Mapping Feminist Discourse from Resistance to Regulation:
Women and the Politics of the New Reproductive and Genetic Technologies in Canada

by

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ABSTRACT

This thesis examines how a dominant liberal discourse dominated and constrained the feminist discourse on New Reproductive and Genetic Technologies (NRGTs). This dominant discourse allowed the Royal Commission on New Reproductive Technologies to name the problems, the parameters of the debate and thus the solutions. During the Commission's public participation program 1991-92, many Canadian women's groups attempted to position themselves within a feminist discourse on NRGTs and present their policy proposals to the Commission. Some women's groups accepted the dominant liberal discourse, some were critical of it and some resisted it. Their proposals ranged from advocating for the regulation of the abusive applications of NRGTs, to requesting a moratorium and eventually regulation of some of the technologies, to seeking a ban on all NRGTs. I examine how the issue of NRGTs "tests" the Canadian reproductive rights movement's ability to enhance diversity and create alternative visions of women's relations to reproduction.

From my reading of the feminist literature on NRGTs and the women's groups' presentations emerged three feminist positions: liberal rights, pluralist choice and social relations. The concepts, theories and ideas, which make-up the feminist discourse, characterize and differentiate these positions. A map of the feminist discourse on NRGTs places the positions onto a continuum and allows me to demonstrate the divisions and distinctions between these positions. The social relations position offers critiques of both the liberal rights and pluralist choice positions and their relation to the dominant liberal discourse and its embedded assumptions. It is a defensive strategy against NRGTs which are indistinguishable from their eugenic possibilities. This position underlines the importance for women as a social group to critically assess the idea that these technologies can make things better for individuals and that social change can make things worse and impinge on individual freedoms. This thesis argues that it is important to open the NRGTs discourse (as the social relations position has) to enable the women's movement to develop strategies which go beyond the dominant individual "rights" and "choice" discourse.

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I can't forget Rocky who is a continual reminder that life is too short.

DEDICATION

To the memory of my sister, Sam, whose beautiful smile continues to brighten my days. Her strength and courage inspire in me a will to succeed and remind me to never take life for granted.

INTRODUCTION

I was wrong to think that the women's movement was going to multiply my alternatives; I see now that it's supposed to pick the alternatives that NAC thinks I should have while protecting me from the unacceptable ones.[1]

Bonnie Beresford who wrote this letter was angry with the National Action Committee on the Status of Women (NAC),[2] a Canadian, feminist organization, for a letter written by the co-chairs of NAC's New Reproductive Technologies committee. Beresford accused the "radical feminists" of trying to decide what was best for her. While this was one woman's opinion, it is echoed by many women in Canada and around the world. Beresford believed New Reproductive and Genetic Technologies (NRGTs) "give us what we want: more control over our bodies through expanded individual choices." Was NAC trying to tell her that the only solution was to replace the 'system' with "a revolutionary anticapitalist utopia devoid of male abuse of power?"[3] This exchange illustrates the sorts of tensions and conflicts that NRGTs have generated within Canadian feminist politics.

When I embarked on this project, reviewed the feminist literature on NRGTs and analyzed the women's groups presentations to the Canadian Royal Commission on New Reproductive Technologies three distinctive feminist positions on NRGTs emerged. I discerned that certain concepts, theories and ideas were employed that combined to form what I have termed a feminist "discourse" on NRGTs. For me, the term discourse suggests that language is more than just the spoken or written word; it is also something that can obscure meanings and is integral to a discourse that is always implicated in certain power relations. My reading also uncovered a dominant discourse that surrounded the feminist discourse and was used to market NRGTs as "choices" for "infertile" couples. This

dominant liberal discourse placed the rights of individuals to choose to use NRGTs at the center of its theory. It became evident that a dominant discourse can exclude certain voices that do not speak the same language, share the same concepts, theories and experiences. From my initial reading, it was also clear that this dominant discourse was not fixed but could be resisted. This thesis is about a crucial time in which the state used a Royal Commission to define the dominant discourse and drew together different voices in a debate that followed.

I mapped the feminist discourse to show the uneasy struggle of feminists as they attempted to position themselves within the feminist discourse and in relation to the dominant liberal discourse. The feminist positions on NRGTs can be mapped onto a continuum; seeing the positions in this manner allows for a way to negotiate the most important issues regarding NRGTs. At one end of the continuum is the position that is fully submerged in the dominant liberal discourse, which I call the liberal rights feminist position. It uses the language and concepts of the dominant liberal discourse to argue that NRGTs do offer choices to women. Near the middle of the continuum is the pluralist choice position that stretches the concepts, language and theories of the dominant liberal discourse to their radical limits in order to argue that certain technologies may fulfil women's needs. At the other end of the continuum is the social relations position that is the most critical of the dominant liberal discourse. The social relations position is the latest development of the feminist discourse to date and could open the dominant discourse to a point where alternative discourse articulations regarding NRGTs could emerge. These positions do not represent distinct enclosed positions; significant overlaps (and contradictions) occur. But the image of a continuum allows me to demonstrate the elisions and the distinctions between these positions, as well as the implications each position has for policy proposals regarding NRGTs. This map provides a useful way of navigating the submissions made to the Royal Commission on New Reproductive Technologies by those women's groups who put women's lives and concerns at the centre of their analysis. My review of the submissions provides the basic materials upon which I built my theoretical understanding of the discourse. My basic premise here is that the differences among the positions need to be teased out and carefully distinguished because among these three different theoretical and

practical responses we find widely divergent readings of the possible consequences resulting from the deployment of NRGTs.

I. New Reproductive and Genetic Technologies

Technology takes many forms in the area of women's health, some are already familiar such as the birth control pill, abortion technology and various childbirth instruments. NRGTs represent a new and significant development as they encompass "the full range of biomedical/technical procedures which intervene in the process of procreation whether aimed at producing a child or preventing/terminating a pregnancy."[4] The Commission mandated to study New Reproductive Technologies did not include in its study all contraceptive and birthing technologies and I therefore have focused only on the conditions, technologies, procedures and practices the Commission and the women's groups did. In this thesis, I emphasize the interdependence of NRGTs. Thus in referring to them as "NRGTs" or as "these technologies," I am not suggesting that NRGTs are indistinguishable but rather that each technology has repercussions for another. Thus my focus is on technologies used in assisted human reproduction, prenatal diagnosis and genetic testing of embryos and fetuses, and genetic research involving human zygotes, embryos and fetal tissue.

The assisted human reproductive technologies include artificial or alternative insemination (AI), in vitro fertilization (IVF) and fifteen different techniques.[5] Prenatal Diagnostic Technologies (PNDT) include ultrasound scanning, preimplantation diagnosis, amniocentesis and Chorionic Villus Sampling (CVS), which are sometimes able to detect characteristics such as "diseases," "disabilities," or fetal sex of an embryo or fetus. The genetic research includes the development of the artificial womb and genetic engineering such as transgenic transplantations.[6] Assisted human reproductive technologies are concerned with the creation of a human embryo and the genetic engineering technologies are concerned with the embryo's quality: without the first the second would not be possible.[7] I emphasize this interdependence between the assisted human reproduction technologies, PNDT and the practice of eugenics. The advancement of NRGTs research includes the practice of eugenics which is the manipulation of genes to perfect human genetics by the

prevention of "problems" before they are born by aborting the fetus or by using gene therapy. Eugenics is also about controlling who can reproduce, and as such has crucial political, social and individual significance.

Underlying the recent deployment and commodifying of these technologies is the dominant liberal discourse that contends that NRGTs are "needed" to either treat the "sickness" of infertility or prevent "disability" and "disease." However, feminist Gwynne Basen provides another interpretation of NRGTs: "the lack of a prevention for infertility creates the market whereby science and industry are partners in the reproduction of life. Science develops the technology, industry markets the cure and medical institutions control the access and availability for women."[8] This interpretation raises several questions. Why have NRGTs been developed? Is it really because women demanded them? Are women in a position to have their demands heard? Do these technologies represent more control over women's reproductive capacities for the researchers who developed these technologies and continue to research them, and for the doctors who perform the procedures who are predominantly (if not exclusively) male? Do NRGTs represent real "choices" for women?

How are these questions related to the issue of the "freedom to choose" in which women should be able to make decisions regarding their own bodies? While this is, no doubt, an important issue for feminists, there are other reasons why the complex issues raised by NRGTs have tended to be overwhelmingly articulated along lines of "choice" and self-determination. Bonnie Beresford points to the principal reasons: in a liberal democratic state, such as Canada, freedom of choice is a central legitimizing mechanism and pervasive ideology. Are the issues surrounding NRGTs simply ones of "choice"? What about the substantial medical supervision and control required to administer these technologies, a development that raises other questions such as those about women's equal access? How will a woman's marital status, physical/mental (dis)ability, sexual orientation, ethnicity, race, religion, culture or region of residence, determine "eligibility"? Can we prevent these technologies from being harnessed to the production of the "right" child to the "right" parents in the "right" countries, in short to eugenics?[9] Is it possible that these "choices" will be offered and exercised "without any recognition of how such choices deprive many women of autonomy, dignity, integrity, well-being and basic social justice"?[10] Are abortion rights,

in their broad articulation of the liberal discourse of "choice,"(so long fought for by feminists but now also dangerously articulated within the repertoire of NRGTs) sacrificing the rights and dignity of people with disabilities? Finally, is the individual "rights" and "choice" rhetoric that resounded in the fight for abortion being used by the male-dominated medical profession to legitimate the use of NRGTs? One way that Canadian women proposed to answer such questions and to raise public awareness through public debate was through the creation of a Royal Commission.[11]

II. The Royal Commission on New Reproductive Technologies

It was in October 1989, after a two-year lobbying campaign by the Canadian Coalition for a Royal Commission on New Reproductive Technologies,[12] that the federal government appointed the Royal Commission on New Reproductive Technologies (RCNRT). From the outset, however, many feminists were critical of the Royal Commission format and many chose not to participate because it was a state-sponsored process. An interesting interview appeared in Healthsharing, a Canadian women's magazine dedicated to health concerns, which highlighted some of these apprehensions. Connie Clement and Diana Majury saw the call for a Royal Commission as a tool to focus media and public attention and increase debate but thought that there was no reason the actual Royal Commission would ever "lie in their [feminists'] favor." Some feminists predicted that "feminist concerns will be reduced to one voice of many" competing with industries and large lobby groups.[13] Would such a state tool appropriate or marginalize feminists' concerns? Many feminists doubted the ability of women's groups to be able to respond to the Royal Commission. Furthermore, women's groups were also in danger of expending a great deal of their meagre time and energy articulating a position that might not reach the government agenda and the policy implementation stage.

During the Commission's four year term, from October 1989 to November 1993 when it released its Final Report, it held twenty-eight days of public hearings. Its mandate was to:

> inquire into and report on current and potential medical and scientific developments related to new reproductive technologies, considering in particular their social, ethical, health, research, legal and economic implications and the public interest, recommending what policies and safeguards should be applied.[14]

An analysis of this Commission reveals that countless problems[15] discredit it and confirm the apprehensions voiced by Clement and Majury. (Chapter Three examines some of these problems.) Nevertheless, many women's groups responded to the call to participate in the hearings of the RCNRTs.[16]

A Royal Commission attempts to achieve a consensus for its recommendations to the government and in doing so often overlooks important distinctions between presenters.[17] I contend that the most important distinctions were among the women's groups that presented to the Royal Commission. I want to help facilitate what Sue Cox called "a critical pause in thinking," by (re) presenting the views of certain women's groups.[18] The views of the women's groups contribute to my map of the feminist discourse because, although I do not take the liberty to call all these groups "feminist," I call them feminist in so far as their recommendations and ideas are centred on women's experiences.

III. Popular Representation of Feminists' Resistance

My interest on the topic of NRGTs was sparked when Sunera Thobani expressed her views on NRGTs in a press conference held to discuss the release of the Royal Commission's Final Report, Proceed With Care. The then newly elected president of NAC was voicing her critical analysis about both the royal commission process and these technologies. She maintained that NRGTs are racist, sexist and classist. Regulation does not sufficiently deal with these technologies, and many of these technologies should not be offered as a "choice" to women. Sunera Thobani presented what I viewed as a very "radical" position in the women's movement. I remember my reaction at the time was, "who is this woman and what gives her the right to speak for women across Canada?"

Undertaking research on this topic, I quickly realized that Sunera Thobani had contributed a very rich, critical analysis of these technologies, in particular with respect to

South Asian Women.[19] She was only one of many feminists who regarded the "choice" offered by NRGTs as masking many controversial issues. When I reflected on what I knew about NRGTs I realized that it was very little outside the "miracle baby" image that the media had created. The media seem to only report on those cases where couples have been "trying" to have a baby and after many cycles of IVF have been successful. The unbalanced media reports have also misrepresented the feminist positions on NRGTs. When some feminists expressed their concerns about the implications of NRGTs for women, the media portrayed them as heartless, callous feminists and set them up as adversaries to infertile women.

This setting up of women against women creates a form of violence. Feminists argue that in the media coverage, the "debate has to take place in an atmosphere where there is some baseline of respect."[20] For example, one group, called Media Watch, examines the portrayal of women and women's concerns in the Canadian media. It has filed many human rights complaints against media for airing statements considered misogynist and sexist. For example, "the usual hot-eyed feminists who would look good sitting at the foot of the guillotine with their knitting," or "there is discrimination afoot here since there is no minister responsible for men." Those women who protested these remarks were said to lack a sense of humour and to be "a bunch of damn fools."[21]

The societal atmosphere that engenders these sorts of comments raises concerns about the fair treatment of a diversity of voices and experiences. Sandra Harding states that "knowledge is supposed to be based on experience, but male dominance has simultaneously insured that women's experience will be different from men's and that it will not count as fruitful grounds from which to generate scientific problematics or evidence."[22] While women's knowledge is often not seen to generate "evidence," this thesis shows how feminist epistemologies reveal the sexist, racist and classist biases of the development and application of NRGTs. The Commission does not consider women's concerns on a par with the scientific evidence but as I demonstrate in this thesis, women's groups and feminist authors have uncovered problems that are integral to an understanding of NRGTs. The feminist discourse that emerged from the feminist literature and the women's groups submissions,

unlike the popular media presentation of these issues and the dominant discourse, take "woman as knower" seriously.

IV. Methodology

Retrieving copies of the presentations made by the women's groups proved to be quite a daunting task. The inaccessibility of the written submissions and oral transcripts typifies the low priority that the government places on this part of the Royal Commission process.[23] These documents could only be consulted at the National Archives or photocopied for a certain price, so I requested these documents directly from the groups via the mail. The groups' names in the Commission's Final Report had many errors and this added to my difficulty in locating these groups. Similarly, when Margrit Eichler attempted to do a survey of the people involved in the research part of the Commission, she encountered problems with the list of researchers. She discovered that 76 out of the 148 researchers who responded made minor corrections to their listings and others were listed but did not do any work.[24] When I attempted to find the groups' addresses, every directory I consulted was outdated: I received many envelopes with "moved-return to sender" on them.[25] I must commend the organizations and volunteer groups that I contacted either through the mail, by fax or by telephone, for their prompt and comprehensive replies. Most of these groups are underfunded, voluntary and nonprofit.[26]

Women's groups have faced increasingly hostile governments during the 1980s and into the 1990s. The conservative policies that emerged targeted women's groups as "special interests" and as dispensable. The government has thereby drastically, if not completely, cut their funding. As a result, these groups do not have the resources to operate, to maintain continuity, or to even stay in one place. It was difficult for the groups to obtain the information needed to respond to the Commission whether by research or by exchanging ideas with other groups. Despite all of this, 103 women's organizations out of over 200 groups and a total of 470 presentations intervened in the Royal Commission's public participation program.

Chapter Two presents the discourse on NRGTs as it appeared in the presentations made by women's groups during the Commission's public consultations. Although I have read and used written submissions, I have mainly examined the transcripts from the public hearings. In Canada, as in most Western societies, there is a "bias in favour of written records [that in Canada] has ignored and devalued the oral traditions of Native people."[27] The oral transcripts from the Commission are verbatim records of the oral presentations and therefore are the least mediated records available. Also, I have mainly used oral transcripts because Native groups were an important part of the process and I wanted to compare similar documents. The oral transcripts as a whole were available and I could access all of them at the National Archives. I supplemented my primary documents from the oral hearings with written submissions, briefs or letters from those women's groups who did not appear at the public hearings and for which oral transcripts were not available. In all, due to logistics and availability, I have consulted sixty-nine presentations from the oral hearings and nineteen written submissions and opinions for a total of eighty-eight.

My goal was to provide the broadest and most diverse range of the key problematics in the women's groups' presentations that indicate where on my continuum they were attempting to position themselves. In Chapter Three I include the different locations and positionalities of each group based on the descriptions provided in their presentations or in the organizations' pamphlets. These were placed in relation to the reproductive rights movement in Canada and to the writing and oral presentation process of the Commission. Chapter Two and Three include short descriptions of the organizations. Of these presentations, I have consulted those made by immigrant women's groups, specifically the National Organization of Immigrant and Visible Minority Women of Canada, the Immigrant and Visible Minority Women of British Columbia, and the Immigrant Women of Saskatchewan; and those made by lesbian and gay groups, including the Halifax Lesbian Reproductive Technologies Committee and the Gay and Lesbian Parents Association, and also those presentations made by the two Native peoples' organizations, the Yukon Indian Women's Association, and the Inuit and Indian Nurses of Canada. I also consulted the groups that represented Northern women's concerns including the Yellowknife Women's

Society, the Yellowknife Association of Women and the Law, the Victoria Faulkner Women's Centre, and the Northwest Territories Status of Women Council.

Part of my focus is on the concerns raised by disabled women with regard to PNDT in particular. Those groups that represented their concerns included the DisAbled Women's Network of Canada, the Canadian Disability Rights Council and the DisAbled Women's Network of Toronto. The other groups that are re-presented in Chapter Two include advisory councils representing the various provinces and the national advisory council, the Canadian Advisory Council on the Status of Women. The National Action Committee on the Status of Women plays an integral role in my analysis because it is a national group and because it has taken a resistance stance to NRGTs that has placed it at the forefront of the NRGTs debate. The Canadian Abortion Rights Action League's position is analyzed because it takes a divergent position to that of NAC.

As well as consulting the presentations made by several Quebec groups including the Federation of Quebec Women, I also consulted several groups representing minority francophones including the Association of Acadian Women of Nova Scotia, the Association of Francophone Women of Southern Ontario and the Provincial Association of Francophone Women of Saskatchewan. A number of groups were consulted because they represented specifically rural women's concerns including the Women of UNIFARM, the Canadian Research Institute for the Advancement of Women in Newfoundland and the Antigonish Women's Resource Centre. Several groups that played important roles as coordinators and educators were consulted including the Canadian Research Institute on the Status of Women and the Vancouver Women's Reproductive Technologies Coalition.

Women's health collectives and health clinics were important constituents to be consulted, for example the Association of Ontario Midwives, the Manitoba Women's Health Collective, the Women's Health Clinic and the Women's Health Interaction. I also included in my analysis groups that represent specific "professional" constituencies including the Business and Professional Women's Clubs, University Women's Clubs, and the Federation of Medical Women of Canada. In addition, both D.E.S. Action Canada and Dalkon Shield Action Canada raise concerns about previous technological and medical advances that have harmed women. The other groups included represent women's drop-in centres, women's

institutes, women's action committees, women's research centres and resource centres including the Women's Centre of Montreal, the Young Women's Christian Association and the Vancouver Status of Women.[28]

The task of analyzing such documents is difficult as it requires the interpretation of women's groups' recommendations and arguments. The interpretation must remain loyal to the group's intentions and must consider the possible contextual influences on them. Marjorie Cohen asserts that "any interpretation can only be partial." The analysis of written work requires one to be "acutely aware of the political process of writing on a specific issue at a specific time."[29] A significant source of documentary analysis is not written; "the motives, philosophy and reasoning of particular groups cannot be fully understood by a single document."[30] As Dorothy Smith states, "the social organization of facts is not discoverable at the level of statement," but there do exist two levels of organization one being its production and the other being its reading.[31] I agree that "the shaping of the textual presence by the social organization of its production is hidden."[32] Even within these constraints, which the Commission did not account for, my analysis can be viewed as useful because it is one reading of how the women's groups responded to the very complex issues that threaten women's reproductive freedom and control.

While I identify different feminist strategies within the debate on NRGTs, there are already several other classifications of the different strands within the feminist discourse on NRGTs. Janice Raymond provides one such classification in her analysis of the feminist literature on NRGTs. Her classification system is twofold; radical feminists and reproductive liberals. Reproductive liberals encompass liberal feminists, most socialist feminists and postmodern feminists. Raymond's classification is based on the distinction between radical feminist arguments that critique the privileging of male reproductive goals (ie., father-right)[33] and the subordination of women's goals, and the feminist reproductive liberals' theories that adopt a freedom and rights framework and are seen as gender neutral. According to Raymond, reproductive liberal arguments lack an analysis of social relations, of male control over women's reproductive freedom and the connection to women's sexual freedom.[34] I contend that this classification system is not sufficiently nuanced to indicate a continuum of positions that are not only polar opposites.

Sue Cox outlined four feminist responses to NRGTs classified according to the degree to which feminists would allow NRGTs to intervene in the reproductive process. Cox classifies these as follows: non-interventionist (some radical separatist feminists and ecofeminists), anti-interventionist (most radical and most socialist feminists), moderate interventionists (liberal feminists and most socialist feminists) and pro-interventionists (early radical feminists and orthodox Marxists).[35] Pro-interventionists are those feminists that view artificial reproduction as desirable, moderate interventionists argue that high technological interventions should be made available and emphasize the importance of access to services and information. Anti-interventionist feminists consider these technologies to transfer too much control to existing powers and non-interventionists view these technological interventions as destructive of nature/women. The strategies for each position as Cox classified them is unfettered development for pro-interventionist feminists, a regulatory framework for moderate interventionists, organized opposition for anti-interventionist and a retreat from technological society for non-interventionist feminists.[36]

While Sue Cox's classification system does demonstrate the continuum of feminist positions, my purpose here is to situate the feminist positions in relation to the dominant liberal discourse's emphasis on individual rights and "choice." I classify three distinctive positions within the feminist discourse that I have named social relations, liberal rights and pluralist choice. The methodology that I have chosen to employ to indicate the continuum of positions is to map the feminist discourse. An example of this methodology is Lata Mani's analysis of *sati*. Although Mani was not examining a feminist discourse, the discourse map of specific positions allowed her to investigate "the conditions of production, the intersections, differences and tensions between them [the positions] and the competing and overlapping ways in which they were deployed."[37] The outcome for Mani was a discovery of "unexpected disjunctures, contests and determinations over what constitutes "tradition.""[38] Employing the same general methodology, my map also allows for the different positions to be mapped first in the feminist literature and then in the women's groups presentations. The goal of my continuum is to examine the constitution of the concepts such as individual rights and choice, and "self-determination" that originate in the dominant liberal discourse in respect to strategies regarding NRGTs.[39]

My continuum includes not only feminist authors but women's groups recommendations and therefore I borrow the concept "yes, but" to name the liberal rights position, and the term "no, not unless" to describe policy proposals emerging from the pluralist choice approach. I call the social relations position the "no, maybe never" approach to NRGTs.[40] The struggle for positioning also portrays how the dominant liberal discourse affects the politics of the Canadian reproductive rights movement. Within this struggle feminist strategies range from those of regulation at the liberal rights end of the continuum, to those of resistance to NRGTs at the social relations end. The pluralist choice strategies fall somewhere between the two, and all are placed on the continuum depending on their different attitudes to technology, to NRGTs, to the state and to liberal discourse.

The liberal rights position, one presented at the beginning of this chapter by Bonnie Beresford, frames the argument around women's equal access to services, based on an individual's right to consent to use these technologies. The liberal rights approach to technology is that it is neutral. Therefore this position is predicated on a use/abuse approach to NRGTs that allows these technologies to progress while its abuses are regulated by the state which is also considered neutral. This "yes, but" approach to policy proposals regarding NRGTs characterizes the RCNRT, even from the title of its Final Report Proceed with Care.

The pluralist choice position on technology is that it is the context in which the technology is applied that determines whether the outcome is beneficial or not. It takes a use/abuse approach to NRGTs but is not convinced that the state is neutral and therefore places the emphasis and responsibility for controlling the technologies on civil society. The pluralist choice proposals are characterized as "no, not unless" because their aim is the creation of a context where certain NRGTs can allow different women to make different informed choices that should not be controlled by the state but controlled by women. The main question for this approach is to ask who benefits from which technology.

The social relations approach considers technology to be inherently political and that a technology's ability to benefit women depends on why the technology was developed historically, and who developed it, which cannot be separated from how it is applied. NRGTs are considered interdependent and while a woman might benefit from one

technology this has negative implications for women as a social group. Therefore this position makes proposals that say "no, maybe never" because these technologies have developed from and for eugenics and population control. There is a certain perception that there needs to be a retreat from relying on the state and technology for social change as both are seen as patriarchal and capitalist and embedded in a society that is sexist, racist, classist, ablest and homophobic. The question that characterizes this position is why do we need these technologies? The social relations position offers a strong defensive stance against NRGTs for women as a social group. The liberal rights and pluralist choice approaches do not appear to consider the different circumstances of women's lives sufficiently and the effects on women as a social group. The social relations position offers critiques of both the liberal rights and pluralist choice positions regarding the dominant liberal discourse and exposes their embedded assumptions. Mapping these three positions demonstrates how the philosophy of individual rights on which abortion rights rested, does not challenge the existence of NRGTs, their development and their ability to displace social change.

The dominant liberal discourse on NRGTs asks if feminists demand abortion on the grounds of self-determination should we demand the same rights for NRGTs and if we oppose NRGTs then we are opposing abortion.[41] An underlying theme of my argument throughout this thesis is that the study of these positions is analogous to and deeply influenced by the abortion rights discourse, because "abortion has been one of the most decisive points of struggle between the women's movement and state power."[42] This statement indicates the importance of examining this discourse and why the liberal rights feminist position remains in the "pro-choice" stage with regard to NRGTs. This stage in the abortion rights movement realized that most women were not able to take up these "choices" and therefore advocated for reproductive freedom and for broad reproductive rights and not just the right to choose. This concept is central to the pluralist choice feminist position on NRGTs and shifted the discourse from "choice" meaning political rights, to substantive choice that recognizes women's plurality. Both positions advocate for the "autonomous and self-determined woman." The pluralist choice position does not uncritically advocate for women's individual choice and self-determination because while this is one element of

reproductive freedom a second element is that women make these decisions based on their social positions and their individual needs.

My research indicates that a dominant discourse names the problems, the parameters of the debate and thus the solutions. Once we employ a certain language our approach to an issue and the political strategy to deal with it changes, because discourse represents the way we understand our lives and our world. The dominant liberal discourse influenced the feminist positions that emerged, structured the NRGTs debate in Canada and affected the politics of the women's reproductive rights movement. I have chosen to examine this discourse more closely for several reasons. As Somer Brodribb cautions, feminists need to avoid a reactive liberal or neo-conservative norm and need to challenge liberal individualism.[43] According to Brodribb, feminists construct reactive arguments in support of women's right to choose because they want to stand in opposition to the "right" side of the argument. She urges resistance to a liberal democratic patriarchy and to liberal individualism that prevent creative alternatives that incorporate "women's autonomy and collective control."[44] Bonnie Beresford is one of these feminists who has accepted the prevalent "proceed with care" approach to NRGTs. This reactive position also reappears in the relationship between abortion rights groups and disabled rights advocates. For example, I examine whether the abortion rights groups, in their attempts to continue to argue for a woman's right to abortion, may want to stand in opposition to the "Right" on issues such as Prenatal Diagnostic Technologies that are explicitly related to abortion and pits them against disabled rights.

I emphasize the individual rights part of the debate because I strongly agree that "Canadians have far more to fear from smug complacency than from critical reflection about their democracy and their rights."[45] Furthermore, individual rights and access are closely examined because they obviously framed the Royal Commission inquiry in Canada. Louise Vandelac concludes that the Commission took the use of NRGTs for granted. This inevitably led the inquiry and the debate in Canada to focus on who is being denied access to NRGTs and to a discussion of freedom of choice and individual rights.[46] The Canadian government often shelves a Royal Commission's Final Report, but the government has used this Report

and its specific recommendations as a resource for policy-makers' specific actions and recommendations. [47]

V. Thesis Outline

Chapter One of this thesis is a review of the feminist literature on NRGTs. This review will allow for substantive conceptual definitions and the introduction of the three dominant approaches to NRGTs. The analysis reviews the critical exchanges between feminist authors considered representative of the principal three feminist positions defined in this chapter. The focus is the feminist authors' ability to critically analyze their assumptions concerning women's individual "rights" and "choices." I examine individual "choice" and "rights" in view of the history of the women's movement's struggle for abortion rights and the marketing of NRGTs. This chapter explains why it is important for feminists to realize that certain "gaps" have developed between women's lives and the concepts used to describe NRGTs.

Chapter Two extends the tripartite classification to an analysis of the written submissions and oral transcripts as presented to the RCNRTs by women's groups. This chapter explores the three feminist approaches to technological assumptions. The women's groups' recommendations regarding access, the decision-making process, prenatal diagnostic technologies, contract and compulsory motherhood and resource allocation are presented. The Royal Commission public hearings process and some of its management problems figure in this chapter, while Chapter Three considers the possible influences on the women's groups and the discourse that emerges.

Chapter Three presents possible motivations and constraints on the women's groups' ability to negotiate the NRGTs discourse. The main question is why certain women's groups supported the "freedom of choice" rhetoric, while others criticized this legacy of the abortion struggle. I answer this question with reference to the polarization of the debate between a "pro-NRGTs" and "anti-NRGTs" side. This chapter relates this polarization to the history of the reproductive rights movement that may have affected the discourse that emerged from

the women's groups submissions. I also consider why the NRGTs debate is a catalyst to the reproductive rights movement's continued efforts to better represent the diversity of women.

The conclusion to the thesis compares the three feminist positions as I defined them in both the literature review and the submissions. This chapter discusses the importance of articulating a position that goes beyond the politics of individual choice and rights and challenges the existence of these technologies and their ability to displace social change. This thesis is one limited moment in the NRGTs discourse and debate in Canada and in the feminist theoretical literature. A map of the feminist discourse is a useful tool to negotiate the debate and to demonstrate the importance of opening the discourse to alternative articulations. In the concluding chapter I explain what the Royal Commission process has meant for women's groups in Canada, for the policy making process regarding NRGTs, and for the politics of the reproductive rights movement.

ENDNOTES

1.Bonnie Beresford, letter, Globe and Mail 17 May 1994: A19. She was responding to Gwynne Basen and Shree Mulay, "Dangerous Designs on Human Architecture," Globe and Mail 30 March 1994: A21, and they were responding to Sightlines: "Make Womb for Mommy," Globe and Mail 17 March 1994: A9.

2.See Appendix A for a list of acronyms used throughout this thesis.

3.Beresford A19.

4.Renate Duelli Klein, "What's 'New' about the 'New' Reproductive Technologies?" Man-Made Woman: How New Reproductive Technologies Affect Women, Eds. Gena Corea et al. (Bloomington: Indiana UP, 1985) 64.

5.Renate Duelli Klein, "Doing it Ourselves: Self-Insemination," Test-Tube Women, Eds. Rita Arditti, Renate Duelli Klein and Shelley Minden (London: Pandora Press, 1989) 382-390.

6.An ultrasound uses high frequency sound waves to provide a video image of the fetus inside the woman's womb and can be used to determine fetal sex. Amniocentesis, usually performed in the sixteenth week of pregnancy, is a procedure in which a needle is inserted in the abdomen of a pregnant woman to withdraw a small amount of amniotic fluid that surrounds the fetus. The fluid can be analyzed for a variety of genetic "disorders" and fetal sex. Pre-implantation diagnosis is the diagnosis of sex or genetic markings before a fertilized egg is implanted into the woman's uterus. Transgenic transplantation is the implantation of one species' genetic material into another species. The artificial womb or ectogenesis is the attempt to construct an artificial environment in which a fertilized egg can be gestated outside of a woman's womb.

7.Varda Burstyn, "Breeding Discontent," Saturday Night (June 1993): 64. Burstyn was the co-chair of the committee responsible for making a submission to the RCNRT by the National Action Committee on the Status of Women.

8. On the Eighth Day: Perfecting Mother Nature, Part 1: Making Babies, film dir. Gwynne Basen, National Film Board of Canada, Studio D, 1992.

9.Gena Corea et al., Prologue, Made to Order: the Myth of Reproductive and Genetic Process, Eds. P. Spallone and D. Steinberg (London: Pergamon Press, 1987) 10.

10.Renate D. Klein et al., RU486: Misconceptions, Myths and Morals (Melbourne: Spinifex Press, 1991) 122. This book demonstrates how the debates and discourse regarding RU486 (which was not included in the Royal Commission mandate) are similar to those regarding NRGTs.

11.Annette Burfoot, "In-Appropriation-A Critique of *Proceed with Care.*" Women's Studies International Forum 18:4 (1995): 500. She cites several references to feminist activists and academics who spoke against the Royal Commission format; See Somer Brodribb, "ReproTech: Script for a new generation," Broadside (August/September 1989): 13-14.; Somer Brodribb and Louise Vandelac, Comments at the March 1987 CRIAW roundtable on feminist ethics, Feminist Ethics 2:2 (1989): 60-68.; or Noreen Shanahan, "No agreement on strategy," Kinesis 3:10 (May 1988): 10.

12.This group was a nation-wide coalition of women's groups, health groups, other groups and individuals, see Margrit Eichler, "Canadian Coalition for a Royal Commission on New Reproductive Technologies," feminist ACTION, 3:2 (1988): 4.

13.Connie Clement and Diana Majury, "Interview: Visions for Women's Reproductive Care," Healthsharing, (Spring 1988): 19.

14.Canada, Royal Commission on New Reproductive Technologies, Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies, Volume 1 (Ottawa: Canada Communications Group, 1993) 3.

15.For a discussion of some of these problems see Margrit Eichler, "Frankenstein Meets Kafka: The Royal Commission on New Reproductive Technologies," Misconceptions: The Social Construction of Choice and The New Reproductive and Genetic Technologies, Eds. G. Basen, M. Eichler and A. Lippman (Montreal: Voyageur Press, 1993) 196-222. Also see Christine Massey, The Public Participation Program of the Royal Commission on New Reproductive Technologies, diss., Simon Fraser University, April 1994; and Louise Vandelac, "The Baird Commission: From "Access" to "Reproductive Technologies" to the "Excesses" of Practitioners or the Art of Diversion and Relentless Pursuit ..." Misconceptions: The Social Construction of Choice and The New Reproductive and Genetic Technologies, Eds. G. Basen, M. Eichler & A. Lippman (Montreal: Voyageur Press, 1993) 253-272.

16.The question of whether a royal commission is an adequate tool for building an agenda was been thoroughly debated during Diefenbaker's term, the heyday of Royal Commissions, when they averaged four per year. See Liora Salter and Debra Slaco, Public Inquiries in Canada, Background Study No. 47 (Ottawa: Science Council of Canada, 1981) or Thomas Berger, Commissions of Inquiry and Public Policy (Ottawa: Carleton University School of Public Administration, 1978), or J. D. Maxwell, Royal Commissions and Social Change in Canada, 1867-1966, PhD Thesis, University of Michigan, 1966.

17.The Royal Commission summarized each intervention, categorized them by region and then assigned each to one or more of 12 sectors: 1-alternative and community health and social services, women's groups; 2-legal and human rights; family, religion, pro-life; 3-ethnocultural; 4- aboriginal; 5-labour; 6-concerned citizens; 7-infertile people; 8-consumers of NRTs, 9-families at risk, support groups; 10-groups and individuals representing people with disabilities; 11-medical community; and 12-industry and commercial interests. Canada,

Royal Commission New Reproductive Technologies, What We Heard: Issues and Questions Raised During the Public Hearings (Ottawa: Communications Group, September 1991) 7.

18.Sue Cox, "Strategies for the Present, Strategies for the Future: Feminist Resistance to New Reproductive Technologies," Canadian Women's Studies Journal/Les Cahiers de la Femme 13:2 (1990): 88.

19.See Sunera Thobani, "Fighting Sex Selection Technology," Sharing Our Experience, Ed. Canadian Advisory Council on the Status of Women (Ottawa: CACSW, 1993) 168-174 or "Making the Links: South Asian Women and the Struggle for Reproductive Rights," Canadian Women's Studies/Les Cahiers de la Femmes 13 (1993): 19-22. or "Keynote Address," Reproductive Rights and Reproductive Wrongs: Proceedings of a Conference held in Victoria, B.C. (Victoria: Ad-Hoc Committee on Reproductive Technologies, January 14-16, 1994) 10-21.

20.These quotes were made by Doug Collins in an editorial aired on a Vancouver B.C. television show. A description of this incident appears in Emma Kivisild, "Women Challenge CKVU," Kinesis (June 1983): 4, and "Mediawatch Demonstrators Form Protest at CKVU Studios", The Vancouver Sun, 17 June 1983, which are reprinted in the documents section of Ruth Roach Pierson, Marjorie Cohen, Paula Borne and Philinda Masters, Canadian Women's Issues: Volume I, Strong Voices (Toronto: James Lorimer and Company, 1993) 156-157.

21.Pierson et al. 156-157.

22.Sandra Harding, "The Method Question," Hypatia 2:3 (1987): 26.

23.While the research volumes and the Final Report are available in all of the libraries I consulted, very few submissions and no oral transcripts were available. The inaccessibility of these documents is not unusual but is not negligible either. In the case of the RCNRT, I was told by an employee of the RC that all of these documents were only available through the National Archives and that the only way to access them was to consult them in Ottawa or pay .20$ a page for photocopies. If I wanted a copy of the Final Report I could pay fifty dollars.

24.Eichler, "Frankenstein meets Kafka"149.

25.For example, I wrote to the University of Moncton and never received a response from Le Comité "Vieillir au Feminin" de l'Université du 3e Age. The West Coast LEAF association and the Yukon Indian Women's Association (YIWA) both stated that they did not intervene in the Royal Commission although they were indexed as doing so. I did receive the oral transcripts of the YIWA's intervention from the National Archives, but I was unable to find any records for the group in Moncton or for le R des centres de Quebec which was also listed.

