Infertility

Problems Getting Pregnant

Vancouver WOMEN'S HEALTH Collective

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The Vancouver Women's Health Collective
Women's Reproductive Health Project

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Pages 68, 73 **FERTILITY AWARENESS,** Regina Asaph Pheiffer & Katherine Whitlock, Prentice-Hall, Inc., Englewood Cliffs, N.J., 1984

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Page 90 Lauri White in **Women's Global Network on Reproductive Rights**, Jan– March, 1987

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Page 144 **WOMEN, HEALTH AND REPRODUCTION,** Routledge & Kegan Paul, Ltd., London

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HOW THIS BOOK WAS WRITTEN

This book is written by women at the Vancouver Women's Health Collective. We are interested in women's health. We're not doctors or nurses. We've learned what we know from talking to women and from reading.

It is hard to get health information. We have all had trouble getting information about how our bodies work and what we can do to be healthier. Sometimes we've done whatever the doctor suggested because we didn't know if there was anything else we could do. We find that reading about health and talking to other women gives us more control over our bodies. It helps us make careful, thoughtful decisions about our health.

We believe all women deserve to be well informed about their health. Most books on health are written so that only people with a lot of schooling can understand them. We have tried to make this book different. Health information is not hard to understand if it is explained in everyday language.

Writing this book has been an exciting project. We've talked to many different women from British Columbia, Alberta and the Yukon. We talked to Native and non-Native women, women from small communities and women from big cities. They told us what information they wanted us to include.

This book has been strongly affected by two organizations, Resolve and the Vancouver Infertility Peer Support Group. Resolve is a U.S. organization. It has helped people in both Canada and the U.S. realize that infertile people need support and good medical care. Both Resolve and the Vancouver Infertility Peer Support Group provide help and support to people dealing with infertility.

Written by:

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Women who worked on the project:

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Frieda Gauthier
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Women who let us know what information they needed:

We held public meetings in Alert Bay, Calgary, Campbell River, Invermere, Cranbrook, Fernie, Kamloops, Port Hardy, Prince George, and Whitehorse. A warm thank you to the many women who talked about their lives and told us what information would make this book useful.

HOW THIS BOOK WAS WRITTEN

Organizations and women who read a draft of this book and made suggestions:

Adoption Options
B.C. Adoptive Parents' Association
B.C. Ministry of Social Services and Housing
SNAP: Special Needs Adoptive Parents
Vancouver Infertility Peer Support Group
Vancouver Women's Health Collective
Yukon Department of Health and Human Resources
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Jill Hurst
Adrienne Ross

Cosponsors: We want to especially thank the organizations who helped this project reach women living outside Vancouver:

Alberta Indian Health Commission
B.C. Native Women's Society
Calgary YWCA Women's Resources Center
Campbell River Women's Center
Fernie Women's Center
Kamloops Indian Band
Kamloops Indian Friendship Center
Kamloops Medical Services Branch
Kamloops Women's Resources Center
Kootenay Area Indian Council
Kwakiutl Tribal Council
Prince George Native Friendship Center
Prince George Women's Resources Center
Victoria Faulkner Women's Center

Project Officers: Marjorie Schurman and Judith McLean, Health Promotion Directorate, Health and Welfare Canada.

HOW TO USE THIS BOOK

You can either sit down and read this book from beginning to end, or you can just read the chapters you are interested in. The **Table of Contents** on the next page tells you the name of each chapter and where to find it. It also tells you what each chapter is about.

We suggest you read the chapters with general information that is useful to anyone dealing with infertility first. These are the names of the chapters with general information:

- **What is Infertility?**
- **Feelings**
- **Patients Have Rights**
- **Your Body**
- **The Steps to Pregnancy**
- **Living with Infertility**

If you are thinking of going to a doctor to find out why you can't get pregnant, read the chapter on medical tests. You may only want to read the sections on the tests you are thinking about having.

If you know why you have fertility problems, you can read just about your condition. The main conditions causing women's infertility and men's infertility are listed in the table of contents.

There is also information about adoption, foster care, shared parenting and donor insemination if you are interested in any of these choices.

The chapter **Getting Healthy** has information on eating well and on other things you can do to balance your hormones and to feel better. We include information about vitamins, minerals and herbal teas in this and other sections of the book. These are natural treatments which have helped some people deal with hormone problems. We aren't recommending you take them. It's up to **you** to decide what you want to try. You may find it helpful to talk to a naturopath, nurse, doctor, or community health worker.

If you come across a word you don't understand, look for it in the chapter called **Words** on page 201. Words is a list of medical words in alphabetical order.

The focus of this book is mostly on women because it is part of a series of books on women's health. We are in no way saying that infertility is only a woman's problem. We recognize how important it is for men to explore their feelings and to get information. We hope the information in this book is also helpful to men. We also believe that women facing infertility have a lot in common with each other. This book is written especially for women.

TABLE OF CONTENTS

WHAT IS INFERTILITY?

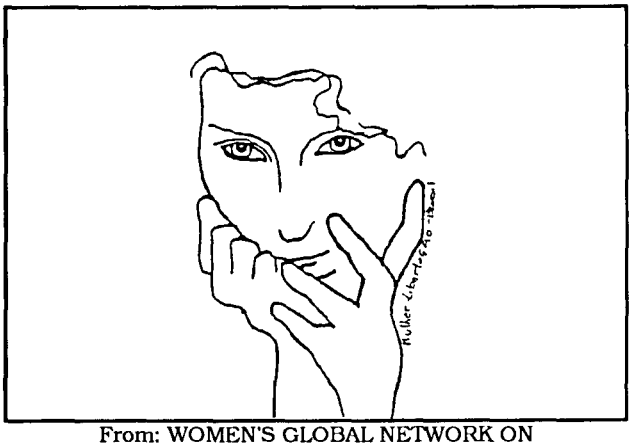
Infertility means having problems having a baby. You may have trouble conceiving, or getting pregnant. You may also have trouble carrying a baby until it is ready to be born.

Infertility is often temporary. Many people are eventually able to have a baby after having problems getting pregnant or staying pregnant.

There are two main kinds of infertility. You have "primary infertility" if you have never had a child. If you have had a child before and are now having problems, you have "secondary infertility".

When are you infertile?

You are considered to be infertile by doctors in Canada if you have tried to get pregnant for a year without success. If you have had three miscarriages, this is another type of infertility.



From: WOMEN'S GLOBAL NETWORK ON REPRODUCTIVE RIGHTS, Fall'87

Many doctors will not start testing you unless you have been trying to get pregnant for a year. This is because some people just take longer to get pregnant. It may take longer than a year. In France, doctors don't consider a couple infertile unless they have tried to get pregnant for two years.

As women get older, it generally takes a little longer to get pregnant. On the average, it takes four to five months of intercourse without birth control to get pregnant if you are in your early 20's. If you are in your early 30's, the average is between seven and ten months. In your late 30's, the average is ten to twelve months.

Whose problem is infertility, the man's or the woman's?

Either a woman or a man who are trying to have a child together may be infertile. In four out of every 10 infertile couples, it's a problem with the man. In another four out of every 10 couples, it's the woman's problem. One out of 10 infertile couples have a combined problem. This means that both the woman and the man have fertility problems. For about one out of 10 couples, doctors never find out what the problem is.

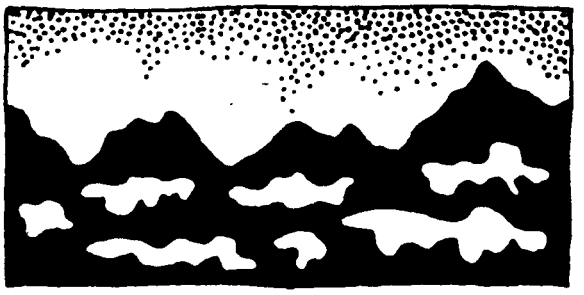
Many people think that infertility is only a problem for couples including a woman and a man. Single women and lesbians who want to get pregnant also sometimes have fertility problems. A lesbian is a woman whose most intimate emotional and sexual relationships are with other women. If you are single or a lesbian, this book is written for you, too.

What are your choices if you have a fertility problem?

These are the main choices you have:

- wait a little longer and see what happens.
- ask your doctor to do tests to find out why you aren't getting pregnant.
- look at other ways to become a parent, such as adoption.
- explore other possibilities besides having your own children.

You may choose more than one of these things.



From: WELLSPRING, December, 1983

Who can get medical tests and treatment?

We think that everyone with fertility problems should be able to have tests and treatment if they want. You may find it hard to get infertility tests and treatment if you are poor, live in a rural area, are Native or a member of another visible minority group, are single or a lesbian. A community organization or a health care worker may be able to help you find a doctor that will work with you.

How successful is medical treatment for infertility?

Overall, about half of the people who go through infertility treatments end up with a baby. Some infertility treatments work better than others. It's always a good idea to find out how likely a treatment is to work. This will help you decide what you want to do.

Doctors use different measures of how likely a treatment is to work. One measure is how likely you are to get pregnant. This includes the women who get pregnant, but have a miscarriage. Another measure is how likely you are to have a baby. This is a better measure of success because it leaves out miscarriages and stillbirths.

A third measure of success looks at success in treating a health problem causing infertility. For example, a fertility drug may make you ovulate or make a man's sperm count higher. A "success" may be to ovulate, but not everyone who ovulates will get pregnant. This type of measure of success will not give you any idea of how likely you are to have a baby.

These different measures can be confusing. Make sure you know what your doctor means by success. Then you will be able to decide what you want to do.

What information is in this book?

In this book, we have tried to answer questions that you might have about infertility. We talk about the way that infertility can affect your life and the feelings it can bring up. We talk about why people have fertility problems. We describe medical testing and treatment for infertility. And we talk about other choices besides having a child yourself.

We hope that this book will be a help.

FEELINGS

Most people think that they will be able to have children if they want to and when they want to. It can be a real shock not to get pregnant when you want to. If this happens to you, you may find that you're thinking about having a baby almost all the time.

Having children and raising children has been a central part of many women's lives. You may have had dreams about what it would like to be a mother ever since you were a little girl. Your family and friends may also expect that you will have children.

Even though infertility is a common problem it still isn't talked about much. Many people deal with it on their own without telling other people.

From: Women's Health Information Centre, Spring, 1987

This is changing. More and more people are getting together with other people with the same problems. There are also more books being written about infertility.

Many women have strong feelings about infertility. This chapter talks about some of these feelings. It also talks about some of the things women have found useful when dealing with these feelings.

What are some feelings that women have?

Women have many different feelings when they are dealing with infertility. Here are some of the common feelings:

- Angry, disapointed and sad that they aren't getting pregnant.
- Like a failure.
- Out of control.
- Jealous when they see pregnant women or women that have babies. They may think they would be a better mother than other mothers.
- Resentful towards women who have children easily or who get pregnant when they don't want to.
- Hopeful that they will be able experience the excitement, joys and satisfaction involved in raising children.
- Blaming themselves or their partners for somehow causing the infertility. Some women think infertility may be a punishment for something they've done in the past, especially if they've had an abortion or a lot of sexual partners.
- Uncertain about the future.
- All alone dealing with a major life crisis.

If you have periods, you may find that your feelings go up and down with your menstrual cycle. You may feel hopeful in the middle of your cycle, anxious as it gets close to the time for your period, and then sad and hopeless when your period starts. This is very natural and common.

The lives of some of your women friends may mostly center around their children. You may go through times when it's too hard for you to be around them. There may also be times when you don't want to go to any social gathering where there are children. At other times you may enjoy being around children.

Many people think that a woman must bear a child to really be a woman and that a man must father a child to really be a man. If this doesn't happen, it can affect how you feel about your body and about yourself as a person.

You may feel very alone. It may seem as if everyone else has children and expects you to have children.

If you are trying to have a baby as a single woman, you may feel even more alone. Most people won't expect you to want a baby. They may not see your infertility as a problem. This can be very hard.

What's important is how **you** feel. You may have some or all of these feelings at different times. You may also have other feelings.

From: SPARE RIB, July, 1983

What about other people?

Other people will probably think that you are able to have a baby. When you don't have one, they may think that it's because you don't want one. They may say things to you that hurt.

They may pressure you to get pregnant. They may tell you that you should have a baby, that you're selfish not to have a baby, or that you won't be really happy until you have one.

If they know that you are trying, they may do things that aren't helpful. Some may give you suggestions about sex. Others may make jokes that don't seem funny to you at all. Still others may give you advice about what doctor to see or what treatment to try when you haven't asked for help. People often think you'll get pregnant right away if you will just do what they say, whether it's adopting a baby, trying a new treatment or going on a holiday.

How does infertility affect relationships?

Infertility often puts a lot of stress on a couples' relationship.

If you both want to have a child: You may both feel disappointed, frustrated, and uncertain about the future. You'll probably have some of the same feelings and some different ones. You may find it difficult to be supportive of each other when you're both feeling upset.

If only one of you wants to have a child: Your relationship may have difficulties if only one of you wants to have a child, or one of you wants to have a child much more than the other. You may disagree over how much testing and treatment to do. You may have trouble understanding each other.

If your partner is a woman: Lesbian couples often don't get as much support from their doctors and families.

It may be difficult to know why you're not getting pregnant if you are trying to get pregnant by donor insemination. There is more information about donor insemination on page 135. It may be harder to get medical information and testing.

Sometimes the only way a lesbian can get medical testing and treatment is by pretending that she is not a lesbian. This can put a lot of pressure on your relationship. Your partner may feel invisible. You may both have a lot of strong feelings about the situation. This can take a lot of the joy out of trying to get pregnant.

If your partner is a man: Women and men often talk about their feelings and concerns in different ways. Most men are taught not to express their feelings. This can make it hard for them to talk about their feelings or even know what they are feeling. Women often want to talk about their feelings with their partner. Some couples find that it's especially hard to understand each other when they are dealing with infertility.

It can be difficult if only one of you is fertile. You may blame your partner or yourself. If you are infertile, you may worry that he will leave you for someone who can have children. You may also think that you're not a good enough partner. These are all common difficulties.

Sex may become tense and difficult. You may think about trying to get pregnant while you're making love. You may be having sex when you should have it to get pregnant instead of when you want to. If you have been going to doctors or a clinic for testing and treatment, it may feel as if sex is a part of that, not a time of love between you. Sex may not be fun or pleasurable anymore.

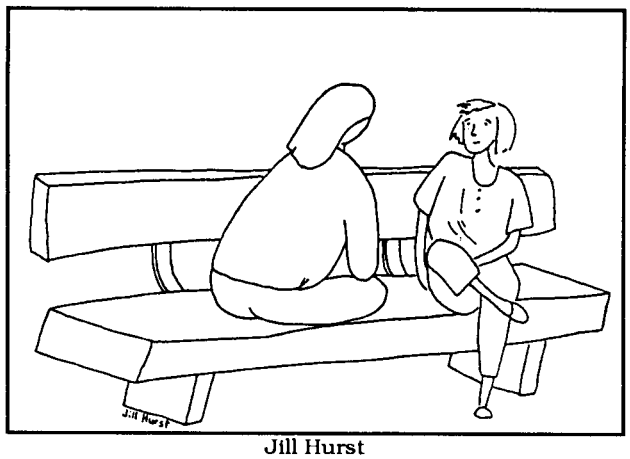
What may help?

Love and support: Many women say the biggest help is the love and support of people who care about them. It doesn't take the hurt and sadness away, but having others who care can help a lot. Think about what you find helpful from family and friends. Here are some ideas of things they could do:

- let you know that they love you just as you are and that they will keep loving you no matter what happens.
- let you talk about your thoughts and feelings as much as you want.
- listen to you without telling you what to do or giving you advice.
- help you get more health information or good medical care.
- encourage you to express your feelings, even if they are painful.

You may also have other things you find helpful.

Feel your feelings: Letting yourself express your feelings as they come may help you feel better. It may seem that if you let yourself cry, you'll cry forever. You may worry that if you get angry you'll never calm down. That won't really happen. You may cry for a long time, or be frightened by the strength of your anger, but the feelings will pass. You'll probably feel better after you express your feelings. You may feel freer. You may also be able to think more clearly so you can make choices that are good for you.



Jill Hurst

Talk to someone: Telling someone else exactly how you feel may help a lot. Finding someone who will listen to you isn't always easy.

You may have good friends or close family members that you can talk with easily. However, your friends and family may really care but don't know what to say or do to help you. They may be able to help if you tell them what you find helpful. Often people want to help and are pleased to know what to do.

You may need to look for someone who you will really be able to talk to.

Peer counselling: You may want to learn peer counselling. A peer is someone you feel equal to. People who do peer counselling spend time talking about their feelings and concerns with a peer. This can work with another woman with an infertility problem, or with anyone that you feel comfortable with. What is important is to make sure that you both get a chance to listen and to be listened to. You also need to remember that you don't need each other's advice. You mostly need each other's caring. It's easy to learn to do peer counselling. To find out more about it, see the book **Women Talking About Health** listed on page 209.

Talk to your partner: Dealing with infertility puts a lot of stress on couples. It can be a difficult time for you to support each other. It may help if you both talk to other people about your thoughts and feelings. Try to talk to each other too. Here are some things you may want to talk about:

- your feelings, including your hopes and fears.
- how infertility is affecting your relationship.
- how you will give each other love and support through this difficult time
- how important having a child is to you.
- how much testing and treatment you want to go through.
- how you feel about other choices besides getting pregnant. See page 152.

If your partner is a man, you may also want to talk about sex and how you both feel if just one of you is infertile.

Talk to other people with infertility problems: Many people say it helps to talk to other people in the same situation. You'll read in this book that many people are infertile. Talking to some of them may help you feel less alone. It may help to hear other people say that they sometimes feel angry, jealous and depressed and think that they are a failure. Hearing what has helped them may also be useful.

Join a support group: A support group is a group of people who get together because they have something in common. In some communities there are support groups for people dealing with infertility. There is a list of support groups on page 206 and information on how to start a support group on page 181.

From: WOMEN'S HEALTH INFORMATION CENTRE Fact Sheet #3

Learn ways to cope with stress: Having problems getting pregnant is very stressful. The feelings that you have are also stressful. You may find it helpful to lessen the amount of stress in your life. This may help you cope with your feelings. There are suggestions for ways to lessen stress on page 194.

See a counsellor: If you are feeling very low and alone, none of these ideas may seem possible. You may find it helpful to talk to a counsellor or therapist. It may be hard to find one that is helpful. In some cities, there are many choices and it can be difficult to know who to see. In small towns there may be no choice at all. You could talk to a women's center, crisis line, community health worker, or a member of a support group if you are looking for a counsellor.

Ask the counsellor or therapist what she charges. Some are very expensive. Some charge different rates to different people depending on how much money they have. Some agencies provide counselling for free. If you are a status Indian, you can see a psycologist for free.

It's up to you to decide whether a counsellor is helpful to you or not. It's fine to stop seeing a counsellor any time you want.

Learn more about infertility and possible treatments: This may help you feel more in control. It may also help you understand your infertility problem so you can make thoughtful choices about what to do. You may be able to get information from doctors, nurses or people in a support group. You may need to ask a lot of questions to get the information you want. Reading books may also help.

Know that many other people have a lot of the same feelings: Some people find it helpful to know that many people go through similar stages when they are faced with infertility. These are the stages:

- **surprise.** Most people expect to be able to have a child. They are surprised when they find out that they are infertile.
- **denial.** It's common to pretend to yourself that you don't have a problem.
- **feeling alone.** As you come to accept your infertility, you may feel very alone.
- **anger.** Many people go through a time of being very angry. You may be angry at your doctor, yourself, your partner, family or friends.
- **depression.** You may feel depressed and hopeless when nothing seems to change.
- **resolution.** In this stage people begin to feel peace or acceptance. They feel they have come to terms with their infertility. This doesn't mean that they don't still think about infertility or have feelings about it. Most people go through this stage eventually. There is more information about this stage on page 175.

People who are dying or dealing with a major loss go through the same stages. Not getting pregnant means the loss of a dream. It's normal to spend time grieving this loss.

What about the future?

You may be faced with many decisions. Are you going to see a doctor? Will you have tests? What kinds of tests and treatments would you consider and which ones wouldn't you want to have? Should you adopt? Could you adopt if you wanted to?

Decisions about other parts of your life will probably be difficult to make as well. After all, one of your biggest hopes and plans isn't working out so far. This makes it hard to make other plans. Should you change jobs or try to get a job? Is this a good time to go to school? Should you move and where to? It may seem like your whole life is on "hold" while you try to get pregnant.

These are big questions and it will take a lot of thought to sort them out. Our hope is that the information in this book will help you understand your options so that you can make the decisions that are best for you.

Many women say that the feelings of infertility come back in waves over the years. There is a section at the end of the book on living with infertility. It starts on page 175.

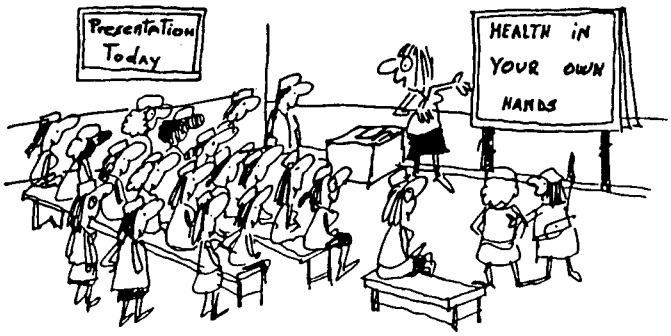
PATIENTS HAVE RIGHTS

Some people go to a doctor every time they don't feel well, and others will not go even if they are very sick.

You have the right to go to a doctor when you want to. The doctor should listen to you and do a complete check-up to see if anything's wrong. She should explain what she thinks is wrong and what she thinks might make you better. You have the right to choose whether or not you do what she suggests.

A doctor can help you if you need to find out what's wrong with you, or if you need surgery or prescription drugs. You may also want to see a doctor to find out more about a health problem, and for a check-up when you're healthy. It helps to have a regular doctor who knows you. If your doctor knows you, she will probably be able to give you better care.

In this section we will give you some ideas on how to choose a doctor and how to get the information you want from her. We will explain to you what it means to give "informed consent". We will also give you some suggestions for what to do if you have had a bad experience with a doctor.



From: ISIS

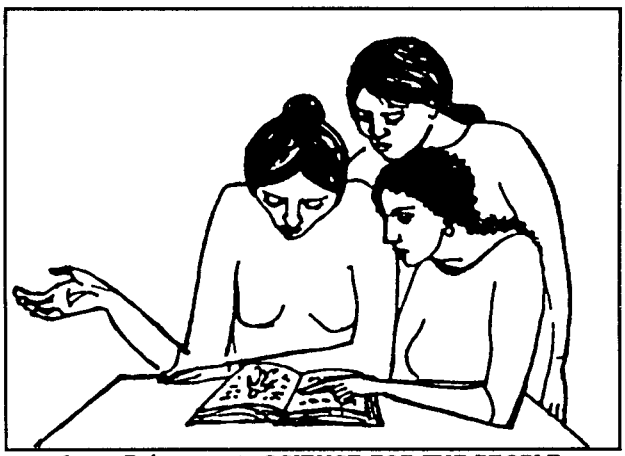
How do I choose a doctor?

How do you decide what doctor you want to go to? You may not have much choice. If you live in the country, or in a small community, there might be only one or two doctors available. If you need to see a specialist, you will probably have to travel to a larger center. Even then you might have a limited choice, unless you live close to a large city.

Just because you go to a particular doctor once, it doesn't mean you have to go back to her. You can "shop" for a doctor, just like you might shop for a mechanic you can trust. Even though you are not paying the doctor directy she is paid by the medical plan and would not be paid if you didn't go to her. If you have no choice of doctors where you live and you don't like the one doctor, it may be worth driving to the next town to see someone else.

When you are looking for a doctor, you can visit a few doctors. Ask them questions and see if you trust them to be your doctor. You might want to know how they'd treat a health problem you have. Or if you have children, what they do to help a child not to feel scared. If you want to avoid taking too many medicines, ask the doctor what else she might do besides suggesting a medicine.

These visits are covered by the medical plan. A doctor should not be angry that you are asking questions. If she is, she may not want you to ask questions about your health either. Go to a different doctor if you can.



Lynn Robertson in SCIENCE FOR THE PEOPLE

Here is a list of questions to ask yourself about your doctor. It will help you to decide if she is the right doctor for you.

- Does the doctor call you by your proper name?
- Does she look at you when you are talking, or when she is talking to you?
- Does she ask you questions?
- Does she answer the questions you ask?
- If she doesn't know the answer to something, is she willing to say so?
- Does she talk to you about choices in treatment? If she suggests one thing, does she also talk about other choices?
- Does she tell you the names of any drugs she prescribes, and the possible side effects?
- Does she explain the tests she does, and tell you when you can expect to hear the results?
- When she explains something to you, does she make sure you understand?
- Do you get a chance to talk to her with your clothes on? Before the examination or treatment? After?
- Can you get an appointment fairly soon?
- When you have an appointment, do you get in to see the doctor without a long wait?
- Does she let you look at your medical records?

How do I get information from my doctor?

Even if you have a doctor you are generally happy with, there may be times when you feel rushed. If your doctor is very busy, it is easy to forget what you want to ask her. If you make a written list of questions ahead of time, you won't forget, and you are more likely to leave the appointment with the information you want.

If you feel you don't have enough time with the doctor for her to answer your questions, you might want to make another appointment. If you know when you make the appointment that you are going to have a lot of questions, you can tell the doctor's office that you will need extra time. Ask them to book a double appointment. This way the doctor can give you the time and care you deserve without keeping other patients waiting.

You may sometimes want to have someone go with you to see the doctor. If you are upset or if you are dealing with a serious health problem, this can be helpful. The other person can make sure the doctor answers the questions on your list, and can write down the answers for you.

If you don't understand the answer a doctor gives you, let her know. Ask her to explain again. Ask her to draw a picture if that would help. She should draw you a picture of where she will cut and what she will do if she is suggesting surgery. If she is using words you don't understand, ask her to explain those words.

Doctors often use medical words. These are words most people don't know. The doctor should explain what she means in everyday words. Many people don't ask questions because they are afraid they will seem stupid. You aren't stupid if you don't understand medical words.

The doctor needs to learn how to talk to you so that you understand what she means. When you ask her to explain, you are teaching her what she needs to know to become a good doctor. You are teaching her how to talk to her patients so they can understand.

How do I find out more about a test or treatment?

Here is a list of questions to ask your doctor when she suggests a test or a treatment. You will probably want to add more of your own questions.

- Why do I need this test or treatment?
- How is it done?
- Are there any other tests or treatments I could use instead of the one you have suggested?
- Does this test or treatment need to be done now, or could it wait?
- Will I get worse if I wait?
- What are the risks if I have this done?
- What are the risks if I choose not to have it done?
- Who else will be involved in my care? Do I need to see another doctor?
- Will it hurt?
- How will I feel afterwards?
- Will I lose time from work?
- Will I still be able to look after my children right away?
- Do I need other tests?
- I want to have a friend go with me. Is this alright with you?
- Do I need to take any drugs? What are their names? What are their side effects?
- If you are suggesting a test, what do you expect to find out from it?
- What will you do if you find what you expect?
- What is the next step if you don't find what you are looking for?

Informed Consent

Your body belongs to you, not to the doctor, or to anyone else. Everything that is done to you should be your decision.

Jill Hurst

You do not have to agree to any medical test or treatment. It is the doctor's responsibility to make sure you understand the reasons for the tests or treatment she wants to do. If you don't agree to have it done, then she can't go ahead, even if she is sure it is the best thing for you. She needs your "informed consent". This means that you have been told what to expect, and you agree to go ahead with the test or treatment.

Informed consent also means that you can agree to one part of what your doctor suggests, but refuse another part.

You might be asked to sign a form giving your consent. You may get the consent form from your doctor, or from a nurse in the hospital. If you decide to sign, be careful that you are only giving permission to do exactly what your doctor has said she will do, and nothing more. You can add a sentence to the form before you sign, if you want. For example, if you are having your uterus taken out, and you want to be sure the doctor doesn't take out your ovaries, you can add, "Do not take out my ovaries".

If you are not sure what the form is giving her permission to do, then don't sign it. Make sure you understand and agree before you sign anything. It's fine to say you don't understand the form.

It is a good idea to get a second opinion about any surgery your doctor thinks is necessary. You can also get a second opinion if you are unsure about a drug treatment or a test your doctor suggests. This means going to another doctor to see if she suggests the same thing.

You can tell your doctor that you would like a second opinion. Most doctors will not object, and will probably suggest the name of another doctor you can go to. Your doctor does not have the right to refuse. If she objects, it is a sign that she is not treating you well.

What can I do if my doctor has treated me badly?

Your doctor may have done something which has given you serious health problems. Or, she may have done something to you that you didn't agree to. She may have been careless, and forgotten to do something necessary to your care. She may have treated you without respect.

In order to practise medicine, a doctor has to be licensed by the College of Physicians and Surgeons. This is a group of doctors who set the rules about how doctors can treat patients. If you are unhappy with the way you have been treated by your doctor, you can write a letter of complaint to the College.

It is important to write down clearly what it is your doctor did that you are unhappy about. You should include all the details, and the dates when things happened.

The College will read your letter, and decide whether or not they think your complaint is serious enough for them to investigate more. If they think it is very serious, and they agree that the doctor did what you said she did, they can take away the doctor's license to practise.

Your community health worker or Women's Centre can help you to write a letter if you are not sure what to say.

From: KINESIS, October, 1984

What about legal action?

If you have had a very bad experience with a doctor, you might decide to take her to court and sue her for malpractice. To do this, you will need to talk to a lawyer. You may be able to do this through Legal Aid. Phone the nearest Legal Aid office listed as Legal Services Society in the Provincial/Territorial Government section of the phone book to see if they will see you. Otherwise, you can find a list of lawyers in the yellow pages of your phone book.

Most lawyers will see you for a first visit for around twenty dollars. Some will do this for free. During this first visit, or consultation, the lawyer will try to get a clear picture of what happened so she can tell you whether or not she thinks you have a case. Write down exactly what happened to you before you go see the lawyer. The lawyer will also ask you for the dates.

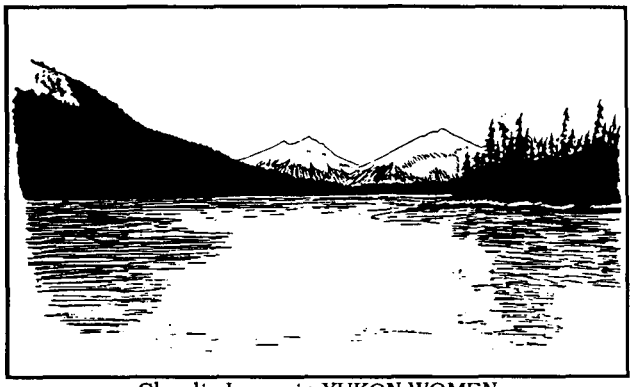
Taking a doctor to court does not always cost a lot of money. It is free if you can get legal aid. If not, many lawyers will work on what is called a "contingency" basis. This means that the lawyer will charge you part of what you are awarded by the court, if you win your case. You should discuss this with her on your first visit, so that you know what to expect. A lawyer usually charges 20%–40% of your court award.

The lawyer will need a copy of your medical records. If the doctor or hospital refuses to give it to her, then she can ask a judge for a court order to get it.

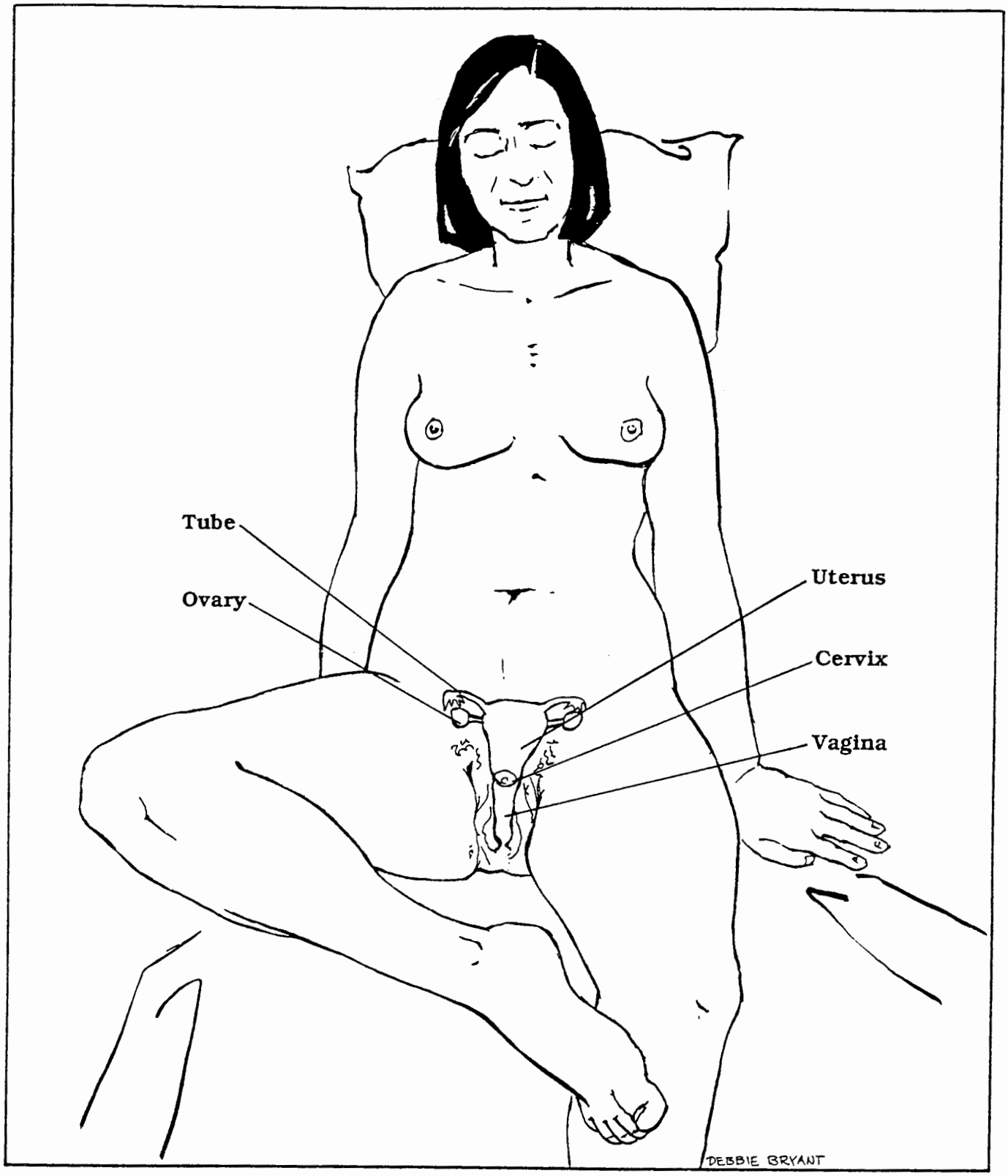
We hope you won't have to sue your doctor. It will take a lot of time and energy. It may also cost a lot of money. You might win in the end, but there are no guarantees.

YOUR BODY

This chapter has general information. In **Reproductive Organs** we describe women and men's reproductive organs. Then we explain the changes your body goes through from one period to the next. This is called the menstrual cycle. The last section of this chapter describes what happens when a woman becomes pregnant.



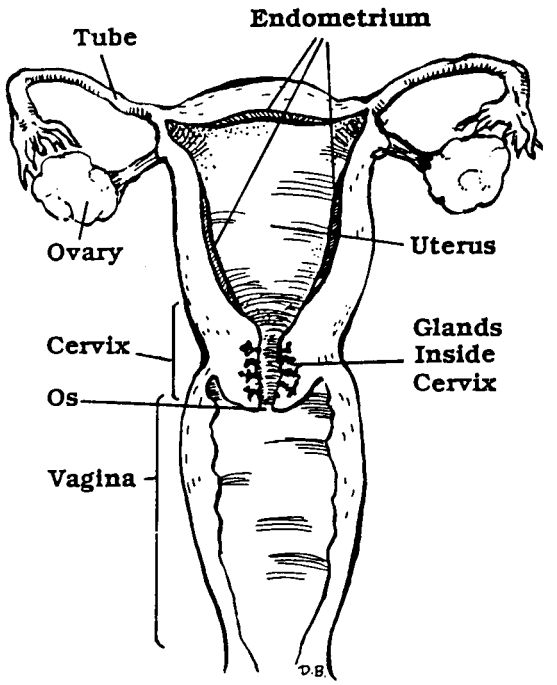
Claudia Lowry in YUKON WOMEN



Woman's Body

WOMEN'S REPRODUCTIVE ORGANS

These are some of the parts of your body that make you able to have periods and get pregnant. You may have other names for them. We have used the medical names because they might be helpful when you're talking to a doctor or nurse.



Women's Organs

Debbie Bryant

Ovaries: You have two ovaries. They are the size and shape of almonds in the shell. They do two things. They make the hormones estrogen and progesterone. They also store your eggs. You were born with all the eggs you will ever have.

Uterus: This is another name for your womb. Your uterus is made of muscle. If you get pregnant the fetus grows here. Your uterus is the size and shape of a small pear when you are not pregnant. It can stretch to 50 times its size to hold a developing fetus.

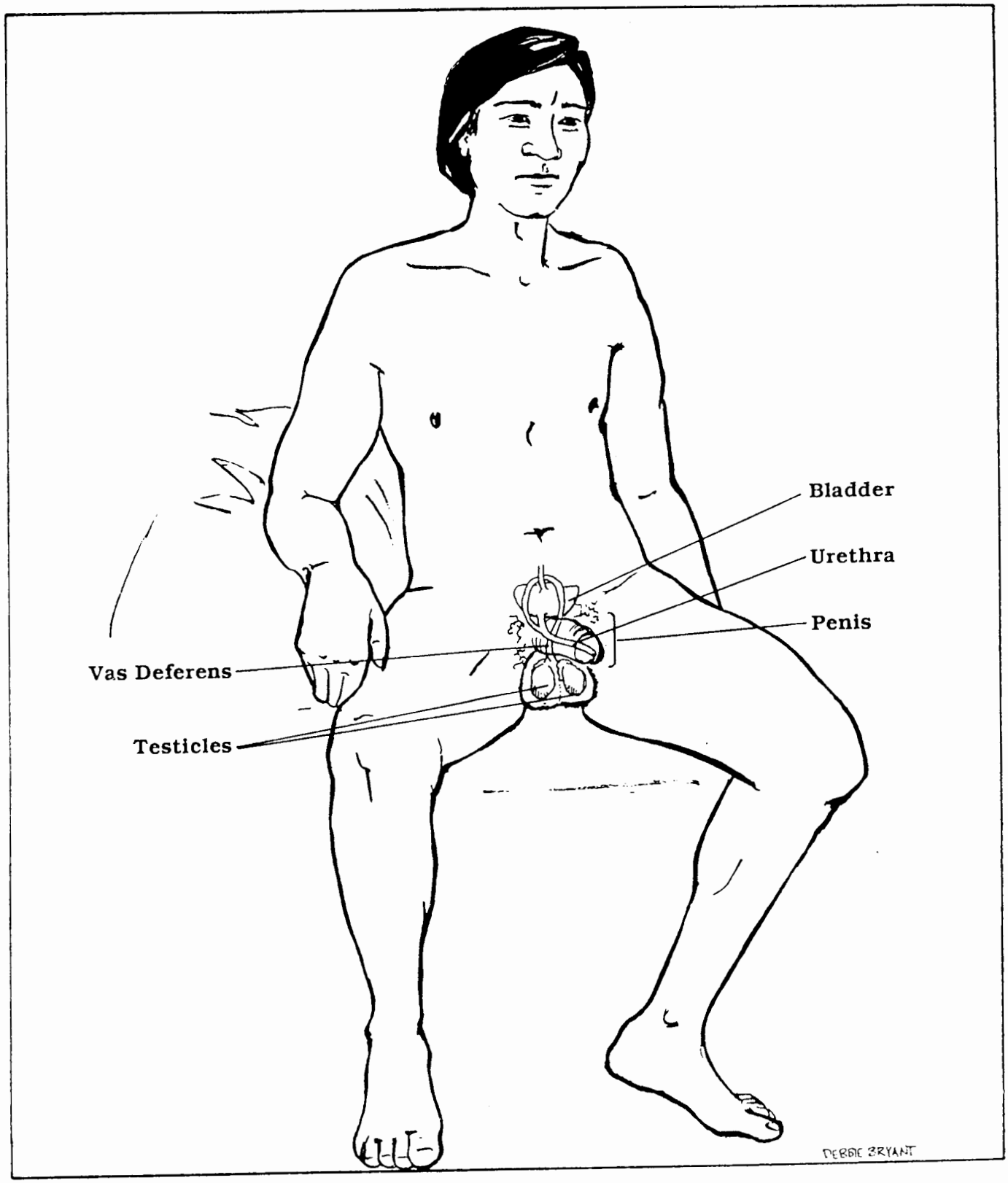
Fallopian tubes: These are the tubes the egg travels through from your ovary to your uterus. They are very thin. The inside walls of the tube have little hairs that help to move the egg towards your uterus.

Endometrium: The endometrium is the inner lining of your uterus.

Cervix: The cervix is the bottom part of your uterus. You can feel the outside of your cervix if you put a finger far back into your vagina. Your cervix feels a lot like the tip of your nose.

Os: Your cervix has an opening, called the os. Your menstrual flow comes through this hole into your vagina. If you have a baby your os widens to let the baby out.

Vagina: Your vagina is a tube made of muscle. It is open to the outside air, and has a lining which always stays moist. The wall of your vagina has many folds in it. The folds allow it to stretch. The outer third of your vagina has a lot of nerve endings which make it sexually sensitive.


Bladder
Urethra
Penis
Vas Deferens
Testicles
DEBBIE BRYANT

Man's Body

MEN'S REPRODUCTIVE ORGANS

Testicles: A man has two testicles. Often, one is bigger than the other. The testicles are glands which make hormones. They also make sperm.

Scrotum: The scrotum is a sack of skin which holds a man's testicles. It holds the testicles away from the rest of a man's body because they need to stay cool.

Epididymis: This is a long coiled tube on the back of a man's testicles. It is where the sperm become mature. They spend about two weeks in the epididymis.

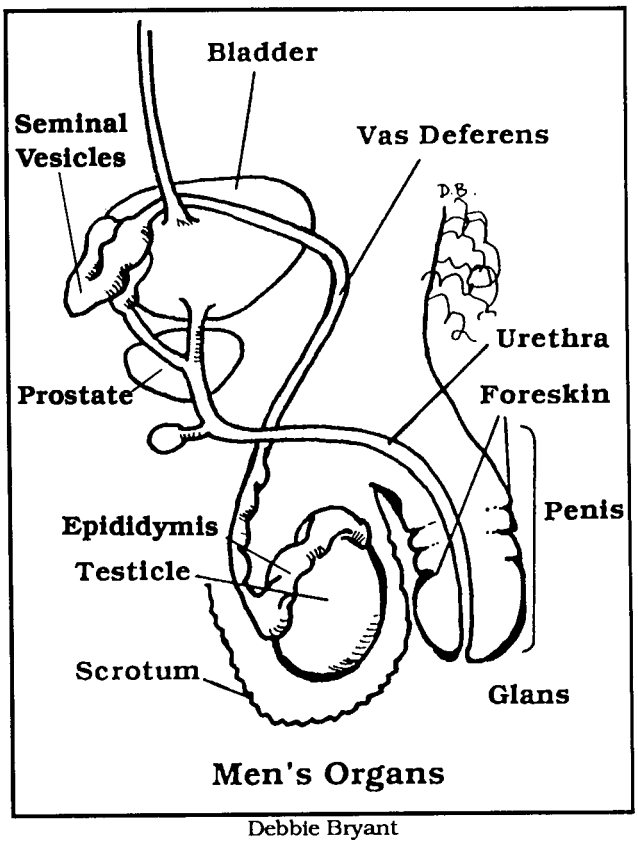
Seminal vesicles: These are two glands. They make most of a man's semen. This is the liquid which holds the sperm. They also make fructose, a sugar in the semen.

Prostate gland: The prostate gland also makes part of a man's semen.

Vas deferens: These are the sperm ducts. The sperm go through these tubes to get to the urethra, the passageway in the penis.

Urethra: This is the passageway in the penis. A man's urine goes through the urethra when he pees. The sperm also go through the urethra when a man ejaculates.

Penis: The penis is sensitive to touch, especially at the tip, which is called the glans. A man who has not been circumcised has a flap of skin, the foreskin, hanging over his glans. If he has been circumcised, this piece of skin has been cut off. The penis becomes hard when a man is sexually aroused. This is called an erection.



Debbie Bryant

MENSTRUATION

Menstruation means having your period. It is a normal and healthy part of being a woman.

Many parts of your body work together to make your menstrual cycle. We will talk about the most important things that happen. If you want to know more about how your menstrual cycle works talk to a nurse, doctor, or community health worker.

THE MENSTRUAL CYCLE

Your menstrual cycle lasts from the first day of one period to the first day of your next period. During each cycle, your body goes through changes. These changes are more or less the same each cycle. Different women have slightly different cycles. Every woman has her own cycle.

A menstrual cycle usually lasts from 21 to 45 days. This is how long most women have between the first day of one period and the first day of the next period.

There's a myth that a normal menstrual cycle is 28 days. That's not true. Women on the pill have periods 28 days apart, but that's because the hormones in the pill tell their bodies when their periods should be.

Hormones control your menstrual cycle.

What are hormones?

Hormones are chemicals made by organs in your body called glands. Hormones travel through your blood. They are messengers. They travel from one part of your body to another telling it what to do next. Hormones control many of the things which happen inside your body, including your menstrual cycle.

What hormones control my menstrual cycle?

The hormones which control your menstrual cycle are made by your ovaries and by glands in your brain. Your brain sends hormones through your blood to your ovaries. Your ovaries then send back different hormones in your blood. Your brain reacts to them. It then sends other hormones to your ovaries telling them what to do next.

