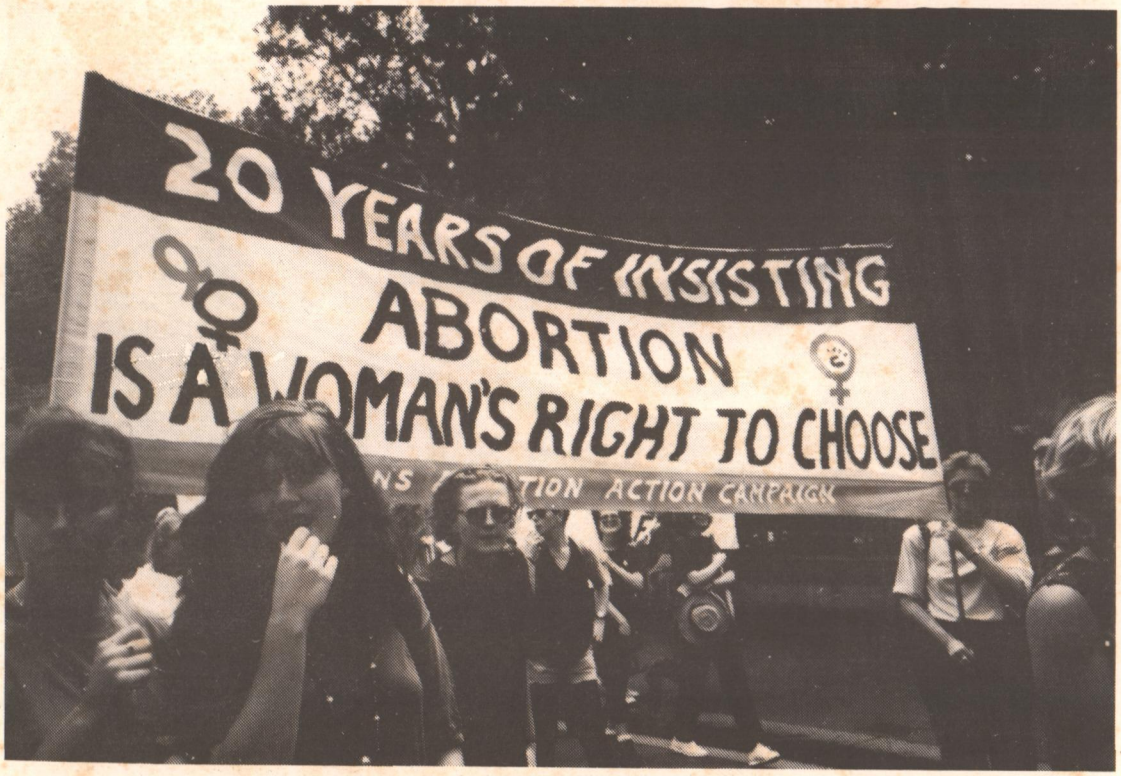
Issue no 33 Spring 1992

Right to Choose

a women's health action magazine



IN THIS ISSUE:

* Women tell their stories of abortion
* The devastating effects of DES
* Info on Eastern Europe
* Well Women Clinics

and more.....

Registered by Australia Post, publication number NBH 2721

$2.50

Issue 33
Autumn 1992

Right to Choose

Right to Choose (ISSN: 0311-8754)

Contents

Women's Stories of Abortion ..... page 3
Campaign News ..... page 6
Well Women Clinics ..... page 10
Hot Flashes ..... page 12
Abortion in Poland ..... page 14
Eastern Europe ..... page 15
The Devastating Effects of DES ..... page 17
International ..... page 18
Psychological Effects of Abortion ..... page 20
Making the Abortion Decision ..... page 22

Those who worked on this issue:

Marg, Toni, Emma, Kate, Jenny, Liz and a big thanks to Virginia for the typesetting.

Why not write for Right to Choose?

We receive a substantial amount of mail both within Australia and abroad and, as you can see, we often reprint parts or all of it.

However, it is even better for our readers and for our coverage of women's health issues if you, our readers, write articles for us, especially if you are involved in women's health issues or a women's health self-help group.

We would greatly appreciate receiving your articles, letters and news items. When sending material:

1. Type, if possible, doubled-spaced, one side of paper only, and with your name on article and an accompanying letter;
2. A stamped, self-addressed envelope with your work would help us to get it back to you.

The *Right to Choose* collective retains editorial control. Alterations will be discussed with the author.

Editorial

Welcome to the first issue of *Right to Choose* for a while. We're glad to be back in print. We hope that you'll find this issue thought-provoking and informative. There's a lot of news from both overseas and interstate. Some of it is good, but unfortunately some of it, regarding access to abortion, is bad. The '90's still holds challenges for women regarding our right to choose abortion and our access to specialised women's health services.

Until recently the issue of women treated during pregnancy with the drug DES has not received much attention. However, as the devastating long-term effects of DES come to light, these women are seeking justice for the horrific after-effects of this drug. See the article by DES Action on page 17.

We still need your help to produce *Right to Choose* and welcome your participation and comments on it. Please get in touch if you have any time to spare (see address on back cover).

We're pleased to report that WAAC's 20th birthday dinner, held in September, was a success and that speeches from it will be reproduced in the next issue.

Happy reading!

Unwanted Pregnancy: One Woman's Story

Until the first time I became pregnant, I had amazingly never thought about the issues around abortion at all. I had not thought to question the prevailing propaganda of the time that abortion was an unspeakable crime, that women who became pregnant against their will were bad women who deserved to as a punishment for their sins, and who would want to have babies if they were at all "natural".

Many of my close friends had admitted, in moments of confidence, to having had abortions but the enormous price they had paid both in money and health problems perhaps explained my reluctance to think about such things. Even when a close friend had a back-street abortion from which she nearly died and other friends had sudden unexplained serious illnesses and/or even suicided amid rumours of their pregnancy, I somehow never thought to question the philosophy or the law of the time on this topic, and particularly believed that it couldn't happen to me.

Then one day I realised that I had had several weeks of severe morning-sickness and that everyone who had noticed this had recommended I get a pregnancy test, and that these things were getting harder all the time to ignore. I had a pregnancy test simply to prove to my friends how ridiculous their suspicions of my pregnancy were, and even when the result was positive I still believed there must be some mistake.

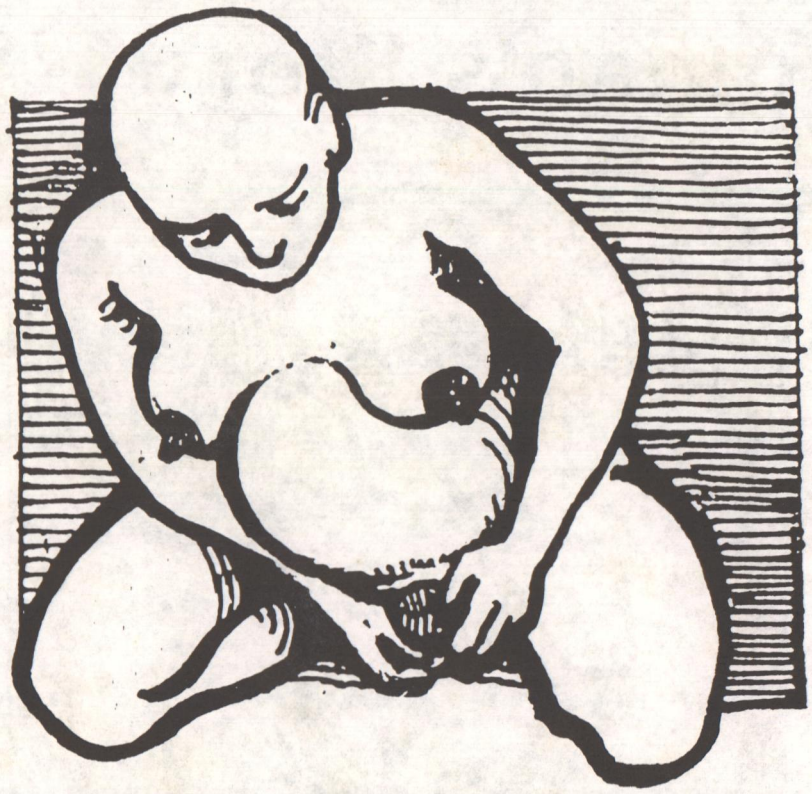
This was partly due to my faith in the efficacy of the Female Barrier Method of contraception, which amazingly has still not been widely questioned even in 1990. The diaphragm, vault cap or cervical cap in combination with spermicide is still being touted as more than 90% effective despite the fact that of the large numbers of women I know who have used it, at least three quarters have experienced failures. These failures have always been accounted for with the allegation "you can't have been using it correctly", although these women were all highly intelligent, educated and competent people, an upside-down logic designed to rule out any question of the sacred cow of the reliability of this contraceptive method.

When the passage of time forced me to face the fact that the nightmare of me possibly being pregnant might in fact be a reality, the absurdity of my previous smug assumptions about abortion hit me with full force. I realised that I needed an abortion more than I'd ever needed anything before. My education, which I was pursuing, my career plans, my living situation, my social life and most of all, my personal psychology would not allow even a full-term pregnancy, let alone a live child and a life of motherhood. Perhaps my unconcern and smugness until it happened to me explains the attitudes of many otherwise intelligent and aware men on this issue. It occurred to me that perhaps only women should be allowed to legislate on it.

In any case, wanting an abortion and being able to take steps towards getting one, or even expressing my desire for one, were two very different things. The counselling available today and to my mind an essential thing was at that time simply an impossible beautiful dream. I tried my husband, my family and people who I had thought were my friends, and received only total dismissive condemnation and even threats to have me locked up if I continued to express my wish for an abortion. The friends who'd

continued over page

Unwanted Pregnancy: One Woman's Story



had abortions were all either uncontactable or the people who'd aborted them were uncontactable (one was in jail). Having a husband was essential for respectability, to avoid total ostracism should one become pregnant and therefore one of the few positive things about my situation, but otherwise a total dead loss. My husband blamed everything on me, claimed I was incompetent to have become pregnant, and criminal and/or insane for wanting to end the pregnancy and refused to do anything to help, instead making tasteless jokes at my expense and being even more than usually demanding of food and housework from me.

