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WINTER '89

Right to Choose

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EDITORIAL

Well! We know you haven't seen an issue for some time but we're really glad to be back in production.

This issue is a double one as so much has happened in the women's health field since our last issue. Not surprisingly, it seems the health issues for women remain the same - the Dalkon Shield saga continues, abortion rights are still under attack (nationally as well as internationally) despite public opinion being in favour of its availability and the medical profession is still anti-woman in its attitude (see our article *Cervical Cancer Outrage*).

We know that many of our articles in this issue are on abortion. And we're very aware that issues such as the role of the drug companies, the directions of contraceptive research, population control policies, the role of the medical profession and so on are also vitally important to women's health activists. However, the reality is that on this planet one woman dies every three minutes from the effects of an illegal abortion. Many of these deaths occur in developing nations yet the industrialised countries can never take the right to choose for granted. Witness the recent reversal of parts of the 1973 *Roe v. Wade* ruling (see pp. 4-5) and the current attack in our country on access to abortion via the proposed Harradine *Abortion Funding Abolition Act* (see page 3).

It is important to engage in the struggle to defend our right to choose both on the national level and the international level. An international perspective on our health activism broadens our horizons, shares the analysis and strengthens the bonds between women.

We hope you enjoy this issue.If you would like to help with the magazine or the abortion campaign please contact us at Women's Liberation House, 63 Palace Street, Petersham, NSW 2049. We meet every second Wednesday night there at 6.00 p.m. Phone 569-3819 to leave messages.

WOMEN'S ABORTION ACTION CAMPAIGN

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THE HARRADINE BILL: NEW ATTACKS IN AUSTRALIA

On Friday 5th May the Sydney Morning Herald published a position paper from a group of 30 anonymous, cross-factional, 'pro-life' politicianson discussing the possibilities of legislating at the Federal level against abortion In early June Senator Brian Harradine (Independent, Tasmania) issued a press release stating that he will move a private members Bill (the *Abortion Funding Abolition Act*) in August this year which, if passed, will restrict women's access to the Medicare rebate on abortion.

This Bill proposes that there will be only two grounds for getting a medicare rebate for abortion. The first is that if the doctor had not performed the abortion the "pregnant person" (sic) would have died. The doctor would be required to sign a document which specifies the relevant pathological condition of the 'pregnant person'. The second condition is if, in order to treat the 'pregnant person' for another ailment, the doctor was unaware that "the undertaking of the medical service would end the life of an unborn child."

Obviously very few doctors would be willing to sign a certificate verifying either of the above conditions.

THE COSTS INVOLVED

The rationale for this Bill is that the "abortion industry" should not be funded by the tax-payer. What this would mean in dollar terms for a woman seeking an abortion is a dramatic increase in the cost for surgery (from approximately $80 to $200-$300). Clearly the social and emotional costs for these women would also be high. We could expect a proliferation of the 'el cheapo' abortion package within entreprenurial medicine. A service which would only be possible if the standard of treatment was so fast and shoddy that a large profit margin could be maintained. Such profit-motivation and the resulting free-market mentality would spell the end of the feminist abortion clinics which are totally non-profit. It would mean the end of their services which provide counselling, a supportive environment and high standards of medical care and after-care. This is a service that women have fought hard for in Australia.

Any woman who could not afford these costs would be forced into waiting until enough money had been saved for surgery, by which time she may well have reached her 2nd trimester of pregnancy. At this stage the abortion would cost more, and may be more complicated medically.

Simply put, the arguments of economic rationality are a facade for a piece of prohibitive and anti-woman legislation.

IF HARRADINE HAS HIS WAY...

A "PREGNANT PERSON" COULD NO LONGER USE THEIR MEDICARE CARD FOR AN ABORTION!

HANDS OFF MEDICARE ABORTIONS!

MEDICARE , ABORTION AND CONSCIENCE

Medicare is meant to be a *universal* health care system.To allow Terminations of Pregnancy to be removed from the Medicare schedule on the basis of the 'moral' position of the boys in Canberra is to set a dangerous precedent. What medicare items will be selected next for the wrath of the (im)moral majority? Would AIDS-related medical treatments be next?

If Medicare doesn't provide full health care to all women in relation to all health-related issues, then women simply no longer have a universal health care fund. We have abandoned the principle that we all have a right to health services regardless of financial circumstances. And we have a health care service that actively disadvantages those women who choose abortion.

Both the Liberal and ALP have a conscience vote on abortion i.e. politicians vote according to their own personal conscience rather than representing their constituents. Opinion polls show an overwhelming percentage of people in Australia are pro-choice. So why is the individual conscience of a politician worth more than your conscience or mine? The answer lies in the move toward the repeal of all abortion laws i.e. remove the decision-making power from the hands of the law-makers and the politicians, and return it to where it really belongs - with women.

THE CLAYTONS ABORTION BILL

The rationale for the removal of Medicare payments for

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ABORTION IN THE U.S. A CHILL WIND BLOWS

In 1973 the United States Supreme Court brought down an historic ruling on the issue of access to abortion. The case, *Roe v. Wade,* was a class action brought by a pregnant single woman, Jane Roe (not her real name - a pseudonym was allowed to be used) challenging the constitutionality of the Texas criminal abortion laws, which proscribed procuring or attempting an abortion except on medical advice for the purpose of saving the mother's life. The case first began in 1971 - it was argued on December 13, 1971, re-argued on October 11, 1972 and decided on January 22nd, 1973. A rehearing was denied on February 26th, 1973.

The decision brought down on January 22nd, 1973 was historic for American women as it asserted that the right to an abortion in the first trimester is a constitutional right of American women. In the second trimester, the Supreme Court ruled, that the state may regulate abortion procedure in regard to preservation and protection of maternal health. And in the third trimester the state, if interested in protecting foetal life after viability, it may proscribe abortion except when necessary to preserve the life or the health of the mother.

A further important part of the 1973 ruling was that it established that the Supreme Court had a role to play in protecting the constitutional right of American women having access to abortion in the first trimester. It was a complex ruling, based partly on the due process clause of the Fourteenth Amendment protecting right to privacy against state action and on a legal interpretation of viability of the foetus.

The complexity of the ruling lent itself to legal challenge which, of course, the anti-abortion groups fostered. Since 1973 the *Roe v Wade* ruling has been reviewed a number of times. The ruling was upheld but by a slimmer majority each time as progressive judges retired or were too ill to continue. During the Reagan administration and, as judges retired, the Supreme Court benches were replaced with conservative, anti-abortion judges. The recent review arose from a disputed Missouri law banning the provision of information to public hospital patients on the option of abortion. Below we reproduce information supplied to *Right to Choose* by the Reproductive Freedom Project of the American Civil Liberties Union analysing the July 3rd Supreme Court review and its implications for American women.

On Monday July 3, 1989, the United States Supreme Court decided *Webster v. Reproductive Health Service*. In 5 separate opinions, the Court upheld three provisions of the Missouri statute: the declaration that life begins from the moment of conception; the prohibition on the performance of abortion in public facilities; and the viability testing provisions. The Court also found that they need not address the validity of the speech restrictions because the question is moot. The Court, by separate order, agreed to hear three additional abortion cases next term.

THE PLURALITY OPINION

Chief Justice Rehnquist in an opinion joined by Justices White and Kennedy upheld the three provisions and joined in the mootness ruling. Although this opinion stopped short of explicitly rejecting *Roe,* the three Justices explicitly rejected *Roe*'s trimester framework. "We think that the doubt cast upon the Missouri statute by these cases is not so much a flaw in the statute as it is a reflection of the fact that the rigid trimester analysis of the course of a pregnancy enunciated in *Roe* has resulted in... making Constitutional law in this area a virtual Procrustean bed... *Stare decisis* is a cornerstone of our legal system, but it has less power in Constitutional cases, where, save for Constitutional amendments, this Court is the only body able to make needed changes (citation omitted). We have not refrained from reconsideration of a prior construction of the Constitution that has proved 'unsound in principle and unworkable in practice' (citation omitted). We think the *Roe* trimester framework falls into that category."

JUSTICE SCALIA'S CONCURRENCE

Justice Scalia also upheld the three Missouri provisions and joined in the mootness ruling but explicitly held that *Roe* ought to be reversed. "It was an arguable question today whether...the Missouri law contravened this Court's understanding of *Roe v Wade*, and I would have examined *Roe* rather than examining the contravention. Given the Court's newly contracted abstemiousness, what will it take, one must wonder, what will it take for us to reach that fundamental question? The result of our vote today is that we will not reconsider that prior opinion even if most of the Justices think it is wrong, unless we have before us a statute that in fact contradicts it.....It thus appears that the mansion of Constitutionalised abortion-law, constructed overnight in *Roe v. Wade,* must be disassembled door-jam by door-jam, and never entirely brought down no matter how wrong it may be."

JUSTICE O'CONNOR'S CONCURRENCE

Justice O'Connor joined the Chief Justice, Justices White and Scalia in the result but offered a differing interpretation as to why the viability testing provisions are constitutional

and declined to address the underlying validity of *Roe*. "The Court today, has accepted the State's every interpretation of its abortion statute and has upheld under our existing precedents, every provision of that statute which is properly before us. Precisely for this reason, reconsideration of *Roe* falls not into any "good-cause exception" to this "fundamental rule of judicial restraint....." (citation omitted). When the constitutional invalidity of a State's abortion statute actually turns on the constitutional validity of *Roe v. Wade*, there will be time enough to reexamine *Roe*. And to do so carefully." She cited with approval her previous abortion rulings in *City of Akron v. Akron Centre for Reproductive Health* and *Thornburgh v. A.C.O.G.* where she had adopted an "undue burden" analysis.

Because (1) there are no longer five votes to affirm *Roe* and its progeny; (2) five Justices have indicated that they do not support the trimester framework; (3) Justice O'Connor has embraced an "undue burden" standard and (4) four others indicated a willingness to overturn *Roe*, there is now tremendous uncertainty about the law of the land.

THE DISSENTING OPINIONS

Four Justices: Blackmun, Brennan, Marshall and Stevens, concurred in the limited part of the plurality opinion that finds the speech restrictions moot. In a strongly worded statement written by Justice Blackmun and joined by Justices Brennan and Marshall, the dissenting Justices cried the plurality and concurring opinions arguing that *stare decisis* and principles of constitutionalism required adherence to *Roe*.

Moreover, applying *Roe* and its progeny, the dissenters all found that three of the Missouri provisions failed to pass constitutional muster. "Never in my memory has a plurality announced a judgement of this Court that so foments disregard for the law and for our standing decisions. Nor in my memory has a plurality gone about its business in such a deceptive fashion. At every level of its review, from its efforts to read the real meaning out of the Missouri statute, to its intended evisceration of precedents and its deafening silence about the constitutional protections that it would jettison, the plurality obscures the portent of its analysis. With feigned restraint, the plurality announces that its analysis leave *Roe* "undisturbed", albeit "modified and narrow(ed)." *Ante*, at 23. But this disclaimer is totally meaningless. The plurality opinion is filled with winks, and nods, and knowing glances to those who would do away with *Roe* explicitly, but turns a stone face to anyone in search of what the plurality conceives as the scope of a woman's right under the Due Process Clause to terminate a pregnancy free from the coercive and brooding influence of the State. The simple truth is that *Roe* would not survive the plurality's analysis and that the plurality provides no substitute for *Roe*'s protective umbrella...Thus, not with a bang but a whimper the plurality discards a landmark case of the last generation and casts into darkness the hopes and visions of every woman in this country..."

Justice Blackmun also stated: "I fear for the future. I fear for the liberty and equality of the millions of women who have lived and come of age in the 16 years since *Roe* was decided. I fear for the integrity of, and public esteem for, this Court."

Justice Stevens filing a separate dissenting opinion which concurs in substantial part with Justice Blackmun's dissent. Justice Stevens, however, provided separate reasoning for rejecting the preamble and the viability provisions of the Missouri statute.

WHAT DO THE DECISIONS MEAN?

Although an in-depth analysis will soon follow, we can say immediately:

1. The decision issued an invitation to anti-abortion activists and anti-abortion legislators, both in the states and in Congress to pass new legislation restricting abortion. At the current time, legislatures in at least 10 states remain in session and could pass legislation which would directly require the Court to reconsider *Roe* and which further restricts women's right to choose.
2. There are five votes to reject the trimester framework and support the proposition that States can legislate to protect foetal life from the time of conception instead of at viability which was the *Roe* standard.
3. Because there are five votes to reject the trimester framework of *Roe* and at least four to either explicitly or implicitly reject *Roe*, federal court challenges to onerous restrictions as a general rule will be extremely difficult to win. Supporters of the right to choose will increasingly turn to state courts, state legislatures and Congress to protect their right to safe and legal abortion.

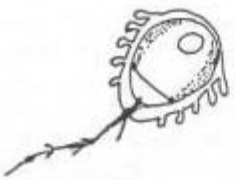
"Thus, not with a bang but a whimper the (majority judges) discard a landmark case of the last generation and cast into darkness the hopes and visions of every woman in this country..."

4. The exact contours of what constitutes the current law are not clear. New litigation will be necessary to give us more guidance. At a minimum additional restrictions on abortion will increase the costs of abortions, delay their performance and will ensure that those with the least resources, the poor and the young, whom are disproportionately women of colour will be most unable to overcome state imposed hurdles and will be forced to carry pregnancies to term against their will.

IMPLICATIONS FOR AUSTRALIA

In the legal sense the reversal of parts of the *Roe v. Wade* decision will not impact on Australia at all. However the main result will be the impetus it will give to anti-abortion forces here to continue with their campaigns against clinics and to limit access to our universal health care scheme, Medicare.

(*Editor's note:* for more detailed information about the U.S. Supreme Court review of the *Roe v. Wade* ruling please write to us for a copy of our pamphlet which we have prepared on this issue. Our address appears throughout this issue.)



STOP PRESS: DALKON SHIELD

Deadline for late claims extended: Many women around the world injured by the Dalkon Shield never got a chance to file claims for compensation in the court in Richmond USA, because publicity and information were so lacking. This was challenged by women's health activists from a number of countries in the court. Now, late claims will be considered - but only after the other claims are settled. Women have got until July 1989 to file late claims for compensation. The address again is: Dalkon Shield Trust Fund, PO Box 444, Richmond VA 23203, USA.

To make a claim, a woman needs to prepare a formal affidavit which includes: her name and address, and the following statement - "I wish to make a claim against AH Robins because I used the Dalkon Shield and believe I was injured by it. Before 30 April 1986, I was unaware of my right to file claim in the bankruptcy proceedings. I first learned of my right to file claim on...[date]...If I had learned of my right to file before 30 April 1986, I would have done so." This statement should be notarised by a notary public before it is sent. Ask to receive the official forms for making a claim. **Do not** state your injuries in this initial communication, because the information could later be used to limit your claim. Women will need good legal advice and support to fill out the forms.

Any woman who tried to file a claim after April 30, 1986, and was told it was too late, should write and check that her claim is still lodged with the Trust Fund, in case it was lost.

Did everyone who has made a claim receive the first option? On 6 December, Option 1 was sent to all women claimants. This is the first of four options for claiming compensation. Any woman who did not receive it should write to the Trust Fund at the above address in Richmond, because the computer has apparently lost an unknown number of women. Any claimant whose address has changed should check that this has been recorded at the Trust Fund, as many letters they sent to women have been returned unopened.

To all women's groups advising women about their Shield claims: there is a new Dalkon Shield Oversight Consortium, which includes many women's groups in the USA and a few from other countries, which has been set up. This Consortium is awaiting formal recognition by the Dalkon Shield Trust Fund as an advisory group, to help to meet women claimant's needs. Let them know about you. They will ask your advice before advising the Trust Fund. Address: 1737 17th Street NW, Washington DC 20009 USA. Phone: Nancy Davis on (1-202) 638-4798, who is a lawyer.

(From: newsletter of the Women's Global Network on Reproductive Rights Sept-Dec 1988.)

Major Setback for Anti-Choice Lobby

A new report on the effects of abortion released in mid-March from the US Surgeon-General, C. Everett Koop, and a panel of the American Psychologists Association undercuts claims by the Right to Life movement that abortions are both physically and psychologically dangerous.

The report, prepared in 1987 at the request of the then president Ronald Reagan, concludes that "abortion imposed a relatively low risk" for women. A self-confesses supporter of the anti-choice lobby, Koop acknowledged that any public health problem associated with abortion is minimal.

As Mr Koop was reluctant to publish these findings, in January, a Congress subcommittee subpoenaed the report and organised a hearing.

On the question of emotional repercussions of abortion the Surgeon-General explained that in reviewing more than 250 case studies he had found "serious methodological flaws" and could therefore not confirm the existence of a so-called "post abortion syndrome". However, an American Psychologists Association panel on abortion told the hearing that after reviewing the same data they concluded that abortion inflicts no particular danger on women. Panel member Nancy Adler said that despite the millions of women who have undergone the procedure since the *Roe vs Wade* case legalised abortion in the US in 1973, there has been no accompanying rise in mental illness. "If severe reactions were common", she said, "there would be an epidemic of women seeking treatment".

With both sides in the abortion fight preparing for the first Supreme Court challenge to the historical *Roe vs Wade* decision in April, the report's conclusions are seen as extremely important by the organisers of the hearings. The original *Roe vs Wade* decision was partly based on the court's conviction that legal abortions are safe. Ever since, anti-choice groups have tried to undermine the decisions medical premises and most recently have claimed to have discovered a kind of delayed post-abortion stress, similar to that experienced by some Vietnam veterans, that can result in severe depression years after the termination. The report did not confirm these claims.

As Surgeon General Koop concedes: "it is very difficult to separate abortion the moral issue from abortion the public health issue".

Elke Wiesmann

The information for this article comes from the Australian edition of *Time* Magazine 27 March, 1989.

Operation Rescue:

The Ways of Anti-Choice Zealots

"Twenty-five million children are dead, with thousands more dying daily. It is long overdue that we rise up in this manner and put an end to this holocaust. Operation Rescue (in New York City) could mark the end of legalized abortion in America by igniting courage in the hearts of decent Americans across the country to obey the laws of God, of nature, of common sense and decency. That the leaders led in Israel, that the people volunteered, Bless the Lord!"

From Operation Rescue pamphlet

Randall Terry, the head of Operation Rescue, is a 29-year-old upstate New Yorker with a profound mission - to end legalized abortion in the United States and close every abortion clinic which provides them. He was inspired to become active in the movement, he says, while in church. "We were praying for God to end abortion and it occurred to me to work to end it. This is my full-time job."

But there is another reason for Terry's anti-choice zealotry, a personal goad for his actions. "I was conceived out of wedlock," he says. "If abortion had been legal I'd be dead now." This is true, he adds, for many in the movement, including his wife.

Cloaked in the language of Christianity, Operation Rescue employs a variety of tactics: praying, demonstrating, singing, chanting and sitting-in at abortion clinics. By surrounding clinics that are free-standing, and lying in front of those that are not, the group has successfully - but temporarily - kept women seeking abortions from exercising their constitutional right to do so in a number of US cities.

Roe vs. Wade, the 1973 Supreme Court decision legalizing abortion, is irrelevant, they say, because they are driven by a higher law, the law of God. One of their literature pieces, written by the International Fatima Rosary Crusade, makes their agenda crystal clear: "Members of Congress and Parliament, as well as people in the courts and in many hospitals, are in effect and in practice declaring themselves independent of Jesus Christ and his reign over our countries and all their individuals and institutions." By making abortion illegal once again, the US, alongside the rest of the world, will be on its way to government under the thumb of an authoritarian, but benevolent Christian God.

