What is this thing called M.E.?

it seems like there has been some interest around this lately and lots of questions. i am curious too. here is some very introductory information. if you've got info to share, please write:

bodyautonomy@riseup.net

enjoy!

REPRODUCTIVE SELF-CARE

a brief history of menstrual extraction

by

The first time this anarcha-feminist got pregnant, she also got a little confused. I knew that I didn't want to be pregnant. But I also knew that I didn't want to pay a wealthy, white, male doctor to perform an invasive and traumatic abortion procedure on me. I wanted to experience my abortion as an empowering event in my life rather than a shameful mistake, and I wanted to actually *experience* my abortion. I wanted a menstrual extraction — the least physically traumatic, least expensive, and, unfortunately, least legal form of early-term abortion that exists today.

For those of us unhappy with inviting chemicals or surgery into the abortion scene, menstrual extraction is an alternative option that can be safe, effective, and cheap. Developed in 1970 by feminist activists as an alternative to back-alley abortions, this underground technique has a rich revolutionary history that has somehow remained disappointingly absent from the struggle to reclaim reproductive rights. In a time when 87 percent of counties in the U.S. lack an abortion provider, according to the National Abortion Federation, menstrual extraction has the potential to provide a low-cost, early-term abortions across geographical, cultural, and economic borders. But, why hasn't anyone heard of it?

In one of the powerful social phenomena of the 1960s, thousands of women across the U.S. formed self-help groups and began to re-explore gynecological self care for the first time since the emergence

of the professional medical establishment decimated our access to woman-controlled reproductive technology. These women peeked at each other's cervixes, completed their own wellness exams, and in 1970 finally developed an abortion procedure that involved no drugs and no doctors.

Menstrual extraction mimics the vacuum aspiration method of abortion but can be performed safely by a trained layperson in a woman's home, without anesthesia or much medical equipment. The procedure is recommended only for early-term pregnancies, no further along than six to seven weeks.

The technique itself is shockingly simple, requiring equipment that can be found in a home kitchen and a scientific supply store for under $100. A flexible plastic instrument with a rounded tip, called a cannula, is inserted into the vagina, through the cervix, and into the uterus. The cannula is attached to a length of aquarium tubing, which empties into a quart jar fitted with a rubber stopper. A second length of aquarium tubing leaves the jar, attaching to a plastic syringe. A two-way bypass valve prevents air from entering the uterus while the syringe creates suction, and the contents of the uterus are safely and quickly extracted into the jar. It's quick, usually lasting 15-30 minutes, and the only pain is like experiencing a regular cycle worth of menstrual cramps all in just a few minutes. The pain is bearable. There's no anesthesia necessary, no painful and traumatic dilation of the cervix, and no sharp metal instruments involved.

When it was developed, menstrual extraction presented an unparalleled level of effectiveness and physical safety for millions of women, when compared to the alternative of a "back alley" abortion. Women flocked to early demonstrations of the technique in 1971, and soon Los Angeles' feminist activists took to the road, sharing menstrual extraction with women across the country. The popularity of women's self-help groups soared, and a strong un-

derground network of menstrual extraction practitioners — almost all female — developed. The new technique succeeded in regenerating fervor for women-controlled reproductive health care, and the struggle for the legalization of abortion continued.

Despite the amazing step forward that menstrual extraction provided for women's access to abortion, the momentum surrounding it slowed almost to a halt with the Supreme Court decision of *Roe v. Wade* in 1973. Women in the U.S. were granted the legal right to have an abortion — that is, the legal right to obtain a socially acceptable form of abortion, provided only by a doctor, for a price. *Roe v. Wade* left menstrual extraction in the dust because the legalization of abortion didn't apply to this underground technique. "In those places where abortion became accessible and inexpensive," due to legalization, "menstrual extraction, quite naturally, lost popularity," stated Lorraine Rothman, the technique's key pioneer. Women returned to a dependence on surgical abortions provided by the for-profit medical profession, and feminist activists turned their attention to the establishment of legal abortion clinics, relegating menstrual extraction to a place in the history of the feminist movement.

