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FEMINIST AND ETHICAL ASPECTS OF THE ASSISTED REPRODUCTIVE TECHNOLOGIES (ARTS): CHALLENGES FOR SOCIAL WORK

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All forms of assisted or new reproductive techniques, such as artificial insemination by husband (AIH), artificial insemination by donor (AID), donor eggs, surrogacy, the gamete intra-fallopian transfer (GIFT), and in vitro fertilisation (IVF), have one thing in common. They all effectively separate reproduction from sexual intercourse. Snowden, Mitchell and Snowden (1983:6) asserted that this simple statement "raises social, moral, and ethical questions which go far beyond the technological and medical considerations that have received most of the publicity to date". Medical technologies do not develop in a vacuum. They reflect complex moral and social issues that scientists are reluctant to debate. These technologies do not merely reflect the social, cultural and political contexts of their development. Their uses in society have quite profound biological, psychological and socio-cultural repercussions that far exceed the complexities of the technologies themselves. This paper addresses some of the debates around the feminist and ethical aspects of the new reproductive technologies.

FEMINIST VIEWS ON THE NEW REPRODUCTIVE TECHNOLOGIES

The literature confirms that the ARTs that have proliferated since the birth of Louise Brown in 1978 (Ludwig and Diedrich, 2000) evolved within the dominant patrilineal ideology that reinforces men's control over women's bodies (Spallone, 1989; Rowland, 1989; Hanmer, 1993). Those most opposed to the ARTs are a group of radical feminists, represented by women like Gena Corea, Jalna Hanmer, Renate Klein, Rita Arditti, Maria Mies and Robyn Rowland, who in 1984 formed FINRRAGE (Feminist International Network of Resistance to Reproductive and Genetic Engineering) (Klein, 1989; Wajcman, 1991; Arditti, 1987; Arditti, Klein and Minden, 1989). These feminists saw the ARTs as attempts by men to appropriate the reproductive capacities which have been women's unique source of power. According to Hanmer (in Wajcman, 1991:58), this is removing "the last woman-centred process from us". The major criticism against the ARTs from feminists has been mainly in response to IVF, as it is currently the most intrusive. It is also IVF that holds the key to a wide array of new reproductive possibilities such as post-conception sex selection, human cloning and ectogenesis. Singer and Wells (1984) pointed out that IVF made ectogenesis – that is, the possibility of conception and the entire period of gestation taking place outside of the womb – a partial reality.

Pappert (1989) and Spallone (1989) indicated that part of the problem in resisting IVF is the argument that it may then deny infertile women a reproductive choice and that an attack on the ARTs may be seen as an attack on the women who use them. However, several feminist writers have argued that the reproductive technologies, especially IVF, do not serve women's interests but the interests of medical and research scientists and of men (Dominelli, 2002; Pappert, 2000) and the state. Winkler and Schonenberg (1989), Spallone (1989); Rowland (1989) and Klein (1989) have documented the relationship between capitalism, patriarchy and the ARTs. Spallone (1989) argued that the commercial interests which influenced the development of the ARTs must be understood, while Klein (1989) provided quite detailed accounts of the commercialisation of the ARTs on an international level. Feminist arguments against IVF may be grouped into five areas: 1) women as sites of medical experimentation; 2) the issue of choice; 3) IVF is a failed

technology; 4) the hazards associated with invasive technological procedures and super-ovulation; and 5) the need to deal with women's health issues within a primary health care perspective.

Women as sites of medical experimentation

Oberauer (1989) described in detail the laboratory conditions and a seminar delivered by an IVF practitioner in an IVF clinic, with a clinical demonstration of vaginal aspiration of ova wherein the rights of the woman were clearly violated. Oberauer (1989:112) concluded that women were subjected to a range of experiments where the principal aim was "to control the female body as if it were a machine", a view clearly supported by Klein (1989), who wrote about the experimental, and trial and error nature of the ARTs.

Spallone (1989) and Klein (1989) write that egg retrieval is one of the most intrusive experimental procedures conducted on women. One way of retrieving eggs is through a laparoscopy, which is done under general anaesthetic and involves the distention of the woman's abdomen with a carbon-dioxide gas mixture. In a laparoscopy a small telescope is introduced into the abdominal cavity through an incision below the naval, thus allowing for the interior of the reproductive organs and the abdomen to be viewed. The ovaries are visually examined and oocytes are aspirated through a fine gauge needle passed through the laparoscope (Laurence, 1989). Spallone (1989:91) quoted Steptoe, who described early experimental work with the laparoscope in the following way: "I discovered how laparoscopy gave a magnificent view inside the female pelvis ... The difficulty was that the electric lamp became hot quickly or would break so the whole procedure had to be performed very rapidly. It was a smash and grab surgical procedure." These "smash and grab" procedures lead to early objections to egg retrieval on ethical grounds. However, the excitement about the making of life, through the birth of the world's first test-tube baby in 1978, quickly put an end to the ethical debates about egg retrieval in women, especially in the scientific community.

