve" UDI into the movement,-- haste and a feeling of resentment for the rather suspect "big organization".
What caused most uproar was the "no" to the national, understood as"executive bodies" elected tothe Congresses, the "no" to the "national secretariat" which was required to provide the political synthesis and line, the "no" to the "officers" as the professionals of women's politics. The fact that this "no" came from the so-called leaders themselves gave rise to fantasy-politics speculation about the recondite motives of an "executive goup" wanting to eliminate itself; in politics the usual function of the executive is to auto-legitimize itself, rather than run the risk of non-survival even on its own: at the very least another group would substitute the existing one. But it was soon seen, from the level of the discussion that arose within the UDI and from the quality of the research undertaken with all the women involved, that no internal power-struggle was taking place.
The only national appointment we made at the congress was the assembly called for October. In order to preserve the continuity and the identity of the UDI,which we value greatly and have no intention of giving up, some motions were proposed to this end. First and foremost the constitution of the UDI, but not the tradtional constitution proposed and voted for at the Congresses, but a constitution to be remade right from the beginning, to be discussed point by point. A flexible instrument to be called our "charter of intent" which will give rise to our individual and collective "declarations of intent and the reasons for belonging to the UDI, and which will contain the aims of the association.
The "charter of intent" is discussed and approved by the national meeting, which also, at every meeting, makes an agenda of work and subsequent national engagements. The use of the Noi-donne supplement for communication and information about news and dates of meetings is confirmed.
As far as the financial continuity of the association is concerned, that is,the responsibility for the funds, for debts and credits past or future, a"guarantor committee" was nominated at the Congress, of four women appointed for a year, who will give a financial report at every autoconvened assembly.
It's true however, that apart from the enthusiasm and the hopes for this new phase of the UDI, there were also a lot of fears,--no more "organizational cages" but the thought of working from now on without "safety nets". A year has passed since the Congress and we can say that if the'bet' has not been won, it's well on the way. Not only are we "dissolved", but in the last few months the association has never been more lively and the political debate more intense. Really, as we wanted to happen, the congress has carried on, in autoconvened meetings; we haven't broken up into little "corporate" groups, (the other frightful spectre), we all, however different we are, feel part of the UDI, and we want to argue our positions within the UDI.
During the last few months, with talk of political crisis on all sides, the UDI has been a very important "political workshop" not only for women's politics. In our meetings (at the last one, 4th and 5th of February, contemporaneous with the great demo against the Casini amendment and for the law aginst sexual violence of democratic origin), we truly discussed and decided everything collectively, including the sort of things generally decided by a few.
The charter of intent was discussed first of all in groups formed at the time the assemby was convened, based on a draft prepared by a group of women who put themselves forward as candidates at the previous meeting to examine the various proposals. Then followed more discussion and proposals of modifications, point by point, with approval at the last meeting. The assembly decided to combine the original motives and ideals of the "Charter of intent" with the tecnical constitution itself, which had been separated in the draft proposal. Therefore, to all intents and purposes the "Charter of the UDI" is its new constitution, not just a straightforward technical instrument, but the Charter of Intent, in short, a kind of "Identity card" containing"my reasons for belonging to the UDI" of all of us, and the basic articles to allow us to "function".
We also approved at that meeting the draft of the "personal agreement card" which substitutes the membership card which also came under discussion. Even in shape the "card" is different: it's a micro-card containing the text of the charter of intent, a page listing all the clubs, centres, services and activities of the UDI, a card with information about the free press Cooperative and Noi-donne: their origins, history and raison-d'etre; finally a form to return, on which the woman writes down her motives, her projects and wishes which lead her to join the UDI.
Apart from the autoconvened national Assembly,"the only legitimate seat of political synthesis and decision making at national level", we have given ourselves the"means of documentation, communication and development of the culture of the women's movement", being our newspaper Noi donne, and it is "the responsibility of whoever supports the Charter of intent, to participate in the running of the newspaper by means of the specific instrument we have created for this purpose-the Free Press Cooperative", the archive " "testimony of the history of the UDI", and a library "useful in the political struggle of women"; and services such as the national headquarters and the administration of accounts and funds at national level. Moreover, "the association is entirely self-financed".
These are the forms, what about the content? Amongst other things, you can read, in the first clause : "Identity, self-determination, separatism, communication are the bases of our power, which means first and foremost being able to be; being able to fulfil need our desires, our projects; to express our political ideas, which presupposes a space and a time created by us and for us".

Women's struggle is the UDI's struggle; this is clear only to judge from the recent demonstrations by the women's movement which, given up for dead too hastily still carries on.

MARIELLA (UDI, Roma)

3rd NATIONAL CONVENTION OF LESBIAN WOMEN
Bologna: 2-4 January 1983

Once more - and this makes the third time now - we have called it a "Convention". But we met together again because of our wish to love, to explain, to grow.
But this over-serious "receptacle" was filled to overflowing with really serious events and energetic activity, so much so that it really doesn't deserve such a "male-chauvinistic" name: it is much more a meeting-party-confrontation. Clear thinking, sensibility, the desire to feel good, and to understand, the need to learn, to love, to have friends,to get at the truth, to take the drama out of certain too-intense experiences, to recover the ability to play and to be ironic....making some money by selling some of the things we have made ourselves (diaries,literature, magazines):all these things, and many more besides, got woven into three days we lived in a totally new way. Three days weren't enough: that was the general complaint. We thought a lot, made lo s of plans for the summer, or perhaps even earlier: one of the discussion groups is going to try to organize a meeting in the spring; the "magazine project" will be worked on in the meantime. However, all this enthusiastic endeavour and interchange of ideas took a great deal of exhausting and not always pleasant preparation. The two tiny groups from Bologna (Gruppo promotore del Convegno Lesbico and the Circolo Culturale Lesbico Tiaso) took on the task of asking the Istituzione Comunale for the space the lesbian women needed, and worked together for this for three months. There were two problems: the most important one involved personal relationships, the differences of language and work-methods between the two groups, one being feminist based the other not. Working together has resulted in a "product", not a confrontation. The other problem-dealing with the Institution - turned out to be less frustrating. In fact, all that was being asked for was actual physical space in the city. Since the City of Bologna Council had taken up an open-minded attitude towards "the cultural phenomenon of homosexuality" with the gays, there couldn't be discrimination against us. All that was needed was a great deal of patience, time and hard work.
During the three days the work was divided up into six subjects, proposed a few months earlier by a national inter-collective meeting which took place in Florence: mistrust of the differences, lesbian culture and creativity, political and existential separatism, ways for groups to work together, the search for the mother in the other woman and in the group, relationships with the outside world and the fears created.
The mother group didn't last long: there was only tension, no willingness to listen,only the clash of individual needs. But the group discussion about"mistrust of the differences" was teeming with analytical ideas and energy: the serenity with which it was possible to "offer" one's own experiences of accepting oneself and also of self-rejection, the absolute need to recognize calmly one's own "bad feelings", the attempts to affirm ones own individual identity, the still timid approach towards a freer, more joyful mode of relationship were a testimony to today's Italian lesbians - less fearful, more secure, full of life and hopes for the future. Bearing witness to this was a show, improvised during the three days on a text by Loredana of Rome by the "culture and creativity" group, with acting, slides and music (flute, guitarand voices). This was the closing item of the convention and it produced a great moment of communication between us all: the "happiness" mockingly referred to in the show was a joke at our expense and provoked howls of laughter as well as food for thought.
Then we also saw the slides presented by Pia from Florence about the Women's Festival at Amsterdam, and some shown by Giovanna from Rome, -part of a piece of research on women before the patriarchal system.
And every evening after dinner, though we were dead tired from the day's intense activity, we still stayed together: time for dancing, singing, exchanging more personal thoughts and feelings.
The work of the general assembly was more tiring and a bit of a waste of time. Most strain was caused during the afternoon devoted to deciding whether or not to admit the women journalists to the session: old fears persisted (and they aren't just fantasy: the kiss of Agrigento is a good lesson), but the politics of visibility prevailed and those journalists willing to discuss what they meant to write about the convention were allowed into the hall. The assembly at once put down a motion analyzing and condemning the seven months suspended sentence imposed on the two women from Agrigento caught kissing in public, no less,by a policeman!
But these rather traditional political moments do not give the real flavour of those three days. Lesbian "politics", firmly rooted in the feminist base consist in continuous subversion of daily life,that women are good at, using analysis, conscious sensibility, self-questioning in every moment of one's private and social life. The Bologna Convention saw the collective creation of a fragment of this reality.



