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Editorial

Dear Readers,

We hope you enjoyed the last issue of FINRRAGE (Australia) in July, 1997. Due to illness and a family death the promised four issues of FINRRAGE (Australia) never made it into press in 1997. Nevertheless, we sincerely hope that you, our subscribers, will continue your support. The Journal depends on many factors: adequate financial support, your submissions, and heaps of time and energy from the co-ordinators. All these elements have contributed to this edition and so far seem to be in motion for the next one too.

We are pleased to announce a renewed group of FINRRAGErs interested in resistance to reproductive and genetic engineering. If you would like to become an active member of FINRRAGE (Australia) please contact the co-ordinators.

Again, thanks to all those who renewed your subscriptions in the last three months. Here is the first issue for 1998 and we have plenty more planned. This issue has articles ranging from surrogacy, contraceptive technologies to abortion. Also, with the current debate surrounding abortion, we thought we would include the FINRRAGE (Australia) submission for your interest. We have also included a conference report on the recent Health for all into the 21st Century - Reproductive Rights and Responses Conference in Canberra, Australia.

FINRRAGE (Australia) continues to support the international campaign to stop anti-pregnancy vaccines. T-shirts are still available which display a woman stamping out the vaccine shown on a previous edition of the FINRRAGE (Australia) Newsletter.

If you would like to contribute to FINRRAGE (Australia) with either articles, conference reports, announcements and news, and views nationally and internationally, write to the co-ordinators at the following address. Preference is for copy to be submitted in Word 5 or 6 on Macintosh discs (we can convert IBM too!!) and email is also fine.

We hope you enjoy this issue of FINRRAGE (Australia) and continue to support us by renewing your subscription. All going to plan, the next issue will appear in July and we look forward to your contributions and comments.

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Letter to the Editor

To the Editors and the Readers of FINRRAGE,

FRESH DONOR SPERM WARNING

A GERMAN woman has been infected with the AIDS virus through artificial insemination with fresh donor sperm. Doctors are now warning against using fresh donor sperm as this does not allow enough time for tests to be made to establish that the sperm is safe to use.

As long as quarentine storage (of a period of three months) of anonymous sperm donation is not mandatory in all countries, artificial insemination still has to be taken into consideration as a source of HIV infection,

Dr Bertfried Matz wrote in a letter to The Lancet journal. Although the sperm donor had been tested negative for the HIV virus at the time of insemination, three months later when he was re-tested, he was HIV positive. Further tests on both the woman and the donor showed the viral sequence in both of them was identical, suggesting the woman was infected by the man's sperm.

NORPLANT: Dangers and Marks[1]

Laurel Guymer

Norplant is the focus of my paper, and as the title suggests, Norplant is more than a long term contraceptive 'choice' for women. Of interest to me is the positive light in which Norplant is framed, given that it remains an experimental method with many overt and hidden problems, and that its long term effects are still unknown. Despite serious previous warnings about its safety, Norplant continues to be promoted worldwide and is currently under trial in Australia. I want to discuss briefly how contraceptives, in particular Norplant, are promoted in countries like Australia and the US as 'choice' which is in stark contrast to Indonesia and Bangladesh where Norplant is part of a sophisticated population control program disguised under the name 'family planning.' Finally I will discuss the significance of implanting hormones under the skin.

Background

Norplant is a five year contraceptive method that is implanted under the skin of women's upper arm. It is a progestagen only method - it works like the mini-pill. In other words, it increases the production of mucus, attempts to stop ovulation and if all of that fails and conception occurs, it prevents the lining of the womb from supporting the growing embryo.

Norplant brings with it many long and short term problems ranging from menstrual irregularities to stroke. Women complain of alterations in weight, numbness in the

hands, depression, anxiety, and most worrying - headaches - which now bring fears of blindness. Norplant's potential to cause blindness is perhaps the most disturbing side effect of Norplant so far discovered, documented in a 1995 BBC Documentary entitled 'The Human Laboratory'. Pseudo-tumour cerebri[2] a condition where increased pressure in the brain crushes the optic nerve. Women in Bangladesh, Indonesia and the US complain of side effects and ask repeatedly to have the capsules removed and are often refused.

The reality contrasts with the much publicised opinions of Norplant researchers, promoters, and the majority of press accounts which promote Norplant as 'the dream method'. But on closer examination, the most obvious omission in the media, medical and pharmaceutical literature is the failure to investigate women's own experiences of Norplant, their perception of the method and their experiences of the side effects.

Irregular bleeding is cited as the most frequent reason for terminating Norplant. For some women this means bleeding continuously for 20 days, some 30, and others every two weeks. However, very little has been written about the consequences of this bleeding for women - such as anaemia, exhaustion, and inconvenience or interference in (hetero)sexual relations. Instead the answer from the Norplant developers is to counsel the women, inform them of the irregular bleeding and explain that this adverse effect is not medically serious (WHO, 1990 and Population Council, 1990). For every side effect women report to their doctor the same answer is given: 'This is quite normal' (Garcia and Dacach, 1993, p.76). In fact, Dr Edith Wiesberg was reported at the Biological Science Meeting (1997) as saying 'the bleeding improves after two years so just jolly the women along tell them it is normal.' Once women accept that these side effects are so-called 'normal', the expectation is that discontinuation rates will be minimised and the experimental and dangerous side effects will be ignored.

The administration of most new contraceptive technologies such as Norplant, Depo-Provera, IUDs and the experimental anti-pregnancy 'vaccine' are all provider-controlled, limiting women's autonomy in controlling their own reproduction. Because Norplant is implanted under the skin, it is impossible for women to remove it without a visit to the health care provider. And, increasingly, women say they want it removed (Hanhart, Jannemieke, 1993, Laura Hinkle, 1994 and Catherine Musham et al 1995). According to nurse researcher, Laura Hinkle, many women spoke of feeling pressured to accept Norplant and not being fully informed of its side effects. All but two were told to 'waitout' side-effects. Many women recalled asking several times to have Norplant removed 'before physicians complied with their wishes' (Catherine Musham, Eva Darr and Mary Strossner, 1995, p.465). Compared with other progestagen-only contraceptives, the provider-controlled nature of Norplant is a distinct disadvantage. For example, if women using the 'mini pill' decide to miss a pill, within hours they experience

a decrease in the amount of circulating hormones and ovulate whether intentional or by accident.

At a recent family planning conference in Australia, Louise Massey, a medical researcher working on the Norplant trial in Sydney[3], did not deny that women experienced many of the side-effects mentioned (except blindness which she has not observed yet). In fact she said 'I would not use it', but in discussions with the audience and panel, these problems were trivialised, with no mention of the effects they had on women's lives.

