FINRRAGE

Feminist International Network of Resistance to Reproductive and Genetic Engineering

Contents

Cover Art: Ulrike Schaz and Marion Roehreke reproduced from cover of Resistance on the Rise

Cartoon: Judy Horacek's *Life on the Edge* published by Spinifex Press, reproduced with permission © 1992

Layout: Laurel Guymer

Editorial

Dear Readers

For those of you who received and enjoyed the revived FINRRAGE (Australia) Newsletter and faithfully renewed your subscription here is the November, 1996 edition. We do promise to keep up the pace for 1997 and produce four issue of this Newsletter with a bit of help from the goddess of time!!

This issue has articles ranging from surrogacy, artificial insemination by donor to foetal reduction, a summary of the *Long-term effects on women from assisted conception* Report by the National Health and Medical Research Council, 1995 and a review of *Vaccination against Pregnancy* by Judith Richter. All very topical and current in Australia with the first legal surrogacy case in Canberra and international cases of multiple pregnancies from infertility drugs. The latter show clearly the cruel dilemmas that these 'miracle drugs' inflict on women and that their decisions can only result in a no-win situation.

FINRRAGE (Australia) continues to support the international campaign to stop anti-pregnancy vaccines. So, thanks to all of you who signed the 'Call for a Stop' postcard action and returned them to Holland. We enclose another copy of the postcard and urge you all to voice your protest.

T-Shirts are still available which show a woman stamping out the vaccine shown on the front cover of the last FINRRAGE (Australia) Newsletter with the caption 'Stop Anti Pregnancy Vaccines' with FINRRAGE –Feminist International Network of Resistance of Reproductive and Genetic Engineering on the back. You can order them in white with purple logo or any variety of colours you can think of!! Please send a cheque payable to FINRRAGE (Australia) for $20.00 including postage to support the campaign.

We hope you enjoy this issue of the FINRRAGE (Australia) Newsletter and continue to support us by renewing your subscription. We plan to have the next issue in March 1997 and we look forward to your contributions and comments.

Laurel Guymer and Renate Klein
Co-ordinators FINRRAGE (Australia)
c/o Australian Women's Research Centre (AWORC)
Faculty of Arts,
Deakin University
Geelong, 3217
capri@deakin.edu.au or
klein@deakin.edu.au

Women from FINRRAGE (Australia) are still interested in talking with women from the Australian FERTILITY VACCINE TRIAL in 1986-1987 in ADELAIDE. For more information on how you can assist this campaign please write to FINRRAGE (Australia) c/o Australian Women's Research Centre (AWORC), Deakin University, Geelong, 3217.

From A.I.D. (Artificial Insemination by Donor) to A.I.D.S (Acquired Immuno-Deficiency Syndrome)

Liz Crock

Introduction

An alarming aspect of reproductive technologies (RTs) which has attracted little attention either from the press or within feminist critiques of RTs is the possibility and reality of transmission of sexually transmissible diseases (STDs) to women (and their children, in the rare event that a pregnancy proceeds to a live birth [see Rowland, 1992 and Guymer and Klein, 1995]) through the procedure commonly known as artificial insemination by donor sperm (AID)[1]. First of all it is important to note that AID is used principally as a means of circumventing *male* infertility. Many fertile women undergo AID using donor sperm when their partner (usually the husband) is infertile.

There have been reports of transmission to women through artificial insemination of *Hepatitis B* virus, *Neisseria gonorrhoea, Trichomonas vaginalis, Ureaplasma urealyticum,* various *streprococcal* species, *Mycoplasma hominis, Cytomegalovirus, Herpes Simplex, Chlamydia trachomatis* and *Human Immunodeficiency Virus* (Alter *et al,* 1987; Moore et al., 1989). The consequences for women if they contract such infections can range from discomfort, pain, vaginal discharges and infertility to premature death from cancers and/or opportunistic infections (see for example, Grist et al., 1987). Despite the potential and well-known dangers of STD infection to women, there are many inherent obstacles within the RT 'culture' and practice which work against effective prevention of STDs and indeed may render women particularly at risk of contracting STDs if they are exposed to pathogens. This certainly seems somewhat ironic, given that AID, by definition, entails no sexual contact[2]. In this paper, some of the obstacles to effective STD prevention which are inherent in RT, especially AID, are briefly outlined and a few central questions are raised which are often obscured by the gravity of the many other factors which form the core arguments in feminist critiques of reproductive technologies, but which have been thoroughly covered elsewhere (see Corea, 1988; Arditti, Klein and Minden, 1985, Scutt, 1988; Rowland, 1992 and Raymond, 1993). Whilst acknowledging the wider ethical and practical implications of AID which feminists have discussed in depth, this article concentrates solely

[1] Although, the word "insemination" itself is problematic for feminists, as it assumes the absolute passivity of both the woman and her egg, it is used here for clarity given its widespread use throughout the literature reporting on STD transmission to women through the procedure.

[2] Perhaps in this context STDs could be renamed "artificially inseminated diseases" or AIDS - but the acronym is already in use.

on the issue of so-called STDs and RTs as it has only, until now been discussed in general terms (see for example, Corea, 1988). The discussion does not imply an acceptance of the technologies but aims to describe another serious problem with RTs which has been neglected by feminists and medical practitioners and researchers alike.

Just Like Cows And A Stud Bull

It is common practice within RT 'culture' for a large number of women to be "inseminated" by a single donor, so that if a donor harbours an undetected STD, it is likely that many women will have been exposed to the infectious agent. In the first reported case of transmission of HIV (at the time named *Human T-cell Lymphotropic Virus Type III)* infection through artificial insemination, in Australia in 1985, eight women were recipients of cryo preserved (frozen) semen from a man with HTV infection who was symptomless at the time. Four of these women were later found to have antibody to the virus (indicating infection), and three of these women subsequently became pregnant more than a year after exposure to the infected semen (Barr et al., 1985) so that their children may also have become infected with the virus. In a North American clinic, one hundred and seventy six women underwent AID with fresh semen from six men who were later found to be HIV-antibody positive. One hundred and thirty six of these women were able to be located and tested for HIV. Whilst only one woman was found to be HIV-positive and had engaged in no other behaviours which may have put her at risk of HIV-infection, so that her infection could reliably be attributed to the AID, many women were not followed up at all as they could not be traced (Chiasson et al., 1990). In a retrospective investigation of cases of HIV transmission through AID, Araneta *et al.* (1995), reported that the semen of one HIV-positive man had been used for two hundred and twenty insemination procedures over a four and a half year period (Araneta et al., 1995). In fifty nine of these procedures fresh semen was used and in the other one hundred and sixty nine the semen had been frozen. Two women who had received the HIV-positive man's semen tested HIV-positive; one had been tested at a blood bank when making a donation herself, and the other was tested as part of a retrospective study tracing the contacts of the donor. It should be noted that these women would have been infected in the early 1980s and were not followed up until the early 1990s! The first woman was diagnosed with cervical cancer, and with ADDS in 1993 (Araneta, 1995). Cervical cancer is now recognized as being related to HIV infection and is considered an "AIDS-defining illness".

Another HIV-positive donor's semen was used for five hundred and eleven *known* inseminations over a five year period in *at least* ninety eight women (the exact number of women could not be determined). One of the women who had received semen from this donor and agreed to be tested was found to be HIV-positive (Araneta, 1995).