NOTES ON ITALIAN FEMINIST PERIODICALS AND IRREGULAR NEWS-LETTERS

This is designed as an introduction to the feminist journals, magazines and newsletters currently being published in Italy. Feminist information and the circulation of a feminist press (both militant and academic) are crucial for the health of the women's movement. For this reason, we have decided to bring to the attention of Italian and foreign women all those publications with which we are familiar.

There have been of course some changes in the women's and feminist press over the course of the past few years: some journals no longer appear, some are just coming out. More importantly, there seems to have been a change in the expectations of a feminist press on the part of both publishers and readers. In general, we can observe a shift toward a more essay-like discourse, as articles take on a more specialized and technical favor. More than in the past these publications also strive to tackle topical issues in a manner that is less ideological and more critical of official positions. In order to examine the various issues in all their complexity, a more analytic approach has been adopted.

We have divided the list into three categories: 1) journals with national distribution that can be found at newsstands and in bookstores, 2) newsletters of feminist or women's research centers, and 3) bulletins of feminist groups and collectives with local distribution (serving mainly as coordinating instruments for initiatives and the circulation of debates).

JOURNALS WITH NATIONAL DISTRIBUTION

Differenze (irregular)
Editorial office: Via Germanico 156, Rome
Comment: Each monographic issue is edited by a different group or collective. It can be found in women's bookstores and some other shops. Twelve issues have appeared since 1976.

Donne e Politica (bimonthly)
Editorial office: Piazza Grazioli 18, Rome
Comment: Journal of politics and culture edited by the women's section of the PCI [Italian Communist Party]. Distributed through subscriptions, newsstands and bookstores. Began publication in 1969.

DWF: Donna Woman Femme (quarterly)
Editorial office: Viale Angelico 301, Rome
Comment: Journal of international women's studies which publishes historiographic, anthropological and social science articles by Italian and foreign researchers. Distributed through subscriptions and bookstores. Began publication in 1975.

Effe (monthly)
Editorial office: Piazza Campo Marzio 7, Rome
Comment: Feminist magazine of culture and topical issues of the movement. Distributed only through subscription. Began publication in 1973.

Memoria (trimesterly)
Editorial office: Via della Dogana Vecchia 5, Rome
Comment: Journal of women's history. Distributed through subscriptions and bookstores. Began publication in 1981.

Noi Donne (monthly)
Editorial office: Via Trinita dei Pellegrini 12, Rome
Comment: Magazine of topical issues and politics put out by UDI [Union of Italian Women]. Distributed through subscriptions and newsstands. Began publication in 1945.

L'Orsa Minore
Editorial office: Via Ripetta 66, Rome
Comment: Magazine of culture and politics focusing on issues being debated in the women's movement. Distributed through subscriptions and bookstores. Began publication in 1981.

NEWSLETTERS OF RESEARCH CENTERS

Ce.D.I.F. (irregular)
Comment: Bulletin of women's news and research center under the supervision of the women's regional center of Piedmonte. Bibliographic in nature providing information on publicatons by women's associations affiliated with various institutions and political parties. Distributed free to other centers and associations. Three issues since 1982.

Center for the History of the Italian Women's Liberation Movement (irregular)
c/o Fondazione Feltrinelli, Via Romagnos i 3, Milan
Comment: The newsletter provides information on activities of the center and has begun cataloguing women's journals and magazines. Distributed free to other centers and groups. Three issues since 1981.

Leggere Donna (quarterly)
Centro documentazione Donna [Women's research center]
Comment: This bulletin is divided into two sections. One is devoted to new publications and book/journal reviews; the second is devoted to discussion of various issues. Can be requested from the center (enclose a contribution of 1500 Lire per issue or 5000 for 4 issues). Eight issues since 1980.

Rassegna Stampa (irregular)
Centro studi sulla condizione della donne [Center for studies on women's status], Via Verdi 35, Naples
Comment: This bulletin compiles articles on women published in Italin newspapers. The center is under the supervision of the Naples municipal government. Distributed free to other centers and groups. Began publication in 1982.

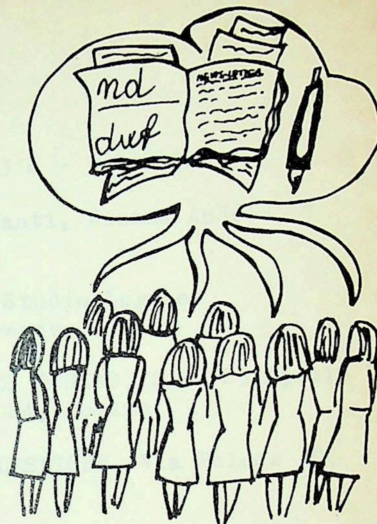
Storia Donna (irregular)
Center for Studies on Women's history, Via San Martino 18, Pavia.
Comment: This bulletin publishes abstracts of dissertations on women's history. Edited by the Italian association of graduate women. Began publication in 1982

Note: (missing addresses from the above list)

Ce.D.I.F.
Via Alfieri 15, Torino

Leggere Donna - Centro Documentazione Donna
Contrada della Rosa 14, Ferrara

NEWSLETTERS OF FEMINIST COLLECTIVES AND NETWORKS



Bollettino del CLI (monthly)
Collegamento lesbico italiano [Italian lesbian network], via del Governo vecchio 39, Rome
Comment: Informatin and coordinating newsletter of Italian and foreign lesbian groups. Distributed through subscription and women's bookstores. Began publication in 1981.