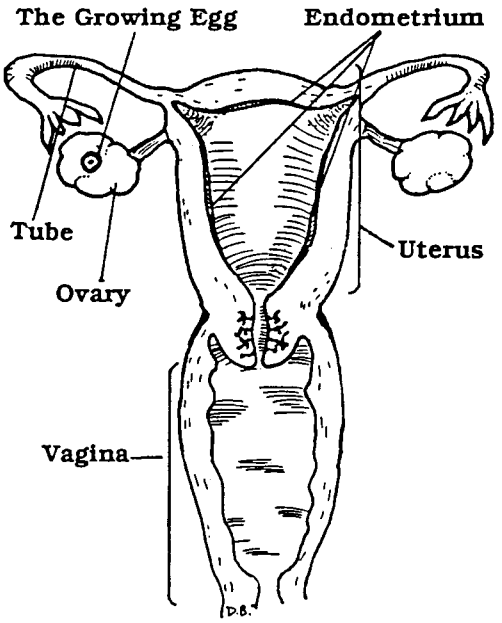
Your menstrual cycle can be affected by your feelings. This is because the hormones which control your cycle come from your brain as well as your ovaries. The same part of your brain which controls your menstrual cycle also controls your emotions.

How do the hormones from my ovaries affect my menstrual cycle?

Your ovaries make two hormones, estrogen and progesterone.

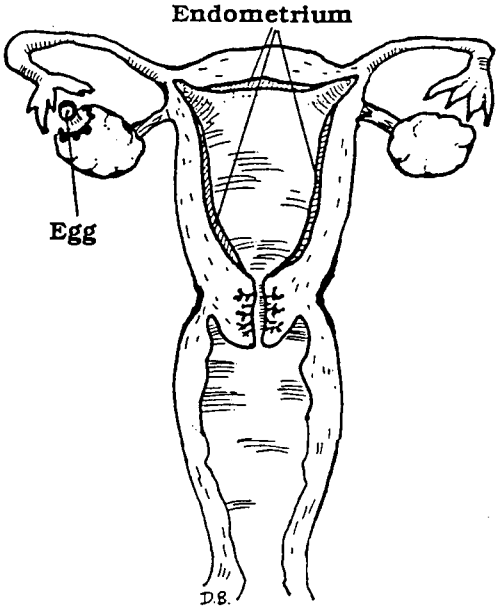
This is what happens in a menstrual cycle:

- 1. During your period your ovaries put out very little estrogen and progesterone.
- 2. After your period, your ovaries start to put out more and more estrogen. During this time some of your eggs start to ripen. Generally only one of these eggs will become fully mature each month. In the first picture you can see the growing egg.
- 3. When you have enough estrogen in your blood the egg pops out of your ovary. This is called ovulation. The egg goes from your ovary to your fallopian tube. The second picture shows ovulation.



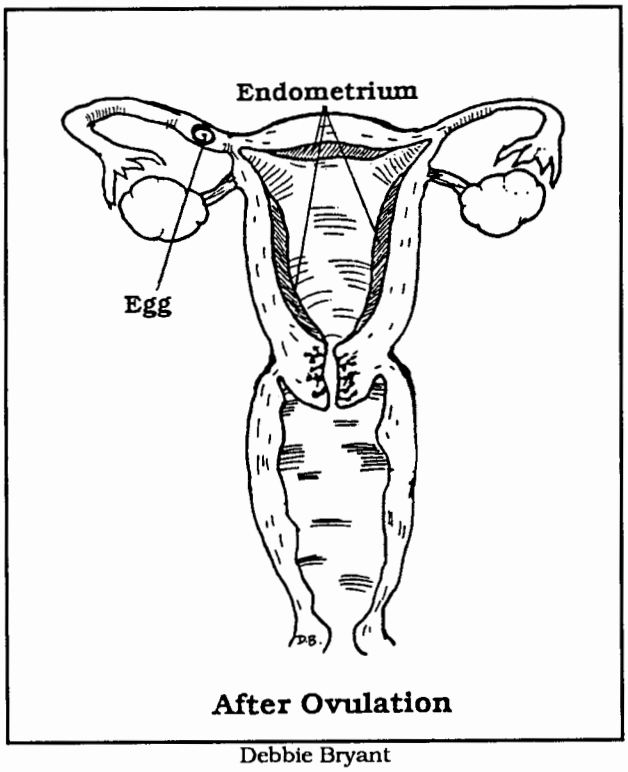
Before Ovulation

Debbie Bryant



Ovulation:
The Egg Leaves the Ovary

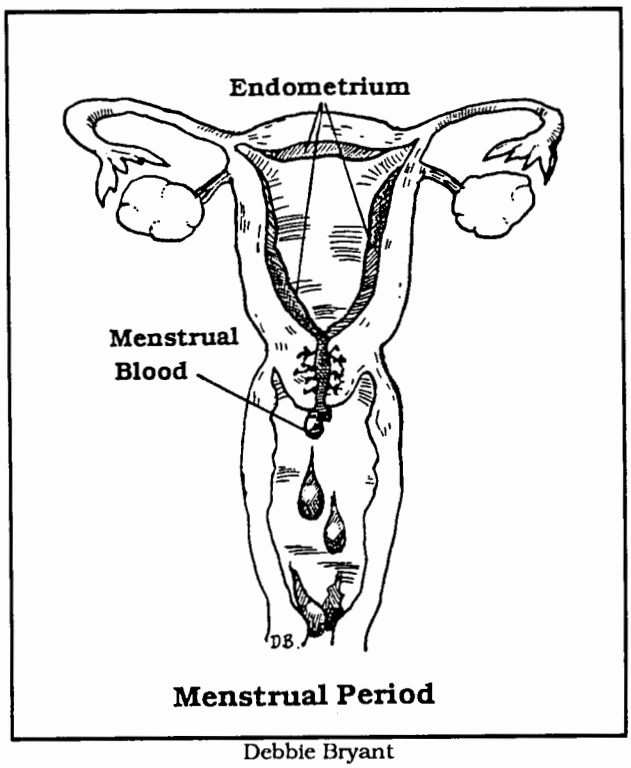
Debbie Bryant



Debbie Bryant

- 4. After ovulation, your ovary makes a lot of progesterone. The walls of your uterus get thick with blood. The egg travels down your fallopian tube. This is shown in the third picture.

- 5. If you get pregnant your body keeps making a lot of progesterone. If you don't get pregnant then it stops making as much progesterone after about two weeks.



Debbie Bryant

- 6. When you have less progesterone in your blood you have your period. You can see the menstrual flow in the last picture.

What happens to the egg if I don't get pregnant?

The egg is very small, about the size of a pinprick. If it isn't fertilized by a sperm, it starts to break down. It is so small that your body just absorbs it.

What happens if I get pregnant?

You get pregnant when a sperm joins the egg in the top part of your fallopian tube. When they join together, they make an embryo. The embryo is the earliest stage of what will become a baby. The embryo takes about four days to travel down your fallopian tube to your uterus. It then attaches itself to the wall of your uterus. This happens about six days after you get pregnant.

After the embryo is attached to the uterus, it starts putting out a hormone called HCG. This hormone tells your body to keep making a lot of progesterone and estrogen. You will have a lot of these hormones in your body the whole time you're pregnant. These hormones stop you from having periods while you are pregnant.

Does ovulation happen during each cycle?

If your period is lighter than what is usual for you, it may mean that you didn't ovulate. Most women have the occasional month when they don't ovulate. This only becomes a problem if it happens all the time and you're trying to get pregnant.

What happens to my uterus each menstrual cycle?

During each menstrual cycle, the lining of your uterus, your endometrium, grows thicker and rich with blood. The hormones estrogen and progesterone make this happen. When you have less of these hormones in your blood, the lining starts to break down. You then have your menstrual period. Your menstrual blood is really the broken down inside lining of your uterus.

THE STEPS TO PREGNANCY

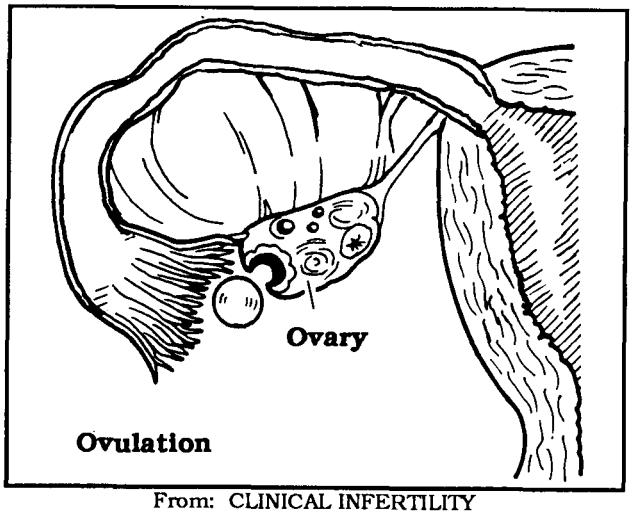
This is a list of the steps that are needed for you to get pregnant. If you are having trouble conceiving, one or more of these steps may not be happening. In infertility testing, your doctor looks at each of these steps to find out where there's a problem.

The steps for pregnancy are the same whether you are having intercourse or using donor insemination to get pregnant. Donor insemination means using sperm from a man who is not your sexual partner to get pregnant. You may be using donor insemination if you are single, a lesbian, or if your male partner is infertile. Donor insemination is described on page 135.

You can become pregnant if the following things happen:

1. Your partner or donor ejaculates healthy sperm.

2. An egg ripens and pops out of your ovary at fairly regular times, about once a month. This is called ovulation.



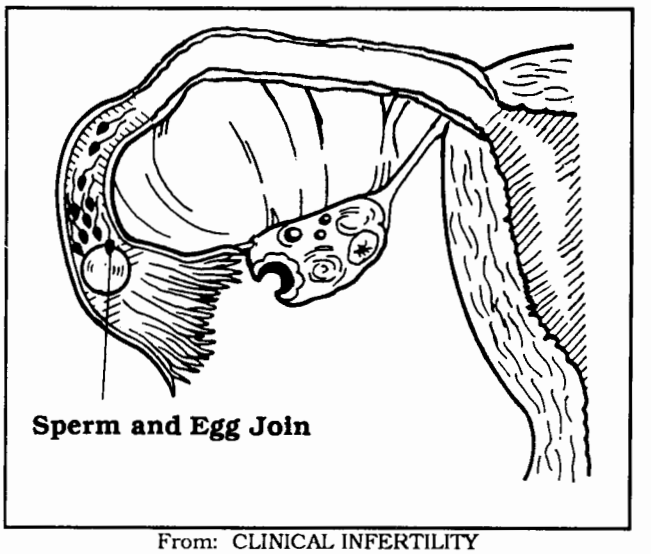
From: CLINICAL INFERTILITY

3. The egg travels into your fallopian tube.

4. You and your partner have intercourse or you inseminate close to the time when your egg leaves your ovary.

5. The sperm travels through your cervix and uterus and into your fallopian tube to meet the egg.

6. The sperm and the egg join. This is called fertilization.

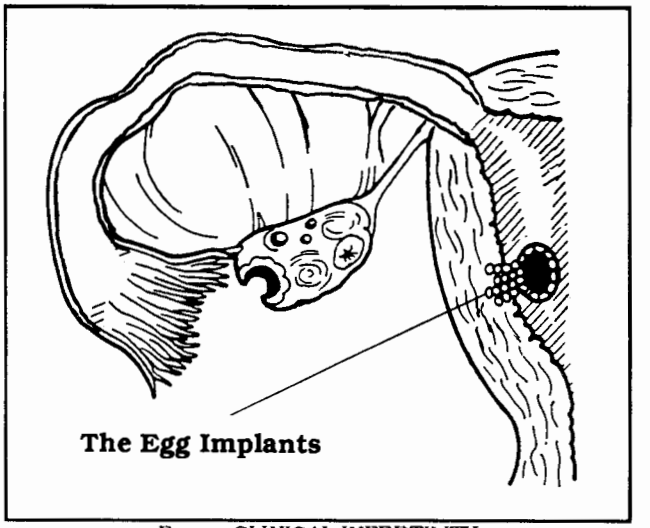


Sperm and Egg Join

From: CLINICAL INFERTILITY

7. The fertilized egg travels through your fallopian tube to your uterus.

8. The fertilized egg implants into the lining of your uterus.



The Egg Implants

From: CLINICAL INFERTILITY

Your pregnancy will continue successfully if the following things happen:

1. Your hormones help keep you pregnant.

2. Your uterus stretches to hold the developing fetus until it is ready to be born.

3. Your cervix is strong and stays closed as the fetus grows.

4. The fetus is healthy.

Pregnancy

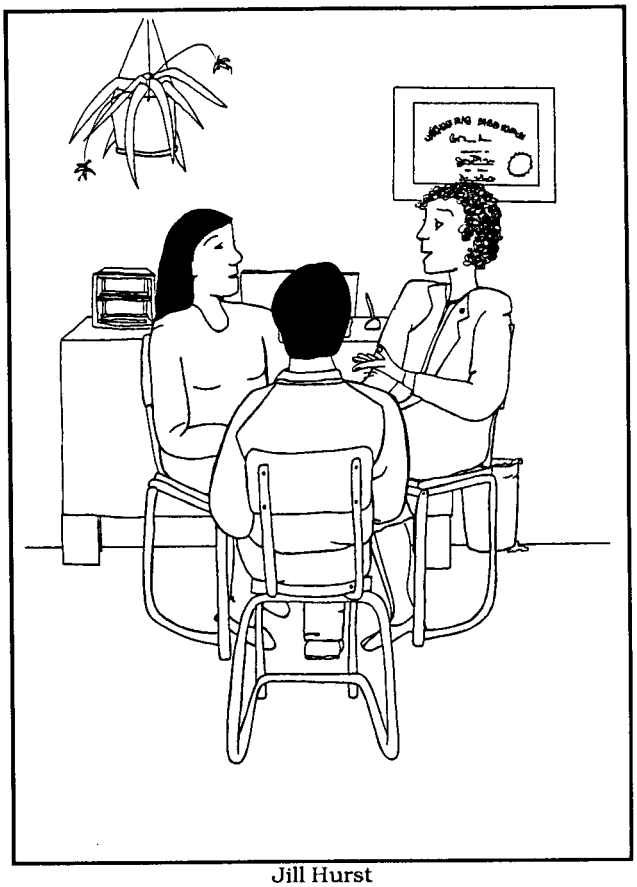
From: THE COMPLETE BOOK OF PREGNANCY AND CHILDBIRTH

THE INFERTILITY WORK-UP

The infertility "work-up" is the name for the group of tests a doctor does to find out why you aren't getting pregnant. If you are in an ongoing sexual relationship with a man, you will both need to go for testing. He is just as likely to have a fertility problem as you.

Your doctor will probably refer you to a specialist. If you live in a small community, you may have to travel to see an infertility specialist. Your own doctor may also be able to do some of the tests.

The costs of an infertility work-up are covered by your provincial or territorial medical insurance.



Jill Hurst

How do you plan your infertility work-up?

You can talk to your doctor about what the whole infertility work-up will be like. You can find out these things:

- What tests the doctor suggests
- What each test will tell you
- What choices you have between different tests
- How long the work-up will take

It is a good idea to meet with your doctor again after you have had a few simple tests. You and your doctor will then be able to plan a work-up that is best for you.

The whole work-up can be done within about three months. It shouldn't take longer than six months. It can't all be done at once, because some tests have to be done at certain times in your menstrual cycle.

This chapter has information on tests for infertility in men and women. We have put the tests for men first because it is simpler to find out if a man has a fertility problem. It makes sense for men to be tested first.

The series of women's tests take longer to do. Some tests also involve risks to a woman's health. It isn't worth going through all of these tests until you know if your male partner or donor has a fertility problem.

Sometimes both people have fertility problems. If you are the partner of a man who has a fertility problem, you may want to have basic testing. This would involve looking at your medical history, a physical exam and basal body temperature. Your doctor may suggest a few other tests as well. These tests are explained in this chapter.

If you only want information on women's tests, turn to page 46.

MEN'S INFERTILITY TESTING

Men's infertility testing is usually done by a doctor called a urologist or an andrologist. A urologist specializes in the urinary tract (kidneys, bladder and urethra) and in male reproductive organs. An andrologist specializes in male fertility.

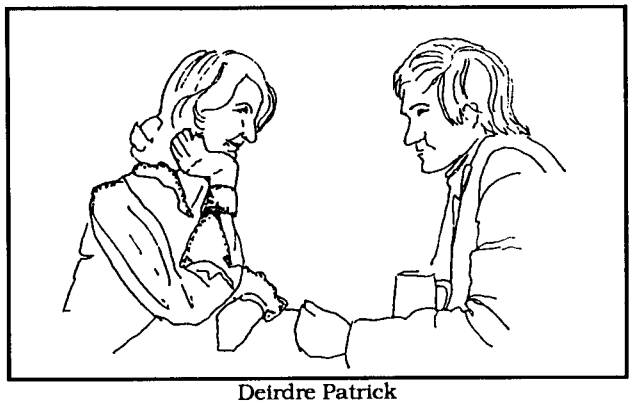
A man's doctor can refer him to one of these specialists. If there is no specialist nearby, his doctor can do the basic tests and then refer him to a specialist for more testing if he needs it.

First, the man tells the doctor his medical history and has a physical exam and a semen analysis.

THE MAN'S MEDICAL HISTORY

The man's doctor will ask him questions about any past illness, injuries, or surgery and about diseases that run in his family.

His doctor will also ask some questions about his daily life. How well does he sleep? Is he under a lot of stress? What are his eating habits? What kind of exercise does he get? Does he smoke, drink alcohol or take drugs? Is he taking any medicines?



Deirdre Patrick

The doctor will also want to know about his work. Does he work with any strong chemicals or x-rays?

The doctor will ask some questions about his sex life. Is he able to have intercourse? About how often does he have intercourse? Is he able to ejaculate during intercourse?

Many people are very embarrassed at the thought of having to tell a doctor about their sex life. The doctor will only ask him questions which affect his fertility. For example, whether he can ejaculate during intercourse will affect his fertility.

THE MAN'S PHYSICAL EXAM

The doctor will do a thorough check-up for health problems. This includes an exam of his penis, scrotum, testicles, and prostrate gland for any problems. The doctor checks his prostate gland with a rectal exam.

To do this, the doctor puts one gloved finger into the man's rectum and feels his prostate gland. The prostate gland will feel larger than it should if it is infected. The doctor also checks his testicles for any unusual lumps and for a varicocele, a varicose vein in his testicle.

THE SEMEN ANALYSIS

The most important step for a man in an infertility work-up is a semen analysis. The man is asked to masturbate and to collect all of the semen in a clean jar. He is usually shown to a private room in the clinic. Many men find it very hard to masturbate in a room in a doctor's office.

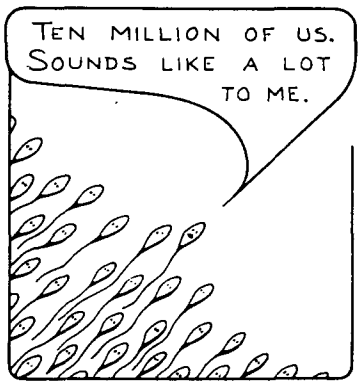
A man can also arrange to take the jar home and bring it back at a certain time. He should bring the semen sample to the doctor as soon after he ejaculates as possible. It must be within two hours. If he waits longer, many of the sperm will die before the doctor looks at the sample.

Some men don't masturbate because of religious or social beliefs. The doctor can give a man a special condom to wear during intercourse to collect his semen.

The man will be asked not to ejaculate for 48 hours before having the semen analysis done. This helps him have more sperm in his semen. If he has ejaculated more recently, he will have less sperm.

"Semen analysis" means looking at what the semen and sperm are like. The doctor looks at the semen under the microscope. The semen analysis can tell the doctor these things:

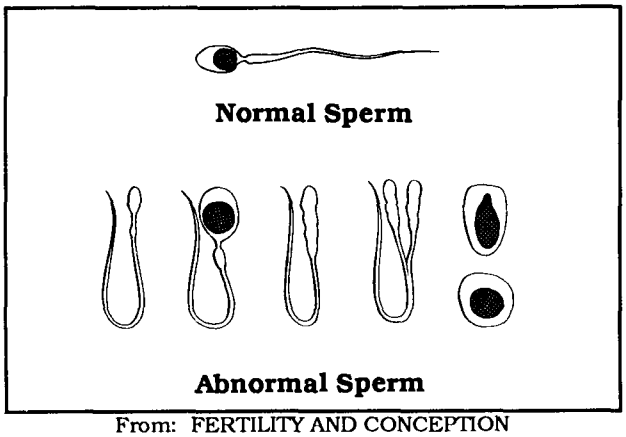
- **Whether there are enough sperm in the semen.** If the semen has less than 20 million sperm per cc, this is a low sperm count. 60– 100 million sperm per cc is a highly fertile sperm count. Men with counts between 20 and 60 million sperm usually can father a child without any problem.



From: THE FERTILITY QUESTION

- **Whether the sperm are moving normally.** This is called sperm "motility". The doctor will give the semen a score from zero to four.
  0 = no movement
  1 = very poor movement
  2 = poor movement
  3 = good movement
  4 = very good movement

- **If too many of the sperm have an abnormal shape.** Abnormal sperm have unusual shapes. They may have too large or too small a head, a double head, no tail or other problems. Every man has some sperm which are shaped abnormally, but at least 60 out of every 100 sperm should have a normal shape.

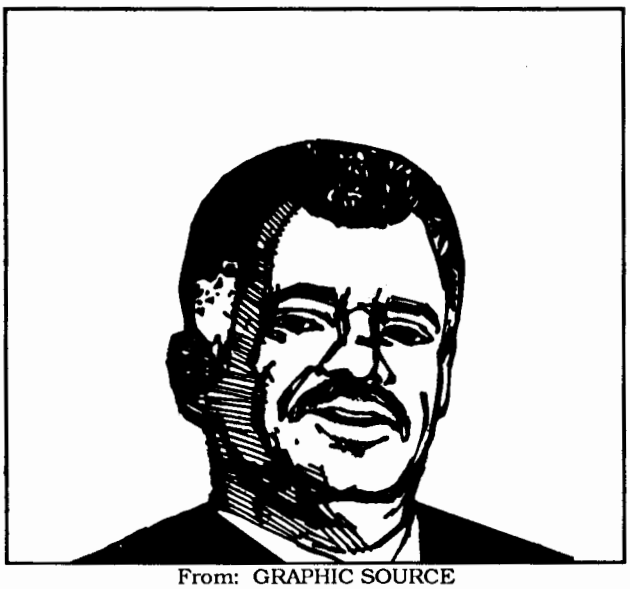


From: FERTILITY AND CONCEPTION

- **If there are any problems with the semen.** Semen is the liquid which holds the sperm. A man may have too much or too little semen. He should have one half to one teaspoonful of semen each time he ejaculates. The semen also needs to be the right thickness. After a man ejaculates, his semen turns very thick. Within about 20 or 30 minutes, it should turn back into a liquid. If this doesn't happen, it shows a problem.

If there is any problem with a man's semen analysis, he will be referred to a specialist. He will be asked for another semen sample, which the specialist will look at more closely. Most infertility specialists look at two or three samples of a man's semen. Usually, the specialist asks for these samples over two to three months.

The doctor shouldn't treat a man for a problem if he's only had one sample. Men's sperm counts are not always the same. The sperm can be affected for a short time by many things, such as sickness, a man's testicles getting too hot, drinking alcohol, or not sleeping or eating well.



From: GRAPHIC SOURCE

What next?

If a man's semen analysis, physical exam and medical history don't show problems, he won't need to have more tests. The next step is for his partner to go through infertility testing. Skip to the section on tests for women, starting on page 46.

If the semen analysis shows that a man has a fertility problem, he will be asked to come in for more tests.

These tests check for the following reasons a man may have a fertility problem:

- a hormone problem
- a problem with his testicles
- blocked ducts
- a problem with his semen which didn't show up in a regular semen analysis

MEN'S HORMONE TESTS

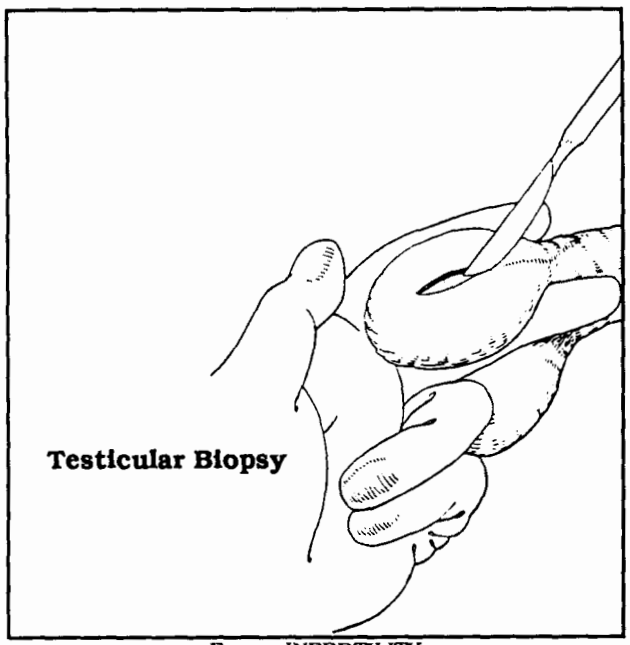
A man can get blood tests for the hormones FSH, LH, and testosterone. The tests will show if he has an unusually low or high amount of these hormones in his blood.

TESTICULAR BIOPSY

A testicular biopsy is a small sample from one of a man's testicles. His doctor will suggest this test if his hormones are normal, but he has a low sperm count or no sperm in his semen.

A testicular biopsy can be done with local anaesthetic or with general anaesthetic. With a general anaesthetic, the man is asleep. The local anaesthetic just blocks the pain where the doctor cuts.

The doctor makes a small cut in the sack of skin which holds the man's testicles called the scrotum. The doctor then takes a very small piece of tissue from one testicle, and sews the cut closed.



From: INFERTILITY

The sample is sent to the lab to see if sperm are being made in the testicle and if they are able to mature. The biopsy can also show if his testicles can make a hormone called testosterone.

If no sperm are being made in his testicles, his infertility is caused by a problem which can't be cured. If the sperm are being made, but can't mature, his situation is more hopeful. He may be exposed to poisons, drugs, or have a varicocele. These conditions are discussed in the chapter on men's infertility on page 109.

The testicular biopsy may also show that his testicles are working fine. If he has no sperm in his semen, it is probably because the tube leading from his testicles to his penis is blocked.

Are there risks from a testicular biopsy?

A man can get an infection in his testicles from the biopsy. This is rare.

He is likely to feel sore for a few days after the biopsy. If he has a general anaesthetic, there are risks from the anaesthetic. See page 201. A local anaesthetic is safer.

VASOGRAPHY

Vasography is a test which checks to see if any of the passageways from a man's testicles to his penis are blocked. A doctor who specializes in x-ray medicine does this test. It can be done with a local or general anaesthetic.

The doctor makes a cut into the man's scrotum and puts dye into the ducts leading from his testicles to his penis. This dye shows up under x-rays. The doctor takes X-ray pictures of the man's testicles and penis. They will show whether the ducts are blocked and where they are blocked.

Doctors often do a vasography at the same time as doing surgery to repair the blocked ducts. They will suggest this if they know a man has blocked ducts. The vasography shows them where the ducts are blocked.

Are there any risks from a vasography?

There is a small risk of infection from cutting into the scrotum and putting in the dye. The man's testicles are also exposed to a small amount of x-ray radiation. Large doses of x-rays are known to be harmful to men's testicles. Large doses can cause cancer, infertility, or genetic changes. These harmful effects are very unlikely to happen with the amount of x-ray radiation used in medical x-rays. However, it is still best to avoid all unnecessary x-rays to the testicles.

This test is needed if a man's semen analysis and testicular biopsy show that he probably has blocked ducts. It is much easier for a doctor to surgically open a blocked duct if an x-ray picture shows where it is blocked.

OTHER SEMEN TESTS

Doctors can do a few more tests on a man's semen besides the standard semen analysis.

Fructose test: Fructose is a sugar which is normally found in semen. If it is not present, the man either has a problem with his vas deferens or his seminal vesicles. These parts of a man's body are described on page 31.

Hamster egg test: This is a test to see whether a man's sperm can fertilize a hamster's egg. His sperm are put near a hamster egg in the lab. Under the microscope, a lab technician can see whether they are able to fertilize the egg. If they can't, it is a sign that they may not be able to fertilize a woman's egg.

Doctors suggest this test if they can't find a reason for a couple's infertility. They also suggest it if a man has a condition called a varicocele. This is a varicose vein in the testicle. There is more information about it on page 114.

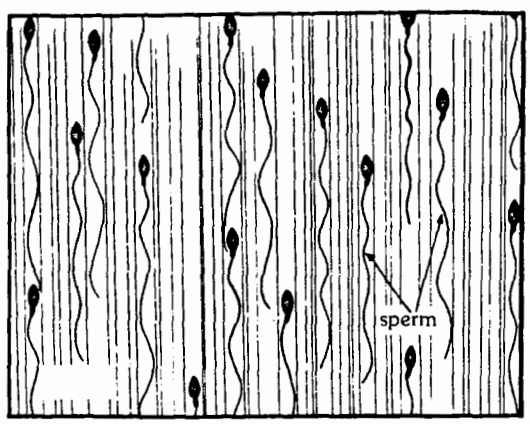
Doctors may also suggest this test to couples having in vitro fertilization, so they know if a man's sperm can fertilize an egg before trying in vitro fertilization. In vitro fertilization means fertilization in the laboratory, rather than in a woman's body. It is explained on page 145.

A man may feel uncomfortable about the hamster egg test, because his sperm will be combined with an animal's egg. The fertilized hamster's egg cannot live and grow. It is destroyed in the lab right after the test. Even if it was not destroyed, it would not be able to live.

If a man doesn't want to have this test, he should tell his doctor. It is his choice.

Bovine cervical mucus test: This is a test to see whether sperm can swim through mucus from the cervix. For this test, "bovine" or cow mucus is used because it is a lot like human mucus. The doctor leaves sperm in a sample of mucus in the lab for an hour and a half. The doctor then looks at how far the sperm have travelled. If they were not able to travel very far, they may not be able to swim well through mucus. This is called a sperm motility problem.

Sperm Swimming Through Mucus



From: A COOPERATIVE METHOD OF NATURAL BIRTH CONTROL

TESTS FOR IMMUNE PROBLEMS

These tests are described on page 65. This is a problem which either a man or a woman may have.

WOMEN'S INFERTILITY TESTING

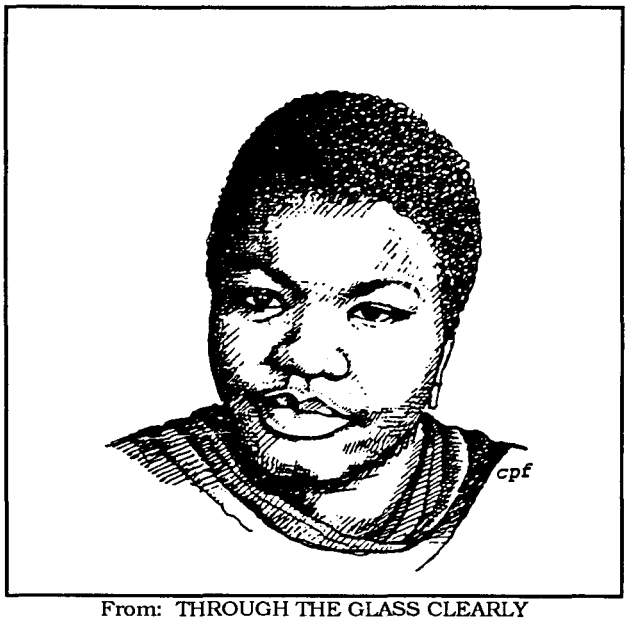
Your doctor will ask you questions about your medical history and will do a physical exam. You will then plan your infertility work-up together.

Your doctor can check you for these things:

- hormone problems
- blocked or damaged fallopian tubes
- cervical mucus problems
- problems with your uterus
- endometriosis
- immune problems

There are many different tests described in this chapter. Not everyone needs all of these tests. You and your doctor will decide which tests you'll have depending on your medical history and pelvic exam.

First we'll list the tests that are usually done to check for specific problems. Then we'll describe each of the tests in more detail. You may find it helpful to skip around when you're reading this section. Just read the information on the tests you are considering having.



From: THROUGH THE GLASS CLEARLY

Tests for hormone problems:

If you have fairly regular periods, these are the tests for hormone problems:

- basal body temperature, page 49
- mucus charting, page 52.
- blood test for progesterone, page 54
- endometrial biopsy, page 54

If these tests show a problem, you can have a cervical mucus smear, described on page 57, or blood tests for hormones, described on page 58.

If you don't have periods, these are the tests your doctor may suggest:

- a cervical mucus smear for estrogen, page 57
- progesterone withdrawal test, page 57
- blood tests for FSH, LH, prolactin and adrenal androgens, page 58

Tests for blocked or damaged fallopian tubes:

- hysterosalpingogram, page 59
- laparoscopy, page 62. Doctors don't usually suggest this until after you've had a hysterosalpingogram

Tests for cervical mucus problems:

- mucus charting, page 52
- a cervical mucus smear, page 57
- the post-coital test, page 58

Tests for problems with your uterus:

- progesterone withdrawal test, page 57. Doctors only suggest this test if you don't have periods.
- ultrasound, page 61
- hysterosalpingogram, page 59.
- hysteroscopy, page 64. Doctors don't do this unless they are fairly sure you have a problem
- laparoscopy, page 62. Doctors will suggest this only after other tests. It shows problems on the outside of your uterus.

Tests for endometriosis:

- laparoscopy, page 62

Tests for immune problems:

- blood tests and cervical mucus tests, page 65

THE WOMAN'S MEDICAL HISTORY

Your medical history will include most of the same questions described under men's medical history on page 40:

- past illnesses, injury, infection and surgery
- health problems that run in your family
- daily life: sleep, exercise, smoking, alcohol, drugs and medicines
- exposures to poisons and x-rays at work
- how often you have intercourse or have used donor insemination

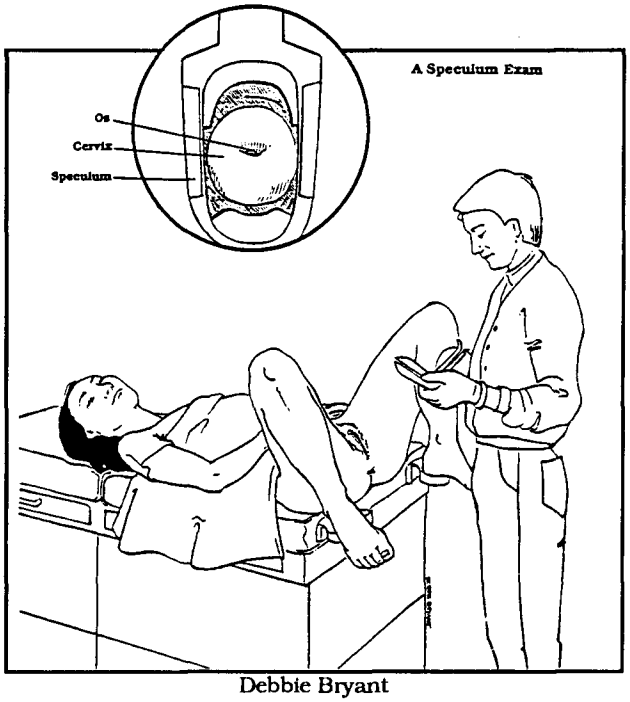
She will also ask you some questions about your periods. How regular are they? How much of a flow do you have? Do you have cramps? Do you have any problems with your periods? She will also ask if you have pain during intercourse, as it could be a sign of a health problem causing infertility.

THE WOMAN'S PHYSICAL EXAM

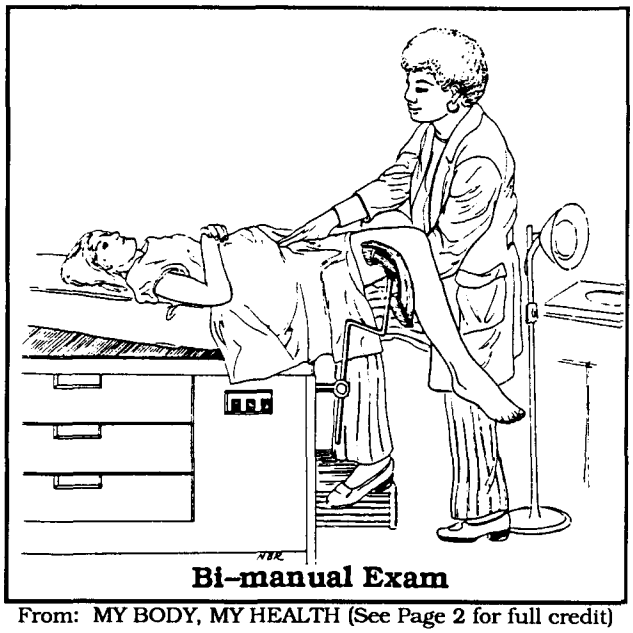
Your doctor does a pelvic exam. There are two parts to this exam: the speculum exam and the bi-manual exam.

First, she does the speculum exam. She asks you to lie on an examining table with your feet in stirrups. She puts a speculum into your vagina. It holds your vagina open so she can see your cervix.

What You See Through the Speculum



Debbie Bryant



Bi-manual Exam

From: MY BODY, MY HEALTH (See Page 2 for full credit)

She uses a cotton swab to take a sample of the mucus near your cervix to test you for infections. She also does a Pap test. She gently scrapes a few cells from your cervix. She then wipes the cells onto a glass slide and sends the slide to a lab.

Next, she does a bi-manual exam. She puts two fingers inside your vagina to feel your cervix. With her other hand, she presses gently on your lower belly. She can feel your uterus, tubes, and ovaries between her two hands.

She also does a thorough check-up to test for any other health problems you may have.

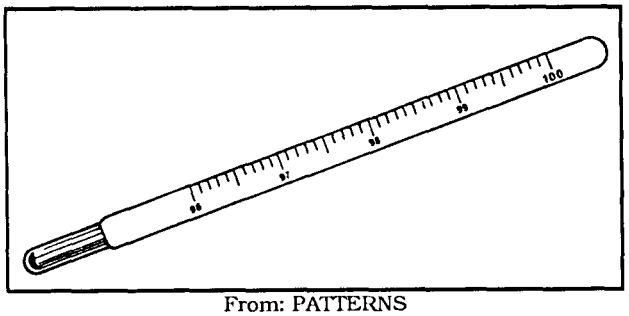
BASAL BODY TEMPERATURE CHARTING

Your doctor will suggest basal body temperature charting if you have menstrual periods. Basal body temperature charting is a way of finding out whether one of your eggs leaves your ovary during each menstrual cycle. This is called ovulating. It is described on page 33. Basal body temperature charting is also a way of finding out when you ovulate.

Basal body temperature is a simple test you can do yourself. Your temperature goes up slightly after you ovulate. It stays higher until right before your next period. You should have higher temperatures for about two weeks before your period. These higher temperatures show that you have ovulated.

Most women's temperature changes only a little after they ovulate. You need to use a special thermometer called a basal body thermometer to measure the changes. It is a little more accurate than a fever thermometer. You can buy a basal body thermometer at any drugstore.

You should take your temperature during two or three menstrual cycles. Most women's menstrual cycles change a little from month to month. It is also very common to occasionally not ovulate. If you keep temperature charts for a few months, you will see what your normal pattern is.



From: PATTERNS

How to take your temperature:

1. Start taking your temperature the first day after your period is over.

2. Shake the thermometer down the night before. Leave it beside your bed.

3. Take your temperature in the morning just after you wake up. You have to take it before getting out of bed or doing anything. It's best to take your temperature about the same time each morning. You can take your temperature in your mouth (orally) or in your vagina (vaginally). Always take your temperature the same way, either always in your mouth or always in your vagina.

4. Mark your temperature on a chart each day with a dot.

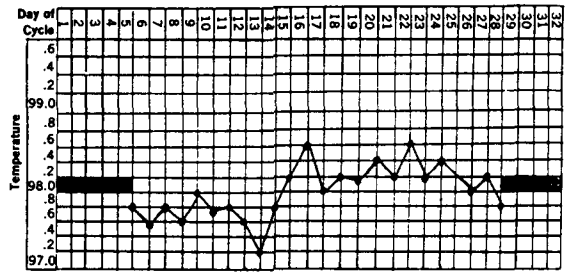
5. After you ovulate, your temperature will be at least .2 C higher than before.

6. After your temperature has stayed at least .2 C higher for three days, you can be sure that you have ovulated.

7. If you have ovulated, your temperature will stay generally higher until just before your next period.

This is Mary's temperature chart for one menstrual cycle. As you can see, her temperature changes a little from day to day, but it is generally lower before she ovulated and higher after she ovulated.

Temperature Chart



From: THE NEW WOMEN'S HEALTH HANDBOOK

Many women find that their temperature drops a little just when they ovulate and then goes up. On the chart, Mary's temperature went down a little on day 13. This is probably when she ovulated. Her chances of getting pregnant this month are highest if she has intercourse on day 13. They are also very high if she has intercourse on day 12 or day 14.

If you don't ovulate, your temperature won't be higher in the two weeks before your period than just after your period. It may go up and down from day to day, but there will be no overall pattern to the changes.

What problems do women have with temperature charting?

- Your temperature can go up if you have a fever, if you stayed up very late the night before, or if you slept in later than usual.
- If you already have a young child, it can be hard to take your temperature before getting up. If you have been up in the night with a sick child, your temperature will be higher than usual.
- Every morning, your thermometer will remind you that you are having trouble getting pregnant. This can be a hard way to start the day. If taking your temperature is getting you down, talk to your doctor about stopping. You may want to set a three month limit for basal body temperature charting. If you are charting for longer, you may want to occasionally skip a month.

MUCUS CHARTING

This is a way of finding out when you are the most fertile. It is mostly useful if you have periods and ovulate. Chart your basal body temperature first. You may want to find out more about when you are fertile in these situations:

- If your male partner has a low sperm count or another sperm problem.
- If you have been trying to conceive for a while and don't know why you are not getting pregnant.
- If you are using donor insemination, described on page 135.

You can also try mucus charting if you don't ovulate, but want to know more about your hormones. By charting your mucus, you can tell if your ovaries are making estrogen.

What is mucus?

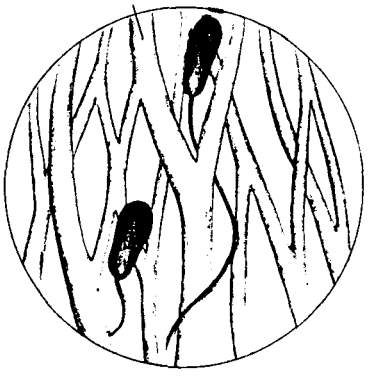
When you aren't having your period, you may have noticed that sometimes you have a little whitish liquid coming out of your vagina. It may be thick and dry at some times and wetter at other times. This liquid is mostly made of mucus from your cervix. It is a normal and healthy part of being a woman.

Your mucus is affected by the hormones which come from your ovaries. When your ovaries are making a lot of the hormone estrogen, your mucus will be fertile. When your ovaries are making more progesterone, your mucus will be infertile.

Fertile mucus is wet and slippery. Many women get a type of mucus which is a lot like raw egg whites just before they ovulate. It is clear and slippery, and if you put some between two fingers and stretch them apart it forms long strands. Other women get mucus around the time they ovulate which is smooth and milky, like hand lotion.

Fertile mucus helps sperm to live and to swim up into your uterus.

Fertile Mucus



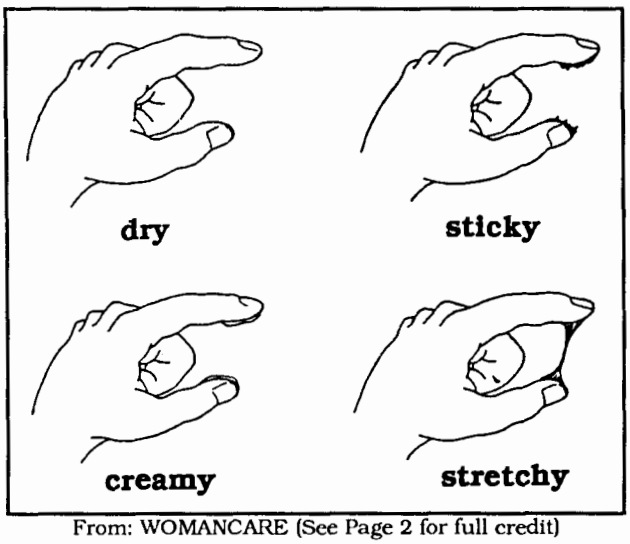
From: A NEW VIEW OF A WOMAN'S BODY

Infertile mucus is thick and sticky. You may find that the opening of your vagina feels dry. The mucus feels sort of like paste. It often feels grainy. Sperm can't live as well in your vagina when you get this type of mucus.

How do you check for mucus changes?

Feel for your mucus with your fingers at the opening of your vagina. How does your mucus feel on your fingers? Is it wet or dry, sticky or slippery? Its colour is less important than its texture. Check your mucus at least three times a day. Write down what your mucus is like every day.

This drawing shows you how different types of mucus look when you have a bit of mucus on your fingers.



From: WOMANCARE (See Page 2 for full credit)

What is the pattern of mucus changes like in a usual menstrual cycle?

1. Just after your period, you may have one or a few "dry days". On a dry day, the opening to your vagina feels dry and you aren't able to find any mucus on your fingers.

2. During the next few days, you will first have sticky, thick mucus. It will gradually change to being wetter and more fertile.

3. In the few days before you ovulate, your mucus will be very wet and slippery. You may notice that the opening to your vagina feels wet, like it feels when there is blood coming out during your period.

4. After you ovulate, your mucus changes to being sticky, thick and drier again. You will have this infertile mucus until your next period starts.

