

**Using Feminist Sociology as a Theoretical Approach in  
Examining Issues Concerning Reproductive Technologies**

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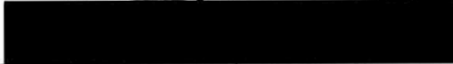



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## ABSTRACT

This thesis examines issues surrounding ten new reproductive technologies from a feminist sociological perspective. The technologies are alternative ("artificial") insemination, donation, cryopreservation, embryo transfer, parthenogenesis, 'in vitro' fertilization, sex preselection, contract ("surrogate") motherhood, the artificial womb, and the RU-486 pill. Details of the new reproductive technologies are presented along with advantages, disadvantages, and social implications.


At the outset of this thesis an empirical study was undertaken. Thirty two informants were asked to complete a questionnaire about their knowledge and attitudes concerning the ten reproductive technologies. These people were viewed as potential policymakers regarding policy decisions on reproductive technologies in British Columbia. Of particular interest were the survey participants attitudes regarding women's roles in the decision making processes. It was discovered that these informants feel nearly everyone should have input into decisions concerning all but two of the technologies (parthenogenesis and artificial womb technology). After an examination of the focuses of feminist sociological theory, it was apparent that a more socially relevant approach was needed.


Feminist sociological theory, following Lengermann and Niebrugge-Brantley's (1988) 'gender oppression' theoretical view, claims to have (1) a particular mode of dialectical thinking, (2) a macrosociological model of social organization, (3)

an examination of the relational situation of women which alters traditional understandings of micro interactions, and (4) a revised model of subjectivity within sociology. Within the context of this theoretical perspective, it was hypothesized that there would be differences in attitudes about rating, funding, access, and policy issues for the ten technologies based on sex.


Frequencies and cross tabulations by the sex of the informant are reported for each question. Contrary to the hypothesis, the results of the survey indicate that the education level of the informant, not the sex, is the better and more often statistically significant predictor of attitudes regarding reproductive technologies. These results are not, however, discussed by level of education here as sex was the variable of theoretical interest. It is likely that sex, age, marital status, education level, religiosity, and number of children are intercorrelated. Further statistical analyses, while beyond the scope of this thesis, could be run to differentiate the effects of these variables from each other. The focus of this thesis shifted from empirical to theoretical with the emphasis now on the feminist sociological approach to research. The above study of informants is discussed in that light. The paper ends with a brief discussion of the benefits of a feminist sociological approach to research which, in short, urges researchers to include the goal of social action and/or social change on their research agendas.

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## Chapter I

### INTRODUCTION

New human reproductive technologies, the application of scientific or technical advances to the production of offspring, have rapidly developed into a focus of controversy across Canada, as in other industrialized nations, but social norms and policy decisions regarding these technological advances are only now taking shape. Many researchers have discussed the importance of making policy decisions quickly to avoid the many possible pitfalls and abuses of the techniques.

Given the relevance of reproductive technologies to basic social issues such as where and when human life begins, what constitutes a family, how parenthood is defined, the extent of control humans should be allowed to have over human existence, who decides what will be 'best' for women, for children, for families, and so on, the examination of policy options becomes increasingly more critical. As feminist sociologist Dr. Rona Achilles notes:

as the technologies become more sophisticated, the social dilemmas posed by them become more complex. The crucial question is: who is going to control these technologies and under what conditions? (1988:310).

In Canada, at the present time, reproductive technologies fall into a legal and ethical abyss. In 1985 the Ontario Law Reform Commission published The Report on Human Artificial Reproduction and Related Matters which dealt with various reproductive technologies in an attempt to determine some of the issues surround-

ing reproductive technologies (see Appendix A). In the spring of 1988 the Canadian Coalition for a Royal Commission on New Reproductive Technologies, led by Dr. Margrit Eichler of the Ontario Institute for Studies in Education, met with Minister of Health and Welfare Canada, Jake Epp, to convince him of the need for a royal commission to look into the various technologies and examine the potential implications these techniques could have for Canadian society in general. Little has been accomplished toward reaching solid decisions regarding reproductive technologies in Canada, however, the April 3, 1989 Federal Throne Speech indicated a commitment to launching a royal commission to look at all issues surrounding reproductive technologies. Dr. Patricia Baird of the University of British Columbia's Medical Genetics Department was named head of the commission which is to make recommendations to the Canadian public by the spring of 1992.

The history of the interplay between the Canadian federal and provincial governments regarding policy decisions shows that policy making, while a political issue at the provincial level, is generally concluded at the federal level. Funding for various outcomes of policy debates comes from the federal arena. Clearly there can be little talk of funding for selected reproductive technological advances until some of these issues are resolved.

This study was begun with the idea of surveying representatives of the groups who are likely to assist in policy formulation as to their knowledge and attitudes concerning various reproductive technologies. Who they saw as having more of a vested interest than the "average" Canadian in the outcome of policy decisions made regarding reproductive techniques and procedures would be asked and the directions policy may take once created would be assessed. It was initially

thought that once these issues had been addressed, it would be possible to imbed them within larger issues of power and examine who the respondents in the survey feel should control, fund, and have access to reproductive technologies in British Columbia.

However, as the study took shape I began to feel that the issue of power regarding the reproductive technologies was actually the central issue and that a study of potential policy makers' knowledge and attitudes would be more illustrative of power issues than anything else. As my knowledge of feminist sociology and my knowledge of the way the concept of power is treated grew, the more convinced I became that my study of knowledge and attitudes could be used for the purpose of illustrating wider issues regarding reproductive technologies.

The paper is composed of the following sections: (1) a review of the literature on reproductive technologies giving a description of selected techniques and their attendant social implications; (2) a presentation of the theoretical foundation which articulates with the study; (3) details of the research guidelines employed in the survey of key individuals; (4) the results of the survey (qualitative and quantitative); and (5) a discussion of the results with an emphasis on the theoretical focus taken.

## Chapter II

### LITERATURE REVIEW

Most people will get the children they desire through conventional methods but technologically assisted births and conceptions are becoming increasingly prevalent. This is due, in large part, to the fact that reproductive technologies are becoming more accessible. Three other factors play a part in increased usage: infertility, adoption, and abortion. There has been a decrease in fertility over the past twenty years which may be due to environmental effects (diet, low level radiation, and so on) or to the practice of postponing childbearing which can result in age-associated sterility. There has also been a decrease in the number of adoptable Caucasian children in North America due to the increasing number of teenagers keeping their children and due to increased abortion rates. Further, the use of amniocentesis for the discovery of birth defects and retardation (and subsequent abortion) has resulted in a reduced number of special needs children available for adoption (Keane & Ketterman, 1984; Romaniuk, 1987; Terry, 1987).

Because reproductive technology has been advancing so rapidly, it is necessary to impose limitations on which technologies will be examined here. I have intentionally limited the scope of this paper to those technologies which are already accessible to the public or, in the cases of the artificial womb and parthenogenesis, are of particular interest to certain groups in society. The technologies discussed in this paper are alternative "artificial" insemination, donation, cryopreser-

vation, embryo transfer, parthenogenesis, 'in vitro' fertilization, sex preselection, contract "surrogate" motherhood, the artificial womb, and the RU-486 pill.

## 2.1 CONTRACEPTION

An overview of reproductive technology would be incomplete without a brief discussion of contraception, a widely used reproductive technology. Contraception has profoundly affected family planning, particularly with the introduction of the 'pill' and of the intra-uterine device (IUD) in the 1960's. The 'pill' and the IUD represent the most highly effective and widely used reversible contraceptive techniques in the world. The popularity of these techniques, however, is being surpassed by the popularity of surgical sterilization as a method of birth control despite its virtual irreversibility. A 1976 survey of methods of contraception in Canada found that 39% of women aged fifteen and over who used contraception used the 'pill', 6% the IUD, and 31% had been sterilized. This sterilization rate does not take into account the percentage of men in couples who have been sterilized for contraceptive purposes so likely underestimates the true rate (Romaniuk, 1987). In British Columbia, B.C. Medical pays for sterilizations but not for reversals (phone call to the Medical Services Commission, 1989).

Surgical sterilization, the termination of childbearing ability, is the most common contraceptive method in the world <sup>1</sup>. Interestingly, Canada began the practice of sterilization later than the U.S. but, even taking account of the initial "catching-up" period, by 1986 Canada's rate had surpassed the U.S.'s by a substantial margin. Reports from Canada, Britain, and the U.S. indicate that the use of

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<sup>1</sup> Sterilization is accomplished, for women, through hysterectomy or tubal ligation and, for men, through vasectomy.

contraceptive sterilization is spread throughout the population: religion, ethnicity, social class, occupation, or labour force status, do not make a difference in determining who uses this technology, nor does the number of children born to a woman seem to make a difference. In Quebec in 1976, 45% of the women who were sterilized had four or more children, 24% had two, and 10% had one child. In Britain in 1981, the picture is slightly different. One third of the women surveyed had three or more children and fully 60% had two children or fewer (Allen, 1981; Holden, 1985; Kanno, 1987; Romaniuk, 1987; Shapiro, 1985).

Other forms of birth control can be interrupted so are excellent for regulating the timing of childbirth but sterilization is usually a "means of terminating procreation" (Romaniuk, 1987:41). Although reversals of the sterilization procedures can be done in many cases, people considering this method are urged to think of it as irreversible. One 1980 study in the U.S. found that one third of the women who had been sterilized regretted the decision at some later point especially if they were less than thirty years of age when the procedure was accomplished. There have been no parallel studies of men's attitudes done.

The fact that there has been such an increase in the use of sterilization along with the fact that the people opting for this method are increasingly younger has led to the prediction that the demand for reversal procedures for tubal ligation and vasectomy will increase in the future. In anticipation, recent advances in microsurgery have increased the possibility of tubal reconstruction. This procedure is known as "reanastomosis". This major surgery can cost up to \$10,000.00 U.S. and requires a highly skilled physician, specialized and expensive equipment, and very good health of the patient. One study in Britain (Allen, 1985) found that

requests for reversals had been increasing substantially in recent years. This is partly due to the increased numbers of sterilizations being done, but also due to increased divorce rates and increased technical competence on the part of doctors (Allen, 1985; Boston Women's Health Collective, 1984, Romaniuk, 1987).

Other reversible sterilization techniques are being attempted. The techniques for women include the injection of substances into the fallopian tubes, the insertion of pellets or plugs, the use of clips and rings, or the modification of surgical procedures. The long term effects of these newer methods are not yet known. The latest techniques being tried for men are the insertion of plastic plugs into sperm ducts or the implantation of valves which can be turned off or on depending on the desire for children (Boston Women's Health Collective, 1984).

Contraception is one technology that has been used to control fertility. While some of the techniques in the following discussion offer the same control over reproduction as contraception (i.e.: timing of childbirth), the focus, with a few exceptions, will be on technologies which correct or compensate for infertility.

The ensuing discussion describes ten reproductive techniques and procedures and their potential to alter society. Although many of the implications seem unlikely, they should be considered as our technical options increase and have therefore been included in this review. The implications in each section have been listed in order from most probable to the least plausible. But as one commentator cautions:

[t]he impossible...contains an uncanny propensity for becoming a reality in tomorrow's world. What for us today is unbelievable may well be taken for granted by our children (Francoeur, 1970:161).

## 2.2 ALTERNATIVE INSEMINATION, DONATION, AND CRYOPRESERVATION

This section of the paper will discuss: (1) alternative insemination by husband, by donor, or by a combination of both; and (2) donation and cryopreservation of sperm.

### **2.2.1 Alternative insemination (AI)**

Alternative insemination, or the introduction of sperm into the vagina by means other than sexual intercourse for the purposes of conception, has been successfully performed using the husband's sperm (AIHusband) since the late 1700's and successfully performed using donor sperm (AIDonor) since the late 1800's. It is the simplest and least invasive to the woman's body of all the reproductive technologies to be discussed. Alternative insemination (AI) is also the most widely used technology, with tens of thousands of babies being conceived this way per year (Andrews, 1984; Boston Women's Health Collective herein after referred to as "BWHC", 1984; Corea, 1985; Hamner & Allen, 1980; Isaacs & Holt, 1987).

The procedure is usually undertaken in situations where the husband has a low sperm count or has unhealthy sperm so either he is unable to fertilize his wife or he is likely to pass on some hereditary disease. The terms "husband" and "wife" are used here to underline the fact that AI is commonly restricted to married, heterosexual, "secure" couples. As a case in point, Corea (1985) noted that in a survey of U.S. doctors conducted in 1979, it was found that ninety percent of the respondents would perform AI only on legally married women (BWHC, 1984; Baby-makers, 1979; Hamner & Allen, 1980; Stossel, 1983).

AI can be performed easily at home but most couples opt for 'treatment' at doctor's offices or at AI agencies where there is greater anonymity. In fact, in

1980 the Quebec Order of Pharmacists was able to get doctors to agree to write prescriptions for sperm to be paid for by Medicare (Corea, 1985).

These doctors or agencies attempt to get sperm from donors whose physical characteristics match those of the husband. This offers some insurance against the AI child ever discovering s/he is not biologically related to the social father. Andrews noted that a 1979 study of 147 couples participating in AI found that 143 couples had no intention of disclosing the information of the child's parentage to the child (1984). However, there is a suggestion that AI children, like adoptees, may be disturbed or angry if they are unable to discern who their biological father is. There is currently a vocal lobby in British Columbia trying to prompt legislation regarding mandatory and voluntary disclosure (BWHC, 1984; Babymakers, 1979; Corea, 1985; Stossel, 1983).

This procedure and the attendant anonymity are not without cost. Usually two or three inseminations are needed per month, or cycle, at a rate of \$70.00 to \$140.00 (U.S. funds) per insemination. Sometimes conception occurs during one cycle but normally three or more cycle attempts are necessary (BWHC, 1984; Isaacs & Holt, 1987; Stossel, 1983).

In British Columbia, insemination attempts are paid for by Medical Services and there are no limits set on the number of attempts a person may undergo (phone call to the Medical Services Commission, 1989).

### 2.2.1.1 Social implications of alternative insemination

Alternative insemination carries with it some important social implications. Beginning with the most likely, the use of AI has the potential to weaken family bonds. This is due to the fact that a child resulting from AI arrangements is most often not biologically related to the social father. Depending on the importance of this to the social father, he could blame a child's misbehaviour on the donor. Marriage breakdowns over this are possible. The social father may even deny parentage in an attempt to evade his obligation to pay child support. It is also possible that a donor could sue for visitation rights and/or custody of the child. Similarly, a woman could sue a donor for child support (See Corea, 1985: 49-58).

Women are now purchasing sperm and inseminating themselves. Single or lesbian upper or middle class women are the most likely users of this service because of the cost<sup>2</sup> of purchasing sperm. In this case marriage for procreation could become an anachronism. There could be an increase in lone-parent families headed by women. To the extent that this path is chosen by women, this could leave men with the option of marriage to lower class women or to none at all. Many women may even prefer to live in non-sexual (or sexual) unions with other women and their children. This is not too unlikely when one considers that there are already several communes inhabited solely by women and children in existence (at least one such place is on Vancouver Island).

Although improbable, it would also be possible to inseminate women without their knowledge making it certain that new laws on rape would have to be considered. This type of situation allegedly happened to a married woman in 1884 who

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<sup>2</sup> Often women will find their own donors, thereby dismissing cost or, as in British Columbia, the cost is covered by the Medical Services Plan.

was hospitalized in Philadelphia seeking treatment for infertility. Her doctor considered the possibility that it was her husband who was infertile and collected sperm from a medical student. The woman was inseminated and became pregnant but was never told that the fertility problem was her husband's. This is considered to be rape by many people and in France, for instance, AI without a woman's knowledge is rape and is punishable under the Criminal Code (Corea, 1985:12).

### 2.2.2 Donation and cryopreservation of sperm

Cryopreservation of sperm, or nitrogen freezing, became a reality in 1949. It was discovered that nitrogen at -196 degrees Celsius stopped virtually all metabolic activity allowing sperm to be frozen in semen, stored, and thawed for use at a later date (Babymakers, 1979; Jequier & Crich, 1986; Stossel, 1983).

In 1970 the first commercial human sperm cryobank opened in the United States and by 1985 there were sixteen others. These banks were originally set up as places to store the donor sperm to be used in alternative insemination programs but have now expanded into businesses which purchase, store, and distribute sperm commercially (Babymakers, 1979; Corea, 1985; Jequier & Crich, 1986; Stossel, 1983).

Because of their availability, medical students and/or graduate students, displaying a wide variety of ethnic backgrounds and physical characteristics, are most often recruited to "donate" sperm at \$20.00 to \$40.00 (U.S.) per acceptable ejaculation. Ejaculations are examined closely for quantity and quality and only those with high sperm counts are accepted. A high sperm count is necessary as approximately one-third of the motile sperm dies or loses potency during the freezing process. To obtain these high sperm counts then, donors are asked to

abstain from any sexual activity for forty eight hours prior to the sale of their sperm (Corea, 1985; Isaacs & Holt, 1987; Jequier & Crich, 1986).

Medical and graduate students are also enlisted because it is assumed that they possess high intelligence. Carrying this to the extreme, one California businessman established the "Smart Man's" sperm bank in the United States in 1980. He collected sperm from several Nobel laureates and planned to inseminate only highly intelligent women. The "Smart Man's" bank has received few donations and fewer requests for 'genius' genes over the past decade but its very existence has led people to raise questions about the selection of sperm donors (Babymakers, 1979; Corea, 1985; Isaacs & Holt, 1987; Stossel, 1983).

Donors can now have their names, addresses, and medical histories filed with cryobanks to be made available to 'their' children when the children reach age eighteen. By 1984, twenty percent of the donors in the United States had elected to do this. Mandatory disclosure has been suggested by several states but bank administrators worry that this would discourage potential donors. A study of Australian donors, however, found that sixty percent of them would not mind if the children created with their sperm contacted them when they reached age eighteen (Andrews, 1984).

Recently men have begun to use cryobanks to store their own sperm at \$25.00 (U.S.) per year. This option may appeal to men who undergo vasectomies, who must undergo chemotherapy, or who work near radioactive or chemical substances (Corea, 1985; Jequier & Crich, 1986; Stossel, 1983).

### 2.2.2.1 Social implications of donation and cryopreservation

Several implications this technique can have for society can be discerned, the most likely of which are presented first.

In large city cryobanks, one donor's sperm is often used to inseminate several women. This can have serious implications for the spread of genetic disease or AIDS. One 1979 study of doctors in the U.S. found that screening of potential donors for genetic abnormalities and/or sexually transmitted diseases was often inadequate: ninety six percent of the doctors surveyed took medical histories using written checklists of common familial diseases but physical tests were rarely performed. Medical researchers in the U.S. and France have recommended that blood tests (for viruses, bacteria, and parasitic mycoplasmas), extensive sexual histories, urethral tests, and genetic screening all be provided by the donor before accepting ejaculations. To date, one British Columbia woman is in the process of suing her doctor as she allegedly contracted HIV through the use of donor sperm provided by the doctor. There is a very good chance <sup>3</sup> she will win her case. All cryobanks have been advised to test donors for the disease (Gay Men's Health Committee Inc., 1986; Isaacs & Holt, 1987).

Extensive use of one donor's sperm could also have serious implications for the inter-marriage of siblings. Apparently in Washington D.C. several would-be marriages have already been halted for this reason (Andrews, 1984).

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<sup>3</sup> This case went to Court in Fall 1991 and the woman won the case with her doctor being seen as negligent.

<sup>4</sup> Incest is defined as sexual intercourse between closely related persons.

Depending on one's opinion about whether technical incest<sup>4</sup> is equivalent to social incest, there are potential problems of incest to be considered with cryo-preservation and subsequent artificial insemination. For example, a woman could purchase sperm from a bank and find out later that her own daughter or son was conceived with the sperm of the woman's father, making the child her brother or sister, with the sperm of the woman's uncle, making the child her cousin, or with the sperm of her brother, making the child her own niece or nephew. This could carry serious implications due to most societies' strict taboos against incest. In this case, all the arguments against incest apply equally here: role confusion, rivalry and jealousy, and compounded risks of hereditary defects being transmitted.

There is little mention in the literature about possible operational errors or failures. Although less plausible, it could become normative for a group in society to bank their gametes and undergo sterilization for birth control purposes. If something were to go wrong at the bank (technical error, long power failure, or human error), that group would risk having no population growth. The most likely groups to use this service would be the middle or upper class groups because there is a yearly fee associated with the storage of sperm. It is also possible that the shelf life of frozen sperm is shorter than scientists believe: semen could be destroyed or could be mutagen-producing furthering the possibility of no population growth for a certain segment of society or giving rise to the possibility of a whole new group of people needing special care.

## **2.3 EGGS, EMBRYOS, PARTHENOGENESIS, AND 'IN VITRO' FERTILIZATION**

This section will be divided into four related parts: (1) harvesting of ova; (2) harvesting and transfer of embryos; (3) parthenogenesis; and (4) 'in vitro' fertilization.

### **2.3.1 Harvesting of ova**

Techniques for freezing, thawing, and manipulating the contents of ova, or eggs, are being developed and perfected. Procuring the eggs for experimentation (egg farming) has been going on in animals since the 1920's and in humans since the late 1960's. Finding enough donors though, seems to be the industry's biggest problem (Corea, 1985; Murphy, 1984).

Harvesting ova is a two-step procedure. First, a woman is given gonadotropin or fertility hormone injections to increase the quantity of ova produced. The ovaries are monitored with ultrasound and when the woman begins to ovulate she is taken to the operating room for the harvest. In step two of the procedure, the actual harvest is accomplished using a hollow needle called a laparoscope which draws the ova out (Corea, 1985; Murphy, 1984).

The ova can then be fertilized 'ex vivo' (outside the body), used for experimentation, or frozen for later use by the woman herself. The cryopreservation of ova works in exactly the same way as does cryopreservation of sperm and will not be discussed again in this section.

### 2.3.1.1 Social implications of harvest and cryopreservation of ova

Firstly, this technique can allow a woman complete control over the timing of pregnancy. She can bank her ova while she is young, undergo sterilization, and return for her ova years later. Either she, or a contract mother, could become impregnated and gestate a child. This is a likely scenario due to increased awareness of the harmful side effects of the pill in women over age thirty and due to increased risk of birth defects in children created with older gametes (Allen, 1985).

As with AI, family bonds can be weakened because individuals can purchase ova as well as sperm and therefore, the same child support and custody arguments apply here. The possibility of unintentional incest occurring also exists as it does with the donation and cryopreservation of sperm.

A more dubious possibility with cryopreservation is that bank operators could thaw the frozen ova of women, or the frozen sperm of men, they considered 'undesirable' (e.g.: those of lower social standing or of certain racial or ethnic backgrounds) and return them to the bank lifeless ensuring they could never engender a child. This way, only people considered to be superior<sup>5</sup> would be reproduced.

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<sup>5</sup> This possibility seems less doubtful when examined in the context of eugenics. For example, only decades ago in the U.S. attempts were made to introduce legislation which would enable the State to reproductively sterilize "welfare mothers" who had more than one "illegitimate" child. In Canada attempts were made to sterilize women institutionalized in Canadian prisons and women with developmental disabilities (Robitscher, 1973; Shapiro, 1985).

### 2.3.2 Harvest and transfer of embryos

In 1890 scientists demonstrated that early rabbit embryos could be flushed from the oviduct and then transferred to a foster mother where they would resume normal development and be born (Biggers, 1982:84). These results led the way for perfecting the research in cattle where fertilized embryos are flushed out and examined: "defective" ones are discarded and "good" ones are frozen for later implantation. Genetic tests for human embryos are imminent and may involve cryopreservation to carry them out. The techniques used for cryopreservation have already been described and will not be presented here (Babymakers, 1979; Corea, 1985; Vines, 1987).

To harvest embryos, a procedure formally called uterine lavage is used. A woman must agree to be inseminated and, if conception occurs, the embryo is washed out before it can implant on the uterine wall. These embryos are then frozen and stored for the woman herself, donated (sold) for \$50.00 (U.S.) to a cryobank, or are used for experimentation (Babymakers, 1979; Corea, 1985; Overall, 1987a).

Most nations considering this technique have disallowed experimentation for embryos older than fourteen days. The fourteenth day termination point was selected because this is when scientists have considered the first recognizable feature of the embryo proper, or humanity, to be in existence (Dickson, 1984; Trounson, 1987; Vines, 1987).

The embryo transfer itself is dangerous to a woman's health and most failures occur at this point. Three or four embryos are usually transferred at once to increase the probability of conception, but even with this safeguard the failure

rates are high. For example, one Canadian clinic reported a successful transfer rate of twenty percent, a U.S. clinic reported seventeen percent, and an Australian clinic reported sixteen percent. While these rates are not high, they are above the twelve percent rate that is most commonly reported (Biggers, 1982; Grobstein et al., 1983; Overall, 1987a; Vines, 1987).

### 2.3.2.1 Social implications of embryo harvest and cryopreservation

Several implications can be determined regarding the use of harvest and cryopreservation of embryos. First, considering that two or more embryos are transferred at once, it has become more common for the embryo recipients to gestate twins, triplets, quadruplets, and so on. This has implications in itself. There are possible economic challenges for couples who were expecting one child and who get three. Further, an old technique called abortion has been renamed "reductionism" or "selective reduction" in order to deal with these extra feti. Some doctors who will not perform abortions will perform 'selective reductions' making the change in terminology an interesting means for transgressing one's beliefs and keeping the procedure out of the political arena (Editors, 1989).

Most users of reproductive technologies are Caucasian so embryo transfer could also be a means of creating more adoptable Caucasian children. For example, some people could give three of their four infants up for adoption. A logical consequence of this is that if there were more Caucasian children for adoption there would be less need for some of the other, more expensive reproductive technologies which would then alleviate the social implications attached to them.

A further possibility is that assessing one's embryo for defects could become normative. Likely users of these procedures would, again, be middle and upper

class women who could afford the costs associated with them. In this case, if a woman either decided not to have her embryo examined at all, or decided to keep a defective one instead of aborting it, she and her child would likely be stigmatized. The woman could be looked upon as irresponsible, psychologically unbalanced, and/or legally incompetent. While this does not seem altogether probable, it has to be considered in a society, such as North America's, where the choice exists to gestate perfect or near-perfect feti.

Finally, using embryo technology, it would be possible for scientists to create people for special needs. We could have disposable labor forces so, for example, rather than getting minority groups to do distasteful work, embryos could be genetically engineered to work with chemicals, radiation hazards, and the like. Scientists could also create disposable people to act as a nation's cannon fodder by programming genes which would make people unresistant to their participation in war. This is, on the surface, the most far-fetched implication mentioned so far. However, a 1989 broadcast of the news special, Sixty Minutes, informed the American public of a drug that is being tested on American soldiers which will depress their emotions to the point that they will be completely unconcerned with their own or other's fate in battle. They will, in effect, become "military machines" (Sixty Minutes broadcast, January, 1989). It is likely more convenient to simply program genes at the outset.

### 2.3.3 Parthenogenesis

Parthenogenesis, the Greek term for "virgin birth", is a method of asexual reproduction involving the spontaneous division of the egg chromosomes or unfertilized ovum. This phenomenon occurs in various plants and animals. Several authors report that mouse ova have been externally induced to undergo parthenogenetic cell division. They further state that Australian 'in vitro' fertilization teams have observed parthenogenesis in human ova (Cherfas & Gribbon, 1984; Francoeur, 1970; Spallone, 1989).

Knowledge of parthenogenesis, or of the idea of it, can be traced to writings in the 1790's. Apparently the idea held appeal for the clergy in their attempts to explain "scientifically" how Eve descended from Adam <sup>6</sup> and how the Virgin Mary became impregnated <sup>7</sup> with Jesus Christ. In 1931, Dr. Ernest Messenger wrote:

[t]here exists in nature many cases of normal parthenogenesis. Further, we have known now for some years that ova which normally only develop when fecundated, can nevertheless develop parthenogenetically under the influence of certain chemical, physical, or even mechanical stimuli (quoted in Francoeur, 1970:131).

Two interesting points can be drawn from this quote. The distinction between the sexes is made concrete. Females are able to reproduce parthenogenetically. Their ova can be induced to divide by means other than male sperm. Cleavage of egg cells can begin, for example, by electrically or otherwise "shocking" a woman's system <sup>8</sup> or by applying cold to the ova. Edwards, the British 'in vitro'

<sup>6</sup> After hearing evidence of parthenogenesis, the idea was put forth that Adam somehow asexually reproduced Eve.

<sup>7</sup> God had induced the chromosomes to begin doubling.

<sup>8</sup> An investigation was carried out in 1955 to test the accuracy of a woman's claim that she had collapsed during heavy shelling in 1944 Germany. She claimed that the shock must have caused her to become pregnant for she was innocent of sexual relations. Her daughter is nearly an exact genetic copy of

pioneer, has stated that human's life potential is encapsulated in the female's unfertilized ova. Males do not, and can not, have this potential due, in part, to the fact that their gametes have no food stores for use in the first stage of a cell's development (Cherfas & Gribbon, 1984; Francoeur, 1970; Spallone, 1989).

Another point worth pursuing regarding the 1931 quote is that, not only can females reproduce parthenogenetically without male's aid, but female offspring are necessarily produced from this method. In the absence of sperm or any potential Y chromosomes, any asexual offspring developed by the division of the female's X chromosomes are necessarily XX or female. Some species are actually comprised completely of asexually reproducing females.

Research on parthenogenesis has shown that three quarters of a percent (.75%) of ova begin parthenogenetic development prior to their movement down the fallopian tubes. Taylor, a British scientist, estimates that one in ten thousand human births are the result of asexual reproduction. As Jeremy Cherfas and John Gribbon (1984:179) portend "the technology of asexual female reproduction in the human species really isn't that far off" (Cherfas & Gribbon, 1984; Francoeur, 1970).

### 2.3.3.1 Social implications of parthenogenesis

Parthenogenesis is likely to produce interesting dilemmas for defining terms and roles. For example, the word "twin" takes on a new dimension when a person's twin is also her mother or daughter. How will "mother" or "daughter" be defined? In this context, what will happen to the socially weighted term "individual"? Perhaps biological "fatherhood" will go out of style.

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· herself lending support to her story. For a more in-depth discussion of this case, see Francoeur, 1970:138).

Perhaps the most obvious scenario is one where males simply become redundant in a reproductive sense. If women became content to asexually reproduce themselves, thereby creating exact genetic copies of themselves, an early death (in evolutionary terms) for the species is probable. For long term survival of the species, mutagens created by combining sets of chromosomes are necessary to allow organisms the ability to change with the environment. This evolutionary fact would leave women the choice of mating with men and ignoring their parthenogenetic potential to ensure the survival of the species, or technologically finding a means of perfectly controlling all disease (Cherfas & Gribbon, 1984; Francoeur, 1970).

#### **2.3.4 'In vitro' fertilization (IVF)**

'In vitro' fertilization, or the fertilization of ova with sperm in a petri dish, can be traced back over one hundred years in animals and back over one decade (since 1978) in humans. In that first decade (1978-1988) more than five thousand such babies had been born with the assistance of several hundred IVF clinics worldwide. Canada boasts nine IVF clinics of its own (BWHC, 1984; Holden, 1984; Isaacs & Holt, 1987; Kanno, 1987).

In 1986 more than five hundred IVF babies were born in the U.S. and one center in 1983 reported they had three to four thousand "patients" hoping to get on their six month waiting list leading the industry to a potential six million dollar per year market. The reason is infertility: There are an estimated 2.7 million infertile couples in the U.S. and more than fifty percent of them believe IVF is an acceptable treatment (Isaacs & Holt, 1987; Kolata, 1983; Landsberg, 1987).

The IVF technique is used mainly to circumvent infertility in women whose uterus and ovaries function normally but whose oviducts are blocked or absent. This condition is estimated to occur in some five hundred thousand U.S. women. The IVF procedure can also be used for a type of male infertility where the male produces sperm but in insufficient quantities or concentrations to permit fertilization of the ovum 'in vivo' (in body). In this case, a woman consents to IVF even though she has no reproductive handicap (Biggers, 1982; Grobstein et al., 1983; Overall, 1987a).

In theory, IVF is simple but in practice it is difficult, complicated, and often painful. The woman's mature ova are captured by laparoscopy and are transferred to an external compatible medium where they are exposed to sperm. The petri dish is covered and placed into the controlled environment of an incubator and is examined from time to time under a microscope (BWHC, 1984; Corea, 1985; Grobstein et al., 1983; Harper's, 1987; Overall, 1987).

Before transfer, the woman's womb is prepared to receive the implant with hormone treatments. As the embryo normally does not attach itself to the uterine wall for several days, transfer of the fertilized egg (the embryo) occurs at the eight to sixteen cell stage and is accomplished by inserting it through the cervix into the uterine cavity (Hamner & Allen, 1980).

Most IVF failures occur at this stage but evidence suggests that if more than one embryo is transferred into the uterus, the pregnancy is more likely to ensue: from a single embryo transferred, ten percent become viable pregnancies; from two embryos, fifteen percent; and from three embryos, nineteen percent. While successful pregnancies using IVF have been reported from two percent to twenty

percent, no one has achieved success above twenty percent (Isaacs & Holt, 1987; Grobstein et al., 1983; Kanno, 1987; Kolata, 1983; Landsberg, 1987; Overall, 1987; Trounson, 1987).

Access to this procedure is generally limited to stable, heterosexual, married couples in which the woman is less than thirty eight years old. The Ontario Law Reform Commission was more liberal in their recommendations stating that IVF should be available to "stable single women" and to "stable single men and stable single women in stable marital or non-marital unions" (Kanno, 1987; Overall, 1987a).

IVF costs range from \$3000.00 to \$5000.00 (U.S.) per attempt and three attempts are most common before pregnancy is achieved putting the full price at \$9000.00 to \$15,000.00 for a less than twenty percent chance at pregnancy (Grobstein et al., 1983; Isaacs & Holt, 1987; Kanno, 1987; Kolata, 1983; Overall, 1987a).

In British Columbia, these costs must be borne fully by the recipients. Medical Services will pay for visits to a physician for diagnostic testing for infertility and will pay for the subsequent investigation of options to deal with the infertility. However, once a decision is made to undergo IVF all cost coverage ends (Phone call to the Medical Services Commission, 1989).

#### **2.3.4.1 Social implications of 'in vitro' fertilization**

'In vitro' fertilization, being a technique that incorporates the use of ova harvest and transfer and/or embryo harvest and transfer, includes those previously mentioned, associated social implications. However, 'In vitro' fertilization could have an additional interesting, albeit improbable, implication for society. For instance, it is possible that the creation of a new generation of clinical offspring

could engender new prejudices. There would be the conventional group, created in the 'old way' through coitus, and the engineered group, created in the 'new way' through laboratory procedures. Societies in this way could see the creation of a new biological caste system within the next two to three centuries (Harper's, 1987). This, of course, is in the advent that the groups were different enough in social characteristics of consequence to sustain such a caste system.

#### **2.4 SEX PRESELECTION**

Sex selection can take three forms: (1) infanticide—after the birth; (2) fetal sex selection—after conception using amniocentesis and abortion or chorionic villi sampling; and (3) fetal sex preselection using new techniques that have been proposed for determining, at the time of conception, the sex of the fetus. While infanticide is still practised (Jeffery et al., 1984), I will limit this discussion to pre-birth or pre-conception techniques.

Amniocentesis is a hospital-based technique in which the doctor inserts a long hollow needle through a pregnant woman's abdomen into her uterus and some of the amniotic fluid that surrounds the fetus is withdrawn. Cells carried in the amniotic fluid can be karyotyped to determine the sex of the fetus and if the fetus is not of the preferred sex abortion can then be obtained. The amniocentesis procedure carries with it a small but real risk of death to the fetus and/or injury to the woman (less than one percent risk in Canada and the U.S.). Chorionic villi sampling works in a similar way to amniocentesis. A small amount of the chorion tissue surrounding the fetus is removed through the woman's cervix. Its main advantage over amniocentesis is that results can be evaluated earlier (i.e.: in 8-14

weeks) (Corea, 1985; Fletcher, 1983; Holmes & Hoskins, 1985; Hoskins & Holmes, 1984).

