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ENHANCING CULTURE SENSITIVE SOCIAL WORK PRACTICE: RELIGIOUS AND ETHICAL ASPECTS OF THE NEW REPRODUCTIVE TECHNOLOGIES (NRTS)

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INTRODUCTION

Social workers are being increasingly called upon, especially within interdisciplinary teams, to participate in complex ethical decision making that requires cultural sensitivity and cultural competence. The development of cultural sensitivity, cultural competence and respect for religious and cultural diversity is enhanced by increasing our knowledge of clients' frames of reference. Through the use of a qualitative, interpretative, feminist research methodology that guided an empirical approach to data collection via twenty-four case studies, this study explored the relationship between religious and ethical beliefs and new reproductive technologies (NRTs) (Sewpaul, 1995). Given the particular focus of the study, efforts were made to ensure that cultural and religious diversity were represented in the sample. While race is not equivalent to culture, in the South African context a person's cultural beliefs (especially religious affiliation and religious beliefs) are more often than not linked to the ethnic group from which they come. Thus efforts were made to ensure inclusion of African, Indian, Coloured and White[1] participants in the study. All seven of the Indian couples belonged to the Hindu faith. All others in the sample were of the Christian faith, with all of the African couples subscribing to both Christianity and African Traditional Religion. All the African couples indicated that, while they held their Christian faith to be important, it was African Traditional Religion that they turned to when dealing with significant aspects of their lives. Thus, as far as religion was concerned, the African couples appeared to be successfully biculturally socialised. While they were affiliated to Western religion, they were at the same time quite profoundly connected with African Traditional Religion (Sewpaul, 1999).

Through the use of the purposive sampling technique, twelve religious leaders, representative of the faith of the primary sample of infertile participants, were interviewed as well. Of these twelve, five represented Christianity, one from each of the following churches: the Rhema Church, the Methodist Church, Full Gospel, the Roman Catholic Church and the Zionist Church. According to the leader of the Zionist Church, Zionism combined Christian beliefs and African traditionalism to a large extent. Three representatives of African Traditional Religion and four representatives of Hinduism were also interviewed. Many people do not recognise African Traditional Religion as a religion with a unique system of beliefs. African Traditional Religion, according to Oosthuisen (1989), is indigenous to Africa and has to be distinguished from other imported religions such as Christianity and Islam. Like most religions, African Traditional Religion does not represent a single unified system of beliefs and practices. For the purpose of this study, African Traditional Religion was viewed within the context of Zulu-speaking people in KwaZulu Natal (Sewpaul,

[1] The distinction made between persons belonging to different race or population groups was abolished in terms of the Population Registration Appeal Act No. 114 of 1991. Although institutionalised apartheid has been abolished - apartheid ideology and the distinctive social groupings created by apartheid are entrenched in South African society. These labels are therefore likely to be used in the foreseeable future.

1995). Unlike other religions, African Traditional Religion has no founders and no scriptures or holy books; it is written into the hearts and minds of people. There is an unequivocal belief in the existence of God, who is omnipresent (Unkulunkulu) and a deep reverence for ancestors which has a direct impact on behaviour and practice (Oosthuisen, 1989).

This paper reflects data pertaining to participants' choices (vis-a-vis their relationship with their religion) in relation to artificial insemination by husband (AIH), artificial insemination by donor (AID), the use of donor eggs and embryos, in vitro fertilisation (IVF), surrogacy and ectogenesis. Ectogenesis, which is according to Singer and Wells (1984:132) "already a partial reality", is the growth and development of a being outside of its mother's womb for the entire period of gestation. Adoption and child-free living choices in an attempt to deal with infertility are also considered.

ARTIFICIAL INSEMINATION BY HUSBAND (AIH)

All of the infertile participants indicated that they had no moral or religious objections to the use of AIH. Five of the Roman Catholics indicated that they did not accept the rigid impositions of the religion. An African woman of Catholic faith said that if her husband would agree, and if she could afford it, she would try the NRTs as "it is what I want. They [the Church] won't give me the baby." The drive to have children appeared to supersede the direct instructions of the Roman Catholic Church. The official position of the Roman Catholic Church, stated in the Instruction (a 40-page document compiled after three years of deliberations), is that it opposes all forms of assisted reproduction, including AIH (Isaacs & Holt, 1987; SALC, 1992; Downie, 1988). One woman described how she tried to reconcile herself to her choice of AIH by examining the tenets of her Catholic faith. However, she concluded by saying: "Perhaps I should have had more faith in God. I should have reached acceptance at that time. I feel I might have been a bit "sneaky" - having gone behind God's back. He's been with me so often." This would appear to confirm the view expressed by Gent (cited in Downie, 1988) that the objections raised by the Catholic Church were not going to stop people from using reproductive technology, but that doing so added guilt and increased their already heightened stress levels.