As the full horror of my situation began to sink in, I became more desperate. I finally contacted one abortionist, the one who had nearly killed my friend, and made an appointment with him. It is an indication of my desperation that I was delighted when I managed to make the appointment and devastated when he didn't turn up or answer any subsequent phone calls. I tried various home remedies I'd heard of such as drinking huge amounts of alcohol, taking boiling hot baths, and jumping off ladders, all to no avail. But there was worse to come. I realised I was now well into my second trimester, so abortion was even harder. I lost my job, my place at university and my home.

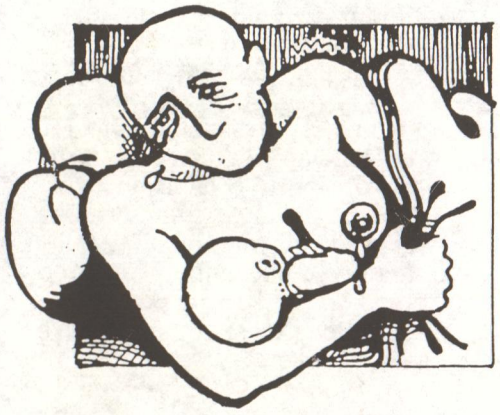
None of these things were available to women with children or about to have children, it seemed. My mother said she was bringing me a present to cheer me up. Since my financial situation was now very poor, I felt this might be a temporary brightener. The present turned out to be a complete set of baby clothes. I burst into tears and threw them in the fire. This confirmed my mother's belief in my insanity, she having believed that not only should I have tolerated her incredible insensitivity, but have actually been grateful for it. The ensuing argument has never since been completely patched up, and ended all illusions I'd had that my mother, as she claimed, wanted what was best for me.

These last events and the realisation that my marriage was at best a mockery and at worst a total exploitation convinced me to commit suicide. I had thought I was a free autonomous being and found I was a slave with no human dignity or respect granted me at all. I had thought I lived in a free country and found I lived in a concentration camp. Suicide became very attractive, but even this wasn't easy. Guns and most drugs were almost as hard to get as abortions. I tried large amounts of a few drugs but just vomited them back up. I was deterred from jumping off a building or under a train by accidently reading about people who'd done this and become vegetables and about a high rate of still-births and infant mortalities. My husband had expressed a firm intention to veto my expressed intention to have the baby adopted should it actually get born, but life in jail for infanticide seemed an increasingly attractive option. Writing of this so many years later, it sounds facetious even, but was unbearably serious at the time.

Before I had expected it, I went into a six-hour labour of mediaeval torture and gave birth to a live healthy child. During this time I was attended by medical personnel who gave me all the respect due to a lump of meat on a conveyor belt, but I had become somewhat inured to this by a few pre-natal checkups of a similar nature. My screams of pain elicited more humiliation and anger and threats.

The many assurances I'd received that "you'll love the baby when it comes" were, as I'd suspected, proved to be more total falsehoods. I hated the baby. It screamed so I couldn't sleep or talk ever, and shat and puked all over my clothes. I found I was the person required to do all the caring for this hated object although my husband and mother had been so vocal in their

Unwanted Pregnancy: One Woman's Story



desire for its arrival. I found I was sentenced to 24 hours a day, 7 days a week solitary confinement at hard labour with no pay, holiday or even sick leave, I discovered that my misery was now called "post - natal depression".

It was considered abnormal although I have yet to find a mother who didn't suffer from it, as who wouldn't? Incidentally, I find women are expected to feel depressed after having abortions although I've met extremely few who ever were.

It was several years before I summoned the courage to leave my husband and by that time I had a second baby as well. Leaving was made hard by lack of money of my own, the difficulty of getting a job since motherhood had caused me to have an incomplete education and no recent work experience. It was also made hard by guilt poured on me by most people around me saying I was ruining the lives of my husband and children and utterly selfish. I didn't at the time have the confidence to articulate my deep feelings of "what about me?", "what about ruining my life, by having babies, by not leaving?". Leaving was made easier by the arrival in my life of the Pill and of increased public awareness of feminist issues. The worst side-effects of the Pill seen over three decades have been both less serious and less frequent than the side-effects of full-term pregnancies.

I still feel guilt about abandoning my children. I also feel regret that they have grown up without me and that I have missed the experience of watching them grow and hardly know them. If I had been able to postpone motherhood a few years I might have been psychologically ready and have found it a rewarding experience. My children have had a hard life growing up without a mother, although they now seem to be happy, healthy and indeed delightful people. I also feel regret that although I belatedly finished university, I never achieved any of my career ambitions and am not likely to.

I feel wonderful about being a pro-choice activist (even though I don't' always do as much as I could in this area), since although it's too late for me, it may save some other women from what I went through. I have never felt that abortion was an entirely positive thing, but it is far, far, a million times better, than wanting but not being able to get an abortion.

Jane Doe

❄❄❄❄❄❄❄❄❄❄❄❄❄

❄❄❄❄❄❄❄❄❄❄❄❄❄

Abortion:

An Easy Decision for Some – One Woman's Story

I'm sure that the decision to have an abortion is a painful one to make for some women and I'm glad that feminist action and writing has meant that health care providers and others now realise this. But I really find it patronising when these people (or anyone else) *assume* it must be a hard decision for *every* woman and say things like "Oh, it must have been awful for you". I know that they're probably well-meaning people, but I think that it illustrates how far the "Right to Life" mode of thinking has penetrated our psyche. "Right to Life" expect women to feel guilty when deciding to have an abortion because in their eyes, "women must know, deep in their hearts, that it's wrong". I do not think this way at all. As has been my experience, deciding to have an abortion is easy: after all, I wasn't planning to become pregnant – I used contraception and it failed me. The technology is available for abortions to be performed and I don't see it as part of my "life-plan" to have children yet. I'll have them when I'm ready. Such is the lot of women in the 1990's. The only regrets I have are about subjecting by body to invasive procedures which it didn't really need – and the inconvenience.

So, whilst I have every sympathy for those women who did find the abortion decision a difficult one, I don't assume that every woman did so. And I *can't stand* people assuming that I should have felt guilty about it. I DIDN'T!!!

Toni Payne

CAMPAIGN NEWS

Children by Choice

For the past twenty years Children by Choice has been campaigning for the repeal of the abortion laws in Queensland. Eighteen of these years were under the repressive Bjelke-Petersen government and realistically this aim would have been most difficult to achieve.

In December 1989 the election of a Labor government, with a party policy endorsing abortion law repeal, gave Children by Choice hope that the long campaign for change would be finally realised.

Unfortunately this has not been the case. While the present government has a more enlightened attitude to controversial social issues, abortion law repeal has not been on its agenda.

Children by Choice continues to campaign for repeal and in 1990/91 maintained a very high profile on the issue. This campaign was funded by Family Planning International Assistance, an organisation based in New York, USA.

The campaign achieved considerable public support and was a catalyst for abortion law repeal being debated in the Labor Caucus. The outcome of this debate was disappointing – the issue was once again shelved.

The campaign continues, with the focus now on individual lobbying of parliamentary members. This is being done both by mail and personal interviews.

The best response comes from personal letters sent by Children by Choice members to their individual parliamentary representative. It seems that contact from a potential voter has more impact than a letter from an organisation.

Queensland is a large state, with remote electorates and it is vital that members of parliament be lobbied by their own constituents in their own electorates. Unless this is done members can delude themselves into thinking that the issue is one restricted to the metropolitan area. Through its wide network both of association members and contacts through other organisations Children by Choice co-ordinates there letter writing operations.

With a state election imminent, Children by Choice will be continuing to pressure for repeal of the abortion laws. Twenty years hard work has to have its reward.

Nancy Leighton
Co-ordinator
Children by Choice, Brisbane

Happy 20th Birthday

CHILDREN BY CHOICE!

The Women's Abortion Campaign in Brisbane

The Women's Abortion Campaign in Brisbane has a long, though sporadic history, in the struggle to secure abortion rights. Formed in the late 1970s WAC has always been an activist group whose members have located their politics within a wider commitment to feminist concerns and campaigns.

Since the 1970s the history of WAC has seen periods of intense activity usually when existing limited access to abortion has been under further threat, followed by periods of burnout.

The group was active in the late 1970s when Federal National Party MP Stephen Lusher attempted unsuccessfully to withdraw Medibank benefits for abortion. WAC played a significant role in helping to defeat the Bjelke-Petersen Government's Pregnancy Termination Control Bill in 1979-1980. At this time WAC was involved in organising many meetings, pickets and rallies designed to ensure the Bill's defeat. At this time, too, the Campaign worked to encourage trade unions to support women's right to abortion.

In 1985-86 WAC worked to mobilise public opposition to the Bjelke-Petersen Government's police raids on two Queensland abortion clinics and the subsequent laying of charges against two Queensland doctors. The doctors were acquitted of the charges in January 1986 in what has become know as the McGuire ruling, following Victoria's Menhennit ruling and New South Wales' Levine ruling.

The Women's Abortion Campaign organised again in Brisbane in 1988-89 when there were further threats in the Federal Parliament to Medicare payments for abortion.

Since 1990-91 the Campaign has again been active, this time in a bid to press the Goss Labor Government to recognise women's abortion rights by repealing Sections 224, 225 and 226 of the Criminal Code, those sections outlawing abortion. State ALP policy commits an ALP Government to the repeal of these abortion laws. The State Labor Government has been in office for over two and a half years and refuses to enact its own policy.

Yet WAC recognises that to secure abortion rights for *all* women, the context is not just legal – it is also social and economic. The Women's Abortion Campaign is, we believe, the only women's organisation in Queensland which campaigns not only for the repeal of abortion laws but also for the guarantee of free,

More Campaign News

safe abortion on demand and for the establishment of clinics for women not profit.

Last year saw the holding of three ALP conferences in Brisbane. The Women's Abortion Campaign organised pickets at all three conferences to encourage delegates to keep women's abortion rights on their agenda. All three conferences passed resolutions supporting abortion law repeal. Yet Premier Goss refuses to move.

In August of last year, the Women's Abortion Campaign organised a rally and march for abortion rights. It was the first abortion rights march through Brisbane streets for a decade.