26.Many groups did have a written record of their oral presentation and those groups which had not presented at the hearings provided me with letters, and briefs which were submitted. For the groups that I did not get a response from or which didn't have any documentation, I had to buy the oral transcripts of their presentation from the National Archives.

27.Mary Crnkovich, "In Our Spare Time," "Gossip": A Spoken History of Women in the North, ed. Mary Crnkovich (Canadian Arctic Resources Centre, 1990) xx.

28.For a complete list of groups and primary documents that I have consulted see Appendix B.

29.Marjorie Griffin Cohen, "The Canadian Women's Movement," Canadian Women's Issues: Volume 1: Strong Voices, Eds. Ruth Roach Pierson et al. (Toronto: James Lorimer, 1993) 3.

30.Cohen 3.

31.Dorothy Smith, The Conceptual Practices of Power: A Feminist Sociology of Knowledge (Toronto: University of Toronto Press, 1990) 70-72.

32.Smith 63.

33.For example "surrogate contracts" reinforce the contracting male as the essential, natural, biological parent whereas the "surrogate" is a substitute mother, see Janice Raymond, Women as Wombs: Reproductive Technologies and the Battle over Women's Freedom (San Francisco: Harper, 1993) 34.

34.Raymond, Women as Wombs 80.

35.Sue Cox, "Dissenting Voices: New Reproductive Technology and Feminist Analyses," diss, Simon Fraser University (1991) iv.

36.Cox, "Dissenting Voices" 12.

37.Lata Mani, "Multiple Mediations: Feminist Scholarship in the Age of Multinational Reception," Knowing Women, Eds. Helen Crowley and Susan Himmelwiet (Cambridge: Polity Press, 1992) 307. She studied the debates on *sati* under British colonialism and how her analysis of these debates were received in Britain and India to discern a continuity or discontinuity in the colonial discourse. *(Sati* is also called widow burning referring to a woman who sacrifices her life for her dead husband.)

38.Mani 310.

39.I am referring to the term as discussed by Maria Mies in "Self-Determination: the End of a Utopia,"Ecofeminism, Maria Mies and Vandana Shiva (Halifax: Fernwood Publications, 1993) 218-230. A further discussion of this is found in my second chapter.

40.The terms "yes, but" and "no, not unless" are borrowed from Liora Salter and Debra Slaco who use these terms to describe Royal Commissions' Final Reports on scientific development projects, in Public Inquiries in Canada. Background Study No.47 (Ottawa: Science Council of Canada, 1981).

41.Mies, "Self-Determination" 220.

42.The Ontario Coalition for Abortion Clinics, "State Power and the Struggle for Reproductive Freedom: The Campaign for Free-Standing Abortion Clinics in Ontario," Resources for Feminist Research 17:3 (September 1988): 113.

43.Somer Brodribb, "Delivering Babies: Contracts and Contradictions," The Future of Human Reproduction, Ed. Christine Overall (Toronto: Women's Press, 1989) 155. This anthology was one of the first collection of papers to examine a broad range of NRGT issues in a Canadian context.

44.Brodribb, "Delivering Babies" 149.

45.Don Carmichael et al., Democracy and Rights in Canada (Toronto: Harcourt Brace, 1991) 18.

46.Vandelac, "The Baird Commission" 257-259. The reader should keep in mind that Vandelac, also a member of FINRRAGE, was one of four commissioners on the RCNRT who was fired essentially because she filed a lawsuit against the government (this is discussed further in Chapter 3). Vandelac has made these conclusions regarding the RCNRT's based on her experiences with the Chair of the Commission and the way the Royal commission was managed.

47.The policies that are behind the ongoing neo-liberal restructuring process in Canada, including the U.S. - Canada Free Trade Agreement, and government downsizing policies, originated as recommendations in the Macdonald Report which was the Final Report of the Royal Commission on the Economic Union and Development Prospects for Canada. See Daniel Drache, and Duncan Cameron, Editors' Introduction, The *Other* Macdonald Report, Eds. Daniel Drache and Duncan Cameron (Toronto: James Lorimer, 1985).

CHAPTER ONE

REVIEW OF FEMINIST LITERATURE ON NRGTs: RETHINKING ASSUMPTIONS

As with any new social process or technology, we are granted an opportunity, through analyzing these technologies, to rethink and reorganize some of our most deeply embedded assumptions.[1]

I. Introduction

This chapter provides an overview of the main arguments and debates on NRGTs, introduces essential analytical concepts and identifies the main positions and issues that emerge in the feminist literature on New Reproductive and Genetic Technologies (NRGTs) from 1984 to 1991. In this chapter, I highlight the dangers of the individual "choice" and "rights" concepts by first situating these concepts historically within the women's movement's struggle for abortion rights and then locating them in relation to the marketing of NRGTs. I delineate and define three feminist positions and their approach to technology and to NRGTs. These three feminist approaches provide the framework for this chapter, and are placed on a continuum according to their relation to the dominant liberal discourse and whether they have critically assessed their assumptions regarding individual "rights" and "choice." One reason this is an important strategy is because of the "gaps" that have developed in the liberal discourse between its concepts and what they mean in the reality of women's lives. These "gaps" are expressed in terms of relations of power, depending on

who is authorized to speak and how and where the concepts are decided. The three different feminist positions are liberal rights, pluralist choice and social relations.

The center of the choice-making process in the liberal rights position on NRGTs then, is also the individual who is responsible for her own "choices" to consent to NRGTs or not. I name this position "liberal" because of its emphasis on individual rights that cannot be violated by the "good of the community" except in extreme cases.[2] I emphasize the centrality of "rights" in reference to its insistence that women should have the "right" to choose to reproduce by whatever means possible, as a constitutionally established freedom. The liberal rights feminist approach to technology is characterized as use/abuse, which means the technology is neutral and progressive but can be abusive. To control the abuse the liberal rights approach feels comfortable to call in the state to regulate the abuses and to ensure that before the procedure is performed the informed consent of the woman is obtained. The most important strategy for the liberal rights approach is to guarantee individual women access to these choices so they can weigh the costs and benefits. This position and these elements are explored in detail in this chapter as are those of the other two positions.

The pluralist choice feminist position on technology differs slightly from the liberal rights position. Although it also accepts the use/abuse model to describe technology, it does not analyze the technology from a position that accepts technology as always progressive. Instead of problematizing the technology it problematizes the setting in which the technology is applied. It is a more contextually specific approach that examines each technology as having the potential to be empowering or disempowering and recognizes that these choices can affect more than the individual making the decision. These feminists support women's informed choice to decide to, or refuse to use, NRGTs because some technologies may fulfil a "need" for certain women.

The pluralist choice feminist position shifts the NRGTs discourse from "choice" as a political right, to "real" *choice* that recognizes the diversity or *plurality* of women's material needs and situation. This approach highlights a woman's ability to choose to be an active agent in the decision-making process. This position assesses a woman's ability to retain control of the decision-making process and of her bodily integrity and dignity, and

raises several concerns including medicalization, access and the social construction of these "choices." According to this approach, NRGTs include a range of different technologies and each affect women differently.

The third position that I develop in detail in this chapter is the social relations feminist position that takes a critical approach to science and to technology. This position considers technology as inherently political and views NRGTs as a threat to women as a social group because NRGTs reflect and reinforce the sexist, racist, classist and ablest context in which these technologies are developed and applied. The historical and social relations in which they developed are built into them. This approach considers reproductive and genetic technologies interdependent: genetic technologies could not exist without reproductive technologies that present the researchers and doctors with access to their research material (ie., eggs and sperm). The social relations position extends the discussion of the problems associated with NRGTs as "choices." It examines the meaning of "self-determination" as a "right" or "a foundational condition for our well-being in society."[3] The social relations position focuses on the effects these technologies have on women as a *social* group, and the importance of reexamining the *relations* that govern women's roles in society. Motherhood is presented as an example of a role individualized, fragmented and commodified under NRGTs. Pronatalist and antinatalist ideologies, and underlying patriarchal and corporate control of NRGTs, are issues emphasized by this position.

This literature review presents the state of the literature at the time that women's groups were preparing to respond to the Royal Commission. As such, this thesis considers an underlying question of whether the Canadian women's movement could "popularize the feminist theory."[4] The women's groups were "advising" the state and attempting to persuade the Commission to adopt their proposals. In the process they may re-present the concepts and arguments from the feminist NRGTs literature to their constituents or/and to women. The material I have reviewed appeared between 1984, the date of FINRRAGE's formation, and 1991, the deadline for submissions to the Royal Commission on New Reproductive Technologies.[5] Why is FINRRAGE so important?

II. FINRRAGE

It was in April 1984, at the Second International Interdisciplinary Congress on Women in Groningen, Netherlands that FINRET (Feminist International Network against Reproductive and Engineering Technologies) was formed. This group was later renamed FINRRAGE (Feminist International Network of Resistance to Reproductive and Genetic Engineering).[6] Members of FINRRAGE's include natural and social scientists, doctors, lawyers, health activists, journalists, demographers, development workers, community organizers, teachers, social workers and academics.[7] In this thesis I identify the feminist authors who are members of FINRRAGE as social relations feminists.

It was in the 1980s that feminists, and in particular FINRRAGE members, initiated most of the debate on the crucial issues regarding NRGTs. These feminist analyses stressed a "decoupling from men"[8] as an important prerequisite for any analysis that attempts to understand the impact of these technologies on women. The "decoupling" emphasizes that while the main target groups of the NRGTs market are heterosexual "couples," women are the objects of their research and application. Women are the "patients" who have an "illness" called infertility and require the "cure" - which is a pregnancy. NRGTs bypass the problem of infertility and ensure fertilization and conception.

FINRRAGE's opposition to NRGTs has been partly based on the "differential treatment of poor, disabled, lesbian, black and foreign women by patriarchal medicine" which is reinforced by the "choices" offered by NRGTs.[9] The following is one of FINRRAGE's resolutions:

> We seek a different kind of science and technology that respects the dignity of womankind and all life on earth. We call upon women and men to break the fatal link between mechanistic science and vested industrial interests and to take part with us in the development of a new unity of knowledge and life.[10]

FINRRAGE believes that "there is no right to a child as property . . . neither for infertile nor fertile women, neither for lesbians, nor for heterosexuals." Resolutions like these have incited opposition from feminists who argue that FINRRAGE members and others are dismissing "the claims of infertile women" and trying to speak for "all women."[11]

There are genuinely unresolved problems here. FINRRAGE members respond to the implications that NRGTs have for women, and are obliged to reexamine their assumptions regarding motherhood and its underlying ideologies of patriarchy, capitalism and technology. Many FINRRAGE members and social relations feminists feel their arguments have been misinterpreted and distorted as essentialist, absolutist and as victimizing women. Therefore, these feminists have begun to clarify some of their arguments. This is required because, according to Gena Corea, too many feminists are taking "a tolerant view of the technologies simply because we are not yet able to fully articulate why the benevolent rationales for these technologies clash with our sense of our own dignity and worth."[12]

III. "Gaps" between Language and Reality

In the NRGTs debate there are "gaps" between the language being used by the scientists and the underlying issues. These "gaps" are comparable to what Canadian sociologist, Dorothy Smith described in another context as "gaps and disjunctures [that] appear between the actualities of people's lives and the categories and concepts laid down for . . . textual realities."[13] When feminists develop and use concepts we must make a conscious, reflexive effort to examine the connections between the theory and the meaning ascribed to women's lives depending on their specific circumstances. Language can serve to obstruct real meanings. If NRGTs are called "cures" what exactly is the "illness"? If these procedures are considered "developing," is it clear that they are "experimental" and that the women are "research subjects" and not "patients"? The gap is between "the world known in experience and the textual realities" and is expressed as a power relation depending on who is authorized to speak and how and where the concepts are formulated.[14]

The science industry maintains its power by using definitions, language and ideologies that can explain or justify its research and obscures the real meaning. For example, scientists are really talking about women and their bodies, not "maternal environments" or "vessels".[15] Science's objective reasoning can obscure the real motivations behind the research.[16] Some fertility specialists have provided women with misleading information or more accurately misinformation regarding IVF success rates and its risks.[17]

There also exists a "gap" between women's perception of success and the doctors'. Success for a doctor is bypassing the blocked fallopian tube and for a woman to conceive even if she subsequently miscarries. For her, however, success is surely nothing less than a healthy child. The woman's primary "desire" is to have a child whereas the doctor is providing a health service, and the doctor's goal is to treat a disease.[18] A professional such as a doctor takes a woman from her social relations to a place where she is constructed as a "patient" or whose "disease" is treated and "where she is detached from the actualities of her living."[19]

IV. Contradictions in the "Rights" and "Choice" Discourse

Historically, the "choice" discourse has dominated the struggle for abortion rights, as articulated in the "pro-choice" movement in many Western countries. The Canadian women's reproductive rights movement has a similar history to the United States movement. The Canadian context is explored in more detail in Chapter Three. Initially, in the United States, the reproductive rights movement's discourse described abortion as "an equality right," as a struggle to stop discrimination against poor women. Poor women were risking their lives to obtain dangerous abortions but the "rich can pay to circumvent the law" and obtain a "safe" abortion.[20] The move to a "pro-choice" slogan was criticized by some as a tactic to allow those women who may not necessarily support abortion, to support "choice." Those who could support "choice" but not abortion could avoid implication; what others do with the choice to abort is their decision. The "right to choice" combined the struggle for "equality" with "freedom" and self-determination for women to control their bodies and lives.

In the 1980s "pro-choice" became the "right to decide" and the movement used extreme cases such as rape and incest to argue that women needed to have this "right" and that a ban was unreasonable. The outcome of the struggle was laws that banned abortions except in extreme cases.[21] Anne Finger describes how the reproductive rights movement had exploited women's fears and stereotypes regarding disabilities in the struggle for abortion rights.[22] Abortion demands were first articulated by middle-class women who were less concerned about economic rights than political rights. When the reproductive rights

movement realized that most women were not able to make "real" choices, it demanded "reproductive freedom" and broader reproductive rights.[23] Reproductive freedom in the context of abortion rights, referred to broad "reproductive rights" not just the "right to choose" abortion. Reproductive freedom recognizes that abortion is not an issue for all women because the right to abortion coexists with forced sterilization of disabled people for example. How have the meanings for "rights" and "choice" been translated from the abortion rights movement into the NRGTs debate?

There is an underlying similarity between abortions rights and the reproductive rights movement, and the NRGTs debate and the disabled rights movement. The issue of NRGTs offers the women's movement an opportunity to bridge the gaps with women with disabilities, and to mediate contradictions that emerged in the abortion rights struggle. The concerns raised by the disabled rights movement regarding abortion are also applicable here. Feminists argue that NRGTs, specifically Prenatal Diagnostic Technologies (PNDT), displace the substantive social change that people with disabilities require to live an "alternative" lifestyle. These feminists are not arguing that there are certain conditions under which women should or should not have the right to abortion, but that a woman's right to abortion should not be solely dependent on certain circumstances and her decision should not be only made because her fetus is diagnosed with a disability.[24] PNDT only places the decision regarding disabled people onto individual women; the disability rights movement wants to place that responsibility onto society for full rights for all disabled people, not just for a right to live, but to live an "alternative" lifestyle that includes sexual freedom and parenting, for example.[25] While the reproductive rights movement has focused to narrowly on individual choice and did not recognize the interconnections between forced sterilization and abortion rights, the same connections cannot be ignored regarding NRGTs.

In regard to abortion, the United States and many other state governments and courts have translated "choice" from substantive demands for real choices, to a liberal demand to prevent active government interference in individual, "private" choices.[26] This is similar to the NRGTs debate and the way researchers, doctors, pharmaceutical companies, etc. have taken up the "choice" and "individual rights" language as a marketing tool for NRGTs. These "marketers" tell women that they should have the right to choose these technologies

because they deserve to try to procreate through whatever means possible. According to Raymond it serves the marketers well - "knowing that many will accept the rhetoric without questioning the reality of what is promoted as choice."[27]

According to Margot Young, the politics of choice "functions as an important legitimizer of social relations and as an important indicator of the assignment of agency to the individual."[28] It may be false to view NRGTs as "choices" and as part of women's freedom to choose because the "gap" between "choice" and their circumstances is wider for some women than others. Is "choice" for choice's sake about liberty, about being free from constraints and not about social justice? The question of whether NRGTs represent 'choices' for women will be examined in relation to the three feminist positions I have outlined. While defining the different feminist positions on NRGTs, I assess whether each position fills the "gaps" in the "rights" and "choice" language in the dominant liberal discourse used to market NRGTs.

V. Liberal Rights Approach

Liberal rights feminists consider NRGTs as genuine choices for individual women facing procreation problems. This approach has the philosophy of individualism at the center. It hinges on a belief that individual rights and freedoms are always more important than community rights and that community rights will take away from individual rights.[29] Indeed, it should be noted that this philosophy does not even necessarily recognize that communities have rights. I explore the liberal rights approach to NRGTs through several authors, in particular Laura Purdy, Antoinette Sedillo Lopez, Barbara Menning, and Lori B. Andrews.[30] The liberal ideological culture teaches women to "double think" that individual solutions can work for the collective good. This culture, which influences the liberal rights approach, allows women to be unconcerned about how an individual "solution" may disadvantage others if they are immediately advantaged themselves.[31]

According to the liberal rights approach women can make the choice to assume the risks because these technologies will be "rigorously screened" and therefore there would be "no danger of inappropriate application."[32] This parallels the argument that contract

pregnancy should be "stringently regulated" so it could then benefit women.[33] In such an approach an important issue is "the extent to which authority to make decisions concerning reproductive potential should be allocated to individuals rather than to governments."[34] This issue can be approached in two ways, one emphasizes rights and the other emphasizes individual autonomy. The first way interprets government regulation as interference and the second accepts the interference since it is regulation in the interest of greater individual good.

Instances of such a liberal a rights-based approach can be arranged on a continuum between libertarian and interventionist policies. Purdy, for example, concedes only that the worst-case scenarios can be regulated by the state based on the principle of the greater good. This is the only allowable limit to individual freedom. Moreover, she urges those feminists who want to limit a woman's individual freedom because of harm done to others, to provide a strong case explaining the harm to the "greater good."[35] Lopez, for her part, concludes that women can choose to use reproductive technologies "unhindered by state interference" and that only "oversight and record keeping regulation" were required to address societal needs.[36] Not surprisingly, such libertarian bravado runs up against typically modern problems. For example, while opposing the state prohibition of surrogacy contracts as preventing individuals from making decisions, Lopez must nevertheless concede the need for minimum protection such as the enforcement of minimum wages and the psychological evaluation of all parties.[37] The central characteristics of the liberal rights position that are dangerous for women's autonomy are its uncritical acceptance of informed consent, of NRGTs as technological fixes and as alternative reproductive choices for infertile couples.

A. Informed Consent

The liberal rights discourse that emerges from this approach depends on the state to "guarantee" these "choices." The two ingredients equal access and informed consent are needed for women to decide to use these technologies or not. Feminists who take a liberal rights position do not discuss the implications of access when it is extended to women who are not infertile themselves, to women who are post-menopausal, or for women to undergo

an unlimited number of IVF cycles. Equal access simply means that no woman should be discriminated against in any way that would prevent her from choosing these technologies. The discussion of NRGTs becomes an access issue that presumes a potential clientele and may deflect from a critical analysis of the technologies themselves. By focusing on informed consent, the liberal rights approach assumes that NRGTs represent "viable" choices for which women should have access. It does not sufficiently address the interrelationship between individual autonomy, informed consent and state regulation. As Maria Mies insightfully argues, "in spite of all the talk about 'autonomy' and 'individual choice' when it comes to protecting the interests of individuals they [liberal feminists] have to call in the state and ask for its control."[38]

The practice of NRGTs and any type of medical procedure based on the principle of informed consent means that women are told the risks of the procedure and given a form to sign which states that they have consented to undergo a procedure. Informed consent is a static legal, medical requirement for doctors to obtain a legal signature on a consent form after a woman is told of the risks involved in a procedure (at the point of signing the woman, in most cases, has already agreed to the procedure or might be already prepped for the procedure even). However, Menning maintains that informed consent is sufficient justification to allow these 'couples' to make the choice to assume the risks.[39] Those who oppose this uncritical use of informed consent emphasize that obtaining informed consent was pressed on the medical profession and is "seldom fulfilled". At best informed consent is a "one-way conversation with the power all in the doctor's hands."[40] The doctor uses it mainly as "legal protection" for him/her and for the hospital, due to the fear and the cost of malpractice suits.[41] For the patients, informed consent usually means agreeing and accepting the consequences of a procedure. Informed consent could entail subtle forms of coercion and persuasion depending on who provides the information. Furthermore, there is an implicit assumption that the decision-making process allows a woman to consent but it does not allow for "informed refusal". The "right not to know" the results is even further marginalized when for example a doctor has performed a test (with or without informed consent) and the woman does not want to know the results.[42]

B. Technological Fix

It seems that the liberal rights approach reflects an underlying faith in a "technological fix". For example, Menning makes a rather shocking statement when she said that there were no more risks with IVF than "the usual maternity risks."[43] I interpret this to mean that she either views maternity as highly risky, impersonal and intrusive or she views IVF as a simple 'natural' procedure, with very few risks. The latter is an absurd statement considering what IVF actually involves.[44] This position believes in the ability of NRGTs to provide a technological fix to the problem of infertility because this approach considers the potential of high technology as a "liberator" and problem-solver. These feminists thus accept the technological fix that might be offered by NRGTs without considering whether the technology addresses the initial causes of the "problem."

The liberal rights approach bases its approach to NRGTs rests on its conception of technology that allows these feminists to argue that state control can be minimal. Menning approaches NRGTs as if they are neutral when developed and the state need only ensure that they are applied correctly so that the abuse is prevented. She further assumes that technology owes infertile couples the option of NRGTs because these couples have often been victims of other technologies such as the Dalkon Shield Intrauterine Device or DES, which this one could possibly correct.[45] Menning states that infertile women will incur the risks because "without IVF there is a certainty of remaining childless."[46]

Menning presents the infertile as having a privileged standpoint from which to evaluate these technologies. She states that if anyone has already had children this "disqualifies them from any understanding of the pain of childlessness" and they should not say that IVF should not be researched or developed.[47] Purdy would agree with Menning's statement as she says: "it is all too easy to evaluate them [the infertile] solely from our own privileged perspective, forgetting that it may blind us to the kinds of choices daily faced by some of those about whom we are arguing."[48] Purdy identifies a "radical" call against NRGTs as one for a "natural progression of pregnancy" and "ideal motherhood."[49] Both authors group "radical" feminists and fertile women together. Feminists are thought to either be fertile or anti-family and anti-technology and therefore unable to make judgements about

infertility. The focus of the liberal rights position is a woman's right to bear a child; what is most important is not whether to bear a child but when.[50] Rebecca Albury argues against this position because she states that using the liberal rights position if the right to bear a child is allowed to be fully extended to included by any means possible, this would obligate the state to provide IVF. While there remains a denial of the differences within society based on race, class and sex.[51]

C. Alternative Reproductive Choices

Corlann Bush pithily characterizes the liberal rights approach when she says that: technological change may make things better but will not necessarily make things different. In contrast to technological change that Bush describes as material change, social change that is both social and personal is thought to make things different and usually worse.[52] The liberal rights approach does not include any significant analyses that would lead to role changes, for example between men and women, or any change in the sexual relations. This approach accepts the definition of infertility as a medical problem, and wants to solve the problem without disrupting the present social relations by simply offering more "choices". Mies identifies this argument as representative of a new NRGTs discourse that had emerged in this "liberal" framework-one that went from referring to 'couples' and infertile women, to speaking of 'reproductive alternatives'."[53]

Given the "rights-choice" articulation of the feminist discourse in reproduction, however, Menning correctly points to the contradiction of otherwise "pro-choice" feminists. Feminist opponents of NRGTs are said to be against the "choice" these technologies offer to infertile women.[54] Maria Mies provides a particularly critical overview of Andrews' article; she describes this position as one that is using the "right to abortion" arguments to argue for a right to NRGTs.[55] Therefore, it is to follow that if we advocate a ban for NRGTs, the government can restrict or ban contraception and abortion. If we do not protect the right to privacy in a woman's decision-making, we "risk losing choices" in this area.[56]

In summary, in a liberal rights approach to NRGTs, the technologies are neutral and the state can regulate their application only to ensure equal access and informed consent and

to guard against coercion and abuses. If these technologies are not offered, it is the infertile women who suffer, as does the feminist ideal of women as autonomous individuals. In short, this approach sees only the "possibilities" that these technologies may offer and not the social, political or economic context in which they emerge. There is no questioning of who is defining infertility and how, and no critique of access. Maria Mies' critique is that there is a direct corollary between liberalizing these technologies and state control; more "reproductive alternatives" means increased legal, state and medical control over these processes will be needed and more control over women's bodies. The very narrow viewpoint of the liberal rights approach ignores why these technologies were developed and does not take a global view of these technologies. Obviously this approach to NRGTs accepts the individual rights/choice ideology quite uncritically. The pluralist choice approach brings some of these concerns ignored in the liberal rights approach to the forefront but it also remains within the "choice" paradigm.

VI. Pluralist Choice Approach

A liberal rights approach accepts the "choice" offered by NRGTs as an end in itself and does not attempt to account for class, gender and racial oppression or distinguish between technologies. For the liberal rights approach the individual can exist outside of society as an unencumbered individual. Shulamith Firestone, writing in the early 1970s, argued that NRGTs offered the final preconditions for a feminist revolution that would allow for the "liberation" of women and was optimistic that women could control these technologies.[57] This type of 'liberation' ideology considered women to be freed from male control when sexuality was separated from reproduction. NRGTs could, in the same way, "liberate" women, as women could procreate without having sex with men. Linda Gordon, in her historical account of birth control in America, illustrates how the "technology" is often taken to replace the "social activity." She argues that there is a lack of analysis of women's overall power, and the social and political motivations behind the development of reproductive control (ie., population control). The continued reliance on abortion reflects how "birth control was as much a symptom as a cause of larger social changes in the

relations between sexes."[58] As Petchesky a pluralist choice feminists states, the effectiveness of any technique or technology depends on the social context from which it emerges.[59]

Pluralist choice feminists examine the technologies as separate "choices" because while some may be the source of alienation for women, some may serve women's needs depending on the context in which the women are situated. This approach takes a more "social" view of "choice" and of technology. One compilation of articles titled Reproductive Technologies reflects this pluralist choice approach. The starting premise for one arguably representative author is that these technologies "meet real needs for real women."[60] Michelle Stanworth states in another way that NRGTs have brought "triumph over natural obstacles for the satisfaction of human needs."[61]

The pluralist choice approach emphasizes the complexity and concreteness of the context in which NRGTs are applied and the inability of a "technological fix" to meet all of women's needs. This approach is represented in the writings of Petchesky, Stanworth, Nsiah-Jefferson and Hall, Asch and others. This approach recognizes that the impact of NRGTs for some individuals may be positive, but for society it is "mixed at best and negative for certain groups" depending on class, race and culture.[62] This is because, as Rosalind Petchesky argues, in opposition to rights are needs that "exist only in connection with individuals and within concrete historical circumstances."[63] Petchesky presents society as not so much made up of isolated individuals but as members of social groups with distinct needs. These needs exist within society where social relations dictate how they are fulfilled.[64] I explore the most prominent authors to take a pluralist choice position, who place emphasis on the themes of reproductive freedom and informed choice as they emerged in the pluralist choice position.

A. Reproductive Freedom

Integral to the pluralist choice approach is the conceptualization of "reproductive freedom" as not just about a "right" to choose. Women face and make "choices" but they are always critically shaped by "when, under what conditions, and for what purposes" they are made.[65] According to Petchesky, the essential ideas of reproductive freedom are

contradictory. One component of reproductive freedom is that women must control their own bodies and procreative capacities. Second, women must make these decisions based on their social position and needs. The first element of reproductive freedom is based on an individual who possesses 'natural' fixed rights whereas the second component is part of a social whole in which conditions are changeable and rights are socially determined.[66] Petchesky concludes that reproductive freedom combines the two because biology is always mediated by social and cultural organization. Furthermore, she rejects a "natural right to procreate indefinitely or at all" because reproduction and parenting are social relations.[67] There is some optimism in this approach that women, not the state, can "create the political and cultural conditions so that women can shape these technologies."[68] The focus shifts from informed consent to informed choice and to a discussion about how to improve the choice-making process for women.

B. Informed Choice

A central tenet of the pluralist choice position is informed choice which is structurally different from the practice of informed consent. The informed choice model endorsed by the pluralist choice authors assumes the woman is an expert on her own experience. Furthermore, if a woman is able to make an informed choice this means she is provided with multiple and viable options from which to choose, and clearer women-based knowledge as the grounds for choosing. Pluralist choice feminists offer "informed choice" because they value women's ability to decide what is best. Her decision may be based upon her own individual desires or upon her consideration of the consequences of her decision on others. Also this concept is important because the pluralist choice approach to technology is that the problems are not a function of the technology but of the context, and therefore women need education and information so they can shape their experiences. The pluralist choice position has problematized the practice of informed consent by emphasizing the complexity of the decision-making process. This model requires that the information must fit into the reality of the women's lives and that there must be interaction and dialogue between the doctor and the patient. The information must be provided so she can make a

choice, not so she can simply decide to consent to the risks.[69] This approach can illuminate certain problems with both the provision and the reception of information and thus the ability of women to make choices. It acknowledges that there are many barriers that influence the provision of information and inhibit the woman from making a "real" decision or substantive choice.

First, the doctor often tailors the information to meet his/her needs. One reason a doctor may do this, with prenatal testing results, is the fear of "wrongful life suits."[70] Should the results indicate that the fetus is "abnormal" the medical practitioner may "inform" the woman of the option of aborting. The practitioner may not provide complete information regarding the best and worst case scenarios, and alternatives such as bringing the pregnancy to term, indeed s/he may not even know what those might be.[71] The type of information that needs to be provided to women not as an "alternative" but in all cases, can be found in books published by the Boston Women's Health Collective including Our Bodies, Our Selves. This group has been behind the impetus for the spread of self-help education for women and has created and promoted innovative knowledge about women's health by and for women.[72] Self-help may not be all women require in this situation but at the very least the woman should have a frame of reference outside what the doctor provides. For example a woman could be offered an opportunity to talk to a mother who is raising a child with a similar disease. In the informed choice model, the participation of the wider community lessens the reliance on the state to enforce informed consent.

A second barrier to the exchange of information and the ability of a woman to arrive at a decision she is comfortable with is the doctor/patient relationship that is usually hierarchical and involves two conflicting value systems. In this relationship the doctor's value system based on an "objective" perception outranks the subjective experience of the patient. Once the doctor defines infertility as a medical condition the doctor can exercise his/her power over the patient. The doctor is considered to have the knowledge, skills and resources to administer the "cure". The doctor claims that everything comes down to observable fact that depersonalizes and objectifies the woman. For example, the inference behind "routine" ultrasounds to determine precisely when the baby will be born is that women cannot possibly know when their last period was.[73]

Isabelle Brabant, a practising midwife, explains how a pregnant woman will have difficulty finding a doctor who will accept her as a patient if she refuses to undergo routine ultrasounds or other forms of medicalizing her pregnancy. This is because doctors consider women who wish to allow their pregnancies to progress "naturally" as "risks," not only to themselves and the baby, but to the doctor anxious of being sued.[74] The doctor practices "defensive medicine" when he/she takes the route perceived to be "the least wrong" or cause the least repercussions for the doctor.[75] For a pregnant woman this may mean that her "pregnancy is tentative."[76] This means a woman may decide to undergo prenatal testing so she can prepare for the care of the child or because she is considering what to do if something is "wrong" with the fetus.[77] This technique then allows for "selective termination" of the fetus considered at "risk" or in IVF, which often results in multiple births, it can be used as "selective reduction" of the number of fetuses.[78] Have these "choices" become obligations and could a woman's medical care be compromised if she refuses to undergo certain procedures?[79]

A third barrier that influences the exchange of information is that the doctor is often a man. If the doctor is a woman she has been educated and socialized in the same way as her male counterparts. Nsiah-Jefferson and Hall bring the analysis one step further and focus on the predominance of white-Anglo, male doctors. This means that often there is a further cultural barrier that may affect the way "choices" are interpreted and offered.[80] Neutrality and objectivity are claimed by some doctors while others just throw up their hands and admit that they, like everyone else, have been socialized. Patricia O'Reilly argues that those who "throw up their hands" are worse than those who claim unbiased objectivity. This is because these doctors acknowledge that they are contributing to the problem and that they are helpless to do anything about it. These doctors continue to practice within a profession based in scientific neutrality and acknowledge that their objectivity is biased.[81]

The pluralist choice position unlike the liberal rights one, critically examines "informed consent" and the role that coercion can play in the decision-making process. It proposes instead "informed choice" and emphasizes the possibility that women could take control of the "choice" process with the help of the community and by considering women's "needs". The pluralist choice position is critical of leaving the state with the responsibility

to intervene to ensure that women are fully informed. For most of these feminists that take this approach NRGTs do represent a choice for certain women and do solve certain problems. This position does not sufficiently question why women would want to use NRGTs except to say that different women need these technologies, but at the same time the social relations position is problematic because it may go too far and not recognize that these choices represent a certain "desire" or "need" for women who want to have a child. How have these "choices" been constructed and why do social relations feminists feel it impossible to use the term "need" in reference to NRGTs while at the same time pluralist choice feminists feel it is impossible not to use the term "need'?

VII. Social Construction of "Choices"

The pluralist choice approach does not question the content of any particular choice, but believes that different women make different choices, not necessarily wrong or right ones.[82] Pluralist choice feminists fear that women's reasons and conditions would have to be ranked if the motivations to choose are questioned. In particular this questioning may lead to a discussion about the difference between an infertile and a fertile woman's desires to have children and between social and biological/genetic parenting.

Christine St. Peter, in an article focusing on discursive strategies in feminist discourse of NRGTs, points to the development of a too univocal discourse among social relations arguments. A discourse that provides an important discussion of the social construction of "motherhood" with its attendant "needs," but one that runs the risk of painting such needs as merely social, almost a form of false consciousness.[83] The pluralist choice feminists would agree with the social relations feminists that the "choice" is socially constructed and that as Williams implies, women may better understand why they are choosing to use IVF if they are conscious of the social construction of the need to mother. At the same time the pluralist choice position maintains that women do have "needs" and "desires" and that the social relations position does not pay adequate attention to these concepts. The danger in the social relations position is the denial of any validity in the idea of "need" among women who want to use these technologies.

The type of study undertaken by Williams does contribute important insights into an understanding of the difference between social parenting and "genetic" parenting. Williams concludes, after interviewing women who had undergone IVF, that the women's motivations were mainly socially constructed and that their lack of understanding of the influence of social factors reinforced their susceptibilities to the IVF marketing.[84] The women that Williams interviewed were not all 'childless'; some women had adopted children, some even had children who were genetically related to either the woman or her partner but not to both.[85] The critique that those feminists who argue against NRGTs do not articulate "convincing rationales for childlessness"[86] is specific only to certain situations because childlessness is only a reality for some IVF clients as illustrated in Williams study. Therefore, there may be a difference between wanting to bear a child that is genetically related and wanting to parent a child no matter what. Stanworth argues that these same technologies that emphasize genetics also put genetic parenthood in jeopardy because donor sperm or/and donor eggs can be used.[87] However, in response to Stanworth, one could argue there are very few cases where the fetus is not related to either the woman or her partner except in gestational contract motherhood. While the pluralist choice approach may question the "motivations" to biological motherhood, it does not call enough into question the notion of compulsory motherhood. First, as Williams concludes, "a lack of understanding of the role that social factors play in parenthood motivation reinforces the continued construction of infertility as a medical problem."[88] Second, as Lene Koch points out, if an involuntarily childless woman has never allowed herself to consider not having her own children the only possible scenario for her is having a biological child. Therefore, with the advent of IVF this woman may feel obligated to seek out IVF as the only possible solution.[89]

The pluralist choice feminists emphasize that infertility is socially defined and constructed. After all, the definition of infertility varies from country to country.[90] This approach is very aware of the infertile women; it is one thing to argue against these technologies, but quite another to make this argument to Lesley Brown or any other infertile women.[91] Thus the pluralist choice approach looks to deconstruct "the stigma of infertility."[92] Stanworth accuses the social relations feminists of portraying women as incapable of making their own decisions, a concern also raised under the liberal rights approach.[93] The pluralist

choice approach asserts that many women do have the agency to exercise control over their lives.[94] The context of their decision affects women's ability to do so and affects the results of their decision, though the weakness in this approach is that it does not recognize that infertility has been redefined by these technologies and that this redefinition is politically driven as well as medically driven. However, both the pluralist choice and the social relations position raise medicalization as a concern with regard to NRGTs.

VIII. Medicalization

According to Laura Woliver since infertility is defined as a medical problem and the solution is thought to be technological, NRGTs have the potential to substitute for social change.[95] This statement typifies the social relations position on NRGTs that says that the technologies are individual "solutions," they do not solve "infertility" or "disability" and do not address the root causes. If the goal was to solve or even prevent these problems real social change would be needed. For example, Maria Mies identifies how fertility became a disease with the contraceptive movement and actually replaced the urgency to change the unequal sexual relationship.[96] The same can be said for NRGTs and the medicalization of infertility. One example is how the technologies construct infertility as a problem that occurs in "older" women who delay childbearing into their thirties and forties. However, though there is a recognition that women should bear their children at an earlier age there is no move to try to allow this to be a viable option. There is a need to understand why women delay their childbearing and to change the conditions requiring one to delay. One of the reasons that is often put forward by "choice" feminists and by NRGTs marketers, is that women do not want to jeopardize their careers and feel that they must make a "choice" between having a baby or having a career. Furthermore, if they decide to go ahead and have a child and a career they face a double work day. Technologies like IVF suggest that all that is needed for these women is a technological fix, that they continue to delay their childbearing and if they are diagnosed as "infertile" they can then use IVF services. If women delay childbearing beyond the age of thirty-five, they are told that the chances of conceiving a fetus with Down Syndrome are increased. These women are offered PNDT as

a way to diagnose whether the fetus has Down Syndrome. These examples demonstrate that "technological fixes" take away the pressure to change the systems that cause the problem and displace the need for social change. These technologies take away the urgency to introduce flexible labour markets and jobs, to clean up the environmental contaminants, to provide services to people with disabilities. There is definitely some overlap between the social relations position and the pluralist choice one as both emphasize the importance of the social, cultural and political context of infertility. But the social relations feminists give emphasis to the social and political institutions that have historically attempted to control women's procreative capacity and continue to do so, even in promoting NRGTs.