All religious representatives of the Hindu, Christian and African traditional faiths indicated that they had no problems with the use of AIH. Despite the official position of the Roman Catholic Church, the representative in this study felt that AIH ought to be allowed.

ARTIFICIAL INSEMINATION BY DONOR (AID)

The diversity of opinions expressed by participants confirm that AID involves complex moral, religious and social issues (Snowden & Mitchell, 1983; Downie, 1988; Herz, 1989). Eleven of the twenty-four women (45,8%) indicated that they would definitely not opt for AID. Of these, six expressed concerns from a religious point of view and saw AID as adultery. Three of the participants who held this view were Hindu, one a Zionist, one a Methodist and one belonged to the Rhema group. These participants reflected the views of the Roman Catholic Church and of Islam, both of which see AID as adultery. It is interesting to note that none of the persons who held this belief were of the Catholic faith.

Four of the five Christian leaders (Catholic, Zionist and Full Gospel) and one of the Hindu leaders indicated that AID was not acceptable. They claimed that AID would be clearly seen as adultery. In 1987 Cardinal Ratzinger, who was said to be the driving force behind the Instruction, called on the world's governments to ban practices such as AID, IVF, surrogacy and embryo research (Isaacs & Holt, 1987; SALC, 1992; Downie, 1988). The leader of the Methodist Church saw AID as "moving into the grey area of adultery." He said: "Like the practice of the African culture

where the husband's brother was allowed to impregnate the wife - the church will look askance at that. The Christian view is that AID would not be encouraged. It would raise problems. It relates to the whole concept of marriage; we move into the grey area of adultery; of bringing a third party into the marriage. It creates a problem of the child belonging to the mother and not the father. Both parents may not bond with the child. This may also be another little grey area."

There was clear discrepancy between what the woman who belonged to the Rhema Church believed and what the representative of her faith thought. The representative of the Rhema Church expressed the opinion that AID was acceptable from a moral point of view. Concerns were raised about possible consanguinity and the husband being jealous of the child that was not his. Three Hindu representatives indicated that AID would be acceptable practice. The reason for this was that the precedent for such practice was set in ancient scriptures. The scriptures, however, described direct impregnation of a woman by a man, other than the husband, a practice referred to as niyoga. The Rig Veda (cited in Bharadwaja, 1915:18) reads: "When a man is incapable of producing children, let him address his wife as follows: - O Thou that art desirous of getting children, do not expect me to raise offspring upon thee. Do thou, therefore, seek another husband." A woman who contracted niyoga for this reason was expected to remain within her marriage and to serve her husband. Children begotten through niyoga were, for all social and legal purposes, not regarded as children of the begetter but of the husband.

Four of the participants indicated that they would not choose AID as they wanted the child to be genetically linked to both partners. One couple expressed concerns about the moral standing of anonymous donors who fathered children toward whom they bore no responsibility. They spoke about the possibility of using combined artificial insemination and were adamant that if they opted for AID they would choose more than one known donor. Multiple donors would render paternity uncertain, and they would not know the background and personality of the donors that they chose. The ethical and social implications of collaborative reproduction, even with unknown donors, are complex (Herz, 1989; Snowden & Mitchell, 1983). The possible complex implications of the use of known donors, within a cultural context that does not make provision for this, are unknown. The possibility of donors claiming custody of children may pose a problem.

One of the African participants indicated that the use of Western type AID would not be permitted. She said that her husband might, if necessary, allow her to cohabit with his brother to assist conception. All three representatives of African Traditional Religion indicated that the use of Western type AID would not be acceptable. In fact, the male representative was totally reluctant to accept the idea of male infertility. When he was told the percentage of male infertility, he said: "That would mean that the human population would soon die out. I don't think it is accurate. I think the figures reflect a socially constructed bias to equalise the relationship between men and women. Women need to get back at men for men blaming them for infertility; women are saying men are now equally responsible." The leaders of African Traditional Religion indicated that, within African traditional norms, the woman would be allowed to cohabit with the husband's cousin or brother with the consent of the elders of the community. The norms of the community, they claimed, would ensure that paternity remained a secret and that the biological father would not seek custody of the child. This is akin to the ancient Hindu traditional practice of niyoga. However, while the leaders of African Traditional Religion claimed that the circumstances of conception should remain a secret, the virtue of niyoga appears to lie in its public declaration.