In September of last year WAC presented a submission to the Queensland Criminal Code Review Committee urging abortion law repeal. The Labor Government had established the Review Committee to prepare proposals for reform of the Criminal Code. In the words of Attorney-General Deal Wells the Review would be "comprehensive". Yet Wells instructed the Review Committee to exclude from its work the abortion laws, the only laws which were not to be reviewed. WAC presented a submission anyway – and organised a picket of Attorney-General Wells' office on International Abortion Rights Day, 28th September 1991.

In March of this year WAC was invited by the International Women's Day Committee in Brisbane to provide a speaker on abortion at the IWD rally.

On 30th April of this year WAC organised a public meeting on RU 486 and Abortion Law Repeal in the City Hall. We managed to bring two speakers from Melbourne, Renate Klein and Jocelynne Scutt. The meeting was the first meeting in Brisbane which has contributed to the debate on RU 486 by presenting both perspectives. It also helped to keep abortion on the political agenda.

On 30th May of this year WAC held a rally and march which called on the ALP Government to honour Labor policy on abortion law appeal.

Queensland is due to have an election before the end of the year and WAC is currently organising a march and rally for abortion rights as a pre-election organising point for women.

We are also developing a strategy to encourage trade unions to take up abortion as an industrial issue.

WAC has a policy of working with like-minded groups where we can. For example, while Children by Choice does not support our campaign for free abortion nor for abortion on demand, the two groups do have an overlapping commitment to abortion law repeal and WAC attempts to work with Children by Choice.

In many ways the time since the election of a Labor Government has not been easy. Activists have found that some prominent Labor women who supported abortion rights campaigns when Queensland had a non-Labor Government would now prefer us to be silent on the issue of abortion. On occasion prominent ALP women have tried to suppress actions organised by WAC.

Because WAC has organised so many events over the past couple of years, we have had little energy to make contact with like-minded groups in other towns cities. We are keen, however, to develop links and may be contacted at PO Box 5226 West End 2101.

Anna McCormack
June 1992

NEW SOUTH WALES

Fred Nile's *Procurement of Miscarriage Limitation* Bill 1991

This Bill, which intended to restrict abortions to being performed in public hospitals only, was resoundingly defeated when voted upon in November last year. The vote was 29 against, 7 for and a small number of abstentions. That's Nile: nil; pro-choice campaign at least 3 (as far as decisions of Parliament go).

Nile's *Unborn Child Protection Bill*

This Bill was first introduced into NSW Parliament in 1988 and lapsed. Nile intends to redraft it and has already placed it on the notice paper, however, the feeling is it won't even come up for discussion. We'll keep an eye on it anyway.

More Campaign News

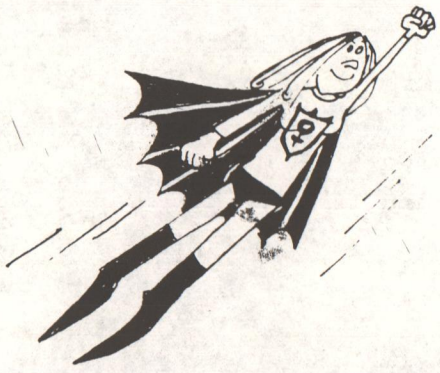
NEW SOUTH WALES (Cont.)

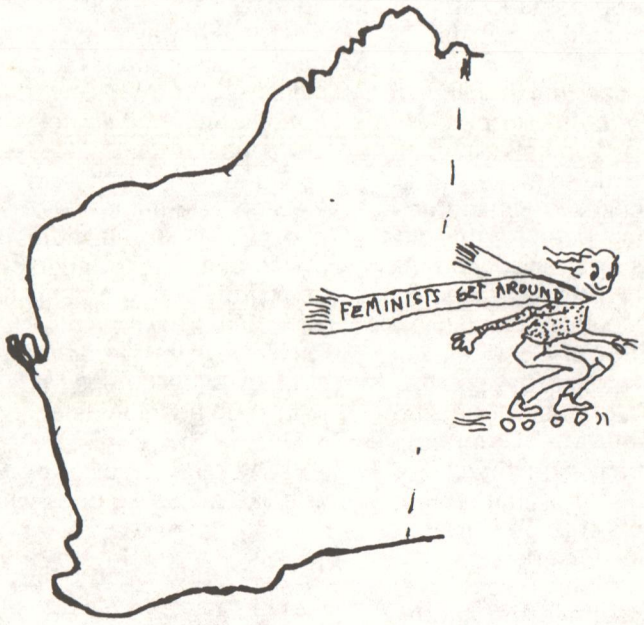
Privatisation of public hospitals

Privatisation of public hospitals in NSW is already underway. We already know from the Mt. Druitt experience that privatised public hospitals may refuse to perform termination of pregnancy operations or only perform them in very restricted circumstances. This will result in restrictions upon availability for many women in different parts of NSW. Such restrictions lead to *unnecessary* delays and, usually, greater expense for women.

WAAC is part of the campaign against privatisation of the public hospital system, however, we are battling a State government determined to push in this direction. Also of concern is the reported denials of patient rights and abuses by the U.S. company which has been bidding to run these hospitals in NSW. Taking a look at the U.S. health care system should be enough to convince readers that a privatised, fee-for-service health care system is equal to an unhealthy populace unable to gain access to non-exploitative health services.

Please contact us if you are interested in being involved in this part of our campaign work.





Western Australia

The Association for the Legal Right to Abortion (ALRA- WA) is still looking at the abortion issue from the perspective of human rights and access to abortion services. Earlier this year at their Annual General Meeting they heard a talk on "Abortion Laws in WA" by a barrister, Gillian Braddock.

Ms. Braddock said most people believe aboriton should be available however the law in WA does not reflect public opinion. Ms. Braddock argued that access to responsible, safe abortion never compels, thus, this raises the question of why it remains such a difficult question for politicians. Ms. Braddock further argued that if there were more women in Parliament

Also of note in regard to Western Australia is that the 1991 WA ALP State Conference adopted into the party's health platform, three new sections relating to: access to abortion: provision of counselling; and training of doctors. The policies complemented the eixsting state ALP policy of repeal of Sections 199, 200 and 201 of the WA Criminal Code.

In the opinion of ALRA (WA) it appears that the WA government has no commitment to repealing abortion laws despite the support for these initiatives from party members.

Vale - Megan Sassi

Regular *Right to Choose* readers will be saddened, like we were, to hear that Megan Sassi, long time ALRA (WA) activist died in mid 1991. We can still remember Megan contacting us many, many years ago in regard to a report she was preparing for the UN Committee for the Elimination of Discrimination Against Women (CEDAW) in regard to access to abortion services in Australia. Megan was highly commended for preparing the report and drawing this matter to the attention of the CEDAW. Megan was an inspiration and, though now gone, she will not be forgotten.

More Campaign News

Victoria

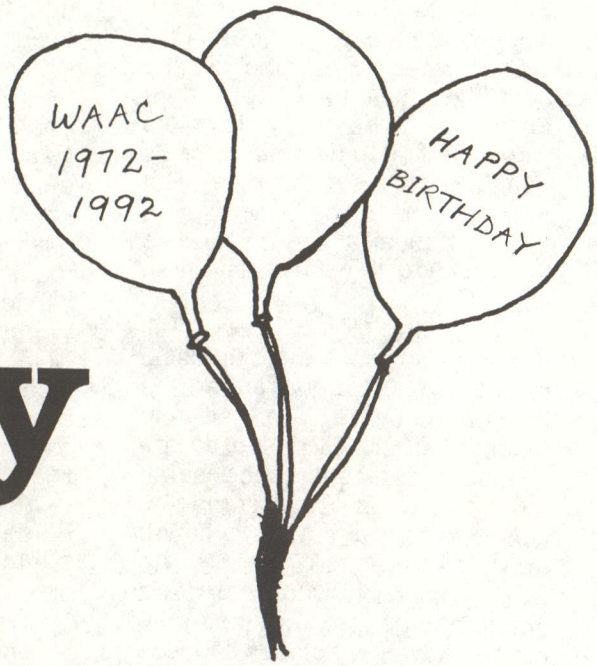
A very active campaign group, the Campaign for Women's Reproductive Rights, has been organising in Melbourne over the past 1-2 years. In April this year they held a march as part of their 'Feminist Offensive for Reproductive Freedom' and many continuing projects have been undertaken since then (e.g. producing a 'flex your reproductive muscle' guide to reproductive health services in Victoria).

Right to Choose did note, with regret, that the Coalition for the Right to Choose (based in Victoria) did fold. We know that the Campaign for Women's Reproductive Rights will continue the campaign work previously undertaken by the Coalition for the Right to Choose.

Twenty years of insisting abortion is a woman's right to choose

Both *Women's Abortion Action Campaign* in Sydney and *Children by Choice* in Brisbane celebrate their 20th year of campaigning this year. In those 20 years much has been achieved with regard to better quality abortion services for women in both states, and both groups have played a strong role in defending abortion rights and participating in international campaigns as well as those at home.

Happy 20th Birthday WAAC!



Well women clinics:

This is a review of an article by Peggy Foster in the book *Women's Issues in Social Policy* edited by Maclean and Groves and published by Routledge.

There are a number of Women's Health Centres around Australia and it is useful to ask what role they play and where they fit in to the whole scheme of health care. Peggy Foster has done such a thing for 'Well Women Clinics' in Britain and I believe that many points she makes are relevant to the Australian context.

Mainstream health services are dominated by medical professionals, mostly doctors. The setting up of Well Women Clinics in Britain and Women's Health Centres in Australia has partly been a reaction to this dominance by medical practitioners and partly to make health care services seem more accessible. Feminists in both countries have argued that women require a health care service which looks at their lives as a whole rather than defining their problems within a narrow medical model. They have also argued that women need to be able to take control of their own health care and not be at the mercy of doctors who all too often dismiss women's health complaints as trivial. But how different are these clinics from the usual medical services and do they really give women any more control?

According to Foster, Well Women Clinics were set up using one of two models: either the holistic model or the self-help model. The clinics based on the holistic model still place some emphasis on medical screening and professional advice, although they do seek to incorporate women's psychological and emotional needs. The self-help model, however, places far less emphasis on a medical perspective. This second type of centre provides health education,

advice and support based totally on a self-help approach. Often they are run by lay volunteers and explicitly exclude the services of a doctor.