United States

Soon after it was introduced in the US, Norplant became embroiled in a series of political and medical controversies. It was implanted into Black teenagers in Baltimore public high schools. Welfare programs advocated Norplant in return for higher benefits. (Hetero)sexual women from poor, marginalised groups were the targets of the promoters of Norplant. So-called contraceptive 'choices' claimed by white women as their right are not being offered to women in these groups. In fact, they are coerced into Norplant use (Barbara Reynolds,1994). One month after the Food and Drug Administration approved the contraception - and before Norplant was even on the market - Superior Court Judge Howard Broadman ordered Darlene Johnson, convicted child-abuser to have Norplant implanted in her arm for at least three years as a condition of her parole (Off Our Backs, 1991). An article in Mediwatch (1991) states that the developers of Norplant were concerned that it would be mis-used by governments to enforce birth-control but had never imagined that the US government would be first to embrace Norplant as a new tool to control women.

But this tool of control is widespread. The fact that Norplant is forced upon young women, as part of their conditions of probation or as incentives to receive increased welfare payments, is quite problematic. The Johnson case illustrates clearly how Norplant is a device that might be forced upon some women by the law regardless of women's prior medical history. It should be taken into consideration that

[t]his is a prescription drug, with certain side effects and certain groups of women for whom it may not be appropriate. How does the Judge know if the woman is a diabetic or has some other contraindication to the drug? (in Tamar Lewin, 1991, pp.90,97).

Plans to offer Norplant to school girls in Baltimore, US, in 1993 caused great controversy. There were suggestions that welfare eligibility may be linked to its use. This is 'social engineering' aimed at the poor, one opponent told the New York Times (1993). 'A potential health hazard' charged others (New York Times, 1993). Eileen Lichwiarz (1991) fears that Norplant will be made available to teenagers, drug addicts and AIDS patients for free, claiming millions of US dollars will be saved in social and medical benefits. The potential misuse of Norplant extends to poor women being coerced into implantation so their babies are not a public burden,

and inner city teenagers who are not old enough to give informed consent. The message is clear as reported in a Philadelphia Inquirer editorial: 'poor women to be offered fiscal incentives to use Norplant in order to reduce the underclass' (in Matthew Rees, 1991, p.16). The premise is that poor women seem unfit to have children based on their race and income.

Norplant, ... is touted by its distribution as 'birth control you don't have to think about every day.' But thousands of women are thinking about it, and they're angry. (Julie Brienza, 1994, p.17.)

Bandgladesh

Reports of the Norplant trials conducted in Brazil, Bangladesh and in Indonesia found that instead of informing the women that they were testing Norplant, family planning workers were in fact promoting and marketing it as a new safe, effective contraceptive. Population control groups in Bangladesh realised long ago that they would face intractable problems if they maintained their support for 'freedom of choice' for the individual - as many of the individual women (and men) wanted a large family. In response to this dilemma, they devised a system of incentives and disincentives. This can be more simply expressed as sticks and carrots, that is bribes for those who tow the government line, and punishments for parents who have more than the permitted number of children (Farhad Mazhar and Farida Akhter, 1993).

Indonesia

Nurse ethicist, Kathleen Powderly, (1996, p.23) argues that

[a]dvocates for birth control generally intended [Norplant] to be an option for all women, regardless of race and class. The reality, however, was that poor, otherwise unempowered women [worldwide], often from minority groups

were the first to experience the push of experimental new contraceptive technologies through coercive population control programs. Details of the Norplant program in Indonesia are the most closely guarded secret. But Maggie Helwig (1994, p.27) argues that what she calls an 'information blackout' has fuelled

suspicion that this is an experimental technology, ideally suited ... [for] a coercive birth control programme, [and that it] is being used most heavily on the population the Indonesian government would most like to reduce: the people of East Timor.

The Indonesian Norplant program is administered by the Indonesian Department of Public Health and funded by the Population Council and the United Nations Fund for Population Activities (UNFPA). It was introduced into Indonesia in 1981 and since then has been part of many clinical trials (Maggie Helwig, 1997). On the basis of these trials, Norplant was registered in Indonesia in 1986 and accepted into the National Family Planning Program in 1987. The aim is to use it in all family

planning clinics. Norplant is seen as an alternative to sterilisation for women over thirty years old (Jannemieke Hanhart, 1993). It is also promoted to women between the ages of 20 and 25 to space their children after weaning.

Indonesia has long been criticised and accused of coercive birth control programs, in which the women are not informed adequately, are not offered options and may be threatened or bribed into compliance (Maggie Helwig, 1994, 1997). In 1994, I went to Java to work as a midwife and found myself and two other colleagues deeply involved in population control programs disguised under other names such as 'family planning' or 'safe motherhood'. As part of the coercive family planning program we were instructed to vaccinate all women getting married with Depo-Provera. According to the government, women needed a tetanus injection before getting married to protect them in potential childbirth. But when the women went to the primary health centre they were not given tetanus but Depo-Provera. In this way the Indonesian government achieved its desired goal: a high number of women using some form of long term contraception.

Indonesian family planning authorities are trying to phase out methods like the pill and condoms that are largely under the woman's control and depend on her cooperation and in the case of condoms, protect against STDs and HIV/AIDS. Whilst working in Java, we were encouraged to promote Norplant wherever we went and at every visit with the women. We went to a private family planning clinic in Jakarta that instructed midwives and doctors from all over the world on how to insert Norplant. We were not taught how to remove Norplant and when we asked, we were told 'a five year method - no need - you all come back in five years and we will teach removal' (personal communication with Rosalina - nurse in charge, 1994).

Indonesia is the world's largest user of Norplant (Maggie Helwig, 1994). During my visit to Jakarta, Norplant was proudly inserted into 400 women on any given morning in one private family planning clinic we attended. Promoting it as a beauty tattoo is another strategy.

Indonesia's Minister for Population/ Head of the Co-ordinating Board of National Family Planning (BKKBN), His Excellency Dr Haryono Suyono spoke at a press conference on Thursday February 24th, 1994. Dr Suyono did not deny that Norplant was promoted as a beauty aid; comparing it to the promotion of Coco-Cola he stated:

[T]he way we inform people is just a variety of ways just like introducing something new, like when you introduce Coca-Cola you introduce it not like a kind of drink but rather to put yourself there, everywhere ... This is the way to inform people and get them attracted to it.