This is an idea of the basic pattern of mucus changes. Every woman will have a slightly different pattern.

The best time to have intercourse or inseminate to get pregnant is just before you ovulate. This is when you have very fertile mucus.

If you don't ovulate, it will be harder to see a clear pattern to your mucus changes. If you get fertile mucus, it is a sign that your ovaries are making estrogen.

There are classes which teach how to chart mucus changes. See page 206 for names and addresses of groups which teach mucus charting. These groups teach charting both for conception and for birth control. When you write or phone for information, you can ask about separate classes for people trying to conceive.

DRUGSTORE TESTS FOR OVULATION

Several companies have started selling kits which you can use at home to find out when you ovulate. These kits test your urine for a hormone called LH, or "luteinizing hormone". Your body puts out a lot of this hormone just before you ovulate.

You test your urine each morning for a few days to a week. When the test shows that you have a lot of LH, you will ovulate within 24 hours.

These test kits for ovulation are expensive, especially if you use them month after month. Basal body temperature and mucus charting are cheaper ways to find out when you ovulate. You may want to spend the extra money to know exactly when you will ovulate if you are using donor insemination (see p. 135) or intra-uterine insemination (see p. 99).

BLOOD TEST FOR PROGESTERONE

This is a simple test to see if you have ovulated. You have a blood test for the hormone progesterone on day 21 of your menstrual cycle. If you have ovulated, the test will show that you have a lot of progesterone in your blood. If your blood doesn't have much progesterone in it, you haven't ovulated.

ENDOMETRIAL BIOPSY

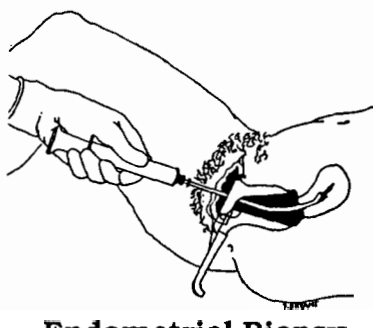
An endometrial biopsy is a sample of the inside lining of your uterus. Doctors do this test for two reasons. The first is to see if you ovulate. You don't really need this test to see if you ovulate. Basal body temperature or a blood test for progesterone can show the same thing. They are safer, simpler tests.

The second reason doctors do endometrial biopsies is to see if you have a hormone problem called a luteal phase defect. If you have this problem, you ovulate each month but your ovaries don't put out enough of the hormone progesterone.

Progesterone helps the lining of your uterus to grow. If you don't have enough progesterone, it won't grow properly. An egg and a sperm can meet to form an embryo, but the embryo can't implant into your uterus.

How is an endometrial biopsy done?

This test needs to be done no more than two or three days before you expect your next period. You will be asked to lie on an examining table. Your doctor will put a speculum into your vagina to hold it open. She will then put a long, thin metal tool through your cervix to scrape off a small piece of the lining of your uterus.



Endometrial Biopsy

Debbie Bryant

This test is usually painful. Your doctor can give you a shot of local anaesthetic in your cervix so you do not feel the pain. This is like the freezing a dentist uses. It's best to ask your doctor ahead of time if you want a shot of local anaesthetic.

Your doctor will send the sample to a lab. They will tell her if the lining was growing the way it should. If it is different from what they expected, they will judge how different it is. They base this on when your next period starts.

Let's say the sample was taken two days before your period. It didn't look like the lining usually does two days before a period. It looked like it should four days before your period. The lab will subtract two from four, and say that your lining was two days "out of phase".

If your endometrial biopsy shows a problem, the lab report always tells your doctor how many days "out of phase" it was. This is important. It should be at least three days out of phase to be called a luteal phase defect.

What are the risks in having this test done?

You can get an infection in your uterus. This is rare.

The test can cause you to miscarry if you are pregnant and don't know it yet. Your doctor will likely suggest that you use birth control during the month you have this test done. You can't use the pill or the IUD. Condoms, foam, a diaphragm or a cervical cap are all fine to use.

How accurate is this test?

A doctor can't depend on one test to be sure you have luteal phase defect. Everyone has the occasional menstrual cycle which is different. The stress of infertility testing makes this even more likely to happen.

Your doctor shouldn't suggest treatment for luteal phase defect unless you have had two or three endometrial biopsies taken during different menstrual cycles.

Can other tests show the same thing?

This is the only accurate test for luteal phase defect. It is not the best test to see if you are ovulating because other tests are safer.

If you know when you ovulate from basal body temperature or mucus charting, you can count the number of days from when you ovulate until your next period. If you don't have a luteal phase defect, it will be between 11 and 16 days. If it is 10 days or less, you probably have a luteal phase defect. Count the days from when you ovulate to your next period during at least three menstrual cycles.

This is less accurate than an endometrial biopsy, but much simpler. It's worth having the biopsy if you're considering drug treatment for a luteal phase defect.

OTHER HORMONE TESTS FOR WOMEN

There are other tests for women who have hormone problems. Your doctor will suggest one or more of them if you don't have periods, have very irregular periods, aren't ovulating, or have a luteal phase defect.

If you don't have a hormone problem, skip to page 58.

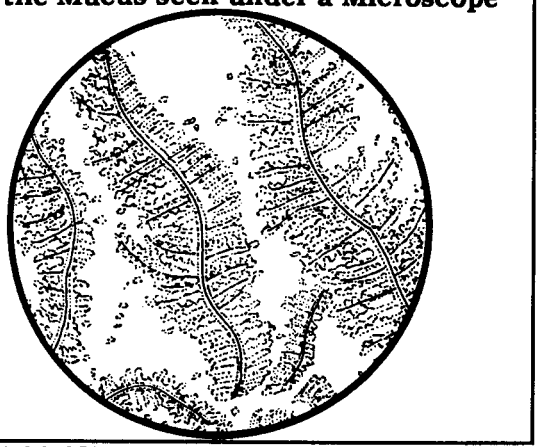
Tests for estrogen

If you don't have periods, your doctor will test to see if you are making enough of the hormone estrogen. This will help her know why you don't have periods or ovulate. She will suggest different treatment depending on whether your ovaries are making enough estrogen.

A blood test for estrogen doesn't give very accurate results. This is because the amount of estrogen in your blood changes all the time. Your doctor will suggest one of the following tests.

Cervical mucus smear: Your doctor can take a sample of the mucus from your cervix, put it on a glass slide, and leave it out to dry. After it has dried, she looks at it under a microscope. When your ovaries put out a lot of estrogen, your mucus makes a pattern which looks like ferns.

Fertile Mucus seen under a Microscope



From: A CO-OPERATIVE METHOD OF NATURAL BIRTH CONTROL

Progesterone Withdrawal test: For this test, you take the hormone progesterone. You may be given pills or a shot. If your ovaries are making estrogen, you will have a period two to three weeks after taking the progesterone. If you don't have a period, it probably means that your ovaries aren't making estrogen. It may also mean a problem with your uterus that stops you from being able to have periods.

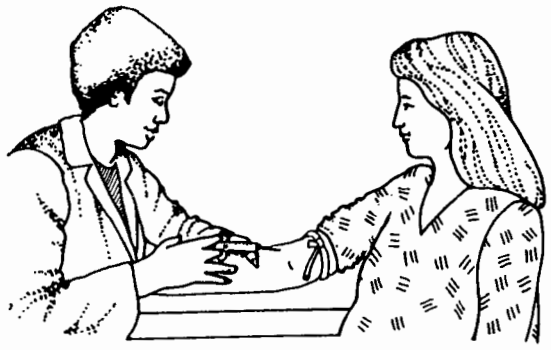
You don't need to use this test to see if your ovaries are making estrogen. You can get the same information by charting your mucus (see page 62) or by having a cervical mucus smear. Manufactured hormones have side effects which you may want to avoid. Many people are concerned about long-term health risks of taking hormones.

If you take progesterone and don't have a period afterwards, your doctor may suggest taking both estrogen and progesterone. You will have a period afterwards if your uterus is working well. If you don't have a period, you have a problem with your uterus. Your doctor will suggest more tests to find out what the problem is. She'll suggest a hysterosalpingogram, described on page 59, and possibly also a hysteroscopy, described on page 64.

Blood tests for other hormones

You can have blood tests for a few other hormones which affect your menstrual cycle:

Drawing a Blood Sample



From: EVERYWOMAN'S GUIDE TO TESTS DURING PREGNANCY

FSH and LH: FSH and LH are hormones put out by your pituitary gland. You may have a condition called ovarian failure if you don't have periods or much estrogen in your blood, but you have a lot of FSH and LH. It is described on page 75. If you have lower than normal amounts of FSH and LH, you may have a problem with your pituitary gland.

Prolactin: This hormone helps your breasts be able to make milk. If you have too much prolactin, you may not ovulate or you may have a luteal phase defect.

Thyroid: Your menstrual cycle can be affected if you have a thyroid problem.

Testosterone and Adrenal Androgens: These are male hormones. Women also have small amounts of these hormones. If you have too much, it is a sign that you have polycystic ovaries (see Page 76), a tumor (a non-cancerous growth) in your pituitary, or a hormone imbalance you were born with.

THE POST-COITAL TEST

"Post-coital" means after intercourse. For this test, your doctor will ask you to come to the office within two hours after having intercourse. If you are using donor insemination to get pregnant, you go to the doctor's office within two hours of inseminating.

Your doctor does a speculum exam and takes some mucus from inside your vagina. She looks at the mucus under a microscope. She can see if there are sperm in the mucus, and if they are swimming and look healthy.

This test can show the doctor how your mucus and your partner or donor's sperm work together. It shows whether his sperm can live in your body.

If this test shows a problem, it can mean one of several things:

- Your mucus is not helping his sperm to live. See page 97 on cervical mucus problems.
- His sperm are clumping together. This shows that you may have antibodies. See page 131 on immune problems.
- You have an infection in your cervix.
- He has a sperm problem which makes it hard for his sperm to live in your body. See page 109 on men's infertility.
- The post-coital test was done at the wrong time. It needs to be done just before you ovulate. If it is done just after you ovulate, your mucus will be infertile. When your mucus is infertile, sperm can't live in it very well.

Post-coital tests can be embarrassing and upsetting. You have to have intercourse "on demand" just before your appointment. You may feel that your private sex life is becoming very public and exposed.

Sometimes, doctors want to do several post-coital tests because of a problem. If you are finding this hard, let your doctor know. She may not need to do the test again.

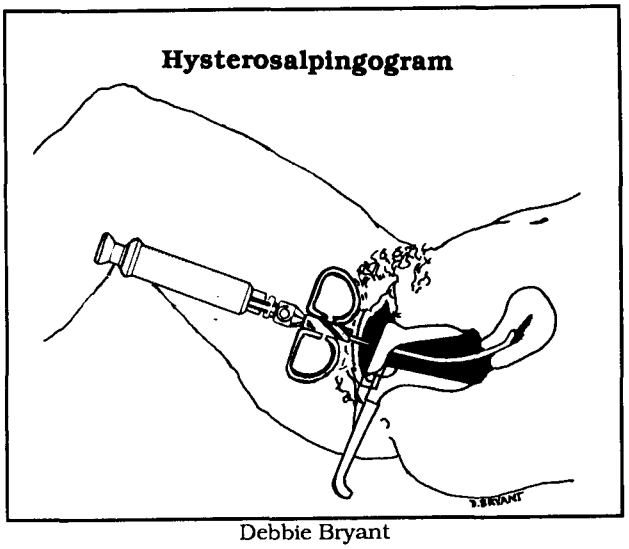
HYSTERO-SALPINGOGRAM

A hysterosalpingogram is an x-ray of the inside of your uterus and tubes. It won't be done by your own doctor, but by a doctor or health care worker who specializes in x-ray medicine. The doctor puts a dye inside your uterus which will show up on an x-ray. She then takes x-ray pictures. These pictures show whether your tubes are blocked or open. They also show if the inside of your uterus or the inside of your tubes have an unusual shape.

A hysterosalpingogram is often a painful test. The pain usually lasts a very short time. It helps to have someone with you to help you breathe deeply and relax.

You lie on an examining table as though you were having a pelvic exam. The doctor uses a speculum to hold open your vagina.

There are two ways a doctor can put in the dye. She can use a cannula or a Foley catheter. Both are thin tubes she puts through your cervix. The Foley catheter is less uncomfortable and more accurate. You have a clamp on your cervix with a cannula. This clamp can feel painful. You don't need a clamp with a Foley catheter. If you have a choice of where to go for this test, go where they use a Foley catheter.



Debbie Bryant

She can use an oil or a water soluble dye. The water soluble dye is better.

The doctor can give you a shot of local anaesthetic in your cervix. This is like the freezing a dentist uses. It will make the hysterosalpingogram less painful. You can ask her beforehand for a local anaesthetic.

Are there any risks to a hysterosalpingogram?

There is a small risk of infection in your uterus and tubes from this test. Anytime your cervix is opened up, there is some risk of infection.

The dye has iodine in it. If you are allergic to iodine, don't have this test. Most people who are allergic to shellfish are also allergic to iodine.

When you have a hysterosalpingogram, your ovaries are exposed to x-rays. It's best to avoid exposing your ovaries to x-rays as much as possible. Large amounts of x-rays are known to be harmful. They can damage your developing eggs and can cause cancer.

A hysterosalpingogram uses smaller amounts of x-rays than the ones known to cause damage. Small amounts are much safer than larger amounts, but they may not be completely safe.

A hysterosalpingogram is the only way of knowing whether your tubes are blocked without having surgery. You may decide that it's worth exposing your ovaries to a small amount of x-rays to find out if your tubes are blocked.

Ask your doctor about having the lowest dose of x-rays possible. Ask how much you will be exposed to. It should not be much more than 2.1 rads.

Are there any benefits to a hysterosalpingogram?

Women sometimes get pregnant soon after this test because their tubes work better after the dye has travelled through them. The liquid dye sometimes flushes out a woman's tubes.

How accurate is a hysterosalpingogram?

Usually, the x-ray picture will show whether your tubes are blocked or open. Occasionally, the dye causes the muscles in a woman's tubes to tighten up. This can make it look like your tubes are blocked when they are really open.

Can another test show the same thing?

The only other way to find out if your tubes are blocked is to have a laparoscopy. Laparoscopy is surgery which allows a doctor to see the outside of your uterus, tubes and ovaries. It is described on page 62. During a laparoscopy, your doctor can put a blue dye into your uterus through your cervix. She will be able to see if the dye comes out the ends of your tubes.

A laparoscopy is surgery. It is probably riskier to go through a laparoscopy than a hysterosalpingogram to find out if your tubes are blocked. But, if you know you will have a laparoscopy later on, you may want to skip having a hysterosalpingogram.

A hysterosalpingogram tells you some things that you don't find out with a laparoscopy. The x-ray picture shows the inside shape of your uterus. Rarely, women are infertile because of problems inside their uterus.

RUBIN'S TEST

Rubin's Test is also called tubal insufflation. This is another test to see if your tubes are blocked. This test doesn't give you very good information. It can't tell you if only one of your tubes is blocked. Most infertility specialists don't use this test anymore.

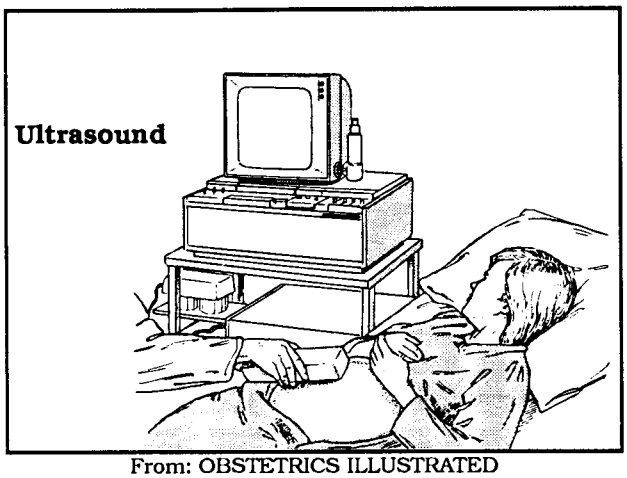
The doctor puts carbon dioxide gas through your cervix. If your tubes are clear, the gas will go out the ends of your tubes. You will feel some pain in your shoulder from the gas. If both tubes are blocked, the gas can't get through.

ULTRASOUND

An ultrasound is a way to see inside your body without having surgery.

Your doctor may suggest an ultrasound if she suspects a problem such as a cyst, a fluid-filled lump, on your ovary. She may also suggest it to see if you have fibroids or scar tissue inside your uterus.

A healthcare worker puts some jelly on your lower belly. Then she holds an instrument against your skin and moves it around. Sound waves travel through your skin to show a picture of your inside organs. You can see a picture of your uterus, ovaries, and tubes on a TV screen.



From: OBSTETRICS ILLUSTRATED

You will be asked to drink a lot of fluid before having an ultrasound. The ultrasound picture is clearer if you have a full bladder. You may be a little uncomfortable because of your full bladder. There is no other pain or discomfort from an ultrasound.

Are there any risks to an ultrasound?

An ultrasound is safer than surgery or x-rays.

Some people are concerned that having a lot of ultrasounds may cause damage to your eggs or to your fetus if you are pregnant. Ultrasound has not been used for long enough to know whether this is true or not.

LAPAROSCOPY

A laparoscopy is usually the last test in a woman's infertility work-up. Sometimes it is done earlier, if a doctor suspects a problem which a laparoscopy could show.

When will a doctor suggest a laparoscopy?

A doctor will do a laparoscopy for the following reasons:

- If your hysterosalpingogram shows you have blocked tubes.
- If you have symptoms of endometriosis. Endometriosis is explained on page 91.
- If your medical history shows a problem which may show up during a laparoscopy, such as scar tissue from past infections around your ovaries and tubes.

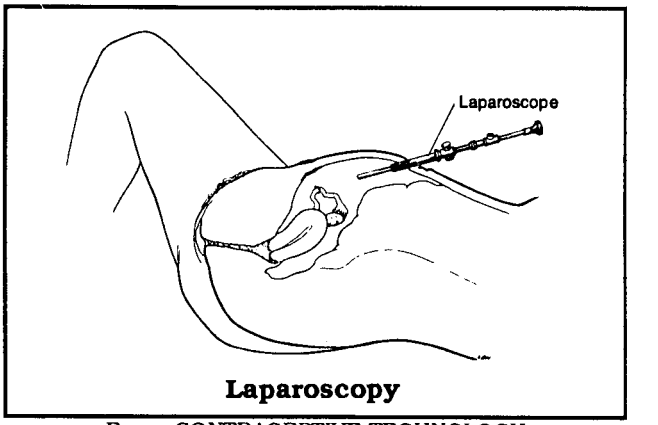
A laparoscopy is surgery. If you don't have any of these problems, don't have this test until you've had all the simpler, non-surgical tests for infertility. If you have gone through all of the basic tests and your doctor hasn't found a problem, she may suggest you have a laparoscopy. Some doctors won't suggest this unless you have been trying to get pregnant for three years. They want to avoid surgery if possible. They know that some people simply take longer to conceive.

How is a laparoscopy done?

A laparoscopy is surgery. It is usually done under general anaesthetic, which puts you to sleep. It can also be done under local anaesthetic. If you have a local anaesthetic, the doctor gives you a shot close to where she will cut. This stops you from feeling pain from the cut. You are still awake.

The doctor makes a small cut close to your belly button. She puts the laparoscope through this cut. The laparoscope is a thin metal tool that's like a telescope. She makes another cut near the top of your pubic hair and puts a probe through this cut. Some doctors have equipment which lets them put both the laparoscope and the probe through the same cut.

She then pumps carbon dioxide gas into your belly so she can see your organs clearly. She can see inside your belly by looking through the laparoscope.



Laparoscopy

From: CONTRACEPTIVE TECHNOLOGY

Doctors can also do treatments during laparoscopy. If you're having laparoscopy as a test, make sure to talk to your doctor about whether or not you want her to treat any problems she may find.

Laparoscopy is usually done as day surgery. You should not have to stay in the hospital overnight. You will probably want to take it easy for a few days afterwards. Some women can go back to their normal activities right away. Other women feel more affected by the surgery.

Are there any risks to a laparoscopy?

There is a small risk of infection from any surgery, including a laparoscopy. If you have general anaesthetic during a laparoscopy, you have a small risk of serious health problems from the anaesthetic. See page 201. A local anaesthetic is safer, but most doctors prefer to use a general anaesthetic for a laparoscopy.

You will feel some pain in your shoulder after the operation. This is from the carbon dioxide gas which was used during the laparoscopy.

Are there any other tests that can show the same thing?

A hysterosalpingogram (page 59) or an ultrasound (page 61) can show some of the same things a laparoscopy shows. A laparoscopy can tell a doctor more, because she can look at your organs.

HYSTEROSCOPY

A hysteroscopy is not part of the standard infertility work-up for most women. If a doctor thinks you may have a problem inside your uterus, she may suggest you have a hysteroscopy.

A hysteroscopy is a way for the doctor to look at the inside of your uterus. You will have either a local or general anaesthetic. The doctor puts a speculum into your vagina to hold it open so she can see your cervix. Then she stretches your cervix open a little so she can fit the hysteroscope through it. The hysteroscope is a thin metal tool. She can look through the hysteroscope and see the inside of your uterus.

Hysteroscopy is day surgery. You don't need to stay in the hospital overnight.

Are there any risks to a hysteroscopy?

As with any surgery which involves opening up the cervix, there is a risk of infection in your uterus and tubes. This rarely happens.

How accurate is this test?

A hysteroscopy lets a doctor see inside your uterus. If you have scar tissue, fibroids or other problems, she can see them. A hysteroscopy is hard to do. If the doctor bumps the lining of your uterus with the hysteroscope, it will cause bleeding. This bleeding will make it impossible for her to see anything.

Can another test show the same thing?

Some problems on the inside of your uterus will show up with an ultrasound. Most doctors don't suggest a hysteroscopy until after they have already done an ultrasound. A hysteroscopy is more accurate, but it involves surgery.

TESTS FOR IMMUNE PROBLEMS IN WOMEN OR MEN

Both men and women can make antibodies to sperm. Antibodies are part of a person's immune system. They destroy germs and protect you from infections. If either you or your partner or donor makes antibodies to sperm, you may not be able to get pregnant.

These are the tests for antibodies to sperm:

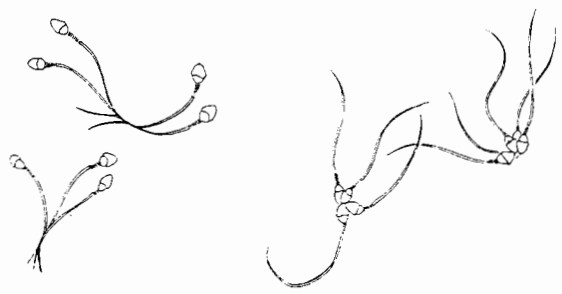
Blood tests: Both women and men can have blood tests to see if their bodies are making antibodies to sperm. These are the blood tests you can have:

- **Agglutination test:** For this test, some of your blood is mixed with semen before looking at it under the microscope. If the sperm clump together, it is a sign that you have sperm antibodies in your blood.
- **Immunobead binding test:** This blood test uses antibodies from rabbits to test for your antibodies to sperm. It is a newer test, and is supposed to be more accurate than the agglutination test.

Mucus or semen tests: The doctor can mix the woman's cervical mucus with semen and look at it under the microscope. The man's semen can be checked under the microscope. The sperm will clump together or shake if there are antibodies.

Sperm—mucus cross test: For this test, some of a man's sperm are put into bovine (cow) cervical mucus. If they swim normally in the cow mucus, some of the sperm are also put into a sample of the woman's mucus. The doctor looks at the sperm under the microscope. If they clump together in her mucus, she must have antibodies against the sperm.

Clumped Sperm



From: CONQUERING INFERTILITY

AFTER THE WORK-UP

If your infertility work-up was successful, your doctor will have found a problem or problems causing your infertility. She will now talk to you about treatment for those problems. You may want to turn to the section of this book describing the problems and how they can be treated. You will find the main conditions causing infertility listed in the chapters on women's infertility, starting on page 67, and men's infertility, starting on page 109.

UNEXPLAINED INFERTILITY

Some people go through an infertility work-up with many detailed tests and never find out what is wrong. This happens to about one in 10 infertile couples. Doctors will say that you have "unexplained" or "normal" infertility.

It can be very discouraging to hear that your doctor hasn't found an answer. Remember, unexplained infertility doesn't mean there is no reason for it. It means that doctors haven't been able to find a reason. This may be because medical science isn't advanced enough yet to find out what is wrong.

From: ISIS, December, 1982

Doctors also often feel discouraged when they can't find an answer. Sometimes doctors will suggest a treatment "just in case it helps". Studies of couples with unexplained infertility have shown that this doesn't help. You are just as likely to conceive with no treatment. This means that the treatment is useless. After all, the doctor has no idea what she is treating.

Most infertility treatments risk your health in some way. If there is no reason to believe a treatment will work, it is better not to have it.

Your chances of getting pregnant on your own are good. Three out of four couples with unexplained infertility are able to conceive within two years with no treatment.

WOMEN'S INFERTILITY

From: SAN FRANCISCO BAY AREA WOMEN'S YELLOW PAGES, 1981-2

This chapter is about the conditions which cause infertility in women. The most common reason women are infertile is because of blocked or damaged fallopian tubes. Many women also have hormone problems or a condition called endometriosis. Cervical mucus problems, problems with your uterus, and repeated miscarriage are less common causes of infertility.

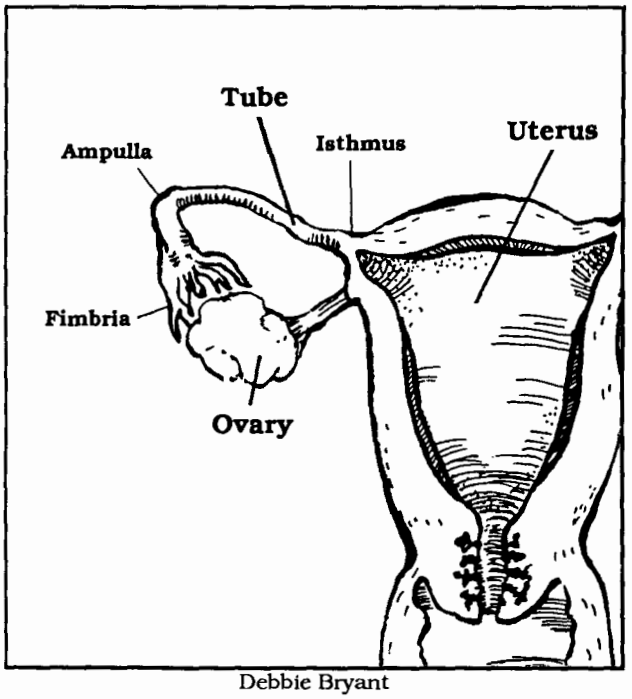
If you know why you are infertile, you may want to read just the section on that condition. If you don't know why you are infertile, you may want to find out what types of problems can cause infertility. You may want to read the whole chapter and the chapter on men's infertility.

DAMAGED FALLOPIAN TUBES

This is the most common cause of infertility in women. Three out of every 10 infertile women have a problem with blocked or damaged fallopian tubes.

Your fallopian tubes have these parts:

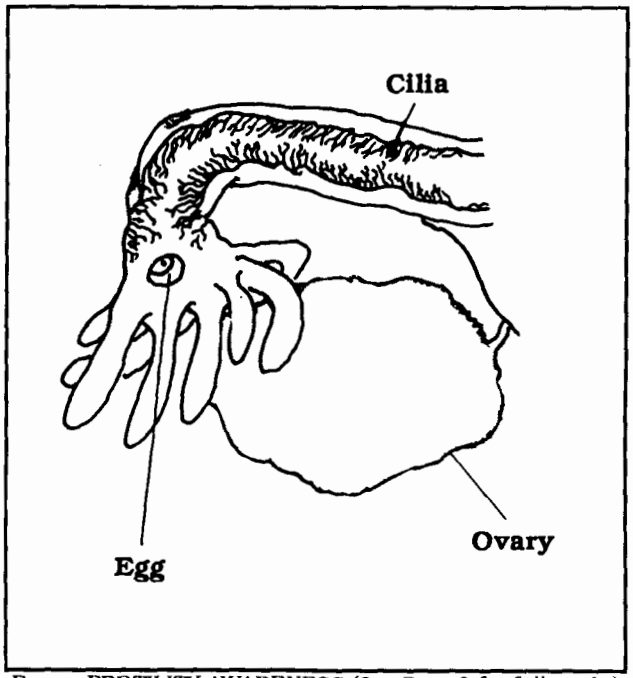
- **the fimbria**: the finger-like ends of the tube
- **the ampulla**: the wide end of the tube closest to your ovary
- **the isthmus**: the narrow end of the tube closest to your uterus



Debbie Bryant

If your tubes are damaged, your doctor may use these names to explain where the problem is. Damage to the ampulla or the fimbria is harder to fix with surgery than damage to the isthmus.

Your fallopian tubes are a passageway for the egg and sperm to travel through. They also make a fluid which the egg and sperm float in when they are in the tube. This fluid helps to keep the egg and sperm alive. Your tubes are also lined with cells with thin hair-like parts called **cilia.** The cilia move in waves which help to push the egg down the tube.



From: FERTILITY AWARENESS (See Page 2 for full credit)

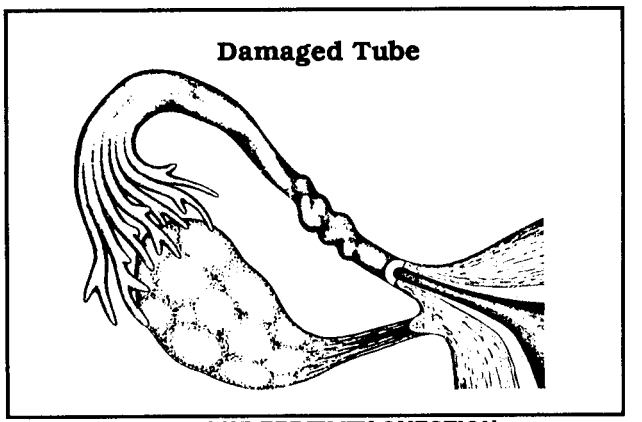
What causes damaged fallopian tubes?

PID: The most common reason for blocked or damaged fallopian tubes is having had an infection in your tubes. The name for an infection in your tubes is PID, or pelvic inflammatory disease.

About a quarter of the women who get PID end up with damaged tubes. This can happen to anybody but it is most likely if you weren't treated with antibiotics right away.

After an infection is cured, you may have these problems:

- scars inside your tubes which block the inside passage
- scars on the outside which may keep your tube from being able to move
- damage to the cells lining the inside passage of your tube



From: THE FERTILITY QUESTION

PID is caused by germs that are passed during sex, such as Chlamydia, Gonorrhea, or Mycoplasmas. It is also caused by using an IUD for birth control. Occasionally, women get PID after childbirth or a miscarriage. PID can also be caused by surgery which opens up your cervix, such as a D&C, abortion, endometrial biopsy, hysterosalpingogram or hysteroscopy.

The signs of PID can be strong or mild. Some women have very mild PID and never know it until they find out their tubes are damaged.

For more information on PID and how to prevent it, see page 198.

Surgery or appendicitis: You can also get an infection and scars which damage your tubes from any surgery inside your abdomen (lower belly). If your appendix bursts, you may get an infection and scars around your tubes.

Tuberculosis (TB): Tuberculosis can infect your tubes. It is rare for a woman in North America to get tuberculosis in her fallopian tubes. In some other parts of the world, especially poorer countries, it is common.

DES: If your mother took the drug DES while she was pregnant with you, your fallopian tubes may not work well. They may be an unusual shape. Most DES daughters don't have this problem, but some do. There is more information on DES on page 104.

Tubal ligation: A tubal ligation is an operation which stops a woman from being able to get pregnant again. Your tubes are cut, burned, or blocked. Some women change their minds after a tubal ligation. You may be able to have surgery to join your tubes again. This depends on how your tubal ligation was done and how badly your tubes are damaged. If you have surgery to rejoin your tubes, you will have to pay for it yourself.

How can I know if my tubes are blocked?

Two infertility tests can show if you have damaged tubes:

- a hysterosalpingogram, described on page 59
- a laparoscopy, described on page 62

What is the treatment for blocked or damaged tubes?

The only way to "fix" damaged tubes is by having surgery. Your doctor will know from your laparoscopy whether surgery may help. Sometimes, surgery won't help because a woman's tubes are so badly damaged. She will also be able to tell you what your chances are for successful surgery. Your chances for success will be different depending on what kind of surgery you need.

The surgery to repair damaged tubes is very delicate and precise. It should be done by a skilled specialist. It is microsurgery, which means surgery done while looking through a microscope. The surgeon uses tiny instruments. She can sew the tube together with thread that is much thinner than a hair.

She will probably cut or burn the damaged area. She will cut away scars. She may cut away a damaged part of your tube and then sew your tube back together. She may use lasers during your surgery. Lasers are very strong beams of light. Sometimes doctors use lasers to cut or burn away scar tissue. The surgeon can make a very fine cut with a laser. Not all hospitals have the equipment to do laser surgery on a woman's tubes.

Ask your doctor to explain what she will do during your surgery. If it isn't clear, ask her to draw a picture.

Microsurgery takes a long time because it is so precise. It usually takes three to four hours of surgery to repair damaged tubes. You will have a general anaesthetic. You won't be awake during the operation.

You will probably stay in the hospital about five days for tubal surgery.

What are the chances of getting pregnant after tubal surgery?

If 100 women have tubal surgery, between 10 and 50 will be able to get pregnant. This depends on how badly their tubes are damaged and where the damage is. You will have to discuss your own situation with your doctor.

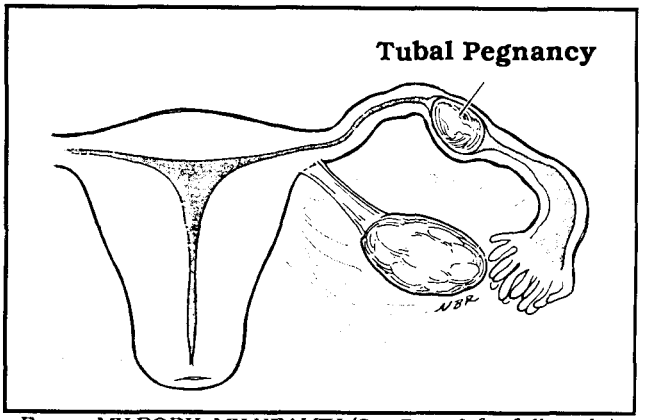
If your first surgery didn't help, your doctor may suggest you have surgery again. After having surgery twice on their tubes, between five and 25 women out of 100 are able to get pregnant. Your chances for pregnancy are even lower if you have surgery a third or a fourth time. It probably isn't worth having surgery more than twice.

These are chances for pregnancy. Generally, about two thirds of the women who get pregnant have a baby. The figures for pregnancy include women who have miscarriages or stillbirths.

Are there any risks from tubal surgery?

There are some risks anytime you have surgery. You can get an infection from the surgery. You also may get side effects from having general anaesthetic. See page 201 for side effects and risks of general anaesthetic.

If you become pregnant after having had tubal surgery, you may have a tubal pregnancy. In a tubal pregnancy, the embryo implants in your tube instead of in your uterus. You are five to 10 times as likely to have a tubal pregnancy as someone who didn't have tubal surgery.



From: MY BODY, MY HEALTH (See Page 2 for full credit)

These are the signs of a tubal pregnancy:

- cramping or sharp pains, which may be on one side
- spotting or bleeding
- dizziness or fainting

If you have any of these signs, go to a doctor or clinic right away. **A tubal pregnancy is a life-threatening emergency.**

What if surgery doesn't help or isn't possible?

Your doctor may suggest a new treatment called in vitro fertilization, or IVF. IVF is a way of bypassing your tubes. It is a very new treatment which is still being developed. It is very expensive and is not covered by medical insurance. For more information on IVF, see pages 145. About one in 10 women who have IVF end up with a baby.

HORMONE PROBLEMS

Hormone problems are a common reason women have trouble getting pregnant. Two or three out of every 10 women with fertility problems have a hormone problem.

The most common type of hormone problem is not ovulating. Then there is no egg to meet with your partner or donor's sperm. If you have a milder hormone problem, you may ovulate but still not be able to get pregnant.

It may help to reread the information about hormones and your menstrual cycle before you read about hormone problems. See page 32.

How can you tell whether or not you have a hormone problem?

You most likely have a hormone problem if you don't have periods, or if your periods are very irregular. Most women with regular periods don't have hormone problems, but some do.

If you don't have periods, you aren't ovulating. You can be tested to find out why you aren't having periods. See pages 56 to 58.

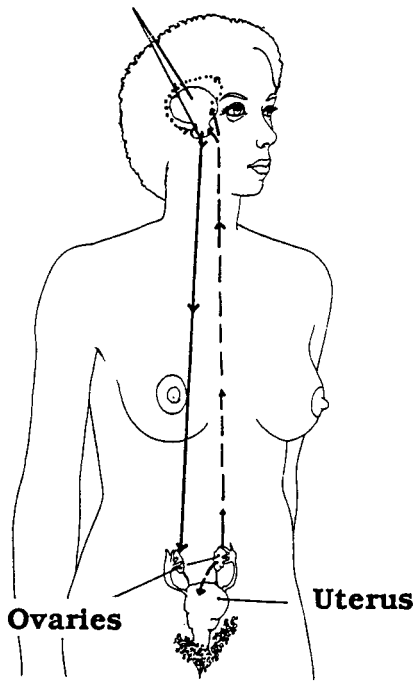
If your periods are not regular, you may not be ovulating, or you may ovulate rarely. It is harder to time when to try to get pregnant if you only ovulate once every three or four months. It will also take longer to get pregnant. Basal body temperature and mucus charting can help you to know when you are fertile. They are described on pages 49 to 54.

If your periods are regular, you are more likely to be ovulating. It is still worth checking to be sure, because you can have regular periods and not ovulate.

Some women are able to ovulate, but still can't get pregnant because of a hormone problem called a "luteal phase defect". Luteal phase defect means a problem with the second half of your menstrual cycle, the time between when you ovulate and when you have your next period. It is called the luteal phase of your cycle. Your periods may or may not be regular if you have a luteal phase defect.

What causes hormone problems?

Your menstrual cycle is controlled by a complicated system of hormones. It is controlled both by hormones from your brain and from your ovaries. These hormones affect each other. If one thing goes wrong, your whole system can go out of balance.



Menstrual cycle Affected by Brain and Ovaries

From: FERTILITY AWARENESS (See Page 2 for full credit)

Many things can affect this balance of hormones. Here are some of the possible reasons for hormone problems:

Alcohol and street drugs: Heavy drinking and narcotics like heroin and methadone can affect your hormones and stop you from ovulating. Alcohol and drugs are also harmful to your fetus if you do get pregnant. To find out how to get help to stop drinking or using drugs, talk to Alcoholics or Narcotics Anonymous, a drug and alcohol counsellor, social worker, or community health worker.

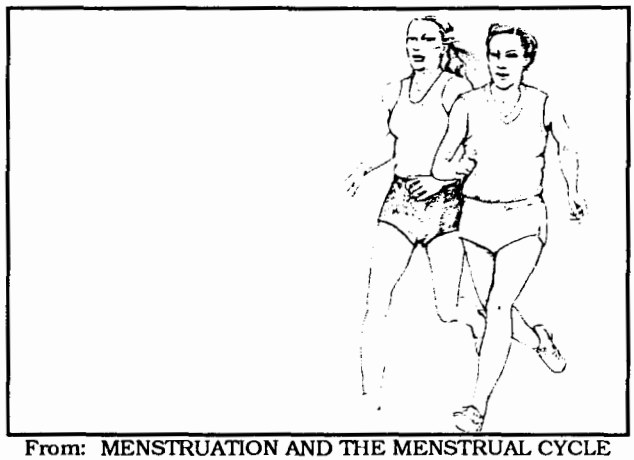
Medicines: Many medicines can affect your menstrual cycle. Talk to your doctor and pharmacist about any medicines you are taking. Some medicines keep affecting your hormones for a while after you stop taking them. Examples of these are Provera, Danazol, anti-depressants, and Valium.

Coming off the birth control pill: It often takes a while for your hormones to balance themselves after taking the pill. It may take three to 12 months for your menstrual cycle to go back to normal. You may have periods, but not ovulate. Your periods may be irregular. About five out of every 100 women coming off the pill find that it takes more than a year to get their periods back. You may simply need to wait longer before getting pregnant.

Too little body fat: If you are very thin, you may not ovulate or have periods.

Poor nutrition: If you are not eating a balanced diet with enough protein, starches, fats, vitamins and minerals, your hormones may be out of balance. See page 188 for more information on how to eat well.

Losing too much weight: If you lose weight suddenly, you may stop ovulating. This could happen from a crash diet or being very sick.



From: MENSTRUATION AND THE MENSTRUAL CYCLE

Heavy exercise: Women who exercise heavily, like athletes and dancers, sometimes have hormone problems. Normal amounts of exercise are good for your balance of hormones.

Too much body fat: Fat cells make estrogen. If you have much more body fat than most women, you may have extra estrogen in your blood. This may keep you from ovulating or having periods. If most women of your height weigh around 150 pounds, you would have to weigh at least 250 pounds to have this problem. Even then, it only happens to about one out of 10 women.

Emotional stress: Stress can affect your hormones. This is because the part of your brain which controls your menstrual cycle also controls your emotions. Often, women find that they miss a period or two when they feel very tense, anxious, frustrated or overwhelmed. If you are under very strong stress or stress that goes on and on, you may stop ovulating.

Poisons and x-rays: If you work with strong chemicals or x-rays, your menstrual cycle and fertility may be affected. You can also be affected by poisons in and around your home. Both women and men are affected by many of the same poisons. See page 122 for more information on exposure to poisons and x-rays.

Disease: Many diseases can upset your balance of hormones. Some of these are diabetes, tuberculosis, liver and kidney disease. Your liver and kidneys clean wastes from your blood. If they are not working well, your menstrual hormones may be affected. "Old" hormones may stay in your blood instead of being cleared out. This can affect your whole balance of hormones.

A thyroid problem: You have a thyroid problem if your thyroid gland is putting out too little or too much thyroid hormone. A thyroid problem can throw your menstrual hormones out of balance. This can stop you from getting pregnant until you get treatment for your thyroid problem.

Adrenal disease: You may not ovulate if your body is making too much of a type of hormones called adrenal androgens. This may be caused by stress or by one of a few rare conditions. The names for these conditions are "Cushing's syndrome", or, if you are born with the problem, "Congenital adrenal hyperplasia". Polycystic ovarian disease also causes your body to make a lot of androgens. It is described on page 76.

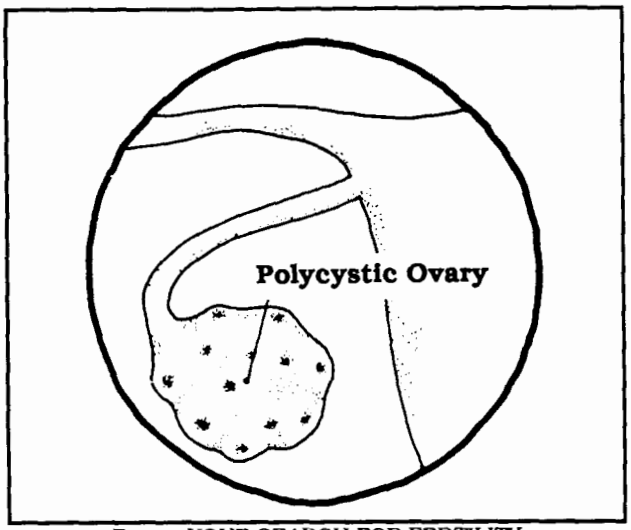
Premature ovarian failure: Premature ovarian failure means that your ovaries stop making hormones before you would normally reach menopause. This happens rarely. It can happen if you've had high doses of x-rays to your ovaries, if you've been exposed to very strong chemicals, or if you have taken strong medicines for cancer. Your doctor can take blood tests to see if this has happened. She should take more than one blood test to be sure. Premature ovarian failure can't be treated.

Having too much prolactin: Prolactin is a hormone which tells your breasts to make milk when you have a baby. You have some prolactin in your blood all the time. You may not have periods part or all of the time you are nursing because you have a lot of prolactin in your blood. Some women still have too much prolactin to be able to get pregnant after they are no longer nursing. There are many other reasons you may have too much prolactin in your blood:

- stress
- exercising very heavily
- after taking the birth control pill, tranquilizers, anti-depressants, high blood pressure drugs or narcotics
- thyroid or kidney problems
- a tumor, a non-cancerous growth, in your pituitary gland (a gland in your brain that puts out hormones affecting your menstrual cycle)

You can have a blood test to find out if you have too much prolactin.

Polycystic ovarian disease: Polycystic ovarian disease is a condition which stops you from ovulating. Each month, one of your egg ripens, but it is not able to leave your ovary. The trapped egg becomes a hard round lump on the surface of your ovary. It is called a cyst. After many months your ovary will be much larger than normal, and will be covered with cysts. Another name for polycystic ovarian disease is Stein-Leventhal Syndrome.



From: YOUR SEARCH FOR FERTILITY

No one knows why some women have polycystic ovarian disease. It isn't easy to tell if you have it. Not all women have the same symptoms.

Many women with polycystic ovaries don't have periods. If you do have periods, they are probably very irregular. You may have extra body fat and extra hair on your face and body. You may get this condition when you first start having periods, or you may get it later.

A doctor may suggest these tests if she thinks you have polycystic ovaries:

- blood tests for hormones, described on page 58
- an ultrasound, described on page 61
- a laparoscopy, described on page 62

Luteal phase defect: In a normal menstrual cycle, women have about two weeks between when they ovulate and the first day of their next period. If you have between 11 and 16 days between the day you ovulate and the first day of your next period, you probably have a normal "luteal phase". If this time is shorter than 11 days, you may have a luteal phase defect. A luteal phase defect sometimes also happens with a normal length luteal phase.