This vision of a homogeneous world has rankled pro-choice people since the so-called pro-life movement began in the early 1970's. And since November, 1987 when Operation Rescue first reared its head in Cherry Hill, New Jersey, pro-choice forces have mobilized in unprecendented numbers and have exhibited creativity and savvy in countering them. In each city that Operation Rescue has to date visited - Philadelphia and Paoli, Pennsylvania, Atlanta, Georgia, Daly City, California, Tallahassee, Florida and New York City - the pro-choice response has been swift and energetic. Nonetheless, the response of city law enforcement personnel is the factor that best determines Operation Rescue's ability to disrupt business as usual. A look at the experience of two cities, Atlanta and New York, will clarify this distinction.

The New York Experience

As Operation Rescue forces began arriving in the city on April 29 (the organization is based in Binghamton, New York, but its members come from cities and small towns across the country. Members are largely male and range in age from 25 to 55), more than 1,500 supporters of choice were rallying in front of St. Patrick's Cathedral, a symbol, they said, of church-sponsored support for anti-abortion activism. Their anger at the anti-abortion crusaders was palpable as they marched past the New York office of the National Right to Life Committee.

Although Right to Life and Operation Rescue are oganizationally separate, the demonstrators felt that the two work in concert with each other - one focused on legislation, the other on grassroots mobilizing. "Operation Rescue, your name's a lie; you don't care if women die," they chanted. Speakers like civil rights lawyer William Kunstler bolstered pro-choice commitment, as did rousing talks by writers Phyllis Chesler and Charlotte Bunch. Veteran activist Bill Baird, a clinic owner who has been jailed numerous times for his activities, carried a photo of his clinic after anti-abortion forces bombed it in 1979 and urged the crowd to "unite against a holy war."

The next day, several hundred members of the New York Pro-Choice Coalition assembled in front of the two hotels where Operation Rescue members were staying. Again, they picketted, chanted and made clear that they would defend clinics, and the rights of women to use them, for as long as Operation Rescue stayed in town.

During the six days that the anti-choice forces remained in New York City, pro-choicers nettled them relentlessly. They tailed the misogynist mob morning after morning, following them from their hotels to the clinics they sought to disrupt. They blew whistles to drown out anti-abortion taunts and escorted women trying to enter the clinics past the pickets.

But while pro-choice people were an obvious thorn on the side of Operation Rescue, they were not as effective in stopping them as they might have been had law enforcement been on their side in upholding women's rights to use abortion facilities without harassment. It was a hard lesson for the pro-choice side to learn, for they expected something far different from the police. And with good reason.

Forty-eight hours before the anti-abortionists arrived in the city, a temporary restraining order was signed prohibiting Operation Rescue from "physically abusing or tortuously harassing persons entering, leaving, working at or using any services at any facility at which abortions or other health-related services are performed or counselled or advised in the city of New York and counties of Nassau, Suffolk and Westchester."

Initially the restraining order was hailed as a victory, but pro-choicers expressed dismay when both the "Rescuers" and police ignored the injunction. On the first day of Rescue, anti-abortionists succeeded in keeping a doctor's office closed during business hours. More than 500 Operation Rescue members blocked the office entrance; more than six hours elapsed before police finished removing the last of the blockaders. Equally appalling, said members of the New York Pro-Choice Coalition, was the fact that the Rescuers were booked quickly and then released, freed to continue the protest they had come to New York to engage in.

It was only after three days of Rescue (and the closing of three clinics targetted by Operation Rescue for one day each) that the temporary restraining order was reinforced by a second judge. Teeth were added in the form of a $25,000 per day fine on Rescuers defying the order. Whether this fine is imposed remains to be seen; the threat, however, deflated Operation Rescue's leaders and caused some members of the group to leave New York earlier than they had originally planned. Members of the New York Police Department under orders from the top responded to the second order; anti-choice violators were arrested quickly and efficiently. A trial on the violation of the restraining order as well as a decision regarding the imposition of fines, is expected to take place sometime this fall.

Unfortunately, say members of the Pro-Choice Coalition and their lawyers, police acquiescence to Operation Rescue allowed them several days of victory they should never have had. Nonetheless, they feel that the lessons they learned about effective coalition building (the New York Pro-Choice Coalition, the broad group that coordinated all opposition to Operation Rescue, included a broad spectrum of civil rights, legal, left-wing and feminist groups alongside service providers) will be long lasting. Secondly, the extent of grassroots support for choice among non-activists throughout the city has lead to on-going discussion and strategizing about ways to ensure community involvement.

On to Atlanta

Between early May, when Operation Rescue was in New York, and mid-July, the start of the Democratic National Convention in Atlanta, Georgia, the group paid one-day visits to Philadelphia and Paoli, Pennsylvania and Daly City, California. In the former state, they succeeded in closing two abortion facilities: the Women's Suburban Clinic in Paoli and the Northeast Women's Centre in Philadelphia. But even this had a silver lining. Pro-choice forces seized momentum by asking their supporters to contribute a small sum of money for each anti-choice picketer who showed up to the Greater Philadelphia Women's Medical Fund, a group that provides low interest loans to poor women needing abortions. More than $3,900 was raised.

Operation Rescue members, undoubtedly irritated by this tactic, headed south, joining forces of other demonstrators at the Democratic Convention. On July 19, as Operation Rescue members were loaded onto buses for a demonstration at the Feminist Women's Health Centre, police stopped the drivers and asked to see their licences and registration forms. Rescuers had been instructed to carry no personal identification, leaving them open to arrest for operating a moving vehicle without the required papers.

Later, when the protesters finally arrived at the clinic, police promptly arrested more than 130 of them for blocking the door and limiting access to care. They were taken to jail where all but a handful refused to give their names and addresses to prison authorities. Those who released this information were quickly let go; the rest remain in prison a month later, at the time of this writing.

In the meantime, the leaders of Operation Rescue have attempted to use their organizational mettle to rally support for those imprisoned. Although they have mobilized their constituents to Atlanta more than 15 times since July 19, attempting to thwart operations at four metropolitan health centres, their efforts have been largely unsuccessful. On the worst day, for example, police cleared the protesters so quickly that the clinic under attack was able to open a mere 30 minutes after the protesters arrived. According to Dazon Dixon, the Director of Community Education at the Atlanta Feminist Women's Health Centre, "the volunteers and pro-choice supporters are picking up the slack and helping women get through to the clinic. They are also trying to protect clients who are entering the clinic from TV cameras and helping them to maintain their privacy."

Operation Rescue, meanwhile, has solicited support from right-wing religious groups across the country. And it has paid off. In early August, the Rev. Jerry Falwell of the Moral Majority presented Randall Terry with a cheque for $10,000. Similarly, members of a charismatic evangelical church in Louisiana have travelled to

Atlanta to join Operation Rescue. Their appearance, however, backfired. "This group charged the police and tried to jump over police barricades," said Health Centre staffer Lynne Randall. "They showed they are not a non-violent group of people."

This tactic upped the ante for Operation Rescue. "The city had been operating in a gentle manner regarding the protesters," said Randall. "Once they charged the police, however, gentility was no longer the order of the day. After that they were forced to post a cash bond of between $300 and $2,500, depending upon the offence."

As more and more time passes, the situation gets more and more desperate for Operation Rescue. "Initially they came to Atlanta for the Democratic Convention," adds Randall. "They expected to do their thing and leave, but they tripped themselves up by not giving their names. The city has said that they can't be released without giving their names and has held firm to that position. They weren't expecting this. They were expecting special treatment. Now they're in trouble. Local people protesting with them are in the minority here and they're having a hard time recruiting people. There is not an endless number of people willing to get arrested."

Indeed, the number of rescuers gets smaller and smaller as their time in Atlanter wears on; a mid-August picket drew fewer than 20 people. Clearly, despite their rhetoric about obedience to the higher law of God, the enforcement of humanly-crafted legal restrictions is having an adverse impact on both Randall Terry and the organization he heads. In fact, the legal system may break the back of Operation Rescue, for unlike the New York Police Department, Atlanta police have arrested those who are attempting to stop clinics from operating time and time again.

All of this has put a crimp in the plans of Operation Rescue. Earlier announcements to the contrary, the group did not make an appearance in New Orleans, the scene of the Republican National Convention.

On the flip side, says Randall of the Atlanta Feminist Women's Health Centre, the group's arrival has helped solidify good working relations between the four clinics under fire. "We are in constant communication with each other. We're all in this together and we're going to keep our doors opened."

Where Operation Rescue will go next is hard to predict. Nor can one anticipate how the group will fare in courtrooms hostile to the idea of a male-dominated Christian state. Nonetheless, one thing is certain. The pro-choice community, bolstered by the masses of people who believe in pluralism and religious tolerance, will fight them every place they appear.

As they chanted in New York: "Racist, sexist, anti-gay; born-again bigots go away." Forever. Finally.

Eleanor J. Bader
Freelancer, USA

From: Integration No. 18 December 1988.

An Australian Linkage

Police arrested 21 "flag-waving demonstrators" outside a clinic in Punt Road, Melbourne, in August 1988. Margaret Tighe, the leader of the group, admitted that inspiration for what she described as a "peaceful blockade" came from Operation Rescue in the U.S.

(From: *The Age,* 23/8/88 and *Freedom to Choose,* newsletter of the Right to Choose Coalition in Victoria.)

... *from page 3*

abortions is assumedly based on the premise that by not funding abortions, that they will somehow cease to be done. This belief is naive, to say the least. Abortions will continue as long as the need for them exists. It is clear that Harradine's Bill would not be effective in preventing abortions - the abortions will continue in different, more difficult circumstances. One wonders in fact if this is not the aim of the Bill anyway. The Bill seems predominantly anti those women seeking abortion rather than acting against abortion per se. It would overwhelming disadvantage women without access to resources. There is a callous disregard for the lives of these women, on behalf of the 'pro-lifers'. 60,000 women a year benefit from abortion being part of the medicare schedule. As Adele Horin has pointed out (SMH 10.5.89) "if abortion is murder, could so many Australian women be wrong? Do we habour so many cruel, amoral criminals in our homes?"

HOT

SEMINAR ON VIOLENCE AND SEXUAL MUTILATION INFLICTED ON GIRLS AND WOMEN

Paris, 1-3 December 1988

"Having conducted an information campaign for a period of more than ten years, we believe that it is now possible to make use of the law as a weapon to achieve the abolition of sexual mutilation. We want a law that prohibits all of the practices of sexual mutilation - Muslim, Christian and animist - from excision to infibulation. In addition, we want to continue the information campaign about these practices and their negative consequences. It is necessary to include in this information better knowledge about how our bodies and organs function."

This is the position of the Commission Internationale pour l'Abolition des Mutilations Sexuelles (International Commission for the Abolition of Sexual Mutilation), who organised this meeting. Women attended from all over the world to expose the many aspects of this type of violence against women, and shared experiences of how the situation was changing. Much information was exchanged and support for each other's work was expressed.

An example of work being done was given in the presentation of the woman Minister of Education of Burkina Faso, where a full programme of education is being implemented. This programme includes information about our bodies and about sexuality, and has succeeded to the point where small changes in people's attitudes were beginning to be observed. She said that in order to achieve the abolition of these practices, a long process is required. In Burkina Faso, excision is done in girls of 7 to 13 years of age, as a traditional practice, and with a resulting rise in morbidity.

The Women's Centre for Education and Research in Somalia presented another interesting project. They are developing a public discussion campaign on the significance of these customs and the consequences for the health and lives of the women.

(From: Women's Global Network on Reproductive Rights newsletter Sept-Dec 1988 by Martha de la Fuente, who attended the meeting on behalf of the WGNRR.)

AUSTRALIA: MATERNAL DEATHS

The government report on maternal deaths in Australia for 1979-81 states that information on deaths among Aboriginal women is scarce and not very reliable. The woman's race was stated in only 48% of the case reports for this period, though figures available are seen as a reasonable estimate. Even with incomplete information, the report states that death rates among Aboriginal women were higher than among other women in Australia in that period.

(From: *Report on maternal deaths in Australia, 1979-81,* Commonwealth Department of Health, Aust. Government Publishing Service, Canberra, 1987, p. 3 and the September-December 1988 newsletter of the Women's Global Network on Reproductive Rights, Amsterdam.)

VIDEO ON EMDOMETRIOSIS

We understand that the Canadian-US Endometriosis Association has produced a half-hour educational video on endometriosis and its impact on sufferers titled *You're not alone...Understanding endometriosis*. The video covers such topics as surgery (including laser surgery), hormonal treatments, coping with endo, and the symptoms of endo. If the video is compatible with any of the Australian video systems the Victorian Endometriosis Association hopes to buy a copy. For further info contact: Endometriosis Assn., 37 Andrew Cres., South Croydon, Victoria, 3136, phone (03) 879-1276.

(From: Endometriosis Assn. Newsletter, Feb. 1989.)

ABORTION ACCESS IN OZ: NOT GOOD, SAYS INTERNATIONAL SURVEY

Australia rates well on access to birth control compared to other developed countries, according to a recently published report, but we rate poorly on access to abortion. According to 'World Access to Birth Control', published by the Population Crisis Committee in Washington DC, the only developed country where abortion is less available is Rumania! Other countries - Italy, France, West Germany, Japan and the USA - were found to be very much better off for access to abortion.

(*West Australian*, 18 August 1988 and *ALRA News*, Dec. 1988 Vol. 16, No. 2)

FLASHES

MEDIA CAMPAIGN ON HYSTERECTOMY REDUCES RATE

A campaign in the media, giving information about hysterectomy which was previously only known by doctors, resulted in a 25% reduction in the hysterectomy rate in one Swiss canton in 1984. The campaign was prepared and coordinated by medical bodies and health care institutions, with the aim of making women more aware of when hysterectomy was and was not needed, and making doctors question their practice in order to improve it.

There were frequent newspaper articles, mainly by doctors, and radio and TV programmes, including a phone-in. The results of research studies on hysterectomy were released to the media in order to generate stories. One radio station considered the hysterectomy campaign to have been one of the major local events of that year.

(From: Domenighetti et al, 'Effect of information campaign by the mass media on hysterectomy rates', *The Lancet* 24/31 Dec 1988, p. 1470-73 and newsletter of the Women's Global Network on Reproductive Rights September-December 1988.)

PLANS TO DEVELOP NEW NON-SURGICAL VASECTOMY DEVICE

The US-based Population Council has agreed to collaborate with VasTech Medical Products to develop and test a new device for performing vasectomy without surgery. The device, to be known as Vasocclude, will allow a vasectomy to be performed non-surgically in a fraction of the time presently required. It is expected to reduce the frequency of common side-effects of vasectomy such as bleeding, swelling, pain and infection. Because the device is to be non-surgical, the procedure should be easily learned and performed by non-surgeons, making vasectomy more accessible to patients in countries where health care services, are provided by nurses and paramedicals.

Using a local anaesthetic, the clinician would puncture the skin of the scrotum with the sharp point of the Vasocclude, which contains a staple-like mechanism. The procedure will not require a scalpel or sutures and takes less than 10 minutes. The Population Council and VasTech plan to produce a prototype device and conduct animal and human tests. Clinical trials are to be conducted by the Population Council, the device is expected to be ready for testing sometime this year.

(From: *News Release* , Population Council, 18 January 1989 and IPPF *Open File* for the two weeks ending 3rd February, 1989.)

Editor's note: we'd like to see more detail on how the 'staple-like' mechanism works and long-term *studies of its effects first.*

★★★★★★★★★★★★★★★★★

$$$ FROM THE CATHOLIC CHURCH (BUT NOT TO US!)

The Catholic Church in the USA has spent $45 million in the past 15 years trying to make abortion illegal again.

(From: Frances Kissling, Catholics for a Free Choice, during the Christopher Tietze International Symposium, Rio de Janeiro, Oct 1988 and WGNRR Sept-Dec 1988 newsletter.)

CERVICAL CAP AND THE DIAPHRAGM

The most recent issue of the *IPPF Medical Bulletin* states that the cervical cap is more comfortable and just as effective as the diaphragm, according to studies conducted by Dr. Gerald Bernstein in the US, cited in an article by Zoe Kopp.

The cervical cap was apprroved last year by the US Food and Drug Administration (USFDA) for use as a safe contraceptive method. Like all contraceptive methods there are drawbacks to the cap, in terms of fitting, it won't fit everyone as it only comes in four sizes, and some people simply do not like barrier methods.

Yet the cervical cap does have advantages over the diaphragm in that it can be placed any time before intercourse, and additional spermicide is not needed for each act of intercourse. It is also useful for people concerned with preventing HIV infection and other sexually transmitted diseases, use of the cap with a condom can provide increased efficacy in contraception and disease prevention.

(From: IPPF *Open File,* two weeks ending 3rd February, 1989.)

Editor's note: recent information in Australia - from FPA (NSW) - suggests that this also applies to the diaphragm in that it can be inserted any time before intercourse and additional spermicide is not needed for each act of intercourse.

Backyard Abortion Blues

On 2nd June, 1988 women of NSW were sharply reminded of how fickle politicians can be when an anti-abortion motion was carried in the NSW Legislative Council. The motion was proposed by Marie Bignold, member of the Call to Australia Party.

The Bignold motion:
– affirms the principle of the "sanctity of life" and this principle should be applied with "equal force and validity to the unborn child",
– condemned the "widespread practice of abortion on demand" and the "public funding of this practice",
– called upon law enforcement agencies to fully and properly enforce existing law... to eliminate the practice of "abortion on demand", and
– called upon the government to "examine the inadequacy of existing law to protect the unborn child".

Though legally this motion does not mean a great deal it was a morale booster for the anti-abortion groups. It was of great concern that the motion came up in the first session of the Liberal Government, however this was not the first time it had been proposed. The motion first arose in NSW Parliament on October 30th, 1986. The Unsworth Government had used parliamentary procedure to prevent debate on it being concluded. It has been suggested that the Greiner Government, in negotiations with Bignold and Nile prior to the election, had promised that they would allow the abortion issue to be debated.

Impetus given to Nile

On 16th June, Fred Nile MLC circulated a press release regarding the introduction of his "historic (sic) Unborn Child Protection Bill". The press release quoted him as follows: "following the recent successful adoption of the pro-life motion in the Legislative Council of NSW, I am very confident my Bill will be passed by the Parliament." Nile's Bill in its draft form seeks to:
– define the 'unborn child' as a person having every legal attribute of personality such as all rights, duties, privileges, powers, and other fundamental concepts of legal relation;
– allow for abortion only in "emergencies or exceptional circumstances", such as when the mother's life is in **current** danger and every other avenue to save the life of the 'unborn child' (not the mother) has been considered; and
– to grant the father of the 'unborn child' the right to claim compensation against the abortionist if the abortion is carried out without the natural father's consent.

There was also an 'ambit' clause in the Bill which has been interpreted as follows: that if women had an abortion outside the meaning of the Bill they could be jailed for three years or face a fine of $20,000.