Or Is She Promiscuous?

Conversely, one woman is usually inseminated by semen from several donors, or by semen from one donor many times, thereby increasing her risk of exposure to undetected pathogens. The women identified as infected with HIV in the study by Araneta et al (1995) had received from one to eleven donations from the HIV-positive men. In another study, one woman whose HIV infection was traced to AID had in fact received semen from five HIV-positive men in a total of fourteen insemination procedures (Chiasson, et al., 1990). In Australia, there are voluntary guidelines which are intended to restrict the number of women who receive semen from a single donor, with the rationale that this will minimize

the chances of incest among offspring who unknowingly have the same father (Plueckhahn and Cordner, 1991). Significantly, there is no suggestion that the regulations have been devised in order to reduce the risk of STD transmission to the women undergoing AID! Other countries do not even have such voluntary guidelines.

Secrets And Silence

The very nature of AID does not lend itself to effective STD prevention strategies. Semen donors typically desire and demand anonymity so that accurate record-keeping is discouraged and is not required, at least in the United States of America (Guinan, 1995) where the greatest number of AID procedures are performed, estimated to be done on about seventy-five thousand women per year (Araneta et al., 1995). Efforts to control infectious complications are severely compromised by this fact, making contact-tracing impossible in some cases, and would arguably not be tolerated in any other area of medicine.

Again in the United States of America, semen donors' characteristics and the number of children each donor "sires" [sic] are not monitored, so that the process may be open to abuse. Australia, New Zealand, England and Sweden keep semen donor registries enabling contact-tracing but other countries have not followed suit and many keep no register (Guinan, 1995). However, in Australia, records are kept at individual institutions and the central register remains empty (Laurel Guymer, 1996, personal communication).

In the cases of HIV transmission through AID reported by Araneta *et al,* (1995), semen donors who had denied engaging in any behaviours which may have put them at risk of HIV infection prior to donating semen admitted after testing HIV-antibody positive that they had sex with other men. Given the stigmatisation of male homosexual behaviour within Western culture, it is not surprising that men who are asked in front of or by health professionals whether they engage in homosexual activities (especially if they are men who identify as 'heterosexual') will deny vehemently, yet this was the screening procedure used in the cases reported.

Who Screens The Semen And Who Screens The Screeners?

In November 1984, before the first four cases of HIV transmission through AID were reported, a moratorium was placed on all AID programmes in Australia and all AI clinics were closed by ministerial decree, pending the availability of a test for HTLV-III antibodies (the enzyme-linked immunosorbent assay or ELISA test) (Barr et al., 1985). At that time, blood donation was controlled merely by a personal declaration that the donor was not a member of a 'risk-group', so that the closing of AID clinics was considered by some to be an overreaction and was quite controversial. Other countries did not follow suit. The ELISA became available in Australia in April 1985, and the clinics were re-opened with the stipulation that a specific donor screening programme had to be followed. However, while in Australia there were and are stringent regulations which are intended to ensure adequate screening of semen donations for STDs is carried out prior to AID, (see Barr *et al.,* 1985), this was not the case at all in the United States and regulations are still not uniform. Although the American

Fertility Society encouraged screening of semen donors for *Hepatitis B* virus in the early 1980s, a case was reported in 1987. Such screening had not been done, a woman was found to have been infected with *Hepatitis B* and became acutely ill with hepatitis after having undergone AID where fresh semen had been used (Berry *et al.,* 1987). This case was only reported in a medical journal in 1987, 5 years after the event and in the article cited, the authors recommended that screening of semen donors for *Hepatitis B* "should become routine practice" - 6 years after the HIV epidemic began! (Berry, *et al.,* 1987:1079). Other cases of transmission of *Hepatitis B* virus infection through AID have been reported where donor semen had been mixed with serum which later was found to contain the *Hepatitis B* antigen (Mascola, 1987).

Furthermore, blood and blood products were screened for HIV as long ago as 1985 in Australia, and although the United States Federal government has been rightly criticized for its failures in the early years of the HIV epidemic (see Shirts, 1987), as have many other countries, the blood supply in most Western countries at least is now closely monitored. As Mascola (1987:1094) asked, "Why should semen donors be less vigorously screened? Why are the procedures for blood transfusions regulated and monitored while those for artificial insemination are not?" He then comments that "artificial insemination should be at least as safe as a blood transfusion" (Mascola, 1987:1094). Whilst he is clearly referring solely to its safety in terms of infection risk (as the risks associated with AID such as those due to the use of fertility drugs can hardly be compared with those related to the administration of blood or blood products), it should be noted that people receiving blood products are generally quite unwell, often close to death, whereas women undergoing AID are not sick at all. Given this, one could argue that AID should be even safer than a blood transfusion, as the benefits of blood transfusion (saving a life) are generally believed to outweigh its potential risks (exceptions would include the case of Jehovah's Witnesses or of course if it actually led to a fatal reaction or disease), whereas a woman undergoing AID starts from a considerably better position; that is, she has no disease requiring treatment.

In addition to the problems related to inadequate and unmonitored screening and AID, a high proportion of semen donors are reported to be medical students and health professionals, groups whose work puts many of them at a relatively higher risk of *Hepatitis B* infection than most people and who demonstrate a higher prevalence of *Hepatitis B* virus infection (Berry et al., 1987). Inadequate semen screening procedures therefore increase the risk to women of infection with this, and other viruses through AID.

Where regulations do exist regarding AID, they usually demand that insemination be performed by a physician and specifically exclude some women from gaining access to the procedure in clinics, notably unmarried and/or lesbian women (see Corea, 1988; Plueckhahn and Cordner, 1991; Daniels, 1995). This means that many women now use 'alternative fertilization' or 'self-insemination' whereby they obtain semen from friends, relatives or acquaintances (Corea, 1988:45; Wilder and Wilder, 1991). Guinan (1995) believes that these women subsequently are at an even higher risk of infection with STDs given that no 'screening' at all

often takes place. Although this claim itself could be controversial, as women performing self-insemination would quite possibly know more about the donor, including whether he harbours an STD, than a woman having the medicalized procedure in a clinic. Nevertheless, as more women choose self-insemination, laboratory semen screening tests need to be made available for them as well as for the women undergoing AID in clinics, as STDs are not always apparent to the infected person. In addition, HIV antibodies for example, are not always detectable in the early stages of infection so that women need to be aware that serial testing is necessary.

Physician Independence Versus Safety

Particularly in the United States of America, private physicians oppose government 'interference' in their work, including the imposition of uniform regulations such as those which would be required for the prevention of STD transmission through AID. As Guinan (1995) points out in reference to the United States, whilst screening recommendations from several respected sources exist (such as those from the United States Centers for Disease Control and the American Fertility Society, [see The American Fertility Society, 1988]), physicians do not have to adhere to them by law. Again women are not assured of their degree of risk of STDs in any AID procedure given this lax situation.