Bollettino delle donne (irregular)
c/o Piera Zumaglino, Via San Tommaso 24, Turin
Comment: Network newsletter of Turin feminist collectives. Any woman or group can write for the bulletin. Distributed by militants in the Turin area and through women's bookstores. (13 issues since 1978)

Filodonna (irregular)
c/o Nara Marconi, via dell'Alberaccio 69F, Prato 50047
Comment: Regional newsletter of Tuscan feminist collectives. Each issue is compiled by a different collective. Distributed by militants in Tuscany. Three issues since 1982.

Mafalda (monthly)
c/o Anna Maria Ceci, Via Imbriani 67, Bari
Comments: Bulletin for local information and intervention on local issues. Can be obtained from editorial offices at above address. Began publication in 1982.

NOTE: This bibliography compiled by the Florence Women's Bookstore and Women's Research Center, Ferrara

Adresses

- COLLETTIVO FEMMINISTA , Via Franchi I3 A - 50047 PRATO
- Coordinamento Toscano, c/o Rosy Maccianti, Piazza Andrea, 7
  Pontedera (PISA)
- COMITATO PROMOTORE SPAZIO DONNA, c/o Studio Legale
  Elisabetta Bavasso, Via Torta 9 - Firenze
- COMITATO ORGANIZZATORE DEL CONVEGNO DI TORINO, 23 - 25 Aprile 83
  c/o Piera Zumaglino, Via San Tommaso 24, Torino
- GRUPPO PROMOTORE DEL CONVEGNO DONNE LESBICHE, Via Polese 30,
  Bologna
- CENTRO DOCUMENTAZIONE DONNA, Contrada della Rosa I4,
  Ferrara
- LIBRERIA DELLE DONNE, Via Fiesolana 2, Firenze
- U.D.I. , Via Trinità dei Pellegrini I2, Roma

Contact persons for the international newsletter and the tuscan women's center projects:

- PAOLA CIARDI , 225 W. I05th Str. (Apt 5RW) Tel 212-316072
  NEW YORK, N.Y. I0025 (starting August I983)
- ALESSANDRA CINI , Via Caboto 5, 50047 PRATO (Italy)

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- PROPOSAL FOR AN INTERNATIONAL FEMINIST NEWS-LETTER AND INTRODUCTION, by Group "International News-Letter" of the Prato feminist collective.

- THE COORDINAMENTO TOSCANO AND THE "SPAZIO DONNA IN TOSCANA" PROJECT, by Tuscan Feminist collectives, and the Promoting Committee "Spazio Donna"

- PREPARING THE INTERNATIONAL MEETING IN TURIN, 23rd/25th APRIL 1983 AND "PRODUCTION AND REPRODUCTION", by women of the Turin organising committee.

- CHANGING AN OLD REALITY: THE TRANSFORMATION OF THE U.D.I., by Mariella (UDI, ROMA)

- THIRD NATIONAL CONVENTION OF ITALIAN LESBIAN WOMEN: BOLOGNA 2nd/4th JANUARY 1983, by the Promoting Group

- NOTES ON ITALIAN FEMINIST PERIODICALS, AND IRREGULAR NEWS-LETTERS, compiled by the Florence Women's Bookstore and Women's Research Center, Ferrara

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The Abortion Procedure

When a woman calls (or comes to) the Women's Abortion Project requesting an **abortion**

(a) a counsellor completes a form with information about length of pregnancy, and relevant details of her medical and gynecological history

(b) if she is less than 12 weeks pregnant (counting from the first day of the last mensrual period) the counsellor schedules her with a doctor, explains the medical procedure discusses precautions and any problems the woman may have. Directions to the doctors facilities are given. Any financial problems are discussed.
Women who wish for in-hospital abortions are referred to other places. Women from New York City are generally referred to the ambulatory clinics of NY voluntary and municipal ho[illegible]itals.

(c) if she is more than 12 weeks but less than 24 weeks pregnant, the counsellor gives her information about all the possible avenues ahe can try depending on her financial position.

All information taken from women is considered confidential. The age&marital status of the woman do not affect our desire to help. All counsellors are well prepared to discuss birth control as well as abortion.

When the woman arrives at the doctor's office she is given initial counselling by a woam from the Women's Abortion Profect who describes to her the whole procedure and discusses any problems which may arise. After the necessary tests and an initial examination to confirm the pregnancy, a local anesthetic is administerd. This is a para-cervical block, involving two shots (usually xylocaine) in the cervix. Some doctors also administer tranquilizers (such as valium).

The procedure itself invoves dilatation of the cervix and removal of all fetal material by vacuum aspiration. The procedure takes no more than 15 minutes depending on the length of the pregnancy. Afterwards the woman may rest in a se separate recovery room with beds. Recovery time is usually 30 to 45 minutes a although some women feel well enough to leave almost immediately.
Women are asked to bring sanitary napkins with them as there is often slight bleeding after the procedure.

All women are given a sheet of instructionso outlinigg post -abortion precautions and possible complications as weel as a 24 hour number where they can re- reach the doctor in case of problems or questions. They also receive a form to complete and return a week after the procedure. The doctor may also prescribe or give the womanuterine contractant or anti-biotics if he deems it necessary.

All doctors are within minutes of fully equipped hospitals. To date though with experience of about 1000 abortions we have never had a need to utilize the hospital facilities

Women's Abortion Project
212-691-2063 212-691-3396

NAME OF COUNSELOR: ______ DATE OF CALL ______

NAME: ______ PHONE #: ______

ADDRESS ______

______ AGE ______

______

DOES THE PREGNANCY HAVE TO BE KEPT A SECRET?
IF SO WHAT SHOULD WE SAY WHEN WE CALL? OR IS THERE A FRIEND WE MAY CALL?

______

FIRST DAY OF LAST PERIOD· ______ NO. OF WEEKS FROM LAST PERIOD·
DOCTOR'S ESTIMATE? ______
KNOWN DATE OF CONCEPTION? ______ NO. OF WEEKS FROM CONCEPTION:
PREGNANCY TEST? ______ ______

______

CAN YOU AFFORD THE DRS. FEE OF $100 AND THE DONATION TO THE PROJECT OF $10 ______
(FOR SALINES ASK) HOW MUCH MONEY CAN YOU AFFORD TO PAY? ______
THIS IS PAYABLE IN CASH OR MONEY ORDER ONLY.

DO YOU HAVE· MEDICAID ______ WELFARE ______ MEDICAL INS. OR COVERAGE ______

______

HAVE YOU EVER GIVEN BIRTH TO A CHILD? ______ IF YES DATE OF LAST DELIVERY ______
ANY CESAREANS? ______ ANY ABORTIONS? ______ ANY MISCARRIAGES? ______
ANY VAGINITIS ______
ARE YOU RH NEGATIVE BLOOD TYPE? ______

HAVE YOU OR YOUR IMMEDIATE FAMILY EVER HAD: TUBERCULOSIS? ______ ASTHMA? ______

HEART DISEASE? ______ DIABETES? ______ SICLE CELL ANEMIA ______ HEPATITIS? ______

EPIPLEPSY? ______ BLEEDING OR CLOTTING PROBLEMS? ______

ALLERGIES TO ANY DRUGS? ______ MAJOR OPERATIONS(esp. within last year)? ______

IS THERE ANYTHING ABOUT YOUR HEALTH A DOCTOR SHOULD KNOW? ______

______

WERE YOU USING BIRTH CONTROL? ______

______

WHERE DID YOU GET OUR NUMBER ______

VERY IMPORTANT TO ASK IF A GROUP OR DOCTOR WHAT IS THE NAME AND ADDRESS?!!!!!!