Pro-Choice lobby responds with vigour

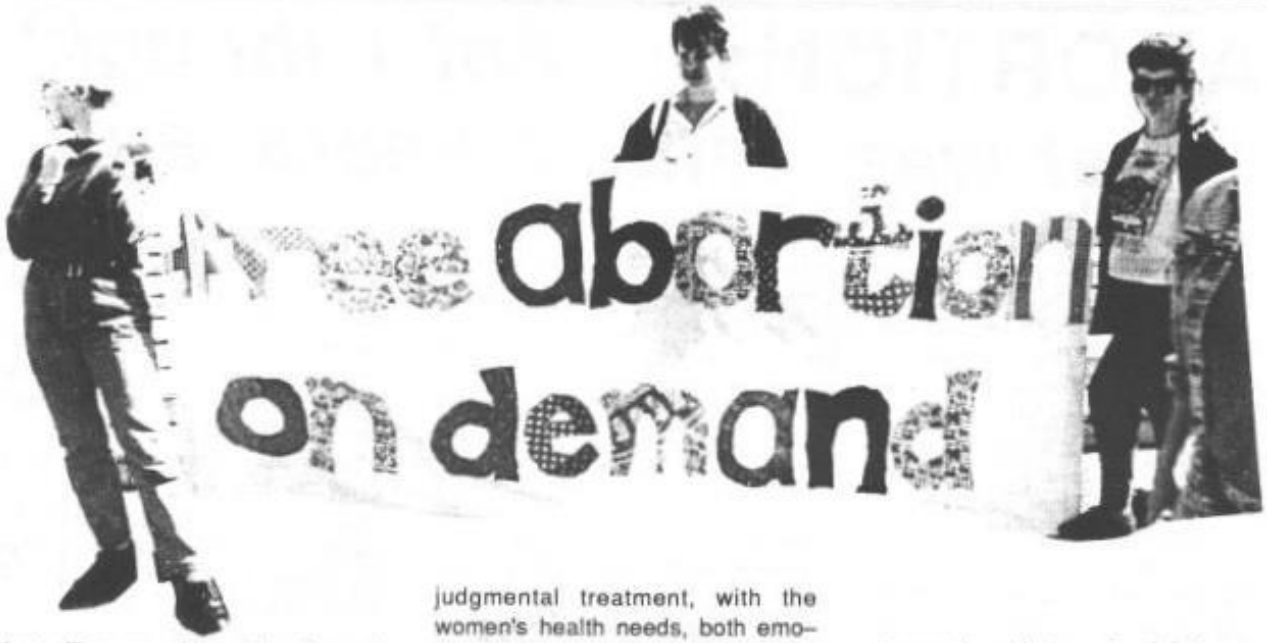
Pursuant to the release of Nile's Bill in its draft form pro-choice lobby groups in NSW such as the Women's Abortion Action Campaign and the Abortion Rights Coalition launched a defence campaign. There was a strong response and many women reacted with outrage to Nile's proposals. A number of pro-choice groups were formed in the southern and western suburbs of Sydney, and there were public meetings held in July.

Over the next few weeks politicians were overwhelmed by the post-card and letter-writing campaign of the pro-choice lobby. WAAC received many letters and submissions which women had prepared and sent to politicians because they felt so strongly about this issue.

On the day of the inner city public meeting – which was well attended and proved to be very successful – Nile released a memo to all members of the Legislative Council. In the memo he stated that he was going to seek leave to bring in his Unborn Child Protection Bill on August 2nd when Parliament was due to resume for one day but he was going to defer debate on it to a later date so that he could consult with all members of the Upper House.

In fact, on August 2nd Nile withdrew the Bill altogether! Apparently two members of the Liberal Party who had voted for the Bignold notion had stated they would not support Nile's Bill in the form it was in. Thus, Nile made a tactical decision to withdraw the Bill altogether rather than face defeat. Nile also complained of the "militant abortionist lobby which had mobilised their members to oppose my Bill and misrepresent it to the media". In effect he was acknowledging the success of our campaign.

Whilst our campaign has been successful so far, resulting in Nile withdrawing his Bill, he has said he will redraft it following "full and complete consultation" with all MLCs. Though the Liberals and the Labor Party are now both saying they do not want this issue brought up, we cannot assume



that alliances will not be formed at a later stage and a trade-off negotiated.

Another threat: Yeomans' Bill

The 'Termination of Pregnancy Restriction' Bill proposed by Guy Yeomans, Liberal Member for Hurstville, provides another major threat to abortion rights. The aim of Yeomans' Bill is to severely restrict the availability of abortion in NSW. Abortions could, if the Bill were passed, be performed in hospitals only, and hospitals would be able to apply for exemptions from performing termination of pregnancy. It would be possible for anti-abortion medical staff and management to further restrict women's access to abortions.

Already facilities in hospitals are stretched to the limit. Women waiting for a termination of pregnancy would join the already long queues of people waiting for surgery.

This would mean an increase in second trimester abortions and the delays could result in more women being forced to continue with an unwanted pregnancy. To force women to have abortions in hospitals would result in a return to the days of unsympathetic and judgmental treatment, with the women's health needs, both emotional and physical, not being met. In the hospital system, of course, there would be no time allowed for counselling, thus Yeomans' Bill would mean a complete reversal of the advances women have made in NSW since 1971 with regard to abortion services. At the moment, abortion clinics in NSW offer women care and support at a vulnerable time in their lives. Aftercare advice and ongoing support is available. If the NSW Parliament adopts Yeomans' Bill then all of these services would go.

The political danger of the proposed Yeomans' legislation is that in comparison to Nile's 'Unborn Child Protection' Bill, it may appear more reasonable and could, therefore, on a compromise deal between the political groupings be passed.

Why there is a need for an ongoing feminist abortion campaign.

The spontaneous response of women and also many men in NSW highlights the fact that women realise that control of their fertility and bodies is central to their lives. Given the tenuous nature of the legislative and judicial law regarding the availability of abortion in NSW, it is imperative that a feminist pro-choice campaign be maintained if the Levine ruling of 1971 which liberalised the interpretation of the law regarding abortion in NSW is overturned, women of NSW will again face the days of backyard abortions.

The Levine ruling came down in the District court, therefore it is possible for a higher court, for example the Supreme Court, to overturn that ruling.

As well as the tenuous legal situation, there are also the continuous attacks against the availability of abortion by the Right to Life Association and other anti-abortion groups such as Foundation Genesis and the Call to Australia Party. A vigilant and active feminist campaign around this and other reproductive issues is vital. Women do not want a return to the days of limited access to abortion. The women's movement has gone too far, with the establishment of two feminist abortion clinics in Sydney in the late 70's, to allow this basic right to be taken from us.

Margaret Kirkby

Reprinted from *Scarlet Woman* Issue 25, Summer '88-'89.

ABORTION: *but I thought that was settled years ago*

Since the election of the Greiner government in March 1988 abortion has returned to the NSW Parliamentary agenda. In what follows I will use some aspects of abortion politics during the past year as a starting point for some reflections on reproduction. I will tease out themes that provide me, as a feminist, with reasons to be both encouraged and discouraged. This is not a time for complacency or to assume that gains won in the area of reproductive freedom will continue in the way that we would like to see them. On the other hand, I think fertility control is here to stay for the foreseeable future, some access to abortion included. I'm not as certain that feminists are meeting the changes in the language of the abortion debate. Nor do I think there is a sufficiently integrated analysis of developments around reproductive technologies during the last fifteen years, from ultrasound to I.V.F., developments that have helped bring about that change.

Action in the NSW Parliament

The election gave the Liberal-Country Party a majority in the Legislative Assembly and thus government, but resulted in a Legislative Council in which the balance of power is held by small political groupings. The most notable are the Australian Democrats and the Call to Australia Party (CTA), a conservative Christian group headed by Fred Nile. One early rumour suggested that the government had made a deal with Nile to allow the debate and a vote on abortion matters then foreshadowed. The ALP Government had used parliamentary procedure to prevent a Right to Life motion sponsored by Marie Bignold (CTA) from coming to a vote. Soon after the new Parliament began sitting the Bignold Motion, which does not have the force of law, was put and MLCs voted according to their consciences on the following motion:

"(1) That this House affirms –

(a) the principle of the sanctity of life as being the supreme principle in respect of human beings;

(b) this principle applies with equal force and validity to the unborn child;

(2) That this House condemns:

(a) the widespread practice of abortion on demand with an estimated 40,000 deaths of unborn children annually in New South Wales; and

(b) the public funding of this practice.

(3) That this House calls upon the law enforcement agencies to fully and properly enforce the existing law contained in 82-85 of the Crimes Act 1900 to eliminate the practice of abortion on demand.

(4) That this House calls upon the Government to examine the adequacy of the existing law to protect the unborn child and to take positive action to supplement any deficiency found in the existing law for the protection of the unborn child."

The vote ended in a 20-20 tie with the President of the Legislative Council, John Johnson (ALP) using his casting vote in favour of the motion. Johnson has long thought that abortion is murder and recently decided that he would devote considerable energy toward curbing its availability in N.S.W.

In addition, Fred Nile has tabled a private member's bill titled, *The Unborn Child Protection Bill.* An earlier version of Nile's proposed bill included a penalty of fourteen years in jail or $100,000 fine for women seeking abortions and counsellors (that included anyone) who helped as well as doctors who performed the procedure. However, in the more recent copy dated 1/10/88 only doctors are subject to the fourteen years or $100,000 penalty, others to three years or $20,000 and the aborted woman is specifically exempted.

Aside from the criminal penalties, there are four interesting aspects to the bill. The first is the definition of the 'unborn child'. Quoting from the draft bill, "'Unborn child' means zygote, embryo or foetus of the biological species Homo sapiens at any time from fertilization to birth". The 'unborn child' is then deemed to be a person under the law (this is not presently the case) and its legal attributes "shall be deemed to be equivalent to those vested in any other child'. Second, there is a spelling out of the rights and duties of 'fathers' from the moment of fertilization. According to the draft bill, every father shall have a duty to do everything possible to maintain the life of his 'unborn child' including the duty to provide support, including financial support to the pregnant woman. He has to give permission for an abortion in case of a medical emergency in which the

continued pregnancy would endanger the life of the woman (as would she; the advice of four doctors must also be sought). He would also have the right to sue a doctor who aborted 'his unborn child' without consent for compensation, though there is no provision for the doctor to provide the sort of pathology that would allow him to be identified as the man whose sperm helped create the child. Only a man who 'has been charged with an offence arising out of the act of sexual intercourse which led to the fertilisation of the unborn child' is exempt from these provisions.

Third, there is the requirement of considerable documentation and record keeping regarding those few abortions that may be defensible under this bill. In fact, the records are so important that there is a penalty for non-compliance of seven years in prison or a fine not to exceed $50,000. Yes, it is badly drafted; no, there doesn't seem to be a lot of support for it as it is written, and I suspect that the public brawl between Nile and Bignold has not helped very much.

Bignold thinks that the present Crimes Act provisions are sufficient and just need to be enforced. She is also a lawyer and so would have some idea of the enforcement problems in Nile's proposed bill. Veterans of past abortion struggles in N.S.W. may remember that abortion is regulated by sections 82-85 in the Crimes Act 1900 and provides penalties for those who 'unlawfully' abort themselves, abort someone else, provide the means by which an abortion is performed or who conceal the birth of a child which died before, during or after birth. Three judicial rulings (Bourne in U.K., Davidson in Victoria and Wald in N.S.W.) are considered when interpreting the meaning of the word ' unlawfully'. In the District Court of N.S.W. in 1972 in R v Wald, Justice Levine ruled that the jury could decide 'whether there existed in the case of each woman any economic, social or medical ground or any reason which in their view could constitute reasonable grounds upon which an accused could honestly and reasonably believe there would result a serious danger to her physical or mental health' (Finlay and Sihombing, 1978: 64-67).

This ruling has never been tested in an appeal, to do so would mean that a Government would have to be willing to arrest a doctor for performing an abortion and then, if s/he was found 'not guilty' using this ruling as a precedent, appeal the case to a higher court. In 1972 the Government was not willing, nor has any Government been since; it is

not clear that the current Government could withstand the political storm that such a course of action would unleash. Nile, however, sees his bill as an appropriate definition which would close off any possibility of future judicial interpretation. Such an insertion would be strongly opposed by doctors, civil libertarians, feminists and many thoughtful voters.

Nile's draft bill and another 'compromise' bill (abortions in public hospitals only) foreshadowed by Guy Yeomans (M.L.A.), have already provoked considerable political action. I was among the many concerned women and men who wrote to the members of the Legislative Assembly during July deploring the passage of the Bignold Motion and opposing Nile's draft bill. While most members have written back the usual vague acknowledgements in response, the replies of the Premier and the Attorney General are instructive.

The following letter came from the Premier's office dated 6 October and signed by Paul Zammit, M.P.:

"I refer to your recent letter concerning abortion.

I should like to thank you for taking the trouble to write to me and I appreciate the concerns which motivated your approach.

You will be aware that there are strongly held views on both sides of Parliament on this issue, which is traditionally dealt with along non-partisan lines.

There are no proposals on the part of the Government to introduce legislation to change the status quo which existed under the previous Government on this issue."

John Dowd replied at greater length on 20 October and, as you will observe, in an educational mode:

"I refer to your letter concerning abortion. I have taken careful note of the views expressed.

Section 83 of the Crimes Act makes it an offence for any person to unlawfully terminate a pregnancy. The interpretation of the word "unlawful" has been developed over time, but since 1971, the position has been that an abortion is lawful if it is necessary to protect the woman from serious danger to life or physical or mental health.

The Courts have held that it is for a jury to decide whether there exist any social, economic, or medical grounds which could constitute reasonable grounds upon which a doctor could honestly and reasonably believe that the continuation of the pregnancy would result in a serious danger to the woman's physical or mental health.

My Government has no plans to change the law concerning abortion.

There have been motions placed before the Parliament dealing with the extent of abortion in the State and, as you are no doubt aware, others have been foreshadowed by certain members of Parliament. Such motions are dealt with on non-party lines. There is currently no motion on abortion before the Legislative Assembly."

I have quoted these in full because they provide the articulated Government position on abortion legislation and law enforcement in N.S.W. (frequently changes to abortion law begin as private member's bills and a non-party, or 'conscience' vote). They also indicate the Government position in the debate over the language of the abortion struggle. In contrast with the emotive discussion of 'unborn child' and the 'mother' used by Bignold and Nile, Dowd uses the more abstract civil libertarian language of 'pregnancy' and 'woman'. This is more important than it might at first seem because the Eighties has been a time of struggle over the language of the abortion debate. It has not always been clear that feminist articulations have prevailed against anti-feminist and overtly foetalist views.

Language and images in the abortion debate

Civil libertarians and feminists used the language of liberal democracy in the struggle for access to legal abortion during the late Sixties and the early Seventies (for a recent analysis of the Australian experience see Coleman, 1988). They saw the campaign as an extension of women's rights, 'a woman's right to choose' was a popular and widely used slogan by the mid-Seventies. Choice is one of the main liberal democratic values, today more popular with the economic Right than another core value that was (and is) a part of the feminist appeal, equality. Many of us would assert that choice without equality is hollow and the reproductive choice activists regularly campaign for the conditions in which childbearing can be a viable choice – good pay for women, high quality child care, and end to race or class based sterilisation programs and methods of contraception that preserve fertility and health (Petchesky, 1986). The battle of words seemed to be won; most newspaper accounts of the debate surrounding the Lusher Motion in Federal parliament in 1979 spoke of the importance of preserving choice and women's rights.

The moral Right was not convinced, of course, and continued a campaign to divert attention from the figure of the choosing woman to the foetus. The debate in 1980 about the Human Rights Commission was mired down in an exchange about whether foetuses were persons with rights that could be brought before the Commission in cases of abortion. In the end the answer was no, the commission deals with the rights of people wholly born and breathing. Yet a newspaper headline in 1983 shows a more widespread shift in language; FATHER FIGHTS FOR HIS UNBORN CHILD (*Daily Telegraph*, 24/3/83) was the story of a man who went to court to prevent a woman who became pregnant following a one-night-stand from having an abortion. He did not want to care for a child, but wanted it given up for adoption; after appeals to the High Court she had an abortion.

Here are the elements we see in Nile's draft bill: the personification of an early pregnancy, the denial of a woman's perceptions of her life situation and the assumption that sperm donation equals fatherhood. It is useful to remember that in the case of a child born as a result of donor insemination, the donor is legally not the father. Something important has been happening. I would suggest that the publicity around the new reproductive technologies has contributed to changing the focus from the woman to the foetus (baby).

The techniques of assisted conception challenge the commonsense notions about the relationship between sexual activity and procreation, and the link between genetic and social parenthood. Scientific publicists and the media have used familiar words with altered meanings to explain what is happening; the nuances of the common usage of the words carry over in complex ways to the new usages (Albury, 1987). 'Test-tube baby' is one example; eggs and sperm are combined in lab glassware to form first a fertilised egg, then as cell division begins, a zygote (usually referred to as an embryo). At this stage it (they) are transferred to a woman's uterus for implantation and gestation, if all goes well, a baby is born from a woman's body in the usual way. No test-tubes, no babies in the lab, but an evocative phrase that both normalises an unfamiliar process and marks an apparently ordinary baby as special. As the techniques have become more familiar the more accurate phrase I.V.F. baby has gained greater currency.

The debates about reproductive technologies have focussed attention on a different kind of inappropriate fertility. If abortion reveals too much of uncontrolled fertility, then I.V.F. and related techniques opens too little fertility to scrutiny and public policy making. The woman with empty arms is the icon of infertility, as the 'selfish' student who won't change her life for an accidental pregnancy is for abortion. The

Continued on page 36

WEST GERMANY AND NSW: Parallels in the Pro-Choice Movement

"The times of grace are well and truly over," warned Alice Schwarzer, editor of West Germany's well-established feminist monthly *Emma*. She meant the attempts of the conservative coalition government of Christian Democrats (CDU) and Liberals (FDP) to restrict the already repressive German abortion legislation in an effort to toughen the procedures a woman has to undergo to have a termination. Legal witchhunts of women, their doctors and counsellors now create a climate of intimidation and fear in West Germany. "If someone would have told me in the 70's that ten years later I'd have to stand up again not to defend the most elementary of rights for women, but to fight for it all over again - I would have laughed at them," she said.

The current abortion debate in West Germany bears some interesting parallels to the developments in New South Wales with Nile's proposed 'Unborn Child Protection Bill'. The means of the anti-choice lobby may differ but their ends remain the same.

Abortion in the Federal Republic is illegal, rules Article 218, a law as old as the first Women's Movement around the turn of the century. Reformed in the 70's by the Social Democrats (SPD) Article 218 now allows abortions in "exceptional circumstances" (*ed: we wonder whether Fred Nile has read the reformed Article 218?)*: for medical reasons, for rape victims and when the continuation of an unwanted pregnancy would endanger the mental and physical health of the woman. This includes consideration of her social circumstances Women have known how to use the loophole "social reasons" to get their right to choose. So much so that the conservative forces who are in power now decided they've had enough.

Previously when you needed a termination you had to ask a doctor or psychologist for their permission, provided you were under 12 weeks pregnant. To create a little more stress for you this doctor then could not perform the termination but had to refer you to a compulsory pregnancy counselling where you had to explain your reasons a second time. Counselling agencies would range from christian charity organisations, to welfare institutions, to the liberal family planning service Pro Familia. The latter one would usually respect your reasons knowing that this is not a light decision for any woman. Then, provided you lived in a progressive state or close to a big city, you could book into a clinic quickly to have a safe and cheap termination with local anaesthetic. The process could still take up to three weeks and was difficult enough. This was especially so in the southern states of Bavaria and Baden-Wuerttemberg where abortions are restricted to very few hospitals and the distressed women were forced to travel north to a clinic for legal abortions.

If the conservative forces in the present government have their way, it will never be so 'easy' again. Many city councils and state governments have already stopped or severely cut Pro Familia's funding, claiming that their counsellors were too obliging to women s wishes. Police in several southern states recently raided offices and charged counsellors with the misuse of the law s "social reasons" provision Patient's files have been confiscated by magistrates and women found to have had legal abortions were questioned, their privacy breached.

The most spectacular case happened a few months ago in the little Catholic Bavarian town of Memmingen where a gynaecologist's clinic was raided because he performed suction abortions with local anaesthetic (which is forbidden in this state) and accepted his patient's decision without insisting that they stick to the correct legal procedure in obtaining permission. In a true witchhunt hundreds of women and some of their supportive partners and friends were publicly accused of and convicted for breaching Article 218. Their private circumstances were publicly displayed in court All got high fines and carry the stigma of a criminal record in a state whose political and church leaders call them murderers, responsible for a 'child holocaust'. One of the state's leading judges publicly contemplated capital punishment for women who have abortions (the last one to go through with this idea was Hitler).

Presently the women have to appear in court as witnesses in the show trial against the doctor who faces at least 15 years in jail and loss of his professional licence. This political climate of fear makes it increasingly difficult for women to obtain the permission for termination because doctors and counsellors are becoming scared.