The exploitative nature of the ARTs, where women do what they are told to do by so-called "medical experts" as they find it difficult to give up the infertility treadmill, is also evident (Bartolet, 1992; Koch, 1992; Klein, 1989). Rowland (1989:356) concluded that all women are used as "living laboratories" in ARTs experiments. However, she went on to say that as women we actively collude with technology and patriarchy because of our own momentary needs and desires. She questioned this in relation to women being agents of male power and exhorted women to begin fulfilling their social responsibilities with regard to present and future generations, who have a right to natural conception and birth.

The issue of choice

Pappert (1989) wrote about the seductive nature of science, where we are led to believe that the ARTs can make all things possible. Williams (1992) indicated that a new reproductive technology could not exist without a market. The motivation for parenthood, according to Williams (1992:271), was largely the result of the role of social factors. The social construction of parenthood, and the social pressures in favour of biological parenthood, serve to make legitimate the medical practice of IVF and help to create and sustain the market. The market exists to the extent that women are willing to undergo extreme emotional, physical and financial costs to become biological mothers. IVF is "an extremely arduous, life-dominating experience" (Bartolet, 1992:254). However, the decision to enter IVF programmes is often not an informed one and not one made on a rational basis as "only a minority of women on IVF programmes actually give birth to a healthy child" (Koch, 1992:275).

Although Williams (1992) argued that the ARTs could not exist without a market, the corollary argument also holds true – in the face of available technology women feel a compulsion to use them. Bartolet (1992), who wrote from her own experience, indicated the complexities of women's "choices" in infertility treatment. Several writers have indicated that the ARTs might have effectively decreased women's choices (Rothman, 1989; Klein, 1989; Bartolet, 1992; Pappert, 1989). Feminists do accept that being a mother is something that can be positive, worthwhile and enriching. Various feminist writers have indicated that it is the patriarchal institutionalisation and social constructs of motherhood which are the problems, not motherhood itself (Rowland, 1989; Bartholet, 1992; Nicolson, 1993). Williams (1992:270) highlighted the unquestionable pervasiveness of pronatalism and quoted Bem and Bem, who said: "The idea that a woman's primary role in life is to become a mother is often so thoroughly inculcated in young girls that it becomes a "nonconscious ideology", and not bearing children therefore becomes literally unthinkable." The ARTs reinforce the notion that it is essential to achieve a fertility fix that will enable reproduction, and that biological parenting is the only "real" way to parent (Pappert, 1989:203). In this respect Spallone (1989) argued that it is repressive social relations that allow the ARTs to happen, and that the ARTs in turn set a repressive ethic of reproduction.

Rothman (1989:31) mentioned the ARTs representing a new burden for infertile women: "the burden of not trying hard enough." Pappert (1989:199) pointed out that the "choices" soon become "compulsions" and Klein (1989) wrote about the sense of coercion that women experience in the face of available technology. Ziehl (1994) reported four case studies where successful pregnancies had been achieved through the ARTs. One of the cases involved fourteen IVF procedures, one GIFT, and three artificial inseminations by the husband. It is interesting to note that in the case example cited by Ziehl (1994) the woman did not conceive via IVF or GIFT, but through the relatively simpler procedure of AIH without any fertility drugs. Although Ziehl (1994:145) acknowledged the high emotional and financial costs of the ARTs, she went on to use quite evaluative language in asserting that "Infertility treatment is definitely not for the faint-hearted or those not entirely convinced that they indeed want a child." Ziehl's is the kind of argument that produces what Harkness (1992) called the guilt of not having tried enough of the available options, and the promotion of "a self-hating, self-blaming attitude in infertile women" (Pappert, 1989:201).