Many doctors reportedly are unwilling to perform amniocentesis or CVS for sex selection and the 1979 Genetic Research Group of the Hastings Center supported this view stating that amniocentesis for sex choice should be discouraged although not restricted legally. Doctors can not be forced to perform a technique they do not see as "lifesaving" however, legal rules on abortion defined by the U.S. Supreme Court stipulate that women do not have to state their reasons for seeking abortion. In this case, it would be a simple task to visit one doctor for amniocentesis or CVS and then visit another for the abortion (Bermel, 1985; Fletcher, 1983).

Aside from amniocentesis or CVS and abortion, several other sex selection techniques have been discussed in the literature, a few of which will be presented below. Each of the following techniques is contingent upon presumed differences between X and Y bearing sperm and, most of the techniques have shown inconclusive results: even the most promising ones can not guarantee success.

A woman's diet is purported to have some effect on the sex of the offspring: she should eat foods high in sodium and potassium for a boy and high in calcium and magnesium for a girl. Timing of intercourse can also have some effect on whether a boy or a girl is conceived due to cervical mucus<sup>9</sup> levels. In order to conceive a girl, intercourse should ideally take place thirty six to forty eight hours before ovulation whereas, to conceive a boy, intercourse should ideally take place two to twenty four hours before ovulation. Of all the 'at home' sex selection methods, alkalinity or acidity of the uterus is supposed to be most sure method.

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<sup>9</sup> Cervical mucus nourishes and guides sperm to ova.

Alkaline environments favour the survival of Y (male) bearing sperm and acidic environments favour the survival of X (female) bearing sperm. Uterine alkalinity or acidity can be achieved in two ways: (1) by using a vinegar douche (to conceive a girl) or a soda bicarbonate douche (to conceive a boy) just prior to intercourse which is timed to coincide with ovulation; or (2) by permitting a woman's orgasm before ejaculation which increases alkalinity (favouring boys) or by not permitting a woman's orgasm before ejaculation which maintains the acidity of the uterus (favouring girls) (BWHC, 1984; Corea, 1985; Hamner & Allen, 1980; Hoskins & Holmes, 1984).

Other techniques such as electrophoresis, racing, ultrasound, and centrifugation are clinically based. Electrophoresis uses alleged differences in electrical charges between the two sperm types to separate them. Racing involves placing sperm in test-tubes full of viscous liquid and allowing the two types (X and Y) to race one another to the bottom: this procedure allows technicians to separate the two types. Ultrasound can also be used to detect differences between the two sperm types and can be used to "snap the heads off the wrong sex sperm" with sound waves (Corea, 1985; Hoskins & Holmes, 1984).

The most promising sex selection technique is centrifugation which is used most often by the sixty five sex selection centers worldwide. Centrifugation reached the clinically usable trial stage in 1985 and is reported to be inexpensive and uncomplicated (Bermel, 1985; Editors, 1987; Overall, 1987a).

Technically, the procedure is simple. To separate X bearing (female) sperm from Y bearing (male) sperm, a sperm sample is placed in a centrifuge and spun for a short time. Because the X bearing sperm carries more genetic material, and

because the Y bearing sperm swims faster, X bearing sperm settle outward when centrifuged. A woman is then artificially inseminated with the sperm sample containing a significant concentration of desired sex cells (Bermel, 1985; Corea, 1985; Overall, 1987a).

Any discussion of sex preselection would be incomplete without mention of preference. All of the literature notes a worldwide preference for male offspring over female offspring and, where they are wanted at all, females are wanted as second children. If an odd number of children are desired, couples want more boys in their families than girls. Further, in a study of U.S. couples it was found that if couples do not prefer boys, they do not prefer girls but rather, prefer 'either'. Many sources indicate that personality differences exist between first born children and second born children: those first born are more likely to be academic and professionals while those second born are more likely to be socially adept and/or popular.<sup>10</sup> Characteristics associated with first born children are the most closely identified with "success" in North American society.

#### 2.4.1 Social implications of sex preselection

Preferences and differences when combined with techniques for sex selection are likely to have profound impacts on the social fabric.

Changes to family configurations are likely. For instance, nations of older brothers and younger sisters could ensue and advantageous first born characteristics would be limited to males.

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<sup>10</sup> Further discussions of preference and social psychological characteristics can be found in: BWHC, 1984; Bermel, 1985; Corea, 1985; Fletcher, 1983; Hamner & Allen, 1980; Hoskins & Holmes, 1984; Jeffery et al., 1984; Overall, 1987a; Powledge, 1983; Rowland, 1985; Steinbacher & Holmes, 1985; Williamson, 1983.

Codes for gender-typed behaviour could become much more stringent as it can be implied that sex selected children are not wanted for themselves but rather are wanted for the gender they represent. Sex selected children will be expected to act in accordance with stereotypical gender roles.

Obviously, sex selection is likely to affect the sex ratio in favour of males <sup>11</sup>. It is possible that societies with fewer females would realize a decrease in culture consumption as women read more, attend the theatre more, and visit museums more. There would be higher crime rates, more violence, and more war as males are usually responsible for these things (Corea, 1985; Overall, 1987a).

Further, if women were a scarcity there would be increases in homosexuality and prostitution. The value of women could change dramatically due to the patriarchal nature of most societies. Women could become cherished and valued polyandrous "queen ants" or conversely, could become restricted, controlled, and safeguarded in a virtual state of purdah and given as rewards to the most determined or "valuable" men as in Margaret Atwood's Handmaid's Tale. Of the two possibilities, the latter is more likely as women are rarely valued except in relation to men <sup>12</sup> (Corea, 1985; Hamner & Allen, 1980; Overall, 1987a; Powledge, 1983).

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<sup>11</sup> India's sex ratio has already been heavily weighted in favour of males due to widespread female infanticide and recently due to amniocentesis and abortion (See Jeffery et al., 1984).

<sup>12</sup> As pointed out by Jefferey et al. (1984) there is no evidence to suggest that scarcity would raise the value of women; rather, scarcity is symptomatic of the low value of women.

## **2.5 CONTRACT MOTHERHOOD AND ARTIFICIAL WOMBS**

This section of the paper deals with commercial surrogacy and with the creation of artificial wombs. Surrogacy involves the gestation of a fetus in the womb of someone who has no intention of raising the resulting child, while artificial womb technology involves the gestation of a fetus in an artificial environment.

### **2.5.1 Contract motherhood**

There are currently more than twenty surrogacy agencies operating in the United States which service Canadian and European couples as well as American couples. Nearly six hundred babies had been born through these agencies in the first decade 1978-1988 of their operation. By February 1989, a conservative rate of one hundred eighteen (118) cases involving Canadian couples in Canada was cited by the Editor of The Globe and Mail. Before her/his birth, each infant has cost the social parents, or those who are to raise the child, at least \$25,000.00 (U.S.): \$10,000.00 goes to the contract, or gestational, mother and \$15,000.00 goes to the agency for legal fees, medical fees, and testing fees (Andrews, 1984; Annas, 1987; Arditti, 1987; Blakely, 1983; Ince, 1984; Overall, 1987a; Scorsone, 1987).

A contract mother can be defined as a fertile woman who arranges with a married couple, who cannot have children because of the wife's infertility, to conceive the husband's child through artificial insemination, carry it to term, and then surrender all parental rights in the child upon receipt of payment or reimbursement (BWHC, 1984; Brahams, 1987; Keane & Ketterman, 1984; Overall, 1987a).

The choice of the term "married couple" is, again, not accidental although the potential does exist for many people other than married couples to make use of

this option. For instance, single men, homosexual male couples, and unmarried or married women who want to bypass the inconveniences of pregnancy or who do not want to jeopardize their careers by taking maternity leave and so on, are also showing an interest in contract motherhood. Noel Keane, who runs a surrogacy agency in Michigan, declared that the one hundred seventy seven arrangements he had handled (to 1987) were predominantly for married, heterosexual couples, with a few exceptions. Most agencies require proof that their clients are married and require further clinical proof that the wife is infertile (Corea, 1985; Keane & Ketterman, 1984).

Some surrogacy agencies screen potential contract mothers carefully, it seems, asking for medical histories, I.Q. tests, genetic screening, psychological evaluations, and physical examinations. The contract mother is expected to surrender her right to abortion or agree to undergo one if the doctor or biological father desires, and to let the agency know her whereabouts and activities at all times (Corea, 1985; Ince, 1984; Overall, 1987a; Scorsone, 1987).<sup>13</sup>

There are two possible procedures involved with contract motherhood. If the wife can produce ova, doctors can extract a number of these, fertilize them with the husband's sperm 'in vitro', and have the resulting embryo transferred to a contract mother who would continue the pregnancy. The most common case however, involves the insemination of the contract mother with the husband's sperm, allowing the conception to take place in the contract mothers' body where the pregnancy will continue to term. In the first case, the contracted woman provides

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<sup>13</sup> The contract mother must tell the agency if she moves, what she eats, her sexual behaviour, if she changes jobs, if there is a death in her family or any other traumatic event, and so on (Corea, 1987; Ince, 1984; Overall, 1987a; Scorsone, 1987).

her reproductive services but in the second case, she provides her reproductive services plus one half the baby's genetic inheritance (Annas, 1986; Arditti, 1987; Isaacs & Holt, 1987; Overall, 1987a).

#### **2.5.1.1 Social implications of contract motherhood**

Implications raised by the surrogacy issue do not seem far off. The possibility now exists for a child to have five parents. An ovum donor, a sperm donor, a gestational (contract) mother and a "social" (purchasing) mother and father can all claim parentage. This has implications for the definition of the family and the definition of parenthood. The confusion about what constitutes parenthood has already been witnessed in the case of Baby "M" in 1987. After being inseminated with a contracting husband's sperm, a contract mother changed her mind about giving up her child to the contracting parents. After nearly one year of debate, the United States Supreme Court ruled in favour of the contracting parents and the contract mother was forced to give the child up in return for the \$13,500.00 fee.

It does seem possible that power holders could create an entire "class of breeder women" of lower socio-economic status. In time, women in the paid labor force may give up pregnancy altogether if they have the option of getting someone else to carry their genetic children. If policy makers in industrialized nations get concerned enough about declining populations, the possibility exists that surrogacy could become a recognized paid occupation—further entrenching the "class of breeder women" notion as contract mothers would nearly always be from the lower classes given the "discomfort, pain, or bother" of pregnancy and childbirth.

Further, elites or policy makers could manipulate immigration policy so that it becomes a stipulation of immigration that young, healthy women agree to embryo transfer and contract motherhood upon entering the country, therefore taking full advantage of women as racial or ethnic minorities and as members of lower social status. On the surface this seems inconceivable. In 1985, however, a surrogacy agency in the United States began advertising for women in Korea, Thailand, and Malaysia to agree to undergo embryo transfer and contract motherhood. In exchange, the contract mothers' travel costs to the U.S. and living expenses while gestating the fetus would be provided by the contracting parents. After giving birth, the woman would be given her "independence" (Corea, 1985:245).

#### 2.5.2 Artificial wombs

Since 1922, researchers have been devising various apparatuses to assist in the study of potential placental and/or uterine functions but to date a viable artificial womb has not been discovered. The womb is a complex chemical environment that surrounds the developing fetus and influences growth and development. The requirements of the fetus are likewise complex and are met through the placenta (Babymakers, 1979; Corea, 1985; Hamner & Allen, 1980; Rowland, 1984).

The placenta poses the greatest challenge to the perfection of the artificial womb: it acts to feed nutrients, to absorb wastes, and to secrete hormones. Incubators can now supply heat and oxygen to fetuses but delicate hormonal, nutritional, and waste exchanges have not yet been imitated. This goal may not be far off however, as incubator technology and methodology can now successfully support fetuses from twenty one weeks (Babymakers, 1979; Corea, 1985; Hamner & Allen, 1980; Isaacs & Holt, 1987; Rowland, 1984).

Creating the perfect, safe artificial womb is a potentially realizable scientific goal, particularly now that embryos can be kept alive for the first eight days 'in vitro' and fetuses can be kept alive at one half the age of full term babies 'ex vivo' (outside the body). The prospect of having an "open window" on the development of the human fetus is fascinating to many people and many reasons have been stated for the creation of artificial wombs. For instance, it is thought that artificial wombs could eliminate birth trauma. Further, artificial wombs "do not drink alcohol, smoke, get the measles, or fall down the stairs" (Corea, 1985:253). The literature often describes women's bodies as hazardous places, hostile to the fetus and as one commentator remarked:

We realize that the womb is a dark and dangerous place, a hazardous environment. We should want our potential children to be where they can be watched and protected as much as possible (Bio-ethicist quoted in Corea, 1985:253).

Thus far there have been many technical problems. Most attempts at creating artificial wombs have involved connecting plastic tubes to the one vein and the two arteries of the human umbilical cord. This is difficult because the veins and arteries are so small. The plastic tubes may themselves damage blood cells flowing through them and the tubes are prone to slipping off. Another concern is the prevention of increases in blood volume in the fetus: slight increases cause the fetus to hemorrhage and die.

Further, no one knows exactly what the placenta provides (e.g.: trace elements, amino acids, vitamins, hormones, enzymes, etcetera), in what proportions, or at what stage of fetal development. Finally, no one is sure what the fetus requires, in terms of both physical needs and emotional/psychological needs.

### 2.5.2.1 Social implications of artificial wombs

Implications of this not-yet-perfected technology could include enabling males to prove their paternity. They would be able to create an embryo 'in vitro' and implant it themselves into an artificial womb ensuring the resulting child was theirs.

Pregnant women who desire abortions could have the fetuses removed and given over to artificial wombs for gestation. These fetuses could be given up for adoption as was discussed in the section regarding embryo transfer.

A likely complication stemming from the use of artificial wombs involves whether or not an ethereal bond exists between a mother and a fetus. We do not know if a child resulting from gestation in an artificial environment would somehow be different from a child gestated in a living womb.

Finally, if a few "superior" women could be induced to superovulate millions of ova, these ova could be cryopreserved and used for IVF upon demand. The embryos resulting from the superovulation and the IVF could be put into artificial wombs for gestation where they could be checked for defects. Any that did not meet some specified standard would be discarded thereby keeping the population "pure" and controlled. If people wanted a "perfect" baby they could purchase one. It is likely that the price of these infants would be high because they would be "perfect" and it is unlikely that any persons of lower social standing would be able to afford such a baby. Lower class people must be content with the "regular" sort of baby further entrenching class divisions.

## **2.6 ABORTION AND THE RU-486 PILL**

So far this review has been concerned with reproductive techniques or procedures that in some way have the goal of an infant in common. RU-486 represents a break from this trend. While it does not assist in procuring an infant, or a particular kind of infant, it is an extremely important and topical reproductive technology. For this reason, a discussion of abortion and RU-486 have been included.

### **2.6.1 Abortion**

Abortion is another means of fertility control. Literally, the term abortion means the emptying of the uterus or the removal of the uterus's contents. It is one of the world's oldest reproductive technologies. Anthropological studies have indicated that abortion was widespread in ancient and pre-industrial societies throughout the world and throughout history. It was legal in the West until the humanitarian reform wave hit Britain in 1803 and spread to North America. This backlash did little to halt abortion. For instance, there were an estimated two million illegal abortions performed per year in the U.S. in the 1890's. A 1980's study in New York City of women who underwent abortions found that 45% of them would have tried to obtain one regardless of the legalities suggesting that there will always be a demand for abortion (BWHC, 1984; Overall, 1987b).

The amendment to the abortion law in Canada in 1969 legalized abortion on therapeutic grounds. Abortion was deemed allowable as long as, in the opinion of a therapeutic abortion committee, the continuation of a pregnancy would endanger the life or health of the woman. A 1975 government study found that there were widespread variations in the application of this law cross-nationally. Currently, in Canada there is a battle raging between the "pro-choice" groups and the

"pro-life" groups regarding the decriminalization of abortion. In 1988 the Supreme Court of Canada ruled that the criminalization of abortion was in opposition to Section 7 of the Canadian Charter of Rights and Freedoms. A government bill regarding this issue was defeated in Senate in 1990. Even though this issue is highly controversial, there is consensus among the majority of Canadians (65%) that abortion should be supported if (in this order) (a) there is danger to a woman's life; (b) there is danger to a woman's health; (c) there exists a high risk of child deformity; or (d) the pregnancy was the result of rape (Bozinoff & MacIntosh, 1988; Romaniuk, 1987). Minorities of the Canadian public cluster at the endpoints of an opinion continuum <sup>14</sup> with small numbers believing abortion can never be justified (13%), and small numbers believing in the equivalent to abortion on demand (20%) (Bozinoff & MacIntosh, 1988).

Most abortions are performed in the first trimester. There is a 1% risk that complications, for instance, infection, will develop during this time. The later in the pregnancy the abortion is performed, the greater the risk of complications. Different methods are used depending on how many weeks the pregnancy is along, the training of the person performing the abortion, and the approaches favoured by the local medical community. Financial costs also range from \$125.00 to \$2000.00 (U.S. funds) depending upon the interrelated factors of timing and method (BWHC, 1984).

In 1971 there were 31,000 abortions performed in Canada and by 1982 this number had reached 66,000 or 8.5 and 17.8 abortions per 100 live births respectively. Recently the number has levelled off to around 65,000 per year. British

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<sup>14</sup> In British Columbia the political split is most extreme on the abortion issue with 28% in favour of unrestricted access and 1% in favour of making all abortions illegal (Bozinoff & MacIntosh, 1988).

Columbia had the highest abortion rate in Canada in 1982 with 30 abortions per 100 live births while, comparatively, Prince Edward Island had less than 2 abortions per 100 live births. The variation between provinces is due, in part, to the different ways in which abortion committees apply the law and due, in part, to regional disparities in accessibility to hospital services (Romaniuk, 1987).

Canadian women who use abortion procedures are generally young, single, and without children. In 1981 66% of abortions were performed on single women, 23% on married women, and 10% on divorced, separated, or widowed women. 28% of the women were less than twenty years of age while 50%+ were in the twenty to twenty-nine age group. Of these women, 62% had no previous deliveries and 16% had one previous delivery (Romaniuk, 1987).

### **2.6.2 The RU-486 Pill**

As already discussed, abortion is widely used as a means to regulate fertility. Maria et al (1988) state that the global abortion rate is approximately 300 per 1000 pregnancies. Most of these are illegal and most occur in less developed nations. The World Health Organization (W.H.O.) defends this statement adding that 500,000 women die every year from pregnancy related causes and approximately one half of these deaths are the result of botched abortions. Advocates of RU-486 use these statistics as proof that safe, effective, and simple methods of pregnancy termination are required (Docherty, 1985; Maggio, 1989; Maria et al, 1988).

RU-486, or mifepristone, is the name given to an anti-progesterone steroid. It was developed in France by Roussel-UCLAF and has been touted as a safe and effective means of pregnancy termination. This steroid "mimics" progesterone, a

hormone vital in early pregnancy because it prepares the uterus for implantation and sustains the pregnancy to full term. By imitating progesterone, it competes with it in binding with the hormone receptors. Progesterone receptors are located in the endometrium, the cervix, the hypothalamus, and the pituitary gland. During pregnancy, progesterone receptors in the the uterine membrane develop. RU-486 acts mainly on these receptors. The result is a separation of the implanted embryo from the uterine wall. Another way this can work is by discharging the fertilized egg before it implants<sup>500</sup> or by inhibiting the embryo from implanting. Because RU-486 can cause abortion it has been coined a "contragestation" method. It interrupts established pregnancies. This fact has led many to express concern that women will see RU-486 merely as a means of inducing menstruation. It has been shown that RU-486 is not a good contraceptive as it tends to disrupt the menstrual cycle following the one in which it was administered (Cahill, 1987; Docherty, 1985; Harper's, 1983; Maggio, 1989, Maria et al, 1988; Roessner, 1987).

RU-486 has been developed in response to a growing demand for safe, effective fertility control. There is especially a demand for an alternative to surgical abortion procedures. Testing still continues but the use of varying doses of mifepristone (200 mgs to 1000 mgs within ten days of a missed period) has given rise to success<sup>15</sup> rates of 61 to 87 percent. When mifepristone is combined with a prostaglandin analogue as an abortifacient, success rates reach 95 to 100 percent. Studies conducted so far have not given any indication why some women were successful in termination of the pregnancy and why others were not. There are several side effects associated with each method. The mifepristone dosage by itself

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<sup>15</sup> Success is determined as the induction of the menses or the termination of the pregnancy with no major side effects.

causes bleeding, nausea, and fatigue. When prostaglandin is introduced it causes gastro-intestinal cramping from uterine contractions and prolonged uterine bleeding requiring careful medical monitoring.

RU-486 is often confused with the "morning after" pill. RU-486 differs from the "morning after" pill or the post-coital pill in how and when it works. The post-coital pill is used immediately after unprotected intercourse, often after rape. It overloads the reproductive system with estrogen rather than depriving it as with RU-486. RU-486 is usually taken approximately ten days following a missed menstrual period. Maria et al report that the pill is most successful up to six weeks after conception. However, it has been speculated that RU-486 could be effective in inducing abortion (or menstruation) at virtually any stage in the pregnancy as long as it is taken for four consecutive days (Cahill, 1987; Docherty, 1985; Dubois et al, 1989; Goodman, 1989; Maria et al, 1988; Roessner, 1987).

RU-486 is available in France, Germany, and China and likely in other European countries as well. It has been strenuously objected to in North America by the Pro-Life lobby. U.S. and Canadian pharmaceutical companies are slow to even test this product because it has been deemed "politically offensive" (Maggio, 1989:135). This may soon change as the National Organization of Women (N.O.W.) in the U.S. has recently begun their lobby. It is likely that other women's groups and Pro-Choice activists will join this group's attempts to get the pill distributed in Canada and the U.S.. The January 1989 Gallup Poll surveyed 1012 individuals eighteen years or older as to their support for, or opposition to, the availability of RU-486 in Canada. 35% of those surveyed supported the distribution; 55% opposed it; and 9% did not know. Not surprisingly, the highest support for RU-486

came from British Columbia with 41% in favour of its availability (Bozinoff & MacIntosh, 1989).

As a manifestation of the potential of RU-486 to cause public outcry, Roussel-UCLAF, the marketers of RU-486, suspended distribution of the drug only one month after the French health minister authorized its use on a prescription only basis. The reason given for the suspension was the vocal Pro-Life lobby in the United States. Roussel's move elicited so much criticism from doctors, women's groups, and family planning associations, that the health minister ordered Roussel-UCLAF to reinstate distribution of RU-486 two days later (Cahill, 1987; Maggio, 1989; Roessner, 1987).

#### 2.6.2.1 Social implications of RU-486

The reason the public has debated the distribution of RU-486 so strenuously is because of its profound implications for the abortion issue. With RU-486, abortion can be taken out of the public arena and will truly be a woman's private decision. This will effectively neutralize any anti-abortion lobby. It will negate the necessity for abortion committees, abortion clinics, and the bombs, threats, pickets, and traumatic movies like The Silent Scream that seem to go along with them may be eliminated.

Moral scrutiny and the public accountability of pregnant women and their doctors will certainly be eradicated. This may also reduce male's concern over the long range consequences of their sexual acts. Cahill (1987:7) warns that society could see a lack of "moral seriousness" regarding outcomes of contragestation. She states "there is a moral distinction between abortive and contraceptive birth control" (Cahill, 1987:8).

## 2.7 CONCLUSION

Many of the implications in the preceding discussion are not likely to occur, but are at least possible now where previously they were not. The purpose of this review was to provide background regarding the issues to indicate some of the reasons for controversy and indicate why policy debates are forthcoming. The main concern that arises throughout the review is the lengths to which society will support scientists and doctors in pursuit of technological goals.

Many argue that reproductive technologies are therapeutic procedures which allow infertile couples to have the children they desire and that these technologies are well within the sphere of medicine whose aim it is to remove limitations on normal, healthy life. Others argue that risks of injury to individuals and/or groups are too high to justify tampering with nature, and that these technologies do not cure infertility but satisfy desires, and so do not fall within the proper sphere of medicine. Regardless of which opinion one holds, it is true that no one can be sure of the effects technological manipulations will have on the development and characteristics of future generations and of society itself.

This overview of the literature on reproductive technology has served to highlight the procedures involved and the attendant legal, social, and moral dilemmas. It seems likely that society will soon be faced with making decisions and creating laws which will (1) serve to protect everyone involved in reproductive technological processes; (2) ensure 'fair' access is granted to those wishing to undergo these procedures; (3) establish 'fair' and accurate screening processes for donors, recipients, and gestational mothers; (4) ensure that informed consent governs all reproductive technological practices; and (5) guarantee that respect for privacy and

constitutional rights will be maintained in any regulations which will be drawn up (Isaacs and Holt, 1987).

Not only do advances in reproductive technology have the potential to affect millions of doctors, lawyers, parents, and so on, they also have the potential to affect the millions of children who will likely be born through technological arrangements.

At the 1985<sup>16</sup> rate of use of artificial insemination, 'in vitro' fertilization, and contract motherhood, a conservative estimate would place the number of children born worldwide with the aid of such technology at nearly six million in the next one hundred years. This number is roughly equivalent to the population of Quebec or about one quarter of the population of Canada. Six million is a conservative number however, as IVF has only recently become feasible and contract motherhood has only recently become acceptable. When these technologies become more accessible and, when rising infertility rates and declining populations alarm national government committees enough, the number of children born through technological arrangements will increase substantially. All that society can be sure of at this point is that reproductive technology will continue to be the focus of controversy until ethical, legal, and social guidelines are established under the rubric of policy. For this reason, important policy decisions concerning rights and obligations are likely to occur in the very near future.

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<sup>16</sup> 1985 is the last year for which rates of use were available.

## Chapter III

### THEORETICAL PERSPECTIVES

As can be seen from the previous chapter, there exists an enormous amount of literature debating the advantages, disadvantages, and social implications of many of the reproductive technologies. Despite this proliferation, there have been very few attempts to examine reproductive technology within any theoretical framework and no attempts to examine it within a sociological framework. In this chapter I will briefly overview one theory from each of several sociological paradigms and one theory from a social change perspective. In order, these will be: symbolic interactionism from the social definition paradigm; exchange theory from the social behaviour paradigm; Marxist theory from the social facts paradigm; and diffusion of innovations theory from the social change perspective.

At the inception of this study on reproductive technology I was interested in examining the knowledge and attitudes concerning the new technologies that were held by people who may be in a position to influence policy on reproductive technologies in British Columbia. As I searched for an appropriate theoretical perspective to examine reproductive technology, I realized that the issue of power infused every element of reproductive technology. The attitudes and knowledge held by policy makers are interesting but are only part of the larger issue of political power. Rather than stay with the empirical study of working with respondents' assumptions and predicting policy outcomes, I have decided that this study

must be analysed within the context of feminist sociological theory, and that the focus should be on knowledge and attitudes as illustrative of power issues and outcomes. Therefore, each of the theories outlined in this chapter will be criticized for their lack of comprehensiveness and feminist sociological theory, which synthesizes the three sociological paradigms, will be held up as the best framework within which to analyse issues surrounding reproductive technologies.

The theoretical issues I focus on include: (1) who uses reproductive technologies and why?; (2) who decides which technologies are researched and funded?; (3) who controls access to the technologies and the information about them?; (4) who sets the rules guiding research?; (5) how are issues surrounding reproductive technology defined?; (6) how are reproductive technologies beneficial or detrimental to individuals and to society?; (7) does the "medical model" dominate decision making on issues concerning reproductive technologies?; and (8) do differences in power between the sexes assist in keeping the control of reproductive technologies in medical hands?

In order to be helpful in this study of reproductive technologies, a theory must have the ability to (a) look at issues of power between men and women, and among the institutions of medicine, science, and technology and citizens (especially women); (b) explain how women are exploited and used as research worktables, as objects, or as commodities; and (c) explain how socially constructed typologies influence women's perceptions of themselves and influence behaviours based on these perceptions. With these criteria in mind it is now possible to move on to a discussion of the theories.

### 3.1 SYMBOLIC INTERACTIONISM

Symbolic interactionists take individual actors as their focus of study. Far from being reactive recipients of culture, actors, instead, actively create culture. The essential concern of sociology within this context is the subjective meaning that actors attach to other actors, events, and objects. Symbolic interaction itself refers to the particular nature of interaction that takes place between humans. The interaction is peculiar to human beings in that we define or interpret others' actions and react to our interpretations rather than merely reacting to the actions themselves:

[t]hus, human interaction is mediated by the use of symbols, by interpretation, or by ascertaining the meaning of one another's actions (Blumer, 1962:36).

Symbolic interactionists also emphasize the use of symbols (language, signs, gestures) in human communication. Symbols are things which stand for other things and whose meanings are arbitrarily determined by the actors who created them. Due to humans' capacity to create symbols, social organization is able to be created, maintained, and changed (Hagedorn, 1990).

Actors can share the meanings of symbols and can therefore communicate and interact effectively. In the process of interaction, humans learn to take the role of the other. Role-taking is the fundamental process by which interaction occurs and by which humans are able to develop a concept of "self". G.H. Mead developed the idea that the self evolves in three stages. The first stage, the play stage, is characterized by a child's limited capacity for role-taking. The child has only the ability to see and understand the world and her/himself from the view of a very few "significant others". In the next stage, the game stage, a child can see her/

himself as a component in an organized field of players. In order to participate in a "game" the child must have the ability to assume the role of all other players, anticipate their actions, and coordinate responses with others' courses of action. In both these stages individuals see themselves in relation to specific others and from the vantage points of these others. The final stage of role-taking involves the ability to assume the role of the "generalized other". The generalized other can be defined as the collective will or the social conscience: "[w]hen an individual can view her/himself in relation to this community of attitudes and then adjust her/his conduct in accordance with these attitudes, then s/he is role-taking with the generalized other" (Turner, Beeghley, & Powers, 1989:446).

The idea of "self" is what demonstrates an actor's individuality as a result of interaction. Symbolic interactionists focus on the meanings that interactions and situations have for actors in everyday life in order to understand how individuals create and define their environments (Hagedorn, 1990). The following list highlights the assumptions stressed by symbolic interactionists:

(1) macro or large-scale patterns of social organization are all ultimately constructed and sustained by face-to-face interactions among individuals; (2) such face-to-face interactions revolve around individuals' capacities to use and read gestures, to interpret each others' dispositions, to define situations, to see oneself as an object in a situation, to construct joint lines of conduct, and to reassess, redefine, and reconstruct their joint conduct; and (3) therefore, human organization can only be understood by concepts and propositions that explain how people interact in micro, face-to-face contexts (Turner, Beeghley, & Powers, 1989:477).

### **3.1.1 Symbolic interactionism and reproductive technology**

Given the criteria set up at the beginning of this chapter that a theory must be able to fulfill in order to be adequate for my purposes, symbolic interactionism presents only a partial view. This is mainly due to the focus on the individual actor's acquisition of self and perceptions of the environment. Using a symbolic interactionist perspective one could describe how individuals interpret each of the technologies within a particular setting. For instance, one could study how contract mothers interpret their roles as "surrogates", and the effect of their perceptions of themselves and others' opinions of them on their self image in an effort to understand their behaviour as contract mothers. One could explain how particular women come to be in situations where they are exploited as research objects and/or commodities. What one cannot explain are the issues of power between men and women and between social institutions and women, which has become a large part of this paper.

## **3.2 EXCHANGE THEORY**

Exchange theorists also focus on interactions between individuals. The difference between them and symbolic interactionists, however, lies in the way each views the "self" and in the exchange theorists' emphasis on patterns of reciprocal behaviour. The actors in the exchange relationship must each be able to take the role of other and the role of generalized other in order to discover what rewards should be offered and received. Symbolic interactionists are more likely to be concerned with the process by which actors decide about the rewards, but exchange theorists are normally only concerned with the exchange relationship

itself. Exchange theorists view interactions between actors as the exchange of rewards and costs. Individuals each have histories of rewards and costs which lead them to repeat behaviour which was rewarding in the past and cease behaviour which was costly. Interactions, therefore, are likely to continue when an exchange of rewards is occurring.

There are five propositions fundamental to an exchange theory of social behaviour; these were developed by sociologist George Homans. Of the first proposition, the "success proposition", Homans says, "[f]or all actions taken by persons, the more often the particular action of a person is rewarded, the more likely the person is to perform that action" (1974:16). Secondly, Homans notes, regarding the "stimulus proposition", "[i]f in the past the occurrence of a particular stimulus, or set of stimuli, has been the occasion on which a person's action has been rewarded, then the more similar the present stimuli are to the past ones, the more likely the person is to perform the action, or some similar action" (1974:23). Of the "value proposition", thirdly, Homans states that "[t]he more valuable to a person is the result of [an] action, the more likely [an actor] is to perform the action" (1974:25). Fourthly, regarding the "deprivation-satiation proposition", Homans notes that, "[t]he more often in the recent past a person has received a particular reward, the less valuable any further unit of that reward becomes for [the actor]" (1974:29). Finally Homans says, of the fifth interrelated propositions, the "aggression-approval propositions", (a) "[w]hen a person's action does not receive the reward [as] expected, or receives a[n unexpected] punishment, [the actor] will be angry; [the actor] becomes more likely to perform aggressive behaviour, and the results of such behaviour become more valuable to [the individual]"

(1974:37) and (b) "[w]hen a person's action receives the reward [as] expected, especially a greater reward than...expected, or does not receive punishment [as] expected, [the actor] will be pleased; [the individual] becomes more likely to perform approving behaviour, and the results of such behaviour become more valuable to [that actor]" (1974:39). Exchange theorists believe that social behaviour can be explained by the application of the reward/cost system found in the five psychologically-based propositions (Ritzer, 1988).

### **3.2.1 Exchange theory and reproductive technology**

Exchange theory also presents only a partial explanation of the issues surrounding reproductive technology. Using exchange theory one could study what psychological and/or physiological punishments had been meted out to individual women in their pasts that would account for their engagement in contract mothering behaviours (for instance some women may participate in order to atone for prior abortions). Conversely, one could study what aspects of contract motherhood reinforce women's ideas about femininity and giving of themselves to help others less fortunate than themselves. One could also study power differences between men and women and between social institutions and women in terms of resources. One could examine the types of exchanges that take place between these groups for what resources. One could not however, explain how social structures or social constructions like sexist stereotypes impinge upon or mediate the power of women's resources. For example, an individual woman may have many resources that place her in a position of equality with, or dominance over, an individual man but, because women are structurally subordinate to men, this equality or dominance in a micro social situation may often be neutralized by structural patterns of interaction.

### 3.3 MARXIST THEORY

In contrast to the micro level views of the symbolic interactionists and exchange theorists, Marxist theorists take social structures and institutions as their main units of analysis. The effects of these structures and institutions on one another and on individual actors are emphasized.

Marx stated that when production of material goods/provisions expanded beyond mere subsistence, some individuals accumulated a surplus. This surplus can be seen as the basis of inequalities and different social classes. Regarding the identification of a social class, three ideas can be distinguished. Firstly, a social class can be recognized by its relationship to the means of production (owners/"bourgeoisie" versus workers/"proletariat"). Secondly, a social class can be recognized by a consciousness of a common position in the productive process (controlling versus exploited). Finally, a social class can be recognized by the political organization of either the dominant class (to create ideology to keep the class structure functioning as is) or the subordinate class (to shed the false consciousness created by ideology and to take action against the exploiting class). These three points summarize Marx's view of the nature of social relationships (Sydie, 1987).

The term "social class" implies class conflict. As noted above, the bourgeoisie or capitalists own the means of production. This includes land, capital, and the labour of the proletariat or workers. It is from this labour that the capitalists extract "surplus value" or profit. The contradiction between the worker's labour value and the surplus value produced by that labour would provide the fuel for a class revolution and the transformation of society. Hence, the actors in Marxist

theory that produce social historical change are the classes. Social change is the product of conflict between the bourgeoisie and the proletariat (Sydie, 1987).