'Physician independence' can sometimes mean working in isolation and ignorance. In a Canadian case reported in *Australian Dr.,* a woman sued her gynaecologist after she became infected with HIV after AID (Barber, 1990). The woman argued that her doctor should have been aware of the risk of HIV infection through AID, as an epidemiologist had suggested this possibility in a letter to the *New England Journal of Medicine* in October, 1983. The woman had undergone AID procedures more than thirty times between 1981 and 1985. The doctor argued that "his practice conformed to the state of medical practice, including knowledge about HIV/AIDS, in 1985" (Barber, 1990:40) and that as soon as he had learnt of the Australian cases reported in *The Lancet* in 1985 he had discontinued his programme. Barber (1990:40) writes:

> The court found that a general obstetrician would not be expected to read journals such as *The New England Journal of Medicine* on a routine basis and therefore would not have known as early as 1983 of the possibility of transmission as a result of artificial insemination.

Furthermore,

> There was a strong body of evidence suggesting that a practitioner of artificial insemination would not, by the standards of the medical profession, be expected to know about the latest developments in HIV/AIDS research.

Given the widespread hysteria and publicity surrounding HIV and AIDS in those early days of the epidemic, when it was clear that the infection was spread sexually if by no other means, one did not have to be a medical practitioner to suspect that semen could have been a possible medium for transmission of the responsible organism. Yet the culture of medicine and medical law is such that the medical fraternity can cite its own ignorance as defence. Women need to be aware that their physicians can legitimately plead ignorance of

important and widespread knowledge with regard to risks of infection and should seek information on such risks themselves if considering AID.

Informed Consent?

According to Rowland (1992), women's consent in AID and in-vitro fertilization procedures is rarely fully 'informed'. They remain ill-informed of the potential side-effects of fertility drugs, the likelihood of a live birth, the risk of foetal abnormalities and that there is a risk of STD transmission through AID. Yet even though the risk may be low, this is no consolation for the women who do become infected through the procedure. Screening of semen donors should be routine, and done according to the most stringent guidelines. But again the 'wall of secrecy' surrounding AID remains a tremendous impediment to effective control of STDs through AID (Guinan, 1995).

Frozen or Fresh?

Conditions which promote conception, the first aim of AID, are again shown to work against STD prevention when the use of fresh versus frozen semen is considered. In the first reported cases of HIV infection from AID (Barr et al., 1985), frozen semen had been used for the inseminations. However, many practitioners in the United States prefer fresh semen, saying that it is more likely to result in conception, although even this evidence has been challenged (Guinan, 1987). Furthermore, whilst frozen semen has been used in Australia for many years, in the United States fresh semen was used in over ninety percent of all donations in 1979 and was still used in many cases well into the 1980s (Barr et al., 1985 and Araneta et al., 1995). In Australia regulations specify that semen must be cryopreserved for at least three months but most clinics store it for six months, then retest the donor, prior to using the semen. Again lack of regulation in the United States leaves the decision up to individual clinicians.

Bypassing Women's Defences

A woman's vagina during the potential reproductive years is inherently able to prevent infection by pathogenic organisms. Circulating oestrogen promotes the production of glycogen in the vaginal epithelium, which is then metabolized to produce lactic acid by a lactobacillus which colonizes the vagina. Lactic acid and other metabolites inhibit colonization by most other microorganisms (Mims, 1977). In many AID procedures, the vagina and cervix are bypassed as the semen is introduced directly into the uterus, again with the assumption that this will increase the chances of conception. However intrauterine insemination has been associated with an increased risk of infection as the woman's natural defences against infection are bypassed (see Araneta et al., 1995).

Looking Back In Horror

Araneta et al. (1995) conducted what they termed "a retrospective 'look-back' study" in which they investigated and reported on cases of HTV transmission through AID before 1986 at five infertility clinics. They noted that such studies, while routinely conducted among blood donors and recipients of blood products, have not been routinely performed for semen donors and the women recipients. They identified seven cases of AI-associated HIV transmission, following up two hundred and thirty women, eighty

seven percent of whom consented to HIV-testing. The authors also point out that, due to "lack of resources", their study was limited to clinics in which an HIV-positive donor or recipient had been identified and it was not a systematic search for cases from all infertility clinics in the areas. Such a "lack of resources" to attend to the problems which arise through AID or other ARTs, while not surprising, is unacceptable when the technologies themselves attract enormous funding and resources (see Rowland, 1992). In addition, the results of Araneta et al. (1995) indicated a transmission rate of 3.5 percent. In the Australian study which reported on the first known cases of HIV transmission through AID (Barr et al.,1985), the possibility of transmission from one donor was shown to be much higher, in fact 50 percent, indicating that in some cases transmission rates can indeed be very high[3].

Araneta et al. (1995:857) conclude their paper by recommending that retrospective studies such as theirs be done on all women who underwent AI procedures before 1986 so that any women identified as HIV-positive "can benefit from early therapeutic intervention and perhaps prevent further sexual or perinatal transmission". This seems overly optimistic, as any women infected that long ago would most likely be quite severely immuno suppressed by now and if they were going to pass their infection on, they would probably already have done so. The authors recommend too that all men who donated semen before 1986 be tested for HIV antibodies and receive counselling, and that counselling and serologic testing should then be provided to all women who received semen from HIV-positive men. How those women would be found is another question. They also point out that such studies

> would be consistent with efforts to encourage and provide HIV testing and counselling to all individuals who received blood, blood products, or tissues and organs before the routine screening of blood donors in mid 1985 (Araneta et al., 1994).

Araneta *et al's* important paper raises some very serious questions. First, why is it that such studies are not routinely done with respect to AID though analogous studies are done with respect to blood and blood products? It cannot be that the number of women undergoing AID is insignificant, for every year many tens of thousands of women actually conceive through AID and it is estimated that at least seventy-five thousand women undergo AID in the United States alone each year (Araneta et al., 1995). This means that a very large number of women underwent the procedures and therefore could have been exposed to pathogens. Why is funding inadequate for such follow-up studies when AID and RTs generally are so well funded? Why is it that a study such as this has only recently been performed when HIV was identified in the early 1980s? Answers to these questions will have to include the fact that, in many cases, it would be impossible to conduct such studies, impossible to identify the donors and subsequently locate them, given the "wall of silence" surrounding AID, the absence of adequate records, the desire for anonymity of donors, and the many obstacles to traditional public health measures which are inherent in ARTs. The women who have been infected via AID will come out of the woodwork themselves, as they appear in doctor's clinics, public hospital outpatient departments and perhaps casualty departments with unexplained symptoms of an Acquired Immune Deficiency.

---

[3] HTV transmission rates can vary considerably due to factors such as the HIV-positive person's degree of immuno suppression, the level of virus ("viral load") in his or her blood, as well as host susceptibility factors, such as the presence of other genital disease or cervical abnormalities (Araneta et al., 1995).

Conclusion

This paper illustrates some of the characteristics of reproductive technology "culture" and practice which hinder effective STD prevention and indeed at times promote the transmission to women of diseases and organisms which previously were primarily transmitted sexually. It should be noted that these are only some of the issues raised by a literature review which turned up just a few articles, and yet a veritable minefield is presented. Public health measures which are expected in all other areas of medicine are impossible to implement or are flouted in the case of AID. The consequences for women of the transmission of so-called STDs through AID can be severe, debilitating and even life-threatening, particularly in the case of HIV infection. STD infection can be devastating and STD infection through AID would be absolutely unexpected for the women concerned. The culture of medicine and particularly of reproductive technologies needs to be challenged by women and a change of practice must be demanded. The issue of transmission of so-called sexually transmissible disease to women through reproductive technologies must be raised in all feminist critiques of such technologies so that further preventable suffering and even deaths of women undergoing artificial insemination do not occur and so that its advocates are called to account on yet another potential 'adverse effect' of reproductive technologies for women.