IVF - a failed technology

The media present the ARTs as exciting scientific breakthroughs and hold out the carrot to desperate women who want to conceive. However, various feminist have argued quite categorically that IVF is a failed technology (Klein, 1989; Bartholet, 1992; Spallone, 1989; Hanmer, 1993; Solomon, 1989; Oberauer, 1989). All these authors pointed to the failure of adhering to ethical standards of truth in reporting results. Solomon (1989) and Klein (1989) rightfully claimed that the only real measure of success for a reproductive technology is the production of a live infant. However, research conducted by Corea and Ince in 1985 (in Hanmer, 1993) in the United States and by Solomon (1989) in Israel in 1986 indicated that clinics state their success rates on the basis of the number of pregnancies compared with the number of laparoscopies, rather than the number of births compared with the total number of women on the programme. It was found that clinics include in their success rates the dubious "chemical pregnancy", measured by a transient rise in the level of the HCG hormone in the woman's blood when she may not even have missed a period (Spallone, 1989; Hanmer, 1993). Ectopic pregnancies, miscarriages and stillbirths have also been included in success rates by some clinics (Klein, 1989; Hanmer, 1993). Some clinics that produced no live infant claimed success rates of between 18 and 25 percent (Corea and Ince cited in Klein, 1989). When the ARTs fail it is often

not seen as a failure of the procedures themselves. It is the women who are regarded as failures. This is reflected in the use of language such as: "clopmiphene failure" for women who do not respond to clomid (Oberauer, 1989:111), or reference to the "hostile environment" of the womb in the event of a spontaneous abortion (Klein, 1989:230).

Following feminist interest in such research, clinics have become more circumspect about their figures. In Britain figures provided by the Voluntary Licensing Association for 1985 and 1986 indicated the success rate (in terms of live birth) to be 8.5 percent. Australian estimates were similar at 8.8 percent (Hanmer, 1993; Spallone, 1989; Klein, 1989). Batman (in Hanmer, 1993) of the National Perinatal Statistics Unit of Australia was the first to report on the worst health outcomes for children conceived by IVF. These included prematurity (26.9 percent) and a higher percentage of babies born with major abnormalities, primarily spina bifida and cardiac problems (transposition of the great vessels): 2.2 percent compared with 1.5 percent of natural pregnancies for Australian figures. The Australian government concluded that the success rate for a normal live birth was only 4.8 percent (Hanmer, 1993; Klein, 1989). The writer has not been able to find other studies that corroborate the findings of this study. IVF practitioners and researchers indicated that the rate of abnormality from IVF is no different from that of normal births (Quinlan, 1995; Herz, 1989; Jones, 1982; The Ethics Committee of the American Fertility Society, 1986).

The hazards of IVF

The physical impact and the potential dangers associated with the ARTs tend to be minimised in practice. Writing about the unrelenting insensitivities of medical personnel and procedures through which he nearly lost his wife, Peter Humm (1989:55) said: "It is politically urgent to connect the glassy language of test-tubes and deep-frozen fertilisation to the daily trial of physical endurance." He asserted that we need to remind doctors who project ideas of "a brave new future" that "we exist not in some science fiction but in real distress and pain experienced every day" (Humm, 1989:55). Maggie Humm (1989) described in detail her experience with severe hyperstimulation from Pergonal therapy, and her sense of being a non-person as doctors discussed her during a clinical ward round. Esser (1989) described the physical and mental side-effects of Clomid and how (because of her fear of a direct confrontation) she communicated these to her doctor in a letter to which she received no response. Solomon (1989a) detailed the case of Rivi Ben-Ari, who died of Pergonal hyperstimulation in Isreal. She quoted medical doctors who indicated that hundreds of women were hospitalised for Perganol hyperstimulation. Klein (1989:231) quoted a Dr Trounson, an Australian IVF scientist who said that unfortunately death from IVF was "a terrible side-effect". Arditti, Klein and Minden (1989) cited five cases where women died while on IVF/GIFT programmes. Pappert (2000) pointed out that several studies at Stanford University School of Medicine found that the risk of ovarian cancer amongst women who had received fertility treatments was almost three times that of women who had not taken fertility drugs. However, these are not publicised by the media, which present mainly an uncritical view of the ARTs. The infrequent successes are highly publicised, with pictures glorifying medicine's miracles, thus giving the public a misinformed view of the ARTs. In a *Sunday Life* magazine, Hetherington (1995) hailed micro-manipulation as *the* answer to male infertility. (Micro-manipulation is a highly sophisticated technique that can only be done as part of an IVF procedure. It involves manually fertilising an egg with one or only a few sperm under a laboratory microscope.) The fact that the overall success rates are very low (about 4 percent) and the exorbitantly high financial costs are not acknowledged. The problems and dangers associated with obtaining such a "fix", and the fact that the majority of women are left childless and psychologically worse off after years down the IVF emotional roller-coaster are ignored as "a bad statistic" (Klein, 1989:230).

Primary health care - not ARTs

There is strong support in the literature for the notion that the solutions for infertility do not lie in the ARTs, but in primary health care. Solomon (1989) and Pappert (2000) contended that if doctors really cared about women and their health, then IVF would be very low down the scale of priorities. If one considers the etiological factors of infertility one sees that most infertility is preventable. In response to the use of surrogacy and AID, Gibson (1992:61) asserted that prevention is certainly more preferable to any "after-the-fact response". Preventive measures would also achieve other socially desirable ends such as health and human sexuality education, ensuring access to basic health care for all, holding manufacturers of drugs accountable for the harm that they cause, enforcing informed consent procedures to prevent sterilisation abuse and improving occupational and environmental health (Gibson, 1992).