Many neo-Marxian writers since Marx have attempted to amalgamate subjective concerns and a traditional Marxist focus on objective material structures. One writer, Antonio Gramsci, acknowledged the importance of structural factors, especially economics, but did not feel these factors would incite the masses to revolution. Instead he focussed on "collective ideas". He believed that an intellectual elite would be required to develop the revolutionary ideology and assist the masses in putting it into action. The idea of an intellectual elite is central to his concept of hegemony, cultural leadership exercised by the ruling classes. Hegemony, as Gramsci viewed it, is the essential ingredient of praxis (the marriage of thought and action) and should be viewed as separate from coercion. Gramsci believed that it was not enough to gain control of the economy and the state apparatus, revolutionaries must also gain cultural leadership over the society in order for the revolution to be successful (Ritzer, 1988).

Other neo-Marxian attempts at reorienting Marxism in a more "micro" direction have been in the areas of subjectivity and dialectics. Regarding subjectivity, neo-Marxists look at the domination of individuals. They believe that control over actors is now so complete that deliberate actions on the part of capitalists are no longer needed. Control is a pervasive aspect of culture and has come to be internalized so that actors have come to dominate themselves in the name of larger social structures. At the cultural level, legitimations are present. Legitimations are defined as systems of ideas that are generated by the political system to support and justify its own existence, often by mystifying it. In this way the status

quo is legitimated and the consciousness of the masses is shaped. Because of this enormous "culture industry" the masses failed to develop a revolutionary consciousness (Ritzer, 1988).

Taking a dialectical approach means focussing on the social totality in relation to a historical whole. Everything is seen in context. This concept lends itself to incorporating micro aspects into a generally macro theoretical perspective. Neo-Marxists have attempted to study the interrelationships between various levels of social reality such as individual consciousness, cultural superstructure, and economic structures. There are two components to a dialectical approach. The first is a synchronic view which focusses on the interrelationships of the components of a society within a contemporary context. The second element is a diachronic view which focusses on the historical roots of contemporary society as well as on the directions it will take in the future (Ritzer, 1988).

### **3.3.1 Marxist theory and reproductive technology**

Marxist theory gives only a partial view for the opposite reasons from symbolic interactionism and exchange theory. It deals with social structures and culture, via ideology, usually to the exclusion of the individual. Despite attempts by Gramsci and other neo-Marxists to incorporate the individual into Marxist theory, the social actor as an individual does not exist, rather the social actor is only visible as a member of a class/group. Marxist theory can be used to investigate power differences and social relations between groups. One could analyse, using Marx's Labour Theory of Value for instance, the relations between women (as contract mothers and producers) and children (as commodities and products); between women and other members of society (capitalists and consumers,) specifically

within the market structure; between women and the institutions of medicine, science, and technology; and between children and other members of society within the market structure. This kind of analysis provides an inception point for further study, but it lacks a means for locating individuals within the overall economic/political/social/cultural structures. Using a Marxist analysis does not enable one to explain how women come to perceive themselves and others or interpret their actions. Gramsci's work on hegemony may assist in answering questions such as what sustains the systems of inequality that place women in exploitable positions. Other neo-Marxian works may assist in answering why women allow themselves to be exploited, if they even feel they are being exploited. It cannot however, explain how, as individuals, women feel about occupying the locations they do in a capitalist system or what their specific experiences are under capitalism.

### 3.4 DIFFUSION OF INNOVATIONS

E.M. Rogers also studied social change but from a much different perspective than that of Karl Marx. Diffusion or innovations theory is a "middle-range theory" that is specifically designed to explain the acceptance or rejection of innovations and the transmission of innovations within a culture. Four elements are crucial to any analysis of diffusion<sup>17</sup> of innovations. These are: (1) the innovation itself; (2) communication; (3) the social system; and (4) time (Rogers, 1962).

An innovation is an idea, product, practice, or technique which is perceived as being new by an individual or group of individuals. Whether the innovation is objectively or intrinsically new is not important, rather it is the novelty of the

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<sup>17</sup> Diffusion refers to the process by which innovations are spread from one place or person to another place or person (Brown, 1981:1 & Rogers, 1962:13).

idea to a particular setting or individual that determines the reaction to it. Rogers outlined five characteristics of innovations: relative advantage, compatibility, complexity, divisibility, and communicability. All five are matters of perception in that how an innovation is perceived by the members of a social system will affect its rate of adoption (Rogers, 1962).

The communication of an innovation is defined as the spread of an innovation from its source of invention or creation to its adopters. This human interaction step is the essence of the diffusion process. The social relationships between the individuals involved will indicate much about the conditions under which the communication will take place and the results or reactions to the communication (Rogers, 1962)

The social system, according to Rogers, is a population of individuals who are "functionally differentiated" and who are engaged in "collective problem-solving behaviour" (1962:13). Adoption decisions range along a continuum from individual choice to group decisions. The intermediate point along the continuum is characterized by the type of innovation that requires prior acceptance by the majority of the system's members before individual adoption decisions can be made (Rogers, 1962).

Time is the final component needed for an analysis of diffusion of innovations. An adoption process carries on over time. This process is a mental series of stages an individual passes through from the time an individual first hears of an innovation until the time of making a decision to accept or reject the innovation. There are five stages in the adoption process: awareness; interest; evaluation; trial; adoption or rejection. Rogers noted that the five stages were not necessarily

the only ones and the rejection of an innovation can occur at any stage in the process (1962:95). The final corollary of this process is that an individual can cease to use an innovation after previously adopting it. This is called "discontinuance".

A point in the diffusion process that Rogers neglected is brought up by Brown (1981). Brown wrote that one step in the diffusion process is the establishment of diffusion agencies or outlets. Strategies are implemented to induce adoption by populations in each agency's service area. Each agency creates differing levels of access to an innovation depending on a potential adopter's economic, locational, social, and demographic characteristics (Brown, 1981).

### **3.4.1 Diffusion of innovations and reproductive technology**

Like the three previous theories, diffusion of innovations theory cannot adequately explain reproductive technology in accordance with the criteria set up at the beginning of the chapter. Using diffusion of innovations theory one could explain how innovations come to be accepted in society by individuals but the theory cannot provide analyses beyond this. Using this theory one can trace the path of a particular innovative technique such as 'in vitro' fertilization from its inception to its eventual adoption by many people in society. One could study issues of power only with regard to the sometimes higher social power of the adoption agent (who tries to convince people they require a particular innovation) over the adoptees. Why one group has more power than another (men over women, doctors and scientists over the general public, and so on) is not analysable in this context. The theory is unable to explain how women come to occupy the positions they do as research objects or how women's perceptions of themselves are socially constructed yet able to influence their behaviours. Finally, one is unable to

explain how innovations come to be perceived as beneficial and therefore, adopted.

### 3.5    SUMMARY

I have presented one theory from each of three sociological paradigms and one theory from a social change perspective. The most striking thing these four theories share is an inability to adequately explain many of the issues surrounding reproductive technologies. This inability differs with each theory by degree and by kind. Each of the theories was able to provide interesting insights into some aspects of reproductive technology but only partial analyses were possible in terms of the criteria that were set up in the introduction of the chapter as necessary issues to explain if the theory was to be adequate. To review, these critical issues include: (a) issues of power between men and women and among the institutions of medicine, science, and technology and citizens (especially women); (b) explanations of how women come to be in situations where they are exploited and used as research worktables, as objects, or as commodities; and (c) explanations of how socially constructed typologies influence women's perceptions of themselves and influence behaviours based on these perceptions. Feminist sociology, due to its dual macro and micro foci, may be better able to account for these situations so we will turn to a review of it now.

### 3.6 FEMINIST SOCIOLOGY

Several theories have been presented as possibilities for explaining various reproductive technologies and each was found to be inadequate for my purposes. I will now introduce feminist sociological theory as a theory which I believe is capable of providing superior analyses to any supplied so far. I will provide a brief background of feminist theory and then present feminist sociological theory, which will be followed by a discussion of its ties to the traditional sociological paradigms. Finally, I will show why feminist sociological theory eclipses others in explaining issues surrounding reproductive technologies.

### 3.7 FEMINIST THEORY

Feminist theory is part of a women-centered scholarship which takes the situations and experiences of women as the inception point for research. In this view women become the central subjects and the world is seen from the various vantage points of women in society:

[F]eminist theory is critical and activist on behalf of women, seeking to produce a better world for women— and thus, they argue for humankind (Lengermann & Niebrugge- Brantley, 1988:282).

Historically, the growth of feminist theory has paralleled that of sociological theory. Despite this, it has been marginalized and ignored by sociologists until about 1960. When feminist concerns have been addressed by sociologists in the past, they were taken up by those writers who were also on the periphery at that time (e.g.: Marx & Engels). Central sociological thinkers have generally ignored feminist issues such as gender inequality and, if they have addressed them, have treated them uncritically.

Three fundamental questions provide the fuel for feminist scholarship. These are "what about the women?", "why is women's situation as it is?", and "how can we change and improve the world?" (Lengermann & Niebrugge-Brantley, 1988). Answers to each of these questions provides feminist theory with its differentiated branches: those that subscribe to theories of gender difference; those that subscribe to theories of gender inequality; and those that subscribe to theories of gender oppression. Within each of these categories there are differences of opinion based on answers to the second and third questions.

These differences within feminist theory have led people to criticize it as a "non-theory" lacking a cohesive set of assumptions. In response, feminist theorists have stated that they are united on beliefs that (a) all feminist theorists offer a women-centered perspective that is distinct from traditional viewpoints and (b) that the resolution of any social situation lies at the intersection of vantage points. Therefore, all interested parties should be able to expect equal treatment regarding their viewpoints. This is particularly important in the face of the second criticism of feminism, namely that most feminist theory reflects a white, middle class bias. This concern has led to a fourth question in feminist theory, "what about differences among women?" (Lengermann & Niebrugge-Brantley, 1988).

Despite the variety of opinions within feminist theory, the quintessential sociological concern with how and why social organization takes the shape it does in society at a given time remains central. It is this concern that feminist sociological theory is based on.

### **3.8 FEMINIST SOCIOLOGICAL THEORY**

The first principle of a feminist sociology is that there are no disinterested observers. As C. Wright Mills (1959) has stated: "no one is outside society; the question is where each stands within it." All sociologists witness and experience society from a relatively advantaged position. This theoretical undertaking can be identified as drawing upon the oppression theorists' ideas about social reality. From this perspective four notable aspects of feminist sociology, drawn from Lengermann's and Niebrugge-Brantley's 1988 summary, can be articulated. The first aspect is a particular mode of dialectical thinking. The second aspect is a macro social model of social organization. The third aspect is an examination of the relational situation of women which alters traditional sociological understandings of micro-interactions. The fourth aspect of feminist sociology is a revised model of subjectivity within sociology (Lengermann & Niebrugge-Brantley, 1988). Each of these four aspects will be discussed in greater detail below.

#### **3.8.1 The feminist dialectic**

Lengermann and Niebrugge-Brantley (1988) state that feminist sociology must begin with a dialectical analysis of the process of knowledge creation. They write:

There is a constant tension between subject and object in which each acts on and changes the other. This tension informs both the formal practice of sociology and the construction of knowledge in everyday life. Thus knowledge of the social world is always created from a social location. The knower or subject must acknowledge the interaction with the object of knowledge (Lengermann & Niebrugge-Brantley, 1988:324).

At the heart of a feminist dialectic is the view that the social world is experienced from the diverse vantage points of actors dissimilarly located within the

social structure. Each actor is an active constructor of knowledge whose actions are based on unique situated experiences and interests.

A central problem for feminist sociologists is understanding how any knowledge of social reality is possible when all actor's perceptions of the world are always partial and interest-based. It is, therefore, the task of feminist sociology to study how actors acquire their particular beliefs about social reality; how they justify their beliefs when faced with contradictory ideas and/or evidence; how they act upon their beliefs; how they condone their own behaviours in keeping with their beliefs; and how they reconcile themselves to their situations according to their beliefs (Lengermann & Niebrugge-Brantley, 1988).

A major concern for feminist sociologists is to provide a theoretical foundation upon which a plan for practical action can be built. Feminist sociologists deny that truth is undiscoverable and believe that there is a reality which can be known and described by individual actors. However, rather than accepting the truth or reality of "a" knower, feminist sociology seeks to arrive at a knowledge of truth or reality through a multiplicity of viewpoints.

The idea that no one view has any final or determinate authenticity in and of itself could lead to a paralysing relativism. This relativism is counteracted by locating the truth of any situation at the point of intersection that exists among the differing points of view of unequally empowered groups involved in situations. This valuation of the perceptions of the less privileged provides a means of countering Marx's statement that "the ruling ideas of any age are the ideas of its ruling class". It provides a means of countering dominant ideology. Truth, then, can be discovered by locating the threads of agreement, woven through each interested party's argument, between parties.

The feminist dialectic stems, too, from women's daily experiences. Women's social situations have made them into experts at dealing with a multiplicity of views. It is often their role as moderators to see that competing views get fair treatment:

women thus find knowledge not in unilateral claims to truth, but in balancing and weighing the accounts of reality presented to them by a variety of others (Lengermann & Niebrugge-Brantley, 1988:313).

Therefore, it is important to question the attempts by traditional sociologists to build static concepts in sociology which overlook the fluid and processual nature of social reality. The social world is a social construction created by the intersection of differently situated actors' viewpoints. While not all actors have an equal voice in the final form the socially constructed world takes, each is still involved. Lengermann and Niebrugge-Brantley (1988) note that people understand and act toward the social world according to their structurally patterned positions. This is reminiscent of the symbolic interactionist view that people define and interpret the world before acting upon it.<sup>18</sup>

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<sup>18</sup> Six ways that certainty about "the truth" can be discerned by sociologists are: (1) seek facts at the point of intersection between the understandings of the world held by differently situated and often oppositionally related groups; (2) stay focused not only on these different accounts but on the situated vantage points from which they arise; (3) remain sensitive to the situationality of their own professional efforts to know the world; (4) remain sensitive to the differences in perception that people may have about the requirements of their structural locations; (5) stay modest about their "certainty" and recognize its processual basis, its precarious state, and the permeability of all their concepts; and (6) stay constantly aware of and attempt to compensate for the ways that structural inequalities weight different groups' accounts of social reality (Lengermann & Niebrugge-Brantley, 1988:314).

### 3.8.2 The macro social order

The view of the macro social order within feminist sociology emphasizes how actors' perceptions of social reality are shaped by social structures and ideology.

Lengermann and Niebrugge-Brantley write that:

macro social structures are based in processes controlled by dominants acting in their own interests and executed by subordinates whose work is made largely invisible and undervalued even to themselves by the social ideology. Thus even the understanding of what constitutes production is distorted. Focusing on women's position can give particular insights into these macro structures of subordination because women, whatever their class position, are primary doers of invisible work: housework, childbearing and rearing, emotional and sexual service, and coordinating activities (such as waiting, adjusting, being interrupted) in wage-sector work (1988:324).

The concept of social production also arises in this approach. Social production includes the construction of market commodities, family and healthcare systems, the organization of housework, the social organization of sexuality, the state and religious systems, and the social arrangements of politics, mass media, and academic discourse. Each of these types of social production is based on unequal control of, and access to, the very resources crucial to the activity.

Another element of the macro social order is the fact that women experience social life as a balancing and merging of role-associated interests and experiences instead of as a movement among compartmentalized roles as sociology often presents. This role balancing can be seen when women link their activities as homemaker, mother, and wife together or when they link their roles as mother and wife and wage earner together in the classic "double day" situation. This merging and balancing is expected of women, but is also disparaged when women "bring outside concerns into the office"; when they "let their emotions affect their performance"; and when they "cannot keep the fact that they are women out of the

situation" (Lengermann & Niebrugge-Brantley, 1988:315). It is speculated that women's experience of role merging or role balancing may be generalizable to other subordinate groups.

Feminist sociologists also stress the importance of ideological domination in the construction of social domination. Because ideology is transmitted so effectively throughout society it becomes taken-for-granted knowledge believed by all groups in society. This public knowledge of reality, as a reflection of the dominant groups' interests and experiences, becomes a crucial index of their power.

Ideology plays a central role in the maintenance of domination and subordination with regard to macro structural patterning of gender inequality:

[g]ender inequality is reproduced by a system of institutionalized knowledge that reflects the interests and experiences of men (Lengermann & Niebrugge-Brantley, 1988:316).

According to the current gender ideology, men are the bearers of socio-cultural authority. This allocates the right to dominate to the male role and the obligation to serve to the female role. Gender ideology systematically distorts women's productive activities by trivializing some activities (e.g.: housework); by idealizing other activities (e.g.: mothering); and by making invisible other activities (e.g.: contributions to the production of market commodities). Lengermann and Niebrugge- Brantley note that the ideological processes that create these fallacies may be generalizable to the macro-structural production of all social subordination (1988).

### 3.8.3 The micro social order

Lengermann and Niebrugge-Brantley write:

micro-interactional processes in society make real [the] dominant-subordinate power arrangements and the nonacknowledgment or distortion of the subordinates' contribution. Thus, women find their contributions to social production either disregarded or idealized. Feminist sociology focuses on how individuals take account of one another as they pursue objective projects or subjectively shared meanings (1988:324 & 316).

There are five points regarding the micro social order upon which conventional sociology and feminist sociology diverge. These are outlined below.

#### 3.8.3.1 Responsive action/purposeful action

Mainstream micro sociology presents a model of determined actors setting and pursuing goals in step by step series of acts where they attempt, either individually or collectively, to attain their goals. Feminist research has found that generally women cannot pursue goals in these kinds of linear sequences but must respond<sup>19</sup> continually to the shifting agendas of others. Their lives have a quality of incidentalness due to the demands of current roles. Feminist sociologists suggest replacing micro sociology's conventional model of purposeful actors with a more realistic view of actors who are responsively located in the middle of "a web of other's actions" and who may find themselves located in situations by forces they can neither predict nor control (Lengermann & Niebrugge-Brantley, 1988).

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<sup>19</sup> The term "respond" is not intended to convey passive reaction. Instead, it means that women are oriented more to tasks of monitoring, coordinating, facilitating, and moderating the wishes, actions, and demands of others than to their own goals (Lengermann & Niebrugge-Brantley, 1988:316).

### **3.8.3.2 Intermittent interaction/continuous interaction**

The picture of social life presented by micro sociology shows active individuals interacting face-to-face continuously. It is assumed that all other actors in the situation are fundamentally the same. Feminist research shows that women's interactive experiences are highly variable and rarely take on the interactive qualities of the micro-sociological model. Usually women are in interactive situations with small children, who are too young, with men, who differ from them in life and social experience, or with other women in office situations, who are close in proximity but allowed little interaction. Only when women come into open associations with other adult women do their interactions match any of the assumptions of the prevailing model which has been built upon the experiences of males.

### **3.8.3.3 Inequality/equality**

Another assumption made by micro sociology is that the "pressures in interactive situations are so great that actors, taking macro structural constraints into account, orient toward one another on an assumption of equality" (Lengermann & Niebrugge-Brantley, 1988:317). Again feminist research on the interactions between men and women has shown results that contradict this. Research shows that the social interactions between the sexes are pervasively patterned by macro structural influences. In their daily lives women are affected by the awareness that they are economically, politically, and culturally subordinate to men.

#### 3.8.3.4 Stratified meanings/common meanings

Micro sociologists propose that actors, interacting and seeing each other in activity, form shared understandings through their communication with each other. Ultimately this leads to common vantage points of their experiences. Feminist sociology insists that this idea be drastically qualified to incorporate the idea that interactions are embedded in, and permeated by the macro structure. As noted before, ideology patterns the meanings assigned to certain activities. In men's interactions with women, they are likely to assign meanings to women's activities that are drawn from a macro structural gender ideology:

[w]omen, immersed in the same ideological interpretation of their experiences, stand at a point of dialectical tension, balancing this ideology against the actuality of their lives. A great diversity of meanings develop out of this tension (Lengermann & Niebrugge-Brantley, 1988:318).

#### 3.8.3.5 Constraint/choice in meaning creating locations

There exists within micro sociology the democratic view that actors have equal opportunity and freedom of choice regarding movement in or out of interactional settings. Feminist research shows that women are able to create meanings out of real life experiences with similarly situated women. Associations between women are attractive to women because of the support they provide. However, ideology works to restrict and demean the choice to associate primarily with other women "so that, insidiously, even women become suspicious of its attractions" (Lengermann & Niebrugge-Brantley, 1988:318).

According to feminist sociologists, current models of the micro order are not inaccurate, just partial. As noted before, the truth lies at the intersection of vantage points. Conventional sociological models have shown how equals in macro

structural power conferring categories create a vantage point. When structural unequals interact there are many other qualities to their association than those suggested by the models. Lengermann and Niebrugge-Brantley suggest that a better model for capturing the reality of subordinates' experience would be one that looks at the:

incidentalness of project, responsiveness of action, movement in and out of very different interaction experiences, continuous enactment of power differentials, activities whose meanings are invisible or obscured, estrangement from the meanings of others involved in the interaction, and restricted access to those settings where meaningfulness is most likely to be a genuinely shared experience (1988:319).

One task for feminist sociologists is to determine whether all subordinates, not just women, share the experiences outlined above.

#### **3.8.4 Subjectivity**

One of the most important ideas within feminist sociology is the emphasis on a third level of social activity, the subjective. Rather than subsume subjectivity under micro sociology, feminist sociologists look at the interpretations of goals and relationships as a distinct level. The specificity of women's (and perhaps other subordinates) subjective experiences may be awareness-creating specifically because their own experiences often run counter to predominant definitions of the world. Lengermann and Niebrugge-Brantley write that:

these conditions create in women's subjectivity a constant "line of fault" that they must navigate. This line of fault separates the patriarchal ideology and women's reflected-on experience of the actuality of their roles in producing social life at the macro and micro levels. Women navigate this line of fault in various ways—by repression, by acquiescence, by rebellion, and by attempts at micro and macro organization for reform (1988:325).

#### 3.8.4.1 Role taking and a sense of other

In the course of role taking actors learn to see themselves through the eyes of others deemed similar to them. However, women are socialized to see themselves through the eyes of men. Even when significant others are women, women learn to see themselves as men would see them.

In this view then, women's experience in role-taking is to take the role of the "genuine other" (men) not just a social other who is assumed to be much like one-self (women). Through role-taking one develops a sense of self. The individual comes to view her/himself in relation to the attitudes of others and makes adjustments to the self concept accordingly. Therefore, for women, the sense of self is dependant on men's "ideas" of women which are not drawn from experience but are derived in large part from a prevailing macro gender ideology.

#### 3.8.4.2 Internalization of community norms

When discussing internalization of community norms in sociology, it is Mead's concept of "the generalized other" that is typically drawn upon. "Other" is singular and indicates that the generalized other is a "cohesive, coherent, singular expression of expectations." But the generalized other represents androcentric community norms that compel women to see themselves as unequal to men:

[t]o the degree that a woman succeeds in formulating a sense of generalized other that accurately reflects the dominant perceptions of the community, she may have in a sense damaged her own possibilities for self esteem and self exploration (Lengermann & Niebrugge-Brantley, 1988:320).

Feminist sociologists also question the very existence of a unified concept of "other" for all people. Lengermann and Niebrugge-Brantley (1988) point out that only with an awareness of the ways in which many people affect an individual's

sense of self can we begin to understand the "complexity of having or being a self."

#### **3.8.4.3 Nature of the self as a social actor**

Within micro sociology the actor is presented as viewing the everyday world as an entity to be mastered according to one's particular interests. Feminist sociologists have found that women may find themselves so limited by their social positions that the idea of projecting one's own plans onto the world is meaningless. Furthermore, women may not see the world as a separate entity to be mastered but rather, may experience it as a place where one balances a variety of interests. This leads back to the idea of role merging, and women's experiences in this suggest a need for renaming "role conflict", "role balancing".

#### **3.8.4.4 Consciousness of everyday life**

Feminist sociologists are critical of the idea of a "unified consciousness of everyday life" that conventional micro sociologists assume. Feminist sociologists suggest that the most pervasive aspect of women's consciousness of everyday life is a "bifurcated consciousness" which is characterized by a "line of fault" between one's own personal, lived, and reflected-on realities and the established ideal types that are available through ideology to describe that reality. So, for subordinates, everyday life is divided into two realities, actual lived realities and social constructions.

The feminist sociology of subjectivity begins at this juncture: how do people cope when their own experiences of reality do not mesh with established norms or ideals of certain experiences? Lengermann and Niebrugge-Brantley suggest sever-

al answers to this question: (1) people avoid acts of sustained reflection; (2) people create their own reality to make sense of their experiences; (3) people seek a community of others who share their sense of a disjointed reality; or (4) people deny the validity of their own experiences<sup>20</sup> (1988:321).

Four aspects of feminist sociology have been presented that can be distinguished from mainstream sociology. These are a distinct style of dialectical thinking, a macro social model of social organization, an examination of the relational situation of women which alters traditional sociological understandings of micro-interactions, and a revised model of subjectivity. Further discussion about the ways in which feminist sociology incorporates traditional sociology are outlined below.

### 3.8.5 Feminist sociology and the sociological paradigms

Feminist sociological theory effectively synthesizes the social facts paradigm, the social definition paradigm, and the social behaviour paradigm. The themes associated with these paradigms are interwoven within feminist sociological theory and thus present a sociology that is convergent, toward realistic and multidimensional explanations of social life.

Feminist sociological theory contains many aspects of the social facts paradigm especially in its use of Marxist theoretical constructs. A central idea in feminist sociology is that the macro structural patterns of social production are based on social inequality. Complex systems of hierarchical organization are sustained by ideology.

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<sup>20</sup> What has been said here about subjectivity may well be generalizable to other subordinates besides women. Parallels exist although the situations are not identical.

Feminist sociology makes an important connection to social definitionism by stressing a construction of production that places importance on micro-interactions in the creation of the social world. As symbolic interactionists believe, production is usually accomplished at the micro level within networks of face-to-face interactions. These interactions involve coordinated activities and mutual orientations but are generally accomplished between unequally empowered actors. Therefore:

the dynamics of domination and control that sustain the macro order are enacted and...made real in these associations by interactive sequences of power, authority, deference, and submission and by fundamentally different understandings of the situation held by dominants and subordinates who remain intimate strangers to each other (Lengermann & Niebrugge-Brantley, 1988:322).

Finally, feminist sociological theory acknowledges the value of social behaviourism in explaining that the continuation of inequality can be seen, in part, as patterned enactments of the domination and subordination scripts acquired in socialization. Because actors have a capacity for rationality, as in exchange theory, perhaps subordinates have learned the value of making themselves indispensable to the society's dominants (Lengermann & Niebrugge-Brantley, 1988).

Feminist sociological theory also successfully transcends the gap between macro and micro sociology. Using women's experiences as subordinates, feminist sociological theory manages to divulge the ways in which the macro social world is maintained by subordinate groups through micro interactions. It also manages to trace the ways in which maintenance activities are formed by the macro structural demands of domination. Lengermann and Niebrugge-Brantley state that:

feminist sociological theory analyses the interface between macro structure and micro interaction whether it begins at the macro level or the micro level. This sense of interface is captured in the feminist principle: 'the personal is political' (1988:323).

### 3.8.6 Feminist sociology and reproductive technology

For this thesis, an adequate theory must have the ability to explain issues concerning power differences between men and women and between medical, scientific, and technological institutions and women. It must be able to explain the existence of differences within each of these kinds of power categories as well (i.e.: show what is different, if anything, between the kind of power men wield over women and the kind of power macro institutions wield over women). Secondly, a theory must have the ability to explain how women come to be in exploitive situations, especially in the cases where they seek these situations out, and how they come to be objectified and commodified by themselves and by others. Finally, a theory must have the ability to explain how social constructions are used to influence behaviour and perceptions of the self. It must be able to explain how the social constructions of a word like "infertile" can cause changes in self image and changes in behaviour.

The theory most capable of analysing complex issues such as those surrounding reproductive technologies, with its macro structural elements and its micro interactional elements, is feminist sociological theory. Reproductive technologies, in my opinion, are chiefly about power. As mentioned earlier in the chapter, power determines who uses the technologies and why. Power dictates who controls what is researched and why. It defines who controls access to technologies and who makes the rules. Reproductive technologies are also about ideology and perceptions of selves and of the social world. They are about perceptions of the technologies as beneficial or detrimental, necessary or frivolous. It is about a powerful medical model which dictates that if the technology exists, it is "good" and

society should use it. Reproductive technologies are also about power differences between the sexes.

Feminist sociological theory is an adequate framework for analyses of issues relating to reproductive technology for many reasons. Working from discussions on the macro social order, with its emphasis on ideological domination (especially with regards to gender ideology), we can explain why women allow themselves to be researched and why men control the research and the funding. We can explain how individuals' value as humans can be mediated by their positions as "women", "infertile" people and "childless" people by focusing on discussions of gender ideology, the feminist dialectic, and subjectivity. Feminist sociological theory can explain, through discussions on the micro social order (for instance, the issue of inequality) and on subjectivity, role-taking and a sense of other, why women do not define themselves or define themselves only in relation to men, or why women do not control their own bodies. It can explain how a medical model of "fixing" individuals in their own best interests can be prevalent by examining ideology. Feminist sociological theory can also explain the differences in power and in access to decision making between men and women by looking again at firmly entrenched gender ideologies, on a macro level, and at the feminist dialectic and the issue of subjectivity (especially regarding consciousness of everyday life), on a micro level.

These issues can be explained by feminist sociological theory because it draws upon elements of the three sociological paradigms and because it bridges the gap between macro and micro level phenomena. One can see it is more useful to use a multi-purpose analytical tool, if it is available, than to allow for the possibility of

being limited in one's analyses by virtue of a restrictive tool. Furthermore, given the nature of the issues surrounding reproductive technologies I feel that, ethically, any analysis must be guided by feminist principles, both in theory and in research. As feminist sociological theory and research are irrevocably intertwined, I will turn my attention now to the research methods section of this paper.

## Chapter IV

### RESEARCH IDEALS AND DESIGN

In the preceding chapter I discussed the rationale for using feminist sociological theory to inform an analysis of some of the issues surrounding reproductive technologies. In this section, three interrelated tasks are at hand. The first is to introduce feminist research ideals and discuss how these are appropriate for sociological research. The second is to outline the ways in which feminist research ideals justify and legitimate the direction this study has taken. The third is to provide detail of the research design employed and to show, consequently, how I have incorporated these ideals into my study of B.C. policy makers.

#### 4.1 FEMINIST RESEARCH IDEALS

Acker, Barry, and Esseveld (1983) have identified three principles of feminist research. These are that research should contribute to women's liberation by the production of knowledge for women's use; research should use only non-oppressive methods of gaining knowledge; and research should continue the development of critical perspectives which question dominant intellectual traditions and which contain a recursive element.

These writers further state that feminist research is intimately linked to the political aims of the women's movement. The women's movement provided the necessary social and political foundations for feminist researchers to start public-

ly asking some of the questions they had been asking privately. Outside an academic setting, new questions and new formulations about women's situations were posed which could be adopted and researched by academics. Finally, feminist researchers were generally members of the women's movement and had a political commitment to doing research which would aid in women's liberation (Acker et al., 1983:424). A discussion of feminist research is not complete without mention of methodology and epistemology.

There has been a great deal of argument over whether a distinctive method of feminist inquiry exists—whether feminist ideals challenge or complement traditional methods.

Research methods have been defined as techniques for, or ways of proceeding in, gathering evidence (Harding, 1987:2). Three styles for attaining this goal are (1) listening to, or interrogating, informants, (2) observing behaviour, and (3) examining historical records. Feminist researchers use any and all of these styles. However, the ways in which they use them are different from traditional researchers. Regarding listening and interrogating, feminist researchers listen carefully and critically and ask questions in a much different manner from typical interviewing methods. For example, feminist researchers do not maintain a one way flow of information but rather, provide information about themselves or about the study area when requested (for in-depth discussions of feminist interviewing techniques see Oakley, 1981 and Acker et al., 1983). Regarding observation, feminist researchers pay particular attention to traditionally non-significant behaviours. For example, feminist researchers study behaviours that other researchers may have ignored because the behaviours did not fit with gender ster-

eotypes or study behaviours that are seen as mundane, uninteresting, or in some way taken-for-granted by androcentric researchers (i.e.: housework). Regarding archival research, feminist researchers seek newly recognized examples and patterns in the data. Feminist researchers are studying documents, journals, letters, diaries and so on, that have most often been ignored previously by social scientists. Eichler (1987:22) notes that basically all methods may be meritorious, and because there are so many different methods, the solution to the use of sexist versus non-sexist research methods is the use of meta-level analyses. In this way it is possible to overcome distorted or partial pictures of social reality derived from traditional androcentric research methods.

An epistemology is a theory of knowledge. It answers questions regarding "who can be a knower?"; regarding "what tests beliefs must pass in order to be legitimated as knowledge?"; and regarding "what kinds of things can be known?" (Harding, 1987:3). Feminist researchers argue that traditional epistemologies have systematically omitted women as "knowers" or as "agents of knowledge". History has been written from the male's viewpoint and therefore, "the voice of science is masculine". The subject of sociology, traditionally, is male. One of the goals of feminist theory and methodology is to rectify this situation.

In determining whether there exists a distinctive style of feminist research it is important to understand the relationship between research methods and epistemologies. Harding (1987) advances that the answer to the question of whether a separate feminist method exists or not is not to be found in the specific styles of gathering knowledge (i.e.: research methods) but rather is to be found in an approach that identifies the characteristics of the "best" (most illuminating) feminist research.

There are three distinctive features of the "best" feminist research. These features are (1) new empirical and theoretical resources, (2) new purposes for social science research, and (3) new subject matter of inquiry.

#### 4.1.1 New empirical and theoretical resources

Women's experiences in social life can be seen as new resources for research. These experiences require a shift in the definition of what is in need of explanation or of what is "interesting" as a topic of research. Harding notes that:

[d]efining what is in need of...explanation only from the perspective of bourgeois, white men's experiences leads to partial and even perverse understandings of social life (1987:7).

Through using women's experiences, feminist researchers generate questions from non-traditional perspectives. For the first time, women can reveal the distinctiveness of their experiences from different cultural, racial, and class locations.

Often women experience contradictions between identity labels that reflect their locations. For example, what a woman may experience as a woman and as a sociologist may produce what Smith (1987) has termed a "fault line" within identity politics. The hyphenated state of women's identities has provided a rich source of feminist insight through explorations of the contradictions. The questions that women may want answered are generally queries about how to change the conditions that generate fragmented identities, how their lives are shaped by forces external to them, and how to "win over, defeat, or neutralize", those forces organized against their liberation and growth. Harding states that:

[c]onsequently, feminist research projects originate primarily not in any old "women's experience," but in women's experiences in political struggles (1987:8).

So the "best" feminist research generates its areas of study from the perspectives of women's experiences.

#### **4.1.2 New purposes for social science research**

Social science research can be modified to incorporate a focus on women rather than a primary focus on men. A goal of feminist research is to provide women with explanations of the social world that they require or desire as opposed to providing medical and political structures with answers to questions they already have. For example, the questions about women that men want answered usually cannot be separated from an ambition to "pacify, control, exploit, or manipulate" women. This can be seen as an example of research of women for men and hence is a separation of purposes of research from its origins. The "best" feminist research does not separate the the purposes of research and analysis from the origins of the research problems.

#### **4.1.3 New subject matter of inquiry**

Orienting the researcher in the same context as the subject matter provides a means to study women from the perspective of women's own experiences. It involves the idea of "studying up" or across in an attempt to understand, not only the social world but also, oneself. This is in response to the recognition that one's location in the social world shapes the results of all analyses. Feminist researchers should identify their class, race, gender, cultural beliefs within their research so as to leave open for interpretation the ways in which these factors may have shaped the research project. In this way, an "objectivist stance" can be discarded and the researchers beliefs become visible along with the beliefs of the infor-

nants'. The introduction of this subjective element increases "objectivity" in research and decreases "objectivism". The "best" feminist research requires that the researcher be placed in the same critical plane as the researched thereby recovering the entire research process for scrutiny in the results of research.

