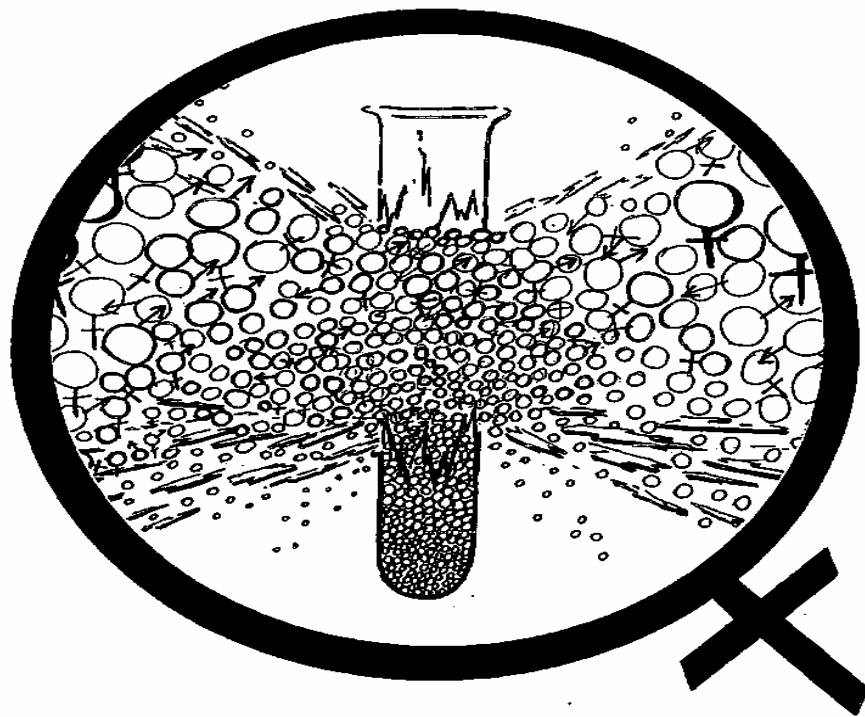


**Feminist
International
Network New
Reproductive
Technologies and
Genetic Engineering**



**INTERNATIONAL
CONFERENCE LUND-
SWEDEN**

July 1985

SWEDISH NATIONAL REPORT

Swedish legislation governing the use of reproductive technologies is currently under revision. In 1981, the government appointed a committee on insemination, which was to investigate the need for new legislation concerning artificial insemination, in vitro fertilization and prenatal diagnosis.

In 1983, the committee presented its first report, Barn genom insemination (Children by insemination) dealing with artificial insemination. As of March 1985, a new law based on the report was enacted. Only married couples or heterosexual couples living in stable relationships are allowed insemination treatment. The woman's partner has to accept legal paternity by signing a paper without which insemination treatment is not allowed. There has to be a medical reason for AI and a psycho-social investigation is made before a couple can qualify for treatment. The sperm donor is not allowed anonymity as the child has a right to information about its biological origin. The biological father has no legal claims to the child. The same sperm donor is allowed to father only six children by AI. Insemination is illegal if done for profit or on a regular basis. A woman who receives insemination outside the medical system cannot be punished directly but will suffer economic disadvantages as she cannot receive child support from the government, which single mothers get when the biological father can't or refuses to pay. Insemination, as opposed to adoption, is paid for by the state. Interesting to note is that adoption laws do allow single women and single men to adopt.

The committee's second report, Barn genom befruktning utanför kroppen (Children by external fertilization), was presented in the beginning of 1985. It proposes that IVF should be allowed only when both egg and sperm come from the social/legal parents. There has to be a medical reason for the childlessness to qualify for IVF-treatment. The committee rejects other methods for conception outside the womb, including all forms of egg and embryo transfer. Surrogate motherhood will not be allowed, but the legislation will probably only cover surrogacy for money. Embryo freezing will be allowed up to one year. If one of the parents dies, the embryo must be destroyed. There are currently four IVF clinics in Sweden: in Stockholm, Gothenburg, Malmö and Lund. As of 1984, eight IVF children have been born. No legislation on IVF has been enacted yet. The proposals will probably be discussed in Parliament during the coming year.

Questions concerning the use of genetic engineering and similar techniques in humans, human zygotes and germ cells have been dealt with by a government committee on genetic integrity. In November 1984, it presented the report Genetisk integritet (Genetic integrity), in which it proposes eleven ethical guidelines. They allow for research on human germ cells and on embryos up to 14 days after conception. Gene therapy on somatic cells is considered acceptable. If gene therapy on human sperm, ova, zygotes and embryos will be possible to perform in a reliable way, and implantation is being considered, the committee writes that such an operation must come under severe ethical examination, which should include full knowledge of the consequences. Prenatal diagnosis should, according to the norms, be restricted to diseases that threaten the development of the fetus or the child. DNA-based diagnosis is to be allowed if the investigation has a clear medical aim and with the person's free and informed consent. The proposed guidelines will probably not be given the status of law, but be mentioned in a law that appoints the National Board of Health and Welfare as an advisory authority which

is to oversee that the norms are followed. The report is currently out for comment and will probably be discussed in Parliament during the coming year.

Both the work of the insemination committee and the genetic integrity committee can be criticised on several points. For example, neither has looked at how the technologies will affect women or other groups that are not in a position of power, such as the handicapped. The basic ideology of the insemination committee is to protect the nuclear family and paternity even if they phrase it as protecting the child's interests.

As far as birth control and abortion are concerned, no new legislation is currently under discussion. Birth control is freely accessible to any teenage or adult woman. Birth control counselling is free of cost. Costs of the methods themselves are subsidized by the state but women still must pay part of the costs. The major forms of birth control are pills and IUDs, however the use of Depo Provera has been approved and it is most often used on women in mental institutions. Abortion is freely accessible and is the woman's own choice up to 12 weeks and up to 18 weeks it is also her own choice as long as the abortion poses no risk to herself. After 18 weeks a woman can only have an abortion if she applies and receives permission from the National Board of Health and Welfare. Permission is only given if there is a good reason for it. It may not be given if there is reason to believe the fetus is capable of surviving outside the womb. Amniocentesis is usually carried out in the 16th week and a woman receives the results after passing the 18 week limit. In the case of genetic defects, the National Board of Health and Welfare has always given permission to those women wanting abortion. They wanted the limit in the case of amniocentesis to prevent abortion on "frivolous!" grounds like wrong sex or minor defects. This problem will crop up again as chorion villi biopsy methods are being used on an experimental basis in Sweden and are being developed as an alternative to amniocentesis. The majority of requests for abortion at this late stage are from women with psychosocial problems connected with alcohol and drug abuse. The Health Board has turned down a small percentage of these women's requests for abortion. Abortions may only be performed by a doctor in a hospital or other medical facility approved by the National Board of Health and Welfare.

Feminist resistance so far has focussed on the insemination law. Lesbian activists have protested outside the Parliament with posters saying "Sperm bank robbed by gang of women. Free distribution to single and lesbian women outside Parliament". One woman is taking a case to the European Parliament charging that the insemination law goes against the Swedish constitution as it discriminates on the basis of sex.

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Bibliography

Barn genom insemination (Children by insemination) SOU 1983:42.

Barn genom befruktning utanför kroppen (Children by external fertilization) SOU 1985:5.

Genetisk integritet (Genetic integrity) SOU 1984:88.

Other Related Reports

Behövs hybrid-DNA-kontrollen? (Do we need recombinant DNA controls?) SOU

Familjeplanering och abort (Family planning and abortion) SOU 1983:31.

All of these reports are published by Liber Tryck, Stockholm, Sweden. Each report has an English summary. Copies of these summaries can be obtained from C. de Wit or A. Nilsson.

GENETIC INTEGRITY - CRITIQUE OF A SWEDISH REPORT ON THE APPLICATION OF GENETIC TECHNOLOGY ON HUMANS.

By Annika Nilsson and Cindy de Wit

In 1981, the Swedish government appointed a committee to investigate the need for and to propose regulations concerning the use of hybrid-DNA techniques. The committee's work was concentrated on the applications on humans. The committee was made up of some members of Parliament and the head of a court of appeals. Experts in the fields of science and ethics were called in to testify. In late fall 1984, the committee presented its report, Genetisk Integritet (Genetic integrity) SOU 1984:88, Liber Tryck, Stockholm, in which it proposed 11 ethical guidelines. The report has been out for comment during spring 1985 and will probably come up in Parliament after the elections in September, 1985.

This paper is an attempt to summarize some of the most important points in the report and to present a critique of some of the underlying assumptions. The critique has been divided in three parts:

1. Definition of ethical criteria
2. Summary and critique of ethical norms
3. Discussion of legislation and control

DEFINITION OF ETHICAL CRITERIA

The committee on genetic integrity has sought to establish an ethical base from which to make specific ethical decisions about new gene technologies. What are then the weaknesses in this ethical base?

The committee uses already established ethical guidelines such as the Helsinki declaration on biomedical research as a starting point. An important premise in this document is that research should be conducted in accordance with commonly agreed upon scientific principles. Commonly agreed upon usually means agreed upon by the scientific community - that is, we have a circular argument where scientists decide both on the general principles to be used in research and how they should be applied. It leaves no room for critique of scientific principles. Moreover, it does not recognize that members of the scientific community in many cases choose to support each other against attacks from the outside even when they would criticise each other in a closed scientific setting.

The Helsinki declaration divides biomedical research into two categories: clinical research (biomedical research which is combined with health care) and non-therapeutic research with human subjects. In the first case, the research should be of potential value to the patient to be considered ethically acceptable. In the second case scientific and social interests are weighed against the well being of the research subject. In no case are the consequences for society mentioned. For example, the consequences of certain knowledge or skills, such as in vitro fertilization, is not a factor in determining whether a proposed research project is ethically accepted and should be allowed according to the Helsinki declaration.

The committee in its discussion of the importance of "genetic integrity", does address some of these problems but mostly on the level of the individual. For example, it considers (but in the end rejects) a constitutional amendment to secure every individual the right to an unaltered genetic makeup. It also discusses and attempts to regulate through ethical guidelines the use of genetic technology as a tool for eugenics. Aside from a discussion of genetic screening for employment, it lacks

discussion of how people in power can use these technologies to enforce their power position.

A second major weakness in the review of existing ethical guidelines is that the committee makes no real attempt at evaluating how well present ethical guidelines are followed. Questions that the committee should have attempted to investigate are: How well known are the existing ethical guidelines among researchers? What are their attitudes toward ethical guidelines, in principle and in practice? How are patients/research subjects informed and how does the researcher receive consent? Is any information critical to the research given? A review of the present situation in biomedical research could bring light to the practical problems in implementing ethical guidelines in new areas.

Another document that the Swedish committee uses as background material is the Council of Europe recommendations on genetic technology. There, and in several other places in the report, genetic technology is described as a marvelous tool in solving the world's problems. "Genetic technology offers an enormous industrial and agricultural potential, which in future generations could assist in solving the world's problems with food, energy and raw materials." Elsewhere in the report, helping infertile couples, toxicity testing and early detection of congenital defects are mentioned as possible applications. The committee does not acknowledge that the problems they say genetic technology will solve in many cases have social and economic causes or are the result of previous technological development.

A fear expressed in many of the existing documents is that genetic technology would allow for selection of individuals with certain abilities, such as musicality, or against other traits such as aggressiveness. Although it is considered a negative side effect of the knowledge gained and regulation is proposed against such use, the discussion shows that the committee has adopted the assumption that behavior is genetically determined, a tenet of sociobiology. This is in spite of the fact that they reject the deterministic view of human behavior as explainable by stimulus-response theory in their discussion of human worth. It is important to remember the complexity of human behavior as well as the complexity of genetic expression itself. Sociobiology has also been under feminists' scrutiny as this "science" often is used to justify women's inferior status as "natural".

The committee's task was to propose ethical guidelines for the use of genetic technology on humans. As part of the work to establish an ethical base from which to work, the committee has attempted a discussion of how ethical norms are developed in a society. Some of the questions discussed are the concept of human value, differences between intrinsic worth and instrumental worth, and differences between facts and values.

The discussion on how ethical norms are developed completely lacks the acknowledgement of power relationships within a society. The committee does not address questions such as who has the power to formulate and enforce ethical norms and who does not. An historical perspective would be of value. For example, what ethical norms have determined attitudes toward abortion during different time periods? Who has had the power to change these norms and what have the reasons been?

Also lacking is a discussion on differences in how women and men make moral decisions.

The discussion on values and facts does acknowledge that these two cate-

gories sometimes are hard to separate. However, a feminist critique requires a much more in depth analysis of this topic. The report does not mention that facts can be incorrect, only partially correct, or one-sided. Neither does the committee address the question of the selective use of facts. In many areas (anthropology, history, medicine etc) feminist researchers have shown that the facts do not describe reality correctly but rather reality as seen by male researchers with a limited perspective. Moreover, facts presented by women are often taken as values (for example facts about rape and incest) while men's values often are considered facts. If women's reality is not described in facts, how can we then expect women's values to be considered in the development of ethical norms?

The committee discusses the differences between intrinsic worth and instrumental worth. The principle presented is that all human beings have intrinsic worth but that it can be relative when it comes to weighing life against life. The two examples mentioned are war and abortion. Questions about reality are otherwise ignored as in many other places in the report. Do women in our culture have the same intrinsic worth as men? Under what circumstances do women only have instrumental worth, for example as child bearers? Are people in other countries or of other races given the same intrinsic worth as people of our own creed. How do power relationships determine the intrinsic versus instrumental value given to other people? How does our ability to identify with other people determine what intrinsic value we give them? These questions of course are not likely to be addressed by authors of ethical guidelines as they would like everyone to see reality as they have drawn it up in their documents. The ethical documents then serve as a cover-up for crimes committed against women, different ethnic groups etc. To establish the intrinsic worth of every human being one also has to confront the prejudice and oppression that actually exist.

The discussion of ethical good takes up two principles: deontology, which is based on whether the action in itself is good or bad and teleology, which is based on whether the consequences of the act are good or bad. The committee proposes a combination of the two principles.

The question not asked in any of the cases is Good for whom? Is it good for the person asking the question? For society? When dealing with research, the point of view is most often male. In the application of genetic technology on humans the questioner would be ethical committees made up of a majority of researchers. The difficulties become even more intricate when "man includes woman" - that is, what is good for men is automatically considered good for women.

The basic problems in the assumptions of the genetic integrity committee can be summarized as follows: It has not looked at actual power and status differences in society. It has not seen patriarchy. Neither has it seen the power relationships between industrial and developing countries, between able-bodied and disabled people, between doctor and patient or between researcher and research subject.

SUMMARY AND CRITIQUE OF ETHICAL NORMS

Ethical norms suggested by the committee

Norm 1. Research and experiments on zygotes and embryos are acceptable, provided they are medically well founded, that they are performed within 14 days after fertilization (freezing time not counted) and that the donor of eggs and sperm has given her/his free and informed consent. Embryos in vitro must not be allowed to develop after 14 days of age.

Committee's motivation

- a. To increase IVF embryo implantation rate (normally 30%-with IVF, 15-30%.
- b. To study cell differentiation, human embryology.
- c. To study the effect of viruses, bacteria and toxic substances on tumor and congenital defect development. (This is considered impractical with human embryos by the committee because of limited access to embryos and the 14 day limit).
- d. To test gene therapy that can later be used on people.
- e. The 14 day time limit is an easier method of ethical control than using morphological changes (neural tube development) as a cut off point for experiments.
- f. Implantation occurs at 10 days, neural tube development in the third week. The 14 day limit was chosen as it doesn't come too near the neural tube limit (where an embryo can theoretically be considered "conscious") but still allows for worthwhile research to be done.
- g. The 14 day limit is also close to the practical limit that an embryo can be cultured at this time. "If culture techniques are developed so that the 14 day limit can easily be passed, the question of time limits should be taken up again. At this point in time, it is impossible for such an embryo, in vitro, to develop into a human being," p 137.
- h. Another reason for the 14 day limit is the risk for commercialization. A longer time limit increases the possibility for developing blastomere banks where blastomeres can be frozen and later sold.
- i. This ethical norm should not be considered absolute. The possibility of exceptions for extremely important basic medical research must be left open.

Feminist Critique

Researchers assume they know what is medically well-founded research. Most review committees (existing Swedish ethical committees for bio-medical research and committees for animal research) are made up overwhelmingly of people with a positive view of new technology and with a belief that research is progress. Their ethical norms are often different from those of the few lay people on such committees leading to an uncritical rubber stamp approval of research projects.

The major underlying assumption in this norm is that it will be possible to get hold of enough eggs and embryos to carry out such experiments. In most cases these are embryos left over after IVF and embryo replacement of a few of them, or eggs taken from ovaries in other ways (ovariotomy, suction).

Motivation c. is considered impractical, but just the fact that it is taken up assumes that it is a future possibility. This combined with f. and h. assumes that in the future it will be possible/practical/allowed to culture embryos longer than 14 days and to use such embryos in teratogenicity studies for example. Teratogens (substances

causing congenital defects) exert their major effects from the third to eighth week. An increase in the time limit to 21-28 days would make such experiments possible. This increases the risk of commercialization as it is the drug industry that does most teratogenicity studies.

Motivation h. leaves a tremendous loophole for getting around the 14 day limit. Who decides what is critically important research that should be given special permission?

Altogether this norm assumes that the 14 day limit is the best alternative for the time being but leaves open future lengthening of the limit when scientists decide it is necessary.

The question of informed consent is treated elsewhere.

The Swedish Medical Association, in its response to this norm, has recommended that the motivations be included as part of the written norm.

Norm 2. Human zygotes and embryos exposed to experiments must not be implanted and developed in vivo.

Committee's Motivation

- a. After experimentation, there is a great risk that a zygote or blastula may be defective and cause congenital defects in a fetus if it were allowed to implant.

Norm 3. Research and experiments on human somatic cells in cell or tissue culture (in vitro) are accepted.

Norm 4. Laboratory work with human DNA outside the living cell is accepted .

Committee's Motivations for norms 3 and 4

- a. Such research is necessary for a better understanding of how genes control cell development, what differentiates a normal cell from an abnormal cell, how DNA based diagnostic tools can be used for diagnosis and therapy in pathological cell diseases (cancer etc.). Such research can also include working with DNA and artificial production of DNA fragments and genes.

Norm 5. Research and experiments on human germ cells (sperm and unfertilized ova) are accepted.

Committee's Motivation

- a. The question of when life begins does not apply here. Such studies have been ongoing for a long time and are necessary for an understanding of such cells morphology, physiology and biochemistry. This is important for studies of fertility.

Critique See under norm 1.

Norm 6. Research and experiments aimed at gene therapy on human somatic cells are accepted.

Committee's Motivation

- a. Replacing a defective gene with a healthy one should be seen as the same as an organ transplant. Such research is comparative to any

other form of experimental therapy.

Feminist Critique

This question has to be considered in the context of the risks to the patients while the technique is being developed and the possibility of exploiting the patient who is in a vulnerable relationship to the researchers. What about informed consent? How much suffering must a person go through to achieve results? What is the possible success rate? Is the psychological price to the patient worth paying? What effect does treatment have on a person's quality of life? The assumption is made that one gene is responsible for a symptom. We don't know in what cases this is really true. In the motivations of norm 7 (below) they say that DNA is too complicated to make predictions about gene therapy results.

Norm 7. If gene therapy on human sperm, ova, zygotes and early cells (blastomeres) is possible to perform in a reliable way, and implantation is to be considered, then the operation must come under a severe ethical examination which should include full knowledge of the consequences.

Committee's Motivation

- a. According to norms 1 and 5, it is possible to manipulate genetic material in sperm and ova and in zygotes and blastomeres up to 14 days, this is not enough to be able to develop adequate gene therapy. These effects must be studied during embryonal and fetal development. This requires implantation which according to norms 1 and 2 is not allowed.
- b. This requires knowledge that may never be available. Human DNA is too complicated to make certain predictions about gene therapy results. There is a risk for disturbance of normal embryonic development. The only way to get this knowledge is by trial and error experiments and this still would give no information on the risks for future generations.
- c. Because such research has consequences for future generations, it is especially important that any attempt to select certain traits or to gradate human life be stopped.

Feminist Critique

The only possible way to acquire the knowledge necessary for this research is by exactly the trial and error research they say is unethical. It is hard to understand why, in that case, they have included this as a norm. It seems that the underlying assumption may be that animal research will eventually give enough information that experiments on human material can be attempted. It is impossible to know the full consequences of such treatment until it has been done.

The biggest risk with such research is the whole value system of what is a sick or undesirable trait and what is not. Who will decide? What will prevent the misuse of such techniques in IVF?

Norm 8. Experiments on a live aborted embryo or fetus should be considered in the same way as those on a child.

Committee's Motivation

- a. Transplantation technology is developing rapidly and there is an increased need for tissues and organs for transplantation. Aborted embryos and fetuses provide a potential resource.
- b. Consent to take tissue and cell samples from a fetus for transplantation etc. must be obtained from the woman involved. The committee is aware that many women undergoing abortion would rather not

have the question of consent posed to them. That does not change the requirement of obtaining her consent.

c. In norm 1 the committee has set a 14 day limit as the end point for research on embryos with respect to human dignity and the humanistic concept of man. According to abortion law, it is possible to break off a pregnancy up to 18 weeks and sometimes later. After 18 weeks, it is possible to talk of the fetus having intrinsic value and human dignity. In both cases a human life is terminated but there are two different points in time where human dignity is used to justify the end point. This leads to an ethical paradox-experiments are treated more restrictively than abortions. The explanation for this view is that abortion, in Swedish law, is an emergency situation where the woman's well-being is valued higher than that of the fetus. With the resources we have today, it is impossible for a woman to know she is pregnant until after the 14 day limit is passed.

d. A live aborted fetus has intrinsic worth even if the mother's right to decide is valued more.

Feminist Critique

Research on aborted fetuses requires the woman's consent. Abortion in a patriarchal hospital is already a stressful, painful and often humiliating experience for a woman. To add to this by asking for her consent is to add insult to injury.

Transplantation technology can be critiqued as any other technology. Do we need it? What is the motivation for such treatment? Who is being used as a source for organs and tissues (third world people, poor people, fetuses)? Where does the question of commercialization come in? Transplantation is an expensive medical technique. One question to pose is who benefits and from what other areas of medicine are resources taken? There is also the basic question of whether it should be allowed to work on aborted fetuses at all. The Swedish committee has commented that there is very little such research in Sweden. However, when one country sets guidelines for such research, they often are used as a model for other countries. The question of how Swedish guidelines may influence other countries' views of such research must be considered. If other countries adopt more liberal rules in this question, there is nothing to prevent Swedish doctors from moving their research there.

Norm 9. The use of prenatal DNA-based diagnosis should be restricted to severe genetic diseases which threaten the development of the fetus or the child. The doctor, in consultation with the parents (mother), should decide whether or not to use a DNA-based diagnosis. The decision should be made with respect to the relevant, guidelines and regulations.

Committee's Motivation

- a. There must be a medical reason for using such techniques. All medical diagnosis must be used to protect life, reduce pain and suffering or to cure illness.
- b. Therefore only in the case where there is risk for severe genetic illnesses, should DNA-based diagnosis be used.

Feminist Critique

Who decides what is a severe genetic illness? How much information does the doctor give the parents in making a decision? What influence do such decisions have on attitudes toward people carrying the disease and parents to children with the disease? What is to prevent its misuse for sex determination?

Norm 10. DNA-based diagnosis may be used in public health investigations on genetic diseases if the investigation has a clear medical aim and if the collected genetic information is reliably protected. Participation in such public health investigations is voluntary. A participant shall give his/her free and informed consent.

Committee's Motivation

- a. "Identification of risk groups with DNA-based diagnosis can be done at the fetal stage, in newborns, in children and adults and can become a part of preventive medicine. Mass screening of this type could become a part of society's duty to enhance the health of its members. These screenings in combination with gene mapping and the establishment of gene libraries can give information that could be used positively so that disease-causing genes could be discovered at an early stage in individuals and in groups of individuals. With early diagnosis and treatment, such a disease could be prevented, cured or the symptoms reduced," p. 168.

Norm 11. Recording, storing and use of genetic information from individuals shall be medically motivated. The individual involved shall give her/his free and informed consent.

Committee's Motivation

- a.. According to Occupational Safety Laws, if a certain type of work can pose a threat to an employee's health, the employee may be required to undergo a medical check up. If the employee is at risk according to the check up, the Occupational Safety Board can step in and forbid that person from working at that job. In such check ups, DNA—based diagnosis could also be of help in determining risk.
- b. The method should be used restrictively however.
- c. The diagnosis should be made as narrow as possible-i.e. looking for one gene or gene combination only, so as to limit the amount of information to exactly what is necessary. Other information that has nothing to do with the person's health should not be collected or registered.

Feminist Critique of norms 10 and 11

There is a potential for classifying people as to susceptibility instead of cleaning up and improving the work environment. The underlying basic assumption is that the cause of disease is in the person's genes and not in the environment. In mass screening how will people not wanting to undergo screening be treated? The future problems are similar to those that women face with prenatal diagnosis today.

For much of the research covered by these 11 norms one should ask what the real motivation for research is. Is it a question of helping people or controlling life?

LEGISLATION AND CONTROL?

The committee prefers that the proposed ethical guidelines should not be given the status of law but should be mentioned in a law so that their existence is manifest. The proposed law appoints the National Board of Health and Welfare as an advisory authority which should edit ethical norms to be used in the application of rDNA-techniques and equivalent techniques in research and experiment on humans, including germ cells, zygotes and embryos. According to the proposal, already existing ethical committees for biomedical research should have the primary responsibility in seeing that the norms are followed.

There are two major problems with this proposal. First, if the ethical guidelines are not written out in legislation, they can be changed without any parliamentary debate, which also is a convenient way to avoid public debate. Second, the guidelines are to be enforced by committees made up of 8-12 researchers and two lay people appointed by the health care authorities. One can question how well this brotherhood network can look after women's interests.

FINRRAGE

Feminist International Network of Resistance to Reproductive and Genetic Engineering

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Dear friends,

La vollà - friendly – the documentation from Sweden. Rather voluminous and this even despite some missing bits and pieces (as noted after the table of contents), which I will send as soon as they arrive.

As agreed in Sweden, I simply compiled whatever I got sent. I arranged the papers in the order indicated on the programme but did not number pages or articles. Again, as said in Sweden, it is up to all of you to do with the documentation whatever you like. If you do find a way to publish all or parts of it, you will probably want to write to individual authors and ask for revisions. Please make sure our money givers are thanked (see Title page of documentation.)

Good reading!

In Sisterhood,

Renate Duelli Klein

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P.S. In a few days I will send you the first mailing of articles, clippings etc. as well as some “news” on Finrrage

WOMEN'S EMERGENCY CONFERENCE ON THE NEW
REPRODUCTIVE TECHNOLOGIES

July 3-8, 1985

Vällinge (Lund), Sweden

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Women's Emergency Conference on the New Reproductive Technologies
July 3-8 1985; Vällinge (Lund) Sweden

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Shelley Minden; "Patriarchal Design: The Genetic Engineering of Human Embryos"

Paula Bradish; "From Genetic Counseling and Genetic Analysis:- to Genetic Ideology and Genetic Fate"

Patricia Hynes; "The Road not Taken; Environmental Protection in the United States: a Paradigm for Regulation of the Biomedical Industry"

Simone B. Novaes; "The CECOS Network of Sperm Banks and Artificial Insemination"

Nicole Echard, Michele Kail, Hélène Rouch; French Information/"Les Nouvelles Technologies de la Reproduction(NTB); Approche Biologique, Anthropologique et Psycholinguistique"

Anne-Marie de Vilaine; "Will Motherhood Become an Archaism?"

Ana Regina Gomes Dos Reis; "In Vitro Fertilization in Brazil: The Story as Told by the Newspapers"

RESOLUTION AND CONFERENCE REPORTS

NOTE

Missing - but promised are:

*National Reports from:

Brazil (but see Ana's paper)
1st part France
Ireland
Japan
and more from Australia

*Individual presentations from:

Jocelyne Scutt on the legal side of repro. tech. in Australia
Francoise Laborie on the concept of "Carrying Mothers"

will be sent upon arrival

CONFERENCE PROGRAM

July 3 (Wednesday) - Day One

- 8 - 9 Breakfast
- Free Morning
- 1 - 3 Lunch
- 3 - 5 OPENING PANEL
Moderator: Renate Duelli Klein
- * The history of FINNRET and goals and purposes of the conference: Jan Raymond
 - * Opening Paper: Robyn Rowland
Additional comments from Conference Organisers
Gena Corea
Renate Duelli Klein
Jaina Hanmer
Jan Raymond
 - * Housekeeping: Renate Duelli Klein
Martha Ullerstam
- 5 - 5.30 Tea
- 5.30 - 7 INFORMAL NATIONAL GROUP MEETINGS to discuss presentations for Day 2 on
- a) state of the technologies
 - b) state of legislation (including guidelines by ethic committees/medical associations)
 - c) (feminist) resistance
- 7.30 - 9 Dinner
- 7 - 10 MAIN PAPER: Maria Mies, W-Germany, "Why do We Need All This?"
Moderator: Renate Duelli Klein

July 4 (Thursday) - Day Two

- 3-9 Breakfast
- 9-11 NATIONAL PRESENTATIONS (JH): Brief summaries of the state of technologies, the state of legislation feminist resistance
- 11 - 11.30 Tea
- 11.30 - 1 NATIONAL PRESENTATIONS cont. (GC)
- 1 - 2.45 Lunch
- 2.45 - 4 NATIONAL PRESENTATIONS cont.
- 4 - 5 MAIN PAPER: Sultana Kamal, Bangladesh “Sterilization and IVF: Seizure of Reproductive Rights?”
Co-discussant: Farida Akhter
Moderator: Maria Mies
- 5-5.30 Tea
- 5.30 - 7 PRESENTATION including video: Nellie Kanno, **USA**
“Contraception and Sterilization fo Women of Developing Countries”
Moderator: Farida Akhter
- 7.30 - 8.30 Dinner (special table for UN NGO Nairobi meeting participants)
- 8.30 - 10.30 TECHNOLOGIES: UPDATES, PROCEDURES AND STATISTICS
Gena Corea “Report on a Survey (with Susan Ince) of IVF Clinics Manipulate ‘ success ‘ rates’ Christine Crowe “How Women Experiencing IVF” Judith Lorber “Gender Politics and IVF Use” Ramona Koval “Causes and Prevention of Infertility”
Moderator: Judith Lorber (USA)

July 5 (Friday) - Day Three

- 8-9 Breakfast
- 9-11 **MOTHERHOOD AND THE EXPERIENCE OF INFERTILITY**
Anne Donchin, USA "The Future of Motherhood: Technology and Feminist Theory" Ramona Koval "Causes and Prevention of Infertility"
Terese Bergfors "The Experience of Infertility"
Judith Dwyer/Doreen Shanahan Medical Causes of Infertility"
Moderator: Stefania Siedlecky (RR)
- Workshop: One hour
- 11 - 11.30 Tea
- 11.30 - 1 **GENETIC ENGINEERING AND PRENATAL DIAGNOSIS**
Shelley Minden "Genetic engineering: Manipulating the Embryo"
Paula Bradish "Genetic Manipulation/Genetic Counseling"
Anniemieck Reyndess, Karin van den Berg, Linda Wilkins "Reflections on Being Handicapped in relation to Prenatal Diagnosis, IVF and Genetic Engineering"
Moderator: Sarah Jansen (RDK)
- 1 - 4 Lunch
- 4 - 5 **MAIN PAPER: Pat Hynes, USA, "Environmental Protection in the USA: A Paradigm for the Regulation of the Biomedical Industry"**
Moderator: Gena Corea
- 5 - 5.30 Tea
- 5.30 - 7 Continuation of National Presentations
France/Japan/Netherlands/Norway/Sweden
- 7.30 - 8.30 Dinner
- 8.30 - 10 Continuation of National Presentations Switzerland/USA/West-Germany

DANCE

July 6 (Saturday) - Day Four

8 - 9	Breakfast
9 - 10	NEW RTs IN FRANCE Laurence Gavarini/louise Vandelac/A.M. de Villaine "Ethics Committees and the Role of the Media and the Government. Link between Animal and Human Experimentation" Francoise Laborie "Motherhood for Some One, Carrying Mothers in France" Simone Novaes The Network of French Sperm banks" AnneMarie de Villaine Personal Reflections on the Articulation of Feminism and the Motherhood in Relation to the New RTs" Moderator: Jocelyne Scutt
10 - 11	National Presentation: West-Germany
11 - 11.30	Tea
11.30 - 1	WHO CONTROLS THE NEW RTs AND HOW Jocelyne Scutt, Australia "Australian legislation" Annette Schmedt, w-Germany "Recommendations from the German Medical Association" Sommer Brodribb, Canada "RTs and the Canadian State" Anne Helium, Norway "State Controlled Legislation" Moderator: Sultana Kamal Workshop: One hour
1 - 3.30	Lunch
3.30 - 5	Formation of groups on national, regional (e.g. Europe as a region) level to discuss strategies for resistance
5 - 5.30	Tea
5.30 - 7	Uma, South Pacific Region (via England) Video: "Peace and Justice" Paper: "Inconceivable!"
7.30 - 8.30	Dinner
8.30 - 10	Ana Regina Gomes de Reis, Brasil "The New RTs in Brasil and the Aims of International Agencies"

July 7 (Sunday) - Day Five

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| 8 - 9 | Breakfast |
| 9 - 11 | STRATEGIES FOR RESISTANCE
Individual Presentations
Moderator: Jan Raymond |
| 11 - 11.30 | Tea |
| 11.30 - 1 | STRATEGIES FOR RESISTANCE
International, regional and national network (networks to draft statements on strategies and approaches to policies on the new RTs and how to organize resistance (including FINNRET) |
| 1 - 4 | Lunch |
| 4 - 5 | Network meetings continued |
| 5 - 5.30 | Tea |
| 5.30 - 7 | FINAL SESSION ON STRATEGIES AND APPROACHES TO POLICY
AND ON THE FUTURE OF FINNRET
Moderator: Jalna Hanmer
Free Evening |

EMERGENCY CONFERENCE ON THE NEW REPRODUCTIVE
TECHNOLOGIES, July 1985

INTRODUCTORY REMARKS BY THE ORGANISING COMMITTEE

Renate Duell Klein:

I want to start by saying how enormously delighted and proud I am - all members of the organising committee are - that this long planned Emergency Conference is now beginning. I remember at one point how there were frantic phone calls among us saying "but where will it be: Lund or Copenhagen - Sweden or Denmark?" The problem was we simply couldn't find VSllinge on our map...

But here we are and as the organising committee we want to thank you all for coming - many of you from far away places and most of you at your own expense which, I believe, reflects the real sense of emergency and urgency and the necessity to take action against the new RTs on an international scale - before it is too late.

Let me say right now how enormously grateful we are to Martha Ullerstam and her Swedish colleagues for getting us this fantastic place and handling everything so superbly. We also thank the Ostra Grevie Centre, the caretaker and the Matron and all the other workers here for their sustenance in terms of accommodation, delicious food and friendly smiles which makes staying here a great pleasure.

In this opening panel we will give you an overview - and some housekeeping details about the program etc - as those of us who organised the conference and have been running FINNRET - so to speak - for the last year. We thought it would only be fair that you knew how we saw the issues.

Unfortunately, however, there is one bad piece of news. Robyn Rowland from Australia whose enormous amount of work for FINNRET and this conference I cannot even begin to tell you about is not here. She came all the way to the US and then to England but is right now on her way back to Australia because she has a hernia in an advanced stage and must urgently undergo an operation. Despite tremendous pains till the last moment she thought she'd made it - but in the end it would have been too dangerous.

So we have to do without her which we are all very very sorry for indeed -we will miss her energy and ideas!

But now on to those who are here from the organising committee: Martha Ullerstam, Swedish sociologist and wonderwoman who organised this conference. - Jalna Hanmer from Britain, who, as we found out yesterday already in 1974 began to warn against the new RTs and since then never stopped. - Janice Raymond, from the USA. Jan too has been involved for many years in the whole area of medical ethics and RTs. She teaches WS at the University of Massachusetts at Amherst - as does Jalna in Bradford England where she coordinates one of the few postgraduate degree courses in WS. - Gena Corea whose first book The Hidden Malpractice - How American Medicine Mistreats Women exposed brilliantly how women's bodies and minds are maltreated by patriarchal medicine. In her new book The Mother Machine she continues this work and gives the most detailed, thoroughly researched and chilling account of the test-tube industry and its makers. - As to myself, I'm a biologist, now doing research on the theory and practice of

WS as an alternative educational concept for women at London University. I am also the co-editor with Shelley Minden and Rita Arditti of Test-Tube Women, the work which raised my consciousness from thinking “Oh well, yes this is all quite important, but...” to “Oh my God - this is one of the most dangerous and outrageous attacks on women’s lives, all women’s lives, in the future more than in the present, that we have come across!”

Before Jan will begin to give us a brief history of FINNRET and an overview of what we see as the goals and purpose of this conference let me say a word on language.

I believe in this room are women from 17 countries. This means that for many of us English is not our first language. This means that those who ARE ‘native’ English speakers - and mind you Canadian/Australian/US/ “English - English sounds already quite differently - please do try to speak slowly and be considerate. For us others we also have to make the effort to interrupt, say, when we can’t understand - ask each other to explain and translate.

With this plea to respect each others’ different grasp of English comes another wish we have for the conference. Obviously, we are all very concerned about the impact of these new technologies - otherwise we wouldn’t be here. But we come from very different places both geographically and I suppose from how we define the issue, where our priorities are and what kinds of resistance seem to us particularly useful to stage against the technologies.

In order to make this conference a success - and it will be what we all make it to be - we will have to be very careful with each other, listen and respect our points of views and our personal involvements, respect our differences - and then, hopefully, see the global nature of this threat and be able to begin organising against it on a global and multifaceted level.

The programme we have drawn up is only a starting point. At the end of this session please tell us your specific wishes to either be on the programme or be off it. Please write them also down on a sheet of paper. This evening we will come up with your version of the programme.

Next it’s Jan’s turn for a brief history of FINNRET.

Janice Raymond:

We thought that we should begin this conference with a history lesson -- a vary brief one -- about FINNRET. FINNRET is the acronym for the Feninist International Network on the New Reproductive Technologies. At this point, you might be seeking the answer to one of the most profound and frequent questions about FINNRET. What does the "E" represent? The answer is nothing! It was added, unilaterally, by one of our founding members who thought it necessary for ease of pronunciation.

FINNRET originated at the 2nd International Interdisciplinary Congress on Women in Groningen in April 1984. Several of us participated in a panel there on the new reproductive technologies which emphasized sax predetermination, but included in vitro fertilization (IVF), surrogate motherhood, and embryo transfer. It became clear to us, on that day, that some kind of international feminist network was necessary to serve as an information base and to monitor developments in these new technologies worldwide.

Since April of 1984, we have a mailing membership of over 500. We have sent out two major mailings and distributed numerous packets of articles from newspapers, journals, magazines, and conferences on aspects of the new reproductive technologies. In April of 1985, a historic meeting of over 2000 women took place in Bonn, Germany, to hold a national conference on the new reproductive and gene technologies. This was the first national feminist meeting convened to discuss the technologies, and it issued in a strong set of resolutions opposing these technologies for women.

However, it was also clear to us in Groningen that we needed to hold some kind of international gathering of women, which would happen soon, to share information on developments in different countries; assess the implications of these reproductive technologies for women; and most important, bring women together to discuss, strategize, and develop an ongoing feminist analysis and resistance to these technologies across national boundaries. The rapid proliferation of these technologies, in different countries, and through different channels, highlights the necessity for response and resistance from women internationally. Public attention must be focused on how these technologies are using women in the service of medical experimentation, are controlling pregnancy and reproduction, and are increasing the international traffic in women for purposes of reproductive prostitution. Thus the "Emergency Conference on the New Reproductive Technologies" which begins for us all today.

Given the short planning time for this conference, we knew that we could not make this gathering as expansive and as internationally representative as possible, had we additional time and funding. Therefore it is an “emergency” conference. We hope, however, that this will be only the beginning of a much larger and better-funded conference to take place at a later date.

The seventy of us who are present in Sweden for the next five days come from 20 different countries. We owe a very special thanks to Renate Duelli Klein who did a large part of the mailing and communication with all of us over several months, and whose steady hand was largely responsible for shaping up this conference; and to Martha Ullerstam who invited us to Sweden, acquired the facilities of this center for us, and has done much of the necessary domestic work for this gathering.

Now let me say a few words about the purposes and challenges of this conference, as I see them. We are a young network, so our first purpose in coming together is to become acquainted with what is happening, internationally -- to share information on the most basic level. At the same time, our purpose is to highlight how these technologies affect all women. Much of the discussion opposing these technologies attacks them because they threaten to change the quality of human life, or because they are seen as part of a growing capitalist economy. None of these male-centered criticisms, be they conservative or radical in perspective, has opposed the technologies because of what they do to women.

Second, I would hope that we can arrive at some position on these issues and make some critical judgments about their consequences for women, without underestimating the complexities of these judgments. For example, the whole issue of choice is one about which many of us are concerned. Much of the discussion of these technologies in the media and medical context highlights the fact that women are “choosing”, even “demanding” for example, more IVF centers. Any kind of more expansive woman-centered analysis has to ask under what life circumstances and conditions women are supposedly choosing IVF. How does the entire cultural, social and political context in which women live their lives not only condition a woman’s “choice” but her motivation to choose as well?

The challenge in responding to these technologies is to put our ethics and politics on our own ground, so to speak. What does this mean? Very often when feminists point out how male reality oppresses women, or especially how women can resist this reality or fight back, our political positions get re-defined as somebody else’s. For example, in the feminist campaign against pornography in the United States, women who oppose pornography

and who support, legal action against it are lumped in the same category as the political right. We are accused of being conservative, promoting censorship, and repressing freedom of speech. In my opinion, this is one more way of telling women we have no independent judgments -- that somehow our ideas and actions always either derive from men or are initiative of them. We see this same accusation made against women who oppose the new reproductive technologies -- that our opposition supposedly puts us in the same camp as the conservative right who opposes abortion, contraception, IVF, and the like.

So our challenge is to assert precisely how we are different from conservative and radical male-defined positions and to define the issues and the resistance on our own terms.

Third, it is important for us to answer some of the arguments that have confused many women and which have distorted feminist resistance to the technologies. The issue of motherhood -- as a political reality -- is crucial to discuss in this context. For example, many feminists have been reluctant to question the language and reality of the "need" to mother expressed by many women, but in the context of the new reproductive technologies, expressed especially by infertile women. Somehow questioning that "need" is perceived as an attack on women. Meanwhile, however, the supposed "need" to mother is being used by the "technodocs" to justify all aorta of invasive medical procedures on women. These technologies are being portrayed as enhancing women's "natural need" to mother by doctors and the media, which has the effect of portraying motherhood as a biological "motor," driving itself to fulfill itself in spite of the invasive procedures and medical control that involuntarily childless women must accept. Thus women are re-created as mothers in the image of a male medical system.

Feminists have de-biologized the supposed biological underpinnings of role divisions, intelligence, athletic ability, and heterosexuality. Perhaps with motherhood, many women don't want to offend women who desperately want to be mothers. Thus the language and reality of the "need" to mother goes unquestioned. But having de-biologized other aspects of women's existence, we cannot afford to let motherhood stand as a natural need or right.

Finally, the real challenge for all of us is to enunciate a radical feminist politics that will change the structure of things as they are for women. We may have different philosophies and strategies of social and political change. We do have many differences -- cultural, national, age, ideological, and professional -- but our differences can also be our strength. We also have many things in common. Most important is the will to work together.

Gena Corea:

THE NEW REPRODUCTIVE TECHNOLOGIES: AN OVERVIEW

While the new reproductive techniques such as in vitro fertilization (IVF) are presented to the public as therapy (“new hope for the infertile”) and as a benevolent means of expanding people’s options, in fact they offer a powerful means of social control. These technologies will not be confined to use in the infertile. According to the visions of various physicians and reproductive scientists (“technodocs”), they will eventually be used on a large proportion of the female population.

A pattern has emerged in the spread of a new reproductive technology. When it is introduced, it is presented as something for a small proportion of women in certain groups. But then, quickly, physicians expand the indications for the technology so that it is used on a large proportion -- or even the majority -- of woman. For example, in obstetrics, electronic fetal monitoring (EFM) was introduced for use on women judged to be at “high risk” of obstetrical complications. But now in many industrialized countries, it is used on most birthing women. The same pattern is evident with ultrasound, amniocentesis, cesarean section and genetic testing and counselling.

It is likely that this pattern will emerge with newer technologies such as IVF, egg donation, sex predetermination, embryo evaluation. IVF, for example, was originally proposed for use on a small group of women--those whose infertility was caused by blocked or absent fallopian tubes (oviducts). But physicians quickly extended the indications for IVF so that now even fertile women are among the IVF candidates. These are women married to men with low sperm counts. Indications for IVF continue to grow. Some physicians have presented rationales for suggesting that in the near future, people may use the sperm and eggs of other, genetically “healthier” people to produce children for themselves. Among their suggested candidates for IVF with donor eggs are:

- Women with genetic deficiencies.
- Women whose eggs have been, or are alleged to have been, damaged by toxins in the workplace.
- Women who have had several miscarriages.
- Older women in their fifties who would like to bear a baby but would be afraid that, because of their age, they would produce a handicapped child.

In 1984, we heard the suggestion from an Australian IVF clinic director that people may want to use donor eggs and donor sperm with IVF rather than their own because they do not like their own or their partner’s characteristics--for example, intelligence, personality, or appearance. (See articles of May 17, 1984 in Australian newspapers: John Schauble, “Babies: They’re better from glass.” Sydney Morning Herald. Karen Milliner, “In vitro babies better adjusted: team leader.” Canberra Times. Fiona Whitlock. “Test tube babies are smarter and stronger.” The Australian.)

In view of the expansion of indications for IVF, we must ask: Will IVF become more common than natural reproduction? Already in 1976, two years before the birth of the world’s first test-tube baby, two scientists were predicting that it might. They speculated that tests for evaluating the health of embryos might be developed and wrote: “Therefore, one day, in vitro fertilization and embryo culture could become the preferred mode of reproduction, with transfer to the uterus of only genetically-healthy embryos.” (Laurence E. Karp and Roger P. Donahue. 1976. “Preimplantation ectogenesis. The Western Journal of Medicine. 124 4)

The expansion of new reproductive technologies to an ever greater proportion of women leads to:
--The reduction of women to the raw materials (eggs, hormones, wombs) used in what is increasingly becoming an industrialized process: reproduction.

--The reduction of babies to products produced by technodocs in their new industrial process.

--The reduction of the number of women relative to men. Sex predetermination technology can translate sexual prejudice (a "preference" for male children) into a sexist reality. It can lead to what American ethicist Dr. Janice Raymond terms "pre-victimization"--the elimination of women before we are even born.

--Greater control over human evolution. With eggs being fertilized in laboratory dishes and embryos being flushed out of women, the embryo has become available for various manipulations, including, eventually, sexing, dividing, and genetic engineering.

In 1982, directors of three American IVF clinics predicted that in the future test-tube embryos will likely be screened to eliminate those of a sex their parents do not want or those with birth defects.

To many, eliminating genetic defects sounds like a worthy goal. But we must realize that the category "genetic defect" is one capable of infinite expansion. As early as 1976, a pioneer in the development of the embryo flushing and transfer procedure termed genetic asthma a severe genetic defect. An obsession with eliminating so-called "defects" from the human population in a search of a more perfect human race, could lead to an increasing intolerance of those of us who are physically handicapped and a reduction in the already meager social support services for us.

Physicians present the new reproductive technologies as boons to women, providing us with new "options" in childbearing. But will women have the option of not using these technologies? Will we be able to refuse them? Or will their use become compulsory as is the tendency with obstetrical technology such as EFM?

The new reproductive technologies are not, as physicians allege, all about providing women with childbearing options or helping infertile women. If technodocs were truly motivated by a compassion for the suffering of infertile women, instead of or in addition to their work on technology, they would be:

--Publicizing and attempting to reduce the preventable causes of infertility. Much infertility is iatrogenic (doctor-induced). It is the result of previous medical experimentation on women with risky drugs and devices such as the IUD and DES (diethylstilbestrol), the synthetic hormone.

--Setting up IVF clinics in the developing countries where the incidence of infertility is often high. Rather than doing this, physicians are concentrating on developing and distributing risky long-acting contraceptives like Depo-Provera and Norplant, and they are implementing sterilization programs for women.

--Asking, when women are channeled into bio-medically manipulated reproduction, what the cost is to women emotionally, physically, and metaphysically. Such a question does not arise in the medical literature.

Technodocs do not want to help women. They want to control us. New reproductive technologies provide them with a powerful means to do so. That is why, increasingly, we women organize ourselves in resistance.

Jalna Hanmer:

THE IMPORTANCE OF MOTHERHOOD TO THE SOCIAL AND INDIVIDUAL CONTROL OF WOMEN BY MEN

Motherhood is being presented as increasingly more important for women. All women must become mothers - so goes the ideology. This has not always been so. For example, in Britain there were periods in the past when as many as 25% of women did not marry and did not become mothers. How are we to understand this growing emphasis on motherhood?

I would like to suggest that despite the power of individual men morality and marriage are no longer the effective controllers of the expression of women's sexuality and, by this route, of women's biological reproductive processes. The dominant mode of control of women is changing hands from the individual man through marriage to men as a social category through science and technology. And the pace, as we know, is accelerating. The locus of control by men and the terrain of struggle between men and women is shifting from the control of heterosexuality to reproduction and childcare, i.e. motherhood.

Women are being increasingly policed by the shaping of the role "fit mother". Motherhood is being more tightly structured; to be a "fit mother" is a more carefully defined concept. It is monitored from ante natal care onwards and involves medical personnel, health visitors, teachers, social workers, social security or welfare workers, housing officials and lawyers. The state directly shapes and supervises the "fit -mother" as concept and individual through the personal social services, social security, housing, health services, education, law and the legal system. Reproductive technology offers the possibility to extend the shaping of the "fit mother" to include the "fit reproducer". The state is directly involved through its support for, and control of, science and technology. There is no corresponding "fit father" role.

The taking of independent actions within biological reproduction and childcare away from women is not really recognised as a major issue within feminist theory - let alone the social sciences and society generally. To see the solution to the taking away of women's control over their biological processes as being based in shared child care (with husbands), or believing reproductive technology to be about overcoming infertility, locates the problem in women as social and biological mothers. Doing this ignores the extension of "rights" and power over women as mothers by men. This occurs both in relation to women as individual mothers & to women as a social category.

We are witnessing a shift in the mode of control and we are seeing proposed solutions focussing on women as the problem. It is our inability to produce children or to care for them that is problematised, rather than the means whereby the subordination of women is maintained and intensified. We need to focus on who benefits and how. We need to analyse the superordinate in order to shift the debate from women as the problem to an analysis of the exploitation of women and how we can struggle against this.

Renate Duelli Klein

THE BIG LIE: reproductive and gene technologies as a new form of social control of women

There is not much I want to add to Jan's, Gena's and Jaina's most comprehensive overview of the impact of the new RTs on women and society at large.

Perhaps just some summaries and reminders:

- * When we are discussing reproductive and gene technologies we should never ever forget that we are NOT - emphatically not - talking about 'help' for involuntarily childless women. What we are talking about is a politics of power and control. We are in fact - and these are Maria Mies' words - talking about a WAR against women: violence against women in yet another form.
- * What we are facing is an international multi-billion dollar competitive ratrace among scientists, pharmaceutical companies, medics and politicians to be leaders in conquering this perhaps 'last' frontier of human domination over nature. We are talking about the production of the 'right' child to the 'right' parents in the 'right' countries. Let us not forget that the motivation to help infertile people is only put forward in the western world. In so-called 3rd World countries women are fed or injected with dangerous contraceptives or sterilised and the slogan is 'the fewer wombs - the fewer babies'
- * The 'new' reproductive technologies are thus not really 'new': they are based on the same old ideology of abusing, disrespecting and exploiting women as objects that can be manipulated according to the needs of the group in power. But what is new is that today parts of women's bodies are being used as Gena Corea has exposed so clearly in her work. And who the 'right' person will be can be manipulated to a yet unprecedented degree will they be male, white, middle-class, heterosexual, able-bodied?
- * What we are told about the benevolent therapeutic nature of these technologies is, in reality a BIG LIE. We need to expose this LIE internationally. We need to break the silence, women need to know what happens to their/our bodies - and minds - when they/we enter an IVF program. People need to know the enormous economic investments at stake for multinational drug companies and. scientists to continue embryo research: to make money for the former; to become famous for the latter.

I think we should all speak out strongly against these technologies. As the German women said in the Resolution approved at the historic conference Frauen Gegen Gentechnik und Reproduktionstechnik (April 1985, Bonn):

We didn't ask for these technologies
We don't need them
They are produced at our expense.

It is, I think, time to put aside that sort of liberalism which says 'anything goes'. It is, I think time to take on responsibility. By rejecting these technologies we are not insensitive or paranoid or anti-technology grouches. We are not conjuring up a conspiracy theory. Reality is bad enough. By rejecting these technologies, we take a women-centred stand, we are with infertile women and not against them. We should not forget that as women we do have one incredible asset: the Big Lie – Big Brotherhood needs our bodies - or parts of them - to continue their work. If we deny them our bodies and speak out angrily against them in public, then, perhaps, they will be forced to stop. We owe this determine resistance to our and even more so to the next generation of women. If we don't expose the issues and make our voices heard they might be even more mutilated and oppressed than we are.

Although IVF is practiced using A.I.D at both hospitals, currently neither use ova donation or embryo donation (these are both outside current national guidelines). No genetic screening of embryos, or of patients is undertaken. Pregnant patients are released from the program at about 8 weeks gestation (i.e. when a foetal heart can be detected) and there is no automatic special obstetric care - though this was the case at first. Estimates of the costs of these programmes put a pregnancy at between \$10,000 and \$15,000. Both hospitals are also in the AID business, but have policies against the use of known or related donors. The Queen Elizabeth has had 277 AID pregnancies, resulting in 209 living children. The success rate per treatment cycle is 12%; overall, approximately half of the couples participating got a baby³.

Research

Research effort in Australia is clearly led by the Melbourne team. Staff in South Australia expressed some concern about the 'more aggressive' policies of Carl Wood and co, citing the recruitment of ova donors from among sterilisation patients and the use of higher levels of hormonal stimulation to yield more 'excess' ova. Both Flinders and Queen Elizabeth researchers claimed lack of excess ova as one factor limiting research projects.

Flinders is conducting laboratory research on cells collected from stimulated follicles and grown in culture. They are examining patterns of metabolism, specifically steroid production. The aim is to improve the treatment used for stimulating maturation of ova.

They are also investigating techniques for freezing mouse ova. One possibility is to get away from freezing at the ovulation stage, when chromosomal material is in the very fragile 'spindle' state. Freezing at an earlier stage with subsequent maturation in vitro may be more viable biologically. The worker who explained this to me also said that he didn't think it would be acceptable (to the community) to do laparoscopies on women for the sole purpose of collecting ova for freezing.

Queen Elizabeth is doing clinical trials on the effect of ovulation stimulation techniques on the endometrium. I understand they are interested in transferring frozen embryos during a non-stimulated cycle to see if implantation rates are improved.

They are also studying the cells surrounding collected ova, in relation to their role in inhibiting or allowing fertilisation. They are using hamster eggs to refine diagnostic techniques in relation to poor sperm counts in men. They are doing bio-assays on follicular fluid, and hope to isolate certain 'nebulous factors' which are present more often in patients who do become pregnant than in those who do not.

They are doing animal research on a larger scale than at Flinders, experimenting with gene transfer into 'pro nuclear' eggs, i.e. at the stage immediately following fertilisation and before the first cleavage. When asked about application of this work, the researcher explained that it may become possible to isolate the genome carrying certain inheritable defects and inject the 'right' DNA to override the defect. I understand the current success rate in the animal studies is very small, and that application to adult humans (for example, injecting the pancreas to enable insulin production in diabetics) is a more immediate prospect than gene therapy for embryos.

I understood from my conversations with the researchers that they are not experimenting on embryos, though the medical directors of both programs favour such research, and favour the lifting of current National Health and Medical Research Council guidelines which state that

'continuation of fertilised embryonic development in vitro beyond the stage at which implantation would normally occur is not acceptable'

In both programs, there are two ethics committees involved from the hospital and the affiliated university. At the Queen Elizabeth, the view is that where a scientific procedure in the IVF area has been 'clinically proven' by other teams then the Department of Obstetrics and Gynaecology does not seek formal approval from either Committee. They do keep the Hospital Ethics Committee fully informed about 'potentially sensitive aspects' with a monthly report, since the issue has become public⁴. At Flinders the Department has given an undertaking to the Hospital Board that all initiatives will be referred to the ethics committee prior to their introduction. However, the Head of the Department at Flinders identifies what aspects require approval. It seems that there is a filtering process which determines which aspects of IVF/ET are brought to the Committees. I understand that this is similar to the situation elsewhere in Australia.

Legislative Framework

Current legislation (the Family Relationships Act 1975) in South Australia does not recognise the relation between children born of donor gametes and their social fathers, and A.I.D. children must be adopted to be 'legitimised'. Concern about this and other policy questions arising from practice at the two hospital AID & IVF programs led to the production of the Report of the Working Party on IVF & AID (the Connon/Kelly Report)⁵ by the South Australian Health Commission in January 1984. The Working Party consisted of two public servants - a doctor and a lawyer - and took a very narrow view. Following concerned reaction from many quarters, the Commission sponsored a one-day seminar on 'IVF & AID: Social, Clinical, Legal and Ethical Issues Facing Health Professionals and the Community'⁶.

This Seminar was aimed at creating a climate of acceptance both for legislative change to clarify the status of offspring and for the sort of administrative controls the Health Commission wanted to adopt. The Family Relationships Bill was introduced into Parliament in August 1984, and has passed the second reading. In October 1984 the upper house formed a 6 member Select Committee with broad terms of reference including legal, medical, ethical and research issues. The Committee is receiving verbal and written submissions and is yet to report. No formal policies will be adopted by the S.A. Health Commission until the report is received. I do not know whether further legislation will result.

Current eligibility criteria at both hospitals contravene antidiscrimination laws (i.e. refusing services on the basis of marital status), but enforcement is based on a complaint process and no complaint has yet been successfully prosecuted.

We have a government women's health policy, which acknowledges the need to increase women's participation and influence over health system priorities and general decision-making processes, both as users and providers of services. This policy is a useful reference point in both public discussion and government policy-making processes.

Community Debate

Public interest in the issue is high in South Australia, as elsewhere in Australia. Feminists, churches and right-wing 'pro life' organisations are the most active participants in the debate. The medicos tend to adopt a bemused 'we're just trying to help people' stance when they participate in discussion. Professor Cox of the Queen Elizabeth Hospital referred publicly to the interested community as 'the great unwashed' and advocates for control to remain firmly within medical hands.

Feminists in South Australia have adopted an approach based on accountability to the community, especially women. We have called for infertility-prevention measures, release of information, public debate, consultation and broadly-based mechanisms for continuing public scrutiny and control. At the same time, we are concerned about the ramifications of the programs for abortion, contraception, anti-discrimination, surrogacy, and genetic engineering. South Australia has a small, fairly cohesive social structure, with a progressive tradition in social policy areas and currently, a labor government. We expect a fairly positive outcome both legislatively and administratively, in the short-term. However, we know that our community is very much involved in the 'softening up' process described by Robyn Rowland, where a radical change in the popular understanding and image of reproduction is achieved through a slow creep.

The need for feminist involvement in discussion, scrutiny and control of the development of the technologies is urgent, and we anticipate that this will be a long campaign.

Judith Dwyer
Adelaide Women's Community Health Centre, Italy, 1985.

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FARIDA AKHTAR

The following is the report on the contraceptives used in Bangladesh as of October 1984. Government figures are available only upto 1984 so far for the public.

Sterilisation:	257929
IUD/Cu-T :	135425
Injectables :	43682
Condoia :	58756621
Oral Pill :	3718323
Emko :	21540
Foam Tablet :	1129253.

The plan for 1984-85 as shown in the World Bank Report is presented below for your information:

Sterilisation :	1611600
IUD :	457030
Oral Pill :	663600
Condom :	758400
Injectables :	47400
Other :	1185000

Injectables means Depo Brovera or Noristerat.

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A Brief Report on the Current State of IVF in Canada, July 1985

Currently there are nine **IVF** clinics in Canada, three of them in Toronto. Two of the Toronto clinics have produced their first live births this last year, while the third clinic has just opened a few months ago. I don't know about the status of the western clinics. As is usually the case, all of these clinics set their own criteria for eligibility in terms of age, marital status, etc. In the absence of any law, they make their own rules.

A Report on the Proposals for Regulating IVF Recently Made by the Ontario Law Reform Commission

This report is very new. It only came out in June of this year. The report puts forth recommendations, not laws. Its full title is "Report on Human Artificial Reproduction and Related Matters" by the Ontario Law Reform Commission.

Background to the Report - In 1982 the Attorney General of Ontario requested that the Law Reform Commission "consider the legal issues" relating to artificial reproduction and "report on the range of alternatives for resolution of any legal issues that may be identified". The last sentence of the Attorney General's request read "I am certain that the Commission will appreciate the deep importance of these issues for the persons involved, particularly the children, and accordingly in the interests of these children, make the report available as soon as possible".

Who sat on this commission? - 5 male lawyers.

The commission dealt with four topics: AID, surrogate motherhood. IVF. and in vivo fertilization followed by lavage (embryo flushing).

The following statements are a sample of the recommendations for law reform in the report. I will concentrate mostly on the recommendations concerning IVF. I want to stress that these are only *recommendations* which are meant to inform law reform in these areas. They are not currently existing law.

1) AID, IVF, and in vivo followed by lavage constitute "the practice of medicine" and are to be regulated under the Health Disciplines Act of Ontario.

2) Eligibility to participate in these programs should be limited to "stable single women" and "stable men and stable women in stable marital or nonmarital unions". No definition of stable was given.

3) Gamete banks, that is, banks that buy and sell sperm, ova, and embryos, should be permitted to operate on a commercial basis, but with strict standards and subject to public accountability, or operated by a public organization, perhaps in the same way the Canadian Red Cross operates blood donor clinics.

4) Licensed gamete banks should be prohibited from supplying gametes or embryos to any person or agency other than a licensed physician, a hospital or other approved health care facility, or another licensed gamete bank.

5) There should be no prohibition of the practice of transferring multiple fertilized ova to a woman.

6) Legislation should not be enacted to deal with whether a woman or couple should be entitled to obtain information concerning the sex of a fertilized ovum intended to be transferred to the woman.

7) Regulations should provide that no fertilized ovum outside the body should be allowed to develop beyond fourteen days after fertilization. This may be changed later as new medical information emerges.

8) There should be a maximum of ten years for the storage of a fertilized ovum, after which time the storage authority should be under a duty to have the ovum wasted.

Artificial Insemination by Donor in Canada

In Canada, artificial insemination by donor is practiced widely with an estimated incidence of between 1,500-6,000 births through A.I.D. annually. The current ad hoc practice is that donors are anonymous, paid approximately \$15.00-\$50.00 per sperm sample and selected to match the A.I.D. mother's partner's physical characteristics. A.I.D. is available to single and lesbian women at the discretion of the physician. To date, there is no regulation of the procedure with the exception of two provincial statutes. In Quebec, legislation has been passed to legitimize A.I.D. offspring and the Yukon has passed legislation to protect the donor from legal suits.

There have been five governmental reports regarding A.I.D. in Canada: *The British Columbia Royal Commission on Family and Children's Law* (1975), the Alberta Institute of Law Research and Reform (1976) report on the *Status of Children*, the Health and Welfare Canada, *Advisory Committee on the Storage and Utilization of Human Sperm* (1981) and *Tentative Proposals for a Human Artificial Insemination Act*, published by the Law Reform Commission of Saskatchewan in 1981. Most recently, (released ten days before the FINNRET conference) is the Ontario Law Reform Commission's *Report on Human Artificial Reproduction and Related Matters* (1985)--the most substantive and comprehensive Canadian report to date which deals with A.I.D. surrogate motherhood, I.V.F. and in vivo fertilization followed by lavage. This report is expected to set precedent for the other provinces and gives some indication of the potential direction of legislation. In effect, the recommendations signal the passing of control over the procedure firmly into the hands of physicians.

Following are some examples of recommendations contained within the report:

- no legislation regarding screening or selection of donors, this is left to the discretion of physicians.
- the issue of sperm donations by minors should be left to the general law which now permits such donations.
- that the frequency of donations be left up to the physicians and preference of participants.
- no legislation regarding record-keeping, but there is a recommendation that physicians establish a method of linking donors and recipients.
- a recommendation that disclosure or access to records be at the discretion of the medical profession.

I am currently writing a doctoral thesis on donor insemination for which I have interviewed fifty participants in donor insemination programs and will comment briefly on these recommendations in light of my interview material.

Regarding the issue of minors donating sperm--my interviews with donors indicate that donors feel

differently about their donations according to their age, frequency of donations and particularly in relation to whether they have children of their own. The ideal donor donates out of altruism and this motive seems unlikely with very young donors.

In relation to the issue of record-keeping, my interview material suggests participants, in particular offspring (who do eventually become adults within a social context where blood ties are considered important, for a variety of reasons) -may want to know more about their biological heritage. In addition, AID mothers who at the time of the interview were either divorced or widowed or had older children through A.I.D. tended to express more interest in the donor. This might be merely more information in terms of medical history, but they do tend to express an interest in more information.

In general, A.I.D. is not regarded as a high-tech procedure and in some cases it is not. There are women who become pregnant easily and quickly with A.I.D. but this is not always the case. A.I.D. is generally used in clinical settings with heterosexual couples where infertility is the problem of the woman's partner. Ironically, it is the fertile woman who becomes the patient, who finds herself constantly in doctor's offices, who undergoes (in some cases, particularly if pregnancy is not achieved after several inseminations) a series of highly invasive procedures including; fertility drugs to regulate ovulation, laparoscopies and histosalpingograms -all performed to increase the efficiency of the procedure. All of the A.I.D. mothers interviewed commented that this period was the most stressful part of the procedure.

The A.I.D. mother who attends an infertility clinic does gain the opportunity to have a child she may not otherwise have. In this sense she may be seen as gaining control over her reproductive process. However, she loses the opportunity to choose the man who will be the biological father of her child. To neither know nor choose the biological father of the child a woman bears is a momentous shift in reproductive relations as we know them. (Note that in surrogate motherhood, recipients frequently choose the surrogate from a catalogue.)