The rationale used in the Warnock Report (1985:10) for the approval of the ARTs was that infertility was the *primary cause* of distress. It introduced IVF with the following argument: "... the psychological distress that may be caused by infertility in those who want children may precipitate a mental disorder warranting treatment. It is, in our view, better to treat the primary cause of such distress than to alleviate the symptoms." By regarding infertility as the primary cause of distress one ignores the full range of the primary preventable causes of infertility, including sexually transmitted diseases, back-street abortions, infections induced through clitoridectomy in certain African countries, contraception such as the IUD, and other iatrogenic and environmental factors. Pappert (1989, 2000) and Spallone (1989) argued that if doctors were truly concerned about infertility and the health needs of women, they would focus on the primary prevention of infertility and call for concerted screening of women most at risk. Spallone (1989) called for a woman-centred, primary health care approach to infertility with efforts to alleviate poverty and to promote social equity. The issues of equity and justice become far more pronounced when one considers the high rates of infant morbidity and mortality in South Africa, especially among groups with minority status. Quoting Frank and Vogel, Holbrook (1990) contended that, while the wealthy are allowed to conjure up babies out of petri-dishes, poor infants are afforded little care. Commenting on the inherent racism in most societies, Gibson (1992) pointed to the fact that, while many people want to be parents, there are at the same time many children in institutions and in foster care who are in desperate need of homes. Yet it is difficult to fill each other's desires and needs. In the face of such situations she considered the creation of children by surrogate contract to be morally unacceptable. Purdy (1992:312), however, pointed to the limitations of distinguishing so clearly between the fertile and the infertile, and asked: "Why ... do radical feminists not argue that so long as there are homeless children, it is wrong for the fertile to have their own babies?"

In contrast to Firestone (1971), who saw the liberation of women to lie in the ARTs, feminists, such as those of the FINRRAGE group, called for total resistance to, and rejection of, the ARTs (Klein, 1989). Feminists who reject the ARTs have been accused of not being able to provide any alternatives to women's suffering. However, some argue that in recognising and highlighting a problem, the solution does not have to be given. This process of conscientisation is in itself empowering and may contribute to the generation of alternatives, such as the feminist model for infertility crisis counselling described by Solomon (1989). Feminists who dispute the FINRRAGE analysis argue that potential hazards do not lie in the ARTs themselves but in their abuse. Here the call is for the regulation of the use of the ARTs, rather than an outright opposition to them (Bartholet, 1992; Wajcman, 1991). In this respect, the ARTs are seen to have the potential to empower or disempower women. Stanworth (in Wajcman, 1991:61) referred to the "double-edged sword" of the ARTs. While it offered women greater technical possibilities regarding when and

under what conditions to have children, the dominion of reproductive technology in the medical profession has decreased women's control over their lives.

ETHICAL ASPECTS OF THE ARTS

The ethical dilemmas produced by the ARTs are reflected in the following statement made by Elias and Annas (in Mallory and Rich, 1986:460):

> None of these technologies and techniques is neutral. Their very existence forces us to decide to use them or not; their use forces us to confront issues of lineage, legitimacy, parenthood, family, and identity; and they not only change what we can do with regard to human reproduction, but they also thereafter change how we think about human reproduction, and perhaps how we think about humanness itself.

From a social work perspective it is imperative that we understand the ethical concerns surrounding the ARTs. The ambivalence about the ethical aspects of the ARTs can accentuate the emotional distress associated with infertility. Practitioners involved with infertile couples need to be cognisant of the various ethical debates and try to understand their own frames of reference as they engage in the personal and public concerns regarding infertility. The ARTs have produced both problems and opportunities, or to use Lee and Morgan's phrase (in Holbrook, 1990:336), "opportunities for liberation and for enslavement." The ethical aspects of the ARTs are discussed in relation to the experimental vs therapeutic application of the ARTs; multiple pregnancies and selective reduction; issues of costs and accessibility and the use of collaborative reproduction.