______

WHAT OTHER REFERRAL GROUPS DID YOU TRY BEFORE CALLING US? WHAT DID THEY ADVISE?

______

______

REFERRED TO· (BE SURE TO GIVE TRAVEL INSTRUCTIONS PRE PROCEDURE INSTRUCTIONS & IF NECESSARY TELL HER TO BRING SANITARY BELT&?OR NAPKIN EXPLAIN DRS PROCEDURE)

DOCTOR DAY & DATE

RESULTS: FOLLOW UP CARD RETURNED? ______
OTHER:

8/20/71 mpo

2

WOMEN'S ABORTION PROJECT AFTER-CARE INFORMATION

ABOUT THOSE PILLS IN THE ENVELOPE

a. If you have been given antibiotics (yellow and orange pill) take 1 every 6 hours starting within 6 hours after the abortion. In order for these pills to be most effective in helping to prevent infection, it is important to take them around the clock for the first 24 hours. If possible, take them about one or two hours before or after meals. DRINK LOTS OF FLUIDS.

Some doctors feel that yogurt, cream cheese or buttermilk should be added to your diet for a few days after the last pill has been taken. This helps to avoid getting a yeast or fungus infection. (There are always certain kinds of organisms and bacteria present in the vagina. However, when antibiotics are taken their usual balance is upset. Some are killed off and others are then able to grow more freely thereby causing very common kinds of vaginal infections.)

b. If you have been given ergotrate (little white pill) take 1 pill every 4 hours starting 1 hour after the abortion. These pills help the uterus to contract back to its pre-pregnant size and thereby help to stop bleeding and prevent infection.

WHAT TO EXPECT

Some vaginal bleeding will occur. It is usually about as much as in a normal menstrual period but may last up to 3 weeks. It is not abnormal for someone to stop bleeding after the first day, just so long as there are no cramps or fever. You may stop bleeding and then begin bleeding again; that is also normal. There is also a chance of passing a few clots; don't worry unless you also have a high fever or severe cramps.

THIS BLEEDING IS NOT A PERIOD. Your regular period will begin in 8 weeks.

WHAT NOT TO DO

For the next 3 weeks it is very important to keep germs out of the vaginal area in order to avoid infection. The following don'ts are important for that reason.

1. To prevent dirty water from entering the vagina don't take tub baths for at least 2 weeks. (If you are bleeding for more than 2 weeks wait until 2 days after all bleeding has stopped.) Take showers or stand in the tub and wash yourself down.

2. Don't douche for 1 month.

3. Don't have sexual intercourse for at least 3 weeks or until 1 week after bleeding has stopped (if bleeding is longer than 3 weeks).

4. Use only sanitary napkins - don't use tampax - until your next period. Change the napkin a couple of times a day even if you are only spotting.

5. Don't drink alcoholic beverages in quantity or use any drug which might affect you to the extent that you'd be unaware of any symptoms of infection. Alcohol may also tend to cause heavier bleeding.

Women's Abortion project after-care information cont'd

SIGNS OF COMPLICATIONS

With the vacuum suction method of abortion complications are rare and almost never serious. The first 5 days after the abortion are the most critical. Please be sure to call your doctor or Dr at if you have:

a Heavier bleeding than with a normal period in any one day

b. Blood clots along with severe cramps and high fever

c. Bleeding lasting longer than 3 weeks (It is not abnormal to spot or bleed less than 1 pad a day for 3 weeks after the abortion.)

d. A temperature of 100.5 degrees or more. (It is good to be aware of your own temperature changes and if you have chills or feel very warm be sure to keep checking your temperature)

e A smelly discharge from the vagina

f. Repeated severe cramps or pains. For such cramps absolutely do not take any aspirin Bufferin Anacin or other medication containing aspirin. Any of these will reduce your temperature and hide symptoms of a possible infection

MORE ABOUT CRAMPS

If you have severe cramps with little or no bleeding and if your temperature is not over 100.5 degrees push down hard and deep with your fingers on your stomach belo your navel and just above your pelvic bone. (You will be able to feel pressure on your bladder) This will push out any clots that may be blocking the flow of blood and causing the cramps. If your temperature is 100.5 de rees or more at the same time that you have cramps call a doctor.

FOLLOW-UP

In about 3 weeks it's a good idea to go to your own gynecologist to get some kind of effective birth control. At that time you can get a check-up to make sure everything's O.K. (Before 3 weeks an internal examination might introduce an infection.) Your doctor will not know that you have had an abortion so you don't have to tell him about it unless you want to.

ALSO After one eek please send us back the post card so that we know how you are

****

5/29/71 es

Women's Health Information Collective

We are all health workers. We feel that too much knowledge is in the hands of too few. This is what gives the professions their power.