As well, in general, physicians counsel secrecy, that is, they advise that no one should be told, including the child about the mode of conception. This reflects a simple, perhaps obvious, but important aspect of these technologies-that their use reflects the social context and values in which they are utilized. All of the practices in A.I.D., the anonymity, secrecy, matching of characteristics, mixing of sperm, etc. are an attempt to normalize A.I.D. to the increasingly mythological image of the biologically-related nuclear family. By placing decision-making in the hands of physicians, the recommendations of the Ontario Law Reform Commission will unquestionably attempt to uphold cultural tradition in this sense.

Rona Achilles. July, 1985.

REPORT ON REPRODUCTIVE TECHNOLOGIES IN DENMARK

Since 1976 amniocentesis and ultrasound scanning have become routine procedures in the hospitals offering these facilities. Today 80% of all pregnant women over 35 years undergo amniocentesis. After the test they get two scannings during pregnancy. Recently chorion villus tests have been introduced as an other offer to what is called 'high-risk groups'. Research in this area is new but expanding.

Criticisms have been put forward regarding these three types of prenatal diagnosis by various groups (e.g. Christians and humanistic groups) and very prominently also by a group of feminist doctors: Gruppen for Medicinsk Kvindeforskning (Group for feminist medical research). One point of criticism they raise is the danger of these tests to the fetus. It appears that several healthy fetuses have been aborted in the process of detecting a 'defect' one. Information about this is virtually unknown to the public and sometimes even denied by leading 'technocodcs'. Another point of criticism is the 'pathologisation' of the pregnant woman (i.e. considering pregnancy a disease). A third criticism emphasises the worsening attitude towards handicapped people if it is increasingly believed that so-called 'defects' could have been detected before birth.

Research takes place in two major centers. The Kennedy Institute; heads Margareta Mikkelsen and The Royal Hospital (Rigshospitalet); heads Allan Philip. Most if not all is publicly funded. One IVF baby was born at the Royal Hospital.

Ethics. In the last few years, the media has been focusing on the ethical problems involved in the new RTs. The Department of the Interior has established a committee to debate and evaluate these problems and nine months ago a report was published: Fremskridtets Pris (The Price of Progress). It advocates the establishment of a national ethics committee for the Health Services by an act of parliament. Proposed composition is 50% doctors (called indispensable medical authorities!) and 50% lay persons. The report does not advocate any other legal action. It is based on the British Warnock Report acknowledged in the preface...

Feminist Reponse. The feminist ethics committee is an independent self-established group of women (doctors, theologians, psychologists, politicians etc.) to criticise and participate in the debate on ethical questions concerning women including those related to the new RTs. It has gotten fair publicity and influence. One member of the group criticised the fact that no women were on the official committee established by the Department of the Interior mentioned above, and two women were included - although one of them turned out to be Margareta Mikkelsen, the head of the Kennedy Institute mentioned above... The feminist resistance is limited to this group. In addition alliances are often made with professional ethicists and also with organisations for the handicapped.

Other. A very good critical film on the new RTs was made by a progressive film maker (Ove Nyholm): Future's Children. Available in an English edition from Statens Filmcentral, Vestergade 27, Copenhagen K. Although not explicitly feminist it is very good and recommended by the feminist ethics committee. The film features interviews with French and US technodocs and talks openly about 'manufacturing' people with larger brains...

LENE KOCH
August 1985

Emergency Conference on the New Reproductive Technologies. Braude) National Report - England 4 July 1985

Presently there are eight clinics providing IVF services in England, six associated with National Health hospitals and two private clinics, one of which is the Bourn Hall clinic of IVF pioneers Robert Edwards and Patrick Steptoe. By now, 300 births have occurred using IVF technology here.

Artificial insemination is provided by the National Health Service. Single and lesbian women have received AI services from medical practitioners.

The Medical Research Council funds research projects relating to IVF now at the Reproductive Biology Unit in Edinburgh (Director, D. Lincoln) and in the Departments of Anatomy (M.H. Johnson) and Obstetrics & Gynaecology (P.R. Baude) at Cambridge. Related research is also taking place at Glasgow University and the London Institute of Obstetrics & Gynaecology.

The Warnock Committee of Inquiry Into Human Fertilization and Embryology convened in 1983 to examine the social, ethical and legal implications of recent developments in the field of human assisted reproduction. Public concern over these issues prompted the government to request the inquiry. Philosopher Dame (now Lady) Mary Warnock held the chair and the remaining members included professionals in science, medicine, the law, theology, sociology and social work, ethics and psychology. Their report was issued in June, 1984.

Their emphasis was on treating infertility, as a "malfunction" of heterosexual couples in stable relationships. Eligibility for IVF treatment was not to be limited to married couples, but was thought appropriate only for heterosexual couples.

A few of the recommendations are:

1. a licensing and storage authority should be set up to regulate the uses of services and research. This body would have lay representation as well as "significant representation of scientific and medical interests". Doctors, it was noted elsewhere, should be the final authority on indications and use of services.

2. Experimentation on embryos would be allowed up to 14 days. Beyond this date, use of embryos would be a criminal offense. Nowhere, Jalna Hanmer has pointed out, is the use of women's eggs without consent to be considered as seriously.

3. Other criminal offences would include commercial surrogacy arrangements, non-licensed provision of services, and unauthorized research with embryos. Since the inquiry included AI within the scope of their investigation, the criminalization of non-licensed services would directly effect women-run self-insemination groups here in England.

4. Follow up on AID and IVF children is recommended to study the results of using these methods. Offspring would be registered and monitored.

5. The development of freezing techniques for embryos and eggs was deemed allowable.

6. On sex-preselection, there must, be a good "medical reason" to use any methods that might be established. They were "dubious" about the wide-spread use of sex-preselection but since it is not yet a precise ability of science, they declined making positive recommendations concerning it.

What the Warnock Report does not mention is as important as what it has mentioned. "Women" as a term of reference in the discussion is absent, the emphasis being making "perfect babies" for "perfect, couples" and the morals of the professions.

This Inquiry is important because it has become a point of reference for the debate. There is great disagreement as to what should be done about these technologies and about the Warnock recommendations.

In the wake of the Warnock Report Enoch Powell, a conservative member of Parliament, submitted a private members' bill, the "Unborn Children (Protection) Bill" in the Fall of 1984. His bill required the permission of the Secretary of State to fertilize human eggs *in vitro* and the naming of the woman who was receiving treatment. Embryo research was to be banned.

This bill was not expected to receive much support but in fact it had a first and second reading and went on to the committee stage before it was finally "talked out" of a third reading without a vote. The bill excited anti-abortion support, probably as much to do with its title and source as with the meaning. This bill would have established the concept of "fetal rights", had it passed, thus providing a back door into repealing the Abortion Act 1967, the goal of the anti-abortion lobby.

A bill to outlaw commercial surrogacy was also submitted to Parliament and passed a first reading. The government let it be known that their own bill on Warnock recommendations, which will include a ban on surrogacy, will be submitted in the next session of Parliament (Fall 1985).

There are various reports and guidelines on the Warnock issues coming from the British Medical Association, the Royal College of Obstetricians and Gynaecologists, the Medical Research Council, and various ethical bodies like the Council for Science and Society.

Pat Spallone. Univ. of York

Abstract

The Politics of Reproductive Technology: A Study in Repression
MA in Women's Studies, September 1985, by Patricia SpaHone

The question that prompted this study was, what are the social and moral preoccupations in the discourse on reproductive technologies in England and what does it mean for women? Three texts were investigated: 1) the Warnock Report (The Report of the Committee of Inquiry into Human Fertilisation and Embryology, requested by the Conservative government of Great Britain); 2) the British Medical Journal, a forum for the entire medical profession; 3.) Nature, the prestigious science weekly. These texts were chosen as representative of the views of the state, the medical profession, and the scientific establishment, respectively. In the three areas investigated, particular concerns, tensions, and ironies revealed that the interests of the state, medicine, and science require the subjugation of women. No matter how many individual women have been given babies by artificial reproduction techniques, the point remains that the policy behind the practice serves elites, not women, and is perverse. Iatrogenic and environmental, causes of infertility are ignored. High-tech reproduction is bound up in selection politics (who is "fit" to breed) and capital.

1) The Warnock Inquiry was concerned with social engineering via reproductive technology. Their aim was to resolve the tension between ideology and technology. The report made it clear that the ideology of motherhood must be maintained in technology practice. Technology is deemed acceptable when it promotes this social order, as exemplified by the Inquiry's acceptance of superovulation techniques, which are harmful to women but necessary to make babies for preferred recipients (heterosexual couples). Technology related practice which disrupts the traditional meaning of motherhood, like surrogacy, is not acceptable. The power of the state to police population is displayed in their acceptance of technologies which aid eugenic principles, that is, the propagation of the genetically "fit" and the elimination of the genetically "unfit". The power politics of the state is revealed in the the Inquiry's paradoxical use of the "sanctity of the embryo". The "interests" of embryos are used to deny women reproductive self-determination (as if women's interests were in conflict with children's interests). Yet, the interests of science and the state override the interests of the foetus for eugenic reasons. Women's bodies are needed to serve the patriarchal family and reproductive technology progress. The Warnock Report made recommendations so that women's service to both could be maintained without disrupting the social order.

2. The medical profession is preoccupied with its own authority and resolving the intra-professional conflict between traditional medical elites and the new elites, the medical technologists. The newest innovations of reproductive technology tighten existing medical controls over women's reproduction. Medicine's concern with its own authority is revealed in its inconsistent evaluation of technologies. AID (artificial insemination by donor) is questioned by some doctors because it allows women reproductive choice with radical implications, or else it is accepted by other doctors as long as the physician maintains final authority in AID matters. On the other hand, neonatal technology is easily accepted by the profession because it gives medical authority more control over women's reproduction, but does not give women more control. Neonatal technology is used to restrict women's self-determination, as exemplified by the Royal College of Obstetrician and Gynaecologist's recommendation in 1985 to restrict the Abortion Act 1967, on the authority of the median definition of foetal viability. Again, the sanctity of the embryo is used to police women's behaviour. However, negative eugenic principles supported by the medical profession supersede the interests of the embryo. Abortions are accepted if the foetus is the "formed".

3. Science, meaning research, is preoccupied with the study of embryology and genetics. Scientific interests centre on the desire for control of individual projects and thus, on the principle of scientific freedom. The concern of science, to maintain their interest in technology and unfettered research, is revealed in professional bodies' suggestions on regulation of reproductive technology and on their constant wooing of public support. Their message is: less regulation for research but more regulation an established procedure, AID, so that researchers can have access to genetic information. That women's bodies are needed for the research and that women's reproductive behaviour will be repressed by regulation of AID is ignored. By technology logic, scientific interests warrant the exploitation of women. Meanwhile, the science of eugenics is being reconsidered favourably within the modern meaning of genetics, where genetic engineering is understood as a means of social engineering.

FRANCE

II. Legislation

So far, there has been no specific legislation dealing directly with any of the new reproductive technology. Sperm donation is regulated by a law passed on December 22, 1976, which prohibits the payment of organ donation (except for research purposes). Present legal provisions have been considered sufficient to deal with problems arising from the developing practice of these new techniques; eventual conflicts are either settled in court, case by case (i.e. a recent post-mortem insemination case, in which Corinne Parpalaix requested from the CECOS sperm banks her deceased husband's sperm, in the hopes of bearing his child), or are submitted to local or the national ethics committees.

There has however been demand for legislation, coming initially from sperm bank managers, who felt the need for clarification of paternity issues in artificial insemination with donor sperm and for legal regulation of their activities. A bill was designed and discussed in 1979, but was subsequently abandoned because of lack of consensus on key issues, such as whether or not the AID father should be allowed the option to disavow the child; whether or not AID practice should be limited to accredited centers; whether artificial insemination of single women and postmortem insemination should be allowed; and above all, whether special legislation for artificial insemination should be drawn up at all.

IVF practitioners have also requested legislation controlling standards in IVF clinics; as well as guidelines from the ethics committees for their experimental activities with human embryos.

There seems to be consensus among legislators, government officials and magistrates that no laws should be passed which might be quickly outdated by scientific development. Moreover, scientific experimentation should be controlled by less rigid institutions, such as ethics committees. A National ethics Advisory Committee for the Life and Health Sciences (Comité Consultatif National d'Ethique pour les Sciences de la Vie et de la Sante) was set up on December 2, 1983, to reflect upon difficulties arising from advances in biomedical research and to propose guidelines for the continuation of such research and its application in an experimental setting. This committee has 36 members; five representing different religious and philosophical thought; fifteen representing the scientific community; and sixteen chosen for their competence and interest in ethical problems" (seven of these however are physicians or are from the scientific community). Local ethics committees have also cropped up in several cities, attached to regional hospital centers.

The case of the first French surrogate mother, Patricia, upset this status quo, bringing once again to the fore the issue of legal regulation of reproductive technology. The National Ethics Committee published a statement on October 23, 1984 opposing the development of surrogate motherhood, and supporting their opinion on an interpretation of prevailing legal statutes which appear to condemn this practice. However, some lawyers feel that French law can be interpreted so as to permit this practice; and because the contract is not legally binding, the surrogate mother is protected

from being forced to give up the child. In the meantime, some government officials, and in particular the Minister of Justice, Robert Badinter, in a speech on Human Rights at a Council of Europe meeting in Vienna, Austria (March 1985), have taken an apparently permissive stand, on the basis that a government should not interfere with a person's basic right to have a child, by whatever means he chooses.

Faced with growing debate and diversity of opinion, the government will decide if and how to intervene in October 1985, after consulting the main trends in public opinion.

Simone Novaes

FRANCE

III. Feminist resistance

The desire to have a child has not been really discussed in the French Women's Lib during the seventies. Motherhood has been analysed mostly negatively and in terms of slavery and double work. Only a few groups (like for example, "Psych et Po", "le groupe des femmes mariées", "Sorcières", "le M.L.A.C. (1) d'Aix-en-Provence) have tried to articulate the link between feminism and motherhood.

The self-help movement, relatively limited, has disappeared when the law liberalizing abortion adopted provisionally in 1975, has been definitely voted in 1980. Since then and since the Ministry of Woman's Rights has obtained full reimbursement of abortion in 1982, the Women's Lib has been losing strength. There are less feminist actions, newspapers, reviews, publications and, at the same time, there is an institutionalization of feminism that has become an object of research in the framework of Women's studies.

At a conference organised by feminist theoreticians and researchers on "Women, Feminism and Research", attended by 700 women (Toulouse, December 1982), a few commissions have tackled the question of women's role in reproduction but one commission only was debating specifically on motherhood. Some of the women attending this commission have created in 1983 an association called "Feminism and motherhood" which has organised a two days conference (Paris, January 1984) during which the problem of medical power over women and the new reproductive technologies have been discussed.

Other groups are working on this subject in province and in Paris (as the A.F.P.A. (2) which organised a one day session on NRT on the 8th of June), but our informations are incomplete as of now. Several debates have taken place among feminists after the large official symposiums. We cannot speak of any active resistance of women against NRT, or of any elaborate or unanimous feminist position about NRT. Among partial considerations and reflexions on the subject, a split is appearing. Some women have a critical approach on NRT. They think they are increasing medical and social control over women-and are shading maternity and reproduction into a male, mechanistic and profit making process. Others see NRT as a possible liberation for women who could be freed from their biological destiny or able to plan better their pregnancies and conciliate career and motherhood.

A certain number of groups from French speaking countries (France, Belgium, Swiss, Quebec) would like to create a French feminist network on NRT that would keep in touch with FINNRAGE.

Anne-Marie de Vilaine

- (1) Mouvement pour la Liberté de l'Avortement et de la Contraception.
- (2) Association Féministe pour une Politique Alternative.

REPORT FROM ISRAEL ON THE STATE OF THE NEW REPRODUCTIVE TECHNOLOGIES

•Increasing the Jewish birthrate is a vital need for the existence of Israel and a Jewish woman who does not bring at least four children into the world... is defrauding the Jewish mission". Thus said David Ben-Gurion, the then Prime Minister in a newspaper interview in 1967.

Fertility is a national priority in Israel. In the 1960's the National Demographic Center was set up to "act systematically in carrying out a natality policy, intended to create a favorable psychological climate such that natality will be encouraged and stimulated, an increase in natality being crucial for the whole future of the Jewish People". In Israel, no-one takes the future or survival of the next generation for granted and for this reason children are all important. In a country where life itself is always on the line, the life cycle must be fostered and cherished lest it be snapped.

In such a climate it is certainly not acceptable to be voluntarily childless - anybody who decides so to be, would certainly not admit it openly - and thus the involuntarily childless are under even more pressure. Israelis are not backward in asking personal questions, so that the infertile are barraged with endless questions about when they intend to start a family, and if a couple has been married for more than a year and are childless it's just assumed they must have "problems". In an article about infertility in "Koteret Rashit" a news magazine, a woman describes the pain and suffering she endured going through endless fertility procedures and how in the end she decided to give up trying to have children. She describes the relief she felt as if a tremendous burden had been removed from her - but what is interesting to note is that she specifically wished to remain anonymous. Her decision to stop trying was not an accepted one, for, as another interviewee in the same article says, "the motto of this IVF clinic is 'you haven't failed until you stop trying'".

94% of all hospitals in Israel have some kind of infertility clinic. Couples are always treated jointly.

The Hebrew language too is very evocative. "Piryon" the word for fertility is the same word for human reproduction, work productivity, agricultural production and industrial growth - part of the desired efficient maximums. A woman without children is called "hashuchat yeladim" - darkened by the lack of children, and a large family is called "bruchat yeladim" - a blessed family.

Jewish Law

Jewish law is pro AIH (although in a few extreme cases the man will be unwilling to give a sperm sample as masturbation is forbidden. However most religious authorities see the act of masturbation for sperm tests or artificial insemination as justified because the sperm is not being "wasted"). AID is not recommended, the problem here being adultery, although this too is circumvented by some religious authorities by the fact that there is no penetration. Some orthodox couples who do request AID will ask for sperm from a non-Jewish donor so as to prevent incest between siblings of the offspring (in Jewish law, parentage is derived from the mother).

Orthodox women have several problems with the new reproductive technologies. One is that an orthodox woman has to abstain from intercourse for 7 days after the end of menstruation and if she ovulates during this time she will never fall pregnant. Her Rabbi will not give her a "dispensation" to have intercourse a day early "just this once" as her doctor may well recommend, so she needs a sympathetic doctor who will give her hormonal treatment to adjust the timing of her ovulation.

Secondly, while all women over 37 are given amniocentesis, since an orthodox women would not have an abortion, she does not usually bother to do an amniocentesis. There is one case when the Rabbis encourage an abortion, and this is if Tay Sachs is diagnosed.

The Jewish Law has taken no stand on IVP. It does not automatically reject it and if the husband's sperm is being used it is more or less sanctioned. Even egg donation is acceptable as long as the woman who donates the egg is single (to prevent bastardy).

Genetic experimentation is completely forbidden.

Israeli Law

Israeli law surprisingly takes little notice of Jewish law (perhaps because in this case national priorities override religious ones). There are no laws on the new RTs except for one regarding sperm banks. This only says that sperm banks may only be run by Ministry of Health recognised hospitals. All other regulation is in the form of Ministry of Health recommendations to doctors and heads of sperm banks. All sperm is registered, named and examined. Nothing on the birth certificate indicates that the baby was donor, not husband. Sperm donors remain totally anonymous (there was a move to register them with the rabinnate but it was felt that many would stop donating if this happened).

A married woman cannot receive sperm without her husband's consent (there was a case of a woman who's husband divorced her for doing this and she forfeited all financial rights for herself and the child)

The Health Ministry recommendations include the following:

1. Each bank will keep two catalogs - one for sperm details, one for donors. Sperm will be labelled according to blood type, skin color, hair color, Rh and other necessary details. Sperm will be labelled by code, not name, (para.9)
2. The doctor must not accept too many donations from one donor [no number is actually specified].(para.12)
3. Insemination may be done only by a qualified doctor.(para.17)
4. A wife may only be inseminated if she cannot become pregnant naturally.(para.18)
5. Donor sperm may be used only where the husband has been treated for sterility, and has proven unable to impregnate his wife.(para.19)
6. Doctor has sole responsibility for matching suitability. Insemination should be a mixture of donor and husband. Doctor must explain to the couple that insemination will not necessarily result in a pregnancy, that the child of a resulting pregnancy has normal chances of being disabled mentally or physically, or of carrying a genetic or hereditary disease.(para 24)
7. The husband must sign that any child born of the insemination will be his for the purposes of alimony and inheritance.(para.25)
8. Donor and recipient couple will remain anonymous one to the other.(para.26)
9. The donor may not be a married man.(para. 27 (4))

The recipient couple sign a form which includes waiving any rights to sue the doctor.

There are a number of discrepancies between these regulations and what happens in practice. As can be seen, the regulations refer only to married couples and include the phrase that only a woman who cannot become pregnant, through natural means may receive AI. However from the doctors I interviewed all said they would treat couples who were not married and several said they would treat single women who wished to conceive a child from an unknown father. All IVF doctors would be willing to treat a single woman who would donate eggs while being treated herself.

Many doctors run private clinics for AID and AIH, using fresh sperm from private donations – generally from the doctor’s medical students. Donors are paid about \$10 a time. One doctor told me that the donor may give as many times as he wishes until up to 9 known pregnancies have resulted from his sperm, but this is not mentioned anywhere in the Ministry of Health regulations.

There has been only one case of litigation – a “father” of an AID child refused to pay alimony (Salma vs. Salma). His plea was rejected.

AIH and AID can be done on the National Sick Fund or privately. Pergonal and IVF are done only through the National Sick Fund hospitals. There are several IVF clinics, three of which have so far registered births – Tel Hashomer (Sheba) in Tel Aviv, Hadassa in Jerusalem and Sorocca in Beer Sheva. There are also clinics in Haifa and Kfar Sava and more starting up all the time. The clinics are all funded by government and sick fund. [It is worth noting here that although most hospitals have fertility clinics they are all dreadfully understaffed and with long waiting lists. It has been pointed out that starting up so many IVF clinics which need such a high staff/patient ratio, when “grass-roots” infertility is not being treated properly, is ridiculous, and a clear case of “infertility” not being the true priority.]

The waiting list for IVF treatment is about 3 years in Tel Aviv and a few months in Beer Sheva. A woman treated unsuccessfully, that is either one who does not yield eggs suitable for fertilisation, or one who’s fertilised eggs do not implant, or one who aborts spontaneously, must go to the end of the waiting list and start the whole process again. In theory everybody has an equal opportunity of being accepted, but it seems more than likely that those who have attended the doctor’s private clinic will receive preferential treatment (as well as those with other forms of “protection” such as relatives working in the hospital, those who can return favor for favor...etc.).

Super-ovulation is practised with up to three embryos being inserted in the woman, the rest being frozen (a relatively new practise. Before this all fertilised embryos were inserted in the woman). Embryo insertion is done in the same cycle as the egg recovery through laparoscopy and so far no frozen embryos have been used. Egg recovery is done through laparoscopy, though the new ultrasound method is being experimented with in Tel Aviv (women are promised that if they agree to it they will receive laparoscopy treatment next time round). So far there has been no embryo replacement, although there seems no theoretical reason why not. All experimentation on embryos is completely forbidden. There are probably about 6-7 IVF babies in Israel so far (nobody seemed to have any statistics. Hadassa hospital in Jerusalem were particularly secretive, possibly owing to the fact that although Prof. Shenkar is one of Israel’s “experts” he only had his first “success” very recently.) Any doctor working in IVF in Israel has to have worked in animal fertility first.

Amniocentesis is given to all women over 37 through the sick fund (though many under 37 also undergo it). Chorionic biopsy testing is now being introduced and is expected to become widespread.

All women in Israel undergo at least 2 ultrasound scans during pregnancy. After the second they are asked if they wish to know the sex of the fetus. If the sex is "important" (ie if already 3 girls in the family) the doctor will generally warn the couple before the ultrasound that he will not divulge the sex of the fetus.

There is no counselling given to infertile couples and there are no support groups, or patient groups besides informal groups of women who get together at the clinic and swap information. A former patient at an IVP clinic, in the medical profession herself and married to a doctor, felt that counselling ought to be a number one priority, and that women who want to remove themselves from the program should be given support and encouragement to do so.

So far there has been no feminist resistance to the RT's but hopefully after this conference, awareness will be increased and various can be projects can be planned, in particular media exposure. We have to make sure that we do not get to the position we were in during the big abortion debate when it was suggested (by Amos Kenan, a political satirist) that the issue was that, "the womb of the woman belongs to the motherland".

Refs: Lesley Houghton, Israeli women.
Article in 'Leah's Review' - Jerusalem Post
Interviews with doctors, nurses, patients at fertility clinics
Ministry of health regulations.

Japan

Abstract

1/01

I. The Present Condition of New Reproductive Technology in Japan

On 14.10.1983, the first test-tube baby was born and until now there may have been born around 20-30 babies, but the clear figure is not open. After the first baby was born, universities made the ethic committee, and in these committees non medical members are contained. The government didn't make the law about IVF & ET.

In Japan, the operation is done only between the legal-married couple, and the using of donor eggs or sperm is not admitted.

The Reproductive Society of Japan admitted using fertilized eggs within 2 weeks and fertilized eggs freezing for study on March 1984.

AIH has been taken since 1949. AID has been also taken place. But there is no law about AI.

Diagnoses of fetus and babies using ultrasound and mass-screen are general in Japan, on the other hand the amniotic fluid check and the sex check are not general.

II. Social Background

In Japan, there is strongly social pressure that women must have children. So, the government made three laws - "The Eugenic Protection Law", "The Abortion Prohibition Act in the Criminal Code" and "The Mother and Child Health Law" - for keeping women's bodies under control to have to have a child, and control child at that.

At many hospitals, doctors, almost men, treat women's bodies for subjects of their study or to get profits.

II. Our Opinion

At present, reproductive technologies are developed not for women but for doctor's investigations. Now, women are used as guinea pigs. ^{more} if technologies are much more developed, it become to be ^{more} difficult for women to control their bodies by themselves, on the other hand easy for government and doctors to control women's bodies.

We think the technology that women have to give their bodies to others are not for women.

(1.) The Present Condition of In Vitro Fertilization Technology in Japan

1. IVF

1) the present condition in Japan

On 14.10.1983, the first IVP-child was born at Tohoku University, and the 11th on 17.10.1984. Until now, there may have been born around 20–30 IVP-children, but the clear figure is not open. It is confirmed that in 4 univs. IVF-children were born as well as in 6 univs. on procedure, and in 17 univs. putting in operation is inquired, (see table 1)

Table 1

Confirmed to have been born.

- 1 Tohoku Univ.
- 2 Tokushima Univ.
- 3 Tokyo Dental College & Keio Univ. group
- 4 Tokai Univ.

Put in practice.

- 1 Asahikawa medical College
- 2 Yamagata Univ.
- 3 Gunma Univ.
- 4 Tayama Medical and Dental College
- 5 Toho Univ.
- 6 Hyogo Medical College

Prepared

- 1 Hirotsaki Univ.
- 2 Akita Univ.
- 3 The Defense Medical College
- 4 Tokyo Women's Medical College
- 5 Showa Univ.
- 6 Nihon Medical College.
- 7 Tokyo Jikei Medical College
- 8 Chiba Univ.
- 9 Yokohama City Univ.
- 10 Nagoya Univ.
- 11 Mie Univ.
- 12 Kyoto Univ.
- 13 Osaka Medical College
- 14 Nagoya City Univ.
- 15 Nara Univ.
- 16 Shimane Medical College
- 17 Kyushu Industrial Medical College

In Japan, IVF is done only between the legal-married couple as the treatment for tubal obstruction in the beginning, but now the cases are broadly adopted to the cases such as oligospermie, immunological infertility and unexplained infertility. The using of donor eggs or sperm is not admitted.

(But Prof. Dr. Suzuki, Tohoku Univ. wants to use donor eggs.)

In Nov. 1984, the Embryo freezing is approved. As Prof. Suzuki, Tohoku Univ. mentioned, in Japan there may be 1,300,000 infertility couples and among them about 25,000 couples are salpinx-infertility. In his inquiry from March to May, 1983, 73.4% cases of infertility want to get IVF if they can only become pregnant with IVF. 64% of the cases do not want to get AID and 75% don't want to become Host-mothers. So, IVF and ET would be much more familiar supported rather than AID or Hostmothers. But in general, from the public-opinion poll by the Yomiuri Press in March 1979, regarding IVP, in favor to – 27%, against – 37% and too early yet – 23%, from the poll in Nov. '82, against – ca.60%.

* Tohoku University

The boss is Masakuni Suzuki, who is also the president of the Reproductive Society of Japan from 1983. Since Jan.1983, IVF operations had been taken place and succeeded in March making the first case of implantation in Japan. Tohoku Univ. authorities say that they made “a charter concerning about IVF and ET”(opened in Jan. 1984) but the ethics committee was first made in the Univ. in June ‘83 to make order after the facts against public criticism, which shows they only wanted to become the first successor, the attitude putting the first priority on study. This very attitude caused the problem encroaching on privacy of the patient. Soon after the implantation, Prof .Suzuki announced the result to the press without opening parents’ names. The press searched to find out the parents and after the birth on 14.10.1984, the Mainichi reported the names. To be surprised with this information, the Univ. clinic authorities would’nt open the procedure at all, nor in the learned society. Also the child and the mother were hidden some-where and even at this stage after two years from that time, nothing was heard of them. (It is said, they are living seperated from the father.) To get the honor of the first successor of IVF without rhyme or reason, they have not considered the patient and the child, encroaching on privacy and the right of to live. After this case, the reports after the birth of IVF have never opened in Japan.

Table 2

Tohoku Univ. IVF and ET team

examination and consultation group	doctor	11	♀ per. (0)
	B.Agr.	1	(1)
	B.Med.	1	(1)
	B.Ped.	1	(1)
Adomi. of anesthesia and operation	doctor		(0)
	chief nurse		(1)

* The Public Hospital of Koshigaya City

In 1985 it was revealed that since June 1984 the invitro operations have been done in the way mixing up ova and spermatozoa outside of the body and turning back into an oviduct after 30 minutes. While the citizens’ groups are calling for opening the information doubting that is experimentation using human body, the hospital authorities insist that the fertilization takes place inside the body, so not IVF. This is the first case, IVF done outside of univs., without sufficient experimentation using animals. They have not yet succeeded in making the case of pregnancy.

2) The movement of The Reproductive Society of Japan
 (The Gynecology and Obsteric Society of Japan)

From Feb. 1982, the operation of IVF was under the consideration, and in August it announced “ethics standard” (to do quality control sufficiently, to obtain patients’ consent, only to be done between legal married couple, etc). On 15.11. The Fertilization and Implantation Society of Japan was established and on the procedure to the operation of IVF. In Dec. at

Tohoku Univ. "Charter concerning about IVF and ET" was made in line with the "ethics standard". In that Charter the operation is taken only in the case of invitro causing from salpinx. Both standards were made only by specialists.

After the announcement of the first IVF implantation in Japan March '83, each university tried to make, its own ethics standard one after another, and also the society opened "the opinion about IVF and ET", which broadened "the definition of the operation to the cases "no expectation without IVF", In these ways, the process has taken without any common consent, only the study precedes and after that the standard are made.

On 12.05.1984, guarded by the armed police, the general meeting of the society was held. It reported "the opinion about the study operating human spermatozoa, ova and fertilized ova" and adopted it on 17.11. In this decision, using fertilized ova within 2 weeks, and Embryo freezing, preserving in the study were admitted.

3) The movement of ethics committee in universities

Since the establishment of an ethics committee at Tokushima University, in Dec. 1982, such kinds of committees have been organized one after another in areas throughout Japan. Among 80 medical departments of universities or medical colleges, those committees are held as 24, and 31 under consideration as of May '85. All of them deliberate in line with the Helsinki Declaration. However there are still some universities which have no ethics committees, while they have already operated IVF.

Committees consist normally of 5–15 members and in 19 committees non-medical members are contained, only 9 committees have members outside of the universities. The number of women members is max. 1 or 2. (by the Asahi on 08.05.1985)

* Tokushima University

On 09.12.1982, Tokushima Univ. set up an ethics' committee to make its own original ethics standard to decide whether it proceeds IVA or not. (in 8 members, extramural 1, non-specialist 2, women 1 or 2). On 12.04.1983 it made the standard and began IVF. This ethics committee was socially high estimated, however it was brought to light that from April '81 to March '83 before making this standard, they were doing the cultivation-and fertilization-tests without patients' approval taking out 78 ova from 35 ovaries which were removed in the cases such as cancer. This case called doctors to no account. Also at Tokushima Univ. IVF which was restricted in the cases of tubal obstruction operated also in the cases of oligospermie. Socially estimated ethic: committee was actually only "providing cover" for proceeding the study.

4) The movement of the government

On 24.03.1983, the Ministry of Welfare set up "Life ethics Council". It reported on 23.09 the discussion-procedure about brain-death, viseera-grafting, IVF, so on, but without any conclusion, without any other actual measures taken. The Ministry of Welfare says, although at this stage IVF is not applying to insurance, it will be applicable to the insurance, if the number of IVF children becomes over 100.

3. Artificial insemination (AI)

As AI, AIH has been taken since 1949 by Keio University as a leading part. AID has been also taken place and it is said, through this procedure thousands of children were born without any legal regulations and they are treated as parents' own children.

4. Diagnoses of Embryos and infants

The amniotic fluid check of embryo has been done since around 1970 in such as the Prefecture of Hyogo children's Hospital or Chiba Univ. For it is not legislated in Japan, actual condition or state is not clear, but still not general, same as the cecking of sex. On the other hand, diagnoses of embryos and infants using ultrasound and the mass-screening of infants are done almost every hospital, although few pregnant women know their meanings beforehand and it is also difficult to reject them.

(II) Social Background.

1 "The Eugenic Protection Law" and "The Abortion Prohibition Act"
(From a bill of '82 Comm. Against Revision of E.P.L)

WE WOMEN NEED FREEDOM "TO DECIDE"

We accept that sexual intercourse includes the possibility of conception and that once a woman becomes pregnant, her physical energy is involuntarily concentrated on the process of giving birth. 'Natural' as it is, conception is not the only motivation for intercourse, and contraceptives, even if used with care, are known to fail. A woman's body and her life should not be simply placed in the hands of chance.

ABORTION'S STATUS AS A CRIME

The State has a history of controlling childbirth according to its own interest with no heed for the actual (and usually difficult) conditions of individual woman. The state's first act to direct a policy of government against women (the Abortion Prohibition Act 1869) passed at the time of Japan's move toward modernization during the early Meiji Period(1868 ~ 1912). Aiming at a larger population, based on the government slogan "A rich country and strong military", and the patriarchal family system, the status of abortion as a crime was established in the Japanese Penal Code (the so-called Criminal Abortion Law), where it remains unchanged even today.

THE EUGENIC IDEAL — IN THE CONTEXT OF MILITARIZATION

As militarization proceeded, priority came to be placed on severity of control rather than just its breadth. This can be seen in the objective of the Japanese People's Eugenic Law(1941) which was "the avoidance of an increase in those who possess poor genetic composition or are prone to genetic disease." This law was modelled on the Nazi Sterilization Law, and enforced "eugenic operations", that is sterilization upon disabled people. At the same time the prohibition of both abortion and contraceptions on "healthy" women meant they were forced to seek out backyard operations where they ran the risk of death, internal injury and jail.

THE EUGENIC IDEAL — IN THE CONTEXT OF ECONOMIC GROWTH

Nevertheless, soon after the defeat at war(1945), with the shortage of food and housing and so on, (and an increase in mixed-blood births), the government immediately set about making adjustments to the former Eugenic Law. A renewed version, the Eugenic Protection Act, which permitted the carrying out of both abortion and sterilization under certain exceptional circumstances, was enacted in 1948. This meant that eugenic considerations came to be given priority despite the continuing existence of the Criminal Abortion Law. Included among those clauses permitting abortion, however, were "maternal health and economic factors" clause ; hence a great number of women who, for many reasons did not, or were unable to, choose to give birth had abortions, under the protection of the "economic factors" clause—a situation which has continued up to the present.

Thus, the clause concerning “economic factors” has actually permitted women to decide whether or not to give birth to some extent. But the Eugenic Protection Act itself is a despicable act that must be abolished. In Japan, therefore we are placed in a complex situation, when we demand woman’s complete freedom to “decide.” We can not allow any amendment of the Eugenic Protection Act to limit conditions permitting abortion while the Criminal Abortion Law remains intact (since if it is almost never applied, its very existence leans that it may be enforced at any time).

THE EUGENIC IDEAL — IN THE CONTEXT OF A STABLE GROWTH ECONOMY AND AN “AGING SOCIETY”

Around 1972 and again ten years later, moves were made to delete the clause “economic factors” removed from the conditions permitting abortion. In 1972 a draft, including in particular the additional clause that it would be permissible to abort “irregular” fetuses, was submitted to the Diet, but the reaction of both women’s and disabled people’s groups and the whole country in general was so strong that it was dropped. Over 1982 - 1983, we formed the “Committee against the Revision of the Eugenic Protection Act”, for the purpose of preventing a similar bill from being passed. Since then a great number of people, predominantly women, have continued to show their anger through participation in hunger-strikes, demonstration and face-to-face meetings with authorities. However, the government is not giving up its desire to move in this direction, having declared its intention to amend the Act in accordance with contemporary standards in medical science and social circumstances. In such a trend we can clearly see the kind of policy aimed at with regard to women.

What is the core of this policy on Women? The government is growing increasingly aware of the dangers posed by the fast approaching “aging society” of Japan. It is therefore doing all it can to ensure absolute quality and quantity control over the required young labour force. Moreover, in order to maintain its advanced capitalist system under such conditions, it is intent upon having women return to the home to support a family-based bureaucratically-controlled society.

Considering the lack of completely reliable contraceptive methods, and the obstacles to women’s economic independence which severely limit a single woman’s choice to give birth, the prohibition on abortion must be seen as a way of enforcing a system where childbirth and indeed sexual intercourse become possibilities only within the marriage system. What is more, for those women who are married, it leads to an increase in mental, physical and economic stress by binding them ever more strongly to the home. What the State fears most in its drive towards a bureaucratically-controlled society is women controlling their own sexuality and childbearing, and determining their own life. And the family system’s “need” for child-bearing can be seen as a need for suitable heirs and disallows the birth of children with disabilities; it thus reinforces the eugenic ideal.

At present, sexual desire is being incorporated into our controlled society as an important support for the capitalist system. Sex is being used and commercialized as a release for the workaholic Japanese male’s pent up frustration. The abolition of the Eugenic Protection Act and the decriminalization of abortion will not be possible, without the development of rich and caring sexual relationships based on the mutual humanity of the sexes.

The freedom of abortion which we demand requires inherently a struggle not only against the State and not but also against the eugenic ideal within women ourselves.

WHAT DO WE WANT?

Our present society enforces a uniformity of lifestyle and a single standard by which to evaluate all human life, the result of which is that those who cannot or would not adapt themselves to society tend to be isolated and discriminated against. What we want is a society quite opposite to this.

What we seek ultimately then is the realization of a society where there exist no conflict between the life of a woman and that of the child, and that is, where we have freedom to give birth and raise our children safely, and when we wish, regardless of the question of "eugenics" or handicaps.

2. Mother and Child health Law

In this Law, women's bodies are controlled to have sound babies and disabled children are separated from "normal" children by physical and mental test.

For example, they guide the age of pregnancy and its interval; Using physical and mental checkup (at birth, six months, three years, six years) the government wants to find out disablement early, so disabled children are separated route (a separated institution, school etc) according to degree of handicaps.

3 Sterilization

Sterilization is allowed under Eugenic Protection Law. That is, it is allowed a eugenic point of view.

* The total hysterectomy for women with disablement

In Japan, most of disablements have to live in a hospital or institution, so it is taboo for women with disablement to get married and have a baby. For strong oppression that they can't take care of themselves, specially menstruation, they ^{are} often perform total hysterectomy.

4 How to Treatment for women in hospital

* Fujimi Gynecology and Obstetric Hospital

Many young women (1,141 cases were reported to the local public health center) were performed non indicated total hysterectomy and oophorectomy by Fujimi Hospital between 1971 ~ 1979.

Unqualified "doctor" diagnosed patients as "myoma uteri and ovarian cyst" using ME device (ultrasonic - tomographic device).

In cases of patients who had a child, total hysterectomy was performed, and in cases of patients never experienced delivery.

"Plastic Surgery of Ovary" (this category cannot be found in medical textbooks).

The Reproductive Society of Japan, the local public health center and the Ministry of Welfare didn't fulfill their responsibility.

The case is now on a civil Trial.

* The case of Gifu University.

In May 1984, the assistant of prof. prosecuted the fact that in Feb. 1984, a schizophrenic woman who was five months pregnant, was performed an abortion in Gifu Univ. and she wanted a delivery, the fetus was dissected and its brain was examined.

It is clearly that they performed an abortion not to obtain patient consent, in order to examine effects of tranquilizer in the fetus brain.

REPRODUCTIVE TECHNOLOGY IN THE NETHERLANDS

August 1985

1. State of the Technologies.

(a) IVF. Total babies on day report submitted: +/-25

The first NL hospital to produce live-born test-tube babies was the Dijk-zigt Hospital of Erasmus University in Rotterdam, with the team of Dr. A.Th. Alberda, gynecologist, and Dr. G.M. Zeilmaker, physiologist. The first birth was in May 1983; by July 1984 they had produced the second deep-freeze baby in the world; through July 1985 a total of 18 babies have been born there, including 2 sets of twins. The figures that they reveal are as follows: as of April 1985, of 139 stimulation cycles started 103 had laparoscopy. There were 16 successful births, giving a 11.6% success rate per cycle, or 15.5% per laparoscopy. Unless they have fudged their data by removing some women from the calculations, this rate matches the best clinics in the world. Ultra-sound guided egg retrieval is used as well as laparoscopy.

Both Alberda and Zeilmaker have done this in their "free time" without financial support or much encouragement from the hospital administration. They get public or private insurances to pay for the laparoscopy; the rest of the procedures for their first 139 stimulations were done free. They have worked on getting special permission for patients to pay the Rotterdam hospital directly (not usually allowed with academic hospitals), and started a new series of patients in June, after a gap of six months. They have a very long waiting list.

Two features about the Dijkzigt Hospital's IVF program may be "world records": one home birth (only home birth IVF baby in world?) and probably the lowest cesarean rate: 2 of the 16 deliveries = 12.5%.

In the last 18 months at least 8 other hospitals have started programs and from 6 to 70 women have been processed in each of these locations. On July 1 one of them (St. Elizabeth Ziekenhuis in Tilburg, a general hospital) produced twins; then in August some babies were born in the University Hospital of Nijmegen (where a woman gynecologist plays an important role); and one baby was born in the Zuiderziekenhuis in Rotterdam, through a cooperative program with Dijkzigt (with laparoscopy and birth at ZZH, and fertilization/embryo transfer at Dijkzigt.) Some of the unsuccessful programs have sought press attention for their first pregnancies (which subsequently miscarried); others have been more covert. Many hospitals have long waiting lists; couples often put their names on more than one.

As in other countries cattle-breeding has taken the lead in researching and exploiting new reproductive techniques. Researchers of the Veterinary Faculty of the University of Utrecht have produced artificial bovine twins by splitting up cow embryos and implanting them in "surrogate" cows. A session on IVF at a medical congress in Amsterdam (April 12, 1985) had its first paper, on maturation and fertilization of bovine ova, by one of these veterinarians, Dr. T.A.M. Kruijper.

(b) Prenatal Diagnosis

Ultrasound. 35% of Dutch women deliver their babies at home with midwives; these women do not get ultrasound unless midwives or doctors believe it is necessary. (Dutch midwives know about and use technologies; they are not anti-technology.) Women who plan to deliver in hospitals usually do get at least one ultrasound scan, especially if it is an academic hospital.

Amniocentesis, Officially the University Hospitals in Amsterdam, Rotterdam and Groningen offer amniocentesis and have diagnostic laboratories. Unofficially the universities of Leiden, Utrecht, the other Amsterdam, and a hospital in Arnhem also do it. A license from the government is renewed every 6 months. The universities in the southern, Catholic part of the Netherlands do not do it since they do not do abortions. However, since all women over 37 are entitled to it at government expense, women from the south may travel to Arnhem for this purpose. Most doctors mention it, but do not push it unless they are working at one of the academic hospitals. About 500/year are done in the University Hospital in Groningen. Roughly 30 to 40% of the women over 37 get it; it is also done after a previous child with a “defect,” with known carriers, with sex-linked diseases, for suspected neural tube defects, for some metabolic disorders, and for maternal anxiety when patients request it. Laboratories at certain centers test for specific disorders; sometimes samples are sent to other countries.

Chorionic Biopsy, (called ‘vlokkentest’ in Dutch) All of the above centers may do chorionic biopsy if they want to, and probably most of them do. The Netherlands is participating in the big international study comparing the risks of amniocentesis and chorionic biopsy; women who are willing to participate are randomly assigned to one or the other method.

Genetic Counseling. There are counseling centers in 3 places in Amsterdam and in 6 other cities, including the Catholic cities of Maastricht and Nijmegen. Advertisements urge couples to seek genetic counseling before trying to have a baby, and it is covered by insurance; as yet, however, there is no compulsion.

(c) Surrogate Motherhood.

For SM in connection with IVF, the Health Council’s Interim Report on IVF advised against this. Low technology surrogacy is personally arranged between friends or sisters, and there is probably very little of it, although some stories (both positive and negative) do get into the women’s magazines.

(d) Artificial Insemination

For many years AID has been practiced at approximately 6 centers. Donors are anonymous, and, as in many countries, mostly medical students. They do not get paid, except for travel expenses, and in some centers, a small honorarium. AID is apparently accepted without question in Dutch society.

2. State of Legislation/Government, Ethics Reports.

(a) The “Interimadvies inzake IVF” (interim report on IVF) was released by a committee set up by the Health Council (advisory organ to the Minister of Welfare, Public Health and Culture) on October 10, 1984. They were heavily influenced by the Warnock Report and by the American Fertility Society’s so-called “Ethical statement on in vitro fertilization” (Fertility and Sterility 41(1), Jan. 1984, p. 12)

The only group testimony they received was from sexual freedom groups who demanded that IVF be available to single women and to lesbian couples. Nothing about these matters appeared in their report.

The report approves IVF for a restricted number of centers, supervised by a national committee, with systematic recording of data. These centers are to be studied for three years and then further recommendations are to be made. IVF is to be used only for women with tubal disorders and with written informed consent. Donor gametes may be used,

keeping secret the identity of the donor, and surrogate motherhood is forbidden. Embryos may be used for experiments, with permission of both parents and the hospital's ethics committee, but in any case no longer than 14 days. Finally (and this may another NL first) the report urges that serious attention be paid to infertility prevention.

This report was debated in the popular press and in the Second Chamber of Parliament. Religiously based parties took stands against embryo experimentation. But the BIG issues in NL were (1) whether these should be private clinics, and (2) whether the public and the various private health insurances (ziekenfondsen) should pay for IVF.

As for issue 01, in the fall of 1984 two different seams announced to the press that they would start private clinics in or near Amsterdam. One of these has already signed up two outstanding physiologists from the Bourn Hall Clinic, Jacques Cohen and Carole Ferhilly. (Ferhilly is the person who created a shoat by combining the early embryonic cells of a sheep and a *****. However, the government put various roadblocks in their way and finally in July 1985 forbade all private clinics.

And for the second issue, much pressure was put on the government by the gynecologists. Then the patients' group (see below) applied pressure. It was real issue because the government supposedly was implementing a policy of retrenchment in health costs. But the pressure by the special interest groups was too great. From January 1985 various announcements were made to the press that people could get reimbursed for IVF during a 3-year period, and then it would be decided whether it should be a regular part of the health insurance package. This policy, however, has not yet really been implemented.

After much consultation with the Second Chamber, and more than 9 months after the report appeared, the Minister of Public Health, van der Reijden, presented his specific recommendations to the Health Council on July 18, 1985. He asked for advice and input first before the recommendations are signed by the Queen and officially take effect. He has limited the number of hospitals that may do IVF to the 8 who are now working at it; they must apply for licenses, and he has stipulated what must be included in such an application. Furthermore, he recommends that each of these hospitals set up an ethics committee of "experts" to oversee the IVF program. To begin with, tubal pathology is to be the only permitted reason for IVF. And private clinics are expressly forbidden.

(b) Prenatal diagnosis has not been the subject of any government reports.

(c) At the end of 1984 the Department of Justice commissioned researchers from several disciplines to prepare reports on surrogate motherhood. These reports, essentially favorable to SM, appeared in July 1985 in the Department's journal. According to one lawyer, forbidding surrogate motherhood would come in conflict with the right of procreation and the right of self-determination. In Dutch family law, a woman is the legal mother of any child she bears; to get their child, contracting parents would need to go through regular adoption procedures (including interviews, home visits, having the child for a while as a foster child). In their report, the ethicists recommend that the interests of the child come first. To that end they suggest that the laws be changed; also that official (non-commercial) bureaus be set up to guarantee anonymity (except that a child in later life should be able to learn the identity of its biological mother). Surrogate mothers must be in good physical and genetic health and get psychological screening; contracting parents must also be screened. Although, according to them, children must not be bought and sold, the service of carrying and bearing a child deserves an honorarium. They suggest that the government determine a standard fee to be used in all cases. (The above ideas, although commissioned by the government, are only suggestions: they are not official recommendations.)

The final report of the ethics committee that considered IVF is supposed to cover surrogate motherhood; the release of this report is planned for December 1985. It will have a more official status than the above.

(d) One of the above reports for the Justice Department also discusses AID, especially respect for privacy and respect for family life in connection with the rights of the child and the sperm donor. The ethics committee plans to consider AID in their final report, particularly record-keeping and anonymity of donors.

3. Media coverage.

(a) There has been extensive, and generally very favorable, coverage of IVF. Some of the women's magazines have featured stories of a few IVF mothers. Developments in and discussions about the two issues above were frequently reported in brief news items. The most intellectual of the national newspapers, NRC Handelblad, invited leading professors of philosophy (and one gynecologist) to discuss the ethical issues in a series of 6 guest editorials from February through April 1985 (Medical Ethics I, etc.).

One semi-intellectual weekly magazine DeTijd has had several articles that raise questions and point out dubious situations. And several television programs have featured panels who provide gentle criticisms of IVF, or groups of mothers who are having babies in alternative ways.

(b) Recently articles have appeared in some women's magazines featuring Dr. H. Galjaard, the leading medical geneticist in NL. (He is also a consultant in prenatal diagnosis for WHO in developing countries.) Dr. Galjaard tells couples that heredity is no longer a taboo subject and urges them to take advantage of genetic counseling. One article tells the story of the 'first vlokken-test mother in NL', showing her with a healthy baby boy and slightly older Down syndrome daughter.

(c) Surrogate motherhood is covered in women's magazines from time to time, and the Baby Cotton case in England took up a disproportionate amount of radio time and newsprint.

4. Input from Patients.

(a) During the winter of 1985 the Dutch Association for Test Tube Fertilization (Nederlandse Vereniging voor Reageerbuisbevruchting = N.V.R.B.) formed (instigated by doctors?). Their brochure says that their goal is to serve the interests of people who want to be considered for IVF, by providing information and support. Their first accomplishment was to lobby for more clinics and for at least provisional insurance coverage. They also prepared a position paper on the interim report, which essentially agrees with the report, although it takes issue in a few places. They emphasize that speed in development of a few large, high quality, centers to treat 7000/year must be a high priority. This group responded angrily to one of the DeTijd articles.

(b) There are 20 organizations of sufferers from specific genetic or other defects (or of their parents). These are all grouped together in VSOP, which is the Association of Cooperating Parent and Patient Organizations. VSOP places ads and has a brochure urging couples to get genetic counseling, but this probably has very little effect.

5. Feminist Resistance.

There has been relatively little feminist resistance. In OpZij, a feminist magazine, two articles in the fall of 1984 discussed British and American feminist positions (such as found in Test-Tube Women), raised critical questions, but took the position that IVF and prenatal diagnosis might be in the interests of some women as individuals. Such a position was also presented on one of the television panels (January 1985). Even such low-key objections brought strong criticism from pro-IVF women. (The N.V.R.B. had not yet formed.)

Now, as we write this, FINRRAGE-NL seems to be gaining some momentum, and we are discovering more opposition – among some women doctors, among the leaders of DES–Action, in the women’s health center in Utrecht. Articles reporting the FINNRET Emergency Conference in Sweden appeared in De Waarheid (a left newspaper) and in Katijf, a feminist magazine, and there may be a feminist influence on the VWW (a group similar to Scientists for Social Responsibility in Science in the USA) who will hold a conference on reproductive technologies this fall. Jeanne Wikler’s television documentaries of the Emergency Conference will be shown July 15 and September 2.

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NORWAY

This report will give a brief survey on the legal situation considering artificial insemination by donor (AID) and in vitro fertilization (IVF).

AID

The actual situation

AID is carried out in 7 state hospitals. About 200 children are borne every year after artificial insemination. There is no legislation directly concerning artificial insemination. This means that anyone may carry out this fertilization technique.

Although there are no legal restrictions most artificial inseminations take place in the state hospitals. There are no private organisations or self-help groups. An informal network exists and some women do the insemination themselves.

When AID is carried out in state hospitals certain principles are applied. There is a rather uniform practice in the 7 state hospitals:

- the service must hold a certain medical standard
- donor anonymity, no records of donor's name is kept
- the doctor chooses the donors
- the service is limited, to married or stable heterosexual couples proving to be psychologically fit

Reforms

- An ethical committee will accept artificial insemination by donor only when the best interest of the child is secured. The committee recommends legislation securing the interest of the child. The committee defines the best interest of the child as growing up in a family with a mother and a father. Artificial insemination is recommended only within the nuclear family.

(Ethiske retningslinjer ved kunstig befruktning (AID) og in vitro fertilisering (IVF). Rådet for medisinsk forskning, AVF)

- The need of law reforms is discussed in an official document worked out by a group of members from the Ministry of Justice and the Ministry of Social Services, (Hvilke lovgivningsmessige tiltak bør finne sted vedrørende kunstig befruktning, Problemnotat fra en interdepartemental arbeidsgruppe. Oslo des. 1984)
- The group agrees that the best interest of the child ought to be secured 'legally. The group agrees that it is in the best interest of the child to grow up in a heterosexual nuclear family.
- The group agrees that the principles practiced by the state hospitals ought to be codified either in a law of artificial insemination or in directions.
- The group disagrees in the question of which legal steps it is necessary to take in order' to secure the best interest of the child.

- One fraction recommends a law ‘of artificial insemination based on the goedish model.
According to this recommendation only authorized specialists in state hospitals will be admitted to inseminate. Inseminations carried out by unprofessionals outside state hospitals will be criminalised.
- The other fraction does not recommend a law of artificial insemination.
This fraction means the best interest of the child will be sufficiently secured by directions to the state hospitals. This fraction means it is the inseminations taking place in state hospitals which ought to be regulated. There are, according to this fraction so few inseminations going on outside the state hospitals that regulations are not required.
- So far the “Norwegian Government has not decided what form they will propose an actual regulation is to be given or what principles it is to be based on.

IVF

The actual situation

IVF is carried out at 3 state hospitals. There is no legislation directly concerning IVF.

Reforms

- An ethical committee will accept IVF when the best interest of the child is secured. (Ethiske retningslinjer ved kunstig befruktning (AID) og in vitro fertilisering (IVF). Rådet for medisinsk forskning, NAVF)
- The need, of law reforms will be discussed in an official document worked out by a group of civil servants from the ministry of Justice and the Ministry of social Services. The group will finish its work in 1987.

FEMINIST RESISTANCE

In the official debate on the new reproductive technologies the feminist movement has not been very active.

Organisations working on the new reproductive technologies:

Syffeminisations

Kvinnehuset, Radhusgt.2

:slo 1.

Anne Hellum

NEW REPRODUCTIVE TECHNOLOGIES IN SWITZERLAND

It's only in this year, 1985 That the NRT began to be a subject in public although the state hospital of Basel had already started in 1980 with attempts of IVF. The doctors involved in it got their training in Australia under Professor Lopata. But the IVF-Team had to wait these procter until (82, until the Swiss Academy of Medical Sciences decided about the guiding principles concerning IVF.

The first test-tube-child was expected in Basel in 83, but was lost. Since then they have tried and tried in Basel, Zürich, Lugano...on the whole in 7 state hospitals and several private clinics. Now, in April, the first child was born, a girl, and two weeks ago the second, also a girl.

Situation of NRT

AID is used since 1970. 1% of then children are born this way. At the moment they are trying to make IVF acceptable in public as one of the most natural methods of medicin.

Further on they develop "fetal therapies" (operations of the Foutus in the womb) in the state hospital of Basel. To this method, they got introduced by english doctors in London. And a field, which has developed very fast in the past is prenatal diagnosis. At the end of 84 the Alpha-Feto-Protein-Test came on the market and it already belongs to the routine analysis. Also at least two ultrasound-examinations during pregnancy are routine for most of the doctors. And the Chorionbiopsie-test will be in practice in about one year. Last but not least the human-medical institute in Zürich prepares a Genetic laboratory for the examination of the Genes This laboratory will be ready in about two years.

Ethic guidelines

In Switzerland there is no official ethical commission on a national political level. The Swiss Academy of Medical Scienc already mentioned is a professional organization and regulate the principles of the NRT and of human gene-technology.

Their guiding principles, issued in 1983 are:

- only married couples are admitted to IVF.
- all the egg cells taken by the operation of the woman must be replaced in the womb. So it's not allowed to freeze embryos.
- only the germ cells of the couple involved are allowed to be used, and surrogate-mothers are refused.
- Further on the germ cells or embryos are not allowed to be manipulated or to be used for any research.

(I talked with professor Ludwig from Basel. He said, this could change at the moment, embryos are necessary for cance research)

The Swiss Academy of Medical Sciences is an ethical commissic concerning the doctors. Doctors, who don't follow these giver guiding principles could be expelled from the professional organisation of the Medizin. But that's about all what would happen.

In the argumentation of this Academy you can follow very well how the regulation of the NRT reinforces the traditional role of women.

An example is the surrogate-mother; regarding the Swiss law, being a surrogate-mother is no legal status. We, women fighting the NRT, are against the practice of surrogate-mothers because it injures the integrity of all women. But the solution is not to forbid it by law, but to discuss in public the causes, reasons of women doing it (economical status etc The Swiss Academy of Medical Sciences and public opinion in general is against surrogate-mothers because it compromises family structure.

It illustrates the importance for us of finding clear argumen in each point arising with the NRT for not reinforcing the point of the liberal-konservative or even rightwing circles.

To the actual situation I want to add that it's not difficult to imagine that in some years surrogate-mothers will be permitted also in Switzerland as a medical indication, as guidin principles will be overcoming the change of accepted values.

Opposition

As I mentioned at the beginning the NRT and genetic technology became a subject of public interest in this spring in Switzer land. One reason for it is the first test tube-child, another quite important reason was a political motion, called the "Right to live", initiated by politically right oriented and catholic groups. Under the pretence of the wish to protect li of human beings in all social spheres, they tried to forbid b law the abortion under social indication. In Switzerland we have, as you may know, a so called "democracy", people can vote upon certain subjects.

I talk about this motion because the initiators made the NRT and genetic manipulation a public subject. They caught and used the new technologies as a flank defense during the voting-fight to underpin their pretence of protecting life. They misused the indistinct and confused fear of the people faced with the new technologies. They talked for instance about the new monsters, coming out of the test tube, if nothing will be done. They built up any kind of horrorpictures to convince people of their proposed motion. They pretended their opposition against the new technologies.

And if you didn't come to *** with it you didn't realize the heavy contradictions in their statements. I will give shortly an example The **** supported IVF but refuted to see the surplus embryos as a technical consequence. They supported the idea of gen-Therapies but refused gen-engineering without saying where they see the difference.

Part from the fact that their motion wouldn't have regulated anything concerning these technologies, their argumentation shows something important: they pretend opposition with their horrorpictures and prevent therewith the perception of the reality, of the present developement. On the whole they end up with the same oppinion as the supporters of the new technologies. You can say they work hand in hand with eachother.

I talk so largely about this because I think we must think clearly of these political games taking place to break them through in public. This June the motion “Right to live” was refused by the voting people. Now another group will start a new motion concerning the artificial fertilization and human genetic technology in autumn. This group belongs politically to the critical liberal. For the reason mentioned above our group doesn’t know yet how to handle this new motion.

We welcome that the NRT and genetic technology is becoming a subject discussed in public through these motions. On the other hand we reject the direction the discussions are taking, because, they touch just some special spheres of the technologies like for instance the experiments with embryos, but not the meaning of the technologies as a whole. To take just some parts of the whole is generally the way to prepare acceptance for the whole. A little bit of criticism is allowed in any liberal country for the price is to accept the whole.

Until now the only fundamental critic in Switzerland is formulated by the left oriented women.

Three months before the congress in Bonn, in April, about ten women in Zürich and about the same number in Basel met to get prepared for the congress. These two groups continue with their work. The women are all working in different professions having nothing to do with these technologies. Our motivation is the political interest and responsibility.

Further on, OFRA (Organisation of women), a Swiss organisation of left-wing women starts this summer to work on the subject.

Our group in Zürich works on two levels.

On the one hand we achieve by work new information and discuss questions and argumentations 1 to find a clear political point of view.

On this way we try to find a strategy for our political work.

On the other hand we make public work. So we published a big article and we broadcast a series in three parts about the subject (NRT and genetic engineering in medicine and agriculture)

In our political work we connect NRT and genetic engineering in human and non-human spheres these two technical spheres must be discussed together. For this reason we propose to change the name FINURET. The connection of both technologies – they have the same background and the same causes – must be made conscious in public.

National FINRRAGE Report: The United States

Participants: Rita Arditti, Gena Corea, Anne Donchin, Judith Lorber, Nellie Kanno, Shelley Minden, Janice Raymond

I. The Technologies

– Artificial insemination is available as both AID and AIH, and a large number of sperm banks are utilized for AID. Single women and lesbians are often denied access to AID, and many women's health centers have developed programs offering donor insemination. A businessman, Robert K. Crahan, established a eugenics sperm bank called the Repository for Germinal Choice that contains the sperm of Nobel Prize recipients.

– In vitro fertilizations According to the Office of Technology Assessment, IVF is offered at at least 60 centers and 200 programs. (108 centers are registered with the American Fertility Society.)

– Embryo flushing. A group associated with the Torrance Harbor UCLA Medical Center has delivered two children who were conceived by this method, which involves the transfer of embryos from one woman to another. They are now waiting for more money in order to use embryo flushing on even more women. A firm called Fertility and Genetics Research, founded by Dr. Randolph W. Seed and Dr. Richard G. Seed, intends to open between twenty and thirty for-profit embryo transfer clinics throughout the U.S.

– Embryo transfer to women without ovaries: Preparation for this procedure is now under way, with a medical group that is putting estradiol and progesterone into (silastic) rings, which they put around a woman's cervix. They take the rings out at various times to manipulate women's hormone cycles. The idea is to make women without ovaries have hormone cycles that match those of other women, whose embryos will be transferred. Dr. John Buster is associated with this research.

– "Gamete intrafallopian transfer" - they call it "GIFT"! It is a variant of IVF, in which the eggs are not fertilized in a laboratory dish but instead are transferred, along with sperm, directly to the fallopian tube. It's done by Richardo Asch, M.D., at the University of Texas Health Science Center in San

Antonio Texas. He claims that it has twice the pregnancy rate of IVF.

II. Legislation

– No federal laws have been passed about the new RTs, but a Congressional decision has been made to avoid using public funds for experimentation on embryos.

– In Congress, a Senator Gore is trying to set up a federal bioethics commission to oversee research into human applications of genetic engineering.

– The United States Office of Technology Assessment (OTA) has published a background paper called "Human Gene Therapy that includes a section on in vitro fertilization and also assesses the prospects for genetic manipulations of embryos. The publication number is OTA-BP-BA-32, and it is available for 2X \$5 from the Office of Technology Assessment/ United States Congress/Washington DC 20510.

– Throughout the U.S., homophobia mounts. In Massachusetts, gay people have recently been denied the choice to become foster parents.

– Abortion rights are increasingly imperiled. Currently, women who cannot pay for abortions can only obtain them ** if they live in certain states. Although the legality of abortion has so far been sustained by the Supreme Court, the event of a Reagan court appointment could change this.

III. Women and Political Resistance

– A large number of women's groups address the issues of abortion rights, and sterilization abuse, and many groups have also addressed the access of lesbians to artificial insemination.

– A group called Women and Reproductive Technologies formed in the Boston area in 1983, and holds discussions about the new reproductive technologies and hopes to someday produce educational materials in the form of a film or pamphlet. A central topic of the group discussions has been issue of disability rights as it pertains to the technologies. The group can be reached in care of the Committee for Responsible Genetics/ 5 Doane St. 4th Floor/ Boston MA 02109.

USA II

Women and Reproductive Technology Group
(Draft paper, OF for proceedings)
June 1985

Rita Arditti
Cambridge, MA.

In the Winter of 1983 five of us * started meeting to discuss some of the implications that the new reproductive technologies have for women's lives and for our children. All of us had been working on different aspects of these technologies and two of us (R.A. and S.M.) were involved (with Renate Duelli Klein) in editing an anthology of writings by women on reproductive technologies (Test-Tube Women- What Future for Motherhood?). We were drawn together by a need to share our concerns and our ideas and to get support from each other in bringing our thinking to other women. Our discussions ranged from amniocentesis and genetic screening, to in-vitro fertilization, eugenics, artificial insemination and embryo transfer, we were also hoping that we would be able to come up with a project that could be funded and in that way provide a job for one of us who was, at that point, unemployed.

We continued meeting during the early months of 1984 and while our discussions did give us some of the support we needed, we started to realize that we wanted to let other women know about our existence. We also realized that in order to learn about the implications of these technologies for women, we needed to be in contact with as many groups of women as possible. Then in the April issue of Ms magazine (Ms is a national feminist magazine in the US, with a circulation of 500000) we read an article by Rayna Rapp about her personal experience with amniocentesis and the subsequent abortion of a late fetus with Down syndrome. We decided to write to Ms magazine to congratulate them for the timely article and to reinforce some of Rapp's important points. Basically, we said, amniocentesis is often described as a "woman's choice", but to leave out the social conditions of our lives that determine our real options is to do a disservice to women, We need to question the lack of services for people with disabilities in our society and the social stigma of parents with "defective" children. Our letter was published in the August 1984 issue of Ms magazine and we received many replies. Women who wrote to us had experiences with multiple sclerosis, spina bifida, hemophilia, cystic fibrosis, some were facing the prospect of amniocentesis, some were genetic counselors or health counselors, others wrote about their personal ordeal with the medical profession. One group of women wrote about their difficulties with a pre-paid health organization (Harvard Community Health Plan) in obtaining artificial insemination for lesbians and heterosexual single women. It seems that the HCHP had refused such women infertility services on the basis that none of them lived in "a permanent relationship with aspermi men". The group pointed out that those women bring in permanent relationship with women were being denied a service that is available to unmarried heterosexual couples.