Both pluralist choice and social relations feminists underline concerns regarding medicalization as one way that women lose control over their bodies' capacities. The term "medicalization" refers to the type of situation in which the medical industry controls different stages in women's "normal" lives, from menstruation to menopause and infertility, and frames these stages as medical problems or as "illnesses". These stages have become medicalized; "medical professionals have become the experts on normal experience or social problems."[97] This increased exposure to the medical industry has left women vulnerable to increased iatrogenic or medically induced risks.[98] The medical profession intervenes and attempts to correct some of its own mistakes, but *causes* health problems and ties women on "the medical treadmill."[99] Some of this harm resulted from DES or diethylstilbestrol,[100] intrauterine devices like the Dalkon Shield, estrogen replacement therapy and unnecessary hysterectomies and cesarean sections.[101] Women who suffered infertility problems because of these technologies and procedures, are now prime candidates for NRGTs, which, in turn, will cause unknown long term harm. Rothman underlines the importance of breaking the medical dominance so that women's experiences determine medical practice, not the other way around. She asks if childbirth, infertility or menopause are medical events only because medicine has a monopoly on their definition as "illnesses" and on their treatments?[102]

Nsiah-Jefferson and Hall ask: "if infertility is a medical problem why do the low-income and women of color not receive a treatment program?" In response, these authors point to the barriers to access, the cost of the procedures, and the highly selective clients chosen for them. Infertility rates are higher for low-income women and women of color

because their general health status is lower due to nutritional deficiencies, sterilization, unsafe birth control, poor working conditions and environmental contaminants.[103] As Nsiah-Jefferson and Hall state, the salience of the issue of infertility "will vary with class position, racial or ethnic identity."[104] Nsiah-Jefferson and Hall propose that more women and especially low income and women of color would benefit if the funds were allocated to addressing the structural causes of infertility. Some solutions include improved education, health care, housing and working conditions. These authors "urge that the health and reproductive concerns of women of color be put at the center of feminist analysis." They recommend this perspective because gender, race and class are "interlocking systems of oppression" and health care is a social system.[105]

Both the pluralist choice approach and social relations approach are sensitive to the effects of medicalization. This is unlike the liberal rights approach to NRGTs that considers it possible to have "more medicalization of pregnancy and childbirth and more self-determination of autonomy for women over reproductive processes."[106] The pluralist choice approach deconstructs the problems with the strict medical definition of infertility but hesitates to question the "need" for NRGTs or the politicization of infertility. The feminists who take a pluralist choice approach remain within the choice paradigm although they emphasize substantive choice and structural equality. To understand why this is so, I will locate the three positions within the historical context of the idea of self-determination and then consider how the question of women's individual "needs" is addressed by the social relations feminists.

IX. Historical Context of "Self-Determination"

Maria Mies, a social relations feminist, portrays the liberal rights argument that NRGTs present a dilemma regarding women's self-determination as follows:

> (a)if we oppose the new reproductive technologies, we should oppose abortion . . . and (b) if we demand the right of abortion in the name of self-determination and reproductive autonomy, we must concede the same right to the woman who decides in favour of one or the other new 'reproductive alternatives'.[107]

Liberal rights advocates do not want to risk losing the advances made by the women's movement and therefore they have equated the restriction of NRGTs with the possible restrictions of abortion rights. Those who emphasize a liberal rights approach are left to argue that the state should ensure equal access to these technologies because it is a natural extension of the dominant liberal discourse. If the state ensures that women have the right not to reproduce then it follows that women should have the right to reproduce. This approach continues to make individual rights assertions like "our bodies ourselves" and the "right to choose" to have an abortion. These assertions eventually fragmented the feminist movement and forced it to "reveal the inadequacy of individual rights."[108]

In the pluralist choice approach there is a recognition that individual "rights" do not challenge the social structure. However, this position still asserts that there will "always remain in society a level of individual desire that can never be totally subsumed."[109] In other words,"different circumstances will cause women to make different decisions" just as different technologies may be applied differently to particular groups of women.[110] The pluralist choice approach sees the potential for women to "seize control" of their reproduction coupled with "full restoration of ownership to their bodies."[111] The way the pluralist choice approach defines self-determination as the "right to make crucial decisions" and to be fully informed.[112] This approach emphasizes women's reproductive freedom; it is not simply "choice" but what kind of choice and who can exercise the choice.

As previously discussed, the "choice" and "rights" rhetoric of the movement was problematic and contradictory. The "right" to "self-determination" which Mies defines as "autonomy and control of one's body" is derived from a fundamental "right" of self-determination. This is a "right to bodily intactness and integrity" and a universal human right.[113] For Mies this notion of "self-determination" is defined and determined by the "other"- whether the other is the state, the practitioner or a patriarchal institution.[114] This "right" did not apply to women who had to struggle first to end the determination -by-others (men). Therefore self-determination was based on a resistance strategy and it included the liberation ideology that surfaced in the first wave of feminism. The feminist strategy was not voiced concerning the social, economic and political realities but was based on the "autonomous and self-determined woman."[115] Mies argues that "self-determination" has

changed and now means emancipation from the female body and nature and not liberation from the oppressive male-female relations.[116] This is a key factor as there are those who argue that we may have to sacrifice something for this greater good.[117] The social relations position emphasizes that whatever is sacrificed is lost; if we continue to argue the right to self-determination in the way that the liberal rights feminists do, based on a woman's ownership of her body, the individual becomes only the sum of the parts. According to Mies, "If the individual -the undivided person- has been divided up into his/her saleable parts, the individual has disappeared. There is only the dividual which can be further divided up".[118] The strength in this portrayal of the liberal concept of "self-determination" is that it emphasizes how dangerous the uncritical acceptance of language without examining how it has evolved, and who is employing it, will not advance women's autonomy. This interpretation of self-determination offers a strong defensive position from which feminists can resist NRGTs.

One of the assumptions associated with the concept of self-determination is that this is an individual strategy that requires an individual solution. Linda Gordon argues that contraceptive technologies as an individual solution de-emphasized the social and economic conditions and gave individuals responsibility only as "consumers" of a commodity.[119] This commodity was marketed to couples and families as family planning devices, but just as with NRGTs they affected women's bodies. Moreover, the clients were of a particular race and class because as Gordon emphasizes, population control was the real reason for the development of contraceptives like the Pill. Mies describes this kind of "choice" as "freedom of choice in the supermarket."[120] The social relations approach attempts to look at what is behind the "choice" and to reorient the discourse to fill the gap between "self-determination," "choice" and "rights" in a way that is commensurate with the particularities of women's lives though the problem is the debate which has never been resolved regarding the relationship between social group (or collective) rights and individual rights. In this case the question raised concern a woman's "desire" to have a child, and her ability to decide and the social relations feminists attempt to build a defensive strategy that reorients the debate completely.

X. Social Relations Approach

According to Raymond, "women do not often create the social conditions within which they act." Therefore the social relations focus is on "a complex assessment of choice" or rather on its constraints.[121] Mies' "ecofeminist perspective" fits under what I have called the social relations approach. It "sees reproduction in the light of men-women relationships, the sexual division of labor, sexual relations, and the overall economic, political and social situations, all of which, at present, are influenced by patriarchal and capitalist ideology and practice."[122] These ideologies also structure the form of NRGTs that are available and to whom they are available. The social relations position emphasizes the capitalist and patriarchal ideologies which drove the development of these technologies and continue to drive the research. Furthermore, unlike the pluralist choice approach, there is a need to make judgements about what is oppressive and beneficial and to act on these judgements.[123] The social relations position considers technology to be a form of social practice and politics whose outcome is predictable given the distribution of power in society.

The social relations position believes that, on the level of the community of women the "actions that one takes for her own benefit should not serve to harm others."[124] The social relations position emphasizes the interconnections between women and between these technologies. For example, one woman might be "fortunate" enough to hire a "surrogate" mother. Another woman is paid to provide the product and controlled by a contract that dictates how she is to live her life for at least nine months. The social relations position politicizes NRGTs and their nature, it focuses on the social use and social need for NRGTs, but where does this position leave individual women who want to use these technologies and how it is implicated in the debate regarding women's agency?

A. A Dilemma Regarding Women's Agency

Social relations feminists identify how the need to defend individual self-determination has led to some destructive discussions and could lead to an endorsement of these technologies.[125] There is a recognition that it is not just the social construction of the

"choice" but about constraints on a woman's ability to decide. There are difficulties posed by this line of argument as I have already discussed in relation to Williams' study. Lati Mani, in her exploration of the debates regarding *sati*, illustrates what it means to remain within this "choice" paradigm and the dichotomy of consent/coercion. She examines the issue of agency within two opposing positions, the feminist and conservative positions. If the discussion remains within the "choice" paradigm it focuses on whether widows were coerced or had consented to *sati*. If feminists consider *sati* undertaken by a 'free agent', as a voluntary act, in any way, this could be misappropriated by the "right." The conservative position could use this to denote the woman's consent and to defend *sati*. To counter this position the feminist discourse emphasized that these women were coerced and that their decisions were made by women in certain subordinate social positions with few, if any, alternatives.[126] An argument based on the second position is problematic because it portrays women as "victims" and does not recognize the different forms of resistance that women undertake even if they are coerced. Mani argues that there is a need for feminists to acknowledge the complexities present in women's lives and their attempts to negotiate and struggle against social and familial constraints. A static conception of agency revolving around the notion of consent is not acceptable because it only considers two possible scenarios, consent or coercion. It does not account for women's ways of struggling against and resisting such practices as *sati* nor could it account for women's struggle regarding motherhood or the use of NRGTs.[127] A more dynamic conception of agency would allow for a discussion of women's oppression as a multifaceted and contradictory social process. To simply view women as agents so as not to portray them as "victims" is not the answer either. For example, if women who attempt *sati* (and live), are considered to have consented to the practice, they are liable to punishment under the law on *sati* in India. This law does suggest that women are "free agents". Mani concludes that "in the short term, then, it seems safest to counter the notion of woman as free agent by emphasizing her victimization."[128]

Social relations feminists face this dilemma in their attempt to construct an argument against these technologies and to allow for women's agency. While some social relations concerns do overlap with the pluralist choice approach, the social relations approach is much more cautious with regard to agency and to these technologies in general as they do not to

"appear complicit to the deed".[129] The "deed" for feminists who responded to the Royal Commission is to be made to appear as if they endorsed the recommendations in the Royal Commission's Final Report when in fact their concerns were misappropriated. Or the "deed" could be the exploitation of other women. When the ideologies and masks of these "choices" are removed the main dangers of endorsing NRGTs "lie at the collective level - for women as a group, for society as a whole."[130]

B. Antinatalist Ideology

Laura Woliver reviewed the feminist NRGTs literature and found a lack of conviction to challenge NRGTs as an apolitical rendition of individual choice and displacement of social change.[131] To define infertility as a medical problem individualizes and depoliticizes it. The medical industry uses the pronatalist ideology to entice individual women. This ideology only applies to those women considered fit reproducers. If feminists realize that this pronatal ideology is not applied to poor and other disadvantaged women this will strengthen their critique of the ideology of pronatalism. These women are the objects of an equally strong and motivated antinatalist ideology. Mies' critique of the "liberalization" agenda is how it is used for "other" agendas and how the "economic, political and cultural impositions of international capital" are left unexamined. Similarly, if the marketers of NRGTs promote pronatalism for some women, they promote antinatalism for others.[132]

Part of the marketing campaign of the medical profession is to "entice the fit to breed and restrain reproduction by the unfit."[133] NRGTs are integral to the practice of eugenics, which is not just the manipulation of genes but the controlling of who can reproduce.[134] This type of antinatal ideology is reflected in Farida Akhtar's account of the population control incentive system in place in Bangladesh, which promises women wheat if they undergo sterilization.[135] Akhtar's account shows how reproductive "rights" mean very little to some women. Some women face reduced choices and increased coercion under medical control. In other countries, doctors can use some widening criteria for sterilization based on genetically determined psychic disorders, thereby expanding the definition of what is

considered "sick" and "defective" to justify the procedure.[136] The pluralist choice approach takes for granted that there are some benefits and falls into a type of relativism, refusing to classify the choices as either wrong or right. However, certain technologies clearly target certain women and social groups.

The social relations position chooses to focus on women with disabilities, visible minority and immigrant women, and poor women who fall under the antinatal category. Women with disabilities have been denied not just the right to reproduce, but also the right to a life with dignity. In the early NRGTs literature, the focus regarding people with disabilities was mainly on the fetus, with the logic: "let us spare what we might be able to prevent through prenatal screening."[137] Is disability inherently painful or does the pain come from its consequences or from how society deals with it? Asch admits that while we all want "healthy babies," we must recognize that we could cope and love a child if it developed a disability because most disabilities do not occur until adulthood. More importantly one must recognize that every life has difficulties, and disabilities need not be "insuperable". If women abort a fetus because it is diagnosed to have "defective" genes they disparage the lives of people with disabilities now and in the future.[138] The development and use of NRGTs means that certain social groups will benefit, and others will suffer from these technologies. For social relations feminists it is crucially important, because of the interdependence of NRGTs, to emphasize their implications for women as a social group, but does this deny some individual particularities, and if it does are the "risks" worth it considering the contextualization of NRGTs?

C. The Development and Use of NRGTs Contextualized

The social relations feminists examine the context in which these technologies were developed and are practiced. They can thus answer the crucial questions about NRGTs: who controls, who profits, who benefits, who pays the price?"[139] NRGTs like technology in general, are inherently political; "technology shapes, and is shaped by, existing power relations and dominant social values."[140] Women may never control these technologies and instead of risking the loss of control; women should refuse to yield the little control that they

have left.[141] The social relations approach warns that any compliance with these technologies perpetuates the collective exploitation of women.[142] Do these technologies fulfill any actual need for individual women? According to the social relations feminists, because of this context, these technologies take away women's control and give more control to men and to the medical industry and reinforce patriarchal control.

Patriarchal capitalism links the development and use of NRGTs to typical male cultural values of objectification and domination. As Mary O'Brien states, reproductive technologies "make the marriage of capitalism and patriarchy fecund."[143] This is supported by Maria Mies, who asserts that technological progress is not possible "without exploitative relations" because it is a function of "capitalist patriarchy."[144] While this statement may appear to be anti-technology these feminists insist that some technologies depending on what has been outlined here represent "choices" for women. Some example of technological "advances" include fertility control, contraceptive technology and abortion technology, but in this case NRGTs are not "progressive" and that none of these technologies dealt with the context in which these technologies were used.

Andrea Dworkin agrees that the advent of NRGTs ushered in "reproduction controllable by men on a scale heretofore unimaginable."[145] This is not a reference to the "culture" of individual men, as scientists or doctors, but to men as a social category and a dominant class and to the patriarchal institutions.[146] One of these in "the private realm where the man affirms his paternity" is marriage. In the public realm men make the "laws and ideologies which shape and justify patriarchy."[147] In Germany under the reign of Hitler, there were "direct, mass, state-led, militarily enforced initiatives in the control of human reproduction."[148] The state may not presently be an active enforcer but "the pressures of the market are as forceful and destructive."[149] The market appears impersonal and apolitical, and "wears the appearance of 'choice'." It promotes decisions based on availability and ability to pay.[150] But what we are paying for?

The legitimation of male supremacy, paternity, racism and control is also made possible in contract pregnancy, otherwise known as surrogacy facilitated by the advent of NRGTs. Women of color can carry embryos that are not genetically related to them. These women are targeted as "breeders". Gena Corea has already found evidence of the use of

Mexican women to transfer human embryos to gestate babies for more affluent American women at a fraction of the price an American woman would ask.[151] One case that shows how surrogacy is played out is eloquently presented by Phyllis Chelser in The Sacred Bond: The Legacy of Baby M. The "sacred bond" she is referring to is not between the mother and the child but the sperm and the child. Baby M's "gestating and biological mother" Mary Beth, decided to keep her but this resulted in a court battle over custody. The Baby M case reflects how a surrogate mother is considered a "free agent," and to have chosen to consent to the terms of a contract. Once the case reached this stage the social context of her decision is obliterated and factors such as systemic subordination are not considered as "evidence," neither is her experience with the pregnancy, childbirth and nursing. Chesler concludes that this case and Baby M represent every child who is taken from her birth mother in the "mistaken belief that a child needs a father, a father-dominated family and/or money far more than she needs her mother."[152]

Corea engages with Canadian political philosopher and former midwife Mary O'Brien's reproductive theory and states that NRGTs as especially evident in this case give males their sense of continuity; "women's claim to maternity is loosened, man's claim to paternity is strengthened."[153] Though Mary O'Brien did not make extensive reference to NRGTs and their link to the state and male reproductive consciousness and control, many other authors have used her theory to support this argument. Ten years after Firestone wrote her book in which she considered NRGTs to have the possibility to "liberate" women O'Brien argued that men have been trying to appropriate reproduction for themselves. Men have always been separated from their reproductive consciousness, having been alienated from their reproductive seed and from their "natural genetic continuity." They then resorted to "artificial modes of continuity," or "artificial" ways to control women and women's ability to reproduce; after all reproduction is where their male supremacy finds its "roots and rationales."[154] O'Brien states that when she wrote her book, there was a need to refocus the women's movement on the experience of motherhood because the movement needed to broaden and could not do that without revaluing birth.[155]

D. Motherhood: Crisis of Authority?

Shulamith Firestone did dare to ask for "an honest reexamination of the ancient value of motherhood."[156] Her reexamination was regarding biological, 'natural' motherhood because Firestone believed that the heart of women's oppression was the childbearing and rearing roles: women were to resist having babies and becoming mothers. Later certain feminists realized that it was not the mothering that was the problem but the lack of control over it. Pregnancy and childbirth were eventually acknowledged as choices in and of themselves.[157] It appears that NRGTs emerged at a time when feminists were trying to reappropriate motherhood and while the social relations feminists would agree that this is an important project, part of their defense against NRGTs is the danger in recognizing this as a "need" for women. The danger is that feminists would accept NRGTs as a choice because they had never acknowledged the possibility of opting out of compulsory motherhood.[158]

In a review of the literature on motherhood, Ann Snitow suggests that there is a crisis of authority regarding "who is allowed to criticize pronatalism or to question having children."[159] This "crisis of authority" is most apparent in the liberal rights approach, but still present in the pluralist choice approach. The social relations approach is criticized for not acknowledging pregnancy and childbirth "as an accomplishment we can actively shape."[160] But this position recognizes the material contribution that women make to reproduction and pregnancy while not essentializing that contribution as natural female destiny.[161] Furthermore, in the social relations approach, motherhood, the experience not the instinct, is seen as a relationship within a cultural, political and historical context. The emphasis is on experience or consciousness not the "maternal instinct".[162]

The social relations position highlights the right to 'just be' -without being labelled infertile or voluntarily childless, for example.[163] There is a replacement of "choices" not new "choices"; to accept infertility without trying NRGTs will become rare. Fertile women and those considered 'at risk' will increasingly be pressured to use reproductive technologies and genetic engineering: "the consciousness of people is shifted so that we all begin to think that these are necessary technological interventions to guarantee a healthy child."[164] The

right to choose sacrifices the "right" to remain childless as an integral part of repr freedom.[165] These technologies make things different and social relations feminists believe worse. Gena Corea predicts that the advancement of NRGTs research alludes to the possibility that "pharmacrats" will finally develop the artificial womb to eliminate the "need" for women and place the embryos into "The Mother Machine".[166] This would provide the opportunity to institute a full program of genetic engineering.

E. Thinking and Acting "Eugenically"

Until the "Mother Machine" is perfected, the scientists rely on the market and its presentation of NRGTs as "choice" to influence people "to think and act eugenically."[167] Paula Bradish states that "the seeds of eugenic ideology did not die out with the end of Nazi `race hygiene' in 1945." These seeds now take the form of genetic engineering and are marketed as "medical therapy aimed at alleviating human suffering."[168] The medical industry can practice "predictive medicine" because it is made possible with the ability to use "markers," to predict disease and predispositions. The scale of this research is unimaginable, the main site being an international project underway in the United States called the Human Genome Project. This project is designed to map human genes to determine the genetic origins of everything, like diseases such as breast cancer and Parkinson's Disease and predispositions like homosexuality(!).[169] The Canadian government continues to contribute millions of dollars to scientists who are participating in the Canadian Genome Project. The overall investment of billions of dollars in the biotechnology industry "has created an economic momentum that . . . will be unstoppable."[170] The gap will continue to widen between the original intent of genetics to map the genes to understand diseases and treat them, and the ability to detect, diagnose and screen as an end in itself.[171]

Genetics individualizes health problems and ignores the historical, social, environmental and economic context. The control is increased but not for the pregnant woman, for the geneticist and the obstetrician who decide "who is justified in having an abortion." Furthermore, governments and insurance companies possess the control to decide which tests are necessary and what actions result.[172] An individual could be diagnosed

with a disease for which there is often no cure. As a result, an individual could be advised or could seek to know how lead a certain kind of life so that the disease's effects are delayed or lessened. If an individual is diagnosed with a disease they could also face discrimination such as, the exclusion from any life insurance plan, or rejection for employment and limits on the provision of other services. Therefore, as Corea et al. argue, genetic testing is primarily about power and control.[173] This control can take the form of either positive eugenics, a proactive approach to generating "good human stock," or negative eugenics which prevents or terminates "problems" before they are born.[174]

Of course, prenatal and preconception technologies for sex choice could be useful in determining whether the fetus carries the gene for a debilitating disease.[175] The use of sex selection technologies is being widely justified on this basis. These technologies are not diagnosing whether the fetus has the disease but only if the fetus is of the sex that will contract this disease. Ruth Hubbard's premise is that NRGTs are not allowing women to gain control over their reproductive capacities, but only serving to reinforce sexism in society.[176] Though in theory both sexes could be aborted historical evidence suggest what Gena Corea describes as "gynicide" or the extermination of females.[177] To date, these technologies may not be the cause of biases in society but they certainly serve to give a more effective expression. Since China has banned most couples from having more than one child, these couples want to ensure that child is a boy. With the introduction of ultrasound machines, "the demographic curve has skewed sharply" as femicide or female infanticide is more efficiently and easily practiced.[178] There is tremendous pressure in India to destroy female fetuses because of the dowry burden on the family and because only male babies can be heirs.[179] Another concern is that sex selection will slot women as second class citizens because of the historical reality of son preference also as the preference for the first born to be male.[180]

In the words of Maria Mies, arguably representative of a social relations position, these technologies solve none of our basic problems so there is no other option but to opt out.[181] This statement is "harsh" but is part of the methodology employed by social relations feminists to analyze NRGTs as indistinguishable from the practice of eugenics and is based on a "principle of showing the connections and linkages between technologies, and their

contexts."[182] An article by Jalna Hamner and Pat Allen concludes that "men have the social power and soon the technology to implement the final solution."[183] This solution is "the biological manufacture of a human being to desired specifications."[184] Stanworth contends that the social relations approach takes "an exaggerated view of the position of science and medicine" without acknowledging the constraints placed on these industries.[185] Certainly, the medical and scientific industries do not have all pervasive powers. But clearly the medicalization of infertility has served many purposes - curing infertility being only the marketing tool. The "cures" of infertility demand access to women's eggs that work with genetic engineering technologies, and allow the "geneticization" of disease and the tendency to reduce differences among individuals to DNA codes.[186] The screening of certain diseases is universally funded but the "special needs" requirements that may be required to then live with the disease are not covered.[187] There is a need not just to request these resources but to shift the focus which remains on the individual's disability or disease to society's discriminatory practices.[188] For these reasons, the emphasis of the social relations approach is on the intricate, complex technological web connected by their ability to control reproduction and practice eugenics. The social relations approach is accused of leaving out infertile women because it does not consider women or society to "need" NRGTs.[189] From a social relations feminist perspective, these technologies are not helping but oppressing women.[190] The key to solving some of women's most "basic" problems lie in the valuation of the social group of women.[191] Within this social group the individual women would benefit from this valuation as well.

XI. Conclusions

The abortion rights discourse was dominated by a liberal discourse as was the NRGTs discourse. In the abortion rights discourse the feminist position on abortion went from one of pro-abortion to pro-choice, and finally to broad reproductive rights. Pro-choice was sometimes used by those who really did not agree to the actual practice of abortion but were more opposed to any infringement on individual rights. It was the choice and the fear of restriction that was being advocated more so than the provision of services. Later the

struggle became one for broad reproductive rights and reproductive freedom, for individual choice and structural equality. The different stages of the reproductive rights movement parallel the liberal rights (pro-choice) and pluralist choice (reproductive freedom) approaches to NRGTs. The social relations approach unveils the dangers in remaining within the dominant liberal discourse and all three positions demonstrate the difficulties of taking a position within the feminist discourse.

This chapter shows how different approaches and meanings are influenced by the prevailing ideology of individual rights, choices and self-determination. Those feminist authors who took a liberal rights approach to access to NRGTs advocate individual choice as an end in itself. These authors are confident that the state can regulate for an individual's right and freedom to choose by managing how they are applied because the technologies are neutral. Therefore, they focus on individual women's need for access to NRGTs and for informed consent. The worst-case scenario for the liberal rights approach is the denial of "choice" to infertile women and couples. These liberal rights feminists accuse the feminist opponents of NRGTs of having an inconsistent "choice" platform.

The strength of the pluralist choice feminist position is its insistent focus on the politics of difference that emerges regarding the concept "women" and to highlight the different implications certain technologies have for different women depending on the setting in which the technology is applied. As it does not consider the technologies to be inherently political or problematic this position affords a certain optimism that NRGTs can be controlled by women because their present application can be modified. Recognizing the possible coercion women may encounter, the focus is the improvement of the decision-making process through *informed* choice. For them, women's needs exist within society, and there is always a level of individual choice and needs that cannot be subsumed under community rights. Therefore, it is ultimately an individual choice to mother or not. The pluralist choice feminists emphasize women's ability to make decisions regarding NRGTs as part of women's reproductive freedom. Another strength of this position is the concept of informed choice which includes the legal-medical practice of informed consent, but which emphasizes the importance of educating women regarding the "choice" they are making. This position, by requiring options and substantive choices to be offered to women regarding

risks and costs of NRGTs, means that many women will refuse to use these technologies. Pluralist choice feminists allow individual women to resist. Their worst case scenario is the denial of "choices" which could benefit certain women and second, the lack of respect for women's ability to make decisions and the alienation of women who "desire" or "need" these technologies.

The social relations feminist approach to NRGTs reveals the "choices" of NRGTs to mean a right to consume. This position contends that instead of trying to control these technologies, women should refuse to yield control. These writers bring to light the constraints on women and emphasize the ideology of antinatalism - the "other" to pronatalism. NRGTs are not about infertile women, but about perfecting human reproduction for the fit reproducers. This position emphasizes the interconnections between reproductive technologies, genetic engineering and eugenics. Unlike the pluralist choice approach, the social relations feminists emphasize how these technologies are inherently political and actually increase patriarchal and corporate control over women. This position concludes that the worst case scenario is the "Mother Machine".[192] While social relations feminists have not solved the ongoing debate within feminism regarding women's agency and autonomy it does go the furthest in advocating for social change and exposes how, in many cases, social change is being displaced by technological change. The social relations position has opened the discourse to allow for an alternative approach to women's agency and autonomy to develop which would not require feminists to rely on the dominant liberal discourse.

I have introduced the significance for this debate of the idea that there exist "gaps" between the concepts laid down in texts and the actualities in women's lives, which demonstrates how language obscures reality. For many women, depending on their living circumstances, "choosing" these technologies is not an option. This "gap" was especially apparent in the liberal rights approach that uncritically accepted the "rights" and "choice" rhetoric and advocated simply for universal access and informed consent. The pluralist choice approach partially bridges the "gap" as it recognizes the problems with material choices. The pluralist choice approach hesitates to leave behind the underlying concept of self-determination, and is not convinced that women's rights as a social group will not be

imposed on the rights of the individual. How can feminists reconcile the "needs" of women and the "horrors" of the eugenic practices of NRGTs?

The social relations position reorients the debate from "self-determination" and "choice" to a discussion of the contextualization of the use and development of NRGTs. In doing so, feminist authors and members of FINRRAGE conclude that NRGTs do not represent "choices" but leave women with less "choice," less control and deflect the urgency for social change. In view of this, Maria Mies' solution is to "recreate living relations" and to completely bridge the "gaps". This entails the re-creation of "necessary living and life-sustaining interrelatedness of life on earth, at the personal as well as social or communal level. It implies materiality and reciprocity."[193] The social relations feminists have created a space for this kind of strategy to develop. Meanwhile, the social relations feminists are not willing to "risk" the continued exploitation of certain social groups of women because some privileged women "desire" a child.

The next two chapters consider certain questions that arise from this literature review. Is there a critical analysis of the liberal assumptions that underpin the marketing of NRGTs? Do the same questions regarding individual and social groups "rights" and "choices" arise over issues like prenatal diagnostic technologies (PNDT) which are explicitly linked to abortion rights? What does it mean to leave behind the concept of "choice" and is there any room for it in the proposals regarding NRGTs? How do the theoretical positions defined in this chapter relate to the strategies and recommendations made by women's groups considering the role they envision for the state?

ENDNOTES

1.Rona Achilles, "Assisted Reproduction: The Social Issues," Changing Patterns: Women in Canada, Eds. Sandra Burt et al. (Toronto: McClelland & Stewart Inc., 1993) 510.

2.This is the definition of the American liberal tradition by Celeste Michelle Condit in Decoding Abortion Rhetoric: Communicating Social Change (Chicago: University of Illinois Press, 1990) 72.

3.Beverly Wildung Harrison, Our Right to Choose: Toward a New Ethic of Abortion (Boston: Beacon Press, 1983) 51.

4.Connie Clement and Diana Majury, "Interview: Visions for Women's Reproductive Care," Healthsharing, (Spring 1988): 22. Clement, a Canadian public health and family planning worker, referred to FINRRAGE members as "some of the leading feminist thinkers about this topic" (22).

5.See Appendix C for a chronology of the major works consulted for this review. I have included a few works outside of this time frame because certain authors provide important precursors to the understanding of how concepts and positions were developed. Other authors are continuing to add insight to this debate and therefore are included.

6.For reviews of this conference see, Annika Nilsson, trans. by Cindy deWitt, "Feminist Forum; Conference Report," Women Studies International Forum 8:5 (1985): ii-iv. See also Somer Brodribb, "Conference Report: FINRRAGE, Sweden, July 1985," Resources for Feminist Research 14:3 (1985): 54. For another conference sponsored by FINRRAGE, see "Conference Report, International Conference on Reproductive and Genetic Engineering and Women's Reproductive Health, Camilla, Bangladesh, March 18-25, 1989," Resources for Feminist Research 18:3 (1989): 83-88. At this conference participation from Asia and Africa increased and FINRRAGE now included 30 countries. This led to a conference held in Brazil, Sept. 30-Oct.7, 1991, see the conference report by Thais Corral, "Women, Procreation and Environment," Issues Reproductive And Genetic Engineering 5:2 (1992): 207-209.

7.FINRRAGE, "The Feminist International Network of Resistance to Reproductive and Genetic Engineering Declaration of Comilla FINRRAGE-UBINIG International Conference, Bangladesh,1989," Misconceptions, Eds. Gwynne Basen, Margrit Eichler and Abby Lippman (Montreal: Voyageur Press, 1994) 243.

8.Patricia Spallone, Beyond Conception: The New Politics of Reproduction (Massachusetts: Bergin and Garey, 1989) 33. The author is a member of FINRRAGE from England.

9.FINRRAGE, Resolution from FINRRAGE Conference, Made to Order: The Myth of Reproductive and Genetic Progress, Eds., P. Spallone & D. Steinberg (New York: Pergamon Press, 1987) 212. This book is in large part a result of the emergency conference held in Sweden in 1985, which was the first conference to deal exclusively with the implications

NRGTs have for women. The group felt the urgency to develop a strong resistance to the increasing proliferation of these technologies.

10.FINRRAGE, Made to Order 212.

11.Anne Donchin,"The Growing Feminist Debate over NRGTs," Rev. of Ethics and Human Reproduction, by Christine Overall, and Made to Order, by P. Spallone and D. Steinberg, Eds. and Reproductive Technologies: Gender, Motherhood and Medicine by Michelle Stanworth, Ed. Hypatia 4:3 (1989): 138.

12.Gena Corea, The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs (N.Y.: Harper & Row, 1985) 323. Gena Corea, one of the founding members of FINRRAGE, provides a very comprehensive and frightening critical analysis of NRGTs.

13.Dorothy Smith, The Conceptual Practices of Power: A Feminist Sociology of Knowledge (Toronto: University of Toronto Press, 1990)104.

14.Smith 103.

15.Corea Mother Machine 299. See her discussion on how medical language obscures the misuses of NRGTs (pp. 155-156).

16.Jalna Hanmer and Pat Allen, "Reproductive Engineering: the Final Solution?" in Alice through the Microscope, Ed. Brighton Women and Science Group (London: Virago Press, 1980) 231. Other critics of the "masculine profession" of science include Evelyn Fox Keller, Sandra Harding and others in the special issue of Hypatia 2:3 (1987), Feminism and Science I. Also Ruth Hubbard, "Science, Facts and Feminism," Hypatia, 3:1 (1988): 5-17.

17.Elizabeth Bartholet, "IVF: The Construction of Infertility and of Parenting," Issues in Reproductive Technology I: An Anthology, Ed. Helen B. Holmes (N.Y.: Garland Publishing Inc., 1992) 259.

18.Lene Koch, "The Fairy Tale as Model for Women's Experiences of In Vitro Fertilization," Issues in Reproductive Technology I: An Anthology, Ed. Helen B. Holmes (N.Y.: Garland Publishing Inc., 1992) 277-278.

19.Smith 92.

20.Condit 64.

21.Condit 165.

22.Anne Finger, "Claiming *all* of our Bodies: Reproductive Rights and Disability," Test-Tube Women: What Future for Motherhood? Eds. R. Arditti, R. D. Klein and S. Minden (London: Pandora Press, 1989) 281-297.

23.Condit 167. These historical references are from the U.S. from the 1960s in the "pro-choice era to the 1980s, the reproductive freedom era.

24.Finger 287.

25.Finger 290.

26.Condit 116.

27.Janice Raymond, Women as Wombs: Reproductive Technologies and the Battle over Women's Freedom (San Francisco: Harper, 1993) 84.

28.Margot Young, "Reproductive Technologies and the Politics of Choice," Reproductive Rights and Reproductive Wrongs: Proceedings of a Conference held in Victoria, B.C, (Victoria: Ad-Hoc Committee on Reproductive Technologies, January 14-16, 1994) 99.

29.Nancy Adamson et al., Feminist Organizing for Change: The Contemporary Women's Movement in Canada (Toronto: Oxford UP, 1988) 100. The authors defined this philosophy and identified it as the dominant ideology which they were challenging by approaching their study of the women's movement from a socialist feminist perspective.

30.Laura Purdy, "Another Look at Contract Pregnancy," Issues in Reproductive Technology 1: An Anthology, Ed. Helen B. Holmes (N.Y.: Garland Publishing Inc., 1992) 303-320; Antoinette Sedillo Lopez, "Privacy and the Regulations of the New Reproductive Technologies: A Decision-Making Approach," Family Law Quarterly 22: 2 (1988), Distributed in The Politics of Reproduction in the 1990s: Contraceptive And Reproductive Technologies: Resource Collection (Washington: Center for Women Policy Studies, 1994)173-197.; Barbara Menning, "In Defence of IVF," The Custom-Made Child? Eds. H. Holmes et al. (N.J.:Humana Press, 1981) 263-267; and Lori B. Andrews, "Alternative Modes of Reproduction," Reproductive Laws for the 1990s, Eds. S. Cohen and N. Taub (N.J.: Humana Press, 1989) distributed in The Politics of Reproduction in the 1990s: Contraceptive And Reproductive Technologies: Resource Collection (Washington: Center for Women Policy Studies, 1994) 1-31.

31.Corlann Gee Bush, "Women and the Assessment of Technology: to Think, to Be, to Unthink, to Be Free," Machina Ex Dea: Feminist Perspectives of Technology, Ed. Joan Rothschild (N.Y.: Pergamon, 1983) 168. Also Ursula Franklin, Will Women Change Technology or Will it Change Women? CRIAW Papers No.9 (Ottawa: CRIAW, 1985).

32.Menning 264.

33.Purdy 303.

34.Lopez 176.

35.Purdy 317-318.

36.Lopez 177.

37.Lopez 178.

38.Maria Mies, "From the Individual to the Dividual: the Supermarket of 'Reproductive Alternatives'," Ecofeminism, Maria Mies and Vandana Shiva (Halifax: Fernwood Publications, 1993) 210. This article was first published in ISSUES in Reproductive and Genetic Engineering Vol.1:3 (1988). Maria Mies is a member of FINRRAGE.

39.Menning 265.

40.Nikki Colodny, "Birth Control and Reproductive Rights," The Future of Human Reproduction, Ed. Christine Overall (Toronto: The Woman's Press, 1989) 43.

41.Ruth Hubbard, The Politics of Women's Biology (N.B.: Rutgers UP, 1990) 152-155.

42.Barbara Rothman, Recreating Motherhood: Ideology and Technology in a Patriarchal Society (New York: W.W. Norton & Co., Inc., 1989) 255.

43.Menning 264.

44.The actual procedure of fertilizing the egg with the sperm in a glass petri dish is one small element in the IVF process which is actually an "operation". The risks of IVF for a woman include hormonal treatments which "superovulate" her and "overstimulate" her ovaries and increase the risk of cysts and possibly ovarian cancer. There are risks involved from the manipulation of her follicles and with the use of anesthesia. The tools that are used during embryo transfer may damage a woman's uterus. IVF results in a number of ectopic pregnancies and multiple pregnancies which are "high risk" for the woman. The risks to the fetus that may result from IVF are unknown as are the effects on the fetus from ultrasound and other prenatal diagnostic technologies.(See Corea, Mother Machine 149-151.)