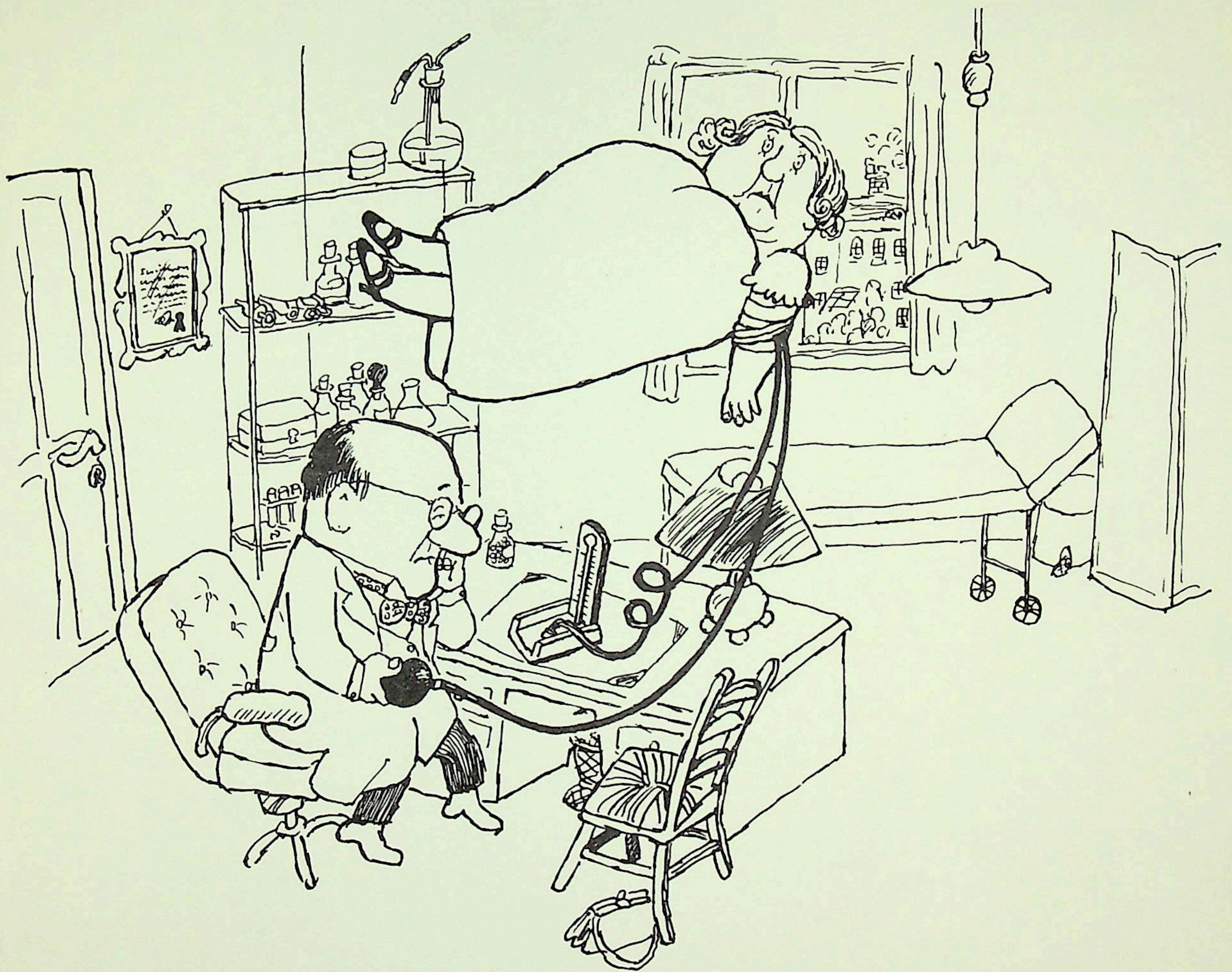
People have the right and the ability to know more about their bodies; and we are working towards this end.

What would you like to know about your body?

We have produced the pamphlet on V.D. and would like your comments.

We are now writing one on the menopause and would welcome suggestions on this and on any other topic.

Please send suggestions back to us via the Women's Liberation Workshop,
3, Schavers Place,
London, W.1.



Women and Health Care

Last June some women got together to talk about health

"There was no gynecologist on the student health plan, they wouldn't touch anything connected with vaginas."

". . . So I put on a ring and pretended I was married and the next doctor I asked gave me a diaphragm."

"I hate to use the pill all these years, but I'm terrified of having an abortion, and the pills are the safest."

"No, he didn't ask whether there was diabetes or high blood pressure in the family, but he gave me a prescription for the pill which I refill every six months. That was four years ago."

As we talked about contraception, we found out that we'd all received very haphazard care, that we'd been ignorant about how our bodies worked and about how contraceptives worked, that our visits to doctors and our discussions had often been surrounded by secrecy, embarassment and guilt. We had made many visits to doctors and spent a great deal of money yet had received very inadequate, often callous, care and advice.

"Sure you can get a legal abortion if you have the money. You just have to go in and say you'll commit suicide. You have to prove you're the stereotype hysterical woman."

"I was terrified because it was illegal."

". . . and I started hemorrhaging and running a fever. When I got to the hospital they said they wouldn't treat me till I admitted I'd had an abortion and told them the guy's name. They said they'd call the cops. I held out and after three hours they gave up."

". . . so they subpoenaed her to appear at the abortionist's trial. The FBI went through her address book."

We all knew how grim the abortion scene was before we began our discussions, but we were still overwhelmed by the trauma and misery all of us had been through. Because of the atmosphere of guilt and fear, few women have talked about their abortion experiences; when women begin to talk with each other about it, a flood of anger and anguish pours out. Some of the worst experiences occur when a woman with an incomplete or septic abortion goes to a hospital emergency room. Some hospitals refuse to treat such women, others harass and moralize unmercifully, threaten to bring in the cops, (which is not legally required) and generally beat down a woman who has already suffered through the illegal abortion.

"It took me 45 minutes to get to the hospital. About 40 of us came in a 9 o'clock. We waited for a long time. Then they weighed us and then we waited again in a long narrow passage till the doctors saw us. They called us by our first names, never Miss or Mrs., and talked to us like people talk to children, you know, slow and loud, repeating everything. Sometimes you'd be up there on the table and eight students would poke around inside. By the time I had the baby I hated them. I heard them call the women there cows and animals."

"The doctor would give me a brief examination and then I'd walk out, there were always lots of questions I wanted to ask but I could never say things right and he always made me feel very foolish."

"They wouldn't let my husband stay with me during labor."

"After the baby was born she asked the clinic doctor to give her the pill and he said they'd already put in an IUD."

We found out that our experiences with prenatal care and childbirth had been uniformly frustrating, often bad, sometimes even dangerous for us. Some of us had used private doctors, had paid enormous sums and still felt intimidated by the doctors, had been made to feel weak and dependent. Those of us who'd been to clinics had been angered by the long hours of waiting, by the arrogance and racism of the professional staff. We worried about the constant changing of doctors, and were always harassed by the financial investigations and reinvestigations that accompanied every change in Medicaid or hospital financing. Through our clinic experiences, we discovered more than has been written about the disastrous medical care given poor, black and brown women, about forced contraception, about the ways in which class and racism condemn women who can't buy health care to constant callousness and uniformly bad treatment.

"I take them to the well baby clinic for shots and checkups, and to the pediatric clinic at the hospital when they're sick. Of course if they're really sick or it's the weekend, I take them to the emergency room where they see you within a few hours."

"She was in the children's ward for three weeks and they only let me see her one hour each day."

"I live in a tenement with peeling lead paint, but they wouldn't test the children for lead poisoning for free."

"He was 2 days when I left the hospital and they said bring him for a first visit at two months."

"I was right there in the hospital with the baby sick and no one would help. God, how I hate those bastards."

We realized that most children get piecemeal care from a variety of sources and from different doctors. Many get no care at all, so that they get their first check-up at school if they're lucky. We know that to get regular preventive care for her child, a poor woman will have to travel long distances, wait long hours, receive cursory examination and tolerate hostile and degrading attitudes. So naturally she'll put it off and hope the kids don't get sick.

Middle-class women who used to rely on private pediatricians may still do so for routine care, but increasingly, private doctors don't live in the neighborhood, can't be reached at night or weekends and won't make house calls, even if you can pay. Consequently middle-class women are beginning to use the clinics and emergency rooms, and are beginning to experience the same frustration and resentment the poor have always felt.

"You're told that your duty is to the patients, that they'd suffer if you went on strike. The hours are terrible and the pay isn't good . . . Doctors do OK though."

"When I was in medical school I was always told I was taking a place away from a man."

"I was specially trained as a medical technician and I have a license, but I'm really stuck. I do the same thing day in day out, and I'm not allowed to do anything else. So I move around, at least I have a change of scene."