Earlier it was stated that there is debate over whether a distinctive method of feminist research exists. The answer, according to Harding (1987), is that it does not or is unnecessary. Instead she proposes that there are three features of feminist research (discussed above) that serve to distinguish it from traditional social science research. These three features are both methodological, in that one can see how to apply sociological methods to research of women and gender, and epistemological, in that they imply theories of knowledge that are different from traditional ones. Before discussing the incorporation of feminist ideals into sociological research methods, I want to discuss in greater detail some of the problems of traditional sociological research that were touched on in the previous paragraphs.

#### **4.1.4 A critique of sociological research**

Social science research has been overwhelmingly sexist. That is, sociology has been shaped and informed mainly by an androcentric point of view, and therefore the results of research can only be biased and distorted views of social reality. Eichler notes three major responses to the criticism of sexism in sociological research: (1) ignore it; (2) incorporate women (the "add-women-and-stir" approach); or (3) adopt a women-centered approach which focuses on understanding women's perspectives (1987:25). She calls for a fourth response, the transformation of sociology into a non-sexist discipline, not by creating a paradigm around women but, by integrating a concern for women.

Seven interconnected forms of sexism in sociology have been identified. Sexism pervades language, concepts, questions posed, methods used, interpretations made, policy recommendations made (where applicable), and overall perspective. These elements of sexism may appear in any or all stages of the research process and they are not independent of each other.

The use of masculine terms for generic purposes has been widely recognized as sexist. Male terms are not experienced as generic and, further, are imprecise and ambiguous. Parallel to the problem of using masculine terms when one means all humankind, is the problem of using generic terms in sex-specific situations. One is committing this error, for instance, when one says "spouse abuse" when "wife battering" is meant or when one says "single parents" when "single mothers" is meant. Eichler says:

[u]sing non-sexist language, therefore, must definitely not be confused with removing sex from language, but instead [must be used] in its proper form and place (1987:28).

Sexist language is unacceptable in scientific discourse because it obscures and confuses descriptions of social reality.

Concepts may be deemed sexist if the context in which they are located, the meanings that are attributed to them, and the manner in which they are used are based on some double standard. For example, the concept of maternal deprivation, applied to children whose mothers were employed outside the home, asymmetrically implies that children require their mother's presence more so than their father's. So concepts can be seen as sexist if they:

- (a) construct ego as of one sex only but apply the concept generally,
- (b) are asymmetrical, in the sense that identical behaviours of females and males are evaluated differentially,
- (c) involve a differential evaluation of male-identified and female-identified traits,
- (d) are premised on a hierarchical sexual ordering that does not, in fact,

obtain in social reality, and lastly (e) are premised on notions of sex appropriateness when in fact we are dealing with a human attribute (Eichler, 1987:31).

The questions that are asked of each sex and about each sex are among the least obvious ways that sexism can enter social science. If researchers ask only women about their experiences with a particular phenomenon and neglect to ask men, inferences cannot be drawn as to what parts of the experience relate to the female sex role and what parts refer to the phenomenon itself. Eichler provides another example of a one-sided question:

[i]t is, for instance, possible that a rather small number of men are responsible for the creation of a rather large proportion of one-parent households. If so, we would have discovered a peculiar "male" behaviour that would require documentation and explanation rather than a peculiar female behaviour, as it is currently perceived (Eichler, 1987:31).

Questions posed, then, may introduce a sexist bias if differential questions are asked of each sex which result in different answers and thus reinforce the stereotype that the sexes are different, or if data about both sexes are collected but are not analysed by sex, potentially distorting the conclusions drawn about both sexes (Eichler, 1987:32).

Any method can be used in a sexist manner. There is, however, a great deal of argument as to whether any method can be used in a non-sexist manner (i.e.: qualitative versus quantitative <sup>21</sup>). One of the most obvious ways that sexism can enter methods is through survey research. The selection of "whom" is being asked "what" is foremost, as well as the formulation of the questions asked. Questions like "Do you think that female surgeons are as good as male surgeons?" only allow women to be as good as men, not better. Correspondingly, male surgeons

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<sup>21</sup> Quantitative methods have been rejected by some feminist scholars because they aggregate people's experiences and ignore their specificity.

cannot be characterized as worse than female surgeons. Further, the validation of data collection instruments using one sex only, when the instrument is to be used for both sexes, is a serious error (especially when the sexes are to be compared).

Eichler makes several general statements about sexism in the use of methods.

Methods are used in a sexist fashion if:

(a) questions asked are of one sex about the other and the responses are subsequently used as if they represented reality for the other sex; (b) questions are asked that do not reflect the theoretically possible spectrum of female-male behaviours, attitudes, capacities, traits, characteristics, etc.; (c) the sex of the participants in the research process is not properly taken into account; (d) any sexually identified objects or persons (whether through verbal, visual, or any other means) are not properly controlled for; (e) research instruments are validated on one sex only but used on both; and (f) data collected on both sexes are manipulated in such a manner that they cannot be analysed (or the researcher(s) fail(s) to analyse them although it is possible to do so) by sex (Eichler, 1987:34-35).

One of the most obvious ways that sexism enters interpretations of data is through overgeneralization. Typically, studies have used males as research subjects, say to study social stratification, and then generalized the results to all humans. A less obvious way sexism creeps into interpretations is by ignoring findings of no sex differences or negligible differences. Eichler points out that "[t]his leads, in a cumulative manner, to an exaggeration of sex differences rather than sex similarities, by distorting the balance" (1987:36). Finally, sexism pervades interpretation through the use of the double standard to explain findings and/or by using biological sex as an explanation for social behaviour. Some examples of this include the concept of "maternal" behaviour or describing sexually active teenage boys as "healthy" and "experimental" and sexually active teenage girls as "promiscuous".

Sexist research designs will make the generation of non-sexist policy proposals impossible but non-sexist designs carry no guarantees of non-sexist policy recommendations. Policy recommendations must be evaluated in terms of the goals of the research. Either the goal is sexist ("by trying to create or maintain a socially generated sex difference") or non-sexist ("by trying to create or maintain social equality between the sexes"). Eichler (1987) gives the example of research which found that boys are physically stronger than girls. Based on these findings, recommending more expenditures for boy's sports, since they are better suited to a particular activity, would be sexist. Recommending more expenditures on girl's sports so they may be trained to catch up with the boys, would be non-sexist.

The overall perspective that characterizes any research is the most important and pervasive means in which sexism can and does enter the research process. The preceding six issues fall under this broad category. In general, research is sexist if it adopts the view of one sex and presents that view as though it encompasses all social reality. Because the social positions of the sexes are different, "the perceptions of one sex will be limited as to their applicability to the other" (Eichler, 1987:37). One can assume that this can also be said for differing class and race locations as well. For this reason, feminist researchers have come to different descriptions of social institutions such as "his" marriage and "her" marriage and so on. Further, the research perspective may be sexist if it views one sex (females) only as they are relevant to the other sex (males) rather than as persons in their own right. If research conceptualizes females as passive, receptive, and acted upon, and conceptualizes males as active, initiators of action, rather than viewing both sexes as having the capacity for either, it is sexist. Finally, if

one sex is deemed more important than the other in any way, or if a double standard is used to evaluate the behaviour, traits, or attributes of the sexes, the research is flawed.

In conclusion, the issue of sex must be dealt with in an explicit manner. Ignoring sex as a variable leads researchers to ignore women, but also blinds researchers to seeing men as men since, traditionally, men have been seen as representing all humanity. Eichler (1987) believes that before sociology can conceive of a non-sexist research tradition, it must first pass through a stage of female-centered thinking and research. She defines feminism as "a movement for the elimination of sex-based injustice" and, based on this, she defines feminist research as:

research that is informed by a commitment to social justice for women and/or research that exposes prevailing biases and/or creates unbiased alternatives and/or constructs reality from a female perspective (Eichler, 1987:47).

#### **4.1.5 Feminist research ideals and sociology**

At the beginning of this chapter I stated that I would introduce feminist research ideals and show how they are appropriate for sociological research. I outlined three principles of feminist research. First, the goal of research should be the liberation of women. This goal is not inherently in opposition to the goal of the liberation of all humankind within traditional sociological research. Some sociologists persist in separating their roles as researchers and citizens. They believe that their duties as researchers (investigating and documenting social reality) should be morally objective instead of using the knowledge that they create in a manner that is accessible and beneficial to society.

Sociologists of the critical/Marxist school hold the emancipation of powerless groups as one of their goals. Unfortunately, one of the biggest barriers to reaching this objective is that they often write using language undecipherable to the lay public in journals and books with the limited readership of other academics.

Feminist researchers have often been criticized for the opposite reason. Their writing is often seen as too "unacademic". Part of this may be due to the interdisciplinary nature of feminist research. Another part may be due to the fact that, if feminist research is to be of women, by women, for women, it makes sense to enable as many women as possible to have access to it. Finding myself influenced by both sociology and feminism, I propose that the results of research be written differently for each of the two kinds of audiences and, in this way, one may remain faithful to one's academic background as well as to the goals of feminist research.

The second principle of feminist research is to use methods of inquiry that are not oppressive. Recalling the previous discussion of Harding's (1983) (a) new empirical and theoretical resources, (b) new purposes of social science, and (c) new subject matter of inquiry, I see no reason why these would be incompatible with sociological research. Furthermore, if one guards against the various pervasive forms of sexism in research that were outlined by Eichler (1987), sociology can only be made better.

The third principle of feminist research is the maintenance of a critical outlook on traditional social science research and on the new feminist research and theory that is being developed. Again there is nothing in this statement that is incongruent with the goals of sociology. Feminist research ideals can be used to

inform all sociology. I therefore conclude that feminist research ideals are not just appropriate "additions" to sociological research but are essential, previously omitted, requirements of "good" sociological research.

#### **4.1.6 Feminist research ideals and this study**

Before I began reviewing the literature on the reproductive technologies I was excited by the emancipatory promise of many of them for women. I could harvest and cryopreserve my ova, undergo sterilization, and still have my biological child years later. And, if I did not want to gestate the embryo I could pay someone who did want to. I could even choose the sex of the fetus, if desired. A close female friend and I had always joked that we should have a child together and with parthenogenesis and ova fusion, it finally seemed a real possibility. If I wanted to have a child on my own, I could go to a sperm bank and order genes from donors who met my specifications (hair color, height, weight, et cetera). These things, among others, make reproductive technologies very appealing to people who are fertile.

Other reproductive techniques promise infants to infertile people and go beyond being merely appealing. Those techniques, 'in vitro' fertilization, alternative insemination, embryo harvest and transfer, and contract motherhood, become, for many people, essential attempts at making life complete.

As I delved into the literature, a malevolent and unappealing side to the technologies began to surface. It is not anything inherent in most of the technologies that make them unliberating and immoral entities. Rather it is the present organization of power in medicine and science that changes the way the technologies can be perceived.

Currently, reproductive technologies are controlled by a male dominated medical profession. Power over decision making includes decisions about "what is worthy of research?" It is unlikely that many research dollars will be contributed toward parthenogenesis, which would make males obsolete. It is equally unlikely that money will go toward technology that would enable men to undergo embryo transfer, gestate a fetus to term in an internal artificial womb, and give birth by caesarian section, which would give men the opportunity to endure massive doses of hormones, surgical transformations, pain, and possibly death.

Furthermore, it became obvious that women have been exploited as research objects in many cases. One has to wonder why some women have been asked to undergo invasive, painful surgery for their partners' infertility problems as in the cases of IVF for male infertility. Often "informed consent" is discarded in favour of research<sup>22</sup> priorities. Truths about procedures, possible complications, and success rates are evaded so as to retain enough "objects of study". Often these evasions are passed by ethics committees (whose members are generally male) if the research is deemed beneficial to the advancement of "mankind"[sic]. Quality of life is ignored, beneficiality to whom is not stringently examined, and the kind of society Canadians want has not been probed. These kinds of ethical dilemmas have prompted my research of the potential policy makers on reproductive technologies in B.C.. Robert Blank, a policy analyst states that:

[p]olicy goals contain both a political and normative component in spite of attempts...to identify the process as value free. Policies reflect the values of the individuals that make them (1984:200).

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<sup>22</sup> Corea (1985) reports that Drs. Steptoe and Edwards, the doctors who delivered Louise Brown, the world's first "test-tube baby", were not operating with informed consent. Ms. Brown stated that if she had had any idea that there were no successes with 'in vitro' fertilization, she would never have agreed to undergo the treatments associated with the 'in vitro' fertilization.

I believe that if any policies were to be developed today on reproductive technology, they would reflect an uncritical and androcentric bias. To expand, I believe that policies would currently be made on the assumptions that (a) reproductive technologies are a right, (b) reproductive technologies are necessary, (c) that the purveyors of medicine and science know what they are doing, (d) that these same people have "our" best interests at heart, (e) that infertility is a curse, and (f) only certain people should be allowed access to technology. This leads into the purpose of this study.

There are certain individuals and groups that may be in positions to influence policy on reproductive technologies in B.C.. It is therefore important to discover what their attitudes and knowledge are regarding each of the techniques. The results of this survey may suggest a course of action for those concerned about reproductive technology. For instance, if the results suggest that policy will be shaped in the direction I outlined above, anyone concerned about this may become involved in trying to raise awareness and counteract this possibility before policies are made. If the results suggest that policy will be very restrictive and limiting, those concerned about this may try to achieve balance.

As I mentioned in the previous chapter, any study of reproductive technology must be informed by feminist research ideals and feminist theory. This study was conceived of as part of an awareness of feminist concerns about current organization of medicine and science and current control by men of reproductive technologies that use women as subjects/research objects. Out of this awareness came the idea, after the fact, that research could be done for the liberation of women by providing evidence for action of some type. Women experience reproductive tech-

nologies from different standpoints than males or "experts" do. If policies in British Columbia lean toward male and medical dominance, women must be advised to take political control of these technologies out of the hands of male dominated professions whose goals in doing research on reproductive technologies often run counter to the goals of the people involved in the studies. I believe that because reproductive technologies impact so profoundly upon the women who use them, they must be controlled by women. For example, women must be consulted in policy, women must sit on ethics committees, medicine and science must be accountable to women, "informed" consent must govern every procedure that has been deemed beneficial for Canadian society, and so on. As Eichler has said,

[u]nless we can establish some connection between the topic and the achievement of social justice for women, either in concrete terms, or in abstract terms through the manner in which knowledge is generated, it does not qualify as feminist research (1987:47).

#### **4.2 RESEARCH DESIGN AND FEMINIST IDEALS**

This section of the paper provides detail of the research design I employed in the study of potential policy makers. The ways in which feminist ideals can be incorporated are interspersed throughout. The first part deals with the sample: the size, the location, the sampling frame, the advantages and disadvantages of the sampling frame, and the special characteristics of the sample. Part two deals with data-collection: the method, the pre-test, the training of the research assistant, and the coding of the questionnaire. Part three describes the method of data-analysis and part four summarizes the salient points of the research design.

#### 4.2.1 The sample

In this exploratory study of potential policy makers' knowledge and attitudes, an effort was made to pinpoint those individuals and groups who are either involved in an attempt to influence policy on some reproductive technology, or those who are likely to have some influence when public debates ensue. Those who may be currently involved in attempts to influence policy were drawn, in part, from the agenda of speakers and participants at the April 1988 meeting of The New Reproductive Alternatives Society (N.R.A.S.) which was held at the University of Victoria. Approximately one-half my sample was drawn from this agenda and included representatives of medicine, law, science, bio-ethics, education, government, and the public. Those likely to come forward, or have influence at a later date, were drawn from a list of possibilities provided by Dr. Eike Kluge, a bio-ethicist and member of The B.C. Provincial Cabinet Advisory Committee on Ethics in Health Care in Victoria. The names of representatives of religious groups, women's groups, research associations, and government agencies were obtained from Dr. Kluge.

The sample was drawn mainly from the Victoria Capital Regional District. When important individuals or groups arose that did not have affiliations in the CRD, efforts were made to contact them in other cities. In a study as small and localized as this one, there exists the danger that groups in the CRD are somehow different from groups elsewhere. This danger may be nullified somewhat by the fact that those in other regions of British Columbia who are interested in influencing policy will likely have ties to those in the CRD, especially given that the CRD is the location of those governmental agencies relevant to policy creation.

Letters introducing the study were sent to fifty-four individuals. Of that number, forty-eight initially agreed to participate. A sample this size may normally be problematic for some research purposes, but because I am relying on "key" informants who are versed in the issues and have an interest in the outcomes of policy in B.C., this study did not attempt to be representative but is, rather, exploratory in nature.

A technique called snowball sampling was used in this study. Snowball sampling is often used to locate members of special or rare populations for which no lists exist. By locating a few members of these populations one can rely on them to provide the names of others known to them who are interested in, or affiliated with, the area of research. This process can be continued until no new names are mentioned. As no lists of "those interested in policy formation regarding reproductive technology" exist, I feel the use of this technique is justified (Sudman, 1976).

The major bias inherent in snowball sampling is the increased probability of higher profile individuals being chosen. In this study such a bias is actually beneficial as those with higher profiles may be so because of their involvement in the issues. Isolates, or fringe groups, may not have as much influence in policy creation as those who are able to capture media attention or those who have selected themselves into groups such as the New Reproductive Alternatives Society.

#### 4.2.2 Data collection

It was initially thought that with issues as sensitive and potentially volatile as reproductive technologies, the best technique for maximizing response rates and probing knowledge and attitudes would be the face-to-face interview. However, two lengthy pre-tests were conducted (one with a sociologist and one with a nurse) and it was found that (a) the interview was too long (about three hours) and (b) the issues were too sensitive to be dealt with among strangers (i.e.: the informants felt defensive about sharing their feelings on these fundamental issues with the interviewer). Therefore the instrument chosen for data collection was the questionnaire.

This method has been severely criticized by some feminist researchers; however, I concur with Eichler (1987) and Harding (1987) that this method is not inherently flawed. In a study such as this one where the sample is very small and the outcome depends on large quantities of detailed information about selected technologies and opinions regarding them, the questionnaire method seemed the best choice. Costs of questionnaire research are fairly minimal as most of the informants were located in the CRD. The major costs incurred were the creation of the questionnaire booklets, the mailing costs, and the telephone costs to those informants in other cities than Victoria.

The informants in this study were initially contacted via a letter describing the aims of the study and their role in it. They were told how their names were obtained and that myself or my research assistant would be contacting them within a specified time to set up time when the questionnaire could be delivered to them personally and reviewed with them. I chose to have the questionnaires

dropped off in person, rather than having them mailed to maximize people's feelings of involvement with the study and to provide personal contact with me in case I was able to assist them in any way. Some questionnaires had to be mailed, however, due to time constraints.

The interview schedule (see Appendix B) consists of eight sections. Each section, except section four, provides both closed and open ended questions. This allowed the informants ease in answering (closed ended) and also the ability to give opinions on the issues in their own words (open ended). Furthermore, research on attitudes suggests that attitudes are multidimensional and vary in complexity making the sole use of closed ended categories too limiting (Kidder & Judd, 1986).

Section one contains a list of ten technologies or techniques ('in vitro' fertilization, human embryo research, donation of gametes, cryopreservation, alternative insemination, parthenogenesis, sex pre-selection, contract motherhood, artificial womb technology, and the RU-486 pill) and asked the informants to indicate their familiarity<sup>23</sup> with each technique. The informants were then asked to indicate whether they felt each of the technologies they were familiar with (as per section one) was (1) beneficial, (2) detrimental, or (3) both 1 and 2. In section 1A, the informants were asked to elaborate on why they felt that "ABC" was a beneficial technique and why "XYZ" was considered to be a detrimental technique. Differentiating the dependent variable (reproductive technology) in this manner allows differing levels of knowledge and differing opinions to be held about each of the technologies.

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<sup>23</sup> Familiarity is operationalized as "knowing what a procedure or technique involves".

Section two asked the informants to indicate whether they felt (1) there should be policies allowing each technique they were familiar with, (2) there should be policies disallowing, or (3) there should not be any policies made on at all regarding selected techniques. Section 2A asked that they elaborate.

Section three asked whether the informants felt there should be policies governing access to each technique they were familiar with. A response of (1) indicates there should be restricted access, of (2) indicates free access, and of (3) indicates no access at all. Section 3A again asked for an elaboration on each informant's previous answers.

Section four asked the informants to indicate whether they believed each technique should be (1) publicly funded, (2) privately funded, (3) funded from both spheres, or (4) not funded at all. No elaborations were asked for because the information should be available from the responses to previous questions on each technique and is therefore redundant.

Section five begins a different format. The informants were asked to indicate in what case(s) each technology is acceptable (this includes the response "in no case"). They were given space to make comments or to add categories to each question of this kind. They were asked to write out what restrictions, if any, should apply to the use of each technique. For human embryo research, the informants were further asked at what point the embryo should be destroyed (if they felt this research was acceptable). The informants were asked, regarding donation, whether they would differentiate between the act of sperm donation and ova donation and why (not). Additionally, regarding contract motherhood, the informants were asked how they felt about the payment of fees to contract mothers.

Sections six and seven contain response matrices. The matrix in section six asks that informants indicate which groups in society are (1) major stakeholders in the creation of policy regarding each technology, (2) minor stakeholders, or (3) are irrelevant to the creation of policies. The matrix in section seven asked that informants indicate, using an "X" which group(s) of people (if any) should be consulted if policies are to be made on each reproductive technology.

Finally, section eight asked informants to answer some demographic questions. Included were age, marital status, number of children, educational level, job title, name of organization worked for, religious affiliation, and religiosity. The sex of the informants was already known from the lists. The demographic information is included to determine if certain groups are likely to be overrepresented in policy-making. If it is the case that any social group seems overrepresented, policies may be biased in that direction.

The penultimate page of the questionnaire instructed the informants to enter the names and phone numbers of others they felt would be able to assist in the study (snowball sampling). Thanks and assurances of confidentiality were also given here. The last page is left blank for each informant's use as additional space for comments on particular questions, on the questionnaire, or on the study.

Closed ended questions are pre-coded and open ended questions are coded with either a "1" indicating something is written in a particular spot or with a "9" indicating a blank space. I will use these written responses to provide insight into the closed ended responses and to provide qualitative data where warranted.

The questionnaire was pre-tested on approximately one hundred and fifty volunteers from the third year research methods course in Sociology at the Universi-

ty of Victoria. It was also scrutinized by several graduate students and professors before and after changes were made based on the pretests. The questionnaire itself went through extensive revisions during this time. Most flaws and weaknesses in clarity and comprehension of instructions seem to have been detected and corrected at this stage.

A research assistant was hired to phone each informant and set up drop off times for the questionnaires. She went through the questionnaire with each informant and made sure each understood how it was to be filled in (i.e.: that there were questions on both sides of the page and that if they were unfamiliar with a technique or procedure to leave it unanswered throughout the questionnaire). She was also instructed to make sure each informant knew how and why s/he was selected as a participant and see that each had a clear idea of the guidelines of the study (i.e.: that each was not anonymous but her/his responses were confidential and that they were free to abstain from the survey at any time). She pointed out that each was free to phone herself, myself, or my supervisor at any time with questions or concerns and reminded each that s/he will be sent a summary of the results of the survey as soon as they became known. Lastly she arranged for a convenient time to pick the questionnaires up in person. At this time the research assistant was to ask about any problems each informant may have had or any comments each wished to make.

### 4.2.3 Data analysis

The goal of this study is to detect potential biases in gestures toward policy formulation. Specifically, I am interested in detecting whether or not potential policy makers are willing to give control of reproductive technology to doctors, lawyers, and technicians. I am interested in what, if any, position the informants see women occupying regarding control of reproductive technologies. The information given in each questionnaire is used to that end. A major concern and area of interest is the effect, if any, of the informant's sex on their responses. Cross-tabulations of sex with applicable questions were conducted.

The rest of the demographic information is used to get an idea of the composition of potential policy makers. Cross-tabulations are undertaken and these results recorded in order to determine whether age, marital status, number of children and religiosity affect attitudes toward reproductive technologies.

### 4.2.4 Summary

This section on research design discussed, in detail, various points of the sample, the method of data-collection, the pre-test, and the method of data analysis. I feel that this study complies with feminist research ideals and is within the guidelines for non-sexist research provided earlier. I have provided the results of the survey to all of the informants but I am especially keen on providing them to people who may have an interest in using them to assist women in taking control of reproductive technologies. I feel the questionnaire used was as non-oppressive a means of gathering information as was possible given the content of the survey. By identifying myself as a white, middle class, Canadian-born female, I hope to enable others to understand how this may have influenced my interpretations of

the results of this study and to therefore be critical based on this information.

Finally, I have outlined the ways in which both myself and this study changed from the outset to the conclusion of the research. I will shift the attention to the results of the survey of knowledge and attitudes concerning reproductive technologies.

## Chapter V

### SURVEY RESULTS

Thirty two people, nineteen females and thirteen males, were given a thirty two page questionnaire containing both closed and open ended questions concerning knowledge and attitudes toward selected reproductive technologies. Two matrices were included asking informants for their opinions as to who the major stakeholders are and who should be consulted regarding policies on the techniques. Ten demographic questions were asked. Finally, a page appended to the questionnaire asked informants to list the names and contact numbers of any individuals they believed could also assist in answering the survey. The list was intended to be used as a method of snowball sampling but, due to various data collection delays and time constraints and due to the variety of names obtained, this proved to be an impossible task. Interestingly, if this is taken as an indication of the cohesiveness of a group of policymakers, it seems there is no actual network of primary "high profile" opinion leaders.

The data are presented here in the following manner. All ten demographic variables are analysed by sex. Each of the ten technologies is shown separately with the responses for knowledge of the technology, rating of the technology, whether there should be a policy regarding the technology, whether there should be free, restricted, or no access to the technology, and how the technology should be funded, analysed by the demographic variables. Open ended responses are

included where appropriate. Each technology is further analysed as to whether informants feel it is acceptable, whether there should be restrictions or not, and so on. Finally, the matrices regarding stakeholder status and consultation are analysed separately by sex. Only highlights of these matrices are presented here. All of the information reported in this chapter is found in Appendix C. Cramer's V and phi are used as statistical measures of association. It was determined at the outset of the analysis that a result of .29 or less indicated a weak association, a result of .30 to .39 indicated a moderate association, and a result of .40 or more indicated a strong association. The statistical significance level was set at  $p=.10$  instead of the conventional  $p=.05$ . With a sample size as small as thirty two, it was decided at the outset of the study that setting the significance level at  $p=.10$  would allow a greater chance of detecting significant results.

### **5.1 DEMOGRAPHIC ANALYSIS**

Each of the seven<sup>24</sup> following demographic variables, age, marital status, education level, religion, religiosity, church attendance, and number of children, is analysed by sex.

Of the thirty two informants (19 females, 13 males), the largest number fall into the age category 36-40 (28%,  $n=9$ ). The next largest category is the 46-50 age group (19%,  $n=6$ ). If one collapses the categories to age 45 and under and age 46 and above, 50% ( $n=16$ ) fall into each. Of those age 45 and under, 11 are female and 5 are male. Of those aged 46 and over, 8 are female and 8 are male.

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<sup>24</sup> Three of the demographic questions concerned the occupations of the informants. These responses, while interesting and relevant to this study, can not be disclosed without compromising the confidentiality of the study participants and therefore, have not been used.

The majority of informants (60%, n=19) are married. 10 (53%) of the females and 9 (70%) of the males fall into this category. The remaining 12 informants fall either into the "separated" or "divorced" category (n=5 females) or the "other" category (n=6, 3 females, 3 males).

The largest number of informants in this survey are medical doctors (25%, n=8, 3 females, 5 males). 3 informants (9%) have PhD's (1 female, 2 males), 5 (16%) have M.A.'s (2 females, 3 males), and 1 (3%) female has a law degree. 5 (16%) females have certificates or diplomas (mainly nursing), 3 (9%) females have some college background, and 1 female and 1 male (n=2, 6%) have high school education. 3 females and 1 male (n=4, 13%) have some combination of degrees.

The largest number (44%, n=14) of the informants are Protestant (8 females, 6 males). 38% of the sample (n=12) answered that they subscribe to no religion (8 females, 4 males). 1 male is Catholic and 1 female responded "other" (n=2, 6%).

34% of the informants (n=11) stated that they are "somewhat religious" (6 females, 5 males). 25% (n=8) answered that they are "not at all religious" (6 females, 2 males), 19% said they are "barely religious" (4 females, 2 males), and 9% (2 females, 1 male) stated they are "extremely religious".

Just under one-half of the informants (47%, n=15) said they never attend church (12 females, 3 males) while 25% (4 females, 4 males) said they attend church several times through out the year. 13% attend 1-3 times per month (2 females, 2 males) and 6% (2 males) attend once per week or more.

Regarding number of children, the largest number of informants (28%, 7 females, 2 males) has 2 children. Those with no children (4 females, 3 males) and those with 3 children (1 female, 6 males) have 22% of the informants in each

category. Those with one child (3 females) and those with 4 children (2 females, 1 male) have 9% of the informants in each category. 1 female informant has 6 children (3%).

The highlights of the above description of the sample by sex are as follows: there are more females than males, most of the sample is under age 50, and most are married with 2 children. Nearly everyone (94%) has some post-secondary education, one-half are Protestant, one-third sees themselves as "somewhat religious", and nearly one-half never attends church.

## 5.2 'IN VITRO' FERTILIZATION

### 5.2.1 Table 1A

Overall, 91% (n=29) have heard of IVF. 84% (n=16) of the females and 100% (n=13) of the males have some knowledge of IVF however the association between sex and knowledge is weak ( $\phi=.27$ ) and the relationship is not significant.

The relationship between age and knowledge of IVF, while also not significant, is  $v=.39$ . The relationship between marital status and knowledge shows no pattern but has a strong association of  $v=.48$  (not significant). The relationship between number of children and knowledge is associated strongly ( $v=.51$ ) but not significant. Education is associated strongly ( $v=.41$ ) but not significant. Regarding the relationship between religion and knowledge, the association is moderate ( $v=.33$ , not significant). Religiosity is also associated moderately with knowledge ( $v=.36$ , not significant) as is church attendance and knowledge ( $v=.34$ , not significant).

### 5.2.2 Table 1B

50% of the sample overall (n=16) believe IVF is a beneficial technique. 37.5% (n=12) feel it can be both beneficial and detrimental, while only 3% (n=1) feel IVF is detrimental. 47% (n=9) of the females and 54% (n=7) of the males fall into the "beneficial" category. An almost equal percentage of females (37%, n=7) and males (39%, n=5) responded that IVF could be both. 1 female (3%) feels that IVF is detrimental. The rating between rating of the technology and sex is moderate ( $\phi=.34$ ) but not significant.

The relationship between age and rating is strong ( $v=.62$ ) and significant at  $p=.05$  as is the relationship between rating and marital status ( $v=.55$ ,  $p=.001$ ) as is the relationship between rating and number of children ( $v=.60$ ,  $p=.005$ ). Similarly, the relationship between rating and education level is strong ( $v=.66$ ) and significant ( $p=.006$ ). Rating and religious affiliation shows a strong association of  $v=.42$  but is not significant nor is the association between rating and religiosity ( $v=.38$ ). The relationship between rating and attendance is strong however, ( $v=.49$ ) and is significant at  $p=.02$ .

Several informants worry that IVF "could lead to genetic engineering" and to a whole gamut of "medical and ethical issues around this". Another informant is concerned that the "statistics given to prospective parents regarding success are skewed and misleading." Other study participants indicate IVF has a positive side in that the medical and genetic backgrounds of both parents can be determined (unlike with donors, for instance) and also with IVF, people are able to have their own biological offspring. On the negative side, informants note that success rates are low, cost factors are high, and "reduction ethics are controversial".

### 5.2.3 Table 1C

The majority of informants (44%, n=14) feel that there should be a policy allowing IVF. Only 3% (n=1) feel there should be a policy disallowing it. 31% (n=10) feel that there should not be any policies on IVF created at all and 6% (n=2) are ambivalent. 26% of the females (n=5) believe there should be a policy allowing IVF, while 69% of the males (n=9) believe the same thing. 1 female (3%) feels there should be a policy disallowing IVF. 37% (n=7) of the females feel there should be no policies created on IVF and 23% (n=3) of the males concur. 11% (n=2) of the females are ambivalent about the idea of a policy on IVF. The relationship between feelings about policies on IVF and sex is strong ( $\phi=.47$ ) but not significant.

The relationship between policy and age is strong ( $v=.64$ ) and significant ( $p=.006$ ). The relationship between policy and marital status is also strong ( $v=.50$ ) and is also significant ( $p=.05$ ). Policy and the number of children are strongly associated ( $v=.50$ ) but the relationship is not significant just as policy and education level are strongly associated ( $v=.47$ ) but the relationship is not significant. Religious affiliation is strongly associated with policy ( $v=.62$ ) and is significant at  $p=.000$ . Religiosity and attendance are highly associated with policy as well,  $v=.41$  and  $v=.40$  respectively, but neither relationship is significant.

A number of informants feel that a policy should be put into effect regarding IVF in order to "ensure safety" and to "establish limits and control use". Conversely, one informant stated that:

[IVF] is a medical treatment and should be treated as such, not 'controlled' by the government. It should be the choice of the affected parties.

An interesting suggestion was made by one study participant, namely that "voluntary licensing would be good, instead of policy".

#### 5.2.4 Table 1D

Regarding funding, over one-half the informants (53%, n=17) feel that both public and private funds should be used to fund IVF. 22% (n=7) feel only public funds should be used while 16% (n=5) feel only private funds should be drawn upon. 47% (n=9) of the females feel both types of funding are acceptable and 62% (n=8) of the males agree. 21% (n=4) of the females and 23% (n=3) of the males believe only public funding should be allowed while 16% (n=3) of the females and 15% (n=2) of the males believe only private funding for IVF is acceptable. The relationship between funding and sex is low ( $\phi=.27$ ) and non-significant.

The relationships between funding and age ( $v=.44$ ), funding and marital status ( $v=.44$ ), funding and number of children ( $v=.48$ ), and funding and education level ( $v=.49$ ) are all strong but only the association between funding and marital status is significant at  $p=.10$ . The relationships between funding and religious affiliation ( $v=.34$ ), funding and religiosity ( $v=.32$ ), and funding and attendance ( $v=.32$ ) are all moderate and non-significant.

#### 5.2.5 Table 1E

The informants are equally divided on the decision between restricted or free access to IVF with 41% (n=13) believing there should be restricted access to it and 41% (n=13) believing there should be free access. 3% (n=1) feel there should be no access to this technology whatsoever. 47% of the females (n=9) and 31% of the males (n=4) feel access to IVF should be restricted while 26% (n=5) of the

females and 62% (n=8) of the males feel access to IVF should be free. 1 female feels there should not be access. The relationship between access and sex is strong ( $\phi=.40$ ) but not significant.

The relationship between access and age is also strong but not significant ( $v=.54$ ). The relationships between access and marital status ( $v=.55$ ) and access and number of children ( $v=.61$ ) are both strong and significant at  $p=.005$ . There is also a strong, but non-significant relationship between access and education level ( $v=.51$ ). The relationships between access and religion ( $v=.37$ ), access and religiosity ( $v=.38$ ), and access and attendance ( $v=.41$ ) are all moderate to strong but not significant.

Several of the informants felt that some restrictions to access should be set. Suggested bases for restricted access include "diagnosis of infertility by a licensed physician", "age, number of children and medical history of parents", and "best interests of child considerations". One informant feels that access to IVF should be open:

to married couples only - criteria used to evaluate adoptive couples could be used for IVF. Society should avoid allowing children to be reared in abnormal family constellations.

Another informant states, "I see no reason to restrict a technology which only enhances what nature intended".

### **5.2.6 Acceptance and restrictions**

In terms of whether IVF is an acceptable practice or not, no one feels it is unacceptable. 63% of the females (n=12) and 85% of the males (n=11) feel IVF is acceptable only when a doctor certifies infertility ( $\phi=.23$ , not significant). 5% (n=1) of the females and 8% (n=1) of the males feel that any time an individual desires IVF, it is acceptable ( $\phi=.05$ , not significant).

