FINRRAGE

Feminist International Network of Resistance to Reproductive and Genetic Engineering

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Contents

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Editorial

Dear Readers,

It has been a very long time since you received a FINRRAGE Newsletter. Not that FINRRAGE affiliates had stopped being active, but Co-ordinator Christine Ewing's departure to the US meant that a group of already (too) busy women at the Australian Women's Research Centre at Deakin University had one more job to do ... hence the long gap hi producing a Newsletter for which we apologise.

But here we are again: FINRRAGE (Australia) has joined the International Campaign against Anti-Fertility 'Vaccines' articles range from pre-natal testing and tubal ligation to population control and the one-child policy in China. Indeed population control has become a critical topic with FINRRAGE International and (Australian) affiliates challenging its proponents - including, unfortunately, any women's health advocates and environmentalists - for its western-centred racist eugenicist and profoundly woman-hating foundations. This is a topic that undoubtedly will keep us busy for many years to come.

Contributors to this Newsletter, with one exception, are all from Deakin University. We very much hope, however, that for the next issue you will send us articles, conference reports, announcements, and news and views nationally and internationally. Re subscriptions: a few of you have still ongoing subscriptions but because it's been such a long time we decided to send this Newsletter free to all others.

(However, please find details to send donations at the back - especially if you want to support the Campaign Against Anti-Fertility * Vaccines'! Make sure to send us your new address if you have moved.) And if this is the first FINRRAGE Newsletter you read, send us your address if you want to be included on our mailing list.

Feedback is much appreciated as are offers to take charge of special sections that we plan for future issues of the Newsletter, for instance book reviews or conference reports, or international/national news on contraceptive as well as new reproductive technologies and population control policies.

We hope you enjoy this first issue of the revived FINRRAGE Newsletter. At this point we plan to have the next issue out in March 1996 and look forward to your comments and contributions. And please pass the signature sheet around and sign the Call for a Stop of Research on Anti-Fertility 'Vaccines'!

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Vaccination Against Pregnancy: A New Contraceptive 'Choice' for Women or a Tool for Population Control?

Laurel Guymer

Between 1986 and 1987, Australia was the first country experimenting with the most advanced contraceptive, the Anti-Pregnancy 'Vaccine'. Adelaide researcher, Professor Warren Jones (1983) who was responsible for the phase I clinical trials stated that his main impetus for involvement in the development of immunological contraceptives was population growth in the Third World. The phase I trial involved testing sterilised women who were still menstruating, simply to look at the safety aspects of the medication and the volunteers immune response. Peter Haynes, a journalist with the *Adelaide Advertiser* reported in 1987 that "[a]n Adelaide woman ... has warned others to think twice before becoming involved in the program". This woman experienced menstrual irregularities and strong pains in her joints which required codeine as a pain killer. The Human Reproduction Program (HRP/WHO) is responsible for the phase II, 1993-1994 trial in Sweden which was stopped when the first seven women injected with the vaccine experienced similar adverse effects.

Immunological contraceptive development and delivery has a distinct history compared to other industrially manufactured drugs and devices. In particular the design of contraceptives has not only been determined by the profiteering motives of the pharmaceutical industry but primarily by the interests of the population control establishment, including scientists. There are now two types of Anti-Pregnancy 'Vaccines' being developed: one by the HRP/WHO and the other by the Population Council in New York with the National Institute of Immunology in New Delhi.

This Anti-Pregnancy 'Vaccine' acts by tricking a woman's body into producing antibodies against her own hormone - hCG (human chorionic gonadotrophin) - which is essential for pregnancy, thus resulting in the prevention of a fertilised egg implanting in the womb. Unlike anti-disease vaccines this is a vaccination against pregnancy. Body parts do not usually turn against themselves spontaneously unless they are affected by some form of auto immune disease. In order to produce such a response the researchers make the body constituents appear foreign by combining part of the reproductive substance with diphtheria or tetanus in a most advanced vaccine.

Problems with Immunological 'Vaccines'

Immunological contraceptives pose a number of problems and serious health risks. Cross-reactivity is a specific predicament because hCG structurally resembles other reproductive hormones. In Australia, Professor Warren Jones and colleagues decided to break down the molecule in an attempt to prevent cross-reactivity which results in interferences with ovulation, disruptions to the menstrual cycle, damage to the pituitary gland and damage to the thyroid gland.

Unpredictability for each woman varies considerably depending on the lag phase[1] and contraceptive phase. Women with a predisposition to inappropriate immune responses (such as allergies or infectious diseases) might find themselves infertile for life. An unexpected low immune response may occur during times of stress, malnutrition or with the onset of immunosuppressive diseases such as malaria, tuberculosis and HTV/AIDs infection, undermining the effectiveness of such a vaccine. The vaccine is not a barrier method therefore it clearly will not protect against sexually transmitted diseases (STDs).

Documented violations of medical ethics have already occurred in clinical trials in India, where misinformation and inadequate informed

1. Lag period denotes the period where the body builds up an immune response.

consent procedures have been captured on film. German film maker Ulrike Schaz (1993) shows an Indian woman enrolling in a vaccine trial being told:

> [w]e have a new injection ... the effect of the injection stops children for one year... you need not be afraid of this. The injection has no side effects ... [it] is absolutely 100 percent effective...

Vaccines have potential for abuse due to their relatively long action. They can be easily administered not only with, but also without, women's consent and cannot be stopped by the user at will. This potential for abuse is being challenged by international health advocates who issued an Open Letter to researchers, hinders and the press. They are calling for a stop to immunological research and development of Anti-Pregnancy 'Vaccines' and a redirection of funds towards safer methods that women can control themselves. Women from FINRRAGE (Australia) have joined the international campaign aimed at raising public awareness and stopping the unethical abuse of women in trials worldwide.

It is imperative that independent feminist research of women's experiences of Anti-Pregnancy 'Vaccines' be undertaken. This vaccine is far from ideal. Hailed by its proponents as the answer to all women's prayers, there is no mention of its threat to women's health or its potential for racist and eugenic population control policies. The failure rate of greater than 20 percent is less than promising as shown by experiments on women in the phase II Indian trials. Its basic premise that pregnancy is a disease that needs to be eradicated is debatable. As Renate Klein (1994) argues, a vaccine that manipulates a woman's immune system to turn against its own body substances and attacks her own pregnancy including its potential of abuse in the Third World does not constitute a positive addition to the range of contraceptives already available to women.

Population control is not aimed at women making their own decisions about contraceptive needs and health but rather consists of enforcing coercive, racist and sexist procedures in the Third World. Women are being targeted with long acting, highly invasive and often inadequately tested technologies about which they have little knowledge, such as Norplant, Depo Provera and now the Anti-Pregnancy 'Vaccine'. These technologies must be administered by doctors or health providers. Women cannot remove the contraceptives or stop their effects once they have been given. They are seldom informed about the potential side effects which is evidence of population control diminishing women's autonomy with regard to their fertility.

Libertarians try to silence critics of immunological vaccines asserting that their criticism endangers women's reproductive freedom and prevents women from making 'choices'. When critics inform women of the dangers associated with abusive contraceptives, we are accused of turning women into victims, supposedly denying women agency. However there is a vast difference between women's right to choose safe, effective, reversible and user controlled contraception and a woman's right to 'choose' unsafe, experimental and provider controlled contraceptive technologies. For all these reasons I suggest that this vaccine has the potential to be used as an unethical tool by the population control establishment.

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Ethics and Prenatal Genetic Screening: Women's Bodies, Women's Choices – Why not Women's Voices?

Alison Brookes

Prenatal genetic screening (PGS) is the subject of a huge volume of literature addressing the ethical issues posed by the development, implementation and practice of screening programs. Commentaries and research within medical and scientific literature generally assume that the introduction of prenatal genetic screening is a positive social and medical move. With few exceptions within this literature it is taken as given that PGS directly or potentially enhances women's reproductive autonomy. Traditional (western) philosophical arguments are employed to justify routine and mandatory use of screening programs, most often utilitarian and/or liberal theories. Relatively unexamined is the assumption that these models are adequate to account for the situation faced by women when confronted with decision-making with regard to PGS.