Twelve (50%) of the women indicated that they would choose to use AID if necessary, but that their husbands would not approve of it. The main reasons for choosing AID were that it would offer the opportunity to be pregnant and to have a child that belonged genetically to at least one of them. One woman had tried the AID procedure nine times.

Although AID is being increasingly used as an option to deal with infertility, all women except the one who had already tried AID several times indicated they would either not resort to it or that their husbands would disapprove of its use. In five of the eight cases where conjoint interviews were conducted, male factors were implicated in the aetiology. Despite this, seven of the eight males who were interviewed indicated that they would not approve of the use of AID.

DONOR EGG/DONOR EMBRYO

The use of donor eggs and donor embryos is not as common as AIH and AID. Although the procedure is more complex medically (including stimulation of the ovaries and aspiration of ova) and more expensive, fewer women (ten) indicated that they would not use it compared with the number of women who would not choose to use AID. Of these, five indicated that they wanted the child to be genetically linked to both partners.

Four of the women, across the Hindu, Christian and Zionist faiths, rejected the use of donor eggs/embryos on moral and religious grounds. They expressed that it was too "far-fetched", that it was "trying God". The woman who belonged to the Zionist Church appeared in her simplistic way to capture the thoughts of the participants when she said: "That's funny, man, that's a funny idea ... I can't do that, my church will not agree."

One of the women, who experienced multiple pregnancy losses and was feeling very vulnerable and threatened about the possible loss of her husband, indicated that she would feel very threatened by the use of a donor egg or donor embryo. As with the concerns with AID, women who accepted the use of donor eggs, were afraid of having a child that was more "his" than "hers".

Fourteen (58,3%) of the women, across all religious groups and affiliations (except Zionism), indicated that they would use the procedure, if necessary and affordable. Three of the women who said no to AID were prepared to use donor eggs/donor embryos. The reasons for the use of donor egg/embryo were similar to that offered for AID. Some of them indicated that accepting a donor embryo was like adoption, only here one "adopted" an embryo and not a child already born. It is interesting to note that while twenty-three (96%) of the women indicated that their husbands would object to AID, only two women indicated that their husbands would not agree to the use of donor eggs or embryos.

Some of the religious leaders held differing views about the use of donor eggs/embryos compared with their views on AID. In relation to the use of donor eggs, the representative of the Rhema group reflected the consequentialist views of Fletcher (cited in Jenkins, 1983), as she said: "The woman would be elated to be pregnant, and that child who is so deliberately conceived will be so loved and wanted." With regard to the use of donor embryos she expressed greater uncertainty: "I don't know. I suppose it would be the same as adopting a baby. I sometimes get a fearful feeling that science is going too far. If one of the partners is contributing to it I can understand. I just feel it is too far removed." The representative of the Methodist Church thought that the use of a donor embryo was a better option than adoption as "the couple come into the life of the child much earlier and they are able to grow together." This is congruent with some of the views of the women who indicated a preference for use of the technique. While the leader of the Full Gospel Church did not approve of AID, he endorsed the use of donor eggs and donor embryos. The views of the leaders the Catholic Church and the Zionist Church remained the same as for AID.

One of the representatives of the African traditional faith indicated that it was not the genetic link that was important, but the resultant child. The Western, mechanistic medical approaches, which robbed conception of its sacredness, he felt eroded the African culture of wholeness. Where infertility existed and had to be dealt with, the mystery around conception should be retained. It

should be thought of in ritualistic terms rather than be reduced to purely clinical, mechanical procedures. The other two representatives of African Traditional Religion, both of whom were women, indicated that Africans would not really use donor eggs/embryos. The reason for this was that in the African community, if the wife could not conceive, the man would simply have a baby from a woman outside of the marriage. One of them said: "What happens, without even getting permission from the wife the man goes out and gets someone else pregnant and just reports this to the wife." This was not merely reported, but fully condoned by the other representative: "The husband should just do it and when the baby is born he should bring the baby and hand it over to the wife. The wife must not even know about it beforehand."

The views of the Hindu leaders were the same as for AID. One of them said that he thought their organisation would favour any technique that helped a couple create life as his spiritual master once said: "A marriage without children is like a desert."

The differing opinions regarding the use of male and female gametes in collaborative reproduction, both on the part some of the infertile participants and some of the religious leaders, confirm androcentric thinking and the patriarchal structures of society. Sperm and ova are in themselves physiological entities with no moral qualities and the use of both involves medical procedures within clinical settings. However, AID was seen to be more morally reprehensible than the use of donor eggs. This is perhaps related to the symbolism of power and masculinity associated with sperm. The differing opinions of the infertile participants also confirm that men tend to alienate themselves from reproductive issues and are unwilling to enter into procedures that they perceive to be an assault on their masculinity. Yet women are expected to undergo difficult and sometimes hazardous procedures in order to bear children (Arditti, Klein & Minden, 1989; Solomon, 1989a). The findings of this study concur with the view of Crowe (1985) that women tend to take ownership of infertility, even in the face of male aetiological factors. Men, in turn, allow women to own the problem.