A number of informants commented on possible restrictions that should be placed on the use of IVF. Some examples include taking the age and medical history of the parents into account: "if public funds are used, then parents should be screened in a similar manner to potential adopting couples", and there should be a "limit on the number of times the procedure is attempted", such as three attempts.

Several informants feel that IVF "should be restricted to people who fit into societies accepted norm". One study participant suggested that IVF be restricted to:

only married couples. I strongly feel we cannot go on weakening families without ultimately destroying society...children need both parents for a reasonable chance at balanced development.

Others feel that IVF should be at a doctor's discretion, stating that it is "most important not to overload the uterus with too many embryos and then have to face fetal reduction".

### 5.3 HUMAN EMBRYO RESEARCH

#### 5.3.1 Table 2A

Overall, 66% (n=21) have heard of human embryo research. 53% of the females (n=10) and 85% of the males (n=11) were familiar with this technology. The association between knowledge and sex is moderate ( $\phi=.33$ ) and significant ( $p=.06$ ).

While the relationship between knowledge and age is not significant, there is a strong association between the two ( $v=.42$ ). The relationship between knowledge of human embryo research and marital status was weak ( $v=.27$ ) and was not signif-

icant. Knowledge and number of children are moderately associated ( $v=.35$ ) but the relationship is not significant. Education level is strongly associated with knowledge of human embryo research ( $v=.68$ ) and is significant at  $p=.07$ . The association between knowledge and religion is moderate ( $v=.36$ ), between knowledge and religiosity is moderate ( $v=.38$ ), and between knowledge and attendance is strong ( $v=.45$ ). None of these results are significant.

### 5.3.2 Table 2B

41% of the informants ( $n=13$ ) feel that human embryo research is both beneficial and detrimental. 37% ( $n=7$ ) of the females and 46% ( $n=6$ ) of the males feel this way. One-quarter ( $n=8$ ) of the informants feel it is beneficial while only 3% ( $n=1$ ) feel it is detrimental. Of the females, 16% ( $n=3$ ) and of the males 39% ( $n=5$ ) think the technology is beneficial. only 1 male (3%) feels it is detrimental. The association between rating and sex is strong ( $\phi=.47$ ) but not significant.

The relationship between rating and age shows a strong association ( $v=.52$ ) but is non-significant. Rating and marital status is only weakly associated ( $v=.20$ ) and is not significant. The relationships between rating and number of children ( $v=.49$ ) and rating and education level ( $v=.58$ ) are both strong but not significant. Rating is weakly associated with religion ( $v=.23$ ), moderately associated with religiosity ( $v=.35$ ), and strongly associated with attendance ( $v=.44$ ) with only the relationship between rating and attendance being significant at  $p=.08$ .

Comments regarding human embryo research are both positive and negative. Some informants feel that the technology is "ethically difficult but has the potential...to greatly increase our understanding of human development". Conversely, one informant is concerned that human embryo research "could lead to an increase in the business of aborting fetuses".

### 5.3.3 Table 2C

11 of the study participants (34%) feel there should be some type of policy allowing human embryo research (HER). 11% of the females (n=2) and 69% of the males (n=9) believe this. 6% (n=2) of the informants feel there should be a policy disallowing the research, 1 female (5%) and 1 male (8%). 19% (n=6) do not feel there should be any policies regulating HER. 5 females (26%) and 1 male (8%) feel this way. The association between policy and sex is strong ( $\phi=.63$ ) and significant at  $p=.03$ .

The relationships between policy opinion and age ( $v=.53$ ) and policy opinion and marital status ( $v=.44$ ) are both strong and non-significant. Policy opinion and number of children is strongly associated ( $v=.81$ ) and the relationship is significant at  $p=.07$ . Education level and policy is also strongly associated ( $v=.54$ ) but the relationship is not significant. The relationships between policy opinion and religion ( $v=.53$ ), religiosity ( $v=.45$ ), and attendance ( $v=.49$ ) are all strongly associated and all but the relationship between policy and religiosity are significant (religion  $p=.02$ , attendance  $p=.06$ ).

Opinions concerning policy formation surrounding human embryo research vary widely. At one extreme, one informant feels that:

there should be no policy related to research. If application of the discoveries becomes controversial then consideration of policies must be made.

In the middle is the feeling that "some control is needed, i.e. notification procedure, approval of the nature of the experiment, ethical review, et cetera." Several informants feel that a policy should be put into place. For example, one study participant voices:

embryo research should only be permitted, first where the mother consents, (legislated), secondly, there has to be safeguards against having a business that exploits poor women whereby they get pregnant to provide embryos for research, (presumably for gain). Further, there ought to be a limit on the age of the fetus and perhaps restricted to fetuses aborted in the ordinary course of events.

One other informant feels that a policy is necessary to establish "rules regarding the disposal of unused embryos".

#### 5.3.4 Table 2D

Overall, 34% (n=11) of the informants believe funding for HER should come from both public and private sources. 32% of the females (n=6) and 39% of the males (n=5) feel this way. 7 (22%) of the participants (3 females, 16% and 4 males, 31%) feel funding should come from public sources while 3 (9%) of the participants (1 female, 5% and 2 males, 15%) feel funding should come from private sources. The relationship between funding and sex is strong ( $\phi=.42$ ) but not significant.

The associations between funding and age ( $v=.49$ ), between funding and marital status ( $v=.39$ ), and between funding and number of children ( $v=.44$ ) are all non-significant. Informant's level of education and funding opinions are strongly associated ( $v=.61$ ) and the relationship is significant at  $p=.03$ . None of the relationships between funding and religion ( $v=.37$ ), funding and religiosity ( $v=.44$ ), or funding and attendance ( $v=.44$ ) are significant.

### 5.3.5 Acceptance and restrictions

13% (n=4) of the informants (3 females, 16% and 1 male, 8%) do not feel it is acceptable to use any human embryos for research. The association between this response and sex is weak ( $\phi=.12$ ) and non-significant. 31% (n=10) feel that it is acceptable to use embryos that are specifically created in the lab for research. 5 females (26%) and 5 males (39%) believe this. The association between this response and sex is also weak ( $\phi=.13$ ) and non-significant. 12 of the informants (38%) feel it is acceptable to use embryos that are left over from IVF procedures for research. 37% (n=7) of the females and 39% (n=5) of the males believe this. This relationship is almost non-existent ( $\phi=.02$ ) and not significant. 28% of the study participants (n=9) feel that any human embryos are acceptable for research use. 3 females (16%) and 6 males (46%) responded this way. This relationship is moderate ( $\phi=.33$ ) and significant at  $p=.06$ .

Many informants agree that "strict ethical limits based on potential gain in the research project", are needed. But, as one informant points out, it is difficult to agree about who decides what the limits should be and what is in "the best interests of [humankind]". One study participant suggests that the technique should be reserved "for the benefit or treatment of human disease, not for creating 'super' humans". Another adds that the procedure "should be monitored carefully to ensure Orwellian scenerios do not develop". Following this, are the opinions of those who suggest restrictions against "cross-species fertilization", "implantation into animals", and "research for profit".

Another common restriction on human embryo research suggested by the informants is exemplified by this participant's comment:

I am truly uncomfortable about the notion of whether or not the embryo can feel pain and think there has to be a time limit for research/destruction of embryos.

Others suggest "it [HER] should not be done after eight weeks regardless" or "no research after the first trimester".

The most common feeling among these informants seems to be that human embryo research should "not be directed to purposes that are harmful to the human race", and should be pursued:

where the research can provide information that would benefit [humankind] and could not be found using other techniques.

When those participants who believe embryo research is acceptable were asked when they feel embryos should be destroyed, answers varied considerably. Responses ranged from "when it [the embryo] is no longer potentially useful" or "when certified research is terminated" to "two or three weeks-- we need a period short enough that there is no question of viability" or "before any size where all the parts are definable." A few informants feel they "cannot answer as this question requires a committee decision in relation to the purpose of the research" but also "feel there is a point beyond which embryos ought to be destroyed" and we "just don't have the required scientific knowledge to properly answer." Some adhere to time limits consistent with current definitions of when embryos become feti (6-8 weeks) or time limits set by authorities: "14 days [should be the limit] as a number of government committees have recommended this as a limit."

Another informant, drawing upon precedent notes:

up to 8 weeks gestation [is fine] considering that in the late 1970's a decision was made through the courts that a "brain dead" human being could come off life support. There are criteria used to describe "brain death." It is reasonable then, to deal with an embryo the same way--until the brain records brain wave activity, research could be carried out.

Finally, one participant stated that:

thirty days [is a good limit] because it is possible to observe a number of early processes and therefore learn the normal functions for human beings...but clearly [this is] not enough time to get into an extended support system.

## **5.4    DONATION**

### **5.4.1    Table 3A**

Overall, 59% (n=19) of the informants have heard of donation. 47% of the females (n=9) and 77% of the males (n=10) were familiar with this technology. The relationship between knowledge of donation and sex was weak ( $\phi=.30$ ) but significant ( $p=.10$ ).

The association between knowledge and age is strong ( $v=.42$ ) and not significant. The association between knowledge and marital status is moderate ( $v=.36$ ) and not significant. The association between knowledge and number of children is also moderate ( $v=.31$ ) and also not significant. The association between knowledge and education level, however, is strong ( $v=.70$ ) and is significant at  $p=.05$ . The relationships between knowledge and religion ( $v=.28$ ), knowledge and religiosity ( $v=.56$ ), and knowledge and attendance ( $v=.70$ ) range from weak to strong but only the relationship between knowledge and religiosity is significant ( $p=.03$ ).

### **5.4.2    Table 3B**

31% of the informants (n=10) believe that donation can be both beneficial and detrimental. 4 females (21%) and 6 males (46%) feel this way. Of the 25% (n=8) who feel it is only beneficial, 4 are female (21%) and 4 are male (31%). Only 3% (n=1 female) see this technology as detrimental. The association between the rating of donation and sex is moderate ( $\phi=.37$ ) but not significant.

The relationships between rating and age ( $v=.59$ ,  $p=.07$ ), rating and marital status ( $v=.57$ ,  $p=.001$ ), rating and number of children ( $v=.60$ ,  $p=.004$ ), and rating and education level ( $v=.63$ ,  $p=.02$ ) are all strong and all significant. The association between rating and religion is weak ( $v=.28$ ), between rating and religiosity is moderate ( $v=.39$ ), and between rating and attendance is weak ( $v=.30$ ) and none are statistically significant.

A number of informants voiced concerns regarding donation. As one study participant feels:

a central registry is badly needed so that donors have to update information about themselves so we know how many half-brothers and sisters our children have. Also, the public needs to know what standards the doctor is working to.

Following from this, a common concern was the "risk of unconscious incest".

#### 5.4.3 Table 3C

13 of the informants (41%) feel there should be a policy allowing donation (3 females, 16% and 10 males, 77%). Only 1 informant (3%), a female (5%), feels there should be a policy disallowing donation. 9% of the sample ( $n=3$ ) feel that there should not be a policy at all. All 3 of these informants are female (16%). The association between policy opinion and sex is strong ( $\phi=.63$ ) and significant ( $p=.01$ ).

The relationships between policy and age ( $v=.62$ ), policy and marital status ( $v=.82$ ), policy and number of children ( $v=.52$ ), and policy and level of education ( $v=.57$ ) are all strong and all but the relationship between policy and education are significant (age,  $p=.03$ ; marital status,  $p=.004$ ; number of children,  $p=.08$ ). Policy opinion and religion are strongly associated ( $v=.62$ ) and the relationship is

significant at  $p=.000$ . Policy and religiosity ( $v=.40$ ) are associated strongly and policy and attendance ( $v=.39$ ) are associated moderately, however, neither relationship is significant.

Many informants feel the need for policy regarding donation. Reasons stated for formation of policy include, "maintaining documented medical history of donor", "[definition of] the rights of children to know about biological fathers" and "[ensuring] physicians are adhering to certain standards". The overwhelming concern seemed to be the need for policy in order to "clarify all parties rights". As one informant states:

it is frightening that all these decisions that involve human life have previously been left in the hands of physicians practicing it.

#### 5.4.4 Table 3D

34% of the informants feel that funding should come from both public and private sources ( $n=11$ ). 5 females (26%) and 6 males (46%) responded this way. 5 informants (16%) believe that funding for donation should come solely from the public sphere (3 females, 16% and 2 males, 15%), while 3 informants (9%) feel the funding should come solely from the private sphere (3 males, 23%). The relationship between funding opinion and sex is strong ( $\phi=.58$ ) and significant ( $p=.06$ ).

Funding and age are strongly associated ( $v=.55$ ) but the relationship is not significant. Likewise, the relationship between funding and marital status is strong ( $v=.60$ ) however this relationship is significant at  $p=.001$ . Both the relationships between funding and number of children ( $v=.56$ ) and funding and level of education ( $v=.59$ ) are strong and significant ( $p=.01$  and  $p=.05$  respectively). None of the

relationships between funding and religion ( $v=.42$ ), funding and religiosity ( $v=.36$ ), and funding and church attendance ( $v=.35$ ) are statistically significant.

#### 5.4.5 Table 3E

12 (38%) of the informants believe that access to donation should be restricted. 37% ( $n=7$ ) of the females and 39% ( $n=5$ ) of the males feel this way. 22% of the sample ( $n=7$ ) feel there should be free access (2 females, 11% and 5 males, 39%) support free access. No one feels there should be no access to this technology. The relationship between access to donation and sex is moderate ( $\phi=.39$ ) but not significant.

The relationships between access and age ( $v=.42$ ), access and marital status ( $v=.42$ ), and access and number of children ( $v=.52$ ) are all strong but non-significant. However, the relationship between access and education level ( $v=.59$ ) is strong and is significant at  $p=.09$ . Access and religion are strongly associated ( $v=.42$ ), access and religiosity are highly associated ( $v=.41$ ), and access and attendance are moderately associated ( $v=.35$ ). None of these relationships are statistically significant.

#### 5.4.6 Acceptance and restrictions

56% of the sample feels that embryo donation is acceptable ( $n=18$ ). Of these informants, 8 are female (42%) and 10 are male (77%). 16% ( $n=5$ ) of the informants do not feel embryo donation is acceptable (5 females, 26%). 1 participant (3%) feels ambivalent regarding this practice (1 male, 8%). The relationship between the acceptability of embryo donation and sex is strong ( $v=.48$ ) and significant at  $p=.06$ .

When asked to elaborate on opinions regarding embryo donation, one informant noted that:

just as couples choose to provide children for adoption, they should also be allowed to give the gift of an embryo. It increases the number of children and is thus good for society.

Some participants feel "informed donors should be able to donate" if that is their wish. Conversely, another informant states that "bearing children should not be an inalienable right" and therefore there is "no need for donation". A few participants express concern that "the interests and rights of the resulting children must come first with the parents a close second. The doctors and donors should be last. Right now doctors and donors come first."

19 of the informants (59%) feel that the donation of gametes is acceptable (9 females, 47% and 10 males, 77%). Only 1 (3%) participant feels this practice is unacceptable (1 female, 5%). the relationship between the acceptability of gamete donation and sex is moderate ( $v=.31$ ) and not significant. Only 19% ( $n=6$ ) of the informants differentiate between the act of sperm donation and the act of ova donation while 53% ( $n=17$ ) do not. Of those who differentiate, 4 are female (21%) and 2 are male (15%) and of those who do not differentiate, 8 are female (42%) and 9 are male (69%).

Those who did not differentiate between the acts of ova donation and sperm donation, seemingly contradict themselves by conceding that "the techniques for retrieval are different", that "it is more difficult for a woman to donate an egg", and that "the donation of eggs requires more of the donor and therefore carries a 'slight' risk". One informant stated that "the only difference between the techniques is "the risk to the female donor of the harvesting technique." Another of

these informants believes "neither are threatening to the donor" and another believes that "morally and ethically there is no difference." Those who did differentiate between the donation acts mainly differentiated on the same basis as those who stated they did not differentiate. These informants noted the "intrusive aspects of ova donation". Responses highlighted the fact that "sperm donation can be achieved by non-intrusive methods" and "sperm is easy to obtain with no risk or harm—ejaculating sperm is very different emotionally and regarding ease of access from the intrusive type of surgery that is required for ova harvesting." One participant cautions that this more intrusive aspect of ova donation "may entail greater concern for informed consent [in order] to ensure commercial incentives are not abused". Further, "sperm donation is not invasive and does not cost the health care system anything". Finally, one informant wisely notes that:

sperm is always donated by design—when a woman donates ova, questions are immediately raised by virtue of design, if nothing else. She is designed to develop her own baby and begin to experience the bonding so important to motherhood.

Several informants feel restrictions regarding donation should include "limits on the number of resulting pregnancies from one donor", "a legal obligation of donors to update medical information to a central registry for the benefit of the children", and "clear legal and social policies and guidelines for the doctor to work to". Other study participants suggest that "donors should be screened for genetic defects, HIV, hepatitis and have a full medical history recorded."

## **5.5 CRYOPRESERVATION**

### **5.5.1 Table 4A**

Overall, 72% of the informants have heard of cryopreservation (n=23). 63% (n=12) females and 85% (n=11) males are familiar with this technique. The association between familiarity with cryopreservation and sex is weak ( $\phi=.23$ ) and non-significant.

The association between knowledge and age is moderate ( $v=.38$ ), the association between knowledge and marital status is weak ( $v=.26$ ), the association between knowledge and number of children is weak ( $v=.21$ ), and the association between knowledge and level of education is strong ( $v=.55$ ). None of these relationships are significant. Likewise, the relationships between knowledge and religion ( $v=.33$ ), knowledge and religiosity ( $v=.35$ ), and knowledge and attendance ( $v=.46$ ) are not significant.

### **5.5.2 Table 4B**

38% (n=12) of the sample think that cryopreservation can be both a beneficial and a detrimental technique. Of the females in the study, 8 (42%) feel this way and of the males in the study, 4 (31%) concur. No one feels the technology can only be detrimental but 31% (n=10) feel it can only be beneficial. 3 of these informants are female (16%) and 7 are male (54%). The association between the rating of cryopreservation and sex is strong ( $\phi=.45$ ) and is significant at  $p=.09$ .

The associations between rating and age ( $v=.56$ ), rating and marital status ( $v=.41$ ), rating and number of children ( $v=.44$ ), and rating and education level ( $v=.72$ ) are all strong but only the relationship between rating and education is sig-

nificant ( $p=.002$ ). None of the associations, rating and religion ( $v=.38$ ), rating and religiosity ( $v=.35$ ), or rating and attendance ( $v=.38$ ), are significant.

A number of informants feel that cryopreservation is beneficial as it "minimizes the AIDS risk of donated gametes" and can "maximize the population size by regional exchange for donated gametes". However, the technology is seen by some informants as being detrimental as it "makes commodities of embryos", and "fresh specimens offer more success than frozen ones".

### 5.5.3 Table 4C

44% of the participants think there should be a policy allowing cryopreservation ( $n=14$ ). 5 of these are females (26%) and 9 are males (69%). 6 (19%) informants feel there should not be any policies created regarding cryopreservation (4 females, 21% and 2 males, 15%). 1 (3%) female informant (5%) feels there should be a policy disallowing cryopreservation. The relationship between policy opinion and sex is strong ( $\phi=.45$ ) but not significant.

Policy and age ( $v=.63$ ,  $p=.02$ ), policy and marital status ( $v=.46$ ,  $p=.05$ ), policy and number of children ( $v=.53$ ,  $p=.05$ ), policy and education level ( $v=.59$ ,  $p=.07$ ), and policy and religion ( $v=.65$ ,  $p=.000$ ) are all strongly associated and the relationships are between religiosity and policy is moderate ( $v=.34$ ) and not significant. The association between policy and church attendance is strong ( $v=.40$ ) and also not significant.

Concerns regarding policy were common, but varied. As one informant states, "a policy is needed to limit activity to research purposes". Several informants, on the other hand, feel that policy is required to answer questions of "who 'owns' the gametes? and what happens in the case of marriage breakup and so forth?"

#### 5.5.4 Table 4D

11 of the 32 informants (34%) believe that funding should come from both public and private sources. 6 (32%) of these participants are females and 5 (39%) are males. 25% (n=8) feel the funding for cryopreservation should come only from private sources (3 females, 16% and 5 males, 39%) while 9% (n=3) feel the funding should come only from public sources (1 female, 5% and 2 males, 15%). The association between policy opinion and sex is strong ( $\phi=.47$ ) but not significant.

The relationship between policy and age is strong ( $v=.50$ ) and also not significant. However, the relationship between policy and marital status is both strong ( $v=.52$ ) and significant ( $p=.03$ ). Policy and number of children ( $v=.46$ ) and policy and level of education ( $v=.56$ ) both show strong associations but neither are significant. Religion and policy ( $v=.41$ ), religiosity and policy ( $v=.41$ ), and attendance and policy ( $v=.41$ ) are all strongly associated but none are significant.

Equal numbers of informants feel access to cryopreservation should be restricted or free (n=10 or 32% in each case). However, 32% of the females (n=6) and 31% of the males (n=4) feel access should be free while 16% of the females (n=3) and 54% of the males (n=7) feel access should be restricted. 2 participants (6%) feel there should be no access whatsoever to this technology (2 females, 11%). The association between access to cryopreservation and sex is strong ( $\phi=.46$ ) but not significant.

All the relationships, access and age ( $v=.47$ ), access and marital status ( $v=.45$ ), access and number of children ( $v=.48$ ), and access and level of education ( $v=.53$ ), are strongly associated but not significant. Religion and access are moderately

associated ( $v=.36$ ) and the relationship is not significant. Religiosity and access are also moderately associated ( $v=.38$ ) and not significant. Finally, attendance at church services and access are strongly associated ( $v=.42$ ) but again, the relationship is not significant.

The need for restricted access to cryopreservation was voiced by one informant, who states the technology should be "limited to authorized researchers".

### 5.5.5 Acceptance and restrictions

3% of the sample (1 female, 5%) feel that cryopreservation is unacceptable in all cases. The relationship between unacceptability and sex is weak ( $\phi=.15$ ) and non-significant. 50% of the participants ( $n=16$ ) feel cryopreservation is acceptable when a person must undergo chemotherapy (7 females, 37% and 9 males, 69%). This relationship is a moderate one ( $\phi=.32$ ) and is significant at  $p=.07$ ). 44% (14) of the sample feel that this technology is acceptable when a person must work near chemical or radiation hazards. 5 females (26%) and 9 males (69%) feel this way. This relationship is strong ( $\phi=.42$ ) and significant ( $p=.02$ ). When combined with sterilization for birth control purposes, only 19% ( $n=6$ ) (1 female, 5% and 5 males, 39%) feel cryopreservation is acceptable. As with the previous relationship, this relationship is strong ( $\phi=.42$ ) and significant at  $p=.02$ . 19% ( $n=6$ ) of the sample also feels that cryopreservation is acceptable whenever a person desires to use the technique. 3 of these informants are female (16%) and 3 are male (23%). This relationship is weak ( $\phi=.09$ ) and non-significant. 13% of the informants feel cryopreservation is acceptable in any case ( $n=4$ ). This includes 1 female (5%) and 3 males (23%). The relationship between acceptability in any case and sex is also weak ( $\phi=.26$ ) and non-significant.

There is agreement among several of the informants that cryopreservation "must be done with full consent and provisions [must be established] for disposal of the gametes not used". Another common restriction suggested by informants is "the destruction of materials on the death of donor or at the dissolution of partnership, (assuming cryopreservation for personal use not donation)".

Still other informants state that restrictions are necessary to ensure quality control, to avoid the "potential for gamete deterioration", and to "assure no unauthorized use of materials" or "abuse by commercial enterprises".

## **5.6 ALTERNATIVE INSEMINATION**

### **5.6.1 Table 5A**

Nearly all the informants, 97%, (n=31) are familiar with alternative insemination. 18 (95%) of the females and 13 (100%) of the males have heard of the technique and the association between knowledge and sex is weak ( $\phi=.15$ ) and not significant.

The association between knowledge and age is also weak ( $v=.29$ ) and also not significant. However, the associations between knowledge and marital status ( $v=.70$ ) and between knowledge and number of children ( $v=.70$ ) are both strong and significant at  $p=.004$  and  $p=.02$  respectively. Knowledge and education level are likewise strongly associated ( $v=.56$ ) but the relationship is not significant. Religion and knowledge are strongly associated ( $v=.48$ ) but the relationship is not significant and religiosity and knowledge are moderately associated ( $v=.31$ ) and this relationship is not significant either. Interestingly, attendance and knowledge are strongly associated ( $v=.86$ ) and the relationship is significant ( $p=.04$ ).

### 5.6.2 Table 5B

One-half (n=16) of the informants feel that alternative insemination (AI) is a beneficial technique. This includes 9 females (47%) and 7 males (47%). No informants feel the technique can be detrimental, however, a further 15 (47%) of the participants feel AI can be both beneficial and detrimental. 10 of the females (53%) and 5 of the males (39%) feel this way. The relationship between the rating of AI and sex is weak ( $\phi=.24$ ) and non-significant.

Regarding the associations between rating and age ( $v=.76$ ,  $p=.002$ ), rating and marital status ( $v=.54$ ,  $p=.02$ ), rating and number of children ( $v=.53$ ), and rating and education level ( $v=.92$ ,  $p=.000$ ), all are strong associations and all but the relationship between rating and number of children are significant. Rating and religion are strongly associated ( $v=.44$ ) but not significant. Rating and religiosity are moderately associated ( $v=.39$ ) and also not significant. Attendance and rating, however, are strongly associated ( $v=.51$ ) and the relationship is significant at  $p=.04$ .

Many informants voiced concerns regarding alternative insemination. Several stated the possibility of it being a detrimental technology without "careful counselling for donors and couples", without "access to medical information", and without the emotional and social issues surrounding alternative insemination being addressed. Further, a number of informants feel that "it should be possible for offspring to eventually locate their biological fathers". Finally, one study participant pointed out what s/he thinks to be a beneficial aspect of alternative insemination, namely, "[the technology] empowers women and enables lesbian women to have families".

### 5.6.3 Table 5C

Overall, 72% of the informants (n=23) feel there should be a policy allowing AI (11 females, 58% and 12 males, 92%). 16% (n=5) of the participants (5 females, 26%) believe there should not be any policies regulating AI and only 1 informant (3%) feels there should be a policy disallowing AI (1 female, 5%). The relationship between policy opinion and sex is strong ( $\phi=.41$ ) but non-significant.

Policy opinion regarding AI and age are strongly associated ( $v=.74$ ,  $p=.001$ ) and the relationship is significant, regarding policy opinion and marital status are strongly associated ( $v=.47$ ,  $p=.05$ ) and the relationship is significant, regarding policy opinion and number of children are strongly associated ( $v=.52$ ,  $p=.09$ ) and the relationship is significant and regarding policy opinion and education level are strongly associated ( $v=.54$ ) but the relationship is not significant. Religion and policy are also strongly associated ( $v=.68$ ), religiosity and policy, strongly associated ( $v=.40$ ), and attendance and policy, moderately associated ( $v=.36$ ). Only the relationship between religion and policy is significant, though, at  $p=.000$ .

A number of informants feel that policy regarding alternative insemination is needed in order to allow for "access to information", both information regarding donors and their medical histories, and information concerning the identities of parents for children. Further, as one informant states:

the public has a right to know how the practice of alternative insemination operates in this province.

A policy would also lay out the "legal implications surrounding paternity suits, inheritance, et cetera" and, as one study participant puts it, policy would set "guidelines to ensure the dignity and respect of all participants".

#### 5.6.4 Table 5D

14 of the sample (44%) feel that funding for AI should come from both public and private sources. This number includes 8 females (42%) and 6 males (46%). 13 of the informants (41%) believe that the funding should come only from public sources (8 females, 42% and 5 males, 39%). Only 3 of the participants (9%) feel funding for AI should come from private sources. 1 who feels this way is female (5%) and 2 are male (15%). The association between funding opinion and sex is weak ( $\phi=.27$ ) and the relationship is not significant.

The relationship between funding of AI and age is strong ( $v=.48$ ) and non-significant, between funding and marital status is strong ( $v=.43$ ) and non-significant, between funding and number of children is strong ( $v=.47$ ) and non-significant, and between funding and education level is strong ( $v=.62$ ) and is significant at  $p=.04$ . Funding and religious orientation are moderately associated ( $v=.35$ ) but the relationship is not significant. Religiosity and attendance are also both moderately associated with funding ( $v=.39$  and  $v=.37$  respectively) but neither relationship is statistically significant.

#### 5.6.5 Table 5E

50% of the sample ( $n=16$ ) think there should be free access to AI. 47% of the females ( $n=9$ ) and 54% of the males ( $n=7$ ) feel this way. Almost as many ( $n=13$ , 41%) think there should be restricted access to AI. Of these informants, 8 are female (42%) and 5 are male (39%). Only 3% ( $n=1$ ) feels there should be no access to AI at all (1 female, 5%). The relationship between access to AI and sex is weak ( $\phi=.16$ ) and non-significant.

Access and age are strongly associated ( $v=.60$ ) and the relationship is significant ( $p=.07$ ). The association between access and marital status is strong also ( $v=.52$ ) and significant at  $p=.01$ ). Likewise, the relationship between access to AI and number of children is strong ( $v=.56$ ) and significant ( $p=.04$ ). Level of education and access are strongly associated as well ( $v=.54$ ) but the relationship is not significant. Neither the relationships between access and religion ( $v=.33$ ), access and religiosity ( $v=.34$ ), nor access and attendance ( $v=.36$ ) are significant.

Comments regarding access to alternative insemination ranged from restricted access for varying reasons to no restrictions to access. Several informants feel that there should be restricted access based on medical histories. One study participant feels the technology should be "restricted as to the donor - heterosexual males only should be able to donate...[and I am] still undecided as to whether gay women should be offered this technique". On the other hand, as one informant states:

no individual or group has the right to control the choices a woman can make with her body, her life!! Any kind of restricted access leads to a potential for discriminatory practices...who will establish guidelines and for what reasons? In other words, who really is capable or has the right to make these kinds of decisions? The government does not make these kind of decisions for women choosing to have children via natural means - why should it interfere for alternative insemination?

Finally, one informant apologized, saying "my views seem rigid, even to me, but I am concerned for the rights of children...the desire of adults to be parents is of secondary importance to me."

### 5.6.6 Acceptance and restrictions

Only 3% (n=1) of the sample feel that AI is an unacceptable technique (1 male, 8%). The relationship between unacceptability and sex is weak ( $\phi=.22$ ) and non-significant. Over one-half (53%, n=17) feel that AI is acceptable only when a medical doctor certifies infertility. Of these informants, 8 are female (42%) and 7 are male (54%). This relationship is weak ( $\phi=.12$ ) and not significant. 19% of the sample feel that AI is acceptable whenever a person desires to use the technique regardless of a doctor's opinion (n=6). 4 of these informants are female (21%) and 2 are male (15%). This relationship is weak ( $\phi=.07$ ) and non-significant. Finally, 28% of the participants (n=9) believe that AI is always acceptable (6 females, 32% and 3 males, 23%). The relationship between unconditional acceptance and sex is also weak and also not significant.

Several informants agree that restrictions involved with AI should include "medical screening of donor", "confidentiality" "no payment to donors", and a "limit to the number of times a donor can donate". Other study participants feel the technique should be restricted within "donor compatibility regarding religion and race and so on", and within the marriage bond. However, one informant points out:

while I don't think it is prudent for single women to participate in AI, it is probably a better practice than deliberately becoming pregnant knowing you choose not to live with the father.

A number of informants feel that the use of AI should be restricted to heterosexual couples. As one study participant points out, "I do not believe homosexual couples (lesbian) should have this technology available as I have heard it 'demanded'". Another informant voices, " I would feel uncomfortable inseminating 'sepa-

ratist' lesbian couples, (i.e.: those who dislike male children)". Finally, one informant stated that s/he has "concerns about the AI practice being strictly in the hands of doctors" and feels that "other health professionals (i.e.: women's health clinics) could be involved." Another participant echoed this saying "I feel doctors have too much power, the children produced are not being considered properly and I do not wish to see too much government interference."

## 5.7    PARTHENOGENESIS

### **5.7.1**    **Table 6A**

Overall, 38% of the informants (n=12) have heard of parthenogenesis. 5 of these are females (26%) and 7 are males (54%). The association between knowledge of parthenogenesis and sex is weak ( $\phi=.28$ ) and not significant.

The relationship between age and knowledge is strong ( $v=.42$ ) but not significant either. The relationship between marital status and knowledge, however, is strong ( $v=.51$ ) and significant ( $p=.08$ ). Knowledge is moderately associated with number of children ( $v=.37$ ) and strongly associated with level of education ( $v=.58$ ) but neither relationship is significant. Knowledge is moderately associated with religion ( $v=.38$ ) and strongly associated with religiosity ( $v=.40$ ). Neither relationship is statistically significant. Attendance of church services is strongly associated with knowledge ( $v=.59$ ) and the relationship is significant at  $p=.02$ .

### 5.7.2 Table 6B

7 of the informants (22%) believe that parthenogenesis would be a detrimental technology. 11% of the females (n=2) and 39% of the males (n=5) feel this way. 1 participant (3%) feels this technology could be both beneficial and detrimental (1 female, 5%) while no one feels parthenogenesis could be beneficial overall. The relationship between the rating of parthenogenesis and sex is moderate ( $\phi=.35$ ) but not significant.

The associations between rating and age ( $v=.58$ ) and rating and education level ( $v=.56$ ) are both strong and non-significant. The associations between rating and marital status ( $v=.36$ ) and rating and number of children ( $v=.31$ ) are moderate but not significant either.

Several informants voiced concerns about the possible detrimental effects of parthenogenesis. As one informant puts it, "[it] is (except at a basic scientific level), a philosophical denial of our biology". Others feel that it is "a genetically abnormal reproductive technology - it reduces humans to the level of lower life forms", and one informant states that parthenogenesis is "silly, unless the Almighty is involved". Conversely, one study participant, although admitting limited knowledge of the technique, "suspects [that] this could be beneficial for reproductive control outside the traditional power structures of modern patriarchy".

### 5.7.3 Table 6C

19% (n=6) of the study participants feel that policies should disallow parthenogenesis (2 females, 11% and 4 males 31%). 1 informant feels there should be a policy allowing parthenogenesis (1 male, 8%) and 2 informants (6%) feel there should not be any policies regulating it (2 females, 11%). The association between policy opinion and sex is moderate ( $\phi=.30$ ) but the relationship is not significant.

The relationship between policy and age is strong ( $v=.55$ ) but not significant. The relationship between policy and marital status is also strong ( $v=.49$ ) and is significant at  $p=.01$ . Policy opinion and number of children are very weakly associated ( $v=.04$ ) and the relationship is non-significant. Also non-significant, is the relationship between policy and level of education although they are strongly associated ( $v=.56$ ). Religion and policy opinion are strongly associated ( $v=.48$ ) and the relationship is significant at  $p=.02$ . While religiosity and attendance are both strongly associated with policy (both  $v=.40$ ), neither relationship is significant.

Following from the opinion of some informants that policies should disallow parthenogenesis, one study participant states that an "extension of the technique to the level of a viable fetus should not be permitted".

### 5.7.4 Table 6D

13% (n=4) of the informants feel this technology should not be funded. 1 female (5%) and 3 males (23%) believe this. 2 of the informants (6%) feel that funding for parthenogenesis should come from both public and private sources (2 females, 11%). 1 participant feels funding should be completely from the public sphere (1 male, 8%), while 1 participant feels that funding must come only from

private sources (1 male, 8%). The relationship between funding source opinion and sex is strong ( $\phi=.53$ ) but non-significant.