Foster notes that the two different types of clinics may occupy different places in the scheme of health services. The most radical self-help clinics usually operate outside the National Health Service (British equivalent of Medicare) on very small budgets. As a result, Foster questions their ability to pose any real threat to mainstream medical services. The better-known Well Women Clinics operate within the NHS. As is noted above, the ideology behind this latter type of clinic is not as radical (if it is at all) as for the former type. Perhaps this is why they are NHS-funded.

Foster goes on to note the criteria by which she believes feminist health care services should be judged. These include:

1. the providers should work together in non-hierarchical co-operative teams;

2. providers should be concerned with a woman's social, psychological and emotional well-being as well as her physical health;

3. the workers should share their medical knowledge with the women and encourage them to play an active part in the health care process;

4. the care should be equally accessible to all women regardless of class, race or sexual orientation; and

5. the women using the clinics should find them acceptable and beneficial.

As Foster rightly points out, there seems to be little point in putting energy into providing alternative health care services if they cannot achieve greater consumer satisfaction than traditional services.

The first criteria is fulfilled in those clinics where doctors work on a sessional basis, rather than being there full-time. In this case, doctors are less likely to see themselves as the boss, thereby allowing greater participation in decision-making of other workers. This tends to happen only in those clinics where doctors aren't on the full-time staff.

The second criteria appeared to be fulfilled where the clinics were community-based rather than set up within general practices. The community-based clinics stressed treating the woman as a whole and doctors were unable to prescribe anything, thereby necessitating the search for simpler self-help style solutions.

The third criteria, that of sharing knowledge and encouraging women to play an active role in their own health care, raises some interesting issues. Foster notes that while in most centres nurses or lay volunteers were able to be consulted, nearly

a serious threat?

all women want to see 'the doctor'. This indicates that women as health care consumers are very much influenced by the dominant, mainstream health care model. It would probably be fair to say that this applies to most people, and illustrates the power of the medical profession. Changing the views of consumers would probably require quite a widespread educational campaign and a number of years before attitudes changed. Naturally this would be against the 'best interests' of doctors. Perhaps women who attend these clinics, and find them satisfactory, would increasingly see doctors as less important. But as we shall see below, this would be a very small proportion of health care consumers.

The fourth objective is to make alternative forms of health care available to all women regardless of class, race or sexual orientation. Foster notes that one of the publicly-stated goals of community-based Well Women Clinics has been "to reach women who may otherwise stay away from their doctor because of class, cultural or religious differences". Evidence thus far seems to indicate that there has not been a great deal of success in this regard. At one clinic in a more middle-class area, it was noted that "it is predominantly white middle-class reasonably well-educated women who came to this clinic and work as volunteers in it". At another clinic, the key reason for women attending the clinic was dissatisfaction with the advice or treatment they had previously received from their GP. This indicates that it is not women who don't normally visit a doctor that are being attracted, it is women who are dissatisfied and looking elsewhere.

In order to reach women not normally using conventional services, an outreach programme would need to be implemented. As is similar to the Australian case, resources are limited and budgets simply do not allow for this necessary work. Perhaps this is why feminist-run clinics are funded by governments: without any serious outreach programme they will never attract women on a large scale and therefore not ever threaten mainstream health services.

"women require a health care service which looks at their lives as a whole, rather than defining their problems within a narrow medical model"

Lastly, are women's health centres meeting women's self-perceived health care needs? Outcome studies are still relatively rare. Some of the limited evidence available does suggest that women are happy and satisfied with the services provided through these centres. Often they are grateful that, for once, someone has had time to listen and treat their problems seriously.

In summary, then, Foster notes that genuine feminist health care cannot be provided on a shoe-string (and I would argue that this is true of *any* health care). A move away from reliance upon doctors would certainly cheapen the costs of this type of health care and would probably also have the benefit of allowing women to become more involved in the process.

Whilst the clinics seem to be very popular with the women who use them, this number is quite small. As a result, this puts little pressure on mainstream health care providers to alter the type of services they offer.

Foster goes on to argue that career paths for women doctors should be improved and that this might lead to more room for feminist doctors to put their principles into practice. I would argue that change needs to be on a much broader scale than this – male doctors need to change too.

In conclusion, Foster argues that separate Well Women Clinics have provided a working alternative model of health care for women. Even if they do not prove to be the long-term solution to women's dissatisfaction with conventional, male dominated health care, they will have played an invaluable pioneering role.

It is important to critically evaluate new initiatives even if, as feminists, they are dear to our hearts. Limited evidence does seem to indicate that feminist-run health centres are valuable for women, but more needs to be done about forcing change in mainstream health services and reaching more women. Unfortunately the perennial problem of limited resources and energy crops up.

However we can hope that increased satisfaction with women's health centres and increasing dissatisfaction with conventional services will pave the way for further change.

HOT FLASHES

Women's stories on tape

A group of people called the Community Media Trust are working at present to make a 48 minute video about the history of abortion practice in New Zealand. This video looks at the personal experiences of women seeking and having abortions in the context of the political and social attitudes of the time. It focuses on periods of New Zealand history when access to abortion was totally illegal to severely restricted, that is, from the 1930's onwards.

The video will be released and available in the not-too-distant future. We will let all readers know more about this as soon as we do!

From: ***WONAAC New Zealand newsletter,*** *August 1992*

From the Report of the Abortion Supervisory Committee for the year ended 30 June 1991

"Fees payable to Certifying Consultants for consultations with women considering termination of pregnancy for the three month period from 1 April 1990 to 30 June 1990, totalled $598, 630.00. Fees payable to Certifying Consultants for consultations with women considering termination for the year ended 30 June 1991 totalled $2,281,840.76."

At present we have a procedure where women wanting an abortion must see two doctors, called Certifying Consultants. These Consultants must give their consent for each woman's abortion. Scrapping the Certifying Consultants would have two immediate effects. Firstly, women would be in the position of deciding whether they could continue their pregnancy; secondly, $2.2 million would be available for other medical essentials. WONAAC continues to call for decriminalisation of abortion and scrapping the two Certifying Consultants.

From: ***WONAAC New Zealand newsletter,*** *August 1992*

Catholic Opinion

The *NZ Herald* (16 June 1992) reports from New York (AFP) that nearly 80% of US Catholics believe they do not have to follow Church teachings on abortion or birth control, according to a Time magazine-CNN poll. It showed that 79% disagreed with the Churches' ban on artificial birth control, while 45% favoured abortion on demand.

From: ***WONAAC New Zealand newsletter,*** *August 1992*

2nd Trimester Cutbacks – New Zealand

The private hospital in Auckland which stepped in to perform 2nd trimester abortions due to cutbacks at Epsom Day (clinic), has now yielded to anti-abortion pressure and stopped the service.

From: ***WONAAC New Zealand newsletter,*** *August 1992*

Premenstrual changes after tubal ligation

While early reports have suggested a link between tubal sterilisation and the premenstrual syndrome, more recent studies have failed to confirm this association. In an attempt to clarify this alleged association, researchers in the USA (Rojansky, Nathan and Uriel Halbreich: 'Prevalence and severity of premenstrual changes after tubal ligation', *Journal of Reproductive Medicine*, Vol 36, August 1991) compared the severity of symptoms and their possible association with hormonal levels in 78 sterilised and non-sterilised women with prospectively confirmed premenstrual syndrome. No significant difference could be demonstrated between the groups in both the retrospective and prospective evaluation of the severity of premenstrual syndrome symptoms or in luteal hormonal levels. The researchers conclude that their data confirm that premenstrual symptoms are probably associated with tubal sterilisation.

From: ***IPPF Open File,*** *November 1991 and* ***WGNRR Newsletter*** *Jan-March 1992*

HOT FLASHES

HIV Transmission in pregnancy

Researchers in Sweden have been studying pregnant women who are HIV positive in order to try and determine when transmission to the foetus is likely to occur, if at all. During 27 pregnancies, HIV was not regarded as definitely present in any foetus although by six months of age, 5 of 19 children (26%) tested as HIV positive. The researchers conclude that there is no consistent spread of HIV across the placenta and argue that transmission is most likely to occur close to or at delivery.

From: ***WHRRIC (Women's Health and Reproductive Rights Information Centre) Women's Health, newsletter*** *and* ***WGNRR Newsletter*** *Jan-March 1992.*

Pill sales to begin in Japan

The *Times* (UK, October 18, 1991) reports that the livelihoods of Japanese door-to-door condom vendors are under threat, since the Welfare Ministry will declare 'open season' in Japan for sales of the contraceptive Pill in 1992. Oral contraceptives were previously banned in Japan, except in some medical circumstances, because the Ministry says that they have "unpleasant side-effects". Yuriko Ashino, Executive Secretary of the Japanese Family Planning Association (FPA), points out that Japanese doctors have created a lucrative abortion industry for themselves and have opposed the introduction of the Pill. However, the article suggests that although Japan's medical lobby is notoriously strong, the influence of pharmaceutical firms is greater. Plants have already commenced to manufacture the Pill under licence in Japan, and a 500 billion yen (£2.2 billion) annual market is anticipated, with "sufficient incentives to the doctors to persuade them to accept the Pill".

From: ***IPPF Open File,*** *November 1991 and* ***WGNRR Newsletter*** *Jan-March 1992*

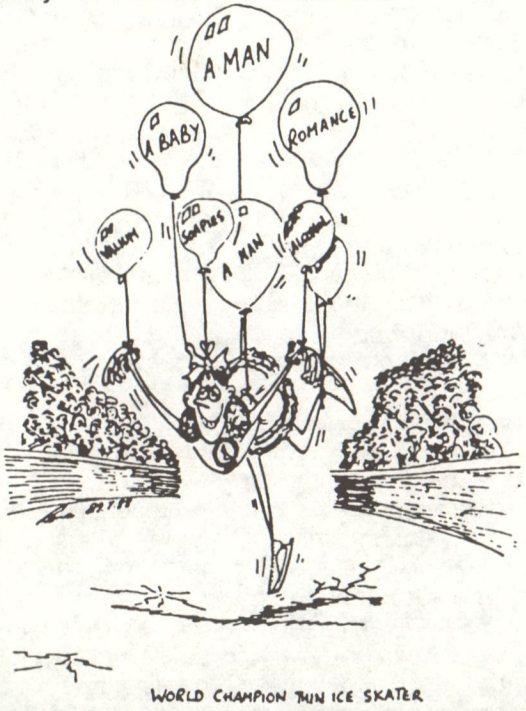
Irish condom bill will change nothing

"Politicians can seriously damage your health", warns the Irish Family Planning Association (IFPA) in its bulletin of October 1991. After the FPA was prosecuted for publicly selling condoms, Irish Prime Minister Charles Haughey advocated law reform on the issue, and a new 'condom bill' is due shortly to be voted upon by the Irish parliament.