IN VITRO FERTILISATION (IVF)

Only four of the participants indicated that they would not choose IVF as an option. Of these, three indicated that they were comfortable with their decision to adopt, while the other couple decided to remain childless. Of the twenty women who indicated that they would like to try IVF, sixteen (80%) indicated that cost was the factor that prevented them from doing so. One of the women, who disapproved of the use of donor gametes, indicated that she and her partner were saving up for the gamete intra-fallopian transfer (GIFT) procedure, and that if this did not work, she saw IVF as the next natural progression of treatment. One of the women indicated that she and her husband were prepared to take an additional home loan of R10 000 for one IVF attempt, although they were aware of the low chances of success. This supports the views of Harkness (1992) and of Bredenkamp (1993), who argued that infertile couples often pushed aside conventional wisdom in their pursuit of fertility.

Cost was not a factor for one of the couples, but as with every other new reproductive technology, the husband would not allow the use of IVF on religious grounds. The other participants who could afford IVF had already tried it. One woman had her first IVF attempt two years after the first test-tube baby was born in 1978 and two subsequent attempts, all of which failed. It was only the age factor that prevented her from trying further IVF protocols. Two of the other women who had failed IVF cycles were willing to have further attempts at IVF, although male aetiological factors that rendered the prognosis poorer were implicated in both cases. Two women, one of whom had already tried IVF, expressed ethical concerns regarding "spare embryos". One of these women, who experienced multiple pregnancy losses, expressed a great deal of conflict about the

possible use of the controversial selective reduction procedure that their gynaecologist mentioned, should more than the desired number of ova be fertilised. She had already had to deal with the guilt and pain associated with making decisions about terminating malformed foetuses in the past. She expressed concerns about the possibility of healthy foetuses being destroyed through selective reduction, the ethics of which has been discussed by Herz (1989). One of the women, who belonged to the Rhema Church and strongly opposed the use of AID, indicated that she went though a great deal of ethical conflict in deciding on IVF. This woman, who did not approve of any of the other NRTs on religious and moral grounds, described the following response:

> It took me a while to decide on IVF because I could not work out if it was a Godly thing or not. I felt, in the Bible, if a person was barren she was barren unless a miracle occurred. I did feel medicine should not get involved with making babies; that IVF wasn't God's creation. I felt I was actually messing with nature. I battled for a long time with the fact that I was going for the IVF. But with people that I spoke to, and my husband, I felt if it is of God, it is going to take. The doctor at the clinic was also a reborn Christian and helped me. I was assured that, even through IVF, it was God's hands that make babies.

It is interesting to note that the first IVF protocol "did not take" for this woman, yet she had two subsequent tries and was willing to continue further IVF cycles. This, and the experiences of the other women in the study, would appear to confirm the view that the drive to have children supersedes one's moral and religious beliefs. As with the Australian study by Singer and Wells (1984), religion had little or no impact on infertile participants' choices regarding IVF in this study. In four opinion polls between February 1982 and April 1983 in Australia, it was found that religion made less difference than was expected. Roman Catholics approved of IVF almost as frequently (67%) as those who said they had no religion (78%). Anglicans (79%) were most approving (Singer & Wells, 1984). Apart from the leaders of the Roman Catholic Church and the Zionist Church, the rest of the religious leaders endorsed the use of IVF involving the gametes of the couple. One of the Hindu leaders who adopted a very pronatalistic view said:

> My spiritual master asked, when scientists talked about creating test-tube babies, what is the great wonder? The womb itself is a natural test-tube and God created millions of embryos in this test-tube. The test-tube was sort of an extension of the natural womb. Scientist cannot create life. For a test-tube baby they have taken from a man and a woman; they cannot do so with chemicals. Scientists cannot make life. IVF would not be regarded as being against the natural order ... The use of donor gametes will also be acceptable. There are various examples in the scriptures of people being brought up by different parents. Love is what makes a parent, not the genetic connection; the real connection is love.

At the same time, all religious leaders rejected the use of IVF for experimental purposes and expressed concerns about how "spare embryos" are dealt with. They supported the freezing of embryos for further use. However, the separation between the therapeutic and experimental aspects of the NRTs is difficult. Also, in Durban some infertility clinics do not have cryopreservation facilities. This invariably involves the destruction of the extra embryos that are created though IVF (Slogrove, 1995). However, the pronatalistic views of the religious leaders appeared to support the contention of The Ethics Committee of the American Fertility Society (1986) that concerns about possible abuse did not invalidate the appropriate use of the NRTs.