The relationship between funding and age is strong ( $v=.61$ ) and significant at  $p=.03$ . Marital status and funding are also strongly associated ( $v=.47$ ) and the relationship is significant ( $p=.10$ ). The association between number of children and funding is similarly strong ( $v=.44$ ) but the relationship is non-significant. Funding and education level shows a strong association ( $v=.60$ ) and the relationship is significant at  $p=.04$ . The relationships between funding and religion ( $v=.33$ ) and funding and religiosity ( $v=.38$ ) are moderate and not significant while the relationship between funding and attendance ( $v=.41$ ) is strong and not significant.

#### 5.7.5 Table 6E

Overall, 16% ( $n=5$ ) of the informants feel there should be no access to parthenogenesis. 2 females (11%) and 3 males (23%) support this position. 2 informants (6%) feel there could be restricted access (2 males, 16%) while 1 informant (3%) feels there should be free access (1 female, 5%). The relationship between access to parthenogenesis and sex is strong ( $\phi=.44$ ) but non-significant.

The association between access and age is also strong ( $v=.55$ ) and non-significant. The relationships between access and marital status ( $v=.40$ ), access and number of children ( $v=.44$ ), access and education level ( $v=.52$ ), access and religion ( $v=.38$ ), access and religiosity ( $v=.31$ ), and access and attendance ( $v=.34$ ) are all not significant.

In line with the majority of informants who feel there should not be free access to parthenogenesis, one study participant states that the technology should "be limited severely to research...and not as an alternate to reproduction".

### 5.7.6 Acceptance and Restrictions

Acceptance among informants seems restricted to "basic biological research only" and one informant states that "this [parthenogenesis] is not a practical possibility except for the Almighty."

Although knowledge and understanding of parthenogenesis was not prominent in the sample, a number of informants feel strongly that the technique should "be restricted to research only". Another suggestion is "no 'embryo' development beyond the very earliest stages".

## 5.8 SEX PRESELECTION

### 5.8.1 Table 7A

Most of the informants, 72%, (n=23) have heard of sex preselection. This percentage includes 68% of the females (n=13) and 77% of the males (n=10). The association between knowledge of sex preselection techniques and sex, however, is weak ( $\phi=.09$ ) and the relationship is not significant.

Age and familiarity with these techniques are associated weakly ( $v=.27$ ) and the relationship is not significant either. Familiarity and marital status ( $v=.47$ ), familiarity and number of children ( $v=.45$ ), and familiarity and education level ( $v=.54$ ) are all strongly associated but none of the relationships are significant. Both religion and religiosity are moderately associated with knowledge of sex preselection ( $v=.33$  and  $v=.30$  respectively) and the relationships are non-significant. The only significant relationship is that between knowledge and attendance at religious services ( $v=.56$ ,  $p=.04$ ).

### 5.8.2 Table 7B

38% of the sample (n=12) think sex preselection can be both beneficial and detrimental (8 females, 42% and 4 males, 37%). Another 38% (n=12) feel that sex preselection is detrimental only. This figure includes 6 females (32%) and 6 males (47%). 2 informants (6%) feel that sex preselection techniques are beneficial only (2 males, 16%). The relationship between rating of the technology and sex is strong ( $\phi=.40$ ) but non-significant.

The association between rating of sex preselection and age is moderate ( $v=.38$ ) but, again, not significant as is the relationship between rating and marital status ( $v=.39$ , not significant). Number of children and education level are both strongly associated with rating ( $V=.40$  and  $v=.58$  respectively) but neither relationship is significant. Rating and religion ( $v=.33$ ), rating and religiosity ( $v=.31$ ), and rating and attendance ( $v=.30$ ) are all moderately associated but none of these relationships are significant.

Several informants stated concerns regarding the detrimental effects of sex preselection. Some include, "[it] lowers the value of human life and will result in a 'backlash' against freedom of choice in abortion issues and other rights". Further, "it reinforces already existing gender biases for male preference", and "could be very damaging to both sexes - what would result in some cultures if men outnumber women 2:1?" On the other hand, one informant points out that sex preselection:

would take pressure off certain cultural groups to produce male children at the expense of girls who often become abused as a result. It would certainly help reduce population as many families 'keep going' until they have a child of both sexes.

### 5.8.3 Table 7C

9 of the informants (28%) believe there should be a policy allowing sex preselection. 4 of these are females (21%) and 5 are males (39%). 6 of the study participants (19%) feel a policy disallowing sex preselection is necessary (3 females, 16% and 3 males, 23%). 7 informants (22%) feel there should be no policy regulating these techniques (5 females, 26% and 2 males, 15%). The association between policy opinion and sex is weak ( $\phi=.28$ ) and the relationship is not significant.

The relationships between policy and age ( $v=.46$ ), policy and marital status ( $v=.40$ ), policy and number of children ( $v=.49$ ), and policy and level of education ( $v=.54$ ) are all strong and non-significant. Religion and policy are strongly associated ( $v=.44$ ) as are religiosity and policy ( $v=.45$ ) but neither relationship is significant. Policy and attendance are moderately associated ( $v=.32$ ) and the relationship is, likewise, not significant.

Several of the study participants feel that a policy regulating sex preselection is necessary "to permit strictly controlled use in exceptional circumstances", and to avoid the "potential to lead into genetic engineering". Another informant feels that the technology is "best controlled by the ethics of the professional bodies and the individuals involved, not by the government bodies", while another states it is "medically unethical to participate in this process". Conversely, one informant voices that:

legislation should only be involved if there is an alarming shift in the sex of the population. Otherwise it is the parents' decision.

#### 5.8.4 Table 7D

28% of the informants (n=9) feel that sex preselection should go unfunded (5 females, 26% and 4 males, 31%), while 13% (n=4) believe that funding should come from both public and private sources (2 females, 11% and 2 males, 15%). 22% of the sample feels that sex preselection should be funded publicly (n=7). 4 of these participants are female (21%) and 3 are male (23%). A further 13% of the informants (n=4) believe that these techniques should be funded privately only (1 female, 5% and 3 males, 23%). The relationship between funding opinion and sex is strong ( $\phi=.41$ ) but not significant.

Funding and age are strongly associated ( $v=.47$ ) but this relationship is not significant. The relationship between funding and marital status ( $v=.38$ ) is likewise not significant, nor is the relationship between funding and number of children ( $v=.39$ ). Level of education and funding is strongly associated ( $v=.64$ ) and is significant at  $p=.008$ . None of the relationships, funding and religion ( $v=.44$ ), funding and religiosity ( $v=.40$ ), or funding and attendance ( $v=.36$ ) are statistically significant.

#### 5.8.5 Table 7E

34% (n=11) of the participants feel there should not be any access to sex preselection techniques. 7 of these informants are female (37%) and 4 are male (31%). Equal numbers of informants believe there should be free access (n=7, 22%) or restricted access (n=7, 22%). Of those who feel free access is most acceptable, 1 (5%) is female and 6 (46%) are male. Those who believe access to sex preselection should be restricted include 6 females (32%) and 1 male (8%). The relationship between access to sex preselection techniques and sex is strong ( $\phi=.51$ ) and significant ( $p=.08$ ).

Access and age are also strongly associated ( $v=.49$ ) but the relationship is not significant. The relationship between marital status and access is strong ( $v=.44$ ) and significant at  $p=.08$ . Access and number of children ( $v=.52$ ) are strongly associated as well and the relationship is significant ( $p=.08$ ), while access and education level are strongly associated ( $v=.53$ ) but the relationship is non-significant. All the relationships, access and religion ( $v=.33$ ), access and religiosity ( $v=.36$ ), and access and attendance ( $v=.34$ ) are moderate and non-significant.

A large number of informants agree that sex preselection should be allowed only to prevent sex linked disorders - not for sex preference. As one informant puts it, there should be "restricted access for those seeking to use this technique for purely social reasons".

#### **5.8.6 Acceptance and restrictions**

31% of the informants indicate that sex preselection is an unacceptable practice in all cases ( $n=10$ ). 6 of these participants are female (32%) and 4 are male (31%). The relationship between feelings of unacceptability and sex is weak ( $\phi=.01$ ) and not significant. 3 informants (9%) feel that these techniques are acceptable if one desires a child on the basis of expected gender characteristics (1 female, 5% and 2 males, 15%). The relationship between this response and sex is weak ( $\phi=.17$ ) and not significant. Over one-half the sample ( $n=17$ , 53%) feel that the use of sex preselection techniques is justified when hereditary sex-linked diseases are likely to be present. 10 females (53%) and 7 males (54%) believe this. The relationship between this response and sex is also weak ( $\phi=.01$ ) and non-significant. 13% ( $n=4$ ) think that sex preselection is acceptable when a certain sex child is desired (2 females, 11% and 2 males, 16%). The relationship between

this response and sex is, again, weak ( $\phi=.07$ ) and not significant. Finally, 9% ( $n=3$ ) feel that sex preselection is acceptable for use in any case. 0 females feel this way but 3 males do (23%). The relationship between unconditional use of sex preselection techniques and sex is moderate ( $\phi=.39$ ) and significant at  $p=.03$ .

When asked what restrictions should apply to the practice of sex preselection, informants' responses varied widely from restricting it completely, that is making it "illegal", to allowing it "only for hereditary sex-linked diseases", to allowing it, but "if concern is for preference, it should be done on a user-pay basis". Still another informant suggested the technique be used "only in the event there is an alarming imbalance in the sex ratio of the population". Finally, several informants echoed the concern of one participant who stated "I suspect that this practice will do nothing but add to increased oppression of women."

## 5.9 CONTRACT MOTHERHOOD

### 5.9.1 Table 8A

Nearly all the informants in the study ( $n=29$ , 91%) have heard of contract motherhood. 16 of the females (84%) and 13 of the males (100%) are familiar with this practice. The relationship between knowledge and sex is weak ( $\phi=.27$ ) and not significant.

Knowledge and age are moderately associated ( $v=.39$ ), knowledge and marital status are strongly associated ( $v=.48$ ), knowledge and number of children are strongly associated ( $v=.51$ ), and knowledge and education are strongly associated ( $v=.41$ ). None of these relationships reached statistical significance. The relationships between religious orientation and knowledge ( $v=.33$ ), religiosity and

knowledge ( $v=.37$ ), and attendance and knowledge ( $v=.34$ ) are all moderate and non-significant.

### 5.9.2 Table 8B

59% of the informants ( $n=19$ ) feel that contract motherhood can be both beneficial and detrimental (11 females, 58% and 8 males, 62%). While 25% ( $n=8$ ) feel surrogacy is detrimental only (5 females, 26% and 3 males, 23%), just 6% ( $n=2$ ) feel it is beneficial only (1 female, 5% and 1 male, 8%). The association between rating of contract motherhood and sex is moderate ( $\phi=.30$ ) but the relationship is not significant.

The relationship between rating and age is strong ( $v=.48$ ) and non-significant. Rating and marital status are associated moderately ( $v=.35$ ) and this relationship is not significant. The relationships between rating and number of children ( $v=.43$ ) and rating and education level ( $v=.48$ ), while strong, are also not significant. Religion, religiosity, and attendance are all moderately associated with rating (all  $v=.33$ ) and none of the relationships are significant.

A number of informants are concerned about the effect of this technique on the contract mother. For example, one informant feels that contract motherhood, "if abused, could demean women to [the category of] 'rented uteruses' for women who choose not to go through pregnancy". Another study participant echoes a common feeling, namely that contract motherhood is:

unacceptable as it uses women as "vessels" and would be used by poor women for monetary contract. Women are not in a position to choose autonomously— re.: 'motherhood for sale'.

Other reasons for believing this could be a detrimental technology include the fact that it "denies bonding between the biological mother and the child", it "lacks

confidentiality and anonymity of a regular adoption process", and there is a possibility of "emotional trauma for the contracting parents if the surrogate changes her mind". One final concern was stated by a study participant who wonders if the result is a:

congenital/handicapped child and the prospective parents don't want it, who then assumes financial responsibility? the government? the tax payers?

### 5.9.3 Table 8C

Overall, 44% of the participants (n=14) feel there should be a policy in place allowing contract motherhood. 6 females (32%) and 8 males (62%) feel this way. 28% (n=9) believe there should be a policy disallowing the practice (5 females, 26% and 4 males, 31%). 9% (n=3) of the participants feel there should not be a policy regulating contract motherhood at all. All 3 of these informants are females (16%). The association between policy opinion and sex is strong ( $\phi=.45$ ) but the relationship is not significant.

Age is also strongly associated with policy opinion ( $v=.54$ ) but the relationship is not statistically significant. The relationships between policy and marital status ( $v=.52$ ,  $p=.03$ ) and between policy and number of children ( $v=.51$ ,  $p=.08$ ) are strong and significant. The informant's level of education is only weakly associated with policy opinion ( $v=.13$ ) and the relationship is not significant. Policy and religion ( $v=.41$ ), policy and religiosity ( $v=.42$ ), and policy and attendance ( $v=.44$ ) are all strongly associated but none of the relationships are significant.

Several of the informants feel that a policy should be put into place regarding contract motherhood, but their reasons differ. For example, one informant feels that "laws [are] needed to make such contracts clearly unenforceable there-

by discouraging this practice". On the other hand, one study participant feels that there should be "legislation to allow it and to allow the moms to be paid", while another states it "should have controls much like that of adoption". Still others feel that a policy should "remove the commercial motivation" of contract motherhood.

Other informants feel that a policy is not necessary in reference to contract motherhood. As one study participant puts it, the technology is "best controlled by the professionals involved and the law - a government policy is not necessary".

Finally, one informant states:

[contract motherhood is] a private matter between individuals if they want to hire a surrogate to avoid the inconvenience of pregnancy.

#### 5.9.4 Table 8D

12 of the informants (38%) feel funding for contract motherhood should come from only private sources (7 females, 37% and 5 males, 39%) while just 6% (n=2) of the informants feel funding should come only from public sources (1 female, 5% and 1 male, 8%). Another 6% believe that funding should come from both public and private sources (1 female, 5% and 1 male, 8%). A further 34% (n=11) of the participants feel that there should be no funding for contract motherhood at all. This figure includes 5 females (26%) and 6 males (46%). The relationship between funding opinion and sex is moderate and not significant ( $\phi=.37$ ).

None of the following relationships attained statistical significance: funding and age ( $v=.50$ ), funding and marital status ( $v=.39$ ), funding and number of children ( $v=.38$ ), funding and education level ( $v=.45$ ), funding and religion ( $v=.34$ ), funding and religiosity ( $v=.46$ ), or funding and attendance ( $v=.37$ ).

### 5.9.5 Table 8E

38% of the study participants (n=12) feel there should be only restricted access to contract motherhood (8 females, 42% and 4 males, 31%), while 19% (n=6) feel there should be free access (2 females, 11% and 4 males, 31%). 28% of the informants (n=9) believe that there should not be access to this procedure at all (5 females, 26% and 4 males, 31%). The relationship between access opinion and sex is moderate ( $\phi=.33$ ) but non-significant.

The relationship between age and access is strong ( $v=.54$ ) but not significant. The relationships between access and marital status ( $v=.55$ ) and access and number of children ( $v=.60$ ) are likewise, strong and both are significant ( $p=.001$  and  $p=.005$  respectively). Level of education and access are strongly associated ( $v=.56$ ) but the relationship is not significant. Neither religion and access ( $v=.43$ ) nor religiosity and access ( $v=.42$ ) are significant relationships, however, attendance and access ( $v=.45$ ) is a significant relationship at  $p=.02$ .

Following from the majority of informants who feel that there should be restricted access to contract motherhood, one study participant states the process should be "based on the medical history" of the contract mother and the contracting parents.

### 5.9.6 Acceptance and restrictions

28% of the informants (n=9) feel contract motherhood is never acceptable. 6 of these are female (32%) and 3 are male (23%). The relationship between complete unacceptability and sex is weak ( $\phi=.09$ ) and non-significant. 53% of the sample (n=17) feels that contract motherhood is acceptable when a woman cannot conceive or carry a fetus to term (9 females, 47% and 8 males, 62%). The rela-

relationship between this response and sex is weak ( $\phi=.14$ ) and not significant. 9% ( $n=3$ ) of the informants feel that surrogacy is acceptable when a woman does not wish to interrupt her career for pregnancy but wishes to have a child with her genetic inheritance (3 males, 23%). The relationship between this response and sex is moderate ( $\phi=.39$ ) and significant at  $p=.03$ . A further 9% ( $n=3$ ) feel surrogacy is acceptable when a woman wants to be spared the danger or discomfort or pain of childbirth (1 female, 5% and 2 males, 15%). The relationship between this response and sex is weak ( $\phi=.17$ ) and non-significant. 44% of the sample ( $n=14$ ) believes that when an "infertile" couple wants a child with the father's genetic inheritance, contract motherhood is acceptable. 9 of these informants are female (47%) and 6 are male (46%). The association between this response and sex is extremely weak ( $\phi=.01$ ) and the relationship is not significant. Nearly one-half (47%) of the informants ( $n=15$ ) feel that contract motherhood is acceptable when an "infertile" couple wants a child with both parent's genes (8 females, 42% and 7 males, 54%). The association between this response and sex is weak ( $\phi=.12$ ) and the relationship is not significant. 41% of the participants ( $n=13$ ) believe that surrogacy is an acceptable practice when a woman wants to become a "surrogate". 9 females (47%) and 4 males (31%) feel this way. The relationship between this response and sex is weak ( $\phi=.17$ ) and non-significant. No one feels that contract motherhood is always acceptable. One informant feels that it is "up to the individuals involved in contract motherhood to establish their own final arrangements and [that] this may need to be done legally." Several other informants disagree with this attitude, echoing this one informant's warning:

the legal and social implications of a 'fee for service contract' wherein a human life is the commodity and a woman's body is the contractual vessel for delivery opens up a myriad of ethical questions which I feel we, as a society, are not ready to answer.

When asked how they feel about the payment of fees to contract mothers, 28% (n=9) said they feel that it is fair to pay these women for this work (6 females, 32% and 3 males, 23%). The relationship between this response and sex is weak ( $\phi=.09$ ) and not significant. 32% of the informants (n=8) feel payment to contract mothers is unacceptable in all cases (4 females, 21% and 4 males, 31%). Unacceptability and sex are weakly associated as well ( $\phi=.11$ ) and the relationship is non-significant. 9% of the sample (n=3) believe that surrogacy should only be done out of compassion or love and that there should not be a fee involved (1 female, 5% and 2 males, 15%). The relationship between this response and sex is weak ( $\phi=.17$ ) and is not significant. 32% (n=8) think that it is acceptable to pay the contract mother for certain pregnancy-related expenses such as medical bills, maternity clothing, and so on. 4 females (21%) and 4 males (31%) feel this way. The association between this response and sex is again weak ( $\phi=.11$ ) and again the relationship is not statistically significant. Finally, 16% (n=5) feel that the payment of fees to contract mothers "turns surrogacy into baby-selling" (3 females, 16% and 2 males, 15%). The relationship between this response and sex is nil ( $\phi=.01$ ) and non-significant.

Responses regarding the payment of fees to contract mothers are represented at two ends of an attitude spectrum. At one end, informants state that contract motherhood is "not beneficial to attitudes regarding 'women,' 'motherhood,' or 'fatherhood'" and that this "'job' cannot be quantified." Further, "women have always been seen as being valuable commodities as "mothers—often as property and not in their own right (i.e.: single mothers are not so valued). Surrogacy [sic] would promote 'job value as mothers' and so I have to think this [contract motherhood] is

bad." On the other end of the 'payment of fees' spectrum are those that state that "if it [contract motherhood] is to happen, payment would be appropriate and perhaps more honest than 'altruistic' mothering for another couple" and further state that "'[l]ove' is an excuse for not paying a woman for what comes down to hard work!" In this same vein, another informant states that:

women should also be paid for the time lost from work. It is a problem, at least potentially, in freely paying surrogates [sic] in that it could attract women for the wrong reasons and pregnancy is not without risks.

Many informants suggest possible restrictions which should be applied to the practice of contract motherhood. One common feeling is that the contracting should occur only within an "iron-clad contract" to "ensure that the 'transaction' can be concluded without prolonged controversy". A number of informants feel that there must be safeguards to:

ban commercial inducements and to avoid the situation where poor women are forced to sell their wombs to survive financially.

Other study participants feel the need for full physical and mental screening of possible contract mothers, the understanding of the motivation of the parents and "extensive counselling' prior to the pregnancy' of all parties involved".

At the other extreme, one informant states there are:

too many potential conflicting rights and obligations and the potential for abuse, especially of the child, is so great that the practice should be illegal.

Still another study participant echoes the unclear feelings concerning this issue. "It [contract motherhood] really must be studied to know the full impact on all people involved".

## **5.10 ARTIFICIAL WOMB TECHNOLOGY**

### **5.10.1 Table 9A**

31% of the informants (n=10) have heard of artificial womb technology (2 females, 11% and 8 males, 62%). The association between knowledge of this technology and sex is strong ( $\phi=.54$ ) and the relationship is significant at  $p=.002$ .

The relationship between knowledge and age is also strong ( $v=.44$ ) but not significant. The relationship between knowledge and marital status is moderate ( $v=.34$ ) and not significant. Number of children and knowledge ( $v=.45$ ) and level of education and knowledge ( $v=.52$ ) are both strong relationships but neither is significant. Religion is weakly associated with knowledge ( $v=.24$ ), religiosity is moderately associated ( $v=.32$ ), and attendance is strongly associated ( $v=.46$ ). None of these relationships are significant, however.

### **5.10.2 Table 9B**

16% of the informants (n=5) believe artificial womb technology can be both beneficial and detrimental (2 females, 11% and 3 males, 23%) and a further 16% (n=5) feel it can only be beneficial (2 females, 11% and 3 males, 23%). 3% (n=1) feel this technology can only be detrimental (1 male, 8%). The association between the rating of artificial womb technology (AWT) and sex is non-existent ( $\phi=0$ , non-significant).

The association between rating of AWT and age is strong ( $v=.66$ ) and the relationship is significant at  $p=.07$ . Rating and marital status ( $v=.40$ ) and rating and number of children ( $v=.47$ ) are both strong relationships although neither is significant. The relationship between the informant's level of education and rating is

strong ( $v=.70$ ) and statistically significant ( $p=.001$ ). The relationships between religion and rating ( $v=.34$ ) and between religiosity and rating ( $v=.36$ ) are moderate but not significant, however, the relationship between attendance and rating of AWT is both strong ( $v=.43$ ) and significant ( $p=.09$ ).

Comments regarding the rating of AWT varied to both extremes. One informant states, "I believe this technology to be superior to surrogacy [sic]", while another feels that AWT is "dehumanizing, has the potential to be abused and this outweighs the potential benefits". One informant sums up both sides well by stating:

[AWT is] beneficial to premature babies as life sustaining and beneficial to potential mothers who are unable to biologically carry a fetus - but again [this technology] requires society to examine the ethics of women as breeding vessels or as simple contributors to the reproductive process. The flip side of women as tools is, are women to be excluded/manipulated in the birthing process?

### 5.10.3 Table 9C

Overall, 22% of the informants ( $n=7$ ) believe there should be a policy allowing AWT. 1 of these informants is female (5%) and 6 are male (46%). Conversely, 16% ( $n=5$ ) feel there should be no policy regulating AWT. 4 of these informants are female (21%) and 1 is male (8%). The relationship between policy opinion and sex is strong ( $\phi=.49$ ) and significant at  $p=.05$

The relationship between policy opinion and age is also strong ( $v=.49$ ) but non-significant. The relationship between marital status and policy, however, is strong ( $v=.51$ ) and statistically significant ( $p=.02$ ). Both number of children and policy ( $v=.59$ ) and education level and policy ( $v=.57$ ) are strongly associated but only the relationship between number of children and policy is significant ( $p=.01$ ). Policy

opinion regarding artificial womb technology and religion shows a strong association ( $v=.50$ ) and the relationship is significant at  $p=.02$ . Religiosity, on the other hand, shows only a weak and non-significant relationship with policy ( $v=.23$ ). The relationship between attendance and policy, finally, is strong ( $v=.41$ ) but non-significant.

#### 5.10.4 Table 9D

9% of the study participants ( $n=3$ ) feel that funding should come from both public and private sources. 1 of these informants is female (5%) and 2 are male (15%). A further 9% ( $n=3$ ) believe that funding for AWT should only come from public sources (1 female, 5% and 2 males, 15%). 3% ( $n=1$ ) of the participants believe funding should be solely private (1 male, 8%), while 6% ( $n=2$ ) feel AWT should not be funded at all (2 males, 15%). The relationship between funding opinion and sex is nil ( $\phi=0$ , non-significant).

The associations between funding and age ( $v=.55$ ) and funding and number of children ( $v=.44$ ) are both strong but neither relationship is significant, while the relationships between funding and marital status ( $v=.48$ ) and funding and education level ( $v=.62$ ) are strong and significant ( $p=.08$  and  $p=.02$  respectively). None of the following relationships are statistically significant: religion and funding ( $v=.40$ ), religiosity and funding ( $v=.40$ ), or attendance and funding ( $v=.44$ ).

#### 5.10.5 Table 9E

5 informants (16%) believe that access to artificial womb technology should be restricted (2 females, 11% and 3 males, 23%). A further 4 of the study participants (13%) feel that AWT access should be free (1 female, 5% and 3 males, 23%).

The association between opinion about access to artificial womb technology and sex is moderate ( $\phi=.36$ ) but non-significant.

The relationship between access and age is strong ( $v=.40$ ) and not significant. Likewise, the relationships between marital status and access ( $v=.42$ ), number of children and access ( $v=.43$ ), and education level and access ( $v=.48$ ), are all strong and non-significant. Neither access and religion ( $v=.39$ ) nor access and religiosity ( $v=.41$ ) show significant relationships, however, access and attendance shows a strong association ( $v=.47$ ) and is significant at  $p=.04$ .

Only one informant commented on access to artificial womb technology, stating:

who would want to limit this research to investigations aimed at enhancing not replacing the natural process?

#### 5.10.6 Acceptance and restrictions

Acceptability of AWT is based upon "medical judgment" and the idea of "assisting a normal pregnancy, after all, an incubator for a premature baby is really a primitive artificial womb".

A number of informants voiced possible restrictions on AWT. One participant suggests that the technology be used:

only for adults who are infertile, have no other avenue, are desperate for a child, are of an acceptable income level according to society norms or on the advice of a physician.

Another informant states an interesting point, namely that AWT should be restricted to:

married couples who are under legal obligation to be responsible for the outcome of such technology. We should not be producing unparented children!

However, one informant suggests the use of AWT is "almost certainly a long way off - surrogacy [sic] is a surer bet".

## **5.11    RU-486 PILL**

### **5.11.1    Table 10A**

Overall, 50% (n=16) of the informants have heard of RU-486. 8 of the females (42%) and 8 of the males (62%) are familiar with the new pill, however, the association between knowledge and sex is weak ( $\phi=.19$ ) and the relationship is non-significant.

The relationships between knowledge and age ( $v=.59$ ), knowledge and marital status ( $v=.40$ ), knowledge and number of children ( $v=.65$ ), and knowledge and education ( $v=.56$ ) are all strong. Only the relationship between knowledge and number of children is significant ( $p=.04$ ). Knowledge regarding RU-486 and religion are strongly associated ( $v=.55$ ) and the relationship is significant at  $p=.05$ . Both knowledge and religiosity ( $v=.36$ ) and knowledge and attendance ( $v=.35$ ) show moderate associations but neither relationship is significant.

### **5.11.2    Table 10B**

41% of the informants (n=13) believe that RU-486 is a beneficial technology. 9 of the females (47%) and 4 of the males (31%) feel this way. 1 (3%) informant feels it is a detriment (1 male, 8%). 6% of the sample (n=2) feels RU-486 can be both beneficial and detrimental (2 males, 15%). The association between sex and the rating of the RU-486 pill is strong ( $\phi=.44$ ) but lacks statistical significance.

None of the relationships between rating of RU-486 and the following independent variables are significant: RU-486 and age ( $v=.45$ ), RU-486 and marital status ( $v=.27$ ), RU-486 and number of children ( $v=.47$ ), RU-486 and education ( $v=.55$ ), RU-486 and religion ( $v=.31$ ), RU-486 and religiosity ( $v=.34$ ), or RU-486 and attendance ( $v=.42$ ).

Following from the majority of informants who felt that RU-486 is beneficial, several study participants feel that it "reduces the need for surgical intervention to terminate pregnancy", and the "choice is then a matter between a woman and her doctor only--confidentiality and privacy are maintained". Others feel that RU-486 "costs less than pregnancy or therapeutic abortion" and is a "safer procedure for women". A number of informants echoed this study participant's views:

easy access to such a technique...will finally remove the issue of abortion from our medical care system where it has been a destructive conflict.

### 5.11.3 Table 10C

9 of the study participants (28%) feel there should not be a policy regulating the use of RU-486 (6 females, 32% and 3 males, 23%). 6 informants (19%) believe there should be a policy allowing the technology (2 females, 11% and 4 males, 31%), while 1 informant (3%) feels there should be a policy disallowing it (1 male, 8%). The relationship between policy opinion and sex is moderate ( $\phi=.38$ ) but not significant.

Policy opinion and age ( $v=.46$ ) and policy opinion and education ( $v=.47$ ) are both strong but non-significant relationships, while the relationships between policy opinion and marital status ( $v=.52$ ) and policy opinion and number of children ( $v=.61$ ) are strong and significant ( $p=.02$  and  $p=.001$  respectively). Of the relation-

ships, policy and religion ( $v=.50$ ,  $p=.04$ ), policy and religiosity ( $v=.38$ ), and policy and attendance ( $v=.50$ ,  $p=.04$ ), only the relationship between policy and religiosity is not significant.

Although a majority of informants feel that there should not be a policy regulating the use of RU-486, a number feel that it "should be approved as all drugs are" and "should be available by prescription only". Conversely, one informant states:

I do not see why a public policy is needed - use can be a private matter. Whose interests other than the mother's requires public protection?

#### 5.11.4 Table 10D

22% of the sample ( $n=7$ ) believe that funding for RU-486 should come from public sources (5 females, 26% and 2 males, 15%). 6% ( $n=2$ ) think funding should only come from private sources (2 males, 15%). A further 16% ( $n=5$ ) feel that funding for the RU-486 pill should come from both public and private sources (3 females, 16% and 2 males, 15%) and 6% ( $n=2$ ) feel it should not be funded at all (2 males, 15%). The relationship between sex and opinion regarding RU-486 funding is strong ( $\phi=.55$ ) and is statistically significant at  $p=.08$ .

The relationships between funding and age ( $v=.54$ ), funding and marital status ( $v=.38$ ), and funding and number of children ( $v=.46$ ) are non-significant but the relationship between funding and level of education ( $v=.60$ ) is ( $p=.05$ ). Religion and funding ( $v=.37$ ) and religiosity and funding ( $v=.34$ ) are both moderately associated but neither relationship is significant. Attendance and funding, while also a non-significant relationship, shows a strong association ( $v=.43$ ).

### 5.11.5 Table 10E

Regarding access to the RU-486 pill, 28% (n=9) feel there should be free access while 22% (n=7) feel there should be restricted access. 5 of the females (26%) support free access and 4 (21%) support restricted access. 4 of the males (31%) support free access and 3 (23%) support restricted access. 1 participant (3%) feels there should be no access (1 male, 8%). The association between access to this technology and sex is moderate ( $\phi=.31$ ) but the relationship is not significant.

The relationship between age and access opinion is strong ( $v=.48$ ) but non-significant as is the relationship between education level and access opinion ( $v=.50$ ). Marital status and access ( $v=.48$ ,  $p=.02$ ) and number of children and access ( $v=.58$ ,  $p=.01$ ) are both strong, statistically significant relationships. All the relationships, access and religion ( $v=.42$ ), access and religiosity ( $v=.40$ ), and access and attendance ( $v=.48$ ) are strong, however, only the relationship between access and attendance is significant ( $p=.02$ ).

A number of informants feel that there should be "access [to RU-486] to anyone who meets time frame requirements to avoid riskier, costlier intervention and fewer unwanted children" and "free access to any women requesting upon doctor's consultation". On the other hand, one informant feels that there should be "access for medical or social reasons, (rape, incest), on doctor's prescription" only. However, the common feeling amongst participants seems to be summed up by this informant's comments:

[RU-486 is] useful for early pregnancy termination, easy to take, safe and doesn't require women to 'request' someone else's decision re: her body and child rearing responsibilities; it should be freely and cheaply available.

### 5.11.6 Acceptance and restrictions

When asked in what cases (if at all) they think the use of RU-486 is warranted, 44% of the informants (n=14) said it is justified in the case of rape and/or incest (6 females, 32% and 8 males, 62%). The relationship between this response and sex is moderate ( $\phi=.30$ ) and significant at  $p=.09$ . 47% (n=15) of the informants feel that RU-486 is acceptable when there is danger to the woman's mental health (7 females, 37% and 8 males, 62%) and 50% of the informants (n=16) feel it is acceptable when there is danger (including death) to the woman's physical health (7 females, 37% and 9 males, 69%). The relationship between the mental health response and sex ( $\phi=.24$ ) is weak and non-significant while the relationship between the physical health response and sex ( $\phi=.32$ ) is moderate and significant ( $p=.07$ ). 44% (n=14) of the participants believe that the use of RU-486 is warranted when the resulting child would be developmentally handicapped in some way, deformed, or not otherwise able to lead a "normal" life. 6 females (32%) and 8 males (62%) supported this position. The relationship between this response and sex is moderate ( $\phi=.30$ ) and statistically significant at  $p=.09$ . 31% of the sample (n=10) feels that the use of RU-486 is justified in any case (7 females, 37% and 3 males, 23%) and no one feels its use is always unwarranted. The association between use in any case and sex is weak ( $\phi=.15$ ) and the relationship is not significant.

Several informants are concerned that the RU-486 pill should be used under "medical prescription and advice only", in order to avoid both abuse and possible side effects. Further, a number of participants feel that there should be "a written time frame", (such as less than eight weeks), beyond which the pill can no longer

be used. One other suggestion indicated the need for "counselling pre- and post-, including birth control counselling". One informant stated that "assuming safety of treatment has been demonstrated, use of RU-486 might also reduce risks otherwise associated with birth control pills." Finally, several informants agreed that "as an adjunct to choice in reproductive rights, [RU-486] should be available as an option for all women" and that RU-486 could "remove the whole abortion issue as a moral issue and allow women themselves to make these choices."

## **5.12    MATRICES**

### **5.12.1    Table 1**

The following section outlines the perceptions of who the major stakeholders are for each technology. These results are analysed separately by sex on the basis of consensus. A group of stakeholders is mentioned if at least 4 of the females (21%) listed the group as significant. A group of stakeholders is mentioned if at least 3 of the males (23%) listed the group as significant. Results are listed in descending numerical order.

Regarding 'in vitro' fertilization (IVF), the females in the sample see infertile heterosexual couples (n=14, 74%), infertile women (n=14, 74%), doctors (n=13, 68%), heterosexual women (n=9, 47%), heterosexual men (n=7, 37%), infertile men (n=7, 37%), donors (n=7, 37%), racial minorities (n=4, 21%), homosexual women (n=4, 21%), children (n=4, 21%), and lawyers (n=4, 21%) as major stakeholders. Male informants indicate that infertile heterosexual couples (n=11, 85%), infertile women (n=11, 85%), heterosexual men (n=7, 54%), the unborn (n=7, 54%), infertile men (n=7, 54%), donors (n=7, 54%), contract mothers (n=6, 46%), children (n=6,

46%), doctors (n=5, 39%), homosexual women (n=4, 31%), homosexual couples (n=3, 23%) and homosexual men (n=3, 23%) are major stakeholders in IVF.

With human embryo research, female participants feel that doctors (n=7, 37%), heterosexual women (n=5, 26%), heterosexual men (n=5, 26%), unborn (n=5, 26%), racial minorities (n=4, 21%), donors (n=4, 21%), children (n=4, 21%), and lawyers (n=4, 21%) are major stakeholders in human embryo research. Male informants believe the unborn (n=6, 46%), children (n=6, 46%), doctors (n=6, 46%), heterosexual women (n=4, 31%), heterosexual men (n=4, 31%), infertile heterosexual couples (n=4, 31%), infertile women (n=4, 31%), infertile men (n=4, 31%), donors (n=4, 31%), and contract mothers (n=3, 23%) are all major stakeholders.