Many women's health clinics - often referred to as 'family planning clinics' - where Norplant is distributed, aim specifically at limiting population growth. For instance, in Indonesia

incentives to health workers are part of the daily work in family planning clinics. All births are recorded on a board, all methods of contraception are tallied and any reductions equates to increased funds to the staff and clinics, which are badly in need of resources (personal communication Susan Clements, 1996).

International Resistance

But it is not all bad news there is international resistance. US women are pursuing class action lawsuits and Bangladeshi, Indonesian and Brazilian women are critical of coercive population control programs where women are unable to have Norplant removed. Moreover, international feminist organisations have rejected the provider-controlled nature of this contraception and are asking for safe, user-controlled methods instead. Such resistance is crucial as the following testimony reveals. A Bangladeshi woman requesting removal pleaded 'I am dying please remove it.' She was told by the doctor 'Let us know when you die, [and then] we will take it out!' (Farida Akhter, 1995, p.75).

Support has been global. It came from the 1991 World Women's Health Congress for a Healthy Planet in Miami and in 1993 at The International symposium on People's Perspectives on Population. The outcome of the Comilla conference was a Declaration which stated that 'Long acting contraceptives such as NORPLANT are not an advance in contraceptive technology but an advance in control' (1995, p.104).

I would argue that women are given the 'freedom' to be (hetero)sexually active whenever men want it, and that, in fact, this is part of the assumption underlying the push for all women to be contracepted. Radical feminists claim that the move to provider controlled contraceptives must be assessed in the light of its power to remove from women the ability to make decisions themselves to start and stop contraception. Moreover, provider controlled contraception has the potential to be used as an unethical tool for population control while at the same time reinforcing the assumption that to quote Alice Rossi 'women are innately sexually orientated towards men' (in Adrienne Rich, 1980, p.631).
The insertion of the silicone rods in the upper arm could be seen as a form of stigma or branding that identifies women as heterosexual and available. Marinette Souza de Faridas of Brazil testified at the Tribunal of Crimes Against Women Related to Population Policies at the UN Population and Development Conference in Cairo. She said 'The doctors told me that I ... would always be ready for sex' (in Susan Hawthorne and Renate Klein, 1996, p.37). Norplant leaves an identifiable mark on the body for others to see, a brand that identifies the woman as (hetero)sexual and available, or, conversely, unavailable (as she is already owned by another man). However, unlike tattoos which signify ownership to an individual man, Norplant signifies ownership to patriarchy - either family planning or men as a social group.

It is interesting to see how contraception has come full circle, from secrecy to publicity. The sexual revolution might have supported women exploring their sexuality but never changed the secrecy involved in buying condoms or obtaining the pill. Not so long ago, women discretely inserted their diaphragm or hid contraception in their bedroom drawers. But now, Norplant is visible on women's skin like a tattoo for all to view.

I suggest that if women had full knowledge of all parts of the Norplant saga they would not select it as their preferred method of contraception. Although promoted as the best contraceptive ever invented, women's experiences of the drug differ from the manufacturer's slogans. Even the medical literature details many of the problems discussed by the women implanted with Norplant. Dr Rosa Tang concluded that there is a possible link between Norplant and blindness and suggested a larger scale study should be done if Norplant is to be continued. However, the question needs to be raised if conducting a trial to investigate whether women go blind, can be considered ethical.[4]

Apart from these serious concerns about the Norplant research ethics, the basic question I want to raise is whether Norplant should be welcomed into Australia under the guise that women want choice? Given the serious problems documented in the literature regarding Norplant use in Bangladesh, Brazil, Indonesia and the US, I believe that Australian women need to be made aware that their so-called new contraceptive 'choice' would be gained at the expense of millions of other women's health or even loss of lives. Trials and testing of contraceptives does not occur in laboratories: 'human laboratories' - 'real' women - are needed to get 'real' results. As Rosa Anne Auguste, Director of Camefour Feuilles Clinic in Brazil**,** put it sarcastically on the BBC documentary quoted earlier, the promoter of Norplant have found cheaper ways for their trials than doing them on animals: 'the slum laboratory' where real live women - usually poor, illiterate and the least able to protect themselves - are experimented upon.

Another conclusion I have arrived at in this research project is that Norplant implants carry a stigma. Norplant has a special twist that makes it quite different from Depo Provera or any other contraceptives because it consists of an actual implant in a woman's body. In Indonesia an old custom exists known as 'susuk' (Adrina Taslim, 1994), in which gold coins, small diamonds or pieces of precious metals are inserted under the skin. 'Today in Indonesia there is a new type of susuk' reports Melinda Tankard Reist (1996, p.12) '[i]t will, say its suppliers, make women more attractive ... it will make them beautiful, popular and lucky.' Promoted as a beauty aid or not, Norplant implants amount to nothing less than branding, labelling women available for (hetero)sexual activities without the complication of pregnancy. Branded like cattle, clearly identifiable to their actual or potential owner, women cannot escape stigmatisation.

The overall picture that emerges from this research project is that Australian resistance is urgently required before this new contraceptive method is

introduced into the country.[5] The first aim is to raise public awareness, and, in so doing, stop the unethical abuse of women in trials worldwide. It is time to expose Family Planning Programs, funding agencies such as Population Council, and the practice and decisions of ethics committees, in particular Family Planning Associations (FPA). Population control programs are not an answer to the economic and social problems of the world. Contraception itself does not alter the power imbalances between women and men. I suggest that women, who represent more than half the world's population, should be adequately informed of the dangers involved in Norplant which has the potential to brand them forever.

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SURROGACY: Further Exploitation of Women - A young Radical Feminist's point of view.

Renee Beggs

All around the world women and their bodies are being experimented on - either indirectly or directly through reproductive technologies. One reproductive technology on the increase of further exploiting women's roles in reproduction and motherhood is surrogacy. Surrogacy programs entail a fertile woman conceiving a child for an infertile couple. The consenting so-called surrogate[6] woman becomes a 'living laboratory', a term eloquently coined by Robyn Rowland (1989).

Surrogacy has been debated for many years. There are numerous texts on shelves which highlight supporting and opposing arguments from feminists who debate the surrogacy topic. Those who argue in support of surrogacy do so in favour of a woman's choice and for the infertile couple's right to have a child of their own biological determinisms. Radical feminists argue that surrogacy leads to further exploitation of women by placing control and power of reproduction in the hands of male doctors and scientific researchers. Radical feminists such as Robyn Rowland, Janice Raymond, Gena Corea and Renate Klein have written various articles or edited numerous texts opposing surrogacy in its entirety.