The experiences of women also confirm that, once on the treadmill of infertility treatment, it is difficult to give it up (Harkness, 1992; Koch, 1992; & Klein, 1989). Holmes & Tymstra (1992), in

a study on women who had gone through IVF protocols in the Netherlands, found that 86% of them were willing to return for further treatment. The popular choice of IVF might reflect the fact that, for most couples, it represents a last chance of biological parenthood. The media also present IVF as the ultimate solution to all infertility problems. The seductive nature of the NRTs makes people believe that anything is possible (Pappert, 1989). Two of the African women indicated that they had read about IVF in popular magazines and would therefore like to try the procedure. Four of the five African women, who could not afford any specialist infertility assessment and treatment procedures, believed that IVF was always successful during the first cycle. The interviews were used to provide information and to clarify costs of the procedure, thus contributing to realistic appraisals regarding the options available to them.

The seductive nature of the NRTs and the need to try the available fertility fix, in the form of IVF, was also seen in one of the cases. This couple had gone through all the adoption procedures successfully, but when they were chosen as adoptive parents they could not come to terms with it. The woman described concerns about "physical realities" in terms of their age and was aware of the low success rates of IVF. She said: "I know if I start I have to be prepared to try it 5/6 times. We could do it and it could still not happen. I ask at what cost ... literally at what cost ... It is not an option for most people." Yet she felt that she could not settle for an adoption until she had tried IVF. In view of the carrot that IVF holds out to infertile couples, and the age criteria in adoption, couples may block adoption as an alternative route to parenthood. The responses of some of the participants, however, confirmed the complexities involved in infertility and that adoption is not the panacea for all infertile persons. It also confirmed the view of Stanworth (cited in Purdy, 1992:310-311) that "the description of infertility as a social condition of involuntary childlessness doesn't hold for all women. For some, pregnancy and childbirth are not only a route to a child, but a desired end in itself."

SURROGATE MOTHERHOOD

Only three of the women in this study indicated that if surrogacy were necessary they would use it as an option. The results of this study differed considerably from those of Maill's (1989) Canadian study of seventy-one infertile women, where she found that 70 percent of the women expressed approval of surrogate motherhood. However, Maill (1989) did not indicate whether or not the respondents would have chosen to resort to surrogacy themselves. Eighty-five percent of the women in this study, and all eight of the men, reflected total rejection of surrogate motherhood. For only two of the women the most expressed concerns arose from religious and moral grounds. Two of the participants said that they were comfortable with their decision to adopt and would therefore not consider a surrogate. The rest of the seventeen women provided the following reasons for not wanting a surrogate arrangement: jealousy of another woman carrying her husband's baby; fear of loss of the husband to another woman; fear that the woman would refuse to give up the baby at birth; the longing for a pregnancy and birth experience; and the complex emotions involved in such arrangements. In relation to the desire for a pregnancy and birth experience, one of the women said: "No, I want to be pregnant and to give birth. I want to feel that pain that every woman has." Twelve of the seventeen women talked about fears associated with the surrogate not wanting to give up the baby and possible custody battles that might ensue from this. Considering the primacy placed on the blood tie, the fears and concerns of the women might be well founded.

It is interesting to note that while the NRTs were developed to assist infertile couples, the society within which they have developed still appears to place a premium on the biological link between mother and child. In a Gallup poll (cited in Singer & Well, 1984:122) the following question was

asked: "If the woman who gave birth to such a baby changed her mind, and wanted to keep the baby, who should have the first claim on the baby - the couple whose fertilized egg was used, or the woman who gave birth to the child?" The results indicated that Australians favoured the surrogate mother by 35 percent to 29 percent. Britons were more clearly in favour of the surrogate mother (50%). Only 19 percent of Britons favoured the couple whose fertilised egg was used. It is possible that if the surrogate mother is also the genetic mother she would receive greater public support. Public opinion may, therefore, not favour court orders compelling surrogate mothers to give up babies to whom they have given birth.

Two of the women who objected to surrogacy on moral and religious grounds were affiliated to the Rhema group. However, the objections to surrogacy from the representative of this group did not stem from moral or religious concerns. As with the concerns with most of the women in this study, for her "the emotional side comes into it. The mother carries the child and it is her maternal instinct that she does not want to give up the baby. We have no real moral objections but the consequences that it produces and who suffers - the children. Custody battles and divorce ... I don't really think we can go with that." The representative of the Methodist Church said they were not rule-oriented. If, after counselling, a couple was unable to come to terms with infertility, they would be supported in their decision. The representative of the Full Gospel Church objected to surrogacy on the basis of the possible negative consequences, while the Zionist Church shared the deontological view of the Roman Catholic Church in its rejection of surrogacy.