A luteal phase defect is a sign that your ovaries aren't making enough of the hormone progesterone. Progesterone helps the lining of your uterus grow thick and rich so the embryo can live in it. If you have a luteal phase defect, the embryo can't implant into your uterus and grow there.

Some women with luteal phase defects are able to get pregnant but then have a miscarriage. If you have had three or more miscarriages, your doctor will check to see if you have a luteal phase defect.

These are some reasons you may have a luteal phase defect:

- stress

  being too thin

- heavy exercise (women athletes)

  coming off the birth control pill

  taking some medicines

- too much prolactin
- a thyroid problem
- endometriosis

  right after breastfeeding, childbirth, abortion, or miscarriage

- treatment for infertility with Clomiphene
- if you are under 18 or over 35

There is only one test which can tell you for sure if you have this hormone problem. It is an endometrial biopsy, which is described on page 54.

What can you do if you have a hormone problem?

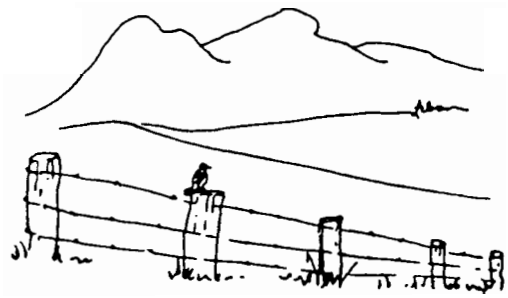
You may be able to make some changes yourself which will help. You can try to lessen stress, gain or lose weight, or stop using drugs and alcohol. Many of these changes are hard to make. You may need help and support from a community health worker, family and friends.

Try to eat well, get plenty of rest and do a moderate amount of exercise. See the chapter on being healthy, on page 187.

Try waiting and seeing what happens if you have a hormone problem after having a baby, miscarriage, or abortion, after taking the birth control pill or another medicine, or after heavy use of alcohol or street drugs. You may start to ovulate on your own if you just give yourself another two to three months. Any changes you can make to be healthier during this time will probably help.

You may want to talk to a naturopath or a nutritionist about what might help. If you are Native, you could talk to an elder about traditional treatments for fertility problems.

It may take three to six months to see a change if you are using a natural treatment.



From: Smithers Human Rights Society

Natural remedies for specific hormone problems:

The foods that are high in vitamins and minerals are listed on page 191.

Just coming off the birth control pill: The pill affects how your body uses some vitamins. Taking extra folic acid and other B vitamins, vitamin E and vitamin C may help you to start ovulating. You can either take a multi-vitamin pill each day which has all of these vitamins in it, or take extra vitamins along with a multi-vitamin pill.

Too much prolactin: If your hormone problem is caused by too much prolactin, vitamin B6 may help you. You need to take a multi-vitamin pill and a B Complex vitamin at the same time for vitamin B6 to work well.

Start with 50 mg of B6 each day. Slowly take more each day until you are taking 250 mg each day. It's important not to take too much Vitamin B6. If you feel sick or dizzy, this is a sign that you are taking too much. Cut down the amount you are taking right away.

Taking this much B6 for six months has helped some women. You may want to have a test for prolactin after three months of B6. If your prolactin is lower, you could start to try to get pregnant again.

It's important not to take high doses of vitamins when you're pregnant as they may be harmful to your fetus. During the months you are trying to get pregnant, only take vitamin B6 for the first two weeks of your menstrual cycle. That way, you won't be taking high doses of B6 when you are first pregnant. You may want to continue with the multi-vitamin and the B complex pill all month.

Luteal phase defect or not ovulating: Some herbal teas can help balance your hormones. Both red raspberry tea and "Vitex agnus castus", or the chaste tree, are teas to balance women's hormones. Some naturopaths suggest drinking red raspberry tea for the first two weeks of your menstrual cycle and then "Vitex agnus castus" for the next two weeks. Don't drink more than three cups a day. You may find these teas at a health food store or a store which supplies herbs.

Another suggestion for balancing your hormones is to take evening primrose oil, flaxseed oil or blackcurrant oil. These oils provide some of the building blocks your body needs to make hormones. You can get them at a drugstore or health food store. Evening primrose oil is more expensive than the other two oils. Take the amounts of evening primrose oil or blackcurrant oil suggested on the bottle or two tablespoons of flaxseed oil each day.

Some naturopaths suggest taking herbs with a form of estrogen in them for two weeks and then herbs with progesterone in them for two weeks to help balance your hormones. They are called phytoestrogens and phytoprogesterones. It's best to see a naturopath if you want to try these treatments. A similar treatment is to take a supplement made from the adrenal glands or the ovaries of cows. These treatments help you to have the building blocks to make your own hormones.

What are the medical treatments for hormones problems?

Your doctor will probably suggest a manufactured or a natural hormone as treatment. The treatments are different depending on what your problem is.

Source Unknown

Look at natural ways to balance your hormones before trying a hormonal drug. These are strong drugs. They can cause annoying and in some cases dangerous side effects. They may also affect your health later on. Some may affect the health of your baby or cause you to have twins, triplets, or more.

Some of these hormones are used in pregnancy or are still in your body in early pregnancy. We are very worried about hormones being used during pregnancy because of DES. This was a hormone, an artificial estrogen, which was used in pregnancy. It caused problems in the children of women given this hormone in pregnancy. These problems did not show up until the children reached their teens or twenties. DES mainly causes pregnancy and fertility problems. It also causes a rare type of cancer of the vagina. Luckily, very few women whose mothers took DES get cancer because of it.

Doctors usually suggest taking hormones for no more than three to six months. If you are not pregnant within six months, the drug is very unlikely to help you become pregnant. It can be tempting to take hormones for longer when you want to get pregnant, but it probably won't help you. It's an unnecessary risk.

Many women are given these drugs when they don't have a hormone problem. Doctors suggest them "in case they will help". This is not helpful. These are strong drugs. They affect your body in many ways. If you ovulate and don't have hormone problems, these drugs can't help you. They may make you less likely to get pregnant by causing health problems.

Drug treatments for hormone problems

You will find information on the following drugs in this section:

These are the treatments your doctor may suggest for each hormone problem:

Luteal phase defect:

- For a mild problem, progesterone
- For a stronger problem, clomiphene (Clomid or Serophene)
- HCG. This treatment is rarely suggested.

Too much prolactin:

- bromocriptine

Not ovulating:

- If your body is making estrogen, clomiphene (Clomid or Serophene)
- If you don't have enough estrogen or if clomiphene has not worked, HMG (Pergonal) or GnRH

Polycystic ovarian disease:

- clomiphene (Clomid) or HMG (Pergonal)
- urofollitropin (Metrodin)

Progesterone

This is the most common treatment for luteal phase deficiency. Doctors give you this drug because your body is not making enough progesterone. You take the progesterone during the last two weeks of your menstrual cycle, after you have ovulated.

cycle, after you have ovulated. If you become pregnant, your doctor will suggest you take the progesterone for about 12 weeks.

You will be taking a hormone while you are pregnant. You will probably be given natural progesterone suppositories to put in your vagina.

Can progesterone harm your fetus?

Some hormones can harm a developing baby. Doctors know that artificial progesterone may harm your fetus. They will give you natural progesterone instead. They are guessing that natural progesterone is safer because it has not been proven to be harmful. They don't know for sure that is safe.

In the U.S., women who are given natural progesterone have to sign a form saying that they know that it might harm their baby. Doctors don't have to warn women in Canada.

What are the side effects of progesterone?

Women may get one or more of these side effects: vaginal dryness or itching, less interest in sex, heavy periods, spotting between periods, hot flashes, yeast infections, depression, migraines, high blood pressure, blood clots, or jaundice (yellow skin).

The long term health effects aren't known.

Source Unknown

How well does it work?

Progesterone hasn't been studied very well to know for sure whether it is helpful for a luteal phase problem. One study showed that it was more likely to help women with a mild problem. Their endometrial biopsies showed that the lining of their uterus was between three and five days out of phase. A biopsy less than three days out of phase means you have such a mild problem that you don't need treatment. Clomiphene (Clomid) worked better for women with biopsies more than five days out of phase.

If you take progesterone, your doctor should do an endometrial biopsy during your treatment. This test will show whether the progesterone is helping the lining of your uterus to grow. If it isn't, stop taking the progesterone.

Who should not take progesterone?

Don't take this drug if you have had blood clots, a stroke, a brain hemorrhage, liver disease, or cancer in your reproductive organs.

Bromocriptine (Parlodel)

Your doctor will suggest bromocriptine if you have too much prolactin in your blood. The bromocriptine will cause you to have less prolactin. You are likely to start ovulating and have regular periods within about six weeks. You will have less prolactin as long as you are taking the bromocriptine.

You will probably start by taking a small amount of bromocriptine and gradually taking more each day. Eventually, you will take a 2.5 mg tablet two or three times a day.

How well does bromocriptine work?

Six to eight women out of 10 get pregnant while they are taking bromocriptine. It is only helpful for women with high prolactin. Doctors have also tried bromocriptine for women with polycystic ovaries and have found that it is not helpful.

Can bromocriptine harm your fetus?

It's best to avoid taking bromocriptine during pregnancy. As soon as you know you are pregnant, stop taking the bromocriptine. Ask your doctor about getting an early pregnancy test each month. You can have a blood test for pregnancy about 10 days after you conceive. That way, you won't take bromocriptine for very long while you are pregnant.

Bromocriptine doesn't seem to be harmful if you stop taking it as soon as you know you are pregnant.

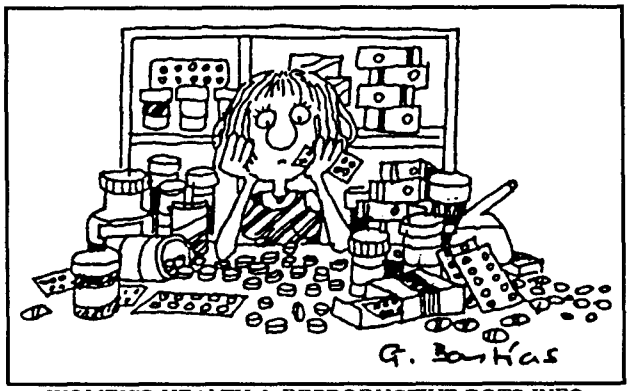
Some doctors suggest taking bromocriptine only during the first two weeks of each month. That way, you take it until you ovulate, but not afterwards. You won't take it during the first few weeks of pregnancy.

What are the side effects of bromocriptine?

You may feel sick to your stomach, have a stuffy nose, feel dizzy, have low blood pressure or get headaches. These side effects are usually strongest when you first start taking bromocriptine.

Who should not take bromocriptine?

Don't take this drug if you have serious heart disease or if you react to other drugs made from ergot, a plant extract. Bromocriptine is made from ergot. Ask your doctor if you aren't sure.



WOMEN'S HEALTH & REPRODUCTIVE RGTS INFO CENTRE, JUNE, 1988

Clomiphene (Clomid or Serophene)

There are two main reasons your doctor may suggest clomiphene. One is if you have a luteal phase defect. The other is if you are not ovulating, but your body is making the hormone estrogen.

Many women with problems getting pregnant are given clomiphene. Often, doctors suggest it "just in case it will help". If you are ovulating, or if your doctor can't find a problem, clomiphene won't help you. Clomiphene is a strong drug. Many doctors and women's health groups worry that clomiphene is given too often.

Only take clomiphene if you know your doctor has checked these things:

- That your partner's sperm count is normal.
- Both that you are not ovulating and that your body is making estrogen.
- If you're taking it for a luteal phase defect, that your endometrial biopsy shows that the lining of your uterus is at least five days out of phase. Clomiphene doesn't help a milder problem.

You will need to take your basal body temperature while you are taking clomiphene. This is described on page 49.

Taking clomiphene to ovulate:

If you are taking clomiphene to ovulate, Your doctor will start you on 50 mg. of clomiphene a day. You start taking clomiphene five days after your period starts and take it for five days.

If you don't ovulate, she will give you a higher dose the next month. If you still don't ovulate, she will give you an even higher dose. The highest dose doctors give is 250 mg. a day. If this doesn't work, she will also give you a shot of the hormone HCG on day 16 of your cycle.

Once you are ovulating on clomiphene, don't take it for more than six months. You are unlikely to get pregnant while taking clomiphene if you haven't gotten pregnant within six months.

Taking clomiphene for a luteal phase defect:

If you are taking clomiphene for a luteal phase defect, you will probably be given 50 mg. of clomiphene a day for five days. Your doctor should do an endometrial biopsy to see whether the clomiphene is helping. If it isn't helping, stop taking it.

Usually, women are given clomiphene for luteal phase defect only for three months. It if hasn't worked within that time, it isn't likely to work.

How well does clomiphene work?

Three to four women out of 10 get pregnant if they're taking clomiphene for a problem with ovulation. There isn't good information on how likely you are to get pregnant if you take clomiphene for luteal phase defect.

You are much more likely to ovulate while taking clomiphene than to get pregnant. This is because clomiphene may also affect your fertility in a negative way.

Many women are able to ovulate, but still don't have a fertile menstrual cycle. One third to one half of the women who take clomiphene develop a luteal phase defect. It is odd that clomiphene can cause a problem it is sometimes used to treat! Clomiphene also makes many women have poor cervical mucus. They are able to ovulate, but the sperm can't get to their egg because of their mucus.

Doctors sometimes give clomiphene with progesterone for women who develop a luteal phase problem while they're taking clomiphene. They sometimes give clomiphene with estrogen to women who develop a mucus problem. Neither of these combined treatments have been proven to work.

Can clomiphene harm your fetus?

You have a higher chance of having twins while taking clomiphene. Seven out of 100 women who get pregnant while taking clomiphene have twins. About one out of 100 women have triplets or more. This is riskier for the babies because they won't be as big. It will be harder for them to survive.

You don't take clomiphene while you are pregnant, but it takes a while for clomiphene to leave your body. You will have small amounts of clomiphene in your blood for up to six weeks after you have taken it. If you get pregnant while being treated with clomiphene, some of the drug will be in your body in the first few weeks you are pregnant.

Some animal studies of clomiphene show that it can affect a fetus in a way that's similar to how the drug DES affects a fetus. This is very worrisome. DES caused problems which didn't show up until the children of women given the drug became teenagers.

If you've taken a high dose of clomiphene, you will have much more clomiphene in your body when you are first pregnant. No one knows for sure if you will have enough for it to be harmful to your fetus. A high dose of clomiphene is 150 mg to 250 mg a day.

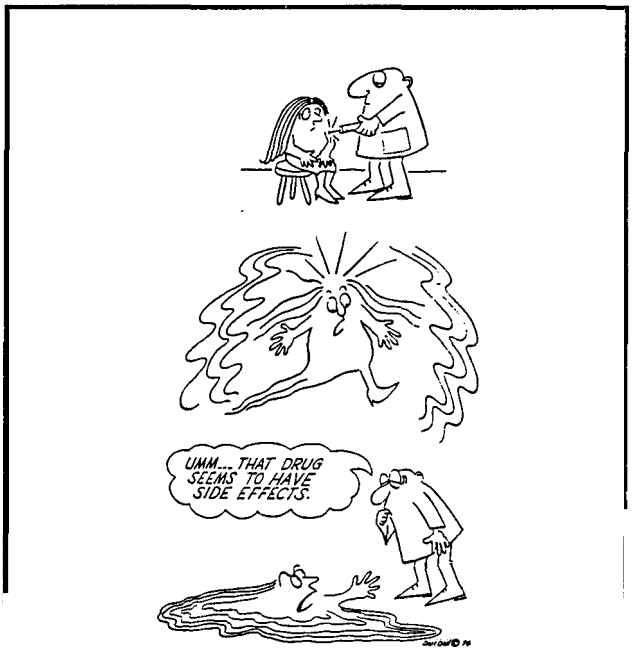
What are the side effects of clomiphene?

Most women have some side effects while taking clomiphene. These are the most common side effects women have:

- being sick to your stomach and vomiting
- trouble with your vision, blurriness
- headache
- trouble sleeping
- hot flashes
- pain or tenderness in your lower belly
- breast tenderness
- feeling more sensitive and moody
- cysts on your ovaries (fluid-filled lumps)

You will need to go to your doctor from time to time while you are taking clomiphene. She will do a bi-manual exam to feel your ovaries. She will make sure that your ovaries have not grown too big and that no cysts are starting to grow. If you are taking clomiphene for polycystic ovaries, she needs to watch you even more carefully to be sure your ovaries aren't getting too big.

No one knows whether clomiphene can also cause health problems later on.



Bülbül (See Page 2 for full credit)

Who should not take clomiphene?

It's important not to take clomiphene when you're pregnant. If your period is lighter than usual while you're taking clomiphene, have an early pregnancy test before taking any more.

You should not take clomiphene if you have one of these health concerns:

- fibroids
- an ovarian cyst or an enlarged ovary
- liver disease
- problems with vision
- depression
- blood clots in your legs
- unusual bleeding from your vagina
- thyroid, adrenal or pituitary glands problems
- your mother took the drug DES when she was pregnant with you

HMG (Pergonal)

HMG is made of hormones from women who are past menopause. It is made of two hormones. They are hormones which your brain puts out to tell your ovaries to ovulate. If you don't have periods and have very little estrogen and progesterone, your doctor may suggest you take HMG. HMG is also the next step doctors often suggest if clomiphene hasn't worked. Women with polycystic ovaries are sometimes given HMG. It is also used during in vitro fertilization, which is described on page 86.

You will have daily shots of HMG for nine to 12 days. These shots will get stronger each day, until your egg is larger and fully ripe. The doctor then gives you a shot of another hormone, HCG. This hormone makes you ovulate. There is more information on HCG on page 89.

How well does HMG work?

Between two and six out of every 10 women who take HMG get pregnant. Your chances of getting pregnant depend on what sort of a problem you have and if you have other fertility problems besides not ovulating.

Can HMG harm your fetus?

If you get pregnant after taking HMG you are more likely to have twins, triplets, or more. This is riskier for the babies because they won't be as big as a single baby. It will be harder for them to survive.

Two out of 10 women who take HMG end up with more than one baby. Most women have twins. One in 20 women end up with triplets or more. If your doctor uses ultrasound to watch your ovaries, you are less likely to have triplets or more. She will not give you the shot of HCG if too many eggs are ripening.

You are more likely to have a miscarriage after taking HMG than if you became pregnant without a fertility drug.

Terri Roberton

From: HEALTHSHARING, SUMMER, 1987

What are the side effects of HMG?

You need to be watched closely when you are taking HMG. Your doctor will take blood tests to check how much estrogen is in your blood. She will also probably use ultrasound to look at your ovaries each day when you are close to ovulating. See page 61 for a description of ultrasound. She is making sure that your ovaries aren't reacting too strongly to the HMG. If they do, she will stop giving it to you. If your ovaries have become too big, your lower belly may become swollen and you may suddenly gain weight. This problem can be dangerous. It is called "ovarian hyperstimulation". Some women end up in hospital because of it.

If you have polycystic ovaries, you need to be watched extra carefully to be sure you are not getting ovarian hyperstimulation when you take HMG.

These are the other possible side effects with HMG:

- fevers
- feeling extra sensitive
- pain and swelling in your lower belly
- blood clots

You will probably have a number of ultrasounds while you take HMG. Many people are concerned about the safety of getting a lot of ultrasounds. They worry that ultrasound could affect your developing eggs in a way that's not yet known. There is more information on ultrasound on page 61.

It is safer for you to take HMG with ultrasound than HMG without ultrasound. Ultrasound can tell you if HMG is affecting your ovaries too strongly.

When you are taking HMG, you need to go to the doctor's for a shot each day for nearly two weeks. You also need to have a lot of tests. This can be very stressful.

Who should not take HMG?

Don't take HMG if you could be pregnant or if you have any of these health concerns:

- a tumour (non-cancerous growth) in your pituitary gland
- cysts (fluid-filled lumps) in your ovaries
- problems with your thyroid or your adrenal glands
- unusual bleeding from your vagina

GnRH (Gonadotropin-Releasing Hormone)

GnRH is a natural hormone from the brain which helps to control your menstrual cycle. It is used for the same reasons as HMG, but is a different hormone. It can also be used instead of clomiphene, but it is much more expensive. It has less side effects than HMG or clomiphene.

Your body needs to have small amounts of GnRH all day long. You need to carry a small pump on you which gives you shots of GnRH every 90 minutes. The pump is three inches by four inches. It is attached to a plastic tube which goes to a needle in a vein in your arm. You need to have the pump with you all the time until you ovulate. If you carry it in your pocket and wear long sleeves, no one will see the pump.

After wearing the GnRH pump for about two weeks, you may be given a shot of the hormone HCG to make you ovulate. This isn't always needed. HCG is described on page 89.

How well does GnRH work?

This drug is fairly new, so it hasn't been studied very well. You are a little less likely to get pregnant than if you take HMG. Two to three out of every 10 women who use GnRH get pregnant.

Can GnRH harm your fetus?

You have about six times the chance of having twins or more with GnRH as a woman who has not taken fertility drugs. This is similar to the rate of twins or triplets with clomiphene.

What are the side effects of GnRH?

There are no known side effects to this hormone. You may have soreness and bruising from having a needle in your arm. The needle needs to be put in a different spot every three or four days.

You may find it annoying to always have the pump with you.

Who should not take GnRH?

So far, it seems that anyone can use this drug.

Urofollitropin (Metrodin)

The hormone in urofollitropin is one of the two hormones in HMG. The name of this hormone is FSH or "follicle stimulating hormone". Urofollitropin is being tested to see whether it is more helpful than HMG for women with polycystic ovarian disease.

Like HMG, urofollitropin is a drug you get in daily shots. You need to have blood tests or ultrasound to see when you are ready to ovulate. You then get a shot of the hormone HCG. HCG is described on page 89.

You are about as likely to have twins, triplets or more with urofollitropin as with HMG. The list of side effects for urofollitropin are the same as for HMG. Even more women seem to get ovarian hyperstimulation with urofollitropin than with HMG. This is a dangerous side effect. Women who should not take HMG also should not take urofollitropin. See the information on HMG on pages 86 to 88.

From: GRAPHIC SOURCE

HCG

HCG stands for "human chorionic gonadotropin". It is a hormone which an embryo makes after it implants into a woman's uterus. Pregnancy tests check your blood or urine for this hormone.

HCG can make you ovulate. You get a shot of HCG to make you ovulate when you take other hormones. HCG makes you ovulate about 36 hours after you have the shot.

When is HCG used?

Women who take HMG or urofollitropin to ovulate always also get a shot of HCG.

Women sometimes get HCG when along with GnRH or when they are given 250 mg. of clomiphene a day.

Most women who take clomiphene do not also need HCG. There is no proof that clomiphene works any better if you also have a shot of HCG. It is not helpful to have a shot of HCG if you are taking less than 250 mg. a day of clomiphene.

Occasionally, women with a luteal phase defect get a shot of HCG right after ovulation. There is no proof that this treatment is helpful. Doctors say that it is not as helpful as progesterone. Progesterone also often doesn't help.

What are the side effects of HCG?

Women usually get HCG with HMG. It is hard to separate the side effects of HCG from the side effects of HMG. If your ovaries are swelling because of the HMG, the shot of HCG will make them swell even more. This wouldn't have happened without the HMG. See page 87 for more information on "ovarian hyperstimulation". This is the most dangerous side effect you can get from HCG with HMG.

Men sometimes take HCG. They can get swollen breasts from it.

HCG can also make you feel irritated, restless, depressed, tired, or bloated. You may get headaches. You may also feel sore where you had the shot.

From: WOMEN'S GLOBAL NETWORK ON REPRODUCTIVE RIGHTS, 1987

ENDOMETRIOSIS

Endometriosis is a condition that can cause pain and other health problems as well as infertility. Endometriosis is a common cause of infertility. About a third of women with fertility problems have endometriosis.

A special kind of tissue lines the inside of your uterus. It is called the endometrium. During each menstrual cycle your endometrium becomes thicker. At the end of each cycle it breaks down and bleeds. This is your period. Hormones bring messages to the lining telling it when to build up and break down.

Usually this special tissue is only found inside a woman's uterus. If you have endometriosis, bits of the same tissue are found outside your uterus. They will probably be on your ovaries, tubes, uterus, bladder or intestine. The bits of tissue are called endometrial implants.

The endometrial implants act like the tissue inside your uterus. They are affected by the hormones in your blood. They build up and then bleed when you have your period. The blood has nowhere to go. It causes irritation inside your lower belly. You can get swelling, pain and scar tissue from the irritation.

Three to four out of 10 women who have endometriosis are infertile. Some women don't discover they have endometriosis until they go through tests for infertility. Other women know they have endometriosis before they try to get pregnant.

What causes endometriosis?

No one knows for sure why some women get endometriosis. Here are some ideas of why you may have endometriosis:

- You were born with bits of endometrium outside your uterus.
- When you have your period, some of your flow backs up through your tubes and stays in your abdomen.
- It may be caused by an operation in your lower belly. The surgeon may have accidentally spread some of the tissue from your uterus to other parts of your abdomen.
- You may have a problem with your immune system or a problem with your hormones. One problem may be that your body has too much estrogen.

How does endometriosis cause infertility?

You may have scar tissue around your ovaries and tubes which makes it hard for the egg to get from your ovary to your tube.

You may also have fertility problems if you have mild endometriosis. You may not have much scar tissue or large implants. Doctors aren't always sure why mild endometriosis causes fertility problems.

These are some ideas of why mild endometriosis can cause infertility:

- You are unable to ovulate because your egg can't get out of your ovary.
- The area around the implants becomes irritated.
- Women with endometriosis have more prostaglandins. Prostaglandins are hormone-like chemicals. They may make it harder for sperm to swim. They may also make the muscles of your uterus and tubes contract or tighten too much.
- Women with endometriosis are more likely to have a condition called a luteal phase defect. See page 76 for more information on this condition.

Some women with endometriosis have repeated miscarriages. This is more likely if you have a mild case of endometriosis, and not a severe case. No one knows why miscarriage is more likely with mild endometriosis. See page 105 for more information on repeated miscarriage.

What are the signs of endometriosis?

If you have endometriosis, you may have one or more of these signs:

- strong pain during your period. You may also have strong pain when you're not having your period.
- heavy and long periods
- pain when a finger or a penis is put into your vagina
- lower back pain
- pain during bowel movements
- irregular periods
- spotting between periods or before periods
- diarrhea or constipation during your period

Some women with endometriosis have no symptoms.

How can a doctor tell if you have endometriosis?

Your doctor may think that you have endometriosis because of your symptoms. She may also feel bumps on the outside of your uterus and tubes during a bi-manual exam.

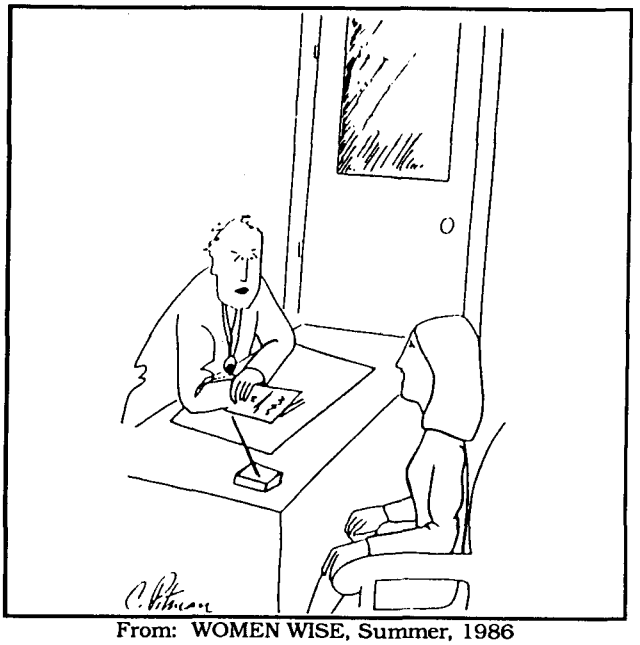
The only sure way to know whether you have endometriosis is to have a laparoscopy. A laparoscopy is an operation that lets a doctor see inside you. It is described on page 62. The doctor can see the endometrial implants during a laparoscopy. To be absolutely sure that you have endometriosis, she should take a small sample of an endometrial implant, and send it to a lab.

She can also burn off small implants and scars during the laparoscopy.

What things can you try for yourself?

There are some things you can try yourself which may help you to have less pain and other signs of endometriosis. They may or may not help you get pregnant. No one knows for sure.

Try the suggestions for a balanced diet in the chapter called **Being Healthy**, on page 187.



From: WOMEN WISE, Summer, 1986

Some foods tell your body to make more estrogen than you need. You can try to cut down or stop eating these foods:

- fats that are solid at room temperature, like margarine and butter
- animal fat in meats
- sugar
- alcohol
- milk and other dairy products
- caffeine in coffee, tea, chocolate and cola drinks

Drinking a lot of liquids and avoiding constipation will help you have less estrogen in your blood. Eat foods that are high in fiber like vegetables, fruits, and whole grains. You might need to try a natural laxative, like flax, at some times.

Taking extra B complex vitamins or evening primrose oil, flaxseed oil or blackcurrant oil also helps some women. Take two tablespoons of flaxseed oil each day or take the amount suggested on the bottle of either of the other oils.

You can try seeing a naturopath or having acupuncture.

If you have mild endometriosis, you may want to combine these suggestions with having your endometrial implants burned off during laparoscopy.

Some women get pregnant using a "wait and see" approach to endometriosis. They use medicines to deal with pain from endometriosis, and give themselves a period of time trying to get pregnant without drugs or surgery. A woman with a mild case of endometriosis is almost as likely to get pregnant with a "wait and see" approach as with drugs or surgery.

You may take pain killers or anti-inflammatory drugs like Ponstan for pain during your periods. If you're trying to get pregnant, it's best to avoid taking these drugs until after your period has started. That way, you'll know you aren't pregnant before taking the drug. It is not safe to take most drugs during pregnancy. It's best to avoid even aspirin.

From: SAN FRANCISCO BAY AREA WOMEN'S YELLOW PAGES, 1981-2

What treatments may the doctor suggest?

Your doctor may suggest surgery or hormones.

Surgery

Your doctor can burn off the endometrial implants and scar tissue during surgery. If you have mild endometriosis, she can do this during a laparoscopy. If you have a lot of implants and scar tissue, she may need to do a laparotomy. A laparotomy is surgery into your lower belly using a larger cut.

Lasers are strong beams of light. Some doctors use lasers to cut away endometrial implants and scar tissue.

Your doctor may suggest you take hormones for two to six months before having surgery. This helps to shrink the endometrial implants so that the doctor can more easily cut or burn them off during surgery. Some doctors prefer to do surgery when you haven't had hormones first. They believe it is easier to get the whole implant this way.

It is important for a doctor not to leave bits of an implant they cut or burn off during surgery. The bits will grow into a new implant.

Hormone treatment

Doctors usually suggest the hormone Danazol. This is a manufactured male hormone. When you take this drug, you don't have periods. You get relief from the pain of endometriosis, and usually the endometrial implants shrink.

Danazol is expensive. A month's supply costs about $100. The drug also has strong side effects for many women. You may have muscle cramps, weight gain, acne (pimples), feel sick, rashes, unwanted hair growth, a deeper voice, smaller breasts, vaginal bleeding, and/or signs of menopause. These side effects do not always go away after a woman stops taking Danazol.

Some doctors give women the birth control pill to treat endometriosis. Usually, women have less painful periods when they're on the pill. Some women prefer the pill to Danazol because it has less annoying side effects. However, with the pill there is more of a risk of developing heart disease or a stroke than with Danazol. These side effects are rare, but they are more dangerous than the known side effects from Danazol. Your chances of getting pregnant after taking the pill are a little lower than after taking Danazol.

Wait three months after you stop taking Danazol or the pill before trying to get pregnant. This gives your menstrual cycle time to get back to normal after taking these hormones.

Buserelin is a new hormone drug which doctors may suggest. It is also called Naferelin or LH-RH agonist. You take it by spraying it into your nose. Taking this drug is like having your ovaries taken out. Your ovaries stop making hormones while you take the drug. This can cause your endometrial implants to shrink. The side effects of Buserelin are hot flashes, vaginal dryness, and less interest in sex. You may also be more likely to get osteoporosis, or lighter and brittle bones. No one knows what the long-term effects of Buserelin are or whether you are more likely to get pregnant after taking it.

Some doctors suggest Provera as treatment for endometriosis. Provera is manufactured progesterone. This is not a good idea if you're trying to get pregnant. It takes many women up to a year to start to ovulate after they've taken Provera for three months or more.

GIFT

Your doctor may suggest a new treatment called "GIFT" or "gamete intra-fallopian transfer" for infertility from endometriosis. GIFT is a combination of surgery and drugs. It is a new treatment which is still being developed. It has not been tested to see how well it works for women with endometriosis. There is no proof that it is any more helpful than doing nothing. It is also expensive and not covered by medical insurance. GIFT is described on page 151.

Which works better, surgery or drugs?

Researchers have done studies to compare how likely a woman is to get pregnant if she has surgery or drug treatment. They found that women were a little more likely to get pregnant after surgery. The women were most likely to get pregnant within two or three months of having surgery. If your endometriosis is very bad, your chances of pregnancy will be higher if you first take drugs for three to six months and then have surgery.

Overall, three to seven women out of 10 get pregnant after treatment for endometriosis. You are more likely to get pregnant if you have a mild case of endometriosis than if you have a very bad case.

Where can you find out more about endometriosis?

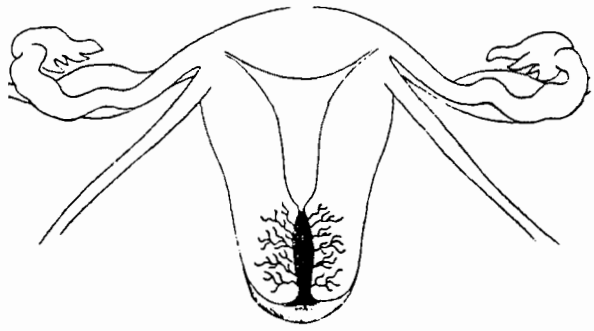
There is a chapter on endometriosis in the book **Talking About Periods** written by the Vancouver Women's Health Collective. The ordering address for this book is on page 209. The address for the Endometriosis Association is on page 207. You can write to them for more information on endometriosis.

CERVICAL MUCUS PROBLEMS

You have probably noticed the discharge you have coming out of your vagina. It is made of mucus from your cervix mixed with some liquid from the walls of your vagina.

Your cervix makes different kinds of mucus at different times in your menstrual cycle. It is affected by your hormones. When you have a lot of estrogen in your blood, your cervix makes thin, wet, slippery mucus. When there is more progesterone in your blood, your mucus is thicker, drier, and stickier.

Glands Inside the Cervix



From: A NEW VIEW OF A WOMAN'S BODY

The slippery, wet mucus helps sperm to live inside your cervix. It also helps sperm to swim from your vagina into your cervix. Sperm may live for several days in your cervix in this type of mucus. This makes it possible to get pregnant when you don't have intercourse or inseminate on exactly the day that your egg leaves your ovary.

If you have a cervical mucus problem, your body may not make the type of mucus which helps sperm to live. You may ovulate each month, but the sperm may not be able to get into your uterus and tubes to meet the egg.

Cervical mucus problems are not very common. Only five to 10 out of 100 women with fertility problems have cervical mucus problems.

How do you find out if you have this problem?

The post-coital test can show if sperm can live in your mucus. This test is described on page 58.

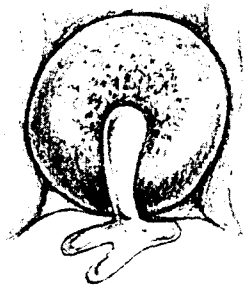
You can also look at your own pattern of mucus changes. This is described on page 52. Your doctor can look at a sample of your mucus, as described on page 57.

What causes cervical mucus problems?

These are the reasons you may have a problem with cervical mucus:

An infection in your cervix: If you have an infection, sperm may not be able to live in your mucus. Your doctor should test you for infections.

Cervix and Infection



From: A NEW VIEW OF A WOMAN'S BODY

Surgery on your cervix: If you have had cryosurgery (freezing),a cone biopsy, or laser surgery, you may have a problem with your mucus. You may make less mucus, because part of the cells in your cervix which make mucus are gone. These are types of surgery you may get for an abnormal Pap smear.

Occasionally, women get scars around the opening of their cervix after surgery. The opening may become too small. This is called cervical stenosis. If you have this condition, it may be hard for mucus to come out of your cervix and for sperm to get in.

Clomiphene: If you are taking clomiphene (Clomid or Serophene) to help you ovulate, you may have problems with your cervical mucus. About one third of the women who take these drugs have problems with their mucus.

DES: If your mother was given the hormone DES when she was pregnant with you, you could have problems with your mucus. There is more information on DES on page 104.

Antihistamines: These are drugs to dry your mucus. Many people take them for allergies, hay fever and colds. They also dry the mucus from your cervix.

What treatments may your doctor suggest?

If you have an infection, your doctor can give you antibiotics. Your mucus should be normal after you are treated. Your partner also needs to be checked and treated.

If you have cervical stenosis from surgery, your doctor can try to open your cervix slightly, using minor surgery.

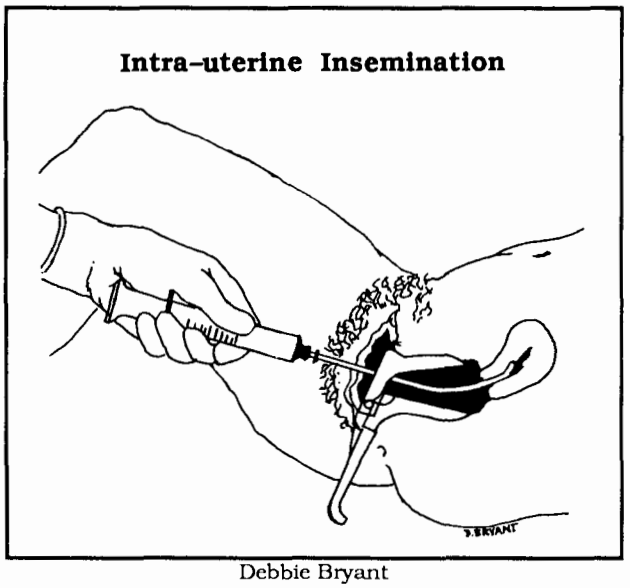
You may want to try some of the suggestions on page 100 before trying other medical treatments. These suggestions are less likely to have harmful side effects, and may be helpful. The medical treatments listed

below are not very well tested. They may or may not be helpful.

The other treatments your doctor may suggest are intra-uterine insemination, estrogen, or cough medicine.

Intra-uterine insemination

Intra-uterine insemination means putting semen into your uterus. Your doctor can put semen into your uterus so that the sperm don't have to swim through your mucus. Your partner or sperm donor masturbates into a clean jar. A lab technician separates out the sperm from his semen. The doctor then puts a thin plastic tube through your cervix to put the sperm into your uterus.



Debbie Bryant

You are more likely to get pregnant if you have intra-uterine insemination very close to the time that you ovulate. Your doctor will suggest putting sperm into your uterus two to three times during each menstrual cycle.

Can this treatment harm you?

You may get some mild cramps. You also run a small risk of getting an infection. Infections are now rare because doctors use sperm that has been separated out from a man's semen. Make sure that you and your partner have been tested for VD before having this treatment. Rarely, women develop antibodies to sperm from having sperm put into their uterus. For more information on antibodies to sperm, see page 131. This would make it harder to get pregnant.

Are you likely to get pregnant?

This treatment is quite new. Women were not very likely to get pregnant before doctors learned new ways to wash semen and separate out sperm. Intra-uterine insemination now seems to work better, but it hasn't been studied very well. So far, it seems to be more likely to help than drugs to change your mucus.

Estrogen

A doctor may give you estrogen pills to take before you ovulate. This can make your cervical mucus wet and slippery.

Are you likely to get pregnant?

Estrogen has not been proven to help women to get pregnant. Estrogen can also affect your menstrual cycle. You may have longer cycles because you don't ovulate until later.

Can this treatment harm you?

Hormone pills are not always safe. Estrogen given after menopause makes women more likely to get cancer of the lining of the uterus. Estrogen can cause birth defects when it is given during pregnancy. DES is an example of a type of estrogen which has caused birth defects.

No one knows if women who are given estrogen to change their mucus will have health problems later on because of it. If you knew estrogen was likely to help you to get pregnant, you might choose to take it anyway. Is it worth the risk for a drug that hasn't been proven to work?

If you have a mucus problem because your mother took the drug DES, it's best to avoid taking estrogen. DES makes you more likely to get a rare type of cancer of the vagina or cervix. Luckily, this only happens to less than one in 1000 women whose mothers took DES. But, some doctors are concerned that taking extra estrogen may make you more likely to get this cancer or may make it grow faster.

Cough medicines

Sometimes doctors suggest you take a type of cough medicine called an expectorant. This makes your mucus wetter and runnier. It affects the mucus from your cervix as well as the mucus from your nose. Guaifenesin is the name of one type of cough medicine doctors often suggest. This treatment has not been proven to help you get pregnant.

What can you try yourself?

These are suggestions which some women with cervical mucus problems have found helpful:

1. If you smoke, try to quit or cut down. When researchers have studied the cervical mucus of women smokers, they have found nicotine and other chemicals from cigarette smoke. These chemicals may kill or damage sperm.

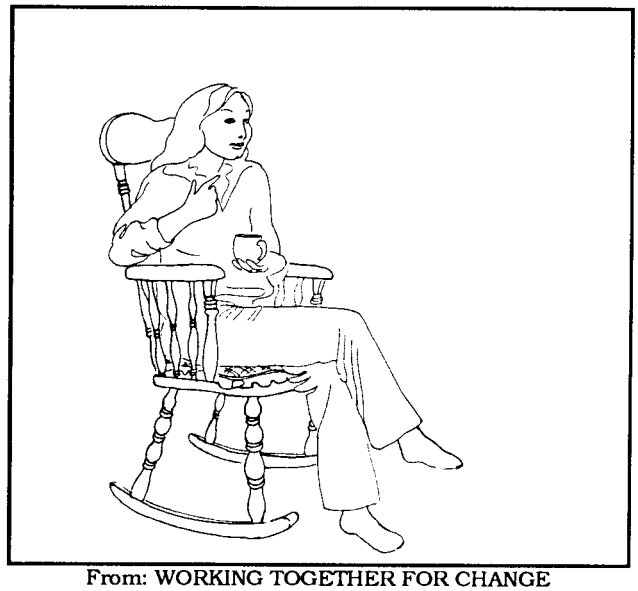
2. Eat a healthy diet with plenty of protein. Your body makes mucus from protein. Some women find that they have very little mucus when they are on a strict vegetarian diet with no dairy products. See page 188 for more information on eating well.

You can also try eating more foods which have estrogen in them. Alfalfa sprouts, wheat, barley, soybeans, peas, beans, sunflower seeds, licorice, corn and apples all have a type of estrogen in them.

3. You can see a naturopath. She may have helpful suggestions.

4. One infertility specialist suggests putting egg whites into your vagina before having intercourse or inseminating. Sperm can live in the egg whites because they are made of protein and are very similar to mucus. Your vagina is too acid for sperm to live in without mucus from your cervix. Egg whites may act like mucus and protect sperm from the acid of your vagina. You can use a bulb syringe or an applicator for douching to squirt part of a raw egg white into your vagina.

5. You are more likely to get pregnant if you have sex or inseminate very close to the time that you ovulate. You can buy a test kit to find out when you ovulate. See page 54 for more information. These kits are sold in drugstores.



From: WORKING TOGETHER FOR CHANGE

PROBLEMS WITH YOUR UTERUS

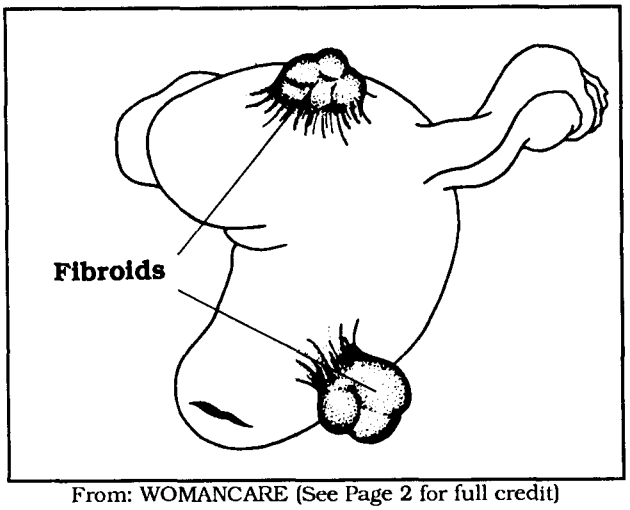
If you have a problem with your uterus, you may not be able to get pregnant because the fertilized egg can't implant into your uterus. This is a fairly uncommon cause of infertility.

Fibroids, Asherman's Syndrome, DES and problems you were born with can all cause infertility. We'll explain these conditions in this section.

Some women with problems with their uterus are able to get pregnant but may then miscarry. If you miscarry when you are between 12 and 20 weeks pregnant, it may be because your uterus couldn't stretch enough to hold the developing fetus. There is more information on miscarriage in the section on repeated miscarriages on page 105.

Fibroids

Fibroids are growths of muscle tissue inside the wall of your uterus. They are not cancer. Many women have fibroids. Only some women develop infertility because of them. Fibroids are more likely to cause infertility if they are larger than two centimeters (one inch) across or if they take up more than half of the room inside your uterus.



From: WOMANCARE (See Page 2 for full credit)

What can be done to get rid of fibroids?

You can have an operation called a myomectomy. The doctor cuts into the wall of your uterus and takes out the fibroids. She then sews your uterus back together.

A myomectomy is a complicated operation. You will go into the hospital and stay several days. You will have a general anaesthetic. There are risks from any operation. You could have problems from the anaesthetic or infection from the surgery.