References

Alter, H., Berry, W., Gottesfeld, R. and Vierling, J. (1987). Transmission of Hepatitis B Virus by Artificial Insemination. *Journal of the American Medical Association,* **257**:8, pp. 1079-1081.

American Fertility Society, The (1988). Revised new guidelines for the use of semen-donor insemination. *Fertility and Sterility,* **49**:2, February, p-211.

Araneta, M.R., Bursaw, M., Collie, F., Eller, A., Friedman, S., Ginsberg, M., Marik, J., Mascola, L., O'Neil, L., Rekart, M., Sims, C. (1995). HIV Transmission Through Donor Artificial Insemination. *Journal of the American Medical Association,* **273**:11, March 15th, pp.854-858.

Arditti, R., Duelli Klein, R., Minden, S. (eds.). (1985). *Test-tube Women: What Future for Motherhood?* London: Pandora Press.

Barber, J. (1995). Woman sues over infected semen. *Australian Dr.,* p. 40, 3rd. February.

Barr, J., Cunningham, A., Driscoll, G., Gold, J., Lamont, B., Stewart, G. and Tyler, J. (1985). Transmission of Human T-Cell Lymphotropic Virus Type IH (HTLV-HI) by Artificial Insemination by Donor. *The Lancet,* September 14th, pp. 581-584.

Chaisson, M, Joseph, S. and Stoneburner, R. (1990). Human Immunodeficiency Virus Transmission Through Artificial Insemination. *Journal of Acquired Immune Deficiency Syndromes,* **3**:1, pp.69-72.

Corea, G. (1988). *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs.* London: The Women's Press.

Daniels, K.R. (1995). Information Sharing in Donor Insemination: A Conflict of Rights and Needs. *Cambridge Quarterly of Health Care Ethics,* **4**, 217-224.

Grist, N.G., Ho-Yen, D.O., Walker, E. and Williams, G. (1987). *Diseases*

of Infection: An Illustrated Textbook. Oxford: Oxford Medical publications.

Guinan, M. (1995). Artificial Insemination by Donor: Safety and Secrecy. *Journal of the American Medical Association,* **273**:11, 890-891.

Guymer, L. and Klein, R. (1995). The New Infertility/TVF Legislation in Victoria - In Whose Best Interests? *FINNRAGE Newsletter (2nd. edition),* pp. 21-23, November.

Mascola, L and Guinan, M. (1987). Semen donors as the source of sexually transmitted diseases in artificially inseminated women: the saga unfolds. *Journal of the American Medical Association.* **257**:1093-1094.

Mims, C. (1977). *The Pathogenesis of Infectious Disease.* London: Academic Press.

Moore, D., Ashley, R., Zarutskie, P., Coombs, R., Soules, M. and Corey, L. (1989). Transmission of genital herpes by donor insemination. *Journal of the American Medical Association.* **261**: 3441-3443.

Plueckhahn, V.D. and Cordner, S.M. (1991). *Ethics, Legal Medicine and Forensic Pathology* (2nd. edition). Melbourne: Melbourne University Press.

Raymond, J.G. (1994). *Women as Wombs: Reproductive Technologies and the battle over women's freedom.* Melbourne: Spinifex Press.

Rowland, R. (1992). *Living Laboratories: Women and Reproductive Technologies.* Sydney: Pan MacMillan Publishers.

Scutt, J. (1988) (ed.) *The Baby Machine: Commercialisation of Motherhood.* Melbourne: McCulloch Publishing.

Shilts, R. (1987). *And the Band Played On: Politics, People and the AIDS Epidemic.* New York: Penguin Books.

Southward, J. (1990). Sperm donor passes on AIDS. *The Sunday Age,* p.6, 18th August.

Wilder, D. and Wikler, N. (1991). Turkey-baster Babies: The Demedicalization of Artificial Insemination. *The Milbank Quarterly,* **69**:1, p. 5-40.

Liz Crock is a Registered Nurse, specialized in Infectious Diseases. She was a Clinical Nurse Specialist in HIV/AIDS at Fairfield Infectious Diseases Hospital in Melbourne until the hospital closed this year. She is studying for a Master of Nursing by Research at the Royal Melbourne Institute of Technology on the topic: Nursing, Ethics and HIV/AIDS. Her interests include feminism and nursing, feminist ethics and scholarship, and she is a union activist.

To Leanne with Love

Melinda Reist

Donna Hill is babysitting her niece - the child she gave birth to almost two months ago. “I am just Aunty Donna with my niece,” she says “My special niece.” Baby Jessica is the Australian Capital Territory’s (ACT) first surrogate birth, permitted under a new ACT law which is the only one in the country specifically allowing altruistic surrogacy. It happened once before in Victoria, when Linda Kirkman carried baby Alice for her sister Maggie in 1986, but the arrangement was made illegal last year. Donna, 25, carried Jessica for her brother Alan Haynes, 31, and his wife Leanne, 30. Donna says she and her husband Martin are not attached to Jessica. “Me or Martin did not contribute anything to the child,” she says. “I was just the incubator. I had gone through it all along thinking it’s not my child, don’t get attached.”

Donna told herself she was going to hospital for an operation. “That’s what helped me through, thinking I was going to have an operation and not giving birth,” she says. Leanne cannot praise her sister-in-law enough. “I didn’t have something for me to be able to carry the child and Donna’s given me that womb for nine months and I love her dearly for that.” The 3kg baby was born on August 7 at the Canberra Hospital. “It was a very big day, an overwhelming feeling to see her being delivered.” Leanne says, “I was worried for Donna, seeing her going through that pain, knowing she’d have nothing at the end. But we’d talked about it - she gained a niece, I’ve gained a daughter.”

Leanne learned at age 17 that she had been born without a uterus. She met Alan a year later. She says it was a big decision to go ahead with the marriage. “He married me because he loved me and he knew he would never be able to have children of his own. Alan’s family knew they might not have a grandchild from Alan.” However they could not accept their childlessness. They joined adoption waiting lists and attended classes for the prospective adoptee parents. But to no avail. “People aren’t giving their children up like they used to,” Leanne says. “We thought we would never see a child for us.” They inquired about hiring a surrogate mother in the United States. But they could not afford the estimated $A50,000 to $A80,000 it would cost. The four also considered travelling to the US with frozen embryos, where Donna would act as a surrogate. But in the end they didn’t have to. The ACT Legislative Assembly approved altruistic surrogacy in 1994 when the Substitute surrogacy Parent Agreements Act was amended to allow non-profit surrogacy. Donna had no hesitation. The birth of her own daughter Alannah, 3 was her motivation. “We realised the excitement and enjoyment she brought into our life” she says. “We would have loved to see Alan and Leanne go through the same situation. I knew I had my own child at the end of the day.”

