Reproduction, Population, Technology and Rights: North and South

by Janice G. Raymond

Much of my work has focused on the social and political consequences of new reproductive technologies (NRTs)—techniques and procedures such as in vitro fertilization (IVF), surrogacy, embryo transfer and freezing, sex predetermination, and the newer groups of contraceptive chemicals such as the implants (e.g., Norplant), the injectables (e.g., DepoProvera), and the antipregnancy vaccines. Although many of these technologies were originally developed in a Northern context, they are now being used worldwide, often in the context of developing countries.

This article will address the globalisation of new reproductive technologies and drugs and, as a framework for this discussion, the industrialisation of reproduction.

It is the reproduction of fertility and infertility with which I am concerned, i.e., the ways in which both fertility and infertility are being created and commodified as medically managed problems by medicine, media, and commerce. When the "disease" of infertility is established, what follows is the deployment of distinctively different technologies developed for use in different parts of the world.

Ideologies of fertility, infertility

Programs and policies supporting new reproductive technologies are governed by ideologies of fertility and infertility.

In the industrialized countries of the North, it is infertility that is being produced and marketed by those who would tell us that infertility rates are skyrocketing. Infertility is the new frigidity, and technology is the new instrumental manipulation that will coax reluctant women's bodies into reproductive performance. Technological reproduction has made medicalised access to the female body acceptable, and medicalised abuse—that a woman will endure anything to become pregnant—standard treatment "for our own good."

Is there a real problem of infertility in the Northern countries?

Certainly, infertility caused by environmental pollution and sexually transmitted diseases (STDs), as well as medically-induced infertility such as pelvic inflammatory disease (PID) caused by IUDs, is on the rise. The media and infertility experts talk about an epidemic of infertility in the North with one out of six or seven couples being infertile. Yet both the National Centre for Health Statistics (NCHS) and the U.S. Office of Technology Assessment (OTA) contend that the more accurate figure is one in twelve.

What has expanded is the definition of infertility.

Although infertility is a concept that has no scientific consensus, the currently accepted medical definition is inability to conceive after one year of intercourse without contraception. The number of years has dwindled in recent times, from five to two to one. Thus the definition conflates inability to conceive with difficulty in conceiving *quickly*. This routes a large number of women into unnecessary, experimental and costly medical treatment all the sooner.

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The media portrayal of infertility and the infertile is deceptively simple and homogeneous. Those undergoing IVF, for example, are portrayed as forever infertile. Yet a large percentage have had children in a present or a previous relationship. Many women undergo IVF because their husbands are infertile. This is probably one of the only examples in medical practice where a proxy is treated, i.e., another undergoes procedures in place of the actual person with the problem. Percentages vary, but it has been estimated that 11-35 percent of women on IVF programs are there because of male partners' problems. Male-factor infertility is as common as female factor, yet often the male partner is not tested in infertility assessments, or only after the woman has undergone extensive and exhaustive evaluation. Women testify that many gynecologists never order analysis of their husbands' sperm. And frequently, men will not undergo the tests, viewing them as offensive to their virility. Because women undergo the IVF procedures, many men are spared the embarrassment of having their infertility known.

What has also increased is the number of office visits to physicians for infertility services. As early as 1984, when new reproductive technologies were being popularized in the North American media, the number of U.S. office visits for infertility services jumped from 600,000 in 1968 to 1.6 million in 1984. The only infertility epidemic is the rash of fertility specialists. Between 1974 and 1988, membership in the American Fertility Society increased dramatically from 3,600 to 10,300.

In the developing countries of the South, Northern population agencies use a different rationale for promoting new reproductive techniques and drugs.

Here, it is fertility that is the perceived problem. The consequences of technological reproduction to women in developing countries have been sterilization and use of new/old and dangerous contraceptive implants, injectables, and antipregnancy vaccines. The pill was initially tried on women in Puerto Rico. The Dalkon shield, an IUD taken off the market in most First World countries, remains implanted in many Third World women. Third World countries have long been a dumping ground for chemicals and drugs such as DDT banned in the industrialised countries.