The numbers and kinds of replies to our letter gave us the sense that there were many women "out there" who might be interested in participating in an ongoing discussion on the reproductive technologies. It seemed that we could attempt to enlarge our network. So, we decided to draft a statement that contained the main ideas about reproductive technologies that we had been discussing and to send this statement to a wide range of groups. Our statement (see attachment 1) went out to women's health clinics and women's centers, health rights organizations, disability rights groups, infertility support groups, feminist journals, childbirth educators, midwives, etc. It was also published in a number of journals and we received many individual replies to it. Some of the letters we received asked for additional information, and so we prepared a selected bibliography (see attachment 2) and sent it out to the people who expressed interest.

As our outreach work started growing, the internal structure and dynamics of the group were starting to change. Marsha Saxton, one of the contributors to Test-Tube Women** and a member of the Boston Self-Help Center, a center fostering independent living and self-reliance for people with disabilities, started coming to our group and shared with us her paper on Women with Disabilities (see attachment 3). As a result of her input, our group decided to solicit the ideas of disabled women activists. A primary consequence of this decision was the commitment to meet in places that would be accessible for people with mobility impairment and a commitment to develop more awareness

about sensory limitations and particular health conditions. As a result the group doubled its size at the following couple of meetings. It now seems to have stabilized with about 12-14 women coming to our monthly meetings.

What do we do in our group? Internal education seems to be a priority for us. In our first meeting at the Self-Help Center, women with disabilities shared their personal concerns with reproductive technologies. In an evening that felt to some of us like early feminist-consciousness-raising groups, disabled women shared stories of attitudes they've encountered from the medical profession regarding fertility and birth control, the experience of highly medicalized pregnancy, societal attitudes to disabled parents, and the feelings of some of the women of the importance of medical technologies, mixed with apprehension about their possible misuse.

One of the constant themes that come up in our discussions, is the conflict we experience in trying to support individual women who are using these technologies and our suspicion and misgivings about the scientific-technological establishment (the "pharmacrats", as Gena C6rea calls them) that has been pushing these technologies. The eugenic aspect of these technologies is, we feel, not fully evident to most people. On the other hand, taking care of children with disabilities can be and often is) a 24 hour day proposition that usually falls on the backs of women, especially poor women. How to strike a right balance, how to make use of what can help women while doing what we can to minimize the increasing medicalization of pregnancy, are some of the issues the group is struggling with. We need constantly to ask questions both at the individual and social levels. Reproductive decisions affect not only individual women but arise out of a set of, social values and ideals that we need to be aware and *** for other. How to support women to make truly informed decisions, in a society where information is constantly manipulated and where "blaming the victim" is a common practice, is a truly difficult matter.

To expand on this discussion, we have recently read Barbara Katz Rothman's article "The meanings of choice in reproductive technology" (from Test-Tube Women) and we invited Beverly Freeman, the Executive Director of RESOLVE, a national network of people with infertility problems to meet with us.

Sometimes it seems that the contradictions and difficulties are almost irresolvable. But it may only look so. As we continue learning and grappling with these complex issues, we may find that the fog starts to lift from the picture. When we asked ourselves, recently, why is this group important for us, why do we keep coming, we came up with the following answer:

– "Feels like the group is trying to break new ground in feminist/disability rights theory and practice which is exciting. Group seems to have a high degree of tolerance of diversity and an openness which I appreciate. I am impatient to get on to some specific projects or focus, but I think we are limited by the ability of people to devote energy to the group*.

– "I like the group's balance between relaxed, non-urgent perspective, high energy, inspired, compelled dynamic..."

– "The main purpose of a group like WRT should be to expose the often obscure reality and to raise public consciousness and debate".

– "This group brings together the most interesting women- the diversity of age, color, abilities, disabilities and thoughts has allowed me to broaden my perception of the reproductive technologies and has made me confront own personal biases and beliefs".

– "as a 38 year old feminist and physician... my interest in the group stems from a need for a forum in which to discuss the difficult issues of enhancing/clarifying individual freedom of choice in creative relationship to the global society".

– “I have liked the fact that the group has not stabilized, but that new people with new interests keep coming in. I have been very glad that there is a mix of women with particular disabilities and the rest of us with the usual, general disabilities and we try to see how that affects our attitude about reproductive technologies”.

– “I think the most beneficial part of the group for me has been the opportunity it’s given me to meet with disabled women and to learn some of their stories. I think this is crucial work-consciousness raising for me, and it’s urgent that it continues. On the “action” side- I’m frustrated. There are so many difficulties with taking a “pro or con” stand on the technologies that we keep getting left in the wishy-washy middle, although many of us have strong feelings of wanting radical women-centered change”.

– “As a woman raised working class in America, I am accessing my deepest abilities to understand technical, political and ethical issues from sharing this issue-reproductive technologies with other women. My fears about the control which patriarchal institutions and patriarchal politic funded by high powered capitalist business have over women’s lives and f generations is kept in check for me by the hope and power I get from this group’s grounded discussions , awareness and willingness to resist the new reproductive technologies”.

As of now, summer of 1985, we have decided to continue to meet meet mon. Although we have not undertaken a project, as many of us had hoped be would, we for that our internal education is bringing us closer to our goal of reaching women outside of our group. Filmmaker Debra Chasnoff, producer of Choosing Children, a film about lesbians who choose to become mothers, interested in working with us to create a videotape or film about reproductive technologies. We feel that such a film could be an exciting and valuable opportunity to share our concerns with a wider group of women.

Our next topic for internal education will be the paper that Gena Corea, Renate Duelli Klein and Ruth Hubbard have written about the conference organized by the German women in Bonn. West Germany, April 19-21, 1985. This conference was organized by the Women’s section of the Green Party and the German Feminist Social Science Association. And it was, as the organizers stated:” a meeting against the technologies- not a pluralistic discussion on its supposed advantages and disadvantages for women”. Clearly this is a most important discussion for our group to have, and it will most likely contribute to the further articulation of our views on the new reproductive technologies. Also, two members of the group, are going to the conference organized by FINNRT (Feminist International Network on the New Reproductive Technologies) in July in Lund, Sweden.

The developing of an international perspective around these technologies seems like the logical next step. From the discussion on the German Women’s meeting and from what will be discussed in Sweden, we hope to broaden our perspective about the implications of these technologies for women in different parts of the world. The fall of 1985 promises to be a most important time in the development of our group...

* Rita Arditti, Robin Blatt, Terri Goldberg, Ruth Hubbard, Shelley Minden.

** Test-tube Women- What Future for motherhood? edited by Rita Arditti, Renate Duelli Klein and Shelley Minden. Pandora Press, 1984. Boston and London.

Women and Reproductive Technology

Women and Reproductive Technology (WRT) is a group of women interested and concerned about the impacts of new reproductive and genetic technologies on women's lives. The WRT is a subgroup of the Committee for Responsible Genetics. The following is a draft of our statement of purpose. Since we are just now coming into existence, we are interested in identifying others who share our concerns and in getting feedback from you on our ideas. Please read the statement and send us your comments.

About a year ago a small group of women in the Boston area began to meet to discuss whether the new prenatal screening techniques have a liberating effect on women's reproductive choices (as some medical researchers claim they do) or whether they further "medicalize" the process of childbearing and reduce the already limited control we have over our bodies. This issue led us to explore broader concerns related to what reproductive choice means in an age when technologies exist that allow prospective parents to learn the sex, some genetic characteristics, and some aspects of the physical health of their fetuses. Furthermore, our discussions were informed by our understanding of the ways in which discrimination in this society against women, people of color, ethnic groups, and people with disabilities can influence the so-called choices that parents make.

We quickly discovered that prenatal screening techniques are only part of the story. Other techniques such as in-vitro fertilization, surrogate mothering, embryo transfer, sex-selection, and artificial insemination are already with us. In the future, we may have cloning, parthenogenesis, and gene manipulation in the early embryonic stages. Clearly, these technologies have the potential to affect women's choices regarding our reproductive lives in a fashion unprecedented in human history. Adequate information on these issues is lacking, and sensationalized and overly optimistic accounts by the media are the main sources of information to which people have access.

We also need to keep in mind that at present the Hyde Amendment

deprives many poor women access to abortion. Instead they often are subtly (or overtly) pressured to be sterilized. Furthermore, pregnant women increasingly are seen as the "fetal environment" that is to be blamed for problems that arise during fetal development.

We affirm a woman's right to choose when and how to bear children, including the right to abortion. We believe that Medicaid funds, both federal and local, should pay for abortion the same as for other medical procedures, so that poor women have this choice. The existence of prenatal screening and diagnostic techniques such as amniocentesis, chorion villus biopsy, and ultrasound increases the range of information available to women regarding the health status of their fetuses and therefore provides a basis for abortion decisions that was not available in the past. Such technologies should be available to all women, irrespective of their ability to pay for abortions and for these tests.

However our society has historically placed a great deal of emphasis on the "normalcy" and "perfection" of children, and mothers are often made to feel guilty or responsible if their children experience even the least "disability." A pervasive social stigma of inadequacy and pity continues to surround families with children who are physically or mentally disabled. These families are often socially isolated and frequently do not receive necessary support services such as child care, information, and special educational and medical services. This atmosphere makes it difficult for many women knowingly to bear a child with, for example, Down's syndrome. Our society has not developed to a point where prospective parents who find out that their fetus has a disability are given the kind of information about the disorder that they would need to make an informed choice. Usually they get few positive ideas of what it means to raise a child with the particular disability about which they have to decide and feel overwhelmed by the lack of the economic and social support they would need to deal effectively with their situation.

Physicians' prejudices and other social and political pressures often determine what is acceptable in terms of "health" or "normalcy." Once *(Continued on page 20)*

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CRG News

(Continued from jmg 2)

someone is labeled as having a genetic problem, they carry a stigma that goes beyond their disability. Disability rights advocates correctly point out that many of the problems that people who have a disability face would be alleviated if our society took more responsibility and modified the physical environment to accommodate their needs and if people confronted their fears and negative attitudes towards people with disabilities.

Others have pointed out that if prenatal screening programs were widely implemented, they could readily be made to support eugenic ideologies. These ideologies claim that through selective breeding one can perfect the human race. In other words, that by preventing people with certain characteristics from bearing children society can get rid of "undesirable traits." These ideas have been used to discriminate against Blacks, Jews, women, the so-called mentally-ill, Eastern European people, people with physical disabilities, poor people, and others. We affirm a woman's right to decide whether to bear a child or to abort whatever her reason because no woman should have to bear a child she does not want. But we also have to recognize the social pressures on women to bear only sons or "perfect" children, while new tests are constantly developed to detect novel "imperfections" For example, in the future will insurance companies make it more difficult to knowingly bear a child with a disability by refusing to provide certain kinds of medical insurance to such families?

Women need accurate information and adequate support so that they can make decisions as free as possible from pressures and coercion. This dilemma has raised some important questions for the members of the Women and Reproductive Technology (WRT) group, and we hope to explore them as we engage in our activities.

The medical system has a long, well-documented history of both discriminating against women as health workers and controlling female patients. Prenatal screening techniques expand the repertoire of medical control and intervention during a time when women are extremely vulnerable because they want the best for their future child and therefore can easily be persuaded by what physicians and other medical personnel think would be best. We believe that women need to be empowered to assert more control in these situations. We need independent sources of information so that genetic counselors, researchers, and obstetricians are not our only resources.

WRT believes that there is a great need for women to understand and monitor the increasingly sophisticated reproductive and genetic technologies that are being developed so that we can formulate our own perspective and share them with other women. Much of the available information is either too technical and inaccessible or too simplistic and patronizing. Furthermore, the information we do get usually is not developed from a feminist and anti-eugenics point of view, but conceals a political stance which is presented as scientific and "objective information."

Heavy attacks from the right-w sometimes make it difficult for feminists to discuss freely all of the physical and social questions raised by abortion for reasons of genetic or other disabilities. We started WR order to create a supportive environment in which these issues can be addressed. We hope to undertake several specific projects:

- Organize a meeting to broaden participation of women with different interests and experiences in the discussion of these issues and to encourage others to take up some of the questions;

- Write a booklet that describes clear, concise, non-jargon language the various technologies, question concerning their safety, and option for women who find out that the fetus they are carrying has a disability. By drawing on stories of women who have chosen to have a child with a disability and of women who have decided to abort a fetus with disability; we hope that the booklet; will give prospective parents a sense of how others have faced such decisions, while making it clear that there is no "right answer."

- Organize politically to demand that services for parents of children who are disabled and for these children become more widely available and extended as needed. These services should include information, care, and more accessible health and educational services for children (and adults) with special needs. If we undertake this kind of activity we will link up with already existing groups so as to take advantage of their history and experience.

Committee for Responsible Genetics

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Draft Statement on Women With Disabilities
By Marsha Saxton

The Nature of the Oppression

There is substantial overlap between the attitudes and behaviors of sexism and the oppression of disabled persons. Both target groups, women and disabled people, are viewed within the oppression as passive, dependent, their skills downplayed, their contributions to society undervalued. The effects of this combined stereotyping seriously limit the lives and resources of the approximately 375 million women with physical, mental, emotional and sensory disabilities and chronic illness.

All women experience the effects of oppression around physical issues (health, appearance and so forth). But women with conditions of particular severity experience a definable, systematic oppression which deserves special consideration. This oppression operates to make disabled women feel asexualized, unattractive, burdensome, isolated and responsible for their own condition. Disabled women who are members of racial and ethnic minority groups and/or who are lesbians, elders, or experience other kinds of oppression are doubly and triply limited by the concomitant oppression there.

The Disabled Women's Movement

There is a growing Disabled Women's Movement, which has begun to produce a substantial literature. Research conducted primarily by the Rehabilitation Community has begun to assess the situation for this population internationally. Disabled women have begun to organize peer groups, caucuses, and networks and are speaking out on all issues of concern. The Disabled Women's Movement has developed largely as an outgrowth of the Disability Rights Movement rather than the Women's Movement.

Barriers to Involvement in the Women's Movement

Certain aspects of the oppression of disabled women have served to separate disabled women from other women and make it difficult for them to identify as members of the women's community; notably 1) The asexualization of disabled women and the resulting feelings of many women of not even being seen as female, and 2) The Reproductive Rights Movement, which has thus far failed to adequately acknowledge the implications for the disabled community, of the trend to pre-natally screen and abort disabled fetuses.

Certain rigidities in some segments of the women's community may interfere with the involvement of disabled women. If members of this group are viewed stereotypically as "weak" or "sick", they may be regarded as not presenting the desired image of women as powerful or independents.

Feelings of urgency about accomplishing immediate goals may make the various accommodations needed by some disabled women seem problematic. This view is as self-limiting as regarding the child-care needs of mothers, or the bilingual needs of non-English speaking women as “too much trouble.” The perspective must be emphasized that the Women’s Movement must address the liberation of all women to really challenge the oppression of any women.

Target Allies

The winning of allies in the general Women’s Movement is key to strengthening the Disabled Women’s Movement. Alliances with other women’s groups are essential; priority groups include elder women, disabled girls, welfare recipients, women of color, mothers and wives of disabled persons, and wage-earning care-givers, where substantial overlap exists regarding priority issues.

Skills and Strengths

Women with disabilities have particular strengths and have much to contribute to the Women’s Movement. Because of their life experiences, many disabled women have unique perspectives in confronting and challenging barriers, establishing meaningful priorities, facing human vulnerability, and asking for and effectively obtaining help. The valuable time, skills and resources of these women can be tapped with a little creative thought and planning.

Priority Issues

The following constitutes an outline of priority issues for disabled women:

1. Accessibility, Women with mobility impairments, sensory limitations or particular health conditions may require awareness and accommodation. Examples include architectural and transportation accommodation, sign language interpreters for deaf women, taped or Brailled material for blind women. Women with “hidden” disabilities including diabetes, back problems and other chronic conditions may require accommodation in terms of flexible scheduling or basic sensitivity to fatigue, pain, or diet needs, appropriate furniture, etc.

2. Healthcare Needs The healthcare system is poorly informed about the medical needs of women with disabilities, and often these women ironically, are blamed or ridiculed for their unmet health needs. Instances of Euthanasia and denial of sustenance aimed at both elderly and infant disabled females are serious problems deserving serious consideration.

3. Reproductive and Parenting Rights Disabled women are often denied access to information and resources regarding birth control, abortion and parenthood, and are sometimes the target of forced sterilization and illegal denial of maternal custody of children.

4. Prenatal Screening The trend to abort disabled fetuses particularly affects women with genetic disabilities, older women, or others identified as “high risk” to produce a disabled child. These women may feel pressured to pre-natally identify and abort offspring with a disability.

5. Education and Employment Opportunities Limited access to public education, and discrimination against disabled women 'in employment is well documented. In the U.S, white non-disabled women earn 59\$ on the dollar of male workers, white disabled women earn 24\$ and black disabled women earn 12\$. Services are needed to bring disabled women into the educational and employment "mainstream".

6. Social Assistance Oppression of people on public assistance in some countries targets disabled women by substantial economic disincentives to work, while in other countries no provisions have been developed which begin to ameliorate the disadvantaged economic circumstances of disabled persons.

7. Institutionalization The movement to deinstitutionalize disabled persons is still very limited. Many millions of women with severe cerebral palsy, mental retardation, mental illness, etc. face life institutionalized.

8. Labels and Language Derogatory terms such as "cripple" and "retard" humiliate and invalidate disabled women, while unnecessary diagnostic labels and categorizations function to limit and reduce these women. Like sexist language, even subtle discriminatory forms are significantly hurtful.

Strategies for Change

Strategies to bridge the Women's Movement with the Disabled Women's Movement and further the goals of both include:

- a.) Outreach to disabled women's organizations for meetings, conferences, training and activities of the women's community, and accommodation to accessibility needs.
- b.) Involvement by prominent women's movement leaders in disabled women's activities, and conversely, involvement of prominent disabled women's leaders in the general movement.
- c.) Disability awareness training, via workshops and one-to-one, for the women's community, (as well as the employer and medical communities). Media coverage.
- d.) Awareness of and support for legislative issues of disabled people.
- e.) Outreach to disabled women's organizations for nuclear disarmament activities and other issues of general concern.
- f.) Dissemination of information regarding the implications of pre-natal screening on the disabled community; development of effective, accurate counseling for women considering amniocentesis, including correct information on:
 - 1) the life experience of disabled children and adults, and available resources in the community.
 - 2) the emotional, social and political costs of abortion of a child on the basis of disability.
 - 3) options other than abortion for placement of disabled infants if parents anticipate not having resources to care for the child.

The Women's Movement has much to contribute and much to gain from examining and encompassing the issues of the group.

FINNRET/FINRRAGE CONFERENCE JULY 3-8, 1985 IN SWEDEN

National "eport West Germany

- Part I: RT in West Germany (S. Jansen)
Factors Influencing Resistance
Resistance Activities and Suggestions
-Generally
-Parliament
- Part II: Legal Status, Funding (H. Satzinger)

Reproductive Technologies in West Germany

a) RT Clinics und Practices

Ivf is practiced and researched at the university hospitals of Kiel, Berlin, Bonn, Erlangen, Münster and Lübeck.

In Kiel a central worldwide data bank to pool all data on ivf and ivf-related experiments on animals and humans is planned. The fundraising campaign for this project is still in process-parliament end government have been approached.

Prof. Liselotte METTLER and Prof. Kurt SEMM head the clinic. Prof. KETTLE is one of the few women in this field. Prof. SEMI. publicly admitted that most funding spent on ivf does not go into the treatment of infertility but into research or human reproductive biology. His papers are rich sources of biologicistic irrationalities: He enjoys to "legitimize" ivf as "natural". E.g. since some female animals store sperm in uterine folds to fertilize several litters from one copulate conserving human sperm by deepfreezing is "natural". He openly calls those women "abnormal" who are not obsessed by the wish to have their physically own baby.

In Erlanaen Prof. Siegfried TROTNOW is the only one in W. Germany publicly admits that he deepfreezes human embryos.

In Berlin the clinic has a reputation for hard techniques in contraception research (endocrinological department gained notoriety for its prostaglandin applications on women in: the third world) and for its psychosomatic- centered approach to infertility until a few years ago. Now they practice ivf according to the "Berlin model" supposedly only due to patients demands.

In Lübeck Prof. KREBS ran a group that moved to the University of Bonn in 1984. Prof. KREBS once admitted in a public discussion that he knows of at least one case in GB where bacterial DNA was introduced into the genome of a human embryo. His "concern as a Christian" did not go as far as publicly naming the experimenter.

In Münster a group investigates primate incl. human reproduction biology. Their research on ivf is linked with research on a new class of contraceptives.

In addition to these ivf centers more and more private practice are popping up all over the country. Hospitals that are not university affiliated get into this business as well.

b) RT on our sister animals

I was surprised that in none of the other national reports our animals sisters were mentioned. We must look at them in their chains, cages and stables, not only for reasons of solidarity, but also to learn what the next plans are against us.

At the “Primate Center” in Göttingen, affiliated with the University of Göttingen, the reproductive biology of apes and monkeys is investigated.

At the University of Münster this work is done primarily on monkeys.

The “Central Institute for Laboratory Animal Breeding” in Hannover established a rat and mice embryo bank in 1984. A major research goal is to reduce interindividual variance in the response to hormone treatments for superovulation.

Ivf in farm animal husbandry has been funded by industry and is widely applied in horses + cows, to a lesser extent in pigs and sheep.

c) Genetic Engineering Directly Related to Reproductive Technologies

Prenatal diagnoses via diagnostic probes based on genetic engineering are realistically viewed as a giant market and many pharmaceutical companies work on them. If successful, their work will start off a new era of applied eugenics. In the organizations that support prenatal diagnosis there is some personal (not only ideological) continuity to Nazi biological and racial “hygiene” programs.

At the University of Hamburg a unit using the euphemism “eco-genetics” for themselves, tries to correlate differential sensitivities to toxic substances and radiations to locations on the human genome. The application will be screening programs for workers rather than safe working conditions.

At the University of Heidelberg (the center of “red”, i.e. medical genetic engineering) a “library” of known locations on the human genome exists.

Most genetic engineering directly linked to RT’s is done on animals today. It is not included in this report, but should be a major topic for our next conference.

Factors Influencing Resistance in W. Germany

During the conference many women asked for the reasons why in W. Germany the resistance to RT and GT is already that active.

One reason is many peoples’ sensitivity in W. Germany when something reeks of eugenics. Auschwitz is the history of our country. The industrially managed extermination of whole groups of people (Jews, Sinti and Roma, POW’s, homosexuals, differently abled people) for social and economic goals had an ideological base in the eugenics movement. Eugenics – at that time an esteemed branch of the science of genetics, is gaining popularity again.

A second reason is the existence of a core of well informed “expert” feminist natural scientists: Since 1977 feminist scientists and engineers have held annual meetings – among other goals – develop a feminist critique of science. From the beginning on major emphasis was put on genetic and reproductive engineering.

A third reason was the presence of the Green Party in the West German Parliament since 1983. The Green Party evolved from the alternative movements and has its focus on environmental and peace issues. Some feminists try to make women’s politics another stronghold within the party. Two feminist scientists decided to work in the Green Fraction in the Federal Parliament in 1983: Erika Hickel as a member of Parliament and myself as a staff scientist. Our goals were to break the organized silence about genetic and reproductive engineering by using the parliament as a forum, esp. the media access, which we did not have with the feminist scientists’ meetings. In 1983 there was practically no public awareness and no activities against GT and RT in W. Germany Thus we were not the parliamentary arm of an existing movement outside the parliament but tried to initiate a movement with the help of a media campaign, a strategy that needs evaluation. We got enough media cover to force the pro-side to give up their strategy of keeping everything quiet. However, after a short while the parliamentary group was overrun by an aggressive backlash media campaign. At least public and feminist interest was sufficient present to hold a major conference, the Bonn conference April 1985, cosponsored by an autonomous feminist group and by the Greens.

A fourth reason was added in the discussion (M.Mies): Women’s Studies have not been officially integrated into universities and have been largely independent of state control. This holds true for the social sciences, but to my knowledge feminist natural sciences have now been officially integrated.

Résistance Activities and Suggestions

a) In General:

At the Bonn Conference many activities were discussed and planned:

- Many feminist groups against GT and RT organize public discussion to raise awareness about GT and RT
- Industrial biotechnology fairs are to be “visited”
- Same attention as to those fairs shall be paid to clinics and practices
- For those of us who are a potential market for GT products: consumer boycott
- For those of us in the biological and medical professions: make information available, participate the development of alternatives
- Support feminist self help medical centers and a feminist access to science/to nature
- “Cripple Groups”, as they call themselves, groups of differently abled people, organize protest against genetic screening and genetic counselling centers
- A group named “Rote Zora” deposits bombs in the unfinished buildings of genetic centers, so that the companies have a financial loss and the opening of the center be delayed, w/out people getting hurt
- An archive on genetic and reproductive engineering exists

- A group of anti-vivisectionists broke into the Münster Primatolog: Lab and freed the monkeys. Their goal was to save the animals and their press release did not mention the kind of research these animals were tortured for. But concerned feminists might find that activity inspiring
- Boycott of prenatal diagnosis and free abortion irrespective of the reasons why a woman needs one (at present one has to apply for an abortion, and only a few indications are accepted, one of them a eugenic indication. Differently abled people experience this as a discrimination and a threat).
- A series of newspaper advertisements has been planned for a long time. E.g. “Natural Scientists against genetic engineering”, etc.
- ...
- ...

b) Parliament

For the Greens we put motions that usually got rejected but drew public attention. A major interpellation on GT and RT was also submitted with interesting/answers by the government. A nation-wide working group on GT and RT (both women and men, but with women majority) has been working for over a year now. In this working group feminists, traditional Greens, eco-socialists and critical unionists cooperate and network. The meetings are financed by the Greens and are to support the Green parliamentary work. The feminists usually meet afterwards in a semi-private circle. However, the climate for active feminists tends to get rougher within the Greens. The parliament is a good source of information, although industry plans for GT cannot always be got, which shows who controls whom!

Three motions put are sketched:

- In the budget debates a motion to stop all funding on research and marketing of GT and RT
- a motion to institute a parliamentary investigation committee (“Enquete Commission”) to draw attention, to gain more information, and have a chance to give financed expertises to critical scientists. Our motion included that the commission a) find legal ways to stop GT and RT, b) to find legal ways to allow (until recalled) certain research iff it is proven to be safe and useful to the public (we expected that none will)—an example of a “positive list” strategy in environmental policies c) compare all approaches that use GT with ecological and preventive approaches/alternatives.

Our motion was rejected and instead a follow up motion by the social democrats accepted with a few changes made. Now the commission works under the headline “Benefits and Risks”, but even with this ideological prejudice built in it will be possible to write a minority vote into the final report of the commission, gain information and have a few expertises done by critical scientists.

- A motion to investigate the evidence for the hypothesis that AIDS might have originated as an accident in a GT lab, and to investigate the new dangers in GT labs that are part of newer techniques such as the use of retroviruses as gene taxis and cell fusion techniques.

Suggestions

Two activities die not happen until now and I mention then as suggestions for our political work:

- a) When in parliament a debate is scheduled about ivf and about surrogate motherhood we can put a motion that the parliament urges the government to develop an anti-poverty program for women to secure their economic independence as a measure against
 - commercial surrogate motherhood
 - revalorization of biological motherhood as a result (and means to) women getting pushed out of jobs

This is to draw attention to the social and economic reasons for these phenomena rather than morally judging and punishing individual women who submit to these technologies.

- b) Linda Bullard, Jeremy Rifkin and I had the plan to introduce a moratorium for GT and RT at the same day in W. Germany, Japan and the USA. The moratorium was to be put in parliaments', press conferences and demonstrations be organized the same day in all three countries. The Greens rejected the idea at that time for a tactical reason: The risk that a backlash reaction by the pro-side would outnumber the resistance activities at a time (X-mas 1984) when public resistance was not yet sufficiently present. We who favoured the actions at that time expected public awareness and resistance to grow through these actions. I suggest that we have e similar action with all countries represented here participating!

Sarah Jansen

Report on E. Germany

(I'll check whether Helga or write will write it)

Legal Status , Financing IVF and AID, AIN.

At the moment these are no laws concerning IVF.

In May 1985 the conference of West German physicians passed proposals for IVF which should become the guidelines for all physicians in West Germany:

The main points are:

- IVF is accepted as treatment for infertility when certain medical indications for that treatment are present
- Only married women are allowed to be treated with IVF, the sperm has to be the sperm of her husband (the recommendations only talk of married couples, they never talk of women...)
- experimentation upon embryos is “fundamentally opposed” except for two reasons: the improvement of the method of IVF and the benefit for the child (so this regulation leaves everything possible)
- “prenatal adoption” is propagated, leftover embryos of IVF should be implanted into another woman’s body.
- surrogate motherhood in connection with IVF is to be banned because of possible commercialisation and possible harmful effects on the child.

In relation to reports on commercial utilisation of embryos for cosmetics f.e. the Bavarian government – which is the most conservative government of the provinces in the FRG, F.J. Strauss is the president of the Bavarian state – made a proposal for a bill in the federal council , this proposal can be brought now to the parliament to be decided on.

This proposal says that it should be a criminal offence to handle with dead embryos or fetuses deriving from abortions, for profit reasons. (it is not said how to define “dead”). Scientific reasons should be excluded from this regulation. This doesn’t cover embryos of an age less than 14 days because these young embryos are excluded from the law concerning abortion anyway, and cannot be the product of an abortion by definition.

Embryos and fetuses deriving from IVF are not included in this bill.

Financing IVF:

The health insurances pay for the treatment with IVF, because they define infertility as a disease.

To give some view on the context in which these decisions take place: there are trials of conservative people to exclude financing of abortions which are allowed because of social reasons (in the FRG abortion is allowed under certain indications until the end of the 12th week of pregnancy, i.e. social, psychological medical, eugenic reasons) by the health insuranceä

Some weeks ago a decision of a judge was published, that allowed a husband to forbid his wife to have an abortion - he was given the legal guardianship of the embryo. The woman had no time left to do something at court against this decision because it would have been too late at that time to have a legal abortion According to a feminist lawyer this decision will not become common practise in the FRG, because it will not be taken up by other courts in the hierarchy of courts - anyway, I give you the example to show what is possible at the moment in depriving women of their right to decide on their own concerning abortion and* to give an idea what could be possible with IVF and prenatal adoption on the basis of the ideology of the cited decision.

There are no clear legal regulations concerning AID.

15 years ago: AID was regarded as unethical by the West German organisation of physicians and therefore it was not an allowed practise for physicians. This changed, it is allowed now. Because of the lack of legal regulation the practise is depending on the decision of the physician him/herself.

To get donor sperms (which they pay up to 200 DM for) they assure the donors anonymity, otherwise the child could claim financial support by its genetical father. The physicians therefore, could be made responsible for financing the child.

The husband of the woman who gives birth to a child conceived by AID can withdraw his consent in AID and reject to be financially socially responsible for the child - because he is not the genetical father.

The physicians are free in their criteria how to select sperm donors or which woman they treat with AID. So in the FRG various forms of practise are to be found – selection of sperm donors according to their height () to these using, according to hereditary diseases common in his family, to his appearance, if it resembles that of the future social father esthetical criteria of the physician are also known to exist, probably there are social and racial criteria existing also. Freezing of sperm is common.

One faction of the organisation of “Pro Familia”, Bremen, are giving AID to single women, they argue that their only criterium is the desire of a woman to have a child - as they accept the decision of a woman to have an abortion. This decision of Pro Familia is very much debated on in the organisation of Pro Familia in the FRG. Left to say that Pro Familia was severely attacked by the conservative government, because they did not appreciate the new foundation “mother and child”, which was established to give women 4000 DM in case of when they are pregnant and don't have an abortion, which was allowed by social indication.

AID is not paid by the health insurance.
AIH is paid by the health insurance.

H. Satrijes

1984-1985 SUKDE
 Première rencontre internationale sur les nouvelles technologies de la reproduction
 Etat de la question de la fécondation in vitro IVF
 First international feminist meeting on IVF/The state of the IVF question
 Louise Vandaele and Laurence Gavrilin
 Technique FIV/IVF
 Over 800 babies were born with IVF method over 20 countries. Source Lancet february 1985

	State-Union/USA	Canada	France	Australia/A	Israel	Allemagne/West Germany	East Germany	Sweden/Subbia	Angleterre/England	Brazil/Brasil	Japan/Japon	Suisse/Switzerland
When was it first practiced? Depuis quand?	1980		1978	1979	1983(?)	April 1967	Dec. 1984	1982 or 1983	1978 Louise Brown	1982	14/10/83 (first baby) 1982 (beginning)	1982-1983/1985 (in 1980 beginning Australian teams)
Which team? Quelle Equipe? Where/ou?	Dr. Howard, Dr. Jones and Dr. Georgiana Jones Norfolk Hospital in Norfolk Virginia		Dr. René Frydman and Jacques Yvelart (biologist)	Queen Victoria Hospital team, Melbourne Victoria	National Health Hospital	Erlangen Dr. Trohnow University clinic	East Berlin University Clinic "Charlie"	Sahlgren's Hospital Dr. Lars Hamberg	Dr. Edwards and Dr. Steptoe	Makamura or Donadio (There is a controversy)	Tohoku University	Basel (Basle)
Since then how many babies have been born/Depuis lors combien de bébés sont nés?	APPROX. 180		Some people are saying 100 and other ones are saying 190	More than 300	About 6 to 8	approx. 130	probably 1	8 (stat. of October 1984)	About 200	7 or 8 Sao Paulo	20 or 30	2 (girls) April 85 (Lugano) June 85 (Zurich)
How many centers? Combien de centres?	108 (Gina Corea enquiry)	9	More than 60 (Nicola Athas report)	10	So far 4 to 6, but new ones starting	19	probably 1	4	8	6	4 with births 6 (beginning) 17 (want to try)	7 public centers several private
Publics/publics?	On 54 responses, 36 centers have academic affiliation	5		3(?)	Only public	plus 2 private practices	public	3	6		16 public Univ. private	7 public
Private/privés?	On 54 responses, 36 centers are private profit making entities	1		3(?)	Not allowed			1	2	1 Clinique de Makamura	Tohoku Univ. in Sendai Tokyo Santa College with 2nd Univ. Tokai University Tokushima University	Basel, Lugano, 1 Lausanne (all public)
The five main centers Les cinq principaux centres	Norfolk Hospital Yale University	Foothill Reg. Calif. Mc Master University (Hamilton/Ontario) Toronto east General Hospital/University of Western Ontario in London CMUL Un. Level	McClure (Paris) Becker (Paris)		Prof. Hashomer-Sheba Medical Center (Tel-Aviv) Madassa Medical Center (Jerusalem) Sorococa Medical Center (near Beas Sheva) Efar Java Waife Bambang (Surabaya?)	Erlangen Erlangen Bonn (formerly Luback) all University clinics	East Berlin	-Sahlgren's Hosp. -Malmö General Hosp. Dr. Percy Liedholm (London) -Lund's Hospital -"Sophiahemmet" Hosp. (private) Stockholm Royal Free London	Bourn Hall Cromwell Hospital (London) Hammer Smith Hospital (London)	Sao Paulo (Makamura) Santa Casa Do Misericordie Sao Paulo Biberon Preto University São Bahia University FGM São Paulo Unicamp-Campinas		
Cost for one treatment/Coût d'une fécondation?	From \$1375 to \$7880 US Average \$4084		About \$1,500 US	\$2500-3000 (Aust. \$)	Free	Approx. 4-5000 DM (15-1800 US dollars)	?	15000-20000 SEK covered by social health care	About \$2,500 US	\$1,500 US		1500 SF for one attempt
Cost for a live baby Coût d'un enfant Average/Moyenne			About \$15,000 US	\$ 20,000 Aust.	Free	?	?		About \$25,000 to \$10,000 US.			
Techniques: Stimulation ovarienne Ova stimulation	Most of the time		Most of the time	Yes	100% Ova stimulation	Yes	?	yes	Ova stimulation since 2 or 3 years	Ova stimulation	Yes	Yes superovulation
Recueil d'ovocytes via Yacino laparoscopic/cellioscopy with anaesthesia without	On 54 clinics 37 use only laparoscopic, and 21 use both laparoscopic and ultrasound. General Anaesthesia most of all		85% cellioscopy et anesthésie générale 3% cellioscopy et anesthésie locale. 6% ponction échographique. 5% ponction avec échographie	Laparoscopy with general anaesthesia	So far laparoscopic general anaesthesia? Ultrasound is being introduced in Tel Aviv	yes with anaesthesia	?	laparoscopy	Laparoscopy with anaesthesia	Laparoscopy		local anaesthesia
Other methods autres méthodes				no			?	Follicle is punctured by a needle through abdomen guided by ultrasound	?		No	with ultra-sound (Basel)
Embryo flushing Lavage utérin	Harbor UCH Med. Center has done it until 84 Torrance California	In vivo & Lavage recommended by Law (Law 1?)		Not done	No embryo flushing	No	?	Not officially	No	Research are doing (Makamura)	No	No
Embryo Freezing Birth Conception d'embryons Naissances	4 of 54 clinics are freezing embryos and 23 others plan to do it. No birth		They have begun to transplant frozen embryo but there is no birth	Embryo freezing is done. About 5 births	Embryos are frozen. So far no frozen embryo have been implanted in a different cycle from ovulation.	embryo freezing no birth yet	?	allowed for 1 year according to proposed law. Experiments are done at Malmö General Hospital	Yes but no baby		(freezing only for the research) since Nov. '84	NO (not allowed by academy of Medical Science)
Other method GIFT (Gamete intra fallopian fécondation and transplantation)	GIFT developed by Dr. Arch 7 pregnancy is about 23 attempts. No birth for the moment.		GIFT is supposed to begin in October 85 in Bordeaux				?		?		GIFT but unsuccessful	

Subje	Angleterre/England	Brazil/Brazil	Japan/Japan	Suisse/Switzerland	Norvege/Norway	Pays Bas/Netherlands	DENMARK
1982	1978 Louise Brown	1982	14/10/83 (first baby) 1982 beginning)	1982-1983 (1985 1st baby) (1980 beginning with Australian team)	1984 first birth	1983	Beginning 1982 1983- 1st baby
's Hosp- lanberger	Dr. Edwards and Dr. Steptoe	Wakamura or Donadio (There is a contro- versy)	Tohoku University	Basel (Basle)	Dr Raze Moine Fylkespsykiatri i Trondheim	Rotterdam Alberola/Saillmaker	Copenhagen/Lauritsen/ Linz/Linderberg
of ecto- -il	About 300	2 or 3 Sao Paulo	30 or 30	2 (girls) April 85 (Lugano) June 85 (Zurich)	4-5 approximately	20	total 1
	8	6	8 with births 6 (beginning) 17 (want to try)	7 public centers several private	2 ordinary hospi- tals have depart- ments	8	2 or 3
	6		10 public Univ. private	7 public	2 public	all public	all public
	3	1 Clinique de Wakamu	Tohoku Univ in Sendai Tohoku Univ. College with Keio Univ. Tohoku University Yokohama University Yokohama University	Basel, Lugano, Zurich Lausanne (all public)		-Rotterdam Academic Hospital (18 babies) -Maastricht Academic Hospital (2 babies)	Copenhagen/ Herliv (suburb of C./ Alborg (Jutland)
's Hosp. erol/Hosp edholm ospital ommet Hosp Stockholm	Bourn Hall Cromwell Hospital (London) Hammermith Hospital (London) Royal Free London	Sao Paulo (Wakamura) Santa Casa De Misericordias Sao Paulo Siberian State Univ sitd Sabin University F&D role.Unicomp-Campinas					
1000\$ by social tax	About 92,500 US	\$1,500US		1500 SF for one attempt	It is paid by the National Health Service	(\$400-500)	approx. 15,000 lev
	About \$25,000 to \$30,000 US.					\$1500 (F. 50000)	?
	Ova stimulation since 2 or 3 years	Ova stimulation	Yes	Yes superovulation		hyperstimulation clomidor pergone or HCG (depending on Centre) all use HCG	Yes
opy	Laparoscopy with anaesthesia	Laparoscopy		local anaesthesia		laparoscopy with anaesthesia	without general anaes- thetispiration of follicles
is punctured through abd. by	?		No	with ultra-sounds (Basel)		ultrasound guided egg retrieval	Ultrasound
lolly	No	Research are doing (Wakamura)	No	No		no	?
or 1 year to propo- -experi- -sion at -ital Hosp-	Yes but no baby		(freezing only for the research (since Nov. '84)	No (not allowed by Swiss academy of Medical Sciences)	No	yes one birth (1984)	?
	?		GIFT but unsuccessful				?

INDIVIDUAL PRESENTATIONS

‘WHY DO WE NEED ALL THIS?’ A CALL AGAINST GENETIC ENGINEERING AND REPRODUCTIVE TECHNOLOGY*

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Synopsis—The central argument of this article is that the discussion on the new reproduction technology should not start with these technologies as such and their possible benefits and abuses but with the basic question whether we need this technology at all. whether the fundamental problems of women in capitalist-patriarchal societies can be solved by technology. According to the author, genetic engineering and reproductive technology are not only *not* capable of solving any of these questions, they are destructive to a human relation to our bodies, nature, other peoples. Exploitative and oppressive relations cannot be overcome by more sophisticated technology—even if it were in the hands of women—but only by a revolutionizing of these relations.

At the concluding general assembly of the 2nd International Interdisciplinary Women’s Congress in Groningen (17–21 April 1984) one well-dressed elderly Dutch lady on the platform described the technological future for us women in the most glowing colours. She said she hoped we would be able to organize the next congress with a lot more technical means and that by then we women would also have overcome our resistance and our ignorance with regard to this high tech have learned more mathematics and have studied

genetic engineering, so that we won’t have missed this third technological revolution as well and have left it to the men. She finally affirmed her optimism by announcing the fact that today a satellite was already hovering over the Fiji Islands in the Pacific and that soon the women on Fiji would be able to communicate with one another via satellite.

I wanted to ask whether the women organizers had been paid by Philips International BV. IBM Nederland, Unilever the Netherlands to turn the congress into an advertising event for their third technological revolution’ and their products.¹

But soon after these statements the chairperson switched off the microphone, so the criticisms and anger of the audience could only be vented in informal talks in the foyer, not conveyed by the media—and so were not carried over into TV or the press, i.e. to the public. This made me realize yet

* This text is a shortened and amended version of a contribution appearing in Michaela Huber and Barbara Bussfeld, eds. *Blick nach vorn im Zorn*. Beltz Verlag. 1985. It was presented initially at the Bremen Women’s Week in 1984.

¹The Congress was promoted *inter alia* by: Royal Dutch Shell. IBM Nederland. Unilever. AKZO. Philips International. Royal Dutch Verkrade. Beatrice Foods Co.

again how much this highly prized technology is employed for the mastery over and political control of people. Right at beginning of the congress an Algerian woman had called on the participants to send a protest telegram to the Algerian government because—for the first time in the history of the new women's movement—it had arrested women because they were feminists. The congress organizers did not allow her to canvass for this action because it was political. But when the Algerian women nevertheless carried on speaking the congress organizers had the microphones turned off by the technicians. Many women were indignant about this behaviour. But it didn't occur to any of the women that we could speak without microphones as well. Nowadays, with a microphone we can be allowed to speak or be made to keep silent. How come?

At this congress it became clear as daylight: it makes absolutely no difference whether it is men or women who apply and control this technology. Nor does it help to denounce the congress organizers behaviour as 'really male'. For here it emerged that this technology is *per se* political, because it deprives us of control over events, or centralizes them in fewer and fewer hands.

In view of this ghastly situation I kept finding myself thinking of the fairy story of the emperor's new clothes. Where was the child who asked: 'What do you need all that for? Can't you see you're naked?' Why do you think you can talk better with one another when there is a microphone, a video camera, a computer or a satellite standing between you? Why do you believe you can abolish the domination of men over women using the gene technology of men? Why do you complain on the one hand that rationalization, high tech, destroys your jobs, but on the other hand that this rationalization must come, 'because otherwise we wouldn't be competitive on the world markets'. Why do you think that, for example when Siemens beats Mitsubishi

on the world market, that is good for you? Why don't you simply say 'no' to this rationalization? Why at least don't you say this in places where you do have a little power—for example here at a congress like this, or at school, or at home, that this new technological development just frightens you, that you don't need it, that it is inhuman and inimical to women and you won't buy it? And finally there are many of you in trade unions or who have husbands in these trade unions. The trade unions are not so powerless as we women. Why don't you tell the trade union bosses and your own men that we have had enough of this technological development, that they should put a stop to this exploitative development, which is inimical to people, women and nature?

Why don't you dare to tell the truth: We don't need this technology. Capital needs it, men need it and both need us and others as buyers of this technology, as otherwise there would be an end to the so-called growth. Are you, are we, really captives of patriarchal capital?

Whoever asks these children's questions today, whoever tries to tear away the veil concealing the gigantic deception and self-deception, encounters repudiation even from these affected.

There is a whole battery of arguments which are wheeled out by men and women, in particular by those traditionally thinking of themselves as left-wing and progressive, against this one child's question: 'Why do we need all this?' Here are some of these arguments:

(1) Technological progress is not bad in itself, it only depends on what system it takes place under, how the technology is employed. Under capitalism micro-electronics, gene technology, etc. lead to alienation, inhumanity, loss of jobs, etc: under socialism that will be different.

(2) We just can't reject rationalization, i.e. the reduction and ultimately the abolition of heavy, boring, monotonous routine work. Only someone who has never done such monotonous work could oppose this work's being taken over by machines.

(3) Technological progress means shortening of (necessary) work time. i.e. it

gives us the opportunity through more free time to develop our creativity, our humanity. Therefore rationalization measures and progress should take into account the demand for a shortening of work time.

(4) We cannot reject this new technology if we don't know it. We can't simply be against microelectronics, gene technology, test-tube babies, without knowing and investigating how they function and how their use will affect us women. We therefore need more education, and courses, to familiarize ourselves with this technology.

(5) Our goal must be to introduce as many women as possible to this new technology and the privileged jobs involved in it. We must break down women's resistance to science, technology, mathematics, etc., otherwise this third technology will bypass women as well (see above).

(6) The whole process is already well under way, anyway. The new media, computers, gene technology, are coming, are here, and will stay. So today it's no longer a matter of the basic question of whether we want them or not. It can only be a matter of preventing their excessive misuse, of creating as much access as possible for women to this 'high tech', of achieving as great a degree as possible of codetermination through the unions and democratic control on their use.²

(7) An alternative use of this technology is also possible, however. Micro-electronics is not ecologically harmful and consumes little energy. It procures us rapid access to more information. This can also be used for political resistance. Gene technology can be used too by feminists for 'cloning away' men. It is not ecologically harmful, and replaces chemistry. *In-vitro* fertilization (test-tube babies) allows infertile women to have a child.

(8) Without 'high tech' the poverty in the Third World cannot be eliminated. Gene technology can, for example, be used for the production of higher-yielding varieties of plants and for combating hunger and disease.³

Although I no longer believe that women and men who produce these arguments will only be brought to a different view of things by other, 'better' arguments (for this is not a matter of an academic discourse, but of interests, power and politics), I should first like to deal with these arguments at the same level.

To I

Technical progress is not neutral. It follows the same logic in capitalist-patriarchal and socialist-patriarchal societies. This logic is the logic of the natural sciences, more exactly of physics, and its model is the machine. It is *always* based—not just in its beginnings—on exploitation of and domination over nature, exploitation and subjection of women, exploitation and oppression of other peoples. Technical progress in Europe would not have been possible without colonialism, destruction of the environment, the witch-hunting and imprisoning of women in the home as housewives. Not even today is it possible without the maintenance of these

² This argument was to be heard in particular at the Coneress 'By the water of Kabylon—Council against the Brave New World from 28 to 30.10.1983 in Cologne

³ For example, recently a woman defended genetic manipulation during a lecture on the new reproductive technologies with the argument that in this way, among other things, malaria in the Third World could be effectively combatted. She asked whether it could be justified to let hundreds of thousands die of malaria in these countries. This woman scientist perhaps did not know that the first purely technological attempt at a 'final solution' to the malaria problem using DDT had led to enormous damage to the environment in many Third World countries. How can she be sure that the gene-technological 'final solution' will not lead to even greater safety risks? If these 'final solutions' did not always at the same time conform to the profit interests of the chemical concerns, it would be possible to find alternative methods

exploitative relations. There would be no microelectronics today without the massive exploitation of southeast Asian women (Grossman, 1979). The method of this progress is the violent destruction of natural links between living organisms, the violent dissection and analysis of these organisms down to their smallest elements (atomic physics, genetic physics, reproduction physics), in order to then reassemble them, according to the plans of the male engineer, as *machines*. These machines appear on the market as commodities and there supplant other living organisms, namely human beings resp their living labour. The scientists and engineers design the machines, the wage-earners work at them, bring them to 'life' and out of them come more and more dead things, 'products', commodities. The goal of the enterprise in which both are caught is, by means of such machine products, to become independent of the hazards, the 'moods' of nature—and of the women out of whom life still comes. Ever-growing abundance of such mechanically, i.e. artificially, produced goods is regarded as the goal and as 'good life'. But as the commodities are always *dead* products (because they are based on exploitation and contain in themselves the murdered, destroyed, robbed, degraded life of other people and the destruction of nature), in spite of the gigantic output of goods by industrial society no 'good life' comes out of it. Commodities do not make people satisfied, but *addicted*. Therefore, because the 'good life', in spite of all the plethora of commodities, never begins, people desperately call for more and more of them.

in these countries for combatting malaria, which took into account both the ecological and the social environment. For example, the removal of open drains, etc. Unless we are prepared to see the causal connection between our over-consumption and the underdevelopment in the Third World. I cannot take seriously the reproof of 'our technological responsibility' for the Third World.

Behind this addiction, kindling it and exploiting it, there is of course in capitalism the greed of capital for constant growth and additional value, or for accumulation. In socialist countries the means of production have, it is true, been nationalized, but technical progress follows the same people–women–nature–exploiting logic, the same method of dissection and reassembly and, which is more tragic, the same social goal—that of equating abundance of goods with the 'good life'. That originally socialism aimed at other relations between people, men and women, people and nature, that it was concerned with the 'good life for all', has long been forgotten.

So this technology is not neutral, it is part of the industrial system and is impossible without exploitation. This does not mean that there *could* not be technologies friendly to people, women and nature. To create them, we should have to begin not with technology, however, but with ourselves, with our relationship to nature, to other people, and we would first have to determine what the 'good life', happiness without exploitation, is. Only then would it be time to consider the right technology with the aid of which we could structure this good, exploitation-free, unalienated life. The first question is: What is the good life?

The second: Which kind and how much technology do we need for this?

To 2

The reduction of heavy physical labour, the abolition of monotony and mindless work could be achieved without great expense in a non-exploitative society, through a fundamentally different organization of labour and a different social common goal of labour. Behind the rationalization argument is the assumption that all work is in principle a *burden* and not a pleasure. This is of course true if the products of my own labour become more and more strange and nonsensical to me. If, for example, someone is soldering microchips together which will somewhere be installed in rocket systems, or if a

woman rents her uterus for carrying the child of a stranger. But the 'routine work' of a woman who is looking after her children, who cooks, washes, cleans, etc.; is never *only* a burden, but always a pleasure too.

What should be abolished is not work, which is part of the purpose of our lives, but what turns it into only a burden.

And there would be less burdensome work if we were to abolish our addiction to consumption. This addiction to consumption stands in direct relationship to the addiction to work and to work as a burden.

To 3

It is an illusion to believe that people who have surrendered themselves heart and mind, body and soul for long years of their lives to the logic of this machine-world, can still be at all creative, to believe that they could still be in a position to be able to develop all their human potential. It should offer food for thought that many women are against the 35-hr week because they are afraid that their men would then drink even more, will sit even longer in front of the box, will watch even more football. Where has the creativity, spontaneity, humanity of the workers in the 'progressive' capitalist or socialist countries been until now? Machine-logic has not remained an external thing for men and women workers, it is not washed off in the shower after work. This logic has by now come to dominate 'work-free' time too, as leisure industry. Anyone working during the day solely on computers can only communicate in the evenings with machines. It is now well known that people, in particular young males, becomes computer-addicted. What I find even worse is the increasing destruction of the human essence in people by this technology, i.e. the capacity for thinking coherently, for association, for feeling sympathy and empathy, or for being creative.

Added to this—because of this very inundation with technical 'means of communication'—is a growing incapacity for simple, spontaneous, human communication. I have noticed, for

example, that women and men no longer know how to address a stranger, a guest one might by chance have brought along.

But it is not only the capacity for thinking and feeling that is destroyed worse still is the destruction of sensuality by this destructive technology. If the physical work necessary for life (for the creation of people, food, clothing, etc.) is increasingly transferred to machines, if people become merely the operators and supervisors of machines, they will not be able to 'feel' their own bodies any longer either—they will know neither tiredness, nor strain, nor relaxation, nor pleasure. In order to be able to feel their own body again—for without physical feeling there can be no happiness—they have to practise some sport, play football or do physical therapy, etc. But here the same competitive principle prevails, the same machismo. Violence against women is also increasingly being used by men as a means for retrieving at least a remnant of physical feeling, as can be seen from porno and zombie films. As we are the victims' we can scarcely have an interest in the continuance of this 'progress'

More humanity, more creativity? At best people try to rediscover it by physical, meaningful, i.e. 'necessary' work. By cooking, chopping wood, gathering mushrooms, working in the garden, for example. *And they enjoy it.*

Of course if all this just remains leisure activity and a hobby then the fun has to stop sometime. But if we have realized that the 'good life' continues to be a mirage for us, as long as it rests on the exploitation and destruction of nature, foreign peoples and women, then we will have to try to give up being accomplices in these relationships of exploitation and structure our lives through our own meaningful work. This work will then be necessary again, and because it is necessary it will be meaningful.

To 4

This argument too is based on an illusion, of misjudging of the actual circumstances. What use has it been to men, for example, that formerly they have been better

instructed in machine-logic (natural sciences, physics) than women, that they know how cars and other machines work? Has not this knowledge in course of time become concentrated today in ever fewer heads? Only a few experts know how computers function, everyone else just learns how to run them. And where have these men, who understand and control this technology, the physicists, chemists, engineers, ever advocated that this technology is *not* employed for war, destruction, annihilation of human beings, exploitation? On the contrary, they were and are so fascinated by the illusion of infinite possibilities, that they have done whatever could be done, without consideration for their own humanity. Everything that pays was and is feasible. But the men who have sold themselves to the 'free' sciences maintain a discreet silence on this.

If today even men who have sacrificed their lives to this machine world, which they know inside out, come round to the view that for themselves and for all of us there is only a future if we opt out of this machine world—Jochen Sonn (1984) of the Plakatgruppe, for example—then it is absurd for us women to believe we should finally opt into it, in order that the blessings of this so-called third technological revolution' do not pass us by.

Furthermore, if men have successfully defended the machine world for 200 years as their field, their monopoly (it is not because of the lack of intelligence of women that there are so few women engineers and mathematicians), where do women derive the hope that this will change *now*? Why should the privileged male job-'owners' share this field with women *now*?

If nothing is altered in the patriarchal man-woman relationship—and it is a relationship of exploitation and domination of a non-technical nature—then arduously won knowledge on computers and genetics, on micro-electronics, DNA and cloning won't be of any use to us. On the contrary, the call for women to give up their resistance to these technologies has nothing whatever to do

with knowledge, understanding, discovery. Women should much rather be persuaded in the one case (computers) to 'serve' these machines as the cheapest most exploitable outworkers (Böttger, 1983) and in the other case (gene and reproduction technology) they should make available parts of their own body (whole ovaries, ova, wombs, placentas) for the commercial, capitalist-patriarchal production of humans (Corea, 1984). The knowledge as necessary for us today as our daily bread is the knowledge of the capitalist-patriarchal interests of domination which lie behind this technology.

In order to be able to decide whether this technology is of any use or not to us women it is this knowledge above all which we need, and not a detailed expert knowledge on the functioning of this technology. What has been published so far by committed and critical women and men on this functioning is enough to come to a political decision on the value and non-value of this technology.

To 5

Here I should like to return yet again to my impression of the Groningen Women's Congress. It had not been of any use to the feminists that the interpreting equipment, the microphones, had been under the control of women. The women did not handle this centralized technology any differently from the men; they switched off the microphones when political opinions were expressed which they found disagreeable.

Nowadays we can no longer pursue the biologicistic fallacy that social conditions would change if as many women as possible were sitting at the control panels of power, in the privileged positions in politics, economics, culture and in the ever more elitist and centralist world of the new technology. For that reason I also consider the mere demand for a quota in such positions short-sighted. It cannot be simply a matter of demanding 'more women'. We must ask what policies, what aims these women represent. The existing technology is still an instrument of domination if women control it. If they do not want to

fight patriarchy and capital at the same time, they will turn it against women too.

This also applies for the technocratic illusion many feminists pursue in the wake of Shulamith Firestone. They think the new reproductive technology and genetics could, if they were in the control of women, be used for finally abolishing men (by cloning them off). These women not only fail to realize that economic/political and military power is not in the hands of Lesbians (the probability under given circumstances is greater that we women would be abolished) but also that bisexuality as such is not our problem, but the relationship of exploitation and domination between women and men. Ultimately, all these arguments are based on a biologicistic interpretation of a historical and social relationship. They are without doubt going in the direction of racist and fascist thinking.

To 6

This is the most widespread, but also the most dangerous, because it is a most defeatist argument, in that it plays directly into the hands of the giant corporations and the technocrats. For according to this argument it is always too late for us women. As we do not participate in scientific and political decision-making on technological innovations—as in principle technological development takes place outside political discussions (for science is 'non-political'), as the question of whether a certain innovation will be used or not, whether it is useful or harmful, is never asked, we shall only ever be able to react in this system. Scarcely have we got used to one item of alarming news from technopatriarchy, which rolls over us like an iron destiny, than the next one arrives. Scarcely have women said, 'We can't do anything against computers any more they came and they'll stay', than an even bigger piece of horror technology is standing there in our house and in our life: gene and reproductive technology. And the latest seems to be the 'Star-War-Technology'. It's like the hare and the tortoise; we run and run, but the old patriarchal-capitalist technology tortoises are always in front with

their destructive toys, and at our expense too!

We shall never beat them on their own ground and with their own logic. So it is never too late either, but right now, today, we can start asking the basic, never-asked questions, and opt out of this logic.

If we don't want to be stupefied by these sham arguments, we must ask: If this technology is not necessary, and if the hazards involved are greater than their benefits, why is it not only promoted with an enormous amount of propaganda, but also supported by vast sums of public money (see the budget of the West German Research Minister for bio-technology)?

The simple answer: Because otherwise capital would not continue to grow. The growth of the old areas of industry (cars, steel, shipbuilding, electrical equipment, etc.) is limited or has come to an end. Only in these modern fields is rapid growth of invested capital still possible. How and with what methods this occurs has been analysed by Rachael Grossman (1979) for micro-electronics and Jost Herbig *et al.* for the bio-business (1981a). Common to all these developments is the fact that scientists directly involve themselves with business, link up with risk-capital and put new products on the market which are finally distributed on a massive scale by multi-nationals with the aid of government pressure. Here ethical considerations are ruthlessly brushed aside (King, 1981: Herbig, 1981b).

To 7

Before an alternative use of technology is possible, alternative conditions would first have to be created. It is a historical fact that technological innovations within exploitative relationships of domination only lead to an intensification of the exploitation of the groups being oppressed. This applies in particular for the new reproductive technologies, the technology of the industrial production of human beings.

We women are baited to accept the reproductive industry with the shaky argument that we apparently have a 'right' to

a child of our own. Since when has there been such a 'right' to a child of 'our own flesh and blood'? And how does this 'right' tally with the fact that in China and India this very 'right' is taken away from women by the same chemical and pharmaceutical concerns which are here entering the bio-business?

In India the technique of amniocentesis, for example, is used for systematically aborting female fetuses (Balasubrahmanian. 1982). In China the policy of the one-child family leads to similar results (Croll. 1984).

Any woman who is prepared to have a child manufactured for her by a fume- and money-greedy bio-technician must know that in this way she is not only fulfilling herself an individual, often egoistic wish to have a baby. but also surrendering yet another part of the autonomy of the female sex over child-bearing to the techno-patriarchs. Would it not be more beneficial to her to concern herself with other women and possibly men too about the causes of increasing infertility of men and women in the overdeveloped countries.

To 8

The most hypocritical argument to be heard in this context is that of the hunger in the Third World, which could allegedly be abolished by the miracle weapon of genetic manipulation. After it has been proved by countless studies that hunger in the Third World is a direct result of the exploitation and bleeding of these countries by the industrialized countries and our over-consumption (see *inter al.* Collins and Moore Lappé. 1982; Strahm. 1981; George, 1976; Franke; 1981; Caldwell, 1977). after it has long been proved that the first attempt to combat hunger in the Third World by bio-technical manipulation, i.e. by the creation of high-yielding varieties of cereals, proved a miserable failure (*inter al.* Feder, 1975, 1976), it is surprising that the scientists and agro-business, who have grown fat on this so-called 'green revolution', still believe people will swallow this argument.

Anyone really wanting to combat hunger

in the Third World can start here and now by no longer buying food produced there for export (we already get around 30 per cent of our food from the Third World). The hunger in the Third World is a result of our over-consumption and not of their being technologically backward.

Similar arguments apply for gene technology as the 'miracle weapon' against illness. Most of these illnesses are a result of the industrial system, of the destruction of the environment, of over-consumption, and could disappear if different conditions were created.

Gene technology and bio-technology also promote the myth that illness and death can basically and once and for all be conquered by technology.

OPTING OUT, BUT HOW? OR, RESISTANCE BEGINS WITH ME

If we want to opt out of the capitalist-patriarchal technology of annihilation we must first ask the only sensible questions, which are of course the most taboo ones, i.e.

- (1) What do we need this new technology for?
- (2) Does it make women happier, freer? Does it improve the chances for overcoming patriarchal man-woman relationships?

Even advocates and supporters of the new technology cannot prove that there is a real need for it. Basic research in atomic research and microelectronics was carried out within the context of state-financed military research (Herbig. 1981a). Now it is a case of opening up civilian markets for these products, in addition to armament (Lenz. 1983). And the few positive effects of this are inflated so much by propaganda as to give the impression that the salvation of the whole world depends on this technology. For example, the possibility of creating artificial insulin by gene manipulation is produced as justification for government-backed genetic research financed by enormous sums of the taxpayers' money. But there is no

shortage at all of insulin obtained from the pancreas of cattle and pigs, which also has the same effect (Hohlfeld. 1984).

It can be said without exaggeration that there is no social need, defined as the satisfaction of real requirements, which could not already be met without this technology. Therefore the need—i.e. the demand—must be artificially created.

Workers—women and men—are caught up in this strategy by the job argument. Entrepreneurs and politicians, followed by the unions, keep on saying that jobs can only be secured by embarking on these new technologies and by maintaining competitiveness on the world market.⁴ Fear of losing one's job or existing unemployment means that many women and men no longer ask whether what is being produced is necessary, meaningful and useful. The main thing is that they (still) have a job or hope to get one, according to the motto: 'After us the deluge.'

Anyone asking the question 'Why do we need all this?' is dismissed as an unrealistic Utopian. Of course a lot of people do realize that these new technologies will destroy our lives even further, but they say: 'Charity begins at home.' And they don't notice—or won't notice or realize—that they are already standing there naked and that capital will quite literally 'skin them alive'.

We women can quite bluntly answer the second question in the negative too. In the underdeveloped countries the new technology leads to even more brutal exploitation, racist humiliation and even

more cheaply. And there the bosses tell the Japanese workers: 'The workers in South Korea work much more cheaply.' The trade unionist had realized this, but didn't draw any conclusions from it in the direction of a genuine international solidarity. His argument remained stuck fast in the context of capital

physical annihilation of women, and here at home it leads to the destruction of women's jobs, increasing tele-outwork, increasing violence against women (see the essays in *Beitrage zur feministischen Theorie und Praxis* 9/10, 12, and 14; Corea, 1984, 1985). Nowadays we can no longer subscribe to the technocratic Utopia of Bebel and all the other scientific socialists who think that the liberation of women will come with the electrification of the kitchen (Bebel) or with microprocessors or even through technical 'liberation' from the biological process of childbirth (Firestone), in short, by the further 'development of productive forces' plus socialism. For us women, a positive answer to the question of liberation and happiness is not to be expected from this development in any of the existing systems.

Therefore, in my opinion, the first step in opting out consists in us women saying loud and clear and in great numbers: The so-called new technology does not bring us and our children any kind of qualitative or quantitative improvement in our lives, it solves none of our basic problems, it will advance even more the exploitation and humiliation of women; therefore we do not need it. And because we don't need it, we don't want it.

To be able to say this, however, we must begin right now with our inner detachment. We must reject our participation in this system, we may no longer allow it to define what a human being is, what our being-human is, what a woman is, what work is, what life is. This participation consists in the fact that many people do want to keep the advantages of this system of exploitation, and are just against a few disadvantages. In other words, they want to have their cake and eat it too. We know that this system lures us day in and day out with a relatively cheap superfluity of goods, we know that it chains us to it by promoting addictions, we know

⁴ A trade unionist from IG Bau-Steine-Erden (Construction and Civil Engineering Union) said at a forum on the 35-hr week in Cologne that technological progress was necessary, for the trades unions too. as otherwise the German economy would not be competitive: if we don't rationalize, the Japanese will. Either all countries must stop the new technologies or none.' A member of the IG-Metall (Engineering Union) said accordingly: 'We are told when we demand higher wages in Japan people work much

that by buying these goods we represent the necessary market for capital, without which market even the production of these things would be meaningless.

We know all this, but none the less it is this very knowledge that we make taboo, because of our complicity, and we always direct our attacks at an abstract enemy outside ourselves: the entrepreneurs, the State, 'men', 'patriarchy'. In discussions on such things women frequently refer to their powerlessness, to the fact that it is objective pressures they are acting under, that here and now, as long as capitalism exists, nothing can be done.

Here the basic question arises: If here and now nothing is to be done against capitalist patriarchy, what should be done against it in the future? Basically it's a matter of concealing one's own complicity in the system by such objections. Women who argue in this way really want nothing to change. They are basically glad that the system seems so 'powerful' and—apparently—gives them no chance.