Among the diverse array of literature written about reproductive technologies, I chose to look closely at surrogacy programs because I see such programs as naively oppressing women as a collective and also as individuals. Male patriarchs in the medical,

pharmaceutical and scientific research fields oppress and coercively dominate women and their reproductive and motherhood roles. Yet on the other hand, women who partake in altruistic (surrogacy occurring between family and friends, sometimes involving IVF) and commercial surrogacy (occurring in commercial agencies) also contribute to the rapid decline of power and control women have over reproduction and motherhood. The surrogate mother decreases her own control and power by allowing herself to be used for the purpose of supplying a child for an infertile couple. She may not intend for this to happen, but by doing her own research into surrogacy programs and questioning the procedures involved, then perhaps the surrogate mother would think twice before signing herself into a contract which exploits her reproductive and motherhood roles. In a majority of cases, fertile women believe they are doing the right thing by an infertile couple. Why doesn't anyone question whether surrogacy is right for the surrogate?

In patriarchy, motherhood is an unquestioned institution and the reason for female existence. Patriarchal society sees that being a real woman involves being or acting like a mother. When a women signs a surrogacy contract, her motherhood rights fall absent and void (Raymond, 1994, p 30). Surrogate motherhood appears to eliminate the birth mother from the motherhood role. Medical and scientific researchers still insist on viewing the mother solely as the 'surrogate'. Radical feminists see the so-called 'surrogate' as the birthmother because she is the one who endures the nine months of pregnancy. There is no denying the child is part of the surrogate's body, growing inside her.
Robyn Rowland (1992) cites in her text *Living Laboratories*, the term surrogate refers to being a substitute - not being the biological mother. But what appears to be overlooked in society is that in a majority of altruistic and commercial surrogacy cases, the woman carrying the foetus is in fact the birth mother as she has a growing relationship with it.

A relationship with the child born based on intimacy of it's development inside her body and the relationship she has formed with the foetus and with the imagined child. Men tend to negate this experience, make it invisible and unimportant, because it is so unfamiliar to them. (Rowland, 1992, p 157)

In July 1993, Marie Meggitt, a founding member of the Association of Relinquishing Mothers, wrote 'Always a mother' for The Age newspaper. She stated that motherhood is fragmented by surrogacy - thus the genetic donor, the birth mother and the social mother. And, 'surrogacy attempts to overthrow the most fundamental element of human nature: that a woman who gives birth to a child is its mother' (Meggitt, 1993, p 18).

Although I agree with feminists such as Rowland and Raymond and oppose surrogacy for the same reasons as they do, I want to try and incorporate their analytical writing with my viewpoint as a young radical feminist. My aim was to research newspaper articles on surrogate motherhood in the 90s and find out how and if it has increased in Australia. The main newspaper I briefly researched was The Age, dating from 1 January 1993 up until November 1997. During these four years, 15 articles (including one letter) were published. From these, 7 articles

were relative to Australia. If I had further access to other newspaper sources around Australia, then I may have found more articles, although I believe that if surrogacy is being performed in our country, with an average to high success rate, then the news would be nation wide. The only Australian example of surrogacy the articles provide is the 1988 Linda Kirkman story - one of which had a happy ending. Surely if surrogacy programs were on the rise, then journalists would be able to quote other and more recent examples.

Coming from a young radical feminist point of view, I see motherhood as an option. Some women decide to become mothers and others don't. Motherhood is an experience some fertile women would like to participate in, yet not all fertile women want to have children. This is where surrogacy programs exploit motherhood and entice women by offering misleading information in becoming surrogate mothers, such as there being no emotional strings to the baby. In 1996, The Age reported a 15 year old Victorian girl, Fiona, giving birth for the second time in two years. As the article progressed, it was reported that Fiona enjoyed pregnancy to the extent that she would consider becoming a surrogate mother. No discussion surrounding relinquishing given her strong attachment with both her children.

By constantly projecting media images of the surrogate mother happily handing her child over to the infertile contracting couple increases the naive notions that surrogate motherhood benefits all women involved.

In expressing my opinions of why I oppose surrogacy, I am told that I am taking away a woman's right to choose to partake in surrogacy programs. In 1993, The Age printed an opinion-analysis piece, 'The ties that bind babes and mothers'. The author, Pamela Bone states that a central theme within feminism is allowing women the right to choose and control their fertility. She says,

[i]f one insists women have the right not to bear a child, it is inconsistent to say women should not have the right to use their wombs to bear children for other women

I think 'choice' is problematic. Before a woman can make an autonomous decision on whether or not she will become a surrogate mother she needs to be told ALL the details, including the ones where she may go through emotional times of wanting to keep the baby, and that she is the birth mother. Also, who does 'choice' lie with? Where is 'choice' in the context of being persuaded or coerced by family members or friends to bear a child for a sister, or friend? Where is the 'choice' for women who do not speak fluent english or live in poverty and see surrogacy as a means of financial gains? Not all infertile women are infertile naturally. Some have become infertile by medical intervention, such as having their tubes tied, only to meet another man who wants a child of his own. The woman isn't given much of a choice: either enter surrogacy or risk losing a man she loves. This can prove to be a no-win situation.

At the end of her article, Bone says: "And what greater solidarity can one

woman show to another than to carry her child for her in that safe place for nine months, and then put her into the arms of her true mother?" This statement too, proves to contain an important flaw. In Bone's eyes the 'true mother' is that of the infertile woman. But through the eyes of this young radical feminist, I see the 'true mother' as also being the surrogate mother. After all hasn't she experienced the nine months of pregnancy?

Women as a class and women as a collective need to reclaim back the right to control our bodies and reproductive systems by refusing to accept and take part in new reproductive technologies such as surrogacy. We need to deny male patriarchs the control of reproduction, otherwise experimentation and fragmentation of the female body will continue if women do not seize the power and control. In order to fully regain control over reproduction and motherhood, women need to resist the patriarchal ideology that women are merely placed on this earth to fulfill the motherhood role. We need to ignore traditional patriarchal views on motherhood and remember that being a woman doesn't necessarily involve motherhood.

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Renee Beggs is a relatively new contributor to FINRRAGE. She is a radical feminist critical of reproductive technologies. She is an undergraduate student at Deakin University. This is her second year studying Women's Studies and identifying and discovering her feminist self.

Misoprostol - Nurse Speaks Out On Dangers For Women

Melinda Tankard Reist

A contentious debate over the abortion drug RU486 resulted in Federal Parliament approving in May 1996 stricter controls on the importation, trialing and marketing of the pill in Australia. This has caused family planning groups to look to alternative chemical abortifacients such as the anti-ulcerant Misoprostol and the anti-cancer drug Methatrexate.