The Federal Government now wants to introduce counselling legislation that would see the southern situation become reality in the whole Republic Lacking the political power to toughen Article 218 itself they resort to increasing the bureaucratic obstacles for women. The planned law, known as the "Patronising Law", will rule out counselling agencies that

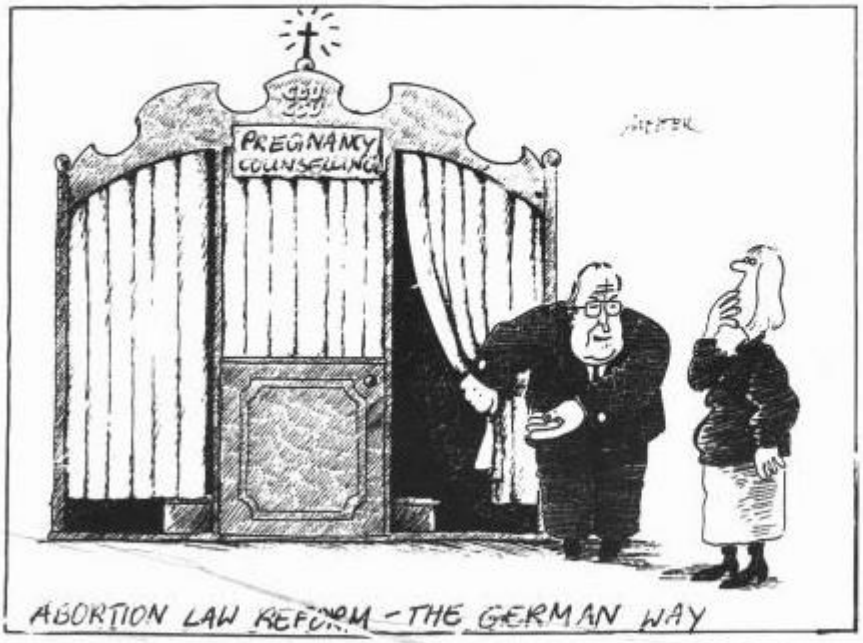
are not ' pro-life" (the foetuses, not the woman's) with the result of the "counselling' already known from the start. Only "specially qualified' doctors and counsellors who attend pro-life' courses will be allowed to grant permission for abortion. The doctor performing the termination will only receive her/his fees from public health insurance after reporting the ' case" to the Department of Statistics.

The political intention behind this legislation is clear: women will be persecuted, intimidated and patronized, doctors and counsellors will be scared off and indoctrinated.

Like in Australia, the political parties in West Germany treat the abortion issue tactically. The opposition Social Democrats, politically responsible for the "reformed ' Article 218 try to sell it to women voters as the lesser evil to be defended against conservative attacks. The then co-authors of the "reform" the FDP, are now governing in a coalition with the conservative Christian Democrats (CDU). They take a similar stand to the SPD, but being notorious opportunists who tip the scales at elections they have retreated on many a promise. Only the Green Party's platform clearly calls for Article 218 to be scrapped but there, too, are factions who fight to save seal babies and foetuses alike.

Not even the ruling CDU is unified in the abortion debate: strong christian fundamentalists along with the influential right-wing Bavarian chapter rally for tough measures against abortions. They not only want to close the loophole "social reasons" but also abortion after rape and for most medical reasons. They further demand public health-care funding of terminations to be stopped. Sounds familiar? On the other hand, the tactically minded CDU faction worries about the dramatic decline of the party s popularity with women voters. Its members like to keep the issue out of public debate. Most CDU-women condemn the proposed counselling legislation. A spokeswoman of the party s women's organisation: 'I am against the torturing of women in conflict situations"

This is the essence of the current abortion debate in West Germany as well as in Australia: should women, after a century's struggle for self-determination still be punished for choosing an abortion? There is hardly a politician who would publicly support a ' yes". In previous decades most charges against women for having an illegal abortion have been dismissed in West Germany. Laws against abortion are virtually unenforceable (otherwise there would be hundreds of thousands of women in jail), but they intimidate women. Intimidated women are controllable women.



ABORTION LAW REFORM - THE GERMAN WAY

German feminists have resisted the temptation to stand on the defensive. They have called on the liberal parties to take ' the root of the evil", Article 218 once again to the Constitutional Court to have it abolished because it conflicts with constitutional guarantees of 'human dignity '. Since none of the political parties was prepared to go ahead with this before the last federal elections in '87, autonomous feminists have taken the matter in their own hands. They have promised to support any woman needing an abortion with legal assistance to challenge Article 218 through the courts. Similar options remain closed to Australian women due to the lack of a proper constitution.

I grew up with the restrictive Article 218 and its subversive application by feminists. When I fell pregnant at 21 without money but a half-finished university education I was still lucky: I lived in a big city, had a supportive partner, an understanding doctor sympathetic counselling and a good clinic was easily available. Although it was no light decision it was the only right one for me. I have never regretted it. Now, I could not face the indignity of having to beg for an abortion like in the bad old days. In West Germany I could still resort to a more progressive neighbouring country and pay for my right to choose

Many women don't have this option In NSW we will perhaps soon have the choice between travelling to a (still) liberal state or going to a back-yard butcher. This won't stop any woman from having an abortion, it never has. The humiliation and the dangers they go through are a measure of their desperation to avoid involuntary motherhood. No law worldwide has ever stopped women from having an abortion it can only determine the circumstances under which they have one. After a century of pro-choice struggle no politician can pretend they don't know what they are doing.

Elke Wiesmann

For herstorical info regarding the pro-choice struggle in West Germany see over to next page.

The Pro-Choice Struggle in West Germany - Some Herstorical Data

Spring 1971: Women rally in a nationwide campaign to abolish the law prohibiting abortion, known as 'Article 218' and dating back to 1875. They declare publicly: "I have had an abortion and I demand this right for every woman" Like in France, this campaign triggers the New Women's Movement.

Jan. 1975: Under pressure from the campaign, the then government, a centre-left coalition of Social Democrats and Liberals, moves to reform the Article 218 to allow abortion on demand within the first three months of a pregnancy - the so-called 'Fristenloesung" (term solution). The Article 218 still outlaws abortion but it has been substantially liberalised.

Feb 1975: The highest German court the Constitutional Court, declares the 'Fristenloesung" unconstitutional even before the new Bill can become law. The verdict of a majority of six male judges: abortion on demand violates the constitutional duty of the state to "protect life . The protection of (potential) life outweighs a woman's right to self-determination.

1976. The same Government has come up with a new "solution", the so-called 'Indikationsloesung' which generally outlaws abortion but allows it under 'exceptional circumstances': when the life of the pregnant woman is threatened, when the pregnancy resulted from rape, when the child is feared to be born handicapped and *when continuation of the pregnancy endangers the mental or physical health of the woman* (i.e social circumstances - comparable to the Levine ruling in New South Wales). However. not the woman herself decides whether her social reasons are valid but an "expert", a doctor or a psychologist. In addition to begging for her/his consent, she has to undergo compulsory pregnancy counselling by an officially approved agency (the churches, welfare institutions but also the liberal family planning agencies). Result: health risks in West Germany are higher than in comparable countries because this process delays terminations unnecessarily. Without a doctor's approval plus the counsellor's OK, abortion remains a crime, punishable with 3 to 5 years prison. Feminists call this legislation an indignity for the woman since it has her begging for an abortion which is only granted "ex gratia' and not a right Burnt out by five years of pro-choice struggle they hope to undermine this legislation in practice. Today, feminists proudly agree with claims of the anti-choice lobby that the 'Indikationsloesung" has in reality become abortion on demand, thanks to liberal counselling agencies and feminist doctors and clinics: 85% of all terminations are done for social reasons.

1987: The re-elected conservative Christian Democrat/Liberal government attacks exactly this liberal practice of the repressive Article 218. Realising that they don't have the political power to toughen Article 218 even further. (A national poll in 1984 shows that 69% of all Germans agree that the choice to have an abortion or not should be left to the woman alone - 64% of all Catholics, 72% Protestants and 86% atheists) they set out to restrict the practice of the termination process by drafting new counselling legislation, that already has beome known as the "patronising law".

CERVICAL CANCER OUTRAGE

In 1966 Dr. Herbert Green, Associate Professor at National Women's Hospital (New Zealand's major gynaecological teaching hospital) commenced a series of trials on his patients who presented with cervical carcinoma *in situ* (CIS). It has been accepted medical opinion for more than twenty years that CIS is a precursor of invasive cervical cancer. In the early 60's cone biopsies replaced hysterectomies as accepted treatment of CIS before invasive cancer developed.

However, Dr. Green's 1966 trials were based on his personal belief that CIS, if left untreated, would not lead to cervical cancer. He, therefore, withheld knowledge from his patients that they had CIS, and withheld even the most conservative type of medical intervention. These trials were carried out on these women without their knowledge and without their consent. Twenty-six women died as a result of the CIS progressing on to cervical cancer.

All the women involved were subjected to repeated vaginal examinations and surgery. None of the women were adequately informed of their condition or of the treatment they were undergoing.

This series of 'trials' continued, unquestioned, for twenty years until Phillida Bunkle, a medical sociologist, read an article in a medical journal which outlined the findings of the trials, and she began to question and investigate how such data had been obtained. This particular article had been given to medical students for many years, none of whom had the critical nouse to question the methodology of such findings.

Together with Sandra Coney, Bunkle began the investigation and discovery of Green's private experiment. This story was published in a national magazine, and was later released in paperback (*An Unfortunate Experiment*).

The outcry from the community following these revelations lead to the setting up of a Committee of Inquiry which was presided over by Judge Silvia Cartwright. The report from this Inquiry was presented in July 1988. The following is a brief summary of some of the findings and recommendations:-

* no consent to the trial was sought from the women;
* mismanagement of the patients continued after Green's retirement in 1982;
* by delaying treatment until invasive cancer occurred, treatment was more radical and life expectancy significantly endangered;
* obvious symptoms of invasive cancer were sometimes ignored or downplayed;
* it was revealed that anaethetised non-consenting women were used as teaching models for students and doctors for vaginal examination procedure and IUD insertion. This went on with the knowledge of the Chairperson of the Ethics Committee, the Auckland Hospital Board and the hospital superintendent;

Continued on page 47

This is a very condensed version of a story run by *The Listener* in New Zealand in August 1988 about how an unusual "religious" group came to control Auckland's largest abortion clinic.

Very Peculiar Practices

The Auckland Medical Aid Centre (AMAC) opened on 17 May 1974. It was set up by a doctor, a lawyer, a housewife, a social worker and an accountant, who formed a trust to foster control of reproduction and offer abortions to women. AMAC was supported by feminists and eminent doctors. It was obviously a much needed service, as witnessed by the fact that over 6,000 women were seen by the clinic in the first two years of its operation.

However, it was not all smooth sailing for the clinic. Anti-abortionists led attacks on the clinic which resulted in police seizing the files of 500 patients in September 1974. In 1975 the clinic's operating doctor was charged with procuring illegal abortions. In the Supreme Court, a jury was unable to reach a verdict and the doctor was discharged. In a second trial that same year, he was acquitted.

The legal status of abortion in NZ swayed to and fro throughout the late 1970's. In 1976 a Court of Appeal ruling widened the legal ground for abortion. At the end of 1977, the Contraception, Sterilisation and Abortion Act was passed, effectively outlawing abortion. AMAC's clinic closed as a result and many New Zealand women had to fly to Australia for their abortions. In August 1979 AMAC's clinic reopened, operating in a way which fell within the law. For a while afterwards, AMAC was not troubled by anti-abortionists.

However, the real source of troubles for AMAC was only just beginning to take a hold: staff discontent. The staff were not represented on the trust's board, nor was the trust accountable to anyone. The sacking of a key counsellor in 1977 led to a staff revolt, as it appeared that the trust wanted to get rid of the feminist element within the clinic. By 1980 the conditions for staff were quite poor, but two new female members of the trusts' board were receptive to staff advances and contracts and better pay were won. However this still had not resolved the problem of staff/trust relations and the lack of communication between them.

Anna Watson was the name at the centre of this conflict. She is the aforementioned housewife who helped to set up the clinic. She was the head of the day-to-day running of the clinic, as well as being a board member. This gave her virtually unlimited power over the trusts' affairs and the running of the clinic.

Only by doing some searching did the staff discover that there were changes being mooted for the clinic. It was a plan for mass sacking of all staff, de-licensing and a move to a one-day system with optional counselling. The staff were concerned that this would reduce the high quality service that the clinic offered to women. These changes did, more or less, occur over the following couple of years. Many of the older staff were made "redundant". They were replaced by members of the Centrepoint Community Growth Trust.

The Centrepoint Group is an unusual "religious" community. It was headed by Bert Potter, a wealthy former businessman. He set up a rural therapeutic community in 1978. Members had to surrender their personal property and assets when arriving at the community and all income earned from outside sources became the income of the trust.

In 1980, a television special on the Centrepoint community Growth Trust and its bizarre activities shocked viewers. This led to fears in the public about the group, and is one of the reasons

why staff at the AMAC clinic did not want Centrepoint's name associated with AMAC.

In 1981, the Inland Revenue Department revoked Centrepoint's charitable trust status, demanding taxes back to 1978. This caused severe financial hardship for Centrepoint. It is not certain how Centrepoint recovered from the 1984-5 crisis, but by 1987 it had done so in a big way. It was during this period that Centrepoint gained control of the AMAC trust.

The first Centrepoint members had been appointed to the AMAC trust in April 1984. A third Centrepoint person took over AMAC's finances. This person happened to be Anna Watson's brother. Eventually Centrepoint gained more and more control of the AMAC clinic's operations. The remaining AMAC staff were totally opposed to Centrepoint's involvement. Centrepoint's rural community appeared to celebrate pregnancy and birth, so the question was why did it want to be involved with the running of an abortion clinic? Bert Potter expressed contempt towards feminists and Centrepoint had never supported the broad women's rights campaign within which the struggle for abortion had been firmly placed.

It seemed that Centrepoint's interest in abortion was purely to do with money, or the potential for generating it. Any Centrepoint members who worked at the AMAC clinic had their salaries paid into Centrepoint's funds. Because of this procedure, many Centrepoint members replaced AMAC staff. In many cases this meant inexperienced, unqualified people replacing people who had worked at AMAC for years. Also, the two day procedure at the clinic was cut to one day.

Centrepoint soon began to operate its counselling service out of the AMAC clinic. The presence of Centrepoint people made many of the women patients feel uncomfortable. There were concerns that the independence and integrity of AMAC were being compromised. None of the Centrepoint members working at AMAC were committed to abortion. Nor, it seemed, were they very sympathetic to women coming for abortions. The AMAC trust, now completely controlled by Centrepoint, met elsewhere, operated rather secretly and no-one ever saw the minutes of the meetings. No-one knew what the concerns of the trust were.

Apart from the treatment of women at the clinic, the procedures were also worrying. Centrepoint owned a goat stud, and the scrub nurse at AMAC reported that she was required to put through the steriliser packs of materials used in goat embryo transfers on the Centrepoint farm. This was illegal. There was the possibility of contaminating the instruments used on the women. When one of the staff threatened to report this to the Department of Health, the practice stopped.

The non-Centrepoint staff at AMAC were pushing for other non-Centrepoint people to be appointed to the trust, but this was ignored. The same staff's jobs were also threatened. Power struggles resulted in some non-Centrepoint staff leaving.

One of the issues worrying non-Centrepoint staff was money. The AMAC trust was set up as a non-profit venture, but Centrepoint was running the clinic at a profit. Staff thought that either the fee for abortions should be lowered or the profit used to educate people about preventing unwanted pregnancies. Centrepoint would not show the accounts for the clinic to anyone. Nor, under New Zealand's Charitable Trust Act, are they required by law to do so. It was ascertained that certain Centrepoint members working at the Clinic are paid well above their public hospital counterparts (except that the money goes into Centrepoint funds) and that Centrepoint gains about $200,000 per annum of its income from its involvement with AMAC

The situation between staff and trust members at AMAC is still not good. Centrepoint continues to control the operation of AMAC. As one non-Centrepoint staff member put it:

"The staff are finding it increasingly difficult to work while the clinic is 'owned' by a religious group which is ambivalent about abortion but which is profiting from it. We want Centrepoint out."

Summarised by Toni Payne

Source: "Why is Centrepoint running the Auckland abortion clinic?" A special report by Sandra Coney, *The Listener*, 10 August, 1988.

Grace de Jesus

Fr. Ed de la Torre

Something has happened in the anti-abortion rhetoric. Embryos and foetuses are represented as children. In some versions they seem to represent the whole of human life. Women, then, are represented as threats to human life when they seek abortion. A similar condensation of social relations is present in the debates about embryo experimentation. Experiments on a fertilised egg are said to kill human life.

Human Life and Foetal Images

This condensation of many aspects of social life into one biological entity has a serious political effect. It makes women invisible by focussing attention elsewhere. It is part of attempts to set the moral agenda for public policy by denying the complexity of social relationships. It does this by creating two equations: embryo/foetus equals baby and woman equals mother.

In the Nile anti-abortion bill in NSW the pregnant woman disappears. Only the foetus (here called the unborn child) and the mother are visible. The experience of pregnancy is reduced to the assertion that a woman is a life support system for a foetus.

In fact, the moment of implantation of the fertilised egg is claimed to be the beginning of human personality.

Current anti-abortion propaganda relies on this misrepresentation. In a film version, the ultrasound image of a foetus is equated with a baby. The movement of the foetal image during the process of abortion is described as the "struggles" of a baby being murdered.

A television version is more graphic. Colour pictures of foetuses are used to convince the viewer that the "baby" is there from the beginning rather than the result of a process of development. In the radio version, the foetus talks. "Emily" calls you mummy, and talks of a shared future, and then asks, "why are you killing me?"

These are powerful because they directly address "you". They require you to enter their version of events. The foetus is personified, "you" enter a fictional relationship with that personification. Resisting the fictional relationship means becoming a killer. When the foetus stands for human life, human adults can represent a threat to life itself.

The two equations are set up. If a foetus equals baby, then any action that would be repugnant if done to a baby is repugnant when done to a foetus. This equation makes any woman invisible in at least two ways.

First, it denies her ability to distinguish between a foetus and a baby. Second, it denies her any feelings or choice about what is happening with her body. This denial takes many forms: overseas doctors have had women undergo major abdominal surgery to "treat" the foetus. Others frequently deny the grief women feel following a miscarriage.

This seems like a contradiction. On one hand, the biological foetus is regarded as a social child, a worthy patient for medical treatment. On the other, the social experience of the pregnant woman is reduced to biology. Once the miscarriage is over, they say nothing is there. Yet these demands on women are consistent in their insistence that women accept an outsider's understanding of pregnancy.

In the second equation woman equals mother. Any refusal of this identification is portrayed as unwomanly or unfeminine. This equation bolsters the denial of the ability of women to understand

their experience. Women's understanding is based on a complex interplay of personal and social considerations as well as knowledge of the biological facts.

Notice, though, that the Right-to-Lifers deny one important aspect of the biological facts as they focus on the foetus. They deny the physiological experience of pregnancy. A foetus is not a parcel that can be carried without effort in the boot of a car. Think about the misrepresentation of pregnancy by a professor of genetics.

"Protected by his (sic) life capsule, the zona pellucida first and, later, the amniotic bag he constructs around himself, the early human being is just as viable and autonomous as an astronaut on the moon. Refuelling with vital fluids is required from the mother ship."

"A purely artificial fluid has not yet been invented, but if it were ever possible complete development outside the womb would ensue. Such 'ectogenesis' would be the most proof that an embryo baby belongs to himself. If the bottle would argue that this baby is my property, no one would believe the bottle." The woman/foetus relationship according to Jerome Lejeune, a darling of the Right-to-Life.