In reality, however—and I'm certainly not excluding myself from this complicity—we evade recognizing and applying our own strength, our own force. This power is where we are—in our everyday lives. This power is first the one we have as buyers, as consumers. If we no longer define being-human, being-woman via consumption and addiction, we can first begin individually with a liberation movement from consumption. It could be applied to these new technologies, i.e. we could refuse to buy a computer, a video machine. I consider it schizophrenic if left-wingers and alternative society supporters on the one hand analyse the negative social effects of these technologies and on the other hand buy these things themselves.

But individual liberation from consumption is not enough. We need a political and collective movement of liberation from consumption. This movement would have the aim of signalling to entrepreneurs and politicians on a massive scale that we are not interested in their products as buyers. Even more, that we shall engage in an active boycott.

All women's organizations and groups

who want to opt out of technopatriarchy should be persuaded to join such a movement.

A far-reaching public campaign must be started by women against gene technology and the new racist reproduction and eugenics technology. It should go beyond the Yes-No-tactics of the German Social Democrats who on the one hand demand codetermination in the development of technology and checking of excesses, but on the other hand adhere to the dogma of the necessity of this technological 'progress' ('We're not luddites').

Basing ourselves on the recognition that we neither need nor want this technology, because it is inimical to people, women and nature, because it opens the door wide to sexism, racism and fascism, the first aim of the campaign should be to block all public money—our tax money—for the further development of these technologies (atomic research, micro-electronics, gene technology). Concretely, this means at the outset demanding a moratorium on government support for research in these fields. This could be introduced for example by the Greens in the West German Bundestag. This moratorium would have to be accompanied by broad public discussion, particularly among women.

In addition to this campaign which is aimed at the prevention of an even worse state of affairs, we should start right now a movement of winning back autonomy over our bodies and lives in as many contexts as possible. This means, in the last analysis, the restoration of our capacity for subsistence (Autonome and Grüne Frauen Köln. 1983). At the same time there would have to be a real 'opting out of the machine world' or a gradual de-linking from the capitalist techno-system.

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Summary of the paper "Seizure of reproductive Rights? A Discussion on Population Control in the Third World and the Emergence of the New Reproductive Technologies In the east," Read by Sultana Kamal In the conference on . 4 July 1985.

With the origination and the projected scope for expansion of the new reproductive technologies In the west along with the obsessive emphasis on population control in the third world countries, the international as well as the national population policies are needed to be examined in a new light. It is as much Important to see the conflicts in rights to procreate between people with different socio-economic-political background. Similarly the rights of the physically handicapped demand more sensitive attention.

Some basis for the urgency noted above to reexamine the global population policies are to be found in the statements made by world population policy makers an example of which is as follows : "Government policies should be of a sort to equalise births between people at different socio-economic levels. They should discourage births among the socially handicapped who cannot give their children adequate opportunities. They should encourage large families among the specially fit."

This 'selection and elimination! approach to population has taken roots in all international and national planning to entice "the fit" to breed and restrain births of "the unfit". Promotion of technologies having exactly opposite purposes in different parts of the world are in fact aimed at a common goal, i.e., control over human reproductive power.

Historically we have seen how restriction and expansion of population is always linked with the need of the society-need directly related to the society's mode of production, sense of private property, existing resources, pattern of access to that societal resource and also the man-woman relationship. We have also seen how at particular developmental stages population policies of Europe were regulated by the Malthusian principle of eliminating the poor instead of eliminating poverty. This was possible mainly because the non-productive predatory mode of appropriation through violence and coercion became the paradigm of all exploitative relations between human beings. Its main mechanism is to transfer autonomous human producers into conditions of production for others or to define them as 'natural resources' for others.

The population policy In Bangladesh is Influenced by the need of the rich donor/investing countries of the west to keep the population size as low as possible and also the interest of the few rich people of Bangladesh who for obvious reasons fear population growth in the poor stratus. That is why the only technology related to reproduction that Bangladesh is familiar with is the technology of contraception as against the new reproductive technologies of the west. Contraceptive technology is imposed, promoted and pushed in Bangladesh, with special reference to the poor women.

The highest emphasis is given on sterilization by tubectomy on women. The next priority is given to injectible contraceptives like depo-provera, noristeret and corplant. Depo-provera is supposed to keep women infertile for either three or six months depending on the dose administered. Noxplant is planted under skin and is expected to act on women's body for five years restricting fertility. That these injectibles and also the sterilization programs are directly stimulated by foreign international organisation will become clear when we see that the main sponsors of these are USAID, the World Bank, the International Projects of the Association for Voluntary Sterilization. Women are induced into accepting sterilization and injectibles by monetary and material incentives. The non-government organization conducts various contraceptive programs as compulsory part of their project and the government along with other programs conducts sterilization camps through all its health centers in the rural as well as urban areas. It is important to note that not much attention is paid to the complaints women have after the injection or sterilization. All side effects are defined to be minor and women are advised to 'eat better'. There is hardly any population control program in Bangladesh which can claim to provide a service preserving the interests and dignity of the people.

In contrast to that when we look at the happenings in the “estern countries, we still find women rallying on the streets for right to free abortion and easier contraception policies. Although abortion , in the name of ‘menstrual regulation’ or ‘medical termination of pregnancy’ is very much recommended in Bangladesh as a method of contraception as well as among the socio-economically disadvantaged and the migrants living in the western countries.

The point I want to make here against the backdrop of what I have said before is that with the expansion and commercialization of the new reproductive technologies more and more people will be brought under the control system ultimately resulting in fewer and fewer people having actual control over their own reproductive behaviour. If we look back how in the past two or three generations practice of breast feeding just had to give in to the fashion of bottle feeding, how the artificial chemical fertiliser replaced the natural fertilisers in agriculture destroying original fertility of lands the fear that the new reproductive technologies may take over major responsibilities of procreation eventually, does not sound so baseless. There is very little to doubt that commercialisation of techniques will not induce its producers try their best to create market for them by fair or unfair means. Looking at the insane process that created consumerism of killer weapons including nuclear ones, we should realise how coomer-cialisation of world’s most undesirable produces and technologies also get marketed, sold and reproduced in the name of consumers’ interest.

The other two points I would like to raise here are, first, regarding the research of the new technologies; and secondly about the attitude that is to some extent responsible in the initiation of invention of these technologies. To get a baby through new reproductive technologies one has to wait years in suspense before she or he is certain of the positive outcome and it is mainly women who have to let their bodies be subject to experimentations. It is very likely that economically handicapped women will have to volunteer their bodies for the benefit of the richer and the similarly the thrid world women may soon be chosen to work for the western world at cheap rates. Secondly the enthusiasm of the commercial producers of these technologies is fanned by the attitude of certain people of not accepting the condition of ‘not-having’ anything. If it is a question of relationships, are not there different ways to relate oneself other than to one’s own children? Does not this obsessive craving to have a child of one’s own in many cases stem from individual’s sense of private property or to have somebody around over whom one has substantial control for some years at least? I think these attitudes need to be examined and resisted, if exist. Considering the cost and complications involved in the new reproductive technologies it is fair to say that only a few powerful and privileged people are going to be able to take advantage of those and as in other cases, here also the powerless will have to bear the major costs for them.

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Seizure of reproductive rights? A discussion on population control in the third World and the emergence of the new reproductive technologies in the west.

With the origination and the projected scope for expansion of the new reproductive technologies in the west along with the obsessive emphasis on population control in the third world countries, the international as well as the national population policies are needed to be examined in a new light. It is as much important to see the conflicts in rights to procreate between people with different socio-economic-political background. Similarly the rights of the physically handicapped demand more sensitive attention.

Some basis for the urgency to examine the global population policy noted in the above statement may be traced in a report of the Population Council conference 1957 published in the Population and Family Planning Programs, a Compendium of data through 1978–Fact Book, New York quoted in Loes Keyzers’ thesis titled ‘Does Family Planning Liberate Women’, It says: Government policies should be of a sort to equalise births between people at different socio-economic levels. They should discourage births among the socially handicapped who cannot give their children adequate opportunities. They should encourage large families among the specially fit.”

This ‘selection and elimination’ approach to population must be seen in a global perspective. It is also essential to see its implications at the national and international spheres separately and then again how the both are linked through principles of selective breeding to entice “the fit” to breed and restraint births of “the unfit”. To me, promotion of technologies having exactly opposite purposes in different parts of the world in fact aimed at a common goal, i.e., control over human reproductive power. The population policies are determined on the basis of requirement of the ruling systems, the differences of interests between the metropolitan centre and peripheral developing countries, between national macrolevel and household microlevel, between race and class and most significantly between men and women on all these spheres.

To explain what I have said above, I would like to go over history very briefly to show how time and again attempts have been made to restrict or expand population according to the need of the society – need directly related to the society’s mode of production, sense of private property, existing resources and the pattern of access to that societal resources and also man-woman relationships. I will mainly relate the historical developments of population policies in Europe at different phases as population activities of today in Bangladesh have direct relationship with that of Europe and the USA for her historical links with them in her colonial and neo-colonial eras. This will also show how the birth control principles gradually assumed the character of population limitation mechanism under the name of development strategies. I will then give a short description of the population activities in Bangladesh, its ties with development aids, operational conditions and its relationship with women.

I have not enough knowledge about the new reproductive technologies developed in the west to discuss their nature and scope. In fact, that is mainly the part I have come to learn here. I will however, explain the reasons for my assumption that the developments of the new reproductive technologies are a part of the controlling system.

We know from ***** that in early ***** the growth or decrease of hunting and gathering societies was in balance with the means of survival afforded by the natural surroundings. Depending on the availability of food and the need for mobility in search of more food, there was a physical limit to the number of children a mother, or for that matter even a tribe could maintain. They had an inbuilt need not to have too many people because they lived from hand to mouth. The practices developed in their struggle for survival, their mode of production kept the population balanced. Mies in her Social Origins of the Sexual Division of Labour has pointed out that men could dominate women because of their coercive power. She writes. “In the last analysis we can attribute the asymmetric division of labour between women and men to predatory mode of production, or rather appropriation, which is based on the male monopoly over means of coercion, i.e., arms and on direct violence by means of which permanent relations of exploitation and dominance between the sexes were created and maintained. This non-productive predatory mode of appropriation became the paradigm of all exploitative relations between human beings. Its main mechanism is to transfer autonomous human producers into conditions of production for others or to define them as ‘natural resources’ for others.”

Among the pastoral nomads the rationale of men’s control over women was the need to have many children, for the work and to maintain a numerical strength to conquer other nomadic tribes and agriculturists. Increase of cattle and people was the inbuilt motive force of their economy. In those societies, as soon as these became class structured, the control over production of people, and the

control over women as procreators became institutionalized. Moreover, with the development of private property and the family concept children became important as heirs of accumulated property and thus wives because of their procreative capacity were treated as property. In the feudal agricultural society of Europe in the early Middle ages most people lived off land and produced barely enough for survival. There was a need for producing next generations of farm labourers. The upper class women were mainly seen as producers of heirs to the landed properties. Women were thus valued for their production of offsprings. Birthcontrol was not socially accepted, but abortion and women controlled contraceptive practices were prevalent throughout the middle ages.

With the emergence of merchant capitalism not only class differentiation developed but also the division of labour between men and women was affected. According to Rowbothom as we read in her 'Hidden from History', with the commercialisation of agriculture peasant women withdrew from work in the field and concentrated on work in and around the house. Also the ideology of allowing sexual relationship between married partners only for the purpose of procreation was helpful in enforcing upon women a societal need for large families and a moral prohibition on birthcontrol.

This was about the time when wise women with their knowledge of herbs and their skilful involvement with and control over life and death through midwifery abortion and healing- posed a threat to the emerging order in which men claimed powerful and gainful positions. From the twelfth century onwards a midwives and healers came under heavy attack they were accused of using the power of magic instead of scientific medical knowledge, and were called witches. Under the insane frenzy of 'witch hunting' thousands of wise women were hanged burnt to death. The witch hunt was aimed not only at midwives and healers, but against all women who constituted a threat to male power because of their skills or their independent challenging behaviour., Women were systematically excluded from certain professions such as medicine, law and trade. The image of 'bad woman' became synonymous with that of the poor woman, the widow, the old, the woman without a means of protection. A double standard regarding sexuality was developed; one aspect of the witch hunt being limitation of woman's sexual freedom, which hitherto could be expressed actively. Now women had to be subservient; but at the same time women were used as prostitutes by men claiming their sexual rights.

In the 17th century when puritanism developed, values such as thrift, diligence and discipline were stressed by propertied middle, class the ideal of a stable monogamous family unit reflects the need of the middle class for a small independent base.

But this was the time when the not-propertied class went through a different process. With the commercialisation of agriculture, pauperisation became enormous in the 17th and 18th century. Many peasants were evicted from their lands, because they could not compete with richer ones and could only join the mass of unemployed or unpaid workers in the cities. Almost regularly the poor got involved in revolts, vehement protest movements induced by hunger and despair. This growing mass of poor people was frightening for people who in fact were responsible in making it. They did not know how to handle this mass poverty. The solution seen in either to recognize society in a more equitable manner- i.e., eliminate poverty or to eliminate the poor. The upper class found the explanation of poverty they required in Malthus against the option of changing the social structure in order to share property. Malthus argued poverty cannot be abolished by sharing property, since the poor will inevitably remain poor because they have too many children in comparison to the resources available to them. In his "Essay on the Principle of Population" Malthus developed his Law of Population trying to prove that by the law of economics the poor would remain poor and that their needs would continually 'outnumber' the resources of society. He writes Population, when unchecked, increase in a geometrical ratio, subsistence increases only in an arithmetical ratio."

The Malthusian notion that reform was futile was extrapolated by the upper classes and used as a 'adientifio' justification for maintaining their privileges, in the same way as it is being done now in

the late 20th Century with multidimensional applications to those colonised internally as well as externally- to the inferiors either by socioeconomic, racial or physical standards or discriminated against by sex. Malthus' argument that since the poor can never obtain higher living standards they could only save the next generation from this awful destiny by keeping their number as low as possible, is still the basic underlying principle of all national and international population programs. And therefore with all its potential for providing support to women's self determination to have or have or no to have children, the birth control programs in the third world countries have characterised themselves merely as facilities for avoiding and delaying pregnancies to fit the macrolevel population policy- a way to population limitation which has nothing to do with women's liberation.

The fear of 'unrestrained breeding' by the poor finally bringing the doom to a nation is reflected in the speech of the President of Bangladesh addressing the population control workers in a meeting on June 11, 1985 in Dhaka . The News Papers report that President Lt. General Ershad on Tuesday called for determined and sincere efforts to combat the population explosion which, if goes unabated, would endanger very existence and bring untold miseries. I noticed the same panic in the voice of a doctor involved in the population control activities who said the risks of injectible contraceptives are nothing compared to the possibility of overwhelmingly breeding too many children. This naturally has led to series of hastily planned, disorganised and mis-managed population control programs in Bangladesh.

Bangladesh has assumed the character of a country where, though it is a very fertile land with good agricultural potentials hunger, poverty inequality, landlessness, unemployment and low productivity are mutually re-inforcing. As a result she has become absolutely aid-dependent hardly enjoying any decision making power. The little she has are obviously much to the interest of the upper stratum of the society rather than that of the general mass who live below poverty level forming 80% of the population. And reasons for this dreadful poverty in Bangladesh has been marked to be population explosion and scarcity of resources. But an equitable distribution of the resources has never been given a serious thought.

Desperate attempts to keep the population in size gave birth to intensive birth control campaigns one after the other emphasising IUDs, sterilisation and menstrual regulation. High dose pills, injectibles and other high risk contraceptive devices are poured on women without necessary information regarding their possible side effects. Abortion is encouraged in the name of 'medical termination of pregnancy' or 'menstrual regulation' by the same International organisations who in their own countries dis-allow abortion in the name of Christianity. Sterilisation is openly promoted as the most desirable and effective measure for family planning. Women are appealed through the mass media to actively go for sterilisation which is advertised as the best way to reach the 'ideal' of motherhood, for Bangladesh, which is now with only one child. Women are given Tk.175 plus a saree if sterilised. The agents bringing women to the clinics for sterilisation are given Tk.35 per patient and another Tk.10 or more as conveyance allowance. This system of incentive creates conditions for abuse In sterilisation as the agents try to draw as many people as possible where poor women fall in the trap, willingly or unwillingly, for money and the cloth. It is learnt that often these women do not even get the total amount of money or the saree. It has been observed that women are very much scared of the operation. Most of the time they come because they are ordered by their husbands- many of them, come for the incentive specially when there is no work for the daily labourers, when they are in big need of cash money. Marina Maspero who worked as a volunteer in a family planning program in Bangladesh comments, "Where people cannot afford to for-go monetary gain, and where they have been accustomed to get some sort of comepnasation by programs which couldn't be bothered with such a nebulous issue as education because they have target sheets to fill out quickly, is open coercion essentially very different from the practice of giving incentives?" In-deed there is a difference. Open coercion, at least, calls things by their name. Sterilisation under incentives is only coercion in disguise. The population control department proudly declares that women prefer

sterilisation or for that matter permanent methods of contraception to other methods.

Similar claim is made ***** by a doctor involved in population control work in one of the districts of Bangladesh. He said Depo Provera has become very popular to women. He added women like this injectible very much because its side effects are 'very minor'. Asked about the two very serious complaints of side effect recorded in his own health center, he admitted that he did not go *** to see those women. According to the health visitor of that area about 255 women were given Depo Provera injections out of which 23 changed to another method due to *** inconvenience and the other 20 rejected any family planning device whatsoever.

The above ***** bring out the role of the international organisations intervening into the reproductive behaviour of women. They also make it clear that Bangladesh and other third world countries are no doubt being used by the international organisations as grounds for drug dumping and experimentation of high risk contraceptives. A quotation from Steve Minkin's paper titled 'United States Family Planning Policy and its implications for Bangladesh' read in the conference on the continuing subordination of women at the Institute of Development Studies, Sussex, 1978 will throw some light on Bangladesh's dependent nature in this respect. Minkin writes, "Technically the Bangladesh Government requests for family planning assistance from the United States. In fact the Bangladesh Government has little choice but to accept the US AID formula for reducing fertility. The United States Congress has made it ominously clear that family planning is tied to foreign assistance and particularly food aid. The government's failure to adhere to US AID strategy would seriously compromise its position with the United States."

The following statement of Gono Shasthya Kendra (people's Health Center at Savar, Dhaka) puts family planning activities in Bangladesh in a proper perspective. It says: Despite numerous analysis which show that poverty is a cause of the population explosion, rather than its result, the myth of population control is perpetuated by an interplay between the large donors, who reflect the terror of the industrialized rich at the teeming Third World poor, and local greed, which finds an opportunity to line its pockets when money is thrown about in crash programs. Our experience in this respect has inevitably influenced our thinking and practice of family planning... At the time we were tempted to follow the counsel of despair and wash our hands off sterilisation and family planning in general, as it seemed impossible to provide a service which preserved the interests and dignity of the poor. But in the end the experience served to clarify our position on the issues we believe that it should be one part of a general, permanent, primary health services, where women can be assured of constantly available advice and supplies, and where family planning is a means towards the emancipation of women. An attitude where pregnancies and babies are treated as an epidemic that has to be eradicated once and for all must be resisted."

The other main organisations besides US AID involved in family planning programs in Bangladesh are Family Planning International Assistance(FPIA), International Projects of the Association for Voluntary Sterilisation (IPAVS) , The Pathfinder Fund along with numberless small organizations.

So much for population activities in Bangladesh which can for many reasons be taken as a classic example for what happens in the third world countries in the field of family planning. Now when we turn to ***** in the western countries, we still find women rallying on the streets for right to free abortion and easier contraception policies although within the same societies abortion is recommended for the socio-economically disadvantaged and the migrants. By this statement I don't mean to say that women not falling into the two categories are free to enjoy independent reproductive rights. Rather, that is also subject to the approval of the population control policies, for the time being which encourage large number of offsprings for certain people. The point I want to make here ***** is that with the expansion and commercialization of the new reproductive technologies more and more people will be brought under the control system ultimately resulting in fewer and fewer people having actual control over their own reproductive behaviour. If we look back how in the past two or three generations practice of breast feeding just had to give in to the fashion

of bottle feeding, that new reproductive technologies may take over major responsibilities of procreation eventually, does not sound so baseless. There is very little to doubt that commercialisation of techniques will not *** try their utmost to create market for these by fair or unfair means. Through the Network News of April 1985 of FINNERT we already know that Monash University in Melbourne, Australia is considering a proposal to market IVF technology through several clinics to be set up in the United States. The News rightly comments that with the commercialisation of IVF will come an economic motivation to expand the market for IVF and related services beyond the infertile.

Looking at the insane process *** created consumerism of killer weapons including nuclear ones, we should realise how commercialisation of world's most undesirable products and technologies also get marketed, sold and reproduced in the name of the consumers' interest.

The other two points I would like to raise here are, first, regarding the research of the new technologies, and secondly about the attitude that is to some extent responsible in the initiation of invention of these technologies. To get a baby through new reproductive technologies one has to wait years in suspense before she or he is certain of the positive outcome and it is mainly women who have to let their bodies be subject to experimentation. It is very likely that economically handicapped women will have to volunteer their bodies for the benefit of the richer and similarly the third world women may soon be chosen to work for the western world at cheap rates. I think women here and of the third world should be made aware of this so that at least new way of exploitation is checked. Secondly, the enthusiasm of the commercial producers of these technologies is fanned by the attitude of certain people of not accepting the condition of 'not-having' anything. If it is a question of relationships, are not there different ways to relate oneself other than to one's own children? Does not this obsessive craving to have a child of one's own in many cases stem from individual's sense of private property or to have somebody around over whom one has substantial control for some years at least? I think this attitude needs to be examined and resisted, if exists. Considering the cost and complications involved in the new reproductive technologies it is fair to say that only a few powerful and (privileged people are going to be able to take advantage of those and as in other cases. Here also the powerless will have to bear the major costs for them *** The reason for which I raise these points for discussion is that, I feel unless we develop clear understanding of the driving forces leading to births of these technologies, our analysis of the implications on *** international and national levels will not have the validity it requires. I hope discussions in this meeting will help us to attain that clarity. Thanking you.

Sultana Karaal
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Nepal's Surgical Contraceptive
Program
1985

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NEPAL'S SURGICAL CONTRACEPTIVE PROGRAM

The object of this presentation is to provide an introduction to a training film of appropriate surgical procedures for sterilization. Sterilization is a major reproductive technology which while not new, has currently gained wide use throughout the world as a family planning method. "Voluntary female sterilization is the most widely used contraceptive method of the world. About 95 million women depend on it to control their fertility." This method is especially subject to wide use in developing countries where governmental concern with population control is in the forefront of governmental policy. While the pressure placed on people to use permanent birth control methods raises major ethical issues, this paper will restrict itself to a discussion of a specific training method.

The case provided will be that of Nepal family planning was introduced to Nepal during the late 50's shortly after Nepal opened its doors to outsiders. This mountainous kingdom, the only Hindu country in the world is a meeting place for diverse religions and groups. It is the birthplace of Lord Buddha and provides meeting places for Buddha, Hindus and host of others. However, Nepal's population explosion has reached a point where there is an expressed need for family planning programs. Many types of family planning methods are available, the pill, condoms, Depo Provera, natural family planning, sterilizations and Nori-Plant. The use of some of these forms of family planning have posed several questions whether they are effective and if they are safe for use with a rural population without ready access to clinics and health personnel. Depo-Provera, though not FDA approved for use in the United States has been used in Nepal for a number of years. Nori-plant, a surgical procedure was introduced to Nepal during the past few months. However, the major contraceptives used in Nepal is permanent sterilizations. There are three types of sterilization procedures which are performed throughout Nepal at "voluntary sterilization camps", the minilaparotomy, laparoscopy and vasectomy. The most common procedure performed is the laparoscopy. This procedure involves "inserting a telescope—like instrument into the abdomen, through which, a doctor can see the internal organs and block tubes by electrocoagulation or by applying rings or clips." The laparoscopy is most, often referred to as "tying the tubes." A similar procedure is involved in invitro fertilization where eggs are removed for fertilization in a laboratory. These camps are set up at various sites throughout the country variety of buildings are used for the "camps," most often depending upon what is available and centrally located to accommodate a large number of patients. Some "camps" are capable of handling only a small number of clients, while other "camps" may handle more than a hundred patients daily. The sterilization season takes place during the winter months before the weather becomes hot and the climate for infections increases.

Many of the sterilization camps function out of empty classrooms, healthposts, health clinics, hospitals, village meeting rooms and other buildings which are empty. While many of the buildings used for the sterilizations are maintained under the most optimum hygienic conditions. Some facilities used as buildings for performing the sterilization procedures are inadequate and often lacking in the most basic hygienic conditions. In some instances, personnel working at these "camps" have not been properly trained in maintaining the most basic sanitary conditions or in handling pre-operative and post operative patients. Therefore, in the authors view, it has become a priority to provide refresher training for health personnel in areas such as logistics of running a sterilization "camp," understanding techniques involved in laparoscopy mini-lap and vasectomy procedures, maintaining minimum basic sanitary and hygienic standards for the "camps", developing counseling skills and providing necessary post operative follow-up.

This film which is shown to you today is not an endorsement for sterilizations, but instead an effort to provide basic refresher training for medical officers and senior public health personnel involved in the sterilization "camps." In a country where sterilizations are the main form of contraception used by a population, it is necessary to continue to provide up

to date refresher training.

Therefore, this film is by no means an attempt to train medical officers and other senior public health personnel to conduct sterilization procedures, but is an attempt to provide additional training to senior Nepalese doctors who have been involved in the sterilization "camps" for years. Training films are considered to be highly effective for Nepal because of the current interest in video films. In some of the most remote parts of the country, where there may be no electricity video films are shown for a fee in private settings and run by privately owned generators. Most video films of any nature are watched by a large number of Nepalese. Training manuals developed for refresher training seminars most often do not enjoy maximum usage, following the closing of a seminar and are sometimes merely stored away. Therefore, it seems that an effort to improve conditions at sterilization "camps" would be most effective if video films are used and if these video films provide relevance to the consumers. Furthermore, if video films use local Nepalese as demonstrators the likelihood of the film's use being continued and reaching a large expanded audience would be higher before and after training seminars. With video films, there is greater interest and a tendency to watch the same video film several times. Therefore, since sterilizations are the major form of contraceptive practice in use in Nepal, emphasis must be placed on upgrading the training of health personnel working in the sterilization "camps". This film, Nepal's Voluntary Surgical Contraceptive Program: A Training Program For Medical Officers and Senior Public Health Personnel explains how sterilizations should be and not how the "camps" are. The film also goes through each of the three procedures performed throughout the world and in Nepal. For medical officers performing these techniques, being able to watch experienced Nepalese perform these operations while explaining the techniques should provide an opportunity to raise questions and also examine their own procedures before going to another camp season to perform the procedures.

The safest and quickest sterilization performed world wide is the vasectomy and will be seen as three males undergo the procedures and then return to work following the operation. The Minilaparotomy and laparoscopy procedures developed since 1960 have sterilizations quick and safe for women in most countries, however, in some developing countries these procedures are not performed under the most hygienic conditions. This film will go through these procedures showing exactly what the procedures consist of and the conditions under which each should be performed.

Sterilizations continue to be used as the main contraceptive method for many diverse countries such as the United States, Brazil, South Korea and Sri Lanka. We must continue to monitor the conditions under which these procedures are performed and provide education to improve conditions in some countries such as Nepal.

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Women's Emergency Conference on the New Reproductive Technologies, Vallinge, Sweden, July 3-8, 1985

by Gena Corea and Susan Inee

Report #1: "Success" Rates

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Whenever one criticizes in vitro fertilization, one can be sure that listeners will at one point protest: "But women want this!"

There is much to be said in response to that assertion but here, we want simply to note that most women do not know what "this" is. And they do not know because they are being deceived.

This is the conclusion we came to after conducting a survey of the 108 in vitro fertilization (IVF) clinics in the United States in February and March, 1985. We had decided to conduct the survey because so little basic information was available on what was actually going on at these clinics. No medical organization appeared to be gathering such information though it was vital to do so if there was to be any assessment of IVF in the United States and any accountability of these clinics to the women they professed to serve. We particularly wanted to know how many IVF babies have been born at each clinic because we suspected that a few clinics were having most of the babies, many were having none or only a few, and that women going to these latter clinics are under the impression that they have that widely-quoted 20% chance of getting an IVF baby.

This suspicion arose when one of us (Corea) was researching her book on the new reproductive technologies, The Mother Machine. She visited a newly opened IVF clinic in June 1983 and sat with a young woman going through the program as she got one of her many hormone shots and, days later, waited in the hall for one of her many ultrasound examinations. The woman, whom we'll call "Julie", explained to Corea that she had about a 20% chance of success.

Her statement shocked Corea because, in fact, her chances were much closer to zero. While the most established and successful IVF clinics in the world were reporting success rates of 20% (and that rate is only as high as 20% because of the tricky way clinics tend to define what constitutes "success"), a brand new clinic with no experience could not reasonably claim to have the same rate. If its experience was anything like that of other clinics, it would produce no IVF babies in its first year. (In fact that clinic has just now—in June 1985, exactly two years after Corea sat around in hospital halls with Julie—announced its first expected IVF birth. One woman in its program is three-months pregnant.)

The last time Corea talked with Julie, she had had two failed IVF attempts. Because of the devastating impact the two failed attempts had had on her emotionally, and because of their great expense, she had decided to drop out of the program for an indefinite time before deciding whether to go on for a third try.

Some time after those conversations with Julie, we decided to do the survey of IVF clinics for the Medical Tribune, a nation-wide publication which goes out to approximately 170,000 physicians, and in other editions, reaches hospitals and medical schools.

Half (54) of the nation's 108 IVF clinics responded to our mail questionnaire. Each was operational and collecting fees ranging from 1,375 to \$7,000 and averaging \$4,084.

For those enrolled in an IVF program, the bottom line is how often the clinic allows a woman to carry home a living baby. But our survey revealed a tendency on the part of clinics to inflate

success rates when talking with news reporters, patients and their own colleagues.

Of the 54 clinics responding to our questionnaire, half have never sent a woman home with a baby. These zero success clinics have been in business from one month to three years and have treated more than 600 women. To repeat, half the clinics had never produced an IVF child. And the clinics responding to our questionnaire are probably those with the better records, as Dr. James Holman, former head of the IVF program at Duke University in North Carolina, speculated in an interview with us. He had heard that various clinics, discouraged by the difficulty of IVF and their lack of success at it, had closed down.

“The thing about a survey like yours,” he told us, “is that the people who have closed down are less likely to respond.”

The clinics which did respond—and they may be, as Holman speculates, the better ones in the country—reported a total of 241 births, with an average of 4.5 births per clinic. Of the 26 clinics with babies, 20 had five or fewer. Standards of “success” are so low, that if one listed the top five clinics in the U.S. in terms of live births, a clinic like the Mt. Sinai Medical Center LIFE Program in Cleveland, Ohio would make the list—with a grand total of nine IVF babies!

The undisputed leader in IVF deliveries is Eastern Virginia Medical School, where Drs. Howard and Georgianna Jones also obtained the first IVF pregnancy in the U.S. three years ago. They now have 100 babies delivered to 89 mothers. As noted, only a handful of other clinics reported achieving more than five births in their clinics’ histories.

The questionnaire allowed clinic directors to enter their success rate and how it is calculated. Most chose “percentage of pregnancies per laparoscopy” as the measure of success. (Laparoscopy is the operation during which eggs are removed or “captured” from the woman’s ovaries while she is under general anesthesia.) Others chose “percentage of pregnancies per embryo transfer” as their definition of success. Dr. Ian Thorneycroft of the Tulane University Medical Center Fertility Clinic in New Orleans told us: “I think the reason people use ‘pregnancies per embryo transfer’ rather than ‘pregnancies per laparoscopy’ is that it [the success rate] is usually higher [with the former].”

One of the success definitions we included in our questionnaire was one we made up “percentage of live births per laparoscopy.” We had never seen a clinic use this success criterion but we included it because it seemed like the most logical one to us. Responding to our survey, Dr. James Holman, former head of the IVF program at Duke University in North Carolina, wrote us that this was actually the most important criterion of success but no clinics use it. We telephoned him and asked him why not.

He explained: “Realistically, when you first get started, it [IVF] is very difficult. Many clinics go for 20, 30 and more attempts before they even have a pregnancy of any sort. In fact the Jones [who established the first IVF clinic in the U.S.] went for over 60 attempts before they had their first pregnancy. Any kind of positive feedback—you get for yourself, for the morale of the team, and also positive feedback for patients who are interested in it, is a big plus. So when you first start getting pregnancies of any sort, that’s what you report.”

So the success rate, which appears to be giving women a deceptively positive picture of their chance of having an IVF baby, is serving the purpose of keeping up the spirits of physicians who are, by and large, failing at IVF. These deceptive success rates, we can assume, help keep women in there paying large sums of money while their bodies are experimented upon. They also help keep women in programs which many experience as emotional torture. One IVF “patient” told a researcher: “What makes IVF so dreadful is that you’re living in your own private emotional hell for four weeks... It makes you focus on that part of your life which makes you unhappy. I can only just cope day to day.” (Burton, 1985.)

Using the pregnancies/laparoscopy index, clinics with no births claimed success rates ranging from 0-25%. For example, the Medical College of Virginia in Richmond has produced no IVF babies but, according to its calculation, has a success rate of 18.2%. The Fertility Medical Group of the Valley in Tarzana, California has no IVF babies but its success is 22%. The IVF Program at the University of Texas Southwestern Medical School in Dallas—again, no babies. Its success? 25% Clearly, some of these clinics had women with ongoing pregnancies, which were included. But, from the questionnaires, and in interviews with a dozen clinic heads, it became clear the clinics use a

variety of success enhancing methods to look better to the public and the profession.

First, as we have seen, they define “success” so loosely that clinics which are failing to produce IVF babies can still claim absurdly high levels of success. Then, clinics “massage” the data, as one clinic head termed the practice. This means that in reporting their data, various clinics will drop out of their statistics factors which, if retained, would lower their success rate, and they include in their statistics items which, if eliminated, would also lower their success rate. So—and I’ll explain these more fully later—they do count: chemical pregnancies, tubal pregnancies and spontaneous abortions (though none will yield a live child) and screening or diagnostic laparoscopies if they happen to yield a pregnancy. They do not count: female patients who are eliminated from the program before the laparoscopy stage; screening or diagnostic laparoscopies that do not yield a pregnancy; and laparoscopies that do not result in an embryo transfer.

Dr. Alan DeCherney of Yale University where 17 women have given birth to IVF babies told us in an interview: “It’s too easy to fudge results. People can say they have a 50% success rate and there’s no way to check that.”

The misleading figures have reached a point where one IVF director, Dr. Michael Soules, of the University of Washington IVF Program in Seattle, pleaded with his colleagues, “Let’s all be honest with each other” in a recent editorial in the major professional journal, Fertility and Sterility (43:511-513, 1985). He refused to let enthusiastic reporters take the rap for inflated newspaper accounts, writing, “The origin of these inflated pregnancy rates has usually been IVF practitioners—not lay writers.”

From the survey data analysis and candid interviews with clinic directors, who were eager to blow the whistle on illusions of success at other clinics while defending their own arithmetic, it became clear that the numbers can be skewed at each step through the complex IVF process.

The first trick to success enhancement is actually not a trick. It consists of selecting the right women as patients. Those clinics with waiting lists full of possible IVF candidates can be selective. Most have an upper age limit, and some indicated that they ration patients by diagnosis. Clinics loaded with young women with unexplained infertility of short duration will have better success rates than clinics with older women patients whose infertility has not been cured after years of various treatments. Explained Dr. M. Yusoff Dawood of the University of Illinois IVF Clinic in Chicago: “If I select my patients highly, then my success rates are going to be better than yours.” The old maxim holds, he said: “The slimmer the indication, the better the success rate.”

According to our survey, clinics which don’t turn away problematic cases frequently discard them from success reporting. Many report pregnancy rates based on a subset of patients for whom they have the best results, say, all those with tubal infertility under age 35 who have previously shown a good response to Pergonal, the drug used to stimulate the maturation of eggs.

Or, as Dr. Edward L. Marut, director of the IVF program at Michael Reese Hospital in Chicago, explained to us: “A lot of people will subset their statistics to talk about their current success rate as opposed to their overall success rate. While that may be fair in certain circumstances—the past year, for example—in very many cases that’s twisted to report from the last month, or two months, quoting an exorbitant success rate. They may be talking about three out of 10—a 30% success—when if they went back over a year it’s really -four out of 50 [8% success].”

At every step through the process, some clinics rationalize removing patients without pregnancies from their statistics. Obviously, a pregnancies/laparoscopy figure doesn’t count cycles which never make it to laparoscopy. “Drop cycles” which most commonly occur because hormonal therapy has not induced an adequate number of follicles to mature, range from less than 10% to around a third of all cycles at some clinics.

Because of the drop rate, Dr. Sander Shapiro of the University of Wisconsin IVF Clinic in Madison suggested that, “Perhaps the fairest definition is the one the Australians are using—that is, pregnancies per induced cycle. I don’t have exact data for our own clinic, but I’m guessing that at least a third of our cycles don’t go on to laparoscopy.”

Some cycles are not “dropped” until a woman is on the operating table, the laparoscopy is inserted, and her ovaries then found to be inaccessible. Dr. J. Clark Bundren, of the University of Tulsa’s Hillcrest Infertility Center, doesn’t tally laparoscopies in which eggs are not recovered. He

told us: “A lot of times we’re doing a screening laparoscopy, where we’re looking to see if the ovaries are available. And we’ll pre-stimulate those patients [i.e., super—ovulate them, inject them with hormones in an attempt to make eggs ripen in the ovary], and if the ovaries are available we’ll proceed with egg retrieval. If not, we’ll pass on the cycle. And I am not counting those patients.”

“That’s not fair,” commented Dr. Marut of Michael Reese Hospital, who was speaking of such a practice in general. “That’s not a true screening laparoscopy. We think the chances of obtaining an egg are so good that we go ahead and stimulate [i.e., super—ovulate the women]. We do the laparoscopy and, if the ovaries are not accessible, then they’re not accessible, and that still counts as a laparoscopy where no eggs are obtained. That’s pretty sneaky to say, retrospectively, ‘That was a screening laparoscopy.’”

Other clinics, although claiming their definition of success is by laparoscopy, don’t count a lap unless fertilization was successful. Dr. Marut told us: “What I notice is a lot of programs will eliminate a lot of laparoscopies that did not go on to embryo transfer, so they don’t count the patients where either no eggs are obtained or eggs don’t get fertilized or develop to embryos.”

In the extreme, clinics only counted a laparoscopy if there had been transfer of more than one embryo.

Once embryos are transferred back, all clinics count that cycle’s laparoscopy in their success calculations. At that point, pregnancy becomes the shifty definition. Doctors do not agree on what a pregnancy actually is. There are “chemical pregnancies” which are simply slight elevations in the level of hormones produced during pregnancy (HCG). They are, by definition, abortions. That is, they will not lead to a live births. And there are “clinical pregnancies”, pregnancies which are firmly established as judged by such criterion as ultrasound and fetal heart tones. Clinical pregnancies are more apt to lead to live births, though they are not guaranteed to. The miscarriage or spontaneous abortion rate with IVF is high.

In interviews with us, definitions of pregnancy differed greatly. For Yale’s Dr. DeCherney, “It has to be a clinical pregnancy confirmed by ultrasound and fetal heart tone.”

Others aren’t so picky, counting one or two elevated HCG levels as a successful “chemical pregnancy”, even if there were no objective signs of pregnancy, not even delayed menses. “They’re just little elevations of HCG that wither away,” said Dr. James Holman, former head of the IVF program at Duke University. And one group, reported Dr. Soule, “even counts prolonged luteal phases [of the woman’s cycle] without rising HCG titers.”

Responding to internal pressure, “The Code of the West [the rule] now is that you don’t report chemical pregnancies,” Dr. Holman told us. “But I think you have to be very careful. If you have a new program that’s done 50—60 attempts and the only thing they’ve got is a couple of chemical pregnancies, it’s very easy for them to say, ‘We’ve had two pregnancies,’ and not be too specific. It’s not that they’re deceiving anyone but it’s really not exactly the same thing.”

One clinic director who disparaged the reporting of chemical pregnancies as a success, described his clinic’s 8% pregnancy rate as “an overall, honest-to—god, per laparoscopy” calculation. However, when we asked him if these were all ongoing pregnancies, the answer was different. “No, all pregnancies [are included]. There’s one in there that’s a pre-clinical abortion—strictly speaking a chemical pregnancy, because she aborted before she could have an ultrasound. And one was a tubal pregnancy. So six out of eight are [on-going] pregnancies.”

Another claimed: “We don’t mess around with those [chemical pregnancies],” but admitted that of the 14 pregnancies on his questionnaire, four were “early miscarriages.” Preclinical abortion and early miscarriage are frequently used as synonyms for a chemical pregnancy and ectopic pregnancies are deemed as successful as those in utero, though no live baby will result. (Furthermore, if the woman loses a fallopian tube to the ectopic, she is apt to be more infertile than when she entered the IVF program.)

Dr. Holman suggested that a more reasonable definition might be that of Dr. Alan Trounson’s group in Melbourne, that defines “clinical pregnancies as those in which there was tissue obtained—either at D & C or the patient passed tissue. Or there was pregnancy on ultrasound. I think those are more solid criteria of a truly established pregnancy.”

Though they don’t agree on what constitutes a pregnancy, clinic directors all admitted that

there are a significant number of pregnancy “successes” that never become deliveries. Spontaneous abortion rates are elevated even during induced cycles and in vivo (i.e., “natural”) fertilization. Tulsa’s lab director Dr. J.W. Edward Wortham Jr. frequently consults with new clinics about their techniques. He told us that his clinic’s spontaneous abortion rate is about 25% and he is aware of some where over 50% of pregnancies abort. Explaining how this can mislead, he cited a recent article which presented impressive success data using a portable laboratory. “Granted, they had a few pregnancies,” he said, “but about 42% of those aborted.”

Should clinics tell referring physicians and patients the chance of getting a live baby? Doctors aren’t so sure. “The only problem with that is that you can have a clinical pregnancy, a real pregnancy, that aborts,” said Yale’s Dr. DeCherney. “For the patient, I agree that’s meaningless. In fact that’s traumatic. But for understanding what we’re doing, that’s important.”

To explain why, he posits a group that has a 10% pregnancy and a 1% abortion rate and another group that has a 20% pregnancy and a 50% abortion rate.

“Now the total number of babies are going to be roughly the same, but it means a heck of a lot about those centers. It tells you a lot in evaluating what they do. I’m not saying that one is better than the other, but there’s a qualitative statement in those numbers.”

As to patient counseling, one IVF counselor explained to us that “people are so up and so high when they start the program that they don’t hear about the failures and the fact that the chances [of bearing a baby] are very slim.”

Her explanations to the women are simple. Perhaps deceptively so.

“I say to the patients, ‘For every 100 people that come in the room, at least 85 go home without a baby, even after doing everything right.’”

This implies a live birth rate of approximately 85%, yet her clinic’s questionnaire reported less than a 3% live birth rate. (The pregnancy rate was 7.5%, including chemical pregnancies.) Asked how she came up with the 15% figure, she said “Taking an average of 15%. But I think it’s 10-20% worldwide.”

Citing a “general” success rate, borrowed from the best clinics in the world, is “very common,” said Dr. Marut. “For success rates, you always have to look to Australia. Here they have a program which is certainly most successful, and they have an honest 10% success rate and they’re not afraid to tell it, which I find very refreshing.”

Dr. Moon H. Kim, director of the IVF program at Ohio State University Medical Center, also believes that citing a “general” success rate to women is common, with patients not being told everything about the record of the actual clinic in question.

He told us: “If patients were told, ‘We have been doing this business for two years and as of today, we have not gotten any pregnancies,’ it’s hard to believe that any sane-minded patient would go there to subject herself to such an expensive procedure. So the fact that they are going through indicates that something is not told to them.”

Misreporting seems to be a particularly free-market problem, according to Dr. Soules, who sees competition as the root. “The widespread practice of exaggerating the IVF pregnancy rate appears to be a marketing ploy to lure prospective infertile couples into becoming active IVF patients.”

A total failure to produce IVF babies does not keep an IVF clinic from staying open and financially viable and, although many clinic directors suggested it, no professional governing board or repository for standardized reporting exists.

The IVF industry owes it to women to give them realistic success rates before starting them on the “incredible” emotional roller coaster of IVF, Dr. Holman told us. He said: “They start off with extremely high hopes because they’ve seen the Time and Newsweek stories showing the babies. I think the IVF business has gone through an evolution of initially being something that was very remote and futuristic and was done somewhere else, to becoming a methodology that was a reality and was available to people here and now. There was a resultant euphoria. There has been a lot of publicity showing the offspring. I think we’ve got to reintroduce a different type of realism and that is: How many people really walk away with babies.”

Report #2: Who are the women going to IVF clinics in the United States?

Who are the women going to IVF clinics in the United States in 1985? Overwhelmingly, according to the IVF clinics responding to our survey, they are white, middle to upper middle class, and well-educated. Only 15 clinic chiefs described their patient population as varied or as reflecting the local population. The University of Illinois IVF Clinic reported the most varied patients—"mixed population, includes Black, White, Hispanic, and Asian couples". This looked impressive until we noticed how many women had been treated in the programs: Four! The only clinic director who stressed that persons of all income levels were accepted, clarified in his interview that even the patients he classified as "low income" had the funds to put cash on the line for the IVF procedures. Forty-eight clinics stated that they reject IVF candidates without money to cover the procedures. Baylor College of Medicine in Houston added: "No exceptions made—everyone pays up front."

Overwhelmingly, the women in IVF programs are married. Forty-two of the 54 clinics will only accept married couples.

No clinic disqualified women from the program if they already had children.

Thirty-nine have an upper age limit for acceptance, usually setting 40 as the cut-off age.

It is not only women with tubal disease who are patients in these clinics. Medical indications for IVF have expanded far beyond tubal disease—the condition for which IVF was first touted. In fact, 96% of clinics surveyed accept couples with male factor infertility (including oligospermia, low quantity and poor quality sperm). The theory is that a man with a low sperm count has a greater chance of engendering a child if his sperm, after having been specially prepared, is spared the difficult journey through the woman's reproductive tract and placed directly in a laboratory dish with an egg. As reported at a recent ob/gyn symposium at Baylor College of Medicine in Texas: "The semen preparation method selects the more motile fraction of sperm, removing less functional spermatozoa that may block ova penetration. The in-vitro technique also bypasses the possibly hostile environment of the female tract. Fertilization is possible with as few as 10,000 sperm per ova." ("In-Vitro Fertilization Often Effective in Oligoasthenospermia." *Ob/Gyn News*. June 1, 1985. 20(11).) The IVF procedure is the same as that performed when a woman has blocked tubes—except that the woman undergoing the hormonal ovulation induction, general anesthesia, laparoscopy, and embryo transfer, has no medical problem. No clinic directors responding to our survey indicated any hesitation about multiple invasive procedures being performed on a woman in order that the husband be granted a slight chance to engender his biological child.

Current medical indications for IVF, and the percentage of surveyed IVF clinics which consider them appropriate, are: tubal disease (100%); low sperm production (96%); intractable endometriosis and infertility of unknown origin (93% each); hostile (sic) cervical mucus (81%); sperm antibody problems (74%); and control of sex-linked disease (26%).

Asked if they saw the indications for IVF expanding still further in the future, 29 clinics responded "yes". Many of the responses were extremely succinct, yet when we read those responses, we certainly wanted to know more. Some examples:

The Medical University of South Carolina in Charleston on the question of whether indications for IVF would grow: "Yes. Genetic engineering." (The director of this clinic was unwilling to expand on his responses in an interview.)

The IVF Program at the Jewish Hospital of Cincinnati: "Yes. Elective timing of conception and pregnancy with frozen embryos,"

Indiana University IVF Program in Indianapolis: "Banking of frozen embryos for future pregnancy (delaying family)."

Medical College of Georgia: "Yes. Control of sex-linked disease. Ovarian failure with donor egg. DES exposure."

The University of Colorado Health Sciences Center in Denver: "Genetic diseases, donor eggs."

The West Houston Fertility Center: "Yes. Surrogate eggs and sperm. GIFT program." GIFT (Gamete Intrafallopian Transfer) is a procedure being developed by the University of Texas Health Science Center primarily for use in couples with unexplained or severe male factor infertility. It works this way: The woman is superovulated with hormones. A semen sample from the male

partner is specially prepared (centrifuged). A laparoscopy is performed on the woman under general anesthesia to get eggs. The prepared semen specimens and the eggs are loaded separately into a catheter which is threaded through the aspiration needle which had been used to get eggs out of the ovary. The needle is positioned at the fimbriated or fringed end of the fallopian tube. Then the catheter tip is inserted into the tube and the eggs and sperm injected. Fertilization is expected to occur in the tube. As of last February, one twin pregnancy had been achieved. I have not seen reports of an actual GIFT birth.

The Fertility Institute of New Orleans did not think IVF indications would expand. It added: "But embryo transfer to host mother will increase for women with recurrent abortion due to uterine disease (DES, Fibroid) or with health problems such as heart disease."

From the information on the questionnaires, it appears that a few clinics envision a more routine freezing of embryos for "family planning" purposes—that is, so decisions can be made about the exact time at which an embryo would be thawed out and transferred into a woman to begin a pregnancy. (This assumes, of course, that frozen embryos will yield live babies with some consistency, an assumption which is not at all valid now.) Some clinics also envision use of IVF with sex predetermination, with the eggs of women other than the IVF candidates themselves, and with donor sperm.

Some other findings of the survey were:

Almost half (26 of 54) of the IVF clinics in the United States are private. Thirty-four have academic affiliations.

Twenty-three of the 26 clinics which had had IVF births responded to our query on their cesarean section rate. The rates ranged from 0% to 100% and averaged 44%.

Ten of the 26 clinics which had IVF babies reported multiple births. Together, they reported 23 sets of twins and four sets of triplets.

How many times will clinics put a woman through the process of superovulation, laparoscopy and embryo transfer before giving up? Most clinics do not set a firm limit on the number of treatment cycles, citing individual criteria such as "patient's choice," "as many as she can emotionally handle," and "dependent on the reason for failed conception." Those which did anticipate a limit usually thought from 3-5 cycles would be tried before giving up.

Other additions or variations on IVF being considered by clinics are embryo flushing and transfer, the GIFT procedure, ultrasound-directed egg retrieval (TUDOR), and better techniques of ovulation induction, embryo culture and embryo transfer. The Fertility Institute of New Orleans plans to do research in 1985—86 on the direct injection of a single sperm into the egg. The IVF—ET Clinic of Childrens Hospital in Buffalo is engaged now in that same research. The Columbia Hospital for Women Medical Center in Washington, D.C. wrote on its questionnaire: "We are looking into the possibility of using host [surrogate] mothers to incubate embryos of couples with no or damaged uterus."

Some clinics chose not to mention the research in which they are engaged. Norfolk responded: "Announcement through scientific channels." William Beaumont (Hospital) IVF Program in Royal Oak, Michigan, noted: "Many other approaches—but only to be discussed when data available." Baylor College of Medicine in Houston stated: "Since we are a research oriented institution, new things are being developed in the lab monthly—of course those things have not been experimented

with completely.”

Fees for IVF range, per cycle, from \$1,375 to \$7,000 and average \$4,084. Most (81%) are billing third party payers such as insurance companies for at least a portion of the costs. One clinic director told us that legal action against insurance companies, brought by a local support group for infertile couples, had been instrumental in increasing reimbursement in his area.

We asked the clinics if they regarded their IVF programs as services for fees, as research or as a combination of both. Most directors replied that their programs were services or service combined with research. Only one replied that its IVF program was a research project with doctors not receiving money from patient fees (although fees were collected from women for lab and hospital costs.) The Medical College of Virginia in Richmond, which sees its IVF program as a combination of service and research, stated: “It is not good enough to be only a ‘service.’” Genetic Consultants of Bethesda, Maryland, which regards its IVF program purely as a “service”, has not had one pregnancy—let alone an IVF birth—since it opened in May 1983.

As to the future impact of IVF technology, the Medical College of South Carolina in Charleston, responded: “The technique is only the first step on the eventual control of the reproduction of the human race.” Again, the director of this clinic did not agree to an interview.

The California Institute for In Vitro Fertilization, Inc. of Los Angeles replied: “1. When perfected, fewer surgical procedures [i.e., tubal reconstructive surgery] 2. Hopefully, SEX SELECTION instead of abortion for sex selection 3. No EUGENIC, ETHNIC or DEMOGRAPHIC problems are foreseen.”

Eastowne Ob/Gyn and Infertility in Chapel Hill, N.C. replied that it thinks IVF will soon be a common office procedure.

Asked if any important item had not been addressed in the survey, one clinic responded: “‘Burn-out’ of IVF team members after string of failed attempts.” Significantly, no one suggested that the effect of failed attempts on the women in the program was an issue needing to be addressed.

Report # 3: Ultrasound-directed oocyte recovery

We interviewed Dr. Mark R. Grier, director of Genetic Consultants in Bethesda, Maryland and a respondent in our survey of IVF clinics in the United States. Genetic Consultants is a medical practice which started out doing prenatal genetics in 1980—amniocentesis, alpha—fetoprotein testing, genetic counselling, ultrasound—and then expanded into infertility services, including IVF.

There are two hot things currently happening in IVF research, Dr. Geier told us. One is egg freezing and the other is the subject of this report: the recovery of eggs with ultrasound guidance, often referred to by the acronym TUDOR.

Right now, the way eggs are “recovered” or “captured” from women’s bodies is through laparoscopy, an operation requiring general anesthesia. Here is what happens .during the operation: The physician pumps carbon dioxide into the anesthetized woman to distend her abdomen and provide room for him to view and work on the internal organs. He tilts her head down 20 degrees so the intestines fall back by gravity. He makes three small incisions in the abdominal wall to allow the insertion of instruments among which is the laparoscope, a slender optical device. The laparoscope contains a bundle of quartz fibers able to transmit light in irregular paths and produce images by means of lenses and mirrors. Light is passed from one end of the device to the other inside the woman’s body. So the physician inserts the laparoscope just below the navel, then a hollow needle for capturing the eggs and, just below that, the holding forceps, which will search for and hold the ovaries. With a hollow needle, the physician pierces the follicle, the small cyst-like structure in which the egg matures, while at the same time using a foot-operated vacuum pump to suck out the eggs. (Corea, 1985, p. 111, p. 176)

So the laparoscopy requires that the woman be under general anesthesia. Seeking an easier method of egg capture, investigators in Europe—two groups in Sweden, one in Denmark, and one in Vienna—began experimenting with the use of trans-vaginal ultrasound-directed oocyte recovery (TUDOR). From first reports, it sounded as though TUDOR, which could be done under only local anesthesia, was a much simpler procedure than laparoscopy, cheaper, and less traumatic for the woman. But that was only at first.

In our survey, we found that most of the clinics—33 of 54—obtain eggs solely through

laparoscopy. Of these, five indicate they would also use TUDOR in the near future. Twenty-one clinics use both laparoscopy and TUDOR.

I'll let Dr. Geier explain how the TUDOR procedure is done. He begins by noting one of the difficulties of the procedure for the physician:

"The problem with the ultrasound is that there is no way to grab the ovary. So you stick your needle through the bladder."

He backtracks and explains the procedure from the beginning:

"The way in which it's done is you monitor the development of the follicles with ultrasound. Then you have two hours before ovulation. [The eggs must be captured before ovulation occurs.] You empty the bladder with a foley catheter. Refill it with sterile saline. Then we use a biopsy probe to guide. This is attached to the ultrasound machine that allows a needle to be introduced at a set angle so that we can follow it on the screen. We use a needle that lights up on the ultrasound. The tip lights up. Then we just go to the follicle. The problem is that sometimes the ovary moves when you try to press against it. When we do laparoscopy, the ovary also moves but we're able to use instruments to hold onto the ovary. But so far there are no instruments you can use in ultrasound other than the needle."

All this manipulation is painful or, as one of the respondents in our survey preferred to term it, "uncomfortable." We had assumed TUDOR was being performed under local anesthesia because this had been touted as its main advantage over laparoscopy but one clinic director told us he used general anesthesia because of the pain the procedure caused. Local anesthesia, he explained to us, does not totally eliminate the pain, because there are some layers of the body one can not numb.

Asked about the pain, Dr. Grier replied: "Yen, there is some. When you touch the ovary, there's a sort of cramping sensation. We've been trying out various medications to see what can be done."

For doctors, one of the other problems with TUDOR is that they get far fewer eggs with this procedure than with laparoscopy—about half as many.

But Grier, who has succeeded in capturing eggs with TUDOR on two out of five attempts, thinks that if it could be worked out so that eggs could be retrieved more consistently, TUDOR would be very promising. Why? He gave these three reasons:

- 1) It lowers the cost of IVF. One does not have to pay for the anesthesiologist and the operating room.
- 2) It lowers the risk. There is not much risk with laparoscopy, he said, but there is always some.
- 3) One might get better eggs with this procedure. He explained: "In theory the eggs might be better because when you do laparoscopy, you have to fill the abdomen with carbon dioxide. That changes the Ph. So everybody's using tissue culture media in which the Ph is regulated by carbon dioxide in the abdomen. If you do it [collect eggs] by ultrasound, there's no carbon dioxide in the abdomen."

Another clinic director we interviewed had a positive attitude toward TUDOR, telling us that its use was growing in leaps and bounds. His clinic, he said, was using general anesthesia with the procedure.

"Women are not willing to accept the pain here," he told us.

Referring to the experience of IVF groups in England and Denmark, he continued: "The thing that bothers me is watching it in other places, women were willing to accept pain. They line up at 5-6 in the morning, know that they will get a sedative, and be very uncomfortable for a while. Here women are not willing to accept short-term pain. They'll get used to it. Here the pain threshold is not quite as good."

Some aspect of the procedure do concern him. At least 20% of the women undergoing TUDOR really have pain. (He did not tell us how he was able to distinguish these women from others.) The vast majority he said have hematuria (blood in the urine) lasting 14-16 hours. A couple

have had bleeding episodes requiring blood transfusions and that bothers him.

The Mt. Sinai Hospital Medical Center LIFE program in Cleveland has done about a dozen TUDOR procedures and gotten eggs in 60-70% of the cases, though the number of eggs were fewer than is typical for laparoscopic retrieval. No pregnancies have resulted from eggs obtained by TUDOR.

“The ultrasound can take a long time,” clinic director Dr. Goldfarb told us, “because you’re working with shadows.”

(When the procedure is done under local anesthesia, all the time the physician is “working with shadows,” inserting biopsy probes and needles in and out of the woman’s bladder and ovary, the woman lies there in pain.)

“Before, we were quite optimistic that ultrasound might be the wave of the future,” Goldfarb said, “but I have reservations about it now.”

He does not think the procedure can be done under local anesthesia and if it can not, it loses its advantage over laparoscopy.

“The problem is that it is uncomfortable, so that you have to put them [women] to sleep anyway, so to do the laparoscopy isn’t that much bigger a deal than the other [TUDOR]. It’s faster to do the laparoscopy, plus you get more eggs.”

The Hillcrest Infertility Center at the University of Oklahoma in Tulsa decided not to use TUDOR.

Clinic director Dr. J.C. Bundren told us: “It’s a lengthy procedure. It involves poking holes in the bladder and all kinds of things. It sounds good, but I think in practice, it’s not as good.”

Bundren said, however, that he would like to go to Sweden and see what the techniques of the physicians using TUDOR are. In their own system of egg recovery through laparoscopy, he said, “we use a very large bore needle to aspirate the follicles, much larger than you could use under ultrasound direction. From an engineering and hydrodynamic point of view, this probably does less damage to the eggs than a small bore needle under those pressures.”

Explaining that his clinic was not interested in the new TUDOR procedure, he told us: “Instead of jumping into new things, we just try to take it one step at a time. Develop an in vitro program that works well, tune up your lab systems, move out one step at a time with slow, steady progress.”

Report #4: IVF Clinics’ Use of Donor Eggs, Donor Sperm, Frozen Embryos, Divided Embryos

There are a number of variations possible with IVF. Rather than fertilize the eggs of the IVF candidate herself, the eggs of a donor woman could be fertilized. Donor sperm could also be used. Embryos could be frozen before being transferred into the woman. In the future, embryos could be divided, a practice which would facilitate embryo evaluation and sex predetermination. This report concerns these variations on IVF and the extent to which IVF clinics in the U.S. make use of them.

Our survey found that:

SPERM DONATION. Twenty-two of the 54 clinics have used sperm donation with IVF.

EGG DONATION. Only two clinics have used donor eggs. They are Norfolk in Virginia and Kansas University Gynecological and Obstetrical Foundation in Kansas City. Nineteen clinics stated that they have no plans to use donor eggs in the future, citing primarily ethical considerations and community attitudes hostile to the use of donor eggs.

Other clinics are either undecided or are seriously considering using donor eggs in the future. “We plan to achieve viable program first,” commented the University of Minnesota’s clinic. “It’s the only way for some patients to achieve pregnancy,” stated the Mt. Sinai Medical Center LIFE

program in Cleveland.

Twelve clinics responded to our question on how egg donors would be recruited, though one simply noted that that method had not yet been determined. Five stated that the egg donors would be volunteers who were undergoing sterilization or diagnostic laparoscopy. Five others stated that the donors must be recruited by the patient herself (“Friends or relatives of the recipient or women undergoing IVF themselves who are willing to share ‘extra’ eggs,” stated the Medical College of Georgia.) The Oregon Reproductive Research & Fertility Program in Portland reported that it was considering using egg donation with IVF and if so, it would use egg donors from the local surrogate mother association.

In an interview with us, the director of that clinic, Dr. Kenneth A. Burry said the clinic has worked with this surrogate firm indirectly in the past and has informally discussed the use of egg donors with it. A common interest in the project was merely expressed, he said.

Asked how eggs would be obtained from the women recruited by the surrogate mother firm, Burry replied that there were three possible methods: laparoscopy, trans-vaginal ultrasound—directed oocyte recovery (TUDOR), and the embryo flushing method developed by a team at UCLA. The third method, he added, could only be used once the technique is better defined legally and medically. The developers of the embryo flushing technique have applied for a patent on the process so use of the technique would partly depend on what kind of patents they get and the royalties they charge for use of the procedure.

The women selling their eggs or embryos would be paid for their services just as sperm donors are paid, he explained.

The Surrogate Parenting Association has its own fee scales for women who carry children to term, Dr. Burry said, adding that they had not even discussed with the Association costs for eggs and embryos to be transferred. The arrangement was at too preliminary a stage for that.

Dr. Burry said he hopes that within a year the clinic will be actively involved in egg donation.

EMBRYO FREEZING. According to Dr. Burry, embryo freezing is one of the two “hot” items in current IVF research. (The other is ultra—sound directed oocyte recovery [TUDOR].) Six of the clinics in our survey are freezing embryos and 25 others plan to add cryopreservation in the future. Most consider freezing as valuable in increasing the pregnancy rate per laparoscopy and in reducing multiple gestations. The Medical College of Georgia, which plans to begin embryo freezing this summer, wrote: “Embryo freezing greatly expands the possibilities!”

Dr. Geoffrey Sher of the Northern Nevada IVF Clinic said that his team has got about 20 frozen embryo and will transfer some of them. It now has its first candidate for receiving a frozen-thawed embryo.

He told us: “We went through a long period of preparation for the freezing process. Six or eight months of animal experimentation and getting all the legalities straightened out.”

We found it interesting that six to eight months experimentation with some animals—they used mice and guinea pigs—is considered a long period of preparation.

SEX SELECTION. Only two clinics are now attempting to select the sex of the embryos to be implanted in order to avoid sex-linked genetic diseases.

Ten clinics stated that they would be willing to implant an embryo of the sex of the couple’s choice at its request. The Northside Hospital IVF Clinic in Atlanta wrote: “I think a physician is there to help, not to hamper.” And the Eastowne Ob/Gyn and Infertility in Chapel Hill, North Carolina noted: “We are here to serve the patients!”

One West Coast IVF clinic stated that it has, and routinely does, transfer an embryo of the sex of the couple’s choice. However, it did not provide information on how it determines the embryo’s sex. The IVF—ET Clinic of Children’s Hospital in Buffalo, New York observed: “Currently there are no reliable techniques for sexing early embryos.” The Brigham & Women’s Hospital in Boston noted: “We are obligated to transfer all fertilized ova back into uterus but would try to increase sex desired.” (Here, as well, the clinic did not add details on how this attempt would

be made.)

Twenty-three clinics did not respond to the question of whether they would be willing to implant an embryo of the sex requested by the couple. Four clinics are undecided. Seventeen are unwilling to do so. “Too difficult to achieve success [at IVF] as it is, let alone try to specify [sex] (and possibly reduce overall success),” commented the Medical College of Virginia. The Alta Bates Hospital IVF Program in Berkeley, California responded: “At present there is no way of determining the sex of an embryo without destroying it. Once such a technique is developed we would apply it when medically indicated.” One clinic commented: “Do not feel supermarket method of sex selection appropriate.”

EMBRYO DIVISION. No clinics are dividing embryos, and many explained that the current state of the technology is poor. Two mentioned ethical considerations as inhibiting factors.

We discussed with Dr. Mark R. Geier of Genetic Consultants the division of human embryos for the purpose of screening those embryos for genetic abnormalities and increasing the number of embryos available. Asked when he thought it might be possible to do that, he replied: “Oh, I think that kind of thing is a number of years off. At least five years, even more.”

Developments in reproductive technology are progressing at such breath-taking speed that five years is considered a very long time for a technique to take in emerging.

Report #5: Patenting the Embryo Flushing Process

Question #26 on the survey of North American IVF clinics we conducted was: “Is your clinic, or any medical school with which it is associated, researching any variations on IVF and ET? Examples of variations would be the artificial fallopian tube and the embryo flushing and transfer technique pioneered by Dr. John Buster’s team.”

This question prompted a letter of protest from Dr. Ian H.

Thorneycroft, head of the IVF team at Tulane University Medical Center in New Orleans and a former colleague of John Buster on the embryo flushing team at Harbor-UCLA Medical Center in Torrance, California. He took strong exception to our implication that Buster was the sole pioneer of the technique. He himself was also one of a number of the pioneers, he wrote, adding that Buster was not even the one who thought up the idea in the first place. Two brothers named Richard and Randolph Seed were.

It is true that Buster and team had worked on the technique with funding from Fertility and Genetics Research Inc, a firm founded by the Seed brothers who had been researching embryo flushing in both cows and women for a number of years.