45.Menning 264. An intrauterine device or IUD was a contraceptive device and DES was a drug given to women who were thought to be at "risk" of miscarrying their fetuses.

46.Menning 264; Purdy 307.

47.Menning, 263.

48.Purdy 319.

49.Purdy 307.

50.Menning 265.

51.Rebecca Albury, "Who Owns the Embryo?" Test-Tube Women: What Future for Motherhood? Eds. R. Arditti et al. (London: Pandora Press, 1989) 55.

52.Bush 161.

53.Mies, "From the Individual to the Dividual" 199.

54.Menning 263.

55.Mies, "From the Individual to the Dividual" 199.

56.Andrews 18. This "choice" dilemma will be explored later in this chapter under self-determination.

57.Shulamith Firestone, The Dialectic of Sex: The Case for Feminist Revolution (N.Y.: William Morrow & Co., Inc., 1970) 224-225.

58.Linda Gordon, Introduction, Woman's Body, Woman's Right: Birth Control in America, Third Edition (New York: Penguin, 1990) xv-xviii.

59.Rosalind Petchesky, Abortion and Women's Choice: the State, Sexuality, and Reproductive Freedom (N.Y.: Longman, 1984) 28-29.

60.Hillary Rose, "Victorian Values in the Test-Tube: the Politics of Reproductive Science and Technology," Reproductive Technologies: Gender, Motherhood and Medicine, Ed. Michelle Stanworth (Minneapolis: U of Minnesota Press, 1987) 152.

61.Michelle Stanworth, Editor's Introduction, Reproductive Technologies: Gender, Motherhood & Medicine, Ed. Michelle Stanworth (Minneapolis: U of Minnesota Press, 1987) 1.

62.Laurie Nsiah-Jefferson & Elaine Hall, "Reproductive Technology: Perspectives and Implications for Low Income Women & Women of Color," Healing Technologies: Feminist Perspectives (Michigan: U of Michigan P, 1989). Distributed in The Politics of Reproduction in the 1990s: Contraceptive and Reproductive Technologies: Resource Collection (Washington: Center for WomenPolicy Studies, 1994) 93.

63.Petchesky 8.

64.Petchesky xxv.

65.Petchesky 6-7.

66.Petchesky 2.

67.Petchesky 40.

68.Michelle Stanworth, "Reproductive Technologies and the Deconstruction of Motherhood," Reproductive Technologies: Gender, Motherhood & Medicine, Ed. Michelle

Stanworth (Minneapolis: U of Minnesota Press, 1987) 25.

69.Colodny 43-44.

70.In Canada a "wrongful life" suit has been filed in Winnipeg, Manitoba. See David Roberts, "Parents Sue Doctor Over Abnormal Son," Globe and Mail 7 September 1994: A1-A2. The parents of a boy born with Down Syndrome are suing their family doctor. The case alleges that there was a "lack of proper medical disclosure regarding the mother's risks of delivering a defective baby." The mother had an AFP test which showed a 1 in 189 chance of delivering a down syndrome baby and was told that was "normal".

71.Adrienne Asch, "Reproductive Technology and Disability," Reproductive Laws for the 1990s, Eds. Sherril Cohen & Nadine Taub (N.J.: Humana Press, 1989) 93.

72.Sheryl Ruzek, "Feminist Visions of Health: An International Perspective," What is Feminism, Eds. Ann Oakley & Juliet Mitchell (New York: Pantheon Books, 1986) 570.

73.Helen B. Holmes, "Reproductive Technologies: The Birth of a Woman-Centered Analysis," The Custom-Made Child? Eds. H. Holmes et al. (N.J.:Humana Press, 1981) 3-7.

74.Isabelle Brabant, "Are NRGTs Medicalising Motherhood?" Sortir la maternite´ du laboratoire: Actes du forum international sur les nouvelles technologies de la reproduction, Octobre 1987 (Quebec: Le conseil du statut de la femme) 97-99. This publication is the proceedings of the first international NRGTs conference held by women in Canada.

75.Abby Lippman, "Prenatal Technologies," The Future of Human Reproduction, Ed. C. Overall (Toronto: Woman's Press,1989) 185.

76.This concept is analyzed by Barbara Katz Rothman, The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood (N.Y.: Viking, 1986).

77.It was reported that 88% of women who are told that their fetus is at risk for down syndrome will abort the fetus, 8% will carry to term (Roberts, "Parents Sue" A1-A2).

78.For a discussion of this issue see Christine Overall, "Selective Termination of Pregnancy and Women's Autonomy" Hastings Center Report 20:3 (1990):6-11.

79.According to Robert,"Parents Sue,"A2, the Manitoba College of Physicians and Surgeons are looking at ways of directing doctors to order the serum AFP test.

80.Nsiah-Jefferson & Hall 95.

81.Patricia O'Reilly, "Small 'p' Politics: The Midwifery Example," The Future of Human Reproduction, Ed. C. Overall (Toronto: Women's Press, 1989) 166.

82.Stanworth, Editor's Introduction 3.

83.Christine St. Peter, "Feminist Discourse, Infertility and Reproductive Technology," NWSA Journal 1:3 (1989): 358-359.

84.Linda Williams, "Biology or Society? Parenthood Motivation in a Sample of Canadian Women Seeking In Vitro Fertilization," Issues in Reproductive Technology I: An Anthology, Ed. Helen B. Homes (NY: Garland,1992) 271. Another article that allows the experience of women who seek IVF to speak is Christine Crowe, "Women Want it: IVF and Women's Participation," Made to Order: the Myth of Reproductive and Genetic Progress, Eds. P.Spallone and D. Steinberg (New York: Pergamon, 1987) 84-93.

85.Williams 282.

86.Michelle Stanworth, "Birth Pangs: Conceptive Technologies and the Threat to Motherhood," Conflicts in Feminism, Ed. Marianne Hirsch and Evelyn Fox Keller (New York: Routledge, 1990) 292.

87.Stanworth,"Reproductive Technologies" 24.

88.Williams 271.

89.Lene Koch 282-283.

90.St. Peter 355. The Royal Commission used two time periods to measure the prevalence of infertility or the" reduced ability to conceive over time". Infertility was defined in two ways for this purpose: "the absence of pregnancy in a [heterosexual] couple who have been cohabiting for at least the past year and who have not used contraception during that period" or for the last two years. The one year period because it is most often used in studies and the two year period because this is what the World Health Organization uses. (See, Canada, Final Report 182-183.) This medical definition excludes single women and lesbian women and does not consider social definitions of infertility.

91.Rose 152. Lesley Brown is the mother of Louise Brown the first baby born who was conceived in a test-tube.

92.Naomi Pfeffer, "The Deconstruction of Infertility," Reproductive Technologies: Gender, Motherhood and Medicine, Ed. Michelle Stanworth (Minneapolis: U of Minnesota Press, 1987) 82.

93.Stanworth, "Birth Pangs" 289.

94.Young 101.

95.Laura Woliver, "New Reproductive Technologies: Challenges to Women's Control of Gestation and Birth,"Biomedical Technology and Public Policy, Eds. R.H. Blank and M.K.Mills (Westport: Greenwood Press, 1989). Distributed in The Politics of Reproduction in the 1990s: Contraceptive And Reproductive Technologies: Resource Collection

(Washington: Center for Women Policy Studies, 1994) 51.

96.Maria Mies, "New Reproductive Technologies: Sexist and Racist Implications," Ecofeminism, Maria Mies and Vandana Shiva (Halifax: Fernwood, 1993) 188. This article first appeared in Alternatives XII, 1987.

97.Boston Women's Health Collective (BWHB), The New Our Bodies, Ourselves, Third Edition,(N.Y.: Simon & Shuster,1992) 656.

98."Iatrogenesis" was introduced by Ivan Illich, Limits to Medicine, Medical Nemesis: The Expropriation of Health (New York: Bentham Books, 1976).

99.Corea, The Mother Machine 6.

100.This is a drug that was initially thought to prevent miscarriages for women with problem pregnancies.

101.Corea, The Mother Machine 3.

102.Rothman, Recreating Motherhood 184. In this section of her book, Rothman offered midwifery as an example of a feminist praxis model with regards to pregnancy and childbirth.

103.Nsiah-Jefferson and Hall l08.

104.Nsiah-Jefferson and Hall 94.

105. Nsiah-Jefferson and Hall 113.

106.Maria Mies, "White Man's Dilemma: His Search for What He has Destroyed," Ecofeminism, Maria Mies and Vandana Shiva (Halifax: Fernwood, 1993) 143.

107.Maria Mies, "Self-Determination: the End of Utopia," Ecofeminism , Maria Mies and Vandana Shiva (Halifax: Fernwood 1993) 220-221. This article was first published in Resources for Feminist Research, 18:3 (1989).

108.Gordon 452.

109.Petchesky 400.

110.Asch 106; Nsiah-Jefferson and Hall 93.

111.Firestone 11.

112.Ruzek 565.

113.Mies, "Self-Determination" 218.

114.Mies, "Self- Determination" 223

115.Mies, "Self-Determination" 219.

116.Mies, "Self-Determination" 220.

117.This idea is explored in numerous works of science fiction quite including; See Marge Piercy, Woman on the Edge of Time (New York: Fawcett Crest, 1977), in her possible future women have also given up their power to give birth so that all hierarchies would be eliminated and everyone could be equal (Piercy105). Children come out of a machine "without the stigmata of race and sex" (Piercy106). But as her main character exclaimed (as she watches a man nurse a baby): "These women thought they had won, but they had abandoned to men the last refuge of women. They had let men steal from them the last remnants of ancient power, those sealed in blood and in milk" (Piercy134). See also Murray Constantine, Swastika Night (London: Victor Gallancz Ltd., 1940). This book was written by Katharine Burdekin, a feminist novelist. It explores the cult of masculinity, dictatorship and reproduction.

118.Mies, "From the Individual to the Dividual" 216.

119.Gordon 426.

120.Mies, "From the Individual to the Dividual" 201-205.

121.Raymond, Women as Wombs 101.

122.Maria Mies and Vandana Shiva, "People or Population: Towards a New Ecology of Reproduction," Ecofeminism, Maria Mies and Vandana Shiva (Halifax: Fernwood, 1993) 293.

123.Raymond Women as Wombs 107.

124.H. Holmes & B. Hoskins, " Prenatal and Preconception Sex Choice Technologies: a Path to Femicide?" Man-Made Women: How New Reproductive Technologies Affect Women, Eds. G. Corea et al. (Bloomington: Indiana UP, 1985) 11.

125.P. Spallone and D. Steinberg, Introduction, Made to Order: the Myth of Reproductive and Genetic Progress, Eds. P. Spallone and D. Steinberg (New York: Pergamon, 1987) 15. Both editors are FINRRAGE members.

126.Lata Mani, "Multiple Mediations: Feminist Scholarship in the Age of Multinational Reception," Knowing Women, Eds. Helen Crowley and Susan Himmelwiet (Cambridge: Polity Press, 1992) 319.

127.Mani 320-321.

128.Mani 321.

129.Annette Burfoot, "In-Appropriation-A Critique of *Proceed with Care*," Women's Studies International Forum 18:4 (1995): 506.

130.Burstyn 67.

131.Woliver 53.

132.Mies, "Self-Determination" 220.

133.Sultana Kamal, "Seizure of Reproductive Rights? A Discussion on Population Control in the Third World and the Emergence of the New Reproductive Technologies in the West," Made to Order: the Myth of Reproductive and Genetic Progress, Eds. P. Spallone and D. Steinberg (New York: Pergamon, 1987) 146.

134.Corea, The Mother Machine 7.

135.Farida Akhtar, "Wheat for Statistics: A Case Study of Relief Wheat for Attaining Sterilization Target in Bangladesh," Made To Order the Myth of Reproductive and Genetic Progress, Eds. P. Spallone and D. Steinberg (New York: Pergamon, 1987) 159.

136.Paula Bradish, "From Genetic Counselling and Genetic Analysis, to Genetic Ideal and Genetic Fate," Made to Order; The Myth of Reproductive and Genetic Progress, Eds. P. Spallone & D. Steinberg (New York: Pergamon Press, 1987) 94.

137.Asch 81.

138.Asch 81.

139.Renate Duelli Klein, "What's new about the 'new' reproductive technologies?" Man-Made Women: How New Reproductive Technologies affect women, Eds. G. Corea, R. Klein, J. Hanmer, H.B. Holmes, B. Hoskins, M. Kishwar et al. (London:Hutchinson and Co. Ltds, 1985) 67. This is another volume from FINRRAGE. Klein is herself a founding member of FINRRAGE.

140.Sue Cox, "Strategies for the Present, Strategies for the Future: Feminist Resistance to New Reproductive Technologies," Canadian Women's Studies Journal/Les Cahiers de la femme 13:2 (1990): 86.

141.Raymond, Women as Wombs 91.

142.Sue Cox, "Dissenting Voices: New Reproductive Technology and Feminist Analyses," diss, Simon Fraser University (1991)149.

143.Mary O'Brien, "State Power & Reproductive Freedom," Reproducing the World: Essays in Feminist Theory (Boulder: Westview Press, 1989) 24.

144.Maria Mies, "Why Do We Need All This?" A Call against Genetic Engineering and Reproductive Technologies," Women's Studies International Forum 8:6 (1985): 555-556.

145.Andrea Dworkin, Right-Wing Women, First Edition, 1978 (N.Y.: Coward-McCann, Inc., 1983) 187.

146.Corea, The Mother Machine 4.

147.Corea, The Mother Machine 56.

148.Burstyn 17.

149.Paula Bradish quoted in an interview with Varda Burstyn, see Burstyn 63.

150.Burstyn 67.

151.Corea, The Mother Machine 43.

152.Phyllis Chesler, The Sacred Bond: The Legacy of Baby M (N.Y.: Times Books, 1988) 17. To follow up on this case, the Supreme Court voided the surrogacy contract and parental rights were given to Mary Beth but custody remained with the Sterns. Mary Beth visits "Sassy" twice a month. Sassy calls both women "Mom". Mary Beth says "mothers are not machines", that she "has a hole in her heart" and that we should say no to surrogacy. Since this time surrogacy contracts are outlawed in 16 states. After the Headlines, NBC, June 14, 1993.

153.Corea, The Mother Machine 289.

154.Mary O'Brien, The Politics of Reproduction, (London & Boston: Routledge, J. Kegan Paul Ltd.,1981) 52-57.

155.O'Brien, The Politics of Reproduction 91-92

156.Firestone 227. She wrote "pregnancy is barbaric, it is the temporary deformation of the body of the individual for the sake of the species". It is "at best necessary and tolerable" (Firestone 227).

157.Adrienne Rich made a distinction between the institution of mothering (under patriarchy) and the experience of mothering in her book, Of Woman Born: Motherhood as Experience and Institution (London: Virago, 1977).

158.Raymond, Women as Wombs 74. Robyn Rowland also identifies this resurgence of pro-motherhood attitudes and the resultant welcoming of NRGTs in "Reproductive

Technologies: The Final Solution to the Woman Question?" Test-Tube Women: What Future for Motherhood, Eds. Arditti, Klein et al. (London: Pandora, 1989) 356.

159.Ann Snitow, "Motherhood-Reclaiming the Demon Texts", Childless by Choice: A Feminist Anthology, Ed. Irene Reti (U.S.: McNaughton & Gunn, 1992) 5.

160.Stanworth, "Reproductive Technologies" 34.

161.Raymond Women as Wombs 190.

162.Raymond, Women as Wombs 38.

163.Chesler 22.

164.Sue Hawthorne and Renate Klein, Introduction, Angels of Power and other reproductive creations (Melbourne: Spinifex Press, 1991) vii.

165.Irene Reti, Introduction, Childless by Choice: A Feminist Anthology, Ed. Irene Reti (U.S.: McNaughton & Gunn, 1992) 1.

166.Corea, The Mother Machine 281.

167.Burstyn 62.

168.Bradish 94.

169.Hubbard, The Politics of Women's Biology 146.

170.Burstyn 63-63. She stated, in 1993 that the Canadian government had contributed $17 million to this project.

171.Abby Lippman, "Prenatal Genetic Testing and Screening: Constructing Needs and Reinforcing Inequities," American Journal of Law and Medecine XVII (1991): 45-46.

172.Lippman, "Prenatal Genetic Testing" 33-35.

173.Corea et al., Prologue 10.

174.Burstyn 62.

175.Holmes, "Reprodouctive Technologies" 21.

176.Ruth Hubbard, "The Case versus In Vitro Fertilization and Implantation," The Custom-Made Child? Eds. H. Holmes et al. (N.J.: Humana Press, 1981) 261.

177.Corea, The Mother Machine 189.

178."Obsession with male babies skews China's demographics", Globe & Mail 20 January1994: A8.

179.Madu Kishwar, "The Continuing Deficit of Women and India and the Impact of Amniocentesis," Man-Made Woman: How New Reproductive Technologies Affect Women, Eds. Gena Corea et al. (Bloomington: Indiana UP, 1985) 36.

180.Roberta Steinbacher, "Futuristic Implications of Sex Preselection,"The Custom-Made Child? Eds. H. Holmes et al. (N.J.:Humana Press, 1981) 187-188.

181.Maria Mies, "Why do we need all this?" 558.

182.Maria Mies, "New Reproductive Technologies" 174.

183.Jalna Hanmer and Pat Allen, "Reproductive Engineering: the Final Solution?"Alice through the Microscope, Ed. Brighton Women and Science Group (London: Virago, 1980) 226.

184.Hanmer and Allen 208.

185.Stanworth, "Birth Pangs" 289.

186.Lippman, "Prenatal Genetic Testing" 19.

187.Lippman, "Prenatal Genetic Testing" 35.

188.Lippman, "Prenatal Genetic Testing" 45.

189.Donchin, Review 138.

190.Robyn Rowland, "A Child at any Price? An Overview of Issues in the use of the New Reproductive Technologies," Women's Studies International Forum 8:6 (1985): 539.

191.Janice Raymond, "Fetalists and Feminists: They are not the Same," Made to Order:The Myth of Reproductive and Genetic Progress, Eds. P. Spallone & D. Steinberg (New York: Pergamon Press, 1987) 65.

192.Corea, The Mother Machine 281.

193.Mies,"Self-Determination" 230.

CHAPTER TWO

THE WORDS AND ARGUMENTS OF THE WOMEN'S GROUPS

the words chosen, the arguments advanced, determine how these techniques become part of the social fabric.[1]

I. Introduction

Aside from the feminist approaches discussed in the last chapter, there are many other ways to approach the study and analysis of NRGTs. The Royal Commission heard from a range of approaches including the narrow medical model (evidence based evaluation), scientific, utilitarian and communitarian. The Royal Commission itself claims to have taken an "ethic of care" approach.[2] From a pluralist choice approach, Thelma McCormack states that the Final Report includes a "feminist sensibility in its recommendations." But, according to her, the Final Report is also "a bitter disappointment to infertile women who had hoped to hear a more positive message, an insult to women of color, an embarrassment to anti-essentialist feminists."[3] Annette Burfoot assesses the report from a social relations perspective and calls it an "inappropriation" of feminist language. I would agree with Burfoot's analysis that the Report "denies their [feminist concepts and arguments] political origins not only in terms of process, but also in regard to its content and adopted epistemology."[4] This chapter contributes to a re-appropriation of feminist language and epistemology by analyzing how certain women's groups negotiate the NRGTs discourse in their presentations to the Royal Commission.

This chapter is a re-presentation and analysis of the submissions made by women's groups to the RCNRT because women's groups represented an important intervener group. Their members have either undertaken feminist research and presented it to the Commission or/and have presented distinctively gendered experiences in their submissions. This thesis concentrates on what the groups said, but a short description of the groups and their briefs is provided in the footnotes since it is not sufficient to simply characterize the groups as "women's groups". These descriptions provide more information about who spoke. The politics of the women's movement also guided the women's groups' presentations but this is examined in Chapter Three.

I examine some of the groups' more "divisive" positions on the important issues that unveil the implications of the dominant liberal discourse for women. While in the last chapter I have classified the main approaches as liberal rights, pluralist choice and social relations, not all women's groups clearly fit into one or the other position, as the line between these positions is often blurred. Their recommendations vary depending on which issue they are addressing. From my reading and analysis of the women's groups' presentations, while the groups themselves are rarely able to be clearly classified as one position or another, their recommendations can be classified as such. After reading the presentations, it became obvious to me that certain issues reappeared in most of them. I then mapped these issues with regard to certain key problematics that appeared in the women's groups' recommendations on these issues. I identify and analyze how the groups recommendations can be positioned on a continuum.

This chapter introduces the technological assumptions and attitudes of the women's groups. The groups are classified as "yes, but"; "no, not unless," and "no, maybe never" and parallel the liberal rights, pluralist choice and social relations positions respectively. The analysis of these positions demonstrates the difficulty of negotiating such a complex discourse and of then making policy proposals to a Royal Commission. Chapter Three presents some reasons why this might have been so difficult.

I focus on several central issues including access, decision-making, prenatal diagnostic technologies, contract and compulsory motherhood and medicalization. Access is explored because it is a key issue for feminists who take a liberal approach to NRGTs. It

also raises questions for the pluralist choice feminists because access to NRGTs results in the increased medicalization women's lives. This concern influences their decisions regarding access to NRGTs. The issue of access has implications for feminists' concerns regarding the conceptualization of family units and in particular "alternative" family structures such as lesbian or single parents who want to have access to AI. Following this discussion is the presentation of women's groups recommendations regarding the decision-making process because once women have access they then need to decide whether to proceed. The first part of this chapter is thus focused on the individual women and their right to choose and the implications of it.

The tensions between social group rights and individual rights are raised in this chapter under the section dealing with prenatal diagnostic technologies (PNDT). This section outlines the three positions and their implications for disabled rights, sex-selection and Indo-Canadian women's rights. NRGTs raise concerns about women's rights regarding custody and parental issues in the context of contract and compulsory motherhood. The last section deals with the policy priorities of the women's groups and in particular their range of recommendations regarding resource allocation, and medical and social solutions to infertility. First, a discussion of the Royal Commission and some of its management problems will set the context in which the women's groups decided to make submissions.

II. RCNRT: Management Problems

One of the reasons the government mandated a Commission to study NRGTs was because of the lobbying efforts of the Canadian Coalition for a Royal Commission on New Reproductive Technologies. Nonetheless, this Coalition saw its initial hopes in calling for a Royal Commission deflated one by one. First, there were numerous problems with the participation process; there was no extensive education program attached to the mandate given to the Royal Commission, and there were no funds provided for interveners from the women's health community.[5] Second, the Commissioners did not use their investigative powers to subpoena witnesses and thus uncover substantially new and otherwise unobtainable information that could then be distributed to women. Third, the Chair, while

a woman, was a geneticist, and as such was associated too closely with the medical/scientific establishment and its involvement with NRGTs. Because of these visible difficulties and others, which I explore in further detail, this Coalition asked for the Royal Commission to be disbanded.

In Canada, Royal Commissions generally lack clearly laid out guidelines regarding what to do with the information and recommendations they receive and how to integrate them into a final report.[6] During the four-year mandate of the Royal Commission on New Reproductive Technologies (RCNRT), it held 28 days of public hearings from September 11 to November 29, 1990.[7] Questions arose regarding the Royal Commission's management when two years into its mandate, four of its Commissioners launched a lawsuit against the Chair and the federal government. The four dissenting Commissioners were Louise Vandelac, sociologist and Quebec feminist, Dr. Bruce Hatfield, a Calgary physician, Martine Hebert, lawyer and former member of Quebec's national assembly, and lawyer Maureen McTeer.

These Commissioners felt that the Commission's research was being directed toward an endorsement of reproductive technologies without adequately addressing the moral and social issues involved.[8] When these commissioners first attempted to voice concerns regarding due management of the Commission, the response from the government was to change the original Order-In-Council and give exclusive decision-making authority to the Chair, Dr. Patricia Baird. It also hired two additional commissioners.[9] The lawsuit of the other four commissioners was filed to request the courts overturn this change to the Order-in-Council because they considered granting the Chair exclusive decision-making authority as contrary to the Public Inquiries Act.[10] Ten days after the commissioners filed their lawsuit, the government fired and replaced them.[11] The Final Report does not mention any of these problems, nor does it name the four original commissioners. It was during the public hearings that many of these problems with the Commission arose and it is possible that this deterred women's groups from presenting to the Commission..

According to Liora Salter and Debra Slaco, Royal Commission reports on scientific development fall into two categories: "no, not unless" and "yes, but". Their description of a "yes, but" report best describes what I call a liberal rights approach to NRGTs. This

approach gives government a green light and "indicates that a development should be allowed to proceed under certain conditions."[12] The "no, not unless" or pluralist choice approach, means government must first meet certain conditions before proceeding to allow the continued development of a scientific or technological project.[13] It is obvious even from the title of this Royal Commission's report, Proceed with Care or "yes, but," which approach it recommended to the government. What is not obvious is how women's groups figure in the discourse that emerges in the Final Report. The women's groups made recommendations that can be classified as liberal rights or "yes, but," as pluralist choice approach or "no, not unless," and as social relations or what I call "no, maybe never." Both the "yes, but" and the "no, not unless" approaches have the same end result - the projects will proceed. Both positions recommend different conditions that the government must fulfill before it allows NRGTs to proceed. The conditions that the women's groups recommend depend on their attitudes towards technological development and use.

III. Approaches to Technological Development and Use

The different women's groups make recommendations that parallel the technological assumptions of the three feminist positions as they were developed in the last chapter. The Canadian Abortion Rights Action League (CARAL) considers these technologies to have the capacity to benefit women.[14] Demonstrating a pluralist choice approach, the Canadian Advisory Council on the Status of Women (CACSW) concludes that often the problems that result from NRGTs are "not intrinsic to the technology but are about control" of women and their reproductive processes.[15] A social relations position on technology considers NRGTs as inherently and necessarily political and not just contextually constructed. NAC states that no technology is neutral because the goals and methods of the researchers "represent the world view, economic and social priorities favoured by those who have developed it."[16]

The Women's Network (WN) states that value-free technological science is not possible and "as long as new reproductive technologies develop without women-centred perspectives then they are instruments of oppression and social control." NRGTs are developed within and reinforce patriarchal values.[17] The Vancouver Status of Women

(VSW) maintains that NRGTs do not support women's equality but have negative implications for women. NRGTs use women as experimental subjects, and exploit poor women and women of colour.[18]

Several groups highlight the racist and sexist implications of NRGTs including the Immigrant and Visible Minority Women of B.C. (IVMWBC) and the Immigrant Women of Saskatchewan (IWS). The IVMWBC focuses on the social and economic consequences of NRGTs for the lives of immigrant and visible minority women. This group concludes that NRGTs reflect and recreate the divisions of race and class among women and reflect the socioeconomic divisions present in society. Integral to a social relations perspective this group describes these technologies, as historically part of the attempts to create "a genetically engineered superior race determined by dominant values of a society that is presently based on patriarchal, racist and classist values."[19] IWS also states that the underlying implications of NRGTs are obvious when women are continuously victimized by racism and sexism in our society.[20] All these groups take a woman-centred perspective which I refer to as feminist by virtue of its main premises: NRGTs will have a significant impact on women, women's bodies and status in society.

IV. Feminist Perspectives

Feminism, feminist action and organizing, mean something different for most women's organizations. However, a majority of these groups would agree, in general, with the Young Women's Christian Association (YWCA) of Yellowknife. It describes the feminist belief that women working together have a positive influence on the community, that feminist organizations are initiators of change, and are accessible to all women. A feminist perspective is one that the YWCA of Yellowknife describes as "rarely without challenge, but never without reward."[21] This group recommends several social relations principles such as the redirection of resources from high technological services to counselling, public education and support programs. It also recommends that no woman should be refused access to these technologies. This group emphasizes the importance of improving the decision-making process with informed choice.[22]

The Nova Scotia Advisory Council on the Status of Women (NSACSW) weighs the risks and benefits of NRGT issues from a feminist perspective. It recognizes how different values of analysis rely heavily on an outdated patriarchal view that does not meet our needs.[23] Its brief concentrates on the impact on women of Donor Insemination (DI), In Vitro Fertilization (IVF), diagnostic tests, fertility drugs, selective embryo reduction, embryo research and contract motherhood. This organization takes a liberal rights approach overall and recommends regulations on the excesses of NRGTs, such as banning sex selection except for medical reasons.[24] This group also emphasizes the importance of a woman's informed consent. For example, it recommends that as long as a woman consents to it, fetal tissue from an abortion can be used for fetal research.[25]

Two groups that take a social relations feminist approach to NRGTs are the DisAbled Women's Network (DAWN) Canada and the Canadian Disability Rights Council. The focus of both these briefs is on prenatal screening and the impact on people with disabilities. DAWN Canada describes itself as a feminist group, but feels that this and its open support for lesbians, for visible minority women and for Native women, have limited its membership.[26] The CDRC, while not specifically a woman's organization, states that a feminist perspective must be adopted when examining NRGTs because a feminist perspective includes the notion of structural equality for all disadvantaged groups.[27]

The Canadian Research Institute for the Advancement of Women (CRIAW) Newfoundland, from a pluralist choice perspective, advances certain feminists principles for analyzing NRGTs. These include a recognition that NRGTs will impact not only women and men differently, but will impact differently on different women. The impact depends on whether the woman is, for example, poor or wealthy, or lives in an urban or rural area.[28] Its brief concentrates on how these technologies can be understood in the specificity of women's lives in Newfoundland and Labrador.

The Prince Edward Island Advisory Council on the Status of Women (PEIACSW) states that it does not consider a feminist perspective to be anti-motherhood or anti-technology but concerned with why NRGTs are developed and used and how they affect women.[29] This group analyzed the implications of NRGTs from a different position depending on the subject area. In general, from a social relations perspective, it was

concerned that these technologies would not represent reproductive choices and control for women as a social group.[30] It does however recommend that a woman should have the right to be a surrogate mother if no money is exchanged. It also recommends universal access to IVF (as a last resort).[31] While both these recommendations are reflective of a liberal rights approach, in the vein of a pluralist choice approach, it also recommends that equal resources be allocated to various services to encompass a broad context of women's health.[32]

V. Recommendations on How to Proceed

From a liberal rights perspective these technologies need to be regulated but only in the extreme cases to control some abusive applications of these technologies. From a social relations perspective the only way to proceed in the policy process is to ban these technologies as they all interconnect "eugenically". A recommendation for a moratorium reflects a pluralist choice approach to these technologies. Those women's groups that take such a pluralist choice approach are concerned about certain aspects of the technologies and therefore may request that NRGTs be stalled, to create a context where women can control these technologies. The difference between a ban and a general moratorium is that a ban is seen as a permanent halt to all current and future activity. A moratorium is the suspension of particular practices or could mean that certain projects cannot be expanded.

The AFEAS recommends a five-year moratorium on the use and development of NRGTs because there is a "need to stop and evaluate."[33] Québec's Planned Parenthood Federation, (FQPN) also recommends a complete moratorium on all NRGT practices and research.[34] The Women's Health Interaction (WHI) recommends that all reproductive and genetic engineering be stopped (except DI and Surrogacy) including research, "because of the threat they pose to women, the damage to the planet and humanity and eugenic purposes."[35] A number of groups made calls for bans on genetic manipulation or alteration research including cloning (asexual reproduction), and transgenic (transfer of genes across species) techniques.[36] WHI, an Ottawa collective of feminist health activists, made the only recommendation for a ban to NRGTs. However, the media criticized NAC for taking an "overprotective stance," although it only recommends a halt to new NRGT clinics and

research.[37] Whether a group discussed a ban, moratorium or regulation, in response to the Royal Commission mandate, all discussed the issue of access.

VI. Access: Universal or Restricted?

The Halifax Lesbian Committee on Reproductive Technologies (HLCRT) is a group that formed to debate the issues related to these technologies and to prepare a brief expressing a lesbian perspective. It focuses on issues of access to Alternative Insemination, on mothering and on the political implications of these technologies. In its introduction, HLCRT states that initially it wanted to recommend a ban on all forms of NRGTs except AI, at least until long term implications are known. However, it felt sure that this kind of proposal would be ignored by the Commission. Therefore, it recommends regulatory guidelines for IVF and Prenatal Diagnostic Technologies (PNDT) instead.[38] This group did however take an overall position on NRGTs that overlaps between a social relations and pluralist choice approach.

The liberal rights regulatory approach is congruent with the legitimacy given to scientific and medical institutions that develop these technologies. There is a general conviction in "developed" societies that science and medicine must continue to evolve and keep pace with the changing world because otherwise "we may be left behind." Furthermore, there is a perception that technology's continued evolution, in general and these technologies specifically, cannot be stopped. According to the Yellowknife Association of Women and the Law (YAWL), many groups including this one, do not want NRGTs to be stopped because the technology itself is benign; how it is used will determine whether the outcome is good or bad.[39] Consequently, though many groups like DES Action Canada express concerns and even fear the implications of these technologies they do not advocate a ban. To solve the problems of NRGTS, according to this group, "is not as simple as disallowing women to pursue every option in order to reproduce."[40] Furthermore, Maureen McTeer, a fired Commissioner, describes the Commission's approach to the study of NRGTs as "questions of management"; how can NRGTs be regulated so that their excesses are controlled? In response to these kinds of questions, she correctly predicted

recommendations that would take the form of regulatory measures, and include universal access and stricter informed consent.[41]

The Women's Health Clinic described a "technological fix" and a popular attitude, indicative of the liberal rights approach. It asks how we can doubt that "technology is good and is the way of the future."[42] At the very least, asks AFEAS, don't NRGTs represent "progress and hope and in certain situations the only possible solution"?[43] In a liberal democratic society based on a capitalist economy, there is a "technological imperative" where the technology is thought to be critical and changes in technology are considered the most important cause of changes in society. The changes that occur are progressive, unavoidable and their necessity and desirability are taken for granted.[44] This dominant ideology led many women's groups to include a rigorous discussion regarding access in their submissions. The women who presented on behalf of the London Status of Women Action Group (LSWAG) were asked after their oral presentation how they could simply discuss access without discussing the implications of NRGTs. The members of this group replied that women want access to NRGTs and therefore they were responding to "what is here and now" and to the needs of their members.[45]

The pluralist choice approach also considers the technologies to be "unstoppable" or at least "unrepealable", but it allows for some redirection and rethinking regarding alternative "choices" to deal with infertility. CRIAW sets forth the dilemma that underlies a pluralist choice approach in its statement that it was: "unable to resolve the ethical dilemma presented to us by the present practice of IVF since the effects of its practice are medically unproven and possibly harmful, yet we are also unwilling to deny individual women access."[46] The women's groups that advance recommendations concerning access have to negotiate this dilemma and for different reasons their proposals range from restricted access to universal access.

Women's groups like HLCRT face a dilemma as they provide "intense criticism of restrictions on access to the technologies, when at the same time [they acknowledge that] universal access is a completely undesirable alternative."[47] This lesbian group does not want NRGTs to be universally available and really would like to see a ban on these technologies

(except AI). If these technologies do proceed this group does not want restrictions to be placed on access that would exclude their members.

Other groups also concerned with the implications of recommending universal access, argue against this recommendation because universal access would only add to society's search for a "technological fix". The Women's Education and Research Foundation (WERF) situates its concerns regarding women's access historically; "many who opposed access to abortion and birth control for the fit were equally adamant about the need to restrict fertility for the unfit."[48] The historical context may explain why groups that represent "excluded" social groups, like HLCRT representing lesbians, approach the issues of access from a pluralist choice perspective.

Those groups less sensitive to discrimination recommend strict medical criteria as a way to restrict the widespread, routine use of NRGTs and in particular IVF. There may be many situations where the infertility problem is due to non-medical reasons or a combination of medical and social, but because the criteria are so broad that they encompass both there is no distinction made between these reasons. CRIAW Nfld. stresses how these broad criteria affect couples in small, rural communities where there is an absence of confidentiality and counselling, when they have to share the possible social reasons why they are unable to conceive, for example. Accordingly, this group in a pluralist choice approach recommends that doctors use simple, medical criteria to assess infertility.[49] Quebec's Status of Women Council (CSF) recommends that access to IVF be limited to couples who have diagnosed infertility problems and present high risks for genetic diseases.[50] The Federation of Quebec Women (FFQ) and several other groups believe that IVF should be restricted to women with the most intractable infertility problems and not idiopathic infertility (when it is not known why a couple is infertile).[51] These groups base their recommendations on reasons of efficiency, cost-effectiveness, or safety.

According to the Halifax Lesbian Committee AI should be demedicalized. This group depicts AI as fundamentally distinct from the other NRGTs. AI is pregnancy without heterosexual intercourse, and is straightforward, easy and safe. Furthermore, the risks are the same as for any heterosexual couple trying to conceive and therefore this group is against AI's medicalization.[52] The dilemma that arises is set forth by the Alberta Women's Institute

(AWI) which insists that DI can and should be done without medical intervention, but the sperm and ova should be screened for HIV.[53] However, the Halifax Lesbian Committee maintains that AI does not require any form of medicalization because anonymous HIV testing should be made available for the population at large which includes the donors.[54] Similarly NAC recommends that DI be demedicalized as women should not have to give up control of this "simple" procedure.[55] The PEI Advisory Council however recommends that DI be limited to specialized clinics. For this group DI is not an exception to other NRGTs, because it is integral to the whole NRGT relationship. AI plays a role in IVF, donor screening and surrogacy.[56]

Strict medical control of DI or IVF, whether to prevent its routine use or to regulate it, is the inadvertent acceptance of discriminatory practices as social criteria such as being a married heterosexual couple can be justified as a restriction. The Ontario Advisory Council on Women's Issues (OACWI) urges that "discrimination cannot be disguised as medical necessity."[57] Lesbians do not interpret the push for medical control of Donor Insemination as a prevention against the risks for women nor as a way to safeguard the "routine" uses of these technologies. Lesbians interpret it as a response to the possibility that women can have children without men and outside of heterosexual relations.