This is an extended analogy with powerful images: foetus as male astronaut, woman as a bottle or space ship. The images deny biology – the zone pellucida of the egg is penetrated by a sperm or there is no fertilisation; cells differentiate to form a placenta, amniotic sac and foetus without the presence of a personified will. Oh yes, lots of foetuses are female.

This amazing process of cell division and differentiation is not uniquely human, of course. Birds, reptiles, marsupials, vegetables and fruit as well as mammals all have genetic coding that allows a fertilised egg or seed to develop into its mature form in the proper circumstances. For humans, contrary to Lejeune's image, those circumstances include the life situation for a woman.

The image of the foetus as heroic astronaut is common. Remember the ultrasound images and the fibre optic pictures of foetuses. The foetus looks like a small traveller in the depths of space like the image at the end of *2001*. The foetus is actually in the uterus of a pregnant woman.

Now, when a woman wants to be pregnant, she personifies the foetus. She strokes her belly, her partner kisses "baby" goodnight, they choose names. The most down-to-earth people display uncharacteristic sentimentality. Of course, when something goes wrong, they grieve.

It is not a little astronaut, lonely and autonomous, but a fantasy baby embedded in social relationships, dependent on the body and imagination of the pregnant woman. In this context, the ultrasound image is the "first photo" for the new album. It is an acceptable way to introduce the fantasy baby to friends.

However, if the pregnancy is both unexpected and unwanted it is something else entirely. It is a threat, a betrayal, a problem to solve. Certainly, many women experience mixed feelings; the fantasy baby may even appear for a while. Women can tell it goodbye, however.

A pregnant woman may have a physical relationship with a foetus, but it is not chosen. If she is unwilling to accept a social relationship, she ends the pregnancy.

What this suggests is that the personification of the foetus comes from the social relationship and cannot be "read off" the biological process of cell division and differentiation. Biological processes do not carry automatic moral values as the Right-to-Life suggests. Human economic, social and political relationships create moral values. Material conditions of life change and so do moral values.

The representation of the new reproductive technologies in the

INTERNATIONAL

IRELAND

RIGHT TO ABORTION INFORMATION CAMPAIGN IN IRELAND

A campaign to overturn the Irish Supreme Court's decision against two women's health services in Dublin, the Well Woman Centres and Open Line Counselling, has been launched. Both centres were advising women on all the options available with a crisis pregnancy, including where they could get safe abortions in England. The Court upheld a lower court's decision that this violated the Constitution and ordered the centres to stop giving this advice.

Both centres stopped doing crisis pregnancy counselling at all, because they could no longer give full information to women. Since then, Open Line Counselling has started a 24-hour telephone answering service which provides full information to women who ring, because they have decided not to let an unjust court decision prevent women from getting help. The campaign to overturn the court ruling is based on the Universal Declaration of Human Rights, where the freedom to give and receive information is protected.

(From: *NAC News* 6, Autumn 1988 and WGNRR newsletter Sept-Dec '88.)

ARGENTINA: BACKYARD ABORTION MEANS DEATH

The Argentine Gynaecology and Obstetrics Society estimates that "every two days a woman dies as a result of an illegal abortion"; physicians fear to become involved due to harsh penalties and the potential loss of the right to practice; unwanted babies suffer "extra-uterine abortion", meaning that they are killed immediately after birth, abandoned or abused.

(From: *Buenos Aires Herald*, 3 March 1988 and *ALRA News* Dec. 1988, Vol. 16, No. 2.)

USA: COURT SAYS IT'S A WOMAN'S CHOICE

No American husband can now legally stop his wife from having an abortion. The US Federal Supreme Court decision overturned an Indiana State Supreme Court ruling, bringing the US into line with most other developed countries.

(From: *The West Australian*, 16 November 1988; *Washington Post*, 23 April 1988; and *ALRA News*, Dec. 1988, Vol. 16, No. 2.)

TOUGH TIMES LIE AHEAD FOR NEW DIRECTOR OF UK FPA

Doreen Massey takes over the Directorship of the UK FPA 'at a time when there are cuts in family planning services, constant scares about the Pill, three new contraceptives under research, and a rise in unplanned pregnancies and abortions'.

In an interview, she says that the FPA is in for many major decisions and battles. 'I think we need to build on our roots as a campaigning organization on issues like clinic closures, the Abortion Bill, and sex education... I see our role as it always has been, a social advocacy role. But we also want to inform and educate where people actually are: in shops, at work, in schools and at home.'

(From: *Sunday Times*, London, 22nd January 1989 and IPPF *Open File* for two weeks ending 3rd February 1989.)

MORE DEVELOPMENTS IN USA

See articles elsewhere in this issue.

SWITZERLAND

In the canton of Zug in Switzerland new regulations on abortion require a commission of four doctors to approve a woman's request for abortion. Federal law requires only one doctor's approval. And only residents of the canton are premitted to request an abortion. The Union Suisse pour Decriminaliser l'Avortement are opposing these regulations as a violation of women's privacy.

(From: USPDA *Courier* 16 July 1988 and WGNRR Sept-Dec 1988 newsletter.)

UNITED KINGDOM: ALTON BILL FALLS

The Alton Private Member's Bill, which would have reduced the permitted legal limit for abortions from 28 weeks to 18 weeks, was defeated in the British Parliament last July. It had completed the second reading and subsequent Committee Stage but ran out of time before voting could be completed at its Report Stage and Third Reading.

David Alton, a Roman Catholic with strong anti-abortion views, had the backing of his Church for the Bill. According to *Breaking Chains* (November/December 1987), the newspaper of ALRA in Britain, only a small number of abortions are performed after 18 weeks (3.3% of all abortions performed). However, they matter because women having late abortions fall into four important groups:

* those women who initially denied that they are pregnant;
* menopausal women who don't know that they are pregnant;
* women who go for help early in pregnancy, but are forced to wait for an abortion until much later;
* women who are recommended medically to have amniocentesis, usually performed at around 16 weeks to detect handicap.

The earliest that a woman can receive the results of many of these tests is 20 weeks, so it is imperative that safe abortion is available at this stage and even later.

(From: *ALRA News*, Dec. 1988, Vol. 16, No. 2.)

LEGAL ABORTION IN NAMIBIA?

At the end of 1987, an MP in the Namibian Parliament tabled a motion requesting the Health Minister to create the necessary facilities in all hospitals and clinics to terminate unwanted pregnancies on a woman's request. The reasoning given in support of the motion was the high population growth rate in Namibia compared to economic growth, and the fact that 60% of births were unplanned. The figures referred to the black population only.

Some doctors responded by saying that this would over-burden hospital facilities, or that abortion would replace contraception, while others supported the need to liberalise the law.

At the moment, abortion in Namibia is only legal in cases of rape or incest, or if the health of the woman would be severely impaired. The majority of doctors advise women to seek abortions abroad, but for the majority of women this is not a real option.

Given that the Parliament is a puppet of South Africa and that sterilisation and contraception abuses in the name of population control have occurred regularly in Namibia under this government, the motive for tabling the bill is no surprise. The bill itself is extremely progressive, however. The question of how it would be implemented if it were ever passed remains to be seen. SWAPO Women's Solidarity Campaign will be monitoring the situation closely.

(From: Maxine Jones, *NAC News* 6, Autumn 1988, p. 17 and WGNRR newsletter Sept-Dec 1988.)

CANADA

Attempts in the Canadian Parliament to introduce a new law restricting abortion, following the Supreme Court's decision that the existing law violated women's right to decide themselves on abortion, have so far failed. The main pressure for a new law has come from anti-abortionists, who tried to use the debate as a means of reintroducing restrictions. Abortion rights activists across Canada are jubilant, as they are campaigning against the need for any new law.

(From: *Pro-Choice News* Summer '88 and WGNRR Sept-Dec 1988 newsletter.)

ABORTION LAW: INTERNATIONAL SURVEY NOW AVAILABLE

'International Developments in Abortion Laws: 1977-88' is the title of an article by Rebecca Cook and Bernard Dickens which appeared recently in the prestigious *American Journal of Public Health*. The authors have tried to explain their findings, not merely to list them, giving a concise and easy-to-read account of the decade's changes.

This review covers only legal developments, but the scope of those is quite wide: access to contraception and sterilisation (to reduce the need for abortion), provisions for conscientious objection as well as changes to abortion laws, litigation and interpretation of the laws. Of the 39 countries included in the survey, 35 increased access provisions, with spectacular and sweeping significance in the case of Canada. The Supreme Court decision in January 1988 saw the prohibition of abortion as an infringement to the right to life, liberty and security of women. An appeal is being prepared, but Chief Justice Brian Dickson's words are worth repeating: 'Forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus an infringement of security of the person.'

(R.J. Cook and B.M. Dickens, "International Developments in Abortion Laws: 1977-88", *American Journal of Public Health*, October 1988, Vol. 78, No. 10, pp. 1305-1311.)

If you want a copy write to: The Editor, *ALRA News*, P.O. Box 143, Claremont, WA 6010.

(From: *ALRA News*, Dec. 1988, Vol. 16, No. 2.)

GHANA AND ZAMBIA

Both Ghana and Zambia have technically got legal abortion on the statute books, but in practice there are almost no safe abortion facilities, so dangerous and clandestine abortions continue unabated.

(From: speaker at the Christopher Tietze International Symposium, Rio de Janeiro, October 1988 and WGNRR newsletter Sept-Dec 1988.)

Most abortion services require that women attend two appointments, the first of which provides women the opportunity to discuss their pregnancy with a counsellor and medical practitioner. The termination is usually scheduled for several days later, giving women time to consider their decision.

Time and accommodation constraints are such that most Melbourne abortion services are obliged to offer rural women both counselling and termination appointments on the same day. Similarly many women in the suburbs are forced to travel long distances across town to secure a service which their local public hospital has the facilities to provide.

A further important reason for the availability of abortion services within the public hospital system is that they are often the most appropriate facilities to assist women who are unable to speak English. Most public hospitals have in-house interpreter services and considerable expertise in working with non-English speaking clientele.

Constraints on the Public Hospital System

Before exploring ways to change the present situation it is worth considering some aspects of the organisation of public abortion services which may act to limit the public share of services.

The low status attached to abortion work makes it a poor competitor with other surgical procedures when it comes to vying for scarce theatre time and other hospital resources. Doctors engaging in the skilled and heroic effort of administering an abortion to an impoverished woman with five children do not, in our pro natalist society, attract the same accolades from their colleagues and the media as their counterparts involved in the technical wizardry of In Vitro Fertilisation. In some hospitals, little has been done at the hospital administrative or board level in righting the imbalances of medical priority setting. For public hospitals there is little kudos associated with the delivery and defence of good abortion services.

Not Too Many: The Troops Won't Like It

The organisation of abortion services within public hospitals can also act to reduce the tolerance threshold of the system. In most facilities, women seeking abortions are treated within the general hospital system and are cared for by the general nursing, medical, counselling and ancillary staff. Not all personnel involved in the care of women may sympathise with the provision of abortion and for many abortion is positively at odds with their religious or personal beliefs. The maintenance of an abortion service within such a system becomes dependent upon keeping numbers at a level acceptable to such staff in order to maintain their co-operation.

To some extent, this may also affect the circumstances under which a hospital service will assist women. For instance, some hospital abortion services are known for their reluctance to treat women seeking a second abortion (the undeserving) but respond with comparative sensitivity to women who have conceived as a result of failed tubal ligation (the deserving).

The Impact on Service Delivery

The public hospital system's reluctant provision of abortion services also influences the way services have developed. Some hospitals have required that their abortion services develop so as to be as innocuous as possible. This in turn has a negative impact on the experience of individual women using public hospital abortion services.

Pregnancy termination and contraception advice services are no well publicised. Many women arriving at a public hospital often do so having fought their way through a maze of referring doctors and other agencies – not all of which may have been sympathetic.

The Menhennit Ruling

In every state except South Australia the laws dealing with abortion have not been changed since their introduction in Australia from the English 'Offences Against The Person Act' of 1861.

In practice, the Law or Statute, as above , is often interpreted by a 'Test Case', which has the function of adding to the practical application of the Statute, and often can serve to liberalise the original Law, so that the particular law is more relevant to changes in society's attitudes as time goes by.

In Victoria, abortion is 'legal' under common law. Common law rulings in Victoria (Menhennit J. in R vs Davidson 1969) found that abortion is lawful if the doctor honestly believes on reasonable grounds that abortion is necessary to preserve the life or physical or mental health of the mother.

The ruling does not change the law, but merely applies it to a particular case. The ruling can be changed by later judgements.

Abortion will only be women's right in Victoria when laws against it are removed from the Crimes Act.

There have been no challenges to the ambiguous legal situation as it relates to abortion by public agencies, although the path may be fraught with danger. Some public hospitals have interpreted the legal situation more conservatively than others. For instance staff in public hospitals can be more rigorous in their application of the Menhennit ruling and consequently refer women on to private services.

Research's Poor Relation

At a broader level, hospitals have not generated literature, and resource material or undertaken research on the topic of abortion. This means that there is a dearth of good Australian material to provide a basis for evaluating and improving abortion services. It is an extraordinary situation that most of the small amount of research which has been conducted on abortion in the last twenty years has originated from private clinics. As major teaching and research facilities, public hospitals should be leading the field in abortion research activity.

Reform of Abortion Services

Any reform of publicly funded facilities must first involve the state coming to terms with its role as a provider of termination and contraception advice services. Hospitals regulate resources allocated to most procedures on the basis of explicit criteria – primarily cost and need. Resources allocated to infertility treatments for public patients are constrained because of the enormously costly nature of the procedures involved. Hysterectomies and mastectomies, meanwhile, are performed on the basis of need (notwithstanding that the medical and lay communities often do not have a shared definition of need).

Abortion, relative to most surgical procedures, is inexpensive. The well documented social, emotional and financial costs of unplanned pregnancy are testimony to the need for abortion services and the wider dissemination of contraceptive information. Yet, with the exception of tubal ligation, it is the only necessary surgical procedure that is limited by political and moral considerations.

Victorian women make a significant contribution to the tax pool which funds public health facilities. The failure of these facilities to accurately reflect health priorities as Victorian women see them is encapsulated in a comment by a participant in the *Why Women's Health* consultation. "You can get a hysterectomy immediately but can wait months for a sterilisation and not be able to get a termination at all."

One of the greatest paradoxes in our medical system is that women have spent the last two decades resisting the level of surgical intervention in many aspects of their lives, while simultaneously having to struggle to gain access to surgical procedures allowing them to have control over their fertility.

A Question of Both Quality and Quantity

The availability of abortion services is only the tip of the reform agenda. Services need to develop in ways that ensure they are accessible, and that women are treated competently and sensitively. Clearly new models of service delivery need to be examined.

Separate Services?

Over the last ten years a number of public hospitals have auspiced the development of separate services in response to health issues requiring specialist or sensitive treatment. The development of the Royal Women's Hospital Centre Against Sexual Assault provides a recent example of this. This service is associated with the hospital, but is located in a separate building and has its own management body. A similar model may be worth investigating for the provision of termination, counselling and information services.

This model would have the advantage of enabling recruitment and induction of staff with a specific commitment to providing abortion services. It could also act as a site for training medical, counselling and nursing students and generate relevant literature, research and resource material. At the same time its proximity to and association with the hospital would mean that it would benefit from specialist expertise, support and where necessary, emergency medical facilities.

The disadvantage of this model is that it would present an identifiable target for anti-abortionists – not a small concern given the recent bombings of abortion clinics in the United States.

It is possible that this model may also lead to the marginalisation of abortion services and make them more vulnerable to being stigmatised and subject to resource 'cut-backs'. Arguably, this is equally an issue when services are provided in the general hospital system. Indeed, it is much harder to close an identifiable 'bricks and mortar' service than it is to whittle away at abortion spaces on an operating list.

This model would allow the rights of those staff who do not wish to undertake abortion work to be respected. It also ensures that women are protected from staff who are either positively antagonistic or who have unresolved issues about abortion. However, this is seen as a major

problem by some service providers who believe that trainee health workers in particular should have some exposure to the abortion issue as part of their general training. The provision of safe abortion services has meant that fewer and fewer health workers have been exposed to the consequences of unsafe 'backyard' abortions. This is particularly important if skills in the provision of abortion services are to be maintained in the medical work force.

A Community Managed Alternative

A further alternative might be to initiate the development of freestanding, community managed clinics on a publicly funded or not for profit basis (similar to the community health centre model). This model would have many of the advantages of a hospital auspiced clinic, but would allow more independent development than might be possible within the political and bureaucratic environment of a hospital. For instance a community managed service would have greater freedom to adopt a more public profile in lobbying for abortion law reform. Family planning clinics could provide one site for separate services. However, this is a role they have not so far taken.

A Shared Commitment to Service

Irrespective of the development of new models of service, there needs to be a greater understanding and acceptance of the role public hospitals play. All publicly funded hospitals should bear their share in providing services to public patients. For this to occur, the Government, in consultation with hospitals, may need to explore ways to overcome various objections to providing public termination services, such as religious beliefs or different priority setting.

The introduction of more day surgery facilities at public hospitals may mean that there is greater scope for termination, counselling and advisory services to be provided through these avenues than through the general hospital services. This may place less demand on the hospital system, both on theatre space and staff.

And the Buck Doesn't Stop with Hospitals: A Positive Role for Health Service Agreements

The difficulties facing public hospital abortion services have not developed within a vacuum. Public hospitals exist within a political and social environment. Change will be influenced as much by activity outside their walls, as within them.

The State Government, particularly since the advent of health service agreements, has a key role in ensuring that the public hospital system responds appropriately to the abortion issue. Certainly the issues have been brought repeatedly to its attention both through the findings of the *Why Women's Health* consultation and by a number of women's and community groups. The Government's reluctance to act may be due largely to fears of the possiblity of electoral damage that may result from the resistance of anti-abortionists. A detailed study of the results of the 1983 election, in which a marginal seat was contested by both 'pro-life' and 'pro-choice' candidates, suggests that these fears are groundless. The outcome of the election was unaffected by the anti-abortion campaign and indeed the 'pro-choice' candidate attracted four times more votes then his anti-abortion counterpart.

What has Happened to Education?

It could be assumed that a spin-off from all the health education campaigns on AIDS, sexually transmitted diseases, etc, which have promoted condom use, would be a reduction in the unplanned pregnancy rate. While it it too early to say, and little research yet done, it seems unlikely that one of the major 'benefits' of using condoms will get through to women. Health Department campaigns on sexually transmitted diseases and pelvic imflammatory disease either do not mention that condoms are a contraceptive, or mention this benefit almost as an aside! This is an excellent example of the disease orientation of illness prevention rather than the promotion of women's control over their health and fertility.

Clearly, in addressing the role of public hospitals in providing termination services, the Government needs also to do more in providing clear, accessible and culturally sensitive information to women on contraception, and not just on disease prevention.

Your Role

Finally as a community of health service providers and users we must also play a role in challenging those attitudes which provide the moral, social and historical milieu which allows the inadequate provision of abortion services. Clearly we must continue to address the causes of unplanned pregnancy. At the same time, we must become far more active in our affirmation of abortion as a legitimate medical and social service, and in our support of those many hardworking and skilled health care workers who struggle to provide abortion services within the public hospital system.

Reprinted from: *Health Issues* 18, March 1989

Advancing Women's Health

In April 1989 Prime Minister Bob Hawke and Minister for Community Services and Health, Neal Blewett, launched the ***National Women's Health Policy - Advancing Women's Health in Australia,*** *at Westmead , N.S.W. The policy is a part of the Commonwealth Government's commitment to better health for all Australians by the year 2000.*

The report was written by Ms Liza Newby, Special Advisor on Women's Health to Dr Blewett, with staff of the Women's Health Unit of the Commonwealth Department of Community Services and Health.