While the FPA welcomes the Government's intent, it argues that the bill will not change anything. Local health boards would be responsible for determining, without government guidelines, the "general suitability" of outlets, and a recent poll revealed that a substantial majority of health board members opposed condom availability in pubs, shops and night clubs. The health boards themselves are said to be angry at having been "dumped with the condom problem", and opposition groups plan to challenge the constitutionality of the Government's delegation of policy determination.

Other problems with the bill include its ban on vending machine sale, vital to preserving confidentiality and removing embarrassment for buyers, and the age restriction for buying of 17 years, a year older than the legal age for both marriage and cigarette purchasing. The issue examines the bill and its opposition to automatic vending point by point, and quotes international experts advocating condoms as the only and effective way of preventing AIDS and STDs. The IFPA concludes that the bill will do nothing but initiate "a plethora of court cases" like that of the IFPA's.

From: ***IPPF Open File,*** *December 1991 and* ***WGNRR Newsletter*** *Jan-March 1992*



The Abortion Debate in Poland

Last December, a code of ethics on abortion was approved by the Second National Doctors Convention, a code that establishes regulations on abortion contrary to Polish law. Two years ago, the First National Doctors Convention appointed a committee to prepare the first code of ethics for Polish doctors. "The positive changes in Poland over the last two years had to be reflected in doctors' circles as well", said Professor Stefan Zgliszczynski of the Doctors' Council.

According to the ethical code, a doctor who performs abortions in violation of the new regulations can be deprived of his right to practice by a Doctor's Court. A doctor can appeal to the Supreme Court, which can revoke the decision. This procedure will remain in effect as long as the 1956 Polish law about abortion stays on the books. According to the law passed in 1956, abortion is legal in Poland.

National debates on abortion began two years ago. The Catholic Church in Poland takes a strict position opposing abortion, and the majority of senators of the last parliament shared the Church's views and attempted to introduce a bill to protect the unborn child. Under this bill, a woman would be sent to prison for three years for having an abortion, even when pregnancy was a result of rape. The Sejm (Parliament) rejected the bill. The new Sejm will also address the issue.

At the Second Convention, doctors proposed a new version of the Hippocratic Oath, which now will begin with the following phrase: "In service of human life and health from the moment of conception...". The doctors determined that "a doctor's intervention which involves any danger to the fetus' life is admissible only in case of threat to the mother's life or health, and when the pregnancy resulted from crime."

Ewa Ketowska, former Commissioner for Civil Rights Protection, who received a protest letter signed by a group of senators and deputies, spoke critically about the new Doctor's Code of Ethics. Senator Zofia Kuratowska said, "No professional group has a right to determine a code of ethics for the entire society." The 500 voting members at the Doctors' Convention decided that "a doctor may undertake prenatal tests only when the method used does not expose the fetus or the mother to danger incommensurate with the expected benefits. The diagnosis of development defects or hereditary illness in the fetus does not justify abortion." Anna Popowicz, the government's plenipotentiary on women's issues, believes that separate opinions of the Polish Gynaecological Society, Genetics Department of the Psychiatry and Neurology Institute and the Mother and Child Institute's Genetics Department are necessary. According to Popowicz, the Code may lead to discontinuation of prenatal testing.

The protests were directed not only against the Code's regulations but also against the way in which the decisions were made. To be sure, the legal adviser of the Doctor's Council, Witold Preiss, asserts that "representatives of the Convention could not be elected in a more democratic process and Code is truly a reflection of doctor's beliefs". However, twenty doctors of different specialisations, outside the Doctors' Council, said in interviews that there should be an opinion poll among doctors all over Poland. A poll was conducted in Garzaw district, and 70% of the doctors spoke against the Code's restrictions on abortion. The doctors we talked to in Warsaw, Cracow, Lublin and Wroclaw health care cooperatives believe that similar proportions (70% against) would hold true for the entire country.

The majority of doctors are convinced the difficulties lie not with the liberal 1956 law, but rather, as one of the gynaecologists said "with women's almost complete ignorance of contraception methods". It is not known how many abortions are performed in Poland, but every doctor agrees that abortion is the main method of regulating births here.

In last week's *The Warsaw Voice*, Professor Tadeusz Chrusciel, the chairman of the Doctors' Council, said he considered the Code not only a reflection of Polish doctors' ethical beliefs but also their vote in the discussion on the moral values of the nation.

Senator Walerian Piotrowski, initiator of the most radical propositions for legal punishment of abortion in the last parliament, says "the code is a step forward, but at the same time also a step backwards". He believes allowing abortion when a mother's health is endangered contradicts the Hippocratic oath; it can allow too freely for the justification of abortion, he says. The code is "too liberal", he said, and he promised to renew his legislative initiative to make abortion illegal early this year.

From: ***The Warsaw Voice****, No 1 (167) 1992 and* ***W G N R R Newsletter*** *Jan-March 1992.*

(For an update of the situation in Poland, see article on page 21).

POST-COMMUNIST EASTERN EUROPE:

Availability of Contraceptives

The political changes which have taken place throughout Eastern Europe over the past two years have brought mixed blessings to women in the reproductive age group. The opening of borders and freeing of economies should have brought greater availability of contraceptives from other parts of the world, but in reality this has not been the case. The wish of newly-formed governments to dispense with the old and bring on the new has meant the reproductive rights are being reduced for many women.

The general picture

The situation in each country varies, but there are some similarities. Throughout this part of the IPPF Europe Region (with the exception of Albania and Romania), in the past abortion has been relatively freely available and contraceptives have been in short supply, and often of dubious quality.

Condoms have been manufactured in Czechoslovakia (some 35-40 million units per year), Yugloslavia ((30 million units per year), Poland (75 million units) and, more recently, in Bulgaria. Many of these condoms were exported among the former socialist countries.

Hungary manufactures Rigevidon, Ovidon and Bisecurin oral contraceptives. Poland used to manufacture the 'Spider Cu' and 'Flower Cu' IUDs, but production ceased in 1989. Spermicidal pessaries are also made in Poland. Bulgaria started to manufacture the Venus Cu3000 IUD in 1990.

However, despite this seemingly reasonable production of a variety of methods, their distribution and use is severely limited. The reasons for this are mainly twofold:

- Financial reasons during the Communist era little funding was made available for the purchase of contraceptives. They were certainly not imported from Western countries, and roubles were not often made available for their purchase within Comecon. Now lack of hard currency makes their import limited and sporadic;
- Each method of contraception has its 'bad press' in this part of Europe. According to some Soviet doctors the Pill causes breast cancer; many Soviet women believe the Pill will cause women to grow beards. Many Romanian women believe that IUDs cause cancer, and everywhere condoms are not trusted and are disliked for being of poor quality.

Country profiles

In **Hungary** the availability of modern methods has been greater than in other countries. However, owing to the pronatalist tendencies of the new government, women are now having to pay for services and supplies which were previously free or heavily subsidised. Anti-choice groups are becoming increasingly loud and calling for a reversal of the current abortion law.

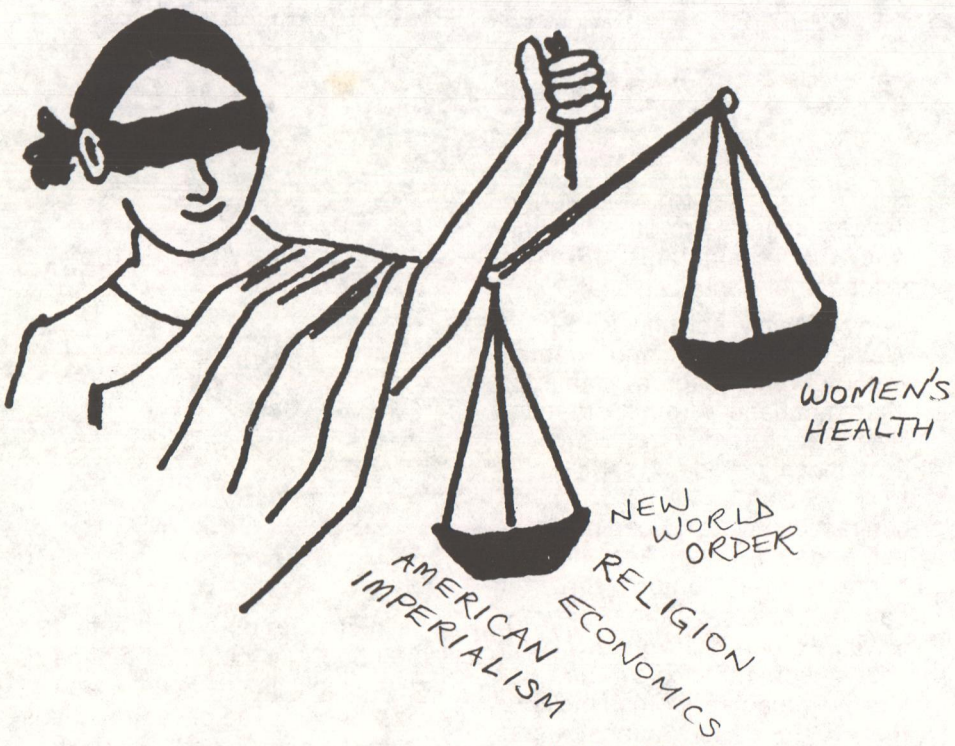
In **Poland**, the government seems committed to making abortion illegal except when a woman's life is at risk. Plans are being considered to make all contraceptives "considered abortifacient" illegal. In the eyes of some doctors and parliamentarians this would include condoms and spermicides, as well as IUDs. Anti-choice are organising and going to pharmacies, purchasing whatever is available in the way of contraceptives and destroying them.