The Director of the Canberra Fertility Centre, Dr Martyn Stafford-Bell, assessed them according to the clinic’s guidelines that the surrogacy must be for a medical reason, that the surrogate must be a relative, in a stable marriage and with one child. (Leanne estimates the IVF and associated procedures cost $10,000.) The four underwent a series of blood tests to rule out genetic problems or diseases. The doctor then matched Donna and Leanne’s menstrual cycles to establish both were

ovulating at the same time. Leanne took hormone treatment in the form of a nasal spray three times a day “to switch me off” until Donna’s cycle was synchronised. For 12 days Leanne received hormonal injections to make her super ovulate. She did, and 17 eggs were collected.
“I was really excited we got that many because it gave us a good chance if Donna didn’t get pregnant the first time, we would have eggs left over,” she says. Her excitement helped overcome the pain. Unconscious during the procedure, she required pethidine afterwards. “I really couldn’t walk around much for quite a few days,” she says. “Your normal ovary is the size of a walnut. Mine was the size of a mandarin.” Alan provided sperm which was added to the eggs - all 17 fertilised. “That was another statistic that blew them out of the water. They were very happy with the fertilisation rate,” Leanne says.

Two eggs were syringed through a catheter inserted through Donna’s vagina to the top of her womb. But the transfer failed. They tried again with two more embryos and this time one implanted. Donna says they were ecstatic. “But then we had to come down to earth and realise ... this isn’t for us.” The four shared the pregnancy as much as possible, attending birth classes together and watched birth videos. Initially they told no one apart from family that Donna was pregnant with Leannes and Alan’s baby. But Donna said she was proud of what she’d done and told anyone who asked “Oh, its not my baby.” Donna said it was easier not to bond with the baby because the eggs were not her own. She understands why surrogate mothers overseas who have used their own eggs have difficulty relinquishing the child. “That’s when I can understand because its half you.”

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.

Foetal Reduction: One Too Many Fertility Drags Or One Too Many Embryos?

Laurel Guymer

> Foetal reduction ... is [a technique] used to selectively terminate a certain number of fetuses (sic) in women who become multiply pregnant as a result of fertility drugs and/or multiple implants (Janice Raymond, 1994, p. 14.)

Geraldine Brodrick gave birth to nonuplets in Sydney in 1971, twenty five years ago. Foetal reduction was not an option for her and if she were pregnant today, she told journalist Evie Gelastopoulos, she would make the same decision and continue on with the pregnancy and chance viability of all nine babies. Her convictions had partly, she said, to do with her Catholic beliefs. Nevertheless, the controversy surrounding 'foetal reduction' arose not from the Catholic quarters but erupted after a British woman, Mandy Atwood decided to continue with her multiple pregnancy. Mandy was prescribed fertility drugs to increase her low chances of conception due to polycystic ovarian disease (Jon Murrie, 1996) which resulted in eight embryos developing at the same time.

Fertility drugs such as Clomid and Pergonal/Metrodin have been prescribed and administered to women as part of the In Vitro Fertilisation (IVF) program or as a solo treatment to stimulate multiple eggs in women having difficulty becoming pregnant (Janice Raymond, 1994).

Unfortunately, the many dangers associated with these drugs are often not told to the women taking them until they experience them first hand. Almost ten years ago Renate Klein and Robyn Rowland documented the harmful effects associated with such fertility cocktail administration (Klein and Rowland, 1988), but these drugs continue to be used on thousands of women worldwide. Apart from the women developing painful cysts on their ovaries, there is an increased risk of cancer and the most widely publicised adverse effect of hyperstimulation of the ovaries. IVF doctors implant multiple embryos to ensure that one 'takes'. For some of these women the end result "fetal (sic) reduction" or "selective termination of pregnancy" or, using seductive retrospeak "selective continuation of pregnancy" (Janice Raymond, 1994, p. 130).

Foetal reduction involves injecting the unwanted foetus with potassium chloride, causing death by heart failure (Janice Raymond, 1994, p. 130), Alternatively medical doctors can inject a saline solution into the uterus to abort one of the foetuses, a procedure that can cause bleeding, infections, increased risk of premature labour, and even loss of both foetuses. There is concern also about damage, to any foetuses that remain after others are 'reduced' (Janice Raymond, 1994, p. 14.) After the foetus dies it is either absorbed by the mother or shrivels up and is eventually delivered alongside its live brother or sister[1]. As described by William Underhill in the Bulletin in 1996 "a poor, unmarried British mother" decided that she could afford one more child, not two but she was pregnant with twins. Her obstetrician and gynaecologist provided an alternative: foetal reduction.

Doctors advised Mandy Atwood not to proceed with the pregnancy involving eight babies. They told her *she* was at risk, *the future of the eight unborn were at risk* and that there was Mandy's daughter to consider also. Sarah Hall (1996) reported that Anne Wheatley, mother who aborted six of her octuplets to give birth to healthy twins "begged expectant Mandy Atwood to listen to medical advice". However, Geraldine Brodrick is simpathetic to Mandy's impossible decision. As she put it if Mandy Atwood makes the decision to abort them, "she is the one who would have to explain to the others when they're older that she had to sacrifice" the others so that some could survive (Evie Galatopoulos, 1996).

These stories and many more like them describe the difficult decisions women face following an often long period of infertility, fertility drugs and finally becoming pregnant only to be offered foetal reduction to interfere with a much wanted pregnancy. Yet western dogma and medical advancement has reached the point where society accepts without criticism that technological problems need technological 'fixes'. This Raymond (1996) describes as "technological determinism" where women are left with "an increase dependency and more and more questionable technological solutions" (p. 14). WA Institute for Child Health Research epidemiologist Jenny Kurinczuk says "selective reductions [are] ... ususally performed for health reasons -but it [is] becoming common in the US to use multiple embryos [in IVF transfers] and then reduce the number later" (p.31).

Multiple implants and superovulation are examples of another new reproductive technology that has gone very wrong. Foetal reduction is the technological fix for experimenting with women's bodies. One dangerous and experimental technology followed with another. It is important that women hear the stories of Mandy Atwood and others like her, so they can make decisions to resist fertility drugs and opt for safer options.

The medical doctor attending to Mandy Atwood's care forbid her to speak with the media about the octuplets and threatened to refuse treating her if she broke the media embargo (Sarah Hall, 1996). The tyranny of silence that pervades the medical professions ethics should be challenged. It is important that women hear about the dangers of fertility drugs in the news and not only in connection with the sensationalised stories of abortion in particular foetal reduction for multiple pregnancies. Raymond argues that "[t]he media discusses the ethics of foetal reduction as if the critical issue is the morality of abortion, not the morality of using powerful fertility drugs on women or the ethics of implanting multiple embryos" (p. 130). Headlines such as "BETTER TO LOSE ONE? A STRANGE CASE STOKES ABORTION DEBATE" August, 1996, "DOCTOR TO ABORT ONE TWIN FOR WOMAN, 28", August, 1996 and "TRIPLETS ABORTED IN IVF PROGRAM" August, 1996 fuels the anti-abortion and pro-life campaigners, the headline should have more accurately read "MULTIPLE FOETUSES RAISES QUESTIONS SURROUNDING FERTILITY DRUGS AND MULTIPLE EMBRYO IMPLANTS"

In conclusion, the use of fertility drugs, implantation of multiple embryos resulting in multiple pregnany puts women in a no-win decision making situation of possibly

[1] In the case of midtrimester foetal reduction.

losing all embryos or some at the expense of others via foetal reduction.