Sometimes, scar tissue forms because of the operation. This can cause pain. backaches, or unusual bleeding from your vagina. Your doctor should be sure that your fibroids are the only reason you are infertile before doing this operation. If there are other reasons, you should treat them first.

What are the chances of pregnancy after a myomectomy?

Half the women who have a myomectomy to treat infertility are able to get pregnant afterwards.

Are there other treatments for fibroids?

Fibroids grow faster if you have a lot of the hormone estrogen in your blood. You can change your diet so your body makes less estrogen. See page 93 for suggestions of how to change your diet. This sometimes helps fibroids to shrink. No one knows whether it can also help you to get pregnant.

If your fibroids are very large and are causing a lot of pain and bleeding, your doctor may suggest a hysterectomy. This is an operation to take out your uterus. If you have a hysterectomy, you won't be able to get pregnant again. The book **Talking About Periods** has information on how to decide whether to have a hysterectomy for fibroids. It also has more information on natural treatments. The ordering address is on page 209.

Asherman's Syndrome

If you have Asherman's syndrome, you have scars inside your uterus. This can happen after a D&C or after several D&C's. A D&C is an operation in which the doctor gently scrapes out the inside lining of your uterus.

How can I know if I have Asherman's syndrome?

If you started having very light periods or no periods after a D&C, you could have Asherman's syndrome. Your doctor can know for sure with an X-ray picture of the inside of your uterus called a hysterosalpingogram. See page 59 for a description of a hysterosalpingogram.

What can be done to treat Asherman's syndrome?

Your doctor can do an operation to cut away the scars inside your uterus. You can have either a local or a general anaesthetic for this operation. You don't need to stay in the hospital overnight.

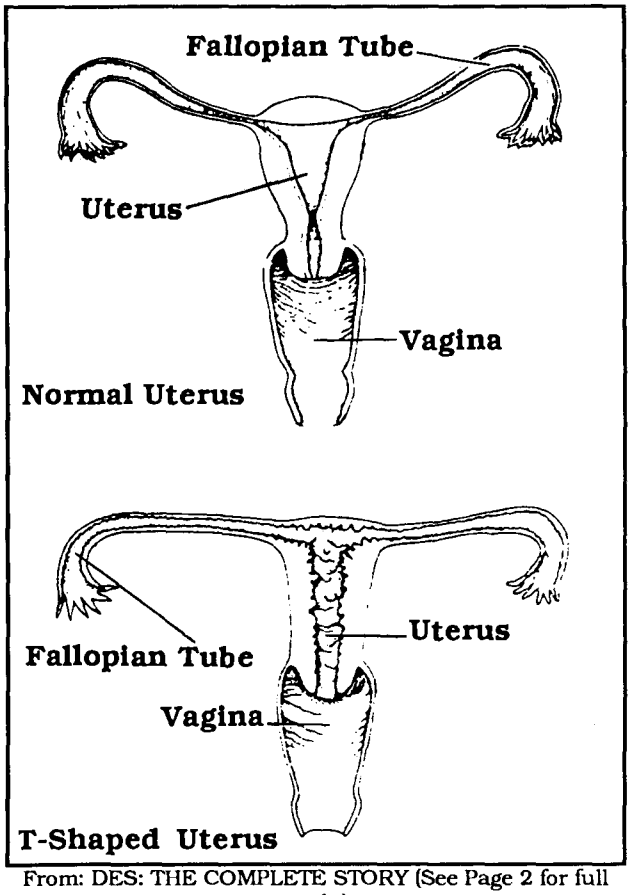
She uses a thin tube which she puts through your cervix. It is called a hysteroscope. She can look through the hysteroscope and see the inside of your uterus. She can also put an instrument through it to cut away the scars.

After this operation, some doctors put an IUD inside a woman's uterus to keep the walls of her uterus apart. An IUD is normally used for birth control. You will need to have it taken out before trying to get pregnant. Not all doctors recommend an IUD after this operation. The IUD makes you more likely to get an infection inside your uterus and tubes. An infection can cause infertility if your tubes become damaged.

Some doctors suggest taking estrogen for two months after the operation to correct Asherman's syndrome. This helps the lining of your uterus to grow back. The lining can also grow back on its own. The estrogen isn't really necessary. It's best to avoid taking hormonal drugs whenever you can.

DES

Some women have a different shape of uterus because of a drug their mother took during her pregnancy called DES. DES is a manufactured estrogen. It was given to pregnant women between 1941 and 1971 in Canada. It was mostly given to prevent miscarriage. Women whose mothers took DES sometimes have a T-shaped uterus. Their uterus may also be smaller than usual. There is no treatment for either of these problems. Many women have miscarriages or go into labour early because of these problems. Women whose mothers took DES also sometimes have problems getting pregnant. If you think your mother may have taken DES or want to find out more, contact DES Action Canada. Their address is on page 207.



From: DES: THE COMPLETE STORY (See Page 2 for full credit)

Problems You Are Born With

Your uterus may have an unusual shape. This is called a misshapen uterus. If you have a misshapen uterus, you are more likely to miscarry than to have problems getting pregnant.

Very rarely, a woman is born without a uterus. Your doctor may suspect this if you have never had a period and she can't feel your uterus with a bi-manual exam. She may suggest you have an ultrasound, described on page 61. The ultrasound will show whether or not you have a uterus.

REPEATED MISCARRIAGE

You may be able to get pregnant, but then have a miscarriage. It's very common for women to have one or two miscarriages during the first three months they are pregnant. This usually happens by chance, and is not a sign that you have a health problem. You will most likely have a baby the next time you are pregnant.

If you have three or more miscarriages, this is called repeated miscarriage. It is a sign that something is wrong, and that it is hard for you to stay pregnant.

You will probably have many of the same feelings as women who can't get pregnant. You may be unsure if you will ever be able to have a child. You may also feel anxious about getting pregnant again, because you are worried that you may miscarry again.

There is more information about miscarriage in the book **Miscarriage: You Are Not Alone**. Ordering information is on page 209.

What are your chances of miscarrying again after three miscarriages?

You have about a one in three chance of miscarrying during your fourth pregnancy. Many women have successful pregnancies even after three miscarriages.

Your chances of having a baby eventually are good. Four out of five women who have had repeated miscarriages are able to have children.

Why do repeated miscarriages happen?

Doctors can find a reason for repeated miscarriages just over half of the time.

These are the reasons for repeated miscarriage:

- hormone problems
- diseases and infections
- immune problems
- problems with your uterus
- genetic problems

There is information about each of these reasons in this chapter.

Hormone problems

You may miscarry if you have a hormone problem called a luteal phase defect. See page 76 for information on luteal phase defects.

What can be done?

You can try to balance your hormones yourself. See page 78 for information on this. You may want to see a naturopath for more help in getting your own hormones into balance.

If you are miscarrying because of a luteal phase defect, your doctor will probably suggest you take natural progesterone. You would take this hormone during your first 12 weeks of pregnancy.

We have strong concerns about using hormones during pregnancy. These concerns are explained on page 79.

Infections and diseases

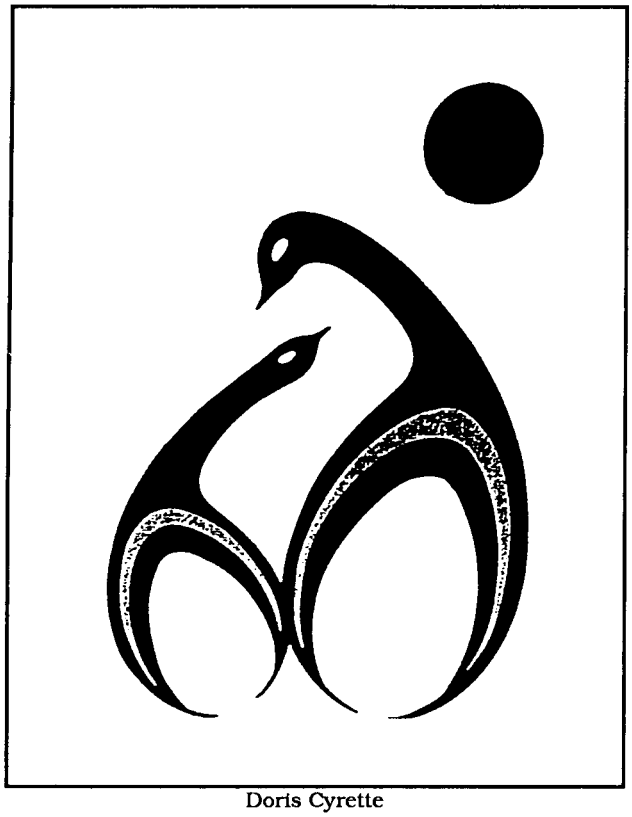
These health problems can cause repeated miscarriages:

- endometriosis
- thyroid disease
- diabetes in you or your partner
- heart disease
- high blood pressure
- multiple sclerosis (MS)
- liver or kidney disease
- diseases passed during sex, such as syphilis, mycoplasmas, Chlamydia and herpes
- an ongoing infection in your bladder, bowel, uterus or pelvis

What can be done?

These health problems have different causes and treatments. Talk to your doctor about your situation. You may be less likely to miscarry if you have treatment for an ongoing health problem.

Your doctor can also test you for infections. You may not know you have an infection if you don't have symptoms. If you have an infection, she can treat you and your partner with antibiotics before you get pregnant again.



Doris Cyrette

Immune problems

You may miscarry because your body treats the fetus as if it was something foreign. Normally, a woman's body makes a chemical during pregnancy which stops her body from rejecting the fetus. You may have repeated miscarriages if your body doesn't make this chemical.

Some doctors guess that four out of ten women with repeated miscarriages have immune problems. No one knows for sure how common it is.

What can be done?

Doctors haven't known about immune problems causing miscarriage for long. They are still developing and testing treatments. One treatment being tested is to give women a shot with white blood cells from their partners.

Problems with your uterus

Most miscarriages because of problems with a woman's uterus happen after the 12th week of pregnancy. These are the main problems:

- misshapen uterus, see page 104
- fibroids, see page 102
- a weakened cervix

If your mother took a drug called DES when she was pregnant with you, you may have repeated miscarriages. These miscarriages are most likely happening because of a problem with your uterus. They may be early or late miscarriages.

Your doctor can do tests for problems with your uterus. For more information on this, see the book **Miscarriage: You Are Not Alone** listed on page 209.

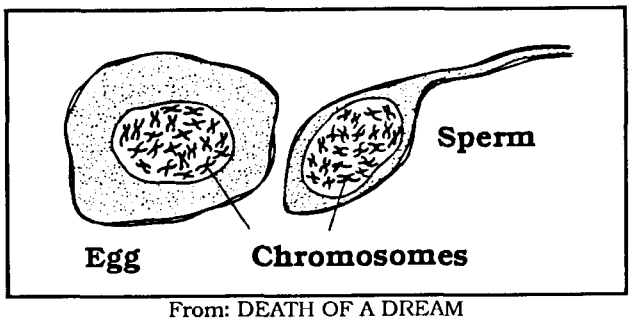
What can be done?

You can have an operation to take out fibroids if they are making you miscarry. You can have an operation only for one type of misshapen uterus, a septate uterus. For a weakened cervix, you can have a stitch in your cervix early in pregnancy. This stitch is called a cervical cerclage.

Other types of problems, including problems caused by DES, can't be treated. You can have close medical care during pregnancy and can watch yourself for early signs of labour.

Genetic problems

Only five out of 100 couples with repeated miscarriages have genetic problems. You and your partner can have a blood test to look at your genes and chromosomes. Genes and chromosomes carry all the information that is passed from the egg and the sperm to a fetus. This test will show if either of you is passing on a genetic problem to the fetus.



From: DEATH OF A DREAM

If you save the tissue when you miscarry, your doctor can test the fetus for genetic problems.

What can be done?

If these tests show a genetic problem, your doctor can send you to a genetic counsellor. Your doctor or counsellor can tell you what your chances are of having a normal pregnancy.

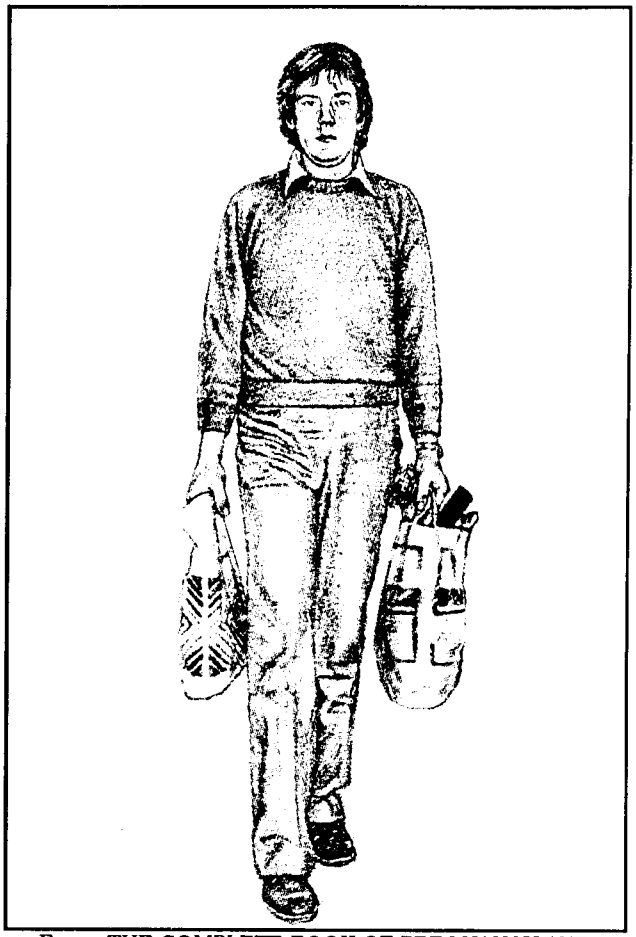
If your partner has a serious genetic problem, your doctor may suggest donor insemination. It is described on page 135. If you have a serious genetic problem, she may suggest adoption. There is more information on adoption on page 153.

MEN'S INFERTILITY

People used to think that infertility was only a woman's problem. Now, we know that men are just as likely to be infertile as women. Unfortunately, not as much medical research has been done on men's infertility. Some conditions causing infertility in men can be treated. Others cannot.

The most common cause of infertility in men is problems with sperm. Some men also have problems with their semen, the liquid that holds sperm. A few infertile men have normal sperm and semen, but cannot ejaculate outwards.

In most of this book we call women "you". In this chapter we don't. This chapter is written directly to both women and men.



From: THE COMPLETE BOOK OF PREGNANCY AND CHILDBIRTH

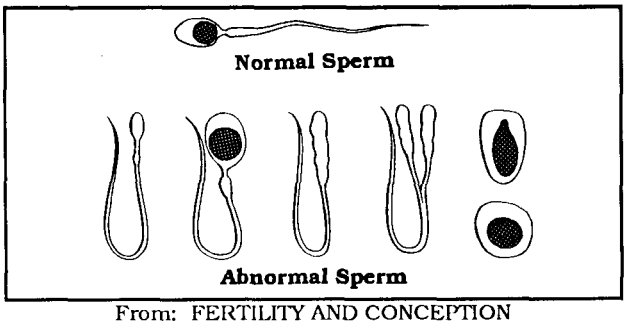
PROBLEMS WITH SPERM

A man may have one of three main problems with sperm: a low sperm count, poor movement, or many sperm with unusual or abnormal shapes.

Low sperm count is the most common infertility problem for men. A low sperm count is less than 20 million sperm in each cc of semen. One cc is about a quarter of a teaspoonful. A man has a very low sperm count if he has less than 10 million sperm in each cc of semen.

A man has poor sperm movement if less than half of his sperm are swimming properly. If four or more out of every 10 sperm have abnormal shapes, this is another sign of a problem.

A normal sperm has a round head and a long tail which helps it swim. The part that joins with the egg is the round head. This is a picture of normal and abnormal sperm.



From: FERTILITY AND CONCEPTION

Low sperm count, poor movement and unusually shaped sperm often happen together. About half the time a man has a problem with his sperm, a reason can be found. There are many reasons. You'll find information about these reasons in this chapter:

Sometimes doctors can't find a reason for a man's sperm problem.

What are the chances of pregnancy if a man has a sperm problem?

When doctors know why a man has a sperm problem, they may be able to treat the cause. Some treatments are simple. For example if a man works with high heat, he can protect his testicles against the heat. Some conditions causing sperm problems can't be treated.

Some men with sperm problems are able to father children with no treatment. One out of every four men with a low sperm count is able to father a child within a year without any treatment. If a man's sperm count is less than between one and five million, the chances for pregnancy are one in six within a year.

One in three women get pregnant within a year if their partner has more than twenty million sperm in each cc, but the sperm have poor movement.

From: GRAPHIC SOURCE

What treatments can a man try if he can't find a reason for his low sperm count?

Timing intercourse: The woman's chances of getting pregnant are highest if you have intercourse close to when she ovulates. A man's sperm count is highest if he ejaculates about once every 36 hours. It will be lower if he ejaculates more often. You can use basal body temperature, mucus testing, or drugstore tests to find out when you ovulate. See page 49 for more information.

Boxer shorts: A man's testicles will stay cooler if he wears loose underwear. Tight underwear holds his testicles close to his body. Heat can interfere with the way a man's testicles make sperm.

Testicle cooling devices: This is something a man wears around his testicles which uses water to keep them cool. It is worn like a jock strap. No one can tell he's wearing one. His doctor can tell him how to get one. Testicle cooling devices are expensive.

He can also use blue ice at night to keep his testicles cool. Blue ice is a plastic package of water and chemicals which is sold in many stores. People normally use it in coolers when they go on picnics. After the package is partly frozen, the man wraps it in a towel and puts it near his scrotum while he's sleeping.

Try to be healthier: Here are some things which may improve a man's health:

- eat well
- get plenty of rest
- cut down on stress
- avoid heavy smoking, alcohol, marijuana or drugs
- exercise a normal amount

There is more information about these things on pages 187 to 200.

His sperm count may go up. It will take at least three months to see a change.

He may want to take a daily multi-vitamin and mineral pill if his diet or his health has been poor. Zinc is very important for men's fertility. He may want to take extra zinc. The amino acid arginine may also help his sperm count. Taking extra carnitine, another amino acid, can help improve sperm movement. He can take them in pill form or try to get them from food. See page 191 for a list of foods high in zinc and these amino acids.

He can see a naturopath or a herbalist for suggestions. If he is Native, an elder may know of traditional medicines for men's fertility.

Split ejaculate: The first squirt of semen which comes out when a man has an orgasm has the most sperm in it. A man can withdraw his penis right after he starts to ejaculate so that only the semen with the most sperm in it gets into the woman's vagina.

This can also be combined with insemination. The man masturbates so that the first part of his ejaculate goes into one clean jar, and the other part into another. He saves the semen which came out first. The woman or her doctor uses that part of his semen for insemination. Usually, the doctor puts it into a small plastic cap on the woman's cervix so that the sperm are more likely to swim up into her uterus.

No one knows for sure how helpful this treatment is.

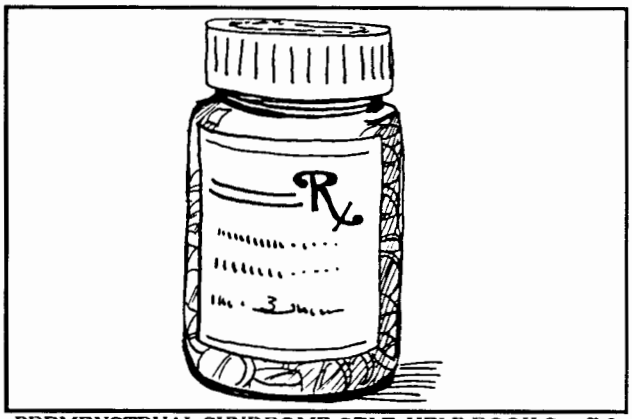
What other treatments may the doctor suggest?

Intra-uterine insemination: This means putting sperm into a woman's uterus. It is described on page 99. There are different reports of how helpful this treatment is. In some studies, it does seem to help.

Fertility drugs: Many doctors suggest that men who have a low sperm count take fertility drugs. These drugs are only likely to help men who have low sperm count because of a hormone problem. Only one out of 20 infertile men has a hormone problem. A doctor can do blood tests to see if a man has a hormone problem.

If a man doesn't have a hormone problem, fertility drugs won't help. The woman's chances of getting pregnant are about the same if he uses these drugs as if he doesn't have treatment. Either way, about one in four women will get pregnant within a year. Doctors often suggest these drugs because they can give a man a higher sperm count. They don't seem to make the woman any more likely to get pregnant, though.

These are strong drugs which often have side effects. They may also make a man more likely to have health problems later on. It doesn't seem worth the risk if they haven't been proven to help.



PREMENSTRUAL SYNDROME SELF-HELP BOOK See P.2 for full credit

These are the drugs doctors often suggest:

- Clomiphene
- HCG, sometimes with HMG
- Bromocriptine
- Testosterone, given for a short time to stop sperm from being made. Sometimes, there is a "rebound" from taking this drug, and a man's body starts making more sperm afterwards. Other times, the drug permanently causes him to have less sperm.

In vitro fertilization (IVF) and gamete intra-fallopian transfer (GIFT): These are two new treatments which a woman can have. In vitro is described on page 145. GIFT is described on page 151. Doctors sometimes suggest them if a man has a low sperm count because less sperm are needed to fertilize an egg in a laboratory than inside a woman's body.

There are serious concerns about how safe IVF and GIFT are. These concerns are explained on page 148.

We have concerns about the moral choice of using IVF or GIFT if a man has a low sperm count. A woman goes through much more than the man. She takes strong hormones and has surgery even though her body is fertile. We would prefer to see more research done on treatments a man can have so that his sperm count goes up.

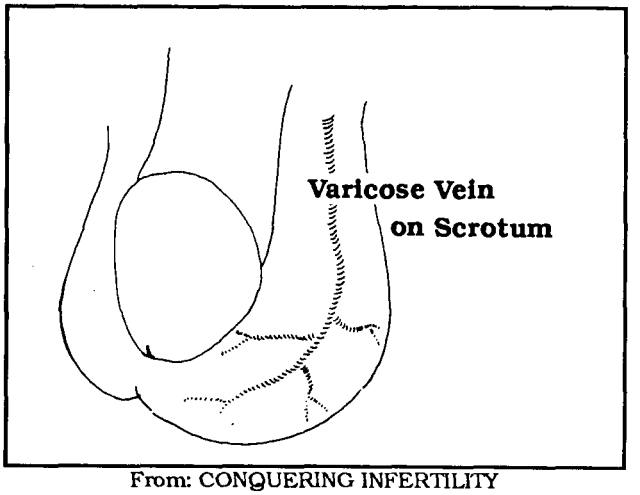
IVF and GIFT are not very likely to work. About 10 out of 100 couples having these treatments end up with a baby. They may be no more likely to work for sperm problems than having no treatment.

Some couples choose to use donor insemination rather than have the woman go through IVF or GIFT. Donor insemination is much safer. The man needs to be sure he is comfortable not being the biological parent. There is more information about this on page 136.

VARICOCELE

A varicocele is a varicose vein in the scrotum. The scrotum is the sack of skin which holds a man's testicles. A varicose vein is a swollen vein. Blood pools in a varicose vein. This happens because a valve in the vein doesn't close properly.

Varicoceles usually happen on the left side of a man's scrotum, near his epididymis.



From: CONQUERING INFERTILITY

Varicoceles are common. About eight out of every 100 men have varicoceles. About half of the men with varicoceles have fertility problems.

One out of every four men with fertility problems has a varicocele.

How does a varicocele lower fertility?

Men with varicoceles often have a lower sperm count, less sperm movement and more abnormally shaped sperm. No one knows exactly why. One guess is that the varicocele causes a man's testicles to have a higher temperature because of the extra blood. The higher temperature may affect the way sperm develop. Another guess is that the pooled blood has a lot of adrenal hormones in it. These hormones may change the way the testicles make sperm.

How can a doctor tell if a varicocele is lowering a man's fertility?

Doctors can guess whether a varicocele is affecting a man's fertility by looking at his sperm. He will have many sperm with tapered heads and many immature sperm if it is affecting his fertility.

Some doctors suggest a second test to see whether a varicocele needs treatment. The hamster egg test can show how likely his sperm are to fertilize a woman's egg. It is described on page 45. If the results are normal, he probably doesn't need surgical treatment for the varicocele. His sperm are normal enough for the woman to get pregnant.

A doctor may also suggest a post-coital test. This test can show how well a man's sperm can live in his partner's mucus. It is described on page 58. If the post-coital test doesn't show a problem, he may not need treatment.

What can a man try himself if he has a varicocele?

These are some things which may help improve his fertility:

- Wearing a device to cool his testicles. See page 111.
- Improving his diet and general health. See page 187.

What is the medical treatment for a varicocele?

Doctors usually use surgery to treat varicoceles. Radiology is another possible treatment.

Surgery:

A man can have surgery under local or general anaesthetic. The doctor makes a small cut in his lower abdomen, and ties off the vein which leads to his scrotum. This keeps the blood from backing up and pooling in the varicocele.

This is usually day surgery. He does not need to stay in the hospital overnight.

Like any surgery, there is a small risk of infection and risks from the anaesthetic.

Radiology:

This a fairly new treatment which does not involve surgery. The doctor puts a small thin tube into the vein which leads to the varicocele. The doctor uses x-rays to see while guiding the tube down the vein to the varicocele. The doctor then leaves a small coil or detachable balloon in the vein to block the flow of blood.

A man's testicles are exposed to radiation with this treatment. Radiation may damage his sperm. This treatment is also harder for the doctor to do than surgery. Radiology is mainly used for men who have had surgery which did not work.

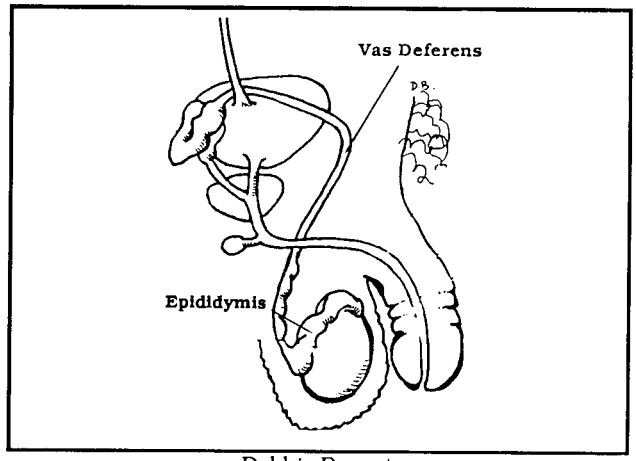
What are the chances of pregnancy after treatment with surgery or radiology?

Four to five out of every ten men who have surgery to correct a varicocele are able to father a child. Radiology is not well tested, but doctors think it works about as well as surgery.

It is difficult to know for sure how helpful surgery or radiology is. One study showed that women were equally likely to get pregnant whether or not the men had surgery. All the men in the study had varicoceles.

BLOCKED DUCTS

The passageways from a man's testicles to his penis are called ducts. If a duct is blocked, he will have very few or no sperm in his semen. The ducts may be partly or completely blocked. The blockage may be in his epididymis or in his vas deferens.



Debbie Bryant

If he has normal amounts of hormones and normal sized testicles but very few sperm, his doctor will check to see if he has a blocked duct.

The doctor will do a test called a vasography. It is an x-ray of the ducts leading from a man's testicles to his penis. It is described on page 44.

What causes blocked ducts?

The most common cause of a blocked duct is scarring from an infection. If a man has had gonorrhea or Chlamydia, he could have scars blocking his ducts. These are infections that are passed during sex. Tuberculosis (TB) can also cause scarring which may block a man's ducts.

Some men are born with a blockage in their ducts or with their vas deferens partially missing. This is rare. A man's doctor may or may not be able to do surgery depending on his situation.

Rarely, doctors accidentally cut men's ducts during surgery. If a man had surgery in his lower abdomen or in his scrotum, this is possible.

What is the treatment for blocked ducts?

A man can have surgery to unblock his ducts. This type of surgery should be done under a microscope. It is best to have it done by an infertility specialist. A man usually has a general anaesthetic. The operation usually takes two to three hours.

Will this operation make a man be fertile?

How likely a man is to be fertile is different depending on his situation and on the skill of his surgeon.

A man may have sperm in his semen after the operation, but it may not be mature or swim well. The doctor should tell him what his chances are of being able to father a child, not just of having a better sperm count.

VASECTOMY REVERSAL

A vasectomy is an operation which a man can have if he doesn't want to have children or any more children. His vas deferens are cut. These are the two tubes joining a man's testicles and penis.

Occasionally, men who have had vasectomies change their minds. There is an operation to rejoin the tubes. Unfortunately, it is expensive and is not covered by provincial or territorial medical insurance.

What is the operation to "undo" a vasectomy?

The doctor trims off the ends of the man's vas and then joins them back together. This is done with microsurgery, which is surgery under a microscope. Most men have this surgery under general anaesthetic, which puts them to sleep. They may have a regional anaesthetic instead. This anaesthetic is put into a person's spine so they cannot feel anything in their lower body. The operation takes one and a half to three hours.

With any operation there are some risks from the anaesthetic and some risk of infection from the surgery.

Will this operation make a man fertile?

A man is most likely to be fertile after the operation if he has not had a vasectomy for very long. If he has had a vasectomy for more than ten years, an operation to rejoin his tubes is less likely to make him fertile. In all, about half of the men who have vasectomies reversed are able to father children.

Many men with vasectomies develop antibodies to their own sperm. Antibodies are made by a person's body to fight germs. If a man has antibodies to his own sperm, his body will destroy the sperm as though they were germs. He is more likely to have antibodies against his sperm if he has had the vasectomy a long time. For more information on antibodies to sperm, see page 131.

If a man doesn't have a problem with antibodies, he will be fertile again six to 24 months after the operation. This is how long it will take for his sperm to have normal movement again.

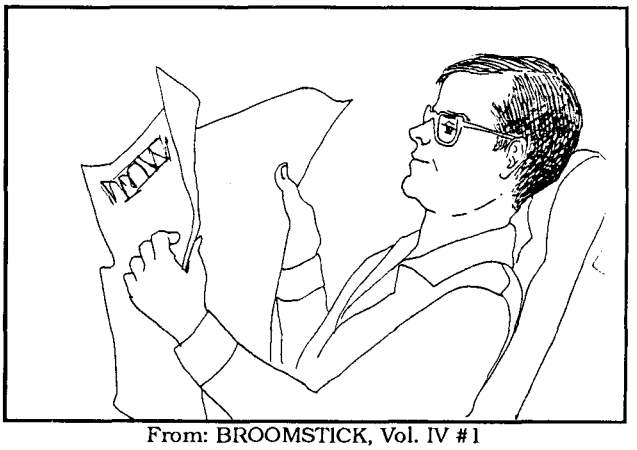
Occasionally, this operation fails because the surgeon was not able to join the tubes together perfectly.

HORMONE PROBLEMS

One out of every 20 men with a fertility problem has a hormone problem. A man's fertility is affected by hormones from his brain and from his testicles.

These are some of the reasons a man may have a hormone problem affecting his fertility:

- A head injury.
- A tumor (a non-cancerous growth) in the pituitary gland in his brain or in his adrenal gland.
- Problems with his pituitary gland, causing it to put out less hormones than it should.
- One of several rare conditions which he may be born with. The names for these conditions are congenital adrenal hyperplasia, Kallman's syndrome and Klinefelter's syndrome.
- Too much of the hormone prolactin.
- A thyroid problem.



From: BROOMSTICK, Vol. IV #1

How do doctors treat hormone problems?

A man's doctor is likely to suggest manufactured hormones to treat his problem. These are the same hormones which doctors often suggest to women with hormone problems. The hormones from the brain which affect a woman's ovaries or a man's testicles are the same.

If he has too much prolactin, his doctor may suggest a drug named bromocriptine. It is described on page 82. Vitamin B6 has also been used as a natural treatment for too much prolactin. See page 78 for more information.

If he has a thyroid problem, his thyroid may be putting out too much or too little thyroid hormone. When his thyroid problem is treated, his fertility should go back to normal.

These are the main treatments that doctors suggest for hormone problems in men:

- **GnRH:** This is described on page 88. The man wears a pump which puts small amounts of hormones into his blood every 90 minutes.
- **HCG and HMG**: First, he is given injections of the hormone HCG. This can continue for six to eight weeks. He then gets a combination of injections of HCG and HMG (Pergonal) for three to 12 months. These drugs can cause some side effects. His breasts may get bigger and he may gain some weight while he is being treated. For more information on side effects, see page 90 and page 87.
- **clomiphene: (Clomid)** A man's doctor will probably suggest he take 25 mg. of clomiphene a day for 25 days, then have a break for five days. The doctor may suggest this treatment for up to a year. Clomiphene has many side effects. Blurred vision, larger or tender breasts, and drowsiness are common side effects. Liver damage is a rare but very serious side effect.

How well do these hormones work?

His chances of becoming fertile are very different depending on what his problem is. He will need to talk to his doctor about his situation. He can talk to his doctor about how long he will be taking hormones. He may want to set up a time limit for how long he will take these drugs. For example, he may choose to take hormones for no more than a year.

If a man is given one of these treatments, his doctor will examine his semen every three months to see if there is a change. If his semen doesn't improve within six months, he may want to stop. If it does improve, he may want to set up a different time limit if his partner doesn't get pregnant. Sometimes, hormone treatment helps men's sperm to improve, but their partners still don't get pregnant.

Should a man take these hormones?

These hormones are strong drugs with strong side effects. He may want to try other ways of balancing his own hormones before taking manufactured hormones. See page 112 for suggestions.

A man should not take any of these hormones unless his doctor has done tests and knows he has a hormone problem. Doctors often give these drugs to men with low sperm counts when there is no known hormonal reason for it. Studies of the drugs show that his sperm count may go up, but his partner is no more likely to get pregnant than if he didn't have treatment.

OTHER CAUSES OF SPERM PROBLEMS

A number of other things can affect a man's sperm.

Alcohol, drugs and smoking

Alcohol affects a man's fertility. If he drinks heavily, his hormones are affected and his sperm count may be lower. If he has been drinking heavily for a long time, he may have liver problems which affect his fertility.

Some street drugs and social drugs also affect a man's fertility. If he smokes marijuana, his sperm may have poor movement and abnormal shapes. His sperm is more likely to be affected if he smokes often.

Tranquilizers and drugs that he shoots up, like heroin and methadone, can cause sexual problem and problems with ejaculation. They can also affect his sperm. These problems usually go away when a man stops using the drug.

It is not easy to stop drinking or using street drugs. Help is available from Alcoholics Anonymous, Narcotics Anonymous, drug and alcohol counsellors, social workers, community health workers and treatment centers.

From: GRAPHIC SOURCE

If a man smokes, it is a good idea for him to quit or cut down. Smoking can affect his fertility. More of his sperm may have abnormal shapes. Smoking also robs his body of some vitamins, such as vitamin C.

Medicines

Some medicines can affect a man's fertility by affecting his sperm count or his sex drive:

- Drugs for high blood pressure such as reserpine
- metholdopa or guanethidine
- nitrofurantoin, a drug for urinary infections
- barbiturates, a type of sedative
- cimetidine, a drug for ulcers
- anabolic steroids, which are sometimes used by athletes to build up their muscles
- propranolol, also called Inderal
- methotrexate, for psoriasis or cancer. This drug can cause permanent damage to testicles.
- sulfasalazine
- spironolactone
- opiates
- colchicine
- drugs to fight malaria
- tetracycline, an antibiotic
- amebicides
- corticosteroids, cortisone-like drugs
- anti-cancer drugs and radiation

If a man is taking any kind of medicine, it's worth checking to see whether it is affecting his fertility. Ask the doctor and pharmacist. If it is, he may be able to switch to a different kind of medicine.

Poisons and X-Rays

A man may work or live with chemicals which affect his fertility. Some chemicals keep affecting a person long after they stop being in contact with them. This is more likely if he worked with a chemical for a long time or was in contact with large amounts of it.

Many of his sperm may be shaped abnormally or may not be mature. He may also have a low sperm count and less movement.

These are chemicals which are known to hurt a man's fertility:

- lead
- cadmium
- pesticides (chemicals to kill insects)
- polystyrene
- benzene
- xylene
- mercury

- Agent Orange, a chemical used as an herbicide (to kill plants) by the U.S. during the Vietnam war
- anaesthetic gases
- solvents

These same chemicals are thought to also affect women's fertility.

Other chemicals may also be harmful. It's worth checking out any strong chemical a person works with or has worked with in the past. Anyone with questions about something they have worked with can write to the following address:

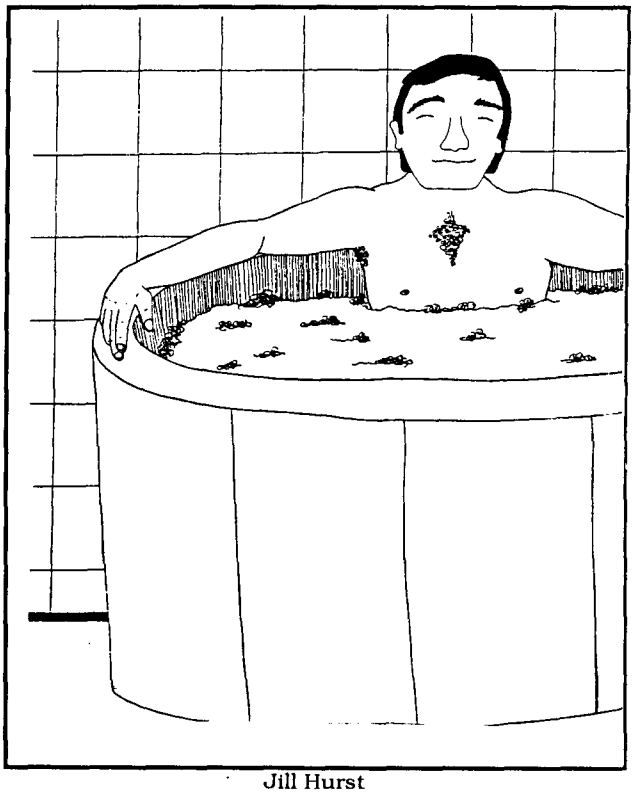
The Canadian Center for
Occupational Health and Safety
250 Main St. East
Hamilton, Ontario L8N 1H6

If a man is exposed to large amounts of x-rays, his testicles may be damaged. The damage may be temporary. Sometimes it's permanent.

Heat

A man's sperm count will be lower if his testicles are overheated. Men who work at jobs where they are sitting for long periods of time, like truck drivers or bus drivers, may have a problem with overheating. Bakers and men who work with furnaces may also have a lower sperm count because their testicles get too hot.

If a man takes a lot of hot baths or likes to soak in whirlpools, hot tubs and saunas, he may be lowering his sperm count.



Jill Hurst

What can be done about heat?

A man can try to avoid exposing his testicles to heat. If he is sitting for long periods of time, he can put an open plastic wire mesh seat on his seat. This will let air flow under him. If he works with high heat, he may be able to change jobs for a period of time or wear an apron which protects him against the heat.

The suggestions on page 111 for ways to cool his testicles may also be helpful. He may need to wear a testicle cooling device at work. It is worn like a jock strap. No one will be able to tell that he is wearing it.

Stress

Being under heavy stress affects a person's body. If a man is under very strong or long-term stress, his fertility may be affected. If he has a fertility problem for another reason, it can also become worse if he is under a lot of stress. See page 195 for suggestions of ways to deal with stress.

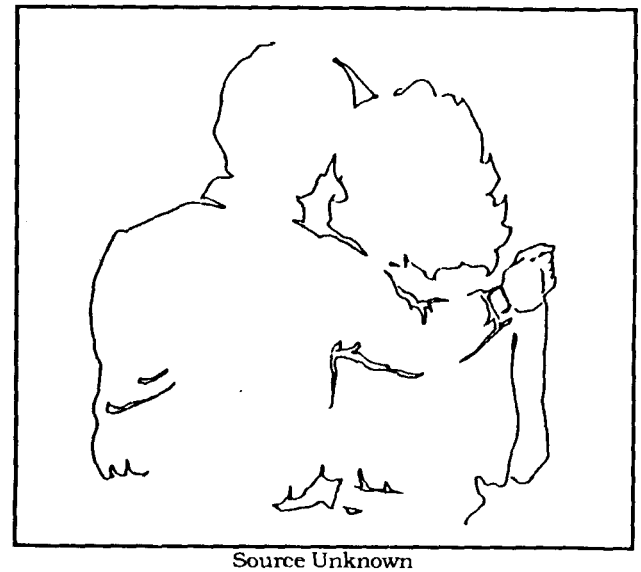
Heavy Exercise

Heavy exercise may affect a man's fertility. Doctors know heavy exercise affects women's hormones. They think it also affects men's hormones in the same way. Heavy exercise means as much exercise as an athlete in training. Moderate exercise is good for a person's hormones.

Athletes sometimes use drugs called anabolic steroids to help them build up their muscles. These drugs can make a man less fertile and less able to have an erection.

Poor Diet

A man may have a sperm problem if his diet is very poor. See pages 188 to 191 for suggestions of how to eat well. Zinc, B vitamins, vitamin C, and the amino acids arginine and carnitine are important to men's fertility. The foods that are high in these things are listed on page 191. If a man takes extra vitamins and minerals, he should take them every day along with a multi-vitamin and mineral pill.



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Undescended Testicles

Undescended testicles means testicles which are up in a man's abdomen or lower belly, instead of hanging down in his scrotum. Some men are born with one or both testicles up in their abdomen.

Often a boy's testicle or testicles come down naturally by the time he is one year old. If this happens, it probably won't make him have a fertility problem later on.

If a boy's testicles stay up, doctors usually suggest he have an operation while he is a baby or a young child to bring them down. They are hoping that this operation will help the testicles to develop normally. They sometimes try treatment instead with a hormone drug called HCG to bring a boy's testicles down.

What causes undescended testicles?

Usually, nobody knows why this happens. Men whose mothers were given the drug DES while they were pregnant are more likely to have undescended testicles than other men. See page 126 for more information on DES.

Why do undescended testicles cause fertility problems?

A man's testicles are cooler when they are hanging down in his scrotum than when they are up in his abdomen. They may become damaged by the heat inside his abdomen.

Sometimes, men have fertility problems from undescended testicles even if they had an operation to bring the testicles down. This may be because their testicles were already damaged by their body heat. Or, the testicles may not have come down on their own because of a problem with how they developed.

How likely are men with undescended testicles to have fertility problems?

Most men born with undescended testicles are fertile. About a third have low sperm counts. One out of every six men born with undescended testicles has no sperm at all.

What can be done?

Men with low sperm count are often able to father a child eventually. They may need to time intercourse very close to the time that the woman ovulates. Splitting the ejaculate, described on page 112, or using intra-uterine insemination, described on page 99, may also be helpful.

DES

If a man's mother was given a drug called DES when she was pregnant with him, his fertility could be affected. DES is a type of manufactured estrogen. Women were mostly given it to prevent miscarriage. If he was born between 1941 and 1971, it's worth finding out if his mother took DES.

If he can, he should ask his mother if she took any medicines. She can try to get her medical records. If she is no longer alive, he can also try to get her medical records. Her doctor, her pharmacy, and the hospital where he was born may have records.

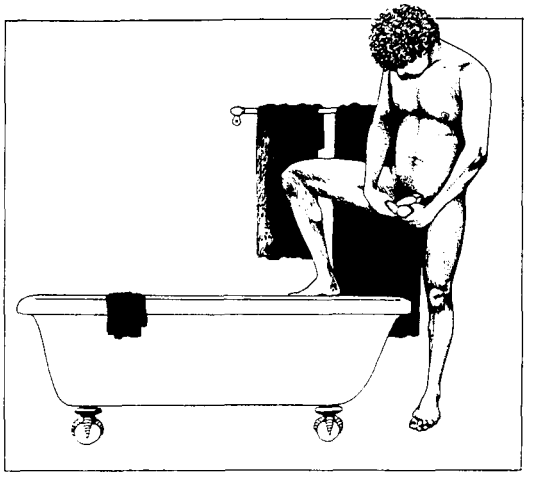
An organization called DES Action can help him. Their address is on page 207. He can write or phone them to find out more about DES. They may also be able to help him find medical records.

What sort of infertility problems does DES cause in men?

Less than one third of the men whose mothers took DES have fertility problems because of it. These are the ways DES affects a man's reproductive organs:

- changes in his ducts making him have less sperm in his semen
- undescended testicles at birth, described on page 124
- smaller than normal testicles or penis
- cysts, small fluid-filled lumps, in his epididymis. His epididymis is at the back of his testicles. This may or may not affect his fertility.

Some men whose mothers took DES have a low sperm count for no obvious physical reason.



Checking Testicles for Lumps
Susan Neri in MEDICAL SELF-CARE Number 5

Long-Term Health Problems

Long-term health problems can affect a man's fertility. This is a list of diseases and conditions which can lower a man's fertility:

- liver disease, including hepatitis
- kidney disease
- diabetes. Men may be more likely to have retrograde ejaculation with diabetes. This means ejaculating back into his bladder instead of outwards. See page 128 for more information on this problem.
- ulcerative colitis, regional enteritis, rheumatoid arthritis and lupus. These are all conditions which go through bouts of being worse and then better. He may make more or less sperm at different times. This may be caused by the health problem or drugs he is taking to treat it.
- sickle-cell anemia
- cystic fibrosis
- multiple sclerosis (MS)

Torsion or Injuries

Torsion means twisting. If one of a man's testicles has been twisted, it may have been damaged. This twisting can happen if a testicle isn't being supported properly by the tissue around it. It usually happens to teenagers at a time when they are growing quickly.

The signs of torsion are very strong pain and swelling of the testicle. A man needs emergency surgery right away to "untwist" and support the testicle if this happens.

A bad injury to a man's testicles can also cause damage which leads to fertility problems. If a large clot of blood collects in his scrotum, he may need to have it drained to keep his testicles from being harmed. He may also need surgery if one of his testicles is injured.