PGS programs are becoming increasingly commonplace within western medical models of obstetric care, aimed at detecting an expanding range of fetal conditions. They currently constitute the widest application of human genetic technology (Lippman, 1992A, p. 141). Women participating in PGS programs may now be informed of a variety of genetic conditions that their children may be born with and make reproductive choices in response to this information. It is predicted that PGS may soon be developed which will also inform women of fetal conditions which may be asymptomatic, adult onset, and/or for which effective treatment is available.

Elena Gates has written that a woman's choice to use prenatal testing to determine the genetic status of her fetus, and what decision she makes on the basis of that information, is 'one of the most serious moral decisions she will make' (Gates, 1993, p. 239). I am interested in how women make these decisions, what moral framework(s) they use during this process and how these frameworks are developed. I don't believe that the current philosophical arguments employed in the extensive debates which surround and support the practice of PGS are adequate to validate women's varied experience of PGS and the variety of approaches they employ to come to terms with the personal ethical dilemmas posed by the programs.

Lack of regard as to how choices and decisions are constructed and constrained socially and validated philosophically deflects attention from assessments of the social and philosophical frameworks themselves. I believe that these should be subject to scrutiny in an effort to both more fully understand women's current experiences of PGS and also to facilitate the development of an ethical framework relevant to women as the central participants of PGS programs.

The unique relationship women have to PGS is regularly obscured within (and by) the ethical debates which are developed within medical and scientific discourses. As Abby Lippman writes:

> [p]renatal testing is a technique applied to women. How, when, by whom and to whom it will be applied will be conditioned by prevailing attitudes about women, their bodies and their roles. Prenatal diagnosis can hardly be neutral in a world where women are as a group disadvantaged ... frequently socialized to follow authority and to acquiesce to certain norms surrounding maternity and motherhood (Lippman, 1992B, p. 5).

While the claim that prenatal testing is a technique applied to women appears obvious it needs to be repeated and emphasized. Throughout much of the medical and scientific literature addressing PGS it is impossible not to notice the relative absence of women: the

emphasis remains on fetuses and society, with women's interests often assumed to be in accord with (largely unexamined) assumptions regarding women's relationship to both.

Many ethical issues are discussed and debated within academic disciplines in response to the development, implementation and practice of PGS. These include:

- equity of access to services;
- eugenic motives and/or outcomes associated with PGS;
- social discrimination resulting from the detection of fetal genetic anomalies;
- the direct and indirect consequences of PGS for people with genetic conditions and disabilities;
- the place of individual autonomy within the programs;
- the reliance upon abortion as a response to PGS results;
- appropriate use of medical resources; and,
- the concerns raised regarding 'genetically chosen' children.

Increasingly, the possibility of obtaining fetal genetic information is being construed as a woman's duty. As a result, PGS programs are commonly introduced as 'mandatory' programs, dependent not upon participants' informed consent, but rather 'informed refusal' if women wish to opt out of the program. Willingness to submit to PGS is presented as an indication of a 'reasonable person' (Fry, 1987, p. 52) as well as a sign of responsible parenting (Gates, 1993, p. 239). Elena Gates asks: 'Is a woman acting irresponsibly in the eyes of others if prenatal diagnosis is foregone?' (Gates, 1993, p. 239). Much of the literature assumes this is the case. This is despite wide acknowledgment that many forms of prenatal diagnosis involve fetal and maternal risks, and the recognition of the unresolved nature of questions addressing the ethical and social implications of screening programs. Further, abortion of affected fetuses has been construed as a social obligation and responsibility. Indeed, it has been argued that 'parents who allow the birth of a baby with a serious defect are inflicting harm and may be legally, as well as morally, liable for their actions' (Wilfond and Fost, 1990, p. 2781).

While PGS is viewed as a responsible undertaking by pregnant women, (and we must always remember to what extent women are constrained from making 'irresponsible' decisions during pregnancy, for example, choice of attendants and place of child birth etc.), it may be increasingly difficult for women to refuse testing. In a discussion regarding the ethical position of mandatory Maternal Serum Alpha-Fetoprotein [MSAFP] screening, Sarah Fry claims that infringement of liberty with regard to initial testing increases autonomy and choice in later decisions (Fry, 1987, p. 52). She says '[t]he essential purpose of mandatory Maternal Serum Alpha-Fetoprotein screening is to inform the pregnant woman of the possible birth of [a neural-tube defect] affected child' (Fry, 1987, p. 30). Relying heavily on Mill's utilitarian philosophy she describes women who do not agree to MSAFP screening as necessarily uninformed (Fry, 1987, p. 52). This argument poses a serious dilemma for women. If valid decisions regarding participation in PGS programs are dependent upon women already being informed regarding fetal genetic characteristics, then any decision by women not to participate in PGS programs is not recognized as valid as it is inherently based on a perceived lack of information. Of course, this information is only available through participation ...

As Barbara Katz Rothman discussed in her book *The Tentative Pregnancy,* women are less likely to announce their pregnancies until after receiving the results of PGS indicating that their fetuses are not affected by targeted genetic conditions in an effort to prevent other people 'being involved in the decision' (Katz Rothman, 1988, pp. 98–100). The availability of prenatal genetic screening has involved others in women's reproductive decision-making in an unprecedented way. Insurance companies, employers, and society as a whole

now have a perceived 'interest' in the outcome of women's decision-making with regard to PGS (Gates, 1993, p. 239). Elena Gates notes that 'it is not clear that reproductive choice is actually enhanced' (Gates, 1993, pp. 238–9). If women are confronted with a narrow choice of socially or philosophically 'valid' choices from ethical frameworks into which their input has been limited then it is indeed unlikely that women's reproductive autonomy is benefited by PGS.

The developed and structured ethical discourse which is evident in medical, scientific, and philosophical disciplines is in marked contrast to the dearth of exchange of positions and beliefs which occurs between women participating in PGS programs in this country. It is true, as Eric Haan writes, that:

> Australians are familiar with and have accepted screening programs which detect children affected by serious disorders. These include the extremely successful screening programs for phenylketonuria and hypothyroidism, and antenatal screening programs for malformations by ultrasound, for neural tube defects by maternal serum a-fetoprote in estimation, and for Down's syndrome by amnio-centesis or chorionic villus sampling in older mothers. More recently, neonatal screening for CF [cystic fibrosis] and maternal serum screening for Down's syndrome have been introduced (Haan, 1993, p. 419).

This familiarity however does not extend to acquaintance with the ethical issues so widely acknowledged within academic literature.

Women share their decision-making with few, if any, other people in, I believe, an effort to avoid justifying their position within frame-works which are not personally valid for them, which restrict their reproductive choices and limit their reproductive autonomy. My contention is that this discourse is not developed within the community of women participating in PGS both because of the nature of the programs and, importantly, the socially taboo subject matter raised by women's decisions surrounding PGS: abortion, disability, and the questioning of the role of mothers as carers and nurturers. Ethical frameworks are developed by an exchange of ideas, by challenging previously held assumptions and by subjecting ethical claims to review, analysis and criticism. In short, ethical frameworks are required to be justified. As the editors of *Ethics: A Feminist Reader* note

> [philosophical theories, and therefore ethical theories, always issue from the experience of a particular human community ... Thus the collective experience, however strangely refracted through the medium of exceptional personalities, is raised to explicit consciousness in the form of a discourse' (Frazer *etai,* 1992, pp. 1–2).

For PGS to approach the goal of enhancing women's reproductive autonomy these social taboos must be challenged and restraints on women's participation in the development of ethical and moral theory development removed.

My Doctoral thesis is exploring these and other issues with women directly and immediately involved with and confronted by PGS. I am interested in hearing from women who have made a decision regarding participation in PGS programs (either to participate or opt out), women with genetic conditions making decisions about parenting, and women who are mothering children with genetic conditions. In the spirit of the development of ethical frameworks involving exchanging and challenging ideas, positions and opinions, I am also very keen for feedback from women on the nature and role of this research.