Experimental vs therapeutic application of ARTs

Religious and public opinions tend to change depending on whether the ARTs are seen to have therapeutic value or not. The Harris public opinion poll on AID in 1969 (Ramsey: 1970) and on IVF in 1978 (Singer and Wells: 1984) lends support to this view. With regard to AID, nineteen percent approved with a simple description of the procedure. When AID was explained as the only way that a couple could have a child, this figure rose to thirty-five percent. With regard to IVF, on a general question about the procedure, only fifty-two percent approved. However, eighty-five percent of the sample agreed that the procedure should be made available to married couples who were otherwise unable to have children. Ramsey (1970) indicated that the results of the polls reflected popular pronatalist views. He pointed out that the pollsters did not bring to the notice of the public the possible hazards associated with the techniques, nor was the public informed about the possible links of such techniques to genetic engineering and genetic control.

As is evident from the previous discussion, IVF is the most controversial of recent medical advances. One of the most disconcerting ethical concerns is that IVF contributes to experimental procedures and to unacceptable forms of manipulating life. IVF specialists claim that IVF is a treatment for fertility and that it has nothing to do with embryo research, selective breeding or eugenics (Oberauer, 1989). However, Mies (1993) argued that these are certainly linked and that the deliberate separation of contexts makes the critical assessment of the technologies difficult. Jones (1989) and Multhaupt and Kloth (1991) confirmed that before the first successful IVF, hundreds of embryos were destroyed in numerous trials. IVF makes possible the creation of spare embryos, which may then be used as research "material". The relationship between the therapeutic and eugenic aspects of the ARTs is aptly captured in the following statement: "Infertility which seemed to be on the increase, provided an excellent opportunity for the entering wedge of positive selection, since couples concerned are nearly always under such circumstances open to suggestion that they turn their exigency to their credit by having as well endowed children as possible" (Muller cited in Mies, 1993:185).

Recent cases that could contribute to what Anderson (1994:4) called the "grave new world" illustrate the potential "slippery slope" that IVF could lead us down (Downie, 1988:137). Anderson (1994) and Beck *et al.* (1994) cite the case of a black woman who gave birth to a white "designer" baby. Ova, aspirated from a white friend, was fertilised by the sperm of her husband, who was a white South African. The argument was that a white child would have a better future than a black child. Such a practice hardly supports the claim of IVF scientists, such as Edwards, that science is value free or neutral (Spallone, 1989; Mies, 1993). Beck *et al.* (1994) raised the possibility of the use of animal surrogates for human embryos and the prospect of creating babies from the ovaries of aborted foetuses, the latter process having been successful with mice in Scotland. Singer and Wells (1984) discussed at some length the possibility, and the pros and cons, of ectogenesis. What appears now to be science fiction may soon become a reality if society does not raise its voice to establish a balance between science and morality. Anderson (1994) also cites the case of Teresa Ferro, the first baby to have her sex planned through post-conception sex selection through IVF in a Naples hospital. Post-conception sex selection would support feminist concerns about the differential application of the ARTs in first and third world contexts. Mies (1993) and Wajcman (1991) mentioned the attempts to perfect pre-conception and post-conception sex selection techniques in India, which have reinforced femicidal practice in an extremely patriarchal society. The most recent claim by Severino Antinori, an Italian fertility doctor, that three human cloned babies are on the way, with the alleged pregnancies being in the ninth, seventh and sixth weeks respectively (*Daily News*: 24/04/02), is a cause for concern. However, in response to this Dr Ian Wilmut, who was responsible for cloning Dolly the sheep six years ago, questioned the viability of human cloning and raised ethical concerns about harm to women and destruction of embryos (Meek, 2002).

Multiple pregnancies and selective reduction

The immediate risk of fertility drugs is multiple pregnancies, which Downie (1988) claimed was the result of mismanagement on the part of medical personnel. While the media hail such multiple pregnancies as scientific successes, the financial, emotional and social costs to the couple are ignored (Weigel, Auxier and Frye, 2000). Neither does medicine take responsibility when things go wrong. Downie (1988) cites the case of Susan Halton from Britain, who gave birth to seven premature children, all of whom died in the seventeen days following birth. One of the ethical concerns about IVF is that it produces more embryos than can be transferred back into the womb. There have been several cases of multiple births as a result of IVF. Most clinics now opt to transfer no more than three or four embryos. This does raise ethical questions about what happens to the spare embryos and questions regarding the moral status of the embryo. In the case of cyropreservation legal concerns arise in relation to the custody of the frozen embryos in the event of the death or divorce of the parents. Cyropreservation itself raises ethical concerns, as embryos may be destroyed during the thawing process. The Warnock Report (1985) allowed for human embryo research within fourteen days after fertilisation. In South Africa embryo research is permitted, although the exclusive production of embryos for research purposes is unacceptable (Lupton, 1988).