And what was the idea the Seed brothers had came up with? Here is a description of their embryo flushing and transfer technique: The ovulation times of a woman who will donate or sell her egg and a woman who will receive it are synchronized either naturally or through the administration of hormones. When the physician believes both women are ovulating, he artificially inseminates the donor woman with sperm from the recipient woman’s husband. The released egg spends the next three days traveling from the ovary to the uterus through the oviduct. The sperm might fertilize the egg during this time. The egg then floats freely in the uterus for another two or three days. Five days after the insemination, the doctor attempts to “wash out” the egg (now an early embryo) by flushing the uterus using plastic tubing and about two ounces of fluid. The embryo is then transferred into the womb of the recipient.

An attempt is now being made to obtain a patent on the embryo flushing process. This would then allow the holders of the patent to charge royalties to those who use the process.

Dr. Thorneycroft wrote us that he did not approve of the attempt to patent the embryo flushing process and this was one of many reasons why he had left Harbor—UCLA and moved an to Tulane. We telephoned Dr. Thorneycroft and interviewed him at length.

He explained that funding for research on embryo, flushing had been obtained by selling a limited partnership to approximately .35. investors. Their investment was basically in the patent and

on any instruments that would result from it. Clinics wanting to perform embryo flushing would need to purchase a license from the company in order to do it.

Thorneycroft was troubled by the fact that a medical procedure would now not be available to the entire medical community. He elaborated:

“The problem is that any practitioner can’t do it without paying a very sizable sum...The other thing is that once these things become patented, things become secretive and you have the potential of them [i.e., the company] hiding adverse results. Now I’m not saying they have by any stretch of the imagination. The Chicago operation has been very free with its information about adverse results. But in theory, a business corporation could suppress facts to make the product 100 more marketable.”

Those involved in developing embryo flushing, he told us, have stock options in the corporation. Whether they exercise these options or not is another matter, but they do exist. “I was forced to sign an option to purchase stock,” he said.

Further explaining the problem with patenting, he posed the following situations: Physicians in a clinic which performs embryo flushing have money invested in the embryo flushing company. Or members of their family do. Patients come to them and the doctors advise them that embryo flushing is a good technique.

“Now, what is their interest?,” Thorneycroft asked. “Money or the welfare of the patient? So you’ll have to ask protagonists for this technique, ‘Do you have stock options in the company? Do any members of your family have money invested in this? Are they saying embryo flushing is an excellent technique and better than IVF because, having done both techniques themselves, they really feel that or is it because they have a vested interest in embryo transfer?’”

Because of the vested interest in embryo flushing, we do not necessarily know what the real facts about a technique—its risks and chances of success—are.

“When a technique can’t be evaluated by others,” Thorneycroft asked “how do you check up on it? How can you check their facts when you can’t do the technique without being licensed by them?”

He adds that so far, the physicians involved in embryo flushing have been publishing their results in medical journals.

“So far things have gone well, to a large degree because of people like me pecking at them all the time. I was quite unpopular with my pecking at them. I advocated complete disclosure. The initial contract that they made us sign actually said that we can’t talk about anything unless it’s approved by the corporation. So the researchers could not release [information on] an adverse effect unless the corporation approved it.”

In fact, the corporation has not limited the information the investigators were able to release. It has allowed them to talk about adverse effects of the procedure, he said. But, he added, this provision is in the contract “and the potential is scary.”

While the company has not hidden information on complications, he said, “I’m just concerned that less honorable people could take over in the future and suppress information.”

Dr. Thorneycroft is not enthusiastic about the embryo flushing procedure partly because he thinks it has few applications. One application would be for a woman whose ovaries are totally inaccessible so that eggs can not be obtained for IVF either by laparoscopy or TUDOR.

The procedure, he explained, is very complex, involving as it does, the synchronization of the cycles of the donor and recipient. The pregnancy rate, he said, is no greater than that for IVF.

Raising another issue—the fact that embryo flushing puts the donor—woman at risk of salpingitis, retained pregnancy, and ectopic pregnancy—Thorneycroft said: “You have to ask yourself an interesting question: Is it moral to put the donor at more risk than the recipient? If the donor of the egg is at risk for salpingitis, for retained pregnancy, for ectopic pregnancy—is it moral and ethical to do it just because the recipient can’t be bothered to have another surgical procedure? Now say a woman has tried IVF and failed or her ovaries have been found to be inaccessible—that’s one kind of lady. But suppose a lady says, ‘Well, I don’t want to do through another surgical procedure.’ In other words, she doesn’t want to put herself at the risk of pain and the inconvenience of that. Nevertheless, you’re putting a donor at a significant risk and that’s another problem [with

the procedure] that I have.”

Two of the potential risks to the donor—salpingitis and retained pregnancies—have already occurred, Thorneycroft continued. And eventually, the third—ectopic pregnancy—will as well.

“Women naturally get ectopic pregnancies,” he said. “Deliberately inseminating a donor will eventually result in a donor getting an ectopic pregnancy. That’s a risk the donor takes.”

Exactly who is putting the donor at risk? Is it the woman into whom the embryo is being transferred? Is she the villain—the spoiled woman who selfishly declines to go through another operation or two or three? Hasn’t this woman been sold on the embryo flushing procedure by those who stand to profit from it and by the public relations firm they have hired? How come some of the women being experimented upon—the embryo donors—suddenly look like exploiters of the other women being experimented upon—the embryo recipients? Just who is exploiting whom?

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NOTE TO PAGE TWO

Clinics, of course, do not have babies. Women do. Ana Regina Gomes dos Reis of Brazil painted this out at the Vallinge conference. We leave this sentence uncorrected to demonstrate how easy it is to fall into speech patterns in which men are the procreators and women are invisible.

‘WOMEN WANT IT’: IN-VITRO FERTILIZATION AND WOMEN’S MOTIVATIONS FOR PARTICIPATION*

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Synopsis—This paper is a partial summary of work undertaken as part of a degree in Sociology in 1984 at the University of New South Wales. Sydney. Australia.

My research centred on two areas: the experience of women participating in an IVF program, and the use of that data to argue against a prevalent theme in discussions related to technology—that technology is neutral.

The analysis of women’s motivations for participation in an IVF program reveals that in order for IVF to be developed and implemented certain prerequisites are necessary. They include (a) adherence to the dominant ideology of motherhood; (b) the discourse on fertility, and (c) the dynamics of male medical science. I argue that IVF mirrors power relations between males and females as groups, and as such already its design reflects specific assumptions.

In this paper I shall briefly outline women’s motivations for participation in an In-Vitro Fertilization (IVF) program conducted at the Royal North Shore Hospital in Sydney. Australia. To conduct such research is important because without women’s participation in IVF programs, medical scientists would have difficulty in justifying the considerable amount of money and resources invested in the development and implementation of this form of reproductive technology. Often they justify the IVF by saying: ‘But women want it’ or: ‘IVF offers more chances or options for the infertile woman’. An analysis of women’s motivations for participation is necessary not only to gain an appreciation of the situation of the infertile woman, but also in order to examine the social context in which IVF is implemented.

I begin by outlining the experiences of women on an IVF program. Then I address

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the question of whether the *control* of reproductive technology by women would in itself, be enough to redress the exploitation of women. I contend that technology is socially shaped and as such contains values implicit in its design. I argue that IVF must be assessed as a ‘technological fix’ for infertility. IVF does *not* cure infertility; it provides (and for a few women only) an avenue to biological motherhood through technological intervention. Technological fixes outline ‘solutions’ to problems without addressing their initial causes. The *causes* of infertility, therefore, are not raised. Nor does IVF allow the issue of the social meaning of motherhood to be addressed. The IVF procedure reinforces the definition of motherhood as a biological rather than social relationship. I argue against the view that it is the use/abuse of reproductive technologies by males which is the most decisive factor in its exploitation of women. Control of the procedure by women would not alter motivations for participation; nor would this control alter the social relations arising from women’s participation in the program.

The data gathered came from interviews with women on the IVF program mentioned above. The interview schedule centred on three areas: motherhood, infertility and the women's experiences on the IVF program.

(a) *Motherhood*

The data obtained exemplifies the complexities and contradictions inherent in the perception of motherhood. The views expressed give credence to some of the traditional tenets of the ideology of motherhood as well as showing an awareness of the social construction of a woman's identity.

Several social prerequisites are necessary for women's participation in an IVF procedure. IVF relies upon women to perceive motherhood as desirable. Another precondition is the social structure in which the term 'motherhood' applies only to women who have either a biological relationship to a child, or a relationship of exclusive nurturance sanctioned by the state. In a society which defines motherhood as such an individual relationship between a woman and her biological or social child, women without this exclusive relationship are termed 'childless'. As Adrienne Rich (1977) states:

'In the interstices of language lie powerful secrets of the culture . . . "Unchilded", "childless" simply define her in terms of a lack; even "child-free" suggests only that she has refused motherhood, not what she is about in and of herself.' (p.253)

(i) *Motherhood and marriage*

The women I interviewed perceived motherhood as an integral part of marriage. Both marriage and motherhood were part of their life plans:

'We had everything planned. We virtually planned right from the beginning what we were going to do with our lives, and children was one of them.'

'My husband would say: "Well, we'll have four or five We'll beat my father who had five". Anyway, I'd say: "Just two or three". You talk like this . . . even before we were married. You do assume, don't you? Until you're so far into it . . . that you sort of have to start all over again.'

No woman considered marriage without motherhood or motherhood without marriage; both were perceived as necessary social relations.

(ii) *Femininity*

The qualities associated with the words 'masculine' and 'feminine' were such that 'masculine' was described in terms of physical appearance to a far greater extent than the term 'feminine'. It was generally thought that women, by virtue of their being women, had feminine qualities, no matter what their general appearance or sexuality. For those women who thought that these terms had any meaning, 'feminine' was described in such terms as:

'Emotional, mothering, caring, nurturant in her support function.'

Many women, because of their infertility were examining traditional traits of femininity. In discussing whether being a mother is an integral part of being feminine, many contradictions were expressed. One woman said:

'Well, I think no, it *shouldn't*, but of course, deep down. I *do* But I don't *want* to believe that, and I don't *really* believe that But emotionally I believe it... I think.'

(iii) *The family*

A prevalent theme throughout the interviews was that a 'family' consisted of a male and a female in a heterosexual relationship and the children of this union. A male and a female without children were described as a 'couple'. Often women would speak of having 'no family', although parents and other familial relations were alive. The advent of a child was perceived as 'beginning a family'.

(iv) Sexuality and its relation to IVF

Although many traditional views about motherhood were expressed in relation to the sexual division of labour and the role of women in the care of children, the women in my study did not so readily adhere to the sexuality/reproduction equation. Overall there was a response that women without permanent male partners, whatever their sexuality, should have the same access to IVF as women with such partners.

Most women, however, thought that 'single motherhood' was not desirable. Responses in this area were invariably in terms of the needs of the child. But only one woman raised this objection to support her view that only 'couples' should have access to IVF. The general view as expressed above was that technology of this kind should not be the custodian of moral social dictates. The argument invoked by the majority of women was that IVF was a 'scarce resource'; it should benefit 'couples' rather than single individuals. In relation to whether women without male partners should have access to IVF, the following statements represent a general view:

'I say no. only because there are so many married couples waiting But really, they [single women] should have just as many rights as we've got. I'm a married person. You've got two people's lives to consider.'

I think the pressures on a couple [to have children] are more urgent and pressing in terms of society, than those on the individual.'

The relationship between sexuality and motherhood was raised as an extension of the 'scarce resource' argument. Women believed that the advent of a child positively affected the lives of two people rather than one; couples therefore have preference over 'single' women. In this context the issue of whether lesbian couples should have access to IVF was raised:

'They've got to be given the opportunity. It's very hard to sit in judgement. . . that's what you'd be doing

... Who's to say they wouldn't make good parents?'¹

'I don't see anything wrong with that. But I don't think society is ready to allow that at the moment.'

(v) Biological and social motherhood

For the women I interviewed adoption of babies born in Australia is not a viable option in the near future. Long waiting lists usually mean a ten year period between the application and seeing a child. Responses in relation to adoption possibilities revealed however that biological motherhood was *not* the priority of these women. The experiences of pregnancy and childbirth, although acknowledged as desirable, were not considered to be a major factor in the desire for a child:

'I would definitely adopt. I think I would miss the part of going through a pregnancy—what you experience, the feelings of actually having a baby. But I think you pass that stage, and you are so involved with bringing up the child, be it your biological child or not.'

'Just to have a child or children in the house . . . as far as the biological—that passes.'

All the women in my sample expressed the view that social motherhood was more important to them than the transference of genetic traits involved in biological motherhood. Of those women who had not placed their names with the adoption agencies, several stated that their husbands preferred to have no children rather than adopt:

My husband "wasn't keen on it" [adoption].... It might put our marriage in jeopardy. He was worried he wouldn't be able to love an adopted child the way he loves his own children.'

'My husband said that he didn't feel as though he could be a real father to somebody else's child, and he would prefer *not* to have any children.'

Analysing the views expressed it appears as if the meaning of parenthood differs for

women and men. Whilst women may be able to relinquish definitions based on biological relationships, men may not be willing to do so. It appears that women may be more likely to define the term 'mother' not only in terms of biology, but also according to the relationship between a woman and a child. Men seem to define their relationship to a child according to the part they play in conception.

The implementation of the IVF program however necessitates that women perceive motherhood as a biological relationship to a child. In other words I believe that the IVF procedure reflects a male centred view of parenthood in that it centres on conception and the production of a biological child. The issue of the social meaning of motherhood and the possible extension of that meaning beyond biological precepts is not addressed (nor is the issue of *non*-motherhood). As a 'technological fix' for infertility, the IVF procedure presents only one 'solution' to the infertile woman who wishes to become a mother.

(b) *The experience of infertility*

All women stated that external social pressures with regard to reproduction were very strong. They reported that it was they rather than their husbands who were subject to more social pressure in terms of the number of times they were asked about their child-bearing intentions:

'Most people ask, especially after you've been married for a few years. Society tends to expect a woman to have a family. I found it hard to cope with, and other women I know find it hard to cope with.'

Many women perceive these questions as an interrogation:

'No one thinks twice about going up to you and saying: "Do you have any children?" I used to try and joke about it, but as it got further along in my infertility, instead of joking. I'd say "No" and change the subject.... But people can't leave it at that!' An attitude of condemnation toward the

woman without children was noted:

'I had a friend ring me up and say: Well. Mary, when are you going on your *next* overseas holiday?'

'People always say: How long have you been married? How many kids have you got? And you say: None. They say: Gee. *you'll* have to get moving! Or are you one those selfish ones who want to work and not have any children?'

(i) *Relationships with friends*

Most women expressed the feelings of being excluded from the social nexus of mothers and couples with children, not only in terms of neighbours, but with long established friends. Parenthood was perceived to be the common experience around which friendships were maintained:

'When we have get-togethers with our friends, they ultimately sit around and talk about kids. I have nothing to contribute. I used to try and relate about my nephew . . . used to try and swap stories, and I just can't do that anymore. I just don't have the energy, or the inclination. We have very few friends now.'

Pregnant friends and members of the family were often very hesitant about disclosing a pregnancy and discussing their experiences of pregnancy:

'A few of our friends wouldn't tell They'd tell my husband and let him break the news to me ... as if I were very fragile.'

'They thought they were helping me by *not* discussing it... but it was hurting me more. They wouldn't want to talk about it.'

The infertile woman is expected to have specifically prescribed reaction with regard to her 'condition'. Many women experienced a tension when the topics of pregnancies and children were raised. This tension often did not emanate from the infertile woman herself, but arose in anticipation of the uneasiness experienced by others:

'The subject of who was expecting, or

their babies, was never raised if I was around. I was very, very conscious of the tension with different people. You could just feel how uncomfortable they felt. A lot of people were very uptight, and that made *me* uptight.... It seemed to be a very vicious circle.'

Although all women stated that they did indeed have times when they did not wish to actively engage in conversations around these topics, the general view was that they did *not* wish to be treated differently because of their infertility. Overt avoidance of these topics led to feelings of isolation, exclusion and 'difference'. Many women resented the prescription of their reactions:

'They'd just assume that I'd be upset. I think I resented that, because I was trying to get myself to a stage where I'd think; Hey, I'm still the *same person*, so what if I get upset? Sometimes I *would* get upset, and other times I *wouldn't*, but don't treat me with kid gloves all the time, and *don't* avoid the subject.'

(ii) *Images of the body*

Although each woman recounted her unique experience of infertility, some prevalent reactions were noted. Many women stated that for a period of time they had various reactions to their bodies:

'I felt my body was *cheating* me. It had let me down.'

'I didn't like my body. It [infertility] makes you *very* contemptuous. Even though I don't think breasts are only for breast feeding . . . when you're thinking . . . any month, when you're looking forward to breast feeding in nine or ten months, you don't like your breasts either. It really does have an affect on your body image.'

'In my most depressive stage, I felt a total *lack* of femininity. I reverted to a... sort of neuter... I felt terribly spayed. It was quite loathsome ... I didn't *really* believe my body was there.'

(iii) *Infertility and marriage*

Many women stated that it would have

been 'fairer' had the husband known of her infertility before the marriage, thus giving him the option to then marry her or not. Most women at some stage wanted their husbands to divorce them. They felt guilty about not being able to produce a child:

'After experiencing the problems, I was quite prepared to leave my husband. I felt so guilty—as if I was depriving him of something. He should be given the opportunity to father children, and I'm standing in the way, because he's tied to me, whether he likes it or not.'

The women stated that it was the woman rather than the man who experienced more implicit and explicitly pressure to reproduce. They saw having a child as more positively affecting their lives rather than their husbands'. Several volunteered the view that despite the physical and emotional distress they have experienced, they preferred the infertility to be *their* problem rather than their husband's:

'I was hoping it wasn't his fault. I was hoping it was my fault because he couldn't handle it like I can.'

'I think women handle it better. It could be the mothering instinct in the extreme.'

'He couldn't cope with it ... I think women are more able to cope with it than men. It must be part of your "make-up".'

It would seem as though, given a choice, these women would prefer to remain either without biological children or to undergo the IVF procedure with its low 'success rate' rather than to have their marriage threatened as a consequence of their husband's infertility. Naomi Pfeffer and Ann Woollen (1983) also concluded that women would prefer to have the fertility problem. They write:

'Rather than rejoice in their own fertility, perhaps women fear that they will have to bear the burden of their partner's anxieties and doubts as well as their own childlessness.' (p.30)

(c) *In-Vitro fertilization: Women's*

experiences on the program

Many women stated that being on an IVF program forced them to centre their lives even more explicitly around reproduction. They recognised *the* inability to *attempt* to accept their infertility and to come to some resolve about life plans:

‘I want to go to Uni... I put my name down this year to start, but I thought: How can I do that around being accepted on the program? You will only know that month, and you have to drop everything that month. I’ve put that off. and put that off, and put that off!’

All women stated that the two weeks after the embryo replacement was a period of the most intense anxiety. Waiting for a period ‘*not* to come’ is the focus of attention:

‘The worst time is definitely the two weeks between when you get out of hospital and your period. There’s nothing that can describe what you go through, the mental torture you put yourself through.’

When menstruation began after the embryo replacement, the women experienced a sense of failure. The days on which menstruation was due were ones which highlighted an overall ‘obsession’ with the body:

‘When you get your period . . . you can’t believe it. The two days you are due are shocking. You feel every twinge in your body. You’re completely obsessed with your body.’

‘You sit... and pray and pray And when it doesn’t work, that’s when you curse everybody. You feel depressed. You’re not worth anything.’

Once a woman has decided to undergo an IVF procedure, participation in the program seems to have a momentum of its own. For various reasons women found it very difficult to ‘give up’ the program. Those who had initially set a time limit to how long they would participate, or how many attempts they would have, found it very difficult to adhere to their initial resolve:

‘I’ve been chasing a baby ever since I was twenty-two. You’ve got to draw the line somewhere. Thirty-five *was* going to be ‘it’ . . . but I still feel that physically and mentally I could still have a child.’

‘For the last twelve months I’ve been trying to kid myself into saying that I don’t care if I quit anyhow. I’d like to be in a position so that I feel more free and not subject to any manipulation But *really*, for all that twelve months it’s been a struggle inside myself, and I *never* really reached that stage where I could say I could quit.’

A contributing factor to women’s participation in an IVF program is that they felt compelled to attempt all possible avenues to motherhood before they could accept a child-free life. Many women felt that they had a ‘duty’ to themselves to participate in the program:

‘When you know you’ve got a chance out there and you’re *not* making the most of it It’s hard to make a decision when to call it quits because you don’t want, in years to come, to think—If *only* we’d tried *one* more time!’

(i) Media reports

Media representations, invariably of ‘successful’ mothers, highlight to those women who have *not* ‘succeeded’ the fact that public attention is only focussed on the ‘positive’ results of the procedure. There is a general lack of community understanding about the IVF procedure itself; these media representations give the impression that IVF is a ‘panacea’ for infertility. Friends, relatives and acquaintances have often suggested that the woman undergo IVF as though it were clear that such procedure would eventually produce a child. The women who had either decided to attempt pregnancy through IVF ‘only one more time’, or had decided to discontinue altogether stated that their friends were ‘shocked’:

‘People would say: Oh. but *surely* you’re going to keep going?’

'They *couldn't understand it ... that you'd consider dropping out.*'

(ii) *IVF and daily life*

Apart from the anxieties related to the program itself, many women stated that participation in the program interfered in their lives in relation to their opportunities for either seeking or continuing paid work outside the home. They expressed being in a 'double bind' in this regard. Being on an IVF program more than once a year interfered with their paid work:

'After my first go, they (the employers) told me that I either go on the program or I give the job away. I've heard of a few girls who've had that happen. They *know* their job is on the line by having to go into hospital every day.'

Many women, in order to be available for the procedure, and in terms of the likelihood of losing their job once they began the procedure, resign from their paid work outside the home:

'You can't be expecting your bosses every three months to let you have virtually a month off.'

At the same time, however, several women said that they would prefer to be in paid work outside the home because their lives would not be so centred on reproduction. This would be of great benefit after the embryo replacement in particular:

'If you're lucky enough to have the embryos put back, and you've got that two weeks before your next period, your job ... is a mind-saver.'

In other words participation in an IVF program necessitates women's financial dependence on their husbands. By means of this dependence, the program makes itself available only to couples that have the financial resources to exist on one income for a lengthy period of time. The distinction between a woman's 'role' as reproducer and her economic independence is brought into sharp focus when examining the social relations necessary for the implementation of the IVF procedure are scrutinised.

As a piece of reproductive technology, IVF contains values in its design which reflect the social relations at the time of its innovation. IVF curtails any potential for the redefinition of parenthood—or infertility—by focussing exclusively on women's biological reproduction. In doing so it reinforces the notion of the 'natural' bond between a mother and her biological child as well as reinforcing the idea that the nuclear family—or indeed one's own biological children—is the only desirable structure of social relations between adults and young children.

Women's lowered self-esteem due to the inability to reproduce reflects the strength of an ideology whereby women are perceived primarily as reproducers. Thus infertility brings with it both personal and social dilemmas for women. Not only does the infertile woman experience negative repercussions such as a feeling of being a 'failure'; she also feels implicit and often explicit social rejection and isolation. Put differently due to the ideology of motherhood in which motherhood is perceived as the 'natural' situation for women, the infertile woman is subject to a considerable amount of social scrutiny.

Feminists have emphasised that the 'right to choose' is an important issue. However, I contend that 'choice' is always mediated by social circumstances. In a situation where women experience personal condemnation and social stigma because of their infertility and in which the social definition of motherhood necessitates a biological relationship, the question must be asked what *real* 'choices' do infertile women have? To participate in an IVF procedure, with its low 'success rate', or to remain without children, with all its negative implications, seems to represent very little choice.

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THE FUTURE OF BOTHERING: Technology and Feminist Theory

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The nurse said I would have to show you, but you reached right for my breast. You suckled right away. I remember how you grabbed with your small pursed mouth at my breast and started drawing milk from me, how sweet it felt. How could anyone know what being a mother means who has never carried a child nine months heavy under her heart, who has never borne a baby in blood and pain, who has never suckled a child... What do they know of motherhood?

Connie Ramos, a mother of our own time.

It was part of women's long revolution. When we were breaking all the old hierarchies. Finally there was that one thing we had to give up too, the only power we ever had, in return for no more power for anyone. The original production: the power to give birth. Cause as long as we were biologically enchained, we'd never be equal. And males never would be humanized to be loving and tender. So we all become mothers. Every child has three. To break the nuclear bonding. Luciente, a 'mother' from a possible future.

Connie's dialogue with Luciente takes place within the imaginative territory explored by Marge Piercy in Woman on the Edge of Time.¹ Hers is a culturally androgynous society based on feminist values and organized about a commitment to the extinction of all systematic sex-role distinctions and the elimination of biological reproduction by females. Instead genetic material taken from human males and females is stored in 'brooders' where it is fertilized and the embryos are grown until ready for birth. The bond between genes and culture is deliberately broken. Knowledge of genetic origins is obliterated. Still the citizens of Luciente's world remain divided over the desirability of genetic intervention. They watch for birth defects, for genes linked with disease susceptibility, but they do not yet breed for selected traits. The 'shapers' push for selective breeding; the 'mixers' "don't think people can know objectively how people should become." They see the 'shapers' proposal as a 'power surge.'²

The breeding practices adopted in Piercy's Utopian society bear a remarkable resemblance to the reproductive arrangements instituted in Aldous Huxley's dystopian Brave New World³ though in this imaginative future the 'shapers' have already prevailed. Eugenics and dysgenics is practiced systematically. Biologically superior ova fertilised by biologically superior sperm are provided with the optimal prenatal atmosphere and finally decanted as Betas, Alphas and even Alpha Pluses. In far larger numbers biologically inferior ova fertilized by biologically inferior sperm are subjected to the Bokanovsky Process (ninety-six identical twins from a single ovum) and treated prenatally with toxins. When decanted they are barely recognizably human, but are capable of performing unskilled work and with appropriate conditioning can be relied upon docilely to follow the commands of superiors. Reproduction has been brought wholly within control of the state.

Since Huxley's dystopian fantasy appeared, the feasibility of such a world has drawn increasingly nearer to us. Researchers have made substantial strides in both genetic research and reproductive technologies. Artificial insemination has become a commonplace occurrence. In vitro fertilization and ovum transfer, though only marginally

successful, is widely practiced. Economically disadvantaged women are readily available to serve as surrogate mothers for a modest fee. When mastery of the processes of extra-uterine gestation is achieved, they will be dispensable too. Already extra-corporeal membrane oxygenation (an adaptation of the heart-lung machine) is being applied successfully to infants weighing even less than one kilogram.⁴ Once the functions of the placenta have been successfully mimicked, perpetuation in vitro to viability (ectogenesis) will render the biological process of pregnancy technically obsolete. Though the mere fact of technological feasibility might suggest possible development within either a Piercean or a Huxleyan social framework, subsequent achievement of effective political control over larger, more diffuse populations than even Huxley envisaged only sharpens the vision of the more portentous future. And were extra-uterine gestation to become available, the potential for such a concentration of political power would be immeasurably enhanced. Those who control the instrumentalities of power can, in a word, bring either future into being.

There is urgent need, then, for the collective participation of women in shaping the direction of reproductive technology in order to safeguard the long-term interests of women. Unfortunately, there has been too little discussion among women about either the fundamental values at stake or the social goals that would best promote women's well-being. Though many feminist writers have expressed concern retrospectively about the increased dominance of male controlled childbirth technologies and some have pointed to the direction in which the larger society is pushing reproductive technology, this discussion has taken place in virtual isolation from both the general context of feminist theorising and the background of social theory out of which feminist theory is developing.⁵ There is need now to integrate grass-root feminist concerns about male controlled reproduction with feminist theorists' attempts to reconstruct the social framework of women's collective past and draw out connections with possible feminist futures. We need to think collectively about whether women's interests are best served by pressing for a social policy guided by Marge Piercy's vision of a feminist future, forsaking the power to give birth; or whether that power is of such paramount value that no social aim achievable in any conceivable technological future could supplant it. Should women whole-heartedly support advances in reproductive technology for the sake of the kind of future Marge Piercy envisages? Or resist all technological innovations in reproductive practices despite their therapeutic benefit to some women individually? Or support technological advances step by step until their deleterious social effects have become clearly manifest?

In the following pages I should like to sketch out a framework within which such a feminist dialogue might proceed. First, I shall briefly discuss the utilization of reproductive technologies within the present social context; then I will describe the principal ethical and social positions regarding emerging reproductive technologies, considering the social values and policy alternatives advocated by each of these groups, attempting to ferret out the implications of these developments for the interests of women. Then I will raise some conceptual and theoretical questions about the very idea of a Utopian feminist future, considering first the arguments of feminist theorists who have taken exception to Firestone's analysis and feminist commentators who share Huxley's dystopian prognosis of a future where the bond between pregnancy and procreation has been severed. Finally, I will contrast their positions with the Utopian feminists in order to better understand the basis of present feminist reaction to reproductive innovation, whether it stems principally from reservations about the nature of technological intervention itself or from fears about the more probable consequences of such a technological future. I will end with some observations about the basis of theoretical differences among feminists and suggest an interim course of action to meet the present situation.

The Present Social Context

Both Great Britain and Australia have established national commissions to investigate the ethical and social implications of new reproductive technologies and recommend appropriate social policy. However, in the United States the development of these techniques remains principally in private hands. The decision to utilize reproductive innovations is left to the discretion of individuals and physicians. Though there has been some consideration at the federal level of ethical issues involving in vitro fertilization and embryo transfer, the Ethics Advisory Board which undertook this work was disbanded in 1980. Though federally supported research into these processes cannot proceed without the approval of the disbanded committee, private research efforts continue to go forward with no ethical constraints other than those researchers themselves choose to impose.⁶ Individuals seeking to benefit from the fruits of reproductive research are left free to negotiate with individual physicians subject only to the constraints of private conscience and economic resources. In instances of artificial insemination, a low-tech, 'cottage' industry, medical and economic constraint virtually fall out and individual choice becomes the exclusive determinant. Recipient choice is limited, however, by available information which lies principally within the control of 'donors' (more accurately 'sperm vendors,' since in most instances they are paid for their product). Out of concern for possible legal liability they usually prefer to protect their own anonymity and their preference generally prevails. For, though most recipients would prefer to receive sperm from genetically screened donors, access to such information is usually denied them.

Hence some controls would appear to be desirable not only from the perspective of those wishing to suppress the dissemination of reproductive technologies altogether but also in the interests of those choosing to utilize reproductive innovations. The principal issues, then, center about the nature of these controls and the goals toward which they are to be directed. Would the interests of all affected be better served by continuing along the present course and pursuing a policy that maximizes 'reproductive freedom,' limited only by the capacity to find a physician who will cooperate in satisfying the desires of a particular patient and by the patient's ability to bear the cost of the service? Or should the options available to individuals be limited by circumscribing choices either at the level of service delivery or in the process of further research development?

Both of these are offered as conservative options. Their advocates point out respects in which their favored position maintains continuities with social and political traditions. One emphasizes individual freedom; the other gives centrality to traditional patterns of reproduction and parenting. However, emphasis upon individualistic values would push us in the direction of technological innovation. Attention to the focal role of the biological family in social organization would subordinate individual interests and suppress unfettered technological development.

Additional, seemingly more radical, options are readily imaginable, options which appeal to some future social vision rather than to continuities with the present social order. Persistent social sentiments favoring eugenic controls might well attach themselves to the cause of individual reproductive freedom, facilitating the formation of some uniform policy governing the selection of sperm available for artificial insemination and ova for transplant; thus furthering both recipient preference and eugenic policy choices. Studies of sperm recipient preference have already demonstrated that the vast preponderance of potential recipients favor measures to prevent the transmission of genetic diseases.⁷ Like preference is to be expected from ovum recipients as well. Once mastery of the technology of in vitro gestation is attained, consumers might prefer this innovation too, some principally out of convenience, others in order to maximize optimal outcomes.

Social reaction to innovative reproductive practices divide roughly into three camps: the noninterventionists, who question the advisability of any practice which tampers with either nature's way of doing things or traditional social institutions; the moderate interventionists, who give primacy to reproductive freedom while acknowledging that some weight should be attached to other values as well; and the radical interventionists who divide into two distinctive factions: those who support advances in knowledge of reproductive processes for its own sake without regard to possible technological applications and those who favor reproductive research for the sake of the technological future such research will make possible. Advocates of the former position are to be found principally among researchers who argue that we should push the frontiers of knowledge forward now and concern ourselves about undesirable applications only when the need becomes manifest.⁸ Most conspicuous among advocates of the latter position are Marge Piercy and her model, Shulamith Firestone whose 1970 work: The Dialectic of Sex: The Case for Feminist Revolution, first focused feminist attention on the political significance of reproductive biology.⁹ Ursula LeGuin's fantasy: The Left Hand of Darkness and Joanna Russ': The Female Male also borrow their central themes from Firestone's proposal.¹⁰ All look with favor upon reproductive innovations which free women from their traditional biological role.

The Noninterventionists

Among the most eloquent and articulate of the noninterventionists is Protestant theologian Paul Ramsey, who participated in the deliberations of the now defunct Ethics Advisory Board. He objects to all forms of reproductive innovation other than medical or surgical treatment of infertility.¹¹ In support of his position he offers three arguments. (1) It is a violation of the received canons of medical ethics to expose a possible human being to any unnecessary risk. The only warranted risks are those undertaken either out of benefit to the patient or with a patient's explicit informed consent. Since a possible human cannot grant consent, there is no ground upon which it is morally permissible to jeopardise its future well being. (2) The proper role of medicine is the correction of 'medical conditions,' such as infertility. However, if there are no remedies for the physical condition itself, then it is not appropriate to intervene further. Any additional measures would extend intervention beyond the proper practice of medicine to the treatment of human desires. (3) Procreation and parenthood are 'courses of action' appropriate to humans as natural objects toward whom an attitude of 'natural piety' is appropriate. They cannot without violation be disassembled and put together again. Instead we should work according to the functions operating in the whole of the natural order of which we are a part. Increasing mastery over nature brings increased power over humans and even greater risk of abuse.

Each of Ramsey's arguments incorporates controversial presuppositions. The first assumes that the canons of medical ethics applicable to actual human beings are extendable without modification to merely possible humans who then would deserve the same protections from harm afforded to the already born. His second argument incorporates a very limited conception of the proper functions of medicine which could not be applied to the full range of medical practice without substantial curtailment of customary practice. Many forms of medical intervention treat patient desires. What is in question here is not the treatment of bodily dysfunction versus treatment of desire, so much as the identification of desires likely to be satisfied through medical intervention and the advisability of allocating medical resources to their satisfaction. In a society such as ours where women's social value is still largely measured in terms of fulfillment of their childbearing and childrearing roles the desire to mother is likely to rank far higher in personal life plans than in a society

that affords to women a greater diversity of socially valued roles. The apparent eagerness of many women to endure considerable pain and suffering at the hands of technological experts in an often futile attempt to bring about a pregnancy cannot be understood apart from this larger social context. Probably some of the women seeking infertility services really desire a social role that is both personally satisfying and socially supported. The only option they see open to them that satisfies those conditions happens to be the childbearing one. Others, no doubt, fully intended to bear children but are victims of ‘family planning’ technologies injurious to their reproductive capacities. The social obligation to such women cannot be dismissed merely on the ground that patient desire is not the proper object of medical intervention. That argument fails to speak to the morally relevant features of the situation.

Ramsey’s final argument is complex, incorporating presumptions about both the place of humans in nature and the tendencies of human nature. There are serious ambiguities here which merit careful examination. It is not clear why the bare fact that something is natural should give it any moral weight. Ramsey is obviously not merely pointing out that it conforms to the laws of nature, for this is trivially true of all of our actions. Nor can he mean that it is free of human intervention; for, the practice of medicine, like all social practices, presupposes the desirability of at least some intervention into the natural course of events. He appears to be appealing to a third sense of ‘natural,’ according to which some moral norm or principle of value is justified by reference to nature. But why moral force should be attributed selectively to normal procreation while human intervention, say, in the processes of aging or control of undesirable living organisms is unquestioningly supported calls for further explanation. For an appeal to nature to stand it would have to rest on some other ground, possibly the fear that human power over reproduction would invite serious abuse.¹²

Despite the fragmentary character of Ramsey’s arguments they do point to several widely shared concerns about the direction in which reproductive innovation is leading technologically advanced societies. His allusion to a relationship between power over nature and power over humans, in particular, captures a concern widely shared by feminist critics of technological innovation, a concern which I shall return to later and examine in detail within the context of feminist criticism.

Leon Kass, a physician and influential writer on medical ethical issues, also frames his principal objection to reproductive innovations on traditionalist grounds, but unlike Ramsey who sees the principal threat in the Violation of ‘nature,’ Kass emphasizes values attached to human respect. However, his notion of ‘respect’ bears the mark of an origin closely linked to Ramsey’s conception of ‘nature.’ Though he claims that what is at stake is the idea of the humanness of human life and the meaning of human embodiment, these conceptions appear to borrow their meaning from their affinity with social arrangements believed to be naturally given rather than socially derived.¹³

On the basis of these assumptions Kaas favors legislative interference to regulate the dangers of in vitro fertilization and embryo transfer which, he argues, “erode fundamental beliefs, values, institutions and practices.”¹⁴ He proposes that the use of embryo transfer be restricted to the married couple from whom the embryo derives in order to sustain traditional bonds among sexuality, love and procreation. Like Ramsey, he proposes that further research be restricted to the treatment of infertility or other measures that support the desire to have a child of ‘one’s own’ (by implication acknowledging a distinction between legitimate and inappropriate desires). He opposes

use of embryos in investigative research, donation to other couples or commercial transactions (such as surrogate mothering arrangements), claiming that such practices violate the traditional human sense of our sexual nature and the experience of relatedness to our ancestors and descendants. He, too, fears the concentration of power such technological developments would place within control of researchers and special interests, but his fear, unlike Ramsey's, is couched within an appeal to cultural practices rather than to nature. However, since his cultural arrangements seemingly owe their authority to what is 'natural' the differences between them are not so great as would first appear.

Though Kass is undoubtedly correct in observing that certain innovative practices were they to become widespread would threaten present conceptions of historical connectedness, it is not self-evident either that such practices would become prevalent or that prevailing norms are more desirable than any that might supplant them. Moreover, there are other traditions, much respected too, which tend to give primacy to individual autonomous decision-making over collective social interests, traditions frequently appealed to by advocates of innovative reproductive practices.

Moderate Interventionists

The right to procreate is firmly imbedded in the Western liberal tradition. However, the desire to have a child of 'one's own' is not harbored exclusively by couples as pairs, as Kass' view suggests, but may extend to individuals one by one. Noel Keane, an attorney involved in facilitating surrogate mothering arrangements, relates the story of a 59 year old lawyer who came to his office.¹⁵ He and his 61 year old wife had no children. She had been infertile throughout their marriage. He had planned to leave his estate to his nieces and nephews but then became intrigued by the renewed possibility that he might still be able to will his property to a child of his own. He asked Keane to find a couple willing to have the wife be artificially inseminated with his semen and to bear his child. He would guarantee financial arrangements for the child and provide for its education. Keane is pursuing his request. He is also working on legislative reform that would facilitate legal enforcement of such arrangements.¹⁶ Decision either to support such individualistic practices within the law or discourage options of this kind will have an important bearing on future social policy determinations marking the boundary between the permissible exercise of personal desire and the sphere of collective social interests. Though the desire to pass on one's genetic endowment seems a predominantly male preoccupation, women's interests in bearing and rearing children outside the institution of marriage might also be served by a social policy that allows individuals free space to construct alternative childrearing arrangements, although the legal advantages presently available to married couples, such as Keane represents, are not so readily extended to the unmarried; who seek to fulfill comparable desires.

Recent judicial decisions have repeatedly affirmed the 'right' of individuals, though often only within marriage, to control their own reproductive activity. This freedom is taken to be derived from the right to privacy, to a domain within which individuals may pursue their own life plans with a minimum of societal interference. Supporters of innovative reproductive technologies are by implication advocating application of these individualistic norms to an increasingly broader range of circumstances. Extension of the scope of the doctrine of personal autonomy to gratification of a desire to parent (either biologically or socially) by technological intervention is highly problematic. The more radical the technology the more seriously

it will impinge upon other social values, some that are preconditions for the very exercise of personal autonomy and others that would command comparable weight in any just social ordering.

George Annas, in testimony to the U.S. House of Representatives Committee on Science and Technology, recently pointed out that if children resulting from such techniques as surrogate embryo transfer (to a woman other than the egg donor) and the use of frozen embryos are to be adequately protected, government will have to intervene into the arena of human reproduction. Failure to regulate private contractual agreements, he argues, jeopardizes the integrity of the family and threatens the interests of children. The claims of some infertile couples, he contends, are outweighed by the interest of the potential child. For the sake of protecting these interests he advocates legal action: (1) defining maternity and paternity at the moment of birth, preserving the current legal presumption that the gestation mother is the legal mother so that it will be conclusive and cannot be overridden by private contractual arrangements, and (2) protecting the human embryo from commercial exploitation by restricting the freedom to use frozen embryos to the purpose specified by the donors.¹⁷

Radical Interventionists

In Piercy's Utopian society all social policies are hammered out at the local level by everyone who will be affected by their outcome, hence unplanned social consequences are minimized. However, even there in that imaginative future some citizens balk at the prospect of genetically selected offspring. That decision lies in the future even for them. Incorporation of Piercy's thought-experiment into consideration of policy options for the more immediate future should prompt us to consider whether present hesitancy to press aggressively forward with reproductive innovation is due principally to ethical reservations about the nature of the activity itself or to fears about the likely consequences of such innovation. Luciente, Piercy's protagonist from *Mattapoissett*, her Utopian feminist world, readily acknowledges that the institution of their new reproductive arrangements required women to relinquish "the only power we ever had...the power to give birth." However, they judge the benefit well worth the sacrifice. All power relations have been abolished. Within such a social context the choice seems obviously sensible. Is such a social framework plausible, or even intelligible? Apart from the obvious difficulty in understanding a set of social circumstances under which the socially and politically advantaged would agree to relinquish power, it is far from clear that we can even comprehend the meanings of the radically new roles envisaged for such a society. The astonishment of Marge Piercy's character, Connie Ramos, is shared by all her readers who wonder what the word 'mother' could mean divorced from both the facts of biological mothering and the set of social expectations imbedded in our conceptions of motherhood. Within a social tradition that ungrudgingly grants women little status and few gratifications apart from the mothering role there is no solid ground upon which so radically novel a conception can get a foothold. Presented with such a set of facts about alternative social structures Connie is at a loss to understand what value to place upon them.

Her plight dramatizes the reaction of many feminists to Shulamith Firestone's case for feminist revolution: The Dialectic of Sex. Firestone's proposals for the "abolition of all cultural categories"¹⁸ and the transformation of procreation so that "genital distinctions between the sexes would no longer matter culturally"¹⁹ boggle the imagination; for without

the mediation of a set of cultural roles and expectations we cannot know what value to place upon our experiences.

Though Firestone's advocacy of technological reproduction aims to serve feminist interests, it rests on conceptual foundations that have much in common with the presuppositions of radical interventionists who would pursue goals antagonistic to her own, who would support technological intervention for the sake of the monopoly of power it would make possible. Both factions view technology as "a victory over nature." They favor not only reproductive technology but the technological transformation of production and the elimination of labor as veil. Both see human biology as a limitation to be overcome—for Firestone, because she takes the relations of procreation to be the base of society and the source of women's oppression; for those who would support "a brave new world," because the diffusion of power among women and families threatens their own power hegemony.

Feminist Reaction

In this section I will try to isolate the issues of deepest concern to feminist thinkers who see advances in reproductive technology as further encroachments on the social status of women. Some of these concerns relate to the theoretical underpinnings of Firestone's theory and, by implication, to similar analyses of the causes of and correctives for women's cultural subordination. Others focus instead on the more probable consequences of technological transformations within a social context still dominated by male power structures. In most feminist commentaries both kinds of concerns are intertwined. However, here I will attempt to disentangle them so that detachable claims can then be examined one by one on their own merits. I will focus first, on one issue that enters importantly into the expression of these concerns: the presumptive neutrality of technology to gender specific social practices. Then I will briefly allude to a second significant issue: the possibility of making meaningful distinctions between the biologically given and the culturally acquired. Finally I will offer a tentative explanation of the importance of the mothering debate for feminist theory, ending with some remarks about conditions for the participation of feminist theorists in shaping reproductive policy.

Firestone's influence on subsequent feminists is a matter of some controversy, particularly with regard to her principal claims: that mothering is more a barrier to women's self-fulfillment than a vehicle for it and that biological motherhood lies at the heart of women's oppression. Hester Eisenstein, in her most recent work: Contemporary Feminist Thought, credits Firestone with considerable influence over subsequent feminist theorists, particularly in the early 1970's when feminism and motherhood were widely held to be in diametrical opposition.²⁰ She attributes opposition to Alice Rossi's advocacy of woman's nurturing role (the position that the capacity to nurture is shaped by biological as well as social factors) to sympathy for Firestone's position.²¹ However, Allison Jaggar in her: Feminist Politics and Human Nature²² points to a lack of enthusiasm for Firestone among grass-roots feminists, probably springing, she speculates, from a widespread suspicion of advanced technology, from the observation that technology has so often been used to reinforce male dominance. Hence these feminists do not see how women could take control of technology and use it for their own ends. This latter position is given further support by Azizah al-Hibri, who argues that:

technological reproductive does not equalize the natural reproductive power structure--it inverts it. It appropriates the reproductive power from women and places it in the hands of men who now control both the sperm and the reproductive technology that could make it dispensable...it 'liberates' them from their 'humiliating dependency' on women in order to propagate.²³

Further, she argues, were cloning techniques to be perfected as veil, men would also be freed from their need to share their-genes with women.

Her argument challenges both the claim that it is women's biological function that lies at the root of their oppression and the derivative implication that technological reform can eliminate oppressive social practices. It rests on a very different analysis of the basis of male domination, the presumption that envy of women's reproductive capacities and fear of their powers creates a male need to control women, limiting the free exercise of those powers. Several features of the present situation support such an alternative analysis. If the root of women's oppression were their biological role, then enormous masculine resistance to the technologization of procreation might be expected; for, each step toward the perfection of technological procreation would further threaten male power. However, the contrary is the case: male dominated social institutions provide the principal basis of support for technological reform of reproductive practices. Moreover, al Hibri's analysis is compatible with conclusions reached by numerous other feminist theorists. Though some, like Mary O'Brien, share a similar starting point,²⁴ others such as Jancy Chodorow²⁵ and Dorothy Dinnerstein,²⁶ are based on very different theoretical assumptions, deriving support from disciplines as disparate as psychoanalysis and anthropology.

Recent criticism of Firestone's position has not focused solely on her analysis of the sources of women's social subordination but extends to her remedy as veil. Of course, exposure of weaknesses in the argument for the biological basis of social stratification would, itself, undermine support for Firestone's solution. But the remedy is also suspect on independent grounds. Carol McMillan,²⁷ for instance, has noted that Firestone's theory of social institutions presupposes that relations between individuals and society are exclusively functional. She sees all barriers to the achievement of the goals envisaged as technical problems, presuming that the ends sought are fully known in advance and we need only figure out the most technically efficient way to get there. This presupposition stems, McMillan thinks, from the presumption that reproduction is analogous to the production and manufacture of goods where the means to bring about a desired end have no significance of themselves apart from their instrumental value.²⁸ Once the expertise to accomplish the aim is at hand, earlier more 'primitive' methods can be abandoned with no loss of value.

Close reading of Firestone supports this interpretation. She compares development of artificial reproduction to the future of cybernetics and speculates that the same reticence underlying reservations about the benefits of artificial reproduction pervades our thinking about a work world where machine thinking and problem solving have displaced human efforts. She attributes this reticence to the presently prevailing distribution of power; to envisage either possibility "in the hands of present powers is to envisage a nightmare."²⁹ But within 'post-revolutionary' systems both reproductive technology and cybernetics would be left free to play a wholly different role in social life.

Hence, within Firestone's conceptual framework technology plays an instrumental role twice over, first by transforming the Beans to achieve socially desired goals without itself affecting the character of the goal, and second, by neutrally serving the interests of whichever party happens to control the means of production or reproduction.

McMillan shares company with the vast predominance of both feminist and nonfeminist women who presently hold a markedly different assessment of values bound up with childbearing and rearing practices as human activities. Unlike Firestone and the utopian feminists who presume that the values attached to mothering can be detached, lifted off and reapplied to a radically different set of social practices, they see the values identified with mothering as integral to procreation and nurturing. Robyn Rowland, for instance, has remarked that:

a groundswell of women within the movement has begun to reassess the value of biological maternity. Reacting against the feeling that the women's movement coerced them to give up having children, many feminists are striving to create the experience of maternity and family in a non-exploitive way.³⁰

She points to Adrienne Rich's contention that the problem is not mother-hood itself but the patriarchal institutionalization of motherhood³¹ and argues that the sources of women's oppression lie in the nature of the social structures within which motherhood is experienced rather than in motherhood itself--which embodies within it a network of affirmative values which women ought not abandon. She and the many women writers she cites all see technological control of these practices as usurpation of a body of values central to the fundamental interests of women. She appropriates Leon Kass' arguments to her own cause, citing his admonition that "some men may be destined to play God, to re-create other men in their own image"³² in support of her own fear that the new reproductive technologies will ultimately be used for the benefit of men and to the detriment of women.³³

Writing in the same volume Janice Raymond not only decries the technological future that new modes of reproduction will impose on women but the present social context "in which women supposedly 'choose' such debilitating procedures" as in vitro fertilization and embryo transfer. Such technologies, she believes, only give scientific and therapeutic support to female adaptation to the patriarchal ideology that reproduction is women's prime commodity, thereby reinforcing women's oppression.³⁴ She, too, echoes the fears first voiced by noninterventionists, such as Paul Ramsey and Leon Kass, that submission even to presently established modes of technological intervention dehumanizes women, imposing upon them 'choices' not of their own making and forcing them to submit to a technology whose developers seek ultimately to render their role obsolete.

The arguments of Rowland and Raymond draw together both issues: that women's historical and social capabilities incorporated within childbearing and childrearing practices possess independent value wholly apart from their patriarchal context and that technological intervention into reproduction would only remove from women occasion to develop these capabilities under the guise of serving their interests. Recognizing this, women need to represent their own interests in accord with the

moral and social values that support their own sense of the good life. Unlike noninterventionists from Ramsey's background or critics of feminism such as Carol McMillan their 'conservatism' attempts to avoid appeal to women's 'natural' function. Their objections to alternative forms of reproduction are not couched in allusions to their supposed 'unnaturalness' but focus on a profound sense of disease, stemming from the threat of further consolidation of power structures which purport to speak for women while simultaneously undermining women's control of their own reproductive activities.³⁵

Nonetheless, despite their deliberate effort to base their case on a direct appeal to women's own expression of their interests, their arguments appear to rely on a theoretical distinction very like Adrienne Rich employs in her analysis of motherhood. She had written:

I try to distinguish between two meanings of motherhood, one superimposed on the other the potential relationship of any woman to her powers of reproduction and to children; and the institution, which aims at ensuring that that potential—and all women—shall remain under male control.³⁶

The institution of motherhood—the “symbolic architecture” that derives from male control — could be lifted off to expose the experience of motherhood in its true reality grounded in women's physiology.

In arguing that we have by no means yet explored or understood our biological grounding, the miracle and paradox of the female body and its spiritual and political meanings, I am really asking whether women cannot begin, at last, to think through their body, to connect what has been so cruelly disorganized—our great mental capacities, hardly used; our highly developed tactile sense; our genius for close observation; our complicated, pain-enduring, multi-pleasured physicality.³⁷

Rich's argument presupposes that we can think intelligibly about mothering experiences in separation from their social context, that they can be lifted off and examined apart from any institutional structures and that we can imagine them transposed into a radically different context, within which the affirmative values imbedded in mothering would be freed from the negative associations bound up with present mothering arrangements. The foundation for these presumptions needs closer scrutiny. Despite her penetrating criticism of “male created dualisms” her own work appears to reintroduce analogous dualisms, relying, as it does, on the distinguishability of the sources of women's experiences, on the presumption that we can trace the derivation of certain experiences to women's physiology and that others owe their origin to patriarchal institutions. Though such scrutiny of the logic of her work might seem to overlook its most obvious intent: to prepare a field on which to celebrate motherhood as a source of women's most cherished experiences, I suspect that the two enterprises are more intimately intertwined, than they might first appear.

I would like to suggest now that a common thread links Rowland, Raymond and Rich's positions together and, whether or not that thread connects them all to a nature/culture dualism, they do share certain common psychological assumptions that hold all of them together and apart from Firestone and her company.

Like many other contemporary feminists they see the relation between the infant and mother as essentially a positive one and look to this relationship for images of what relations between woman and woman might be once women have given expression to their own values and shaped social institutions that foster their unfettered expression. Their vision stands in marked contrast to the perceptions of Firestone and her generation of feminists. They looked to sources outside of the mother-child relationship for models on which to build a sense of the unity and solidarity of women.

In a recent paper critical of Rich's position, Janet Sayers has argued that any attempt to ground relationships between women in images of the infant-mother bond rests upon a fantasy, that in reality this relationship is marked by contradiction, by both positive and negative elements. She writes:

The merits of Melanie Klein's work as far as feminism is concerned is that it draws attention to the way we often deny contradictions in personal relationships through the defensive mechanism of splitting, and draws attention to the hatred as well as love that inheres in the early infant-mother relationship—an ambivalence that is not only overlooked in feminist writing that celebrates this relation as the basis of women's solidarity as a sex, but that is also overlooked in that writing which by contrast sees in this relation the very source of women's oppression and alienation.³⁸

By way of example she cites Luce Irigaray as illustrative of the latter view, though she could as easily have cited many other feminists, including Firestone. Though her reliance on the Kleinian perspective might be called into question her cautionary warning ought not to go inheaded. Both attitudes toward the mother-infant relation are amply represented within feminist writing. Neither can be claimed to capture the true expression of feminism. Her appeal to Klein is an attempt to draw together both positions within a more inclusive framework. The development of such a framework leaves much theoretical work to be done but the need for feminist action cannot be delayed until its accomplishment.

For the present, lacking any feminist theory capable of providing unambiguous direction in guiding the development of reproductive technology, three options lay before us: 1) we might take our lead from the supporters of a Richian position and forcefully oppose all attempts to formulate a social policy incorporating developments in reproductive technology; 2) we could join forces with the heirs of Shulamith Firestone though it is by no means clear what implications this might have for present social policy or 3) we could work to integrate the plurality of feminist positions into an interim policy, commit ourselves to intensified dialogue and attempt to influence the present direction of reproductive technology in much the same pragmatic ways feminists are now participating in framing other social policies.

Though pursuit of the third option is likely to put the cohesiveness of the feminist community to its most severe test, adoption of either of the remaining options would already presuppose a cleavage far more irreconcilable. Over this issue either the current 'wave' of the feminist movement will lose its momentum and disintegrate or feminism will emerge a far stronger, more unitary force for social transformation than ever in its prior history.

NOTES

1. Marge Piercy, Woman on the Edge of Time, Fawcett Crest, N.Y., 1976, pp. 105–106.
2. Ibid., p. 226.
3. Aldous Huxley, Brave New World, Chatto and Windus, London, 1932.
4. R.H. Bartlett, “Extracorporeal Oxygenation in Neonates,” Hospital Practice, April 1984, pp. 139–151.
5. A notable exception is a recent collection edited by Joan Rothschild, Machina Ex Dea: Feminist Perspectives on Technology, Pergamon Press, N.Y., 1983.
6. In the summer of 1984 the US House of Representatives subcommittee on Investigations and Oversight (of the Committee on Science and Technology) heard testimony on the need for reproductive technology with the intent of proposing legislation similar to that recently recommended by the Warnock Commission in Great Britain.
7. N. Curie-Cohen, L. Luttrell and S. Shapiro, “Current Practice of Artificial Insemination by Donors in the United States,” Hew England Journal of Medicine, Vol. 300, pp. 585–590, March 15, 1979.
8. See for instance, Science, Vol. 223, March 2, 1984, p. 916.
9. Shulamith Firestone, The Dialectic of Sex: The Case for Feminist Revolution, Jonathan Cape, London, 1971.
10. Ursula LeGuin, The Left Hand of Darkness, Harper and Row, N.Y., 1976. Joanna Russ, The Female Male, Bantam, N.Y., 1975.
11. Paul Ramsey, “Shall We Reproduce?” Parts I and II, Journal of the American Medical Association, Vol. 220, June 5 and 12, 1972, pp. 1346–1350 and 1480–1485.
12. This argument was first suggested to me in a discussion of Ramsey’s position by Samuel Gorovitz in his volume, Doctor’s Dilemmas, Macmillan, N.Y., 1982.
13. This relationship was pointed out to me by an anonymous reviewer to whom I owe a debt of gratitude.
14. Leon Kaaa, “Making Babies Revisited,” The Public Interest, N. 54. 1979.

15. N.P. Keane, "Surrogate Motherhood: Past, Present and Future," in Difficult Decisions in Medical Ethics, Alan R. Liss, N.Y., 1983, pp. 155–164. I do not cite other 'moderate interventionists' by name here only because their arguments are not directly pertinent to the issues I emphasize. However, many scientific researchers employ a version of the moderate interventionist position advocating unfettered research into reproductive technologies with imposition of regulation (if at all) only at the level of application.

16. Several states have already considered legislation that would hold such contracts legally enforceable. Kentucky has supported en-forcibility; Michigan denied it.

17. See: "Redefining Parenthood and Protecting Embryos: Why We Need Hew Laws" in Hastings Center Report, Vol. 14, Ho. 5, Oct. 1984, pp. 50–52.

18. Firestone, op.cit. p. 182.

19. Ibid. p. 11.

20. Contemporary Feminist Thought, G.K. Hall and Co., Boston, 1983.

21. See Alice Rossi's "A Bisocial Perspective on Parenting," in Daedalus, Vol. 106, Spring 1977, pp. 1–31 and summaries of a symposium on the article in Signs, Vol. 4, No. 4, Summer 1979.

22. On this point see Allison Jaggar's discussion in: Feminist Politics and Human Nature, Rowman and Allanheld, Totowa, NJ, 1983, especially p. 93.

23. Azizah al-Hibri, "Reproductive Technology and the Future of Women: A Feminist Perspective," in Research in Philosophy and Technology, Vol. VII, ed. Paul T. Durbin, JAI Press, Greenwich, CT, and London, 1984, pp. 255–270.

24. Mary O'Brien: The Politics of Reproduction, Routledge and Kegan Paul, Boston, 1981.

25. Nancy Chodorow, The Reproduction of Mothering, University of California Press, Berkeley, 1978.

26. Dorothy Dinnerstein, The Mermaid and the Minotaur, Harper and Row, N.Y., 1976.

27. Carol McMillan, Women, Reason and Nature, Princeton University Press, Princeton, NJ, 1982.

28. Ibid., p. 77.

29. Firestone, op. cit., p. 90.

30. Robyn Rowland, "Reproductive Technologies: The Final Solution to the Woman Question?," in Teat-Tube Women edited by Rita Arditti, Renate Duelli Klein and Shelley Minden, Pandora Press, London, 1984, p. 358.

31. Adrienne Rich, of Women Born, Norton, N.Y., 1976, p. 369.
32. Kass, op. cit.
33. Rowland, op. cit., p. 356.
34. Janice Raymond, “Feminist Ethics, Ecology and Vision,” in Test-Tube Women, ibid., pp. 433–434.
35. My appreciation to an unnamed reviewer for helpful comments incorporated in revision of this paragraph.
36. Rich, op.cit., p. .13.
37. Ibid. p. 24.
38. “Feminism and Mothering: A Kleinian Perspective,” in Women’s Studies International Forum, Vol. 7, No. 4, p.240.

From genetic counseling and genetic analysis – to genetic ideology and genetic fate?

Perfecting, -expanding and more widely employing the repertoire of medical and genetic instruments which can be used to sort out which women should have how many and which children – this is a goal which is being pursued not only with the help of new technologies of conception.

The complementary techniques, the other pieces in this puzzle are genetic counseling, gene analysis and, in the near future, gene therapy. On the one hand, “good” potential parents (on the basis of criteria such as socio-economic status, nationality, race, productivity etc) are to be encouraged to have children –especially those who might not now have children for fear of genetic or age-related defects, but who can guarantee the “right” kind of educational environment. On the other hand, “undesirable women” – on the basis of the same criteria – are to be discouraged from bearing children, under the implicit assumption that lower class, poor women with a low level of status and education inevitably bear genetically inferior children. The campaign being carried out by the government of Singapore is simply the most blatant example of this neoeugenic outbreak.

In ‘the Federal Republic of Germany, which has one of the lowest birth rates in the world and where Turkish “guest worker” women have an average of three times as many children as German women, the methods are a bit more subtle, but the aim is the same. In the words of one physician in a handbook of genetic family counseling, it is “decisive, that these fewer and fewer pregnancies and births (of German women, of course!) receive optimal care” (1)

Within the scientific and medical community the main argument in favor of genetic counseling and diagnosis – after the smoke screen of alleviating human suffering is blown away – is a simple economic analysis. The physician and human geneticist prof. Tinte goes on to cite cost-benefit analyses which demonstrate that prenatal diagnosis performed on all women over 40 in the FRG would cost 28 000 per detected pregnancy with a chromosome damaged fetus. (2) Compared with the average cost of lifelong care of a child with such a chromosome defect of approx. 200 000 DM yields a cost-benefit-relationship of 1:7. Some of this professor’s colleagues go on to calculate the loss in contributions to the gross national product through productive labor, resulting in even more horrendous losses to the national economy.

On the other hand, an increase in births of children capable of later working a full productive lifetime of 50 years would further contribute to the nation’s wealth. These are, for example, the children not being born today, because their potential mothers are afraid of chromosome defects due to their age.

In order to attract potential patients – or perhaps the term “client” would be more appropriate – geneticists and physicians employ different arguments and strategies than with their peers. Shockingly high percentage of infants born with “genetic” defects are presented, without an adequate definition of what is included in this category. Quite often, correct statistics are cited for the incidence of congenital defects, but within the context of a discussion of genetic disease and the need for genetic diagnosis. The authors “forget” to mention that the category

congenital defect includes numerous illnesses or handicaps of unknown origin, not to mention those caused by environmental pollution, medication taken during pregnancy or medical malpractice, e.g. during birth. A recent report in German television featured the plight of a number of women whose children had suffered brain damage due to induced births. To date, none of them had been successful in at least receiving financial compensation through the courts, let alone in forcing sanctions against the physicians involved. What about “optimal care” here?

It would seem that genetic counseling got a somewhat slower start in the FRG than in other industrialized nations, due to the specter of national socialist “race hygiene” theory and practice. In the Fifties and Sixties, institutes for human genetics performed genetic analyses at various German Universities on a relatively small scale. The new beginning was in 1969 at a symposium in Marburg under the title “Genetics and Society”; here, a program to begin a public information campaign was devised. The same city was then host to the first genetic counseling center open to the general public, which opened in 1972. The director, Prof. Wendt, sent out information pamphlets to 3500 general practitioners and gynecologists in the province of Hesse. Counseling services were free of charge for the first 3 years, financed by the Federal Ministry of Health and the Volkswagen Foundation. Since 1974, the costs for genetic counseling are covered by the state health insurance plan.

The introduction of genetic counseling centers in Germany was accompanied by reports in the newspapers and other media, aimed at cultivating the acceptance of this service in the general public. Wendt was quoted for example with a definition of genetic counseling as “medicine serving newborn infants”, a therapy aimed at helping individuals and thus not to be equated with eugenics, as the promotion of “good hereditary traits” within the population as a whole (in the nationwide daily “Die Welt”, 5.11.1976). Such articles usually set the goal of creating a nationwide network of counseling centers, referring to the existence of such a network in Great Britain, for example. By 1977, this goal had been reached; only 5 years after the first center opened its doors, a total of 41 were at work, handling an ever increasing number of cases each year.

Up until now, at least, the vast majority i.e. nearly 75% of persons advised in these centers did not come of their own accord but were recommended for counseling by their doctor or by a clinic. However, this situation may now be changing. Of the two labs which do prenatal chromosome analysis following amniocentesis in West Berlin, the large one did a total of 700 such lab tests in 1984 (this analysis is recommended in about two-thirds of the 1500 cases handled by the genetic counseling center per year). A projection on the basis of the first four months predicts that more than 1000 chromosome studies will be done in 1985 and in a growing number of cases, women are asking for amniocentesis (and getting it) even though there is no history of genetic disorders in their families and they are below the current age cutoff of 35 (recently lowered from 37 for coverage under state health insurance). The “demand” by women for prenatal genetic diagnosis is apparently increasing rapidly, as documented by the fact that there are now about six private labs doing these studies for a fee and more due to open this year. Some centers agree to amniocentesis for women below the age limit, if they appear to be under such emotional stress because of their fear of a genetically damaged child, that the risk posed for the health of mother and fetus is termed greater than the risks involved with amniocentesis. Some women are apparently finding out before counseling what they should tell the doctor in order to be “granted” amniocentesis on the basis of a “psychological indication”.

3

But what is behind the apparently increasing demand for amniocentesis and genetic diagnosis on the part of women? On the basis of my knowledge of the practices of some genetic counseling centers (which does, however, vary greatly from one to the next) and reports from women considering or referred to genetic counseling, a lack of adequate, information or outright misinformation certainly plays a role. One woman recently asked me for advice after her gynecologist recommended amniocentesis because “the chances of having a handicapped baby were about equal to the chances of a miscarriage due to amniocentesis”. The woman is 31 and didn’t know, nor it seems, did the doctor, that she was below the age limit set by the Berlin center. She was not informed by the doctor as to just what damage can be determined by a routine chromosome analysis following amniocentesis. This case is clearly typical, as is the original decision of this woman to seek genetic counseling, as an extra precaution in view of all the potential sources of damage to her child during pregnancy due to environmental pollution etc.

There are currently about 300 different tests available for prenatal diagnosis of genetically-based metabolic disorders. However, the frequency of these disorders in the general population is extremely low. Since the amount of fetal gene material which can be won for study by amniocentesis is also very limited, these tests are only carried out in those few cases for which a clear indication makes them seem warranted: a history of a particular disorder in the family of one or both parents, a sibling of the fetus has a particular genetic disorder etc.

*The only studies done on a routine basis in dependence of the age of the mother are chromosome analyses to determine a trisomy or other severe structural damage to the chromosomes.

*The same holds true for the approximately two dozen single gene disorders which can currently be identified with methods based on gene technology. The number of traits which can be analysed in this way is, however, rapidly increasing.