"They prefer black and Puerto Rican women for the low paid jobs. They know they need the work more and can't leave easily."

We realized that for women working in hospitals, it's the usual story of low pay, lack of advancement, lack of respect. Women serve, do the shit work, get treated as sexual objects or work horses. But the hospitals are particularly hierarchical and rigid, and 70-75% of the workers are women, so in some ways it's worse.

What started out as discussion quickly became anger. We began by treating 'Women and Health' as a discussion topic, and now we're considering what kinds of action to initiate. Since most of us were already involved in either the health movement or the women's liberation movement, we became the Women's Health and Abortion Project.

Our premises are simple—

Women, more than men, need and use health care, especially preventive care, for themselves and their children.

Since women and young families have relatively low incomes, they can't afford to pay for adequate care. The only health system that can fully meet women's needs is a health system that gives care on the basis of need, not on ability to pay, a health system fully oriented towards prevention.

Since women use the health-care system during their active healthy years, unlike men who go to doctors only when they are sick or old, women are more likely to engage in an active struggle for change in health-care.

Those in power, doctors and health administrators and the executives of the insurance, drug, and health industries which all profit off the health system, will not change unless they are forced to do so.

A strong women's health movement—an alliance of patients and health workers—could be an important force for change—could begin to initiate the demand for free and complete health care as the right of every citizen.

The further growth of the Women's Health and Abortion Project in New York is only one example of the growing involvement of the Women's Liberation Movement in health issues all over the country.

September, 1969
Women's Health & Abortion Project
36 West 22nd Street
New York, New York

"Vacuum aspiration" si possono trovare i materiali arretrati.

THE WOMEN'S ABORTION PROJECT of NYC WOMEN'S LIBERATION

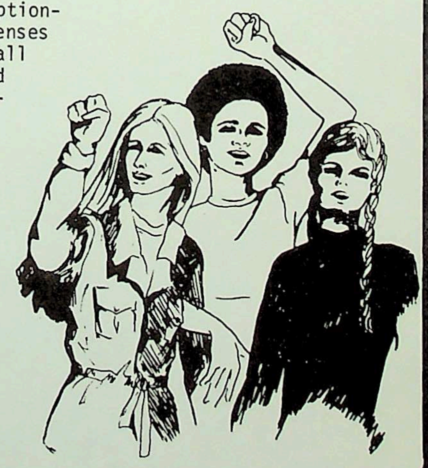
36 West 22nd St., New York City, N.Y. 10010

The Health and Abortion Project was originally formed to create ways to make health and abortion care informational and accessible to all women. We are a Women's Liberation collective providing women throughout the country with inexpensive abortions -- abortions that are medically and psychologically excellent. We are building free clinics, pressuring hospitals to respond to community needs, uniting with other groups throughout the country so that all of our voices can be heard, all of our strength can be felt.

Because of our belief in the right of each woman to control her own body -- to control her own life -- we have been very active in the area of abortion. Exorbitant hospital prices and doctor's fees have made safe abortion an impossibility for most women. We have devised an alternative that enables any woman wanting an abortion to have one.

When women call us, we refer them to one of several highly experienced gynecologists. These doctors have clinic-type offices in the New York City vicinity. Their medical competence and psychological attitudes have been carefully evaluated by us in advance. The doctors are re-evaluated every time they perform an abortion by at least one Abortion Project woman who is present throughout the entire procedure. The functions we serve at the doctors' offices are, we think, invaluable. It is here that we can talk to women about any problems or fears they have regarding the abortion; it is here that we can explain the abortion procedure, and how the body functions; it is here that we can answer any questions on birth control. We believe that the presence of women from the Project makes the abortion a warm, friendly, and educational experience, rather than a cold and alienating one.

There are two types of abortions that the doctors can perform: the aspirator, or suction method, for women who are less than twelve weeks pregnant; the saline abortion, for women over fourteen weeks pregnant. It is most important that women come to us before they are twelve weeks pregnant (counting from the last menstrual period), because the suction-method abortion is the simplest, quickest, and safest. This procedure takes ten to fifteen minutes, and involves dilating the cervix (inserting metal instruments ranging from soda-straw to cigar size) large enough to insert the aspirator (two-bottled suction machine with tubing) tip into the cervix to clean out the uterus. The doctor's fee for this type of abortion is generally $100 -- a price that we hope to lower in the near future. The Project asks for an optional $10 donation, which goes solely to meet our operating expenses and finance other health projects. A certain percentage of all the abortions are free or less than $100. These are reserved for poor women and women who are the sole supporters of themselves and their children.



A limited amount of help for salines -- over twelve week abortions -- is presently being provided by us. The high price and the prolonged time necessary for the procedure makes the saline abortion very unpleasant for the woman. We cannot over-stress the importance of a woman getting an abortion under twelve weeks.

We have sent you this letter because we believe you have the ability to reach out to women in need of abortions, and because we believe that women in need of abortions will reach out to you. We ask you to help these women by informing them of the Project; they can reach us by phone from 10 a.m. to 10 p.m., every day except Sunday. Our numbers are (212) 691-3396 and (212) 691-2063.

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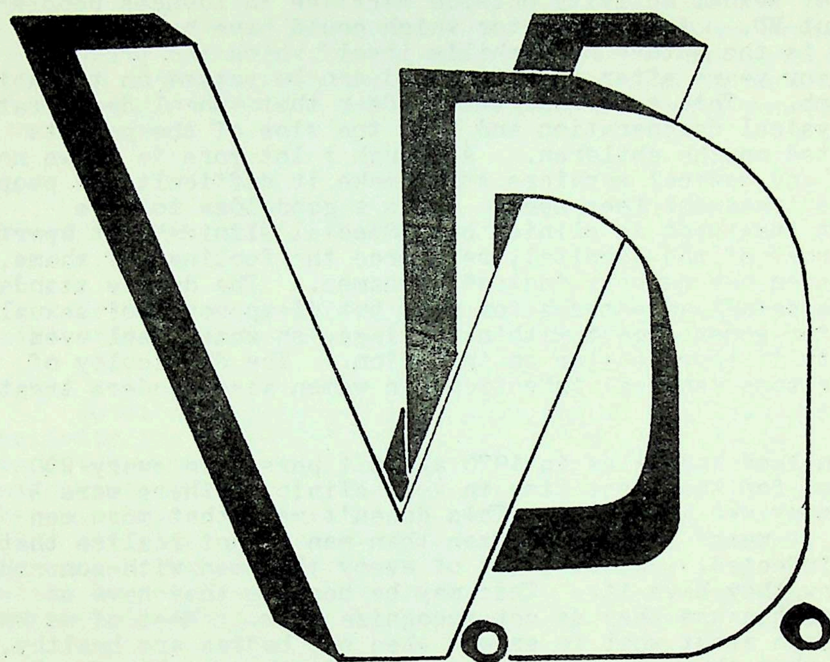

THE FACTS FOR WOMEN

The term VD is used to describe a group of infections which can be passed on through sexual activity. Although the name is derived from the goddess of love Venus, it has come to mean something which sets people apart like lepers and makes them ashamed to get treatment or even to think about the nature of their infections. From the purely medical point of view these are simply infections, no different from any other; but disapproval of sexual activity outside marriage influences people's ideas about VD. Another factor which could have had a big influence is the nature of syphilis itself which can produce disease many years after infection and can be passed on to babies in the womb. This gave rise to the fear that "moral degeneration" led to physical degeneration and that the sins of the parents were visited on the children. Although a lot more is known now, attitudes and medical services still make it difficult for people to get the treatment they need. It's a good idea to have specialist treatment in clinics but "Special Clinics" set apart from the rest of the hospital, reinforce the feelings of shame, and some even use numbers instead of names. The double standard encourages sexual adventures for men, but disapproves of sexual activity for women except within marriage, so women feel even more guilty if they develop an infection. The difficulty of diagnosing some venereal infections in women also hinders treatment.