Women in Brazil and Bangladesh were among the first tested in Norplant trials. Norplant is the contraceptive implant that remains embedded under a woman's skin for about five years. It generated such problems in Brazilian women—dramatic change in body weight, heavy bleeding and menstrual irregularities, and severe alterations of the central nervous system—the feminist groups, in cooperation with a government study committee, succeeded in cancelling the trials—for a time. Yet when Norplant was approved by the USDA for use in the United States, the Brazilian data was not evident.

The rationale of female-fertility-out-of-control-in-the-Third-World has generated another and more drastic "treatment"—sex predetermination. Women have long been viewed as the cause of population proliferation in developing countries and, for the last 25 years, some scientists have proposed that by reducing the number of women born, the so-called population problem would be solved.

In India especially, massive termination of female pregnancies has been achieved by abortion after amniocentesis reveals the sex of the foetus. Between 1978 and 1983, almost 80,000 female foetuses were aborted there. Given the overwhelming preference for male children, the maltreatment of girl children, and the

punishment meted out to women who do not produce sons, it is not surprising that, as the rationale goes, women "ask for" the technology.

A U.S. entrepreneur of sperm separation technology—Ronald Ericsson of Gametrics, Inc.—has set up a chain of clinics in India, Jordan, Pakistan, Egypt, Malaysia, Singapore, and Taiwan, as well as several in the United States. Pivet, a west Australian company, has established in vitro fertilisation clinics in Brazil, India, Malaysia, and Indonesia, partially for sex predetermination goals. Clinics have been deluged with requests from financially well-off women both affected by infertility but also by the stigma of not having produced a son. Pivet is a prime example of a company developing a technology (IVF) usually used to promote fertility that, in a developing country context, is used quite differently to prevent fertility.

In the industrialised countries of the North, in vitro fertilisation is the basis for all the rest of the technologies. One egg and sperm are placed in a petri dish, researchers and clinicians determine the sex of the embryo, freeze eggs and embryos, transfer the embryo from one woman to another, or use the embryos for experimentation and genetic manipulation. Initially looked upon as a "fringe" technology, today IVF is regarded as the most conservative of new reproductive procedures.

Over 200 U.S. institutions performing IVF treatment have been established in the last decade. In the absence of federal funds for research in this area, the tab has been picked up by patients, pharmaceutical companies, universities and hospitals, and private organisations often relying on venture capitalism. A large number of these centers are for-profit "fertility institutes" that perform other reproductive services such as surrogacy and sex predetermination as well. Although rates vary, a conservative figure that clients pay is about $5,000 per IVF cycle. Many women return for two, five, and sometimes 10 cycles.

The United States, however, is not the reproductive technology capital of the world. France and Australia compete for this title. For example, France has more IVF centers per capita than any other country in the world; Australia has had the highest success rates and an infusion of government spending for the technologies. Australia has exported its IVF technology to the United States in a venture known as IVF Australia which has set up many for-profit fertility centers in this country, as well as in Europe and many developing countries.

Despite the absence of federal monies in the United States, the technological reproduction market is expanding rapidly. Groups of doctors have joined the entrepreneurial fray here and have helped spawn a rapid proliferation of new drugs and technologies. For example, doctors who own Northern Nevada Center, an IVF clinic, believe that eventually IVF could be a $6 billion annual business.

Rarely has a technology with such a dismal success rate been so quickly accepted. Half of the clinics in the United States reporting success had never had a live birth. Definitions of pregnancy varied widely (you thought you knew one when you saw one, but not in the realm of IVF statistics). In a statistical sleight of hand, some centers claimed success by the number of completed implantations that never resulted in births, or by the number of chemical pregnancies (elevation of hormone level that may but often doesn't indicate an ongoing pregnancy). Even some of the IVF experts admitted that "it's not easy to fudge results."