A resurgence of interest in menstrual extraction is well documented in media archives from the late 1980s and early 1990s, when the Supreme Court's *Webster* decision granted states new power to restrict abortion. Articles in every major U.S. newspaper and news magazine profiled a renewed concern among women regarding menstrual extraction as a safeguard against the recriminalization of abortion. In 1989, Lorraine Rothman and the Federation of Feminist Women's Health Centers (FFWHC) produced the film "No Going Back," an instructional guide to performing a menstrual extraction. FFWHC activists again traveled the country, doing demonstrations of the technique and marketing menstrual extraction kits for $90. The resource guide *A Woman's Book of Choices: Abortion, Menstrual Extraction, RU-486* was published in 1992 by Rebecca Chalker and Carol Downer, and remains the only widely available resource on the technique.

"There is a resurgence of women digging out their menstrual extraction kits," and remembering why they had them in the first place, Rothman stated in 1991. Menstrual extraction had reached a point of being publicly acknowledged and thus somewhat legitimized. Carol Downer cited the existence of approximately 2000 menstrual extraction practitioners in the U.S. in 1992 — a significant number in consideration of the truly grassroots beginning and clandestine nature of menstrual extraction.

That was the last time menstrual extraction appeared in the public spotlight. Underground, the body of knowledge surrounding menstrual extraction still exists. So do networks of experienced women who've been performing them for 30 years, — but these practitioners are few and far between. It's amazing how many anarcha-feminists and reproductive rights activists have never heard of this technique that has the potential to change the way women experience abortion. It's amazing that in 2002 — almost 30 years after the legalization of abortion — I found myself making a secret phone call and using code words to obtain an abortion. *Roe v. Wade* may have granted women the legal right to obtain publicly acceptable forms of abortion, but it didn't grant me access to the low-tech, empowering abortion I wanted.

The current political climate in the U.S. places the future of legal abortion in the U.S. in danger, and many concerned women anticipate a battle against the Bush administration in the not-so-distant future. Feminist communities across the country are beginning to recognize the need to arm themselves with options, and the need to "take up the cannula" as a way of "taking up arms," as suggested by Lynne Randall, former director of the Atlanta Feminist Women's Health Center. Once again, menstrual extraction may very well become a visible act of resistance to the recriminalization of abortion. Until then, it maintains the potential to serve as an accessible, empowering, and safe alternative to conventional abortion, and it provides every woman the opportunity to use her abortion as a step toward reclaiming the skills and the technology of her reproductive heritage. ★

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from the NOV/DEC 2005 issue of Clamor

Menstrual Extraction

Through working for abortion reform in the early 1970s, the early self-help clinic in Los Angeles became acquainted with the new, gentler suction method of removing the uterine contents—a method which was to revolutionize abortion technique. Out of this work they evolved the technology for removing a woman's flow, on a monthly basis or less often, and called it menstrual extraction.

They unearthed articles in Russian and Chinese medical journals showing hand-operated vacuum equipment and recommending the procedure for contraceptive purposes. They were aware of research in the United States on early-termination aspiration abortion without cervical dilation and with the use of a large syringe attached to a flexible plastic cannula (similar to a soda straw) or a portable foot pump.

The group found that menstrual extraction was not difficult to learn and that the introduction of a sterile four-millimeter cannula into the uterus was not traumatic because it did not require that the cervix be dilated. There was no cutting or scraping, so simple sterile procedures were sufficient; anesthetics were not necessary; and the suction was sufficient to extract all or most of a woman's flow in around 20 to 30 minutes.

The discovery that almost any woman could learn the technique of menstrual extraction was accompanied by the discovery of several obvious and very practical uses for it. Women could free themselves of heavy, crampy periods, or avoid having a period if it would interfere with travel, vacation or perhaps an athletic event, and could extract the contents of the uterus if there was the possibility of unwanted pregnancy.