While not manufactured as an abortion-inducing agent, Misoprostol is, nevertheless, being used off-label in Australia to terminate pregnancies. It was trialed in Sydney last year by Australian Birth Control Services and the Sydney Centre for Reproduction Research (the research division of the

Family Planning Association of NSW) as part of an international trial coordinated by the New York Population Council.

The drug had been used in conjunction with RU486 in an earlier trial but the Sydney trial was the first time it was been trialed on its own.

The aim of the trial was to determine the effectiveness of Misoprostol in aborting pregnancies between 9 and 12 weeks. The drug was given twice a day for two days or until the abortion took place. Patients were advised they may bleed for up to two weeks and that if they were between 10 and 12 weeks they may pass "obvious products of conception". They had to agree to a surgical termination if the drug failed to expel the foetus - which was the case for 39 percent of the women in the trial. Sixteen percent of women in the trial experienced a drop in haemoglobin levels greater than 20 percent. four required emergency D & C, one a blood transfusion and one collapsed at home due to heavy bleeding. Another witnessed the foetus after expeling the pregnancy at home.[7]

Dr Geoff Brodie of Australian Birth Control Services told a Biological Sciences Meeting of the Family Planning Association in May last year that the length of time between the drug's administration and termination of the pregnancy was difficult for many women. He told the conference that a woman had expelled her foetus in McDonalds.[8]

Misoprotol

A prostaglandin, Misoprostol causes the uterus to contract and expel the foetus. Misoprostol is not manufactured as an abortion-inducing agent. Searle, which manufacturers the drug, has distanced itself from its use as an abortifacient. Dr Eric Meyer, medical affairs managers, says: "Searle is not involved in, and in no way endorses, the study of Misoprostol as an abortifacient, either separately or in combination with other medical therapies. In fact, labelling for Misoprostol contains prominent warnings and contraindications against use by pregnant women."[9]

Methotrexate

Methotrexate, which is being used overseas in abortion procedures, is distributed in Australia for cancer treatment by Pharmacia. A spokesman said the company did not intend promoting its cytotoxic drug as an abortion method.

A controversial report by an 'expert panel' appointed by the National Health and Medical Research Council called for further research into Misoprostol for use in chemical termination of pregnancy. That report has just been withdrawn by the NHMRC because of serious errors.[10]

Some women's health activists fear the risks of abortifacients like Misoprostol are being downplayed in the enthusiasm to develop methods of chemical abortion. Dr Renate Klein, Senior Lecturer in Women's Studies at Deakin University, criticised the patient information sheet as 'hopelessly inadequate' in providing full and accurate information on the health risks. She says chemical abortifacients such as Misoprostol

are also psychologically manipulative in that a woman is encouraged to think she is experiencing a natural miscarriage and not an abortion. 'The medical literature has documented many problems with Misoprostol,' Klein says. 'There are many cases of 'persisting pregnancies' requiring manual evacuation or a curette.' Klein says the drug has also been linked with congenital or neurological disabilities where pregnancies have been continued after the drug being administered.[11]

What is not widely known is that although the prostaglandin was only approved for trial in Sydney last year, it has been used for many years in second trimester abortion.

Laurel Guymer, former women's health nurse, has witnessed the drug's hazards to women. Having witnessed both oral and vaginal administration of Misoprostol to women in a prominent private Melbourne clinic for almost two years, she resigned because of her concerns.

Guymer recalls how she saw one woman almost bleed to death after a Misoprostol abortion.

I'd call it haemorrhaging. She needed to be re-evacuated twice, (her uterus was suctioned), she had an ultrasound to make sure that there were no parts left behind. The doctor and I thought we could see something so she was re-evacuated again. She was soaking pads every 10 minutes. The doctor gave her a curette. She had three litres of fluid (intravenously) because her blood pressure dropped, she was very pale and sweaty and quite shocked. The woman was taken to a speciality facility and survived.

Guymer, 34, has 15 years nursing experience including midwifery and critical care. Her involvement with Misoprostol took place prior to any Australian trials of the drug as an abortifacient in its own right. While Guymer believes a woman should be able to decide if she wants to have an abortion, she feels the dangers of drugs like Misoprostol are being played down. Distressed while recounting her experience, she described the vigorous uncontrollable contractions caused by the drug. 'I was worried that they were going to rupture their uterus,' she says. 'Once it's there, that's it. You can't turn it off. And sometimes there was no midwife working at all.'

According to Guymer, prior to her complaints there was no real consent procedure. The women were not told that Misoprostol was an experimental drug, and they were not given the option of other methods.

After awhile the nurses designed an information sheet that explained the drug started labour and that the patient had to consent to emergency treatments, including resuscitation, if required.

However, she says the doctors put a positive spin on the drug.

But there were many occasions when the procedure was not as straight forward as the women were told.

Sometimes the Misoprostol was administered orally when they were sitting in the waiting room. They would start labour and no one would know. I just had fears of them delivering these foetuses in the bathroom or in the waiting room, and it's frightening, Guymer recalls.

The clinic did not have an ethics committee to approve the drug's use. 'Some of the nurses got together and spoke amongst themselves of their concerns about the consent procedure especially as the RU486 consent process was under scrutiny,' Guymer says.

It was them brought up at a general meeting that perhaps we needed a proper trial, a proper consent form, ethics committee approval and so on. But the nurses were told Family Planning (Victoria) has an ethics committee and if we wanted we could pursue it there. But Family Planning worked in cooperation with the clinic, so we didn't think that was satisfactory.

Her concerns about the women coming to the clinic did not ease.

You've got to remember that in the clinic where women are having mid-trimester and regular abortions, it's just a number of trolleys lined up with curtains beside each other, she says. There's no privacy or anything, there's not enough space or room for them to have a person with them. In (normal) labour you'd always be able to have someone with you. We nurses started a practice of putting in IVs and giving women a litre of fluid so that they weren't hypovolemicaly compromised, so if they had blood loss, shock could be avoided. The drip also means we could give emergency drugs quickly.

According to Guymer, the uterine contractions were far more powerful than normal labour - even where labour was induced by drugs such as Oxytocin.

It's even stronger than Oxytocin. You can at least stop Oxytocin through the IV if the woman gets into trouble. But because Misoprostol is a tablet, you can't turn it off, she says.

Women were given heavy doses of Pethidine intravenously to manage the pain.

According to Guymer, the clinic preferred Misoprostol because the foetus was usually delivered in one piece reducing any damage to the woman's cervix.