Two of the four Hindu leaders rejected the use of surrogacy on religious and moral grounds. The one representative, with the exceptionally pronatalistic view, indicated that it should be permitted only via the use of artificial insemination. The other emphasised that commercial surrogacy was totally unacceptable. He said that it should be done in the spirit of altruism, and should be non-coercive and voluntary. This supports some of the recommendations made by the South African Law Commission (1992). The leader who supported non-commercial, altruistic surrogacy, however, expressed the view that, although niyoga was not currently practised, there is a religious sanction for it and that it was "far more radical and far more socially acceptable than artificial insemination and surrogacy." Niyoga, according to Bharadwaja (1915), also allowed for a man to conceive outside marriage, if his wife could not bear children. This leader used the following rationale for his argument that niyoga was more acceptable than surrogacy:

> A marriage after all is bringing about a relationship that is sanctified by society. As marriage is essentially a socially sanctioned relationship that allows for the conjugal act, there is really no need for all these technologies. Deriving from this logic, if a couple cannot conceive naturally, all that society has to do is condone a man and a woman (other than the husband and wife) cohabiting in order to produce a child irrespective of who has the medical problem. This is perfectly all right as long as there is no secrecy around it and the offspring is told the truth about its origin.

The values reflected above have been endorsed by Bharadwaja (1915:133), who contended that: "Just as in marriage, the consent of the bride and bridegroom and the approval of good men are essential, even so it is in niyoga ... when a man and a woman have agreed to contract niyoga, they should declare before an assembly of their male and female relations that they enter into the relation of niyoga for begetting children, they will have sexual congress for generating a new life once a month."

One of the representatives of African Traditional Religion expressed similar views. He said that in the African community it was not at all unusual for one woman to give birth to a baby and for another woman to raise it. The practice would be totally accommodated within and not even

questioned in the African world view, which placed a sovereign value on children. When asked about the morality of procreation outside of marriage, he asserted that:

> There is no such thing as morality. People have to fulfil a higher purpose in life and husbands and wives serve each other in this way. The highest morality is the creation and continuation of life. We are only instruments and we are celebrated as long as we fulfil this higher meaning of life. We have to stop and look inside - the rules are not important. We should never lose sight of what transcends particular realities. All the biological realities [that we had been talking about in relation to conception and the new reproductive technologies] are not absolutes.

Such a pronatalistic view serves to reinforce the notion that childless couples are not fulfilling their "higher purpose in life." If the "highest morality is the creation and continuation of life", the implication then is that childless couples are not really being morally responsible.

ECTOGENESIS

IVF and the survival of extremely premature babies with birth weights of no more than 470 grams (kept alive through tube-feeding in humidicribs) have made ectogenesis a partial reality (Singer & Wells, 1984). When scientist initially proposed the possibility of conception outside the womb, it was met with public outrage and was seen as something belonging to the realm of science fiction. However, IVF is now no longer considered an experimental but a routine therapeutic procedure. Similarly, while ectogenesis may now seem impossible, it may some time in the future become a reality.

While all the women expressed that the idea of ectogenesis was too far-fetched and unnatural, ten of them (across all religious faiths) indicated that they would use the procedure if it were available. They indicated a preference for ectogenesis over surrogacy. The reasons for the choice of ectogenesis were: the opportunity to have a child genetically linked to both spouses; it did not involve a third person; and it did not contain the human factors that might contribute to difficulties, as in surrogate arrangements. One of the women, who said no to surrogacy, in response to the question on ectogenesis said: "Yes, definitely more than a surrogate. With a surrogate now you will be jealous." Another woman, who also said no to surrogacy, said: "It sounds so unnatural, but if we could afford it I would do it. It is a better idea than a surrogate, there is no obligation, there is no other human being, there is no third person involved." The views of the women supported the assertion of Singer and Wells (1984:134) that if "experience with surrogacy showed that the surrogate mothers could not be relied upon to give up to its genetic parents the child that they carried, ectogenesis might be thought better than a battle over custody." This might constitute one of the most compelling factors in favour of ectogenesis.