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Surgical Sterilisation: Dispelling the Myths

Lyn Turney

The success of surgical sterilisation, or 'tubal ligation', as a commonly used method of contraception is premised on two main grounds, its permanency and its efficacy. I wish to contest issues around each of these claims.

In our uncertain times when permanent heterosexual relationships are becoming less normative and men as well as women win custody of children in the event of failed relationships, it is crucial for women to be absolutely clear about what sterilisation means in terms of future possibilities. It seems that for sterilisation providers any uncertainty about future family arrangements is consistently countered by the potentiality for reversal. 'Permanent' in relation to sterilisation can then be misread as 'until circumstances change', that is, as semi-permanent rather than for forever.

Despite claims that surgical sterilisation is reversible and even 'semi-permanent' (Frazer, 1995), sterilisation reversal for women is not a simple procedure but requires major micro surgery to rejoin the fallopian tubes, part of which must be destroyed completely (by crushing, burning, strangulating or cutting) if sterility is to be effected. Reversal has been shown to have relatively low success rates particularly since the rates given are for women who have been carefully pre-screened for suitability. Even if the tubes are successfully rejoined, many women have to undergo fertility treatment in order to become pregnant because of reduced ovarian function. This means that although the tubes are technically viable in terms of providing a conduit for sperm and ova, the possibility of pregnancy is severely reduced because of hormomal deficiency and resultant inability of the ovary to produce ova.

A recent study showed ovarian deficiency within 12 months after tubal ligation in 60% of women who had been carefully pre-screened for 'normal' ovarian function, and a staggering 30% of the study group were not ovulating after one year (Hakverdi *et al.,* 1994). Both ovulation and the control of endometrium shedding (period bleeding) are dependent on the hormone progesterone which these and other researchers have shown to be significantly decreased after tubal ligation (for example, Donnez *et al.*, 1981; Radwanska *et al*., 1979 and Berger, Radwanska & Hammond, 1978). Reduced progesterone is believed to occur either because of interruption at surgery of the blood supply to the ovary causing overall reduced hormone production (Lu & Chun, 1967; Chamberlain & Foulkes, 1976; Radwanska *et al.*, 1979; Alvarez-Sanchez *et al.*, 1981; Cattanach, 1985 and Cattanach & Milne, 1988). Alternatively, damage to the fallopian tube interrupts the direct flow of progesterone between the ovary and the uterus, which means that progesterone is degraded in its journey via the liver, reducing both its capacity to ensure the release of ova and to inhibit menstrual flow (Ringrose, 1974).

The second claim, that female sterilisation is a highly effective surgical procedure and therefore the most efficacious contraceptive method is accurate only because destroying fertility is very much more effective than controlling it (which less invasive contraceptive methods do). The failure rate (resulting in pregnancy) following tubal ligation claimed by the Royal Australian College of Obstetricians and Gynaecologists in their brochure is one or two in every 500 women. However, a recent large hospital audit found the failure to be as high as twenty-two in one thousand (2.2%) or one in every fifty women[1] (Birdsall, Pattison and

1. The researchers divide this group into 'surgical' and 'administrative' failures, the former being due to mistakes such as misapplication of the occlusive device (86%) and the latter related to those women who were already pregnant at the time of surgery. In terms of the result for the women concerned and for the consent process, this technical division is meaningless.

Wilson, 1994). This audit reviewed all sterilisation procedures carried out over two years (on 1094 women) and the auditors clearly state that 'sterilisation is associated with a significant failure rate' (1994: 473). For those women who do become pregnant, the effect can be devastating. Because the pregnancy is highly likely to be ectopic (a pregnancy which occurs outside of the uterus), a condition which can be life threatening[2] and almost certainly unwanted, most women who do become pregnant under these circumstances are faced with an abortion. Abortion for these women is often a traumatic experience and particularly so for those who oppose it on moral grounds, for moral opposition to abortion is frequently the reason many women decide on sterilisation in the first place.

More importantly though, measuring success in terms of the prevention of pregnancy overlooks the impact this procedure may have on the lives of women 'successfully' sterilised. Women experience complications at surgery at a rate of 4%, (Chick, Frances & Paterson, 1984) as well as the short and long term problems which include: infection, (LoBue, 1981; Lanes *et al.*, 1986: 989); hydrosalpinx (accumulation of a watery fluid in the tube) (e.g. Russin, 1986; Togashi *et al.*, 1986; Phillips & D'Ablaing, 1986; Bernardus *et al.*, 1984; Stock, 1983 and Gregory, 1981); torsion[3] (a twisting of the tube or ovary) (e.g. Russin, 1986), increased incidence of endometriosis (Denton, Schofield, & Gallagher, 1990 and Fakih *et al.*, 1985), slightly higher incidence of cervical cancer (Stock 1984 and Koetsawang *et al.*, 1990), heavier bleeding and increased pain, (Shain *et al.*, 1989; Richards *et al.*, 1991; Wilcox *et al.*, 1992) and an increased risk of undergoing hysterectomy (Templeton & Cole 1982; Cohen, 1987; Kjer & Knudson, 1990 and Goldhaber *et al*., 1993).

A research paper from The Collaborative Review of Sterilisation (CREST)[4] found that by five years after sterilisation, 35% of 5070 women reported high levels of menstrual pain and almost half of the study group (49%) reported heavy bleeding (Wilcox *et al.*, 1992). The researchers say that these changes cannot be explained by the usual effects of ageing nor by amount of tissue damage caused by older methods. In fact, increased menstrual pain was more likely to be experienced after the application of spring clips (a modern method).

Research since the 1970s has consistently shown that women who have tubal ligation are more likely to undergo subsequent hysterectomy due to bleeding disorders (for example, Muldoon 1972; Mattingly 1977; Gupta *et al.*, 1979; Templeton & Cole, 1982 and Cohen, 1987). More recently, Kjer and Knudson (1990) observed a large group of women over a period of four to seven years and concluded that the risk of undergoing hysterectomy for bleeding disorders subsequent to sterilisation was increased three to four times compared with women who did not undergo sterilisation. Goldhaber *et al.*, (1993), in a study of 80,007 women, report that sterilised women were significantly more likely than their non-sterilised counterparts to undergo hysterectomy; that relative risks varied little by method of tubal occlusion; but were highest when hysterectomy was performed for menstrual problems or pain; and doubled for women under 25 years at sterilisation (see also Shy *et al.*, 1992).

Shy *et al.* (1992) found that the risk of hospitalisation for menstrual disorders was almost two and a half times (2.4) greater for women who had been sterilised. I have argued elsewhere (Turney, 1993) the problematic of measuring morbidity in terms of hospitalisation because it overlooks the pain, suffering, embarrassment and inconvenience

2. These women have a 25% to 75% chance that the pregnancy will be ectopic Chick, Frances & Paterson 1984.
3. Weeks & Entman (1991) report iatrogenic gonococcal peritonitis and LoBue (1981) reports pelvic inflammatory disease and peritonitis following tubal ligation.
4. 'The Collaborative Review of Sterilisation (CREST) is a large, multicentre, prospective study of tubal sterilisation in the United States' (Wilcox *et al.*, 1992:1368).

that women who are not hospitalised (and therefore are omitted from any of these statistics) may endure as a result of surgical contraception method.

Surgical sterilisation is not a method which is equal to other non-invasive methods, nor indeed to male sterilisation and should therefore never be promoted as innocuous. It is unethical not to consider, or to trivialise, the impact that sterilisation may have on women's everyday lives, and even more so not to inform them of the possible ill-effects of this method. To promote surgical contraception as anything other than the permanent destruction of fertility, which sometimes fails and which has attendant side effects, at least equal to but certainly less reversible than other contraceptive methods, is to misinform women and to deny them their basic human rights.