Although menstrual extraction evolved out of work to make abortion safe and legal, the 1973 Supreme Court decision changed the group's primary interests to research of the method. They did not expect that all women would use menstrual extraction as a backup when birth control failed. They were aware, however, that one or two menstrual extractions a year carry far less health risks than either an IUD or the Pill.

from: A New View of a Womans Body
The Federation of Feminist Womens Health Centers

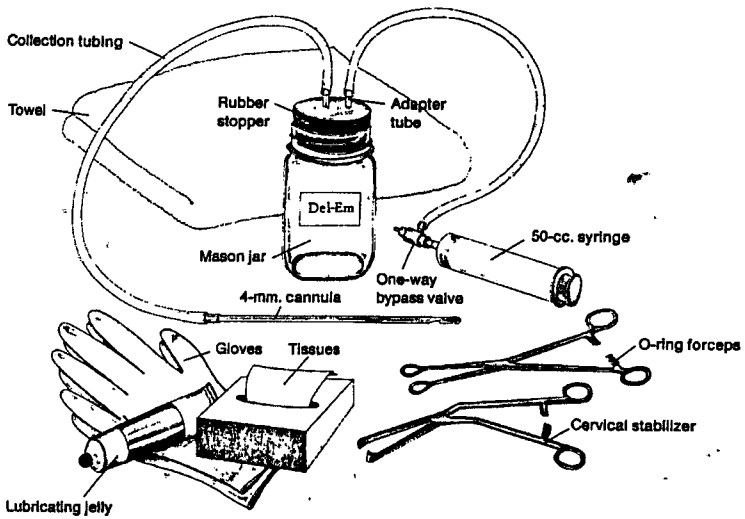
Menstrual extraction and early termination abortion are similar technically, but menstrual extraction is not performed in a medical setting. When done by an experienced group, it can be used simply as a home-care procedure by women wishing to gain knowledge about their bodies and menstrual cycles and to exert more direct control over their reproductive lives.

Although prior discussion with her doctor as to her intention in using this particular technique is not absolutely necessary, having a physician available, should any medical questions arise, would further increase the safety of the procedure.

Menstrual extraction can be done in a woman's home or a self-help group's meeting place and the woman having her flow extracted controls all aspects of the procedure. Women generally learn the technique by participating in groups with more experienced women, first observing and then having their own menstrual extractions. Although the rudimentary aspects of the procedure can be learned in a few weeks, the knowledge and skill necessary to the reasonable safety of the procedure usually develop over a period of several months or even a year. Without this body of knowledge, the isolated woman, who generally has little or no familiarity with her own body, is risking the dangers commonly associated with self-abortion.

One frequent objection to menstrual extraction is a fear that the introduction of a cannula into the uterus will cause infections or other complications. Over the past decade, hundreds of women doing menstrual extraction in the United States and in other countries have reported that they do not have more or fewer infections than other women and have noted that the passage of a very small cannula into the uterus does not appear to have any effect on a woman's ability to carry a future pregnancy. It would seem, however, that the primary reason for this excellent safety record is the rigorous selection process any group doing menstrual extraction follows and the care with which the procedure is carried out. Women who have a tendency toward infection probably should not elect to have menstrual extraction. If they do, they take extra precautions. Sometimes a woman who is highly motivated but has a very sensitive cervix chooses to tolerate the additional discomfort in order to have an extraction.

Menstrual extraction should not be viewed as an attempt to avoid menstruation or short-circuit natural functions. It is a means for a woman to exert influence over changes in her body which she could not control before, in order to eliminate occasional discomfort or inconvenience or an unwanted pregnancy.