Most of these women, or indeed the majority of all women who get genetic counseling are not the ones many human geneticists and physicians would prefer seeing in the centers. They repeatedly lament the fact that “very young women, older women, foreigners and women who already have several children” make less use of these services; the unstated assumption being, that they are more in need of them. The goal is clearly stated by Prof. Wendt of Marburg: in his opinion, in caring for the handicapped, “we are like someone who is desperately trying to pitch water out of his flooded home, but doesn’t think of simply plugging up the leaky water tap.” (3) He recommends that gynecologists doing abortions “should perform a sterilization at the same time if the mother is the sole carrier of the risk (i.e. a genetic disorder).” (4) Wendt, it is interesting to note is the head of a foundation for handicapped children originally established by Axel Springer, the rightwing monopolist who owns the majority of West German tabloid newspapers. Such personal connections between human geneticists working in university research and genetic counseling centers and foundations or charity organisations devoted to helping handicapped persons are quite frequent. The physicians and geneticists involved apparently see no possible conflict of interests arising from their activities. This fact becomes less surprising but a good deal more frightening if one follows the trail of certain geneticists back into past decades and uncovers the continuity of individuals and ideology. (This work is very well documented in the book “Die Wohltäter-Mafia” by Udo Sierck and Nati Radtke, cited in the notes, from which I derived much of the material used in this paper.)

A group of handicapped persons and physicians in Hamburg recently uncovered the activities of Dr. Maria Stoeckenius, Director of the genetic counseling center in Hamburg-Barmbek. Although Dr. Stoeckenius is a geneticist, not a physician or a psychologist, she has chosen to specialize in the diagnosis of what she considers to be genetically determined psychic disorders. In recent years she has begun applying her “experience” in this field not only to her counseling services, but also to cases referred to her by her colleagues in hospitals and institutions for the mentally and physically handicapped. Dr. Stoeckenius applies her own special criteria in deciding whether or not patients should be recommended for sterilisation, due to the genetic nature of their handicaps. One of the central tools she employs is the careful study of family histories, leading in some cases to a log list of “abnormalities”: “grandmother high-strung”, aunt late-developer”, “older brother nervous”, grandfather and great-grandfather shy loners”, uncle committed suicide”, aunt hysterical”, parents divorced”, grandfather alcoholic”, uncle never finished apprenticeship, constantly changed jobs” etc (5).

Many of the “patients” for whom Stoeckenius recommended sterilisation were children or minors. In her opinion, it is more prudent to have parents consent to a sterilisation of their children before they come of age and might be influenced by personal or therapeutic institutions to reject sterilisation. She therefore has also frequently held talks for the parents of children attending special schools for the mentally or physically handicapped. In the course of one such talk she mentioned the fact that she was unable to clarify the legal questions surrounding such sterilisations – due to her heavy workload, she had not had time to look up the relevant laws!

The public interest stirred up by the publication of the documents about Dr. Stoeckenius has led to enquiries not only in Hamburg but also in other German cities, which have clearly shown that Dr. Stoeckenius is only the tip of the iceberg.

In some schools for the Handicapped, more than one-half of the girls in some classes have been sterilized—the majority of such sterilisations are performed on girls and young women (6). And in the meantime, Dr. Stoeckenius have had sufficient opportunity to be informed that such sterilisations are illegal and subject to prosecution, carrying prison sentences of two to ten years. (A revision of the law regulating such sterilisations was proposed in 1972 but hasnot been acted upon by the government.) Apparently, government officials are wary of raising the spectre of eugenics and race hygiene which was seemingly put to rest with the end the National Socialist regime in 1945. But was it indeed put to rest?

Sierck and Radtke have documented the biographies of a number of German geneticists and physicians which clearly show that nothing could be further from the truth. The most prominent example is Otmar von Verschuer, Director of the “Kaiser-Wilhelm-Institut für Anthropologie” in Berlin until 1945, teacher and mentor of the SS-physician in Auschwitz, Josef Mengele. Verschuer was Professor of genetics in Münster from 1951–1965. Some of Verschuer’s other students also went on to become professors or institute directors, e.g. Heinrich Schade and Hans Grebe. And while those who were actively involved in or at least students of Nazi euthanasia and race hygiene programs generally had no problems landing on their feet after the war, the majority of the victims of such atrocities have still received no form of compensation for the physical and mental damage to which they were subjected (7). A proposal aimed at providing such compensation has only recently been put forward by the Green Party in the German Parlament.

Although in the meantime a new generation of human geneticists has for the most part taken over the scene, I am not at all convinced that the ideologies underlying their work differ greatly from those who were already active as “researchers” under fascism. Rather, I think we must be wary of the more subtle and seemingly more scientific forms with which genetic and biological “evidence” is being used to support discrimination and the categorization of children and adults into valuable and unvaluable life. Work being done today in the fields of genetic analysis and so-called ecogenetics is leading to the broadening of the definition of what is considered to be sick or defective.

Prof. H. Werner Goedde in Hamburg is searching for evidence of genetic predispositions for sensitivity to drugs, pesticides, heavy metals, as well as for increased risks of developing cancer, heart disease, allergies or other disorders. He states his goals quite clearly: “Human geneticists working, in ecogenetics and pharmacogenetics, as well as physicians specialized in labor medicine and preventive medicine should use genetic tests with the aim of acheiving maximum protection against damage caused by in born errors”. (8) In other words, health damage due to drugs and pollutants or poisons is caused not by these agents, but rather by people with errors in their genes!

Goedde was recently invited to present his views during a hearing of the Enquiry Committee of the German Parliament on Gene Technology dealing specifically with genetic screening at the work place. Unfortunately, he failed to show up. One of his leas prominent colleagues jumped in for him and documented the current direction of genetic research of this type with a slip(he which chen hurried to correct),Only five minutes into his talk, Dr. Propping expounded upon lactose intolerance (the inability to digest milk) as an example of such a genetic defect with a specific ethnic distribution. This “defect” is found in most people in Asia and Africa; presumably, the majority of tie world’s population “suffers” from lactose intolerance, which .they are perhaps unaware of, because milk is not part of the normal diet of adults in these regions of the world.

Another expert went on to define handicaps which should be identified as relevant for occupational safety as: “any irregular (age-independent) physical, mental or emotional condition which is not merely temporary and, which results in a reduction in the ability to earn a living” (Dr. Kollmeier from the Federal Office of Occupational Safety,(9)).

In the context of increasing structural unemployment resulting in part from the new rationalisation technologies (including, in future, gene technology in its various applications)genetic analysis offers a finer method of sorting out individuals worthy not only of reproducing, but of getting a job and earning their livelihood. It is a small step from genetic tests in connection with job applications toprotect workers from hazards on the job to testing for “sensitivities” to environmental pollutants to which we are all being subjected. And then, of course, it makes much more sense to perform such analyses on unborn fetuses, rather than on adults. The technique of chorion villi sampling which is now .being introduced in many genetic counseling centers, would allow such genetic tests to be applied during the seventh to eleventh week of pregnancy. Given these methods and increasingly poor chances of finding a job one can speculate on future parents deciding to abort a fetus which, on the basis of genetic analysis, has a slightly reduced capacity of metabolizing hazardous chemicals.

Notes

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3. Hickl, Genetische und geburtskundliche..., as quoted in Sierck, Radtke, p. 81.
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7. Die Zeit, 27.September 1985.
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9. Dr. Kollmeier, Bundesanstalt für Arbeitsschutz; Paper prepared for the hearing of the Enquete Kommission "Chancen und Risiken der Gentechnologie" on "Genetische Analysen bei Arbeitnehmern", Bonn, 19.September 1985.

The Experience of Infertility in Discussion on Reproductive Technology by the Feminist Movement by Terese Bergfors

It is impossible to talk about reproductive technology (RT) without talking about infertility since if infertility did not affect a significant percentage of the world's population (both in the Western and Third Worlds) the creators and manufacturers of reproductive technologies would not have any basis for the claim that their research is fulfilling a market demand, i.e. helping the childless have children. Nonetheless, the subjects of infertility and the experience of the involuntary childless are the most ignored aspects of all the discussion around RT.

One of the reasons for this is that infertility is seen as a personal problem. Most people never think about it unless they are forced to i. e. if it actually happens to them, or the person with whom they are involved. It is a minority question, albeit a huge minority (10–15% in Sweden,) and therefore not especially newsworthy. RT though borders on the science fiction-like and makes for dramatic headlines. People's interest can be more easily engaged in scientific developments which, on a broad level, will have consequences for them, whereas infertility, so long as it affects only a small part of the population, concerns just the individuals involved and not the entire society.

The feminist movement has also tended to be more interested in RT than the state of involuntary childlessness which is the precursor to why women seek solutions through RT. One example of this could be taken from the International Women and Health Meeting held in Amsterdam in 1984 (1). From a total of 300 participants, the workshop entitled "Childless women" drew a crowd of two (and was therefore cancelled) whereas the workshop "Reproductive technology" was well attended.

Other feminists have complained about the lack of interest in the problems of infertile women. Naomi Pfeffer and Anne Woollett, authors of the book *THE EXPERIENCE OF INFERTILITY*, say: "These feelings of isolation were accentuated for us because, as feminists, we had expected to be able to talk to other women, to be able to discuss our infertility within a feminist context. But we found the taboos and silence just as strong within a feminist context. This made us very angry. It denied the reality of our experience."(2)

Another writer on childlessness comments: "It is interesting that feminist literature and anthropological and sociological studies of women in the Third World take the need for a woman to have access to fertility controls as a given; there is virtually nothing written about the position of an infertile woman in the societies studied. Yet because of the complex of factors which force women in many societies to see motherhood as their only road to achievement, esteem and self respect, one would have thought that the lives of women who do not achieve motherhood would be found more worthy of consideration in the literature."(3)

If one considers for instance that in Gabon over 31% of the women have no living children (4) one must ask with astonishment why there is so little discussion about a problem affecting such a huge number of women.

In rejecting the view that motherhood is not a biological imperative nor a prerequisite for happiness just because one happened to be born female, has feminism failed to see that infertility can be a problem nonetheless for the woman affected by it?

WHY INFERTILITY IS NOT DISCUSSED

I suggest that there are several reasons for why infertility and the problems of the involuntary childless have been ignored by the public in general and also within the feminist movement.

1) The taboos surrounding discussion of infertility

It is difficult for the infertile person to talk openly about her (5) infertility. To do so is to expose an extremely private side of one's life and often a very painful one. It is already an incredible infringement of one's privacy to have to reveal for doctors how often one has intercourse and when one ovulates, as one must when undergoing infertility investigations. To have to explain one's infertility to curious acquaintances is an additional abridgement of privacy to which no fertile person is subjected.

There is also still a lot of shame associated around infertility since society has very defined notions about "real" women being mothers and "real" men being potent.

The lack of discussion about the problems of the infertile gives rise to an enormous amount of ignorance on the part of the public and even among the professionals who come into contact with the infertile as part of their work. This ignorance often expresses itself in some of the crudest forms of insensitivity which in turn cause the infertile to be even more reluctant to speak openly about their infertility.

2) Minority question

The right to safe (legal) abortion has been a cornerstone of the feminist platform. Perhaps part of the reluctance in taking up the problem of infertility has been due to the idea that to do so would jeopardize abortion rights. The needs of the majority of women for birth control and abortion are juxtaposed to the situation of the infertile and the two groups appear to have conflicting, or at least opposite, interests. Actually the issue is control over one's fertility in both cases.

Paradoxically the fight for legal abortion and the problem of infertility are closely related. Critics of legal abortion often will utilize the existence of the involuntarily childless as an argument:

“Women having abortions should be carrying their pregnancies to term and giving the babies up for adoption to the infertile. “As feminists, it is important to meet these arguments so that the infertile women’s needs are not seen as a contradiction to the fight for fertility control. Two points should thus be made. Firstly, while it is true that legalized abortion has reduced the number of children available for adoption, it is precisely because adoption is no longer widely available that a discussion even occurs nowadays about infertility. It was only when the number of adoptive children decreased that motivation even existed for research to be done on the causes of infertility.

Reducing poverty would also cause a decrease in the number of potential adoptive children but not even the Right is so crass as to suggest that the existence of poverty should be encouraged for the behalf of the infertile. Feminists must point out the contradiction in the Right’s argument against abortion.

It is the poor quality of women’s health care and the lack of access to knowledge about our bodies which are often factors behind unwanted pregnancy and also infertility. Both of these are major women’s health issues but if feminism is to truly be a movement for all women it must not ignore those health aspects that affect only a minority, in this case the infertile.

3) Assumption of fertility

Almost all people simply assume and rightly so* that they are fertile until proven otherwise. Most women do not consider the possibility that they could be infertile until they have tried to become pregnant. At the same time it is not uncommon to find, especially among teenagers, that riskful exposures to pregnancy occur out of an unconscious desire to see if their bodies actually do function as they are supposed to. There is no desire to have a child or continue the pregnancy, only to test one’s fertility. The psychological impact of finding out that one is not fertile is tremendous.

4) Anxiety evoking

Another reason why infertility is so little discussed is because reproduction is an issue which raises profound personal and existential questions for all people. The motivations for reproduction are extremely complex and it can be safely argued that all women feel some degree of ambivalence about the role of motherhood and childbearing. If a woman has never experienced doubts about becoming a mother it is probably because until feminism we have not even been allowed to pose the question “Why have children”? As Dowrick and Grundberg say in their book WHY CHILDREN? “to even ask this question is to start a revolution”.(6) There are few aspects of adulthood that cause so radical a change in one’s life as having a child. Any moderately conscious woman is therefore bound to have some conflicts about what those changes mean.

The childless, especially the voluntarily so, can represent a threat to parents. “Probably many parents, in their ambivalence as they experience the costs and disadvantages of children at times wish they were childless. However they must typically repress these wishes, perhaps equating them with death wishes. These wishes may be projected onto the intentionally childless (who threaten the repression and arouse jealousy) and condemned there.” (7)

For other women, the decision to have or not to have a child is so agonizing that they wish they were sterile so as to be relieved of the burden of decision making. As one woman interviewed in the book "WHY CHILDREN?" put it, "women often yearn for the perfect excuse which will relieve them of the burden of having to choose to remain childless. (If I were forced to have a hysterectomy) I would be childless because I could not bear children. What could anyone say to me then?"(8) Therefore, when one does encounter the woman who is both infertile and unhappy about it, it is a threat to the picture that these two above groups have built up around infertility as being somehow a more peaceful state than either the agonies of parenthood or the agonies of deliberate childlessness.

Regardless of whether a woman chooses to have or not to have a child(ren) there will always persist, to varying degrees, some ambivalence about her choice. To discuss infertility means then that she must examine her own reproductive choices, and in general, the more ambivalent a woman is about her own choice, the more threatened she will be by the discussion of involuntary childlessness.

Voluntarily childless women (and just what "voluntary" really means will be taken up later) sometimes have difficulty in understanding why the involuntarily childless woman should be upset about her infertility. After all, she is childless but she does not see it as a problem. The difference is that she, the voluntarily childless woman, has CHOSEN her state, (what with all the difficulties which that entails in our society) but the infertile woman has been forced into her situation, which means she will necessarily experience the state of childlessness quite differently. (By way of comparison, women experience an abortion and a miscarriage quite differently for the same reason. Although the ostensible end result is the same, choice is involved in only the first instance. Thus miscarriages usually are more traumatic than abortions.)

INFERTILITY AS CRISIS

Discovering that one is infertile is rarely a neutral event. The major Swedish researcher on the psychological impact of childlessness stated that "most people react very strongly when they find out they are sterile."(9) It invariably precipitates some kind of crisis, although not necessarily at perhaps just that time when one learns that she is infertile. The young woman (early 20's) who discovers she is infertile may indeed even find it practical. One such woman reported though that it was not until 10 years later that she experienced her infertility as a crisis, but then it had a terrible impact (10).

Nonetheless, the crisis, although acutely painful is in many ways what could be called an INVISIBLE crisis. Firstly it is a crisis involving an invisible part of the body. Somehow we understand that one is entitled to feelings of loss if that loss involves a part of the body we can see, for example, an arm or eyes. We do not see much of our female reproductive organs and yet they have extremely strong symbolic Value which means that the loss of their function can seem just as real and painful (and even more so) than the loss of the function of another body part. As an example of the extreme symbolic value of the womb it is an interesting test to ask women to draw a to scale picture of their reproductive organs. Almost without exception women draw them many times larger than they could possibly be in a non-pregnant state. (Try it!)

Secondly, it is also the loss of a child, but an invisible child, one that has never existed and therefore cannot even be legitimately mourned.

And finally, it is still a taboo subject so the possible role models of women who have successfully resolved this crisis of involuntary childlessness and could therefore offer us valuable experience on how they did it, are invisible to us.

UNHELPFUL ATTITUDES ABOUT THE CHILDLess

It can be a devastating shock to discover that there is something “wrong” with one’s body. In the campaign to reduce funding for infertility treatment in Sweden, politicians frequently resort to the argument that “childlessness is not a disease”. While this is technically true, it ignores the psychological effect and social consequences that infertility can have for the infertile. There is a definite reluctance to allocate medical resources for the infertile. In view of the tremendous investment made in pre-natal care in this country* even though pregnancy is no disease either, the infertile must necessarily ask why such a contradiction exists. Is it because, grossly stated, that fertile women are a better investment for the state?

Unfortunately even feminists can have difficulty in understanding how very painful infertility is for the woman who experiences it. In a review in MS magazine, May 1985. of the book THE MOTHER MACHINE, the reviewer comments that the “upbraiding tone...almost ensures that the women who could most benefit won’t read it...her central accusation (that the reason so many women want children so badly is to meet ‘patriarchy’s prescription that women must produce children for their mates’) is demeaning. ‘(11) The objection must be raised that this line of reasoning is simply too reductionist. The motivations for reproduction are more complex than so and in point of fact, the desire to have children more often is grounded in the need to gratify one’s own mother than one’s husband! (12)

The infertile woman who wants to have children must defend herself on two fronts. If she seeks medical treatment, her motives are regarded with suspicion. She is often characterized by the physicians as being neurotic or, in feminist circles, as a dupe of the patriarchy. For example, one Swedish doctor writes: “Infertility investigations are often very gruelling. Since the women with the strongest need for pregnancy do not infrequently have strong neurotic problems, the expectations become easily high and disappointment occurs afterwards, regardless of the result” (12). However, why is this argument used only against the infertile? Many women do indeed have neurotic reasons for wanting to have children, but it is only the neurotic motivations of infertile women that seem to concern anyone! A strong need for pregnancy (whether because of a need to please the patriarchy or one’s mother, neurosis or just because one likes children) seems to be an issue only if the woman with that need happens to be infertile. Control studies with populations of fertile women are invariably missing.

Rather than search for latent neuroses in infertile women, as if their motives are somehow suspect but those of fertile women are not, the more relevant study would be to compare the infertile women who tries to have a biological child with those who choose to adopt and those who accept their childlessness.

ALTERNATIVES TO REPRODUCTIVE TECHNOLOGY

Such a study though would have to take into consideration that there are many non-psychological, quite practical reasons, why infertile women cannot adopt and therefore must seek medical treatment if they are to have any child at all. Here are just a few examples with respect to Sweden:

a) It can be quite simply an economic issue. IVF is free but adoption costs 40–50,000 kronor, which is a tremendous amount of money for the average Swede. b) Lesbians cannot adopt, single and or handicapped women have much difficulty and if a married woman (or her husband) has been previously divorced the chances are almost non-existent that the adoption bureaus in the foreign countries will approve their request for adoption since the adoption agencies are often religious and always conservative. (All adoptive children in Sweden come from abroad.)

c) Third world countries are far less than enthusiastic about letting their needy children be “helped” by being adopted by white nuclear families in the first world. Many view international adoptions as just one more instance where their resources and people are being exploited by the first world. This consideration and the problems of racism which the adoptive child might face are reasons enough to prevent many infertile women from considering adoption.

Foster children are sometimes named as another alternative. However, the social welfare authorities are reluctant to place foster children with childless couples because these children cannot be adopted and are not infrequently, returned to their biological parents. This loss would be felt much deeper by a person who has no other children.

The third alternative to RT is to remain and live childless. How or where can the infertile woman get help to accept her situation? If she turns to the medical profession, the only help that will be offered are technical solutions aimed at producing a baby. If this medical recourse fails* she is then still faced with the problem of coming to terms with a state of childlessness. Often the real problem which she has is not that she get a child at any price, but how to deal with the pain and disappointment of not being able to, the social pressure, grief, guilt and lack of understanding for her feelings.

The rest of this paper will deal with practical suggestions on how to cope with the state of involuntary childlessness.

SOLUTIONS

1) The most Utopian solution will be discussed first, namely that attitudes toward the childless be changed. If we begin by changing society’s attitude to the voluntarily childless woman, even the involuntarily childless woman will be helped. Also, the difference between being childless voluntarily and childless involuntarily can be difficult to define. A woman can be one or the other and even both at the same time during different periods of her life. For example, is the fertile woman in a monogamous relationship with an infertile man or the diabetic who has a sterilization childless voluntarily? The cause need not even be medical. There can also be compelling social and psychological reasons that are as strong as any physical reason why a woman cannot bear a child. Regardless of whether the women in these examples or any instances not mentioned above consider themselves voluntarily or involuntarily childless, what is most important to remember is that EVERY WOMAN IS A CHILDLESS WOMAN AT SOME POINT IN HER LIFE whether she defines herself as such or not. Every woman therefore can only benefit from an increased tolerance for the state of non–motherhood.

Unfortunately a common reaction to just such a demand is that it is evidence of hostility to children. An example of this is the umbrage sometimes expressed over the introduction of the word “childfree” for “childless” into the vernacular. The woman who does not find motherhood attractive and therefore abstains from it, more often than not does so out of recognition of her limitations as a potential parent than because she does not like children. Irritation over the usage of a word like “childfree” instead of “childless” is due more to prejudices against people without children than consideration for children. It is to suggest that there is NEVER anything positive about childlessness and the person who might imply that there is by using the more positive word “child–free” for “childless” risks being called a child–hater. (As an aside, it should be noted that the 13 children who are murdered EVERY DAY in the USA by their parents are not being murdered by either the childless or the childfree 14)).

These attitudes against non-parents are not unusual. It is still TABOO to even suggest that there might be something positive about being childless. With the increase in unemployment and low population growth in Sweden, a campaign to increase the birthrate is underway. That this discussion on the advantages of childlessness can even hope to gain a forum is less likely than ever in the present political climate. Nonetheless no one would benefit more than the infertile for it is impossible to ask them to see anything positive about their situation if the society around them refuses to let anyone dare to suggest it. One professional who counsels the infertile begins consultation by asking them to write down all the advantages they have by NOT having become parents. It is for many up until that point a forbidden idea (15).

2) Since one of the biggest problems of being infertile is the overwhelming isolation one feels in a world where all one's friends, relatives and working companions are parents (85% of Swedish women are mothers), suggestion two is directed towards the need for creating a support system for the childless woman.

One interesting project along these lines was RFSU's (Riksforeningen for Sexuell Upplysning) project last summer on the topic "Childless Women". RFSU is a voluntary organization for questions around sexuality and relationships. In the context of this work they organize week long encounter groups during the summer around different subjects. This particular summer camp on childless women, voluntary and involuntary, was given advance notice in Sweden's largest daily two days in a row. The reactions so typify the problem of childlessness that they are worth repeating here. The journalist who wrote the article spent most of her interviewing time talking about her own two children. One week after the articles were published another woman wrote in and was granted her own half page article where she wrote breathlessly that "at last she understood all the talk about mother love" after having had a baby and said that "she felt forced to write to the newspaper after reading about childless women." (16) (Apparently there is no greater threat to the myths of motherhood than the existence of women without children!) Although RFSU must usually turn, people away from their camps because they receive so many applications, this particular camp was reduced from a week to 3 days because so few women signed up. (Those who did attend though considered it an overwhelmingly helpful experience.)

3) A third observation on coping with the state of infertility is that one must be allowed to grieve over it. While it is important to be able to see positive aspects of childlessness (as discussed under item 1), one must also recognize that a necessary grief accompanies it. Ignoring that aspect or being told to ignore it by those who have children or those who have chosen not to, will not be successful in repressing the grief in the long run. (No feminist would suggest to a rape victim that she best deal with the problem by trying to forget about it or belittling her pain.)

Like any other crisis, there will be stages of denial, avoidance, anger, guilt, etc. in coming to terms with one's infertility. Although there is a big difference in the grief of a childless woman and that of someone mourning the loss of a living person who has died, there are many similarities. The chief difference is that it is an UNFOCUSED grief which the involuntarily childless woman faces (17). However, one can benefit a great deal by studying reactions to childlessness in the same way as other grief processes. The discovery that one is infertile or might be is usually a big crisis for most people but its severity lies in the fact that, unlike other crises, it is one that is extremely long. The woman might spend years trying to get pregnant before she finally gives up. It is hard to begin the process of acceptance if one is still secretly hoping against all hope. For this reason many women do find it helpful to get some kind of definitive diagnosis as to the cause of her infertility. It allows the woman to then deal with the next stage of coming to terms with her infertility.

Guilt plays no small role in the feelings of the infertile. Many women blame themselves for the reasons for their infertility. A woman can also feel guilty for “giving up” trying to have a baby, although she has reached the point where having one is simply no longer worth the psychological toll it demands. It is not always just a question either of trying all available medical solutions. Even if AID or IVF did not exist, women would still be under pressure to adopt. It is not the existence of new RT which makes woman have to have children. It is society and religion’s view that women’s only proper role is that of mother.

4) There must be better education on infertility. All too often the views of the public, medical profession and politicians are based not on any knowledge of what it feels like to be infertile but upon their own feelings and conflicts around reproduction.

5) Finally, the infertile must find a substitute for what a child would have done in her life. Only the person directly affected can know the answer to this but there are ways to go about finding that out. It is not so simple as a process of substitution (“let’s get a dog instead”) but there are ways to replace those things in one’s life which a child would have given. But in order to do that one must know WHY one wanted a child in the first place and what it represented. There are few people with children who understand so well or have more deeply thought about why they really want children than those who could not have them,

SUMMARY

One of the reasons why RT is such an explosive issue is because our feelings around the issue of reproduction are complex. In a world where women have little power, their reproductive ability may seem to be the only vestige of any way to have control in the future of the human race. At the same time, it is this idea that creates such a conflict for that woman who is infertile.

We react strongly to questions of reproduction because they awaken deeply rooted feelings about our own childhoods. It forces us to look at the society in which we live and its values in a way that we have perhaps never done before. It makes us ask how we feel about being born in a female body and how we feel about that body which does not perhaps function like the majority of other women’s. It is an existential question, a coming to terms with one’s own death knowing that one is not “continued” through the existence of any children. What view of motherhood does a woman have and how does she reel about her own mother? All of these are enormous questions in and of themselves, but to face the question of infertility/ fertility is to ask all of them and more. That so much more time is spent discussing reproductive technology is perhaps because, as threatening as all the new techs may seem, it is less threatening to talk about reproductive technology than to talk about reproduction. To talk about reproduction means that one must examine one own’s motives around her reproductive choices and deal with a lot of personal questions that are avoided when the discussion is focused on the more personally neutral question of whether reproductive technology is good or not.

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PATRIARCHAL DESIGNS: THE GENETIC ENGINEERING OF HUMAN EMBRYOS*

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Synopsis—This paper describes medical research pertaining to the future potential for genetic engineering of human embryos, and considers some of the consequences that this technology may have for women's lives. It points to both the religious right and the medical profession as groups that could potentially benefit from human genetic engineering and emphasizes the need for feminists to monitor and respond to emerging reproductive technologies.

'Under the microscope, their long tails furiously lashing, spermatozoa were burrowing head first into eggs; and fertilized, the eggs were expanding, dividing, or if bakanovskified. budding and breaking up into whole populations of separate embryos. From the Social Predestination Room the escalators went rumbling down into the basement, and there, in the crimson darkness, stewingly warm on their cushion of peritoneum and gorged with blood-surrogate and hormones, the fetuses grew and grew. or. poisoned, languished into a stunted Epsilonhood. With a faint hum and rattle the moving racks crawled imperceptibly through the weeks and the recapit-ulated aeons to where, in the Decanting Room, the newly-unbottled babes uttered their first yell of horror and amazement.'" (Huxley, 1932: 174–175.

In 1932. when Aldous Huxley first envisioned a world in which natural birth was considered a disgusting aberration. readers might have been comforted by the notion that human control over the steps of fertilization, embryogenesis and birth was far too meager to allow for the translation of such an image into reality. Today, however, science fiction merges into reality with the development of techniques for the laboratory fertilization and culturing of human ova, and the successful transfer of genes into the embryos of other mammals. The barriers to the genetic engineering of the human embryo are rapidly becoming social and political rather than technical. How will our society be affected by this technology? Although the full answer to this question is hard to imagine, one thing that is certain is the first people to be affected will surely be *women*, whose eggs, wombs and lives will form the raw material for this intervention.

The ever-increasing reach of technology into conception, pregnancy and birth has been met with concern by feminists. Although these technologies promise things that many women want—possibilities of healthier babies and of reduced infertility—the price that they exact is no less than that of women's autonomy over

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our own bodies. Gena Corea writes that women are increasingly becoming 'mother machines,' incubators for life that is controlled by *manmade* technologies from conception to birth, indeed, as Renate Duelli Klein (1984) points out, these technologies are not simply 'technical "problems" or successes, but powerful socio-political instruments of control in the hands of the patriarchy which can be used to reinforce the oppression of women.' To what extent might the new capabilities of genetic engineering lead to the further oppression of women?

In this article, I would like to examine some of the recent research pertaining to the genetic engineering of embryos, and to suggest some of the consequences that may emerge for women's lives.

THE PROGRESS SO FAR: EXPERIMENTS ON ANIMALS AND PEOPLE

An experiment reported in *Nature* (Palmiter *et al.*, 1982) provided the first indications of the dramatic possibilities inherent in the genetic manipulation of embryos. The authors were a team of researchers from five laboratories, who had isolated a gene for growth hormone from rats. They removed eggs from female mice and fertilized them in the laboratory, using a procedure called *in-vitro* fertilization. During the process of fertilization they injected the eggs with the gene for growth hormone, which they had isolated from rats and cloned in the laboratory. Finally, they put the engineered mouse eggs back inside female mice and waited to see how the pups would develop.

The baby mice grew to rat size, acquiring the name 'supermice' because they were nearly twice as large as their litter-mates that had not been tampered with.

The researchers enthused about the 'practical ways in which this information could be applied to 'commercially valuable animals.' With the appropriate growth hormone, they suggested, animals might be made to grow more rapidly and on less food. Furthermore, they suggested that such genetic treatments could help to increase milk yields, and sure enough, their suggestion has already been taken up by researchers in the cattle industry (Rutledge, 1983).

But what about those other 'commercially valuable animals'—people? Are we, too, subject to 'improvement?' Although no researchers have suggested that people be engineered for faster growth like farm animals, genetic manipulations have been proposed as a way to treat genetically based diseases. Some diseases result from disturbances in the many complicated interactions between genes and the rest of the organism, as well as its environment, but others depend primarily on changes (called mutations) in single genes. These single gene disorders are probably the most likely candidates for human genetic manipulations. In theory, they could be cured by the insertion of 'normal' genes into cells to compensate for faulty' genes. Perhaps euphemistically, medical researchers have adopted the term 'gene therapy' to describe this human application of genetic engineering.

According to *Nature* (Budiansky, 1984)) an experiment with gene therapy may soon be carried out by researchers at the University of California. The subjects will be children with a devastating disease called Lesh-Nyhan Syndrome, and their treatment is anticipated to consist of the injection of a cloned gene¹ into the children's bone marrow.

Because the 'germ line,' i.e. reproductive cells, of the children will not be affected by the procedure, it is described as 'somatic' gene therapy. (In contrast, genes inserted into a fertilized egg would theoretically become incorporated into every tissue of the growing individual, including eggs and sperm, and therefore

¹ "Cloning" involves the insertion of a DNA fragment (from any species) into bacterial DNA. As the bacteria replicate, copies are made of the inserted genetic material, which can later be separated from the bacteria.

this procedure is called ‘germ line genetic therapy.’)

The recent burst of medical technologies involving the fertilized egg bring the likelihood of ‘germ line genetic therapy’ closer and closer. The technology of *in-vitro* fertilization (IVF) is particularly connected with the potential for genetic manipulations. This procedure involves the surgical removal of eggs from a woman, to be fertilized with sperm in a laboratory dish (fulfilling Huxley’s prediction of sperm ‘burrowing into eggs’ under a microscope.² This procedure was essential to the ‘supermouse’ experiment described above, in which foreign genes were inserted into mouse eggs during laboratory fertilization. Hundreds of women have already used IVF to overcome the problem of blocked fallopian tubes. The injection of genetic material during fertilization, before the egg is returned to a woman’s body for implantation, would constitute only a slight modification of medical procedures already used on women (Bartels, 1983).

So far, no experimental attempt to introduce genes into human embryos has been reported. The lack of research may result in part from the fact that since 1975, Congress has refused to provide government funding for research involving any experimentation on human embryos. But it is easy to imagine that somewhere, perhaps in a privately funded institution or in a country outside the U.S., some researcher has already begun to experiment with the insertion of cloned genes into human embryos.

MEDICAL TECHNOLOGISTS AND THE RELIGIOUS RIGHT

For a new technology to come into being, someone has to want it—and one

doesn’t have to look far to see people who might benefit from the development and applications of human genetic engineering. Both the medical establishment and the religious right have interests that could be well served by the development of human genetic engineering. For the medical establishment, with its interest in technological control over the physical process of birth, gene therapy would be a new source of medical interventions, offering possibilities for control not only over *how* babies are born, but also over the *kind* of babies that women give birth to. And the religious right, should it achieve its goal of bestowing constitutional rights upon fertilized eggs, could find gene therapy to be an unprecedented source of power and control over women’s lives.

Human genetic engineering fits in precisely with the medical establishment’s increasing ‘technological takeover’ of pregnancy and birth. During the 1960s and 1970s, medical doctors established control over nearly every possible aspect of the delivery of babies, including fetal monitoring, epidural anaes-thesia, and even the provision of out-of-the-womb life supports (neonatal intensive care) for increasingly premature infants. With the new technologies of conception, medical researchers are shifting their focus from the end of pregnancy to its beginning. The ability to diagnose and treat fertilized eggs would be a logical extension of this new research emphasis.

Not all of the challenges faced by the medical profession are technical ones. The increasing popularity of midwives among middle- and upper-class women threatens both the authority and financial status of obstetricians. Seen in this light, the new technologies of conception might be welcomed by medical doctors as a means to lure middle-class women away from the low-technology care of midwives, with the promise that the new technologies will increase women’s chances of having healthy babies.

² The term test-tube babies’ is misleading, however, because it implies that the embryos develop to maturity in an artificial womb. Eggs fertilized by IVF are returned to a woman’s body for pregnancy; an artificial womb has not yet been developed.

So far, the religious right has vociferously opposed research into reproductive technologies, fearing that the rights of fertilized eggs will be violated in the process of research. This group was influential in developing legislation to insure that the uses of *in-vitro* fertilization accorded with patriarchal values: women using the technology were required to be married, or to be in a permanent relationship with a man, and the practice of discarding fertilized eggs (rather than implanting them) was forbidden. A continuing target of the religious right is the practice of prenatal genetic screening, with the possibility of aborting a fetus with a known genetic disorder.

Unlike genetic screening, the genetic therapy of the embryos would by definition provide therapy to embryos, rather than lead to their abortion. The religious right might well lobby to establish such a procedure as a replacement for the current screening tests. With the establishment of legal rights for the embryo, all abortions would be banned, and the only legal means of preventing genetic diseases would be the diagnosis and treatment of embryos and fetuses.

Protection of the 'rights' of the embryo, combined with the availability of gene therapy, could also mean that women would be coerced into these procedures against their will: Even with our present abortion laws, women have been brought to court by physicians for refusing to have cesarean sections. Several women in the U.S. have received court orders to undergo cesareans in the interests of the fetus (Gallagher, 1984).

Should women be held legally responsible to undergo 'embryo therapy,' we would indeed lose all freedom of choice.

WOMEN'S LIVES AND GENETIC ENGINEERING

What the actual procedures of 'embryo

gene therapy' might entail for women can be anticipated by the current procedures of *in-vitro* fertilization. The IVF procedure begins with hormonal treatments, so that the woman will ovulate several eggs ('superovulation') instead of just one. The eggs are then removed through a surgical procedure called laparoscopy. For this surgery, a woman must undergo general anaesthesia while her abdomen is distended with an inert gas, and both a viewing device and an aspirating device (to collect the eggs) are inserted. The egg(s) are then fertilized with sperm in a laboratory dish, and it is at this stage that genetic therapy might be administered. The fertilized egg(s) are then returned to the woman's body. (Because of the low success rate of IVF in achieving pregnancy, doctors insert up to four eggs at a time, hoping to increase the chances of pregnancy.) Most women using IVF undergo extensive procedures for fetal testing and monitoring throughout pregnancy, and their babies are usually delivered by Cesarean section.

But will we really have to use such a technology, even if it becomes a technical possibility? The question of choice with respect to the new reproductive technologies has been addressed with urgency by many feminists. For women who cannot afford to pay, the technologies are not even a nominal choice. But even for privileged women, the extent to which these technologies are choices' is questionable. Barbara Katz Rothman has described how our society's demand for 'perfect' babies makes a woman vulnerable to any technology that promises to insure them. Rothman (1984) points out that, 'in gaining the choice to control the quality of our children, we may be losing the choice *not* to control the quality, the choice of simply accepting them as they are.'

Feminists have also pointed out that the very existence of new reproductive technologies creates pressure on women to use them. Now that prenatal screening through amniocentesis is an option, women with access to the test must choose it or know that if they do refuse it, they may later be made to fee 'negligent.'

Ruth Hubbard has described a 'not so sci-fi fantasy' of a future in which pregnancy through IVF and embryo replacement is the norm. She writes that 'at that point "in body fertilization" will not only have come to seem old-fashioned and quaint, but downright foolhardy, unhealthy and unsafe.' (Hubbard. 1984: 340).

The issues of prenatal screening and gene therapy have been followed closely and critically by feminists in the disability rights movement. Anne Finger (1984) points out the ignorance of both our society in general and the medical profession in their stereotypes about disabilities, showing that the categoration of genes as 'good' or 'bad' are not simply medical decisions, but political ones. An increasingly thin line exists between efforts to help individual mothers to make choices about their pregnancies, and the societal effort to 'improve the gene pool' by urging the abortion of fetuses with genetic traits that medical doctors or government officials may find 'undesirable.'

Thus, for most feminists who have written about this issue, the concept of 'choice' is problematic and even dangerously misleading in light of the general lack of options and support for women, mothers, and children in our society. Furthermore, in the present wave of right-wing power and influence, even our present options are tenuous. Should the fertilized egg come to be recognized as a person, technologies like embryo genetic therapy would be totally out of women's control. It would truly be a 'Brave New World.'

FEMINIST STRATEGIES

Women may soon be affected not only by the technology of genetically engineered human embryos, but also, in

the present political climate, by regulatory policies formulated by the religious right. Yet we are in a strong position to insist upon a major role in the formulation of policies effecting reproduction. The women's health movement has exercised considerable political clout in promoting women's interests in health care policies. And feminists are already organizing to discuss responses to the newest technologies.³

One important strategy for feminists is to monitor and stay informed about research on the development of human genetic therapy. Such information is often difficult to obtain and interpret, given the competition and secrecy among research labs and the fragmented, out of context presentation of reports in scientific journals. Attending medical conferences is one way that we can learn not only about what the current developments are, but where future research projects are headed. Although professional conferences are usually expensive, and often admit participants 'by invitation only,' one way to be admitted, and without a fee, is to apply for a press pass.

We can also try to forge bridges with women who work in laboratories that do research in this area, and invite them to share information with the feminist media. Recently, social psychologist Robyn Rowland, working with an IVF team in Australia, went to the press in order to expose the practice of 'embryo flushing,' the transfer of an embryo from one woman to another (Blake, 1984).

Those of us who are concerned with this issue can urge the feminist media to inform women about the threat to our tenuous control over our bodies inherent in these new technologies. Through feminist newspapers, books, journals, and political networks we can insist that women are included in all policy decisions that affect our health and that of our children. We can also urge groups with related interests to do the same, particularly disability rights groups and ethnic groups that are likely targets for eugenics programs.

³The feminist International Network on the New Reproductive Technologies (FINNRET) is organizing a Women's Emergency Conference on the New Reproductive Technologies, to be held in Sweden in July, 1985.

The reproductive rights advocacy that feminists have long carried out may be more essential now than ever before. Access to abortion, freedom from sterilization abuse, and the availability to all women of child care and child health services: the extent to which we have these rights may well determine whether the new technologies will represent new options or intensified control.

Finally, we will surely benefit from continuing our feminist tradition of sharing the stories of our personal reproductive choices. Several hundred women have now undergone IVF, and it is crucial to know why they chose the procedure, and what their feelings about it are in retrospect. Disabled women have already begun to speak about the new technologies both in terms of their impact on disabled people in general, and on women with disabilities who have chosen to bear a child. We also need to hear the stories of women who lack financial access to technologies they might otherwise choose to utilize, of women who have been sterilized without their consent, of lesbians whose doctors deny them the options of artificial insemination and IVF, and of those women who choose to live child-free lives in a society that equates womanhood with motherhood.

The medical technologists introduce each new technology with the justification, 'women want it, it is in their best interests.' Rita Arditti has addressed this claim with skepticism: 'I find it paradoxical that the excesses of an impersonal technology developed by males in a sexist society can be viewed as important for the liberation of women.' (Arditti, 1974: 31). Only women, through the sharing of our personal stories, can define our needs, and only our own organizing efforts can insure that they are met.

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THE ROAD NOT TAKEN

Environmental Protection in the United States:
a Paradigm for Regulation of the Biomedical
Industry

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The edifice of Rachel Carson's Silent Spring¹ was built upon a spare, but controversial foundation — a two page parable of a town in which wildflowers, birds, animals and children sicken and die mysteriously after a white granular substance is aerially Sprayed over the town. Spring was silenced by chemical poisoning. Upon its publication the Monsanto Chemical Company immediately commissioned a parody of Silent Spring to be written entitled, The Desolate Year, which depicted the horrors of famine, hunger, and death in a world without chemical pesticides. Carson's graphic but allegorical portrait of endangerment to human beings and ecosystems from aerial spraying of pesticides was belittled by the pesticide industry as ahistorical and unscientific: Name one town where all of this devastation had happened, they challenged. It was scorned as emotional and irresponsible: She would cause many more deaths by famine due to crop losses from pests out of control, than would be caused by the use of synthetic pesticides, they forecast.

Nearly twenty-five years later, the major American environmental program, the Superfund Program, bases its decision-making as to where and how to expend funds for clean-up of environmental contamination, on an evaluation of the phenomena which Carson depicted in her allegory: the presence of hazardous chemical residues in the environment; stressed vegetation; contaminated drinking water; and unusual incidence of human and animal sickness and death. The detection of pesticides at many Superfund sites bears out her prescience in warning that, "The methods employed [for insect control] must be such that they do not destroy us along with the insects."²

Rachel Carson's purposes in writing this book were two-fold: to alert and educate the American public about the increasing use of synthetic organic pesticides and to advocate for governmental regulation of the chemical industry and development of sound alternatives to the mass spraying of poisonous chemicals across the United States. Despite the waves of controversy generated by the book and the backlash from the chemical industry, the United States Department of Agriculture, and academic scientists, Silent Spring has remained the most influential book on the environment written to date. Carson's work, to paraphrase the CBS news commentator Eric Sevareid, succeeded in building a fire under the Government. ³ It was the catalyst for the American environmental movement; it provoked the creation of the federal Environmental Protection Agency and many State agency counterparts. It inspired the enactment of a set of statutes powerful enough to prevent a worsening of the environment, at a minimum, and which, if courageously enforced, would belie the notion that the price a person must pay for the resources and convenience of modern society is the diminishment of Nature and the risk of our own health and wellbeing.

The success of Carson's work lies in the thoroughness of the critique, the compelling passion of the argument and writing, (she broke "the dullness barrier in science writing") and in the fact that, at its core, Silent Spring is profoundly ethical and political. As an ethical and political work which was

successful in affecting social consciousness and governmental policy, it holds paradigmatic value for the international feminist movement against the new reproductive technologies (NRTs).⁴ The campaign of criticism and trashing instigated by the chemical and agricultural industries and carried out by their lackey scientists against her and her work parallels the attacks on feminists' writing and speaking against the misogyny of biomedical technology. Industry alleged that in her call for alternatives to chemical pesticides, she was aloof and uncaring about and would ultimately be responsible for the famine and hunger which would ensue in a world without pesticides. So also have women protesting against the control of women through the new biomedical technologies been accused of being hardhearted toward infertile women, women without equal access to the technologies, and surrogate mothers. Finally, the regulation of the chemical industry for which Carson lobbied and the subsequent environmental laws enacted in the United States may serve as a model by which to assess the potential as well as the limitations of law to protect women against the increasing medical manipulation and control of our bodies by the perpetrators and peddlers of the new reproductive technologies.

In this essay I shall begin building a bridge from what is now an established terrain of ideas, policy and protective law — environmental protection in the United States — to a frontier where ideas and analysis must be forged into policy and laws, the feminist critique of the new reproductive technologies as “high-tech” subjugation of women.

Why environmental protection and protection of the rights of women? The parallels between women and nature, as playgrounds of male scientific tinkering and manipulation, as those whose rights have been least and last protected, can be used to weld vital intellectual alliances between them. Why a bridge? Both analyses share a common philosophical footing, the conviction that we ought to have an inviolate civil right to live unendangered in our society. Rachel Carson asserted this axiom before a Congressional subcommittee in 1962 in calling for protective legislation for human beings and wildlife against the indiscriminate aerial spraying of chemical pesticides. She described how these synthetic poisons not only ignore the realities of biology and create worse insect problems than the original ones they were used to solve, but that they also drift beyond where they were directed into yards, gardens, and wildlife habitats endangering all life. She called for a curb on the licence of the chemical industry to silence spring.

The right of women to live unendangered in our society is further jeopardized by the emergence of the new reproductive technologies which are essentially experimental on the bodies of women, yet are promoted as a “cure for infertility.”⁵ While it is only a small number who are subjected to these technologies, who are injected with hormones and repeatedly undergo anaesthesia and operations, all women are exposed to their “drift” into the society at large. These technologies' benign portrayal in the media invigorates the myth of fulfillment through motherhood: biological or surrogate. The talk of the expanded options offered women by the NRTs anaestheticizes women to the deeper questions of freedom of choice and motivation of choice. If medicine operates as secular religion in society, then its gospel of women to be manipulated and expropriated in order to be saved by the high priests of medicine affects us all.

Both Carson's original analysis of the then “new” synthetic pesticides and feminists' recent analysis of the new reproductive technologies embody what I call an “ecology of ideas.” They are connected to reality; they are enlivening and controversial. Not satisfied to stay entombed in the literature, these ideas insist themselves into public forums, tribunals, and before lawmakers. Their connectedness to the world betrays the disengagement of

unjustified impression that safe limits have been established and are being adhered to. Carson calls for “0” tolerance for chlorinated organics and organo-phosphorous chemicals, for reduced use of toxic chemicals, and for larger enforcement resources in FDA.

4. People ought to have the civil right to live unendangered in their society. The application of poisons in their environment could justifiably be seen as a violation of that right.
5. There are ecologically sound alternatives to mass spraying of poisonous chemicals. All are biological solutions which derive from an understanding of the living organisms they seek to control, and of the whole fabric of life to which these organisms belong. These include, among others, sterilizing and releasing large numbers of male insects and the introduction of insect parasites and predators, including birds, ants, spiders, and bacteria.
6. The U.S. Department of Agriculture (USDA) has functioned as the major federal promoter of chemical pesticides through a series of broad-scale pest eradication programs such as the mass aerial spraying campaigns against the gypsy moth and the fire ant. In the case of the fire ant program, the mass aerial spraying of millions of acres with heptachlor and dieldrin was preceded by a publicity campaign in which USDA distorted the impact of the fire ant in order to justify the pest control program. In the campaign to manipulate perception, an insect which had been no more than a nuisance in Southern states became a menace to crop and livestock and human health. USDA showed complete ignorance of or deliberate disregard for the known toxicity of the poisons applied: both were many more times toxic than DDT. Subsequently, USDA cited the evidence of damage especially to domestic and wildlife from their eradication campaigns as exaggerated and misleading.

Much more money is being poured into research on chemical insecticides than into natural biological control studies. Major chemical companies subsidize research assistantships and university research programs, a fact which explains why certain outstanding entomologists are among the leading advocates of chemical control. Would they bite

1. Modern insecticides fall chiefly into two categories, chlorinated hydrocarbons and organic phosphates. They are easily manufactured because of their chemical simplicity; but the complexity of their metabolism and pathways in the environment is overlooked at worst and not fully known at best. The one crop-same pests-same insecticides agricultural model is “the engineers’ approach to agriculture,”

The production of synthetic pesticides in the United States soared after World War II, increasing more than five-fold between 1947 and 1960, to about 650,000,000 pounds.

Hundreds of new, synthetic chemicals are introduced annually into actual use in the United States. Synthetic chemicals have the potential to alter nature within a few decades, while nature has altered life over billions of years.

2. When forests and crops are sprayed, the spray falls into lakes and rivers; in periods of high rains, it is carried by surface runoff to nearby streams; it filters through soil, enters groundwater which surfaces at rivers; it is discharged through stormwater sewer pipes and effluent pipes into receiving streams. These persistent organic compounds do not disappear. No longer detectable in the water column, they will be found in sediments, larvae, worms, fish and people. Repeated applications of pesticides to soils will cause a build-up of concentration (bioconcentration) in tubers; it will harm or destroy nitrogen-fixing bacteria, fungi, and earth-worms important for development of soil.

The suggestion that herbicides, such as 2,4-D and 2,4,5,-T, used to destroy unwanted weeds and plants, are not as toxic as pesticides is dangerous. They may result in reproductive effects at levels much lower than those causing death.

3. In theory the public is protected against unsafe residues of pesticides on food by the Food and Drug Administration (FDA), which determines and regulates the maximum residue of a pesticide which can remain on food sold in interstate commerce and not cause harm to human health. These maximum permissible limits are called “tolerances.” To establish tolerances is to authorize contamination of public food supplies with poisonous chemicals. This system provides paper security and promotes a completely well overdue. After all, were not the industries’ advertisements, the endorsement of the Department of Agriculture and many research scientists — the other side of the story — well publicized and widely known? Published in the literature and held as private suspicions among ecologists and biologists, Carson’s findings and judgments had not yet been presented or defended in a public forum.

“For the first time in the history of the world,” Carson wrote, “every human being is now subjected to contact with dangerous chemicals, from the moment of conception until death. In the less than two decades of their use, the synthetic pesticides have been so thoroughly distributed throughout the animate and inanimate world that they occur virtually everywhere.”¹¹ These facts bore out the truth of Ellen Swallow’s concept of ecology, pioneered 70 years earlier: air, food, water, and human health are so interrelated that the science of ecology must comprehend hydrology; chemistry; public health; plant, marine, aquatic and wildlife biology; and environmental engineering.¹² In that tradition, Silent Spring brought together the findings of many scientific disciplines (for which critics labeled her work generalist, superficial, and unrigorous) in order to warn the world about the dangers of the increasing use of synthetic chemicals as pesticides.

The major points of Silent Spring are summarized accordingly: our bodies, just as our bodies pass in and out of our land.”¹⁰

The power of her dual vision was the ability to focus the real source of the farmers, plight of increasing damage to food crops by insects in the heedless change from integrated, diversified farming (farming as a culture of the land) to mechanistic, one-crop farming (the engineer’s approach to agriculture, Carson called it); to foresee the addictive and debilitating effects on soil and insects of chemical dependency ; and to apprehend the consequences of applying synthetic chemicals in the environment with no insight into the interconnections of ourselves with our world.

The Findings of Fact

In the chapter entitled “Elixirs of Death,” Carson compiled a litany of chemical pesticides, reciting their toxic properties. She did so in full critical judgment of the mindset which had declared “war on insects,” and consciously connected these chemicals and that mindset with their progenitor, the Second World War. The chemicals had originally been developed for chemical warfare and tested for their biocidal potential on insects. After the war, excess planes and chemicals were re-cycled into so-called “peacetime” uses — aerial spraying of pesticides on farmland, forests, and towns.

She argued as a plaintiff conscious that her arguments against the defendants and apologists of “the war on insects” were nature which has influenced environmental law and also to illumine other vital critiques, namely the feminist analysis of the new reproductive technologies.

Two Sights Seeing

Silent Spring was written with what Janice Raymond has else-where called a “dual vision.”⁹ Carson looked more closely into and was, simultaneously, more far-sighted about the widespread application of synthetic chemical compounds in the ecosystem, than her critics. Looking backward and forward in time, Carson contrasted the “deliberate pace of nature” in shaping, directing, and diversifying the planet and its life forms over hundreds of millions of years with “the impetuous and heedless pace of men” in introducing thousands of new chemicals from laboratories annually into the marketplace and, ultimately, into the environment. Most often, these chemicals are used without complete certainty of their effect upon aquatic life and wildlife, if they find their way into the water cycle, or upon humans, if they enter the foodchain,. Whether bacteria can biodegrade them, and if so, at what rate and into what by-products, are questions whose answers come, if at all, after the compound has contaminated the environment. Looking more closely than her critics at the web of life, she conveyed the awesome complexity of introducing biocides into a matrix where soil, water, plants, wildlife and humans are inextricably interconnected. We ignore at our own peril, she warned, the simple but profound truth that, “Our land passes in and out of so much traditional scientific research like that of the American geneticist and Japanese biologist at the University of Massachusetts, Amherst who are studying genetic mutations in descendants of ferns irradiated by the atomic bomb in Nagasaki and insist their work is apolitical and for the interest of “pure science” only.⁶ In the sense that Janice Raymond has written about “affection,” both Carson’s analysis of the chemical war on nature and feminists’ analysis of biomedical manipulation of women’s lives are affective. They have the power to attract, to influence, to stir, to move to action.⁷ And they have vision. Rachel Carson called for “the road not taken,” that is, biological solutions which derive from an understanding of the living organisms they seek to control and of the whole fabric of life to which these organisms belong. Likewise, the final resolution of the Women’s Emergency Conference on the New Reproductive Technologies calls for

...a different kind of science and technology that respects the dignity of woman-kind and of all life on earth... [and]... break[s] the fatal link between mechanistic science and vested industrial interests and to take part in the development of a new unity of knowledge and life.⁸

This essay offers a brief life history of Rachel Carson's ideas in Silent Spring. Life history because her ideas live and they inspired people and governments to action. Life history because nearly 25 years later they can be employed to rebuke stodgy, sterile environmental institutions which were originally "affected" by her ideas. The ecology of these ideas lies in their power both to arouse a unique consciousness of the value of the hand that feeds them? "But knowing their bias, how much credence can we give to their protests that insecticides are harmless?"¹³ Since natural biological controls do not promise the fortunes which seduce companies and scientists, alike, it is left to state and federal agencies to advocate for and find them, if at all.

Plunged into a War

Silent Spring was published in September 1962 by the Houghton Mifflin Company. The prior June, The New Yorker published a condensed version in three parts. By July, yet before the book appeared in bookstores, the uproar in government, chemical, and agricultural circles had commenced.

On August 2, the Velsicol Chemical Corporation sent a registered letter to Houghton Mifflin suggesting that the company reconsider its decision to publish Silent Spring. The letter cited "inaccurate and disparaging statements" about two chlorinated hydrocarbon pesticides, chlordane and heptachlor, both manufactured solely by Velsicol. It allied Carson with "food faddists" and others, which are manipulated by pernicious influences which attack the chemical industry for being grasping and immoral, but whose real intent in advocating a limit on the use of pesticides is to reduce the productivity of American and western European food supply to "east curtain parity."

The Federal Pest Control Board, smiting from her critique of government support of the war on insects, met in a session where they alternated between angry attacks on Silent Spring and remarks about Carson. One well-known board member said, "I thought she was a spinster. What's she so worried about genetics for?"¹⁴ By publication day, September 27, the book had been sold to Book-of-the-Month-Club and its advance sale reached 40,000 copies. The attacks on Silent Spring and Carson mounted, swinging between the intent to discredit her work by associating her with fanatics, attributing idiosyncratic tendencies to her, and making misogynist insinuations about her person, personality, and lifestyle to charging that the book was unscientific because emotional; biased because it only argued the ecological arguments; and dangerous in its dire implications for the planet. A colleague of Carson's from the Fish and Wildlife Service, and a leading wildlife specialist Clarence Cottam, summarized the attacks on her person accordingly:

Miss Carson has been referred to as a priestess of nature, a bird-, cat-, or fish-lover, and a devotee of some mystical cult having to do with the laws of the Universe to which critics obviously consider themselves immune. 15

The chemical industry bonded as a united front to stymie the book's power and influence. Certain companies threatened to withdraw advertising from garden magazines and newspapers that favorably reviewed or cited Silent Spring. The Manufacturing Chemists Association began to saturate the news media with feature stories stressing the positive side of chemicals. The National

Agricultural Chemicals Association doubled its public relations budget and distributed enormous numbers of critical reviews of Silent Spring.

In an address before the Seventh Biennial Conference of the Food and Agriculture Organization (FAO) of the United Nations in Rome in November 1971, Norman Borlaug credited Carson with promoting poverty and world-famine from a pedestal of privilege.

The current vicious, hysterical propaganda campaign against [pesticides], being promoted today by fear-provoking, irresponsible environmentalists, had its genesis in the best-selling, half-science, half-fiction novel Silent Spring, published in 1962 . .

If the use of pesticides in the U.S.A. were to be completely banned, crop losses would probably soar to 50 percent, and food prices would increase four-fold to five-fold. Who then would provide for the food needs of the low income groups? Certainly not the privileged environmentalists.¹⁶

What emerged in the campaign waged against Silent Spring was an amalgam of personal prejudice and hostility toward Carson; misquotation of her ideas; and unsubstantiated assumptions and claims of the universal success and benefits of pesticides — all packaged with a veneer of scientific respectability. Industry's and applied science' defense of themselves and their attack on Silent Spring are classic examples of perceiving the prophet as obstacle to progress.

Synthetic pesticides and the NRTs are begotten from a common mindset and mythology. Both are technical "fixes" which replace a more ecological solution to the problems they purport to solve. The major defenses of the use of synthetic chemical pesticides put forth by the chemical industry parallel very closely the more recent defenses of the new reproductive technologies by the medical industry.

Myth of Technological Progress.

The world cannot feed itself without pesticides. A return to a world without pesticides is an ignorant and backward movement which augers impending doom. "As one reads this skillful fantasy," writes the noted ecologist La Mont Cole, "it is easy to become persuaded that years like those just before World War II could not possibly have occurred: no chlorinated hydrocarbons; no organic phosphates, payments to farmers to reduce production and still crop surpluses!"¹⁷

In a survey of 108 in-vitro fertilization(IVF) clinics in the United States, Gena Corea and Susan Ince have examined the myth of technological success used to promote IVF. Their conclusion: false success rates are motivation for doctors and for women.¹⁸ Some clinics define success as pregnancies per laparoscopy; others, as pregnancies which made it to embryo transfer. None defines it as do the authors, as a baby born.

Even with the spurious definitions of success, the highest “success” rate from the 54 respondents was 20%. Twenty-seven of the 54 clinics never produced any babies.

The myths of success and progress seduce for many reasons. One is people’s failure to examine the definition of success and progress, as did Corea and Ince, and to bring any historical perspective to the results of the technologies. For the pesticide industry progress is dead bugs, even if their parasites are also killed and the problem insect comes back in greater numbers in subsequent years. For the biomedical businessman, success is a pregnancy not a baby. Second, the myths succeed because people are convinced that technical solutions are more scientific and thereby superior to non-technical or less technical ones. The myths persuade people that chemical pesticides are advanced and more reliable than integrated pest control. Finally, biomedical technologies offer the pseudo-reliability and pseudo-predictability of a man-made birth.

False cost-benefit comparisons.

Carson is accused of worrying about cats’ deaths from DDT applications in Java, while not mentioning “the 10,000 people throughout the world who die of malnutrition or starvation everyday.”¹⁹ Her critic sets up a smug cost-benefit analysis in which cats’ lives are lost but humans are saved — a small loss from a great gain. “If DDT kills some cats,” he writes, “but saves many humans; if weed-killers destroy a pocket of wildlife shelter but increase highway safety, so much the better.”²⁰

This very neat but deficient equation ignores the ecological impact of the cats' death in Java – an epidemic of disease-carrying rats. Also it is built on the unproven assumption that DDT and its counterparts will save those 10,000 people from starvation and malnutrition.

At the time of this critic's review of Silent Spring and of Norman Borlaug's doomsaying that a world without pesticides would condemn us to pestilences, plagues, and famine, pesticide economists were only beginning to assemble the information needed for an accurate analysis of the changes wrought in agricultural production since the introduction of pesticides. Wellmore states the case for the fallacious and self-serving nature of criticisms, such as those of Borlaug and the critic cited above:

.....As of 1971, the benefits and costs of pesticides even in the most narrow sense of their marginal effect on the farmers' profits (disregarding external diseconomies), remain unmeasured in agriculture. On what then do USDA and the chemical companies base their claims for pesticides? One answer is that uncertainties in the methods used to evaluate pesticide benefits allow them to interpret the results as they choose. For example, one method involves comparing production figures before and after the use of pesticides from the same farms or regions over a period of years. USDA and the pesticide companies, using this method, attribute the large increases in crop yield achieved by American farmers since the early fifties to pesticides. But they do not distinguish the contribution of increased use of machinery, fertilizers, better crop strains, and other changes. Indeed, the deductive logic of the numbers game can cut both ways: at least one standard textbook on economic entomology estimates that %crop losses to insects in 1936 and 1957 were virtually identical, although organic synthetic insecticides had come into widespread use in the interval.²¹

In other words, while pesticide promoters talked glibly about success and economic advantage to the poor of the world, as of 1971, there was no proof that pesticides' benefits to food production were a result of pesticide use and not due to other changes in agriculture.

If a cost-benefit approach to evaluate and justify the use of pesticides is to be employed, then we must weigh all of the costs – economical, ecological, and those to human' health – that accompany their use. There are the risks inherent in manufacture and transport of these acutely toxic compounds. For example, the tragedy in Bhopal, India which killed over 2,000 people and maimed and injured more than 100,000 more, was caused by a leak of methyl isocyanate used in the manufacture of the pesticide Sevin. Other risks include the exposure to pesticides in application by farmworkers; the residues on foods eaten by animals and humans; the drift of spray to wildlife, wetlands, aquatic areas, and neighborhoods causing multiple exposure; and most recently, the discovery that residues in soil in agricultural areas have contaminated private wells and endanger entire aquifers under Florida and Hawaii. Finally, there is the risk documented by van den Bosch²² that synthetic chemical pesticides result in the opposite of their intended use: they create more pests than originally existed.

An honest weighing of pesticides' proven benefits against their known harm corroborates Carson's warning that the methods employed for insect control may be such that "they will destroy us along with the insects." The simple arithmetic of adding for benefits to agricultural yield and subtracting for the multiple losses and risks shows the use of pesticides to be a decision driven by a cover-up of their preponderant harm and by a belief in the myth of progress from their use.

The same manipulation of costs and benefits is present in the promotion of the new reproductive technologies. The doctors who practice them and the women who surrender to them assume that the benefits outweigh the costs. Much as women accept the suffering of natural childbirth as a “small price” to pay for a child, so women expect and are expected to pay a price, any price, for a child through IVF. What is that price? A woman’s life is no longer her own – it is completely expropriated and medicalized during the period of treatment. De minimis she risks adverse effects from the hormones, anaesthesia, and medical procedures, and potential damage to her ovary and uterus. What are the benefits? A very, very small chance that she will bear a child. And who has proven yet that the very small “real” success rate of IVF is any greater than the natural success rate of “infertile” or “problem” women using the age-old method of conceiving and carrying a child? The simple arithmetic of adding for the alleged benefits to infertile women from the IVFs and subtracting for the multiple risks and harm they suffer from the procedures shows the promotion of the IVFs to be driven, as with pesticides, by the cover-up of their preponderant harm and by a belief in the myth of their success.

Lighting a Fire under Government

In stark contrast to the war declared on Silent Spring by manufacturers and users of pesticides was the book’s consciousness-raising effect on key federal politicians. President Kennedy, after reading Silent Spring, requested that the Life Sciences Panel of the President’s Science Advisory Council (PSAC) study “the pesticide problem” and prepare a report with recommendations concerning use and regulation of pesticides in the United States. The PSAC report, entitled The Use of Pesticides, was issued on May 15, 1963. Its “blue ribbon panel of men of achievement in scientific and public affairs” concurred with the major premise of Silent Spring, that the massive and growing use of persistent pesticides as the only solution to agricultural pests and disease vectors, ignores the realities of biology and ecology and is endangering to human health and the environment. That evening on CBS news Eric Sevareid summed up the situation accordingly:

Miss Carson had two immediate aims. One was to alert the public; the second to build a fire under government. She accomplished the first months ago. Tonight’s report by the Presidential panel is prima facie evidence that she has also accomplished the second.²³

What is interesting to note in the wake of this report is the reversal on the part of critics of Silent Spring. Many who had initially denigrated the book praised the PSAC report for its temperate and balanced tone and acknowledged it as a “vindication” of Silent Spring. Vindication implies that the book was badly received and in need of rescue; it plays into the view mediated by the chemical industry that the book was widely repudiated by scientists. Using the word “vindication” dislocates the problem onto the book as if it were in need of legitimation by Presidential and Congressional committees, rather than acknowledging the contradictoriness of critics who did a complete about-face once Silent Spring was endorsed by the PSAC. The report was not a vindication of Carson’s work; it was a consequence of its political and ethical persuasion.

Eight years after Rachel Carson educated the American public and government in the principles of ecology and advocated for an unequivocal protection of human health and the environment, President Nixon created the Environmental Protection Agency(EPA). In so doing he stated that its purpose was “the protection, development, and enhancement of the total environment...”²⁴ He created a single federal agency because “the environment must be perceived as a single, interrelated system.”²⁵

EPA is the most powerful regulatory agency in the United States government;* yet one of its hallmarks has traditionally been an independence from industrial and political interests. Conceived from the ethical moorings of Silent Spring at a time of great social ferment throughout the world,

it has always attracted environmentalists who might otherwise disdain working for the federal government.