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China's Crimes Against Women: Population Control and the Beijing Conference

Melinda Tankard Reist

In China, women are dragged from their beds in the dead of night, herded into cattle trucks and taken to hospitals where they are tied to tables and forcibly aborted up to nine months of pregnancy. Anaesthetic or pain relief is often not given. Sometimes their babies are killed via hypodermic syringe plunged into the soft spot on the skull at the point of crowning. Countless women have their desire for a second child thwarted by coerced sterilisation. Those deemed unfit under the new eugenics laws designed to "avoid new births of inferior quality people" are permitted no children. In many parts of China, women must present their blood-stained sanitary pads to family planning officials to prove they are not pregnant. Many must submit themselves for regular X-ray checks to ensure their IUDs are in place. Chinese orphanages, more accurately described as children's gulags, liquidate surplus baby girls by the thousands.[1]

Hundreds of thousands of China's women have been abducted and trafficked to meet the growing demand for wives, slaves and prostitutes. "Women have been the silent victims of government policies which encourage or tacitly accept human rights abuses" says a recent report.[2]

1. There are many references to these practices in recent literature. See "China's wanted children," *Independent* (London), 11 Sept 1991. Reprinted as "Brutal Lessons in the Facts of Life", *Sunday Age* (Melbourne) 22 Sept 1991: 13; Melinda Tankard Reist, "China's children of the damned", *Age,* 31 Mar 1995: 17; "A Confession of a Birth-Control Plan Cadre", *Dong Xian* (Hong Kong) 1992; Steven Mosher, *A Mother's Ordeal: One Woman's Fight Against China's One-Child Policy,* (Harcourt Brace, New York, 1993), "The Baby Police", Women Out Loud, ABC Radio National, 18 March 1995); "Birth of a Nation: China proposes eugenics policy", *Far Eastern Economic Review,* 12 Jan 1994: 5; Ann Durdin "The Shame of China: girl children abandoned to die of neglect", *ITA,* October 1993; Tom Hilditch Waiting to Die: The babies sacrificed for China's one-child policy", *Sunday Morning Post Magazine,* June 25, 1995.
2. "Women in China face epidemic of violence", *Australian,* August 18, p. 8.

A US State Department report on human rights concludes China made no progress in any major human rights area in 1994.[3] This is the country that played host to the biggest women's human rights conference in the world. The UN Fourth World Women's Conference, designed to empower women, eliminate discrimination against them, develop their full potential and promote their human rights, recently concluded in the capital of a government which has made crimes against women an art form.

In China, a woman's body is not her own. The government enforces an intrusive one-child-per-couple birth control policy (only slightly relaxed in outlying regions) with fertility decisions controlled by the State. A couple is not free to decide when to have children, nor how many to have. The lives and bodies of women and men have been subordinated by the State; its heavy hand reaches into the intimate lives of Chinese women and their partners with merciless precision.

The freedom to have children, taken for granted by women in other parts of the world and upheld as a human right in various conventions, is unknown to women in China. To defy the birth plan is an act of treachery, a crime against the State. A woman's right to bodily integrity and her freedom of conscience are forfeited daily. Her rights continued to be violated during the days of the world conference on women.

The official host of the parallel NGO forum was Chen Muhua, the first Minister-in-Charge of the State Family Planning Commission. She headed family planning when the brutal one-child policy came into force in 1979.

The UN justified its awarding the conference to China with a leverage argument. Things might

3. *Country Reports on Human Rights Practices for 1994,* Washington DC, Government Printing Office, 1995.

change if the conference is held there. This cannot but be viewed with cynicism. What has the involvement of the United Nations, through its Population Fund (UNFPA) done for the millions of victims of China's population control program for whom the "right to life, liberty and security of person", the "right to found a family" and the prohibition against "cruel, inhuman or degrading treatment or punishment"[4] count for nothing?

The UNFPA is up to its neck in China's program – it has been funding it for two decades and things have not improved. Supposedly committed to the "basic right of all couples and individuals to decide freely and responsibly the number and spacing of their children" as laid down in the 1974 World Population Plan of Action (and reaffirmed in Beijing) the UNFPA allocated $50m in a five-year assistance plan to China in 1979 – right at the start of the coercive one-child policy. During 1983 when the fitting of IUDs in all Chinese women of childbearing age with one child became mandatory, a new IUD factory was built with the UNFPA assistance. The UNFPA has so far given more than $157m in population-related assistance to China.

UNFPA's Nafis Sadik has described the program as "totally voluntary" and claimed that there was no such thing as a license to have a birth. In April 1991 she told XINHAUA newsagency: "China has every reason to feel proud of and pleased with its remarkable achievements made in its family planning policy and control of its population growth over the last 10 years. In July 1994 she told the Clinton Administration that the UNFPA found coercion "morally repugnant" and repeated China's claim that it opposed coercion.[5]

The UNFPA has given China awards for its great success in family planning. It is a co-conspirator with China in the abuses carried out there. Why would it want to exercise leverage on a program it has commended universally?

Australia helps fund the UNFPA and is currently giving direct funding to two family planning programs in China, adding further legitimacy to the program. At the same time the Australian Government has attempted to ban asylum claims based on fear of persecution under China's one-child policy by couples seeking protection in Australia from forced sterilisation and abortion.

Migration Legislation Amendment Bill (No. 4) was introduced earlier this year to overturn a Federal Court ruling by Justice Sackville that a Chinese couple fearing forced sterilisation if returned to China should be granted refugee status under the "Membership of a particular social group" category of the UN Convention and Protocol Relating to the Status of Refugees. The Immigration Minister Nick Bolkus also appealed the court ruling and won. That decision is to be appealed in the High Court. The legislation appears to be on hold.

China perpetuates violence against women through the most brutal, most inhumane fertility control plan in the world.

The PRC's idea of protecting the human rights of women is demonstrated in its "Law for the Protection of the Rights and Interests of Women" 1992. Article 42 reads: "When a wife terminates gestation as required by the population program her husband may not file for divorce until six months after the operation."[6] Are Chinese women supposed to take comfort in this?

China's population control propaganda machinery was working overtime at the Beijing conference. Large glossy publications on China's wonderful family planning program were everywhere to be seen, including one with the

4. Universal Declaration of Human Rights, Art 16, 3); International Covenant on Civil and Political Rights, Art 7).
5. John S. Aird, "Human Rights and US Reactions to the Chinese Family Planning Program", testimony to Sub-committee on International Operations and Human Rights, 17 May 1995.
6. Michael Schwartz "The Culture War Goes Global," *Human Life Review,* 21, 2 (1995): 21.

magnificently ironic title "Baby friendly action in China" wall to wall with photos of blissful mothers with babies at their breasts. Another, "Women and family planning in China" featured the most beautiful and elaborate artwork of mothers and children. You'd put it on your wall if it didn't remind you of all the women grieving over their rifled and bleeding wombs.

At a workshop to laud their great love for women, family planning officials, appropriating the language of "informed choice" and "reproductive rights", bragged about the "quality of care" in their family planning programs, with an emphasis on the importance of counselling. ("Counselling makes a difference" was a prominent theme. It certainly does when you are counselled that you will be forcibly aborted, sterilised, fined, have your house pulled down and that an unauthorised child will be denied household registration, milk rations, free kindergarten etc.) Professor Wang Shao-Xian of Beijing Medical University made the extraordinary claim that Chinese women "have the right to determine the number of children" they want. Professor Xiao Bilian of the National Research Institute for family planning said: "When the people have unwanted pregnancy we do provide the service (of abortion)".

At another workshop titled "Heart to Heart with Tibetan Women" seven speakers, all with the All-China Women's Federation, sang the praises of China's achievements in Tibet in taking it from ignorance and misery to unspeakable prosperity. They fell over themselves to correct my mistaken belief that forced abortions and sterilisations were being carried out by Chinese authorities on Tibetan women. Tibetan women have complete freedom to determine their family size, I was told. (Meanwhile, a small group of Tibetan exiles withstood harassment and surveillance to distribute evidence of population control violence against Tibetan women from a tiny rain-sodden tent.)[7]

7. For detailed descriptions of China's population control actions in Tibet, see *Tears of Silence: Tibetan Women and Population Control* (Tibetan Women's Association, Dharamsala, India, 1994) and Martin Moss, *Children of Despair,* Report 3, Campaign Free Tibet.