PROBLEMS WITH SEMEN

A small number of men have problems with their semen. Semen is the liquid the sperm swim in.

Too much semen

A man's sperm may not be able to get up into the woman's cervix if they are swimming in too much semen.

There are two things he can try for this problem:

- Splitting the ejaculate, described on page 112.
- Intra-uterine insemination, described on page 99.

Not enough semen

Semen is made in a man's seminal vesicles. If his seminal vesicles are blocked, he won't have enough semen. The seminal vesicles also make a sugar called fructose. The doctor can check to see if his semen has fructose in it. If it doesn't, his seminal vesicles may be blocked. He may be able to have surgery for this problem.

Rarely, a man doesn't have fructose because he doesn't have seminal vesicles. This is a problem he was born with, which can't be treated.

Semen that doesn't become liquid

Shortly after a man ejaculates, his semen becomes thicker and more like a solid gel. After five to 20 minutes, it turns back into a liquid. Sometimes, semen doesn't turn back into a liquid. Then the sperm become trapped inside it.

There are a few things he can try:

- the woman can put suppositories of cocoa butter into her vagina before intercourse. Cocoa butter helps make semen become liquid.
- he can mix his semen with a little spit. He needs to masturbate and ejaculate into a jar. Enzymes from a person's spit can help semen to turn into a liquid. The woman then uses an eyedropper or syringe without a needle to put the semen into her vagina.
- his doctor may suggest intra-uterine insemination, described on page 99.

These suggestions may or may not help. There isn't any good information on how likely the woman is to get pregnant using them.

RETROGRADE EJACULATION

A problem called "retrograde ejaculation" can make a man infertile. Retrograde ejaculation means that the semen goes backwards into his bladder instead of coming out of the end of his penis.

He may have noticed that no semen or very little semen comes out of his penis when he has an orgasm. He may have also noticed that his urine (pee) is cloudy afterwards.

There are a few reasons he may have this problem:

- a spinal injury
- an injury during surgery on his bladder, prostate or lower abdomen
- medicines for high blood pressure
- diabetes
- a problem he was born with

One out of every sixty-five men with fertility problems has this problem.

What can be done for retrograde ejaculation?

For some men, it helps to have sex with a full bladder and while standing up. This makes the muscle around the opening of his bladder more likely to stay closed. If he has a spinal injury or nerve damage, this won't be possible.

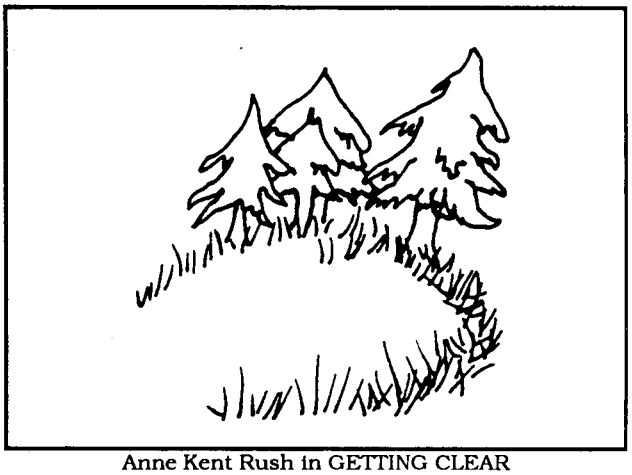
Some medicines help the muscle at the opening of the bladder to tighten. Decongestants, medicines which stop your nose from running when you have a cold, can do this. They aren't helpful for everyone.

A doctor may be able to do surgery on the opening to a man's bladder. This is not always possible.

Sperm can also be collected from the man's urine. If he drinks a glass of water with a teaspoon of baking soda in it four times a day, his urine will be less acid. This makes sperm much more likely to live in it.

He needs to masturbate with a full bladder. He collects just the first teaspoon of urine in a jar. His doctor washes the sperm out of the urine and puts the sperm into the woman's vagina.

He can also pee and then masturbate. His doctor then uses a thin tube called a catheter to take the semen out of his bladder. It can be uncomfortable or painful to have this done.



Anne Kent Rush in GETTING CLEAR

SEXUAL PROBLEMS

This section is about sexual problems between men and women. Some sexual problems cause infertility. Some men have trouble having an erection or having an orgasm inside a woman's vagina. Both of these problems can cause infertility.

Sometimes, sexual problems are caused by a physical problem. Some medicines can stop a man from being able to have an erection. See page 122 for a list of medicines that can cause fertility problems. Some of these medicines also cause sexual problems. Heavy drinking and drugs that you shoot up can also cause sexual problems. Other times sexual problems are caused by emotional problems or stress.

Problems with sex are very common, but they aren't talked about much. People make a lot of cruel jokes about sexual problems. Sometimes, men with infertility find that their friends make jokes about their sexual performance. This is hard enough to take if you aren't having any sexual problems. It's even harder to take if you are.

Infertility often **causes** problems with sex. Both men and women often find that their sex life gets more difficult because of infertility. Many men go through periods of time when they have trouble having an erection.

Sex may remind you of your failure to conceive. If you are timing intercourse to try to conceive, you may both resent having a schedule which has little to do with when you feel like having sex.

What may help?

If you have a physical problem, try to treat that problem.

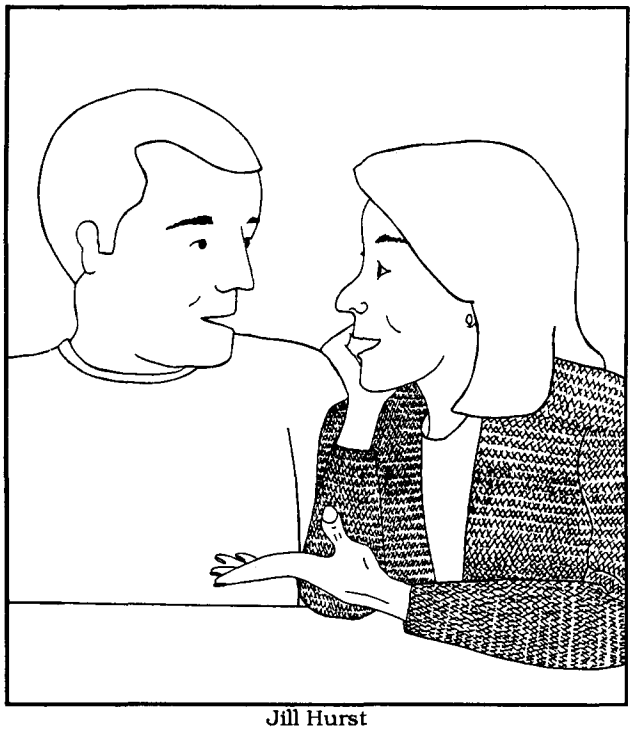
It may help to know that it is very common to have sexual problems when you're infertile. You may find it helpful to take a break from trying to have a child. It may help you to relax and to enjoy sex more.

If the sexual problems are caused by emotions or stress, you may be able to come up with solutions together. You can each talk about what would help you to enjoy sex more.

Some men find it helpful to talk with another man who has had the same problem with sex. You may each want to talk to someone else that you are close to or someone from a support group. He may find it helpful to talk to a counsellor or a therapist. You may both want to see someone together.

If a man can ejaculate by masturbating, you can then use insemination. This is easy to do at home. You can make it part of making love if you want. See page 140 for how to inseminate at home.

SPERM ANTIBODIES (IMMUNE PROBLEMS)



Jill Hurst

Antibodies are part of a person's immune system. They are normally made by people's bodies to fight germs. They are too small to see. They attach themselves to germs and destroy them. Sperm antibodies attach themselves to sperm and stop them from swimming or fertilizing an egg.

A woman's body can make antibodies to a man's sperm. A man's body can make antibodies to his own sperm.

Men sometimes have sperm antibodies in their semen. Women sometimes have sperm antibodies in the mucus from their cervix, or inside their uterus and fallopian tubes. They may also just have sperm antibodies in their blood. Sperm antibodies are less likely to cause fertility problems if they are just in a person's blood.

Antibodies to sperm are a problem for five to 10 out of 100 couples with infertility problems. Doctors disagree about how likely you are to be infertile if you have this problem. They are not sure if antibodies to sperm stop a woman from getting pregnant, or just make it harder for her to get pregnant.

What causes antibodies to sperm?

Usually, there is no known reason. This problem is like an allergy to sperm.

Some women develop sperm antibodies when they have intra-uterine insemination. Intra-uterine insemination means putting sperm into a woman's uterus. It is described on page 99. Women usually only make sperm antibodies for a short while if they develop this problem after intra-uterine insemination.

Sometimes, a woman develops a reaction just to her partner's sperm. If a doctor takes a sample of her mucus, and puts another man's sperm in it in the lab, there is no problem.

Other women have antibodies against all sperm.

The most common reason for men to have antibodies against their own sperm is having had a vasectomy. A vasectomy is an operation which stops a man from being able to have children. The doctor cuts the tubes leading from his testicles to his penis. Between one half and three quarters of all men with vasectomies have antibodies to their own sperm.

If a man has an operation to undo a vasectomy, he may or may not still have antibodies afterwards. He is more likely to have them if he has had his vasectomy for more than 10 years.

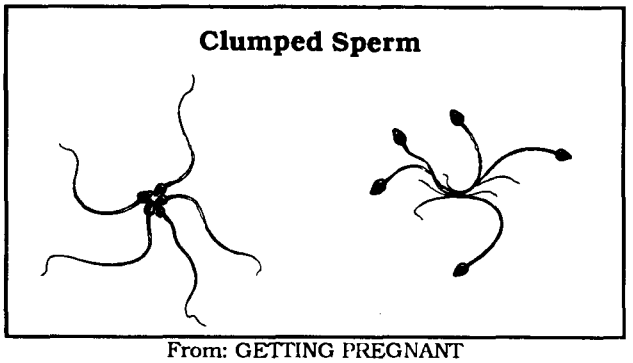
About four out of 100 men who haven't had a vasectomy have antibodies to their own sperm.

How can you tell if you have antibodies?

If a woman has antibodies to sperm in her mucus, the sperm will clump together or shake instead of swimming well. A post-coital test will show this. It is described on page 58.

If a man has antibodies to his own sperm, the doctor can see sperm clumped together during his semen analysis. The semen analysis is described on page 41.

Clumped Sperm



From: GETTING PREGNANT
(See Page 2 for full credit)

A woman or a man can also have blood tests for sperm antibodies. These are the names of the tests:

- the agglutination test, described on page 65.
- the immunobead binding test, described on page 65.

These tests can show whether you have antibodies to sperm. They can't show how likely you are to be infertile because of the antibodies. Some people have antibodies to sperm without any fertility problems. Doctors aren't sure why this is so.

What can you do yourself for antibodies to sperm?

If you are a woman, one suggestion is to avoid all contact with sperm for six to 12 months. You must avoid getting any sperm on your skin or in your mouth. If you have intercourse, your partner needs to wear a condom.

If you have no contact with sperm for this long, your body may stop making antibodies. This may happen long enough for you to get pregnant.

Many doctors suggest this. There isn't good information on how likely it is to work. This is a treatment that can't hurt you. You may be interested in trying it if you are willing to take a break from trying to get pregnant. For some people, six months to a year is a long break.

One suggestion that some men with antibodies to sperm have found helpful is to take vitamin C. They take 500 mg of vitamin C twice a day for a month. This has helped some men, but it has not been well tested to make sure that it works. If you have kidney stones, don't take a lot of vitamin C.

What other treatments may your doctor suggest?

Your doctor may suggest either intra-uterine insemination or cortisone.

Intra-uterine insemination: This treatment is described on page 99. It can be used either if a woman has antibodies to the man's sperm or if a man has antibodies to his own sperm.

If a man has antibodies to his own sperm, the doctor separates out the sperm which don't seem to be affected by antibodies. Only these sperm are used for intra-uterine insemination.

This treatment may or may not work. About 25 out of 100 women get pregnant with this treatment. Doctors don't know how many of them would have become pregnant without treatment.

Cortisone: Cortisone is a drug which stops a person's body from making antibodies. Sometimes doctors prescribe high doses of cortisone for sperm antibodies in either a woman or a man.

Cortisone is a strong drug which can have serious side effects, including ulcers, diabetes and mental illness. These side effects are rare. It is common for a person to get some side effects, including muscle weakness, less protection against infections, digestive problems, bloating, and problems after suddenly stopping the drug.

About 20 out of 100 women get pregnant after cortisone treatment. This is in couples where either the woman or the man took cortisone. Doctors don't know how many of them would have become pregnant without treatment.

DONOR INSEMINATION

Donor insemination means using the sperm of a man who is not your sexual partner to get pregnant. It has also been called artificial insemination or self-insemination.

You can have donor insemination through your doctor or arrange it yourself. If you have donor insemination through your doctor, you won't know who the donor is and he won't know who you are. If you arrange donor insemination yourself, your donor may be a friend or someone you don't know.

Women in these situations may choose to have donor insemination:

- lesbians and single women who want to have a child without a male partner.
- women whose male partner is infertile and can't be treated or chooses not to go through treatment. Many treatments for male infertility don't work very well.

From: SAN FRANCISCO BAY AREA WOMEN'S YELLOW PAGES 1981-82

As this is a book on infertility, this chapter is written for women choosing donor insemination because their male partner is infertile. If you are choosing donor insemination because you are a lesbian or are single, you may want to read books on donor insemination. These books have information on making the decision, choosing a donor, how to inseminate, and on legal questions. See page 208.

You can also contact the Vancouver Women's Health Collective for more information. The address is on page 206. You may want to talk to other lesbians or other single women who have had children through donor insemination. You may also need to find doctors who arrange donor insemination for lesbians or single women. A women's centre, lesbian group, or lesbian information line may be able to help.

You may be a lesbian or a single woman who is using donor insemination, but not getting pregnant. If you can, ask your donor to go to a doctor for a semen analysis. This will tell you if he has a fertility problem. If he does, you will probably need to find a new donor. Don't go for fertility testing yourself until you are sure that your donor is fertile. He may have problems now even if he has had children in the past. If your donor is fertile, you may want to go for infertility testing. You may have trouble finding a doctor who will help you. The groups listed above may be able to help you find a doctor.

How do a woman and man choose whether to have donor insemination?

You may find it helpful to talk to parents who have children through donor insemination. You may be able to find them through your doctor or through an infertility peer support group. In B.C., there is a group called The New Reproductive Alternatives Society which includes many parents whose children were born through donor insemination. Their address is on page 207.

If you are planning to be parents together, this is a choice you both need to feel comfortable with.

Your partner may feel happy with this choice. He will be with you through your pregnancy and the baby's birth and will be the baby's father in every way except through blood.

He may also feel unsure about it. It may bring up strong feelings about his own infertility. He may feel inadequate. He may feel jealous that you are pregnant using some other man's sperm. He may feel separate from you. He may worry that the baby will be your baby more than his.

You may also have mixed feelings about donor insemination.

It's important to spend time talking together about your feelings before making a decision. Think about all the ways this decision makes you feel happy and excited and all the ways it makes you feel sad or worried. Talk about how you will make sure that you are both equal parents to your child. You don't need to rush into deciding. You may want to take time to look at all your possible choices.

From: GRAPHIC SOURCE

Do you want the donor to be someone you know?

Most people who have donor insemination through a doctor don't know who the donor is and he doesn't know who they are. Some people who arrange to inseminate at home also have a donor they don't know. They may ask a friend to be a go-between so they don't know the donor and the donor doesn't know them.

You can also choose to ask someone you know to be your donor. You can either arrange the donor insemination through a doctor, or arrange it yourself.

If you arrange donor insemination with someone you know, it's best to have a written agreement which you and the donor sign. This agreement would say that you don't expect child support from the donor and that the donor doesn't expect any legal rights towards the child. It could also include any other agreements you make. For more information on written agreements, see the books on donor insemination listed on page 208.

Who can have donor insemination through a doctor?

Your doctor may give you a referral to a doctor who arranges donor insemination. Many doctors will only arrange donor insemination for you if you are married and your husband is infertile. Some doctors include couples who are not married, but have been together a while. A few doctors also do donor insemination for single women and lesbians. It is up to the doctor to decide.

If you are having trouble finding a doctor who will arrange donor insemination for you, contact a women's centre, lesbian organization, or the Vancouver Women's Health Collective.

Is donor insemination covered by provincial/territorial medical insurance?

It is only partially covered. You will have to pay the cost for the sperm itself. In Vancouver, the cost is $150 a month for two inseminations each month. This money goes to the sperm donor.

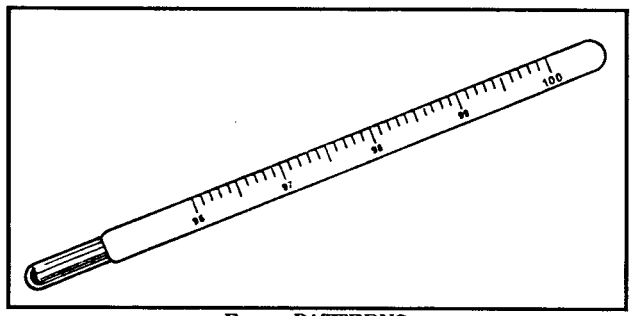
When do you inseminate?

Usually, you do two inseminations during each menstrual cycle. Your chances of pregnancy are much higher with two inseminations than with just one. You can also inseminate a third time. It is useful to inseminate a third time if you have long or irregular menstrual cycles. Otherwise, it only makes you a little more likely to get pregnant.

It's best to schedule the two inseminations two days apart. This keeps your donor's sperm count high. His sperm count would be a little lower if he ejaculated more often.

You need to know when the most fertile part of your menstrual cycle is. It's best to start watching your menstrual cycle two to three months before you start inseminating, and to keep on watching each cycle when you inseminate. This is how you can tell when you are most fertile:

- basal body temperature, described on page 49.
- mucus charting, described on page 52.
- drugstore tests for ovulation, described on page 54. These tests are expensive. You can have a good idea of when you ovulate without them. They are the most accurate way of knowing.
- if you have very regular periods, you can guess when you are most fertile. You will ovulate about two weeks before your next period.



From: PATTERNS

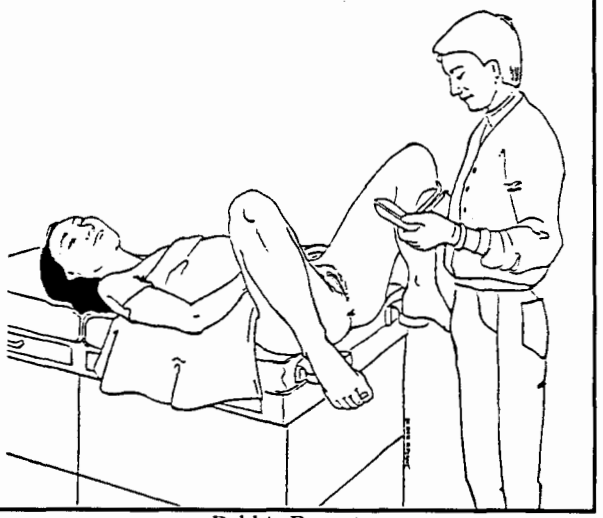
You are most fertile the day you ovulate and the day or two beforehand. Sperm can live for a few days in your body. You can get pregnant even if you don't inseminate on the exact day you ovulate.

If you are going to a doctor, you will set the appointments together about two weeks ahead of time. If you have your own donor, you need to let him know ahead of time when you will need his sperm. Ask him how flexible he can be. He needs at least two days notice. He shouldn't ejaculate for two days before giving you the sperm. This way he will have a lot of sperm in his semen.

How is insemination done in a doctor's office?

Your doctor will ask you to lie down and will do a speculum exam. Then, she will put the donor's sperm in your vagina, close to your cervix. There are two ways she can do this.

A Speculum Exam



Debbie Bryant

Many doctors use an insemination cap. This is a small plastic cap which fits over your cervix. The doctor puts the sperm into the cap. The cap keeps the sperm close to your cervix, so it doesn't have far to swim to get into your uterus. You leave the cap in for eight hours.

Your doctor can also put the sperm close to your cervix with a syringe without a needle in it. She will ask you to lie on the table for 20 minutes after the insemination. This gives the sperm time to swim up into your cervix before you stand up.

Most doctors in Canada use fresh sperm. The donor ejaculates in another room just before your appointment. You never see the donor.

In most large cities, doctors can use frozen sperm that has been thawed. You are a little less likely to get pregnant with frozen sperm. The advantage of using frozen sperm is that you have more of a choice of donors. You also are a little better protected against AIDS. This is talked about on pages 141 and 142.

How do you inseminate at home?

Your donor needs to ejaculate into a clean glass jar. He should keep the semen warm, just below body temperature. He also needs to keep it out of the light. Ask him to put the jar in a paper bag. He can wrap the jar in a towel or newspapers to keep it warm.

The sooner you can get the semen, the better. It should be no more than two hours after he ejaculates, but it is best if it is less than an hour.

There will only be about a half teaspoon of semen. Use a syringe without a needle or an eyedropper to get the semen from the jar into your vagina. You can get either at a drugstore. Some pharmacists won't sell syringes.

It's best not to use a turkey baster. Because it's so big, you can force air into your cervix by mistake.

Lie on your back and put the syringe or the eyedropper into your vagina the way you would put in a tampon. You may want to feel first for your cervix with your finger. Put the semen close to your cervix. Then lie back for about half an hour. This gives the sperm time to go into your uterus before you stand up.

Your partner can help you to inseminate. You may want to do this together.

From: GETTING PREGNANT OUR OWN WAY

How long does it take to get pregnant with donor insemination?

About six out of 10 women get pregnant within six months. For a few women, it takes up to a year. Overall, six to eight women out of 10 get pregnant inseminating with fresh sperm. With frozen sperm, five to seven women out of 10 get pregnant.

Does the donor go through tests?

The donor needs to be tested to make sure he has no infections which can be passed to you in his semen. Doctors test men who want to be donors for AIDS, Chlamydia, gonorrhea, herpes, syphilis, and hepatitis.

If you are going to a doctor for insemination, ask how often the sperm donors are tested for VD. Most doctors do tests every three months. They should test for AIDS at least three times, three months apart.

You or your doctor also need to be sure that your donor has no health problems which can be passed on to your child. Your doctor will ask him for a complete medical history, including family health problems.

If you are not going through a doctor, you can ask your donor questions yourself about their health problems and health problems in their family. These are questions you may want to ask:

- age, height, hair and eye colour, race and cultural background and blood group
- if he has fathered any children
- if he works with radiation or strong chemicals
- if he smokes, drinks, uses street drugs, and if so, how often
- what health problems he or his family has had. His family includes brothers, sisters, parents, aunts, uncles and grandparents. This includes birth defects like cleft palate, clubfoot, Down's syndrome, and so on. It also includes conditions that appear later on: Huntington's chorea, early blindness, kidney disease, neurofibromatosis, deafness before age 50, liver disease, heart attack before age 50, diabetes before age 30, and cystic fibrosis.
- if he is a carrier for hemophilia, Tay Sachs disease or sickle cell disease
- if he is willing to be tested for VD, including AIDS
- how long a time he is willing to donate sperm
- if he is available two to three times a month

If you have any questions about your donor's medical history, talk to a doctor or another health worker.

Are there health risks to donor insemination?

The main health risk is that you could get a disease which is passed through the donor's semen. You may be worried about getting AIDS.

The chances of getting AIDS from a donor are very low if he is tested regularly for the virus that causes AIDS. People can carry this virus and show no signs of illness for years, so every donor should get tested.

The test won't show that a man has been infected with the virus that causes AIDS until three to six months after he has been infected.

If a donor had sex with someone infected with the AIDS virus less than six months ago, he could be infected without the test showing it.

To avoid this risk, some doctors use only frozen sperm. They use the sperm at least six months after it is frozen. The donor has a test for the AIDS virus six months after he donates the sperm. If the test shows that he isn't infected with the AIDS virus, he would not have been infected when he donated the sperm.

Many doctors do not have the equipment to freeze sperm. This is also not possible if you are arranging your own donor insemination.

To avoid any risk of AIDS, you may want to make sure your donor is not at high risk. These groups of men are at a higher risk for AIDS:

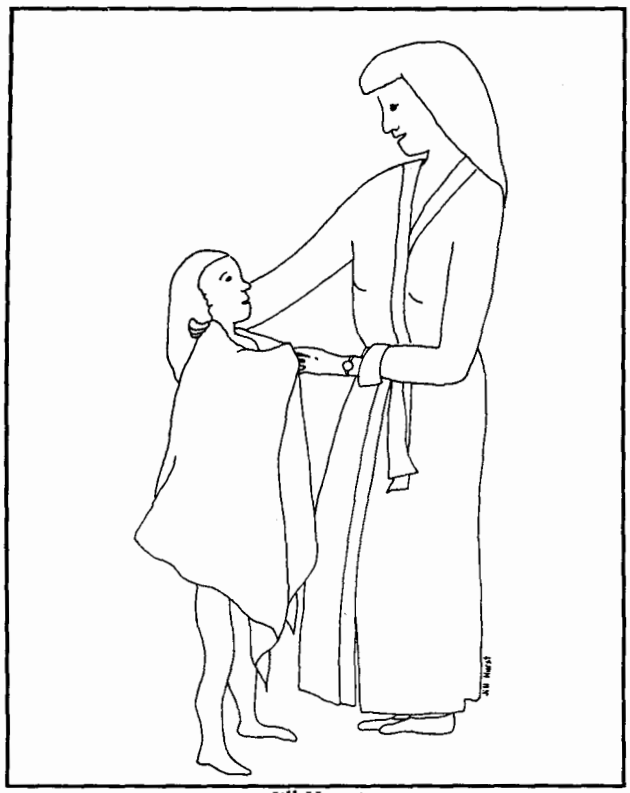
- IV drug users (men who shoot up drugs)
- gay and bisexual men, if either they or their partner have had more than one sexual partner
- heterosexual men with several sexual partners

You could ask your donor to have one test for the AIDS virus and then another test six months later. In between he should practice safer sex.

You may also want an agreement from your donor that he uses safer sex if he has any new sexual partners while he is your donor. For more information on AIDS and safer sex, write one of the AIDS organizations listed on page 207.

What do you tell your child?

Thousands of children have been born through donor insemination in Canada. In spite of how often donor insemination is done, people tend to keep very quiet about it.



Jill Hurst

Many children do not know they were born through donor insemination. Many grandparents, aunts and uncles do not know that this is how a child was conceived.

People used to keep adoption a secret. Now, most people think it's better for the child if they know that they were adopted from a young age. Many people are starting to feel the same way about donor insemination.

There are a few reasons for this. One is to respect children by letting them know as much about themselves as you can. Another is to keep children from finding out in a way that hurts them later on. A third is so they will have the right information about their family medical history.

Your child may be curious about the donor. You won't know who the donor is if you have donor insemination through a doctor. If you want, you can ask your doctor some questions about the donor. Your doctor may be willing to tell you a few things which you could tell your child later on.

In Sweden, a child who is born through donor insemination has the right to find out who the donor is at age 18. They can seek out and meet the donor if they want. This is very different from the way things are in Canada.

If you want more information on this, get in touch with the New Reproductive Alternatives Society. They are very interested in the rights of children born through donor insemination. Their address is on page 207.

NEW REPRODUCTIVE TECHNOLOGIES

This chapter is about new treatments for infertility which are still being developed. These treatments are often called "the new reproductive technologies". We will talk about the following treatments in this chapter:

- In vitro fertilization, also called IVF
- Gamete intra-fallopian transfer, also called GIFT

Many people have questions and concerns about these treatments. At the same time, newspaper, TV and radio reports exaggerate how new and important these treatments are. They talk about them as though they were the answer to everyone's infertility problems. Many people think that they could have a baby if they only had a chance to try one of these treatments. As you will see in this chapter, this is not true for most people.

From: WOMEN, HEALTH & REPRODUCTION (see P.2 for full credit)

These treatments are very expensive. They are mostly not covered by medical insurance. They have also not been tested very well to make sure that they are safe.

IN VITRO FERTILIZATION (IVF)

"In vitro fertilization" means fertilization in glass, or in the laboratory. Most people know it as "test-tube babies". We will call it IVF in this section. This is a very new treatment which is still being developed. It has not been tested very well yet to be sure that it is safe either for the women who go through it or for their babies.

IVF is very expensive. In January 1989, Ontario is the only province which covers it through the medical insurance plan. In other provinces, the woman who goes through it pays between $1800 and $4200 for each try at IVF. Usually the woman also pays more to begin with to cover drug costs. She may get some of the costs of the drugs back.

What problems does IVF treat?

IVF was developed as a treatment for blocked or damaged fallopian tubes. It is a way of bypassing your tubes. Most women go through IVF for this reason.

Doctors are starting to use IVF for a number of other reasons as well. They use it for other kinds of infertility if other treatments haven't worked. These are the other reasons women may go through IVF:

- their partners have sperm problems
- endometriosis
- cervical mucus problems
- immune problems
- infertility caused by DES
- unexplained infertility
- anyone who hasn't become pregnant when they have tried other treatments, including trying GIFT three times. GIFT is discussed on page 151.

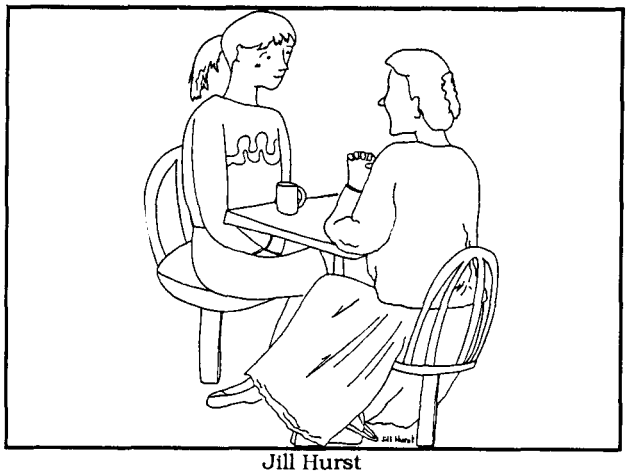
There is no proof that IVF really helps women in any of these other situations. There is no proof that it is any more helpful than not having treatment.

Who can have IVF?

The programs set limits to who can have IVF. One limit is money. In every province but Ontario, you must pay for IVF. These are other limits set up by the program in Vancouver:

- You must be legally married.
- You must have blocked fallopian tubes or have tried other treatments, including GIFT.
- You must not have a history of psychiatric treatment.
- You must be 38 or younger when you apply.

Lesbians, single women, and women in common-law relationships can't have IVF. People who have gone for treatment when they've had emotional problems can't have IVF. Many people have concerns that this is discrimination.



Jill Hurst

What happens during IVF?

There are several steps to IVF:

- You are given fertility drugs. You'll probably be given both the drugs clomiphene and HMG. You are given a very strong dose of these drugs. See page 83 for information on clomiphene and page 86 for information on HMG.
- Normally, only one egg becomes ripe inside your ovary during each menstrual cycle. During IVF, you are given a strong dose of fertility drugs so that several eggs will become ripe at once.
- You have blood and urine hormone tests each morning for 10 days to two weeks. You also get ultrasound scans when your doctor knows that you will ovulate soon. See page 61 for a description of ultrasound. Your doctor can see your ovaries and the ripening eggs.
- You are given a shot of another hormone, HCG, so that you will ovulate. HCG makes you ovulate 36 hours after you have the shot.
- Just before you ovulate, you have a laparoscopy. Laparoscopy is described on page 62. The doctor uses a syringe to take each of the ripe eggs out of your ovaries.

- The doctor mixes the eggs with your partner's sperm in the laboratory. They stay there for two days, in a liquid which is a lot like the liquid inside your tubes. A lab technician looks at the liquid through a microscope to see if any eggs have joined with sperm. When they join, they make an embryo.

- If there are any embryos, the doctor puts them back into your uterus two days after you have the laparoscopy. You lie on an examining table and she puts a speculum in your vagina to hold it open. She puts a soft plastic tube through your cervix and uses a small amount of liquid to flush the embryos into your uterus. This part of IVF is called "embryo transfer". She is putting the embryos into your uterus.

- In some IVF programs, you are given the hormone progesterone during the second half of your menstrual cycle. This is done to help the lining of your uterus to grow. There is no proof that you are any more likely to get pregnant if you have progesterone during IVF than if you do not.

- You are given a blood test for pregnancy about 10 days after the embryos were put back into your uterus.

From: TAPESTRY, Spring, 1988

What are the chances of having a baby through IVF?

For every 10 couples who go through IVF in Canada, one baby is born. This number groups all couples together who have tried IVF. It includes people who have gone through it once, twice, or several times.

Almost half of all IVF pregnancies end in miscarriage.

Many IVF programs count their successes in a misleading way. They tell women they have a 20 to 30% rate of success. They are counting all pregnancies, whether or not they ended in miscarriage.

They also often don't count some women who weren't helped by IVF. Women who started the program, but never had embryos put back into them are not counted. These are women whose eggs never joined with sperm to form embryos. Other women don't end up with eggs that can be taken out during laparoscopy. They are also not counted as women for whom IVF did not work . This makes the chances of success seem higher than they really are.

What are the risks of IVF?

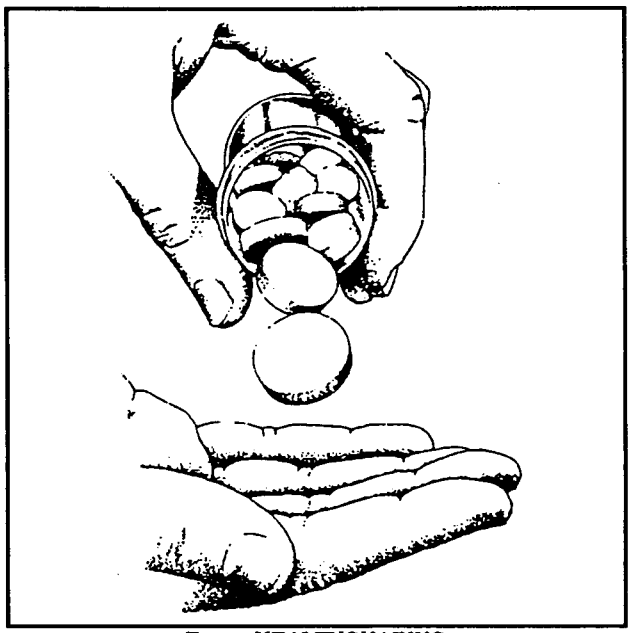
Because IVF is complicated, there are risks from a number of its steps.

Hormonal drugs

Women are given large amounts of clomiphene and HMG. The drugs are being used to force women's ovaries to do something they would not normally do. Normally, only one egg ripens during each menstrual cycle. There are health risks to taking normal doses of these drugs. At higher doses, the chances of problems are higher.

No one knows whether women who take large amounts of these drugs will have long-term problems. It hasn't been studied.

Drugs must be tested by the federal government before they are approved. These drugs weren't specially approved for IVF because they were already being used for fertility problems. However, in IVF they are being used in a new way, at strong doses. This may be riskier.



From: HEALTHSHARING

See pages 83 to 87 for information on the side effects of clomiphene and HMG.

Progesterone is sometimes given during IVF. In this case, a hormone may be used during the first few weeks of pregnancy. See page 79 for information on why there are concerns about using progesterone during pregnancy.

Surgery

A woman has a laparoscopy to take out her eggs in most IVF programs. She usually has a general anaesthetic. Surgery always involves some risks of infection and health risks from having an anesthetic. See page 64 for the health risks of having a laparoscopy.

Some IVF programs use ultrasound to take out a woman's eggs without surgery. The ultrasound shows exactly where the ripe eggs are. It helps guide the needle which is used to take out her eggs. The needle can reach a woman's ovaries either through the wall of her lower belly and through her bladder, or through the wall of her vagina. It is probably safer to use ultrasound to see and reach the eggs than to have surgery. Not all programs have the equipment or the experience to do this.

Ultrasound

During IVF, a woman has many ultrasounds of her ovaries. Her developing eggs are exposed to a lot of ultrasound. This may be harmless, but it may also have harmful effects that we don't know about yet.

Embryo transfer

A woman may have a tubal pregnancy with IVF. This is a pregnancy which attaches and grows in her tube rather than in her uterus. Normally, about one in 100 women have tubal pregnancies. With IVF, it is three out of 100 women.

This may happen because the embryos are washed up into a woman's tube when they are put into her uterus. It may also happen to women whose tubes are damaged. A tubal pregnancy is dangerous. If this happens, you need to go to a hospital and have surgery right away.

Miscarriage

About 40 out of 100 women miscarry after getting pregnant through IVF. This is a high rate of miscarriage. It is hard to know if it is really higher because of IVF. Women get early pregnancy tests with IVF. Some women miscarry so early that they would have never known they were pregnant without an early pregnancy test.

More than one baby:

About one out of every five women who has a baby through IVF has several babies. These are mostly twins. About three out of 100 women have triplets. The risk of having several babies is different in different IVF programs. It depends on how many embryos they put back into your uterus. They usually set a limit. Most programs put in four to six embryos. They do this because it makes you more likely to get pregnant than if they just put in one embryo.

Risks of birth defects:

No one knows yet whether a baby is more likely to have birth defects if it is born through IVF. Most birth defects are very rare. Thousands of babies must be born before anyone can tell whether some types of birth defects are more common with IVF babies. So far, it seems that babies born through IVF may not have more birth defects than other babies.

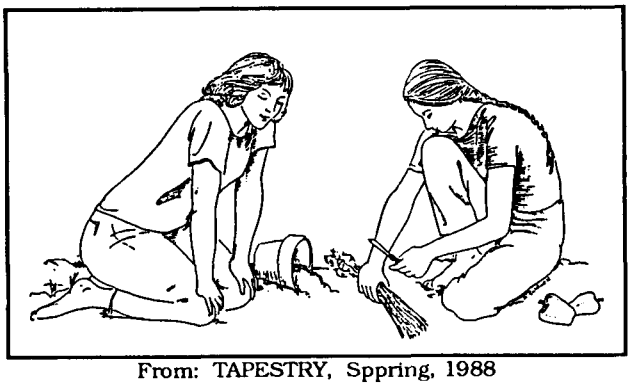
Are there other concerns about IVF?

IVF is very complicated and expensive. Some people have concerns that money which goes into IVF could be better spent preventing infertility.

Good testing and treatment programs for VD could prevent a lot of infertility. This would prevent many women from getting blocked tubes. Better treatment of P.I.D., infections in women's tubes, could also prevent a lot of infertility.

Another concern is that IVF is being used more and more for problems that men have. Less sperm is needed to fertilize an egg during IVF than in a woman's body. A woman goes through a lot if she has IVF for her partner's sperm problem. She may risk her health in the long-term.

Many people see IVF as a solution to their infertility problems. They may wait a long time to save the money for IVF. They may also spend years on the waiting list. Nine out of 10 people who go through IVF don't have a baby. They may have had very high hopes and be very disappointed. They may have put off looking at other solutions while they waited and hoped for IVF.



From: TAPESTRY, Sppring, 1988

GAMETE INTRA-FALLOPIAN TRANSFER (GIFT)

Gamete intra-fallopian transfer, or "GIFT", is a lot like IVF. The difference is that GIFT is for women whose tubes are not blocked.

Like IVF, GIFT is very expensive and is not covered by medical insurance.

Who can have GIFT?

You must have the money to pay for GIFT. It is less expensive than IVF, but it can still cost several thousand dollars. You must be legally married, less than 38 years old, and never have had psychiatric treatment.

GIFT is for these people with these infertility problems:

- infertile for no known reason for more than three years
- endometriosis
- cervical mucus problems
- immune problems
- low sperm count or other sperm problems. If these problems are very strong, GIFT may not be possible.

How is GIFT done?

These are the steps for GIFT:

- You are given a strong dose of fertility drugs, usually clomiphene and HMG. This makes a few eggs ripen in your ovaries instead of one.
- You have blood tests and ultrasounds.
- You have a shot of HCG to make you ovulate.
- You have a laparoscopy just before you ovulate.
- Your doctor takes ripe eggs from your ovaries with a syringe. She mixes them with sperm and puts them back into your fallopian tubes.

The last step is the only step in GIFT which is different from IVF. During IVF, the eggs and sperm are mixed together in the lab and the embryos are put into your uterus two days later. The health risks for either treatment are similar. See page 148 for information.

How well does GIFT work?

GIFT is new and still being developed. There is no proof that you will be any more likely to get pregnant if you have GIFT than if you have no treatment. Overall, about one in 10 women have a baby from GIFT.

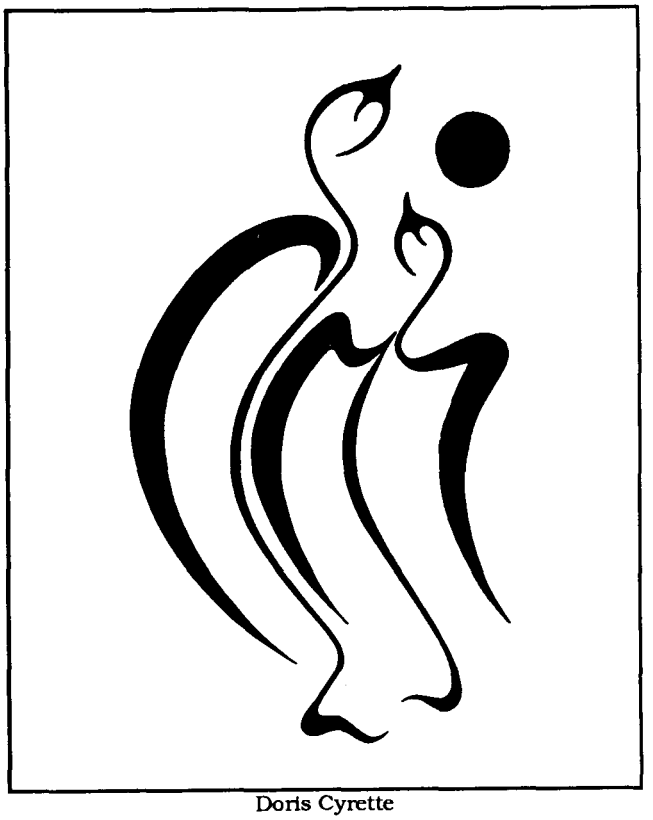
OPTIONS

This chapter is about things you can do other than get pregnant and bear a child of your own. It has information about adoption, birth contracts, being a foster parent, and shared parenting. It also has ideas about alternatives to parenting including being an adult friend, volunteering and looking at other dreams and goals.

These things won't take away all your feelings about not being able to bear a child. You will probably still need to deal with your feelings about your infertility. See the chapter **Living with Infertility** on page 175.

Many people say that they feel out of control when they are trying to get pregnant. Choosing one of these options may help you feel more in charge of your life.

None of these things are right for everyone. Try to think about what you want. If you have a partner, talk together about what you both want. Other people may think that they know what you should do. You may also find that you are thinking about what would please your family or friends, not what you want. It's your life. Try to think what will feel best for you.



Doris Cyrette

Here are some things to think about if you are thinking about these options. If you have a partner, you may want to answer the questions together.

- Why do you want a child? Make a list of all your reasons.
- Why would you not want to have a child? Write down as many reasons as you can.
- Do you want to be pregnant and have a baby or do you want to raise a child?

- If you were to have a child, what would the child need until she or he grows up? Will you be able to meet those needs? (Remember no parent completely meets the needs of their children.)

- Think of the time before you tried to have children. What things made you happy? What things did you look forward to? What did you do with your time?

- What are some of your other goals and dreams besides having a child?

These questions may help you decide what you want to do. You may also find it helpful to talk to family, friends, and other people dealing with infertility.

Adoption means taking a child as your own and becoming a family. A birth contract is an agreement to have another woman bear a child for you. Foster parents provide temporary homes for children whose parents aren't able to care for them. Some infertile people share the responsibility of parenting a child with someone who is able to bear a child. Alternatives to parenting include being an adult friend, volunteering, and looking at other dreams and goals.

There is information about each of these options in this chapter. You may just want to read about the options that interest you. As you are reading, think about how that choice would change your life.

ADOPTION

Adoption means taking a child as your own. There are ways that being an adoptive parent is like being a biological parent. There are also ways that they are different.

People who have adopted children say it's good to try to think about both these similarities and differences when you are deciding whether to adopt.

Both adoptive parents and biological parents have the same rights and responsibilities. You care for your child or children and try to provide them with a good home. You make the parenting decisions. You are responsible for all the costs involved in raising your children. You have many of the same satisfactions, worries and joys.

Everyone involved in adoption faces special issues. This includes the child, the birthmother or birthparents and the adoptive parents.

The child needs to deal with the loss of their birthfamily and come to accept that she or he is adopted. The birthmother is the biological mother. She needs to deal with the loss of the child that she has carried and given birth to. The adoptive parents need to deal with the loss of the child they had hoped to give birth to. They need to come to terms with their infertility. There is more information about this on page 175.

Families formed by the adoption of older children face extra issues. The child will have had a life that you haven't been a part of. She or he will probably have had some difficult times. These families usually go through a time of adjustment. It takes a while for the adoptive parent to learn how to parent the child with special needs. It takes a while for the child to find her or his place in the new family.

Families formed by the adoption of a child from another race or culture face extra issues that are different. Everyone is raised with ideas about people from their own race and cultural group and also ideas about people from other races and cultural groups. These are called stereotypes. It's important that the adoptive parents think about their stereotypes, learn a lot about the child's race and culture and help the child feel proud of their background. The child may face discrimination and feel confused about who they are.

People choose to adopt for many reasons. Some choose adoption because there is no treatment to their infertility. Others choose adoption instead of going through infertility treatments. Still others adopt because so many children need a home. The decision to adopt is an important decision that takes a lot of soul searching and thought.

There is a long waiting list to adopt healthy infants. The waiting time is different in different provinces and territories. In January 1989 it's at least four years and may be up to ten years. If you decide that you might like to adopt an infant, think about applying right away. Many people spend years going through infertility testing and treatment. If your infertility can be treated, you can cancel adoption plans. If you wait until you've tried all the tests and treatments that many help you, you may still have the long wait for adoption.