In fact, IVF's very lack of success has been the justification for

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developing new technical variations of IVF (such as GIFT and TUDOR) as well as superovulation and embryo freezing. Doctors argued for embryo freezing to reduce the number of egg retrievals, and thus the trauma to the ovaries cased by multiple inductions of ovulation. They also claimed that superovulation—medical sorties of powerful fertility drugs used to blast the ovaries into multiple egg production—would enable clinicians to "capture" eggs not accessible to laparoscopy.

More recently, the problems created by superovulation and multiple implants of fertilized eggs into a women's uterus, i.e., multiple foetuses, have been used to justify foetal reduction—or in its kinder and gentler idiom, "selective termination of pregnancy." Doctors inject a saline solution into the uterus to abort a certain number of foetuses. This technique can cause bleeding, danger or premature labor, and even the loss of foetuses. There is a concern also about damage to any foetuses that remain.

With the infinite expansionism of technological reproduction—IVF, embryo transfer, embryo freezing, and the use of fertility drugs,—medicine inflates the perceived "need" for newer technologies to solve the complications caused by the older procedures. Has faith in medical progress reached the point where people accept, without criticism, the reality that last technological "mistakes" need more technological solutions which themselves turn into problems? If so, this is the height of technological determinism.

When technologies harm foetuses and children, people take note—but not when the harm occurs to women.

What has been most invisible in the whole debate over new reproductive technologies worldwide is the harm that accrues to women and which, in reality, could be viewed as a form of medical violence against women: hyperstimulation of the ovaries and possible cysts resulting from superovulation, along with the pain and trauma of the entire IVF process itself. There have also been at least 10 deaths of women that have been connected with IVF procedures.

Traditional morality has challenged these technologies from a foetal-centered perspective, but not from the viewpoint of feminist ethics which is woman-centered. Many ethicists, scientists and policy-makers are worried about the quality of life—the humanity—of so-called test tube babies. Feminist critics are primarily concerned with the quality of life of women who submit to being used as "living laboratories" of reproduction. Traditional ethics is preoccupied with experimentation on foetuses; feminists have consistently pointed out that the primary experimentation in this realm is on women. Would that women enjoyed the same respect and dignity that foetuses get in the halls of traditional morality and law.

Then there is surrogacy, or contract pregnancy. In this situation, a woman bears a child for another person or couple and gives over the child at birth to be raised by the contracting party. In the United States, the surrogate industry has brokered many contract pregnancies that for the most part have been looked upon as an individual arrangement between an altruistic woman (usually one who needs money) and a couple who is supposedly desperate to have a child.

But others view surrogacy as reproductive purchase orders where women are procured as instruments in a system of commercial breeding. It is more accurate, in this view, to call surrogacy reproductive trafficking because it creates a national and international traffic in women in which women become moveable

property, objects of reproductive exchange, and brokered by go-betweens mainly serving the buyer.

There are many women in the United States hired as surrogates who now speak out against this reproductive servitude. Beyond the reality of "regular" surrogacy" is "pure" surrogacy involving women who contribute no egg but do the "mere" carrying to term. In 1990, Anna Johnson, an African-American, bore a child for Mark Calvert, a Euro-American man, and his Asian-American wife, Christina Calvert. Before Johnson delivered the baby, she announced her intention to fight for custody in court. But the California court awarded all parental rights to the gamete providers—the ejaculatory father and the egg mother—and in so doing, affirmed that genetics was the primary criterion of parenthood.

Feminists predicted the exploitation of Anna Johnson about 10 years ago in warning that surrogate brokers and contracting individuals would seek out "pure" surrogates from women of color since, at that point, the skin color wouldn't matter. Yet in surrogate gestation where the so-called surrogate contributes her egg, there is an insidious way in which skin color is exactly what does matter. It was the blackness of Anna Johnson's skin that worked against her legal claim to the light-skinned child.

Indeed surrogate brokers have frankly admitted that they will turn to Third World women for their stables of contract breeders. There, brokers maintain, the going rate will be cheaper and the labour supply more submissive. John Stehura, president of the Bionetics Foundation, talked about his plans for a surrogate business in Mexico that would use local women for U.S. clients. In an interview with Gena Corea, Stehura maintained that "You could devastate them (Mexican women) with money and things...It would save them 20 years of scratching."