Women's activists who have struggled long and hard to expose population control abuses of women around the world and who refute those who see the "right to choose" as synonymous only with abortion and not encompassing a woman's desire to have children,[8] saw some victories in Beijing.

The issue was raised by Hillary Clinton. Addressing the UN conference, she said: "It is a violation of human rights when babies are denied food, or drowned or suffocated or have their spines broken, simply because they are girls." She also said it was a denial of human rights when women are denied the right to plan their families "and that includes being aborted or sterilised against their will." US Ambassador to the UN Madeline Albright stated: "No woman – whether in Birmingham, Bombay, Beirut or Beijing – should be forcibly sterilized or forced to have an abortion." (Of course, we cannot be somewhat cynical about these statements when the US is funding population control programs in China (through UNFPA) and other countries and has denied asylum to Chinese couples fearing forced abortion or sterilisation if deported. But it was still good to have this violence raised in an international political setting. It certainly upset China. Its press made no mention of the Clinton/Albright remarks however featured articles in the following days about how much better things were for Chinese women than American women. The US had so many poor people because it had failed to implement strict family planning, one report stated).

More significantly, the 150 page non-binding plan of action adopted by 198 nations and

8.1 conducted my impromptu survey among a number of family planning people I met in Beijing. I asked a US Planned Parenthood woman: "Do you believe in freedom of choice?" "Yes, of course" was the answer. "Reproductive rights?" "Absolutely." "Does freedom of choice mean the freedom to have children?" "Oh ... well ... no, that's different..." A man I spoke with who had been involved in population programs with the Rockefeller Foundation (and who, incidentally, was fundraising director for *Roe v Wade)* reacted angrily at the attention being drawn to population control abuses, because this distracted from the real problem of too many pregnancies.

designed to be a blueprint for advancing the rights of women around the world, listed forced abortion and sterilisation, coercive/forced use of contraceptives, pre-natal screening and female infanticide as violence against women.[9] These words which struck at the heart of China's fertility control plan had all been bracketed in the draft platform and the Chinese delegation naturally fought to keep them there.[10] China, with others, did succeed in getting the clause condemning female foeticide deleted, along with wording condemning discrimination against the girl-child "from conception". Governments were called on to "enact and enforce legislation against the perpetrators of practices and acts of violence against women" including prenatal sex selection and infanticide.[11]

The over-emphasis on family planning/ population control was criticised by a number of women from developing countries who felt acutely targeted by these lobbies. UBINIG Bangladesh led a protest march against the abuse of women in the trialing and promotion of long-acting provider-controlled hormonal contraception.[12] A Kenyan doctor I interviewed told me that there was no shortage of Western-supplied contraceptives for her patients, but she could never find enough penicillin and tetra-cycline to treat them. She said they gave birth to babies on the floors of leper wards because funding shortages had closed hospital beds. "Safe Motherhood" was reduced to contraception and abortion, with primary health care ignored. For example, the doctor said, women were instructed how to check their IUD strings internally, but there was no clean water for them to wash their hands.

The language against population control-inspired violations against women in the final document was a win. However, whether it reigns in the zealotry of the gung-ho birth control bullies who see women as tubes, wombs and targets remains to be seen. Women's health activists must ensure that the gap between rhetoric and reality is eventually closed.

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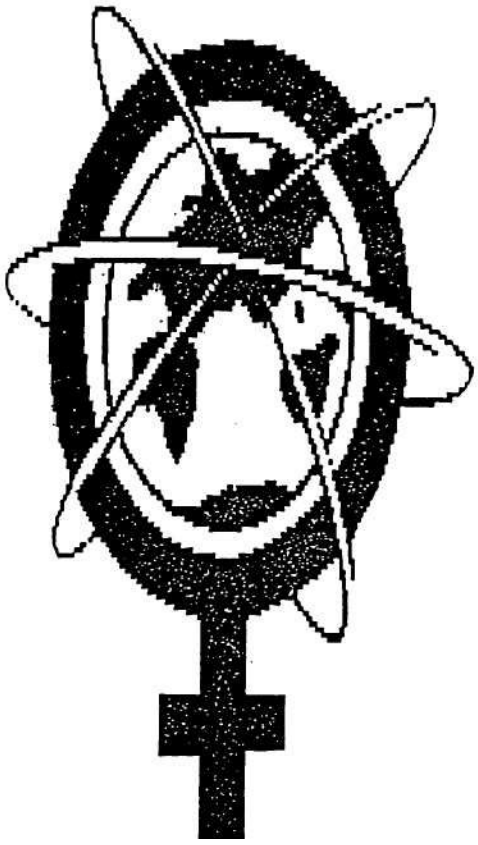

9. See para 40, 96 bis, 108 (a), 115 (bis.).
10. The head of the Chinese delegation demanded deletion of the word "coercive" from the paragraph requiring governments to "ensure women's reproductive rights and eliminate coercive laws and practices." "All laws are coercive. I think that in all countries when a law has been promulgated all citizens are forced to obey the laws," the delegate argued.
11. Para 125 (i).
12. The document does state: (105) "Clinical trials involving women to establish basic information about dosage, side-effects and effectiveness of drugs, including contraceptives, are noticeably absent and do not always conform to ethical standards for research and testing". Par 107 (h) says governments should 'Take all appropriate measures to eliminate harmful, medically unnecessary or coercive medical interventions, as well as inappropriate medication and over-medication of women. All women should be fully informed of their options, including likely benefits and potential side-effects, by properly trained personnel."

‘Empowerment for Women’: The Population Controllers’ latest Anti-Feminist Rhetoric or ‘One Can’t Save the Earth by Killing Women’*

Renate Klein

In the mid-seventies, the Development Establishment recruited ***women*** as new objects of attention. Coinciding with the launching of the UN Decade for Women in 1975 came the first demands that enhancing the status of women in the so-called developing world would reduce fertility rates which was, unquestionably, in the women’s best interest. From the beginning this allegedly two-pronged strategy had one implicit long-term goal: the drastic reduction of people in poor countries. This goal seemed even more pressing after it became evident that the wonders of the ‘green revolution’ had led to millions of displaced peasants and vastly increased areas of land that had been devastated through the misguided efforts of western technologists (see Vandana Shiva, 1988 and Maria Mies and Vandana Shiva, 1993).

Integrating women into development sparked new hope in the disillusioned development establishment (see Pam Simmons in Irene Diamond, 1994, p. 130). Women were now seen as labourers and the ‘targets’ of aid projects in their own right – sometimes with loans from establishments such as the World Bank – specifically focussed on their role as small business entrepreneurs. However, to this day such efforts remain largely export oriented and not of an environment friendly nature. They further contribute to the disintegration of local economies and environments (see Betsy Hartmann, 1987/1994). Women’s social standing is rarely enhanced as it is frequently middlemen who take control over their products. Current figures that for every ‘aid dollar’ given, $2.66 flow back to the donor countries (ABC-TV Asia Report, 24 March, 1995) demonstrate that the rhetoric of ‘women’s advancement’ is a good cover for making money.

Quite predictably, the international population control establishment latched on to this western-styled strategy to integrate women into global economic development and began the well-known propaganda campaigns in so-called third world countries that ‘smaller families are happier families’. Too often such propaganda amounted to coercion: fertility limitation was at the heart of the matter rather than economic self-sufficiency – no money without accepting whatever contraceptives were supplied by the donor countries under the misleading label ‘birth control’.