Collection tubing
Towel
Rubber stopper
Adapter tube
Del-Em
Mason jar
50-cc. syringe
One-way bypass valve
4-mm. cannula
Gloves
Tissues
O-ring forceps
Cervical stabilizer
Lubricating jelly

8-1 Lorraine Rothman, one of the original members of the group which developed menstrual extraction, invented the Del-Em. After years of being a housewife, raising four children and numerous pets and working around her husband's biology lab, finding the components she needed was easy. She took a Mason jar from her pantry, a large stopper, some aquarium tubing and a 50-cc. syringe. She made inquiries at industrial supply houses and found a one-way bypass valve, which prevents air from returning once it has passed through. The total cost was just a few dollars, it worked, and anyone could make one. A kit similar to this one is currently being marketed for use in physician's offices. This illustration shows the basic supplies and equipment needed for menstrual extraction.

Many women report that their best experiences with menstrual extraction have taken place six weeks after their last period, give or take a week. However, we know of menstrual extractions that have been done with complete safety and success up to eight or nine weeks after the last period. If the group has been doing self-examination consistently, they will be very familiar with the size and placement of the uterus and there will be much less chance of miscalculations.

8-2 The menstrual extraction usually takes place on the first day of a woman's *expected* period or several hours after her period starts. It can be done in comfortable surroundings, often in the woman's home. One or more experienced women in the group do a uterine size check to determine the size and position of the uterus, so that the group does not find itself dealing with a more advanced pregnancy than they are prepared for. Such a case could result in an incomplete extraction, which usually involves resorting to medical personnel who have access to the necessary equipment and skills to complete the procedure.

Wearing a surgeon's plastic glove, one woman inserts her index and middle fingers into the vagina. Pressing down on the abdomen just above the pubic hairline, she can feel the outline of the uterus between her hands. In early pregnancy, the uterus is usually the size of an unshelled walnut, and firm.

8-3 The woman who is having the extraction then inserts her own speculum and checks her cervix with a mirror. Then the other members of the group check it also. If she is pregnant, her cervix might very well be puffy and have a bluish tint. This change usually occurs in the first three months of pregnancy.

It is very important to the group to have information about the woman's menstrual cycle and her past experiences with menstrual extraction, irritations or infections or signs of pregnancy. Although the whole group should evaluate this information before proceeding, the final decision to proceed is always left to the woman who is having the extraction, provided she is sufficiently familiar with the technique to evaluate the information.

8-4 The next step is to pump up the vacuum in the Del-Em. Some women prefer to have the vacuum established before the cannula is inserted and this can be done by pinching the tube attached to the valve. Others prefer the suction to be built up slowly after the cannula is inserted into the uterus. If the woman decides to use the stabilizer, which looks like a pair of tweezers, it is attached to the cervix at this point. The stabilizer is used to keep the cervix from moving.

8-5 The cannula is now inserted carefully through the cervical canal into the woman's uterus. With the size four or five cannula, there is normally no need for dilation (stretching of the canal). The woman holding the cannula will feel it pass through the inner cervical opening and know the cannula tip is in the uterus.

8-6 If the cannula does not go in easily, it is helpful to grasp it with the O-ring forceps to give it more stability.

8-7 When the cannula is in the uterus, the woman doing the extraction turns the cannula first in a clockwise direction, then in the opposite direction, and moves it forward and back as well, to make sure she is picking up all of the uterine material.

The woman having the extraction should always be in control. If her cramps are too heavy or if she feels too uncomfortable, she can ask that the extraction be stopped.

8-8 If a pregnancy has been interrupted, it is important that the extraction be complete. This can usually be determined by the woman, who will feel the stronger cramping that indicates the emptied uterus is contracting down to its usual size. The woman holding the cannula will usually notice a difference also. The cannula is harder to move in and out, and the interior of the uterus, which at first felt smooth, feels rough, something like a washboard, when it is empty. The contents of the uterus—blood, clots or small bits of tissue—are examined in a shallow dish or glass. If chorionic villi, the yellowish material with branchlike structures which is the beginning of the placenta, are present, then it is a good sign that the menstrual extraction ended the pregnancy.