Cyropreservation also provides for possibility of siblings being born generations apart. For this reason the South African Medical Research Council (in Lupton, 1988) does not recommend the long-term freezing of gametes and embryos – not longer than the expected reproductive life of the donors. Some IVF practitioners in Durban do not have facilities for cyropreservation. This means the inevitable destruction of spare embryos. The embryo does not survive for longer than sixteen days outside of the womb. Some practitioners leave the embryo until it disintegrates on its own; others may choose to put a drop of formalin over the embryo to destroy it earlier (Slogrove, 1995).

In discussing the ethical aspects of dealing with spare embryos Steptoe (1986) recommended that all IVF centres have facilities for cyropreservation.

A controversial method of dealing with a multiple pregnancy is a technique of selective foetal reduction, where one or more of the foetuses are aborted in the interest of ensuring the survival of others (Harkness, 1992; Downie, 1988; Weigel *et al.*, 2000). This can be extremely traumatic for couples who do want children but are carrying an unwanted number of foetuses. The psychological impact and the ethical dilemmas related to aborting healthy foetuses after a battle with infertility can be enormous (Sewpaul, 1995). Downie (1988) quoted the example of a woman who opted to terminate three of the five foetuses that developed after IVF. However, the operation ended in total abortion. This left the woman extremely depressed and guilty about having deliberately destroyed life. Downie (1988) concluded that more effort should be put into avoiding multiple pregnancies from fertility drugs and IVF instead of looking at selective reduction of foetuses.

Costs and accessibility

Accessibility to the ARTs is restricted in most instances to the rich, thus producing a socio-ethical problem. In Durban specialised infertility treatments are offered by private practitioners only. The cost of one IVF attempt usually ranges between R8 000 to R10 000. The majority of medical aid societies do not cover infertility treatment. Financial security on the part of potential adopters plays a role in determining whether or not they qualify as adoptive parents. Thus infertile couples who are poor are not only denied access to infertility treatment, but they may be totally denied any chance at parenthood as well (Holbrook, 1990).

Golding (1993) highlighted the fact that infertility in South Africa is not a middle-class problem. There is a clear relationship between sexually transmitted infections (STIs) and infertility. In men an STI may cause inflammation and blockage of the upper reproductive tract or epididymitis, which impairs fertility. In women pelvic inflammatory disease, which is primarily linked to STIs such as chlamydia and gonorrhoea, is one of the most common causes of tubal damage and infertility (Harkness, 1992). Socio-political factors such as the past migrant labour and influx control laws, which have contributed to split families and poor health care in South Africa, make STIs and infertility common among the poor. Walther and Young (1992) indicated that in some parts of Africa the rate of infertility may be as high as 40 percent among women of childbearing age. Yet at the same time the emphasis in these contexts is on population control, with almost no attempt to enhance female reproduction (Mies, 1993; Walther and Young, 1992). The high costs of the ARTs restricts access to "a homogeneous subpopulation who reflect the values of selected segments of society" (Walther and Young, 1992:112). This is clearly contrary to the ethical principle of justice that, according to Herz (1989:120), grants "to everyone his or her due." The right to found a family is enshrined in the Universal Declaration of Human Rights (1948). However, Boult (1990:1034), writing from a South African perspective, asserted that this right to parenthood by alternative methods such as AID, IVF or GIFT "is at present undeniably a privilege reserved almost solely for the economically advantaged", an assertion supported by Sewpaul (1995).

Ethical aspects of the use of collaborative reproduction

Collaborative reproduction, according to Herz (1989), refers to the introduction of donor gametes, donor embryos and surrogacy into the procreative process. The complexities and moral dilemmas associated with surrogacy, highlighted through the cases of Baby M., Mary Beth Whitehead, and Pat Anthony (the South African who gave birth to her grand-children), have raised a great deal of

public concern. In their submissions to the South African Law Commission (1992) many societies, including the South African Council for Child and Family Welfare, called for the total banning of surrogacy. Some called for government-regulated practice. The South African Law Commission (1992) recommended the following: the acceptance of surrogacy for altruistic reasons where the commissioning mother could not bear children; that no payment be made except for direct medical expenses; that the surrogate must have given natural birth to at least one child, that the ova of the surrogate not be used; that the child's identity remain confidential; and that the surrogate mother contract be confirmed before the Supreme Court. It is now possible for a child to have up to five parents. The traditional female role as a genetic, carrying and nurturing mother can now be split into three. The male roles can be split into two: that of genetic father and nurturing father (Boult: 1990). Such practices challenge the whole notion of genetic parenthood and jolt the very foundation of the traditional family (Wajcman, 1991; Herz, 1989).