In England and Wales in 1970 about 1 person in every 200 was treated for the first time in a VD clinic. There were 3 times as many men as women. This doesn't mean that more men have VD; it means that more women than men do not realise that they are infected. About 6 out of every 10 women with gonorrhoea do not know they have it. This may be because they have no symptoms or because they do not recognise them. Most of us know little enough about what to expect when our bodies are healthy, let alone when they are diseased. This is the result of a lack of health education, a lack which will not be remedied in a society which commercialises our sexuality.

VAGINAL DISCHARGE

Attitudes to women's bodies are shown by the use of the word "discharge" - usually meaning a sign of infection - for the NORMAL activity of the vagina. Like all internal body surfaces the vagina is kept moist by secretions of the cells lining it - just as the nose and the mouth are. These vaginal secretions are slightly acid and this keeps the area free from infection. Normal vaginal secretions vary in quantity and colour from person to person and in any individual throughout the month, and staining is usual, varying from white to yellow. There are wide variations, but if there is a marked change in the nature of the secretion in colour or amount or if it causes you irritation you should go to a doctor.

VAGINAL DEODORANTS

These alter the normal protective acidity of the vagina and make you more prone to infection. Many women using these sprays get inflammation and swelling of the vulva or vagina, and irritation of the skin round the genital area. This is even more likely if it is used before intercourse and can also then cause inflammation of the man's genital area.

Some contain hexachlorophene which has been banned in baby products. Others contain cancer-producing substances. Some contain aluminium chlorohydroxide (also used in underarm doedorants) which can dry up the skin and cause gonorrhoea-like skin lesions.

Finally the warning smell of an infection may be masked. DO NOT USE THESE PRODUCTS.

To get rid of vaginal odours wash the genital area with a mild soap (not deodorant). Tights and nylon pants don't help.

Women's anxiety and ignorance about this normal body activity are exploited by the sale of vaginal deodorants. Companies seeking to increase their profits probe these fears and exaggerate them. On the one hand advertising insists that to be sexually attractive is a woman's chief aim. On the other hand advertising implies that this aim is virtually impossible to achieve because the body is dirty and smelly. Healthy women do not need to hide their body odours, and the use of vaginal deodorants may be dangerous to them and their partners.

CYSTITIS

This is an infection and/or inflammation of the bladder. It is not always clear what has caused it. It may be due to a germ or irritation and is not necessarily a sexually-transmitted infection. The symptoms are an urge to pass water often and pain and burning when you do so. In order to find out what has caused it, it is important to have laboratory tests of your water before starting any treatment. If an antibiotic is prescribed it is important to finish the course of treatment even if the symptoms have disappeared. Cystitis is very common and often regarded as trivial. But it is not and you should insist on the appropriate treatment.

SEXUALLY TRANSMITTED INFECTIONS

The most important venereal infections are gonorrhoea and syphilis, but there are others. The commonest signs of infection are painful and/or frequent peeing and a discharge. Sometimes there is a fever and pains in the lower part of the belly.

GONORRHOEA - "CLAP"

Gonorrhoea is caused by a bacterium - germ - which can only survive for a few seconds outside the warm moist areas of the body. Sexual intercourse gives the ideal conditions for passing it on. In women it may cause soreness, a vaginal discharge, pain and frequent passing of water, but in almost half the women infected there is little or no discharge or pain and they may not realise they have been infected until later. A woman may find out if an infected partner tells her, or if she is traced by a health worker from a VD clinic as a contact, or through a check in an ante-natal clinic. The infection can spread up through the womb and affect the tubes which lead from the ovaries to the womb. Acute inflammation of these tubes (salpingitis) is a serious illness. It can give pains in the lower half of the abdomen and also lead to permanent sterility by blocking the pathway of the eggs from the ovaries to the womb. In the end removal of the tubes may be necessary. Since gonorrhoea is much easier to diagnose in the early stages, it is very important for a woman to go for help immediately she has the least suspicion that she might have it. Diagnosis is confirmed by examining, for the presence of the bacteria, the vaginal discharge in women and the urethral discharge in men. It is important the test specimen reaches the lab. quickly and in the right condition. Because the secretions of the vagina reduce the concentration of germs and the infection may be present in parts of the body where it cannot be sampled, the test is less reliable in women. If the test is positive, this means that the woman is definitely infected, but if one test is negative, several more are needed to make certain. Under the present organisation of health care GP's may not have the special facilities: so until they have, it is better to go to a clinic.

Treatment is by penicillin or possibly another antibiotic. Unfortunately strains of bacteria have developed which are resistant to the commonly used antibiotics. This is mainly because people do not finish their courses of treatment. They are not told that the few remaining bacteria which may still be inside them can give rise to further infection which is more difficult to cure because it will not be killed by the previous type or strength of antibiotic drug. IT IS VITALLY IMPORTANT THAT A COURSE OF TREATMENT SHOULD BE PROPERLY COMPLETED and that tests should have been repeated and found negative before you stop going to the clinic.

SYPHILIS

Syphilis is much less common than gonorrhoea, but is more serious if it isn't treated. The first sign of infection is painless ulcer which usually occurs in the vagina or on the eck of the womb (cervix). Women may not notice it if it is nternal. In about two months this ulcer heals even without reatment but it may then be followed by an illness with fever, wollen glands and a non-irritating rash. If still untreated if this stage is not noticed (it may be very mild) the disease y remain in the body and after many years may appear in various rts of the body, causing paralysis and other brain disorders, rt disease and blindness. Syphilis can be passed on to the y in the womb, although it usually causes a miscarriage or llbirth. If the baby is born alive it may be a sickly baby is blind, deaf or mentally retarded. This kind of syphilis ot common now because treatment has lessened the

numbers of women affected, and antenatal tests find women who can be treated and cured in the early stages of pregnancy.

Syphilis can be diagnosed by finding the bacteria in the sore when infection begins. Later it is difficult to find the bacteria themselves and diagnosis is made by tests of the blood or on the fluid from the spinal cord which show that the disease is present in the body. These testsare more reliable than those for gonorrhoea, but it is possible to get false positive tests due to glandular fever and some other conditions.