Lesbians struggle against the privileges of the heterosexual mainstream that have a capacity for making its privilege invisible by presenting white middle class, heterosexual experience and values as universal.[58] This is obvious as the Gay and Lesbian Parents Association took the opportunity during the public hearings to make a presentation regarding its day to day concerns to dispel stereotypes regarding Gay and Lesbian lifestyles. It "assured" the Commissioners that lesbians and gays "do procreate, desire parenting and raising children." Moreover, any restriction placed on their parenting by access criteria to AI or other technologies, would "only place them in limbo and force them to go through the pain of court process."[59] As Gays and Lesbians face discrimination from access to NRGTs they may turn to the courts for a ruling. The larger theoretical consideration of access in the submissions is the (re)conceptualization of the family unit.

What is needed according to WERF is " to unthink the family, its definition, structure and operation."[60] The women's groups differ on what to do about the medical control of

Alternative Insemination and the implications of this procedure for the family. Several liberal rights groups approach these issues from a "conservative" point of view, while the pluralist choice groups made recommendations that recognize diversity. OACWI recommends that AI must be available to all women regardless of unproven fertility, marital status or reproductive history.[61] The most conservative groups among the liberal rights women's groups I examined include the New Brunswick Business and Professional Women's Club (NBBPWC), the French Women's Network in Southern Ontario (RFSO) and the National Council of Jewish Women (NCJW). The NCJW states that donor insemination should not be allowed because of the possibility of incest, lack of genealogy and the problem of inheritance. The RFSO believes that NRGTs go against the family unit, are incestuous and adulterous.[62]

Similar family concerns are raised regarding donor secrecy. CRIAW wants the "veil of secrecy" for both the child and society to be lifted.[63] CRIAW's reasoning probably stems from concerns surrounding adoption. Feminists argue that the secrecy surrounding adoption should be lifted because the reasons that the secrecy was imposed in the first place are no longer legitimate. The secrecy was imposed not as many advocates would suggest in the "interest of the child" It is integral to DI's donor matching and adoption's child matching in adoption that is "part of the heterosexual culture where there is an attempt to match physical characteristics to the male partner in particular."[64] "Matching" was initially done to hide the "illegitimacy" of the child, now this has extended to a reinforcement of the myth that the nuclear family is the ideal form, and it leads to a discussion about "fitness".[65] Lesbians recommend anonymity for the sperm donors, not because they oppose an 'open' system, but because of the discrimination lesbian parents face regarding parentage and custody. Though any adopting couple faces similar anxieties with regard to the 'natural' mother's claim to her child, HLCRT states that the main concern for lesbians is a safeguard against a sperm donor's paternal claim. This sperm claim or "father-right" is considered the "sacred bond" to a child as the Baby M case demonstrated.

Most of the groups agree that some information regarding the sperm donor should be available to the child when the child reaches the age of majority. For example, AFEAS stipulates that AI babies should know their biological origins.[66] According to AWI, it is not

a question of a child knowing its origins but only the medical history of the donors.[67] YAWL recommends that the sperm donor should be identified when the child reaches adulthood, but that no parental claims to the child be made possible.[68]

Although the identity of the sperm donor and recipient may cause concerns regarding legal parentage, the lessons learnt from adoption suggests a system based on secrecy and deception is not ideal either. OACWI urges that the law recognize the legitimacy of private AI between consenting adults and that the sperm donor be prohibited from making parental claims.[69] The NSACSW, assuming the heterosexuality of the recipient of the donor sperm, states that the partner of the woman undergoing DI should be considered the legal father.[70] The CFUW resolves that the sperm donors should remain anonymous but that their histories should be registered.[71]

Perhaps the donor/recipient system should have two tracks until the validity of social parenting is recognized and the patriarchal reasons behind the anonymity and medical control claims are uncovered. CACSW proposes that both the donor and the recipient should be offered the option to agree on the unveiling of certain information. The information revealed could be the medical history of the sperm donor or the identity of both parties depending on what they agree to. Another option would be to agree that all parties are to retain anonymity.[72] Similarly, OACWI recommends two levels of confidentiality that would allow sperm donors and recipients a "choice" between absolute confidentiality where neither the identity of the sperm donor nor of the recipient is revealed, and consent where AI children can obtain information if the man agrees.[73] As DI is increasingly medicalized and used in other procedures such as IVF, it allows for the possibility for eugenics and selective breeding. Any "screening" of genes, and characteristics is a "ranking" and should be opposed. However, the NBACSW requests that the woman should be able to choose the race but not the sex of the child.[74] Restricted access can translate into discrimination, universal access into widespread use and medical control into social control and could limit women's range of decision-making.

VII. Decision-Making Process

The women's groups that made liberal rights recommendations regarding equal access went on to make recommendations regarding the decision-making process and informed consent. The proposals of a pluralist choice approach to the decision-making process are based on the principle of informed choice. There are no social relations recommendations because they did not focus on access or decision-making but on the problems of posing the technologies as "choices." The Manitoba Advisory Council on the Status of Women (MACSW) proposes that "just because the technology is available does not mean we have to avail ourselves of it. We can still say no. What it means is that women need to have a positive self-worth to be able to consent to use it or refuse it."[75] This statement parallels the liberal rights attitude towards technology, access and agency. Similarly, according to CARAL, individuals and families should be able to exercise their right to choose, and women should be trusted "to make good, moral, conscientious decisions." Therefore, the fewer restrictions on or prohibition of NRGTs the better; "education is a better solution than coercion."[76]

The CACSW advises that medical practitioners should not just obtain a woman's consent to a procedure by providing the woman with the minimum understanding of what the procedure entails. The medical practitioner should offer women informed choice, and provide her with complete knowledge of risks, benefits and alternatives. The Federation of Francophone Women of Saskatchewan express a similar concern: "[women] lack the information to take control, women need the education in order to exercise their choice."[77] This Advisory Council defines the following basic guiding principles that they propose form the basis of women's reproductive freedom: the ability to decide when, with whom, how and if to have children. This group contends that these principles could be used to evaluate NRGTs.[78] Also central to women's reproductive freedom is informed choice because, as the Women's Network states, we must be guided by our history in which women have been denied reproductive freedom and choice. Therefore, this group views NRGTs as only one one reproductive service and reproduction as only one dimension of women's lives.[79]

The Federated Women's Institute of Canada (FWIC) recognizes the difficulty in balancing the real needs of infertile women with the need to protect women in general.[80] The balancing of needs and broadening of choices is central to the pluralist choice approach. The types of organizations that exemplify this approach include women's health clinics, health centres and health collectives. The Association of Ontario Midwives (AOM) recommends the restructuring of the counselling system to include the concept of informed choices with women at the centre and with the widest definition of risks and benefits. With the principle of informed choice, the risks and benefits include not just physiological ones but economic, psycho-social and emotional ones and an assessment of available alternatives. Making a "choice" is a complex decision making process and the educational part of it should "lead to empowering women so that they can make autonomous decisions for themselves."[81]

These groups did not recommend informed choice without accounting for its many barriers including the doctor-patient relationship and the way information is exchanged between them. The Maternal Health Society witnessed how difficult it is to obtain any information beyond what the medical profession deems important.[82] The focus of its brief was the lack of information about reproductive health care and the relationship between consumers and providers of health care. It told the RC that hospitals, doctors and government ministries do not distribute information such as C-Section rates.[83] With regard to informed choice, CRIAW Nfld. stresses that there is not only a literacy barrier to be considered but for Native women and recent immigrant women, there is also a language barrier.[84] The Toronto Women's Health Network (TWHN) attests to how the choice to refuse treatment is unsupported by doctors. Women may feel coerced to consent and therefore women need "help in interpreting tests results not advice or coercion."[85]

A key issue regarding the unequal doctor/patient relationship is medicalization. Both the pluralist choice and social relations positions believe that NRGTs contribute to the over medicalization of women's lives.[86] Medicalization refers to the medical profession taking control of a process not otherwise seen as medically structured but which is defined as medical concerns. As the use of NRGTs increases it will become more difficult for women to refuse the technologies and actually reduce the scope of decision-making. The social relations approach resists any further medicalization of women's lives and the pluralist

choice approach attempts to minimize the medicalization and social control. The development of NRGTs concerns the Canadian Advisory Council because NRGTs give more power over women to the medical profession and the pharmaceutical industry.[87]

The proposals regarding medicalization from a social relations perspective are to resist any further medical control and attempt to demedicalize DI. Pluralist choice groups want to minimize this control and liberal rights groups do not necessarily consider medicalization as problem. The full extension of medicalization means that a woman has to struggle for her autonomy, and for the right to decide to let her pregnancy progress "normally".[88] The Maternal Health Society (MHS) in Vancouver describes a case in which a woman was ordered by a Family Court judge to undergo a C-section to save the fetus she was carrying. Once the mother gave birth to her baby the Children's Aid Society apprehended it. When this case went to court, the judge ruled that the woman was an unfit mother for refusing to undergo a C-section because the doctor judged the fetus to be in stress. The reasoning behind the judgement was that the mother did not care about her baby.[89] This case underlines many issues. It illustrates the full implications of medical control on the erosion of autonomy, the complexities involved in decision-making and raises the issue of women's right to decide and what consent really means.

Many groups maintain their optimism that if informed choice is expanded, unbiased and nondirective counselling is possible. At the very least, any education program provided must include societal attitudes and values.[90] Others are less optimistic and believe that women are encouraged to make a choice "concurrent with the beliefs of the practitioner and societal pressure."[91] Consequently, counselling is a central concern for advocates of people with disabilities who oppose the use of prenatal technologies to detect fetal "abnormality". According to the Canadian Disability Rights Coalition (CDRC), women need to understand that the medical practitioners can only inform them of a negative or positive test result. Amniocentesis could detect whether a fetus carries a certain "defective" gene, but it and other prenatal technologies cannot provide any indication of the extent to which the fetus would develop the diagnosed disability or disease. There are only a few instances when medical practitioners can interpret PNDT results to distinguish between a disease where a baby will die shortly after birth, and a disability where the child may need "alternative

methods for performing life activities."[92] Both CDRC and DAWN Toronto recommend that genetic counselling should not consider the "disability" as the main focus but should consider the fetus as a potential baby that may develop a disability.[93]

VIII. Prenatal DiagnosticTechnologies

The debates regarding prenatal diagnostic technologies display the stark contrast between the three positions but especially between the liberal rights position and the social relations position. One reason is because this issue is explicitly related to abortion which feminists have struggled for as an important choice for women regardless of why women require the service. Therefore there is some concern that feminists should now support women who choose to abort a fetus because of the diagnosis by a PND technology. Many of the feminist opponents to PNDT only suggest that women should be presented with other options when they face the information that their fetus may develop a disability or disease. Because of this stance, NAC is argued to be eroding the "feminist conception of choice" and taking away women's ability to decide.[94]

Those women's groups that make liberal rights claims recommend that women be offered PNDT. Other women's groups advance recommendations from both pluralist choice and social relations approaches, and raise some serious concerns regarding the possible infringement of disability rights, of Indo-Canadian rights and of women's rights. The underlying theoretical context is an apparent conflict in these proposals between individual and collective rights.

Given CARAL's mandate it is not surprising that it has taken a liberal rights approach to NRGTs as it does for abortion. This group has been active in the field of reproductive health for 17 years, it is a national pro-choice organization that regards safe, legal abortion as a fundamental right. CARAL states that it understands why both feminists and disabled activists oppose prenatal technologies and genetic screening. But it maintains that feminists who say that PNDTs displace social change only place the burden of how society cares for people with disabilities on individual women. It is the individual women who are then left to decide whether they can raise a child with a disability. These women

may feel obligated to raise the child or guilty for disparaging the lives of people with disabilities.[95]

CARAL describes feminists' rationale for opposing these technologies as "anti-choice" because they stipulate for what reasons women can exercise their choice to abort a fetus. CARAL contends that those who say that women cannot abort a fetus with a disability because this "demeans disabled people," is "fallacious reasoning and a confusion of two issues." Disability rights are being waged at the expense of a woman's right to choose abortion.[96] However, all of the women's groups that oppose PNDTs, support a woman's right to abortion whatever her reasons and say as much. DAWN Toronto stresses that it strongly supports women's right to abortion.[97] NAC underlines its continued support for the right of a woman to choose to abort whatever her reason, but it states that we must also acknowledge that society has extremely negative attitudes toward people with disabilities.[98]

The social relations opponents to PNDT reorient the debate regarding disabilities and disease away from individual problems and solutions. According to the Canadian Disability Rights Council (CDRC), PNDTs ignore the social, economic and legal barriers that people with disabilities face and the discrimination that women with disabilities feel.[99] MACSW states that genetics do not cause fetal disabilities. It identifies the causes as prematurity, and low birth weight due to poverty, lack of nutrition, and housing, which are all encompassed in socioeconomic conditions.[100] NAC, DAWN Canada and CDRC situate their approach in the history of birthing and reproduction for disabled people. Historically, the medical profession has treated people with disabilities as passive and asexual. The scientific profession focused on wanting to cure, fix or correct disabilities.[101] Now rather than restructuring society and enhancing equality for people with disabilities, PNDTs attempt to diagnose and prevent disabilities, only 1% of which occur at birth.[102] "Environmental and systemic barriers" impede the equality and ability of people with disabilities to develop alternative methods of doing life activities. Therefore, according to CDRC, the only way to empower disabled people is through societal change because a disability is "a social construct, a product of our social environment."[103] DAWN Canada concludes that the oppression and discrimination of disabled people "does little to instil confidence that reproductive technologies will be used in a positive and progressive manner."[104]

While the medical profession legitimizes the use of PNDT for "medical" purposes, one obvious non-medical reason PNDTs are used is to detect the sex of the fetus. This is of particular concern for immigrant women, who have struggled hard to "find their voices," and have too often been faced with a decision over what level of oppression they should be struggling against: racism or sexism.[105] Sunera Thobani, now President of NAC, has been an important voice for immigrant women and in particular South Asian women. She was a presenter for the Immigrant and Visible Minority Women of British Columbia (IVMWBC) during the hearings in Vancouver. The IVMWBC's presentation drew attention to the disturbing practice of those doctors who target Indo-Canadians (as was done in Vancouver) for the sale of sex selection techniques which "perpetuates racist stereotypes of our culture."[106]

The women's groups made different recommendations regarding PNDTs but most were not in favour of sex selection techniques because they threaten to further oppress and devalue women. A liberal rights and pluralist choice recommendation to prohibit the abuses of PNDT declares the nonmedical diagnosis of sexes a criminal offense.[107] The Federation of Medical Women of Canada (FMWC) believes that these tests must be made available to assist "the medical management of the pregnancy."[108] FMWC argues in favor of PNDTs for sex-selection on two problematic grounds. For one, FMWC states that policy makers may need to make "ethnic" considerations regarding who "needs" access to sex-selection. However, the FMWC ignores that women have resisted this "ethnic" devaluation and therefore it is important to restrict the availability of PNDTs for their sake.[109] Second, the FMWC argues that if the government was to ban these technologies, this would only drive them underground. What "choice" is sex selection when, as the IVMWBC states, it means a woman has internalized her own devaluation so much that she is willing to abort the fetus she is carrying because it is of her sex?[110] What "choice" do these technologies offer in general?

IX. Collective Responsibility

These "choices" are offered to individuals when NRGTs actually affect more than just the individual. The use of PNDT to diagnose and "prevent" disabilities individualizes and medicalizes a social problem. PNDT for sex-selection is a similar problem because of its racist and sexist implications. While CARAL argues that feminist opponents place the burden of responsibility on individual women, it is actually these technologies that are "burdening" the individual women. These technologies and also IVF and the other NRGTs deflect "collective responsibility" because they are marketed to "couples" as "choices". By doing this NRGTs also serve to displace needed social change for members of these disadvantaged social groups whether immigrant women, or people with disabilities. Society refuses to take responsibility for needed structural changes and instead promotes a quick "technological fix".

A social relations approach to IVF states that it displaces social change and sometimes bypasses the problems because it ignores a "collective response[which] looks at the root causes not the individual symptoms."[111] This is very similar to FINRRAGE's declaration that these technologies do not solve real problems such as hunger, disease and pollution but "divert attention from real causes."[112] Many groups support the social relations view regarding "collective responsibility". The Ontario Advisory Council (OACWI) concludes that these technologies, especially the assisted conception techniques of IVF, are an "unjustifiable luxury" given "children with malnutrition and women with inadequate health care."[113] The Maternal Health Society, in Victoria since 1979, makes the point that women can get expensive medical interventions but not adequate food and shelter before or after the baby is born.[114] The Manitoba Women's Health Clinic (WHC) attests that we cannot "underestimate the suffering experienced by women unable to conceive but neither the suffering caused by treatments nor suffering experienced by women with other health issues which are under-resourced and under-researched."[115]

The Northwest Territories Status of Women Council (NTSWC) urges policy makers to look at the conditions of women's childbearing years such as housing, income, and the problems of alcoholism, abuse and violence. In the North, women of childbearing age face

small and overcrowded housing, high illiteracy and high unemployment rates. One in every three Tawao women is abused by their partners, and 70% of Dene women face violent partners and alcohol abuse.[116] The Council brought these problems before the Royal Commission. It told the Commission that access to basic reproductive services is very limited in the North with one male, residential gynaecologist in the Northwest Territories. The most basic services of a physician specializing in obstetrics, for example, are either not available or only available with great disruption to the individual and family. Northern women feel strongly about regaining control of the birthing process as the present system is contrary to their traditional cultural values and practices.[117]

The Yellowknife Association of Women and the Law (YAWL) states that health care should focus on improving the health of pregnant women and improving the living standards for all northerners.[118] Other groups in the North echo similar concerns. The Yukon Indian Women's Association (YIWA) recounts that NRGTs are not priorities for their association because their main health issue is alcoholism.[119] The YIWA presented the Yukon First Nation's story of life, their traditional laws and beliefs, their health care priorities and told the Commission how it deals with infertility. It concludes that NRGTs should not be funded unless Native women's basic health needs are met first.[120]

While it is difficult to comprehend and justify NRGTs when there are such high levels of infant mortality in the Canadian North, the Saskatchewan Action Committee reasons from a pluralist choice position that it is also hard to ask the infertile to bear the brunt of world inequality.[121] Similarly, WHC asks how we can expect a woman to be able to evaluate the general social and health implications for women generally? WHC is concerned because women have historically borne the cost and burdens of a male dominated medical system. In the area of reproductive technologies this experience has been and will not be different from women's usual experience in the medical system.[122] From a social relations position DES Action Canada states that its members "are not negating consent, liberty and choice." This group recommends that an examination of the whole picture of individual freedom, collective responsibility and trans-generational responsibility is urgently required.[123] Its evaluation of NRGTs is based on the principle of social justice. Similarly, as YAWL states, the Western view of human rights takes an individual focus but other

cultures, most notably indigenous groups, place a higher value on the collective or on social justice.[124]

The CACSW empathizes with the desire for the involuntary childless women to conceive and bear children, but highlights that this is done in a context where women as a social group face inequality and discrimination, certain groups of women more so than others.[125] NRGTs represent dangers to an individual's health as long term effects are not known, but on a collective level the FQPN urges the Commission to consider the effects of genetic manipulation and commercialized procreation.[126] Some "other" problems that NRGTs do not solve include environmental deterioration and violence against women which both affect women's health and possibly fertility.[127] The National Organization of Immigrant and Visible Minority Women of Canada expresses concerns that other women will manipulate immigrant and visible minority women for their benefit. [128] The underlying principle of the social relations approach as clearly articulated by the Vancouver Women's Reproductive Technologies Coalition (VWRC) that "collectively our actions, whether exercised at the individual or the institutional level, are what constitute making and remaking society." This means our individual choices should reflect more than our personal needs.[129] Those groups that were sensitive to the interconnected social relations approach discuss the implications of eugenics as an example of how an individual decision affects certain social groups and some more than others.

X. Eugenics

DES Action Canada states that "medical solutions are reducing the pressures for societal change and allowing some "to profit from existing economic and political orders."[130] Genetic screening is constructed as the alternative to employment opportunities and social services for disabled people.[131] Genetic screening ignores the "complex interaction of environmental, biological and social causes" to these problems.[132] In a society with systemic racism and sexism, genetic engineering and other reproductive technologies have a breeding ground - literally. The National Council of Jewish Women asserts, as a group "very aware

of discrimination," that the reminder of Nazi Germany is sufficient reason to oppose the tinkering with human genetic perfectibility and to use criminal law to rule against it.[133]

The FQPN asks whether infertility is only the pretext and whether women are the primary material?[134] The primary materials are the eggs, sperm and embryo that can be combined ex-uteri to provide all the ingredients needed to do research on "perfecting" reproduction but not necessarily to "cure" infertility. Hitler wanted to construct a perfect "strong" race, one with no individual, "weak" deviants, but he did not have the techniques that exist today. Instead, he resorted to forced sterilization, and exterminated Jewish people, the disabled and others who were thought to be unfit to reproduce or even to live. This type of eugenics also occured in North America, although on a smaller scale. For eample in Canada, until the 1970s developmentally delayed, disabled women were forcibly sterilized in Alberta and B.C.[135] Eugenics take many forms and today they are much more subtle and scientific and more fine tuned. According to CDRC the goal behind NRGTs is to improve human reproduction and create perfect babies.[136]

NAC calls eugenics the "prizing of conformity," where individual differences are being exploited and manipulated to conform to certain dominant characteristics and qualities.[137] Genetic screening is a form of eugenics but so is the marketing of NRGTs. NRGTs are marketed to "fit reproducers" with a pronatalist ideology that excludes those considered unfit. While these marketing strategies manipulate certain women's right to mother under IVF, they devalue this right under contract motherhood.

XI. Motherhood- Compulsory and Contract

Due to the fact that the pluralist choice and liberal rights approaches do not examine why women choose to use NRGTs, they have overlooked several important factors that should be considered when making policy recommendations. Women are conforming to doctors' requests to have their pregnancy electronically monitored, women over 35 years old conform to doctors' definitions of "high risk", and women conform to many of society's dictates of compulsory motherhood. Society's attitudes toward women include the patriarchal view of motherhood and the maintenance of the nuclear family, with the woman

as the primary childbearer and care giver. There is a cultural expectation that fosters the belief that only genetically related children are acceptable and therefore the development of these technologies is appropriate.[138]

The FANRGT states that "there is a dangerous gap between theoretical considerations around ethical issues, the way they are put into practice and the actual experience of life, illness, and suffering on people."[139] The way groups respond to the issues of NRGTs depends on their interpretation and definition of women's needs. Presently society defines women's health and autonomy with negative, narrow attitudes towards women as a social group.[140] Women's groups must examine the definition of infertility since it is the underlying push for NRGTs and it is being narrowly defined by a medical industry that holds specific interpretations of motherhood.[141]

Women receive contradictory messages regarding motherhood. IVF and other assisted conception technologies idealize women's ability to give birth, while the social role of mothering in Canada is often done in isolation and is devalued.[142] From a liberal rights perspective, CSF believes that women can reappropriate motherhood as something that is valuable and powerful for them; women do not need to be liberated from reproduction.[143] Women can fall into "compulsory motherhood" and therefore it has to be confronted. These technologies, according to MACS, link the value of women to their reproductive capabilities. The social construction of motherhood is coupled with a medical construction of infertility and "there is an equation of motherhood and womanhood that occurs: you either become a mother or you do not become a woman."[144] CRC stresses the need to discuss the possibility of not having children because women are still "presumed to want motherhood."[145]

The issue of compulsory motherhood is especially prevalent in the Quebec women's groups presentations, due to the pervasive pronatalist ideology present in Quebec. In Quebec the government offers a baby bonus that reinforces the status quo. It provides financial assistance to childbearing women - an incentive of $500 for the first child, $3000 for the third or forth. As the Women's Centre of Montreal (WCM) points out "the government is encouraging fertility and not promoting the alternatives therefore it is propagating the concept of women as childbearers."[146] GREMF also considers the social construction of compulsory motherhood and states that the government solicits women to have children, and

constructs childbearing as a vision of happiness (as psychological balance and personal success). This is because an alarm has sounded in Quebec regarding the fertility rate and the survival of the French language and culture.[147] This type of pronatalism may not be as prevalent elsewhere but to question how motherhood is constructed allows for a discussion of how these technologies affect women's autonomy and status in society and reinforce the status quo.

Under contract motherhood, couples face societal pressure to have genetic offspring but surrogacy and other procedures devalue the contract woman's link.[148] GREMF picks up on the irony presented with surrogacy as it was not too long ago that women who gave up their babies were stigmatized and shunned as horrible and now they are seen as altruistic.[149] The ultimate sacrifice for a woman, depending on her race and class, is to sign a surrogacy contract. In most cases the fetus is genetically linked to the contract father and the value of the male's genetic link is presumed to far outweigh any connection the woman might feel toward the fetus.

These technologies also fragment motherhood so that it is easier to control. The commercialization of and control over women is never more apparent than in contract motherhood. NAC describes contract motherhood as "the extension of the marketplace into a woman's body" and therefore recommends a ban on all types of contract motherhood.[150] A liberal rights approach raises the concern that, if contract motherhood is banned, it will be driven underground. Therefore, we must legislate to control it, making it illegal to advertise, and make all contracts for profit illegal and unenforceable.[151] The other option is to govern contract motherhood using adoption criteria. Other groups insist that consideration be given, as the South Surrey-White Rock Women's Place did, to the exploitation of poor women in relation to surrogacy.[152]

Any contract, like a surrogacy contract, which "regulates women's physical, social existence, denies her first claim on her child, or involves a monetary transaction" must be unenforceable as it serves to completely control women's lives. For CRIAW contract motherhood is a "dangerous precedent for the rights of all pregnant women."[153] Other groups like FFQ recommend that the government ban all forms of contract motherhood because it tears motherhood into pieces (one woman may carry the fetus, another woman may have

donated the egg, and yet another woman may raise the child). For others, surrogacy is exploitative and advertising such services should be considered criminal acts.[154] The OACWI recommends that the government draft wide enough legislation to regulate all types of surrogacy contracts. However, it did not reach a consensus on who shall be liable because some believe that no parties can be exempted not even the "surrogate".[155]

According to the IVMWBC the "cost for exploitations of women of colour far outweigh any benefits that might accrue to affluent couples."[156] Gestational surrogacy is when a contract mother carries an embryo that has no genetic link to her. It creates the possibility of increasing the exploitation of women of color. As IVMWBC suggests, a white, affluent couple could contract a woman of color to gestate their embryo. Women of color risk being exploited and commercialized not just because of racism but classism as these women are "disproportionately represented among the poor."[157]

Taking all of this into consideration might have influenced many groups to take either a liberal rights or pluralist choice approach, and to distinguish between noncommercial arrangements and preconception contracts for money.[158] This distinction is made because there is a need to avoid exploitation but CFBPW feels this can be done by ensuring that these contracts are not for profit.[159] AWI is further concerned, whether the contract is for profit or not, about the role of the contractor, the question of ownership over embryos and regarding the specifics of social and legal arrangement.[160] Some pluralist choice groups agree with CRC as it recommends commercial surrogacy be unenforceable and arranging it be criminalized because a woman's personal freedom is being sold.[161] They like the PEIACSW and NBACSW postulate that the rules of adoption should apply for all other kinds of surrogacy.[162] This adoption model approach would mean that contract mothers have the same rights as birth mothers in adoptions. Contract mothers would have a set number of months to change their mind and request to have custody of the baby. The adoption model does not include the number of people who are involved in contract motherhood such as the sperm donor, the contract mother's partner, the contractors' wife, and the egg donor. It also does not resolve the child's legal parentage.[163]

Most of the women's groups recognized that these contracts were not "woman-empowering," and that there are obvious problems with the commercialization of

reproduction. Many of these groups, in particular liberal rights, accept surrogacy arrangements when no money is exchanged. But this does not go far enough for some pluralist choice groups. These groups insist that we account for the legal rights of the women, or consider their poverty, their emotional attachment, the relation of domination or "other areas of duress."[164] Many groups that accept these contracts do not recognize that contract pregnancies do not solve the problem of infertility. The women's groups offer their recommendations for medical and social solutions to infertility and their recommendations for government funding, both of which indicate where their priorities lie.

XII. Prioritizing Recommendations

While the medical profession defines infertility as a medical "disease" there are different socio-cultural interpretations of infertility and solutions that need to be researched.[165] The solutions need to go beyond guidelines because, "the science-industrial push means that there is a close interaction between research and industry" and therefore it is not in their best interest to prevent infertility.[166] According to Dalkon Shield Action Canada, the relationship between doctors, lawyers, and pharmaceutical companies is no different now then it was when the Dalkon Shield was marketed.[167] These industries commodify women by fragmenting a woman's body into its reproductive parts, and separating the egg, the womb, the sperm and the embryo.[168] Given what is known, the FQPN recommends prevention as one "solution" arguing that we cannot let the same industries that caused infertility profit from it.[169]

DES Action Canada and the Vancouver Women's Health Collective make some concrete proposals regarding prevention. DES Action Canada argues that the similarities between the development and implementation of DES and IVF procedures and the iatrogenic or doctor induced risks to fertility are striking. It is concerned another generation of women may be candidates in yet another cycle of cures, just as the daughters who were exposed to DES in the womb are now candidates for IVF.[170] The group insists that Clomid, a hormonal drug given to women to stimulate their ovaries to produce a hyper number of eggs per cycle, is similar in molecular structure to DES. Accordingly, the government should ban Clomid

because it could cause infertility and other health problems just as DES did. Therefore, this is one way to prevent infertility and to reduce the exposure to risks that women face from the medical and pharmaceutical industries. Another example is the Dalkon Shield, an intrauterine contraceptive device that caused infertility. Since there is no certainty that other IUDs do not pose the same risks, the Vancouver Women's Health Collective recommends that IUDs be banned and the stocks be destroyed to avoid dumping.[171]

As the University Women's Club of North York points out it is difficult to statistically account for prevention techniques because the medical system records only diagnosed and reportable cases.[172] Furthermore, it would be difficult to determine whether a woman would have developed fertility problems if certain factors had not been present. For these groups to suggest that if infertility is prevented then the technologies will no longer be used is an almost simplistic supply/demand equation of the problem of infertility. It is true as VSW states that if women choose not to have a baby, to adopt, and to foster, they challenge the marketing assumptions for NRGTs.[173]

The FMWC recommends that women be encouraged to adopt, and that the government speed up the process of international and national adoption. This would, it argues, alleviate the problems that might occur if NRGTs were to be universally available and funded and "inundated" with women. Therefore, it recommends that current adoption and immigration laws be changed because there are few Canadian babies available for adoption.[174] The AACWI considers NRGTs to discourage the "consideration of alternative ways in which people could nurture children to whom they are not biologically related."[175] The diversion of the demand elsewhere is at minimum a reductionist vision of the "desperation" of women seeking to have a child. Furthermore, as YWCA of Vancouver states, while many groups may consider international adoption as an alternative, it is not. "The perceived needs of childless people in developed nations totally ignore the needs and rights of parents in the Third World." We cannot "benefit from the marginalization and oppression of women in poor countries."[176] Concerning domestic adoptions, MHS Victoria recommends that closed adoptions should be opened so that a birth mother can choose the adoptive parents; the links between the parties are kept open.[177] NAC recommends increased access to nontraditional adoptions and increased value placed on social parenting.[178]

Those NRGTs such as IVF that are to assist in human reproduction do not solve the infertility problem and are not preventative. Furthermore, these technologies often displace the urgency for social change which could prevent infertility. Therefore, there is a need for solutions that are not narrowly medical and therefore these "technological fixes" may continue to erode the traditional ways of dealing with infertility decreases. Moreover, there are no social resources to replace the traditional, cultural coping solutions as they continue to be eroded.[179] YAWL states that Northern women fear that "factoring in these technologies at this time will only hasten the process of cultural erosion" and based this on the devaluation of their traditional birthing practices by the Western medical model.[180]

One example of a Native practice used to deal with infertility is custom adoption. As YAWL states, it is rare except in the larger communities in the North, to find families who have not adopted a child either into their family or out of their family. The difference between surrogacy and custom adoption, in the words of YAWL, is that under the latter women do not get pregnant to give up the child.[181] The significance of this distinction is that there are no contract and no intentional control over the reproductive process by "contracting parents." Custom adoption is a social solution that Native people have used to deal with pregnancy. The adopted Native children commonly know their biological parents and have a social relationship with them.[182] YIWA states that though Natives people practice custom adoption the genetic line is very important and the families will try to have the children of young, unmarried mothers, for example, adopted by the same clan line. Identity and names are very important for the survival of Native culture.[183] Custom adoption is arranged because of concerns regarding cultural continuity. Contract motherhood is arranged for the male's reproductive conscious. Custom adoption demonstrates the need to undertake historical and anthropological research regarding the experience of infertility and non medical solutions and also epidemiological research.[184]

The Indian and Inuit Nurses of Canada (IINC) group recommends that the government's immediate concern should be for "optimum reproductive health which is appropriate to their [Native people's] cultural aspirations."[185] This group expresses concerns regarding the incidence of infertility in the North. It states that although the birth rate in the

North is higher than in the rest of Canada right now, infertility may be on the increase because of the higher than average rate of STDs in the aboriginal population.[186]

The women's groups' proposals regarding public funding indicate how they would set the priorities on these issues. There were different approaches about the allocation of health care funding. Some groups want equal amounts for NRGTs as for other areas of women's health. Other groups want some funds to be diverted from NRGTs to the prevention of infertility and other women's health priorities, and still others distinguish between different types of funds.[187] The CACSW states that budgets should reflect a primary commitment to the prevention of infertility. The provision of infertility services should include prevention, social options (adoption, fostering, voluntary childlessness and custom adoption) standard medical and surgical treatments and then conceptive technologies.[188] CRIAW agrees with other groups that research funds should be redirected to researching the causes of infertility, promoting safer contraceptives and more male contraceptives.[189] The YWCA of Vancouver recommends that the government and pharmaceutical companies allocate at least equal funds to infertility prevention as to NRGTs.[190] NBACSW recommends no public funds for research and development but only for government funding for preventive methods.[191] One of CARAL's main opening points, however, is that economics cannot be of primary concern when deciding the availability of these technologies.[192] CRIAW Newfoundland urges that underlying these priorities "we must avoid technological determinism" and the way to do that is to critically analyze "the wider political social factors that impact infertility."[193] This then allows a reorientation of the debate to a discussion of alternatives and recommendations for solutions such as the improvement of structural equality for women.

The Women's Action Coalition of Nova Scotia (WACNS) stresses that women as a group need to be equal in practice but this will not be achieved through reproductive manipulation; there need to be real changes in social attitudes.[194] For example, women need more equality and control in the workplace. The lack of flexible hours, flexible vacation time, parental leaves, time-off, and lack of a national child care program, are displaced onto women. Women are blamed when they have problems conceiving a child, for delaying their childbearing time and increasing their exposure to risks. The Women Action Coalition of

Nova Scotia recommends improving the general situation of women as a group, and protecting the reproductive rights and the equality of women as a social group.[195] The CACSW warns that NRGTs will "deflect from measures which could contribute to women's health," when the measures that women need are "encompassed in socioeconomic factors such as poverty, adequate housing, and water."[196]

XIII. Conclusions

Those groups that made recommendations commensurate with the liberal rights approach are characterized as "yes, but"; the state regulates the abuses of these technologies and guarantees informed consent. CARAL expresses some key concerns about the risks posed to maternal autonomy by PNDT but it is unwilling to restrict the use of these technologies. The "no, not unless" or pluralist choice recommendations propose that NRGTs not be widely disseminated unless women's basic health needs are met as well. Many groups made both social relations and pluralist choice recommendations. However, groups such as HLCRT, ultimately accept the pluralist choice premise that there is a need to guard against discrimination for access. These groups recognize that women (couples) could possibly use NRGTs for certain "needs" but that right now their basic needs are not being met. The women's groups that take a "No, maybe never" or social relations approach, such as NAC, consider the exploitative capabilities of NRGTs to outweigh any possible "choice". These groups feel that NRGTs might never benefit certain groups of people. NRGTs displace some basic health care needs and solutions to such problems as hunger and pollution which would enhance social justice.

The Royal Commission took an overall "yes, but" approach, as did several women's groups on most of the main issues discussed in this chapter. Other groups took a "no, not unless" and still others a "no, maybe never" or more appropriately "no, not ever" approach. On the issue of access, the approach was yes, universal access should be permitted, but the access should include a woman's right to informed consent. Other groups that took a "no, not unless" approach, however, felt that universal access should not be offered but that access should be based on clear medical criteria for eligibility otherwise social control and

also concludes that women may never control contract motherhood, and argue that the ideologies of patriarchy and capitalism that underlie this kind of arrangement only decrease women's autonomy. The social relations position recommends that NRGTs should not be offered and the resources should be re-allocated to other programs.

The idea behind the liberal rights approach is a "here and now" attitude that NRGTs exist, they have been "successful" and will continue to be developed and improved therefore we should proceed, but with care. The reasoning behind the pluralist choice approach is a "what might be" attitude regarding women's control of these technologies. While it also agrees that NRGTs will continue it is more optimistic that their potential benefit to women can be realized. The reasoning behind the social relations position is that women need to resist these technologies because they decrease women's control and increase the control of "technodocs". With these opposing viewpoints in mind the next chapter examines why certain groups, in particular CARAL, extend the "right" to abortion to a "right" to NRGTs. As well, I consider why other groups such as NAC problematized this discourse. What could have been some of the pressures the groups faced to take one position over another?

discrimination will result. The "no, maybe never," proposals consider that women may never control these technologies and therefore NRGTs only mean increased medicalization.

On the issues raised in this chapter, the liberal rights approach recommended certain conditions be met before NRGTs are to proceed. On the issue of decision-making the liberal rights recommendation is to give women the right to decide to use these technologies since they can make an informed consent. Prenatal Diagnostic Technologies should be offered but the state must ensure that its abuses are regulated. Similarly, women should have the option to choose contract motherhood if a contract is signed and no money is exchanged.