In **Bulgaria** raging inflation (300-500%) is putting the price of contraceptives out of the reach of most people. The government has so many financial difficulties that, for example, when it is estimated that more than 3,000 people will die for lack of kidney dialysis, contraception is not a priority. Condoms have been imported from Singapore and then spermicide and packaging added locally, but lack of hard currency has caused this operation to cease. Now that the borders are open, more than one million young people are leaving the country, causing concern about the demographic balance. Abortion on demand is available free of charge. Recently, women have heard about and are requesting contraceptive implants, but none are available.

All contraceptives, except condoms, are available free of charge in **Czechoslovakia** and availability is no longer a real problem, but modern methods are not widely used. Some 16% of women use IUDs, 5% use oral contraceptives (they are not popular as choice is limited and they tend to be high dose). In 1989, 25 million condoms were sold within the country. Abortion is

continued on page 16

Contraception in Eastern Europe



provided free of charge if performed within eight weeks after the last menstrual period, but has to be paid for after that time; this is an effort to encourage women to seek terminations earlier rather than later. An advisory commission on abortion was established in March 1991, and while its members are not recommending an absolute ban on abortion, they are proposing increasing the cost to the woman (by six times). They also say that the government has a role to play in educating couples in respect for human life, which, according to the Charter of Principal Rights and Liberties "is worthy of protection before birth".

In **Albania** the State implements a pronatalist demographic policy. Women are only allowed to use hormonal and mechanical contraceptives when there are medical indications. Family planning and health education policy is aimed at convincing women to increase the number of children they have, to improve their birthspacing, and to use condoms, which are sold in pharmacies.

In the **USSR** and **Romania** both governments have made an overt commitment to national family planning programmes. For the first time, the Soviet Ministry of Health has allocated hard currency to be used to import contraceptives. A three year plan to introduce family planning services, using already existing Mother and Child Health Care centres, has just started. Joint ventures with American, British and Japanese condom manufacturers are underway, with a view to an eventual annual total production of 876 million condoms. Estimates for the total annual need are in the region of 1-1.4 billion units. Registration of other methods is taking place more quickly than in the past, and clinical trials undertaken in other countries are being accepted as evidence by the Pharmacological Committee, shortening the process.

On 26 December 1989 in **Romania**, recognising the devastating effect illegal abortion was having on women's health and lives, the caretaker government at that time legalised abortion. Since then maternal mortality as a result of abortion has dropped dramatically. The number of abortions being performed is not yet decreasing from 990,000 in 1990 in a population of 5.2 million women in the fertile age group because the majority of women are not aware of alternatives. The government purchased 6,000,000 IUDs and 1 million vaginal pessaries, and will, with the assistance of the World Bank, also be introducing family planning services throughout the country in MCH centres. The need to make information widely available about contraception is vital. Romanian women are not starting fertility regulation from level zero, they are starting from a minus point, since for 25 years they have been forced to have children and have been subjected to humiliating and degrading treatment and examination as 'baby-producing machines'. It will take time to reinstate their dignity and to reassure them that they do have a right to choose the number of children they want, and that abortion is not the only way to achieve this.

Yugloslavia is now in such a state of fragmentation that it is difficult to obtain clear information about what is available. Coitus interruptus, is, after abortion, the most widely used means of controlling fertility. Attacks are being directed at the liberal abortion law. Concerns run deep about the demographic differences between, for example, Serbia with a low fertility rate and Kosovo where only 9% of married women use any method, compared to an average of 55% in all other republics, and pro or anti-natalist policies are being discussed.

Sterilisation legislation varies throughout the region. In **Czechoslovakia**, for example, it is permitted only for medical reasons for both men and women. In **Hungary** it was made available for family planning purposed in 1987.

The Devastating Effects of DES

The Devastating Effects of DES

Between the years of 1941 and 1971, a synthetic oestrogen named Diethylstilbetrol (or DES for short) was prescribed to about 5 million American women in order to prevent miscarriage. It was also prescribed to women in Canada, Australia and throughout Europe.

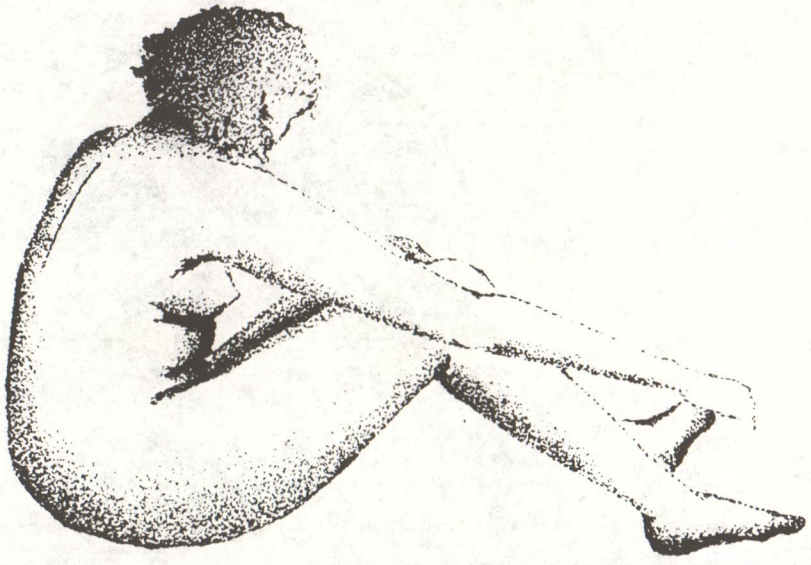
However, not only did it have no beneficial effect on preventing miscarriage, it crossed the placenta and caused reproductive abnormalities in the developing foetus and other problems which would occur later in the child's life.

It is unknown as to why DES was prescribed to pregnant women, as it was untested for this use. It was, in fact, known as early as 1939 that DES caused uterine cancer in laboratory animals, yet it was prescribed to women up until 1971. It was in this year that eight young women presented at the Massachusetts General Hospital with an extremely rare from of invasive vaginal cancer. The women were between 14 and 22 years of age. Only then was the link between the fact that their mothers had taken DES during pregnancy and the daughters' cancer realised.

There are five groups of people affected by DES, each with different effects:

1. DES mothers, who took the drug to prevent miscarriage;
2. DES daughters;
3. DES sons;
4. DES daughter's who've developed clear cell cancer;
5. the third generation (children of DES-exposed offspring).

Studies have indicated that DES mothers are more likely to develop breast cancer earlier in life. One study showed this group to have a 44.5% greater risk of breast cancer than non-exposed women. There is also a greater risk of endocrine-related cancer for exposed women.



As mentioned above, DES children are likely to be born with structural abnormalities of the reproductive system. For women this includes changes in endometrial tissue, blocked fallopian tubes, t-shaped uterus, incompetent cervix and anovulation. For males this includes benign cysts inside the scrotal sacs, malformations of the penis and sterility due to a low sperm count. Undescended testicles and unusually small testicles also pose a serious threat, as they are linked with an increased risk of cancer.

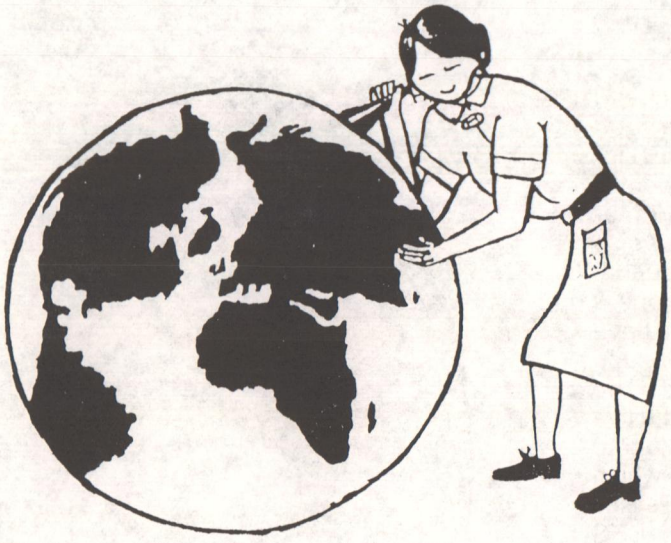
Living with the necessity of frequent medical examinations, a fear of cancer, knowledge of deformities and anxiety about the ability to have a healthy child also generate emotional effects aside from the physical effects.

One out of every 1,000 DES daughters will develop clear cell cancer of the vagina or cervix. This usually necessitates a radical hysterectomy as well as surgical removal of all or part of the vagina. Twenty percent of patients do not survive, and for those who do survive, lifelong problems such as vaginal dysfunction, bladder or bowel dysfunction and severe, chronic swelling of one or both legs may occur. This cancer is occurring in quite young women (average age 19), but may also occur in women in their 30's or 40's. For these women, childbearing is obviously not an option. But for those DES daughters who do manage to become pregnant, their pregnancies are classified in the high-risk category. They have increased risks of ectopic pregnancy, miscarriage or stillbirth, and premature labour and delivery. Some premature babies have been born with cerebral palsy.

Estimates of the DES-exposed population in the US are in the range of 10 to 12 million. Despite this, research on the DES-exposed population is in danger of drying up. This is worrying because many of the DES children are only just reaching childbearing age. The harmful effects of DES have not been immediately apparent and thus further research is warranted. The DES population are an unprecedented model of transplacental carcinogenesis and merit the sustained interest of the medical community.

continued on page 23

INTERNATIONAL



Abortion information suppressed Ireland

More than 2,000 copies of the *Guardian* carrying a full page advertisement for the Marie Stopes abortion clinics were destroyed by the newspaper's Dublin distributor at the end of May because the advertisement gave illegal information about abortion. The distributors withdrew the copies watched by a police inspector. The withdrawal was raised in the Dail twice but ministers denied prior knowledge or involvement in the affair. The leader of the democratic Left Party, Proinsias de Rossa, said that the incident was the latest ludicrous consequence of the 1983 pro-life amendment to the Irish constitution. "To treat one of the most respect newspapers in the world like some smutty pornographic magazine will be greeted with incredulity in virtually every democratic state," he said. Peter Preston, editor of the *Guardian*, said that this was not an organised effort to test Irish opinion on abortion.