Throughout the 1970's and early 1980's the Agency promulgated regulations to protect air, rivers and lakes, the ocean and drinking water; to prohibit the manufacture and distribution of toxic substances which endanger human health and the environment; to require virtually every company in the United States to safely handle and dispose of hazardous waste; and to clean-up every major abandoned hazardous waste site in the country. With the Clean Air Act, EPA limits air pollution from over 150 million cars, trucks, buses, and over 20,000

*EPA is responsible for implementation and enforcement of the following major statutes: Clean Air Act; Clean Water Act; Marine Protection, Research and Sanctuaries Act; Federal Insecticide, Fungicide, and Rodenticide Act(FIFRA); Safe Drinking Water Act; Toxic Substances Control Act(TSCA); Resource Conservation and Recovery Act(RCRA); Noise Control Act; Comprehensive Environmental Response, Compensation, and Liability Act (Superfund). factories, power plants, and other major stationary sources of pollution. The Clean Water Act regulates pollution at close to 100,000 different industrial sources. The Resource Conservation and Recovery Act enables EPA to protect the public and the environment from endangerment as a result of society's production of over 500 billion pounds a year of hazardous waste. The new RCRA Amendments encourage minimization of hazardous waste and discourage, by the stringency of technical requirements, the proliferation of hazardous waste facilities. The Superfund law, EPA's current "heroic" program, has created a fund from taxing industry, to study and clean-up the major hazardous waste abandoned sites in the country, of which the estimate is currently greater than 10,000. Perhaps the laws with the most radical potential for protection are FIFRA and TSCA. According to them, EPA is responsible for evaluating all pesticides and several thousand new chemicals each year for their safety before allowing them to be registered for use. One writer has described the all-encompassing regulatory framework of EPA accordingly:

Federal law requires the EPA Administrator to make decisions that affect everything from the cost and performance of a new Chevrolet to the way a farm community in Oklahoma disposes its sewage. Decisions that determine whether children in urban areas will breathe debilitating lead fumes and whether fish will survive in the water of rural lakes and streams.²⁶

Environmental Protection; A Paradigm for Regulation of the NRTs

The Environmental Protection Agency was founded on principles which had become common cause in the American society since the publication of Silent Spring.

- People and nature have rights to exist unendangered from pollution and should be enabled to do so by regulatory protection.
- This can only be done by a framework which is set up to control polluting industries whose primary imperatives have been to compete for markets and to increase profits.

- The regulators must be free of ties to politicians and industry and of an inherent bias for chemicals which engenders a nonchalance about their toxicity.
- They must be grounded in the “realities of biology.”

These principles are easily transmogrified to the reality of women whose right to physical and metaphysical integrity is subsumed by the manifest destiny of those whom Gena Corea calls “pharmacrats”; they who would biomedically manipulate reproduction and thereby women and in so doing create bio-political “rule by physicians.”²⁷

- Women have the right to exist unendangered from medical technologies and drugs which are risky or for which the risks are undetermined.
- This can be done by a framework which is established to control the biomedical industry whose imperative is to develop profitable biomedical technologies and make them standard operating procedure so that they become indispensable.
- The policymakers and regulators must be free from professional ties to the biomedical complex and of a bias for technical solutions to gynecological problems, such as infertility, which engenders a nonchalance about the technologies’ risks to women.
- They must be committed to the rights of women: to knowledge of the risks inherent in the technologies; to refuse biomedical technologies; to protection against all environmentally and doctor-induced causes of sterility; to redress from harm suffered from the technologies; and to maximizing autonomy in our lives.

The materialization of principles into law and regulation is crucial for the translation of the reality of ideals into the reality of daily life. So, too, is the enforcement of those laws and regulations. What follows is a reflection on the realization or failure to be realized of the ideals of Silent Spring in EPA’s enforcement of environmental statutes, and a series of recommendations to those concerned about devising an analogous framework to protect women against the New Reproductive Technologies.

I Conflict of Interest

Environment

EPA was created not only to consolidate protection of the environment under one agency, but also to rid the government of the conflict of interest and ties to special interest groups and politicians to which the Department of Agriculture was subject in regulating pesticides. However, with the President of the United States appointing the Administrator who then selects top level officials in Washington and throughout the United States, there is a political bias built into the administration of EPA. Loyalties to the President and the ruling political party vie with the Administrator’s concerns for the environment when the two are at odds. Second, since upper level managers come and go with the administration, there is the chance that they may not in fact be environmentalists and that they may have ties to industry or political lobby groups which will dissipate their support

of strong enforcement programs or tough legislation. Third, environmental laws are only as safeguarding as they are creatively and vigorously enforced. Rigorous enforcement, such as assessing penalties for violations, cancellation of a toxic chemical from the market, administrative and civil actions, is difficult for many people because it is confrontative process which presumes a tension between the regulator(EPA) and the regulated(industry). It requires aggressive, environmentally committed, and ethical persons who are un-bribeable and unable to be intimidated. Finally, as an institution enlarges and ages, it takes on a life – an institutional life – which generates its own purpose for existence which may overshadow the original ideals or mission for which it was created. Unless they are vigilant, managers of an institution can find themselves making decisions to safeguard the institutional life of the agency (e.g. its image and popularity with the media, its rapport with the business community or local government, its “loyalty” to the current Administrator, etc.) at the expense of fidelity to the original ideals of the Agency. For all of these reasons it is imperative that an agency such as EPA be scrutinized and checked by public interest groups, such as the Conservation Law Foundation and Natural Resources Defense Council (NRDC), to name two, as well as have the public participation in major decisionmaking as is mandated in the hazardous waste laws, the Wetlands Protection Act and the 1978 amendments to FIFRA. The NRDC has a national network for environmental information and legislative action and watchdogs the enforcement of federal legislation. They help draft legislation and legislative amendments and present expert testimony in Congress. By suing the Agency they have compelled EPA to carry out their regulatory responsibility and have won the ability to sue directly polluters of the Clean Water Act where EPA has failed to enforce pollution laws.

Public participation has gained the central position it holds in the federal and state hazardous waste programs because of Lois Gibbs, a high school graduate, housewife, and mother turned environmental activist. In 1978 Lois Gibbs at 26 was elected president of the Love Canal Homeowners’ Association at the height of the neighborhood’s protest against the government’s resistance to looking beyond the ring of homes identified as affected by the wanton disposal of chemicals in a mile-long trench by the Hooker Chemical Company. She waged a two-year daily campaign to get honest studies and government attention, which included holding EPA officials hostage in the Homeowners’ Association office. Afterwards she published an article in the Journal of Public Health Policy in which she stated that the community endangered by the hazardous waste site must be involved in the fate of that site and ultimately their own health and lives and that a public process should be established which enables them to participate in the design of studies and to formally review and comment on the final conclusions and the choice of options for remedial action. As a result of her advocacy, EPA has established formal community participation on all hazardous waste sites whereby the community is regularly briefed on all scientific information about a site and is requested to submit formal comments on studies and recommendations on final clean-up of a site. While not having final or majority vote in remedial action decisions on hazardous waste sites, well-organized communities have been very effective in shaping the direction of studies and in hindering solutions or decisions they think are inadequate.²⁸

Women and the New Reproductive Technologies

Ethics committees, policy committees, legislative committees formed for the purpose of writing national policy, laws, and regulations to control the development and/or use of the new reproductive technologies must be comprised of people who are knowledgeable in the field, but not invested economically or professionally in the technologies’ use or development. Doctors regulating doctors is akin to industry regulating industry.

Recently Nature magazine carried an editorial arguing against Enoch Powell ‘a bill in British Parliament to prevent the use of fertilized human embryos for any other purpose than the

treatment of embryos. The force of Nature's argument advocates, contradictorily, for holding to tradition in regulation while forging new frontiers in research on human embryos. It states that there are already many fields of research which raise complex moral issues, but "in no case has it yet been thought necessary to institute an outright ban." It concludes that regulation, not banning, has always been and should be sufficient. The editor, then invites scientist readers to submit proposals for investigation on human embryos in order to create a convincing need for this research. Contributors are offered a 1 year issue of Nature free.²⁹ These scientists, with more technique than good judgment, are like boys who discover that tools can be used as weapons but lack the commensurate wisdom or will to avoid war.

A trenchant example of the conflict of interest in scientists' regulating themselves is the history of regulation of recombinant DNA in the United States. Ross Feldberg, a biochemist working on radiation-damage to DNA at Tufts University in Massachusetts, writes that initial guidelines on recombinant DNA research were relaxed and lifted by the late 1970's not because of any clear proof of safety but rather

...because of the desire to maintain the competitive edge in basic research over European and Japanese scientists, because it was easier to evaluate the benefits than the risks, and because of the fear of opening the issue of control over science and technology to a broader audience.³⁰

The National Institute of Health(NIH) committee used to evaluate experiments was comprised of scientists, while the nonscientists invited to participate were used to carry out policy not formulate it.

The committees formed to regulate the NRTs should be comprised of people who have studied them, not only or primarily from a medical perspective, and people who are most affected by them, women. Women are the counterpart within the NRTs of people and nature in the case of pollution caused by industry. As people represent themselves and have a determining voice in comment on regulations and in final studies and decisions on hazardous waste sites; so women must have a voice, and a determining one, in what are acceptable technologies.

All women, not only infertile women, are affected by the NRTs. No woman is an island; the medical colonization of one or some women makes all women potential bodies to be colonized. At the Emergency Conference on the New Reproductive Technologies, Gena Corea expressed the expansionist spirit of the biomedical industry. The imperative of the pharmacrats, she said, is to expand the technologies "to the outer limits of probability." I think it is likely that the majority of women in the world, if informed, would recoil from the empire-building which is being carried out by the biomedical industry with pieces and parts of women's bodies. International feminist groups like FINNRAGE can serve to represent women in at least two ways: as members and expert witnesses to national and international regulatory committees on the NRTs; and second, as critical outsiders, like the NRDC, to watchdog the implementation of policy and regulations, prepared to sue an agency for failure to protect women through rigorous enforcement of protective legislation. As such, FINNRAGE members can work to counter the empire-building with women's bodies, to bring feminist analysis to political forums, and also support alternative solutions to the problem of infertility.

Let us look at where women as a people singularly affected by the biomedical technologies could have a determining voice in whether or not the technologies proliferate. Many choices involve the concept of acceptable or allowable risk, such as using a pesticide on agricultural crops, issuing an industry a permit to discharge into a river where the permit establishes an allowable level of

contaminants in the discharge, and many daily activities, such as wood-burning, driving, smoking, and eating a certain diet. Acceptable or allowable risk means the degree of risk, usually expressed in the chance of someone dying from the activity (e.g., 1 death per 10,000) which people may be willing to live with for the sake of the benefits from the activity or because an alternative activity has even higher risk or does not exist as a possibility.

In the case of issuing an environmental permit, if the actual risk posed by the contaminants permitted to be discharged is greater than the calculated allowable risk, then the action is not taken or the permit is made more stringent to lower the risk. In the case of siting a hazardous waste facility, such as an incinerator, people have often insisted on “0” risk or so little risk that the degree of safety required is considered either too expensive or technically unobtainable and discourages the facility entrepreneur. Thus, the dearth of hazardous waste incinerators in the United States.

Carson, in her testimony before Congress, called for “0” tolerances or residues of pesticides in food because no concentration can be proven to be without risk. Women who protest violence against women and who march to “take back the night” are exposing the risk for any woman to be sexually assaulted. Recently in a New York Times interview, Andrea Dworkin, co-author with Catharine MacKinnon of the Minneapolis anti-pornography ordinance, said that her goal is to “live in a world where women aren’t raped.”³¹ In the language of risk, her goal is to reduce to “0” the risk that any woman will be raped.

Consider the same concept applies to the NRT’s. Women fully represented on ethics committees and in policy-making could force the knowledge and calculation of risk: risk to the woman from hormones and invasive surgery; risk to few percent embryos which survive to become human beings from the initial manipulated existence. Women representing themselves on policy boards and regulatory committees as the subjects of those risky technologies would be in the position of requiring and enforcing the calculation of risk and of establishing the acceptable level of risk, if there is any at all, before these procedures are allowed to be used.

II Ethic of Environment as Resource for Its Own Sake

The Wetlands Protection Act, a federal act which is enforced by conservation commissions of each town and city in each state, is a unique example among federal legislation of the crystallization of the ethic of the environment as valuable for its own sake and not only as a resource for human use, one heritage of Silent Spring. Environmental law could have envisaged the environment to be protected for the sake of human use; air, water, and land as resources necessary for human health and happiness. However, in both the Wetlands Protection Act as well as in the hazardous waste statutes, the environment, solely in the case of the former and co-equal with human health and welfare in the case of the latter, is intended to be protected and valued for its own sake (which will always accrue to the well-being of human beings since we live in nature).

Wetlands, once deemed useless, insect-ridden land to be drained, filled, and developed, are now recognized as so valuable an ecosystem for native plants, waterfowl and animals and as an integral part of the hydrological cycle, that activities in or near them which will adversely affect them are subject to regulation. In the process of evaluating a proposed action in or near wetlands (e.g., dam repair, dredging to remove silt, etc.) every alternative to that action which offers the same or comparable benefit is compared to the original proposed action according to the risks it poses to the integrity of the wetland. In so doing, the intent of the law is to weigh the benefit of the proposed project against the risks to the integrity of the wetland and to choose the alternative which offers the original or a comparable benefit at the least impact to the wetland. If the risks of the actions under consideration and those of the alternative actions exceed the project’s value or alleged benefit, then “no” action is recommended. The wetlands’ continued, undisturbed existence

is judged to be more important than the project which jeopardizes it.

We could apply this model of decision-making to the problem of how to remedy infertility – the alleged goal of the NRTs – in order to demonstrate how a government’s funding for infertility projects or research could be directed away from the NRTs.

<u>BENEFIT</u>	<u>METHOD</u>	<u>RISK</u>
Enable infertile women to bear children with for uterus pregnancy	<u>In-vitro</u> fertilization	Adverse effects from hormones Trauma to ovary Risks from anaesthesia repeated operations Risks from procedures monitoring IVF Potential damage to Risk of ectopic

<u>BENEFIT</u>	<u>METHOD</u>	<u>RISK</u>
Enable infertile women to bear children; Reduce infertility permanently; Additional health benefits	Research industrial, environmental, and medically induced causes of infertility. Recommend reduction in exposure to chemicals and technologies identified to cause infertility and that they be taken off the market. Quantitate % change in infertility expected.	“0” risk to women; Cost to industry to replace chemicals which cause infertility and to modify workplace exposure. Costs offset by savings in insurance from lessened liability.

If risk-benefit analysis is to be used seriously and not as some slick numbers game, it is extremely important that all the risks involved in the use of a technology or compound be considered and that benefits which are not equivalent be identified as such. The success rate of IVF is estimated to be somewhere between 0 and less than 20%, when success is defined as curing infertility, i.e., a fertilized egg survives to become a child.³² If the chemical, industrial, and medical causes of infertility can be estimated to be no less than 10%, then the benefit of identifying and reducing or removing them is greater than that of IVF. In consideration of risks, it is crucial that all manner of risks be considered. For example, in the use or manufacture of a pesticide, the decision to use it is weighed against its hazards when properly used (residues on crops which are eaten by domestic animals, wildlife and humans). However, the entire risks of the pesticide include the risks of malfunction and exposure to workers and nearby residents; risks of accident and spill in transport; risks involved in application for the applicator and in drift to other properties; risks only recently realized to entire aquifers in agricultural states, such as, Hawaii and Florida; risk of upsetting the ecology of insects creating greater insect problems than existed initially; and risks when used or manufactured in countries where there are minimal safety regulations or training or warning labels in appropriate language because health and safety standards imposed on corporations in the United

States are not imposed on the same corporations' manufacturing facilities in developing countries.³³

In considering risk in the most comprehensive manner, I would add the category of existential risk to the litany of physical risks listed above for the NRTs. The medicalization of women which results from medicine's appropriation of those activities which women do in their own bodies poses the following metaphysical risks to women:

- experimentation on women's bodies without full knowledge of the effects reinforces the valueness and expendability of women.
- legitimates medical fantasy of unlimited technocratic control over women's procreative powers.
- reduces women to sources of eggs, embr yos, and wombs and further obliterates the value of women as autonomous beings. Much as wetlands were treated as useless lands to dredge and fill, women become bodies to dredge and fill. Women's bodies are useful only as sites for medical engineering.
- generates a false security in safety and success of technologies when in fact they create greater risk of infertility because they sidetrack society from the predominant causes of infertility and blunt any protest against exposure to chemicals and industrial products and medical practices which cause sterility.

Just as the ethic of the environment as valuable for its own sake is crystallized in the Wetlands Protection Act, so it is crucial that policy and regulation controlling/banning risky drugs and technologies, as well as experimentation on women and traffic in women for surrogate motherhood, convey and defend the value of women as autonomous beings whose primary value is to exist as full human beings in society. Thus far, the preponderance of legislation worldwide has focused on the commercialization of surrogacy, regularizing the status of offspring, controlling traffic in eggs and sperm, and limiting experimentation on embr yos. The foci of concern are commercialization of wombs, not the traffic in women; experimentation on embr yos, but not on women's bodies; crass profiteering in eggs, embr yos, and wombs, but not the crass reduction of women to bodily parts and reproductive resources.

Women must represent ourselves on ethics, policy, and regulatory committees if we are to have law and policy that insists on ... a different kind of science and technology that respects the dignity of womankind and of all life on earth.

III Regulatory Considerations for the NRTs

Banning vs. Regulation

The framework of risk-benefit analysis must always encompass the idea that some risks are not worth taking. A few prescient physicists argued that no matter what its benefits, the detonation of

the atomic bomb on Japan would ultimately cause greater evil in the world than the good of whatever lives it would purportedly save. Rachel Carson, argued that the risks in proliferating chemicals in agriculture were too great and that the biological “road not taken” should be preferred. While neither argument prevailed, women must not take an attitude of defeat about calling risks inherent in the techniques and chemicals of the NRTS too great a price to pay.

Legislation should call for regulation and banning. Banning a medical technology or drug therapy will be as difficult as banning a pesticide or other chemical has been. Industry has adapted somewhat to the concept of regulation in the form of permits or guidelines, but banning represents an infringement on the “free enterprise” system. It reasserts that there are some risks, no matter how small, which are too dangerous to take and that no economic benefit to the industry can justify the risk.

Bans can and should include prohibiting research and experimentation. We know from the development of the atomic bomb that research generates momentum to use. The editorial in Nature called for scientists to submit research ideas and objectives for experimentation on human embryos. The techniques are known but need a raison d’etre. Most bans are established retrospectively, after a crisis, after the damage is done: DDT, PCBs, thalidomide, etc. We must break this pattern of needing thali-domide babies or radiation sickness or “Yusho” disease to have the intellectual and moral courage to impose a ban. Bans must be imposed prospectively, because of expected toxicity or en-dangerment from experimental data; because of what is suspected but not fully known; or because the process of pursuing the knowledge is in itself inherently dangerous.

Let us also define experimentation with respect to these technologies. Where failure rate is so high and the reasons for success and failure are unknown, the technique is experimental and women are being experimented upon. Legislation must address the “right to know” on the part of women as to the experimental status of what is being done to them and the unknown nature of risk to themselves and to the embryo and prohibit experimentation upon women as well as human embryos.

Potential Endangerment

The concept of endangerment in hazardous waste regulations includes a precautionary or preventive element. Proof of potential harm can establish endangerment and it is not necessary to establish that actual harm has already occurred. This concept of endangerment could be very important for prohibiting the use of synthetic drugs or techniques where a crisis from their use has not yet happened. The known toxicology of the drug and the known or expected risk of a procedure could be used to establish the potential endangerment to the woman in question and to justify regulation or prohibition.

Liability

Both strict liability and joint and several liability are powerful deterrents in environmental law to industry handling hazardous waste irresponsibly or unsafely. The concept could be applied in the NRTs context, whereby the doctor, entire clinic or practice, and the drug and instrument manufacturers could be held liable for women injured by IVF procedures and for birth defects in children born through IVF. Successful liability suits drive up the costs of insurance, and, as has happened in hazardous waste, become an economic discentive for the industry. Insurance companies are becoming increasingly reluctant to insure hazardous waste landfill clients because of their potential for environmental pollution and the spectre of liability suits.

Absolute Freedom in Science

No industry, government, or person enjoys the right of absolute freedom. In so-called free enterprise countries environmental laws curtail the freedom of industries to market chemical products unless they are deemed safe enough to not pose unreasonable risk to humans and the environment. Governments have imposed safety regulations, the “right to know” in the workplace and required expensive pollution control devices of industry. Nor should medicine or any other realm of applied science be any freer to pursue technologies without examining their risk. They are not above doing harm and should not be above being curtailed from doing it and punished for doing it.

Absolute freedom in science is envisaged as that which is given or allowed to scientists rather than that which scientists exercise and express by the diversity of their work. There are many “roads not taken” in science. The real question is not ought one to have absolute freedom in science, but why scientists have exercised their freedom of research and development in the restricted paths they have taken. Why the predilection for “hard” solutions or what Maria Mies calls “machine logic”³⁴, e.g., nuclear vs. sun and wind-based energy technologies; chemical pesticides vs. integrated pest control; etc. Following the beaten path of “hard,” high-tech solutions for problems which could be studied and solved in a more ecological manner is the battery of new reproductive technologies. Promising to expand women’s options, the bio-medical engineers limit women to one unsuccessful schema for having a child. Basking in the illusion of absolute freedom in research and technique, they have foreclosed on the paths of the environmental, industrial, and medical causes of infertility.

Conclusion

Environmental protection at its best in the United States springs from some human beings’ love for the earth, a love which was crystallized into an ethic in law because of Silent Spring. It does not exist because the earth rose up and insisted protection of itself onto human beings. How much more refractory most human beings would be about protection of nature if it were not their own idea.

When women rise up and insist protection of ourselves from a profession which employs drugs and technologies indiscriminately on our bodies, we are not representing wetlands, peace, or children – we are representing ourselves. Women must crystallize the fact of love for ourselves and the desire for procreative and personal autonomy into an ethic of self-protection in policy and regulation of the new reproductive technologies. This move to represent and protect ourselves will never enjoy the liberal popularity of the environmental movement, where human beings stand in for nature. As important as freeing ourselves from the licence of the bio-engineers to manipulate reproduction is freeing ourselves from the myths which these technologies’ proliferation depends on:

- A woman’s fulfillment is in having a child.
- An infertile woman is not a whole woman.
- A woman must give a man a child(his child), even if she cannot conceive or carry it herself.
- Any suffering or risk to herself is worth the chance of a child and the love of her man. The suffering may be deserved for her sin of infertility. She will cherish the child more for having suffered for it and her man will cherish her more. Her suffering is a sign of her love for her husband and her wished-for child.
- The woman’s body is underdeveloped and resource poor and in need of

advanced biotechnologies.

- The woman’s body is unreliable, unpredictable, and unsafe. Doctors and medicine provide reliability, predictability, safety, and superior performance.
- Where she is ignorant and a failure, they are knowledgeable and successful. If they have to gain knowledge on her body in order to be successful, their success, her husband’s happiness, and her potential child are worth the risk.

These myths are fused, and their power to destroy women is heightened, in the Japanese novel, The Doctor’s Wife, by Sawako Ariyoshi.³⁵ Two women, initially loving friends, become arch enemies over competition for the love of a man – the son of one, the husband of the other. He is an ambitious, driven physician who experiments on animals in order to develop an anaesthetic for major surgery. In order to win his love, they offer themselves to him as experimental subjects for his dangerous anaesthetic potions. Each wants to suffer more than the other and begs for stronger dosages. The more she suffers, the greater her love, the more his career will advance, the greater the chance he will favor her over the other. In his lust for eminence, he is driven to use them for his drug experiments which convulse them and risk killing them and which ultimately blind one of them. Only the physician’s sister sees the two women’s collusion in their own unfreedom and in the misogyny upon which their culture and family and his career in medicine are constructed. As she is dying, she says to her sister-in-law, the doctor’s wife:

Don’t you think men are incredible? It seems... that an intelligent man like my brother would have noticed the friction between you and mother... But throughout he shrewdly pretended he didn’t see anything... which resulted in both you and mother drinking the medicine... I think this sort of tension among females is to the advantage of every male. And I doubt that any man would volunteer to mediate in their struggles... As long as there are men and women side by side on this earth, I wouldn’t want to be reborn as a woman into such a world.³⁶

The power of this novel is its searing insight into how two women’s internalization of the primacy of the male as son/child and as husband/lover enabled a medical doctor to build a career on the infrastructure of their bodies. It is the story of the NRTs writ large – men become lionized because women allow them to experiment on their bodies, willingly suffer for men, and will pay any price, even themselves, for a child.

But we need more vision and more hope than the visionary in Ariyoshi’s novel who would not wish to be a woman in this world. We need an ethic of our bodies not as, “reproductive bodies in service of patriarchy,” but as “bodies sustaining our lives.”³⁷ Where law controls and regulates science and medicine, we must ensure that the principle of women as autonomous beings and not as reproductive resources is its central ethic. We need to believe that our own passion for justice for ourselves will, like Rachel Carson’s for nature, arouse and insist change in this world.

1. Rachel Carson, Silent Spring (Boston: Houghton Mifflin Company, 1962).
2. Ibid., p.261
3. Frank Graham, Jr., Since Silent Spring (Boston: Houghton Mifflin Company, 1970), p.85.

4. The most frequently discussed new reproductive technologies include superovulation and egg flushing; in vitro fertilization; embryo transfer; sex predetermination; and the attendant drugs and invasive techniques which are being used on women throughout the world and envisioned as a new frontier for biomedical science and technology. Related technologies and realities include fetal monitoring and screening; surrogate motherhood; the artificial womb; and cloning. See Gena Corea's The Mother Machine for a radical feminist analysis of the real intention and effect of these technologies which is not to enable the infertile women to conceive a child but to "manufacture a life better than that which women can birth."
5. Later in this paper I will discuss a survey conducted by Gena Corea and Susan Ince which exposes the myth of these technologies as a "cure for infertility." By the common definition of success, these technologies are unsuccessful. They rarely cure infertility.
6. Patricia Wright, "The Greening of Nagasaki," Contact, Vol.X No.4, (June 1985): pp.30-34. Both scientists assert that the science of the plant mutations, not the ethical questions about the bomb, is what engages them. "Neither one of us is interested in politics," one says, "except the politics of getting institutional support for our research."
7. Janice Raymond, A Passion for Friends: Toward a Philosophy of Female Friendship (Boston: Beacon Press, 1986). In this brilliant book, Raymond invites women to create a feminist politics based on friendship – a turning of women toward each other and a recognition of woman as Self and not as the other of man. She looks beyond theories of women's oppression to historical examples of women's empowerment, which she finds in convents, among the beguines of Europe, and in the tradition of the Chinese marriage resisters of the 19th and 20th centuries.
8. Conclusion to the Resolution passed by the conference participants of the Women's Emergency Conference on the New Reproductive Technologies, Vallinge, Sweden, July 3-8, 1985.
9. Raymond, A Passion for Friends. Raymond's vision of female friendship is based on "two-sights seeing – near- and farsightedness." This is the essential tension of feminism, i.e. living in the world as men have fabricated it while creating the world as women imagine it to be.
10. Wendell Berry, The Unsettling of America: Culture and and Agriculture New York; Avon Books, 1977), p.22.
11. Carson, Silent Spring, p.24.
12. For an expanded history of Ellen Swallow's work as pioneer of the science of ecology, see; H. Patricia Hynes, "Ellen Swallow, Lois Gibbs, and Rachel Carson: Catalysts of the American Environmental Movement," Women's Studies International Forum, Vol.8 No.4 (1985), pp.291-298.
13. Carson, Silent Spring, p.29.
14. Graham, Since Silent Spring, p.60.
15. *Ibid.*, p.72.
16. Harrison Wellford, Sowing the Wind (New York: Grossman Publishers, 1972), p.264.
17. La Mont Cole, Scientific American, December 1962, p.173.

18. Corea reported on this study at the Women's Emergency Conference on the New Reproductive Technologies(see footnote 8).
19. Edwin Diamond, "The Myth of the Pesticide Menace," Saturday Evening Post, p.16.
20. Ibid., p.18.
21. Wellmore, Sowing the Wind, p.273.
22. Robert van den Bosch, The Pesticide Conspiracy (New York: Doubleday and Company, 1978). This book is an exposé of the effort on the part of industry, special interest politicians, and agricultural schools to undermine the regulation and banning of pesticides. The author, a noted entomologist, also describes studies he conducted to demonstrate that the use of synthetic chemical pesticides actually worsened and created pest problems in agriculture.
23. Graham, Since Silent Spring, p. 85.
24. Jonathan Lash, Katherine Gillman, David Sheridan, A Season of Spoils (New York: Pantheon Books, 1984), p.14.
25. Ibid., p.14.
26. Ibid., p.15.
27. In his analysis of medicine allied with the state as a method of socio/political control, Thomas Szasz has given the name "pharmacocracy" to the political rule by physicians. Extending this word, Gena Corea, in analyzing the reproductive technologies as a political issue, refers to the physicians, embryologists, and others as "pharmacrats." See The Mother Machine, p.2.
28. For an expanded history of Lois Gibbs' influence on the American environmental movement, and especially, the EPA, see article by Hynes cited in footnote 12.
29. "An Appeal to Embryologists," Nature Vol.314, March 7, 1985, p.11.
30. Ross Feldberg, "Framing the Issue," Science for the People Vol.17 No.3, May/June 1985, p.8.
31. New York Times, August 28,1985, Style Page, B6.
32. See footnote 18.
33. In conversation with Farida Akther at the Women's Emergency Conference on the NRTs, Akther compared the ecological losses to the naturally rich soil in Bangladesh as a result of chemical fertilizers and pesticides applied in the "Green Revolution" to the infertility induced in women as a result of contraceptive technologies, such as Depo-Provera, forced on women in developing countries as part of the economic aid package from the United States.
34. In a paper at the Sweden conference, Mies said that the logic of science is the "logic of machines," a logic based on the domination of nature. The NRTs are an outcome of that logic in medical science. However, there is more than one tradition of doing science, some of which are older than the masculinist "domination of nature" scientific spirit. Women who love nature and study science must find a different tradition than the "logic of machines." If

we cannot find one, then we must invent one.

35. Sawako Ariyoshi, The Doctor's Wife (Tokyo: Kodansho International, 1978).
36. Ibid., pp.163-164.
37. Rita Arditti, Renate Duelli Klein, Shelley Minden, Test-Tube Women (London: Pandora Press, 1984), "Egg Farming and Women's Future," p.73.

Simone B. Novaes

FRANCE:
THE CECOS NETWORK OF SPERM
BANKS AND ARTIFICIAL
INSEMINATION

The first French sperm bank was set up in 1973 by Prof. Georges David at Kremlin-Bicetre Hospital in the Paris region: this was the beginning of what has now become a network of 19 sperm banks called CECOS (Centre d'Etudes et de Conservation du Sperme). Set up as autonomous units in almost every major French city, they nevertheless form a federation and have agreed to function according to the same ethical principles (to be described below). It was hoped that the use of a cryobanking institution to organize and regulate the practice of AID would improve AID'S public image and moral standing, transforming it into a socially acceptable solution to infertility.

The first obvious requirement in this direction was to provide a sperm-banking service with high quality standards which would inspire confidence among potential clients. CECOS banks therefore set up rigorous screening procedures for donors: a complete medical history, a physical examination, complementary laboratory tests (usually blood group, Rhesus factor, and genetic caryotype). All semen samples are tested for infection and for an acceptable fertilizing capacity before and after freezing (sperm count, motility and morphology). Continual research activity parallel to banking activity has permitted the CECOS banks to perfect their cryopreservation techniques, thus improving sperm viability after thawing, and increase their knowledge of the physiological factors favoring conception. The CECOS even control, for research purposes, the insemination protocol used by the private clinicians who perform inseminations; they have thus been able to improve and standardize it, compensating for the decreased fertilizing capacity of frozen semen by the precise timing of inseminations. Finally, accurate records are kept in coded form on donors (medical history and characteristics of sperm) and on recipients (date and timing of inseminations, donor(s) and. resulting pregnancy). Anonymity is at all times guaranteed; nevertheless, information is available when necessary to account for eventual errors or abnormalities in the procedure or in the resulting child.

But given the CECOS larger social objectives, the improvement of technical standards did not appear sufficient, and a great deal of thought was given to the social meaning of AID and to ways in which AID could be transformed into an acceptable option for couples facing childlessness because of the husband's infertility. Major objections to AID come from religious quarters; so it seemed essential to respond with an ethical model of the AID transaction, which would help potential donors and recipients to overcome doubts about the morality of AID.

The idea of a "gift from one couple to another" is the ethical guideline for CECOS policy governing the social aspects of donor recruitment and the selection of recipient couples. A potential donor must be married and father of at least one child; he must have his wife's consent and receives no compensation for donating sperm. The recipient couple must also be married (or at least established in a long-term relationship); they must be referred to the CECOS banks for a medically-proven male infertility problem (or in some cases, because the husband is a carrier of an hereditary disease which he does not wish to transmit to his offspring). Both donor and recipients must accept an interview with a psychologist: the purpose of this interview is counseling, giving each candidate an opportunity to explore his/her feelings and motivations, but it does on rare occasions permit the banks to weed out persons presenting severe psychological problems. Finally, no donor's sperm is used for more than five pregnancies: this virtually eliminates the risk of consanguineous marriage between children of donors and recipients and moderates the public's image of the donor as a stud. In this way, CECOS policy gives altruistic meaning to a sperm donor's motivations, restricts AID potential as an alternative reproductive technique to medically justified situations, and attempts to control the social and biological consequences of the transaction.

CECOS banking activities are not limited to the preservation of donor semen and the organization of the AID procedure. They also include : the freezing of fractional samples of husband's semen in the hopes of improving its fertilizing capacity for AIH: the storage of semen as "fertility insurance" for men undergoing a vasectomy or some sterilizing medical treatment (radiation or chemical therapy); and the storage of semen from volunteer donors for research purposes (cryogenics and male sterility). However, it is their reorganization of the practice of artificial insemination around a sperm banking system which has attracted most of the attention, both in France and abroad.

FINNRET, July 3-8, 1985. Sweden.

FRENCH INFORMATION

Following the First National Congress "Femmes Féminisme, Recherches" in Toulouse Dec. 1982, The National Center for Scientific Research (C.N.R.S.) has promoted a program (1983-1987) of research on "Studies on Women and Feminist Studies".

The second call for projects (1985) included a topic on "New Reproductive Technologies". Among the projects concerning this topic, three have been selected and will be financed: two during one year; one during two years.

The participants of this last project have undertaken the organization of a French Network on the New Reproductive Technologies in order to insure links with the FINNRET (now FINNRAGE). At the beginning of July 85, about 50 French women have given a positive answer for participating to this network.

A general meeting is programmed in October 85, the summary of which will be sent to the FINNRAGE.

Nicole ECHARD; Michèle KAIL; Hélène ROUCH.

projet
ATP. CNAI

LES NOUVELLES TECHNOLOGIES DE LA REPRODUCTION (NTR) Approche biologique, anthropologique et psycho-linguistique

I – RESUME

Le propos est de mener une réflexion interdisciplinaire sur les “Nouvelles Technologies de la Reproduction” (NTR) qui, loin de n’être que des palliatifs de la stérilité, s’inscrivent dans les stratégies de contrôle de la reproduction humaine propres à notre société.

Ces nouvelles techniques, bien que marginales et présentées comme des réponses ponctuelles à des demandes individualisées, nécessitent néanmoins une réflexion informée sur la question centrale que posent d’ores et déjà à leurs utilisations: en quoi sont-elles bénéfiques pour les femmes en tant que groupe social?

Nous partirons de l’hypothèse que les “Nouvelles Technologies de la Reproduction” sont promues dans un contexte idéologique où l’inflation du vivant fait florès et où les réalités de la domination masculine sont masquées par des discours arguant des progrès scientifiques et de la liberté individuelle de choix.

Ce travail s’articulera à partir d’interrogations portant sur:

– Le caractère paradoxal des NTR qui, alors qu’elles prétendent maîtriser la reproduction biologique, se situant délibérément du côté de “la nature”, répondent en fait à des demandes sociales et, à terme, accentuent par leurs effets la prééminence du social dans la définition de la maternité comme de la paternité.

– L’évaluation comparée des effets des “Nouvelles Technologies de la Reproduction” et des techniques de la contraception du point de vue de la libération des femmes.

Cette réflexion, qui associera la biologie, l’anthropologie et la psycho-linguistique, devrait aboutir à une première évaluation prospective des effets des “Nouvelles Technologies de la Reproduction” d’une part sur les femmes en tant que groupe dominé, d’autre part sur les rapports sociaux de sexe.

Chercheurs: Nicole ECHARD, Michele KAIL, Héïène ROUCH

Will motherhood become an archaism ?

I would like to develop this reflexion of Janice Raymond in “Test-tube women” :

“It is my contention that the engineering of human reproduction, and the forms it has taken, could only occur in a society where the anti-feminist dimensions of the technologies run far deeper than is apparent at first glance”.

It seems interesting to me to attempt to measure how deeply rooted is this misogyny of the masculine society. Is it not rather a motherphobia which expresses itself with a great ambivalence ? Ambivalence which physically affects women’s bodies: the insistence on women’s fertility after years of abusive castrations succeeding to a very long period of prohibition to abort...

“Anatomy is destiny”, said Freud who wanted to reduce women to her biological functions. I think also that anatomy has determined our destiny but I give it a completely different meaning from Freud. My interpretation is that men have always envied and feared this scandalous phenomena: the feminine body, unlike the masculine body, possesses a specific biological power which is the ability to bear, give birth and feed another being.

This biological inequality has been reversed into “penis envy” by men who called it the “little difference”...

According to me, it is this men’s “uterus envy” and the desire to control and to appropriate women’s descendance which is the origin of what I call the conflictual man/woman developing of civilisation and of man’s domination over women. Domination which may have been the primary pattern of all the forms of political dominations.

We must not forget that, in fact, each sex envies each other attributes and that men’s “uterus envy”, even if denied by them, is not less important than women’s “penis envy”. Both underlie men/ women relationships and the organisation of society. But “uterus envy” is biologically rooted and “penis envy” is culturally over-determined.

May be it is the reason why men deny to-day the importance of nature, matter or biology and are so eager to master them as if it were nothing but inert matter to be manipulated or inadequate organs: to be improved by their “genetic genius”, as we say in France.

But let’s continue to explore the hidden reasons laying behind the explosion of the life sciences. In the last 15 years, women have began to satisfy their need of social insertion and assertion that have been made possible by the control of their fertility.

Moreover, since 1968, men have felt themselves free to express their feminine part and to experience paternity in a more sensual and affective way. Neverthe less they might have feared on one hand, professional competition from women, and on the other hand, the loss of control over reproduction without being at all able to satisfy their “uterus envy”.

Will not the artificial womb – logic finality of the actual research in NRT – be for them a good means to get rid at last of a frustration which is all the more difficult to overcome that it cannot take the form of a social demand ?

Ken’s often unconscious desire to appropriate women procreative power can be easily detected behind politicians, biologists, doctors and so (well) called “test-tube babies’ fathers” declarations. As Doctor Jean Cohen, a gynecologist and IVF big supporter (1), say : “This new power (to decide life, to retain it here, to facilitate it there, to even make it) is exhilarating”... Research now made in Australia to make it possible for men to bear children are another sign of this men’s fascination for women’s life power.

I must say I feel very pessimistic about all that and I found problematic the survival of the feminine/maternal in the world.

I even think that because of feminist disdain for women biological specific power and experiences added to men’s envy for these powers, womanhood will disappear with motherhood that will, very soon, be considered like an archaism.

Bio-technological progress is developing along a masculine pattern. Men make love and procreate outside their bodies. In vitro fertilization and, one day, the artificial womb will extend to women those masculine characteristics.

The question is : do we want to think of ourselves, to define and to defend ourselves as female human beings or are we going to let Man absorb woman, be pregnant of the feminine and generate life directly ? Do we want to produce theories and discourses and create cultural values related to our differences and diversities that are biologically and culturally determined in a different way from man's diversities and differences ? Or are we so colonized by men so eager to imitate them, to embrace their values that we no longer even know how our body functions ? Why and for what reasons, it functions this way ? And if it deserves to be preserved from pollution or if it is worthwhile to protect its potential fertility ?

I have been told that more and more women ignore how their bodies work. 17 and 18 years' old girl-students come to family planning centers to ask for contraception and discover, on that occasion, that they are four months pregnant ...

Have men convinced us of the disgrace and inferiority of being a woman ? Of its lack of significance ? Not only men, but also a certain number of feminists who would have preferred to be men ?

Millions of women have died, suffered, been physically and morally handicapped and deprived from cultural and socially prized achievements, to give birth, keep alive and help developing human beings. If we, humans, are here, it is because generations of women have paid our existence with their own flesh and blood and have invented compromises to perpetuate life.

The masculine civilization which has never wanted to acknowledge and pay this debt has now found the best way to definitely get rid of this obligation: machines will replace mothers and the debt shall be very soon forgotten. So will be the female origine of humanity ...

Anne-Marie de Vilaine

SERVICO PUBLICO FEDERAL

IN-VITRO FERTILIZATION IN BRAZIL: THE STORY AS TOLD BY THE NEWSPAPERS

This study consists of quotations taken from articles about in-vitro fertilization published in the Brazilian press in the period from 1979 to 1985.

I selected and arranged these extracts from press-articles with the objective of trying to obtain information which would enable me to reach an understanding of the current state of this technique as it is practised in this country. In addition to this, I was trying to find out how the technique of in-vitro fertilization was portrayed by the media, and what sort of public opinion was being created from the information given by doctors involved in the application of the technique.

Even in the first analysis of these extracts it was possible to identify certain elements common to all the various narratives.

By organising these elements into groups, certain underlying themes contained within the overall story became apparent.

By breaking up the texts in this way I have neither destroyed their original arguments nor created new ones. I have simply highlighted the main ideas, eliminating here and there those explanations of the technique itself which would have made the re-reading tedious.

I have decided that an epistemological analysis of the contents of the articles is unnecessary. They are too obvious to merit further comment.

Other arrangements of this dramatic mosaic would also be possible.

It is hoped that this study will help to give birth to other stories which will make a new history.

ANA REGINA GOMES DOS REIS

July 1985

IMPORTING THE IDEOLOGY

An English idea in the Brazilian womb. Test-tube babies? Yes, and sooner than many people might think (...) It depends on the arrival of Dr. Patrick Steptoe and Dr. Robert Edwards who were responsible for the birth in England of the first test-tube baby in the world.

They shall offer a few months' consultation to Brazilian Specialists, at the request of Milton Nakamura. (31 / 03.79) (1)

When the scientific father of Louise Brown visited Brazil to spread his work, Nakamura led him through hospitals and to the OBA-OBA, a "mulata" nightclub for men owned by Oswaldo Sargentelli. (17.10.84) (10)

However, the projects of the Brazilian specialist do not end there. It is now almost certain that Dr.J.K. Sherman, the north-american who conserved human semen for over 17 years, by 1963, at the low temperature of minus 197 degrees F. in liquid nitrogen, will come to São Paulo, Brazil, for a one-year visit, in order to transmit his knowledge of artificial insemination to Brazilians.

For these reasons, once again Brazil will approach the technological and scientific achievements of countries who are ahead in the field of medicine.

Treating the fact as a reason for national pride Nakamura hopes to help Brazilian women who are unable to become pregnant through natural methods and who, therefore,

" go to a specialist hoping that by using some other method, their wish may come true."

Both invitations were proposed discussed and approved during a Seminar held by the Brazilian Society for Human Reproduction, which assembled over twenty specialists from various countries, amongst whom was Prof. Sherman himself (...)

Besides transmitting his vast experience in artificial insemination, during his stay in Brazil Dr. Sherman will take charge of the foundation and installation of human semen banks, to be used by all interested Brazilian doctors, as seen in the United States.

Sherman, the first scientist in the world to demonstrate, in 1963, the conservation of human semen, considers quite natural the fact that in his country there are several commercial semen banks, where donators receive twentyfive to thirty dollars for semen which is sold to doctors.

According to Dr. Sherman, there are private and university-owned banks and the choice is made by both doctor and client. (...)

Nakamura states that homologous and heterologous artificial insemination has been performed for years, all over the world, regardless of religious belief, or moral, ethical or judicial aspects.

He explained that John Hunter was the first to achieve artificial insemination of human beings in the United States between 1770 and 1799.

Nowadays, heterologous insemination (...) is used in various countries, on a wide scale.

While homologous and heterologous insemination are common in the United States and several other countries, in Brazil severe restrictions exist in relation to heterologous insemination which involves a donator. In 1969, the Penal Code considered homologous insemination legal,

although this law is not enforced. According to Nakamura, the moral beliefs of the Brazilian people impose restrictions on artificial methods and, for this reason, they are used with constraint. (31.03.79) (01)

Doctors from São Paulo now control five of the six phases of the artificial fertilization of the human ovule in the laboratory (the test-tube baby), and if Patrick Steptoe, the British scientist who developed this method, along with Prof. Robert Edwards, come to Brazil next year, there are ten volunteers for his first experiments.

This information was given by Prof. Milton Nakamura who also said that Dr. Steptoe will supervise in-vitro fertilization. (28.12.79) (02)

In six months, a team of doctors from the Endocrine and Fertility Foundation, led by endocrinologist Arnal do Ferrari will begin experimenting with laboratory Fertilization of human beings outside the mother's uterus, as a mean of solving the problem of female infertility. If the method is successful, Brazil will be alongside other countries who use ovule transplantation such as the United States and England. (13.01.82) (03)

The ovule is fertilized outside the uterus and the first test-tube Brazilian is on the way (...)

Dr. Alan Trounson, from the Australian University of Monash. is carrying out all the laboratory work (followed by Brazilian doctors who are taking the course).(15.10.82) (04)

The Brazilian doctor arrived this week from the United States, where he spent three weeks observing the work of specialists from all over the world assembled in Virgínia, U.S.A. (...)

Nakamura expects to extend his work (IVF) to mothers of lower economic classes. In order to achieve his goal, he will develop the system that is used in Austrália, where community representatives form commissions to raise funds for popularization of technology. The system has been a success and is now used as a reference for research, keeping in mind the fact that studies of the Australian University of Melbourne have proved that it is possible for a man to gestate a child. (22.11.84) (05)

The head of the laboratory is Bela Zausnem, who returned recently from the United States and Europe where she acquired much experience which she now practices in Salvador. (19.11.83) (06)

Test-tube babies have no funds in the South (...) a biologist spent a year in England, specializing in human reproduction and a doctor spent four years of doctorate. Studies in the same field in Germany, all in order to carry out an experiment which, according to Ferrari, has already cost over ten million cruzeiros and will require an equally large sum in order to reach positive results. (15.04.82) (07)

The major problem faced by Brazilian researchers in the field of infertility is that of financial resources, principally in the application of methods brought in from the United States and Germany.

This is the complaint of Jacy Bastos, a gynaecologist of the Federal University of Minas Gerais. (22.10.83)(08)

The Australian University team, composed of Alan Trounson, Luca Giancarli and Angelo Conti, will return to Australia tomorrow. (16.10.82) (09)

A SCIENTIFIC FABLE

Medical centers, such as Nakamura's, Donádio's and Coutinho's are multiplying in Brazil and, at faster rates, in the United States, France, England and even in Australia, for a simple reason: infertility, (sterility)

Drugs are of little use in these cases and surgery can only solve approximately 70% of the cases. A possibility still exists, for the other 30%, in the laboratories" of the new magicians of life who can produce in-vitro fertilization.

(...) "the difference between our success-rate and that of the best clinics in existence comes from our relative lack of experience but we are still doing well, despite this fact."

(...) No matter how many failures of in-vitro fertilization there are, the number of women ready to undergo the experiment as a last resource, grows daily.

(...) "If we can fertilize a woman in two weeks, why have her go through a longer treatment, with a smaller probability of success ?" asks Nakamura.

(...) There are 6 in-vitro fertilization centers in Brazil. (17.10.84) (10)

M. Nakamura affirmed that in Japan over five thousand children have been born using the technology developed by Prof. Sherman.

"All of the couples who choose the artificial method were thoroughly examined and psychologically prepared to avoid certain problems such as a possible rejection of the child by the genetically illegitimate father. Doctors who work in this field must, in the first place, try all the possibilities of attaining a harmonious relation between the man and woman involved, without resorting to artificial fertilization or insemination. However, this is only possible in a few cases, since women do not accept adoption as a solution, nor do they accept their physical condition. They want and insist on having artificial methods, and therefore doctors should be ready to help these women to solve their problem without, however, imposing anything."

Nakamura has said, being careful to clarify his position as regards the artificial methods of insemination, that he is satisfied when he is able by those means to solve the problems of a couple without children, through a surgical operation.

That way, they'll have no problems with their wives in case of an undesired pregnancy and they will be able, later, if they want, for any reason, to have a new child in case of changing their mind or changing their wives.

(...) Artificial methods are recommended in several cases, according to Nakamura, and can be necessary .due either to the man or to the woman. First, Nakamura searches for the origin of the problem using laboratory tests, after which he discusses the next stages of the process with the couple, until a final decision is taken. "I do not interfere, at any moment, with my clients' opinions (...) if they choose artificial insemination, I do not proceed any further until I am convinced of the couple's emotional and psychological stability. Clients who show their interest to go through a series of tests and much though is given to problems which may appear after birth, such as rejection by the father. (31.03.79) (01)

(...) Now with four well-developed cells derived from the fertilized ovule, the embryo obtained during the Human Reproduction Course was transferred, at 17:25 o'clock,yesterday, to the mother's uterus. (16.10.82) (09)

Pregnancy, through laboratory fertilization, is the solution for approximately two million

women whose problems could not be solved with surgery, “asserted Dr. Nilson Donádio at the 11th Brazilian National Congress on Human Reproduction. (12.09.84) (11)

Nevertheless, Nakamura utterly condemns the possibility of this technology becoming a dangerous threat to humanity, through the creation of a superior race, “an intention already revealed by many scientists”. (Nakamura) (31.03.79) (01)

THE EXPROPRIATION OF WOMEN’S BODIES

From the Rape of the Sabine women- to the theft of the ovule.

São Paulo doctor prepares to implant a test-tube baby in 10 women volunteers in 1980. (28.12.79)(2)

In Curitiba (...) doctor Karam Saab, 32years old, professor of Gynecology at the Paraná State University has already attempted six extra-uterine conceptions.

In Salvador, Elsimar Coutinho has a laboratory similar to doctor Saab at the Bahia State University where he is a research worker and professor “We have already made three attempts, but have not yet had any success”. (17.10.84)(10)

(...) the candidates are already undergoing a battery of exams to select those who can best participate in the experiment.(19.05.84) (12)

The five patients were selected from an original group of 30 women, from which 12 were chosen who would probably ovulate during the period when the Australian doctors, Alan Trounson, 35 years old, and Luca Gianaroli, 28 years old, would be in São Paulo to give the technical and practical course on in-vitro fertilization (IVF). (17.10.82)(13)

Support for mass ovulation is understandable (...) the doctor implants the embryos in the desired locality (...) without the women feeling any pain.

(...) Some clinics outside Brazil reject women approaching 40 years of age (...)

The doctor sucks the ovum using a cannula which penetrates the woman’s abdomen (...)

When the Louise Brown scientific father of visited Brazil to talk about his work, (...)

The “parents” of the first test-tube baby, by now very experienced in manipulating ova and spermatozoids (...) doctors responsible for the feat (...)

“Louise Brown’s birth now looks almost like a “Stroke of luck” says Jones who was in Brazil two years ago (...) He is an ace in this field: he has made 200 attempts

at IVF of which about 20% have had positive results.

In seventeen cases Nakamura has lost, because, the women aborted (...)

(...) the five test-tube babies Nakamura has promised for the coming months.

There is (...) the use of the “genius sperm bank” a laboratory in Escondido, in Califõrnia, which stores samples of sperm obtained from highly intelligent men, including some Nobel Prize

Winners(...) the founder of the sperm bank, the millionaire Robert Graham, intends to inseminate specially selected women with a view to contributing to an improvement in mankind's Genetic Standards. (17.10.84)(10)

A proposal to legalize artificial insemination using semen belonging to donors unknown to the couple in cases of proven infertility in the husband was suggested by some of those members who debated the subject at the Brazilian Medical Congress. (12.09.84) (11)

A curious fact was raised by the North America Researcher (Sherman). According to him, in his country a lot of men deposit a certain amount of semen on commercial banks and then have a vasectomy.(31.03.79) (1)

Nakamura says that studies at the Melbourne Australian Faculty have revealed the possibility of men conceiving a child "They discovered that from a physiological point of view it is perfectly possible for a man to carry an in-vitro inseminated ovum but the commissions in charge of designating funds have not accepted the programme, which has been shelved until further notice". (22.11.84) (5)

The mother, in tears, at the end of the caesarian section described the birth as "a gift from God".

She might have added that it was also a gift from Dr, Nakamura, the doctor (...) who forty weeks earlier had fertilized one of Ilza's ova with one of Caldeira's spermatozoid at the Sta. Catarina hospital in São Paulo, where he works. After celebrating the marriage of the cells his laboratory, Nakamura implanted the embryo in the patient's uterus.

"Nothing moves me more than a baby's first cry he says". "But only the first cry because the others, the mother must put up with".

Among his hobbies Nakamura enjoys playing to an invited audience in his living room on the electronic keyboard he brought with him from Hong Kong.

On such occasions the hands that conducted the conception of the first tube-baby in Brazil are performing a simpler trick: Nakamura's keyboard plays blues with the aid of a cassette tape while the doctor simply pretends to be playing the keyboard (...) (17.10.84) (10)

(...) Regarding the test-tube baby, Elsimar Coutinho guarantees that he is against it not only for economic reasons but "because there are also very important ethical and legal problems" involved. He mentioned that the risk the doctor runs are as high as the mother's, apart from the risk that the child may be born with deformities. (05.01.82) (14)

Dr. Wilson Donadio, 50 years old, professor of Obstetrics and Human Reproduction at the Santa Casa de Misericórdia Medical School in São Paulo, runs a laboratory that (...) has already implanted embryos in forty women, two of whom are now pregnant.

(...) According to them, the wheels of test-tube fertilizations are turning faster than one might imagine in Brazil. (17.10.84)(10)

THE SHOW-THERE'S NO SIN BELOW THE EQUADOR

With ten thousand patients registered in his large and sophisticated clinic in São Paulo, Nakamura was sure that he was ready to lead the extremely advanced research that would make him famous throughout the country (06.11.82)(21)

(...) Dr. Nakamura explained the fact, 'stating that the project was very expensive, costing

20 million cruzeiros, and that the medical team was earning nothing. The **Globonet** work, (one of the sponsors) had paid for the travel and other expenses of the visiting Australian doctors, and had for this reason obtained priority, though not exclusivity, in the information.

Ever since patients from all over Brazil have been confined (...) to undergo the technique as part of the International Course on Human Reproduction under the supervision of doctors Monash University in Australia, the 4th and 10th (operating Center) floors have been partly taken over by security guards (principally TV Globo “Rangers”). Globo is one of the sponsors of the course. This has caused complaints from the participants of the course.

(...)Nakamura explained that since he opened his Family Planning Center he has set up an ethics commission. (18.10.82) (15)

The Santa Catarina hospital, one of the best-known maternity hospitals in São Paulo, also appears to have felt the effects of the Course in Human Reproduction. After the presentation of Dr. Nakamura as the man who would produce “the first Brazilian test-tube baby”, the hospital reception received dozens of mainly working - class women asking for the doctor to solve their “problem with having babies”.

Sister Celsa, the director-General, affirmed that Dr. Nakamura had been working with the hospital for several years, and that he had asked her to allow the hospital to host the course, to which request she had agreed.

“The hospital has always been receptive to science. Our style is to encourage research, as far as is compatible with ethics and morality, “stated the sister. However, when asked whether she thought it ethical that two floors of the hospital should have become a TV Studio she would only reply that “perhaps they want to make scientific films”.

As regards the heavy security, she observed that the hospital had nothing to do with it. “We have merely allowed them to use part of the fourth floor and part of the tenth floor, and are giving a discount in the daily expenses of the 12 patients”.

(...) Owing to the controversy which surrounds Nakamura, there have even been rumours that he was receiving money. When asked about this he laughed and said “I’m not a rich man. I earn enough to live. However, I am in no way ashamed to ask for money in order to help others,” he concluded, referring to all the sponsors of the course: TV Globo, TV Manchete, the State Government, the Safra Foundation and the publishers Roca. (18.10.82)(15)

In the Anna Paula case there was by no means excessive publicity on the part of the doctor. “The family has identified itself and so there is nothing left for me to do but to give the medical details of the case.”

He seemed at ease before the cameras, ignored all questions on the Zenaide case the patient who died and ended the day by throwing a party into cake and champagne in the grounds of his luxurius private clinic.

(...)After announcing the birth of Anna Paula they celebrated with cake and champagne, Nakamura looking the picture of triumph. (17.10. 84)(10)

THE DEATH OF ZENAIDE

She dreamt of having a test-tube baby and never woke up again. Her doctor dreamt of giving her that baby and sank into a nightmare. Why did Zenaide die? Accident, bad luck, destiny, incompetence no convincing explanation will bring her back to life. The only consolation for Dr. Nakamura – who has lost his first patient in 22 years of career, at a time when the attention of whole country is focused on his work, -is that Zenaide may have lost consciousness under the sweet illusion that she was going to have a baby.

Nakamura's first failure was given national coverage: very bad luck. (...) She was the most fertile of the candidates for a test-tube baby (...). One, two, three abortions Zenaide: suffered considerably from the consequences of curettages and underwent intensive treatment to eliminate the causes of her inability to sustain a gestation (...)

(...) In the operating room the doctors discovered that her tubes were infected (...). When she regained consciousness Zenaide was sterile. "They removed my tubes without my authorization". She said (...)

At heart, her despair at not being able to give Paulo a child was even greater than her desire to have one (...) She discovered that one English doctor could already solve the problem of women with no tubes (...)

It was at this point Zenaide and Dr. Nakamura's paths crossed (...) and Zenaide became one of Nakamura's ten thousand patients. (00.11.82) (21)

Zenaide was one of a dozen women who were then trying to have a test-tube baby with Nakamura's help. During the relatively simple operation (...) Zenaide suffered a respiratory collapse. Nakamura attributed the problem to an "anaesthetics accident" and the Regional Medical Board in São Paulo which has set up an inquiry into the case, has not yet reached a conclusion about what occurred, as it is still hearing audience.

The fact is that Zenaide's brain was starved of oxygen for a long time and ceased functioning while she was still on the operating table. Eight days later Zenaide died and Dr. Nakamura's long sought-after dream of producing a test-tube baby seemed to die with her (...)

Zenaide's death cast a long shadow over IVF on Brazilian soil and over the best known agent Milton Nakamura. The doctor, however, has not lost heart. He says that he does not consider that he is to blame for what happened. He considers the accident a "lamentable and rare misfortune" and refers to it as "... water under the bridge". The birth of Anna Paula Caldeira, represents a long awaited ray of light for Nakamura. He waited in silence. Two years ago he made a song and dance about his work and then, it went wrong and Zenaide died. (17.10.84) – (10)

(...) Zenaide's abdomen were given between 1, 5 to 3 liters of carbone gas (...) the ovary was then localized. The Brazilian doctor who assisted Gianaroli was excited by what he saw. As the exam had indicated, Zenaide had four follicles. As they were preparing to collect the ova, the alarm was sounded. Zenaide was no longer breathing – she may not have been for some time as the purplish colours of her nails indicated. And the doctors for reasons that could be difficult to establish – took some time to notice (...) "The next day I took Paulo to visit Zenaide in the intensive therapy unit. He was so shocked to see his wife unconscious that I had to give him a sedative. Paulo slept straight though for 24 hours; this may be why he complained about a delay in information."

From a scientific point of view the programme had been a success: four ova, four implanted embryos, perhaps four pregnant women.

I congratulated Gianaroli on the success of the programme but he was upset and continued to regret the accident involving Zenaide. "This should never have happened, we left Brazil feeling sad." (06.11.82) (21)

He has no fear that the reputation of the actual technique itself of creating test-tube babies, unjustly associated with the risk of death, will be damaged by this accident.

"Several patients who were -not selected in the first group are already phoning the hospital, asking when we are going to re-start the work."

This is an idee fixe of Nakamura's: to carry on with his test-tube baby centre, and give them the name of Zenaide, "in honour of the woman who symbolized the iron determination to be a mother. (06.11.82)(21)

Nakamura has called his club SERO-FIV (...) the name of a great swiss laboratory famous throughout the world for producing drugs to combat human sterility. "This laboratory was the first company to join the club and so I decided to honour it in this way." (19.12.06.85) (.20)

Of the five patients selected for IVF, one suffered a respiratory arrest lasting one minute last night whilst undergoing a laparoscopy exam. Zenaide Maria Bernardo according to Dr. Nakamura, had already undergone two laparoscopy exams and may have had an allergic reaction to the anaesthetic provoked by emotional tension this time. She's still in the Intensive Therapy Unit, as a medical precaution, but is not at any risk. (17.10.82) (13)

THE CONTROVERSY

The experiment on the test tube-babies has brought Dr. Nakamura back into the limelight he is holding an international course on Human Reproduction, with the presence of doctors from Monash University in Australia.

Patients from various parts of the country have been hospitalized in order to undergo the implantation technique. The presence of the press with photographers and TV cameras has led the president of the Brazilian Society for the Advancement of Science to criticise the project which he describes as an "Obstetrics Carnival". (18.10.82) (15)

"IVF has a very limited practical application and best serves the vanity of certain publicity seeking doctors", says Paulo Canela, a gynaecologist at Rio de Janeiro Federal University. (17.10.84) (10)

"This Obstetrical carnival is a veritable crime against the child", according to Pavan Experiments which can be carried out in private are being commercialised. I am radically opposed to this."

The geneticist observed he is not against scientific development and “prof. Nakamura seems to be competent and should thus be supported by the Scientific Community”. However he emphasized that Brazil should have its own legislation, norms laid down by medical entities for carrying out this sort of experiment. (18.10.32) (15)

SERVICO PUBLICO FEDERAL

four children and I have one adopted child and three grandchildren. I had a fallopian tube operation 15 years ago and then I missed having a little baby, so I adopted one. But I would have the courage to have a test-tube baby even knowing that a woman died trying to have one”. Catarina Montagner, 42 years old, maid, married for 27 years. (26.10.82) (18)

“I am on the waiting list for an operation in São Paulo”, recounts Elodi. “Any sacrifice is worthwhile to have a child”. “Without a child of your own, life is meaning less and you blame yourself for not conceiving.”

“People advise me to adopt a baby”, says Maisel, “but I want to bring my own child into the world.

“As long as it doesn’t put Elodi’s life at risk we are going to go in trying.”

The Catholic Church is against test-tube conception. Nakamura, who was an altar-boy in his childhood and calls himself a Catholic, thinks the church is excessively rigid on this point. “But the priests have never bothered me with direct criticism”. (17.10.34) (10)

“I’m against it. Whichever way it is done. I’m against anything that is wrong”, declared the carpenter Ismael Nascimento, 45 years old, married with two children, catholic.

“I’m against it” said 28 years old, bachelor lawyer, Norberto Vilela, “because it is unnatural and consequently anti-life. This is technocratized life; even in the case of a sterile woman. I’m against it”.

“I’m neither for nor against because I’m unmarried, but if I were married I’d try to have a test-tube baby, if I couldn’t have babies normally if it were to give the man I’d chosen a child. Though it could also be good to adopt one”, Odália Silva, 45 years old, hairdresser.

Half of the 100 people (50 men and 50 women) in the Folha de São Paulo news paper survey said they were in favour of Brazilian women, having test-tube babies while 35% were against and 15% were undecided. (26.10.82) (18)

Cardinal remembers Nazi eugenic methods.

Although the creation of test-tube babies cannot be rejected outright “there is a fear that this may end up repeating a method that was utilized at the time of nazism to purify races and create a perfect species”, commented the Archbishop of São Paulo, Cardinal Paulo Arns yesterday.

In Brazil, where millions of children are born without access to the

minimum nutritional requirement from the foetus until the first years of life, it is irritating to know that vast sums of money are being spent on extremely rare cases, while mothers and children are abandoned before our very eyes, suffering problems that can be solved with a minimum of aid.

Human Love.

“We believe that what is at stake here is human love itself”, stated the cardinal having observed that experiments like those on test-tube babies should not be condemned and deserve more research from the moral point of view, especially if they are undertaken to facilitate the birth of a child which is the fruit of the two parents in order for life to continue. (23.12.79) (2)

“When my grandson asks me, I’ll say that I’m for it, because we’ve got to keep up with the way things are changing, “says Michai Vargas, 60 years old, retired, three children, Catholic.

“I’m in favour of test-tube babies in every case. Even when a woman can have a baby naturally, if she wants a test-tube baby, let her have one. At least she’ll satisfy her curiosity. You know women are sometimes just curious, and nowadays the problem is that they like to show off, they’ll take their clothes off straight away. So she might feel tempted to have a test-tube baby, just to make the headlines in the papers.” (26.10.82) (18)

The São Paulo Regional Medical Board begins today its investigation into events involving Dr. Nakamura’s team in order to determine if there was an infringement of The Medical Ethical Code or not. The investigation is to be carried out behind closed doors, as established in the Code. (26.10.82) (18)

THE ANCESTRAL BATTLE GOES ON: WHO IS THE FATHER. OF THE CHILD?

“He (Nakamura) was rather discredited for announcing things which didn’t come about” (Elsimar Coutinho).

“There are already two children in the country produced by that process” guarantees Donádio who nevertheless refuses to reveal their identity or give the names of the doctors responsible for the fact.

“The birth of the in-vitro fertilized babies will probably not be announced publicly as .this might cause the child to be discriminated against, says Wilson Donádio in São Paulo who also makes a dig at Nakamura. (17.10.84) (10)

“The professor of Andrology at Campinas Federal University, Roger Abdulmasser stated yesterday at the opening International Symposium on the treatment of Conjugal Sterility that there are no test-tube babies in Brazil” (...) Although some doctors have announced conception in Brazilian laboratories (...) there is no scientific proof of this. Speculation about the subject is merely a question of a personal and promotional interests”. (24.09.82) (22)

Test-tube baby. Doctor challenged. The gynaecologist Milton Nakamura, responsible for the IVF birth of Anna Paula Caldeira on the 7th of this month in São Josã dos Pinhais in Paranã, challenged Nilson Donádio vice-president of the Brazilian Human Reproduction Society, to prove that she was not the first Brazilian test-tube baby.

Donádio stated in an interview (...) that the first Brazilian test-tube baby was born there months ago. He simply state that the parents are doctors and that the child was fertilized at the one of the country’s human reproduction ceñtors. He added that the names of the couple ant the baby will never be revealed because the parents want to preserve the famiily’s privacy. (16.10.84) (16)

Gaūcha to have test-tube baby.