According to Lupton (1988), until recently a child born through AID in South Africa was regarded as illegitimate. The Children's Status Act of 1987 deems that a child born to a consenting husband and wife through AID is, for all purposes, their legitimate child. The law, according to Herz (1989), by legitimising the status of the AID child, in most countries took away the onus of adulterous conception for the protection of both the child and the marriage. This calls for a legal redefinition of the terms "parent" and "father" (Lupton, 1985). In order to cope with the increasing popularity of donor gametes, Lupton (1985:281) proposed the following legal definition for parent: "A parent is the mother or father of a child born to lawfully married spouses or who is legitimated by a lawful marriage including a child conceived within wedlock by donated semen or ova and to whose birth both the mother and husband consented in writing." According to the *Oxford Dictionary* (in Lupton, 1985:282), a "father" is defined as: "One who has begotten a child, a male parent, the nearest male ancestor". Lupton (1985:282) proposed that the following be added to the definition: "Including a husband who has consented to his wife begetting a child by artificial insemination" (as defined in section 1 of the Human Tissue Act as amended).

Some ethicists argue that gamete and embryo donation confuses the child's genealogy and may threaten the formation of a child's identity (Herz, 1989). Thus, the desire for children by childless couples may be viewed by some as a selfish indulgence of their own needs without consideration of the offspring. Infertile couples may find it difficult to reconcile themselves with such views as they invest so much to obtain a biological child. Literature on the potential long-term consequences of AID on children is scarce as most couples choose to keep the child's origin a secret. Snowden and Mitchell (1983) and Snowden, Mitchell and Snowden (1983), who have conducted extensive investigations into AID, found that the majority of AID parents had no intention of ever revealing the child's identity.

The advantages of AID are obvious. It provides for the genetic link to the mother, for the experience of pregnancy and childbirth, and the option of avoiding public disclosure of the infertility (Herz, 1989). One of the important ethical questions about AID revolves around the secrecy that is maintained. Some argue that social and psychological problems may arise by keeping AID a secret from the child and from other members of the family. Concerns have been expressed that AID may produce psychosocial problems for the husband, wife and/or the donor, whether the donor is identified or not (The Ethics Committee of the American Fertility Society, 1986). However, available studies to date indicate that AID couples seem to have more stable relationships, with a lower incidence of divorce, compared with couples with biological children (Herz, 1989; The Ethics Committee of the American Fertility Society, 1986; Snowden, Mitchell, and Snowden, 1983). The reasons for this, according to Snowden, Mitchell, and Snowden (1983), were unclear. One proposition was that couples who opted for AID might have been particularly

committed to each other and were determined to surmount their problems of childlessness together.

There is also concern about the psychological impact that may result if a child inadvertently learns about his/her origins, or when the child is told under unfavourable conditions. During a divorce or marital strife a parent may use the child to get even with the spouse. Snowden and Mitchell (1983) argued that there are problems implicit in deception, which might increase as the child grows and that the child does have the right to information about his/her origins. Some argue that at a certain age (in adoption) the child should have the option of accessing the identity of the donor. However, this right of the child might conflict with the donor's right to confidentiality. It also complicates the role of the physician involved in the procedure, who assures the donor of anonymity. The relative advantages and disadvantages of disclosure and nondisclosure are unknown. While some argue for mandatory disclosure, others want to leave it up to the parents to decide (Herz, 1989). As there have been concerns about consanguinity, it has been suggested that the number of offspring per donor be limited. In South Africa the Human Tissue Act of 1986 specifies that a donor may not parent more than five children.

CHALLENGES FOR SOCIAL WORK

The psychosocial consequences of infertility have been well documented in the literature and the feminist and ethical debates on infertility provide us with an understanding of the personal-political links between infertility and the ARTs. If we, as social workers, have to fulfil our advocacy and social change functions in relation to infertility and the ARTs, it is imperative that we take seriously the pain and suffering that infertility produces (Sewpaul, 1995). Within feminist critiques of the ARTs there are contradictory opinions, with Firestone (1971) expressing the view that women's emancipation lay in procedures such as ectogenesis, as she saw the ultimate cause of inequality between men and women to be women's reproductive functions. At the other extreme are feminist of the FINNRAGE group, who called for a total banning of the ARTs, as they believed that, through the ARTs, men sought to appropriate women's unique sources of power. I have elsewhere contended that both these arguments are based on flawed premises (Sewpaul, 1995). Given popular pronatalism, women's desire for biological parenthood (Sewpaul, 1995), the real concerns raised by feminists, and the ethical concerns around the ARTs, a more realistic option would be regulated use of the ARTs.