After menstrual extraction in which the woman was pregnant, the group stays in phone contact. If the woman thinks that she is still pregnant, the group may decide to repeat the procedure. In those rare instances when there are any signs of an infection, such as fever or discharge, heavy bleeding or pain and tenderness in the pelvic area, she must consult a physician immediately to obtain antibiotics since untreated uterine infections can be quite severe. She will know that the menstrual extraction was complete if the signs of pregnancy are gone with a few days and any minor cramping or bleeding has disappeared.

From: A woman's Book of Choices: Abortion, Menstrual Extraction, RU486
Rebecca Chalker and Carol Downer

MENSTRUAL REGULATION IN THE DEVELOPING WORLD

At the same time that menstrual extraction was developing in California, international family planning activists began using a nearly identical method of fertility control in developing countries. The technique has had a variety of names: "minisuction," "menstrual induction," and "menstrual aspiration." However, the term most widely used today is menstrual regulation (MR). Like menstrual extraction, the procedure is often done without a laboratory test to confirm pregnancy. MR can also be used for teaching women about their anatomy and fertility, diagnosing uterine cancer, menstrual disorders, and infertility, and for completing self-induced or incomplete abortions.

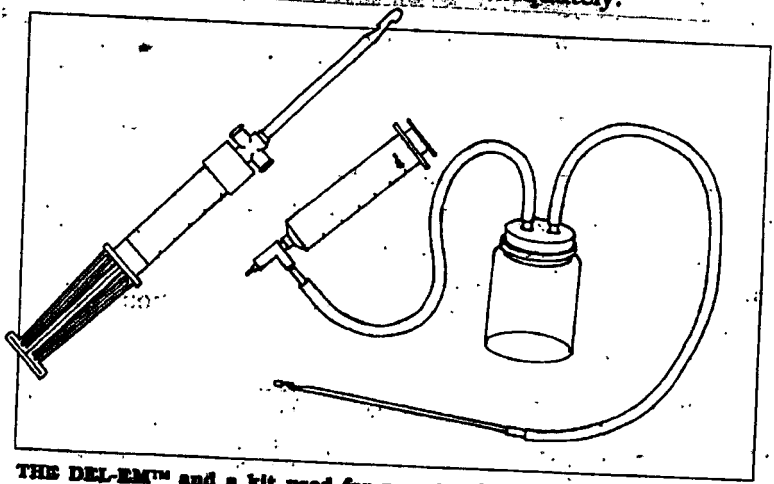
One distinctive difference between the practices of menstrual regulation and menstrual extraction is in the equipment used. The Del-EM™ used in menstrual extraction is individually assembled, while the kit used in menstrual regulation is commercially produced and marketed.* With this kit, the uterine contents are suctioned directly through the cannula into a syringe, while with the Del-Em™, the contents are suctioned through the cannula and a plastic tube about two feet long into a collection jar.

Early on, it became clear to medical professionals and family planning experts that paramedics and lay people with even minimal education could learn to use hand-generated suction devices safely and effectively. Today, training in most countries typically lasts from one to three weeks, occasionally longer, and is done on both a formal basis, including classroom lectures, demonstra-

*This device is manufactured by the International Projects Assistance Service (IPAS), P.O. Box 100, Carrboro, NC 27510, (800) 334-8446.

tions, and supervised practice; and on an informal basis, often consisting of demonstrations only. Trainees may observe from 10 to 20 procedures before beginning hands-on training, and then do up to 20 procedures under supervision before doing them on their own. Because of the lack of qualified trainers, and the demand for MR services, trainees sometimes begin doing unsupervised procedures without much hands-on instruction, but this is not recommended.[1]

In developing countries where health education and contraception are not widely available, women who fear they may be pregnant often seek to induce miscarriages with sticks, wires or other instruments, by drinking toxic substances, or by douching with harmful concoctions. In Nicaragua, for example, women commonly use wire from telephone cables to induce miscarriages. Others resort to poorly trained abortionists who often use stiff, unsterile instruments. As a result, at least 200,000 women die each year,[2] and many more are left infertile or with lifelong health problems. In addition, hundreds of thousands of children are left motherless or with a mother who may be too ill or disabled to provide for them adequately.