Until about 1992, many feminist and environmental groups from both the ‘north’ and the ‘south’[1] strongly exposed the practices and termed them racist, eugenicist and misogynist (see among others works by Vandana Shiva, 1988; Farida Akhter, 1992; Betsy Hartman, 1987; and Betsy Hartman and Hilary Standing, 1985, who in *Food, Saris and Sterilisation* exposed a particular scandalous practice in Bangladesh). In many developing countries, women’s fertility rates were dramatically reduced; in fact, Farida Akhter speaks of *Depopulating Bangladesh* (1992), and Vandana Shiva in *Staying Alive* (1992) highlights the exploitative practices of the Gene Age: replacing the Green Age but perpetuating the anti-feminist processes of colonialism including an increasing elite of indigenous people who collaborated with the western exploiters.

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* This is a version of a paper delivered at the Australian Conservation Foundation Conference ‘Women and the Environment, Melbourne, March 24–26, 1995.

1. This is frequently used but unsatisfactory northern hemispherist terminology which does not differentiate between dominant-group women in Australia and Aotearoa/NZ and poor women in many so-called third world countries in the ‘south’.

But then a strange thing began to happen. Increasingly so-called feminists and environmentalists jumped on the population bandwagon and declared 'population' the Number One problem the world now has to face. In other words ***not*** the reduction of consumption and waste production in rich countries, the elimination of structural adjustment programs as well as debts and the social injustice of the GATT agreement needed to be critiqued, as well as demands be made for the re-allocation of money formerly going to population control policies into programs for basic water, food, education and health – and not only reproductive health, but ***general health***. No, it was 'population' – that amorphous mass of statistics that on a chart can be seen as not even replacing itself in developed countries and still having fertility rates of 2.4 and more in poor countries[2] – that began to be the focus of a renewed hysteria that equals the one the 60s triggered when Paul Ehrlich's *Population Bomb* (1968) threatened to explode and sent hysterical shock waves through western countries which were terrified to lose their economic and cultural power and privilege to run the world (see Renate Klein, 1995b).

In the 90s this hysteria has reached a new peak. The exploitative privilege of belonging to the 20% of the world's population who uses 80% of the world's resources (and produces a similar amount of waste and pollution!), doesn't seem to be 'safe enough'. It is these countries (and their elite allies in the 'south') who urge the world to put better measures into place to curb fertility in those countries that need to stay in a subservient relation to the powerful rich – and among those unfavoured 'fringe groups' in rich countries that must not become part of the group in power, such as for instance indigenous groups in many countries and to some extent black people in the USA. The new twist is that some feminists and environmentalists are now at the forefront of preaching this message.

Women are explicitly named as key players whose 'reproductive rights' and 'empowerment' will guarantee the successful slowing down of the world's population: a continuation of the gradual cooption since the mid-seventies of (some) women into the service of global technopatriarchy.

In May 1993 at the second Preparatory Committee Meeting for the International Conference on Population and Development in Cairo – the IGPD – 'The Women's Declaration on Population Policies' was launched by a group called Women's Voices '94 Alliance. The document advocated a ***feminist*** population policy. What was intriguing was how widely this declaration was circulated for signatures and how it was followed by more international women's meetings resulting in classy Conference Proceedings which were freely and in multiple copies dispatched by air mail throughout the world.

If it hadn't been obvious until then, the cat was out of the bag: 'someone' had a vested interest in financially supporting these groups including bringing participants from around the globe to this and at least six other international meetings before Cairo. Not surprisingly, among the supporters range the Ford Foundation and the United Nations Fund for Population Activities (UNFPA), the MacArthur Foundation who in 1988 established the Population Program, The World Bank, the Population Council and USAID. And the US-based International Women's Health Coalition is one of the major key players in this take-over and cooptation of women's health activists (Renate Klein, 1995b and c).

Question: Is the rhetoric of 'empowerment' and women's 'reproductive rights' commensurate with the philosophical and political stance of feminism? Is the co-optation of feminist language feminism?

Answer: No. As the theory and practice of the Women's Liberation Movement, feminism is committed to contribute to social change for *all* women. A policy manipulating people as statistics using pseudo-scientific logic does not

2. See Maria Mies (1994) for a splendid analysis of 'People, not Population'.

sit comfortably with feminism. Most importantly, feminist theory and practice is committed to eliminating hierarchies of oppression, hence a 'feminist' population policy which endorses the necessity of reducing 'some' women's fertility in 'some' parts of the world because of the alleged problem of 'overpopulation' – without seriously looking at their own 'over consumption' – is racist and eugenicist and a contradiction in terms. It is not 'population' that is the root cause of poverty, it is not women's fertility that is causally linked to environmental degradation, world hunger and poverty, but the legacy of colonialism and neo-colonial theories such as 'overpopulation' and the suppression of research that shows the connections between technopatriarchy and the exploitation of Third World Peoples.

International feminist organisations – mainly from the 'south' – responded with anger to the 'Women's Declaration on Population Policies' by meeting in Bangladesh in December 1993 and writing a feminist critique of the logic of domination that underlies population control policies. Instead of using the rhetoric of 'choice' and 'reproductive rights' we demanded an examination of the ideology 'bullets turned into contraceptives' (see *Declaration of People's Perspectives*, 1993).

Strangely enough – and I now shift to Australia – whenever 'population-as-problem' is discussed, and the formulation of a population policy advocated that would have as part of its brief the stabilisation of 'population', as for instance put forward by the Chair of the House of Representatives Long Term Strategies Committee The Hon. Barry Jones at the 3rd National Immigration and Population Outlook Conference in Adelaide (1995), apart from reducing immigration, it is not discussed ***how*** such reduction of numbers will be achieved. Since Cairo we're only too familiar with the rhetoric of women's empowerment and reproductive rights – but what do these words actually mean? Far from being reasonable methods of 'family planning' that allow women to decide on their numbers of children with ***user***-controlled contraceptives and back-up abortion, the increasing move to ***provider***-controlled hormonal and immunological contraceptives such as injectables (Depo Provera), implants (Norplant) and the contraceptive vaccines (see Judith Richter, 1993), are coercive in and of themselves. Together with often mandatory sterilisation, chemical abortion (RU486) and new reproductive technologies such as IVF, they hold the potential for a global manipulation of the world's population (see Renate Klein, 1989,1994 and 1995b and c and Renate Klein, Janice Raymond and Lynette Dumble, 1991). In fact, they constitute nothing less than *crimes* against women's human rights.[3] They do not give women 'choice'. The means by which the empowerment rhetoric is to be fulfilled fundamentally threatens women's health – short and long-term – as well as assaulting women's bodily integrity.

To give an example: in Australia, will it be Aboriginal women who will be allowed to have the precious babies? Immigrant women? Poor urban white women? The renewed philosophy that our genes are our destiny – to paraphrase Freud – that leads to an increasing pressure on an increasing number of people to undergo genetic testing before they have children does not bode well for anybody being 'allowed' to procreate who is not 'normal' what ever normal will deemed to be at a specific time. In Australia and globally: who

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3. China undoubtedly provides a worst case scenario of population control. In the 90s the forced sterilisation, infanticide and forced abortions in China continue unabated predominantly as femicide (Melinda Tankard Reist, 1992,1995a, b) – and as genocide in Tibet (Tibetan Women's Association, 1994). In 1995, the Australian Department of Immigration is trying to pass a shameful Migration Legislation Amendment Bill (no 4) which would make it easier to return to China boat people who fled their country because of the torture and human rights violations experienced through China's Population Control Policy (Lynette Dumble, 1995; Renate Klein, 1995a). The justification for the Department's action was squarely couched in overpopulation rhetoric based on the 'consensus' achieved in Cairo: because 'population' was clearly identified as the number one problem in the world today, China's population policy appeared to be 'reasonable'. At the time of writing the outcome of the proposed amendment remains unknown.