*From: The **Guardian**, UK, The **Times**, UK, The **Independent**, UK, 22 May 1992 and **IPPF Open File** July 1992*

The age of consent in Europe

The *European* newspaper carried an article on the recent lowering of the age of consent in Switzerland, and the arguments surrounding it. Sex between under-16s is no longer a criminal offence as long as the participants are older than 13 and there is no more than a three-year age gap between them. Swiss family planning expert Mary-Anna Barbey said she was "delighted and relieved" that she will no longer be breaking the law when advising youngsters under 16. The move is seen as a Europe-wide trend which acknowledges that no amount of legislation will prevent adolescents having sex if they want it. When the Dutch set an age limit of 12, there was an outcry in other countries. "The Dutch themselves simply could not understand why there was such a fuss," said Karen Newman of IPPF. "The trend in each country now is for legislation that makes it easier for youngsters with problems to come forward without fear of prosecution."

*From: The **European**, 29 May 1992 and **IPPF Open File** July 1992.*

No abortion for US servicewomen overseas

Servicewomen stationed outside of the US who find themselves in need of an abortion discover that they do not have the same access to medical facilities as they had at home. Since 1988, abortions have been prohibited at all military hospitals except when they are necessary to save the life of the mother. This policy has recently come under scrutiny. The House passed a military budget bill including an amendment that would rescind the 3 year old Pentagon policy. Under the bill, abortions would be performed by military doctors and paid for by the women receiving them.

Congress passed the amendment, but it was subsequently vetoed by President Bush. Military women, as well as Peace Corps volunteers, will remain unable to obtain an abortion at US medical facilities overseas.

*From: **Women oughta know – the monthly female fact sheet**, a publication by Women to Women Communications (US), December 1991 and **WGNRR Newsletter** Jan-March 1992*

Irish students plan to defy ruling on abortion advice

Irish students have vowed to continue providing women with information about abortion, having lost an appeal at the European Court of Justice for the right to distribute details on British abortion clinics to Irish women.

The *Guardian* (UK, October 5, 1991) reports that anti-choice campaigners welcomed the ruling as a "great victory for our side". However lawyers have suggested that the ruling has opened up the possibility that British clinics would be able to advertise their services in Ireland, suggesting that this new case would have to be taken to the European Court.

From: ***IPPF Open File*** *November 1991 and* ***WGNRR Newsletter*** *Jan-March 1992*

Germany approves liberal abortion law

The German government has finally resolved abortion law for the unified country, voting 357 to 300 to allow abortion up to 12 weeks, with a mandatory pre-abortion counselling session with a doctor. In the run up to the vote, the ruling Christian Democrats had been putting pressure on an estimated 60 party members who support draft legislation legalising first trimester abortions. The *Guardian* reports that amid rumours of anonymous letters threatening these politicians' careers, party managers had to work to restore discipline on the sensitive issue. Christian Democrat members of parliament from North Rhine-Westfalia, the biggest federal state group of the party with 63 members, have voted unanimously to oppose any liberalisation of the abortion law, and had demanded that party rebels back the party's restrictive draft law. The former law in Western Germany allowed abortion only on health, genetic and psychological grounds, and it was a criminal offence for women and doctors to ignore these conditions.

From: The ***Guardian****, UK 3 June 1992 and* ***IPPF Open File*** *July 1992.*

World Bank support for abortion reform in Latin America

The World Bank has recommended that Latin American governments institute legislative reforms regarding abortion, whose illegality and practice in unsafe conditions is the leading cause of maternal death in the region, reports the *Women's Health Journal*. In a session of the Central American Safe Motherhood Conference, held in Guatemala, World Bank officials suggested that regional governments hold national consultations with all social sectors, but particularly women, on the subject of abortion. A World Bank health specialist has indicated that at least 100,000 women in the region will die from pregnancy-related causes in the 1990s, despite health and family planning programs. Of these, 17% will be victims of illegal and unsafe abortion. Recognising the urgent need to collate reliable information on abortion, he promised that World Bank funding will be made available for such studies. The World Bank also called for the creation of a safe abortion programme in Central America, expressing the need to reduce the social, medical, and economic costs of abortion and maternal mortality rates in the region.

From: ***Women's Health Journal****, No 1, Jan-March 1992 and* ***IPPF Open File*** *July 1992.*

Clarification of 1984 Mexico City Policy on abortion restrictions

In a recent court case challenging the *Mexico City Policy* (Pathfinder Fund et al. vs. AID) Dr Duff G. Gillespie, Director of the US Agency for International Development (USAID) Office of Population, made an official sworn statement on USAID's behalf stating that some abortion activities are in fact permissible under the policy. The clarifications were also made in recent testimony by US foreign aid officials before the US Congress. They are summarised here, with the relevant language from official USAID documents.

They cover:

- demographic and health research on abortion;
- provision of training and equipment to treat septic and incomplete abortion (including illegal abortions);
- abortions to save the mother's life and abortions in cases of rape and incest;
- post-abortion counselling and services (including contraceptive services).

In addition the documents make it clear that USAID funding can go to governmental organisations involved in abortion activities as long as the funding is accounted for separately. Government organisations are broadly defined to include public universities, hospitals and national councils.

Background

For the last several years, leading US family planning organisations have challenged the US government's *Mexico City Policy* abortion restrictions in the court system and in the US Congress. So far these efforts have been unsuccessful. However, they have forced USAID to clarify the specific restrictions imposed by the policy, and to acknowledge that foreign non-governmental organisations (NGOs) may use funds from non-USAID sources for certain types of abortion-related activities and still remain eligible for US population assistance. The longstanding prohibition of the use of USAID funds for most abortion activities remains unchanged. The written guidelines used by USAID to implement the *Mexico City Policy*, called The Standard Clauses, require foreign NGOs to certify that they do not and will not "perform or actively promote abortion as a method of family planning". The perception of many NGOs in developing countries who receive USAID population funds, and even some USAID Cooperating Agencies, has been that any involvement at all with abortion will disqualify them from USAID support. This is not accurate.

From: Population Crisis Committee, 1991 and ***WGNRR Newsletter*** *Jan-March 1992.*

Women cope well with abortion

The Psychological Sequelae of Induced Abortion: A New Literature Review.
(Reference: Romans-Clarkson, S. E. (1989) Psychological Sequelae of Induced Abortion, *Australian and New Zealand Journal of Psychiatry*, 23, 555-565.)

This article is a review of the scientific literature of the psychological sequelae of induced abortion, written from a psychiatric perspective. Despite the fact that only 17 studies are reviewed, Romans-Clarkson has compiled a comprehensive range of data. The review covers studies from Sweden, U.S.A., U.K. and Australia conducted between 1955 and 1980, which have follow-up periods ranging from 2 weeks to 3 years and which include a fairly wide range of subjects (across race, age, socio-economic status, religious affiliation and marital status). Romans-Clarkson considers that;

"Research accruing from several countries and across two decades has shown that abortion does not cause psychological problems for the women concerned. Such a consensus is rare in the social sciences and medicine. This conclusion reiterates that derived from previous literature reviews, and thus should not be regarded as a new or surprising finding" (p.560)

Research accruing from several countries and two decades has shown that abortion does not cause psychological problems for the women concerned.

The review has four major objectives:

1) A review of the literature on the psychological sequelae of abortion.

There is an extensive body of scientific literature in this field (this particular review is well referenced and would be a suitable source for wider investigation of the topic), although very little has been published in the last 10 years. It appears that the majority of the research in this field was done in the 1970's as a response to legislative changes in the countries involved. Given the remarkable consensus that emerges in the literature it would seem that further studies of this kind are considered unnecessary.

Romans-Clarkson has a number of criticisms of the studies under review. For example, most of the studies investigate the degree of guilt experienced by the women, but Romans-Clarkson considers that there is no adequate way of reliably measuring guilt. Moreover;

"... as guilt is deliberately induced as part of a traditional system of social control, it is superfluous to ask whether abortion patients experience guilt. It is to be expected that they all will do so to some extent" (p.558)

Certainly guilt following an abortion is not to be viewed as pathological. The other criticisms that Romans-Clarkson mentions are of a methodological nature; subjects should be pooled from sources other than clinical referrals, there seem to be intrinsic difficulties in maintaining good follow-up rates and generally there is poor use of statistical analysis to support the research.

2) Directions for future research

Romans-Clarkson suggests that there is no need (as far as the psychiatrist is concerned) for further studies of the kind reviewed. Instead she suggests that more modern epidemiological methods should be employed, so that "a past history of induced abortion should be routinely included in the general surveys of female psychiatric disorder in the same way as sexual and physical abuse should be measured" (p.563). This pool of data would provide a valuable source of information for any subsequent investigations.

3) An assessment of the factors that may be predictive of poor psychological outcome of abortion

While for the vast majority of women there are no long-term, deleterious psychological effects of abortion (indeed many of these studies report an immediate improvement in the woman's psychological well-being following an abortion), there are a number of factors that health professionals working in the area of abortion services should be aware may be predictive of a poor adjustment to termination of pregnancy.

Romans-Clarkson considers the most common of these is ambivalence about going ahead with the abortion. Women who show an uncertainty or unwillingness prior to an abortion are more likely to to show guilt and depressive reactions following the procedure. However this can be readily ascertained by a trained professional and should be highlighted in the woman's decision making process. Other factors which are predictors of poor outcome include a history of psycho-social instability, little support from family or friends, uncaring or hostile reactions from the health professionals involved, inadequate post-abortion support services (especially contraceptive advice) and where the woman has had the abortion decision imposed on her by others (especially where the abortion is the result of medical or foetal contraindications, or she has been coerced into the procedure by her partner or family members).

4) Implications for abortion legislation

Romans-Clarkson asserts the unjust nature of restrictive abortion laws given the data of the psychological effects of an abortion.

"This review has clearly established that restrictive legislation cannot be logically justified on the grounds of a deleterious psychological aftermath to induced abortion. *Virtually all women who genuinely desire an abortion benefit from it.* It is only when the woman herself does not wish to have an abortion, but succumbs to pressure from others, that problems arise" (p.564 italics added).

This clearly rebutts the claims from anti-abortion activists that a woman will experience long-term guilt and instability if she terminates an unwanted pregnancy. Romans-Clarkson also documents the deleterious psychological effects of 'mandatory motherhood' in women refused abortion. In one study 75% of women denied abortions suffered from significant psycho-social disruption e.g. problems at work, with family, with future social and sexual relationships (p.561). Similarly the children resulting from refused abortions were significantly more likely to suffer from psychological, educational and anti-social problems (p.562).