References

Bower, Amanda (1996) Triplets aborted in IVF program *The West Autstralian* August-7

Gelastopoulos, Evie (1996) Aussie mum lost *Sydney Moring Herald*

Hall, Sarah (1996) Listen to doctors, says mother who aborted six babies Press Release August, 15

Klein, Renate. and Rowland, Robyn (1988) Women as test-sites for feritility drugs: clomiphene citrate and hormonal cocktails. *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1(30) pp.251-273

Murrie, Jon (1996) Eight-Baby Mum Says It's For Love *Herald Sun* August 19 p.27

Raymond, Janice (1994) *Women as wombs reproductive technologies and the battle over women's freedom* Spinifex Press: North Melbourne

Toy, Mary-Anne (1996) Doctor faces inquiry over twin abortion *The Daily Telegraph* August 10

Underhill, William (1996) Better to lose one? *The Bulletin* Sydney August . 20.

Woodcock, Andrew (1990) Doctor to abort one twin for woman, 28 *The Canberra Times* August 5, p.7

Laurel Guymer is a radical feminist, women's health activist, critical care nurse and midwife. She is very concerned about the unethics of population control programs internationally often disguised under other names family planning or safe motherhood. Her current research interests include the Anti-Pregnancy 'Vaccine', Depo Provera and Norplant.

Long-Term Effects On Women From Assisted Conception Report By The National Health And Medical Research Council 1995

Jill Wraight

In September 1992, the Health Care Committee (HCC) of the National Health and Medical Research Council (NHMRC) established a Working Party to examine the long term effects on women from assisted conception. The initiative for this report arose out of concerns raised by the lack of structured research within Australia of the long term effects on women of products such as Clomiphene citrate and human menopausal gonadotropins which have been used for the past thirty years to assist conception. These drugs were originally used in cases of failed ovulation and while over the years have developed broader usage, they have not been accompanied by ongoing long term research regarding their effects. Another alarming event that prompted concerns was the death of four Australian women from 1990 to 1993 from Creutzfeldt-Jakob disease (CJD) acquired through treatment for infertility using human pituitary hormones. These events highlighted concerns that long term effects of many new treatments cannot be predicted and have not been adequately researched. The report was endorsed and published by the NHMRC in November 1995 with an outcome of eighteen recommendations.

The terms of reference established by the working party were as follows:
1. Review the outcomes and long term effects for women from all forms of assisted conception including ovulation induction, embryo transfer and IVF.
2. Evaluate the appropriateness and adequacy of existing data bases.
3. Undertake a needs analysis and identify issues, outcomes and long-term effects which require further examination.

Within this report the term ‘assisted conception’ is defined as a mode of infertility treatment that implies the use of technology for conception including; assisted insemination (AI), the use of a husband or donor’s semen (AIH), IVF and gamete intrafallopian transfer (GIFT). Assisted conception is considered to be a treatment that must be repeated because it has no therapeutic effect and does not cure infertility.

The major physical risks and hazards associated with assisted conception were identified as being: risks of ovarian stimulation, operation for follicle aspiration and egg or embryo replacement and receiving sperm, eggs or embryo donated by a third party. Additional risks identified included: the impact on the psychological well being of participants, fertility and health of donors, and continued infertility for participants even after the birth of a healthy child.

One of the previous activities of the NHMRC was the endorsement, in 1982 of the Medical Research Ethics Committee’s (MREC) guidelines on IVF. This report found that with regard to long term effects of new or experimental procedures used by assisted conception programs, that no attempts have been made to monitor or comply with the requirement for long-term care, observation and maintenance of records.

Although legislation has been passed in Victoria, South Australia and Western Australia which relate to artificial

conception, other states have carried out reviews only. In regard to National regulation of fertility treatment in Australia it was found that although reports have been produced, no uniform legislation or regulations have been passed.

Concerns were raised that several IVF drugs have bypassed evaluation by the Therapeutic Goods Administration (TGA) through a special access scheme under which their use is regarded as experimental. Drugs which have not been evaluated by the TGA are not subjected to the controls that monitor quality, safety, efficacy and availability within Australia.

This report did not have resources to undertake formal research. The sources of data collected came from literature reviews, surveys of all IVF clinics in Australia regarding complications of assisted conception, consultation with a wide range of national bodies, population based registers, international government publications, media reports, relevant papers, reviews, reports, theses and books.

The literature review revealed an absence of systematic long-term study of health effects on women and children, it also identifies specific adverse effects regarding the psychological and psychosocial well being of those participating in assisted conception programs. It was found that there is limited information available about women, their partners and children. The psychosocial impact of infertility itself is complex and the effects of assisted conception become intertwined with this rather than separate.

Twenty two registered IVF programs in Australia were contacted to gain information about instances of mortality and serious morbidity of program participants. Reports were collected of the number of women who had experienced the following complications: death, visceral injury from egg retrieval, serious infection, severe ovarian hyperstimulation with vascular complication, torsion of the ovary and cancer of the breast, uterus or ovary during or after treatment.

Although several research studies are currently in progress in Australia relating to issues of IVF, related cancers and multiple births, it was found that studies about assisted conception were lacking and should include: assessment of medical and psychosocial aspects before, during and after any active intervention, qualitative studies investigating issues from the participants view point, systematic assessment of assisted conception programs, regular review of social, emotional, spiritual and physical effects of assisted conception, specific research studies on assisted conception and cancer and long term physical and psychological wellbeing of women, children, partners and families.

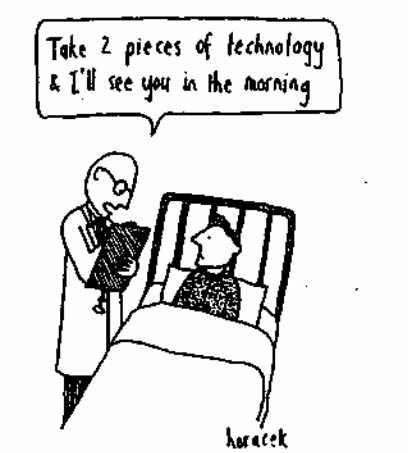
A number of consumer issues relating to assisted conception were identified and particular concerns were raised that much of the information reaching consumers plays down adverse side effects of treatments and uses reassuring language. This report suggests that responsible and adequate provision for consumers should include:

- clarification for consumers of the definition of experimental and non experimental drugs, devices and procedures.
- realistic information about side effects and complications and consent procedures.

- accurate information about outcomes and treatments.
- accurate, accessible and well presented information brochures for consumers
- adequate and appropriate counselling
- independent source of consumer information about long term effects of assisted conception.

The report identifies the existing information available and areas in which there are gaps of information regarding the long-term effects on women from assisted conception. It also identifies the need for further resources and development to be allocated for provision of information, counselling, support and specific ongoing research.

Jill Wraight became interested in reproductive medicine while she lived in Tokyo and finished her MA in Women's Studies at Deakin University, Geelong, Australia, 1996.



Anti-Pregnancy 'Vaccines': More than just a sting*

Vaccination Against Pregnancy: Miracle and Menace? By Judith Richter Spinifex Press $24.95 182 pages Paperback

Reviewed by Kerrin Delbridge

> ... soldiers rounding up women from East Timorese villages so that Norplant® could be inserted ... (p.63-64.)

Science fiction, unfortunately not, fictional not even, reality, unfortunately yes and what's even more frightening it happened within the last 20 years. This statement is only one of many in Judith Richters book entitled *Vaccination against pregnancy: miracle or menace?* that will leave the reader with serious doubts and sheer disbelief about the whole issue of immuno-contraceptives.