will decide which women in which countries will be allowed to have what kind of children? Moreover, as US environmental engineer, Patricia Hynes has observed so well (Hynes, 1991): how come that it is now recognised that pesticides, insecticides and herbicides and other poisons threatens the well being of our earth, yet women continue to be bombarded with a steadily increasing plethora of harmful contraceptives – and hormones for other so-called diseases such as menopause and PMT – poisons that kill us softly? The newspapers report that Depo Provera's legalisation in Australia is allegedly greeted with popping champagne corks by Melbourne Family Planning; Depo Provera is an injectable that leads to bone loss, bleeding and a host of other problems. Who needs enemies with friends like this? The only thing a cynic might say is that white women too will now be harmed in addition to Aboriginal women and mentally handicapped who were given this injectable long before its legalisation – and that of course the multinational manufacturer of Depo Provera will increase their profits – as do many others from the increased use of drugs.[4]

So what is there to do? The premise that 'population' is the 'mother' (*sic*) of all evils and needs to be reduced needs to be forcefully challenged. To this end women everywhere in the world must question the dangerous empowerment rhetoric and refuse to be used as pawns in the old western supremacist strategy to 'reduce' – or 'increase' 'population' which amounts to nothing less than acts of (re)colonising both women and poor countries. People – women, men, children, not the abstract mass 'population' – are not the enemy of the planet. Yes, they will continue to increase in numbers and it seems to me that it would be far better to develop long-term strategies for co-existing in spaces that will be reduced ***and*** respecting one another at the same time. It is not good enough to keep enclaves of rainforest in between unplanned jungles of monsters made of concrete. Not individual people but the fragmentation of the ecosystems will kill the rainforest – or, I might add, logging companies that deforest whole areas as, for instance, happened in Thailand.

To conclude I suggest that more than ever we need fierce determination to mount a passionate non-aligned feminist resistance that challenges the world and exposes the old/'new' crimes committed against women by population control – now also supported by so-called feminist and environmental groups. 'One can't save the earth by killing women' but if this population madness does not stop, this is exactly what will happen. I for one will continue to resist with countless other women whose very survival is at stake and build on what Susan Hawthorne has termed a life-loving 'wild politics' (Hawthorne, 1993).

4. A cynic might also despair at the unquestioning embracing of genetic engineering by some environmental groups as the solution, see Ruth Hubbard and Elijah Wald, 1993, and Abby Lippman, 1993 for summaries of the dangers of geneticisation of our world.

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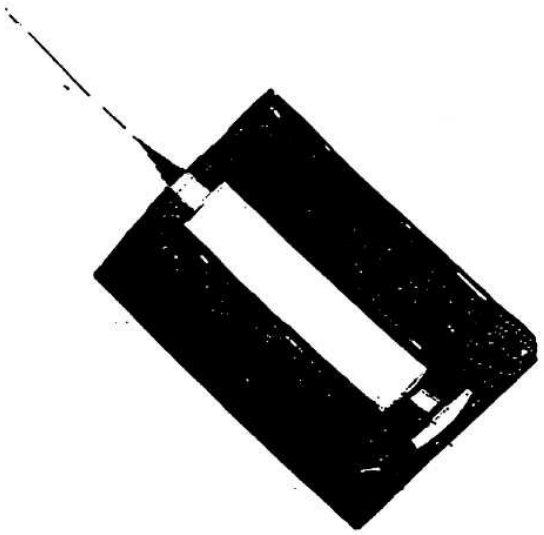

The New Infertility/IVF Legislation in Victoria – In Whose Best Interests?

REPORT FROM SEMINAR 19TH OCTOBER, 1995

Laurel Guymer and Renate Klein

On May 4th, 1995, the *Infertility Treatment Bill* was introduced by the Victorian Govemmenrto parliament. After much debate, an agreement was reached on a number of amendments and the Bill was passed on June 2nd, 1995. The *Infertility Treatment Act* 1995 has been given Royal Assent. When fully proclaimed, it will replace the current IVF legislation, the *Infertility (Medical Procedures) Act* 1984 and the Infertility (Medical Procedures) (Regulations) 1988.

The Standing Review and Advisory Committee on Infertility (SRACI) which was established under the current Act will be continued with newly appointed 14 members. It will advise the body, the ***Infertility Treatment Authority (ITA)*** consisting of seven members. Together with SRACI, ITA is responsible for keeping the records, granting licences to IVF centres, approving research, considering requests for research outside the Act, etc (see details below).[1]

SRACI arranged an all-day public Seminar to allow for discussion of the new legislative changes. Specifically ITA will be responsible for:

- the oversight and monitoring of 'assisted conception' programs and procedures;
- the licensing of institutions, doctors, scientists and counsellors involved in the provision of 'assisted conception' programs and procedures and related research;
- the central registrar of births arising out of 'assisted conception' procedures where these involved the use of donated gametes or embryos;
- the approval of applications to carry out research (as defined in the new Act) which also must be approved by the Standing Review and Advisory Committee on Infertility (SRACI).

SRACI will be established under the new act. It will have a broad membership (not known as yet) who will be required to keep well informed to ensure that new developments and issues related to infertility, IVF and prenatal genetic diagnosis are brought to the attention of the Minister for Health. The Committee will have statutory responsibility for the approval of applications for research (as defined in the new Act) which also must be approved by the Infertility Treatment Authority (ITA).

The new Act states that procedures can only be performed by a licensed doctor and the premises must be licensed for storage of embryos. Where treatment procedures on embryos occur, the institutions must either have an ethics committee on the premises or access to an ethics committee for consultation and approval. The registered medical officer or scientist can apply for a licence by writing to the ITA and paying a fee fixed by the authority. There is an administrative appeals tribunal (AAT), so if refusal to grant a licence occurs or failure to renew a licence AAT will reconsider "on the merits" of each application. If research applications are refused, the decision is *final.* The medical officers or scientists can redesign and resubmit research but there is no guarantee of acceptance.

The big problem is who will finance the ITA?

1. Copies of the new laws concerning IVF in Victoria may be purchased from the Victorian Government Bookshop, Ground Floor, 318 Lt. Bourke Street, Melbourne, 3000.

It was suggested that funding will come from the licensing fees – but it is doubtful that this will be enough. Financing the ITA could prove very expensive and the need for supplementary funding from IVF clients themselves could be necessary, possibly in the form of increased rates for treatments. (A representative of IVF Friends present at the Seminar protested against the possibility.) Wouldn't it be a good idea to make IVF clinics pay this extra money – a suggestion they will, no doubt, strongly reject.

Banned Research

Gametes (egg or sperm) cannot be removed and used from a child, foetus or deceased person nor can they be transported out of Victoria. A gamete used in research cannot be used for fertilisation and implantation (treatment cycle). Scientists are not allowed to alter the DNA of zygote/embryo and then use it for implantation. Embryos cannot be harvested for research nor can they be created, it is illegal. Sex selection is banned with the exception of sex selection for the determination of x-linked diseases. It is a condition of the ITA that states that research procedures must not harm the embryo.

Approved Research

Research on unfertilised egg and sperm is allowed. Up to syngamy approval is needed for research. Research on parthenogenetic oocytes is permitted. Embryo biopsy for diagnostic genetic disorders is permitted from 8 cell embryos and embryo biopsy on stored embryos is OK.

Offences will be punished by imprisonment up to four years.

Identification of Donors and Genetic History of Donor-conceived Children

The new Act is serious in keeping a central register with information on donors of eggs and sperm. However, this new legislation is not retrospective, in other words donor children cannot under the old legislation access their records. Under the new legislation donor children can access identifying information. Given that under a UN declaration – biological knowledge is a basic right – the interests of adopted persons are paramount, it is surprising that this new legislation is not retrospective.