The first attempt in Rio Grande do Sul at in-vitro fertilization, the so-called test-tube baby, will be mađe this year by the Foundation of Endocrinology and Fertility.

According to the Director of the Foundation, Arnaldo Ferrari “the first experiment is extremely unlikely to succeed”. (19.03.84) (12)

The first Brazilian test-tube baby will be from Bahia, provinding the IVF work carried out an a 34 year old wōman by professor Elsimar Coutinho team at the Maternity Unit of Bahia

University is successful. (19.11.83) (06)

The scientist from Bahia, Elsimar Coutinho, diretor of the World Health Organization Human Reproduction Center in Bahia, condemned yesterday in Salvador suggestions that Brasil should carry out studies leading to the creation of test-tube babies. "What Brazil really needs is to control the birth rate". (05.01.82) (14)
SERVICO PUBLICO FEDERAL

BUSINESS IS BUSINESS

(13) Dr. Nakamura still has no idea how much IVF will cost Brazilian couples. (17.10.82)

As it is a very large investment, we are trying to interest a hospital to set up adequate installations (Ferrari) C15.04.82) (07)

(...) the popularization of the method is justified because, besides the large numbers of sterile women it can serve, it is simple and non selective. Once we reach a rate of three or four cases a week the cost of laboratory fertilization followed by embryo implantation in the patient will cost the equivalent of removing an appendix" (Nilson Donadio). (12.09.84) (11)

In the next six month three Brazilian test-tube babies well be born using the IVF technique developed by the gynaecologist Milton Nakamura.

There are still fifty couples on the waiting list (for the operation) willing to pay 1500 dollars. (22.1184)(05)

For the first time in Brazil a woman of reduced means has given birth to a baby produced by mean of IVF – Eudinete do Nascimento from the state of. Paraiba whose husband sells sandwiches. The fertilization was paid for by a group of 10 patients undergoing treatment at the center for Biological Human Reproduction attached to the Santa Casa de Misericordia Hospital (...) The silence maintained by the doctor, Nilson Donadio, was broken by the father, Matias (...)

In the not too distant future the process Could be extended to the entire population. The cost of IVF is now equivalent to that of an average operation, such as a caesarian section, about 4, 5 millions cruzeiros (US\$ 700) including expenses with doctors ant the hospital. (12.06.85)(19)

Life club. Test-tube babies are ceasing to be a novelty. Last week, Nakamura announced the creating of a club which will be able to turn the laboratory production of human beings into a veritable production line. "The aim of the club is to raise funds through private companies so that I can treat women who cannot put up the money." Each financed fertilization would work out at 1,500 dollars, excluding doctor's fees.

"I will not charge anything for my services," says Nakamura.

Nakamura has baptized his club SERO-FIV (...) the name of a big Swiss laboratory renowned world-wide for its production of drugs to combat homan sterility". "This laboratory was the first

company to join the club so I decided to honorr it in this way.”

According to Nakamura, another five companies are about to join the club. One of the attractions for prospective members is tax relief (...) (19.06.35) (20)

THE OTHER SIDE OF THE COIN

Patients, before going to Santa Catarina hospital for surgery, pass through this clinic. This is one side of Nakamura. There is another – the oposite side: he has a second clinic, this time for poor patients, the Materno-Infantil’ Clinic for Family Planuing, where there is no consultation fee. There he dedicates himself not to increasing the birth-rate but to controlling it. “I do the opposite, and for free, and for this reason few people know”, he says proudly. (17.10.84)(10)

There has been no shortage of the work of the gynaecologist in recent years.

When Zenaide died the paediatrician Luis Carlos Raia accused Nakamura of sensationolism, and of accepting subsidies and orientation from international organizations interested in controlling the birth-rate in São Paulo. According to the paediatrician, Nakamura struck a bargain with the Paulo Maluf State government to implement the Pro-Família programme, in setting up sixty centers to control the birth-rate.

(...) The directing foundation gave scintific support to the Pro-Familia programme – a programme developed three years age by the Paulo Maluf State government. At the time Nakamura struck a bargain between his clinic and the Japanese government with the purpose of setting up birth-control, parasite-control, and nutrition-control projects. (12.10.84) (17)

The Bahian scientist, Elsimar Coutinho, director of the Human Reproduction Centre of the World Health Organisation, condemned yesterday in Salvador the suggestions that Brazil should carry out studies leading to the creation of test-tube babies. “What Brazil really needs is to order and control its birth-rate.” (05.01.82) (14)

(1) Folha de São Paulo	31 .03.79
(2) Jornal de Brasil	28.12.79
(3) Jornal de Brasil	18.01.82
(4) Jornal de Brasil	15.10.84
(5) Folha de São Paulo	22.11.84
(0) Manchete	19.11.83
(7) O listado de São Paulo	15.04.84
(8) O Estado de São Paulo	22.10.83
(9) Jornal de Brasil	10.10.82
(10) VEJA	17.10.81
(11) Jornal de Brasil	12.09.84
(12) Jornal de Brasil	19.03.84
(13) Jornal de Brasil	19.03.84
(14) O listado de São Paulo	05.01.82
(15) Jornal de Brasil	18.10.82
(16) O Globo	16.10.84
(17) Folha de São Paulo	12.10.81
(18) Folha de São Paulo	26.10.82
(19) Jornal de Brasi l	12.06.85
(20) VEJA	19.06.85
(21) Manchete	06.11.82
(22) Folha de São Paulo	21.09.82

WOMEN'S EMERGENCY CONFERENCE ON THE NEW REPRODUCTIVE TECHNOLOGIES

July 3-8, 1985 – Vällinge, Sweden

RESOLUTION

(as passed by the conference participants)

“Science, it would seem, is
not sexless; she is a man, a
father, and infected too.”

Virginia Hoolf, Three Guineas, 1928.

We, women of Australia, Bangladesh, Brazil, Canada, Denmark, England, France, Ireland, Israel, Japan, Netherlands, Norway, Sweden, Switzerland, USA and West Germany, declare that the female body, with its unique capacity for creating human life is being expropriated and dissected as raw material for the technological production of human beings. For us women, for nature, and for the exploited peoples of the world, this development is a declaration of war. Genetic and reproductive engineering is another attempt to end self-determination over our bodies.

We know that technology cannot solve problems created by exploitative conditions. We do not need to transform our biology, we need to abolish patriarchal social, political, and economic conditions.

We shall resist the development and application of genetic and reproductive engineering.

We want to maintain the integrity and embodiment of women's procreativity. Externalization of conception and gestation facilitates manipulation and eugenic control. The division, fragmentation and separation of the female body into distinct parts for its scientific recombination disrupts historical continuity and identity. The individual becomes the dividual, the divided one.

There is no right to a child as property. Neither infertile nor fertile women, neither lesbian nor heterosexual women require permission to have a child from authorities like the state or the medical profession.

We call on women to resist the take-over of our bodies for male use, for profit-making, population control, medical experimentation, and misogynous science. Life for us always means risk. It can not be programmed or perfected. Living demands courage. We shall not surrender ourselves to the technocrats. We shall hold fast to the collective responsibility for ourselves and our lives.

We resolutely oppose all attempts through genetic and reproductive engineering, to bring about a racist and fascist division of women into “valuable” women in the industrial world, who should have children, and “inferior” women in exploited countries, who are forbidden to have children. In our own countries, we oppose differential treatment of poor, disabled, lesbian, black, and foreign women by patriarchal medicine. We resolutely oppose eugenic population policies, in particular the fabrication of “perfect babies”.

We condemn all governments that allow genetic and reproductive engineering.

We condemn the international traffic in women, specifically for purposes of reproductive prostitution.

We condemn the use of women from exploited countries and poor women by men and international conglomerates in the interests of global capital and patriarchy.

We condemn men and their institutions that inflict infertility on women by violence, forced sterilization, medical maltreatment, and industrial pollution and repeat the damage through violent “repair” technologies. We oppose coercive prenatal diagnosis.

We support the exclusive rights of all women to decide whether or not to bear children, without coercion from any man, medical practitioner, government or religion.

Recognizing that infertility is often determined by political, social and economic conditions, we support

compassionate treatment of infertile women and intensive study into the prevention of infertility.

We support the recovery by women of knowledge, skill, and power that gives childbirth, fertility and all women's health care back into the hands of women.

We seek a different kind of science and technology that respects the dignity of womankind and of all life on earth. We call upon women and men to break the fatal link between mechanistic science and vested industrial interests and to take part with us in the development of a new unity of knowledge and life.

STATEMENT

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We women of the Third World representing 80% of humanity come to this conference to say the following:

It is difficult for us to express fully our cultural differences on account of the language and expression barrier. So, in a few words we'd like to propose a guideline for the next international conference:

1 We shall begin conferences by a powerful, agitated, perhaps erotic dance program.

2 We shall abolish the abuse of saying: "I'm sorry", "thank you", "I've appreciated your ideas", "Excuse me", "I think I don't quite agree with you" and so on.

3 We propose, instead of saying it with words, saying it with our bodies, our hands, our teeth and our bellies.

4 We wish to establish the permission of the expression of our minorities' feelings as shouting, breaking out laughing, crying, being very angry, confused, bored and enjoying a lot.

5 What we also want to say is that, in spite of our historic problems of economic poverty and political dependence, we would like very much to share with you our disorganised, terrific and absolutely unexplained joy of life.

Vällinge, Sweden, July 8th 1985

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FINRET/FINRRAGE CONFERENCE, SWEDEN, JULY 1985

Statement Sarah Jansen, W. Germany

STRATEGIES FOR RESISTANCE

During the conference I got more and more impatient. Not only with the reproductive engineers, but also with us. Almost all of our attention focused on technical details, on how patriarchal science deals with our bodies/with us, and on detective work: compassionately tracing all links of the Egg Snatchers' International Network.

No doubt: These informations are important – that's why I do my share of that work, too. But: If we pay our attention exclusively to the actions of "our" aggressors" – without reflection on how we want to deal with ourselves, with our in/fertility, with our own nature, with technologies – then we start identifying with that aggressor. Without leaving this paradigm we become part of it, tangible in the exclusively mind-centered work we did here. Oppressing our souls and bodies, an attribute of male' culture proper. And there are structures in us, on which reproductive engineering and ail patriarchal science can pick up, structures beyond some worsens' desire to have their own child that are worth investigating, e.g. the wish to control other people is not alien to all of us to me resistance means much more than saying/acting 'no' and knowing the reasons for that 'no'. It means the positive feelings of searching for our own solutions, alternatives to a destructive science and technology, the curiosity, becoming independent of the technocrats, living the responsibilities for ouselves as much as we can.

We know that – in Europe at least – most of wise womens' knowledge of, among other subjects, the healing arts and the knowledge of being in touch with our (and with non-human) fertility was destroys. Some of it women try to recover: herbal treatments, rituals, trances, exercises. "Healing" can mean different things in these approaches: For some a desired change in physical condition (e.g. becoming fertile for others a way of lovingly accepting their condition. In non-European cultures probably more of this knowledge survived (see the manual "Birth Control Through Yoga Exercises" put in the xeroxing file). In our home countries and during our next Finrrage ccnference we should take the lime and share information on this.

S. Jansen, Finnret/Finrrage Conference, 1985, Strat. Resistance, p.2

These “soft” technologies and approaches have their limitations, other limitations than the violent “treatments” by the reproductive engineers. We should never expect a perfect treatment, not even with non-violent, women-centered approaches. Non-violent, “soft” technologies cannot deal deal with all problems caused by violent impacts. This holds true for soft technologies to clean up heavy pollution, but also for a non-violent healing art, maybe for non-violent resistance in general. And many causes for infertility are a form of violence: direct violence, malpractice, but also stress, industrialized nutrition, pollution. At that point, we have to find and fight the causes and again – find alternatives, a feminist science and technology, or better, a feminist access to nature, including our own.

An exclusive focus on genetic and reproductive engineering bears yet another problem: the “monster phenomenon”. These branches are often portrayed and perceived as monstrous exceptions to an otherwise beneficial (to whom ?) science, that could be “used or abused”. Part of this ideology are ethics committees. They have the ideological function to pretend that science can be controlled. Not in its undemocratic geneses, but in its applications – as if the two could be separates. Membership in an ethics committee is highly reputable, As is always the case in this society if there is a (this time home-make) monster to take. Some women suggested the creation of “feminist ethics committees” as a tool to attract attention to the fact that women as a group are excluded from science and attempts to control it. While I am not generally opposed to feminists holding powerful positions in institutions, I believe that establishing “feminist ethics committees, if only for purposes of demonstration, is misleading. It would suggest that feminists share the ideology of a science that of controlled in its applications. And no tactical reason *** sufficient to put up with an ideological fraud.

RAPPORT SUR LA

“REUNION D’URGENCE (Emergency conference) DES FEMMES FEHINISTES SUR LES NOUVELLES TECHNIQUES DE REPRODUCTION HUMAINE”

OSTRA GREVIE (LUND) – SUEDE- 3-8 juillet 1985.

Cette conférence fait suite à une série de débats organisés par des femmes féministes, depuis 1984, sur la question des nouvelles techniques de la reproduction. Elle avait notamment été précédée en avril 1985 par un congrès de 2000 féministes (essentiellement allemandes – des) à BONN, en Allemagne, sur ces mêmes questions.

Mais surtout, elle est la première conférence internationale du réseau FINNRET (Feminist International Network on the New Reproductive Technologies) créée à Groningen en Hollande en 1984, au cours du 2eme congrès interdisciplinaire sur les femmes.

La conférence suédoise a été organisée par un collectif de six femmes (2 américaines, 2 anglaises, 1 australienne et 1 suédoise), toutes participantes au réseau FINNRET. Elle a rassemblé 60 à 70 femmes de 16 pays différents: Allemagne, Australie, Angleterre, Bangla-Desh, Brésil, Canada, Danemark, France, Irlande, Israël, Japon, Norvège, Pays-Bas, Suède, Suisse, USA.

Elle s’est ouverte par la présentation de l’histoire, des intentions et buts du réseau international FINNRET.

Celui-ci se propose de:

- 1) Constituer une base d’informations sur l’ensemble de ce qui se fait dans le monde en matière de technologies de la reproduction.
- 2) Faire une analyse critique de différents facteurs-culturels, sociaux, politiques – en jeu dans ces développements technologiques.
- 3) Analyser les implications de ces pratiques pour les femmes dans les différents contextes sociaux et politiques où elles se trouvent: les femmes veulent-elles, choisissent-elles ces techniques? Dans quelles conditions? Quelles en seront les conséquences pour elles quant à la qualité de leur vie, leurs rapports sociaux etc...?
- 4) Développer des stratégies de résistance féministes contre ces techniques ou des stratégies alternatives pour les femmes.

Et c’est la première fois qu’une conférence réunissait des femmes de très nombreux pays du monde pour tenter d’élaborer des analyses critiques de ces technologies, d’une part, et prendre position vis à vis d’elles, d’autre part.

D'entrée de jeu, le ton de la conférence était donné par les analyses produites par quelques unes des organisatrices.

GEIM COREA, auteur d'un livre récemment paru aux USA, "THE MOTHER MACHINE" (Harper and Row. Ed) avance l'hypothèse suivante: si, le plus souvent, les NTR. sont présentées à la fois comme solutions à la détresse des femmes infertiles, et nouveaux choix pour les femmes, ces techniques sont en réalité mises en place pour établir une nouvelle forme de contrôle social sur les femmes.

Cette hypothèse est soutenue par les faits suivants résultant d'une enquête réalisée aux USA:

Alors qu'à l'origine, les NTR n'étaient employées que sur un très petit nombre de femmes, la catégorie des femmes concernées s'élargit de plus en plus. Quelques exemples:

La FIVETE ne concernait, au début, que les femmes ayant les trompes bouchées ou absentes, désormais, elle est aussi pratiquée dans les cas des stérilités "idiopathiques" (incompréhensibles du point de vue médical) voire sur des femmes fertiles mais dont le mari est stérile. D'autre part ce procédé permet aussi d'améliorer la "qualité" de la procréation: selon des médecins spécialistes de la FIVETE, cette technique permettra à des femmes estimant avoir ou ayant (selon les médecins) de "mauvais oeufs" (à la suite de contacts avec des substances toxiques par exemple) d'avoir recours à de "meilleurs oeufs

De même le procédé dit "Flushing embryo" ou récupération d'un embryon de cinq jours par lavage d'utérus, pourrait devenir routinier, dit l'un des spécialistes américains de cette technique; ceci permettrait d'examiner les éventuels défauts des embryons, de les manipuler, voire d'en choisir le sexe.

Autre exemple: l'amniocentèse qui ne concernait au début que des femmes ayant plus de 42 ans, est aujourd'hui appliquée aux USA, à des femmes de plus de 30 ans. C'est dire que la catégorie des femmes dites "à risques" s'élargit tellement que le nombre d'accouchements par césarienne augmente énormément dans tous les pays occidentaux.

Au titre des anomalies, on sait, grâce au diagnostic prénatal, actuellement détecter environ 300 défauts génétiques (dont celui qui est responsable de l'asthme par ex...). Mais que fera une femme dont le fœtus aura 150 tests positifs et les autres négatifs??

Par ailleurs le sexe féminin ne risque-t'il pas d'apparaître comme l'une des principales anomalies, lorsqu'on sait qu'en matière de "choix du sexe de l'enfant", une très forte préférence va vers le sexe masculin pour le 1er enfant, et amène à vouloir éliminer les filles dès avant leur naissance... N'y a-t'il pas risque de voir s'installer un préjugé sexuel, voire une réalité sexiste?

Ces techniques visent donc aussi à la réalisation d'une population parfaite.

Concernant le mode de production de ces techniques, on peut dire qu'elles font appel à des processus de type industriel où le corps des femmes, utilisé comme matière première devient aécable et manipulable selon des logiques techniciennes d'une part, de production industrielle d'autre part. Les enfants deviendraient alors des produits les plus parfaits possibles, réalisés grâce à la recombinaison, selon le type voulu par "les techno-doc", de différentes parcelles du corps

* NTR: Nouvelles Techniques de la Reproduction humain et notamment du corps des femmes.

MARIA MIES, allemande, auteur d'un livre déjà paru en allemand et qui sera traduit, cet automne, en anglais "Women, the last colony" renchérit sur cette dernière analyse. Elle développe l'idée que le corps des femmes, via les techniques de la reproduction, et de la manipulation des gènes et des embryons serait l'un des points d'exercice essentiels du développement du capitalisme aujourd'hui: les NTR viendraient alors offrir de nouveaux biens de consommation et relancer l'économie.

Concernant les NTR, telles qu'elles sont pratiquées dans les pays occidentaux, diverses analyses soulignent donc, avec force, qu'elles constituent ou constitueront un moyen de contrôle social: utilisées sur des fractions de plus en plus larges de la population féminine, penchées comme substitut possible, voire meilleur, aux modes "classiques" de la reproduction, elles placent les femmes en situation de

dépendance vis à vis de la sophistication technologique, et à l'exercice médical qui vise à morceler le corps, en manipuler les parties et faire du corps des femmes de véritables "machines à produire du vivant".

Par ailleurs, alors que le mariage et la morale bourgeoise permettaient aux hommes de contrôler la sexualité de leurs femmes au niveau individuel; désormais le contrôle change de mains: ce sont la science et la technologie, les "techno-doc" qui, par le biais des NTR, vont assurer un contrôle de la reproduction et des femmes en tant que catégorie sociale, en promouvant à nouveau la maternité, mais la maternité en tant que contrôlée et technologisée.

Mais l'un des axes majeurs développés au cours de cette conférence, visait à conjoindre à la fois l'analyse des NTR dans les pays occidentaux-avec notamment les perspectives ouvertes par les manipulations génétiques au niveau des gamètes et des embryons et celle des diverses techniques de contraception ou de stérilisation telles qu'elles sont pratiquées dans les pays du Tiers-Monde.

Qu'au niveau des discours des biologistes. et des médecins eux-mêmes, les NTR soient souvent associées à la stérilisation est patent. La FIVETE est souvent présentée comme forme de réversibilité possible à la stérilisation ou à la stérilité résultant de l'usage de certains moyens contraceptifs: stérilet ou drogues hormonales à effet de longue durée (DEPO-PROVERA ou NORPLAN par exemple)

Or ces deux dernières techniques (stérilisation et contraception de longue durée) sont, par dessus tout, employées chez les femmes du Tiers-Monde; le plus souvent, avec promesse de paiement en retour, et sans qu'elles soient informées des risques qu'elles encourent (saignements prolongés, violents maux de tête et risques de cancers notamment). Ces risques sont, bien entendu, le plus souvent connus des firmes fabricantes, ne serait-ce que pour la raison qu'elles ne sont pas autorisées à tester ni vendre leurs produits dans les pays occidentaux.

Il est clair, ont fortement affirmé les femmes du BANGLA-DESH, que les femmes du Tiers-Monde sont utilisées par divers organismes internationaux comme marché où écouler et tester certains médicaments et champ d'expérimentation des contraceptifs à haut risques. Et alors que diverses études ont prouvé que la pauvreté n'était pas la conséquence mais la cause de l'explosion démographique, les gouvernements du Tiers-Monde, s'ils veulent recevoir une aide alimentaire ou financière de pays -tels les USA par exemple- se doivent d'accepter la formule proposée-imposée par ces mêmes pays de diminuer fortement la natalité.

Dans les pays du Tiers-Monde, le contrôle de la population s'effectue donc clairement par un contrôle à la baisse de la capacité de reproduction et non pas en cherchant à modifier les conditions sociales ni les rapports de production existants qui génèrent et maintiennent les très fortes inégalités sociales.

Voici donc, résumées, ce qui a paru être l'essentiel des interventions de types théoriques (toutes en langue anglaise véhiculée par divers accents)

§§§§§

Une large place a aussi été accordée pendant cette conférence aux différentes présentations nationales toutes axées sur les trois points qu'avaient suggérés les organisatrices:

- 1) Information concrète; état des technologies: quels scientifiques ou médecins font quelles recherches ou quels traitements dans chaque pays?
- 2) Etat de la législation; prises de position des comités d'éthique
- 3) Etat de la résistance féministe.

L'ensemble des données recueillies dans les diverses présentations a été- à l'initiative de Laurence Gavarini et Louise Vandelac présenté sous forme de tableaux synoptiques.

Un des points remarquables de cette confrontation internationale, a été de constater à quel point les différentes conditions historiques/et culturelles des pays d'origine donnaient un style particulier aux analyses produites par les femmes de ces pays.

Quelques traits pour expliciter ceci:

Ont déjà soulignées les différences majeures des points de vue entre femmes du Tiers-Monde et femmes occidentales.

Parmi ces dernières une très grande vigilance est exercée par les femmes allemandes sur les aspects eugéniques et de manipulation des corps des femmes et des embryons, vigilance encadrée par des analyses politiques-aux sens marxiste et écologique du terme-; relatif empirisme et pragmatisme des femmes anglo-saxonnes notamment qui accèdent une très grande importance aux faits; quant aux analyses produites par celles que les anglo-saxonnes ont avec humour dénommé la "FRENCH CONNECTION" (je parle ici des six femmes françaises ou francophone: Laurence GAVARINI; Françoise LABORIE; Simone NOVAES (sociologues); Hélène ROUCH, professeur de biologie; Louise VANDELA sociologue québécoise travaillant en partie en France sur ces questions; et Anne-Marie de VILLAIN, journaliste et écrivaine- qui étaient présentes à la conférence), elles étaient plus nuancées et assez diversifiées: d'une réflexion sur les effets en retour d'une illusion de totale "maîtrise" de la reproduction; à une prise en compte de la dimension économique des NTR; en passant par une analyse des formes de leur institutionnalisation; de leurs taux de réussite et d'échec et de la façon dont ils sont présentés par les médecins et les médias très à la hausse dans tous les cas; à l'analyse d'une possibilité de modifications des rapports sociaux par élargissement des parentalités grâce aux NTR ou à la maternité pour autrui, etc...

Le poids d'une prise en compte du sujet, y compris dans sa dimension inconsciente était à l'évidence plus sensible dans leurs interventions que dans la plupart de celles de femmes des autres pays.

La plupart des interventions faites à la conférence ont porté sur la fécondation in vitro et les manipulations génétiques. Le problème des mères porteuses et celui de l'insémination artificielle avec sperme d'un Donneur ont été peu évoqués au nom de deux présumés peu ou pas discutés: la mère porteuse relève d'une prostitution reproductive, et l'IAD est une technique non agressive pour le corps des femmes et donc indiscutable/indiscutée en tant que telle. Positions qui furent néanmoins fortement contestées par les françaises.

Enfin, ce n'est qu'après une session fort houleuse qu'une résolution finale a été adoptée par les femmes et présentée au cours d'une conférence de presse locale.

Cette résolution en anglais-fait état du changement d'intitulé du réseau qui désormais se nomme

FINRAGE

(Feminist International Network on Reproductive And Génétic Enginneeriu, en plus du jeu de mot sensible en anglais et en français, se marque la volonté de mettre l'accent sur l'aspect manipulative et en particulier les risques de manipulations génétiques.

§§§§§

Il a été demandé qu'une femme par pays soit désignée comme contact pour le réseau: c'est Simone Novaes qui est le contact pour la France.

Outre la décision de présenter à la conférence de NAIROBI en juillet 1985, la résolution finale de la conférence, il a aussi été décidé d'organiser une conférence européenne sur ces questions en 1986-choix du pays non encore fait- et aussi un Tribunal International sur les crimes scientifiques subis par les femmes qui pourrait se réunir en 1987.

§§§§§§§

Ajoutons encore que Françaises ont annoncé la constitution de deux réseaux de femmes féministes intéressées par ces questions, qui examineront en novembre 1985 les possibilités de connexion entre eux.

§§§§§§§

Rapport rédigé par Françoise Laborie en collaboration avec les femmes de la délégation française.

Keeping a watch on the hi-tech wonders The Age Melbourne August 14, 1985 p. 26

SULTANA KAMAL was forced to leave her job as head of the women's program in an integrated development project in Bangladesh after she was accused of not filling the quota of sterilisations.

She told an international conference in Sweden last month that the accusation came from the US aid program that was financing the project. She had thought the emphasis should have been on education and training villagers to become economically self-sufficient.

Western delegates to the first Women's Emergency Conference on the New Reproductive Technologies listened open-mouthed as they learnt of measures taken to prevent women having children. Third World women were equally amazed at the length to which the West goes to overcome the infertility of some people.

Delegates heard that wealthy Western couples were turning up at London clinics with Bangladeshi surrogate mothers in tow. The West German women spoke of a resurgence of concern for racial purity, with the sterilisation of "defective" women, and the promotion of pre-natal screening as a means of eliminating imperfect babies.

American author Gena Corea criticised US profit-making IVF clinics for misleading infertile couples by quoting success rates based on pregnancies rather than live births. Some claimed more than 20 per cent success when they had never produced a live baby, she said.

The conference of about

The new reproductive technology offers a plethora of options, but how much choice do women really have? RAMONA KOVAL, reports on an international conference which brought together women from East and West to monitor the effects of this technology on their lives.

100 women from 18 countries was organised by the Feminist International Network on Reproductive and Genetic Engineering (FIN-RAGE). The final resolution reflected a new mood among women of resistance to the so-called wonders of reproductive technology, offered in the name of free choice but often in a context which allows women no real choice at all. The conference condemned the "men and their Institutions that inflict infertility on women by violence, forced sterilisation, medical maltreatment and industrial pollution, and repeat the damage through violent repair technologies".

It supported "the exclusive rights of all women to decide whether or not to bear children, without coercion from any man, medical practitioner, government or religion" and the "recovery by women of knowledge, skill, and power that gives childbirth, fertility and all women's health care back into the hands of women". It opposed attempts "through genetic and reproductive engineering, to... (divide) women into 'valuable' women in the industrial world who should have children, and 'inferior' women in exploited countries who are forbidden to have children".

Sultana Kamal spoke of the experience of Bangladeshi women sterilised in makeshift camps funded by many aid

agencies. Most food and economic aid programs have a population control program tied to them. No population program means no aid. She described the conditions for the sterilisations as terrible. "They are performed by doctors in camps called rural health clinics without any real facilities for such work. Sometimes they are done on tables in schools that are vacant for the day. Local anaesthetics are used with minimal antiseptics."

Site was critical of the lack of post-operative care. The aid agency she worked for did not provide any money for after-care, only for the sterilisations. "It is so hard for the women who come to the camps and then go back to their villages. By the time she may need help the camp is gone."

She was also concerned that women were being pressured into having the operations. "The family planning organisations have 'motivators' who are supposed to bring in clients and get paid so much money for each case. You can imagine the enthusiasm they work up. The women are given an incentive — a sari and the equivalent of one month's income."

Another issue was the use of injectable contraceptives like Depo-Provera and Norplant, an experimental hormone implant which is sewn under the skin and releases hormones for up to five years. She said: "The population control agencies

are not interested in side-effects from these things, only how to make them more acceptable to our people. They have not noted side-effects because they have not looked for them. Women who complained to one doctor about side-effects of Depo-Provera — bleeding problems and malaise — were told that it was their own fault because they should be eating better foods."

Farida Akhter, also from Bangladesh, worked for five years as an economic researcher for several aid agencies. One project was a study of the social and economic conditions of fishermen in a small village. "I found that the agencies were not interested in changing the social conditions of the fishermen, but in how to sell Western boats and net technology to them. It was ridiculous, so I left"

She is now executive director of her own social research agency where she can set appropriate priorities for research into the conditions she understands, and towards goals she sees as constructive.

Both women brought a different view about the new reproductive technologies. Farida Akhter was concerned about the links between these technologies and the sterilisation programs. "Contraceptive technology applied to developing countries is creating the conditions of infertility. The users of Depo-Provera are not guaranteed that they will regain their fertility. This new reproductive technology may eventually be used to treat them."

She compared this to what

happened in the “green revolution” — the introduction of high-yielding seed varieties to developing countries in the 1960s. The land was fertile in Bangladesh. Then they came with these new seeds that depended on chemical fertilisers and intensive farming. They claimed that it would increase food production fourfold. But the costs of production — the energy, the fertilisers — increased at an even greater rate.

“The result is that our land is losing fertility and we are becoming more and more dependent on the West for fertilisers and other farming technology. Our traditional farming methods do not succeed any more because the land is so depleted. The green revolution perpetuated the food problem. And when you have a food problem, a population problem is created.

Farida Akter was also critical of aid programs that set up industries which exploited women in developing countries. The garment industry employs mainly women. They are paid a little more than rural laborers and so the women are flocking to the factories. “Already it has been found that there is a link between prostitution and women factory workers. The women are brought from their villages and come into a situation that they are unfamiliar with. They are dependent on those who brought them to town, and are often exploited physically and sexually.

“I have seen advertisements for women in the garment industry saying they want widows, sterilised women, or unmarried women. A widow is badly in need of a job to

support herself. A woman may become sterilised to get this work. One indication of poverty in these families is that the women work for wages outside. So the families of these women are really in trouble.”

Sultana Kamal commented that her government says things are changing for women now they can work. “But they are only allowed to work because the Government feels that they should be engaged in industrialising activities, not because the Government says that women have a right to work or a right to lead a life other than the one they are supposed to lead.”

Both women are members of a small feminist group in Bangladesh called Naripoko which means “from women’s side”. The group provides a forum for women to begin to discuss the problems of women in their country, which is overwhelmingly Moslem.

Although both women have the advantage of an education and an upper middle-class background they also had to struggle to gain recognition. Farida Akter had to fight a long family battle to be allowed to get an education, and was always pressured about getting married.

“In our feminist group we are a small number of women, with very different levels of feminist consciousness. We are united on the basis that women’s position must change. We try to denounce all religious restrictions on women. We have a long way to go.”

Sultana Kamal talked of the problems of aid agencies, advisers going into developing countries without respect for those they are trying to help.

“People in the donor

countries should be more informed about the countries they go into. They should change their attitude about their own roles: that they don’t go there as saviors but for an exchange of information. In 1985, saw a report that said for every SUSI given in donor program there was \$US8 in return to the US from economic investment in Bangladesh. So who exactly is the donor country?

“But we must continue to communicate and share with each other. We cannot shut ourselves off from each other. This would benefit no one.”

Ramona Koval is a lecturer in environment and technology policy at the Royal Melbourne Institute of Technology and was a delegate to the Swedish Conference

Das Retortenbaby — ein Nebenprodukt!

Vom 3. - 8. Juli haben sich 70 burtkontrollprogrammen in «helfen» Frauen aus 19 Ländern an der den Entwicklungsländern und Nicht geborene Konferenz mit dem Thema den neuen Retortenkind interessiert Forscher den Reproduktionstechnologien im und Aerzte inerster Linie, sondern «Abfallprodukte» dieser die Schwedez war vertreten. Auch aus machtpolitischen Gründen in ihren Konferezz ist von 5 Frauen der dort abzubauen und hier Händen bleiben. Und erstes Ziel vor einem Jahr gegründeten aufzustocken, greift zu kurz. In der Embryoforschung ist nicht, Organisation FINNRET einzelnen Ländern der Dritten intelligente, blauäugige Super (Feminist International Welt ist die IVB (In-Vitro- menschen zu zuchten. Sondern sie Network on the New Befruchtung) bereits Praxis, erforschen, wie der Mensch am Reproductive Technologies) andere bekunden ihr Interesse. besten an seine vergiftete, organisiert worden mit dem Es mag irr scheinen, in ein zerstörte, immer ressourcenärmere Ziel, der internationalen und demselben Land Kinder Umgebung angepasst werden kann technischen Entwicklung einen gleichzeitig verhindern *und* — das ist ihr Programm'.

internationalen Widerstand produzieren zu wollen. Es mag Der Zusammenhang zwischen engegengestellten. Aus der verrückt wirken, die irrwitzige den Dritten Welt waren leider nur teure IVB-Methode mit ihrer Reproduktionstechnologien und drei Länder vertreten niedrigen Erfolgsquote auch der Gen technologie im humanen (Brasilien, Bangladesch, für Frauen armer und nichthumanen Bereich liegt Bevölkerungsschichten zu auf der Hand. Aus diesem Grund propagieren (so geschehen in beschlossen die Konferenz- Brasilien). Doch irr ist dies nur Teilnehmerinnen, die Austausch der Information ein solange man glaubt, die IVB- Widerstandsorganisation nun zentraler Aspekt Methode sei entwickelt FINRRAGE herausgeschält: Es bestehen worden, um unfruchtbaren klare Zusammenhänge Frauen z" zu zwischen den bevölkerungspolitischen Ge

nennen: «Feminist International Network of Resistance to Reproductive and Genetic Engineering.» Der fünfzügige Informationsaustausch war wichtig, um die weltweiten Zusammenhänge und Auswirkungen dieser Technologie zu erfassen. Doch die unterschiedlichen Einschätzungen der politischen Situation flackerten immer wieder kurz und heftig auf. Es müssen einige Fragen neu gestellt werden, wollen wir der technischen Entwicklung adäquate Strategien entgegenstellen. Auf 1986 ist deshalb ein europäisches Treffen geplant, 1987 wird ein internationales Tribunal stattfinden; angeklagt werden die von Medizin und Forschung an Frauen begangenen Verbrechen.

Claudia Roth

Ein Hintergrundbericht folgt in der nächsten WoZ vom 31. Juli.

Athen-Flug
Retourflug: 18/25
Fr. 490.- 01/08/15/
Fr. 470.- für Schölerinnen und
für schlechte Flüge auf Anfr

Kreta-Flug
Retourflug:
Fr. 490.- für Sch
Fr. 620.- für alle
22/29 Juli und

SSR-RE
Weitere Flugmöglich
auf Anfrage, natürlich

WOZZE MOS A LA PLAYA - PROXIMA EDICIÓN: 31.



REPRODUCTIVE TECHNOLOGY

emergency conference

I went to the *Women's Emergency Conference on the New Reproductive Technologies* held in Sweden 3rd-8th July '85. The papers and reports included National Presentations, information on research developments, issues of motherhood and strategies for resistance. The very few Blackwomen *** And from the West *** out ovum and *** for experimental purposes through to the jumping of unwanted products from the West in the First Nations while our land, our seas, our people are leeches of everything then polluted and poisoned. When food is either stock-piled in enormous quantities in places such as Britain and the US or destroyed for the *** benefit of multi-nationals millions of Black People around the world curve and are made 10 limit reproduction because there isn't enough food and *** have children. Meanwhile as women

from *** Western *** that those who already have a



Images

Left to right, Farida, Sultana and Jalna.

are involved in *** gave their reports. *** became awesomely clear was the pattern is basically the same *** all these countries. The growth in this industry is mind-boggling in swiftness. *** placate the public and justify themselves, governments are setting up Ethical Committees. But the people appointed are

stake in the present system and are often the very same people who benefit from profits of this technology. Ethical Committees seem to be *** preserving the status quo for they are determined that only hetero-sexual couples (mainly privileged white people) have access to this technology. Moreover they

concerns are the *** foetus/embryo. It is patent that absolutely no concern is shown for the rights, health and welfare of *women* involved. Indeed preservation *** paternity and men's property rights over offspring are paramount. His other issue is that in the rush to be 'first' or most 'successful' researchers such as those in 'fertility' clinics

*** around their statistics and findings – thereby ensuring continued funding. This also means that they have a willing supply of unaware and desperate women who are only too eager to pay for experimented on.

For example clinics that have in fact never had a client who has actually given birth to a real live baby, will 'borrow' the statistics of other clinics. And did you realise that for a 'fertility' clinic, 'success' is deemed not 'as you and I might think – a live baby, but a woman client retaining a pregnancy for more than about 8-10 weeks?!

Genetic Engineering is the result of the 'eugenics' theory and belief that is the 'Master Race' = white man. This theory, which appears to have originated in England *** during the Nazi Regime under Hitler. But the end of the second World War did not in any way mean the cessation of this ideology. What about

the increasing use of 'standard' foetal scans that are done in most hospitals? Men not only want, through technology to wrest control of childbearing from women both as mothers and midwives, but also to improve on 'nature'. In their attempts to justify themselves and make their appalling theories acceptable to us they have, with propaganda actively encouraged our use of some of this technology. Consequently we ourselves have inculcated these beliefs and use its products without being aware of it nor realising or understanding the actual implications. White governments around the world are all actively involved in financing projects such as these for they all 'secretly' believe in and want themselves to be perpetuated as, the 'Master Race'. They are no less fascist in this aspect than was Nazi Germany.

Of approximately 40 women from about 15 countries only 4 of us were Black – an Afro-American woman, 2 Bangladeshi women and myself from the South Pacific. And although most of the women present came out very strongly against RT and GE, I feel that the reasons, approach and *** women and us. There was not much lime or encouragement given for real discussion, especially regarding implications and effects on our daily lives. The organiser seemed to want to remain in power and keep a tight rein over which issues were raised at the conference. As per usual, *we* were asked to provide ‘answers’ for ‘problems’ instigated and perpetuated by white people.

The organisation that was once called FINNERET has now changed its name to FINRAGE (feminist International Network of Resistance to Reproductive And Genetic Engineering). If you are poor, marginalised or a Blackwoman then, at the moment, the best it can offer is news and recent information on ‘advances’ in RT and GE.

Yet it is imperative that

we become actively involved. However, we need to do it *together* because otherwise we will run the continual risk of being used; drained of our energy as they try and ignore us: tokenised and co-opted: or played off against each other. Meanwhile vital information and power will continue to be held from us by privileged white women.

Remember white people’s justice is exactly that – *just us!*

Uma

*FINRAGE. 7 Carlingfurd Rd.*****

Reageerbuisbabies en genetische manipulatie

'Reageerbuisbabies zijn slimmer en sterker.' Aldus een Australische arts, werkzaam in een kliniek voor in vitro fertilisatie, de officiële naam voor het maken van reageerbuisbabies. Deze uitspraak werd geciteerd door één van de Australische vrouwen op de FINNRET-konferentie in Zweden. FINNRET staat voor Feminist International Network on Reproductive Technology.

Sinds de geboorte van 's werelds eerste reageerbuisbaby, Louise Brown, in 1978 hebben de ontwikkelingen van de reproductieve technologieën als in vitro fertilisatie, embryo-transplantatie en prenatale diagnose een grote vlucht genomen. Ook in Nederland wil men niet achterblijven in deze internationale 'rat-race'. Een commissie van de Gezondheidsraad heeft in oktober 1984 een aantal academische centra toestemming gegeven de techniek van in vitro fertilisatie te ontwikkelen. Dit voor een proefperiode van drie jaar, waarna besloten zal worden of de behandeling opgenomen wordt in het ziekenfonds.²

Vanuit grote bezorgdheid over deze razendsnelle ontwikkelingen organiseerde FINNRET van 3-8 juli jl. een spoedkonferentie. Doel was de netwerkleden bijeen te brengen, informatie uit te wisselen en een gezamenlijk standpunt in te nemen ten aanzien van deze technologieën. De informatie die wij, 65 vrouwen uit 20 landen uit Europa, de Verenigde Staten, Zuid-Amerika, Australië en Azië deze vijf dagen bijeen brachten is nog maar het topje van de ijsberg. Niemand weet precies wat er allemaal af-geëksperimenteerd wordt door op kennis en macht beluste technokraten in laboratoria en klinieken. Maar wat we weten is schokkend en alarmerend.

Geneties 'gezonder'

De nieuwe reproductieve technologieën worden in de media gepresenteerd als 'nieuwe hoop voor onvruchtbare vrouwen' en een vergroting van de keuzemogelijkheden. In feite

deze geneties 'gezonder' zijn. Wanneer er sprake is van een genetische afwijking, of wanneer de eicellen mogelijk beschadigd zijn door giftige stoffen in de werkomgeving, of wanneer vrouwen ouder zijn dan 50 kan het gebruik van donoreicellen de voorkeur verdienen. Eén arts heeft zelfs geopperd dat mensen hun eigen eigenschappen of die van hun partner (zoals intelligentie, persoonlijkheid of uiterlijke verschijning) niet waarderen en daarom donor-eicellen of -sperma preferen.

Zal in vitro fertilisatie gewoner worden dan natuurlijke reproductie? Al in 1976, twee jaar voor de geboorte van de eerste reageerbuisbaby, voorspelden twee wetenschappers dat dat zou kunnen. 'Gezondheidstesten voor embryo's zullen worden ontwikkeld en daarom zou IVF de beste manier van voortplanting kunnen worden – als je alleen de geneties gezonde embryo's terugzet in de baarmoeder'⁴

Ook voor in vitro fertilisatie wordt het aantal indicaties groter. Niet alleen vrouwen met geblokkcerde eileiders zijn kandidates voor deze behandeling, zoals in het begin. Zelfs vruchtbare vrouwen komen nu in aanmerking als ze toevallig getrouwd zijn met een man die lijdt aan een te lage hoeveelheid spermacellen. En dan te bedenken dat het voor vrouwen een langdurige, pijnlijke en psychies belastende procedure is met een zeer lage kans op sukses. Een Australische 'ex-patiënte' vertelde: 'You leave your pride on the threshold when you walk in, pick it up when you walk out, and in the meantime you feel like a piece of meat in a factory.'

deze geneties 'gezonder' zijn. Wanneer er sprake is van een genetische afwijking, of wanneer de eicellen mogelijk beschadigd zijn door giftige stoffen in de werkomgeving, of wanneer vrouwen ouder zijn dan 50 kan het gebruik van donoreicellen de voorkeur verdienen. Eén arts heeft zelfs geopperd dat mensen hun eigen eigenschappen of die van hun partner (zoals intelligentie, persoonlijkheid of uiterlijke verschijning) niet waarderen en daarom donor-eicellen of -sperma preferen.

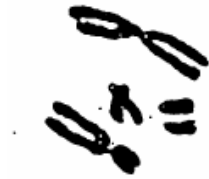
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Technodocs

Wanneer deze ontwikkeling doorzet wordt reproductie meer en meer een geïndustrialiseerd proces. Vrouwen worden gereduceerd tot het 'ruwe materiaal' (eicellen, hormonen, baarmoeders) en babies tot producten, geproduceerd door 'technodocs' – art-sen en wetenschappers.

Zowel door 'links' als in de vrouwenbeweging zijn argumenten naar voren gebracht om de ontwikkeling van reproductieve (en andere) technologieën niet a priori af te wijzen. Deze argumenten zijn

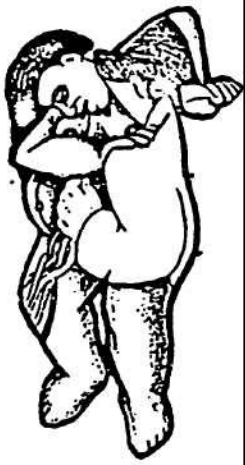
systeem leidt mikro-elektronika, gen- en reproductieve technologie tot vervreemding, onmenselijkheid, werkloosheid etcetera, in een socialisties systeem zal dat anders zijn. En een



feministische variant gen- en reproductieve technologie zijn onderdrukkend in een patriarchale kapitalistische maatschappij. Maar als vrouwen meer ingewijd worden in de technologie en 'wij de macht hebben', kunnen we er ons voordeel mee doen (bijveeld mannen 'wegklonen', een kind krijgen als we onvruchtbaar of lesbies zijn).

Deze argumentatie werd op de konferentie fel bestreden door *Maria Mies*, sociologeuit West-Duitsland. Technologiese 'voortgang' is niet neutraal, stelde ze.⁵ Deze heeft dezelfde kenmerken in kapitalistische en socialistiese systemen, en is altijd gebaseerd op exploitatie en dominantie van de na-

100



22 oktober 1984
10.30-15.30 uur

Positieve actie
De Nederlandse Vereniging voor Vrouwenbelangen organiseert op 9 november van 10.30-15.30 uur een studie- en informatiedag over Positieve Actie. 's Ochtends wordt er een inleiding gehouden. 's middags is er een paneldiskussie. Het september-nummer van het blad Vrouwenbelangen is een themanummer over dit onderwerp. Aanmelding en inlichtingen: elke dinsdag en donderdag van 10-14 uur. tel. 071-1S5063.

22 oktober 1984

Vrouwenmishandeling
De werkgroep Vrouwenstudies wil onderzoek naar vrouwenmishandeling aan de Leidse Universiteit stimuleren. Ze inventariseert daartoe wat er op het gebied van onderzoek naar mishandeling van buitenlandse vrouwen in Nederland (met name Surinaamse, Marokkaanse en Turkse vrouwen) al is gebeurd. Vrouwen die zich hiermee bezig (hebben) gehouden of over informatie beschikken worden verzocht contact op te nemen met de werkgroep. Middelstegecht 4, 2312 TW Leiden (Adriejenne, Tamara), tel. 071-148333, tst. 6380.

22 oktober 1984

Vrouwenboekenweek
Van 2 tot en met 9 november wordt de eerste landelijke Vrouwenboekenweek gehouden. De officiële opening is op 2 november om 14.00 uur in het NV-huis, Oudegracht 245, Utrecht, met een forum over de relatie vrouwenboek en vrouwenbeweging, een talkshow over de invloed van theorievorming op de praktijk wat betreft gezondheidszorg, carrièrefeminisme en zedenwetgeving, kulturele activiteiten, een borrel en 's avonds een feest. De hele week zijn er tal van activiteiten in het hele land. Het programma is opgenomen in een speciale vrouwenboekenweekkrant te verkrijgen bij de vrouwenboekhandel. Inlichtingen ook bij de Meld- en Regelkamer van de vrouwenboekenweek, le Sweelinckstraat 10. Amsterdam, tel. 020-647638.

22 oktober 1984

tuur, van vrouwen en van niet-westerse volken. We moeten onze sociale relaties veranderen, en daarvoor bestaan geen technologische oplossingen. De elektrische keuken heeft de relaties tussen mannen en vrouwen ook niet veranderd.

Een voorbeeld van hoe technologie in een socialisties systeem gebruikt kan worden komt uit Oost-Duitsland, waar men op zoek is naar een 'biologische eksponent' van de ideologie. Een wetenschapper daar stelt dat genetiese manipulatie aangewend kan worden om een 'socialistiese persoonlijkheid' te kreëren.

Met name in West-Duitsland is het verzet tegen de genetiese en reproductieve technologie de laatste jaren sterk gegroeid. Een groep vrouwen van de Grünen en vanuit de sociale wetenschappen organiseerde april dit jaar een konferentie in Bonn, die door zo'n 1700 vrouwen bezocht is. 'Wij kunnen niet om onze historic heen', zei een van de aanwezige Duitse vrouwen als verklaring voor de grote weerstand juist in haar land.

Maar overall zijn er wetenschappers en politici die in de ban zijn van het kreëren van een menselijk superras, van de eliminatie van sociaal ongewenste eigenschappen. En vrouwen zijn de proefkonijnen bij hun eksperimenten. In de zogenaamde derde wereldlanden worden onder het mom van het tegengaan van overbevolking en 'dus' honger, miljoenen vrouwen koste wat kost onvruchtbaar gemaakt. Door middel van langdurig werkende, gevaarlijke antikonceptiemethoden als de prikpil (Dopo-Provera), of tijdens grootscheepse sterilisatiecampagnes, gesubsidieerd door onder andere de Verenigde Naties. Het probleem is echter niet de overbevolking daar, het probleem is de ongelijke verdeling van voedsel over de wereld.

In de geïndustrialiseerde landen daarentegen moeten vrouwen meer kinderen krijgen en worden ze daartoe in ziekenhuizen en klinieken mishruikt en voorgelogen. Om proefkonijnen te trekken stellen de IVF-klinieken hun suksespercentages veel hoger

voor dan ze in werkelijkheid zijn.

Als artsen en wetenschappers werkelijk bezorgd zijn om onvruchtbare vrouwen, dan zouden ze in plaats van hun technologiese werk onderzoek doen naar de oorzaken en preventie van onvruchtbaarheid. Zoals gevaarlijke medicijnen en voorbehoedmiddelen, chirurgiese ingrepen, radio-aktieve straling en andere vergiftiging van het milieu.

Onvruchtbare vrouwen helpen is het alibi. Het vergroten van de mediese en sociale controle over onze reproductie is het werkelijke motief.

Aan het slot van de konferentie is de naam van het netwerk daarom veranderd in: Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINRRAGE). In een gezamenlijk opgestelde resolutie keren we ons tegen alle vormen van reproductieve en genetiese manipulatie en roepen we vrouwen en mannen op te zoeken naar een andere manier van wetenschaps- en technoloiefriebeoefening. Een die de waardigheid van vrouwen en alle leven op aarde respecteert.

NOTEN

- 1. FINNRET werd opgericht in april 1984 tijdens het tweede internationale interdisciplinaire vrouwenkongres Groningen.
- 2. Interimadvies inzake In Vitro Fertilisatie. Gezomheidsraad. 10 oktober 1984.
- 3. Gene Corea. The Mother Machine, reproductive technologies, from artificial insemination to artificial wombs. Harper & Row, publishers, inc., Maryland, USA, 1984.
- 4. Laurence E. Karp and Roger P. Donahue. "Prcimplantation ectogenesis". The western journal of medicine, nr. 4. 1976.
- 5. Maria Mies. 'Why do we need all this?', a call against genetic engineering and reproductive technology. In Women's Studies International Forum 8 (G). 1985.

LITERATUUR
MEER
Rita Arditti, Renate Duelli Klein and Shelley Minden (eds.). Test-tube Women, what future for motherhood? Pandora Press, London, England, 1981

We shall resist the development and application of genetic and reproductive technologies as they are attempts to end our self-determination over our bodies. This is the essence of the statement presented at the end of the international conference on reproductive technologies held in Sweden in the beginning of July 1985.

The resolution addresses the social control made possible by old and new reproductive technologies and was the result of five days of discussions and presentations. It also points out and rejects the view of children as property and women as the raw material which is implicit in the new reproductive technologies.

The Swedish conference, which drew women from 16 different countries, was initiated by FINNRET (Feminist International Network on the New Reproductive Technologies). During the conference, the organization was renamed FINRRAGE (Feminist International Network of Resistance to Reproductive and Genetic Engineering). The purpose of the conference was to share information on the state of the technologies, legislation and feminist resistance, in the various countries.

Several of the women attending travelled directly to Nairobi afterwards to present the results of the conference at Forum 85 and to take part in two workshops on reproductive technologies and their development in relationship to international population policy.

Doctors, scientists and the mass media present developments in reproductive technologies as new hope for the childless and a way to overcome nature's imperfections. During the conference, however it became very clear that they are in fact powerful tools for social control, which will have far-reaching consequences for women's lives and health.

The development of technology surrounding in vitro fertilization (IVF) has gone fast. The first test-tube baby, Louise Brown, was born in 1978 in England. Today there are several hundred IVF clinics spread all over the world. In 1983, only 5 years after Louise Brown's birth, researchers for the first time succeeded in using an egg that didn't come from the woman who later went through the pregnancy. In November of that same year, the first baby without genetic material from the birthing mother was born.

The next step was embryo transfer. The egg is fertilized in the donor woman's body and after a few days flushed out of the uterus. The embryo can then either be implanted into another woman who then bears the child, or frozen to be used at a later date. The first embryo transfer baby was born in January 1984 in the USA. That same year, the first child who had been frozen as an embryo was born.

The national up-dates showed that these "firsts" have been followed by commercial exploitation and the application of the technologies to larger and larger groups of women. The other factor that pushes the development is the researcher's wish to be the first to succeed with a new technique and the excitement among scientists in controlling life. "We're fighting a scientific rat race," as one woman put it.

Many of the techniques that are being used in IVF clinics are experimental even if the women who seek treatment for infertility think of themselves as patients rather than research subjects. American journalist and writer Gena Corea presented a report about success rates at different IVF clinics in the USA. Success rates are defined in many different ways. The most common is to calculate the number of implantations per laparoscopy i.e. per egg “harvest. “Many such pregnancies are so called “chemical “pregnancies (they result in the increase of a certain hormone) and are by definition abortions,” said Gena Corea. The most experienced clinics have success rates of 15-20%. Treatment is, in other words, unsuccessful 80-85 times out of a hundred. Gena Corea’s study showed that many clinics had had no babies but still used more positive statistics. Many of the women Gena Corea interviewed judged their chances of having a child as much higher than what the statistics actually showed.

The medical risks for women who go through IVF treatment are significant. These include repeated anesthesia during laparoscopy, which is an operation where the doctor inserts an instrument (the laparoscope) through a cut in the woman’s abdominal wall in order to see and get at her ovaries, hormone treatments to enhance chances of a good “egg harvest”, repeated ultrasound examinations to determine the eggs’ maturity and to see if successful embryo implantation has taken place. The insertion of the egg into the uterus carries the risk of lesions and also an increased risk for ectopic pregnancy when compared to normal pregnancy.

In addition to the medical risks, there is the psychological stress caused by miscarriages, repeated treatments and total dependency on the doctor.

So far only a small group of women go through IVF treatment, usually because of infertility caused by damage to the Fallopian tubes. Gena Corea warned however that the new reproductive technologies are going to be used on a large portion of the female population. Similar developments have occurred with other technologies having to do with reproduction such as ultrasound examinations, caesarian sections and amniocentesis. Already, IVF is used when the man’s sperm are damaged and can’t meet the egg to fertilize it inside the woman.

New groups of women will become IVF candidates with the development of donor eggs. Gena Corea cited a doctor who said that women with “bad eggs” could benefit from IVF. According to this doctor, women can get bad eggs from bad work environments, exposure to chemicals etc. Another doctor told of women who want to use someone else’s egg for IVF instead of their own because they weren’t satisfied with themselves-they weren’t pretty or smart enough.

Certain doctors already talk of IVF as preferable to “normal” fertilization as it allows for quality control of the embryo. In other words, one could sort out those embryos with genetic defects or that are of the wrong sex. Of course no one has been able to satisfactorily define the category “genetic defect”.

“With this development, children are seen as a product and women as the raw material,” said Gena Corea.

Surrogate motherhood limelights this question. The new reproductive technologies increase the risks of reproductive prostitution. “This is just one example of how reproductive technologies will be used differently depending on what class a woman belongs to or which part of the world she comes from,” said British sociologist Jalna Hanmer. At the concluding press conference, it was reported that traffic in women as surrogate mothers between developed and Third World countries probably has already started.

IVF is often presented as a technology that gives women new choices and the mass media emphasizes that women are demanding this treatment. American philosopher and feminist ethicist Janice Raymond said that we must ask ourselves under what circumstances women choose, to what extent the cultural, social and political situation that women live in affects our choices and our possibilities to choose. How easy is it for a woman to choose not to be a mother in a society where that may be the only role that society values?

Instead of offering new options, the new technologies are actually leading to an increased control of women’s fertility. Gena Corea told of doctors talking about IVF in connection with sterilization. One example is Dr. Edwards (one of the doctors behind the first test tube baby) who has said that IVF would decrease a woman’s resistance to sterilization as IVF opens the possibility of having children later in life if she were to start a new family. “The truth,” Gena Corea declared, “is of course that the woman has relatively very little chance of having a child even if she does have access to IVF. It would just mean she’s more dependent on doctors”.

If the point of political, social and economic control over women’s procreative abilities hadn’t become clear in discussing reproductive technology in the so-called developed countries, it became very clear during the presentations from women from the so-called Third World. Farida Akhter and Sultana Kamal from Bangladesh told of sterilization campaigns that were often accompanied by coercion or economic rewards. They also told of how hormonal birth control methods such as Depo Provera and Norplant (a hormone preparation that is implanted under the skin and makes a woman infertile for at least 5 years) are distributed without any restrictions and without any follow-up of the side effects. In these countries, women are often made sterile against their will.

An oft used motive for the development of reproductive technologies is to cure sterility. Ramona Koval from Australia was one of the women who talked about the causes of sterility. Many women are sterile today because of earlier experimental or medical treatment. IUDs are a common cause of pelvic inflammatory disease which can damage the Fallopian tubes so that an egg can no longer be transported from the

ovary to the womb. Careless handling of the ovaries during surgery and hormone treatments are other causes of sterility. Hazardous work environments, pollution and stress may very well be other factors involved.

The criticism that the women at the conference formulated in a resolution was not aimed only at reproductive technologies. The discussion also included the patriarchal definitions of motherhood and how we can create new definitions. Jalna Hanmer was one of the women who took up the patriarchy's power over motherhood. According to her the definition of a "good mother" has become more narrow at the same time motherhood is increasingly stressed. She said that the new reproductive technologies and the legislation concerning them can be seen in an historical perspective where men's power over women is shifting from individual control through marriage to control through science and technology.

The critique of reproductive technologies is also a concretization of a more general criticism of science and technology. Sociologist Maria Mies from Germany warned that the model of the machine is inherent in the logic of technology and it is this logic we see when a woman's body is turned into a machine and a child becomes a commodity. She and other women at the conference also pointed out that technology will not change social relationships. In the resolution they formulated thus: "We know that technology can not solve problems that result from conditions based on exploitation. We don't need to change our biology, we need to get rid of patriarchal social, political and economic institutions".

The conference at Östra Grevie was one step in building up an active resistance to reproductive and genetic engineering. The work will continue on national and international levels. FINRRAGE will function in the future as a contact network for the national groups. Also planned is a European conference next year to continue the exchange of information and to prepare for an international tribunal on medical and scientific crimes against women to be held in 1987.

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Feminist International Network of Resistance to Reproductive and Genetic Engineering, Conference Report, Sweden, July 1985.

FINRRAGE began at the Second International Interdisciplinary Congress on Women held in Groningen in April, 1984. The network was sustained by the efforts of Jalna Hanmer, Renate Duelli Klein, Gena Corea, Robyn Rowland and Janice Raymond. This Emergency Conference in Sweden reflected the urgency of feminist response to reproductive technologies and genetic engineering. Organizers argued that reproductive technologies have been criticized as dangerous to fetal health and because they reflect the logic of the capitalist economy, but few critiques have emerged which focus on their implications for women. The conference placed these concerns on women's ground, and the 80 women from 20 countries discussed the state of development of these technologies in each country, current movements in medical ethics and social policy, and feminist organizing and responses. Presentations exposed how these techniques have not been developed in response to female infertility, nor are they part of any significant move to research and remedy its environmental and iatrogenic causes. Rather, the new reproductive technologies are about the excitement of control, making history, making points; part of an aggressive, competitive thrust towards the mastery and exteriorization of the birth process. The scientific discourse behind the new reproductive technologies is based on a masculine model of sexuality, of division, quantification and control. For example, Simone Novaes reported that French doctors hope to produce sperm bank babies who are better than "bébés banals."

The five days of discussions highlighted the shared situation of women internationally. We are either sick with fertility, or sick with infertility, depending on our race and location in the underdeveloped or developed world. Presentations from Bangladesh revealed plans to involve women in economic production in order to reduce their opportunities to "breed." Women in Bangladesh are valuable as producers, not breeders, while in the Western world, we are important as breeders and consumers.

Sultana Kamal reminded us that in this Malthusian logic of population programmes worldwide, these techniques are not being used for women's self-determination. Farida Akhter argued that women's bodies have been used by men, and are now being used by government and international contraceptive companies. The commercialization of human reproduction is at the cost of women. She argued that we do not need a technical response to social problems, we need a feminist critique of science and we must redevelop a matriarchal axis to Nature.

Maria Mies asked why we need all this technology now, and argued against the erasure of sensuality and involvement in the physical that modern technologies necessitate. She criticized the mind/body split of the idealist tradition, arguing that the purely biological doesn't exist. We are our body, we do not possess or think it.

Paula Bradish emphasized the political history of genetics, its racist biases and implications for the lives of the disabled who were the beginning point in the eugenics rationale.

Jalna Hanmer signalled the links between state legislation, medical ethics and business interests. International scientific exchanges and training visits are underway, and some in vitro fertilization techniques have already been patented.

The new reproductive technologies are a powerful means of social control emerging in a context of the New Right's search for biological and genetics answers to social, political and economic issues. The trend towards a perfect population and a worthy citizenry is being put forward as in the best interests of the child. What will be women's rights to refuse these technologies, first amniocentesis and fetal monitoring, now in vitro fertilization, and next embryo flushing and replacement after manipulation and checking for defects? The emerging rhetoric of the "rights of children to be wellborn" could lead to accusations of selfishness against inadequate women and men who insist on using their own genetic material for reproduction. This resonates with previous methods of evaluating and policing women as fit mothers. In Australia, men and women are already "asking" to use sperm and eggs of the more adequate, more beautiful, more intelligent. And women whose eggs have been damaged by toxic substances in hazardous workplaces are already being targeted as candidates for donor eggs. In this context, it is the population and not the environment that will be cleaned up.

These intense meetings confronted women with desperate news, yet strategies and resolutions emerged in resistance. FINRRAGE will continue to monitor developments in the areas of reproductive and genetic engineering internationally, and assess the implications of these practices for women's well-being. In 1986, there will be a FINRRAGE planning session attended by European members to further a feminist critique of science, and to organize an International Tribunal on Medical and Scientific Crimes against women, focussing on reproductive and biogenetic engineering.

FINRRAGE has already published two information packages, and proceedings and information arising from the conference will be available by October. To order information packages or join the network, write your national contact person:

July 24, 1985

WOMEN RESIST REPRODUCTIVE AND GENETIC ENGINEERING

An International Tribunal of Medical and Scientific Crimes Against Women will take place in 1987, according to plans made by women from 16 countries who met at the Women's Emergency Conference on the New Reproductive Technologies in Vällinge, Sweden, July 3–8, 1985.

The crimes to be exposed will be in the area of reproductive and biogenetic engineering. They will include abuses of women involved in such new technologies as in vitro fertilization and embryo transfer, embryo flushing, sex predetermination, prenatal diagnosis and the rental of so-called "surrogate mothers". Furthermore, women will expose the environmental, workplace, household, and radiation causes of infertility.

Personal testimonies of women who have been abused in relation to abortion, contraception, sterilization, obstetrical practices, and medically-managed clitoridectomies will also be presented.

The Tribunal will be held in either Ireland or in Costa Rica.

Evidence presented at the conference on the abuse of women through reproductive technology made it clear to the 74 participants that a forum for the public exposure of these abuses was essential as a step in their eradication. Women reported:

—Sterilization camps in Bangladesh.

—Experimentation and egg snatching under the guise of fertility research in the developing countries.

—Lack of access to contraception and abortion for women in Ireland.

The Emergency Conference in Sweden had been called by the Feminist International Network on the New Reproductive Technologies (FINNRET), a network formed in April 1984 at the Second International Interdisciplinary Congress on Women in Groningen, the Netherlands. In Sweden, conference participants voted to change FINNRET's name to: Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINRRAGE), a name that acknowledges the interrelationship of reproductive and genetic technologies.

At the conference, participants passed resolutions of resistance to reproductive and genetic engineering. (Enclosed). FINRRAGE will send these resolutions to the European Parliament, to the United Nations Conference on Women in Nairobi, to the legislative bodies of a number of countries, and to the international press.

Sixteen women participating in the Emergency Conference agreed to act as contacts for an international network. They come from the following countries: Australia, Bangladesh, Brazil, Canada, Denmark, France, Great Britain, Ireland, Israel, Japan, Netherlands, Norway, Sweden, Switzerland, USA and West Germany. Each of these contacts will coordinate a national resistance group in her own country. The international coordinator is Renate Duelli Klein, a Swiss neurobiologist living in London.

FINRRAGE members will present a panel on reproductive and genetic engineering at the UN Conference on Women in Nairobi and expect that in Nairobi women from even more countries will join the network of resistance.

In Sweden, delegates from the European countries decided to hold a conference for European FINRRAGE members in 1986. The purpose of the four-day meeting will be to: 1) exchange information and feminist analysis of European developments in genetic and reproductive engineering 2) further the feminist critique of science 3) consider joint action and 4) organize in Europe for the International Tribunal on Medical and Scientific Crimes Against Women.

For further information and/or far press interviews, please contact one of the following FINRRAGE members:

RITA ARDITTI, 617-491-4038, biologist, co-editor of Test-Tube Women (Pandora Press, 1984) and Science and Liberation (South End Press, 1980). Faculty member of Union Graduate School.

GENA COREA, 617-729-1433, author of The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs (Harper & Row, 1985) and The Hidden Malpractice: How American Medicine Mistreats Women (Harper and Row, 1985).

SHELLEY MINDEN, 617-776-5836. Co-editor of Test-Tube Women (Pandora Press, 1984). Member of Women and Reproductive Technology group. Adjunct faculty member of the Adult Degree Option Program at Lesley College in Cambridge, Massachusetts.

JANICE RAYMOND, 413-367-2287, professor of women's studies and medical ethics in the women's studies program at the University of Massachusetts. Widely published in the field of medical ethics and the new reproductive technologies. Author of The Transsexual Empire: The Making of the She-Male (Beacon Press, 1979).