The whole idea was to deliver the foetus all in one piece so that you don't damage the woman's cervix in the process of dismembered limbs coming through the cervix.

Guymer describes the procedure when the foetus does not come out in one piece:
Well then they put an ultrasound on the woman's abdomen and then they check to make sure that there's nothing left behind and then they use a strainer that you'd strain the soup in or something, And they put all the pieces together and they make sure that they have the arms and the legs, the ribs and the head. They're

quite meticulous about making sure they get every piece so that the the woman doesn't get an infection.

Up to six later term abortions were carried out on Fridays and Saturdays. Some nurses refused to be involved in these procedures. But as one of only three midwives in the clinic, Guymer felt she had little choice.

One major fear for everyone was that the Misoprostol might work too quickly.

There was one woman who sat on a pan, she was desperate--and we could see that the head was right there ready for delivery, Guymer recalls. So we popped her onto a trolley and took her into theatre, and the anaesthetist anaesthetised her as she was being transported into the theatre. So by the time we actually popped her onto the operating trolley, she was unconscious.

Finally, Guymer decided she had to leave.

I'd tell them my concerns about Misoprostol and they'd laugh and say: 'You're a feminist!' I'd point out I was an intensive care nurse and, in fact, a midwife, she says. My concerns with Misoprostol were never attended to really. They continued to use it without providing extra staff to look after the women. They continued to give it to the women and leave them sitting in the waiting room; they continued to do five or six mid-trimesters on one day which is just too many. It was just a disaster waiting to happen. I thought no, no it's time that they did something about it.

Misoprostol is still being used at this clinic. Two other midwives have since left the clinic because of their concerns over the drug's use.

Melinda Tankard-Reist is a Canberra based writer with a special interest in women's health, bioethics and the abuse of women in coercive population control programs.

Submission on Ethical and Clinical Practice Issues on Late Term Termination of Pregnancy.

Laurel Guymer and Renate Klein

General Comment

FINRRAGE (Australia) welcomes the opportunity to contribute to this report.

FINRRAGE International and FINRRAGE (Australia) are part of an international network of women that since its inception in 1984 has monitored developments in new reproductive technologies as well as contraceptive technologies. Our stance on abortion is that we support a woman's decision whether or not to have a child.[12] FINRRAGE (Australia) is a feminist organisation and our focus is on the needs and interests of women rather than the foetus which we see as part of a woman's body. For these reasons we support abortion at all stages of a woman's pregnancy. Nevertheless we have great concerns about the ethics[13] and practice

of mid trimester and late term termination of pregnancy for the following:

As a result of prenatal screening the number of women facing a mid trimester to late abortion is increasing. Due to the detection of so-called genetic abnormalities this means that more and more women face the decision of having to terminate a wanted pregnancy.[14] FINRRAGE (Australia) believes that abortion at any stage of a pregnancy - whether wanted or unwanted - is a serious and difficult decision for women. Adrian McGregor reported in the *Weekend Australian,* that

> some major Australian hospitals will perform abortions post 20 weeks ... but only where a lethal or disabling abnormality has been detected in the foetus. Grundmann is the only doctor in Australia who will also proceed for severe mental health risk to the mother.' [15]

Nevertheless, mid- and late term abortions compound the weight of the decision for women because of the advanced pregnancy. For wanted pregnancies, a termination at a late stage presents women with even greater dilemmas. On the grounds of abstract and nonconclusive evidence of deviation from the norm after screening, women have to make a life or death decision. In addition to this enormous moral responsibility they are faced with a number of late term termination methods all of which are hazardous and dangerous to women's health.

Practice Issues

One particular method of termination, that is the use of prostaglandins[16], in particular misoprostol, gives us serious cause for concern and we wish to focus on this method in our submission. Although not strictly confined to late termination of pregnancies we wish to alert the medical board of Victoria to the problems inherent in misoprostol abortions carried out in Victoria.

Misoprostol is approved for treatment of duodenal and gastric ulcers. It is stated that it should not be used by pregnant women as it might cause miscarriage. According to the MIMS[17], misoprostol effects on a developing foetus are not known, but Schönhöfer[18], has widely documented teratogenic effects in first-term abortions in Brazil. We are aware that it is not illegal to use a drug off-license in Australia for other purposes, but are seriously concerned whether the use of off-licence use of a dangerous drug is ethically justifiable in pregnancy termination which is not a disease.

Adverse effects known of prostaglandins are: hypotension (which may proceed cardiac arrest), epileptic seizures, cervical tear[19], bronchospasm as well as diarrhoea, serious abdominal pain[20], vomiting, bradycardia, haemorrhaging and loose stools. Misoprostol is also used in kidney transplants where it reduces the incidence of rejection.[21] This shows that it works as an immunosupppressant. Since pregnancy is not a disease we believe it is unethical to use abortion drugs that jeopardise a woman's immune system.

Added to these adverse effects is the unpredictable nature of using misoprostol in mid or late termination of pregnancy. Most private abortion settings do not

employ midwives to care for women undergoing termination of pregnancy in particular mid to late term terminations. FINRRAGE (Australia) finds it quite unacceptable that unqualified nurses who are unable to assess uterine contractions are responsible for the care of women undergoing termination of pregnancy with the use of prostaglandins, in particular misoprostol. Once the pill is inserted vaginally into the cervix, or taken orally, the uterine contractions begin. The problem is that once the contractions start there is no way of stopping them or preventing sustained contractions that may lead to a ruptured uterus. Because of the strength and unpredictability of the contractions, the foetus may be forced through a cervix that is not yet fully dilated which may lead to damage and haemorrhage. Misoprostol is used for abortions at all stages but the effect is greater the further the pregnancy is advanced.

The following incident was observed in a Melbourne clinic in 1994:

A woman having a mid trimester termination of pregnancy almost bled to death following the insertion of Misoprostol to induce abortion. She was 'soaking through her pads every ten minutes.' She had to be reevacuated three times to check she hadn't any retained products. After attempts to empty her bladder, her fundus 'rubbed up' both abdominally and vaginally and several doses of subcutaneous ergotmetrin given, she continued to haemorrhage. This woman required urgent fluid resuscitation. Fears of a ruptured uterus were allayed by ultrasound. The outcome of a bleeding cervix was noted by medical practitioners at a major metropolitan hospital.

It has been reported that eight women have died following the use of prostaglandins in termination of pregnancy.[22] Neither of the women who died in the first report had any cardiac or neurological abnormalities as they were both tested prior to the abortion. This should warn others using prostaglandins that screening is not a foolproof safeguard in preventing a fatal outcome.