For the donation of both gametes and embryos, female informants said that donors (n=9, 47%), heterosexual women (n=6, 32%), infertile heterosexual couples (n=6, 32%), infertile women (n=6, 32%), infertile men (n=6, 32%), lawyers (n=5, 26%), doctors (n=5, 26%), heterosexual men (n=4, 21%), homosexual women (n=4, 21%), and children (n=4, 21%) are the major stakeholders. Male informants said that infertile heterosexual couples (n=8, 62%), infertile women (n=8, 62%), infertile men (n=8, 62%), donors (n=8, 62%), contract mothers (n=7, 54%), the unborn (n=6, 46%), heterosexual women (n=5, 39%), homosexual couples (n=5, 39%), homosexual women (n=5, 39%), children (n=5, 39%), heterosexual men (n=4, 31%), and doctors (n=3, 23%) are the major stakeholders regarding donation.

Female informants feel, with cryopreservation, that heterosexual women (n=6, 32%), infertile heterosexual couples (n=6, 32%), doctors (n=6, 32%), heterosexual men (n=5, 26%), infertile men (n=5, 26%), lawyers (n=5, 26%), infertile women (n=4, 21%), and donors (n=4, 21%) are the major stakeholders. Male infor-

mants feel that donors (n=7, 54%), the unborn (n=6, 46%), infertile heterosexual couples (n=6, 46%), infertile women (n=6, 46%), infertile men (n=6, 46%), heterosexual women (n=5, 39%), children (n=5, 39%), heterosexual men (n=4, 31%), homosexual women (n=3, 23%), and doctors (n=3, 23%) are the major stakeholders in decisions about cryopreservation.

Regarding alternative insemination, female study participants believe that infertile heterosexual couples (n=14, 74%), donors (n=14, 74%), heterosexual women (n=13, 68%), infertile men (n=13, 68%), homosexual women (n=12, 63%), infertile women (n=11, 58%), doctors (n=11, 58%), children (n=9, 47%), homosexual couples (n=8, 42%), lawyers n=8, 42%), heterosexual men (n=7, 37%), the unborn (n=7, 37%), contract mothers (n=6, 32%), and racial minorities (n=5, 26%) are all major stakeholders. Male informants see infertile heterosexual couples (n=11, 85%), infertile men (n=10, 77%), donors (n=9, 69%), contract mothers (n=8, 62%), infertile women (n=7, 54%), heterosexual women (n=6, 46%), the unborn (n=6, 46%), heterosexual men (n=5, 39%), homosexual couples (n=5, 39%), homosexual women (n=5, 39%), children (n=5, 39%), and doctors (n=5, 39%) as being the major stakeholders in alternative insemination.

There is no female consensus (n=0, 0%) regarding major stakeholders in parthenogenesis while 3 males (23%) believe the unborn are major stakeholders.

Regarding sex preselection, female informants feel that the unborn (n=6, 32%), doctors (n=5, 26%), heterosexual women (n=4, 21%), heterosexual men (n=4, 21%), and children (n=4, 21%) are the major stakeholders. The male informants, however, feel that the unborn (n=6, 46%), heterosexual women (n=5, 39%), heterosexual men (n=5, 39%), infertile heterosexual couples (n=4, 31%), infertile women

(n=4, 31%), infertile men (n=4, 31%), children (n=4, 31%), racial minorities (n=3, 23%), homosexual couples (n=3, 23%), homosexual women (n=3, 23%), and doctors (n=3, 23%) are the major stakeholders in sex preselection.

Female informants, with contract motherhood, feel that contract mothers (n=11, 58%), infertile heterosexual couples (n=10, 53%), infertile women (n=10, 53%), lawyers (n=10, 53%), infertile men (n=6, 32%), heterosexual women (n=5, 26%), heterosexual (n=5, 26%), doctors (n=5, 26%), homosexual couples (n=4, 21%), donors (n=4, 21%), and children (n=4, 21%) are the major stakeholders. Male informants feel that infertile heterosexual couples (n=11, 85%), contract mothers (n=11, 85%), infertile women (n=10, 77%), the unborn (n=9, 69%), donors (n=8, 62%), children (n=6, 46%), heterosexual women (n=5, 39%), infertile men (n=5, 39%), lawyers (n=5, 39%), doctors (n=5, 39%), heterosexual men (n=4, 31%), and homosexual couples (n=3, 23%) are the major stakeholders in decisions about contract motherhood.

Regarding decisions about artificial womb technology (AWT), the females in the study believe that the unborn (n=4, 21%), lawyers (n=4, 21%), and doctors (n=4, 21%) are major stakeholders. The male study participants feel that the unborn (n=5, 39%), infertile women (n=5, 39%), infertile heterosexual couples (n=4, 31%), heterosexual women (n=3, 23%), homosexual men (n=3, 23%), donors (n=3, 23%), children (n=3, 23%), and doctors (n=3, 23%) are the major stakeholders.

Female informants feel that heterosexual women (n=7, 37%), doctors (n=7, 37%), and homosexual women (n=4, 21%) are the major stakeholders in decisions regarding the RU-486 pill. Male informants feel that the unborn (n=5, 39%), doctors (n=5, 39%), heterosexual women (n=4, 31%), heterosexual men (n=3, 23%), and children (n=3, 23%) are major stakeholders.

### 5.12.2 Table 2

The following section outlines informants perceptions of who should be consulted regarding each of the technologies. The results are, again, analysed separately by sex on the basis of consensus. Other than for parthenogenesis and artificial womb technology (both had lowest consensus), most informants stated that nearly every group, offered to them as choices in the matrix, should be consulted in policy making for each technology. Therefore, a group is mentioned only if, for females, consensus is reached by 13+ (69%+) people and, for males, consensus is reached by 9+ (69%+) people.

For 'in vitro' fertilization, females believe infertile women (n=14, 74%), infertile heterosexual couples (n=14, 74%), and doctors (n=14, 74%) should be consulted. Males believe that infertile heterosexual couples (n=10, 77%), infertile women (n=10, 77%), heterosexual women (n=9, 69%), heterosexual men (n=9, 69%), infertile men (n=9, 69%), and doctors (n=9, 69%) should be consulted.

Regarding donation, male informants feel that infertile couples (n=9, 69%) and infertile women (n=9, 69%) should be consulted. Males further believe that doctors (n=9, 69%) should be consulted in decisions concerning cryopreservation.

Regarding alternative insemination, females think that infertile heterosexual couples (n=15, 79%), infertile men (n=15, 79%), donors (n=14, 74%), infertile women (n=13, 68%), and doctors (n=13, 68%) should be consulted primarily. Males believe that infertile heterosexual couples (n=10, 77%) and doctors (n=9, 69%) should be consulted.

Finally, with contract motherhood, male informants feel that infertile heterosexual couples (n=10, 77%), infertile women (n=9, 69%), contract mothers (n=9, 69%), and lawyers (n=9, 69%) should be consulted in policy making decisions.

### 5.13 SUMMARY

The goal of this chapter was to provide the results of the survey of stakeholders both statistically and in the informant's own words. Regarding the empirical portion of this chapter, the variable of theoretical interest is the sex of the informant. It was implicitly hypothesized that there would be a difference in the responses of the study participants based on sex. Statistically, sex\* as a significant predictor<sup>25</sup> of attitudes, only arises in terms of knowledge of each technology. More males are familiar with each technology than females. Attendance at church\* is equally likely to assist in prediction of knowledge about the technologies. The education level of informants\* and church attendance\* are the two significant predictors of attitudes about the ratings of the technologies as beneficial, detrimental, or both. With the exception of RU-486, more males than females feel the technologies are beneficial. Males and females are equally likely to view the technologies as detrimental or as being both beneficial and detrimental. The religion of the informant\* is the better predictor of policy stance with the marital status\* and the number of children\* following. Males are consistently more likely to vote for policies allowing the technologies while both sexes are equally likely to vote for creating policies disallowing each technology. It is interesting to note that females are always more likely to choose a 'no policy' option regarding the regulation of each technology. With funding, education\* and marital status\* allow better prediction of attitudes. Female's responses are concentrated in the public funding sphere while male's opinions are either concentrated in the 'no funding' category or choose funding from both private and public sources. Finally, knowl-

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<sup>25</sup> Statistically significant results are denoted in this paragraph using the \* symbol.

edge of marital status\*, number of children\*, and church attendance\* assists in predicting attitudes access to the technologies. Males and females are equally in favour of restricted access to the technologies or 'no access'. More males are in favour of free access than females. It is probable that the variables examined in this survey are intercorrelated to a large degree, therefore the effects of each independent variable on the dependent variables should be statistically analysed separately<sup>26</sup> if further research is undertaken.

It was discussed in earlier chapters that providing study participants with a forum for expressing their opinions, in their own words, conforms to feminist research principles. Interspersed throughout this chapter are the concerns of the informants. These comments could in no way be reflected in the statistical analysis of the data alone: allowing informant's as many opportunities for specificity, in the form of open-ended questions, is consistent with the idea of research as a tool for empowerment.

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<sup>26</sup> Multiple regression analyses and/or factor analyses could be done in future to explore this idea.

## Chapter VI

### DISCUSSION AND CONCLUSION

New reproductive technologies will, in some way, impact on the lives of all citizens. In Chapter One, a conservative estimate of the number of children born worldwide with the aid of just three of the technologies in the next one hundred years was six million. Granted, most of these children will be born in industrialized nations to Caucasian upper and middle class couples, but it must be understood that the effects of these technologies are farther reaching than what is generally recognized. As one informant contemplates:

one wonders about the long term implications and the "craziness" of such intricate technologies to control nature—when we face poverty, famine, and environmental desolation on a global scale.

So reproductive technologies may only have an impact on many in the sense that money which could be directed toward research on problematic global issues or toward direct aid or toward social programs will be spent, instead, on reproductive technological breakthroughs. Regardless, we will all be affected.

The idea for this thesis began with an interest in the evolution of reproductive technologies. Hedley points out that a single innovation paves the way for additional innovations and so technological innovations grow exponentially (1992:18). One study participant commented that:

The reproductive technologies themselves do not present...a lot of concern. What is [of] concern is the ability of society and people to make wise decisions. For example, are the technologies being developed at a faster rate than our ethical frameworks to deal with the

issues? Mechanisms need to be developed to deal with these issues.

Echoing this sentiment, I set out to survey potential policymakers regarding their knowledge and attitudes concerning ten reproductive technologies. I believed it possible to assess the directions policies might proceed in based on the information I received from the thirty-two page questionnaire. What was problematic from the outset of this study was the question of what would be done with the results of the survey. It seemed that with such volatile issues as those attached to the all of the technologies, mere prediction of policy creation left too much unexplained and undone. Resolution to this dilemma came in the form of feminist sociological theory and research methods.

Feminist sociology, as with feminist theory, calls for action: knowledge for the purpose of empowerment rather than knowledge simply for the sake of knowledge. The concept of power infuses every one of the issues surrounding reproductive technologies, making the idea of knowledge for social action significant. Feminist research makes use of new empirical and theoretical resources in defining what is in need of explanation. In my case, as my thinking became informed by my broadening knowledge of feminist ideals in research and theory, policy prediction became less an issue for investigation while issues around power seemed a more interesting avenue of intellectual pursuit. Feminist sociology has shifted the focus of inquiry from traditional research objectives within sociology, for instance, the overextension of concepts or asking questions with an androcentric bias<sup>27</sup> to using women's experiences as inception points for study. Regarding reproductive technologies, a more socially relevant study than policy

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<sup>27</sup> Refer back to Chapter Three for a discussion of how feminist sociology has shifted the focus of the research process.

prediction is discovering how women from different racial, cultural, economic, and educational locations experience the many issues and practices surrounding the technologies. These are especially important areas of inception given that women are the primary consumers of, and worktables for, the technologies. Furthermore, a basic contradiction between women's values and the "operational principles of the technological order" is noted by Franklin who also states that this order must be regarded "as the current evolutionary successor of the traditional male hierarchical power structure" (1985:8).

Further, one should investigate the broader social structures in terms of their roles in perpetuating imbalances in power regarding aspects of reproductive technologies. As mentioned previously, feminist sociology has defined the purpose of research and analysis as social action. Generally, feminist inspired research is conducted in order to provide women with explanations of social phenomena. This is in order to achieve some concrete means of overcoming imbalances in power insofar as knowledge is power. The results of this type of research may also be used to provide all people with explanations from a different perspective than what is conventionally offered. With regard to my study of stakeholder's knowledge and attitudes, as discussed above, it seems too limiting to predict simply for the sake of prediction. The Nebraska Women's Collective asserts that:

data collection for the 'sake of knowledge' cannot be tolerated. The research act is a social/economic/political act which must empower women outside the academy as a priority (1983:536).

A more socially relevant purpose then, revolves around the idea of using the survey results to inform women how potential policymakers view reproductive technological issues. This will be discussed in greater detail below.

The final issue regarding feminist sociology worthy of mention is the idea of recursiveness. A sociology of women, for women, has emancipatory possibilities for researchers as well as for those they are informed by. This is of particular relevance to me as women researchers have been either "absent or unheard within main sociological traditions" (Acker et al., 1987:424). The ways in which I, and the study, changed as a result of the research must be acknowledged, particularly because the changes in me and in the study were of a dialectical nature. As I have attempted to clarify earlier, the more I learned of feminist sociological theory and methods, the more the survey of attitudes took on a different significance. For example, the survey results can now be used in explorations of issues around social power and can be used for the purposes of liberation of women embroiled in reproductive technological practices/"treatments" by providing potentially useful information. It can also be used in the realization that although "much of the present technological system amplifies the power structure onto which it is grafted, this need not remain so" (Franklin, 1985:6). A focus on women's values regarding technology may assist in changing current technological practices so as to make them more humanistic and make the practitioners more accountable. Two issues are offered by Franklin (1985) as starting points for changing the technological order. The first is the idea of 'community' or strengthening the bonds between women. The second is the idea of 'clarity' or understanding the structures and dynamics of the technologies better than many women traditionally have in the recent past.

Acknowledging the myriad relationships between researchers and informants is perhaps a necessary first step in equalizing the power between the two. Acker,

Barry, and Esseveld caution that, "as researchers, we must not impose our definitions of reality on those researched, for to do so would undermine our intentions to work towards a sociology for women" (1987:425). Building upon this concept, the act of analysing the results of my survey questionnaire put me in the position of one with the "power to define". The most significant question one can ask at the end of a research process such as this one is "is this research worthwhile?" I believe that had I remained working within the empirical, positivist tradition I began in, I would not be able to answer this question positively. This is not to dismiss empiricism completely. It is possible to discuss feminist research in the context of its use in enlarging the scope of inquiry (i.e.: focusing on women's experiences and so on) and also to discuss empiricism in the context of its use in the logic of explanation and research. The two are not innately incompatible<sup>28</sup>. In answering the question, "is this research worthwhile?", one must ask if the research meets an emancipatory goal, keeping in mind that "an emancipatory intent is no guarantee of an emancipatory outcome" (Acker et al., 1987:431).

The results of my survey can be discussed in this light in two ways. Firstly, regarding the actual survey data and worthiness, I am no longer interested in mere prediction. I am, however, interested in accurately representing the informant's views. So in answering the query "do the research findings fairly and accurately reflect aspects of social life?" , (Acker et al., 1987:431), I believe the best way to ensure that this happens is by allowing informants the opportunity to speak for themselves in the form of as many open-ended questions as possible. By reporting those types of responses, one gives informants a voice and a forum. This can only be emancipatory. Furthermore, several of the informants indicated either in

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<sup>28</sup> For a full discussion of "feminist empiricism", see Harding, 1986:183-184.

writing or via the telephone that the study provided them with additional knowledge about many reproductive technologies as well as enabled them to explore many of their own attitudes and beliefs surrounding numerous fundamental issues.

One should be able to locate both the researcher and the informants in the social structure and in the research. Therefore, for a theoretical interpretation to be adequate, it must be able to provide a reconstruction of the social relations that have produced the research problem at this time, in this society and it must be able to reconstruct what processes were at work that resulted in the researcher and informants coming together in this particular type of social relationship.

The second manner in which I wish to discuss the worthiness of my study with regard to its emancipatory potential, is in terms of political and social action. Reproductive technologies are currently, largely things that are done "to" women and "on" women, rarely "by" women. One cannot ignore that there are many female doctors, technicians, and researchers working to the same reproductive technological ends as their male counterparts, however, it must be noted that these women are operating within traditionally male-dominated fields under male models of care, delivery, and inquiry. Franklin notes that:

...the modern technological system...encroaches upon and becomes a replacement of the old social order, which is essentially the traditional white male hierarchical power structure. Modern advanced technology continues and extends it. For women it is particularly important to understand this relationship and to recognize the process of grafting technology into a system of traditional power (1985:5).

As an example of the androcentric bias illustrative of reproductive technologies in general, an informant has this to say:

Gamete donors should not be paid. It should be a public service. Sperm donors are currently being paid. So we have male physicians setting up a payment system to male donors to deal with a problem

of male infertility, yet these practices are on women's bodies.  
What could be more sexist?

Sex was the variable of theoretical interest in my survey. There are very few statistically significant differences in attitudes between the sexes but to ignore these results would be erroneous. Statistical significance aside, there appear to be a number of sex differences worthy of mention. Firstly, more males are familiar with each technology than females. In terms of rating, except for RU-486, more males than females believe the technologies to be beneficial. Males and females are equally likely to see the technologies as detrimental or as having the capacity to be both beneficial and detrimental. Regarding policy, males are consistently more likely to vote for a policy allowing each technology. Both sexes are equally likely to vote for a policy disallowing each technology but, interestingly, females are always more likely to vote for having no policies regulating the use of each technology. More of the males in the survey choose funding from both private and public sources while the female's responses are concentrated in the 'public' funding category. Males are also more likely to state that no funding would be appropriate. Finally, males and females are equally in favour of restricted access to the technologies or no access. More males are in favour of free access than females. Based on the number of significant results marital status, education, number of children, and church attendance are most often the best predictors of attitudes. These are followed by sex, age, and religion. It is almost certain that sex, age, education level, marital status, number of children, religion, religiosity, and church attendance are correlated, a factor which serves to obscure possible sex differences. Eichler (1987:40) notes that ignoring sex as a variable, as one may be tempted to do with findings such as these, leads to ignoring women but

also blinds us to seeing men as men, because men are often seen as representing all of humankind. By ignoring sex as a theoretically important "descriptive" variable, researchers cannot see what kinds of attitudes and behaviours are specific to the sexes.

It is my belief that women need to politically control reproductive technologies. Men, however, need not be excluded from this emancipatory process for women. Women's and men's social experiences are not equal and therefore can provide different yet reliable claims to knowledge. Herein lies the strength of a careful non-sexist approach. This harkens back to the concept of "truth" being found at the intersection of vantage points within feminist sociological theory. Realities regarding reproductive technologies and regarding policy decisions can, in this light, be found at the heart of differing ideas, opinions, knowledge, and experiences. It is likely that the best decisions concerning reproductive technologies and who controls them (technologically speaking and in terms of access, funding, restrictions, and so on) will be those arrived at through a process which manages to pull the varied opinions and experiences of unequally situated and hence, unequally empowered groups together. As discussed in the introduction to the paper, a royal commission to study issues surrounding new reproductive technologies has been appointed the task of gathering information over a two or three year period. It is perhaps, no accident that permission for this Royal Commission was strenuously lobbied for by a group of Canadian women headed by Dr. Margrit Eichler, a concerned feminist writer and researcher.

The Royal Commission has a broad edict: "to inquire into, evaluate, and make recommendations about new reproductive technologies in terms of their social,

legal, ethical, economic, research, and health implications for women, men, and children and for society as a whole" (Royal Commission information pamphlet: March 1991, pages 2-3). Toward this end, information is being solicited from various sources. Research and evaluation programs are being integrated with the findings of private consultations with individuals and groups and with information gained through public forums and debates.

Although some of the information obtained overlaps that of the Royal Commission's, my study differs in scope. It also differs in data collection method but, perhaps the most important difference between the research lies in the sample itself. My study relies on information provided by a very small, select, and more or less homogeneous, group of key individuals while, at least in theory, the informants providing information to the Royal Commission<sup>29</sup> are vastly more in numbers and more heterogeneous. It is my hope that the information provided by this paper is timely enough to be of some value despite these limitations.

Other limitations detected in my research centre on the fact that knowledge from the points of view of individuals who are actually involved in the technologies (from the vantage points of "patients", "surrogate" mothers, "infertiles", and so on) needs to be procured. Again, in line with feminist sociological research ideals, one of the goals of research must be to understand any given reality from the perspectives of the people experiencing it. I am hopeful that the work of the Royal Commission will make up for the paucity in what this thesis is able to offer in this respect.

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<sup>29</sup> The informants in both groups are the same individuals in some cases.

In conclusion, I would like to stress that the issues surrounding reproductive technologies are incredibly complex and need to be investigated seriously from numerous vantage points. The Royal Commission has the means to tap knowledge from many resources and hence, has the potential to be truly representative of, and provide a voice for, unequally situated individuals and groups. This is an exciting prospect. I suggest that attention be focused on the work of the Royal Commission. When it presents its findings to the Canadian public, it will provide interesting material for future study in several ways. I suggest that when the findings become available, that a content analysis be done. It would be interesting to discover if the Commission's report reflects the views of all those informants who submitted information, or whether certain groups are systematically left out of the process as a result of some bias. The Royal Commission on New Reproductive Technologies will provide a wealth of information for further study on several different fronts. That information is used for the empowerment of all is the critical point of this, and all, research.

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**APPENDIX A**  
**ONTARIO LAW REFORM COMMISSION REPORT**

The Hastings Center Report (1987:6-7) put together an overview of several international government committee's responses regarding 'in vitro' fertilization, contract motherhood, and embryo research. The countries surveyed were Australia, United Kingdom, United States, Western Europe, Federal Republic of Germany, New Zealand, Japan, German Democratic Republic, and Canada. Only results from the Ontario Law Reform Commission Report on Reproductive Technologies will be presented here.

**A.1 ISSUES IN CLINICAL 'IN VITRO' FERTILIZATION**

1. Acceptability in principle    YES
2. Eligibility & counselling requirements (recipients)
  - A. Couples only    NO
  - B. Marriage required    NO
  - C. Medical grounds only    YES
  - D. Counselling required    UNSURE
3. Freezing & Disposal
  - A. Freezing of embryos permissible    YES
  - B. Freezing of eggs permissible    YES
  - C. Time limit on storage of embryos    YES

D. Duration of storage time permitted 10 YEARS

E. Disposal of embryos permitted YES

4. Third-party involvement (donation)

A. Acceptability in principle YES

B. Donor screening required YES

C. Counselling of donors required UNSURE

D. Donation of eggs permissible YES

E. Donation of embryos permissible YES

F. Limit on # of donations YES

G. Anonymity required YES

H. Payment permissible NO

#### **A.2 ISSUES IN CONTRACT MOTHERHOOD**

1. Acceptability in principle of payment of a fee YES

2. Acceptability in principle of no payment of a fee YES

#### **A.3 ISSUES IN HUMAN EMBRYO RESEARCH**

1. Acceptability in principle YES

2. Source of embryos

A. Unneeded embryos from clinic YES

B. Embryos created for research purposes YES

3. Time limit on duration of embryo culture

A. Time limit set YES

B. Duration in days 14 DAYS

**APPENDIX B**  
**REPRODUCTIVE TECHNOLOGY SURVEY QUESTIONNAIRE**

The questionnaire in its original form appears on the following pages.

### Human Reproductive Technology Questionnaire

As you are aware from the phone call made to you, this questionnaire has been given to you in order to assess the implications that some of the reproductive technologies may have for society. Some experts believe that new government policies may soon be formulated regarding these technologies. We are requesting your input about this.

Your name was selected from a list of people who may have some interest in, or knowledge about, reproductive technology. This list was created on the basis of the New Reproductive Alternatives Society's agenda of speakers and participants from their last meeting and from a list of people known to Dr. Eike Kluge, a professor at the University of Victoria and a bio-ethicist.

The following sections deal with ten reproductive technologies. Most of these address ways to compensate for infertility. Reproductive technologies such as contraception are not included.

Your efforts in this study are important and valued as this is the only study of these issues in British Columbia so far. Confidentiality will be strictly maintained. This is an independent study being done by members of the UVic Sociology Department.

Thank you most sincerely for your assistance.

If you want more information regarding this study please contact either:

**Vicki Nygaard**  
721-7583 / office  
592-1592 / home

**Dr. Paul Baker**  
721-7576 / office

**Instructions to the Informant**

1. Please answer ONLY those questions on the following pages that pertain to technologies and/or procedures with which you ARE FAMILIAR.
2. Please provide only one "best" answer except where you are asked to indicate all answers that apply.
3. If you wish to make comments on certain questions or issues, please include them on the additional page provided at the end of the questionnaire.
4. All answers will be held in the strictest confidence. In all cases, the information obtained will be used to provide an overall perspective regarding reproductive technology. Data will not be reported so as to identify particular individuals.

University of Victoria

Department of Sociology

## Human Reproductive Technology Questionnaire

Section 1

1. The following is a list of reproductive techniques and procedures. Please place an "X" beside a technology ONLY if you are familiar with it (e.g.: know what it involves).

'In vitro' fertilization (IVF)	_____
Human embryo research	_____
Donation of gametes	_____
Cryopreservation	_____
Artificial insemination (AI) or Alternative insemination (AI)	_____
Parthenogenesis	_____
Sex pre-selection	_____
Surrogate motherhood or Contract motherhood	_____
Artificial womb technology	_____
RU-486 pill	_____

2. Using the rating scale provided below, please indicate your overall feelings about each of the technologies you are familiar with. Use the category "0" if you are unfamiliar with a technology.

Use the category that you feel "BEST" characterizes each technology and reflects your views. You will have the opportunity to elaborate on these issues on the next few pages.

#### RATING SCALE

BENEFICIAL	"1"
DETRIMENTAL	"2"
CAN BE BOTH	"3"
NOT FAMILIAR WITH IT	"0"

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'In vitro' fertilization \_\_\_\_\_

Human embryo research \_\_\_\_\_

Gamete donation \_\_\_\_\_

Cryopreservation \_\_\_\_\_

Artificial insemination \_\_\_\_\_

Alternative insemination \_\_\_\_\_

Parthenogenesis \_\_\_\_\_

Sex pre-selection \_\_\_\_\_

Surrogate motherhood \_\_\_\_\_

Contract motherhood \_\_\_\_\_

Artificial womb technology \_\_\_\_\_

RU-486 pill \_\_\_\_\_

**Human Reproductive Technology Questionnaire**

Section 1A

3. On the previous page, I asked you to rate each of the technologies, generally, as to whether you felt they were (1) beneficial, (2) detrimental, or (3) can be both. In the space below please elaborate a little upon WHY you feel the way you do (e.g.: Why is ABC a beneficial technology? Why is XYZ a detrimental procedure?).

'In vitro' fertilization (IVF)

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Embryo research

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Gamete donation

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**Cryopreservation**

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**Artificial insemination (AI)**

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**Parthenogenesis**

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**Sex pre-selection**

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**Surrogacy**

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## Human Reproductive Technology Questionnaire

Section 2

4. Using the categories listed below, please indicate how you feel about the creation of provincial POLICIES regarding the technologies and procedures with which you are familiar. You will be given the opportunity to elaborate on your feelings.

## RATING SCALE

THERE SHOULD BE A POLICY ALLOWING IT	"1"
THERE SHOULD BE A POLICY DISALLOWING IT	"2"
THERE SHOULD NOT BE A POLICY AT ALL	"3"
I AM NOT FAMILIAR WITH IT	"0"

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The IVF technique	_____
Human embryo research	_____
Gamete donation practice	_____
Cryopreservation technique	_____
The AI procedure	_____
Parthenogenesis technique	_____
Sex pre-selection techniques	_____
Contract motherhood practice	_____
Artificial womb technology	_____
Distribution of RU-486	_____

**Human Reproductive Technology Questionnaire**Section 2A

5. On the previous page, I asked you to indicate how you feel about policy creation regarding the techniques and procedures. In the space below, please elaborate on why you feel the way you do. Leave blank those spaces associated with the technologies with which you are unfamiliar.

'In vitro' fertilization (IVF) technique

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Embryo research

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Gamete donation practice

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**Cryopreservation technique**

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**Artificial insemination (AI) practice**

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**Parthenogenesis technique**

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**Sex pre-selection techniques**

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**Surrogacy practice**

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## Human Reproductive Technology Questionnaire

Section 3

6. Using the categories listed below, please indicate how you feel about the creation of provincial policies regarding who would have ACCESS to the technologies and procedures with which you are familiar.

## RATING SCALE

THERE SHOULD BE RESTRICTED ACCESS	"1"
THERE SHOULD BE FREE ACCESS	"2"
THERE SHOULD NOT BE ACCESS AT ALL	"3"
I AM NOT FAMILIAR WITH IT	"0"

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The IVF technique	_____
Donated gametes	_____
Cryopreservation	_____
The AI procedure	_____
Parthenogenesis	_____
Sex pre-selection techniques	_____
Contract motherhood	_____
Artificial womb technology	_____
RU-486 pill	_____

**Human Reproductive Technology Questionnaire**Section 3A

7. In question six, I asked you to indicate how you feel about the access to the various technologies and procedures. In the space below please specify why you answered as you did. If you answered category #1 ("restricted access") to any of the technologies, be sure to identify which groups of people access should be restricted to and why.

'In vitro' fertilization technique (IVF)

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Gamete donation practice

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Cryopreservation technique

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Artificial insemination practice (AI)

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Parthenogenesis technique

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Sex pre-selection techniques

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Surrogacy practice

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Artificial womb technology

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### Human Reproductive Technology Questionnaire

#### Section 4

8. Using the categories listed below, please indicate how you feel about FUNDING for the various technologies and procedures with which you are familiar.

#### RATING SCALE

IT SHOULD BE PUBLICLY FUNDED	"1"
IT SHOULD BE PRIVATELY FUNDED	"2"
IT SHOULD BE FUNDED USING BOTH PRIVATE AND PUBLIC FUNDS	"3"
IT SHOULD NOT BE FUNDED AT ALL	"4"
I AM NOT FAMILIAR WITH IT	"0"

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The IVF technique	_____
Human embryo research	_____
Donated gametes	_____
Cryopreservation	_____
The AI procedure	_____
Parthenogenesis	_____
Sex pre-selection techniques	_____
Contract motherhood	_____
Artificial womb technology	_____
RU-486 pill	_____

University of Victoria

Department of Sociology

## Human Reproductive Technology Questionnaire

Section 5

The following section asks that you answer more specific questions regarding each of the techniques and procedures you are familiar with. Please DO NOT ANSWER questions associated with technologies with which you are unfamiliar: leave those questions blank.

9. In what case, IF AT ALL, do you think 'in vitro' fertilization is an acceptable practice? (Check one)

I DO NOT THINK IVF IS AN ACCEPTABLE PRACTICE \_\_\_\_\_

ONLY WHEN A DOCTOR CERTIFIES INFERTILITY \_\_\_\_\_

WHENEVER AN INDIVIDUAL DESIRES IT  
REGARDLESS OF A DOCTOR'S APPROVAL \_\_\_\_\_

- 9A. Additional comments?

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10. What restrictions, IF ANY, do you feel should apply to the use of the IVF technique?

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NONE \_\_\_\_\_

11. Which embryos, IF ANY, do you feel are acceptable for use in research?  
(Check as many as apply)

I DO NOT FEEL IT IS ACCEPTABLE TO  
USE ANY EMBRYOS FOR RESEARCH \_\_\_\_\_

ONES CREATED IN THE LAB SPECIFICALLY  
FOR RESEARCH PURPOSES \_\_\_\_\_

EMBRYOS LEFT OVER FROM IVF  
PROCEDURES ARE ACCEPTABLE \_\_\_\_\_

ANY EMBRYOS ARE ACCEPTABLE FOR RESEARCH \_\_\_\_\_

- 11A. Additional comments?

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12. IF you feel human embryo research IS ACCEPTABLE, at what point do you think the embryo should be destroyed?

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\_\_\_\_\_ I DO NOT FEEL IT IS AN ACCEPTABLE PRACTICE

12A. If possible, please elaborate on why you answered as you did.

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13. What restrictions, IF ANY, do you feel should apply regarding human embryo research?

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NONE \_\_\_\_\_

14. Do you feel embryo donation is acceptable?

YES \_\_\_\_\_

NO \_\_\_\_\_

14A. If possible, please elaborate on why you answered as you did.

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15. Do you feel that the donation of gametes is an acceptable practice?

YES \_\_\_\_\_

NO \_\_\_\_\_

15A. If possible, please elaborate on why you answered as you did.

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16. Would you differentiate between the act of sperm donation and the act of ova donation?

YES \_\_\_\_\_

NO \_\_\_\_\_

16A. Please elaborate on your answer.

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17. What restrictions, if any, do you feel should apply regarding the donation of gametes?

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18. In what case(s), IF AT ALL, is cryopreservation an acceptable technique?  
(Check as many as apply)

IT IS UNACCEPTABLE IN ALL CASES \_\_\_\_\_

WHEN A PERSON MUST UNDERGO CHEMOTHERAPY \_\_\_\_\_

WHEN A PERSON MUST WORK NEAR  
CHEMICAL OR RADIATION HAZARDS \_\_\_\_\_

WHEN COMBINED WITH STERILIZATION  
FOR BIRTH CONTROL PURPOSES \_\_\_\_\_

WHEN EVER A PERSON DESIRES THE TECHNIQUE \_\_\_\_\_

IT IS ACCEPTABLE IN ANY CASE \_\_\_\_\_

- 18A. Additional comments?

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19. What restrictions, IF ANY, do you feel should apply regarding the cryopreservation of gametes?

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NONE \_\_\_\_\_

20. What restrictions, IF ANY, should apply regarding the cryopreservation of embryos?

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NONE \_\_\_\_\_

21. In what case, IF AT ALL, do you think artificial insemination is an acceptable practice?

I DO NOT THINK AI IS AN ACCEPTABLE PRACTICE \_\_\_\_\_

ONLY WHEN A DOCTOR CERTIFIES INFERTILITY \_\_\_\_\_

WHEN A PERSON DESIRES IT REGARDLESS  
OF A DOCTOR'S OPINION \_\_\_\_\_

IT IS ALWAYS ACCEPTABLE \_\_\_\_\_

21A. Additional comments?

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22. What restrictions, IF ANY, do you feel should apply to the use of the AI technique?

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NONE \_\_\_\_\_

23. In what case(s), IF AT ALL, do you think parthenogenesis is an acceptable practice?

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24. What restrictions, IF ANY, do you feel should apply to the use of parthenogenesis?

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NONE \_\_\_\_\_

25. In what case(s), IF AT ALL, do you think sex pre-selection techniques are acceptable? (Check any that apply)

IT IS NEVER AN ACCEPTABLE PRACTICE \_\_\_\_\_

WHEN ONE DESIRES A CHILD ON THE BASIS  
OF EXPECTED GENDER CHARACTERISTICS \_\_\_\_\_

WHEN HEREDITARY SEX-LINKED DISEASE IS  
LIKELY TO BE PRESENT \_\_\_\_\_

WHEN A CERTAIN SEX CHILD IS DESIRED \_\_\_\_\_

IN ANY CASE \_\_\_\_\_

25A. Additional comments?

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26. What restrictions, IF ANY, do you feel should apply to the use of sex pre-selection techniques?