Treatment

Large doses of penicillin given over 10 to 12 days by injection cure most early cases. In longstanding cases longer courses of treatment may be necessary. It is very important that the course of treatment should be completed to make sure that the germs are all destroyed, and usually the patient is checked up for at least three years to make sure that he or she is completely cured.

TRICHOMONIASIS

This infection is caused by a small parasite which is frequently found in both men and women. It may be caught through intercourse; rarely from infected clothes or towels. In men it may give rise to very little or no sign of trouble; in women there is usually inflammation of the vagina and a yellowish itchy discharge with a nasty smell. Diagnosis is confirmed by finding the parasite in the discharge when it is examined under a microscope. Treatment with tablets of metronidazole is usually successful. Pessaries may be needed for resistant cases. (These are special tablets which are put into the vagina.) You may get reinfected by your partners so they should get treated as well.

NON-SPECIFIC URETHRITIS

This name is used for a large number of genital infections in which no germ causing the trouble can be found. In men there is a discharge from the urethra: in women there may be a discharge and pain in the genital area. Various antibiotics are used in the treatment.

HRUSH

Some microbes normally live in parts of the body without ausing disease, but under certain circumstances the numbers ay increase so much as to cause actual symptoms. For instance, hrush is caused by a yeast which is nearly always present in the agina but if, for example, antibiotics have been taken for some-ning like a throat infection this may affect the normal acteria in the vagina and allow the yeast to begin growing more, eading to redness of the vulva and vagina, severe itching and discharge which is thick and white. Sometimes this can also ppen when you are taking the pill. The condition can be red by means of pessaries (nystatin).

VD CAN BE CURED. This is still so of gonorrhoea as well as of syphilis in spite of the resistance of the gonococcus. If the dose of penicillin does not work a larger dose usually will: alternative drugs are always available for those who do not respond to penicillin.

A SOCIAL PROBLEM?

It is difficult to be objective about VD because feelings about it are so affected by attitudes to sex. Take, for example, the Family Doctor booklet on VD published by the British Medical Association: this shows the way past attitudes persist:

> "They (boys and young men) have a demanding and persistently recurring need for sex..... Girls, on the other hand, seldom have a demanding and persistent need for sex.... they need attention and admiration."
> "Anyone having casual intercourse is liable to become infected." "Some groups of people have contributed to the rise (in incidence of VD) more than others. These special groups are the young (particularly girls), travellers, and male homosexuals."

The periods in our history which have been admired for their morality have actually seen the majority of women sexually repressed and others, a minority, sexually exploited and abused. In the past, as in Vietnam today, it has been the prostitute, the fallen woman, who was considered responsible forthe spread of VD, not the men who exploited the women's precarious social situation. 100 years ago in this country the Contagious DiseasesActs made it compulsory for prostitutes to be registered and for those found to have VD to be compulsorily detained in hospital until cured. A number of "lock" wards, in which the majority of patients were women, were built by the government near army or navy barracks !. The only times when governments make special efforts to spread knowledge about VD and to control it are when it becomes a threat to essential manpower, in war-time. (The first special VD clinics were set up in 1916, in the middle of the first world war.)

At such times it is essential that young men are healthy, therefore VD is tackled without anyone moralising about the relationship between promiscuity and increase in the spread of VD. In peace-time VD is a threat to the health of 1/4 million people every year, but when the country can get by with large numbers of men and women in ill-health, the blame is put on us for failing to keep to one sexual partner. This conveniently masks the fact that our range of sexual interests would be irrelevant to the matter if everyone had adequate knowledge about VD and easy access to diagnosis and treatment. Treatment centres should not be separate and "special": diagnosis and treatment should be integrated into a comprehensive health-service. The most important part of such a service would be health education, including a programme for informing people about the nature of VD. Health education isn't just putting notices on the backs of lavatory doors. It's giving people enough information so they can take an active part in attaining a Revolution in Health Care.

These are the clinics in your area - treatment is free and you don't need a letter from your doctor. Do go if you are worried because they won't mind if it is nothing serious.

Brent	Special Clinic, Central Middlesex Hospital, Park Royal N.W.10. 965 5733 Ext. 464/5
Camden	Marlborough Clinic, Royal Free Hospital, Gray's Inn Road, W.C.1. 837 6411 Ext. 28
	Special Clinic, University College Hospital, Out-Patient Building, Grafton Way, W.C.1. 387 9300 Ext. 528
City of London	Special Treatment Centre, St. Bartholomew's Hospital, E.C.1. 606 7777 Ext. 555
Croydon	Special Clinic, Croydon General Hospital 688 7755 Ext. 124
Greenwich	Special Clinic, Miller General Wing, Greenwich District Hospital, S.E.10. 692 1136 Ext 45
	Dreadnought Seamen's Hospital, S.E.10 858 3433 Ext. 32
Hackney	Homerton Grove Clinics, Eastern Hospital, E.9. 985 1193 Male Ext. 28. Female Ext. 26
Hammersmith	West London Hospital, Hammersmith Road, W.6. 748 3441 Exts. 2 & 40
Haringey	Prince of Wales's Hospital, Tottenham, N.15 808 0550 & 1081 Ext. 229
Havering	The Annexe, Oldchurch Hospital, Romford 46090 Ext. 219
Hillingdon	Genito-Medical Dept., Hillingdon Hospital, Uxbridge. Uxbridge 38282 Ext. 537
Hounslow	Genito Medical Dept., West Middlesex Hospital, Isleworth. 560 2121 Ext. 425
Islington	The Diagnostic Clinic, Moorfields Eye Hospital, City Road, E.C.1. 253 3411 Ext. 103
	Special Clinic, Royal Northern Hospital, Holloway Road, N.7. 272 7777 Ext. 345
Lambeth	Lydia Dept., St. Thomas' Hospital, S.E.1. 928 9292 Male Ext. 2129. Female Ext., 2329
	"A" Block, St. Giles' Hospital, St. Giles Road, S.E.5. 703 4221 Ext. 24
	The South London Hospital for Women and Children, Clapham, S.W.4. 673 1221/4 Ext. 146
Lewisham	St. John's Hospital, Morden Hill, S.E.13 852 4467 Ext. 27
Newham	Albert Dock Hospital, Alnwick Road, E.16. 476 2234 Ext. 19

Newham	Special Clinic, Queen Mary's Hospital, Stratford, E.15. 534 2616 Ext. 7.
Southwark	Guy's Hospital, S.E.1. 407 7600 Ext. 292.
	Royal Eye Hospital, St. George's Circus, S.E.1. 928 4477 Ext. 67.
Tower Hamlets	Whitechapel Clinic, London Hospital, TurnerSt., E.1. 247 7310
Westminster	St. George's Hospital, Hyde Park Corner, S.W.1. 235 4343 Ext.104
	Middlesex Hospital, James Pringle House, 73/75 Charlotte Street, W.1. 636 8333 Ext.666
	Special Clinic, St. Mary's Hospital, Praed St., W.2. 262 1280 Male Ext.108. Female Ext.113
	Westminster Hospital, St. John's Gardens, S.W.1. 828 9811 Male Ext. 2302. Female Ext.2225.

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