In sum, we have selected criticism of this method for this submission because we are particularly worried about its adverse effects. FINRRAGE (Australia) condemns all misoprostol use in the termination of pregnancies and suggests the Medical Practitioners Board of Victoria conduct an investigation into misoprostol abortion in Victoria.

Laurel Guymer teaches Women's Studies at Deakin Univeristy. She is a radical feminist, women's health activist, critical care nurse and midwife. Her current research includes Australian Nurses' perceptions of euthanasia and its implications for women.

Renate Klein teaches Women's Studies at Deakin Univesity and is the Director of the Australian Women's Research Centre. For the past ten years she has ben part of FINRRAGE exposing the inhumane nature of both pro- and anti-natalist technologies and is the (co)author/ (co)editor of six books on reproductive medicine.

Conference Report: Health For All Into The 21st Century - Reproductive Rights And Responsibilities[23]

Elizabeth Shannon

Auspiced by the All Party Parliamentary Group on Population and Development, and organised by the Australian Reproductive Health Alliance (ARHA), this conference was held at Parliament House Canberra, February 11-12 1998. Although I was only able to attend the first of two days, I decided to write this 'partial review' because I feel that it is particularly important to be able to present a broader picture of reproductive rights in Australia than is currently being expressed, by the news reports of the events in Western Australia. As there was a great deal of written material available at the conference it is from both the speakers and the information distributed that I draw upon.

Why Do 'Rights' Matter?

Many of the speakers kept close to the conference theme - reproductive rights and responsibilities - and this, in part, included a definition and discussion of the discourse of 'rights'. The United Nations suggests that not only are 'accepted standards of human rights their own justification' but that 'a number of global trends add to the urgency of strengthening international, national and local commitments to common standards of human rights, including reproductive rights' (Berstein, 1997, p.15). These include rapid urbanisation, accelerating internal and international travel and migration, the twin trends of the increasing complexity and (at the same time) a decentralisation of government decision-making and administration, the need to strengthen the institutions of civil society as some countries experience the collapse of civil administration structures, the growing influence on nations by transnational entities, and other forms of rapid social change.

What Are Sexual And Reproductive Rights?

International Planned Parenthood Federation (IPPF) have developed a Charter on Sexual and Reproductive Rights which list twelve categories (IPPF, 1996). I will briefly paraphrase these and pick out some pertinent points from each for illustration:

1. The right to life. In part this states that the IPPF recognises and believes that all persons' have a right to life and that no one shall be arbitrarily be deprived of the their life. (Persons are recognised in international law as human beings having been born.) This means that no woman's life should be put at risk or endangered by reason of pregnancy and that all girl infants have a right to be free from the risk of female infanticide.

2. The right to liberty and security of the person. This includes the statement that all persons have the right to be free from forced pregnancy, sterilisation, and abortion.

3. The right to equality and to be free from all forms of discrimination. For example, all women have the right to protection from discrimination in social, domestic, or employment spheres by reason of pregnancy or motherhood.

4. The right to privacy. All persons have the right to express their sexual orientation in order to have a safe and satisfying sex life, having due regard to the well-being and rights of others, without fear of persecution, or denial of liberty, or social interference.

5. The right to freedom of thought. All persons have the right to be free from the restrictive interpretations of religious tenets, beliefs, philosophies and customs as tools to curtail freedom of thought on sexual and reproductive health care and other issues.

6. The right to information and education. All persons have the right of access to education and correct information related to their sexual and reproductive health, rights and responsibilities which is gender sensitive, free from stereotypes, and presented in an objective, critical and pluralistic manner.

7. The right to choose whether or not to marry and to found and plan a family. All persons have the right to protection against a requirement to marry without that person's full, free and informed consent.

8. The right to decide whether or when to have children. All women have the right to information and services necessary for the protection of reproductive health, safe motherhood and safe abortion and which are accessible, affordable, acceptable and convenient to all users.

9. The right to health care and health protection. All persons, and in particular the girl child and women, have the right to protection from traditional practices which are harmful to health.

10. The right to the benefits of scientific progress. All persons shall be entitled to protection from and information on any harmful effects of reproductive health care technology on their health and well-being.

11. The right to freedom of assembly and political participation. All persons have the right to seek to influence governments to place a priority on sexual and reproductive health and rights.

12. The right to be free from torture and ill treatment. All women have the right to protection from traffic in women or exploitation of prostitution of them.

Responsibilities

Both the papers presented on the first day and the written material available emphasised that reproductive rights

must be comprehensive across all sections of the community if they are to be meaningful. It is the responsibility of service providers and governments to ensure that indigenous people, rural and remote people, people of different language or cultural backgrounds, intellectually or physically disabled people, old people and young people - men and women alike - are enabled to make autonomous, informed, and responsible choices.

It was in this context that Dr. Edith Weisberg (Family Planning NSW) discussed the constraints faced by Australian women by the lack of availability of the latest contraceptive methods; that Lesley Vick (ARHA) spoke of the continuing legal ambiguity in relation to abortion (with particular reference to the events in Western Australia); Professor Peter McDonald (ANU) set out men's role and responsibilities in reproductive health; Lynore Geia (Congress Alukura, Alice Springs) talked about indigenous women's health; Ally Parnaby (Ballarat Community Health Centre Sexual Health Coordinator) gave some case studies illustrating the difficulties for people from rural and remote areas; Jane Lazzari Wegener (Women in Industry and Community Health Victoria) detailed the issues for workers with non-English speaking backgrounds; Patsie Frawley (Family Planning Victoria) described the work of the Disability Unit; and Brigid Inder (Family Planning NSW) told of her work with young people.

The implementation of reproductive rights in a domestic context was only part of the story. This was a conference that was truly international in its outlook. Australia's commitment to overseas aid is said to 'focus on simple, cost-effective methods of prevention and treatment. We will concentrate on helping those people most in need, particularly women and children. There will be a strong focus on primary health care and disease prevention ...' (Downer, 1997: 6). Yet when The Hon. Seruwaiia R. Hong Tiy (Minister for Information, Women and Culture, Fiji) launched the Australian/ New Zealand edition of the Briefing Pack on Population and Development, she was at pains to point out that many developing countries were not meeting the financial commitments they gave at the Cairo Population Conference - with the burden falling disproportionately upon developing countries - such as Fiji and others in the Pacific region.