Most of the discussion centred around the rights of donor children. Women from the adoption services tried to share their experiences and strongly indicate the need for a retrospective legislation in relation to donor children. They also talked of situations when men found out they had fathered a child and the grief and loss associated with this. The reasons why some donor children want the legislation made retrospective was touched on also. A young woman who declared she was a 'donor child' and all she knew about her 'father' was that he was a 4th year medical student indicated her desperation in finding out her 'donor's identification'. She desperately wanted to find out if she had any siblings in case she met one of them at university and inadvertently had a relationship with them. There was little discussion in relation to the women who donated their eggs or the women who accepted the eggs and progressed to give birth to the child. In fact women seem to be invisible in the whole process. Kay Oke from the Royal Women's Hospital's IVF unit believes that the question of egg donor does not interest donor children. This seems a dubious assumption: just because the other knows who the donor egg came from doesn't mean that she will tell her child – there is no identifying information like in adoption. Birth certificates are the same (unlike in adoption) where a schedule 6 birth certificate is issued.

Most of the discussion centred around men donating, finding fathers and their loss associated with donating and not ever knowing their children. The idea of a central register provoked heavy resistance from IVF doctors. New research was cited which had shown that a great number of children were not 'fathered' by the man named by the woman: in other words DNA testing would have to be done first before a donor could be identified as a 'father'!

An IVF Friends representative said she was offended that donors of gametes and eggs were called 'true parents'. She indicated that this could lead to misunderstandings and confusions in the community as to who are the parents. The irony is, of course, that in IVF surrogacy it is precisely egg and sperm donors who insist on being the 'real' parents: a contradiction that is rarely acknowledged!

IVF Research

The Seminar was also an opportunity for IVF doctors and scientists to present some of their latest 'breakthroughs'. High on the list was the research on immature sperm and immature egg cells. IVF researcher Dr Robert MacLachlan from Monash IVF reported on the search for the gene(s) responsible for sperm production and a high likelihood that they are located on the y-chromosome as 15% of men with low or no sperm count have deletions on that chromosome. If substantiated, microinjection would carry the danger of introducing infertility in the male offspring. There was no discussion at the Seminar of this serious ethical issue which could give rise to another exception for sex selection so that only x-bearing sperm might be used.

Clinical trials on egg maturation using oviductal fluids are underway and 200 women are currently enrolled. Dr Leeanda Wilton from Monash IVF presented research done on the structure of egg cells which, she suggests, will reduce the number of embryos transferred through 'embryo assessment scoring' ... 'we select good-quality embryos'. So far two babies have been born using egg maturation technology and Dr Wilton described the procedure as very positive for women as there would be 'no more inconvenience, cost and exposure to [fertility] drugs'. The possibility of abuse by unethical IVF practitioners through maturing hundreds of eggs from a slice of any woman's ovaries, fertilising it with sperm (easily obtained), and possibly putting the embryos into hired 'surrogate women' and so-called third world countries to 'breed' babies for the adoption market was of course not mentioned at the Seminar. FINRRAGE has been discussing this alarming abuse potential since 1989 and in 1994 we wrote a submission to the NH&MRC to cover egg cells in forthcoming legislation – a suggestion obviously not taken aboard in the new Victorian *Infertility Treatment Act* 1995.

Discussion

Bioethicist Nick Tonti-Filippini commented that in his view the new Act was too big and that there are 67 criminal offences. For the legislation to work it would need great co-operation. But how realistic is it to expect IVF teams to co-operate freely with the ITA (and SRACI) if information they give can be used in criminal proceedings?

Predictably, IVF doctors complained that they would lose 'patients' as already now allegedly half of all potential IVF couples go interstate to avoid legislation.

To sum up: the new Act appears to be a definite improvement in enabling children conceived with donor gametes to trace their genetic parents. The ongoing prohibition of all forms of surrogacy is another positive aspect. It remains to be seen, however, if the legislation is indeed workable, and if IVF clinics will co-operate. Moreover, the absence of regulation of research on gametes – egg cells and sperm – remains cause for great concern. In addition it is deplorable, but, as was to be expected, never mentioned during the Seminar that medical procedures which continue to have a 90% failure rate are given so much attention and resources.[2] This, much more than their actual results, makes them viable. Hence lawmakers and IVF promoters are complicit in keeping alive a failed and health-damaging technology.

2. The latest National Perinatal Statistics Unit Report will be reviewed in the next Newsletter.

Book Review

Resisting Norplant

"We were given Norplant as an effective contraceptive method. But they did not tell us about its potential side-effects. Now we are sick, we cannot carry out household works, cannot even look after the children, We though by accepting this method we will remain in good health, but now we are crippled.

"This is a 5 year method; it is good for poor people because within the next 5 years there will not be any pregnancy – no children, which is good for you. Some of you may get too much bleeding, and some may get no menstruation ant all – it all depends on Allah(God). This is nothing, it will be alright after a while. Eat eggs and milk – you will be fine."

"Let us know, when you died, then we will come to remove the method from your body."

Resisting Norplant: Women's struggle in Bangladesh Against Coercion and Violence (Narigrantha Prabartane 2/8 Sir Syed Road, Mohammadpur, Dhaka 1207 Bangladesh, fax 880 2 8130065) is the latest work of prominent Bangladesh women's health activist Farida Akhter. Akhter, who has been tireless in exposing the racist, anti-poor, anti-women population control ideology through the research organisation UBINIG, has provided a well-documented, disturbing account of Norplant trials in Bangladesh.

Norplant is a long-acting sub-dermal method consisting of flexible non-biodegradable rods filled with synthetic hormone levonorgestrel (a progestin). Provider-controlled, it is inserted under the skin on the inside of a woman's arm where the hormone is released over five years.

Norplant's history in Bangladesh began with a 1981 newspaper advertisement by the Bangladesh Fertility Research Programme, promoting it as "A wonderful innovation of modern science." Protests followed which postponed its introduction, however it was brought in by stealth four years later in a pre-introductory clinical trial.

Resisting Norplant details the Population Council-supported trials on illiterate and semi-illiterate slum women, the lack of informed consent, the unethical procedures. Norplant promoted as safe and effective although still in trial phase the health problems women suffered including amenorrhoea, constant and severe bleeding, headaches, severe itching, the provider's dismissal of side-effects and refusal to remove implants on request. Some Norplant recipients were told they must pay Tk.2000 to remove Norplant ($US55).

It was given to breast-feeding women (despite potential danger to the baby). The lack of trained health personnel and proper facilities in rural areas of Bangladesh have made insertion and removal more dangerous.

With USAID funding, Norplant has been promoted through Family Planning NGOs and concentrated in poverty-stricken northern districts. In Dinajpur, the Family Planning Association Bangladesh has a target of 200 Norplant insertions a month. Trial personnel have lost track of a number of homeless and poor women who still carry the rods in their arms after five years.

According to Akhter, Norplant centralises power in the hands of the medical profession, pharmaceutical companies and the population controllers. "While the promoters of Norplant pretended in papers that it was a trial, in practice it was an implementation of a policy of coercion and violence against women," Akhter writes. She quotes a doctor: "In order to have a good thing there is always a price to pay. If two or three women die – what's the problem? The population will be reduced ..."

UBINIG's investigation of Norplant abuses reveals stories like this: "When bleeding starts it stays for two or three weeks. I am becoming weaker and weaker. My husband is angry at me. I am not able to carry out household work. I am afraid my husband may think of marrying again."

Akhter's expose of Norplant abuse in Bangladesh provides solid, hard-core evidence of the risks inherent in long-acting provider-controlled contraception. It will be a formidable tool in the hands of activists fighting to stop these abuses.

For a **copy** ***of Resisting Norplant*** **make out** cheques **for** Aus$20 **to FINRRAGE (Australia) and send to AWORC (address on last page).**

All correspondence should be sent to:

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Your donations will assist:

- Anti-Pregnancy 'Vaccine' Campaign
- FINRRAGE (Australia)
- $10 to receive a 40-page background paper on Anti-Pregnancy 'Vaccine'
- $20 to receive a copy of Farida Akhter's *Resisting Norplant*

All cheques should be made out to FINRRAGE (Australia) and sent to the above address.

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 and 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 fertilization 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.

Regular **FINRRAGE** information packs contain a bibliography, selected articles of special interest, network news of **FINRRAGE** activities, working groups, dates, new books etc. Theme packs on specific issues are also produced.

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