The pluralist choice approach insists on the complexities of these decisions and as such recommends that these technologies not be offered unless women can make an informed choice. The pluralist choice approach recognizes the problems with certain procedures. It recommends that these technologies be offered but only if certain uses are not allowed, for example, the use of sex-selection for nonmedical reasons. Similarly, "surrogate" motherhood should not be offered unless there is no contract involved. Unless other basic health care services are guaranteed, pluralist choice feminists recommend that funds should not be allocated for the provision of NRGTs. It appears that the pluralist choice groups felt that they did not have a choice to make certain social relations recommendations. For example, HLCRT wanted to recommend a ban but instead recommended regulation of these technologies. Furthermore, this group recommended universal access to NRGTs because it did not want any restrictions to be used to discriminate against its members. On the issue of demedicalization of AI, HLCRT did recommend the complete demedicalization of this procedure. But, other pluralist choice recommendations concede that at least the sperm should be tested for HIV. With regard to access, the key problematic for CRIAW was that though IVF was medically unproven it was not willing to deny women access to the technology.

A social relations perspective proposes that PNDT technologies should not be offered because they only serve to deflect attention away from real social changes that are needed. Groups that make these kinds of recommendations argue that women are being coerced to use these technologies and then to abort a fetus because these procedures are administered in a society with very negative attitudes toward disabled people. A social relations approach

ENDNOTES

1.Louise Vandelac, "The Baird Commission: From "Access" to "Reproductive Technologies" to the "Excesses" of Practitioners or the Art of Diversion and Relentless Pursuit ... " Misconceptions: The Social Construction of Choice and The New Reproductive and Genetic Technologies, Eds. Gwynne Basen, Margrit Eichler and Abby Lippman (Montreal: Voyageur Press, 1993) 257.

2.For a discussion of this framework, see Canada, Royal Commission on New Reproductive Technologies, Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies, Volume 1 (Ottawa: Canada Communications Group, 1993) 52-58.

3.Thelma McCormack, "Reproductive Technologies: Rights, Choice and Coercion," Women and Canadian Public Policy (Toronto: Harcourt Brace,1996) 215.

4.Annette Burfoot, "In-Appropriation-A Critique of Proceed with Care," Women's Studies International Forum 18:4 (1995): 500. I agree with Burfoot's review of the Final Report, as she states it ignored the "diverse precedents in the feminist literature on reproductivity and reproductive technology"(500). Feminist precedents were presented in my literature review.

5.For an indepth study of these problems see Christine Massey, The Public Participation Program of the Royal Commission on New Reproductive Technologies, diss., Simon Fraser University, April 1994.

6.Liora Salter and Debra Slaco, Public Inquiries in Canada, Background Study No. 47 (Ottawa: Science Council of Canada, 1981) 194.

7.See Appendix D for a chronology of important Royal Commission events.

8."Commission Dispute Breaks out in Lawsuit," Globe and Mail 7 December 1991: A6.

9.Margrit Eichler, "Frankenstein Meets Kafka: The Royal Commission on New Reproductive Technologies," Misconceptions: The Social Construction of Choice and The New Reproductive and Genetic Technologies, Eds. G. Basen et al. (Montreal: Voyageur Press, 1993) 200. It was thought at the time that the additional commissioners were hired to balance out the "feminist" voices. The new commissioners were Bartha Marie Knoppers and Susan McCutcheon.

10.Eichler, "Frankenstein meets Kafka" 202-203.

11.Eichler, "Frankenstein meets Kafka" 203.

12.Salter and Slaco 210.

13.Salter and Slaco 210.

14.Canadian Abortion Rights Action League (CARAL), Brief presented to the Royal Commission on the New Reproductive Technologies, Presented in Halifax, Nova Scotia (October 16, 1990) 6.

15.CACSW 54. This council was an independent organization funded by the federal government, established in 1973. Its brief was one of the most comprehensive submissions and included basic guiding principles to assess NRGTs from a feminist perspective, a focus on issues of women's general reproductive health care, such as preventative reproductive health care, over medicalization, infertility services and rational health policy (prevention of infertility, safe contraception) and on technologies (IVF, genetic manipulation-cloning, transgenic, prenatal screening and diagnosis, AI), fetal tissue research and contract motherhood.

16.National Action Committee on the Status of Women (NAC), The New Reproductive Technologies: A Technological Handmaid's Tale. - A Brief Presented to the Royal Commission on New Reproductive Technologies (Revised June 1991) 24.

17.Women's Network (WN), Brief Submitted to the Royal Commission on New Reproductive Technologies (October 16, 1990) 5. This nonprofit, feminist network, situated in Charlottetown, PEI, evolved from an ad-hoc committee formed in 1981. It is now an organization of 170 members and its main goals were to strengthen and support the efforts of PEI women, to promote equality, educate and empower women.

18.Vancouver Status of Women (VSW), A Brief presented to the Royal Commission on New Reproductive Technologies (November 26, 1990) 1. VSW was founded in 1971. It is a nonprofit charitable organization engaging in advocacy, services and other activities including an information and resource centre, assertiveness training, and it publishes the journal Kinesis. Its brief responded to the negative implications these technologies have for women, examining the prevention of infertility, the commodification of reproduction, the experimental nature of NRGTs, and the possibilities for the obstruction of women's rights.

19.Immigrant and Visible Minority Women of B.C. (IVMWBC), Oral Transcripts of Presentation made by Sunera Thobani, Gulzar Samji and Betty Lough to the Royal Commission on New Reproductive Technologies (Vancouver, November 26, 1990) 182.

20.Immigrant Women of Saskatchewan, Brief Presented to the Royal Commission on New Reproductive Technologies (October 25, 1990) 2-4. The Immigrant Women of Saskatchewan (IWS), a non-profit organization that offers various services and programs to immigrant women, focused on the ideological framework guiding NRGTs and on infertility and the reinforcement of inequalities among women.

21.YWCA of Yellowknife, Annual Report 1993-1994: 3. The YWCA of Yellowknife, was founded in 1966 out of a need for housing for single women. It is dedicated to improving

the social, political, and economic positions of women. The brief it presented focused on five concerns: public education, alternatives to NRGTs, informed choice, accessibility and international adoption.

22.YWCA of Yellowknife, Brief to the Royal Commission on New Reproductive Technologies (December 1990) 3-4.

23.Nova Scotia Advisory Council on the Status of Women (NSACSW), Submission to the Royal Commission on New Reproductive Technologies (October 1990) 1-2.This organization which functions at an arms-length from the government was established by the provincial government in 1977.

24.NSACSW 13.

25.NSACSW 17.

26.Sharon Stone and Joanne Doucette, "Organizing the Marginalized: The DisAbled Women's Network,"Social Movements/Social Change: The Politics and Practice of Organizing, Ed. Frank Cunningham et al. (Toronto: Between the Lines, 1988) 88. DAWN Canada was formed at a national networking meeting for women with disabilities in June 1985. It is a national, nonprofit, self-help group comprised of and controlled by women with disabilities, and its goals include full equality and integration of disabled women into mainstream society.

27.Canadian Disability Rights Council (CDRC), Presentation by Yvonne Peters, Sheila Day and Gwen Brodisky inVancouver, B.C., Oral Transcripts, Royal Commission on New Reproductive Technologies Documents, National Archives (November 27, 1990) 33. This group is also a national, non-profit organization that works to secure legal education and research regarding equality rights for people with disabilities.

28.Canadian Research Institute for the Advancement of Women, Newfoundland, New Reproductive Technologies and Women's Health in Newfoundland and Labrador: A Brief to the Royal Commission on NRTs, Brief prepared by Dr. Barabara Neis at St. Johns, Newfoundland, (October 15, 1990) 3. This group is an autonomous regional body that sets its own goals, priorities and policies separate from CRIAW, the national organization. Its interests are specifically regional focusing on rural and isolated women. Its objectives are to help activists develop research skills, strengthen skills required to intervene in the public process, networking, and disseminating research.

29.Prince Edward Island Advisory Council on the Status of Women (PEIACSW), Submission to the Royal Commission on New Reproductive Technologies (October 1990) 7. This advisory council is a government appointed volunteer, arms-length organization, established in 1975.

30.PEIACSW 1.

31.NSACSW 6.

32.PEIACSW 2.

33.AFEAS 6-7. Other groups that supported a moratorium included Women of UNIFARM, Submission to the Royal Commission on the New Reproductive Technologies (September 14, 1990)5; and the Feminist Alliance of New Reproductive and Genetic Technologies (FANRGT), Oral Transcripts of the presentation made by Laura Sky and Margrit Eichler to the Royal Commission on New Reproductive Technologies, Toronto, Ontario, National Archives (November 20, 1990) 16.

34.Fédération du Quebec pour le Planning des Naissances (FQPN), Présentation de la Fédération du Québec pour le planning des naissances aux auditions de la Commission royal d'enquete sur les nouvelles techniques de reproduction humaine, Montréal, Québec (21 novembre 1990) 2. This organization was founded in 1972. Its mandate was to increase the freedom of choice for women when it comes to family planning. Its brief focused on the effects of NRGTs on women's well-being, fertility and the future of motherhood. There were a number of groups in Quebec that supported FQPN's position, including le Centre des femmes du Haut-Pays (women's centre), Naissance-Renaissance (birth-rebirth), Alliance québécoise des sages-femmes practiciennes (practicing midwives association of Quebec), Le R des centres des femmes du Quebec (association of women's centres in Quebec), la Federation des associations des familles monoparentales du Québec (federation of single parent family associations of Quebec), et le Regroupement québécois des centres d'aide and de lutte contre les aggression à caractère sexuel (association of sexual assault and crisis centres of Quebec) and Conseil d'intervention pour l'acces des femmes au travail du Quebec inc. (the Intervention council for women's access to the labor force of Quebec inc.).

35.Women's Health Interaction (WHI), Brief to the Royal Commission on New Reproductive Technologies (September 18, 1990) 2.

36.See for example, Alberta Women's Institute (AWI), Brief to the Royal Commission on New Reproductive Technologies, Submitted by Lynane Thunberg, National Archives (No date) 5. See also the Canadian Advisory Council on the Status of Women (CACSW), Brief to the Royal Commission on New Reproductive Technologies (March 1991) 44.

37.NAC 30.

38.The Halifax Lesbian Committee on Reproductive Technologies (HLCRT), Brief to the Royal Commission on Reproductive Technologies, (October 17, 1990) ii.

39.Yellowknife Association of Women and the Law (YAWL), Oral Transcripts of the presentation made by Carol Roberts (Yellowknife, September 12, 1990) 12.This association is affiliated with the National Association of Women and the Law, whose mission is to promote equal rights, legal education, research and law reform. The national association includes about 1000 women across Canada, including 30 caucuses and 11 working groups,

the national association did not present, but YAWL did as one of the caucuses.

40.D.E.S. Action Canada, Mémoire Soumis à la Commission Royale sur les Nouvelles Technologies de la Reproduction (Juin 1991) 309. This is a national non-profit organization which provides information packets, physician referrals and peer counselling to those persons who have suffered adverse effects of D.E.S. Its brief focused on the history of birth and reproduction for women with disabilities and on the counselling component of prenatal technologies.

41.Maureen McTeer,"The New Reproductive Technologies: The Body Politic: Temple or Bazaar," Herizons (Spring 1994): 22.

42.Women's Health Clinic, Brief to the Royal Commission on New Reproductive Technologies, National Archives (October 24, 1990) 6. This feminist, community based health centre, was founded in Winnipeg, Manitoba in 1981. Its approach is holistic emphasizing prevention, education and action to allow women to make informed choices. The services it offers include health and wellness services, public advocacy and research on health issues of concern to women, health education to the community, and it offers free and low cost counselling services and a teen clinic.

43.L'Association féminine d'education et d'Action sociale (AFEAS), Mémoire Présenté à la Commission Royale sur les Nouvelles Techniques de Reproduction, Rédigé par Claire Levaisseur (Novembre 1990) 17. This group, founded in 1966, is a non-profit organization with 23 000 members including 200 local groups. It is mainly a lobby group, a majority of their members are identified as rural women. Its brief included a number of recommendations for a moratorium, ethics committee, regarding embryo research, AI, prevention, and contraceptive research.

44.Salter and Slaco 152-153.

45.London Status of Women Action Group. Oral Transcripts of the Presentation by Margaret Buist to the Royal Commission on New Reproductive Technologies. London, Ontario (November 2, 1990) 105. LSWAG's brief focused on the findings of an informal survey with regards to the provision of AI, IVF and contract motherhood services in Southern Ontario.

46.Canadian Research Institute for the Advancement of Women, Submission to the Canadian Royal Commission on New Reproductive Technologies, prepared by Jacqueline Best for Christine St. Peter, contributors Monique Begin, Linda Clippingdale, Lise Martin and Jerilynn Prior (September 20, 1990) 20. Emphasis placed by me.

47.HLCRT 18.

48.Women's Education and Research Foundation of Ontario (WERF), Brief to the Royal Commission on New Reproductive Technology, National Archives, Vol. 12 (London, Ontario, November 2, 1990) 4. This organization is committed to research and education

on matters related to women's equality. Situated in London, Ontario. The focus of its brief was the accessibility of NRGTs for Canadian women.

49.CRIAW Nfld. 5-6.

50.Gouvernment du Québec, Conseil du statut de la femme, Les nouvelles technologies de la reproduction: Avis synthèse du Conseil du statut de la femme (Mai 1989). This status of women council was appointed by the Government of Quebec. It stated in a letter to me that it did not remit any documents to the Royal Commission, but I included this document which was submitted to the Quebec government and to the Royal Commission. It focused on the main challenges women face with regards to NRGTs. For an examination of the Québec groups' response to the actual Royal Commission see, Bibiane Béland, Synthèse Critique des Audiences Publiques de la Commission Royale sur les Nouvelles Techniques de Reproduction Tenues au Québec en 1990 (GREMF: Université Laval, 1993).

51.Fédération des femmes du Québec, Transcriptions orales de la présentation faites par Cécile Coderre et Louise Marquis, Montréal, Québec (21 novembre 1990) 15. This federation of Quebec women was officially founded in 1966, has 350 individual members and 112 associations which totals more than 100 000 women. See also CACSW 20; and Ontario Advisory Council on Women's Issues (OACWI), Presentation to the Royal Commission on New Reproductive Technologies (October 1990) 44.

52.HLCRT 2-4.

53.AWI 5. This Institute is an organization of over 200 women. It is an education, non-partisan, non-sectarian and non-racial group.

54.HLCRT i.

55.NAC 31.

56.PEIACSW 3-4.

57.OACWI 26.

58.Carolyn Egan, Linda Lee Gardner and Judy Vashti Persad, "The Politics of Transformation: Struggles with Race, Class and Sexuality," Social Movements/Social Change: The Politics and Practice of Organizing, Eds. Frank Cunningham, Findlay et al. (Toronto: Between the Lines,1988) 36.

59.Gay and Lesbian Parents Coalition International, Brief to the Royal Commission on New Reproductive Technologies, National Archives (September 19, 1990) 1-2.

60.WERF 8.

61.OACWI 25-26.

62.RFSO wants NRGTs to be stopped; Réseau des femmes de sud de l'Ontario (RFSO), Transcriptions Orales de la présentation faite par Vicky Lehouck et Claudette Pisa à la commission royale sur les nouvelles techniques de reproduction, National Archives (le 20 novembre 1990) 105; NCJW sees anonymity as a problem because of the incest possibility, lack of genealogy, problem of inheritance; National Council of Jewish Women (NCJW), Vancouver Section, Brief to the Royal Commission on New Reproductive Technologies, Presented by Lila Auastel, Shirley Human, Dr. Grances Rosenberg (Vancouver, B.C., November 28, 1990) 3; NBBPWC believes God to be the giver of life and therefore NRGTs that fragment parenting roles are problematic; New Brunswick Business and Professional Women's Club (NBBPWC), Brief to the Royal Commission on New Reproductive Technology (October 19, 1990) 6.

63.CRIAW 14.

64.Margaret Denike, "Normalizing Lesbian Mothers: Thoughts on the Royal Commission's Recommendations on Donor Insemination," Reproductive Rights and Reproductive Wrongs: Proceedings of a Conference held in Victoria, B.C. (Victoria: Ad-Hoc Committee on Reproductive Technologies, January 14-16, 1994) 5.

65.Denike 24.

66.AFEAS 11.

67.AWI 5.

68.YAWL 9.

69.OACWI 32.

70.NSACSW 25.

71.Canadian Federation of University Women (CFUW), Presentation to the Royal Commission on New Reproductive Technologies, Presented by Dr. Linda Williams and Dr. Mary Saunders (November 19, 1990) Resolution 21. A national organization founded in 1919. Its current membership is 1200 university graduates in 130 clubs across the country. Its objectives include the promotion of education and the improvement of the status of women.

72.CACSW 49.

73.OACWI 35.

74.New Brunswick Advisory Council on the Status of Women (NBACSW), New Reproductive Technologies: What Price Hope? - Brief Submitted to the Royal Commission on New Reproductive Technologies (Moncton, N.B., October 1990) 11. This agency was created to advise the NB government. It reported directly to the Premier who is the Minister

Responsible for the Status of Women. It consists of 12 members appointed by the provincial cabinet for a three year term. Its mandate includes recommending research, proposing legislation and policies to promote the status of women, writing report and studies.

75.Manitoba Advisory Council on the Status of Women (MACSW), Submission to the Royal Commission on New Reproductive Technologies (October 23, 1990) 5. This organization is an arms-length government organization responsible for advising the Manitoba Government on women's issues.

76.CARAL 1.

77.Fédération provinciale des Fransaskoises, Transcriptions orales de la présentation faites par Maria Lepage, Françoise Sigar-Cloutier au Commission royale sur les nouvelles technologies de la reproduction, Saskatoon, Saskatchewan (25 octobre 1990) 195-196. This federation was established May 1990, and represents the interests of francophone women in Saskatchewan. It includes 11 local organizations.

78.CACSW 10-11.

79.WN 5.

80.Federated Women's Institutes of Canada, Oral Transcripts of the Presentation made by Charlotte Johnson and Marion McNabb to the Royal Commission on New Reproductive Technologies (Winnipeg, Manitoba, 23 October 1990) National Archives Document, Vol.13: 184.

81.Association of Ontario Midwives, Submission to the Royal Commission on New Reproductive Technologies (November 20, 1990) 1-2. It has advocated the midwifery model of health care which includes informed choice and has worked for the legal recognition of midwifery over the last 10 years.

82.MHS Vancouver 358. The Vancouver chapter of this organization has been in existence for around 15 years. It is a non-profit society whose goal is to provide information to childbearing women and their families.

83.MHS Vancouver 352.

84.CRIAW Nfld. 2.

85.Toronto Women's Health Network.(TWHN) Submission to the Royal Commission on New Reproductive Technologies (November 1990) 3.

86.CACSW 15.

87.CACSW 2.

88.The Coalition for Reproductive Choice (CRC), Submission to the Royal Commission on New Reproductive Technologies, Presented by Penni Mitchell and Amanda le Rougetel (Winnipeg, October 23, 1990) 11. For example, not all groups would agree with NAC that DI should be demedicalized,

89.Maternal Health Society (MHS), Oral Transcripts of the Presentation by Laurie Brant to the Royal Commission on New Reproductive Technologies, National Archives (Vancouver: November 27, 1990) 354. See Maggie Thompson, "Whose Womb is it Anyway?" Healthsharing (Spring 1988): 14-17 for more information on the case of Baby R, May 20, 1987 in a Vancouver Hospital. Or see Sherene Razack, Canadian Feminism and the Law: The Women's LEAF and the Pursuit of Equality (Toronto: Second Story Press, 1991) 120-122.

90.DisAbled Women's Network (DAWN) Toronto, Oral Transcripts of the presentation made by Liz Stimpson and Sharon Wood to the Royal Commission on New Reproductive Technologies (Toronto: November 20, 1990) 4. This feminist organization is an affiliate of DAWN Canada.

91.TWHN 2.

92.CDRC 27.

93.DAWN Toronto 31.

94.McCormack 206.

95.CARAL 2.

96.CARAL 4.

97.DAWN Toronto 35.

98.NAC 21.

99.CDRC 32.

100.MACSW 3.

101.CDRC 27.

102.CDRC and DAWN Canada, Four Discussion Papers on NRTs (August 1990) 17.

103.CDRC 27.

104.DAWN Canada 2

105.Roxana Ng, "Finding our Voices: Reflections on Immigrant Women's Organizing,"Women and Social Change: Feminist Activism in Canada, Eds. Jeri Dawn Wine & Janice Ristock (Toronto: James Lorimer and Co., 1991) 185.

106.IVMWBC 185.

107.AWI 2; PEIACSW 11, recommends that non-medical diagnosis be a criminal offence.

108.Federation of Medical Women of Canada (FMWC), Presentation to the Royal Commission on New Reproductive Technologies, National Archives (Vancouver: November 27, 1990) 8. An independent, national organization of women physicians. Concerned with the professional, social and personal development of women physicians, and the promotion well-being of women in and outside of the profession. It acts as both a patient and physician advocate.

109.IVMWBC 185.

110.IVMWBC 194.

111.FANRGT 6. A woman's organization based in Toronto. Formed in 1990 largely in response to the RC. Its mandate is to research, public education, outreach and coalition building and action in intervening in public policy development in these areas. Support women's reproductive rights and take a critical approach to NRTS. It is a non for profit surviving on the support of their members solely.

112.FINRRAGE, Resolution 239.

113.OACWI 45. OACWI was established in 1973 by the provincial government as an arms length government organization. It makes recommendations and advises the government through the Minister Responsible for Womens' Issues.

114.Maternal Health Society, Victoria Chapter, Oral Transcripts of the Presentation made to the Royal Commission on New Reproductive Technologies, Ann Livingston (November 29, 1990) 52.

115.WHC 9.

116.The Northwest Territories Status of Women Council, Brief to the RCNRTs (September 12, 1990) 4.

117.NWTCSW 5-6.

118.YAWL 9.

119.Yukon Indian Women's Association, Oral Transcripts of the presentation by Linda Macdonald and Pearl Keenen to the Royal Commission on New Reproductive Technologies,

in Whitehorse, Yukon (September 11, 1990) 52.

120.YIWA 56.

121.Saskachewan Action Committee, Status of Women, Brief presented to the Royal Commisssion on New Reproductive Technologies (25 October 1990) 5.

122.WHC 4-5.

123.DES Canada 32.

124.YAWL 12.

125.CACSW 2-3.

126.FQPN 3.

127.IWS 5.

128.National Organization of Immigrant and Visible Minority Women of Canada. Brief to the Royal Commission on New Reproductive Technologies (October 19, 1990) 3.

129.Vancouver Women's Reproductive Technologies Coalition (VWRTC), Presentation to the Royal Commission on Reproductive Technologies (Vancouver, B.C. November 26, 1990) 4.

130.DESAC 5.

131.AWI 16.

132.CRIAW 10.

133.NCJW 14. NCJW is a voluntary organization operating within the context of Judaism. It has 325 members and has been in existence for 66 years. Their presentation focused on actions through law, public information and research to reduce the risks associated with these technologies.

134.Fédération du Québec pour le Planning des Naissances (FQPN), Transcriptions Orales de la Présentation de la Fédération du Québec pour le planning des naissances aux auditions de la Commission royal d'enquête sur les nouvelles techniques de reproduction humaine, National Archives (Montréal, Québec: 21 novembre 1990) 304. .

135.DAWN Toronto 25.

136.CDRC 29.

137.NAC 22.

138.PEIACSW 9.

139.FANRGT 12.

140.FANRGT 6.

141.WHI 8.

142.Vancouver YWCA, Brief to the Royal Commission on New Reproductive Technology from the Vancouver YWCA Board of Directors (December 1990) 3. The largest women's organization in BC, serving women and children since 1897 through a variety of programs and services designed to empower women. The focus of its brief was the implication of NRTs for women's reproductive health and well-being, individually and as a social group. Some of the issues it explored included mother and fetus relationship, choice, control and equality, informed choice, medicalization, access and impact on children.

143.CSF 7.

144.MACS 8.

145.CRC 3.

146.Women's Centre of Montreal (WCM), Brief on New Reproductive Technologies. (November 1990) 3. It was founded in 1973 as a non-profit organization. 10 000 women use their services each year. Its Social Action Committee was formed in the fall of 1991 to discuss issues of NRGTs and it held informal discussion groups with women who used the centre. The centre's main objective is to offer women practical solutions to information to improve their lives. It offers an information and referral service, counselling, self-help services, and educational programs to immigrant women and their families.

147.GREMF 15. For a further discussion of pronatalism in Quebec see Heather Jon Maroney, "'Who has the baby?' Nationalism, Pronatalism and the Construction of a 'Demographic Crisis' in Quebec 1960-88," Feminism in Action Studies in Political Economy, Eds. M. Patricia Connelly and Pat Armstrong (Toronto: Canadian Scholars' Press, 1992) 237-265.

148.YWCA Vancouver 3.

149.GREMF 5. GREMF is a research group situated at Laval University, created by professors, professionals and students from various faculties and schools. Its principal activities include research, distribution, teaching, and community intervention.

150.NAC 15.

151.RAIF 6.

152.South Surrey-White Rock Women's Place, Oral Transcripts of the presentation by Susan Cram and Halina Struser to the Royal Commission on New Reproductive Technologies, Vancouver (November 27, 1990)102.

153.CRIAW 10.

154.FFQ 6; CSF was the first to recommend a ban, see CSF 29); see also CRIAW 10.

155.OACWI 14.

156.IVMWBC 187-188.

157.IVMWBC 188.

158.CACSW 52.

159.Canadian Federation of Business and Professional Women's Clubs (CFBPWC), Brief Prepared for the Royal Commission on New Reproductive Technologies, Presented at Toronto, Ontario (October 29, 1990) 9.These clubs provide support to women who have been engaged in the last two years, or who will be actively engaged in business, profession or industry this included students in post-secondary institutions. This organization works to equality of opportunity and economic security for all women. This group has numerous clubs with a membership of 3000.

160.AWI 4.

161.CRC 13.

162.PEIACSW 2; NBACSW 11.

163.OACWI 99.

164.OACWI 8.

165.MACSW 5.

166.NAC 20.

167.Dalkon Shield Action Canada, Oral Transcripts of the Presentation to the Royal Commission on New Reproductive Technologies, National Archives (November 27, 1990) 309.

168.CRC 9.

169.CACSW 4.

170.DESAC 1.

171.Vancouver Women's Health Collective (VWHC), Submission to the Canadian Royal Commission on New Reproductive Technologies (April 1991) 8. Founded in 1971 on the principle of self-help. It is an information and referral centre. It provides education workshops and publishes womens' health information. Its goals include providing clear, detailed information to enable women to make informed choices about their health care in a supportive environment.

172.University Women's Club of York, University Women's Club of North York, Chapter of the CFUW, Submission to the Royal Commission on New Reproductive Technologies. Presented (Toronto: October 30, 1990) 3.

173.VSW 5.

174.FMWC 6-7.

175.Alberta Advisory Council on Women's Issues (AACWI), Submission to the RCNRT. Prepared by Margaret Cooke, Laurie Bateman and Peggie Graham (September 13, 1990) 4.The Council was made up of 15 women appointed by the government of Alberta.

176.YWCA of Yellowknife, Brief to the Royal Commission on New Reproductive Technologies (December 1990) 3.

177.MHS Victoria 55-56.

178.NAC 31.

179.FFQ 23.

180.YAWL 11.

181.YAWL 22.

182.YAWL 7-8.

183.YAWL 64.

184.CRIAW Nfld. 6.

185.Indian and Inuit Nurses of Canada (IINC), Oral Transcripts of the presentation made by Madeline Dion Stout and Mary Lanigan to the Royal Commission on New Reproductive Technologies, Ottawa, Ontario, National Archives (September 20, 1990) 87.

186.IINC 85.

187.VWRTC 5.

188.CACSW 19.

189.CRIAW 19.

190.YWCA of Vancouver 7.

191.NBACSW 7.

192.CARAL 1.

193.CRIAW Nfld. 2.

194.Women's Action Coalition of Nova Scotia (WACNS), Women and the New Reproductive Technologies, A presentation to the Royal Commission New Reproductive Technologies (October 17, 1990) 3. A coalition of women's groups from across N.S. Its primary purpose is to lobby the government. It was formed in 1987 as an independent body.

195.WACNS 6.

196.CACSW 12.

CHAPTER THREE
DISCOURSE NEGOTIATION: MOTIVATIONS AND CONSTRAINTS

over this issue the current 'wave' of the feminist movement will lose its momentum and disintegrate or feminism will emerge a far stronger, more unitary force.[1]

I. Introduction

In this chapter I discuss the motivations and constraints on the women's groups as they struggled to negotiate the feminist discourse on NRGTs and make specific policy recommendations. I explore why the map of the proposals on a continuum has regulation at the liberal rights end, resistance at the social relations end and the pluralist choice position in the middle because of its varied positions on different technologies. I examine how these recommendations are positioned according to their relation to the state and the dominant liberal discourse embodied in it. In the literature review the social relations position emerges as the alternative approach to NRGTs that could fill several "gaps" between the concepts used and the actuality of women's lives. In Chapter Two, I showed how several women's groups take up certain elements of the social relations approach including the National Action Committee on the Status of Women (NAC), the Disabled Women's Network (DAWN) Canada, and the Immigrant and Visible Minority Women of British Columbia (IVMWBC). This chapter conjectures why some women's groups could adopt the central tenets of a social relations approach to NRGTs and why others did not.

I recognize that we cannot fully understand the motives, philosophy and reasoning

of the women's groups by examining one document. Still, I argue that certain factors have influenced the women's groups' decisions, choices of language and roles in the social process involved in the construction of a NRGTs discourse. The main question that guides this chapter is "why was there a divide between women's groups who support the rhetoric of "freedom of choice" and those who criticize the legacy of the abortion struggle as inappropriate for analyzing Reproductive Technologies?"[2] I examine NAC in more detail since it is at the forefront of the critique of the unfettered "choice" discourse. This chapter examines several factors that may have influenced the polarization of the debate including the state's control of the agenda, the media reporting of the Commissioners' problems, the media reporting of the hearings, and the public discourse regarding the representation of women's concerns in Canada. The principal divisions as they became constructed and entrenched in the discourse of the debate as it evolved are between "heartless" feminists and infertile women, between the "Left" and the "Right," between pro-choice and anti-choice, between opponents attempting to "protect women" and proponents wanting to provide women with "services" and finally between pro-science/technology and anti-science/technology.

I explore the main reasons for the polarization of the debate in the reproductive rights movement. I locate the groups within the reproductive rights movement to understand their positions and to present possible justifications, reasoning and contextual influences. The issue of representation contributes to an understanding of why certain recommendations were made to the RCNRT. By examining the social relations and liberal rights approaches taken by NAC and the Canadian Abortion Rights Action League (CARAL), I draw conclusions about the significance of the language used in their presentations. I explore these groups here because of their divergent recommendations and positions on Prenatal Diagnostic Technologies.

Chapter Two sketches several problems with the management of the Royal Commission. Here, I provide a further discussion of other problems that may have served to impede the women's groups ability to offer alternatives to the "choice" and "rights" discourse. In particular, this chapter examines problems with regard to due process and "fairness". The intent of the Royal Commission may have been to hear from all concerned

and affected parties. However, the Royal Commission did not facilitate participation, and therefore it did not ensure that these groups and individuals had the resources required to effectively submit and respond to it.

II. RCNRT: Problems with the Public Participation Process

The government leads citizens to believe that it is aware that certain issues require public consultation and that, as part of the democratic process, this consultation is integral to the development of public policy. The government then strikes a Royal Commission, gives it a mandate, and appoints Commissioners. The government plays a non-interventionist role and awaits the Commissioners' Final Report and recommendations. As already discussed, however, this scenario is not always so "simple" and is definitely not depoliticized. The government uses the Royal Commission as a tool to set the agenda, to be able to claim that effective participation has occurred and thus to justify the Commission's recommendations.

One way a royal commission claims that participation has taken place is to quote how many groups and individuals were "consulted".[3] In this case the Royal Commission stated that it held hearings in 17 cities across Canada and heard from "more than 550 people, on behalf of more than 250 organizations."[4] The Royal Commission and its Commissioners continually emphasized the fact they consulted 40 000 Canadians.[5] But, for one, the numbers presented by the Royal Commission are quite misleading because if taken as mutually exclusive categories, while 221 groups presented, several individuals presented on behalf of the groups and not as individual citizens. The Royal Commission appeared to have one interpretation of "participation" while the women's groups had another. For the women's groups, consultation does not equal participation especially if the Royal Commission does not take the responsibility to do more than consult as many Canadians as possible.

The point to be made here is that numbers are often very misleading. This quantitative view of participation does not suggest the real differences between groups and constituencies and the reasons they made recommendations or not. For example, there is

no distinction to be made between those who submitted a letter stating they were unable to attend the public hearings or to submit a written brief, like the Association of Acadian Women of Nova Scotia did, and those groups who attended the public hearings and/or presented a 500-page written submission, like the Canadian Medical Association did. The number of groups and individuals that appear before a Royal Commission is not a sufficient measure to judge its success. I would argue though, that it is significant that, of 103 women's organizations that presented to the Royal Commission, only two were Native women's, three were immigrant women's, two were disabled women's, and two were lesbian groups.[6] One immigrant women's group made the observation that the absence of more visible minority women on the Commission and the lack of presentations from these women reflects their marginalisation in society.[7]

The women's groups had certain expectations of the Royal Commission, not the least of which because of the important catalyst the Canadian Coalition on Reproductive Technologies provided in its lobbying as well as in its recommendations. Royal Commission mandates do add to the way a group interprets the possibilities and limitations on its agenda. Considering this, the women's groups may have had certain expectations considering that "central to the Commission's deliberations was how new reproductive may affect women's reproductive health and well-being; their individual autonomy and scope for reproductive decisions; and their status, rights and interests as members of society."[8] The women's groups were undoubtedly an important constituent to be consulted and for which effective participation should have been facilitated. Furthermore, the women's groups had a certain interpretation of a "fair" process and "participation" which did not seem to coincide with the Commission's.

An example of a consultation process said to reflect a "true spirit of public inquiry," was the Mackenzie Valley Pipeline Inquiry or Berger Inquiry.[9] Native people received intervener status and were funded by this inquiry. The intent was to allow Native groups, who were obviously affected by this project, to undertake research that would then be presented to the public inquiry. The Berger Inquiry also held an extensive public education campaign before the public hearings. This inquiry considered the Native people's submissions to be of equal value as the "technical" submissions. It went a long way to

equalize the opportunities for participation, and could claim effective participation. Daniel Drache and Duncan Cameron conclude that this "empowering of these groups was undoubtedly an influence on the commission's landmark decision to slow down resource development in the North."[10]

The RCNRT did not provide for either intervener funding or an extensive public education program. It had a toll-free telephone information line, it mailed out a newsletter, information kits, brochures, and other pieces of information, which were distributed through a mailing list and at public events. It also published information in newspapers and other venues, and prepared media releases.[11] The one thing all these strategies have in common is that they "depend on the initiative of citizens to contact the Royal Commission" and to do this these individuals or groups would require an education or information campaign.[12] There was no real public education campaign except study guides distributed to those groups or individuals who requested them.[13]

This Commission thought that it was assured of certain ready constituents: pharmaceutical companies, legal representatives, fertility clinics and doctors.[14] However, an internal communications memo from the Commission acknowledged that there was a lack of input "from industry, the francophone community, various ethnocultural communities, youth, religious groups and aboriginals." It stated that this is because "they [these groups] had nothing to say or did not understand the issues/process."[15] In reality, the representation process was most problematic for many women's groups that lacked the education and funding needed to intervene and were unable "to afford the required significant contribution" a Royal Commission demands.[16] The Yellowknife Women's Society states that although the Royal Commission on NRTs went North, the government still did not give them appropriate tools to be able to respond. The process made the group feel that if it did not respond it would be considered not interested. However, to respond means that the government could say they were consulted.[17] The government uses this strategy as a way to legitimate an otherwise inadequate process. The public participation process has parallels with liberal rights as it left it to individual groups to choose to participate or not.

Groups are often unable, or unprepared to respond, or are forced into being reactive because the government does set the agenda and the timetable. Sue Findlay concludes that

not only does the state organize social relations and control the form of representation, it is also a part of the everyday workings of organisations.[18] For example, the government continues to fund many organizations that presented to the Royal Commission. With the funding comes certain conditions and "appropriate practices" such as funding contracts, ways of working, speaking, writing and organizing.[19] Whether the government funds the group or not there are certain ways that groups have organized, fought for their voices to be heard, and sought representation within the Canadian state. There are certain decisions that are made when feminists engage in a state process.

The liberal rights feminists in the literature review saw the state as being neutral, while the pluralist choice feminists do not trust the state but do not consider it to be inherently controlled by capitalism or patriarchy. For the pluralist choice feminists, the state could be a site of struggle. The regulation and resistance these women recommend are based on transforming the social and material conditions under which choices are made. The social relations feminists are very distrustful of the state and consider it to play a functional role in controlling the power relations in society. For the social relations position it is important to resist state control. Although their main recommendation is for a ban on NRGTs (sometimes AI is exempted), a recommendation that requires the state to intervene, nonetheless they would argue for as little state intervention as possible. These feminists insist instead that alternative institutions can be established to deal with infertility, with a ban being a definite policy that requires no negotiation on the part of the state but only implementation.

For the women's groups who presented to the Royal Commission there is a certain history that has influenced the Canadian women's movement, more particularly the English Canadian reproductive rights movement, and its relationship with the state. All of the groups regardless of the recommendations they made, whether liberal rights, pluralist choice or social relations, were asking the state to intervene and were willing to lobby the state. The strongest resistance were of those groups and individuals who chose not to respond to a Commission because it is a state tool. This strategy meant that feminists risked being excluded from the policy process. At the same time, those groups who decided to present briefs and to participate like any other interest group risked being coopted by the state's

agenda and may have felt they had to ask or accept token legal/formal reforms.

Historically, feminist have accepted reforms that "have been constrained by a liberal democratic definition of politics that is premised on the belief in the neutrality of the state and its capacity in a fundamental sense to represent (to protect and negotiate) the interests of "the people"."[20] There are certain questions that are raised that suggest that feminist principles are compromised as feminists attempt to persuade the state to adopt their recommendations. The liberal recommendations were for the state to regulate the technologies, but the danger is that it is women's lives and "choices" that will be regulated and not the technologies. The dangers of engaging with the state are the same with regard to adopting the concepts of the dominant liberal discourse. There is a danger of internalizing the limits of both, of allowing the state and the discourse to define the demands requested in terms of what is "acceptable." The state response usually means some benefits for some women, just as the "rights" and "choice" concepts of the dominant liberal discourse benefits some individual women.