All those who said yes to ectogenesis thought that their religions would not approve of the technique. This supports the notion that, for some participants, the drive to have children superseded any religious injunctions that they thought existed against the NRTs. The one woman, who expressed a great deal of anger toward God after her multiple pregnancy losses, said that she would go ahead with any option that she chose irrespective of what her religion said. With a great deal of anger she said: "God has given me the right to choose, and I can sometimes make a decision independent of religion. He also had a choice and he chose me. He gave me a chance and he then denied me that chance ... Even if I regret the decision, but I made the decision." In response to the question about whether or not they thought their religion would approve of the NRTs that they would opt for, one woman said: "They won't say much, they will say all these new generation things are not good, but if you feel something is going to help you I think you shouldn't

worry about the religion and people. If I think it is something that I want, I don't want somebody else to tell me that is not right and that I am going against my religion." Her husband, however, did not agree with her. He said: "I feel that religion is right, all these modern things are not right." In his simple way he expressed real perplexity. He couldn't understand why people had to go to all those lengths to have babies when you could adopt and "they give you papers to show it is your child."

One of the couples expressed ambivalence about the use of ectogenesis. The husband thought "maybe" but expressed concerns about the possible psychological effects on the child in view of the lack of bonding. The wife reflected the insidious but powerful effect that science and technology tends to have on people. She said: "The more things are around, the more you would accept it as the norm. Maybe if other people were doing it as well I'd feel differently. Now it seems horrific ... too much playing the hand of God. I believe it's playing the hand of God, I really do."

The remaining thirteen women, across all religious affiliations, expressed total rejection of the procedure primarily on religious and moral grounds. The religious and moral concerns arose from the unnaturalness of the procedure, and the possible entry into the world of science fiction. In this respect several of the women indicated that the concept "scared" them. One of the women responded with: "No, I am sorry that turns me off, I can't accept it. It is a concept that offends me. It is almost as if we're starting to deal with science fiction. It has all sorts of warped connotations that if you projected would seem to upset the natural order of life as we know it. That worries me. I wouldn't want to be part of it." The objections to ectogenesis lie in the possible effects on the ectogenetic child and the ectogenetic mother, the possibility of the mass production of babies, the unnaturalness of the procedure, and the farming of human embryos for the production of human spare parts (Singer & Wells, 1984).

All religious leaders, except one Hindu leader, expressed rejection of ectogenesis. The one Hindu leader who approved of all the other techniques said this of ectogenesis: "I can see where this can lead to with people trying to avoid childbirth for convenience. I would draw the line here. The more unnatural we make our lives, the more difficult we make our lives ... We don't know the more artificial we become, growing a child in a plastic womb. We see the pressures of modern life and even the basic unit of the family has a problem staying together. We don't know what effect these unnatural things will have on the child and on the family." The leader of the Methodist Church expressed similar views. He said: "The church cannot accept that. We believe that conception and birth are God ordained ... If it is just a mechanical thing where you just go and collect your child, I don't know what this will do. It is a whole secular and commercial world. The ways in which we think we are solving problems are definitely creating new problems. People may want to avoid the inconvenience of child-bearing." The one Hindu leader endorsed ectogenesis as there was a precedent set for this in the scriptures. In one of the Hindu mythologies, the Ramayana, there is the description of the Goddess Sita having being conceived and brought to full term in a clay pot. This leader only approved of technology where precedents were set in the scriptures. The NRTs were regarded as good or bad, in and of themselves, only in so far as the precedents were set in the scriptures. It was not the concerns of infertile persons or the possible consequences of the NRTs that motivated his responses. In this respect he reflected a rule-oriented deontological approach that lacked flexibility and humanitarian values.

ADOPTION AND CHILD-FREE LIVING

Fifty percent of the women indicated that they would choose adoption as an alternative route to parenthood. Of these, five had made firm decisions to adopt and had begun adoption procedures.

However, women still hoped that pregnancy would occur, thus supporting Daly's (1990:490) view that infertile persons move from the "once-exclusive identification with biological parenthood ... to a split identification between biological parenthood and adoptive parenthood." Apart from one couple, who could afford to pursue the NRTs, the others in this category indicated that in terms of their financial circumstances adoption was the only viable option for them. Seven of the twelve women who said yes to adoption indicated that it would be an option of last resort; only "if all else failed." The participants generally expressed the view that an adoption would mean a final confrontation with infertility and, in a way, would entail a public statement of their infertility status.