Family Planning Australia (FPA) also reported the Australian government's 1997 proposal to raise the amount of money non-government organisations (NGOs) need to raise in Australia and spend on their overseas development in order to remain eligible to access to AusAID funds from $30,000 to $200,000. Although this proposal was eventually overturned, there is concern that it is likely to be raised again and perhaps phased in, to the detriment of many small but effective NGOs, including FPA, which has recently received a very positive review of their work by AusAID.

Rights And Responsibilities: Implementation And Debate

All the conference speakers, both

those presenting papers and those asking questions from the floor, were obviously committed to the reproductive rights and responsibilities enunciated above. This does not mean that there was a perfect harmony to be had! There was vigorous debate as to how these should be implemented. I was personally very impressed by the ability of the conference participants to listen respectfully to others' opinions and respond to them in a measured and thoughtful way. The vast majority of the papers presented concentrated on either areas of common cause, or on clarifying specific areas of difference, rather than simply denigrating and dismissing the perspectives held by others. The overwhelming impression I have taken away from this conference is that of a remarkably diverse group of people passionately committed to improving the situation for women and men in Australia and around the globe.

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Elizabeth Shannon completed her thesis, 'The Influence of Feminism on Public Policy: Equal Pay and Abortion in Australia and Ireland' in July 1997. She is employed at the Centre for Public Management and Policy, University of Tasmania, on the Coordinated Care Trial evaluation project. She also runs the Australian Feminist Policy Network e-mail list.

Further Reading

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Mazur, Laurie Ann. 1998. High Stakes: Global Population and Our Common Future, New York: The Rockerfeller Foundation.
McMurray, Christine, David Lucas, and Thomas Schindlmayr, Briefing Pack on Population and Development. 1998. Australian Reproductive Health Alliance/Family Planning International Development.

AWORC SEMINARS
BURWOOD M-205 4-6 PM
March 23rd RANNVEIG TRAUSTADOTTIR 'Minority Women and the Social Construction of Gender'
April 20th DI BROWN 'A Feminist Print Culture'
May 18th GRAZYNA ZAJDOW 'Women an Drug Abuse Rehabilitation: Health, Human Rights and Public Concerns'

GEELONG AF14 4-6PM
April 8th SUSAN STEVENS ' Women in Decision-making in the University
June 3rd CAROLE FORD 'The Impact of Economic Rationalism on the Provision of Government Provisions for Women'

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Check out our new web page via http://www2.deakin.edu.au/aworc/finrrage.htm

International FINRRAGE (Feminist International Network of Resistance to Reproductive and Genetic Engineering) is a network of feminists in over 35 countries concerned with the development of reproductive and genetic technologies and the attempt to control population quantity an quality through controlling women's reproductive capacities. Women in the developing world and poor women in the industrialised countries are increasingly faced with unsafe, harmful and coercive contraceptives. Other women are the subjects of experimental technologies, such as in-vitro fertilisation which are promoted as pro-fertility and involve the use of harmful drugs and invasive surgery.

FINRRAGE aims to monitor international developments in the area of reproductive medicine and technology; to assess their implications for the socio-economic position and well being of women in different situations, cultures and countries and the impact on the environment; to raise public awareness and extend links with women internationally; to analyse the relationship between science, technology and social relations in patriarchal societies, and the implications for the feminist movement and the development of alternatives; to work towards feminist resistance to population control policies.

For more information contact:
FINRRAGE via the World Wide Web
http://www2.deakin.edu.au/aworc/finrrage.htm

Bronwyn Whitlocke -
Chinese Medicine for Women: A Common Sense Approach
ISBN 1 875559 701
Take a spin on the Spinifex Homepage
http://www.spinifexpress/~women

(Footnotes)

[1] A version of this paper was delivered at the 6th Women and Labour Conference at Deakin University, Geelong, November, 1997.

[2] Pseudo-tumor cerebri is described as cerebral oedema (increased fluid on the brain) and raised intracranial pressure (swelling inside the skull) without neurological signs except occasional 6th nerve palsy - paralysis of the 6th cranial nerve which causes double vision (Miller and Keane, 1972, 1978, p.1, 251, 837).

[3] The current Sydney trial includes 30 women. This information provided in May, 1997 at the FPA conference contradicts Ian Fraser's application in which he suggests 110 women by mid 1997. The data presented at this forum included women's experiences in the first 12 months of Norplant use (Louise Massey, 1997).

[4] I wonder if Tang was successful in obtaining permission for such a trial and if yes whether there are not serious flaws in an ethics committee that would make such a decision.

[5] The Australian chapter of FINRRAGE - Feminist International Network of Resistance to Reproductive and Genetic Engineering - has joined the international resistance to Norplant.

[6] Women who undergo surrogacy use their womb and their egg to produce a child - yet they deny themselves of the birth mother title. Where-as the infertile woman wanting to use the services of a surrogate mother exploit (alongside her male counterparts) women and motherhood by denying the surrogate mother the right to call herself the foetus' birth mother.

[7] Uterine Evacuation by vaginal misoprostol after second trimester pregnancy interuption, Antonio Bugalho, Cassimo Bique, Caetano Pereira, Ana Carla Granja, Staffan Bergstrom, Acta Obstet Gynecol Scand 1996; 75:270-273.
Effect of vaginal misoprostol application for cervical softening in pregnancy interruption before ten weeks of gestation, Cem Ficicioglu, Murat Tasdemir and Sevel Tasdemir. Acta Obstetricia et Gynecologica Scandinavica, 1996;75:55.

[8] Geoff Brodie Misoprostol paper presented at the Family Planning Association Biological Sciences Meeting, 2-4 May, 1997, Sydney, Australia.

[9] *MIMS Annual* 1991:699

[10] *The Sydney Morning Herald,* Errors cancel abortion report, 1998;Feb17:4.
Frank Devine Health research body's bad blunders raise disturbing questions, *The Australian*, 1998; Feb23:11.
Anna Krohn Abortion Review: Embarrassingly Flawed, *Bioethics Research Notes,* 1998;10(1):1-2

[11] Renate Klein, Lynette Dumble and Janice Raymond RU 486: Misconceptions, Myths and Morals, Spinifex Press, Melbourne, 1991:84.

[12] David Grundmann claims to 'consider the mother's physical and mental well being' as he was reported telling *AM Report*, October 27th, 1994 'Queensland: Brisbane doctor performs abortions up to and after twenty weeks, in an interview with Ellen Fanning (reporter), Transcript online.

[13] See David Grundmann (1994)'Abortion after twenty weeks in clinical practice: Practice, ethical and legal issues' in John McKie (ed) *Conference Proceedings Ethical issues in prenatal diagnosis and the termination of pregnancy* Centre for Human