The policy was developed as a result of widespread consultation with Australian women and women's health practitioners. Regardless of their socio-economic, ethnic of educational background, their age or the region where they live, women identified the same concerns about health.

The policy addresses seven major health issues:
- *reproductive health and sexuality;*
- *the health of ageing women;*
- *women's emotional and mental health;*
- *violence against women;*
- *occupational health and safety;*
- *health needs of women as carers;*
- *health effects of sex role stereotyping.*

The policy document also identifies five key areas in the health care system for action to improve women's health:
- *improvements in health services;*
- *provision of health information for women;*
- *research and data collection on women's health;*
- *women's participation in decision-making in health;*
- *training of health care providers.*

The final chapter contains recommendations that include proposals for a National Women's Health Program and action in existing programs in States and Territories. In addition there are details of strategies for implementing the overall National Women's Health Policy.

Australia is unique in having a National Women's Health Policy, but implementation will not be automatic. Women's health activists have our work cut out for us to turn this policy into practice. The first step will be to read and discuss the policy document. Then each of us can begin implementation in our own sectors.

A summary of the policy is available from Ms Laurie Gilbert, the Women's Health Unit of the Department of Community Services and Health, P.O. Box 9848, Canberra, 2601. The full report is available from all Australian Government Publishing Service Bookshops for $16.95.

The following short extracts from the section on reproductive health and sexuality provide some idea of the issues considered in the development of the policy. (Due to lack of space references have not been included, however page numbers are included for easy location in the policy book.

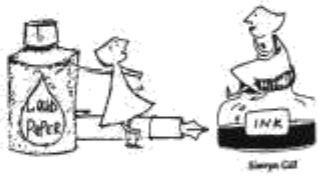
Fertility Control

Fertility control is an overriding issue in women's lives. The capacity to control the number and spacing of children since the introduction of the contraceptive pill in the early 1960s has contributed to the overall improvement of women's health and to the quality of their lives.

Choice of method has varied over time with many young women in recent years using the contraceptive pill before and following marriage and between pregnancies. As Siedlecky has noted, 'after some years of pill use, or possible side effects, women turn to the IUD, condoms, diaphragms and periodic abstinence methods. By their mid-30s, or when anticipated family size is complete, couples often decide that one of them will have a sterilisation' (1986). Because of this pattern of changing approaches to contraception, women need access to reliable up to date information and advice on both accepted and new methods which identifies comparative advantages for each method and potential disadvantages so that they can make informed choices.

The responsibility for contraception has been taken mainly by women although vasectomy and condom usage rates have been increasing in recent years, the

Government Action



latter due to concerns about AIDS and sexually transmitted diseases.

Surgical, device and chemical methods of contraception carry with them some degree of risk, but it is widely accepted that this is less than the risks of complications of pregnancy (Ory 1983).

Women in Australia are concerned that they are denied some of the choices of contraceptive methods available in other countries. Several submissions sought a review of mechanisms affecting the importation of drugs and the approval of devices. There is also

concern that if general practitioners have not kept up to date with the varied methods available, women may not receive expert advice.

The problems experienced as a consequence of male doctors, in particular, stereotyping women and applying the doctor's own values to women seeking help to control their fertility are substantial and discussed in section 3.8.

Access to appropriate information and care is thus a major issue for some women. The Family Planning Program of the Commonwealth Department of Community Services and Health, which received funding of $10.64 million in 1987-88 from the Department, provided services to over 244,000 clients, mainly through the State and Territory Family Planning Associations and the natural family planning services under the auspices of the Australian Catholic Social Welfare Commission. The Associations undertake a significant training and information role and the Program also has a small budget component for research projects on the social, medical and demographic aspects of family planning.

Although the Family Planning Associations (FPAs) focus on disadvantaged 'at risk' groups, FPA services are mainly located in cities and the larger towns. Thus access is difficult for many clients, including Aborigines in rural areas. lack of translation services and cultural differences also make access to appropriate services difficult for women of non-English speaking backgrounds and Aborigines.

Results of a current survey of the family planning needs of recently arrived Lebanese, Turkish and Vietnamese women will assist policy makers and planners to make family planning services more accessible to migrant women (pp17-18).

Sexuality

Although relevant at all ages, the issue of sexuality was addressed most frequently in consultation meetings and submissions in relation to young people, people with disabilities and women at the time of menopause.

Young people stressed the need to consider sexuality broadly, by taking account of social circumstances, culture and personal experience, self-esteem and quality of relationships. Emphasis was also given to the need to address sexuality both in the home, and early and effectively in the education system for boys as well as girls. Studies of young people show that this broad approach frequently does not happen.

Personal development courses are not provided in all schools and many which do exist are not seen as appropriate by many young people (Richters 1984, Finlayson et al. 1987). Most feel unable to discuss issues of sexuality or sexual activity with their parents, and they most often obtain information from their peers or from books and magazines. Because of earlier physical maturation, implicit and explicit sexual advertising in media material, and changing attitudes towards sexuality, teenagers are subject to stress and confusion. Conway (1982) also identifies the power of peer group pressure as an additional stress and the need for accessible and acceptable information for healthy development and preparedness for responsible parenthood.

Finlayson found that 'the greatest perceived needs of youth were of an interpersonal and emotional nature, rather than of a material one'.

The consequences of sexual activity on the lives of girls can be dramatic if they are not well

informed about contraception and sexually transmissible diseases. Contrary to common belief, sex education does not lead to an increase in sexual activity - the reverse is true (Collomb and Howard 1988).

The risk of STD infection for younger women is high. Early sexual activity and multiple sexual partners are linked with an increased incidence of abnormal cell development in the cervix. Submissions from medical professionals have indicated a high rate of human papilloma virus (HPV) infection and pre-cancer of the cervix in smear tests of teenagers. One estimate indicated that 60 per cent of young sexually active women could carry HPV. Sexually transmitted diseases are discussed further later in this chapter.

Bennett (1985) discusses the challenging medico-legal and ethical issues to be considered by medical practitioners regarding maturity and consent in relation to provision of contraception and abortion advice or referral for very young girls. Medicare cards are now being issued to minors over the age of 15. He also drew attention to the psychological consequences of sexual abuse and the possible long term effects of self-esteem and future relationships for many girls whose first sexual experience was rape, especially by someone known to the family. Each of these areas needs substantial research and development to provide guidance for practitioners in relating effectively to young women.

There is a general understanding and tolerance in our society of different ways of expressing heterosexuality which recognises differences of age,

personality and circumstance. This does not uniformly apply to same sex expressions of sexuality.

There are no Australian research data on the health of lesbian women, and no reliable estimates of the number of lesbians in Australia. A survey commissioned by *Cleo* (cited by Talbot 1985) estimated that 13 per cent of women in Australia (about 800.000) had engaged in some form of homosexual experience. One per cent of the total sample (men and women) were exclusively homosexual at the time of the survey.

Lesbian women in Australia have similar health needs to other women. Like other women, they complain of unsympathetic and belittling treatment by medical and hospital staff. One woman in a submission noted that 'a lesbian, when seeking health care, can never feel secure. She must always be wary of some level of discrimination. Unless she is particularly naive and/or inexperienced she will, to some extent, approach the situation defensively'.

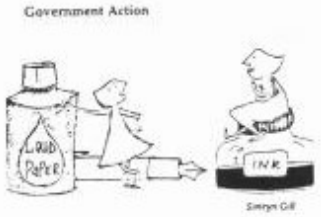
Lesbian women complain of their invisibility to policy makers and the bureaucracy, and the powerlessness arising from exclusion. In the consultations and submissions they sought wider community understanding and education of health care professionals so that their experiences within the health system could become more acceptable.

Women with disabilities also experience difficulties because their sexuality is often not acknowledged. Minter (1982) says: 'because I am viewed as 'handicapped' – a term referring to being 'unable' – then I am also viewed as being devoid of normal sexual responses'. Wilkinson (1982) notes that the sexual needs of people with disabilities are slowly being recognised, but more is required than acceptance of sexuality as part of personhood, and more is required than professional assistance in sex education and counselling. Opportunities for normal communication and relationships are needed. The Commonwealth deinstitutionalisation policies currently being implemented recognise this need.

During the consultation meetings and in a number of submissions the sexual exploitation of women with disabilities in institutions was raised as a necessary area for action, sometimes movingly and haltingly, by women with disabilities themselves. Vigilance of managers, the employment of trustworthy, professional staff and strengthening of legal protection are essential to eliminate such activities.

Women in their middle years are concerned at their limited access to accurate and balanced information about menopause. Because of the myths and misunderstandings about sexuality experienced earlier in their lives, this issue assumes great importance at a time when they are often affected by changing family circumstances. Initiatives like the development of the manual, *Women's health: the middle years*, by Westmead Hospital's Department of Community Medicine, and the provision of workshops, have proved very helpful for women. Additional initiatives of their kind would help to meet the needs expressed by women.

Other important issues of sexuality raised in the consultations and submissions which require monitoring relate to unintended outcomes of sexual activity such as sexually transmitted diseases (discussed later in this chapter), or outcomes for young Aboriginal women or women with disabilities who may be involuntarily administered contraceptives such as Depo-Provera or subjected to sterilisation procedures (pp18-20).



Abortion

Abortion is an issue of great concern to women. On the one hand, there is strong support for abortion on demand. This rests on the argument that women should have the right to control all decisions regarding their actions and bodies. On the other hand, there is strong support for the view that abortion should not be allowed or should be allowed only in limited and strictly defined circumstances. The question of whether, or under what circumstances, abortions should be performed and financed is one which there is no community consensus.

Bourne and Kerr (1982) reported on two samples of women seeking abortions in Queensland in 1973-74 and 1980, and compared their findings with studies in other areas of Australia and New Zealand. The studies demonstrated the range of ages and reasons for the women's actions, their poor contraceptive knowledge and changes in social attitudes over time. They concluded:

> It is a fundamental tenet of democracies that the laws embody acceptably community attitudes. Our examination of women seeking abortion does not characterise them as atypical but as a growing minority whose practices and views have to be considered in delineating the circumstances in which abortion is to be legally available.

A limited number of detailed studies have been undertaken

concerning contemporary community attitudes towards abortion in Australia with very few identified in a literature search. However, a comparative evaluation of three surveys (Fraser and Fraser 1982), provides some information about changing attitudes towards this sensitive and still socially divisive topic. The research populations were two groups of Victorian primary teacher trainees at an interval of five years and an Australia-wide *Age poll* sample.

The findings of the two studies were very similar, showing that although attitudes vary according to religious orientation and circumstances, 'a very large majority (81-91 per cent) favoured legal abortion in the case of rape or incest, birth defects and for the health of the mother' – between 81 per cent and 91 per cent (Fraser). A slight majority favoured abortion in cases where the child is unwanted or for unspecified reasons if the pregnancy is less than three months. Fraser also identified a need for further research to confirm the trend towards greater acceptance of abortion and to identify the underlying reasons for this change.

Questions about the provision of abortion services and the legality of these practices fall within the responsibility of State and Territory governments, and differences currently exist in Commonwealth, State and Territory abortion laws. Groups representing opposing views on abortion are seeking reviews of the legislation for very obvious purposes. Some groups are seeking the removal of abortion from Commonwealth and State Crimes Acts and the elimination of differences, while others are seeking to have current laws strengthened and enforced.

The Commonwealth Government's position on abortion is clear. It does not accept or advocate abortion as a form of fertility control or as a substitute for contraception. Medicare benefits are paid for necessary medical services, including pregnancy termination, where the patient has incurred medical expenses as a result of the service. In the Australian Capital Territory, where the Commonwealth Government has power to legislate on such matters, termination of pregnancy is permitted on health grounds only, in recognised hospitals (pp28-29).

Infertility and IVF

Around 10-15 per cent of heterosexual couples experience some problems with fertility, due to difficulties in either or both partners. The major causes of infertility in women are tubal blockages and endometriosis (a condition where the endometrium, the tissue that lines the uterus, grows on other parts of the inside of the abdomen). About 5 percent of all infertility is unexplained.

There are competing views on the extent to which infertility relates directly to pelvic inflammatory disease (PID). Swedish data suggest that 85 per cent of cases of tubal blockage are related to PID (Brown 1986). The Fertility Society of Australia in its submission on the Women's Health Policy stated, however, that 'sexually transmitted pelvic inflammatory disease probably accounts for less than half the cases of fallopian obstruction in IVF programs in Australia'.

The negative impact of infertility is undeniable. The infertile woman often experiences a range of very negative emotions concerning her condition:

> I felt my body was *cheating* me. It had let me down. I didn't like my body. It (infertility) makes you very contemptuous. In my most depressive stage, I felt a total *lack* of femininity. I reverted to ... a sort of neuter ... I felt terribly spayed. It was quite loathsome ... I didn't *really* believe my body was there (Crowe 1986).

Infertility can also have a negative effect on sexual pleasure, and women may feel socially stigmatised.

The existence of IVF technology can hinder acceptance of infertility. As West (1986) has noted, for some, pregnancy has now become a cure, a means of becoming socially normal, and a reward for the significant effort required in investigation and treatment of the problem. Some women argue that efforts should be directed to assisting infertile women to feel more accepting of themselves rather than towards expensive interventions to reverse the problem.

Despite this, the number of IVF pregnancies is rising rapidly. There were two IVF pregnancies in 1979 and 920 in 1987. It has been estimated that over 5,000 couples began IVF treatment in 1986. However, under 10 per cent of IVF treatment cycles result in an ongoing pregnancy or the birth of a child. The success rate is much lower when infertility is due to a male factor (Batman 1988). In addition, almost half of ongoing IVF pregnancies result in either stillbirths, babies with congenital deformities, or low birth weight babies, who may possibly suffer severe handicaps (Batman 1988).

IVF is also emotionally taxing and costly. Because IVF treatment requires daily blood tests for ten or more days, as well as ultrasound examinations and at least one full day in hospital each month, women on IVF programs may be absent from their jobs for considerable periods of time. Some women resign from their jobs in order to undergo IVF. Others rely on support or under–

Continued on page 41

More Snippets More Snippets More Snippets

POST-MARKETING SURVEILLANCE OF NORPLANT BEGUN

A 'post-marketing surveillance' pilot study of 618 users of Norplant, the five-year implant, was conducted in Chile, Thailand and Sri Lanka in 1987. The WHO Special Programme on Human Reproduction, Family Health International and the Population Council collaborated on it.

In the pilot study, women using Norplant generally had more experience of contraceptive use, and of hormonal contraceptive use in particular. Overall 45% of Norplant users reported bleeding disturbances after 6 months. They had more minor complaints than IUD and sterilization users, 14% compared to 8%.

A larger prospective study, involving 8,000 women, including controls who chose the IUD and sterilization, will now be launched in those same three countries and others where Norplant has been approved. The aim is to collect data on longer-term effects, both beneficial and adverse, of use. Women will be checked one week after starting use and then every six months. It will be the first-ever multinational study to monitor the effects of a new contraceptive over a long term. The length of the study has not been stated, nor what effects will be looked for.
(From: *Progress 7*, 1988, p. 1/6)

The Population Council has organised an international database to keep records of side effects reported on Norplant. It is not clear whether reports will be accepted from the above study only, or whether all doctors offering Norplant will be encouraged to send reports.

Training centres for Norplant insertion and removal, counselling and management of problems have been set up in Santo Domingo and Jakarta, and two others in Brazil and Egypt will be set up.
(From: *International Family Planning Perspectives* 14:2, June 1988, pp. 43-44.)
(Both of the above reprinted from the newsletter of the Women's Global Network on Reproductive Rights, September - December 1988.)

NEW TESTS AND TREATMENT FOR CANDIDA

There are 70 different strains of candida. Up to now, treatment has been hit-and-miss because tests have not shown which strain is responsible for the imbalance of yeast in the body. The Candida Research and Information Foundation in Toronto has developed a set of laboratory tests which answer this question, so that appropriate anti-fungal treatment can be identified. A candida 'vaccine' has been developed by an allopath/homeopath. It is a homeopathically prepared solution made with a small amount of a woman's own yeast.

For more information, ask *Healthsharing* 14 Skey Lane, Toronto M6J 3C4, Canada, where to write.
(From: Burstyn, 'New candida diagnosis and treatment' *Healthsharing* Fall 1988 and WGNRR newsletter Sept-Dec 1988.)

BIAS IN AIDS CONFERENCES

The USA National Women's Health Network recently did a survey of 35 AIDS conferences in 1987 and 1988. They found that most had been conducted by and for white males. Of conferences directed at a broad audience, in 1987 only 10% of presentations were about women and AIDS and in 1988 only 7%. In technical conferences (e.g. for doctors or lawyers) in 1987 only 26% of presentatons were about women and in 1988 only 11%.

In most cases, presentations about women portrayed us only as carriers of the virus, prostitutes giving it to clients, or mothers passing it to children in pregnancy. It is, therefore, not surprising to learn that an estimated 60% of women find out they are HIV positive only when their children are diagnosed (unstated where, presumed USA).
(From: *The Network News* Sept/Oct 1988 and WGNRR newsletter Sept-Dec 1988.)

MIGRANT WOMEN AND CANCER SCREENING

Three women researchers here in Australia are studying sociocultural factors associated with low uptake of breast and cervical cancer screening services among migrant women. They are focussing on Italian and Macedonian women, and exploring their attitudes to and knowledge of breast and cervical cancer.

Unusually, the researchers have set up an advisory committee for their work, to provide guidance relating to cultural issues, and to help to disseminate the research results among the women being studied. This committee includes women from the communities and those who have experience with research in those communities.
(From: *Women in Industry: Contraception and Health Newsletter*, 1988 and the newsletter of the WGNRR Sept-Dec 1988.)

W.H.O. GUIDELINES ON CERVICAL SCREENING IN DEVELOPING COUNTRIES

According to the World Health Organisation, cervical cancer deaths in developing countries occur most often among poor rural women over age 35. Yet most women screened in those same countries are young urban women, who are screened when they attend family planning clinics. This is because practice in developed countries, has been carried over to developing countries without taking into account scarcity of resources for other women.

The WHO recommend that developing countries with the most scarce resources only screen women between age 35 and 40 once, but try to include all of them. Those countries who can afford it should screen all women between ages 35-55 once every five years. This means that some individual women would be screened less, but more women would be screened overall. This should bring down the death rate.
(From: *International Family Planning Perspectives* 14:2, June 1988, p. 43 and newsletter of the WGNRR Sept-Dec 1988.)

More Snippets More Snippets More Snippets

THE PILL AND GENITAL TRACT CANCER

An epidemiological study of 47,000 women in Britain since 1968 compared incidence of genital tract cancers in ever-users and never-users of oral contraceptives. Overall mortality rates from these cancers were the same in the two groups. But the type of cancers that women developed was very different between the two groups.

There was a reduction in ovarian cancer among ever-users of the pill, but it was not statistically significant. There was also a reduction in endometrial cancer among ever-users.

Ever-users of oral contraceptives had a higher incidence of cervical cancer, and this increased the longer they took the pill. **Women who had taken the pill for more than 10 years had four times more incidence of cervical cancer than never users.** In ever-users, cervical cancer accounted for 75% of the invasive genital cancers and 74% of deaths from these. In never-users, only 31% of invasive cancers and 30% of deaths were from cervical cancer. The main reason why the mortality rate between the two groups is not different is that treatment for cervical cancer is so effective.

This study is weakened because the women's sexual practice was not compared, and there is not enough information on other relevant factors. However, the clinical results stand on their own.
(From Beral et al, 'Oral contraceptive use and malignancies of the genital tract', *The Lancet* 10-12-88, p. 1331-4 and the newsletter of the WGNRR Sept-Dec 1988.)