Infertility is regarded as a life crisis. During a crisis people are most vulnerable and susceptible to alternative proposals. A crisis is also a turning point in one's life and many of the decisions that infertile couples make might be dependent on the initial handling of the crisis. Bartholet (1992), Solomon (1989) and Klein (1989) called for a women-centred approach to infertility counselling, where the counsellor is not part of the medical establishment and does not have any vested interest in the ARTs. It is important to advocate for the provision of counselling services at the point that couples first discover infertility and think that they want to do something about it, rather than only when couples enter ARTs programmes. Counselling should focus on feelings about infertility and on the full range of options available, including the option to remain child-free or to adopt. Sewpaul (1995) highlighted the personal-political identity links of women and advocated for the use of consciousness-raising through which women may begin to understand the impact of external medical, social and cultural pressures. In helping women transcend external pressures and constraints, we need to begin the condition of infertile women, which means understanding the pain of infertility and the needs of infertile women for biological parenthood.

Daniels (1993) advocated that policy documents and legislative acts ensure the provision of counselling for all couples and donors. This is incorporated in the Human Fertilisation and

Embryology Act of 1990, which recommended that couples entering the ARTs programmes and donors receive suitable opportunities for counselling. The Infertility Medical Procedures Act 1984 of Victoria, Australia recommended that all couples and donors receive counselling from an approved counsellor, whose appointment has to be approved by the Minister of Health. According to Daniels (1993), this is the first legislation of its kind in the world. It is, however, the kind of legislation that in itself raises further ethical concerns in respect of people's right to privacy and to choice.

Self-help support networks that help infertile couples come to terms with infertility may decrease a couple's need to pursue high-tech infertility treatments, or where couples choose to use them they could make more informed choices. Menning (1975, 1980) has written extensively about the counselling, education and advocacy functions of RESOLVE. RESOLVE has become an active lobby group for the needs of the infertile in America. Daniels (1993) describes the important functions of the Christchurch Infertility Society, which provides psychological and social help for couples. As part of our advocacy functions it is imperative that we call for appropriate research and accurate dissemination of information regarding health and safety risks, success rates and the potential abuses of the ARTs. However, we need to ensure that support groups do not become another source of stress in forcing infertile couples to try every possible fertility fix (Sewpaul, 1995; Pappert, 2000).

Snowden and Mitchell (1983) and Daniels (1986) called for public debates and participation in the formulation of policy on the ARTs. Questions regarding, *inter alia*, regulation, the role of the state vis-a-vis reproductive technology; the implications of the ARTs for eugenic purposes and genetic engineering; the use of IVF in post-menopausal women; ARTs and primary health care; and the potential impact of the ARTs with regard to traditional family values and structures need to be opened for public discussion and debate. Beck *et al.* (1994), after having reviewed ARTs practices in America, London, Paris and Germany emphasised the importance of society setting some limits and defining priorities. Prof. Paul Wessels of the University of the Orange Free State (in *Die Volksblad*, 1987) called for a unified policy for the ARTs in South Africa to minimise abuse of the technology and to ensure that standards of training and practice are high and ethically sound. He contended that the reasonable approach would probably result in control of the ARTs by law or statutes, a view supported by Schutte (1985) and Bredenkamp (1993).

Given the premise that the public should be informed and should contribute meaningfully to national policies, the media play a vital role in information sharing. For some medical personnel and couples who prefer to see infertility and the ARTs as "privates troubles", raising them as "public issues" via the media can cause concern. However, Daniels (1986) argued that respect for the right to, and the need for privacy, need to be balanced against the public's right and need for information and involvement. Walther and Young (1992) contended that the collective wisdom of consumer experiences could be a powerful tool that allows infertile persons the opportunity to have their voices heard at policy-making levels. It can also help social workers develop appropriate micro-, meso- and macro-level responses to a growing population. The use of the media is useful for the social worker's roles as educator and advocate. Daniels (1986) warned that, as the ARTs are a clear example of the conflict of interests of various parties, advocacy for one group would invariably contribute to loss of support from another group. The social worker's advocacy role in the field of birth technology is, however, vital. In order not to minimise the mediator and educator roles of the social worker, decisions need to be made about when to adopt the advocate role, on what issues, for what goals and whose support can be secured in the process.

It is clear that the solutions to the ethical dilemmas created by the ARTs cannot be addressed by science alone. Charlesworth (1990) called for parallel progress between science and ethics and the

need to build bridges between the two, with science addressing ethical issues more vigorously. However, the limitations of science and the need for philosophical debate and reflective discussion are captured in the following statement by Charlesworth (1990:201):

> *Science does make a commentary about matters such as love and hate, good and evil, right and wrong, consciousness, beauty, but, given the limitations of the model-building on which science depends, this commentary rarely surpasses the trivial. Despite the aesthetic qualities of new knowledge, it is finally as useless to ask science to slake our thirst for value and meaning, for poetry in life, for justice and for transcendence.*

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