It's usually quicker to adopt an older child or a child with special needs. There is more information about this later in this section.

There are organizations of people who have been through adoptions listed on page 207. They can give you more information. They can also tell you what adopting a child has been like for them. You may find it helpful to talk to them about your questions, concerns, and feelings.

Many Native people arrange to care for children without going through the provincial or territorial government. You may take care of your sister's, brother's, or friend's child. You may live in a community where friends and family share the work and responsibility of taking care of children. You may not need to go through the type of adoption described in this chapter.

From: HEALTHSHARING, Winter 1984

Do you want to adopt a child?

Choosing to adopt a child is an important decision. Think carefully about the questions on pages 152 and 153. Here are a few more questions to ask yourself. If you have a partner, you may want to answer the questions together.

- All parents have dreams and goals for their children. What do you expect of your child or children? People often say that adoptive parents expect a lot from their children. How will you feel when your child doesn't live up to your dreams and goals?
- How will you help a child accept that she or he is adopted?
- Most adopted children go through a time when they want to find out who their birth families are. How will you support them through this?
- If you already have children, how do they feel about having another sister or brother?
- People sometimes think that adoptive parents don't love their children as much as biological parents or that families formed by adoption aren't quite as good. How will you deal those attitudes?
- Do you want to adopt a child with special needs? There are more questions to think about on page 159 if you are thinking about this.
- Do you want to adopt a child from a different race or culture than you?

Are you thinking of adopting a child from a different race or culture?

Here are some questions to think about if you are thinking about adopting a child from a different culture or race:

- What stereotypes do you have about people from the child's race or culture?
- How will you learn about the child's culture?

- How will you help the child learn about and be proud of his or her background and culture?
- Would your families accept him or her?
- How will you deal with people staring at you and your child or asking questions about you being together?
- How will you help your child to deal with stereotypes, prejudices and discrimination as she or he grows up?
- Are you prepared to be a family of mixed race from now on?

How do you adopt a child?

There are five types of adoptions:

1. Government Adoptions
2. Relative Adoptions
3. Private Adoptions
4. Government International Adoptions
5. Non-Government International Adoptions

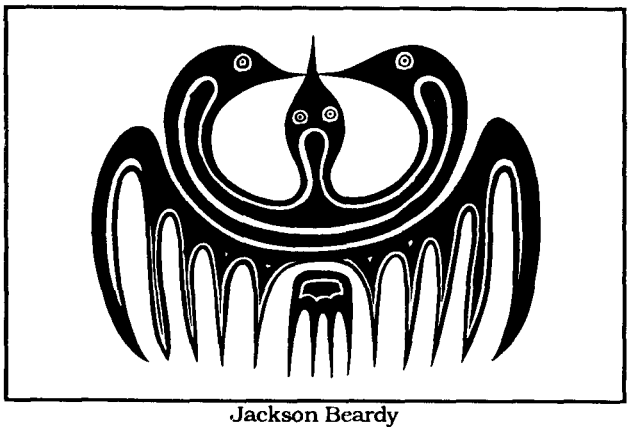
Government Adoptions

Most adoptions are arranged by the provincial or territorial government. To begin this type of adoption, you meet with a social worker. The social worker will be from one of these departments or ministries:

- B.C. Ministry of Social Services and Housing
- Alberta Social Services
- Yukon Department of Health and Human Resources

There are two main types of government adoptions, healthy infants and special needs children. Healthy infants are babies up to two years who are in good health. Children with special needs are described on page 159.

The government tries to place children with adoptive parents of the same race and religion.



Jackson Beardy

Who can adopt through the government?

There are different rules in each province or territory. There are also different rules for healthy infants and special needs children. You'll need to talk to a government social worker to see if you are eligible.

In B.C. the government prefers married couples. Lesbian and common-law couples can't adopt through the government. Healthy infants are only placed with married couples. Children with special needs can be placed with single people if the government thinks it's a good home for the child. Single lesbians and gay men may be able to adopt a child with special needs, but it's unlikely.

In Alberta and the Yukon, any adult can apply. This doesn't necessarily mean that you will be able to adopt a child.

How do you apply?

When you apply for adoption, you will meet with a social worker. She will do the following things:

- She will encourage you to think about your strengths and weaknesses, how you would parent, what kind of child you are able to parent, and how you will face the challenges that adoption brings.
- She will ask you why you want to adopt children, what your family and friends are like, how much money you have, what you think is important, and how you would raise children. If you are in a couple, she will see you together and also see you each on your own. She will also ask you to fill out forms.
- She will ask you for names of reference people. These are people who know you well. She will talk with them and ask them questions about you.
- She will visit your home several times. These are called home visits. She's checking to see if she thinks you'd be able to provide a good home.
- She will write a report about you. In B.C. and Alberta it will go to the Superintendent of Child Welfare. In the Yukon it will go to the social workers' supervisor.

The office of the Superintendent or the supervisor then decides whether they are willing to "place" a child in your home. If they are, you will go on a waiting list. The social worker will write a report about you called a homestudy. This may be done soon or it may be done in a few years. This depends upon where you live and what kind of adoption you are applying for.

The homestudy will describe what you are like, what you do for work and in your free time, your religion, a bit about your background, and why you want to adopt a child. It won't have your name on it. You will get to read the homestudy and say what you think of it. It will be read to birthmothers or birthparents choosing homes. They don't get a copy to keep.

What happens next depends on whether you have applied for a healthy infant or a child with special needs.

Healthy Infants

Many people want to adopt healthy babies. If you ask to adopt a healthy infant, you will be put on a waiting list. When you get near the top of the list, you will go into a group of families that are being considered. What happens next depends on where you live.

In B.C. and Alberta copies of your homestudy will be read to birthmothers who are choosing homes. It's up to the birthmother to choose the home. There's no guarantee that a birthmother will choose your home. If a birthmother chooses your home, the government will tell you a few days after the baby is born. You'll probably only have a few days to get ready.

In B.C. and Alberta, there is a waiting period of 10 days after the baby is born in which the birthmother can change her mind. After that, she will sign consent papers and you are able to bring your new baby home.

In the Yukon, copies of your homestudy may be read to birthmothers, but the government chooses the home. The birthmother signs the consent 10 days after the birth and then has 30 days to change her mind. Babies usually go into foster homes for this time.

Special Needs Children

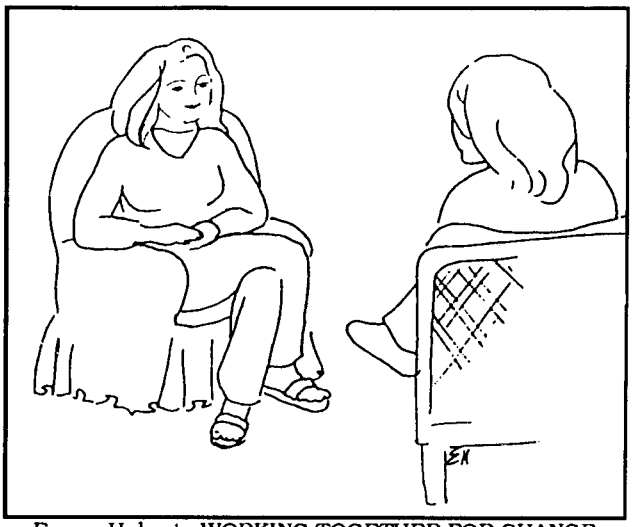
Children with special needs are infants with health problems, children over two with emotional, physical or mental handicaps, children who have been abused, neglected or been in a lot of foster homes and groups of brothers and or sisters. Here are some questions to ask yourself if you are thinking about adopting a child with special needs:

- Are you able to provide love and affection to a child who may not be able to return those feelings for a long time?
- Do you have the parenting skills and patience to parent a child with special needs?
- Are you in good physical and emotional health to cope with the extra stress of having a child with special needs?

- Do you have friends and family who will give you help and support?
- What services will the child need? Are those services available in your community? What do they cost? Can you afford them?
- Will you be able to deal with children that have been sexually or physically abused and all that it involves?
- Are there things that still trouble you from your childhood? These things are often brought up when caring for children with special needs.

The government is always looking for homes for children with special needs. They will try to match you with children who need the type of home you can provide. When this happens, they will contact you with information about the child or children.

Ask lots of questions and find out as much as you can about the child. Talk with the social worker about what special services the child may need. They may need special health services, counselling, or other special support. The Adoptive Parents Association of B.C. has a list of questions for you to ask. There are organizations of people who have adopted children with special needs listed on page 207. They can help you when you are trying to decide whether to adopt a child with special needs.



Emma Haley in WORKING TOGETHER FOR CHANGE

If you think you might want to adopt the child, your social worker will arrange for you to meet each other. You will probably meet several times. This gives you and the child time to see how you feel about each other. You can choose whether or not you want to adopt any child that the government suggests. If you decide not to adopt a specific child, you can still adopt other children with special needs.

What happens after the child comes to live with you?

The social worker will stay involved. She is supposed to help you and your child get used to being a family. She will probably keep in touch for about six months after the child comes to live with you.

Many people find they need information and support after adoption. There is a list of organizations that provide support to families formed by adoption on page 207.

The B.C. government is also starting to provide extra support for special needs adoption. They have set up programs in some communities to help prepare the child and adoptive family and to provide help after you become a family. Ask your social worker what support is available for you.

In B.C. and the Yukon, you will sign papers after the child has lived with you for six months. In Alberta, you can sign the final papers anytime after the child comes to live with you. You and your social worker will decide this together. The papers go to court and then you'll be legally a family.

Relative Adoptions

If someone in your family has a child that you can adopt it is called a relative adoption.

You don't need to go through a social worker. You or your lawyer can apply directly to the provincial or territorial court to become the adoptive parents. In B.C. and the Yukon, you need a lawyer to do this. In Alberta, you can do this on your own.

In B.C. and Alberta, a social worker will only get involved if the court orders the government to do an inquiry. If that happens, the social worker will do a homestudy. She will also talk to the birth parents and talk to the child if she or he is of school age. The government will then write a report for the court.

In the Yukon, the government always does a homestudy and report for the court.

From: THE IMPORTANCE OF PLAY

Private Adoptions

Some people choose to try to adopt a child privately. In a private adoption the arrangements aren't made by the government. They are often arranged through doctors, lawyers, friends or private adoption agencies. In this type of adoption, the child and the adopting parents aren't related to each other.

Private adoption is legal as long as no money is paid for the baby.

Most people who choose private adoption want to adopt a healthy baby. Some don't want to go through the government because of the long wait. Others can't adopt a baby through the government. Some people choose private adoption because it gives them more control and choices. The birthmother and adoptive parents make their own decisions about how much information about themselves to share. Sometimes they arrange to meet each other and keep in touch over the years.

How do you arrange a private adoption?

Here are the steps you could go through:

Spend some time thinking

There are many different ways to arrange private adoptions. Sometimes the adopting parents ask someone to act as the "go-between" between them and the birthmother or birthparents. This person keeps the names of everyone involved secret. This isn't possible in Alberta because the legal papers must include both of your names. Sometimes the adopting parents and the birthparents talk together. Think about what you want.

Write a letter about yourself

Start the letter "Dear Birthmother". Include information about yourself and why you want to adopt a baby.

You may want to also have a social worker do a homestudy about you. It can be reassuring to the birthmother to know that a trained professional thinks that you would provide a good home. In B.C., government social workers aren't allowed to be involved in private adoptions. You need to hire a private social worker. In Alberta or the Yukon, a government or a private social worker can do the homestudy. You can get a list of private social workers from provincial Associations of Social Workers. See page 207.

The questions that the social worker will probably ask are on page 158.

The letter from you and the homestudy can be shown to birthmothers or birthparents.

Find people who will help you find a child

Make a list of all the people you can think of who may be able to help you. Here are some ideas: friends, relatives, doctors, professionals, people you work with, people in your church or neighbors.

Contact the people on the list. Explain that you are hoping to arrange a private adoption. Ask them if they will help you by watching for any woman who wants to give up a child for adoption. If they say yes, give them a copy of your letter and a copy of the homestudy if you have one. They could show them to any woman who may be interested.

Make sure to talk to them about how to keep both of your names confidential if that is what you want.

It helps to keep in regular touch with these people to tell them that you are still interested.

Get a lawyer

In some provinces and territories you need a lawyer and in others you may not. If you need a lawyer, try to find one before you find a child that you want to adopt. Ask them how much experience they have with private adoption and how much they charge. Lawyers charge different fees.

In B.C. and the Yukon, you need a lawyer to apply for the adoption to the provincial or territorial Supreme Court. They also need to tell the government that the child has come to live with you. In B.C. this needs to be within 14 days and in the Yukon it needs to be within 30 days.

In Alberta, most people don't need lawyers. If you are arranging the adoption yourself, Alberta Social Services will make the legal arrangements. If you are going through a licensed private agency, they will do this work for you.

What happens if you hear that a birthmother may want to place a child with you?

You will probably have a lot of feelings. Try to remember that women sometimes change their minds after having the baby. The legal papers can't be signed until after the baby is born. The birthmother has the right to keep the child or give it to someone else even if she promised to give it to you.

Try to find out as much as you can about the birthparents. Make sure that they understand that they have choices and are sure that they want to go through with the adoption. Ask about their health and their families health. You will want to know if health problems run in your child's birth family.

Sometimes birthmothers ask to meet with the adoptive parents. If this happens, you'll need to decide if this is right for you.

In some provinces and territories you can offer to help pay the birthmothers medical, legal, and travel costs. In B.C., you or your lawyer needs to apply to the Superintendent of Child Services for permission to do this. You don't need to apply in the Yukon. This isn't allowed in Alberta.

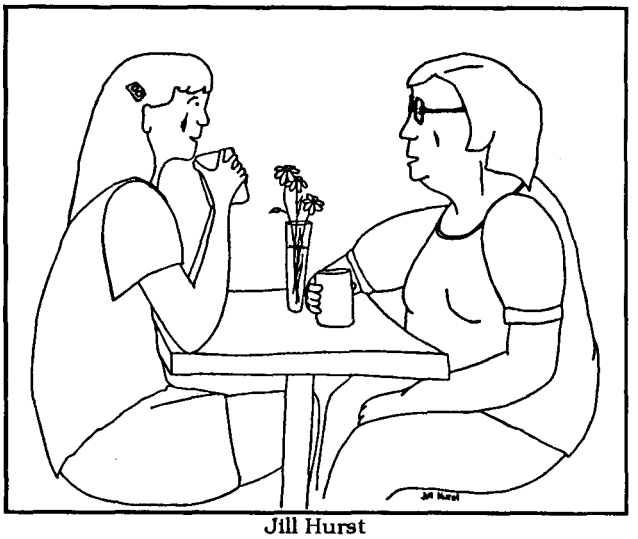
What about the birthmother?

It's a good idea for the birthmother to get counselling to make sure this is what she wants. She can talk to a government social worker, counsellor, or private social worker. It's best if this isn't your social worker.

Someone needs to explain her legal rights when she signs the consent papers. They should make sure that she isn't being pressured and is aware of her choices. In B.C. and the Yukon this must be a lawyer. You cannot both see the same lawyer. In Alberta it will be a government social worker.

She may want to write a letter to the baby explaining why she couldn't keep her or him and why she arranged the adoption. This will likely be very important to the child later on. She may also want you to tell her how the baby is doing. You can arrange to send letters and pictures through a doctor, lawyer, friend, or directly to her.

In B.C. and the Yukon, a government social worker will visit her after she signs the papers. The social worker will make sure that she was aware of her choices. She will also ask about her medical and social history.



Jill Hurst

How do you make the final arrangements?

It's helpful to get a signed letter or report from a social worker or other professional saying that the birthmother has had proper counselling. She should say that she is aware of all her choices and has chosen adoption. In most cases counselling from her doctor isn't enough.

You may be worried that if you do this she may change her mind. It's a lot better if she is sure of her decision before the baby comes to live with you. You don't want to end up with a court case over the child.

In B.C., she can't sign the papers until 10 days after the baby is born. In Alberta, she can sign anytime after the birth but she will have 10 days after she signs to change her mind. In the Yukon, she can't sign the papers until 10 days after the baby is born and then she has 30 days to change her mind.

If the biological father has helped support the baby or if his name is on the birth certificate, he also needs to sign the consent papers.

In B.C., it's suggested that you leave the baby in the hospital until the consent papers are signed. You may be able to arrange to visit during that time. This depends on what the birthmother wants and the hospitals rules.

In Alberta and the Yukon, you can take the baby home after the birthmother signs the papers. In Alberta, this is usually three or four days after the baby is born. In the Yukon, it's 10 days after the birth. The birthmother can still change her mind. The baby can go to a receiving home or a foster home while you wait to be sure, if you want.

After you take the baby home, a government or agency social worker will come and visit your home. She will be making sure you are providing a safe and loving home.

In B.C. and the Yukon, you can sign the adoption papers after six months. In Alberta, a social worker will start to visit you within 14 days. When she is satisfied that you can provide a good home, your adoption will be completed by the government or the agency.

Jill Hurst

Government International Adoptions

The federal government and provincial or territorial governments work together to arrange international adoptions. The federal government has a "National Adoption Desk". It keeps in touch with the countries that Canada arranges adoptions with. They pass this information on to the provinces and territories. In 1989 Canada arranges adoptions of children from Brazil, Columbia, El Salvador, Hong Kong, India, Korea, and the Philippines.

If you want to adopt a child from another country, talk to your social worker. She will tell you which countries are accepting applications for adoptions and whether you are eligible to apply. Each country has different rules. Many want adoptive parents to be within a certain age range and to have been married for a specific amount of time. Some require that you have never been divorced. They may limit the number of children you have.

Some countries will let you apply if you are single. We don't know of any country that will consider you if you are lesbian or gay.

You will need to have a homestudy done, and be approved from the provincial or territorial government. They will then send information about you to the National Adoption Desk. The Adoption Desk will send the information to the other country.

It varies how long you will need to wait. It depends on the country you apply to and how smoothly everything goes. It usually takes at least two to three years for an international adoption. It may be longer.

You can be on the waiting list for a government adoption and also apply for an international adoption from one other country at the same time.

International government adoptions are expensive. In 1989 they cost anywhere between $2000.00 and $10,000.00. This depends on the country the child is from. This covers the legal expenses and the cost of the child's travel to Canada.

Often the children come to Canada with an escort. You may also be able to travel to pick up the child if that's what you prefer.

In some communities there are support groups for people who have adopted children from a particular country. You may find it helpful to get in touch with one of these support groups if you are thinking about international adoption.

Non-Government International Adoptions

From: MOTHERING, Fall, 1984

Non-government international adoptions can either be arranged by agencies or by you. You will need help from either lawyers, orphanages, doctors or other people in the country where the child is born. A number of agencies arrange private adoptions. A magazine called "Ours" lists many of these organizations. See page 209 for ordering information.

This type of adoption can be arranged in two ways. The adoption can take place in the country where the child is born. You then apply to the Department of Immigration in Canada to bring your child into Canada.

You can also bring the child into Canada unadopted and then apply for a private adoption. To do this, you apply to the Department of Immigration to bring the child into Canada. They will ask the child welfare agency to approve this. The government will then do a homestudy on you and also get information from the other country to make sure this is the best thing for the child and the biological parents. If they approve of the adoption, they then send a letter of "no objection" to the Department of Immigration so the child can come into Canada. You then go through a private adoption.

International private adoptions are complicated. If you decide to try this type of adoption, make sure you get good help. An adoptive parents association, agency, private social worker, or lawyer may be able to help you. You will need to arrange a lot of paperwork.

This type of adoption is by far the most expensive. In 1989 a private international adoption can easily cost $10,000 or more.

BIRTH CONTRACTS

A birth contract is an agreement to bear a child for someone else. Usually, a woman is paid to become pregnant using donor insemination. Some infertile couples choose birth contracts as a way of having a child. Usually, they choose this if the man is fertile and the woman is not. The man is the sperm donor. The child is then biologically related to him.

Birth contracts are usually called surrogacy or surrogate motherhood. A surrogate means a replacement for the real thing. We choose not to call a woman who is paid to have a child a surrogate. She still becomes pregnant, like any other woman who bears a child. She is still a real mother to the child. We prefer to call her the birthmother. This is a name for women who bear a child and then give that child up for adoption.

After a birth contract, the man in an infertile couple does not need to adopt because he is the biological father. The infertile woman usually legally adopts the child.

Many birth contracts don't respect the rights of the birthmother. This is especially true of most "surrogacy" contracts arranged by American companies. It is possible to write a birth contract which is respectful to the birthmother. You will find more about this in this section.

Are birth contracts legal in Canada?

In early 1989, there are no laws yet on birth contracts in Canada. This means that birth contracts aren't against the law. They are also not recognized as being legal. There are no laws saying what happens if someone doesn't live up to their side of the contract.

So far, no birth contract has ever ended up in a court in Canada. This could happen if either the birthmother or the couple changed their mind. It could also happen if the couple refused to pay.

No one knows for sure what would happen if a birth contract ended up in court. It is likely that the court would rule that it was not a "legally binding" contract. This means that even if the contract was carefully written and signed, it would not be enforced by a court.

In the United States, cases involving birth contracts have come to court. These contracts are legal in some states. One case involved a severely disabled child. Neither the contracting couple nor the birthmother wanted the child. In another case, a birthmother, Mary Beth Whitehead, changed her mind and wanted to keep the baby. The court ruled that the baby should go to the contracting couple.

What does a birth contract cover?

The birthmother usually agrees to the following things:

- to have donor insemination.
- not to have intercourse around the time of the insemination to be sure that the child is biologically related to the donor.
- to have pre-natal care during her pregnancy. She is often also asked not to smoke or drink during pregnancy. She may be asked to have certain tests, or simply to agree to all tests and treatments her doctor suggests while she is pregnant.
- to give up the child after birth.

If she is married, her husband may agree not to claim to be the child's father.

The contracting couple usually agrees to pay a fee to the birthmother or an agency arranging the contract. The fee to a birthmother may be $10,000 to $15,000 in the U.S. he fee to an agency is higher, but the extra money doesn't go to the birthmother.

Are birth contracts "baby selling"?

Many of the arguments against birth contracts refer to them as baby selling. This would be against the law, since a person can't be bought or sold.

People who are in favour of birth contracts say that the birthmother is not being paid for the baby. She is being paid for going through donor insemination and becoming pregnant. She is also being paid for any extra expenses she has while pregnant and for lost work time.

If the birthmother was only being paid for getting pregnant, she would have the rights of a parent after the baby was born. This isn't true with most birth contracts.

Women giving up their babies for adoption have 10 days after the baby's birth to be sure of their decision. In a birth contract, the birthmother does not have the right to change her mind. She cannot take the time to be sure. We think that if all the rights of the birthmother are taken away in exchange for the money, then it is baby selling.

What other rights do birthmothers lose?

The contracts often say what the woman can and can't do when she is pregnant. She may agree in the contract to having tests and treatments her doctor suggests. She may lose the right to choose for herself what she thinks is needed.

Women often disagree with what their doctors suggest when they are pregnant. Many people think that doctors interfere too much during pregnancy and that drugs and surgery are used too often during labour. We think a pregnant woman should have the final say on what happens to her body.

Bülbül (See Page 2 for full credit)

What about the rights of the biological father?

The man who donates the sperm is the biological father of the child. We don't think that he should have equal rights to the baby at birth. He has donated sperm. The birthmother has had the baby growing inside her for nine months. She has felt her body go through all of the changes of pregnancy. She has felt the baby kicking. She has gone through labour and given birth.

We believe that at birth the mother's rights to the baby should come first.

We disagree strongly with a U.S. court decision which treated a birth contract like a child custody case between two parents. The court judged that the father should have the baby, since he could give the baby a better education and more advantages. Needless to say, he also had more money.

We do believe that men have rights to their children. This is true when the two parents have shared care and responsibility for a child. We would like to see men having more responsibility in the care of children. We see this as very different from saying that a man who has donated sperm has equal rights to a woman who has been pregnant and has given birth.

What other concerns do people have?

Birth contracts are one way for women to make money. Many women have few other choices. They may see this as one way out of being poor. They may not have chosen it if they had other ways to support themselves.

Women who give up children for adoption often have strong feelings about it for years afterwards. They may have strong feelings even if they are sure they did the right thing. They may wonder how the child is. They may feel sad on the child's birthday. Birthmothers who have a child in a birth contract often have a lot of the same feelings.

One worry about birth contracts is that they will become more common. Rich women who are fertile could choose to pay to have someone else bear a child for them.

What if a friend or family member wants to have a baby for you?

You may know someone who has had other children, likes being pregnant, and wants to have a baby for you.

You can arrange your own birth contract in a way which respects of the birthmother. She could have control over what happens when she is pregnant. She could decide what medical tests or treatments she wanted.

You could arrange to help with money while she is pregnant if she wants or needs it. This should be arranged in a way which doesn't make her feel that she has to give the baby up because she has had help with money. The money should at least cover the time she needs to take off work, extra expenses because she is pregnant, a good diet, and her other basic needs.

She would have time after the baby is born to be sure that she wants to give it up after all. It should be at least 10 days. She could have some part in the child's life if she wants. She could choose how much of a part she wanted.

This is one idea how a birth contract could give control and respect to the birthmother. You may have other ideas.

Like other birth contracts in Canada, this kind of a birth contract would probably not be recognized in court. You would need to go through a private adoption after the baby was born. See page 161.

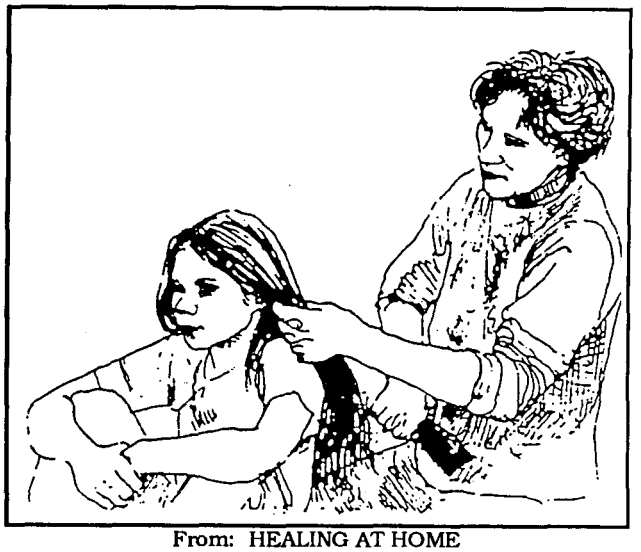
BEING A FOSTER PARENT

Some people choose foster parenting as a way to have children in their home. Foster parents become the parents to a child or children when their own parent or parents can't look after them. You are like a family to the child. You try to meet the social, emotional and physical needs of the child while she or he lives with you.

Being a foster parent and adopting a child are different. When you adopt a child, they come to live with you permanently. You are responsible for all the costs and decisions involved in being their parent. When you foster a child, they just stay with you for a while. They may stay for a short time or for years. The provincial or territorial government pays for their costs and also pays you a little extra. A social worker and/or the child's parents are involved in making decisions about the child's care and future.

Many children have no home or taken from a home when their parents can't care for them. There is a great need for foster parents.

A lot of the children in care are Native. In the Yukon eight out of every 10 children in care are Native. Native organizations, Bands and Tribal Councils are now working with the government to try to keep Native children in Native homes. There is a severe shortage of native homes, especially in rural areas.



From: HEALING AT HOME

Do you want to be a foster parent?

It can be difficult deciding whether to become a foster parent. You may find it useful to talk to people who are foster parents to ask them what's it's like. In most provinces and territories there are organizations of people who are foster parents. You can get in touch with them. They will suggest ways to get in touch with foster parents in your community. They will also be able to give you up-to-date information about becoming a foster parent. The names and addresses of these organizations are on page 208.

Here are some things to think about when you are deciding whether to become a foster parent:

- Being a foster parent takes parenting skills and patience. You may find it easier if you already have experience as a parent or working with children.

- Many of the children who need foster care have special needs. They will have been through some difficult times before they arrive at your home. They may need extra support and firm guidelines.

- It's best if every member of your family wants a foster child in your home.

- The goal of the government is to return the child back to their own family as soon as possible. You need to provide as much love and support as you can and also be able to give the child up when the time comes.

- Foster parents usually have contact with the natural parents. Sometimes this is hard, especially if a child has been mistreated.

- You will need to work with the government. You will have regular meetings with a social worker. They may sometimes make decisions about the child's care or future that you don't agree with. You will have to go along their plans.

Most people who become foster parents have some training to help them prepare to become a foster parent. You can also get ongoing support from the government and from foster care associations.

Who can be a foster parent?

Many different people become foster parents. You must be over 19. People of all races, single people, married couples, couples living common law, and lesbians and gay men are all foster parents.

If you are interested, talk to the government office in your area:

- B.C. Ministry of Social Services and Housing

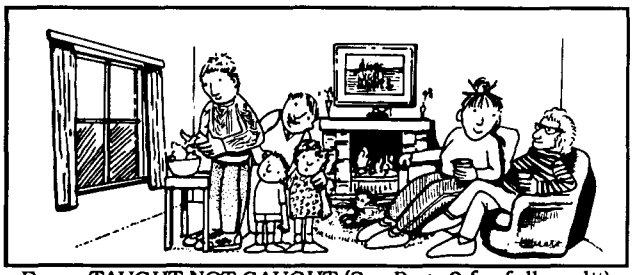
- Alberta Social Services

- Yukon Department of Health and Human Resources

They will ask you a lot of personal questions about why you want to be a foster parent, what your family and friends are like, and how you would treat and discipline children. They will also check your criminal record and ask for references. Then they will decide if you can be a foster parent.

You must be able to provide a bed for the child and have smoke detectors in your home.

SHARED PARENTING



From: TAUGHT NOT CAUGHT (See Page 2 for full credit)

Parenting is a lot of work and responsibility. Some people make arrangements to share the responsibility for raising children with people who aren't the biological parents. We'll call the people who aren't the biological parents the co-parents. You could make arrangements with a friend, family member or someone you don't know as well to share parenting. It needs to be someone you respect.

A co-parent can be an extremely important part of a child's life. Some people get a lot of joy and satisfaction from being co-parents.

There are many different ways to share parenting. Some people try to equally share the responsibility for parenting. More often the co-parent has less responsibility than the biological parent. It takes a lot of talking to decide how things will work out best for you. Here are some things to talk about if you are thinking about sharing parenting:

- How much time will you each spend with the child?
- How will you make parenting decisions?
- How will you share the financial costs?
- How will you divide the time you spend with the child or children?
- Will you live together?
- If you live separately, the child could either stay in each home some of the time or the parents could switch homes. Which would work best?
- How will you work out problems or differences of opinions when they come up?
- The child may go through times of feeling closer to one of you. Usually the child will feel closer to the biological parent. How will you deal with jealous feelings when they come up?
- What will you do if one of you wants to move?

Shared parenting can be rewarding. It takes commitment and a lot of work.

ALTERNATIVES TO PARENTING

Being an adult friend

You could arrange to spend time with a child or children on a regular basis. The child could be the child of a friend, family member, or someone you know casually. This can work well with a child of any age.

Being a volunteer

You could spend time with children through volunteering. There are many children and organizations that need help. Volunteers are needed in hospitals, schools, community centers, daycare centers and many other organizations.

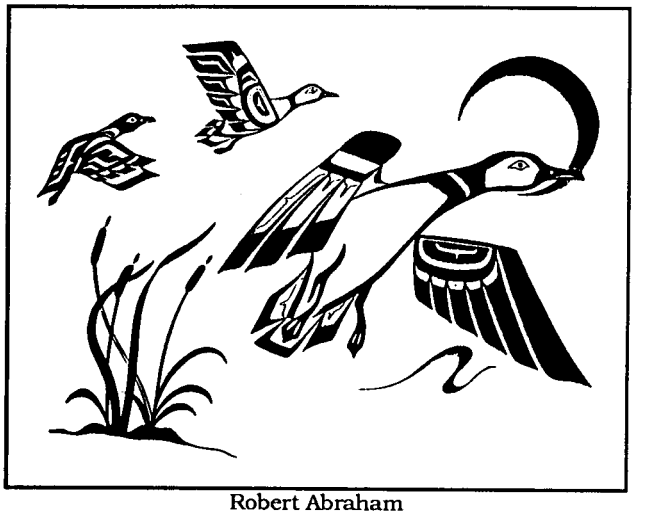
Looking at other goals and dreams

If you have been dealing with infertility, you may have been spending most of your time thinking about becoming a parent. Other goals may have become less important.

Some people find it a relief to focus on other goals and dreams besides being a parent. You may want to pick up other dreams and interests which you set aside because you wanted a child. You may want to spend your time on your work, going to school, learning new skills, travelling, hobbies, or whatever else interests you.

Many people say that it's very helpful to finally choose not to have children. They say that they felt freer when they made a choice to stop trying.

LIVING WITH INFERTILITY



Robert Abraham

Eventually, you will find a solution to your infertility. You may adopt a child or get pregnant. You may choose to be a foster parent, share parenting or have a special relationship with a child or children. You may choose not to have children after a period of trying. You may enjoy focusing on other things besides children.

You'll probably still have strong feelings about infertility sometimes. This happens to most people, even if they are generally happy with their solution. You'll probably feel sad, angry, frustrated or whatever you felt when you were dealing with your infertility.

Many people say that their feelings about infertility come in waves.

What happens if you don't get pregnant?

Everyone has their own limit for how long they want to try to get pregnant. For some people a year is enough. Others need to feel that they've tried every possible test and treatment.

At some point, you may need to decide to stop trying. Often the doctor isn't the one to suggest this. It will probably need to be you.

If you don't get pregnant, you may go through a time of wishing that you had never tried to get pregnant. You may think that you have wasted a lot of time. Try to be kind to yourself. You made the decision that felt right for you at the time.

What happens if you get pregnant or adopt?

You may be very excited and pleased. You may also have a lot of mixed feelings. You may be very worried that something will go wrong.

You will probably have a lot of hopes and dreams about what it will be like to be a parent. Real life never works out exactly like dreams. You may feel disappointed at times because things don't turn out the way that you had hoped.

You may have just as many hopes and expectations for your child as you have for yourself. You may be worried that if you lose your child, you won't have another chance to be a parent.

Your child can't take away the struggles you've been through to either get pregnant or adopt. You will probably still have feelings because of your infertility.

What may help you deal with feelings of infertility that keep coming up?

Here are some things that many people have found useful:

Pay attention to your feelings

Letting yourself feel your feelings may be one of the most healing things you can do. There is more information about feelings on pages 13 to 20.

If you are in a couple and only one of you is infertile, talk about how this makes you both feel. Try to be honest with each other. Pretending that you don't have feelings won't help your partner in the long run.

Take time to grieve

Many infertile people say that it's very important to grieve. Taking time to grieve may help you feel freer and more able to move on with your life.

It's normal and healthy to feel sad and mourn when you lose something that's important to you. Here are some things many infertile people grieve:

- the loss of children that they hoped for
- the loss of being pregnant and giving birth
- the loss of fertility
- the loss of control over their life goals

You may have a lot of painful feelings. You may feel very sad and empty. You may cry a lot. Nothing else may seem important or interesting. It may seem that you keep going over the same things over and over again in your mind.

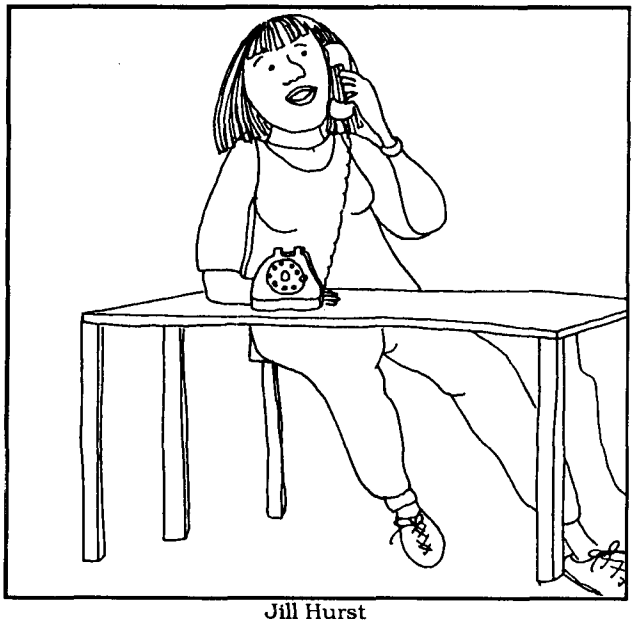
The pain that you feel now may make you remember times that you found painful in the past. You may find that you are mourning a lot of the losses in your life at the same time.

If you let yourself have these feelings, gradually they will change. You will probably start having other feelings.

You may start feeling curious or interested in other things. You may begin to get pleasure and satisfaction out of the things that you do.

You may want to avoid these painful feelings and "get on with your life". Many people feel that way. But, people who have been through infertility say that grieving has made it possible to get on with their lives. Afterwards they didn't have to force themselves to get on with things because they were ready for change.

It's easier if you get support while you are grieving. Your family and friends may not realize how important your losses are. This makes it even harder. You may need to ask them for help.



Jill Hurst

Make choices

Many people say that they feel out of control when they are dealing with infertility. You may feel better when you make choices in the ways that you can. This will be different at different times. Here are some examples of making choices:

- choosing to go for help
- choosing to have a test or treatment
- choosing to stop trying to get pregnant
- choosing to adopt a child
- choosing not to have children

Don't try to force yourself to make choices or new life goals before you are ready. In your own time, you will come to choices that feel right for you. Paying attention to your feelings and spending time talking with supportive people may help.

If you are in a couple, you may want to make different choices. It may help to talk about your feelings and your reasons for what you want to choose. This may help you come to a solution that you can both live with.

What about the future?

Many infertile people say that their feelings change but that they don't completely go away. You'll probably still have waves of feelings now and again, even when you have accepted your situation, grieved and gone on with new things.

Notice which things bring up your feelings. This will help you understand what's happening when the feelings come up. It may also help you prepare if you know that you're going to be in a situation where your feelings will likely come up.

Some people who have been though infertility say that they have learned a lot about what is important to them. Coming to terms with infertility has helped them to know themselves and feel better about themselves.

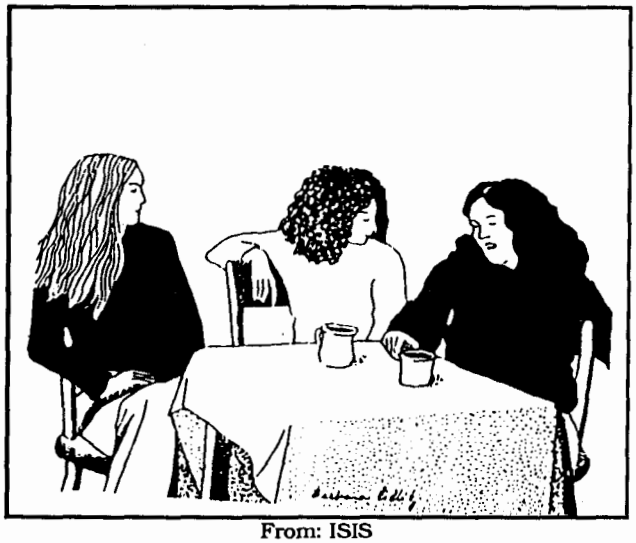
TALKING WITH OTHER WOMEN

We think it's very important that women talk with other women about their health. Here are some reasons:

- Women know a lot about health. They spend a lot of time taking care of their family and friends.

- Women have traditionally been the healers in most cultures. Through the years women passed their knowledge down to future generations. Women still get useful information from talking to other women

- The world around you affects your health. Social problems such as not being able to get a job or suffering racism can be stressful. Environmental problems can also make you sick. If the factory near you is polluting the air you may get headaches or other health problems. People need to work together to make a lot of the big changes that will help everyone to be healthier. Talking is a first step.



From: ISIS

- There are many messages telling women that the natural life stages they go through are illnesses. These messages come from the TV, magazines, doctors, and often family and friends. An example of this is menopause. It's a natural part of growing older and usually doesn't need to be treated with medicines.

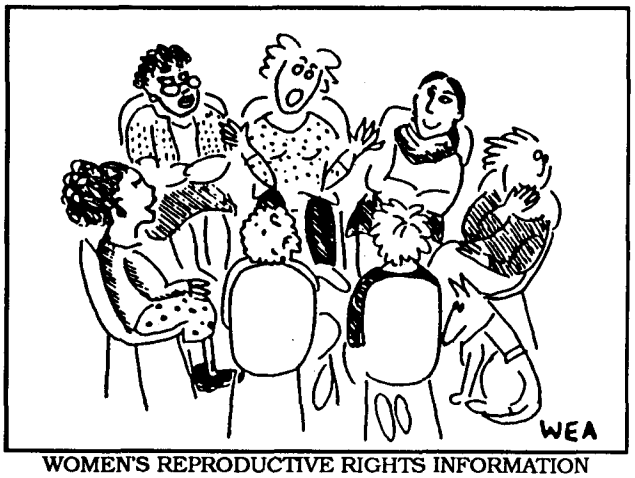
- Many of the health concerns women face are kept secret. Periods are an example. Even though periods are natural and healthy most women hide their periods and feel embarrassed about them. Talking with other women can help you feel less embarrassed. Together you can develop understanding and pride.

- Most of the research about health is done by drug companies. They are sometimes more interested in making money than in health. You may sometimes need drugs, but they aren't always the best way to deal with health problems. By talking to other women, you may be able to find other ways of taking care of your health besides using drugs.

- Women can help each other get good information and treatment from doctors when they need it. You can help each other decide what information you want from the doctor. You can also take a friend with you when you go.

- It helps to talk with other women. You may learn new ways of treating a problem. You may get help and support. Often it feels better just knowing that other people have the same problems and concerns.

STARTING A SELF-HELP SUPPORT GROUP



WOMEN'S REPRODUCTIVE RIGHTS INFORMATION CENTRE, Spring 1987

Self-help groups are groups of people who get together because they have something in common. Usually they don't have a leader. Each person in the group does their bit to make the group useful for everyone.

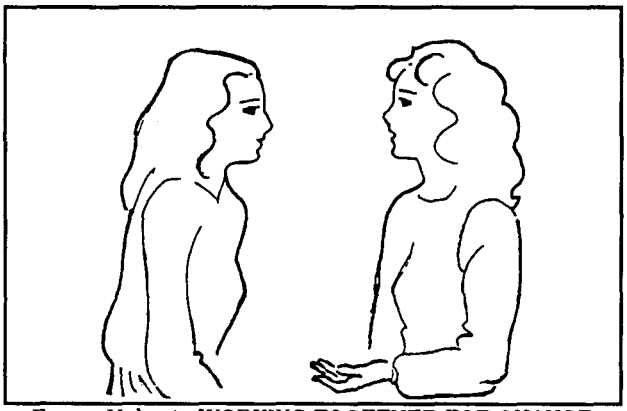
You may find it helpful to meet with other people who are dealing with infertility. This could be a group for women or a group for women and men.

Ask if there is a support group in your area. You could ask a library or bookmobile, a women's center, , a crisis line or a community center. Sometimes doctors and nurses know about support groups.

If there is no self-help group in your area you could start one. The information in this chapter will help you get started.

Finding other people who are dealing with infertility

The first step is to find other people who are dealing with infertility. If you only find one person, that's okay, you can talk to each other. It's best if the group isn't more than about 10 people. If there are more, some people may never get a chance to talk.



Emma Haley in WORKING TOGETHER FOR CHANGE

Here are some ways you may be able to find other people :

- Ask your friends.
- Put posters up in local stores, churches, a women's center, band hall, or anywhere else people may see it.
- Tell your public health nurse, community health worker or doctor that you want to talk to other people dealing with infertility.
- Put an ad in the local paper or on the radio. Here's an example of an ad:

> PEOPLE who have problems getting pregnant interested in talking to other people who have problems too, call Jane to start self-help group, 999-2222.

Planning the first meeting

Once you have put out the word that you want to form a group, other people may contact you. You don't have to figure out everything about the group on your own. The group will work better if all the members of the group plan what the group will be like together. What you will need to do is plan the first meeting.

Planning the group together

When people come to the first meeting let them know what you have planned for the meeting. Ask if there's anything they want to add. Explain that you don't want to be the group leader. Say that you hope everyone will decide together what the group will be like and work together to make the group a success.

In the first few meetings you will need to decide together what you want your group to be like. Here are some ideas that may help you make plans.

Talk about how to make the group a safe place for everyone to talk. It's helpful to get everyone to say what things would help them feel comfortable. Make a list of everything that gets said. Then go through the list and decide which points you all agree on. These will then be the guidelines or rules for the group. If anyone doesn't follow the guidelines you will need to talk about it as a group. These are some of the things that groups have found useful:

- We respect each person's right to make their own choices about their life.
- Everything that we say will be confidential. We won't repeat anything personal that anyone else says in the group.
- We will try to be honest.
- We won't interrupt each other.
- We won't give advice to each other unless a person asks for it. We believe that we can all come up with solutions to our own problems if we're given a chance to talk and be listened to.
- We won't force anyone to talk. We'll make sure there is time for everyone to talk but we won't push anyone to talk if they don't want to.
- We will share the responsibility for the group. We will all do our bit to make the group useful for everyone.
- We will tell the group if we're going to miss a meeting or if we're leaving the group. This saves a lot of worry.

Find out why everyone has come to the group and what they hope to get from the group. One way to do this is by giving each person a chance to say their name, why they've come and what they hope to get from the group. You may want to do this by doing a round. In a round everyone gets a chance to talk without being interrupted. One person talks first and then everyone else takes a turn. If anyone doesn't want to talk, they can just say "pass". Everyone sits and quietly listens to the others talk.