Editor's comment (written by the Women's Global Network on Reproductive Rights but which *Right to Choose* agrees with): *the implication is that regular cervical screening for women using the pill is crucial. This is now standard advice, because this study is not the first to show these results. However, in the developing world, cervical screening is widely unavailable, particularly outside urban areas, yet many women are using the pill. In developing countries, cervical cancer deaths from many causes are high. In the absence of screening and treatment facilities, aren't different guidelines for safe use of the pill required? Are women who decide to use the pill being taught to watch for signs of cervical abnormalities?*

PERTH: ANTI-CHOICE RALLY

State Members of Parliament exercised their choice not to attend a recent anti-abortion rally in Perth. Although each one was reportedly invited, none of the almost 100 MP's turned up.

One of the organisers representing fundamentalist religious groups publicly claimed to abhor violence, according to news coverage (well, it was a 'slow' news day). However, five of their colleagues are currently facing charges relating to a Rivervale medical clinic where abortions are performed. The five face charges of refusing to leave after police asked them to go, and were remanded until Jan this year. Three of them are men aged 29 or over who are students; the other two are women.

Anti-abortion and anti-violent? Well, that infamous anti-abortion terrorist, Joe Schiedler, was an invited guest to Western Australia a couple of years ago, but that trip was a fizzog for his hosts, too. ALRA understands that the Minister for Immigration would not look favourably on a visa application by Joe for a return visit. We think that anyone who truly abhors violence would not welcome him in the first place.

(From: *ALRA News*, Dec. 1988 Vol. 16, No. 2.)

SURROGATE PARENTING IN NSW

The NSW Law Reform Commission has published its Third Report into Artificial Conception *Surrogate Motherhood* (Dec. 1988). The Commission was set up to examine all aspects of artificial conception, and to make recommendations for legislation. Acts already exist in Queensland, Victoria, South Australia and Western Australia.

In the Commission's view surrogate motherhood is detrimental to the child, and as this is its main consideration, they believe that laws should be enacted to discourage it. At the same time the report states that respect for personal freedom and individual autonomy should be maintained. Unlike Queensland, where the Surrogate Parents Act 1988, bans surrogacy, (whether formal or informal, paid or altruistic), the Commission accepts that successful surrogacy can, and will, take place in private arrangements for altruistic reasons.

The Commission recommends laws that include strict deterrents for persons (including all health workers involved in advertising and arranging surrogacy, including friends and family members). Where surrogacy agreements have been made they would be regarded as void. There need be no specific provision for IVF surrogacy as it would be an offence for medical practioners to be in any way involved in surrogacy arrangements. All health workers should be encouraged to warn their clients and patients of the dangers of surrogacy.

The Commission did not examine the ideology of motherhood or the ways in which women's potential for pregnancy and parenting have been constructed. However they believe that surrogacy is an abuse of this potential, and that it is unreasonable to put the body of the surrogate woman to the service of the commissioning parties. Surrogacy "denigrates the position of women in society and the process of childbirth".

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woman with empty arms can be transformed by the scientists into a mother, the very identity the aborting woman is refusing. These are powerful representations, in a culturally symbolic language they assert that if the childless woman (or couple) is incomplete, then the woman who chooses abortion is choosing incompleteness, a spoiled identity. It is difficult, if not impossible to think of a culturally powerful image that makes motherhood refused a positive experience, except perhaps a religious vocation.

The widespread use of ultrasound in obstetrics adds further weight to the changing focus. During problem pregnancies ultrasound can be used as a tool of diagnosis and treatment, but in normal pregnancies it provides the 'first picture of baby' before there is a baby (Petchesky, 1987). In an ultrasound image the pregnant woman disappears and only the foetus remains, as 'autonomous as an astronaut on the moon' (Lejeune, 1987: 46) or floating in space like the last image in the film *2001* (Sofia, 1984). The visualisation of the foetus alone makes it possible to perceive the woman and the developing foetus as radically separate. These images deny the sensual experience of pregnancy. All of that growth and development is dependent and inside a woman's body. Women are not immune to this new representation of pregnancy; ultrasound has changed the experience of pregnancy in a significant way for individuals and for our culture. As feminists we need to make better sense of that change.

Demonstrations: here we go again, or do we?

At the end of July the Women's Abortion Action Campaign held a public meeting about the proposed private members' bills in the N.S.W. Teacher's Federation auditorium. There was a distinct sense of 'been here, done this' for many in the overflow crowd. There were messages of solidarity, educational talks by a W.A.A.C. activist and a lawyer, impassioned speeches filled with determination not to return to the past by a doctor and a State Parliamentarian, inspirational songs by the solidarity Choir. In the foyer there were posters, information leaflets and postcards to send to M.L.C.s, when the buckets were passed around people donated generously. A good meeting, with women (and a few men) ranging in age from school students to pensioners. In spite of the annoyance expressed by a number of veteran campaigners that we had to 'do this again', I think the meeting exposed many reasons for feeling encouraged about the outcomes of feminist struggles over the past nearly twenty years.

Why was I encouraged? Everyone on the platform was a woman, most with considerable experience in abortion politics and service delivery in N.S.W. The chair had been a member of Control, the first feminist referral service in Sydney and on the collective that established the Leichhardt Women's Community Health Centre. The W.A.A.C. activist has worked at one of the feminist abortion clinics as well as put in years of effort in reproductive choice politics including membership of the Board of Directors of Family Planning and attendance at international reproductive politics conferences. The lawyer has a considerable academic reputation in discrimination law and had available the stunning analysis of abortion politics by Ros Petchesky (1986). The doctor has been active for years in fertility control and women's health including a period of time at Liverpool Women's Community Health Centre and on the Board of Directors of Family Planning. The Parliamentarian has worked in a private abortion clinic and at Leichhardt W.C.H.C. and was recently elected to a safe seat. Many in the audience were similarly distinguished; we have been busy and many of our achievements have a quality of things that have always been there by those who missed specific struggles.

The audience included a large number of women for whom legal abortion has always been available, women who missed the past meetings because they were too young. The meeting was an eye-opener, so many different women, so much commitment, so much history. There haven't been many meetings recently that brought together a wide spectrum of the women's movement (no, of course I'm not glad the draft bills are circulating or that Greiner has made the other attacks on women). The success, however limited it seems, of past campaigns has changed the practice of feminist action in Australia. The sense of history and a recognition of the diversity of our chosen community, never very strong, are seldom a part of on-going practice. Young women today don't have much idea of what it was like to be exploring sexuality twenty or twenty-five years ago, much less forty or fifty years ago; women who began sexual activity in 1972 when Justice Levine made his ruling are in their thirties. For women beginning to be sexual in the eighties, the idea of a time before AIDS may seem idyllic. It is meetings about a common threat that reveal the bonds that unite us in spite of our differences in experience and outlook.

There have been other demonstrations and meetings, of course: outside Parliament House, in the streets, in suburban halls, women and men have passed petitions, written letters, sent in postcards, lobbied Parliamen-

tarians. I hope the M.L.C.s have exceeded their postage budget sending out replies because that will be a quantifiable indicator of the level of support for abortion services in N.S.W.! In addition, those meetings and opportunities to take action bring women into the chosen community of feminism at a time when the biological community of family is receiving so much emphasis by politicians. As many activists know, shared political work helps develop a social identity that is not dependent on father or husband or number of children. So I have been encouraged, both by the opportunity to reflect on past achievements and the possibility of expanding our chosen community.

What does it all mean?

This current crisis in abortion politics in N.S.W has highlighted both strengths and weaknesses in feminist theory and practice. We are relatively good at responding to a crisis with all of the appropriate political action, but less good at maintaining connections and sharing information between crises. I am not suggesting the formation of a bureaucracy to pass paper around, but rather that we give some serious thought to communication within and between issue areas – health and reproduction, education and training, welfare services, housing, child care, sexual assault, substance abuse, disability, ethnicity, Aboriginality, aging; just listing them reveals connections. Developing connections may make it easier for new members of groups and services to discover the history they have joined and thus to build on the past rather than repeat it or ignore it. As a first step, let's listen better when other women are speaking.

In general in Australia, it seems to me that feminists are good at local political action and/or fairly abstract grand theory. While I know individuals who are working somewhere between, there is just not enough of what is often called middle-level theory. This sort of 'regional' theory would be useful in understanding local struggles, sorting through similarities and differences. In the area of reproduction this sort of work is particularly sparse. Women come to meetings on the new reproductive technologies knowing virtually nothing about past struggles around reproduction and have few local sources available. When I give papers on contraception or abortion I am struck by the lack of prior knowledge beyond personal experience; women speaking on workforce participation and activism don't have the same experience (at least my experience has been different when speaking on E.E.O.). The changing language in the abortion debate reminds us how important the development of analytic tools is.

We are trying to develop a politics of reproduction in a political climate in which 'choice' is on the banners of the economic Right and the banners of medical practitioners offering suspect 'treatment'. It is a climate in which the moral Right tries to monopolise the positive aspects of family life and in which politicians of most hues try to mobilise the same family values in support for cutbacks in welfare, health and education spending. Feminist visions of a combination of autonomy for women within supportive communities do not seem credible to most people. Reproduction never fit very well with those visions in the past and so was easy to privatise.

'My body, my life, my right to decide', we chant. The need to work out a 'regional' theory of reproduction that includes detailed consideration of 'localities' like abortion, contraception, lesbian experiences, new reproductive technologies, AIDS and female sexuality may provide the opportunity to figure out what we mean as we chant.

Rebecca Albury

Thanks to Margaret Kirkby for the on-going 'seminar' on abortion politics that has formed one part of our friendship.

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Natural Methods of Treatment for Endometriosis

This article has been written for the Endometriosis Association by a naturopath from Maryborough, Heather Barber, who gave a talk on the same topic to the Ballarat-Maryborough endometriosis group last year.

As a naturopath I use different natural methods to treat health problems. Some of these are:

* herbal and homeopathic remedies;
* vitamins and minerals if needed;
* biochemic cell salts;
* Bach flower remedies;
* touch for health (muscle testing then balancing the body's nerve, blood and lymph supply to areas needing help);
* reflexology (acupressure points on feet, hands and other areas);
* massage and adjustment if needed;
* diet;
* iridology as a means of seeing which areas in the body are not functioning properly.

These are natural remedies available for the following symptoms felt by many endo patients:

* pain;
* depression;
* PMT;
* period abnormalities and flooding;
* candida;
* weight gain.

One thing that's helpful if someone doesn't know where to start is to build up one's general health - that will improve many symptoms. To do this have the best possible diet: cut out all rubbish and concentrate on natural unrefined foods, plenty of fruit, salads, steamed vegetables, water and wholegrains. Also have sufficient exercise to keep things moving and to improve any depression. Try to relax and eliminate stress - not easy - but see if there's a way to cut down on some of the stress you're having. Do something you enjoy doing: join a class, have a massage, or take up a hobby that you've dreamed of doing but never started.

Some can improve their endo by seeing to some of the other health problems that they know about - perhaps by seeing a naturopath to check what's not working or by doing some reflexology themselves.

One thing that could be contributing to your health problem is candida. This is often only familiar to many as thrush but it causes a wide range of problems, including endometriosis for some.

Candida is a yeast-like fungus that is normally found in the respiratory and gastro-intestinal systems and on the skin but because of taking cortisone, the pill or antibiotics over a period of time it can get out of control and invade the tissues.

Some of the symptoms of candida are:

* inability to lose weight
* confusion
* sudden crying spells
* agoraphobia
* explosive irritability
* palpitations
* swelling of the ankles
* shortness of breath
* chronic cough
* recurrent bronchitis
* digestive upsets
* colic
* depression
* mood changes
* hyperactivity
* headache
* blurred vision
* chilliness of limbs
* poor memory
* loss of self confidence
* sore throat
* blocked ears or nose
* ear pain or infection
* nasal itching
* diarrhoea

* perianal and genital itching
* itchy scalp
* dry flaky skin
* athlete's foot/tinea
* psoriasis
* chronic rashes and itching
* mouth ulcers
* fungal infections of the nails
* shaky and irritable when hungry
* cravings for sweets or alcohol
* bruise easily
* upset by perfumes, tobacco smoke, insecticides, fabric shop odours, etc
* bladder frequency
* fluid retention
* cystitis
* recurrent thrush
* PMT
* irregular or painful periods
* endometriosis
* arthritis
* muscle aches and cramps
* recurrent infection
* allergies
* numbness or tingling

The treatment for candida is to eliminate all yeast foods (i.e. yeast bread, brewer's yeast, vegemite, mushrooms, vinegars, alcohol, soy sauce, peanuts and mouldy fruit). Also eliminate sugar as this feeds the yeast and don't have too much fruit as they contain natural sugars. Watch for the presence of mildew (which is fungus) on walls and housepaints, etc. The drug Nystatin can be taken or natural homeopathics can be used instead. *(See also article on Herbal Remedies for Vaginal Infections).* Also build up the immune system, Lactobacillus acidopholus and evening primrose oil are beneficial as are other remedies to help control this. Garlic can be used also. Candida can be passed back and forth between partners so it's necessary to treat both partners.

From Endometriosis Association Newsletter (Victoria) Feb 1989 issue.

"DESPERATELY SEEKING GENE"??

Want to know more about reproductive and genetic engineering techniques and their implications?

On Tuesday 8 August 1989 there will be a meeting and video night at 7pm at Women's House, 63 Palace St, Petersham. Come along to hear about what's happening in Australia and internationally, meet other women interested in these issues, and see "The Soft Cell: A Feminist Analysis of Reproductive and Genetic Engineering".

ALL WOMEN WELCOME. Drinks provided. Entry by donation.

Organised by FINRRAGE For more info please contact:

FINRRAGE (above address) or
Ph: (02) 569-1782.

media and in some government reports rely on the same two equations as the anti-abortion propaganda. Here, not only does foetus equal baby, but fertilised egg equals embryo equals baby.

The choice of the word embryo for this very early stage of development encourages the reader to imagine something other than a group of undifferentiated cells. (Remember, in school biology, this stage was called the zygote.) Those experimental embryos in Melbourne will not have begun cell division, no one will know if the processes would even begin.

For couples in an infertility program the fertilised egg carries their hope for a baby. For doctors and politicians like Nile and Harradine, the use of the word embryo has other meanings. It is a tactic to get us to deny our perception of the world and to accept theirs.

There are objections to experimentation with embryos and fertilised eggs that have nothing to do with the "potential life" of the cells. Those objections come from an analysis of the economic and social relations in which the experimentation occurs, from the vulnerability of the women and men in infertility programs.

It is true that human development begins with the union of egg and sperm. However, the continuity of development is not assured, nor does it provide guidance about how to treat either embryos or adults. Moral decisions can be made only with thoughtful consideration of the whole social situation. It is seldom easy or clear-cut.

In addition, these representations rest on the equation of woman with mother. The experiments and programs are supposed to allow women to become themselves, to become mothers. The researchers seem to offer this justification in answer to every challenge as if no other argument is needed. Even more than embryo experimentation, the sister surrogacy cases show that nearly anything can be justified with an appeal to motherhood.

Yet motherhood is also a social relationship, an experience of emotional connection, not a simple biological process. In a commonsense way people experience the social and the biological as linked.

The new reproductive technologies challenge that commonsense view. At the same time, various participants in the debate about the use of the technologies rely on the blurring of the two aspects of the same relationship to support their positions.

The medical researchers appeal to the social relationship that is the outcome of the successful use of the technology to justify their experimental biology. The Right-to-Life opponents of embryo experimentation rely on the assumed identity of the biological and the social to make their argument seem self-evident. Both of these are misrepresentations of the relationship between social life and biological processes.

Politically, this commonsense blurring of meaning works to set the agenda for medical research and moral debate about public policy. Respect for human life must not be reduced to respect for foetuses or embryos. In the complex "real world" of social and economic relationships a woman's life is a human life.

The only way to respect human life is to let women make decisions about their own lives. It is not, after all, decision-making women who pose the threat to all human life in the form of warfare or nuclear weapons.

Rebecca Albury

Reprinted with permission from *Tribune* Aug 10, 1988.

Abortion in Hungary

The issues surrounding abortion - the underlying dilemmas of human rights and choices; heated emotions in defending and offending them; as well as serious critiques of health care provision in executing them - have got, from time to time, into the focus of political debate during the last thirty-five years in Hungary.

The classical 'fifties' period of pre-1956 Stalinism was dominated by a strict and anti-humanist population policy which forced the birth of each and every foetus. Its ideological emphasis was on the military and production requirements of Hungary, the 'national task' of every male and female citizen was defined as negating personal choice in the overriding interests of national population requirements. The 1953 abortion law strictly prohibited abortions, refusing even the possibility of abortion on medical grounds.

One of the signs of political liberalisation in the early 1960's was the abolition of that law. This declaration of private choice and of the right for personal decision-making in family affairs has led to the introduction of a system that made abortion literally free. That achievement has been regarded by the public as an unacknowledged but important victory of the 1956 revolution. The counter-effect of the formerly forced population policy had been the speedy decline of the fertility rate for several years. The number of abortions performed following liberalisation nearly equalled that of live births. This prompted the introduction of a childcare grant (an allowance for three years for full-time motherhood, paid by the Social Security, with job protection at the workplace) as a positive attempt towards stimulating population increase in the late 1960's. Its political aim was to ameliorate the conditions of bringing up children and to express a liberal attitude towards the family. It was hoped this would rehabilitate the important social role of the family while at the same time avoiding the forced 'collectivisation' of the earlier period.

This liberal period ended in 1973 when the new restrictions on freedom of choice within family affairs were introduced as part of the more restricted political climate. There was, however, no retreat to the extremes of the early fifties. The regulations in operation at present were introduced as part of a package of new incentives to increase population growth. This package included a reassertion of the rationale of national over individual interests and attacked the 'unhealthy' spirit of individualism as unacceptable in a socialist society.

The prevailing regulations on abortion are as follows: permission for an abortion is granted by a committee operating within outpatient clinics. (No other avenue for abortion is available within the Hungarian health service). The committee meets twice weekly and consists of two or three doctors from the clinic and two voluntary members of the neighbourhood. The influence of the lay members on decisions is generally insignificant, their participation on the committee being largely nominal. The committee examines cases in terms of their medical and social implications, and has full power to accept or refuse the application. If their decision is positive, then the abortion can be carried out within a week. There is a strong commitment to performing abortions as early as possible in the interests of the woman's health. Terminations almost always occur within the first twelve weeks, and exceptions (made for serious medical reasons only) are rarely made. Demonstrated disability of the foetus however can be a reason for abortion between the 12th and 24th week. The positive feature of the system is that it takes the 12-week limit very seriously and therefore waiting lists for abortion are generally much shorter than for other medical treatment.

Nevertheless there remain many serious problems with the present system. The first is that the criteria for abortion are quite restricted. The regulations introduced in 1973 list the acceptable conditions for a termination. These are: if the woman is unmarried; if she has at least three children; if she is over thirty-five (the age limit was changed to forty in 1980); if the family has serious housing problems or lives in poverty; or, if a detailed examination exposes serious health hazards for the woman. But, for example, the shortness of the period since the last pregnancy or birth (a well-known health hazard) is excluded from the list of acceptable criteria. These limits have obvious and unavoidable social consequences: better-educated women learn the regulations and are sophisticated enough to argue convincingly. The applications procedure is humiliating for all

women, even those who have quite a good chance of a positive decision. The 3,500-3,600 refusals yearly (some 7-9% of all applications) affect those who have less access to the hidden agenda of the regulations. The restrictions can be seen, then, to cause and increase existing social inequalities.