Ten of the women indicated that they would not choose to adopt. The two main reasons for this choice were: disapproval by husbands and fear that the child might leave once the child grew up. One woman, with strong involvement in the Rhema Church who objected to the use of all the NRTs, except IVF, which she had tried, was the only person who said that she would not adopt on account of her religious beliefs:

> I would not consider it at all. We don't know what we are getting. You don't know what the genes are like, you don't know if it has got all sort of diseases that you are unaware of. As a Christian you really believe that things are hereditary. A lot of things can be brought upon us through heredity and it is quite often evil. In the Bible it says that diseases and curses can be brought onto children from three to four generations before. Unless you are rid of the evil, it will reflect in the child. We could adopt but we do not know what the parents are like. We don't know if they are drug addicts, how they cared for the child while in the womb; the mother might have wanted to abort; is there insanity in the family? We would choose to remain childless rather than adopt.

This woman's view was totally in contrast to the view of the religious representative of the Rhema Church, despite the fact that this leader was from the same church as herself. All religious leaders favoured adoption as an option. Even those who approved of all the NRTs (except ectogenesis) asserted that, over and above all these technologies, they would favour adoption, as it was something noble and humanitarian and provided a home for a child who is in need of one. Two of the participants had gone through all the adoption procedures, but on being informed about being chosen as adoptive parents they reversed their decision.

Although 50% of women indicated that they would choose adoption as an option, only five of them had made firm decisions about it and had begun adoption procedures. The reversal of the decisions of two of the couples, and the fact that seven of the participants would choose adoption as a option of last resort supported Maill's (1989:50) claim that society and the NRTs lend "credence to the belief that the blood tie is one of the most important components of good parenting" and that adoption is a "second best" alternative.

CONCLUSION

The literature and the results of this study confirm the desire of women for the experiences of pregnancy and labour. Feminists such as Klein (1989), Koch (1992) and Bartholet (1992), who called for resistance to the NRTs, used primarily the social construct paradigm to explain women's need for pregnancy and childbirth experiences. Snowden and Mitchell (1983), however, argued that the biological drive for children and the social constructions of parenthood are linked, and that any effort to separate them are futile. In fact any such effort at splitting body and mind would be antithetical to the importance of holistic biopsychosocial considerations in social work practice. In

view of the trauma of infertility and the drive for biological parenthood, the outright rejection of the NRTs, as advocated by some of the radical feminists, may not be a viable option. The overwhelming support of IVF by the participants and by the religious leaders in this study appears to confirm Maill's (1989:50) view that "the development of reproductive technology can be viewed as the logical extension of a value system that esteems pronatalism and biological kinship." A large part of this value system derives from religion that makes fertility an imperative (Solomon, 1989; DeCherney & Harris, 1986). Women's desire for pregnancy and genetic parenthood (whether biologically and/or socially constructed) will ensure, as pointed out by Williams (1992), that the market for the NRTs is maintained. What is required is regulated use of technology that is developed through informed public opinion. Survey type opinion polls would have little purpose as people are often unaware of the realities surrounding the NRTs. In informing public opinion the social worker's roles as advocate, educator and mobiliser may be implemented through effective use of the media.

There appeared to be little congruence between the views of participants and those of religious leaders. While participants tended to feel that their religions would not really approve of many of the NRTs, most religious leaders reflected quite pronatalistic views. For the majority of participants the drive to have children superseded any religious injunction that they thought might exist against the NRTs. While some of the religious leaders did not approve of Western-type NRTs, they felt these could be accommodated within the religious and cultural contexts of people. For some reasons it would appear that the views propounded by religious leaders do not filter down to people. One plausible explanation is that religious groups have not really considered infertility and the NRTs as serious issues for discussion and debate. This might reflect the fact that the higher orders of religious institutions are usually male-dominated, while infertility is typically seen as a woman's issue. It might also reflect the notion of the leader of the Methodist Church that, while ministers might be supportive of people using the NRTs, the church would not openly endorse the use of some of the NRTs. Making public statements means taking some risks when dealing with issues that generate much ethical debate and this might jeopardise the positions of religious institutions. It is an ethical imperative that social workers undertake research into such value-laden areas and disseminate as much information as possible. This type of information might help ease some of the guilt and decision-making conflicts that couples experience when making choices about the use of NRTs.

The results of this study and the literature highlight the complexities involved in the NRTs. This is an area fraught with social, sexual, psychological, medical, economic, ethical and cultural dilemmas. The NRTs, which are developing at an unprecedented rate, have implications not only for infertile persons but for society as a whole. In a pluralist society like South Africa achieving a consensus on the full range of questions relating to the NRTs would prove to be difficult. The ultimate goal is to incorporate their use for the benefit of the individual without detrimental effects to the child or to society. This calls for the ready availability of infertility counselling services, cultural sensitivity and cultural competence, interdisciplinary teamwork, research and effective dissemination of information regarding the costs, accessibility and the potential hazards and success rates of the NRTs. It also calls for public participation and debate in the formulation of policy regarding the development and regulation of the NRTs.

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