If the women's groups consider the state as "itself one of the structures and relations of masculine dominance," can they expect the state to achieve its goals?[21]There is an overwhelming concern that the state will reformulate their recommendations so they are unrecognizable and severed from any critical analysis of gender or social relations.[22] Therefore, whether the feminist policy proposals are for a moratorium or a ban, one influence on these groups was undoubtedly their past "experience organizing against, around and within the state" and examining "the assumptions which have informed their strategies."[23]

Many groups Christine Massey interviewed in her study of the public participation process expressed their frustration of this state process. The groups told her how difficult it was to develop "expertise" in an area with an obvious lack of accessible information and then to present it to an official body in such a short time.[24] Those groups that did present faced many logistical problems, including the lack of child care and travelling expenses.[25]

In the submissions that I examined, many groups expressed their various complaints and demands to the Royal Commission. The Planned Parenthood Federation of Canada requested a whole morning for the consultations instead of the half hour that the Royal

Commission proposed.[26] The Royal Commission tried to cut costs by limiting the duration of the presentations to twenty minutes with ten minutes for Commissioner questions. The Manitoba Action Committee on the Status of Women (MAC) stated that the lack of funding for feminist organizations undermined its ability to operate, and to respond to issues such as this one.[27] The YWCA of Yellowknife "did not feel qualified to comment on specific technologies."[28] The Women's Health Clinic also raised the issue that many women believe that they are unqualified to respond [to the issue] because of the language employed by professionals, which is very exclusionary.[29] The Association of Acadian women in Nova Scotia sent only a letter to the Royal Commission, because it did not feel its knowledge of this subject was profound enough, and because of the lack of time the Royal Commission provided to prepare a response.[30]

According to the Saskatchewan Action Committee on the Status of Women (SAC) more Saskatchewan groups did not present because of the Commission's mandate; NRGTs are not widely available in Saskatchewan and because most Saskatchewan communities lack basic information services and support for their reproductive health care.[31] Similarly, the Women's Health Clinic (WHC) in Winnipeg, stated that they held information sessions that were sparsely attended. They believe this was because most "women are more concerned with fertility control, birth control, abortion, labor and delivery rather than these technologies."[32] In the words of Mussi Cho, a member of the Yukon Indian Women's Association (YIWA), "reproductive technologies is not an issue for us, nor is it even on the bottom of the list of our health issues . . . it is difficult to think of infertility as an issue when our overall well being is lower, and some statistics show alarming disparity with the rest of Canadians." This group reports that Native people face higher neonatal and postnatal mortality rates, higher suicide rates, and also higher birth rates. YIWA concludes that "it is difficult not to associate the quest for new reproductive technologies with an elite group of people in Southern Canada . . . This is not a poor man's issue, nor is this a First Nations issue."[33]

For certain groups the barriers to participation were more difficult to surmount. For Native women their groups are important vehicles "for political education and involvement as well as a means of combatting isolation and powerlessness," and in which the struggle for

identity and solidarity is paramount.[34] Native women face language barriers and logistical problems when they attempt to make these kinds of "official" presentations. These problems and others were uncovered by Mary Crnkovich, the editor of a book for Native women, in her study of feminism and ethnicity. She wrote about how difficult it was to overcome the barriers to interview the women for her book. Barriers existed not only in reaching the Native people, but barriers in communicating with the Native women during interviews and informal gatherings.[35] The nature of the NRGTs issues may have been difficult to respond to for many women as well. For example, a Native woman may have been concerned that she would face certain "ramifications if she talked about the tradition of custom adoption . . . [as] she was scared of losing her child."[36] Due to the nature of the issues being debated the Royal Commission should have felt obligated to consider all of the voices. It should have considered not only the voices that had direct input into the process despite the many barriers erected, but those who remained silent either because of the lack of public education, of information, time, energy or because of their deep cynicism of this process.[37] Part of the "cynicism" could have erupted for several reasons in this case because of the polarization of the NRGTs debate that appeared to mask the complexity of the issues, or because of the way this Commission conducted its business.

III. Polarization of the NRGTs Debate

To polarize the NRGTs debate is to control the parameters of the debate. In February 1992 the Quebec Planned Parenthood Federation (FQPN) deemed that the Royal Commission had lost all credibility and legitimacy because of the way it had responded to the problems with the Commissioners. In response it boycotted any further communications with the Royal Commission. The Quebec Planned Parenthood Federation (FQPN) would not be responding to the request to further develop some points made in their brief during the public hearings.[38] NAC also boycotted all further requests for appearances to the Royal Commission.[39]

In May 1993 women's groups began to question the Royal Commission's power of inquiry because of the information the Commission released regarding the risks surrounding

DI. This information was not news to those groups who had presented the risks posed by fresh sperm and HIV at the public hearings two years before. The Commission merely said that it was up to women undergoing DI to ask the right questions. As FQPN asked, in its press release, how are women to know if they receive a truthful answer?[40] It was at this time that an article finally appeared in the media that was critical of the Royal Commission process stating that the best the Commission could do was say "let the buyer beware." What it did not do was "end the masquerade of reproductive technologies as medical treatment."[41] The Coalition that initially made the call for the Commission asked the government to disband it because of the Chair's "systematic failure to conduct the Commission's business in a manner that would enable us to trust any recommendations that may be contained within the Baird report."[42] What purpose did the Royal Commission serve for the government?

The government uses Royal Commissions as a tool to achieve consensus when an issue is said to be "controversial" and divisive. A Royal Commission can lend legitimacy to the state's discount of "other" interests as "special interests" and can then discount "feminists" as such biased groups. This state can then "accept" the "mainstream" liberal interests on these issues.[43] The actual polarization of a debate can also serve many purposes for the Royal Commission. It can lead to a clarification of issues but this usually reduces the debate to a pro and anti side; and it can force coalitions to form that mask differences between groups. The worst result of the polarization of issues is that it "forces an adversary debate . . . issues become stereotyped."[44]

When the Commissioners filed their lawsuit against the Commission, the media reported this as an ideological division between the anti-technology commissioners and the objective rational scientific ones.[45] The media quoted the Clerk of the Privy Council describing these divisions as corresponding to those in society. The dominant views of these technologies are split between those who view NRGTs as normal, scientific progress and those that view NRGTs as aberration of science emphasizing its genetic manipulation side.[46] One women's group in response to these reports and the subsequent firing of the Commissioners, expressed concerns that only the former - "scientific progress" side of the debate would be developed.[47]

During the hearings held in Toronto, the media reported a different division between pro-choice and anti-choice. The coverage included Morgentaler quoted as saying he supported IVF and surrogacy and that "ironically NAC has found itself on the same side as the Roman Catholic Church."[48] The Vancouver Status of Women urged that the debate not be reduced to one between women who just want to have a baby and the anti-family feminists. This is misleading as it sidesteps the threats that these technologies pose for all women. It pits women against each other, it upholds sexist, racist, classist social status quo, and it prevents positive change.[49]

The Vancouver Women's Reproductive Technologies Coalition stated that it decided to present to the Royal Commission at the hearings held in Vancouver because it was concerned about the effects of the media coverage from earlier Royal Commission hearings.[50] It urged the RC to address this polarization of feminist and infertile women and reject this ideological tug of war; it must recognize the socioeconomic status, ethnicity, history and other variables that diversify women's reproductive needs, preferences and experiences.[51] For its part, the "Royal Commission sat back and allowed the media to make a circus event out of serious concerns."[52] The agenda of the Commission itself may have contributed to these polarizations. Louise Vandelac, an ex-commissioner, described the discourse of the Commission (especially Baird) as confined to individual "choice" and "access" issues.[53] To construct the agenda around access is to argue against discrimination and construct the debate in a way that assumes a potential client and "certain persons are seen as opposed to others wanting to have children."[54]

IV. Representation and the Reproductive Rights Movement

In an opinion piece the question asked was: "who speaks for women on the issue of new reproductive and genetic technologies?" It could not be NAC because it requested a moratorium and therefore it left out the concerns and "needs" of infertile women.[55] During the hearings, Judy Rebick, then President of NAC, responded to the portrayal of NAC as contradictory. She wrote that NAC was not calling for a ban but "for a pause, a slowdown and for no new clinics because IVF has not been proven safe and effective like abortion

techniques have." There is no comparison and therefore no contradiction between the position to support abortion and not to support NRGTs.[56]

In the last chapter, CARAL argued that not offering women access to these technologies is no solution either. At the center of this "conflict" over "choice" was the issue of prenatal diagnostic tests (PNDT). PNDs determine if a fetus will develop a "disability" or "disease" and if the tests indicate that a fetus may have one of these conditions the woman can then decide whether to abort the fetus. Groups like NAC, DAWN Canada and CDRC are not willing to defend the use of these technologies for the sake of "choice." NAC took a social relations approach and chose not to defend individual choices, and did not focus on individual "desires" or "needs" but nor did it deny them. NAC reframed the issue considering the most important strategy is how to open the discourse to the "Left." They argue that these technologies are simply "eugenically" motivated to decide which life is worth more than another. This ranking of life affects the status of disabled people as these technologies are used to diagnose whether a fetus has a disability so that women have the opportunity to decide whether to keep it or not or whether to prevent the disability or disease. This type of technology does not help to solve any problems that people with disabilities face, but suggests to them that they could have been prevented had this technology been available when they were born. There is no consideration for improving the ability of these people to live their lives differently. CARAL argues that those groups that are against PNDT are invoking "anti-choice opposition."[57] CARAL did not sway from its struggle for abortion access and it took a liberal rights approach to NRGTs. What influence could the reproductive rights movement have had with regard to their recommendations and those of NAC which took a social relations approach?

The National Action Committee on the Status of Women (NAC) is the largest feminist, voluntary, non-governmental organization in Canada. Its membership includes over 500 member groups with a combined membership of 3 to 4 million women.[58] The Coalition's objectives include actions to change attitudes, legislation and customs that will benefit women. It encourages communication and cooperation among women's organizations and exchanges information with them. The main issues examined in its brief included the implications of the scientific/industrial push, of prenatal technologies and

genetic intervention, of insemination techniques and artificial fertilization technologies, for women. In particular NAC examined what these technologies mean for the equality of disabled people and for women in general.[59] NAC stated that it supports the right of every woman to search for ways to overcome her infertility, but that it could not support technologies that harm women in the process.[60] NAC recognized the importance of allowing women the opportunity to make their own decisions but it also did not accept NRGTs as "choices" that can be uncritically offered to women. NAC's position on NRGTs is central to the reexamination of the "choice" discourse proved to be critical in the literature review.

Thelma McCormack recently wrote a critical review of NAC's position toward these technologies in which she accuses NAC of eroding the "choice" discourse. According to McCormack's criticism, NAC has dangerously distinguished between equality and autonomy, between individual and collective rights, and ultimately between the pro-choice position and structural equality.[61] McCormack's position is that the feminist struggle for equality has always meant equality of opportunity and that the primary distinction to be made is one between those who choose to have children and those who choose not to.[62] Women need access to reproductive technologies and need to control the childbearing/rearing process but how and why they have children is not relevant. She concludes that as a political strategy, to suggest that the harm of NRGTs outweighs their possibilities for women, leaves women "overprotected and underserviced" when these technologies are regulated, or banned.[63] NAC was also accused of contradicting its advocacy for a woman's right to choose to have an abortion.

NAC states that much of the criticism has been focused on the question of whether individual women should be given the "choice" to accept the risks. NAC said that NRGTs were not an issue of "choice" because these technologies are "not of significant benefit to a significant number of women."[64] As a national women's organization, NAC feels that it has "a special responsibility to argue for women's health interests as a group and the long term interest for them and their children."[65]

"It is the movement that gives meaning to the individual organizations."[66] NAC is described as the "major institution of the contemporary women's movement in English Canada."[67] It is true that NAC has played a major role in the women's movement but not just

for what it did, but more for how it did it and what it did not do. Lorraine Greaves describes how irrelevant many of NAC's forms of organizing have been to feminist activists. NAC's representation is of a highly "institutional" character and highly structured nature. NAC had, according to Greaves, ignored the many suggestions that have been made over the years to devolve the agenda-setting, and policy development process within NAC so as to increase its representativeness and accessibility. Greaves warns that NAC must "not just embrace diversity but enhance it" and its present structure appears little able to accomplish this.[68]

As NAC attempts to meet these challenges it is being asked how it can better represent diversity. As it attempts to do this, mainstream, white middle class heterosexual women ask NAC to respond to their "alienation". These women are accusing NAC of misrepresenting them and have gone as far as to suggest that NAC has "cut its links to the mainstream and will never be able to rebuild them," and is "out of touch."[69] They challenge NAC's "competence to represent the broader experience of Canadian women and to understand Canadian politics."[70] The shift in NAC is described as one from a "broad issue of equality to distinct issues that largely affect women of color."[71] This shift is not seen as a "positive" one, but as shift to a narrow focus on a "special" group of women.

On the other hand, the group that upheld the "choice" platform was CARAL and the critique levelled at it is that "it did not lead the way in rethinking the feminist debate." This is in reference to pro-choice activists who should have learned about the dangers of "the absolutism of arguments separated from the context of lived experience" from their fight for abortion rights.[72] CARAL identifies itself as the "voice of the pro-choice movement in Canada" and argues that to be against NRGTs is to have an inconsistent choice platform.[73] The Coalition for Reproductive Choice (CRC) differs drastically from the CARAL brief, although this group also originated as an organization fighting for the decriminalization of abortion, and for which freedom of choice is as fundamental as for CARAL. For CRC however, the central question became what is "the nature of that choice?"[74]

I would argue that CARAL has lumped together two very different ways to argue against these technologies. One critique that CARAL alluded to was the one by disabled rights activists and feminist groups like NAC. It is really arguing against is the real "anti-choice" position brought by the "Right", by anti-abortionists who would oppose abortion at

any stage for any reason. In the NRGTs debate, many feminists are afraid to condemn the use of abortion in certain cases, for example when deciding whether to terminate a pregnancy solely because the baby is said to have a birth defect. The abortion issue has divided women's groups, which in this case pitted women's individual rights against those of women with disabilities. Feminists know that once the state is given an opportunity to place restrictions on abortion, it will not hesitate to interpret them broadly. This demonstrates the concerns of those groups about taking an opposing position on NRGTs that means that it could be aligned with the Right, with antifeminists and nonfeminists. But, as Nancy Chater concluded in her study of race and class and the Canadian women's movement, it is "far more important to be self-critical in an ongoing and constructive way" than "to give in to the fear of providing the right with ammunition."[75] Sunera Thobani contends that the proliferation of NRGTs has forced the feminist movement in Canada to reassess its position on reproductive rights as it had advocated for in the past on behalf of its largely white-middle class.[76]

V. Conclusions

This chapter has presented an interpretation of some barriers women's groups faced in attempting to respond to the RCNRT and to the many complex issues regarding NRGTs, and the possible reasons, and motivations behind their recommendations. It is difficult to discern which factor had more of an influence than another. The problems I have outlined concerning the agenda of the state, the lack of an education program, the lack of "empowerment" of the interveners, and the very serious problems with the Commissioners were significant influences. If a women's group took a social relations approach or expressed opposition to NRGTs as "choices" they are the ones that are accused of being accused of aligning with the "Right", of leaving out infertile women, of trying to "protect" women, and of being anti-technology. The main reason for the polarization of the debate in the reproductive rights movement was the apparent contradictions over "choice" and over abortion and the extension of the same "right" to women for NRGTs.

There is a perception that to oppose individual "rights" and "choice" in any context poses "risks" that cannot be taken by women's groups who are increasingly facing a "backlash". There are those who fear that feminism is about to disintegrate or lose its momentum because of these tensions. I conclude that several groups, such as NAC, along with groups of immigrant women, Native women, lesbians and disabled people, did attempt to open the discourse and to broaden and strengthen the reproductive rights movement forward. They did approach this issue with different experiences of women than those in middle-class mainstream in mind and succeeded in constructing an alternative discourse to the "pro-choice" one. Even the Coalition for Reproductive Choice has recognized that the "nature of choice" is problematic. In response to all of this, groups like CRIAW and others have taken a pluralist choice approach that was "cautious." While the social relations approach is responding to what it feels are the worst case scenarios, the pluralist choice approach is attempting to be optimistic and discuss some possible better case scenarios. This chapter provided an analysis of policy proposals using the template of feminist positions that emerged from the academic literature. Why is it important to map the feminist positions in this way and what are the map's implications for the politics of the reproductive rights movement in Canada?

ENDNOTES

1.Anne Donchin, "The Future of Mothering: Reproductive Technology and Feminist Theory," Hypatia 1:2 (1986): 137.

2.Louise Vandelac, "The Baird Commission: From "Access" to "Reproductive Technologies" to the "Excesses" of Practitioners or the Art of Diversion and Relentless Pursuit ... "Misconceptions: The Social Construction of Choice and The New Reproductive and Genetic Technologies., Eds. G.Basen, M.Eichler & A. Lippman (Montreal: Voyageur Press, 1993) 259.

3.Brian Ceckoway, "The Politics of Public Hearings," The Journal of Applied Behavioral Science 17:4 (1981): 566.

4.Canada, Royal Commision on New Reproductive Technologies, What We Heard: Issues and Questions Raised During the Public Hearings (Ottawa: Canada Communications Group, September 1991) 7.

5.Christine Massey states that the 40 000 included respondents of the surveys that the fired commissioners considered to have had "unsound method" and to include questions with misinformation.See Christine Massey, "The Public Hearings of the Royal Commission on New Reproductive Technologies," Misconceptions: The Social Construction of Choice and The New Reproductive and Genetic Technologies. Eds. G. Basen et al. (Montreal: Voyageur Press, 1993) 245.

6.While three other Northern groups presented they were from Yellowknife and Whitehorse and there for not very reflective of the Native situation.

7.Immigrant and Visible Minority Women of B.C, Oral Transcripts of Presentation made by Sunera Thobani, Gulzar Samji and Betty Lough to the Royal Commission on New ReproductiveTechnologies (Vancouver, 26 November 1990) 182.

8.Canada, RCNRT, Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies, Volume 1 (Ottawa: Canada Communications Group, 1993) 4.

9.Daniel Drache and Duncan Cameron, Editors' Introduction, The Other Macdonald Report, eds. Daniel Drache and Duncan Cameron (Toronto: James Lorimer, 1985) x.

10.Drache and Cameron xi.

11.Canada, RCNRT, Final Report 136.

12.Massey, "The Public Hearings" 249.

13.Massey, "The Public Hearings" 243-244. Certain groups and individuals attempted to distribute information. A number of groups used the information kit about NRGTs by

CRIAW, see Canadian Research Institute on the Advancement of Women, Our Bodies ...Our Babies (Ottawa: CRIAW, 1989).CRIAW also distributed a compilation of articles, see Christine St. Peter et al., Reproductive Technologies and Women: A Research Tool, Edited by the CRIAW Working Group on Reproductive Technologies (Ottawa: CRIAW, 1989). DAWN Canada and CDRC distributed a compilation of papers about concerns of disabled people. Dawn Black, then an NDP member of Parliament also mailed out information to groups.

14.Christine Massey, The Public Participation Program of the Royal Commission on New Reproductive Technologies, diss., Simon Fraser University, April 1994, 92.

15.Massey, The Public Participation Program 24. In response to these gaps the Commission held special consultations and round tables but the documents from these discussions are not available. Notably, the Commission held a special discussion with the Pharmaceutical Manufacturers Association of Canada, Serono Canada and Roussel-Uclaf (the company that manufactures RU486) because they did not present either written or orally to the RC. The Commission held a round table dubbed as the aboriginal round table but called it a special consultation in N.W.T. It also held a round table regarding prenatal technologies with no representative from the community of people with disabilities, only 'professionals'.

16.Ceckoway 569. An obvious illustration of this is the 600 page submission made by the Canadian Medical Submission versus the two page brief by the Toronto Women's Health Network.

17.Yellowknife Women's Society (YWS), Oral Transcripts of presentation to the Royal Commission on New Reproductive Technologies (September 12, 1990) 26. This group of more than 40 women was officially formed in December 1989. Its goals are to actively seek and encourage all women to become involved in deciding their future.

18.Sue Hawkins Findlay, "Democratizing the Local State: Issues for Feminist Practice and the Representation of Women," A Different Kind of State? Popular Power and Democratic Administration, Eds. Gregory Albo et al. (Toronto: Oxford U Press,1993) 163.

19.Sue Findlay, "Problematizing Privilege: Another Look at the Representation of "Women" in Feminist Practice," And Still We Rise: Feminist Political Mobilizing in Contemporary Canada, Ed. Linda Carty (Toronto: Women's Press, 1993) 217-218.

20.Sue Findlay, "Feminist Struggles with the Canadian State, 1966-1988," Resources for Feminist Research 17:3 (September 1988): 9.

21.Melanie Randall, "Feminism and the State: Questions for Theory and Practice," Resources for Feminist Research 17:3 (September 1988): 10.

22.Randall 15.

23.Randall 15.

24.Massey, "The Public Hearings" 241. For the timeline see Appendix D.

25.Massey, The Public Participation Program 115-116.

26.Planned Parenthood Federation of Canada, Letter to Dr. Patricia Baird, From Bonnie Johnson, Executive Director, National Archives (August 2, 1990). Letter.

27.Manitoba Action Committee on the Status of Women, Oral Transcripts of the Presentation by Jenny Robinson to the Royal Commission on New Reproductive Technologies (Winnipeg, Manitoba, 24 October 1990) 92.

28.YWCA of Yellowknife, Brief to the Royal Commission on New Reproductive Technologies (December 1990) 1.

29.Women's Health Clinic, Brief to the Royal Commission on New Reproductive Technologies (Winnipeg, Manitoba, 24 October 1990) National Archives Document: 4-5.

30.L'Association des Acadiennes de Nouvelle-Ecosse, Lettre à Dr. Patricia Baird. De Monique Jawed, Directrice de service aux femmes, le 21 novembre 1990. Its belief is that the development of the full potential of women which will enrich the whole of acadian people. This group is addressing all Acadian and francophone women of Nova Scotia. Its goals are to promote the exchange and collaboration amongst women and encourage communication and organization on all levels.

31.Saskachewan Action Committee, Status of Women. Brief presented to the Royal Commisssion on New Reproductive Technologies (25 October 1990) 1.

32.WHC 4-5.

33.Yukon Indian Women's Association (YIWA), Brief to the Royal Commission on New Reproductive Technologies (11 September 1990) 5.

34.Marian Lykee Thomson, "Inuit Women in Greenland and Canada: Awareness and Involvement in Political Development," 'Gossip': A Spoken History of Women in the North, Ed. Mary Crnkovich (Canadian Arctic Resource Centre, 1990) 247.

35.Mary Crnkovich, "In Our Spare Time," "Gossip": A Spoken History of Women in the North, Ed. Mary Crnkovich (Canadian Arctic Resources Centre, 1990) xvi.

36.Lynn Brooks, "Guided by our Bellies," 'Gossip': A Spoken History of Women in the North, Ed. Mary Crankovich (Canadian Arctic Resource Centre, 1990) 39.

37.Vancouver Women's Reproductive Technologies Coalition, Presentation to the Royal Commission on Reproductive Technologies (Vancouver, B.C. , 26 November 1990) 2-3.

38.FQPN, Lettre à Madame Baird, De Anne St-Cerny, Présidente, 12 fevrier 1992: 2.

39.Rod Mickleburg, "NAC attacks Commission over Research," Globe and Mail 4 February 1992: A8.

40.FQPN, "Lettre d'Opinion: Insemination artificielle: Un Scandale pour Masquer les Question de Fond, 5 mai 1993: 1.

41.Gwynne Basen, "Experiments on Women and Children," Globe and Mail 21 May 1993: A27.

42.Margrit Eichler, "Frankenstein meets Kafka: The Royal Commission on New Reproductive Technologies," Misconceptions: The Social Construction of Choice and The New Reproductive and Genetic Technologies, Eds. G. Basen et al. (Montreal: Voyageur Press, 1993) 217.

43.Sue Findlay, "Feminist Struggles with the Canadian State," Resources for Feminist Research 17:3 (1988): 9.

44.Salter and Slaco 199-200.

45.Ross Howard, "Reproductive Technology Commission Facing Lawsuit," Globe and Mail 30 November 1991: A1.

46.Quoted in FQPN, Lettre et Communiqué de Presse, 5 decembre 1991:2.

47.FQPN, 5 Decembre 1991 1.

48.Paul Taylor, "Morgentaler, Women's Groups hold opposing views on Reproductive Technologies," Globe and Mail 21 November 21 1990: A10.

49.Vancouver Status of Women (VSW), A Brief presented to the Royal Commission on New Reproductive Technologies, Prepared by Bonnie Waterstone (26 November 1990) National Archives: 4.

50.Vancouver Women's Reproductive Technologies Coalition (VWRTC) 1. Initially this group was formed to help other women's groups respond to the RC, it was not planning on making a presentation itself.

51.VWRTC 2-3.

52.VSW 4.

53.Vandelac, "The Baird Commission" 256.

54.Vandelac, "The Baird Commission," 259.

55.Opinion: Who Speaks for Women? Globe and Mail 19 December 1991: A18.

56.Judy Rebick, Letter to Editor, NAC not Seeking Ban on IVF, Globe and Mail 24 November 1990: D7.

57.CARAL, Brief presented to the Royal Commission on the New Reproductive Technologies, in Halifax, Nova Scotia (16 October 1990) National Archives 2.

58.NAC, Pamphlet, May 1988 reprinted in the documents section of Cohen 83-84.

59.National Action Committee on the Status of Women (NAC), "The New Reproductive Technologies: A Technological Handmaid's Tale, A Brief Presented to the Royal Commission on New Reproductive Technologies", Revised June 1991.

60.National Action Committee on the Status of Women (NAC), Oral Transcripts of the Presentation made ot the Royal Commission by Judy Rebick, Pat Israel and Varda Burstyn (Toronto: October 29, 1990) 9.

61.Thelma McCormack, "Reproductive Technologies: Rights, Choice and Coercion," Women and Canadian Public Policy (Toronto: Harcourt Brace,1996) 206.

62.McCormack 206.

63.McCormack 217-218.

64.NAC, Brief 13.

65.NAC, Brief 9.

66.Nancy Adamson et al, Feminist Organizing for Change: the Contemporary Women's Movement in Canada (Toronto: Oxford UP, 1988) 253.

67.Christine Vickers et al. Politics as if Women Mattered: A Political Analysis of the National Action Committee on the Status of Women (Toronto: Toronto University Press, 1993) xi.

68.Lorraine Greaves, Review of Politics as if Women Mattered, Women's Studies International Forum 17:5 (1994): 556.

69.Margaret Wente, "The Sad Decline of NAC", Globe and Mail 4 February 1995: A2.

70.Deborah Wilson, "Heir to NAC Stung by Attack," Globe and Mail 10 May 1994: A1-A2.

71.Doug Fischer, "Most Women Don't Identify with Group,"Vancouver Sun 10 February 1994: A4.

72.Heather Menzies, "The New Reproductive Technologies: Maybe We Can Control the Means of Reproduction," Herizons (Spring 1994): 20.

73.Canadian Abortion Rights Action League, Letter to the Commissioners, Royal Commission on New Reproductive Technologies, From Kit Holmwood, President, National Archives (July 30, 1990) 1.

74.Coalition for Reproductive Choice (CRC) 2. Interestingly, the president of CARAL, Amanda leRougetel was also president of the CRC. In a letter to me she pointed out the obvious differences in the positions taken by these two groups but gave no further explanation but to say that is the nature of the movement.

75.Nancy Chater, "Unexamined History Repeats Itself: Race and Class in the Canadian Reproductive Rights Movement," Fireweed: A Feminist Quarterly Issue 33 (1993): 57.

76.Sunera Thobani, "Making the Links: South Asian Women and the Struggle for Reproductive Rights." Canadian Women's Studies 13:1 (1993): 19.

CONCLUSION

Only by understanding how the struggle over discourse works, how meaning is made, can we begin to envision alternative articulations.[1]

From my reading of the feminist literature and the women's groups submissions, there emerged three distinct major positions. These are all located in a context where liberal rights and individual choice rhetoric are dominant discourses. Some groups rejected the dominant liberal discourse, some returned to it and some reclaimed it. The way the women's groups negotiated their submissions to the Royal Commission also depended on their concerns, aims, and fears. I have illustrated the possible barriers to the articulation of an alternative discourse in the last chapter. In this conclusion, I examine how the struggle over discourse worked, and how feminists struggled to take discursive space and make new meanings for and from women's lives. I review the possibilities of creating alternative articulations on NRGTs within the politics of the Canadian reproductive rights movement.

From the start, the Royal Commission clearly located itself squarely within the prevailing discourse of individual rights. The Final Report discusses the possibility of a moratorium (a ban was not considered). It concluded, however, that "only a small group of Canadians believes that the risks to society far outweigh the potential individual benefits." The Royal Commission justifies its position on the grounds that to curtail the development of these technologies "assumes that women are not the best judges of what is good for their own reproductive health and well-being."[2] A central tenet of this liberal rights approach is to continue to argue for an individual woman's right to self-determination. A liberal, individualist approach never acknowledges why "choice" may not be possible for all women

and simply says "let the buyers beware." Some groups may have understood the consequences of espousing liberal rights and individual choices for NRGTs but they nevertheless concluded that "while society may be served by a ban," individual choices must be respected and emphasized.[3] My main question was whether the feminist NRGTs discourse, as it appeared in the women's groups presentations to the Royal Commission, left "gaps" between the concepts employed and women's actual lived experiences. I now conclude on how the words chosen, arguments advanced, pressures faced and assumptions embedded affect the construction of an alternative, discourse on NRGTs.

I. Feminist Discursive Spaces and Struggle

When groups attempt to develop their positions on these technologies, they are involved in a negotiation process. The resulting positions may open new understandings but they could also preclude others. In the feminist NRGTs discourse both the liberal rights and pluralist choice approaches foreclose to some extent an exploration of alternatives to the dominant individual "rights" and "choice" discourse. The social relations feminists were able to outline critiques of these two positions and to expose the embedded assumptions in a liberal approach to NRGTs. All these positions are located on a continuum based on their relation to the dominant discourse, to the state and their attitude toward technology. The liberal rights "yes, but" position is at one end of the continuum, views the technologies to be neutral and has confidence in the state to regulate their abuses. According to the liberal rights approach, informed consent, as a legal-medical requirement, provides sufficient information for a woman to know what a treatment involves so as to consent. The pluralist choice "no, not unless" position argues that a general moratorium is important because this would allow women to be educated and informed regarding NRGTs. Technology in general, according to this position, is not inherently political but the context in which it is applied determines the outcome. Therefore it recommends that once the moratorium has been lifted the state could regulate their abuses. However, this position is critical of the state and its role in creating the context in which women are often losing control over "normal" stages in their life. Therefore, it has informed choice as its central recommendation because it

recognizes that while the state is still a site of struggle for women, women can resist these technologies on a day-to-day, individual level if they are able to make informed choices. As they are provided with more information and more viable options, many will refuse to use NRGTs. Meanwhile, certain NRGTs fulfill certain needs for women. The social relations position at the opposing end of the continuum distrusts the state and therefore considers the strongest resistance to be a request for a ban on all NRGTs. Although the state would intervene as the institution to legislate the ban, social change will be sought and high technological solutions will eventually be displaced.

In the submissions several women's groups advocate a liberal rights approach including the Canadian Abortion Rights League (CARAL), and the Federation of Medical Women (FMWC). FMWC takes a medical management approach and wants to let women decide whether to use these technologies on the advice of their physicians. CARAL takes a position reflecting its pro-choice mandate. The Coalition for Reproductive Choice (CRC) whose mandate is pro-choice also examines what "choice" means. However, this group still did not advocate denial of access to individual women because it felt that women needed more access to a broad range of health services.

Groups like CRC that take a pluralist choice approach emphasize the importance of women's autonomous decision-making and informed choice. These groups were conscious of the dilemmas that some of these issues presented but instead of taking a social relations position they ultimately argued for "choice." Social relations feminists realize that women could refuse to use NRGTs but their ability to do may depend on their race, class, ethnicity, (dis)ability and living circumstances. However, they argue that even if women "freely" accept to use NRGTs this will not increase women's autonomy because of the nature of that "choice" and the technologies themselves.

The liberal rights and pluralist choice approaches accept the dominant discourse on women's self-determination and both argue for NRGTs on this basis. The pluralist choice approach does not uncritically advocate self-determination but it still accepts the idea that women could control these technologies and could make an informed individual choice. From a social relations perspective, self-determination, meaning women's increased autonomy of her body, is not possible with NRGTs.

The worst case scenarios for the liberal rights approach are first, that women would be denied the option to choose NRGTs and second, that arguing against these technologies risks the "other" rights that women have gained in the realm of reproductive health care. The pluralist choice feminists' worst case scenarios are these: the exploitation of women because of their different circumstances, and the lack of respect for women's ability to make decisions and "choices" regarding NRGTs. For the social relations feminists the "Mother Machine" looms as the worst case scenario, a "machine" that would allow techno-pharmacrats to commodify, geneticize and completely control women and reproduction.

The liberal rights approach proposes that it is better to take the chance on the state to regulate the abuses of NRGTs and expand "choices" for women than to see women left without these "choices". For the pluralist choice feminists, a ban on these technologies would solve none of the problems facing women, though some pluralist choice feminists were not averse to a pause or a moratorium to better educate women regarding NRGTs. This position places an emphasis on different women's ability to exercise their agency and make different choices. For the social relations feminists the risks posed by NRGTs are not worth the rare "benefits" for certain clients as these technological "choices" displace the real changes needed and replace other socioeconomic reforms. The medicalization and geneticization of infertility and other "diseases" individualizes the problems and the solutions and de-emphasizes collective responsibility.

The liberal rights feminists are interested in the possibilities of a technological fix which is the application of a neutral, high technological solution to infertility. A technological fix does not address the initial causes of the problem and does not prevent the problem from occuring. Buying into the technological imperative which says that technology is critical for society to progress because changes in technology are the most important changes in society, liberal rights feminists believe that a technology can cease to exist or no longer be used, but that social change is not easily reversed. Liberal rights feminists emphasize women's ability to consent, and the state's ability to regulate the excesses of these technologies. The pluralist choice feminists underscore the need to provide women informed choices. They believe that NRGTs can be redirected to serve women's needs and included as only one of many options for women's reproductive health

care. The social relations approach focuses on women's systemic subordination and argues that the right to refuse is eroded because some of these technologies do make things different and often worse for everyone, most especially women. Profit-motivated, sexist, racist, scientific/industrial interests developed these technologies. Therefore, if social changes can benefit social groups than they can benefit their individual members because each shapes the other.

There were some differences between the positions as they are presented in Chapter One and the discourse presented in Chapter Two. In Chapter one, the literature review reads with a certain amount of urgency. The authors exchange ideas and critique each other. The articles, chapters and books I review make arguments of resistance to NRGTs, complete support of them, or of qualified support for NRGTs. The authors negotiate in a discursive space regarding language, assumptions, concepts and issues. In Chapter Two, the submissions to the Royal Commission by the women's groups, for the most part, did not construct complex arguments but presented "practical" recommendations to the Commission.

The question of the relationship between practice and theory underlies my analysis. One reason I presented the literature review before the submissions was to provide a view of the state of the feminist NRGTs literature at the time of the Royal Commission's public hearings. Furthermore, I wanted to determine how the groups handled the feminist literature. Both the submissions and the writing of the feminist authors represent a kind of praxis. The feminist academics were not just individuals writing "theory". For example, part of my literature review focuses on authors who were members of the activist group, FINRRAGE and several of the books reviewed were results of emergency conferences. The women's groups are not practicing in the sense that they "lobbied," but writing of submissions and making presentations are also forms of political action. Nonetheless, there were costs associated with devoting so much time and energy to a Royal Commission that provided the groups with no intervener funding and conducted no public education campaign. Furthermore the Royal Commission was fraught with problems that discredited it for many groups. The costs of presenting are especially high for these underfunded, voluntary groups that spent their resources writing a submission when these resources could have devoted to grass roots work. The costs the women's groups faced far outweighed any parts of the

feminist theory they may have circulated to their members. As my problems retrieving the submissions showed, these submissions are not easily accessible and the oral transcripts can only be accessed through the National Archives. I suggest that those groups who presented, in effect, were not able to "popularize" the feminist theory. The Final Report did not present the important points of divergence among the women's groups and as Annette Burfoot argues it is an "inappropriation" of feminist concerns.[4]

I characterize the women's groups recommendations as "yes, but," "no, not unless" and "no, maybe never". The "yes, but" approach used the language of the liberal rights position to argue for universal access to NRGTs, but this access should include informed consent. Another "yes, but" recommendation is that PNDT should be offered but only if women are not coerced. Similarly, contract motherhood is a legitimate "choice" for women, but only if money is not exchanged and a contract is signed.

The recommendations characterized as "no, not unless" parallel the language of the pluralist choice approach. This approach takes a holistic approach to women's health care and recommends that NRGTs should not be offered unless women's basic health needs are also being met. Regarding access, this approach considers universal access to be too open but discriminatory access completely unacceptable. Therefore it recommends that women not have universal access unless clear medical criteria are used to determine eligibility. These criteria would guard against social control that can result from broad medical control, and against the continued unnecessary medicalization of infertility. This approach insists on the complexities of choice-making and recommends that women not be offered NRGTs unless they can make informed choices. The only acceptable recommendation regarding contract motherhood is that arrangements should be made but without a contract being signed and only if it resembles the Native people's practice of custom adoption.

The "yes, but" or liberal rights approach considers NRGTs as "alternative reproductive choices" which will improve as research proceeds, with care. The "no, not unless" or pluralist choice approach also considers NRGTs to fulfil certain needs for women. This position is therefore not willing to make a good/bad judgement regarding their continued use but focuses instead on the ways women can control these technologies. The "no, maybe never" or social relations approach is not optimistic that women can or should

control NRGTs. NRGTs were not developed because of women's demands but with a specific eugenics and patriarchal agenda. Therefore social relations feminists recommend that PNDT not be allowed because these technologies only serve to displace real social changes. Contract motherhood only erodes women's autonomy. According to this position, NRGTs should not be offered and the resources should be redirected to areas that will benefit more women such as prevention.