THE DEL-EM™ and a kit used for menstrual regulation in developing countries made by the International Projects Assistance Service (IPAS). The major difference is that the Del-Em™ collects the uterine contents in a jar, while it goes directly into the syringe of the IPAS kit. Both kits have a two-way bypass valve, to prevent air from entering the uterus.

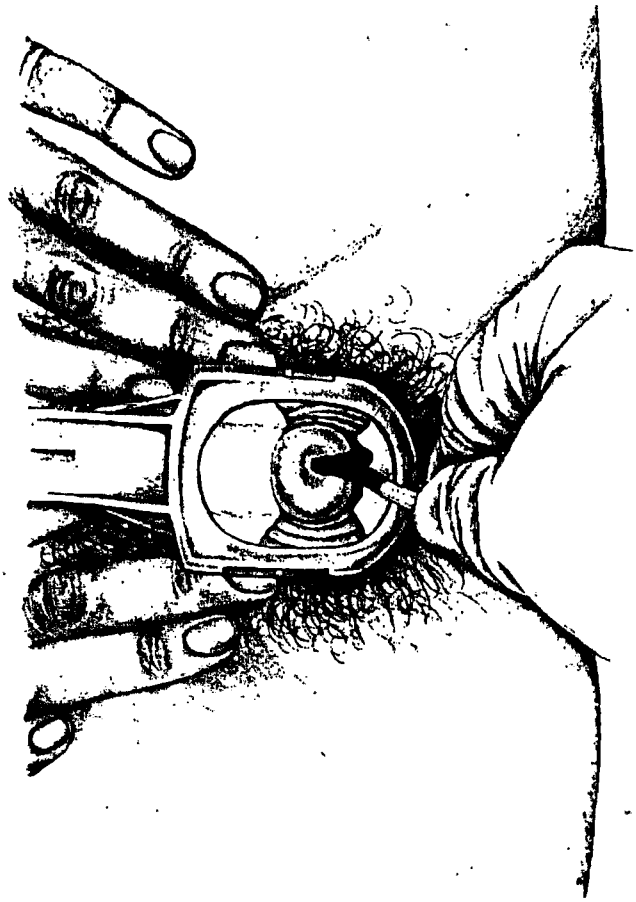
Many doctors who do menstrual regulation may use anesthesia, but in some clinics, the only anesthesia that is used is the comforting hand and soothing voice of a counselor. Zarina, a counselor at a women's clinic in Bangladesh, reports that most of the women who seek MR have already endured childbirth; most say the discomfort from the procedure is quite tolerable, even without anesthesia.

In practice, menstrual regulation is performed up to eight to 10 weeks from the last period, but in many countries, the procedure is also done up to 12 weeks from the last menstrual period. There are no reliable statistics on the rate of incomplete procedures in Bangladesh or other countries where MR is in use, but the rate of incompletes appears to be low, according to Zarina because "most women in these countries usually don't come in until they are eight to ten weeks from their last period, when it is easier to determine, by examining the tissue, whether or not an implantation has been missed."

Menstrual regulation is practiced throughout Latin America, Asia, in many African countries, and on a limited basis in the Middle East. *In every setting in which this technique has become accessible, the complication rate for self-induced and poorly done abortions has been dramatically reduced.* In Indonesia, for example, one study found that the rate of septic abortion was 80% higher in areas in which menstrual regulation (in this case, suction curettage) was not available, but that where MR was available, wards formerly reserved for cases of septic abortion were no longer necessary.[3] Clearly, if menstrual regulation were employed more widely, the health of many women—and the lives of many others—would be saved.

IN AN ERA that is hostile to reproductive freedom, menstrual extraction and other home health-care techniques (see Chapter 9) are profoundly relevant. Women may con-

sciously choose to use menstrual extraction or to take herbs for fertility control for a variety of reasons. When used properly, these techniques are far safer than childbirth, and can put an end to the makeshift methods that desperate women have often used to prevent unwanted pregnancies.



8–7 The cannula inserted into the uterus