Richter gives an excellent description which is quite simplified but by no means simplistic on all the different types of immuno-contraceptives being developed and an overview of the trials to date carried out worldwide. The anti-pregnancy 'vaccine' or 'immuno-contraceptives[1] often combined with tetanus or diphtheria are designed to trick our immune system in order for it to respond adversely to our body substances/parts thereby preventing conception occurring, or, in the case of anti-hCG vaccine, the pregnancy from continuing. However, throughout the book the hCG (human chorionic gonadotrophin) antigen development is referred to under the umbrella of immuno-contraceptive agents, when itself by its very physiological nature is only present when 'conception' has occurred. Therefore, in my view the anti hCG vaccine should only be classed as an abortifacient.

This brings up a new set of issues that have not been discussed or addressed within this book. Especially as the term 'vaccine' is discussed at length leaving the reader in no doubt that this substance known as a 'vaccine' is given to stimulate our immune system to recognise a certain micro-organism in order to protect our body against that specific disease and its process. A 'vaccine' developed to actually prevent or cease a 'normal' physiological function that can be reversible in itself is quite contradictory as 'vaccines' are usually developed and given in order to prevent a disease process, an 'abnormality', a potentially life threatening process and is certainly not reversible.

Any new birth control agent device needs to be better than what is already available says Richter and to date immuno-contraceptives do not offer any such advantages. As these agents will be targeted at predominantly young healthy fertile women they should not have any long term adverse affects, be reversible, reliable, pose no immediate health risks to the user and definitely no potential health risk to any future babies. It is unlikely that immunisation against one's own body parts will occur without side effects.

It could be questioned here that after 20 years why do they keep going with this research? The products to date have hideous adverse affects ranging from joint pains, irregular bleeding, auto-immune diseases to permanent sterility. Interesting enough, the major funders for all these research projects are various international population control organisations.

Richter begins to unravel the web of deceit as she discusses the potential for abuse, the

* I acknowledge Susan Clements contribution to the title of this review

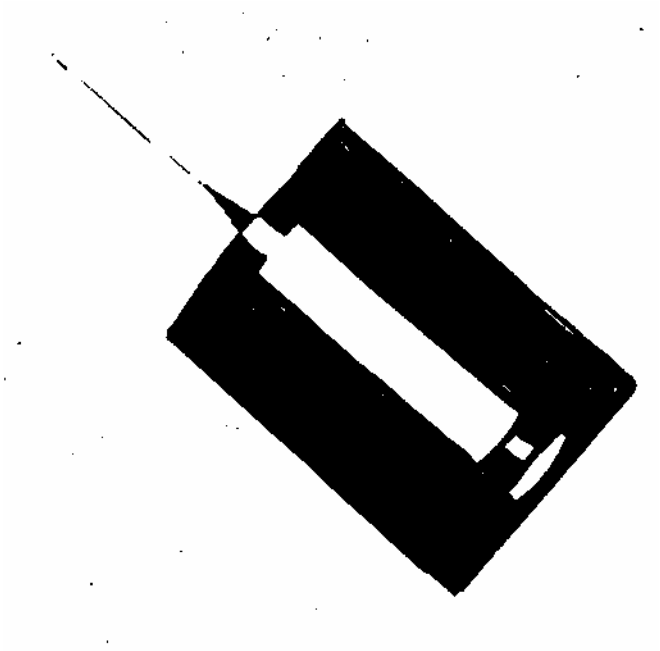
inadequate and lack of informed consent of women who have participated within the phase II clinical trials that have been undertaken in India. Women in third world countries such as the Philippines have refused tetanus vaccinations for fear that the 'vaccine' contains 'anti-fertility' agents, threatening public health programs. This potential widespread threat not only to their health, but indirectly a potential threat to world health, is of great concern.

The author dedicates a chapter to discuss the public debate that has occurred to date and the international campaign that is ongoing calling for the immediate cessation of the current research projects worldwide on the development of immuno-contraceptives. The shallow and weightless 'theoretical advantages' of immuno-contraceptives as cited throughout the scientific literature are quite easily dealt with by Richter without too much effort at all. Sadly, the rationale of the scientists and population control establishment does not measure up against the authors demand for a 'contraceptive' revolution, where the challenge is to improve the current contraceptives available.

Richter however seems to have chosen not to attempt to unravel one particular strand of the web, that is regarding the anti-hCG 'vaccine' and that people are not being told exactly what its action is and that it is not a contraceptive but rather an abortifacient. This particular lack of recognition, exploration and discussion of the above point is regrettable, I wonder about the author's rationale for excluding this important aspect of the vaccine.

This book leaves the reader questioning the true underlying agenda regarding the development of immuno-contraceptives. Are the various 'population control' agencies of the world who are the primary funders of the research projects indeed seeking a long term contraceptive agent? Or are they perhaps more interested in a permanent sterilisation agent in order to achieve effective mass fertility control of particular social classes of people?

Kerrin Delbridge is critical care nurse with a postgraduate diploma in critical care from Royal Melbourne Institute of Technology (RMIT). Her interests are in equal rights for all. She is also a fertile woman concerned that one day some World Organisation will decide she is no longer fit to reproduce



Resistance On The Rise:
International Action Meeting On Anti-Fertility "Vaccine"

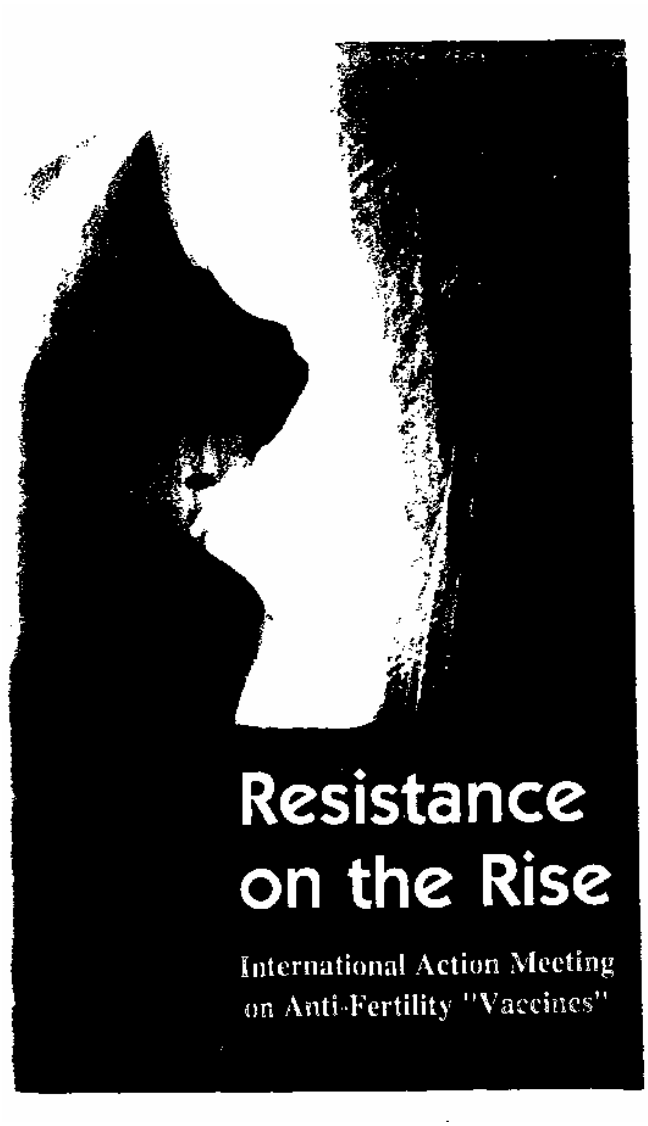
The documentation of the International Action Meeting on Anti-Fertility-"Vaccines" June 1-5, 1995 that took place in Ottawa, Canada is now available. This booklet begins by introducing anti-fertility 'vaccines', the campaign to stop these vaccines and its activities.