Varda Burstyn was one of the co-chairs of NAC's NRGTs' committee when it responded to the Royal Commission. She travelled to Germany and researched the feminist resistance there. She realized that her own critical positions considered "extreme" in Canada were not so "extreme" compared to the resistance to NRGTs in Germany. The standards of the contemporary Canadian debate are very different from those in Germany. Burstyn states that Germans "are much more uncompromising about what they see as the negative tradeoffs between very limited health and fertility gains . . . and the major losses in health, fertility and human rights."[5] While the Canadian social relations position pales in comparison to the German one, it is "radical" compared to the American feminist positions on NRGTs which are very "liberal." The reason may be because of the complete "distrust" of the German state, the contradictory relationship of feminists to the Canadian state and the institutionalized positioning of feminists within the American state, all of which affect the standards of the debate which follows.

II. Standards of the Canadian NRGTs Debate

The conditions under which the groups produced their presentations were problematic. The few women's groups that took a social relations position, as NAC did, faced almost unsurmountable obstacles. Chapter Three examines some of these obstacles including the divisions and polarization of the debate. The debate was polarized between infertile women and "heartless" feminists, between anti-choice, anti-family, anti-technology feminists and pro-choice feminists.

The media highlighted the more extreme positions, privileged conflict and attempted to polarize the discursive space. The media treated NRGTs as similar to abortion rights, as

a "condensing symbol around which groups with conflicting morals, values, and cultures tend to oppose one another."[6] As discussed in Chapter Three, the media coverage of the Toronto hearings portrayed Morgentaler as pro-choice and quoted him suggesting NAC was aligned with the religious Right as anti-choice.

The women's groups' struggle to negotiate the historical significance of the language being employed, faced pressures from the state agenda and from the media. Chapter Two presents some of the problems with the public participation process of the Royal Commission, whereas Chapter Three examines the management problems of the Commission. The Royal Commission considers women's groups as a "special interest" group.[7] While the conditions that may influence one group more than another are not definable, some influences can be traced to the nature of the discourse that emerged. Furthermore, these groups, unlike the feminist writers, represent a very specific membership and are speaking on their behalf. Most of the groups that presented have a lobbying element and many receive state funding. The women's groups' experiences dealing with government would influence their proposals and their decision not to be too 'radical'. In their view, they needed to present concrete recommendations or the Royal Commission would displace, misappropriate or not take their concerns seriously.

The Commission needed to consult or at least try to consult certain constituents but the extent of the consultation was not made explicit. The Final Report lists even those groups who wrote to the RCNRTs saying that they could not participate. From the outset groups decide whether to even participate in such a process. The group must consider the impact on the movement, on the coalitions it may have built, and on its autonomy. Furthermore, the groups with a lack of resources face the challenge of doing research required for the Royal Commission. They decide how this activity fits in with their priorities. A group may decide to align with another group, or to provide the government with brief notes or not to participate at all. If they decide to present, they then must decide whether to challenge the embedded assumptions regarding women's "rights" and "choice" in a liberal democracy.

III. Embedded Assumptions of Liberal Democracy

The divisions in the NRGTs debate in Canada were constructed between potential clients and supporters and those denying access. Those women's groups that did not challenge the "rights" and "choice" rhetoric did not want to figure into the media portrayal of anti-technology, anti-motherhood "heartless" feminists versus infertile women. They feared being accused of aligning with the Right and the possible threat to abortion rights. Moreover, these groups were anxious about the entrenched popular attitudes about the infringement of individual rights by social group rights.

In this debate, abortion politics were both explicit and implicit. On the explicit issues such as PNDT, many groups were not able to go beyond the pro-choice rhetoric because they believed this would threaten abortion rights. Women's groups did not want to be accused of having an inconsistent "choice" platform because this would open abortion rights to challenges from the state and the Right. Maria Mies posed this false opposition clearly: "if we demand the right of abortion in the name of self-determination and reproductive autonomy, we must concede the same right to the woman who decides in favour of one or the other new 'reproductive alternatives'."[8] Maria Mies is referring to the conflation of the two issues of abortion and NRGTs on the grounds that women have the right to self-determination. This statement points to the reasoning of the liberal rights approach which then conversely suggests that if we oppose NRGTs then do we necessarily oppose abortion and we are opposing women's right to self-determination. To avoid the dilemma altogether CARAL would respond that these two issues should be kept separate. While abortion rights may be implicit or explicit in the NRGTs debate the presentation of this kind of dilemma can only erode the present abortion rights. They are suggesting the converse by asking for the extension of a woman's right to abortion as an equivalent right to NRGTs.

The social relations feminists do not accept this reasoning in either arguments for or against NRGTs for several reasons. For one, the literature review demonstrates the implications self-determination has when used to argue for women's right to choose NRGTs. A gap was shown to exist between the "self-determination" of the "autonomous" woman and NRGTs' actual implications for women. Self-determination in this debate has come to mean

emancipation from the female body. It once meant liberation from the constraints and subordinate position of women in male-female relations, but even this was tied to a narrow definition of women's needs (i.e., the need to enter the public sphere as an "equal"). Women's groups need to reappropriate "self-determination," or replace it with a new concept and a new understanding of the context of women's autonomy and women's well-being as a social group.

The second reason social relations feminists would not agree with CARAL's contention that their line of argument is opening women's right to abortion to the "Right" is because the Right is already a contender in this debate. There is a doublethink for the liberal rights groups that the repercussions from the liberal mainstream positions would be few but if women open the discourse up it would take away some women's rights. The social relations feminists' response would be that the backlash from the state exists without our "help". It is more important to challenge and go beyond the status-quo than to give in to the "Right" or allow the state to set the parameters of the discourse.

Writing on abortion in the U.S., Linda Grindstaff states that negotiations "among competing viewpoints generate new narratives on abortion and reframe old narratives in new ways."[9] There are many parallels to the NRGTs discourse. First, as in the abortion rights struggle, the Right's campaign allowed for the division between maternal rights and fetal rights. This campaign for "choice" ignored the complex interaction of socioeconomic and other factors in a pregnancy and it ignored maternal-fetal inseparability[10] and maternal autonomy. A similar division arose concerning prenatal technologies where the discourse opened the abortion rights debate and divided the individual rights of women and social group rights of disabled people. Second, the focus on "choice" was too narrow, where in abortion rights the right to bear a child under humane conditions was excluded.[11] In the NRGTs debate, the right to remain childless and other socio-cultural alternatives are given secondary consideration over the right to have a genetic child.

The pluralist choice groups were not able to solve the dilemma presented between individual rights and collective responsibility and so they took an individualist stance that there is no right or wrong answer. In a liberal democracy everyone has the right to freedom of "choice." Pluralist choice feminists did shift the boundaries of the NRGTs discourse but

were in the end rather indifferent to difference. The relativism of that position is reflected in the statement that "different women make different choices". It is an improvement on the liberal rights approach that was oblivious to differences. Social relations feminists emphasized differences among women as primary factors when making judgements about the impact of NRGTs.

The main division in the discourse arose because the social relations feminists dared ask why we need these technologies and questioned compulsory seeking of motherhood. By virtue of this and their request for a ban, they are described as anti-technology and anti-family feminists. My goal was to show the uneasiness of positioning within the feminist discourse, but why then did many groups not take a social relations approach? The answer has to do with the way the debate was presented as a division between infertile women and heartless feminists, not as a catalyst for the development of the reproductive rights movement. However, groups like NAC did portray this issue as very important to the strengthening of the reproductive rights movement. Therefore groups may have been fearful to open the discourse to the "Right," and to the state, but also to the politics of diversity. Groups like NAC did not focus on an individual woman's "need" to have children but examined the implications these technologies have for disadvantaged groups of women who face an antinatal ideology. Furthermore, NAC's standpoint was that the movement is only strengthened if it can better represent diversity.

The pluralist choice approach may have been an easier approach for women's groups to take because the social relations feminists are accused of alienating infertile women. With regard to IVF and other NRGTs the pluralist choice approach does not suggest a ban but a moratorium, but attempts to take a position that allows the technologies to proceed but not at the behest of women's autonomous decision-making powers. This allows the procedures to proceed but only if combined with informed choice and a restriction on their use. This approach did deconstruct the stigma of infertility but not the need for NRGTs. Therefore it did not confront the privilege of women who are considered the ideal clients for these technologies (i.e., those who have money, who are in stable, heterosexual relationships, who able-bodied with no gene defects).

IV. The Impact on the Reproductive Rights Movement

The submissions emerged at a decisive point in the history of the reproductive rights movement. The groups representing immigrant women, lesbians, disabled women and Native women were the impetus behind the broadening of the reproductive rights movement to better represent diversity. The usual media attacks on the authority of representation[12] were obvious with regard to NRGTs, but more importantly, the presenting groups like NAC were being pressured by their own constituents to better represent women's voices. Here was an issue immediately constructed as anti-technology, anti-motherhood, "radical" feminists versus infertile women and "choice" feminists. This issue was a crucial "test" of the movement's ability to critically analyze individual choice and its shortcomings for women in disadvantaged groups. Moreover, once NRGTs were presented as an equivalent "right" to abortion, the temptation was to accept the "choice" and allow women to decide. Consequently, instead of maintaining their commitment to the broader reproductive rights movement, some of these groups that presented to the Royal Commission did not challenge the "choice" rhetoric of the NRGTs debate.

In particular, within feminism the abortion issue has pitted the rights of individual women against the rights of women with disabilities. Groups like CARAL may have considered the problems but recommend universal access to PNDT because they saw opponents as all being aligned with the "Right" as anti-choice. But Anne Finger states that what distinguishes feminist opponents of these technologies from the "Right" are their recommendations for full rights for all disabled people, not just the right to live for disabled people.[13] In the attempts to bridge some of these "gaps" in the reproductive rights movement, certain groups such as NAC did not advocate restrictions on a woman's right to abortion, but argued for full rights for all disabled people. Women should have the right to abort any fetus, just not a particular "kind".

Learning from their narrow pro-choice advocacy during the abortion rights debates, many groups taking the pluralist choice approach stressed the need to move beyond "choice" as a political right, to focus on broad reproductive rights - the need for basic reproductive health care to be provided together with NRGTs. This position looked for a balance between

the needs of infertile and other women, but not a blanket acceptance of any of these technologies. Many groups advanced the discourse as far as they thought possible. Taken together these groups presented a discourse that grounded women's concerns. Their ability to present the concerns they did to the Royal Commission is a triumph considering the obstacles they faced. The same groups that initially challenged the reproductive rights movement, Native women, immigrant and visible minority women, lesbians and women with disabilities, opposed the individual rights and choice discourse. Some groups like NAC did display their ability to enhance the representation of diversity and not as an "add on" revision.

Chapter Three examines the issue of representation in reference to NAC. These "radical feminists", as they were referred to by Bonnie Beresford at the beginning of this thesis, are accused of excluding infertile women. I conclude rather that immigrant women, Native women, disabled woman and lesbian women have challenged NAC to be more accountable to them. These social groups (not often portrayed as infertile women in the media) are those women who require real social change the most - disabled women, immigrant and visible minority women, Native women and lesbians. The accusation levelled at NAC is its alienation of white middle class women and infertile women but the two groups are rarely connected. The connection is that the women who presently have access to IVF, AI and surrogacy are white middle class and heterosexual women. The real issue is that these women were already feeling excluded from the feminist discourse and had been since NAC advanced past the abortion "rights" and "choice" rhetoric. Women who are not willing to give up the aspiration of individual rights privilege are pitted against NAC in this debate. Because these women are located within the dominant culture, they construct this issue like abortion, as a matter of personal choice. Consequently only those groups that did not fall within that category attempted to develop an alternative discourse. Can we call NRGTs a "choice" if it is only available to certain people depending on their relative privileges? Social relations feminists would respond that "gaps" in the dominant liberal discourse have developed between the concept of "choice" and the actuality of women's lives.

I maintain that because of individuals like Sunera Thobani and groups like NAC, IVMWBC and DAWN, an alternative discourse on NRGTs is possible. A conference in

November 1994 titled "New Reproductive Technologies: DAWN Canada and NAC; The Contradictions of Choice: The Common Ground Between Disability Rights and Feminist Analyses"[14] represents the first time that DAWN and NAC came together to develop an answer on a national scale to the urgency of NRGTs. The title of the conference is an indication of where this debate has gone since the Royal Commission; the common ground is to develop a strategy regarding NRGTs that is able to deal with the contradictions of choice and NRGTs. This conference displayed the movement's willingness to bridge some gaps left in the discourse. The discourse has been pushed forward, and affords an optimism that this issue will strengthen the movement as well.

V. The Post-Royal Commission Discourse

The RCNRT's Final Report was tabled after a significant length of time. The women's groups presented in the Fall of 1990 and the Commission tabled their Report in November 1993. This time lag produced a kind of anti-climatic response by the women's groups to the Final Report. The Royal Commission "is a temporary forum that involves institutions and advocate groups that have responsibilities and loyalties elsewhere."[15] These women's groups have come away from this process to continue their research and share their knowledge but not because the Royal Commission process was a positive catalyst. Rather these groups have spent time responding to the Final Report, work which, it can be argued, still takes away from their grass roots work. Consider the ongoing process of responding to the agenda that has been set by a report and that several groups had boycotted. Several others had not even presented to the Royal Commission precisely because they did not want to divert their time and energy to it.

The release of the Final Report resulted in a negotiating process for the women's groups. The groups must decide whether to respond to a Report that represents the findings of a RC fraught with problems and one that several groups boycotted or face the consequences of not responding. If the groups do not respond they risk being excluded from the post-Royal Commission consultation, policy development process. There was some uncertainty regarding the future of the Final Report under a new Liberal government.

Apparently Health Canada has accepted this Report as the agenda setter since it requested consultation with groups regarding the central recommendation of the Royal Commission which was to establish a national regulatory commission.

In the few weeks following the release there was a concerted effort by the women's groups to respond to the Report. The CSF was satisfied with its general orientation and ethical principles and what they criticize is that it has given too much power to the federal jurisdiction and encroaches on the provincial government's jurisdiction.[16] The PEIACSW stated that based on the Report's general tone they are "cautiously positive". It also stated that to assess this Report one must address the concerns about the Royal Commission proceedings to determine whether the Report is tainted.[17] CRIAW believed that the RC had produced some solid recommendations. It supports the idea of a National Regulatory Commission but was less satisfied with the recommendations regarding genetic research.[18] The National Council of Women of Canada (NCWC) was pleased to see the many areas of commonality between the RC report and their recommendations.[19]

The Final Report is extensive, consisting of 1275 pages, and, although it was evident even from its title that it took a liberal "yes, but" position, several groups took time to generate responses. There are certain ways the government can set the agenda for a policy area. In this case, the government provided the Commission with a mandate that would concentrate the debate on the management or regulation of NRGTs. In Manitoba the network that formed to deal with NRGTs, meeting for over seven years, felt that a regulatory commission may not be an effective vehicle.[20] I attended an interactive forum of the Vancouver Women's New Reproductive Technologies Coalition as they were preparing to respond to the request for stakeholder consultations with Health Canada. From my experiences, I conclude that this Report is difficult to ignore and that groups are frustrated by being pressured to respond to specific recommendations in the Final Report. The outcome of this forum was to recommend a moratorium on the implementation of the RC recommendations because the Commission appropriated and distorted feminist principles, did not adequately reflect women's groups, and because their consultative process was flawed.[21] But the group also provided their criticisms of the proposed regulatory commissions, which was the proposed question for consultation. The general response,

shown at the actual presentation of this group's report to Health Canada and other workshops, is that enough time (too much) has passed and there is an urgency to have some kind of legislation carried out. These groups feel that the Final Report cannot be ignored because it is a reality and to ignore it is to risk being excluded from the next policy stages. To ignore it means that these technologies proceed and not even with care. Women's discursive space has been re-appropriated by the state and the agenda set.

VI. Reflections

NRGTs raise some very difficult questions; I myself felt overwhelmed by them at many times. Throughout this process I have felt a whole array of emotions regarding these technologies. I embarked on this project because I was being drawn in by the popular media's presentation of these futuristic technologies and the women who opposed them. In the past two years I have seen widespread acceptance of NRGTs. IVF is considered a risk worth taking, sometimes successful and other times not. Prenatal screening is considered essential for women over the age of thirty-five. Women have on average two to three ultrasounds per pregnancy. DI has entered the realm of medical control complete with ovulation drugs administered to clients.

My mind is crowded with the images of the invasion of women's bodies and women's loss of bodily integrity. I have heard and read of the psychological and emotional trauma recounted by women who have gone through the IVF process, these women whose bodies and lives were scrutinized and controlled by a team of fertility specialists. Alongside this I am bombarded by the everyday headlines about a new gene being discovered and how this feeds into the booming industries of genetic screening and genetic counselling.[22] I cannot ignore the images of the beautiful, apparently healthy babies, nor can I ignore the women for whom the technology was not successful but who are quoted as saying that they would do it all over. However, the other images of eugenics weigh more heavily.

As I attempted to position myself within the feminist discouse on NRGTs, my initial reaction was a liberal rights one, in which I felt that Sunera Thobani and NAC could not prevent NRGTs from being offered to women as "choices." However, I conclude liberal

regulations of the abusive applications of NRGTs are not sufficient. As I delved deeper into the literature and the research, the pluralist choice position offered an attractive theory that attempted to balance the "needs" of infertile women by offering them informed choices. The pluralist choice position ultimately takes an individual stance that says that different women make different choices. This position does recommend a moratorium. But, it considers the technologies separately and focuses on the context in which they are applied, a weakness in the final analysis. While the social relations position has not solved the dilemma regarding women's agency and individual "desire" which cannot be subsumed by the collective, it was best able to respond to the dangers of remaining within the dominant liberal discourse. I consider NRGTs to be independendent and inextricably linked to the practice of eugenics: controling who can live and who can reproduce. The social relations feminists emphasized the differences among women as the primary factors used to make judgements regarding the impact of NRGTs even though it argued that these technologies affect women as a social group negatively. Consequently, as a woman I feel the social relations position is the best defensive strategy to take because of the path that these technologies are apparently taking and because the social relations position offers the latest development of the feminist NRGTs discourse. The implications of the social relations position carried to its fullest is that NRGTs will be banned. This pales in comparison to the "Mother Machine" that could result should the government allow NRGTs to proceed either with care (the implications of the liberal rights approach) or with caution (the implications of the pluralist choice).

When I think about the literature and the submissions that I have read, certain images remain with me. It is inhumane that as a precaution medical authorities evacuate Native women from their support and their communities, for as long as four months before their baby is due to be born. How is it that women with disabilities are still being forcibly or coercively sterilized and considered unfit to mother? How can the medical profession and the state consider poor women and young women irresponsible and coerce them into doing "the right thing"? This "right thing" might be to undergo contraceptive implants, to give up their babies, and if on welfare to have a tubal ligation. I am reminded of the woman on her back, feet in stirrups, the male doctor impregnating her, the husband standing proudly by, feeling that they are doing the only possible thing they can. What of the pregnant woman

who is undergoing childbirth lying down, with the fetal heart monitors strapped to her stomach, the nurse ready to call the doctor if any fetal distress occurs, despite how the woman feels? The doctor can then decide to quicken the birth or perform a C-section. I am enraged at the further possibility that the woman's wishes could be overlooked and her right to refuse curtailed.

The disturbing reality regarding the feminist NRGTs discourse is that a marketing discourse surrounds it. The feminist discourse highlights the right to refuse, the loss of control, and the loss of traditional, cultural and social ways to deal with infertility. It must confront a discourse centered on presenting these technologies as more "choice", and more freedom for women. These technologies present frightening eugenic possibilities, will increase the medicalization of women's lives, and will even alienate women from their own bodies as their body parts are fragmented and commodified. Women are selling their eggs and renting their wombs. Women's groups should no longer proclaim "our bodies, ourselves," without realizing what this means to women depending on their specific circumstances. As the women's groups attempted to pressure the state to adopt their recommendations, they also faced pressures from the Commission itself to comply with its process, from the state and its "everyday" pressures. The groups faced expectations from their members, women in general and the public. The women's groups were making presentations in the public realm about a "private" issue, reproduction. In that public realm, the dominant discourse about women's "private", individual "rights" and "choice" constrained the forms of women's speech. The submissions to the Royal Commission were in a different realm than the work done by the feminist writers which was done on its own terms, among women.

The history of the medical treatment of women and the history of sexist, racist, classist oppression and discrimination weigh heavily on the liberal rights and pluralist choice feminists. They need to prove why NRGTs should be allowed to continue when these technological fixes will not contribute to what is really needed. Solutions need to benefit all women, specific to their lived experience, will enable women to face the idea of infertility and together construct a solution. The solutions will not only benefit women individually but will benefit their community and women as a social group. The feminist resistance to

NRGTs must continue in Canada, at the grassroots level where the questions and criticism raised by the social relations position can be taken up. I believe that the social relations position causes "a critical pause in thinking" about the implications of NRGTs for women as a social group, making meaning, and envisioning alternatives.

Endnotes

1.Linda Grindstaff, "Abortion and the Popular Press: Mapping Media Discourse from Roe to Webster, " Abortion Politics in the United States and Canada: Studies in Public Opinion, Ed. Ted G. Jelen and M. A. Chandler (Connecticut: Praeger, 1994) 83.

2.Canada, Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies, Volume 1 (Ottawa: Canada Communications Group, 1993) 36.

3.Planned Parenthood Federation of Canada, Brief to the Royal Commission on New Reproductive Technologies (August 1992) 8.

4.Annette Burfoot, "In-Appropriation-A Critique of Proceed with Care." Women's Studies International Forum 18:4 (1995):500.

5.Varda Burstyn, "Breeding Discontent," Saturday Night (June 1993): 16.

6.Grindstaff 59.

7.Many other groups which presented to the Royal Commission such as doctors, pharmaceutical companies would not be considered "special interests".

8.Mies, "Self-Determination: the End of a Utopia," Ecofeminism, Maria Mies and Vandana Shiva (Halifax: Fernwood Publications, 1993) 220-221.

9.Grindstaff 83.

10.Grindstaff 79.

11.Grindstaff 80.

12.See for example, Greg Coleman, "Feminist Picket Raises REAL Women Issues," The Victoria Times-Colonist 4 June 1995: A3.

13.Anne Finger, "Claiming all of our Bodies: Reproductive Rights and Disability," Test-Tube Women: What Future for Motherhood? Eds. R. Arditti, R.D. Klein and S. Minden (London: Pandora Press, 1989) 290.

14.At this conference, Amanda leRougetel, president of CARAL stated that looking back on its submission, CARAL regrets some of the positions it took; "lines were drawn that now haunt us". It developed a brief without sufficient time to prepare and with no resources. See Robyn A. Cryderman, Conference Notes, DAWN Canada and the National Action Committee on the Status of Women present: The Contradictions of Choice: The Common Ground Between Disability Rights and Feminist Analyses,

Unpublished (Vancouver, B.C.,November 10-12, 1994) 29.

15.Liora Salter and Debra Slaco, Public Inquiries in Canada, Background Study No. 47 (Ottawa: Science Council of Canada, 1981) 15.

16.Conseil du Statut de la Femme (CSF), Communiqué: Le CSF se penchera sur les Recommandations de la Commission Baird, CSF: Gouvernement du Québec: 1.

17.PEIACSW, Media Release: PEIACSW Responds to Report on New Reproductive Technologies, 2 December 1993: 1.

18.CRIAW, Press Release: CRIAW's Response to the Final Report of the Royal Commission on New Reproductive Technologies, 1 December 1993.

19.NCWC, News Release: National Council of Women Supports Strict Regulation of NRTs, 3 December 1993.

20.Manitoba Reproductive Technologies Network, Response to the Final Report, 22 September 1994 (Draft): 7. Other later responses by women's groups included: National Council of Women of Canada response to the Canadian Government on the Report of the Royal Commission on Reproductive Technologies 1 May 1994.

21.VWNRTC, Submission by The Vancouver Women's New Reproductive Technologies Coalition to Health Canada, 20 September 1994: 1. Since then Minister Marleau has called for a **voluntary** moratorium on nine unacceptable technologies. The nine practices are: fetal sex selection for non-medical reasons; commercial preconception or surrogacy arrangements; buying and selling of eggs, sperm and embryos; egg donation in exchange for IVF; germ-line genetic alteration; creation of artificial wombs; cloning of human embryos; formation of transgenic hybrids; retrieval of eggs for fetuses and advertisements for purposes of donation, fertilization and research. See Edward Greenspon, "Ottawa backs off test-tube issues," Globe and Mail 28 July 1995: A1 & A3; Michael Valpy, "Creepy Genetics Unchecked," Globe and Mail 28 July 1995: A19. Also the response by the clinics, "Clinics indifferent to Marleau moratorium," Globe and Mail 29 July 1995: A9.

22.To date, far six to eight thousand genes have been discovered which leaves seventy-five or eighty thousand.

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APPENDIX A - Acronyms Defined

Women's Groups;

AACWI	Alberta Advisory Council on Women's Issues
AANE	L'Association des Acadiennes de la Nouvelle-Ecosse
AFEAS	L'Association féminine d'éducation et d'action sociale
AOM	Association of Ontario Midwives
AWI	Alberta Women's Institutes
AWRC	Antigonish Women's Resource Centre
CACSW	Canadian Advisory Council on the Status of Women
CARAL	Canadian Abortion Rights Action League
CDRC	Canadian Disability Rights Council
CFBPWC	Canadian Federation of Business and Professional Women's Clubs
CFUW	Canadian Federation of University Women
CIAFT	Conseil d'intervention pour l'accès des femmes au travail du Québec Inc.
CNA	Canadian Nurses Association
CRC	The Coalition for Reproductive Choice
CRIAW	Canadian Research Institute for the Advancement of Women
CSF	Conseil du statut de la femme, Gouvernement du Québec
DAWN	DisAbled Women's Network (Canada and Toronto)
DESAC	D.E.S. Action Canada
DSAC	Dalkon Shield Action Canada
FANRGT	The Feminist Alliance on New Reproductive and Genetic Technologies
FFQ	Fédération des Femmes du Québec
FINRRAGE	Feminist International Network of Resistance to Reproductive and Genetic Engineering
FMWC	Federation of Medical Women of Canada
FPF	Federation provinciale des fransaskoises
FQPN	La Fédération du Québec pour le Planning des Naissances
FWIC	Federated Women's Institutes of Canada
GLPA	Gay and Lesbian Parents Association
GREMF	Groupe de recherche multidisciplinaire feministe
HLCRT	Halifax Lesbian Committee on Reproductive Technologies
IINC	Indian and Inuit Nurses of Canada
IVMWBC	Immigrant and Visible Minority Women of B.C.
LSWAG	London Status of Women Action Group
MACS	Manitoba Action Committee on the Status of Women
MACSW	Manitoba Advisory Council on the Status of Women
MHS	Maternal Health Society (Vancouver and Victoria)
MWI	Manitoba Women's Institute
NAC	National Action Committee on the Status of Women
NAWL	National Association of Women and the Law
NBACSW	New Brunswick Advisory Council on the Status of Women

NBBPWC	New Brunswick Business and Professional Women's Club
NCJW	National Council of Jewish Women
NCWC	National Council of Women of Canada
NOIVMWC	National Organization of Immigrant and Visible Minority Women
NSACSW	Nova Scotia Advisory Council on the Status of Women
NTSWC	Northwest Territories Status of Women Council
OACWI	Ontario Advisory Council on Women's Issues
PACSW	Provincial Advisory Council on the Status of Women (Nfld.)
PEIACSW	Prince Edward Island Advisory Council on the Status of Women
PPFC	Planned Parenthood Federation of Canada
RAIF	Réseau d'action et d'information pour les femmes
RFSO	Réseau des femmes du sud de l'Ontario
RNAEF	Réseau national d'action et d'education des femmes
SAC	Saskatchewan Action Committee, Status of Women
TWHN	Toronto Women's Health Network
UWC	University Women's Club (North York and Calgary)
VFWC	Victoria Faulkner Women's Centre
VSW	Vancouver Status of Women
VSWAG	Victoria Status of Women Action Group
VWHC	Vancouver Women's Health Collective
VWRTC	Vancouver Women's Reproductive Technologies Coalition
WACNS	Women's Action Coalition of Nova Scotia
WCM	Women's Centre of Montreal
WERF	Women's Education and Research Foundation of Ontario
WHC	Women's Health Clinic
WHEN	Women's Health Education Network
WHI	Women's Health Interaction
WN	Women's Network
WUNIFARM	Women of UNIFARM
YAWL	Yellowknife Association of Women and the Law
YIWA	Yukon Indian Women's Association
YWCA	Young Women's Christian Association (Yellowknife andVancouver)
YWS	Yellowknife Women's Society

Technical Terms;

AI	Artificial Insemination or Alternataive Insemination
CVS	Chorionic Villus Sampling
DES	Diethylstilbestrol
DI	Donor Insemination
GIFT	Gamete Intro Fallopian Transfer
HIV	Human Immunodeficiency Virus
IUD	Intrauterine Device
IVF	In Vitro Fertilization
NRGTs	New Reproductive and Genetic Technologies

PNDT	Prenatal Diagnostic Technologies
STD	Sexually Transmitted Disease
RCNRT	Royal Commission on New Reproductive Technologies

APPENDIX B - List of Groups and Primary Documents

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Manitoba Action Committee on the Status of Women. Oral Transcripts of the Presentation by Jenny Robinson to the Royal Commission on New Reproductive Technologies. Winnipeg, Manitoba. October 24, 1990.

Manitoba Advisory Council on the Status of Women. Submisssion to the Royal Commission on New Reproductive Technologies. October 23, 1990.

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National Council of Women of Canada. Submission to the Royal Commission on New ReproductiveTechnologies. July 1990.

National Organization of Immigrant and Visible Minority Women of Canada. Brief to the Royal Commission on New Reproductive Technologies. October 19, 1990.

New Brunswick Advisory Council on the Status of Women. New Reproductive Technologies: What Price Hope? - Brief Submitted to the Royal Commission on New Reproductive Technologies. October 1990.

New Brunswick Business and Professional Women's Club. Brief to the Royal Commission on New Reproductive Technology. October 19, 1990.

North West Territories Status of Women Council. Brief to the Royal Commission on New Reproductive Technologies. September 12, 1990.

Nova Scotia Advisory Council on the Status of Women. Submission to the Royal Commission on New Reproductive Technologies. October 1990.

Ontario Advisory Council on Women's Issues. Presentation to the Royal Commission on New Reproductive Technologies. October 1990.

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South Surrey-White Rock Women's Place. Oral Transcripts of the presentation by Susan Cram and Halina Struser to the Royal Commission on New Reproductive Technologies. Vancouver, November 27, 1990.

Toronto Women's Health Network. Submission to the Royal Commision on New Reproductive Technologies. November 1990.

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Women's Centre of Montreal. Brief on New Reproductive Technologies. November 1990.

Women's Education and Research Foundation of Ontario. Brief to the Royal Commission on New Reproductive Technology. November 2, 1990.

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Women's Health Clinic. Brief to the Royal Commission on New Reproductive Technologies. October 24, 1990.

Women's Health Education Network. Presentation to the Royal Commission on New Reproductive Technologies. October 17, 1990.

Women's Health Interaction. Brief to the Royal Commission on New Reproductive Technologies. September 18, 1990.

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Yellowknife Association of Women and the Law. Oral Transcripts of the presentation made by Carol Roberts. Yellowknife, September 12, 1990.

Yellowknife Women's Society. Oral Transcripts of the presentation by Anne Lynagy and Brenda Percy. Yellowknife, N.W.T. September 12, 1990.

YWCA of Yellowknife. Brief to the Royal Commission on New Reproductive Technologies. December 1990.

Yukon Indian Women's Association. Brief to the Royal Commission on New Reproductive Technologies. September 11, 1990.

Yukon Indian Women's Association. Oral Transcripts of the presentation by Linda Macdonald and Pearl Keenen to the Royal Commission on New Reproductive Technologies. Whitehorse. September 11, 1990.

*The presentations to the Royal Commission were transcribed by Farr & Associates Reporting Inc.

APPENDIX C- Chronology of the Literature Reviewed

1970 Shulamith Firestone,The Dialectic of Sex

1974 Linda Gordon, Woman's Body Woman's Right

1976 Marge Piercy, Woman on the Edge of Time

1978 Andrea Dworkin, Right-Wing Women

1980 The Brighton Women and Science Group, Alice Through the Microscope: the Power of Science Over Women's Lives

1981 Helen B Holmes, Betty B Hoskins and Michael Gross,eds; The Custom-Made Child? Women-Centered Perspectives. One of two volumes to emerge from The Conference on Ethical Issues in Human Reproduction Technology: Analysis by Women, held in Massachusetts in 1979.

Mary O'Brien, The Politics of Reproduction

Helen Roberts, Women, Health and Reproduction

1983 Margaret Eichler, Families in Canada Today

Joan Rothschild, Machina Ex Dea, Feminist Perspectives on Technology

1984 Rita Arditti, Renate Duelli Klein and Shelley Minden,eds. Test-Tube Women:What Future for Motherhood? 2nd edition(1985), 3rd edition(1989).

Somer Brodribb, Reproductive Technologies, Masculine Dominance and the Canadian State

Rosiland Petchesky, Abortion and Woman's Choice: The State, Sexuality and Reproductive Freedom

Second International Interdisciplinary Congress on Women in Groningen, Netherlands. FINRET was formed.

1985 Margaret Atwood, The Handmaid's Tale

Canadian Journal of Women and the Law, I, No.2 (1986). Special Issue; Women and Reproduction, papers presented at: National Association of Women and the Law, Sixth National Biennial Conference, Who's in Control? Legal Implications of Reproduction, held Feb.21-24, 1985.

Gena Corea, The Mother Machine:Reproductive Technologies from Artificial Insemination to Artificial Wombs

Gena Corea, Renate D Klein et al.eds., Man-Made Woman:How New Reproductive Technologies Affect Women

Ursula M Franklin, Will Women Change Technology or Will it Change Women?

P. Spallone & D. Steinberg, Eds. Made to Order: The Myth of Reproductive and Genetic Process(1987); this book is in large part a result of FINRRAGE's The Women's Emergency Conference on the New Reproductive Technologies, Sweden, July, 1985

Women's Studies International Forum. Special Number 8:6

1986 Hypatia, Vol.1, No.2 (Fall 1986) Special Issue, Ethics and Reproduction

Barbara Katz Rothman, The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood

Mary Beth Whitehead v. Bill and Betsy Stern, surrogacy case retold by; Phyllis Chesler, The Sacred Bond: The Legacy of Baby M (1987)

A.-M. deVilaine ed, avec A.Gavarini, et M.LeCoadic, Maternité en Mouvement: Les femmes, la re/production et les hommes de sciences. France-Québec collaboration.

1987 Boston Women's Health Collective, The New Our Bodies, Ourselves, 3rd Edition 1992.

Conseil du statut de la femme, Sortir la Maternité du Laboratoire, The proceedings of an international forum on new reproductive technologies held in Quebec, October,1987.

Hypatia, Vol.2, No.3 (Fall 1987) Special Issue, Feminism and Science I

Christine Overall, Ethics and Human Reproduction: A Feminist Analysis

Michelle Stanworth, Ed. Reproductive Technologies: Gender, Motherhood and Medecine

1988 Somer Brodribb, Women and Reproductive Technologies, Prepared for the Status of Women

Reproductive and Genetic Engineering: A Journal of International Feminist Analysis (RAGE) First Issue

1989 Sherril Cohen & Nadine Taub (Eds), Reproductive Laws for the 1990's

FINRRAGE's International Conference on Reproductive and Genetic Engineering and Women's Reproductive Health, Camilla, Bangladesh March 18-25, 1989

Hypatia, Vo.4, No.3 (Fall 1989) Special Issue Motherhood and Sexuality

Mary O'Brien, Reproducing the World: Essays in Feminist Theory

Christine Overall (ed), The Future of Reproduction

Barbara Kutz Rothman, Recreating Motherhood: Ideology and Technology in a Patriarchal Society

Patricia Spallone, Beyond Conception: The New Politics of Reproduction

1990 Lynda Birke, Susan Himmelwiet and Gail Vines, Tomorrow's Child; Reproductive Technologies in the 90's

Ruth Hubbard, The Politics of Women's Biology

Royal Commission on New Reproductive Technologies, Public Hearings from September 11, 1990 to November 29, 1990

APPENDIX D- Royal Commission Chronology of Events

Royal Commission Apppointed	October 1989
Announcement of Public Hearings	May 1990
Start Date of Public Hearings	September 11, 1990
Whitehorse	September 11, 1990
Yellowknife	September 12, 1990
Edmonton	September 13, 1990
Calgary	September 14, 1990
Ottawa	September 18-20, 1990
Quebec City	September 26, 1990
St. John's	October 15, 1990
Charlottetown	October 16, 1990
Moncton	October 19, 1990
Halifax	October 17-18, 1990
Winnipeg	October 23-24, 1990
Saskatoon	October 25, 1990
Toronto	October 29, 31 & Nov. 19-20, 1990
London	November 1-2, 1990
Montreal	November 21-22, 1990
Vancouver	November 26-28, 1990
Victoria	November 29, 1990
End Date of Public Hearings	November 29, 1990
Symposia, Colloquia	March 21, 1991 to June 11, 1992
Release of What We Heard	September 1991
Filing of Lawsuit by Four Commissioners	December 1991
Hiring of two additional Commissioners	December 1991
Firing of the Four Original Commissioners	December 1991
Boycott by Women's Groups	February 1992
Initial End Date of Royal Commission	October 1992
End Date Extended	July 1993
Release of Information Regarding D.I	May 1993
Final Report Released	November 1993

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University of Victoria	1993 to 1996
Laurentian University (Canadian University in France)	1989 to 1990
University of Ottawa	1988 to 1992

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Honours and Awards:

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University of Victoria Teaching Fellowship	1993 to 1994
University of Ottawa Entrance Scholarship	1988

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Title of Thesis:

Mapping Feminist Discourse From Resistance to Regulation: Women and the Politics of the New Reproductive and Genetic Technologies in Canada

Author [redacted]

Christine Saulnier
April 27, 1996