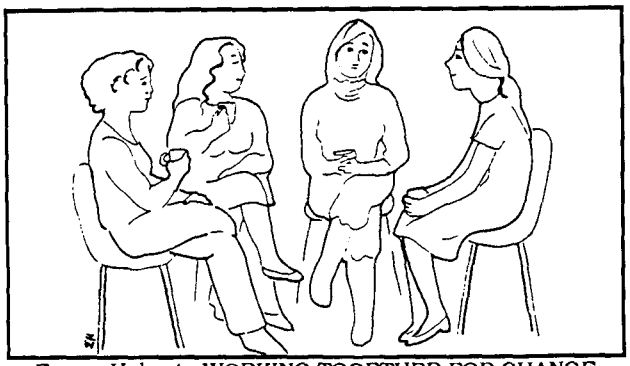
Here are some of the reasons people may come to a support group:

- to talk to other people who are dealing with infertility
- to get health information
- to share feelings and get support
- to work with other people who want to make health services for people dealing with infertility better

Once everyone has had a chance to speak, you can have a discussion. You may want some of the same things and some different things. Talk about this and decide what you want the purpose of the group to be.

Talk about how you want your time together to be organized. It's helpful to have a general plan that you follow each time you meet.

1. Start your time together in a way that helps everyone feel comfortable and part of the group. You may want to begin with a meal or coffee and tea. Many groups start with a round in which each person says their name and how they are feeling.



Emma Haley in WORKING TOGETHER FOR CHANGE

2. Have time for discussion. You may decide you will have time every meeting for people to talk about how they are feeling and also time to talk about a specific concern. Here are some ideas for topics:

- causes of infertility and how to find out what's wrong
- natural and medical treatments
- alternatives: adoption, foster care, shared parenting, and not having children
- talking to family and friends
- getting good care from your doctor

3. End the group in the same way each time. People may have strong feelings about things you have been talking about. They may have questions or want to talk more. Plan a way of ending the group so that everyone has a chance to say how they are feeling and what questions they still have before they leave.

Some groups do a closing round in which everyone says how they are feeling. If some people are feeling very emotional, they may need to take some time to get ready to leave the meeting. You can also say what you liked or didn't like about the meeting.

Many women's groups end with appreciations. This is a time for group members to tell other people in the group things they have said in the group or done for the group which they appreciate. It's also a time for people to appreciate themselves for things they have done or said in the group which they are proud of.

Some support groups like to finish by doing something together at the end of each meeting. They may all hold hands, meditate together, or sing a song.

Talk about who will plan each meeting. It usually works best to plan the meetings ahead of time. You may want to have someone take responsibility for each meeting. In many self-help groups the members take turns planning what they will do each time. You may want someone

who has been in a self-help group before to plan the first few meetings and then start to take turns after that.

Plan where and when you will meet. It's best to set up a regular time. You may decide to meet at the same place every time, or you may decide you want to take turns having the group meet in your own homes.

Organize childcare. Some people have trouble getting pregnant after having one child or more. Find out how many of the people in the group need someone to care for their children when you are meeting. Then figure out a plan for childcare. You may want to find someone to take care of all the children close to where you meet. Or, it may be easier if the parents leave their children with someone they know. Either way, everyone in the group could help pay whatever it costs to have the children taken care of.

Emma Haley in WORKING TOGETHER FOR CHANGE

Decide if you want to let new members join your group after the first meeting. You may want to keep the group small to really get to know each other well. Or, you may decide to have the group open to any person who wants to come.

Plan a way of dealing with conflict or problems in the group before they come up. Most groups have conflict at some point. If you take time to plan how your group will handle problems, it can save a lot of frustration later.

Most people haven't learned constructive ways of telling other people that things are bothering them. We'll write about one way of doing this. You may decide a different way is better for your group.

If something about the group or another group member is bothering you, think about it before you say anything. Think about what is bothering you, why it bothers you, and what you would like to be done differently. Then tell the other group members that something is bothering you and that you would like to talk about it.

Bring up the problem directly. Be as specific and direct as you can. Try to point out exactly what is bothering you and what would be more helpful.

Each person can make sure that the group is a safe place for everyone. If anyone feels that someone in the group is being hurtful or indirectly criticizing another group member, they can say, "Stop. There is a problem and we need to talk about it."

Emma Haley in WORKING TOGETHER FOR CHANGE

The life of the group

Once you've made your plans, try to stick with them for awhile. Most groups go through changes. Be flexible but also make sure you spend time talking about infertility.

You may want to talk about whether you're finding the group useful after you've met a few times. Make sure you talk about the good things about the group as well as ways you could make it better.

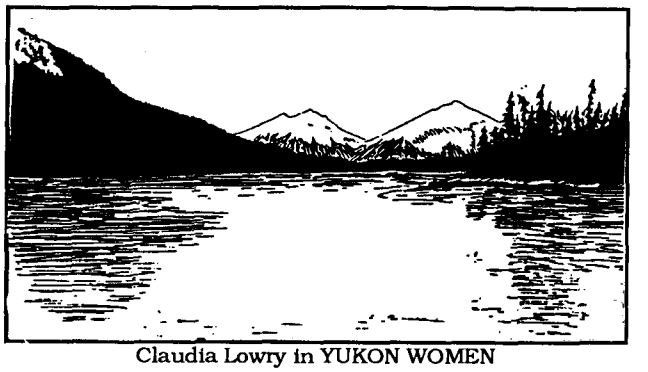
Sometimes self-help groups last for a long time and sometimes they just meet a few times.

When it seems time to stop meeting, it's a good idea to have a "goodbye" meeting. You may want to do a round and say what you learned in the group and what you have appreciated about the group and group members. Many groups end by talking about what group members will take from the group into their lives.

How to get more information

There is more information about self-help groups in a book called **Women Talking About Health: Getting Started With Workshops And Groups**. You can order it from the Vancouver Women's Health Collective. The address is on page 209.

BEING HEALTHY



Claudia Lowry in YUKON WOMEN

Your fertility may be affected by your health. This chapter is about some of the things that may help you improve your general health and your fertility. The ideas in this chapter could help a woman or a man.

These suggestions won't solve everyone's infertility problems. They may help if your infertility is caused by one of the following things:

- hormone problems
- problems with sperm
- a combination of problems
- you don't know why you're not getting pregnant

Trying to be healthier may help you be "as fertile as you can" in your situation. It may also help you cope with the stress of infertility. Getting healthier may also help you feel better whether you get pregnant or not.

Here is a list of the things we talk about in this chapter:

- Things to avoid
- Food
- Vitamins and minerals
- Exercise
- Other things that may help
- Stress
- Give yourself time to change

It usually takes time for these sorts of changes to affect your body. Give yourself a few months. It takes about three months for a man to make new sperm. Men probably won't see changes to their sperm problems for four to five months.

THINGS TO AVOID

Try to avoid alcohol, street drugs, and cigarettes. They all affect your general health and your hormones. Your body loses vitamins and minerals when you use them.

Debbie Bryant

Alcohol, marijuana, street drugs and cigarettes all affect men's sperm. There is more information about this on page 121.

It's not easy to stop using any of these things. Help is available from Alcoholics Anonymous, Narcotics Anonymous, alcohol and drug counsellors, social workers, community health workers, doctors and treatment centers.

FOOD

This section gives you a general idea of how to eat well to balance your hormones. You may want to also talk to a community health worker, public health nurse, nutritionist, doctor or naturopath. She can help you to figure out what changes might help you be healthier. She can also help you to choose cheap and nutritious foods that you like eating.

What is a healthy diet?

The best diet for you is the one that makes you feel the healthiest.

Everyone needs starch, protein, fat, vitamins, minerals, and water. You get most of these from the foods you eat. Some people need more vitamins and minerals than they get from food. There is more information about this on page 190.

Patricia Mitchell (see Page 2 for full credit)

What are good foods to eat?

Foods can be divided into four general groups:

- fruits and vegetables
- bread and other grains
- milk and foods high in calcium
- fish, meat, poultry, and dried peas and beans

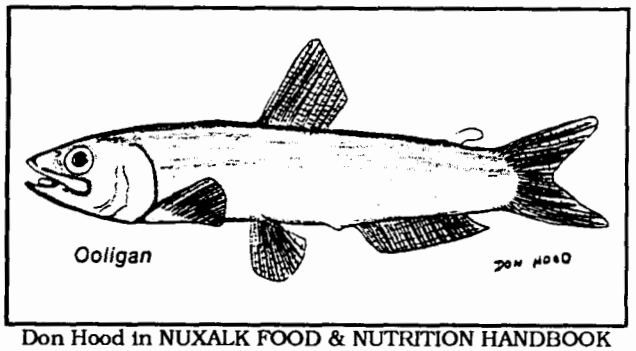
It is best to eat foods from all the groups every day.

Fruits and vegetables: These are the best sources of almost all the vitamins you need to be healthy. Eat a variety of vegetables that are different colours. Vegetables that are the same colour usually have many of the same vitamins and minerals. Fresh fruits and vegetables have the most vitamins. Frozen are better than canned.

Breads and other grains: This food group includes bread, bannock, cooked cereal and cooked grains like rice. These foods are high in starch and give you energy. Try to eat a variety of grains. It's better to eat whole, unprocessed, grains than white, processed grains. Bread made from whole grains has more B vitamins and iron, than bread made from white flour. Whole grain breads and brown rice are often no more expensive than white bread and white rice.

Milk and foods high in calcium: It's especially important for women to get enough calcium to develop strong bones. Milk is a good source of calcium and protein. Make sure you eat foods that are high in calcium if you don't drink milk. See page 191.

Fish, meat, poultry, dried peas and beans, nuts, seeds, and eggs: These foods all have a lot of protein. Eating a lot of red meat can cause health problems. Try to get some of your protein from foods other than red meat.



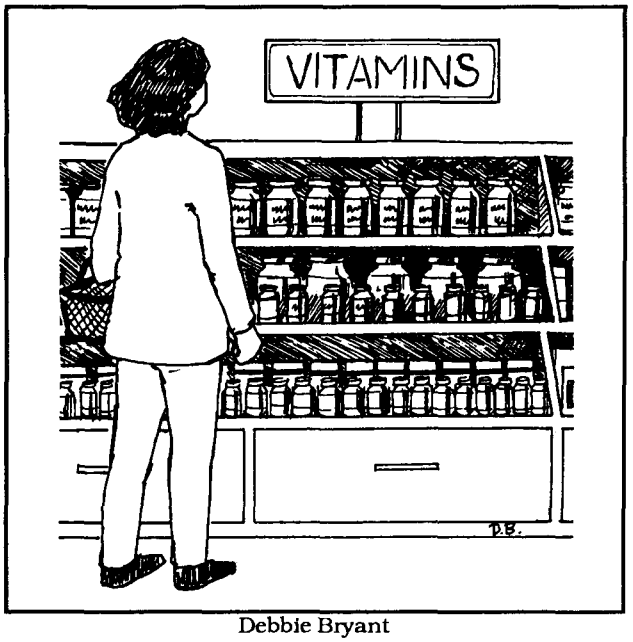
Don Hood in NUXALK FOOD & NUTRITION HANDBOOK

Fluids: Drink at least six to eight glasses of water, juice and herbal teas a day. This helps keep your hormones in balance. It also helps keep you regular.

Are some foods unhealthy?

Some foods affect your hormones. They also make it harder for your body to be able to use vitamins and minerals. It is a good idea to cut down or stop eating these foods:

- foods with added chemicals
- fats that are hard at room temperature, like lard, butter, and fatty cheese
- salt
- sugar
- caffeine in coffee, cola drinks and chocolate



Debbie Bryant

VITAMINS AND MINERALS

Vitamins and minerals are important in a healthy diet. If you eat a variety of foods from the four food groups each day, you may get all the vitamins and minerals you need to be healthy.

You may sometimes need more vitamins and minerals than you get from foods. Vitamin and mineral pills are expensive. They don't replace eating well. Try to get as many vitamins and minerals from food as you can.

You could try taking a daily multi-vitamin and mineral pill. If it helps, that may be all that you need. Sometimes it is helpful to take extra vitamins and minerals for specific problems. The vitamins and minerals that may help balance women's hormones are on page 178. The vitamins, minerals and amino acids that may help balance men's hormones are on page 112. Amino acids are found in food. They are the building blocks that protein is made from.

You may find it hard to figure out which vitamins and minerals you need. It can be helpful to talk to a nutritionist, nurse, community health worker, doctor or naturopath.

If you take extra vitamins and minerals, make sure you keep taking the multi-vitamin and mineral pill. Vitamins and minerals work together. Always take the pills with meals.

This is a list of foods high in vitamins and amino acids that are talked about in this book.

Vitamin A: liver, eggs, cheese, butter, milk, and vegetables that are yellow, orange, and dark green.

B Vitamins: wheat germ, sunflower seeds, safflower oil, almonds, liver, oysters, whole-grain cereals and breads, wheat germ, fish, milk, nutritional yeast, dark green vegetables, nuts, beans and peas, and kidneys.

Vitamin B6: sunflower seeds, wheat germ, tuna, whole-grain cereals and bread, liver, avocados, spinach, green beans, nutritional yeast, and bananas.

Vitamin C: many fruits and vegetables, including berries, citrus fruits, tomatoes, melons, green peppers, potatoes, and dark green vegetables.

Vitamin E: vegetable oils, whole-grain cereal and bread, wheat germ, liver, dried beans, and green leafy vegetables.

Arginine: alfalfa, green vegetables, carrots, beets, cucumber, celery, lettuce, leeks, radishes, potatoes, and parsnips.

Bioflavonoids: lemons, grapes, plums, black currants, grapefruits, apricots, buckwheat, cherries, blackberries, rosehips, and prunes.

Calcium: milk, yogurt, cottage cheese, cheese, canned sardines and salmon, leafy green vegetables (except spinach and Swiss chard), citrus fruits, dried peas and beans, and unhulled sesame seeds.

Carnitine: beef, bacon, fish, chicken, whole milk, and cheese.

Folic Acid: wheat germ, liver, kidneys, dark green leafy vegetables, nutritional yeast and bran.

Iron: kelp, dark molasses, wheat bran, pumpkin and squash seeds, wheat germ, liver, lean meats, dried peas and beans, whole grains, dark green vegetables, eggs, shrimp, oysters and nutritional yeast.

Magnesium: whole grains, nuts, beans, leafy vegetables, and milk.

Potassium: bananas, peaches, broccoli, yams, potatoes, squash, nuts, sunflower seeds, garlic, halibut, herring, sardines, lentils, whole grains, molasses, kelp and nutritional yeast.

Zinc: milk, liver, shellfish, herring, wheat bran, and split peas.

EXERCISE

Regular exercise helps your blood flow through your body. It helps to balance your hormones and will probably help you to feel good.

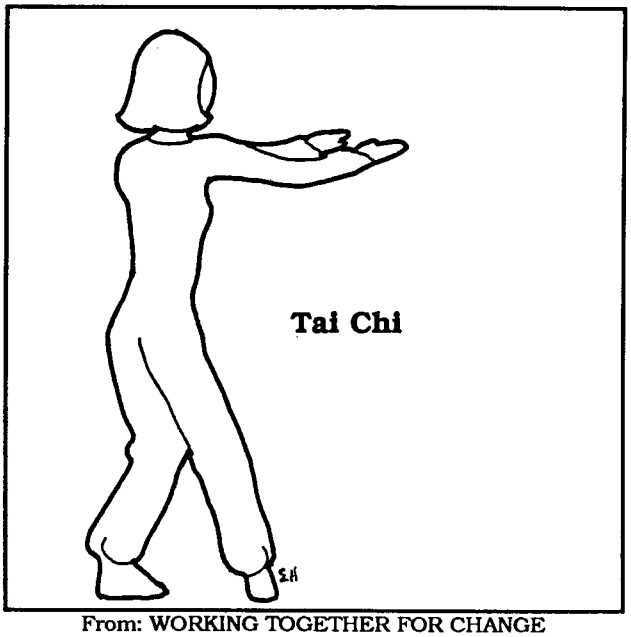
It's best to get moderate exercise. Athletes or dancers in training who exercise heavily each day often become less fertile.

It's best to exercise at least three times a week. Exercise doesn't need to be unpleasant or strenuous. Think of activities which you like and which you'll want to keep doing.

What are good types of exercise?

Aerobic exercise gets your heart pumping and your blood flowing. Good aerobic exercises are running, cycling, swimming, dancing, and brisk walking. They need to be done for at least twenty minutes at a time.

Other more gentle forms of exercise are also good. Yoga, Tai Chi or stretching all help balance your hormones. It's best to take classes if you live in an area where there is a teacher. If there is no teacher, there are books to help you learn.



From: WORKING TOGETHER FOR CHANGE

People on social assistance can get free passes to the community center, ice rink or pool in some areas. If you are on social assistance, and you have any of these facilities in your area, ask your social worker for a free pass.

OTHER THINGS THAT MAY HELP

The following things may help you balance your hormones.

Get enough sleep: Everyone needs different amounts of sleep. Figure out what you need and then try to find time for sleep.

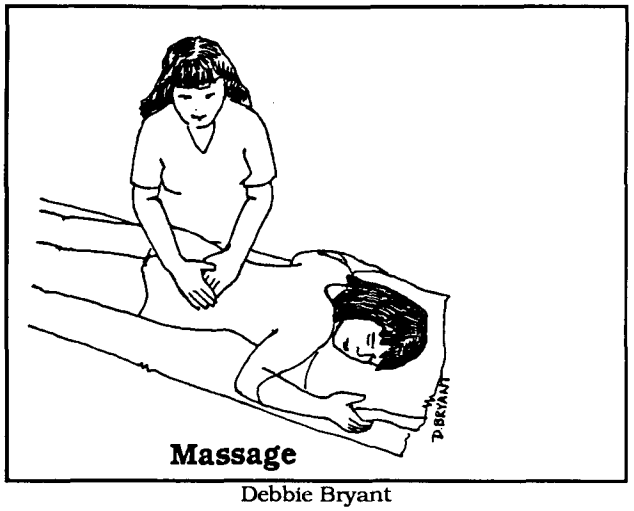
Find out if you have allergies: Your hormones can be affected if you have allergies. Your doctor or naturopath can test you to see if you have allergies. There is the name of a book about allergies on page 209.

See a naturopathic doctor: Naturopaths are doctors who are trained to heal without the use of drugs. A naturopath will suggest natural ways of helping your body heal itself. She may suggest changes in your diet, vitamins and minerals, homeopathic remedies or acupuncture. Seeing a naturopath may be very helpful if you are having problems with fertility.

If you live in B.C., going to a naturopath is mostly paid for by the medical plan. You don't need a referral from another doctor. In Alberta and the Yukon, the medical plan does not pay for visits to naturopaths. Some of the treatments that the naturopath suggests may be expensive. Tell her that you want to know the cheapest things you can do. If she suggests vitamins or herbs, you don't need to buy them from her. They may be cheaper in a drugstore or health food store.

Many rural areas don't have naturopaths. To find out if there's one near where you live contact the Naturopathic Association. Their address is on page 207.

Massage: Massage can help your blood flow through your body, lessen stress, and make you feel better. It can be done by yourself, a friend or by a massage therapist.



Massage

Debbie Bryant

Treatments by a massage therapist are partly paid for by B.C. Medical if you are referred by a doctor. Massage is not paid for by the Alberta medical plan. In the Yukon, it is not paid for unless you are referred to the Yukon General Hospital.

Shiatsu and Acupuncture: These are special treatments that can help balance your hormones and release stress. Shiatsu is a Japanese form of massage. They use finger pressure on different parts of your body. Acupuncture is a Chinese form of treatment. Thin needles are put into your body at special places.

These treatments are not paid for by the medical plan. They are expensive and are often difficult to get in rural areas.

STRESS

Your hormones can be affected by your emotions. This is because thoughts and emotions affect the parts of your brain that control your hormones.

A lot of the information in this section is from the book **Taking Care** by Mary Breen. Your library or bookmobile may have a copy of this book.

What is stress?

Stress is a normal part of life. It can be caused by pressures from the many different things you do each day. Being poor and suffering from discrimination add to these pressures. Stress itself is not bad. It is only a problem when there is more of it than you can handle. Then it can affect your body and mind in harmful ways. Too much stress can cause many health problems including problems with fertility.

What causes stress?

Large changes in your life, like moving to a new place to live, a death of a close friend or family member, or starting a new job, can be stressful.

Many day to day things can also be stressful. Things like not having enough money, having too much responsibility, and not having enough respect and support are all very stressful. These day to day things can add up and affect your fertility.

Sometimes it's difficult to know what's causing you stress. Take some time to think. Think about what things worry you or make you angry. You can do this alone or by talking with someone you trust.

From HEALTHSHARING, Summer, 1984

What special stresses do women face?

Here are some examples:

- The work that women do often isn't valued as much as the work that men do. This is true for paid work as well as work around the home.

- Women hear many messages that they aren't good enough. These messages come from T.V., the radio, bosses, family and friends.
- Overall, women earn less money than men.
- Many women spend a lot of time taking care of families and friends. Women often give much more support than they get.
- Women are often taught that they don't deserve much. They often feel uncomfortable, selfish or embarrassed when they try to take care of themselves.

How can I deal with stress?

When it's possible, try to get to the bottom of problems. Think about what's bothering you and try to change it if you can. This may be easier if other people help you.

Unfortunately, stress often comes from things that are not easily changed. For example, your job may be stressful but you may need the money. Sometimes the best thing you can do is be kind to yourself and make the best of the situation. With time you may be able to develop the strength and support to tackle the problem.

Many of the causes of stress are very big and need bigger changes than you can do alone. You may need to work with other people in your community to make some changes. For example, if the noise from a nearby factory was bothering you, you'd need to work together to try to have the factory owners stop the noise.

What can I do for myself?

Here are some things you could try on your own:

Get regular exercise

You will feel better and be able to handle more pressure when you are getting regular exercise. There is information about exercise on page 192.

Find a way to relax

There are many different ways you can relax. There is a book with information about stress and relaxation listed on page 209.

Think about your values

Your values can affect how much stress you feel. For example, here are some traditional Native values which lessen stress:

- respect for life
- sharing
- harmony with nature
- living in the present
- help from the extended family
- not interfering with anyone else
- silence

Some Native people find it helpful to turn to these values when they are under a lot of stress. Thinking about your values may help lessen your stress.

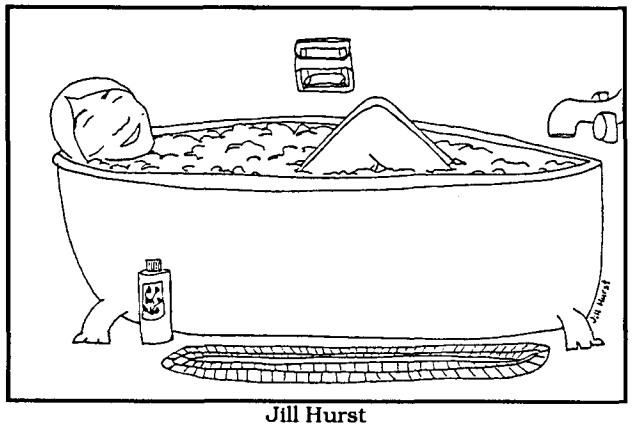
Think well of yourself

Many people have trouble thinking well of themselves. You may have heard a lot of unkind things about yourself. It's easy to start telling yourself the same unkind things that other people have said to you. You can change how you think about yourself. It may take practice, but you can learn to be kind to yourself.

Take time for yourself

- have a bath
- go for a walk
- meditate or just sit quietly
- listen to music or do crafts

Sometimes you may need to ask for help from others to get time on your own. Try to find time.



Jill Hurst

What are things I can do with other people?

Here are some things you could do with other people which may help you lessen stress:

Talk to someone

Everyone needs help. Try to ask for help when you need it. Talk to anyone you trust. This could be a friend, someone in your family, an elder, a counsellor, a community health worker or a public health nurse.

Join a support group

If you go to a support group, you'll find that many other people share the same problems as you. There is a list of support groups on page 206 and information about how to start a support group on page 179.

Get involved in your community

People need to work together to change many of the things that are stressful. Try to find other people who are concerned about the some things that you are.

GIVE YOURSELF TIME TO CHANGE

Many people have made changes and become healthier. This has helped some people with infertility. You may find it difficult to take good care of yourself. Most people find it hard to change things they're used to doing. There are lots of good reasons why it is hard.

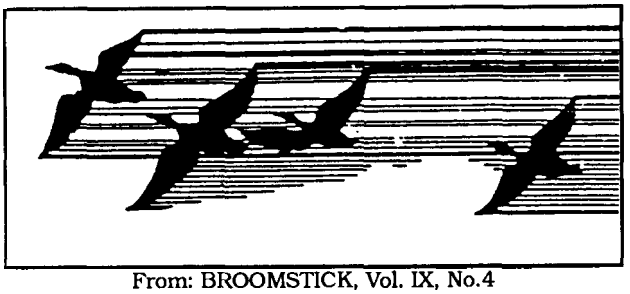
Some things that are healthy take time and money. You may not have enough money for the basics, let alone vitamins or a holiday. Some things that are healthy don't cost money. Going for walks, talking to friends, and learning to ask for help are free.

When you make changes they can affect your family, friends and social life. If you decide to change what you eat, your family may complain. It may be harder to be with your friends if you decide to stop drinking. When you make one change it often leads to other changes.

Change is often slow. Be patient and gentle with yourself as you try to be healthier.

PREVENTING INFERTILITY

Many types of infertility can't be prevented. But, there are some things you can do to avoid becoming infertile. If you already have fertility problems, they are suggestions you can pass on to a young friend or family member.



From: BROOMSTICK, Vol. IX, No.4

Protect yourself against diseases that are passed during sex:

The most common reason women are infertile is blocked fallopian tubes. This is often caused by infections that are passed during sex, such as gonorrhea and Chlamydia. Most women who get these infections don't have symptoms. The infection can spread and become PID, pelvic inflammatory disease. This is an infection of a woman's uterus and tubes. Twenty out of every 100 infertile women are infertile because of PID.

Men can also become infertile from blocked tubes. This usually happens from gonorrhea or Chlamydia which spreads into a man's testicles.

There are things you can do to protect yourself:

- Use condoms for intercourse each time you have a new sexual partner or your partner has another partner.
- Don't use an IUD for birth control. An IUD makes germs more likely to spread to you uterus and tubes.
- Go to a doctor or clinic if you have any itching or unusual discharge from your vagina. Ask for a Chlamydia test as well as tests for other infections. Chlamydia is the most common infection passed during sex. Doctors don't always test for it.
- When you go for a Pap test each year, ask for a test for Chlamydia along with tests for other infections.
- If a man has any itching in his penis or a discharge, he should go for tests right away.
- Make sure there is a way for your sexual partners to let you know if they find out that they have VD.
- If you need to take antibiotics for VD, always take the whole amount. Don't stop taking the pills when you feel better. You may still have some germs inside you. Your partner or partners also need to take antibiotics.

Avoid surgery that you don't really need:

Surgery inside your uterus, lower abdomen, or on your cervix can cause infertility. You can get scars from surgery which affects your fertility. Surgery on your cervix can make it harder for sperm to get into your uterus and meet your egg.

Women often get surgery on their cervix for abnormal Pap tests. Sometimes, this is needed. There may also be other choices besides having surgery. **A Feminist Approach to Pap Tests** has information that could help you avoid unnecessary surgery for an abnormal Pap test. See page 209 for ordering information for this book.

Men's testicles are sometimes damaged during surgery, but this is rare.

Unless you are having surgery because of an emergency, always ask what else could be done besides having surgery. It's a good idea to go to a second doctor for another opinion.

These types of surgery can cause infertility. Many people think they are done more often than they are needed:

- D&C. This is often done for problems with periods. You may get scars leading to repeated miscarriage or problems with your uterus.
- surgery on a woman's cervix. This includes cone biopsy, cryosurgery, and laser surgery. Cone biopsy is surgery which takes off a cone shaped piece of a woman's cervix. Cryosurgery is freezing. Laser surgery uses strong beams of light. You may get cervical mucus problems or cervical stenosis from these types of surgery. Cervical stenosis means too tight an opening to your cervix. You are more likely to have this problem after surgery if your mother took a drug called DES when she was pregnant with you. Women who have a cone biopsy are also more likely to have repeated miscarriages.
- hysterectomy. This is surgery to take out a woman's uterus. It is often done for fibroids and for period problems. The book **Talking About Periods** has information on other possible treatments. See page 209. You can't get pregnant after a hysterectomy.

Avoid work-related infertility:

X-rays and some strong chemicals can cause infertility in women and men. Men may also become infertile because of heat at work. Some people work with germs which can cause infections leading to infertility.

You may not be able to leave a job. You can be careful to always use safety equipment. You can also talk to your union or to the Canadian Centre for Occupational Health and Safety if you have any concerns about something you are working with. Their address is on page 123. You may be able to work with your co-workers to change an unsafe situation.

Use birth control that can't harm you when you're trying to avoid getting pregnant:

Don't use the IUD. You are much more likely to get PID if you use an IUD. This is a major cause of infertility. The birth control pill can cause hormone problems after you stop taking it. This is most likely if your periods weren't regular before you took the pill or if you started taking it very soon after your periods started.

Methods which you use just when you have sex are safer. These are called barrier methods. They include condoms, foam, diaphragms, and cervical caps. Natural methods, such as the ovulation method or the sympto-thermal method are also safer. These methods don't change your body in any way. For more information on birth control, see the book called **Avoiding Pregnancy**. Ordering information is on page 209.

If you don't want to get pregnant, use birth control methods that work. Use them each time you have intercourse. You can get an infection after an early abortion which makes you infertile. This is rare. If you have many early abortions or if you have more than one abortion after you are 12 weeks pregnant, you may end up with a problem with repeated miscarriages.

Don't take any hormones while you're pregnant:

You could cause fertility problems in your children. The drug DES, a manufactured hormone, was taken by many women during pregnancy. It has caused pregnancy and fertility problems in their daughters and sons. This drug is no longer given in pregnancy. Other hormones won't necessarily cause similar problems, but they might. It's best to avoid them. It's best to avoid most medicines while you're pregnant. If you're pregnant or trying to get pregnant, talk to your doctor and pharmacist about any medicine you're taking.

If you have a serious drinking problem, or a problem with street drugs, get help:

Talk to Alcoholics or Narcotics Anonymous, an alcohol and drug counsellor or a social worker about what kind of help is available. If you or your partner has had a serious drinking problem for years, you may not be able to have children because your liver has been damaged.

WORDS

This is a list of medical words we use in this book and what they mean:

Abdomen: Lower belly.

Abortion: An operation to end a pregnancy on purpose.

AIDS: AIDS stands for Acquired Immune Deficiency Syndrome. It can be passed from person to person during sex. It can also be passed by sharing needles. There is no cure for AIDS.

Anaesthetic: A drug which blocks the pain of surgery. There are three main types: general, local and regional. A general anaesthetic puts you to sleep during an operation. A local anaesthetic blocks the feeling where they will operate, but you are awake and aware. A regional blocks the feeling in a large part of your body. A local or a regional is safer than a general anaesthetic. Some people get headaches, dizzyness, or feel sick to their stomach after a general anaesthetic. One out of every 20,000 people who have a general anaesthetic die or end up paralyzed.

Appendicitis: An inflamed or infected appendix. The appendix is a small pouch on a person's intestine.

From: SAN FRANCISCO BAY AREA WOMEN'S YELLOW PAGES 1981-82

Basal Body Temperature: A test to find out when a woman ovulates. She takes her temperature every morning before getting up. See page 49.

Biological parent: A woman who gets pregnant and bears a child, or the man whose sperm joins with her egg.

Birth Control: Anything a person uses to keep from getting pregnant when they're having intercourse.

Bladder: The sack that holds a person's urine (pee) inside their body.

Cervix: The lower part of a woman's uterus. See page 29.

Chlamydia: An infection which is passed during sex. A Chlamydia infection can spread to a woman's uterus and tubes or to a man's ducts. It can cause infertility.

Cramps: Pain in the lower belly or the lower back which some women have during their periods.

D&C: A D&C is an operation in which the doctor gently scrapes out the inside lining of a woman's uterus.

DES: A manufactured hormone which some women were given in pregnancy between 1941 and 1971. DES has caused health problems in the daughters and sons of women given the drug. One of these health problems is infertility.

Discharge: Liquid or mucus that drips from a woman's vagina. It may be clear, white or yellow. It is normal and healthy to have discharge. If it smells bad or looks unusual, it is a sign of an infection.

Donor insemination: When a woman uses the sperm of a man who is not her sexual partner to get pregnant.See page 135.

Ducts: Tubes which sperm travel through. A man's epididymis and vas deferens are called his ducts. See page 31.

Ectopic pregnancy: A pregnancy which grows outside a woman's uterus. The most common place for an ectopic pregnancy is in a woman's tube. The tube cannot stretch enough to hold the growing embryo. You need to go to the hospital if you have an ectopic pregnancy. If the tube bursts, it is a life threatening emergency.

Egg: A woman's eggs come from her ovaries. One egg is about the size of a pinprick.

Ejaculation (to ejaculate): When a man has an orgasm (comes), and semen comes out of his penis.

Embryo: When an egg from a woman and a sperm from a man join, they make an embryo. The embryo is the first stage of what will become a baby.

Endometriosis: Women with endometriosis have bits of tissue like the tissue lining their uterus outside the uterus. See page 91.

Endometrium: The tissue lining a woman's uterus.

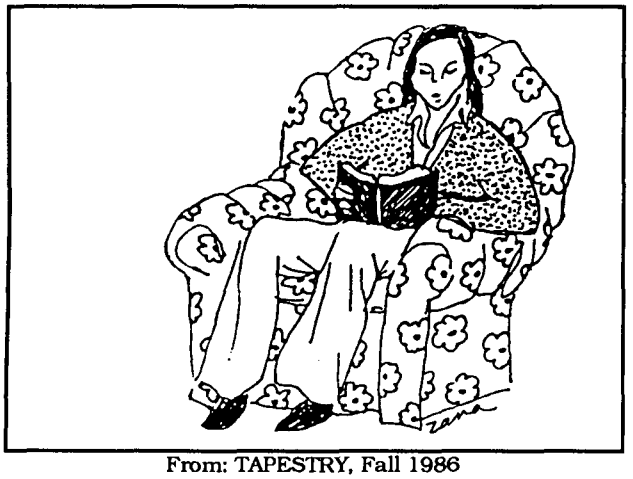
Erection: When a man's penis becomes hard.

Estrogen: One of the hormones made by a woman's ovaries.

Fertilization: When an egg and a sperm join together.

Fetus: The embryo starts being called a fetus from the second month of pregnancy. At this time, it starts to have a shape with body parts that can be recognized.

Fibroids: Fibroids are lumps of muscle tissue which may grow inside a woman's uterus. See page 102.



From: TAPESTRY, Fall 1986

Genetic: Genetic means having to do with genes. Genes are too small to see. Physical traits are passed from parents to their children in genes. The traits include what colour children's hair will be, what they will look like, and many other things about them. These genes are in the egg and the sperm.

Glands: Body organs which make and put out a chemical or a liquid.

Gonorrhea: A disease that is passed during sex. A gonorrhea infection can spread to a woman's uterus and tubes or to a man's ducts. It can cause infertility.

Hormones: Chemicals made by one part of a person's body which travel through their blood and tell other parts of their body what to do.

Hysterectomy: Surgery to take out a woman's uterus.

Hysteroscopy: A way of looking inside a woman's uterus. The doctor puts the hysteroscope through the opening in a woman's cervix. The hysteroscope is like a thin telescope. She can look through it at the inside of a woman's uterus. See page 64.

Hysterosalpingogram: An x-ray of the inside of a woman's uterus and tubes. See page 59.

Immune system: The parts of a person's body which help to fight infection.

Intercourse: Sex between a woman and a man with the man's penis in the woman's vagina.

IUD: An IUD is a small plastic object which a doctor puts inside a woman's uterus for birth control.

Laparoscopy: Surgery to look inside a woman's lower belly. The doctor makes a small cut. She then uses a harmless gas to blow the woman's belly up a little. She looks at her organs through a laparoscope. The laparoscope is like a thin telescope. See page 62.

Lesbian: A woman whose most intimate sexual and emotional relationships are with other women.

Luteal phase defect: A hormone problem affecting the second half of a woman's menstrual cycle. This is the time from when she ovulates until she has her next period. See page 76.

Menstrual cycle: The time between the first day of one period and the first day of the next period. For most women, a menstrual cycle is about one month long.

Miscarriage: Losing a pregnancy. Most miscarriages happen during the first three months of pregnancy.

Mucus: A thick liquid which may be sticky, stringy or slimy.

Orgasm: When a person comes, or reaches the peak of sexual excitement.

Os: The opening in a woman's cervix which leads from the inside of her uterus to her vagina. See page 29.

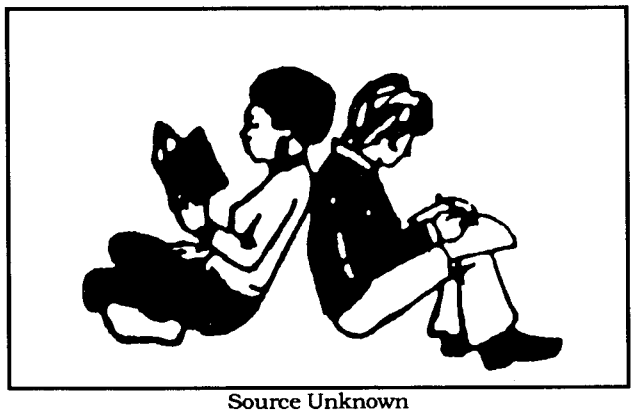
Ovaries: The organs which hold a woman's eggs. See page 29.

Ovulation (to ovulate): When an egg pops out of a woman's ovary. This usually happens about half way through her menstrual cycle.

PID (Pelvic Inflammatory Disease): An infection of a woman's uterus and tubes. It needs to be treated right away with antibiotics. PID can cause infertility from blocked tubes.

Post-coital test: A test to look at how well sperm live in a woman's mucus. See page 58.

Progesterone: One of the hormones made by a woman's ovaries.



Source Unknown

Scrotum: The sack of skin that holds a man's testicles. See page 31.

Semen: The liquid that comes out of a man's penis when he has an orgasm. Semen is the liquid that sperm swim in.

Semen analysis: A test which checks a man's semen to see if there are enough sperm and if the sperm are healthy. See page 41.

Side effect: A side effect is any change from a drugther than the reason a person took the drug. For example, you may take a drug to ovulate and also get headaches. The headaches are a side effect. Most drugs have side effects.

Speculum: A beakshaped instrument which a doctor or nurse puts inside a woman's vagina to hold it open so she can see the woman's cervix. A woman can also use a speculum herself.

Sperm: A man's testicles make many sperm. Millions of sperm are in his semen. A woman becomes pregnant when her egg joins withone sperm.

Spotting: Light bleeding before, after, or between periods.

Tubal ligation (having your tubes tied): This is an operation to stop a woman from being able to get pregnant. The doctor cuts her tubes so that the egg can no longer get to her uterus.

Testicles (balls): The organs that make a man's sperm. See page 31.

Tubes (fallopian tubes): The egg travels through these tubes to get from a woman's ovary to her uterus. See page 29.

Ultrasound: This test uses sound waves to make a picture of a person's inside organs. It can be used to see if a woman has problems with your uterus and tubes. See page 61.

Uterus (womb): The organ that holds the developing embryo and fetus if a woman gets pregnant. See page 29.

Vagina: One of a woman's sexual organs. See page 29.

Vas deferens: The tubes that sperm travel through to get from a man's testicles to his penis. See page 31.

Vasectomy: This is an operation to stop a man from having sperm in his semen. If there's no sperm, his partner can't get pregnant. The doctor cuts the tube that goes from a man's testicles to his penis.

VD (Venereal Disease): Diseases that are passed from person to person during sex. They are also called STD's or "sexually transmitted diseases".

Womb: Another name for your uterus.

HOW TO GET MORE INFORMATION

Lynn Roberson

Infertility Support Groups

Vancouver Infertility Peer Support Group
4522 - 199 Street
Langley, B.C. V3A 6A1
Telephone: Debbie 530-8291,
Jennifer 874-8487, Karen 433-4655

Kamloops Infertility Support Group
Telephone: Debbie Ramsay 374-2274

Infertility Outreach
P.O. Box 814
Leduc, Alberta T9E 2Y4

Resolve
5 Water Street
Arlington, Mass 02174
Telephone: 617-643-2424

General Information on Women's Health

Vancouver Women's Health Collective
302– 1720 Grant Street
Vancouver, B.C. V5L 2Y7
Telephone: 255-8285

Calgary Women's Health Collective
316– 223 12th Avenue S.W.
Calgary, Alberta T2R 0G9
Telephone: 265-9590

Victoria Faulkner Women's Center
204– 100 Main Street
Whitehorse, Yukon Y1A 2C5
Telephone: 667-2693

Mucus Charting

S.E.R.E.N.A. B.C.
1210 Hammond Avenue
Coquitlam, B.C. V3K 2P1
Telephone: 937-0022

S.E.R.E.N.A. Alberta
2220-C 7th Ave. N.W.
Calgary, Alberta T2N 0Z6
Telephone: 428-6104

Natural Family Planning Method Alberta
829 - 17th Street South
Lethbridge, Alberta T1J 3E1
Telephone: 329-0525

Ovulation Method Teachers Association
P.O. Box 10– 1780
Anchorage, Alaska 99510-1780

AIDS

AIDS Vancouver
509– 1033 Davie Street
Vancouver, B.C. V6E 1M7
Telephone: 687-2437

AIDS Calgary Awareness Association
223– 12th Avenue S.W.
Calgary, Alberta T2R 0G9
Telephone: 262-2522

Communicable Diseases Officer
Medical Services Branch
2 Hospital Road
Whitehorse, Yukon Y1A 3H8
Telephone: 667-1702

Other Health Organizations

Canadian P.I.D. Society
P.O. Box 33804, Station D
Vancouver, B.C. V6J 4L6
Telephone: 684-5704

D.E.S. Action Canada
5890 Monkland Avenue, Suite 104
Montreal, Quebec H4A 1G2
Telephone: 514-482-3204

Endometriosis Association
P.O. Box 92187
Milwaukee, WI U.S.A. 53202
Telephone: (in Calgary) 252-6572

The New Reproductive Alternatives Society
2621 Rosstown Road
Nanaimo, B.C.
Telephone: 758-0074

Association of Naturopathic Practioners
306– 259 Midpark Way, South East
Calgary, Alberta T2X 1M2
Telephone: 256-0272

Adoption

B.C. Adoptive Parents Association
205– 15463 104th Avenue
Surrey, B.C. V3R 1N9
Telephone: 588-7300 or 588-6111

Adoptive Parents Association of Alberta
Box 3674, Station 8
Calgary, Alberta T2M 4M4
Telephone: 255-0566

SNAP: Society of Special Needs Adoptive Parents
205– 15463 104th Avenue
Surrey, B.C. V3R 1N9
Telephone: 588-9477

Information– Support Group for Couples Considering Adoption
4490 Oak Street
Vancouver, B.C. V6H 3V5
Telephone: Rea 271-0892
or Lorraine 875-2283

B.C. Association of Social Workers
865 W. 10th Avenue, Suite 8
Vancouver, B.C. V5Z 1L7
Telephone: 876-9535

Alberta Association of Social Workers
11831 123rd Street, Suite 100
Edmonton, Alberta T5L 0G7
Telephone: 454-1426

Adoption Agencies

AES: Adoption Education Services
1841 Rideau Avenue
Coquitlam, B.C. V3J 3H1
Telephone: 936-9748

Adoption Options
8– 7340 78th Street
Edmonton, Alberta T6C 2N1
Telephone: 465-1238

Foster Care

B.C. Federation of Foster Parent Associations
Suite 24 – 800 Cassiar Street
Vancouver, B.C. V5K 4N6
Telephone: 660-7696

Alberta Foster Parent Association
Bank of B.C. Building
1250– 10055 106th Street
Edmonton, Alberta T5J 2Y2
Telephone: 429-9923

Books

You can ask your nearest library or bookmobile for these books. Libraries will order a book for you through inter-library loan if they don't have it. You can also ask them if they carry other books that may help you.

Infertility

Infertility: A Guide for the Childless Couple by Barbara Eck Menning

The Infertility Book: A Comprehensive Medical and Emotional Guide by Carla Harkness

Infertility: How Couples Can Cope by Linda P. Salzer

Miracle Babies by Mark Perloe

Overcoming Endometriosis by Mary Lou Ballweg and the Endometriosis Association

Understanding Infertility: A Guide For Family and Friends by Patricia Irwin Johnston

Adoption

The Adopters Advocate by Patricia Irwin Johnston

Information packages on private and international adoption by the B.C. Adoptive Parents Association

Donor Insemination

Considering Parenthood: A Workbook for Lesbians by Cheri Pies

Getting pregnant our own way: A guide to alternative insemination by Lisa Saffron

General Health

The Allergy Self-Help Book by Sharon Faelton and the Editors of Prevention Magazine

The Relaxation and Stress Reduction Workbook by Davis and McKay

Taking Care by Mary Breen

Support groups

Helping Ourselves by the Women's Counselling Referral and Education Center, 348 College Street, Toronto, Ontario M5T 1S4

From: EAST WEST JOURNAL, August, 1985

Newsletters

Resolve National Newsletter
5 Water Street
Arlington, Mass 02174

Adoption Issues
28—7340 78th Street
Edmonton, Alberta T6C 2N1

OURS Magazine (international adoption)
#203, 3307 Highway 100 N
Minneapolis, Minn 55422 U.S.A.

Other resources

Four other books were written on this project:

Avoiding Pregnancy: Choosing Birth Control That's Right For You

Infertility: Problems Getting Pregnant

Miscarriage: You're Not Alone

Women Talking About Health: Getting Started with Workshops and Groups

The Vancouver Women's Health Collective also carries booklets on:

Breast Health
Fertility Awareness Method of Birth Control
Pap Tests
Sexuality
Vaginal and Cervical Health

Booklets in Spanish and Chinese on:

Birth Control
Correct Use of Medication
Pap Tests
Sexually Transmitted Diseases
Stress

To order write:

The Vancouver Women's Health Collective
302—1720 Grant St.
Vancouver, B.C. V5L 2Y7

There is a charge for some of these books.