The second problem with the restrictions on the availability of abortion is the curtailment of the civil right to have personal control over this most personal and individual decision. The limitations force unwanted births, thereby causing serious emotional and material difficulties to those affected (both the potential parents and the child). The arbitrariness of the decisions of the committee is often evident, and gives rise to prejudice and suspicion. The whole procedure is very degrading and suggests that 'unwanted pregnancy' is a personal failure, even a semi-criminal deviance, and the powerful medical committee often behaves in the manner of legal courts by reinforcing these assumptions of 'criminality'. These features are affirmed by the fact that the committee has the right to impose a financial charge for the abortion, even in cases where permission is practically automatic. The decision as to whether the abortion is free of charge or whether the woman has to pay anything between 10 and 18% of her monthly salary is made at the discretion of the committee, and is an obvious mechanism for imposing punishment for unwanted pregnancies. Moreover, many women are reluctant to argue for their right to free medical care in case this might jeopardise their chances of gaining permission.

The third negative feature of the system concerns the conditions under which abortions are performed. Since women applying for abortions are regarded as deviant, it is not surprising that their treatment differs significantly from 'normal' cases within the health service. Women are placed in overcrowded wards and often do not receive adequate medical treatment and medication. This procedure and style of treatment increases psychological stress, reinforces feelings of guilt and causes long-lasting problems for both women and their partners.

In light of these existing conditions surrounding the availability of abortion in Hungary, the pro-abortion movement has focused its main attention on procedures within the medical committees. This has been mainly concerned with ensuring that the medical committees recognise women's rights and administer equitable treatment for all women. Another focus of the pro-abortion movement has been on the health issues for women undergoing abortions. No serious challenge has been made however to the 12-week limit on abortions.

Julia Szalai

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standing from their employers. Either way, these difficulties add to the stress involved in participating in IVF. In addition there is a cost to the patient of about $700 or more per treatment cycle (Batman 1988).

There is a range of views on the value of IVF. analysis of responses tot he Commonwealth's discussion paper on IVF (Batman 1988), released in May 1988, is to yet complete. While the majority of submissions favoured continued funding of IVF, the cost of IVF is often cited as a concern. Each IVF baby costs more than $40,500, of which the Commonwealth pays over half. There is also concern about the lack of attention given to the prevention of infertility in the first place:

> ...while these large amounts of money are spent on in-vitro fertilisation, the study of the causes of infertility or its primary prevention in Australia virtually is neglected - a gross imbalance. There may be very important preventable factors, for example the use of intrauterine contraceptive devices, pelvic inflammation, and venereal diseases such as chlamydial infections. We urgently need more epidemiological research (Stanley 1988).

A number of submissions noted a need for support services and sensitive counselling for infertile women. Much of the benefit one infertile woman had received from the IVF program was due to the support of other infertile couples (pp30-31).

Reprinted from ***National Women's Health Policy*** *Commonwealth Department of Community Services and Health, AGPS Canberra 1989.*

Herbal Remedies for Vaginal Infections

It is very easy to upset the delicate chemical balance of the vagina. Your emotional state, the contraceptive pill, pregnancy, diabetes, antibiotics, overwork, poor diet, irritating chemicals like soap or vaginal deodorants, nylon pants, pantyhose, tight pants, can all upset the ecology of the vagina and lead to infection. Vaginal infections can be extremely hard to shift, especially as the chemistry of the vagina changes throughout the month. For a healthy vagina, wear cotton underpants only and don't wear tight jeans. At every opportunity expose your vagina to sun and fresh air. Avoid using chemicals, including strongly perfumed soaps (Pears is a mild soap). After going to the toilet, wipe yourself from front to back and wear clean pants. If you are having a bad time emotionally, make sure you get enough sleep and a good diet - eat lots of fresh fruit, vegetables and protein (eg. meat, fish, eggs, nuts, beans, mild, cheese and yoghurt).

Even if you intend to treat yourself, get a vaginal swab done so you can find out exactly what type of infection you have.

Herbal Remedies

With the herbal remedies listed below, you may have to try each of these one by one until you find one that works. Because there are different causes of vaginal infections and people are so different, what works for one person may not work for another - you need to find out what works for you.

OINTMENTS: Apply these liberally on a tampon or just with your fingers inside the vagina and around the vulval lips.

Golden Seal and **Comfrey** are both available as ointments. So is **Thuja**, a fungicide which is supposed to kill Monilia and Trichomonas. **Calendula** ointment is a mild soothing antiseptic, a sort of herbal savlon. **Comfrey** ointment can be applied on Herpes sores.

DOUCHES: These are *not* necessary if you haven't got an infection as the vagina is self-cleansing. If you have an infection, douching is a good way to apply medicines to the actual infected area. If you don't have a douch, try spooning it up.

White Pond Lily and **Golden Seal** are both soothing, antiseptic herbs that can be applied with a douch. You can make a tea of them, but the fluid extract is stronger (one tablespoon of extract to one cup of warm water). Douche with **vinegar** or **lemon juice** (one part to three parts water) if the vagina is too

alkaline (ask at a women's health centre for details of how to test the acid/alkaline balance of your vagina).

Rosemary and **Sage** are traditional female herbs. Try douching with a tea made from one teaspoon of the herbs in a pint of boiling water and let it draw until cool enough to use.

Comfrey is a powerful healing herb for all inflammations. Try douching with Comfrey tea. You could also try douching with **Marshmallow** herb which is soothing.

MEDICINES TO BE TAKEN INTERNALLY: While being used externally, **Comfrey**, **Golden Seal** and **Thuja** should also be taken internally. They can be taken in tincture form - 10 drops of tincture in water three times a day.

Cornsilk is also very soothing. You can take the tincture or if you grow corn make a tea with the fresh silky part.

Take **garlic** regularly - a clove a day or, more pleasantly, garlic capsules, for any infection. Garlic is 80% sulfur and acts as a natural antibiotic. You should also take extra Vitamin C.

The internal herbal medicines may take a week or two before you start noticing a difference, but the douches and ointments should relieve the symptoms within a couple of hours. For a complete cure, you should continue until a swab shows that the infection has gone.

Should the infection recur, simply repeat the treatment. If it keeps coming back... see a Herbalist or Naturopath.

From a pamphlet produced by Liverpool Women's Health Centre.

Women and AIDS Project

The Women's Information and Referral Exchange (WIRE) intends to produce a comprehensive booklet on women and AIDS, for which it has received funding from the Commonwealth Government's National AIDS Program.

The aim of the project is to provide the sort of information women want about AIDS including: anti-body testing, AIDS and the workplace, children, safe sex alternatives and information for women directly or indirectly affected by AIDS.

It is estimated that the booklet will be released around Sept/Oct.

Women and AIDS Project
3rd Floor
238 Flinders Lane
Melbourne 3000

Abortion in the Republic of Ireland

The year 1980 marked a turning point in the Irish Republic in the debate over reproductive rights. It was the year when contraception was finally legalised, albeit in a restricted form. Women's organisations had been to the forefront in successive campaigns for full legalisation through the 1970's. The new Act was a highly restrictive and unworkable piece of legislation: to get contraceptives you were supposed to be married and to have a medical prescription. Ironically, family planning clinics had been defying the law right through the 70's. They had managed to exploit a loophole in the law, highlighted by a constitutional case in 1973, allowing contraceptives for 'personal use' but prohibiting their importation, sale and promotion.

Despite the restrictive nature of the new legislation, Right-wing forces within the State interpreted the change as a major and ominous defeat. It represented the first real break, in the area of social legislation, between the laws of the State and the teachings of the Catholic Church. Whereas in other countries the Catholic Church had been forced to accept new and changing social realities, in the Irish Republic it has stubbornly maintained the most rigid positions on 'mixed religion' marriages, contraception, divorce, abortion and sexuality. In the process, it spawned myriad Right-wing, fundamentalist-style Catholic organisations. They are its front line. Family Solidarity, the Responsible Society, the Society for the Protection of the Unborn Child (SPUC) and others are the new face of Catholicism. Alliances have been formed with older, more established organisations of the right, such as Opus Dei and the Knights of Columbanus. All these organisations share an obsession with and a fear of human sexuality: they oppose divorce, sterilisation, contraception, abortion and homosexuality.

The defeat over contraception spurred on the right to forge a new and openly campaigning alliance, with abortion as their chosen issue. A new organisation was launched, the Pro-Life Amendment Campaign (PLAC), which acted as an umbrella organisation for the various individuals and groups. The aim of PLAC was to campaign for an amendment to the Constitution, by way of a referendum, asserting the 'right to life of the unborn'. At this time abortion was already illegal in the Irish Republic under the 1861 Offences Against the Person Act, a 19th century piece of British legislation which had been carried through into the newly established Irish Free State (which later became the Republic) following political independence in 1922.

This Act made abortion illegal under all circumstances, including severe medical complications and rape. PLAC was campaigning for an amendment to the Constitution which would have the effect of preventing the enactment of any legislation dealing with abortion, without a national referendum. The fact that abortion is already illegal within the Irish State has meant that Irish women who choose to terminate a pregnancy, for the most part do so in England. Official figures show that about 5,000 Irish women go to England every year to have an abortion. The number of Irish women going to England for abortion has risen steadily since the passing of the 1967 Abortion Act in Britain. These figures represent only those women who give Irish addresses. Estimates put the total figure at 10,000.

PLAC emerged as the most powerful campaigning group in recent Irish history. Within a matter of months it had secured the commitment of the two major political parties to the holding of a referendum to amend the Constitution. No other campaigning force, despite drawing enormous numbers of supporters and high levels of organisation, has managed to shift the Irish political system so rapidly. PLAC was openly supported by most sections of the Catholic Church, whose infrastructure was intensively used during its campaign. They used the most sophisticated public relations techniques and were clearly *very* well funded.

For nearly two years, between 1981 and 1983, the battle raged between PLAC and the Anti-Amendment Campaign (AAC), an alliance of feminists, left-wing and progressive forces. The amendment issues dominated newspapers and T.V. and acted as one of the most divisive issues in recent Irish politics. Professional associations, cultural organisations, community associations, women's groups and political parties were all forced to state their position, amid an atmosphere of increasing tension and 'moral blackmail'. The medical and legal professions split down the middle with doctors' and lawyers' groups forming for and against the amendment. Those who came

out against the amendment were labelled 'murderers' and 'sluts'. Insidious political literature was distributed to garner forces by stealth against individual politicians who joined the AAC. Not one of the mainstream political parties argued in favour of a 'woman's right to choose', although the Labour Party and sections of Fine Gael (Christian Democratic Party) argued that the amendment was unnecessary as abortion was already illegal.

The outcome of the referendum produced a 2:1 vote in favour of the amendment. Just over half the eligible electorate voted. The strongest vote against the amendment came in urban, mainly middle-class areas. The actual wording of the amendment which now forms part of the Irish Constitution reads as follows:

> The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees to respect, and as far as practicable, by its laws to vindicate that right(1).

One of the most interesting aspects of this amendment is the wording itself. The ideology which shaped the amendment draws little on traditional Irish Catholicism; it is, in fact, the influence of the American 'pro-life' movement and particularly its ideology of foetal rights which provides the framework for it. The rhetoric of rights is not one which is rooted in the prescriptive-style Catholicism which has been imposed on Irish people. Rather, Irish social history is littered with examples of bitter conflicts over questions of rights and the role of the State. As late as 1951 the Catholic Church opposed a welfare scheme for pregnant women and newborn infants, on the basis that the State should not interfere in family welfare.

Yet in this amendment we have Right-wing Catholicism formulating a constitutional amendment asserting foetal rights and looking to the State to 'vindicate' those rights. In effect the battle to amend the Irish Constitution is an integral part of an international movement to undermine gains made by the women's movement in the sixties and seventies. The right's victory in the referendum meant that the Republic of Ireland became the first country to enshrine the 'right to life' of the foetus in law - a victory being used to strengthen and consolidate its ground in many other countries.

The consequences for Irish women have been severe. This amendment puts the right to life of a pregnant woman on equal terms with the foetus she is

carrying. Without a doubt, this is a radical redefinition of woman under the law: Irish women have been recategorized to be equal to that which is *not yet born.* The legal ramifications of such a situation are immense. What happens in a case where a conflict between the life of a pregnant woman and her foetus develops?

Sections of the American right are arguing in favour of a situation in which a pregnant woman can be forced to behave in a particular manner 'in the interests of the foetus'. Can this amendment be used to restrict the lifestyle of a woman during pregnancy? Ruth Hubbard has explored the implications of establishing foetal rights in law. In her view, the New Right is gradually moving towards a position which characterizes pregnancy as:

> a conflict of rights between a woman and her foetus [within which] attorneys and judges (predominantly male of course) have injected themselves into the experience of pregnancy where they have appointed themselves advocates for the foetus (Hubbard, 1984).

It is this kind of thinking which informed the Irish Right-wing lawyers who formulated the wording of the anti-abortion constitutional amendment. It wasn't considered sufficient to insert a clause into the Constitution prohibiting the legislature from legalizing abortion. The amendment as formulated went very much further than that, establishing the 'right to life' of the foetus and rendering the life of a pregnant woman equal to that of her foetus.

Since the passing of this amendment into law, the right in Ireland have by no means been content to rest on their laurels. Within two years, the Society for the Protection of the Unborn Child, one of the key member groups of PLAC, had issued civil proceedings against women's clinics who were offering a non-directory pregnancy counselling service to Irish women. These clinics (Open Line Counselling and Well Woman Centres) were the only agencies providing information on all the options facing women with unplanned pregnancies, including abortion (involving travel to England). SPUC alleged that the clinics were acting in breach of the 8th Amendment to the Constitution. On 19 December 1986, Mr Justice Liam Hamilton, President of the High Court, granted SPUC

"The committee on women's rights will now come to order."

an injunction against the pregnancy counselling services. As a result of this ruling, Open Line Counselling has been forced to close down and Dublin Well Woman Centre has suspended its counseling services. In the course of his ruling Hamilton assumed that the 'unborn child' which was to be protected by the Constitution came into existence from the 'moment of conception', an assumption which itself side-steps major debates within the scientific community. An appeal against this judgment was lost in March, 1988.

The implications of the Hamilton judgment have stunned the women's movement and other democratic organizations within Ireland. In effect, information and advice concerning abortion facilities in Britain or elsewhere can no longer be publicly made available to women in the Irish State. Justice Hamilton argued that the 'right to life of the unborn' is a more fundamental right that the 'right to information'. Ironically, a further constitutional referendum was held within a year of this ruling to coincide with the Irish Republic signing the Single European Act. One of the main aims of this Act is the creation of a more unified and integrated market among the member states of the European Community. Meanwhile access to basic information by Irish women on services available across the Irish sea has been deemed unconstitutional.

However, the Hamilton ruling has not stopped Irish women going to England for abortions, although more and more women are travelling without advice or support of any kind. Its effect is to remove information from the public arena and drive it underground whilst creating an atmosphere of fear and paranoia. A clear example of the level of fear emerged recently when a document containing legal advice on the abortion issue for RTE (the national radio and television service) was made public. This document, which was circulated to all programme-makers to be used for programme guidelines, argued that the Hamilton ruling meant that no one could put forward the view that women should avail themselves of abortion facilities outside the State. It further stated that *no live programmes* dealing with abortion should be broadcast in case such an event should occur.

There are some sources of information still open to women in Ireland. British magazines, such as Cosmopolitan, continue to sell despite the fact that they carry information on abortion facilities in England. Emergency counselling phone lines have been established, operating in a fragile financial and legal climate, while in England the Irish Women's Abortion Support Group has been providing invaluable support to women arriving to avail themselves of abortion facilities. One of he consequences of this situation is that many Irish women who decide on abortion will be forced to waste critical time securing the information and advice they need. In this context, Alton's bill, which serves to shorten the period during pregnancy when an abortion can be performed, could leave an increasing proportion of Irish women beyond the time limit.

Abortion has not been the only issue which the Right has concerned itself with over recent years. The same Right-wing alliance formed the major force of the anti-divorce campaign in 1986, when another referendum was held aimed at removing a

constitutional ban on divorce. This amendment would have paved the way for divorce legislation but was heavily defeated, once again by a 2:1 majority. Before the announcement of the referendum, opinion polls showed a clear majority in favour of divorce. Within a short space of time, the anti-divorce campaign managed to upturn all the predictions of opinion pollsters, by emphasizing the economic position of women in Irish society, which Right-wing ideology reinforced accross the world.

Looking back over the seven-and-a-half years of this decade, one can only conclude that the abortion referendum and the Hamilton judgment which followed constitute a serious and important setback for Irish women. Legalization of contraception marks a victory, but one that had already been reflected in the sexual practices of Irish women long before the law was actually changed. At another level, the abortion issue moved out of the realm of 'taboo subjects' and became the most hotly debated issue for some time. Extreme Right-wing groups were forced out of the woodwork and into the political arena. For so long the

Right in Ireland relied on a diffuse, hidden process of exercising power. The abortion referendum changed all that. The Right emerged as an extremely powerful campaigning force but one that can no longer assume its authority, but rather must assert and very often impose it.

Notes

Ursula Barry is a social researcher and lecturer in Economics and Sociology at the College of Technology, Bolton Street, Dublin. She is the author of Lifting the Lid: A Handbook of Information on Ireland (Dublin: Attic Press, 1986). She is a feminist researcher and activist.

1 Eighth Amendment to the Irish Constitution, September 1983. Ireland has a written constitution which acts as the basic legal framework of the State. Statue law can be challenged on the basis of whether or not it is compatible with the Constitution. The Constitution can only be changed be referendum.

2 Emergency Counselling Line: telephone Dublin 680043 or 794700.

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reprinted from Feminist Review, no.29, May 1988

WOMAN WINS IN QUEENSLAND

Despite misogynistic reporting in the mass media a Queensland man lost in his attempt to stop his ex-wife having an abortion.

The couple had a 4-month-old son when they decided to have a second child to save their marriage, the court heard, but the woman changed her mind after they separated.

The man's application for an injunction was based on whether the foetus has rights under common law, and at what stage during the pregnancy those rights exist. The Court heard that the man was seeking the injunction because he was against 'killing the child'.

In rejecting the application, Judge Linder-mayer said he had considered the fact that the foetus grew in the wife's body, and not that of her husband. Another consid-eration was that the marriage appeared to have broken down and the woman was now living in a relationship with another man.

The granting of an injunction would force the woman to carry a foetus which "she clearly does not want and which she may resent in those circumstances".

In support of his decision, Judge Lindermayer quoted a precedent set in 1983 when the then Chief Justice of the High Court, Sir Harry Gibbs, refused to grant an injunction to stop an unmarried Queensland woman having an abortion against the wishes of the father.

Lawyers for the man ruled out an appeal against the decision. However, the Queensland President of the Right to Life Association, Mr. Douglas Kerr, said urgent advice would be ob-tained from QC's to determine whether the Attorney-General, Mr. Clauson, should be petition-ed to appeal.

(Info from *Sydney Morning Herald* 13/7/89)

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Depo-Provera is an injectable contraceptive that, like the Pill, is a synthetic hormone, in this case progesterone.
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* women stop having periods
* some women have prolonged or unpredictable bleeding
* loss of interest in sex
* large weight gain
* delay in return of fertility
* depression, headaches, bloating

UNKNOWN EFFECTS
World Health Organisation studies suggest an increased risk of cervical cancer.
Also under investigation is the development of infants breast-fed by mothers using Depo.

IRREVERSIBLE
There is no known antidote to Depo, so any effects will last up to 3 months and in some cases up to 5 years after one injection.

Your doctors may say that Depo is very easy to use and has few side effects. The problem is that you can't be sure until you've tried it. This may mean you'll be stuck with the symptoms until they wear off. Depo Provera is the contraceptive over which YOU have least control. Depo is a very convenient drug for the busy doctor and health worker. It can be given with little or no explanation apart from "Come back in 3 months for another injection"

There are women in Australia receiving Depo in this way, particularly:
* women in mental institutions;
* women who are developmentally disabled.
* migrant women who speak very little English.
* Aboriginal women in rural and city areas.
* women who are considered 'unwilling' or 'unable' to use any other contraceptive.

Given what is known - or rather what is NOT known - about this experimental drug, we, the Anti-Depo Campaign, cannot recommend its use and we call for the removal of it from the market.

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