There is a comprehensive report of the meeting held between thirty women's health activists and officials of the Canadian International Development Research Centre (IDRC), one of the major funders of the anti-fertility "vaccines" research at the National Institute of Immunology in India. The meeting was held to make visible to funders the international resistance to anti-fertility 'vaccines', demand that funding for Indian trials be, stopped and to raise questions and concern regarding ethics, safety, health and human rights issues of this research.

Also included in the documentation are summaries of the workshops - public awareness raising, strategies concerning clinical trials and the redirection of contraceptive research.

A whole chapter is devoted to contributions to the debate from Ulrike Schaz, Renate Klein, Pat Durish, Luiza Bairros, Annette
Will, Forum for Women's Health (India) and a discussion on Pro-Life Groups. The booklet tells how to join the campaign and get involved. There is a list of the funders, participants at the meeting, endorsers for the call for a stop to research on anti-fertility vaccines, follow up letters to IDRC and a critical press release about pro-life groups' activities.

For a copy of *Resistance on the Rise*
write to Women's Global Network of Reproductive Rights (WGNRR)
Amsterdam, THE NETHERLANDS



All correspondence should be sent to:

FINRRAGE (Australia)
c/o Australian Women's Research Centre (AWORC)
Deakin University
Faculty of Arts
Geelong, 3217
Phone 052 271 335 (Dr Renate Klein)
Fax: 052 272 018
Mobile 018 946 912
email: klein@deakin.edu.au or capri@deakin.edu.au

Your donations will assist:

- **Anti-pregnancy 'vaccine' Campaign**
- **FINRRAGE (Australia)**

All cheques should be made out to FINRRAGE (Australia) and sent to the above address.
Copies of Judith Richter's book Vaccination *Against Pregnancy* may be obtained from most book shops or ordered directly via the spinifex homepage http://www.publish.aust.net.au/~spinifex
For a copy of *The Politics of Euthanasia: A Nursing Perspective* edited by Megan-Jane Johnstone write to the Royal College of Nursing Australia 1 Napier Close, DEAKIN, ACT, 2600

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 engineering 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 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 implication for the socio-economic position and well-being 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 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.

For more information contact:
FINRRAGE, International Coordination, PO Box 201903, D2000 Hamburg 20, Germany.

I.V.F. & A.I.D. PROGRAMS IN SOUTH AUSTRALIA

My purpose today is mainly to report on the IVF & ET programs in South Australia, which is one of the six states of Australia. I will also talk about the current legislative and policy frame-work; and the sorts of responses being made in the community and by women in particular. I will not be addressing many aspects of the very complex historial, social, economic, legal and medical and scientific contexts within which these programs operate. But I would like to state one of my assumptions, which is that the new Reproductive Technologies are a technological extension to the historical process of bringing women's reproductive ability under social (read patriarchal) control. They are thus deeply embedded in social institutions - marriage and the family, the subjugation of women and children, property and inheritance etc.

IVF & ET programs are provided from 2 of the 3 main teaching hospitals in Adelaide, which also conduct some research projects. Published material is scarce. My information is gleaned from interviews with clinical and research staff working on the programs, and public statements made by their medical directors and by 'the Minister of Health.

The Queen Elizabeth Hospital has had a program since 1982. They have produced 98 pregnancies and about 60 births with some women awaiting delivery. The proportions of male and female babies are equal. An earlier report of 32 living children included 6 sets of twins and 2 sets of triplets[1]. Currently they have about 60 couples on active treatment cycles each month; there are about 700 couples on the waiting list, with reported waiting times somewhere between 14 months and 3 years.

The failure rate per cycle is about 84%. This is claimed to be comparable to the 'natural' losses of fertilised ova, i.e. about 40% fail to implant and a further 20% abort around the expected time of the next menstruation [2].

Overall, about 1 in 5 women participating in the programme walk out with a baby (or 2 or 3). The program has had two pregnancies using frozen embryos. They have had 3 pregnancies using IVF with donor sperm. Couples can stay on the program 'as long as they like', but a 6 month break is required after each treatment cycle.

The Flinders Medical Centre has been offering services since 1982. About 35 children have been born through their program. They have 30-35 women on a treatment cycle at any one time, with a couple of hundred active patients and 'hundreds' on the waiting list. The waiting time is about a year. Their failure rates are equivalent to those of the Queen Elizabeth. They do not freeze embryos at the moment, but plan to do so.

Information about the people participating in the programs is very scarce. At both hospitals, only 'couples' are treated and they must be married; the woman must be under 38 years of age. At Flinders, private health insurance is required; at Queen Elizabeth Hospital almost all patients have private insurance (this is a general indicator of socio-economic class in Australia, but of course is not valid for a patient group). Flinders patients are described as 'mainly middle class'; non-English-speaking people are not accepted, on the grounds that it is too difficult; and staff say that most of the women are in the paid workforce. At both hospitals, the geographic distribution of patients is very wide, with perhaps about 40% being non-urban residents. Some overseas residents are treated in both hospitals, particularly from countries where programs are not available. Patients pay $400 per treatment cycle, on top of insurable costs. Absolute childlessness is not a criterion, and both hospitals report couples returning for a second IVF baby. One of the issues attracting public debate in South Australia is the question of inequitable access to the programs across race, class and marital status lines.

There are also medical criteria. About 60% of patients in both programs have tubal infertility, mainly from pelvic infections, but also from medical sterilisation, or previous ectopic pregnancy or endometriosis. Poor sperm counts, problems with ovulation and 'unexplained' infertility (evidenced by 3 years or more of trying unsuccessfully to get pregnant) are the other main factors. Host participants will have undergone tubal surgery before being admitted to the programs.

Many of you will be familiar with what's actually involved for a patient, so I will not go into detail about that. I will just say that it is a major commitment of time, energy, disruption to normal life, submission to surgical procedures and confronting emotional extremes of anticipation and disappointment etc each treatment cycle - we are talking about a very compliant group.

The requirements of the treatment cycle are such that women are dropped out at various stages; about 40% of cycles are dropped at some stage prior to embryo transfer (because of, for example, hormone levels going outside accepted range, failure of follicles to ripen (about 5%), or a failure of fertilisation (about 10%)). the pregnancy rate per cycle of those who do get as far as embryo transfer is reported either as 12 or 20%. Of these the miscarriage rate is 40%, compared to 12-15% in the general population. However, staff consider that this difference may be almost entirely explained by the fact that all early pregnancies are diagnosed (using HCG test at 12 days after laparoscopy) in the IVF patients and this is not the case in the general community.