While anti-abortion activists are showing an overwhelming disinterest in the psychological well-being of women with unwanted pregnancies (choosing instead to crusade for the life of the foetus), this review issues a very damning statement about the deleterious psychological effects for women if abortion is restricted through moral or legal prohibitions.

Summarised by Liz Wilson.

It is only when the woman herself does not wish to have an abortion, but succumbs to pressure from others that problems arise

Still waiting for decisions on abortion in Poland

The *British Medical Journal* reports that since the Polish General Medical Council's new ethical code came into force at the beginning of May it has become practically impossible to get an abortion in Poland. Women are turning to private clinics rather than going to state hospital where they may be refused. Despite the Polish ombudsman's statement that he will defend those who carried out abortions in accordance with the existing law, doctors fear a ban on practising from the Medical Council if they break the Council's code. On 13 May, the ombudsman said that he had started proceedings against a hospital that had refused to perform an abortion. Until the new legislation is submitted and passed, doctors are left in a situation where doing something that is within the law contravenes their governing body's code. The Constitutional Tribune has not yet been able to reach a decision because it is still awaiting a final version of the code. A spokesperson for the Tribune says that it has only received a document detailing errata in the text of the code. The publicity surrounding the case has meant that far fewer women are requesting abortions. The *British Medical Journal* concludes that the delay in determining the Tribune's decisions, and the two new bills currently in front of the Polish Parliament, are ensuring that the role of the state versus that of an individual doctor will continue to be a major issue in Poland.

*(From **British Medical Journal**, vol 304, p 1399, 30 May 1992 and **IPPF Open File** July 1992)*

Abortion:

Making the Decision

The following article is an excerpt from a booklet titled "Abortion: A Guide to Making Ethical Choices" which was published by **Catholics for a Free Choice** in the USA. The booklet covers almost all the possible issues involved in the abortion decision in a non-judgmental, non-dogmatic way. The emphasis is very much on the woman being the final arbiter and choosing what she feels is right for her. Women's life-plans and aspirations are taken seriously and women are not viewed merely as baby producing machines. It is refreshing to read material that takes women and their approach to life seriously without romanticising children or motherhood.

Unfortunately this short excerpt doesn't really do justice to the entire booklet, and may sound a bit preachy. However we are reprinting it here for you to read as it raises some interesting issues.

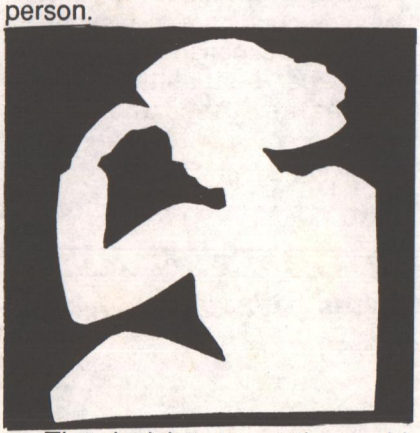
Abortion : Making the Decision

Every decision related to procreation is important. In case you find yourself in the dilemma to have to determine whether you'll have an abortion or not, admit first you are the person who should be making that decision.

Given that abortion arouses deep feelings in people, many will attempt to make the decision for you. Do not forget that you are the one who has to make this decision, do not give up this right.

Admit and take into account the personal and moral commitments you have in your life, remember there's no single moral justifiable way to live your life. Your personal commitments will influence very much your decision, and that is the way it should be.

When making moral decisions, the first rule to follow is to know exactly what your are deciding upon. You have to know the medical aspects such as abortion and maternity, medical procedures and risks involved. You need to understand your own feelings, religious beliefs and values regarding the foetus and consider them in the context of your own circumstances and pregnancy. To make a good moral decision, you also should look at your options. As far as abortion is concerned neither options are absolutely good nor bad. But it is important to consider all your options in order not to regret later that your actions were based on not completely understanding the whole situation. If you decide to give birth, you should think about the duties you'll have to your child in the long run. In a sense, pregnancy embraces at least twenty years: the nine months of pregnancy and many more years until your child becomes an adult, independent person.



The decision to continue with the pregnancy until the end is only the beginning of a long history which involves a great part of your life.

If the foetus you bear suffers genetic defects, you should think in terms of both the baby and your own future. The gift of life is not always generous. If possible pay a visit to parents of children with the same genetic problem and learn everything you can from their experience. That experience might not be the same as yours, perhaps you will not be able to face the situation as satisfactorily as they do, or maybe you might do it better. The teaching from those contacts is what is involved in such situation and what the child and her/his parents have to suffer.

If an adolescent is the one asking herself if she will be a single mother, visit a friend who has left school to become a mother. You should also visit other adolescent mothers with babies in different stages of development. Some of these mothers begin to question their decision only after the baby starts walking and becoming more independent and needing more supervision as well as having to find someone to look after him/her if she wants to go out. But then it is too late to question this decision to have a baby. You should face this important decision the same way you do with all the important ones in your life.

People adopt decisions in different ways. For any one making a meaningful one it is good to talk to friends you trust and/or to counsellors who are impartial. If possible, try to talk to women who have had abortions. The abortion clinics can generally refer you to a counsellor who will *not* make a decision for you but who will point out the questions you should be making yourself.

That person should be well disposed to help you and support your decision. In all processes of making decisions, remember, that many good women have adopted decisions either pro or against abortion. The decision of having an abortion does not place you in a good or bad world. Whatever the outcome of your struggle to reach a decision, this will not stop you from having some doubts left. That is the human condition. To do whatever is possible to make a decision you can live with, and after be strong knowing that you made your best decision.

From: Illawarra Women's Community Health Centre Newsletter July/Aug 1989 and summarised from Catholics for a Free Choice booklet 'Abortion: a guide to making an ethical decision" by Marjorie Reiley Macquire and Daniel C Macguire.

from page 17

The immune systems of those exposed to DES are also likely to have been weakened. This means a greater incidence of respiratory tract infections, asthma, arthritis and lupus in this group. Conditions that may involve altered endocrine function were also more frequent among such persons.

Major questions, such as how DES came to be released onto the market, remain unanswered. The issue of who is responsible for this disaster also remains unsolved. DES has had devastating consequences on the health and lives of many people who were exposed to it before they were even born.

As one woman, active in the struggle for the rights of those exposed to DES has said, "DES sums up consequences: those of improper drug testing and trial, of the corporate race to market, and of the idea of improving women's pregnancies with medications. DES may have been prescribed in the past, but we hare living with the consequences *now* and will do so in the future, until we know the full effects that this drug has upon people. DES people may shed light on similar problems also. One of the problems in the US is that research is compartmentalised into organ systems or the type of disease. Such a model is too fragmented for a drug such as DES which has wide-ranging effects.

DES Action Groups around the world are calling for continued research into the effects of DES and justice for the victims of this horror drug. In Australia, contact:

DES Action Australia
PO Box 282
CAMBERWELL Victoria 3124

From the DES Action Newsletter ***Despatch****, June 1992.*

Eastern Europe (continued)

The person must provide a written request, must be over 40, over 35 with three children, or over 30 with four children. In **Bulgaria** sterilisation was legally regulated in 1989 and is now permitted, but there is a severe lack of equipment and training.

Conclusions

The common thread among all the countries of Eastern Europe is that abortion is still the main means of fertility control used by women. It is accessible, cheap and well known.

Efforts are being made to encourage women to choose contraception over abortion, but until supplies are widely available on a regular basis, until clear information and educational programmes are under way for doctors and health workers as well as women who wish to use conception, abortion will continue to be used. It is critical that abortion remains legal in order to provide safe medical services for women. More than 20,000 women died in Romania during the time abortion and contraception were banned. Many thousands are still suffering from the results of serious infections and infertility.

With all the debates going on in the governments about making abortion illegal and with pronatalist concerns, it would appear that in many of those countries where women's rights were imposed ideologically, rather than democratically won, they are not always perceived as being associated with democracy, but with the regimes being supplanted. In the words of one Polish woman I recently spoke to: "We have exchanged reproductive rights for democratic rights".

Lynn Thomas

Lynn Thomas is Director of the IPPF (International Planned Parenthood Federation), Europe Region. This article is reprinted from ***IPPF Medical Bulletin****, Vol 25, No 4, August 1991 and* ***WGNRR Newsletter*** *37 Oct-Dec 1991.*

Subscribe to Right to Choose!!

We hope you have enjoyed this issue. If you would like to subscribe, please complete the form below – we will notify you when each subscription is due for renewal. A subscription is one of the best ways to support the right to choose.

☐ **I wish to subscribe to *Right to Choose*, enclosed is $8 for 4 issues.**

☐ **I enclose $ for the pro-choice campaign.**

☐ **Please send more information about Women's Abortion Action Campaign (WAAC) to:**

NAME: _____

ADDRESS: _____

_____

Post to: Women's Abortion Action Campaign, P.O. Box E233, St James, 2000.

How to get an Abortion

If you suspect you are pregnant, obtain a pregnancy test from a Women's Health Centre, a chemist or the Family Planning Association. Once your pregnancy is confirmed and you decide you do not want to continue with the pregnancy, act quickly, the earlier you have an abortion, the safer it is. There are abortion counselling and referral services in most states.

Canberra
Abortion Counselling Service,
3 Lobelia Street,
O'Connor, A.C.T. 2601
Phone: (062) 47 8070

Brisbane
Brisbane Women's Community Health Centre
Phone: (07) 844 1935

Children by Choice
237 Lutwyche Road,
Windsor, QLD 4030
Phone: (07) 357 5377

Adelaide
Adelaide Women's Community Health Centre
Phone: (08) 267 5366

Perth
Abortion Information Service
Phone: (09) 227 6178

Hobart
Women's Health Foundation Clinic
(002) 28-0997

Casuarina, N.T.
Women's Information Service
Phone: (089) 27 7166

Alice Springs
Women's Information Service
Phone: (089) 52 6006

Melbourne
Women's Health Resource Collective
Phone: (03) 380 9974

Sydney
Bessie Smyth Clinic
Homebush
Phone: (02) 764 4885

Everywoman's Health Centre
Leichhardt
Phone: (02) 569 9266

Published by Angela Rome, c/o 63 Palace Street, Petersham, NSW 2049