The specter of international reproductive exploitation has become so serious that the vulnerability of women in developing countries at risk for surrogacy, or "womb renting" has been raised at various committee hearings overseeing the Convention to Eliminate All Forms of Discrimination Against Women (CEDAW).

The use of women in developing countries as breeders is closely allied with the flow and routes of international adoption. Surrogacy has, in fact, been called intrauterine adoption.

International adoption has always moved from less developed to more developed countries, or, as a Council of Europe report stated, "from poor women toward rich men, in all directions." The main child-importing countries are the United States, Canada, and many European countries, especially Sweden, Denmark, the Netherlands, Italy and France. In addition to Korea which was a major child-exporting country in the past, the main-child exporting nations are in Latin America.

Many people see international adoption as a welfare issue, i.e., benevolent Northerners adopting unwanted children from abroad and providing them with care, nurturing, and a good home. And certainly, many adoptions have proceeded in this way. But many of these children are very much wanted in their own countries and have literally been taken from women, families, and their own culture. This happens in many ways.

Northern demand for adoptable children from abroad exceeds legal supply so often babies are obtained illegally. In Guatemala, the exporting of children has become the primary cash crop of the country, much of it the result of U.S. involvement in Central America. Many children adopted—even under legal conditions in the First World—are originally pro-

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cured, kidnapped, or stolen from women in their countries of birth. This usually happens by falsifying the child's birth certificate after which anything else can be made legal. Other children who end up in the adoption trade are the result of pregnancies caused by rape during war. Many children are picked from the streets of developing countries and lumped into the category of "abandoned" children, many of whom are not truly abandoned. And in countries where religion and tradition deprive women of birth control and abortion and single women become pregnant out of marriage, and where nothing is demanded of the father for his responsibility in producing a child, children are ripe for export. Thus international adoption becomes a form of reproductive trafficking.

I think we are at a stage in the recognition of reproductive trafficking where we were in the recognition of sex trafficking 30 years ago, i.e., it is barely beginning to be recognised. Those of us who have worked against sex trafficking since it first became an internationally acknowledged issue remember when many would scorn the term trafficking, as if it were an exaggeration of the sexual exploitation to which women were subjected.

There is a similar unwillingness today to recognize the magnitude of reproductive violations. Unrecognized is the creation of a new form of the international medical research networks; the technology transfers; the global markets for surrogacy which follow established international adoption routes; the expanding international demand for and supply of foetal tissue, eggs, embryos for medical research; the international stockpiling of frozen embryos. Dr. Fritz Hondlus, deputy director of legal affairs for the Council of Europe, reported that as of 1989, over 200,000 embryos were stored in Europe alone because, as he characterised it, IVF practice was out of control in European clinics.

All reproductive technologies and arrangements are a political issue. They are an indication of the power or lack of power that women have over our bodies. And they are an indication of the degree to which access to the female body has become as normative in the reproductive realm, as it has been in the sexual realm. The image of women as reproductive objects, as the image as sexual objects, is fast becoming reality.

Portrayed as medical miracles by the media, we must ask why these medical miracles require that women adapt to painful and debilitating intervention.

Why are women channeled, at such a cost to their bodies and themselves, into reproducing children for themselves and for others? Or, as is the case in many developing countries, why are women routed into not reproducing by state mandate or incentive programs that promote more risky and harmful methods such as Norplant, DepoProvera and the vaccines? In many countries, why is it that women who want safe and adequate contraception have difficulty obtaining it when religion and the state combine to legislate women's reproductive options? Why do these techniques reinforce the biomedical view that a woman's reproductive system is pathological and requires an enormous amount of intervention?

Under the cover of a new science of reproduction, is the female body being fashioned into the biological laboratory of the future?

Janice G. Raymond is a professor of Women's Studies and Medical Ethics at the University of Massachusetts in Amherst, co-executive director of the Coalition Against Trafficking in Women, and the author of five books, the most recent of which is Women as Wombs: Reproductive Technologies *and the* Battle over Women's Freedom.