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NONE \_\_\_\_\_

27. In what case(s), IF AT ALL, do you think contract motherhood is an acceptable practice? (Check any that apply)

IT IS NEVER ACCEPTABLE \_\_\_\_\_

WHEN A WOMAN CANNOT CONCEIVE OR CARRY A FETUS TO TERM \_\_\_\_\_

WHEN A WOMAN DOES NOT WISH TO INTERRUPT HER CAREER TO GIVE BIRTH BUT WANTS A CHILD FROM HER GENETIC INHERITANCE \_\_\_\_\_

WHEN A WOMAN DOES NOT WANT THE DANGER/DISCOMFORT/PAIN OF CHILDBIRTH \_\_\_\_\_

WHEN AN "INFERTILE" COUPLE WANTS A CHILD WITH THE FATHER'S GENETIC INHERITANCE \_\_\_\_\_

WHEN AN "INFERTILE" COUPLE WANTS A CHILD WITH BOTH PARENT'S GENES \_\_\_\_\_

WHEN A WOMAN WANTS TO BECOME A "SURROGATE" \_\_\_\_\_

IT IS ALWAYS ACCEPTABLE \_\_\_\_\_

27A. Additional comments?

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28. How do you feel about the payment of fees to contract mothers?

IT IS FAIR TO PAY THESE  
WOMEN FOR THIS WORK \_\_\_\_\_

IT IS UNACCEPTABLE IN ALL CASES \_\_\_\_\_

IT SHOULD BE DONE OUT OF COMPASSION OR  
LOVE ONLY--NO FEE SHOULD BE INVOLVED \_\_\_\_\_

ONLY CERTAIN EXPENSES SHOULD BE PAID  
e.g.: MEDICAL, CLOTHING, AND SO ON \_\_\_\_\_

IT TURNS SURROGACY INTO "BABY-SELLING" \_\_\_\_\_

28A. Feel free to discuss the above question further.

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29. What restrictions, IF ANY, do you feel should apply to the practice of contract motherhood?

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30. In what case(s), IF AT ALL, do you think an artificial womb would be an acceptable place to gestate a fetus?

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UNSURE \_\_\_\_\_

31. What restrictions, IF ANY, do you feel should apply to the use of artificial womb technology?

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NONE \_\_\_\_\_

32. In what case(s), IF AT ALL, do you think the use of RU-486 is warranted? (Check as many as you feel apply)

I DO NOT THINK ITS USE IS EVER WARRANTED \_\_\_\_\_

IN THE CASE OF RAPE AND/OR INCEST \_\_\_\_\_

WHEN THERE IS DANGER TO THE WOMAN'S MENTAL HEALTH \_\_\_\_\_

WHEN THERE IS DANGER TO THE WOMAN'S PHYSICAL HEALTH (including death) \_\_\_\_\_

WHEN THE RESULTING CHILD WOULD BE RETARDED, DEFORMED, OR NOT OTHERWISE ABLE TO LEAD A NORMAL LIFE \_\_\_\_\_

I THINK ITS USE IS WARRANTED IN ANY CASE \_\_\_\_\_

32A. Additional comments?

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33. What restrictions, IF ANY, do you feel should apply to the use of RU-486?

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NONE \_\_\_\_\_

**Human Reproductive Technology Questionnaire**Section 6

34.

Table ONE will be used to highlight how much "STAKE" (degree of legitimate interest/concern) you feel each group has in the creation of provincial policies on the technologies or procedures included in this form.

Please use the legend provided to rate each group's "STAKE" by technology. Answer for one technology at a time. Please attempt to answer each category. Only leave the box BLANK if you are UNFAMILIAR with a given technology or procedure.

PLEASE FILL IN THE ENTIRE TABLE COLUMN BY COLUMN

## LEGEND

MAJOR STAKEHOLDER	"1"
MINOR STAKEHOLDER	"2"
IRRELEVANT	"3"



**Human Reproductive Technology Questionnaire**Section 7

35.

Table TWO focuses on which groups of people, if any, you believe should be consulted if policies on reproductive technologies or procedures are created.

Please indicate (using an "X") whether a group should be consulted for each technology listed. Consider one group of people at a time. Please answer COLUMN BY COLUMN. For example, using the first stakeholder category, you would ask yourself, "Should heterosexual women be considered in (and therefore consulted regarding) policies on IVF? On human embryo research? On gamete donation? And so on." If you DO NOT think a group of people should be consulted, please indicate this by placing an "O" in that box instead of an "X".

Please attempt to answer each category. Only leave the box BLANK if you are UNFAMILIAR with a given technology or procedure.

Reproductive Technology Questionnaire

TABLE 2

Stakeholder Categories/ Technology	Hetero-sexual Women	Hetero-sexual Men	The unborn	Infertile hetero couples	Infertile women	Infertile men	Racial minorities	Surrogate mothers	Homo-sexual couples	Homo-sexual women	Homo-sexual men	Donors	Children	Lawyers	Doctors	Others (specify)
In vitro Fertilization																
Human embryo research																
Donation																
Cryopreservation																
Artificial insemination																
Parthenogenesis																
Sex preselection																
Surrogate motherhood																
Artificial womb technology																
RU-486 pill																

University of Victoria

Department of Sociology

## Human Reproductive Technology Questionnaire

Section 8

Please take time to answer these last few questions about yourself.

36. What was the year of your birth?

year \_\_\_\_\_

37. What is your marital status?

\_\_\_\_\_

38. How many children do you have?

Number \_\_\_\_\_

39. Please indicate the highest level of education and/or training you have obtained, specifying the area of study if applicable.

\_\_\_\_\_  
\_\_\_\_\_

40. What is your job title?

\_\_\_\_\_

41. What is the name of the organization you work for?

\_\_\_\_\_

42. If applicable, what agency, branch, or department within the organization do you work for?

\_\_\_\_\_

43. If you are affiliated with a religion, please indicate which one.

\_\_\_\_\_ OR

None \_\_\_\_\_

44. How religious do you consider yourself to be?

extremely \_\_\_\_\_

somewhat \_\_\_\_\_

barely \_\_\_\_\_

not at all \_\_\_\_\_

45. How often do you attend religious services?

Once a week or more \_\_\_\_\_

One to three times per month \_\_\_\_\_

Several times per year \_\_\_\_\_

Never \_\_\_\_\_

Finally, we need to contact more individuals who may be interested in, or know something about, reproductive technology for this study. If you know any people that we could contact to assist us with this survey in the same manner as you have, please specify below.

ENTER NAME(S) AND METHOD(S) OF CONTACT BELOW  
(e.g. business name, phone number, etc.)

Name \_\_\_\_\_

Contact \_\_\_\_\_

Name \_\_\_\_\_

Contact \_\_\_\_\_

Name \_\_\_\_\_

Contact \_\_\_\_\_

Name \_\_\_\_\_

Contact \_\_\_\_\_

Name \_\_\_\_\_

Contact \_\_\_\_\_

Thank you for taking the time to answer this questionnaire. Your assistance is greatly appreciated. Copies of the results will be mailed to you as soon as they become available. Please remember that your responses will not be reported in a way which would identify you. COMPLETE CONFIDENTIALITY IS ASSURED. THANK YOU AGAIN FOR YOUR ASSISTANCE.



**APPENDIX C**  
**TABULAR RESULTS OF REPRODUCTIVE TECHNOLOGY**  
**SURVEY**

The following is the complete set of tabular data compiled from the Reproductive Technology Survey Questionnaire.

**AGE BY SEX**

Frequencies and Percentages\*

AGE (years)	FEMALE	MALE	TOTAL
31 - 35	3 (15.8)	0 (0.0)	3 (9.4)
36 - 40	6 (31.6)	3 (23.1)	9 (28.1)
41 - 45	2 (10.5)	2 (15.4)	4 (12.5)
46 - 50	4 (21.1)	2 (15.4)	6 (18.8)
51 - 55	2 (10.5)	3 (23.1)	5 (15.6)
56 - 60	0 (0.0)	1 (7.7)	1 (3.1)
61 - 65	1 (5.3)	1 (7.7)	2 (6.3)
66+	1 (5.3)	0 (0.0)	1 (3.1)
NR	0 (0.0)	1 (7.7)	1 (3.1)

Cramer's V = .47    significance = .54

N = 32

\* percentages indicated by ( )

**MARITAL STATUS BY SEX**

Frequencies and Percentages\*

MARITAL STATUS	FEMALE	MALE	TOTAL
married	10 (52.6)	9 (69.2)	19 (59.4)
separated	1 (5.3)	0 (0.0)	1 (3.1)
divorced	4 (21.1)	0 (0.0)	4 (12.5)
other	3 (15.8)	3 (23.1)	6 (18.8)
NR	0 (0.0)	1 (7.7)	1 (3.1)

Cramer's V = .36    significance = .40

N = 32

\* percentages indicated by ( )

## NUMBER OF CHILDREN BY SEX

227

Frequencies and Percentages\*

# OF CHILDREN	FEMALE	MALE	TOTAL
0	4 (21.1)	3 (23.1)	7 (21.9)
1	3 (15.8)	0 (0.0)	3 (9.4)
2	7 (36.9)	2 (15.4)	9 (28.1)
3	1 (5.3)	6 (46.1)	7 (21.9)
4	2 (10.5)	1 (7.7)	3 (9.4)
5	0 (0.0)	0 (0.0)	0 (0.0)
6	1 (5.3)	0 (0.0)	1 (3.1)
NR	1 (5.3)	1 (7.7)	2 (6.25)

Cramer's V = .56052    significance = .12240

N = 32

\* percentages indicated by ( )

## EDUCATION LEVEL BY SEX

Frequencies and Percentages\*

LEVEL OF EDUCATION	FEMALE	MALE	TOTAL
combination of degrees	3 (15.8)	1 (7.7)	4 (12.5)
high school	1 (5.3)	1 (7.7)	2 (6.3)
some college	3 (15.8)	0 (0.0)	3 (9.4)
certificate / diploma	5 (26.3)	0 (0.0)	5 (15.6)
Master's degree	2 (10.5)	3 (23.1)	5 (15.6)
Doctoral degree	1 (5.3)	2 (15.4)	3 (9.4)
lawyer	1 (5.3)	0 (0.0)	1 (3.1)
medical doctor	3 (15.8)	5 (38.5)	8 (25.0)
NR	0 (0.0)	1 (7.7)	1 (3.1)

Cramer's V = .59    significance = .19

N = 32

\* percentages indicated by ( )

**RELIGION BY SEX**

Frequencies and Percentages\*

RELIGION	FEMALE	MALE	TOTAL
none	8 (42.1)	4 (30.8)	12 (37.5)
Catholic	0 (0.0)	1 (7.7)	1 (3.1)
Protestant	8 (42.1)	6 (46.2)	14 (43.8)
other	1 (5.3)	0 (0.0)	1 (3.1)
NR	2 (10.5)	2 (15.4)	4 (12.5)

Cramer's V = .28    significance = .63

N = 32

\*percentages indicated by ( )

**RELIGIOSITY BY SEX**

Frequencies and Percentages \*

RELIGIOSITY	FEMALE	MALE	TOTAL
not at all	6 (31.6)	2 (15.4)	8 (25.0)
barely	4 (21.1)	2 (15.4)	6 (18.8)
somewhat	6 (31.6)	5 (38.5)	11 (34.4)
extremely	2 (10.5)	1 (7.7)	3 (9.4)
NR	1 (5.3)	3 (23.1)	4 (12.5)

Cramer's V = .31    significance = .55

N = 32

\*percentages indicated by ( )

**CHURCH ATTENDANCE BY SEX**

Frequencies and Percentages \*

ATTENDANCE	FEMALE	MALE	TOTAL
never	12 (63.2)	3 (23.1)	15 (46.9)
several times per year	4 (21.1)	4 (30.8)	8 (25.0)
1 - 3 times per month	2 (10.5)	2 (15.4)	4 (12.5)
once per week or more	0 (0.0)	2 (15.4)	2 (6.3)
NR	1 (5.3)	2 (15.4)	3 (9.4)

Cramer's V = .46    significance = .14

N = 32

\* percentages indicated by ( )

## KNOWLEDGE OF 'IN VITRO' FERTILIZATION

**TABLE 1A**  
**Frequencies and Percentages \***

		FAMILIAR	NOT FAMILIAR	ASSOCIATION Phi / V	SIGNIFICANCE
SEX	FEMALE	16 (84.2)	3 (15.8)	.266 (Phi)	.132
	MALE	13 (100)	0 (0.0)		
AGE	31 -35	3 (100.0)	0 (0.0)	.389 (V)	.772
	36 - 40	7 (77.8)	2 (22.2)		
	41 - 45	3 (75.0)	1 (25.0)		
	46 -50	6 (100.0)	0 (0.0)		
	51 - 55	5 (100.0)	0 (0.0)		
	56 - 60	1 (100.0)	0 (0.0)		
	61 - 65	2 (100.0)	0 (0.0)		
	66+	1 (100.0)	0 (0.0)		
	N.R.	1 (100.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED	0 (0.0)	0 (0.0)	.483 (V)	.328
	MARRIED	19 (100.0)	0 (0.0)		
	COMMON LAW	0 (0.0)	0 (0.0)		
	SEPARATED	1 (100.0)	0 (0.0)		
	DIVORCED	3 (75.0)	1 (25.0)		
	WIDOWED	0 (0.0)	0 (0.0)		
	OTHER	5 (83.3)	1 (16.7)		
	NR	1 (50.0)	1 (50.0)		
CHILDREN	0	6 (85.7)	1 (14.3)	.506 (V)	.225
	1	2 (66.7)	1 (33.3)		
	2	9 (100.0)	0 (0.0)		
	3	7 (100.0)	0 (0.0)		
	4	3 (100.0)	0 (0.0)		
	6	1 (100.0)	0 (0.0)		
	NR	1 (100.0)	0 (0.0)		
EDUCATION LEVEL	COMBINATION	4 (100.0)	0 (0.0)	.408 (V)	.723
	HIGHSCHOOL	2 (100.0)	0 (0.0)		
	SOME COLLEGE	2 (66.7)	1 (33.3)		
	CERT./DIPLOMA	4 (80.0)	1 (20.0)		
	BACHELOR	0 (0.0)	0 (0.0)		
	MASTERS	4 (80.0)	1 (20.0)		
	DOCTORAL	3 (100.0)	0 (0.0)		
	LAWYER	1 (100.0)	0 (0.0)		
	MED. DOCTOR	8 (100.0)	0 (0.0)		
	N.R.	1 (100.0)	0 (0.0)		
RELIGION	NONE	10 (83.3)	2 (16.7)	.333 (V)	.469
	CATHOLIC	1 (100.0)	0 (0.0)		
	PROTESTANT	14 (100.0)	0 (0.0)		
	JEWISH	0 (0.0)	0 (0.0)		
	OTHER	1 (100.0)	0 (0.0)		
	N.R.	3 (75.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	7 (87.5)	1 (12.5)	.356(V)	.399
	BARELY	5 (83.3)	1 (16.7)		
	SOMEWHAT	11 (100.0)	0 (0.0)		
	EXTREMELY	2 (66.7)	1 (33.0)		
	N.R.	4 (100.0)	0 (0.0)		
ATTEND RELIGIOUS SERVICES	NEVER	13 (86.7)	2 (13.3)	.342 (V)	.441
	SEVERAL/YR	8 (100.0)	0 (0.0)		
	1-3/MONTH	4 (100.0)	0 (0.0)		
	1/WK +	2 (100.0)	0 (0.0)		
	N.R.	2 (66.7)	1 (33.3)		

N = 32

\* percentages indicated by ( )

## RATING OF 'IN VITRO' FERTILIZATION

**TABLE 1B**  
Frequencies and Percentages \*

		BENEFICIAL	DETRIMNTL	CAN BE BOTH	NOT FAMILIAR	NR	ASSOC	SIGNIF
SEX	FEMALE	9 (47.4)	1 (5.3)	7 (36.8)	2 (10.5)	0 (0.0)	.335 (Phi)	.465
	MALE	7 (53.8)	0 (0.0)	5 (38.5)	0 (0.0)	1 (7.7)		
AGE	31-35	2 (66.7)	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)	.617 (V)	.030
	36-40	3 (33.3)	1 (11.1)	4 (44.4)	1 (11.1)	0 (0.0)		
	41-45	2 (50.0)	0 (0.0)	1 (25.0)	1 (25.0)	0 (0.0)		
	46-50	5 (83.3)	0 (0.0)	1 (16.7)	0 (0.0)	0 (0.0)		
	51-55	1 (20.0)	0 (0.0)	4 (80.0)	0 (0.0)	0 (0.0)		
	56-60	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	61-65	2 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	66+	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED						.548 (V)	.001
	MARRIED	11 (57.9)	0 (0.0)	8 (42.1)	0 (0.0)	0 (0.0)		
	COMMON LAW							
	SEPARATED	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	DIVORCED	2 (50.0)	0 (0.0)	1 (25.0)	1 (25.0)	0 (0.0)		
	WIDOWED							
	OTHER	2 (33.3)	0 (0.0)	3 (50.0)	1 (16.7)	0 (0.0)		
	NR	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	1 (50.0)		
CHILDREN	0	4 (57.1)	0 (0.0)	2 (28.6)	1 (14.3)	0 (0.0)	.598 (V)	.005
	1	2 (66.7)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		
	2	6 (66.7)	0 (0.0)	3 (33.3)	0 (0.0)	0 (0.0)		
	3	3 (42.9)	0 (0.0)	4 (57.1)	0 (0.0)	0 (0.0)		
	4	0 (0.0)	0 (0.0)	3 (100.0)	0 (0.0)	0 (0.0)		
	6	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
		NR	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	1 (50.0)	
EDUCATION LEVEL	COMBINATION	1 (25.0)	0 (0.0)	3 (75.0)	0 (0.0)	0 (0.0)	.660 (V)	.006
	HIGHSCHOOL	2 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	SOME COLLEGE	2 (66.7)	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)		
	CERT/DIPLOMA	1 (20.0)	0 (0.0)	3 (60.0)	1 (20.0)	0 (0.0)		
	BACHELOR	1 (20.0)	0 (0.0)	3 (60.0)	1 (20.0)	0 (0.0)		
	MASTERS	2 (40.0)	0 (0.0)	2 (40.0)	1 (20.0)	0 (0.0)		
	DOCTORAL	2 (66.7)	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		
	MED. DOCTOR	6 (75.0)	0 (0.0)	2 (25.0)	0 (0.0)	0 (0.0)		
		N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	
RELIGION	NONE	6 (50.0)	0 (0.0)	4 (33.3)	2 (16.7)	0 (0.0)	.417 (V)	.136
	CATHOLIC	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		
	PROTESTANT	8 (57.1)	0 (0.0)	6 (42.9)	0 (0.0)	0 (0.0)		
	JEWISH							
	OTHER	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		
	N.R.	2 (50.0)	1 (25.0)	0 (0.0)	0 (0.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	3 (37.5)	1 (12.5)	4 (50.0)	0 (0.0)	0 (0.0)	.384 (V)	.275
	BARELY	4 (66.7)	0 (0.0)	1 (16.7)	1 (16.7)	0 (0.0)		
	SOMEWHAT	7 (63.6)	0 (0.0)	4 (36.4)	0 (0.0)	0 (0.0)		
	EXTREMELY	1 (33.3)	0 (0.0)	1 (33.3)	1 (33.3)	0 (0.0)		
		N.R.	1 (25.0)	0 (0.0)	2 (50.0)	0 (0.0)	1 (25.0)	
ATTEND RELIGIOUS SERVICES	NEVER	6 (40.0)	0 (0.0)	7 (46.7)	2 (13.3)	0 (0.0)	.487 (V)	.016
	SEVERAL/YR	7 (87.5)	0 (0.0)	1 (12.5)	0 (0.0)	0 (0.0)		
	1-3/MONTH	2 (50.0)	0 (0.0)	2 (50.0)	0 (0.0)	0 (0.0)		
	1/WK +	0 (0.0)	0 (0.0)	2 (100.0)	0 (0.0)	0 (0.0)		
		N.R.	1 (33.3)	1 (33.3)	0 (0.0)	0 (0.0)	1 (33.3)	

N = 32

\* percentages indicated by ( )

## POLICY REGARDING 'IN VITRO' FERTILIZATION

TABLE 1C  
Frequencies and Percentages \*

		ALLOW POLICY	DISALLOW POLICY	NO POLICY	AMBIV	NOTFAM	NR	ASSOC	SIGNIF
SEX	FEMALE	5 (26.3)	1 (5.3)	7 (36.8)	2 (10.5)	2 (10.5)	2 (10.5)	.474 (Phi)	.206
	MALE	9 (69.2)	0 (0.0)	3 (23.1)	0 (0.0)	0 (0.0)	1 (7.7)		
AGE	31-35	0 (0.0)	0 (0.0)	2 (66.7)	0 (0.0)	0 (0.0)	1 (33.3)	.641 (V)	.006
	36-40	3 (33.3)	0 (0.0)	4 (44.4)	1 (11.1)	1 (11.1)	0 (0.0)		
	41-45	2 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (25.0)	1 (25.0)		
	46-50	5 (83.3)	0 (0.0)	1 (16.7)	0 (0.0)	0 (0.0)	0 (0.0)		
	51-55	3 (60.0)	0 (0.0)	1 (20.0)	1 (20.0)	0 (0.0)	0 (0.0)		
	56-60	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	61-65	0 (0.0)	0 (0.0)	2 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	66+	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED							.496 (V)	.051
	MARRIED	11 (57.9)	0 (0.0)	7 (36.8)	0 (0.0)	0 (0.0)	1 (5.3)		
	COMMON LAW								
	SEPARATED	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	DIVORCED	0 (0.0)	0 (0.0)	1 (25.0)	1 (25.0)	1 (25.0)	1 (25.0)		
	WIDOWED								
	OTHER	3 (50.0)	1 (16.7)	1 (16.7)	0 (0.0)	1 (16.7)	0 (0.0)		
NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
CHILDREN	0	2 (28.6)	0 (0.0)	4 (57.1)	0 (0.0)	1 (15.3)	0 (0.0)	.496 (V)	.117
	1	0 (0.0)	0 (0.0)	2 (66.7)	0 (0.0)	1 (33.3)	0 (0.0)		
	2	4 (44.4)	1 (11.1)	2 (22.2)	0 (0.0)	0 (0.0)	2 (22.2)		
	3	6 (85.7)	0 (0.0)	1 (14.3)	0 (0.0)	0 (0.0)	0 (0.0)		
	4	2 (66.7)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)		
	6	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	NR	0 (0.0)	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)		
EDUCATION LEVEL	COMBINATION	2 (50.0)	0 (0.0)	2 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	.470 (V)	.678
	HIGHSCHOOL	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)	0 (0.0)	1 (33.3)	1 (33.3)	0 (0.0)	1 (33.3)		
	CERT/DIPLOMA	3 (60.0)	1 (20.0)	0 (0.0)	0 (0.0)	1 (20.0)	0 (0.0)		
	BACHELOR	3 (60.0)	1 (20.0)	0 (0.0)	0 (0.0)	1 (20.0)	0 (0.0)		
	MASTERS	3 (60.0)	0 (0.0)	1 (20.0)	0 (0.0)	1 (20.0)	0 (0.0)		
	DOCTORAL	2 (66.7)	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	MED. DOCTOR	3 (37.5)	0 (0.0)	3 (37.5)	1 (12.5)	0 (0.0)	1 (12.5)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
RELIGION	NONE	5 (41.7)	0 (0.0)	5 (41.7)	0 (0.0)	2 (16.7)	0 (0.0)	.624 (V)	.000
	CATHOLIC	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	PROTESTANT	7 (50.0)	0 (0.0)	5 (35.7)	1 (7.1)	0 (0.0)	1 (7.1)		
	JEWISH								
	OTHER	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	1 (25.0)	0 (0.0)	0 (0.0)	1 (25.0)	0 (0.0)	2 (50.0)		
RELIGIOSITY	NOT AT ALL	4 (50.0)	0 (0.0)	3 (37.5)	1 (12.5)	0 (0.0)	0 (0.0)	.405 (V)	.396
	BARELY	1 (16.7)	0 (0.0)	2 (33.3)	1 (16.7)	1 (16.7)	1 (16.7)		
	SOMEWHAT	6 (54.5)	0 (0.0)	4 (36.4)	0 (0.0)	0 (0.0)	1 (9.1)		
	EXTREMELY	1 (33.3)	0 (0.0)	1 (33.3)	0 (0.0)	1 (33.3)	0 (0.0)		
	N.R.	2 (50.0)	1 (25.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	6 (40.0)	0 (0.0)	5 (33.3)	1 (6.7)	2 (13.3)	1 (6.7)	.400 (V)	.429
	SEVERAL/YR	3 (37.5)	0 (0.0)	4 (50.0)	0 (0.0)	0 (0.0)	1 (12.5)		
	1-3/MONTH	2 (50.0)	1 (25.0)	1 (25.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	1/WK +	2 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	1 (33.3)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	1 (33.3)		

N = 32

\* percentages indicated by ( )

**FUNDING OF 'IN VITRO' FERTILIZATION**

**TABLE 1D**  
**Frequencies and Percentages \***

		PUBLIC FUND	PRIVATE FUND	PRIV & PUBLIC	NOFUND	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	4 (21.1)	3 (15.8)	9 (47.4)			1 (5.3)	2 (10.5)	272 (Phi)	.670
	MALE	3 (23.1)	2 (15.4)	8 (61.5)			0 (0.0)	0 (0.0)		
AGE	31-35	1 (33.3)	1 (33.3)	1 (33.3)			0 (0.0)	0 (0.0)	.436 (V)	.834
	36-40	1 (11.1)	1 (11.1)	5 (55.6)			1 (11.1)	1 (11.1)		
	41-45	0 (0.0)	0 (0.0)	3 (75.0)			0 (0.0)	1 (25.0)		
	46-50	2 (33.3)	0 (0.0)	4 (66.7)			0 (0.0)	0 (0.0)		
	51-55	1 (20.0)	1 (20.0)	3 (60.0)			0 (0.0)	0 (0.0)		
	56-60	1 (100.0)	0 (0.0)	0 (0.0)			0 (0.0)	0 (0.0)		
	61-65	1 (50.0)	1 (50.0)	0 (0.0)			0 (0.0)	0 (0.0)		
	66+	0 (0.0)	0 (0.0)	1 (100.0)			0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)			0 (0.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED									
	MARRIED	4 (21.1)	2 (10.5)	13 (68.4)			0 (0.0)	0 (0.0)	.435 (V)	.084
	COMMON LAW									
	SEPARATED	1 (100.0)	0 (0.0)	0 (0.0)			0 (0.0)	0 (0.0)		
	DIVORCED	1 (25.0)	1 (25.0)	1 (25.0)			1 (25.0)	0 (0.0)		
	WIDOWED									
	OTHER	1 (16.7)	1 (16.7)	3 (50.0)			0 (0.0)	1 (16.7)		
NR	0 (0.0)	1 (50.0)	0 (0.0)			0 (0.0)	1 (50.0)			
CHILDREN	0	1 (14.3)	1 (14.3)	4 (57.1)			0 (0.0)	1 (14.3)	.483 (V)	.190
	1	0 (0.0)	0 (0.0)	2 (66.7)			1 (33.3)	0 (0.0)		
	2	3 (33.3)	2 (22.2)	4 (44.4)			0 (0.0)	0 (0.0)		
	3	2 (28.6)	0 (0.0)	5 (71.4)			0 (0.0)	0 (0.0)		
	4	0 (0.0)	1 (33.3)	2 (66.7)			0 (0.0)	0 (0.0)		
	6	1 (100.0)	0 (0.0)	0 (0.0)			0 (0.0)	0 (0.0)		
	NR	0 (0.0)	1 (50.0)	0 (0.0)			0 (0.0)	1 (50.0)		
EDUCATION LEVEL	COMBINATION	2 (50.0)	1 (25.0)	1 (25.0)			0 (0.0)	0 (0.0)	.489 (V)	.538
	HIGHSCHOOL	0 (0.0)	0 (0.0)	2 (100.0)			0 (0.0)	0 (0.0)		
	SOME COLLEGE	1 (33.3)	0 (0.0)	1 (33.3)			0 (0.0)	1 (33.3)		
	CERT./DIPLOMA	1 (20.0)	0 (0.0)	3 (60.0)			1 (20.0)	0 (0.0)		
	BACHELOR	1 (20.0)	0 (0.0)	3 (60.0)			1 (20.0)	0 (0.0)		
	MASTERS	1 (20.0)	1 (20.0)	3 (60.0)			0 (0.0)	1 (20.0)		
	DOCTORAL	1 (33.3)	0 (0.0)	2 (66.7)			0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	1 (100.0)	0 (0.0)			0 (0.0)	0 (0.0)		
	MED DOCTOR	1 (12.5)	2 (25.0)	5 (62.5)			0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)			0 (0.0)	0 (0.0)		
	RELIGION	NONE	3 (25.0)	3 (25.0)	4 (33.3)			1 (8.3)	1 (8.3)	.339 (V)
CATHOLIC		0 (0.0)	0 (0.0)	1 (100.0)			0 (0.0)	0 (0.0)		
PROTESTANT		2 (14.3)	1 (7.1)	11 (78.6)			0 (0.0)	0 (0.0)		
JEWISH										
OTHER		0 (0.0)	0 (0.0)	1 (100.0)			0 (0.0)	0 (0.0)		
N.R.		2 (50.0)	1 (25.0)	0 (0.0)			0 (0.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	2 (25.0)	2 (25.0)	3 (37.5)			0 (0.0)	1 (12.5)	.316 (V)	.690
	BARELY	1 (16.7)	1 (16.7)	3 (50.0)			1 (16.7)	0 (0.0)		
	SOMEWHAT	3 (27.3)	1 (9.1)	7 (63.6)			0 (0.0)	0 (0.0)		
	EXTREMELY	0 (0.0)	0 (0.0)	2 (66.7)			0 (0.0)	1 (33.3)		
	N.R.	1 (25.0)	1 (25.0)	2 (50.0)			0 (0.0)	0 (0.0)		
ATTEND RELIGIOUS SERVICES	NEVER	3 (20.0)	3 (20.0)	7 (46.7)			1 (6.7)	1 (6.7)	.318 (V)	.674
	SEVERAL/YR	1 (12.5)	1 (12.5)	6 (75.0)			0 (0.0)	0 (0.0)		
	1-3/MONTH	2 (50.0)	0 (0.0)	2 (50.0)			0 (0.0)	0 (0.0)		
	1/WK +	0 (0.0)	0 (0.0)	2 (100.0)			0 (0.0)	0 (0.0)		
	N.R.	1 (33.3)	1 (33.3)	0 (0.0)			0 (0.0)	1 (33.3)		

\* percentages indicated by ( )

N = 32

**ACCESS TO 'IN VITRO' FERTILIZATION****TABLE 1E**  
**Frequencies and Percentages \***

		RESTRD ACCESS	FREE ACCESS	NO ACCESS	NOT FAM	NR	ASSOC	SIGNIF	
SEX	FEMALE	9 (47.4)	5 (26.3)	1 (5.3)	2 (10.5)	2 (10.5)	.395 (Phi)	.287	
	MALE	4 (30.8)	8 (61.5)	0 (0.0)	0 (0.0)	1 (7.7)			
AGE	31 -35	0 (0.0)	3 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	.542 (V)	.227	
	36 - 40	3 (33.3)	4 (44.4)	0 (0.0)	1 (11.1)	1 (11.1)			
	41 - 45	1 (25.0)	1 (25.0)	1 (25.0)	1 (25.0)	0 (0.0)			
	46 -50	5 (83.3)	1 (16.7)	0 (0.0)	0 (0.0)	0 (0.0)			
	51 - 55	3 (60.0)	2 (40.0)	0 (0.0)	0 (0.0)	0 (0.0)			
	56 - 60	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)			
	61 - 65	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	1 (50.0)			
	66+	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)			
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
MARITAL STATUS	NEVER MARRIED						.545 (V)	.002	
	MARRIED	8 (42.1)	10 (52.6)	1 (5.3)	0 (0.0)	0 (0.0)			
	COMMON LAW								
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
	DIVORCED	2 (50.0)	1 (25.0)	0 (0.0)	1 (25.0)	0 (0.0)			
	WIDOWED								
	OTHER	3 (50.0)	2 (33.3)	0 (0.0)	1 (16.7)	0 (0.0)			
	NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)			
CHILDREN	0	4 (57.1)	2 (28.6)	0 (0.0)	1 (14.3)	0 (0.0)	.545 (V)	.002	
	1	0 (0.0)	2 (66.7)	0 (0.0)	1 (33.3)	0 (0.0)			
	2	4 (44.4)	4 (44.4)	1 (11.1)	0 (0.0)	0 (0.0)			
	3	2 (28.6)	5 (71.4)	0 (0.0)	0 (0.0)	0 (0.0)			
	4	3 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)			
	6	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
		NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)		
EDUCATION LEVEL	COMBINATION	2 (50.0)	1 (25.0)	0 (0.0)	0 (0.0)	1 (25.0)	.511 (V)	.396	
	HIGHSCHOOL	1 (50.0)	1 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)			
	SOME COLLEGE	0 (0.0)	2 (66.7)	0 (0.0)	0 (0.0)	1 (33.3)			
	CERT./DIPLOMA	4 (80.0)	0 (0.0)	0 (0.0)	1 (20.0)	0 (0.0)			
	BACHELOR	4 (80.0)	0 (0.0)	0 (0.0)	1 (20.0)	0 (0.0)			
	MASTERS	2 (40.0)	2 (40.0)	0 (0.0)	1 (20.0)	0 (0.0)			
	DOCTORAL	0 (0.0)	3 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)			
	LAWYER	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)			
	MED. DOCTOR	4 (50.0)	3 (37.5)	1 (12.5)	0 (0.0)	0 (0.0)			
		N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
RELIGION	NONE	4 (33.3)	5 (41.7)	0 (0.0)	2 (16.7)	1 (8.3)	.374 (V)	.329	
	CATHOLIC	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)			
	PROTESTANT	7 (50.0)	6 (42.9)	1 (7.1)	0 (0.0)	0 (0.0)			
	JEWISH								
	OTHER	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)			
	N.R.	0 (0.0)	2 (50.0)	0 (0.0)	0 (0.0)	2 (50.0)			
RELIGIOSITY	NOT AT ALL	2 (25.0)	4 (50.0)	0 (0.0)	0 (0.0)	2 (25.0)	.375 (V)	.322	
	BARELY	1 (16.7)	4 (66.7)	0 (0.0)	1 (16.7)	0 (0.0)			
	SOMEWHAT	6 (54.5)	4 (36.4)	1 (9.1)	0 (0.0)	0 (0.0)			
	EXTREMELY	2 (66.7)	0 (0.0)	0 (0.0)	1 (33.0)	0 (0.0)			
	N.R.	2 (50.0)	1 (25.0)	0 (0.0)	0 (0.0)	1 (25.0)			
ATTEND RELIGIOUS SERVICES	NEVER	6 (40.0)	6 (40.0)	0 (0.0)	2 (13.3)	1 (6.7)	.409 (V)	.165	
	SEVERAL/YR	3 (37.5)	4 (50.0)	1 (12.5)	0 (0.0)	0 (0.0)			
	1-3/MONTH	2 (50.0)	2 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)			
	1/WK +	2 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)			
		N.R.	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)	2 (66.7)		

N = 32

\* percentages indicated by ( )

## KNOWLEDGE OF HUMAN EMBRYO RESEARCH

**TABLE 2A**  
**Frequencies and Percentages \***

		FAMILIAR	NOT FAMILIAR	ASSOCIATION Phi / V	SIGNIFICANCE
SEX	FEMALE	10 (52.6)	9 (47.4)	.331 (Phi)	.061
	MALE	11 (84.6)	2 (15.4)		
AGE	31 -35	1 (33.3)	2 (66.7)	.421 (V)	.684
	36 - 40	5 (55.6)	4 (44.4)		
	41 - 45	3 (75.0)	1 (25.0)		
	46 -50	3 (50.0)	3 (50.0)		
	51 - 55	4 (80.0)	1 (20.0)		
	56 - 60	1 (100.0)	0 (0.0)		
	61 - 65	2 (100.0)	0 (0.0)		
	66+	1 (100.0)	0 (0.0)		
	N.R.	1 (100.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED			.272 (V)	.668
	MARRIED	14 (73.7)	5 (26.3)		
	COMMON LAW	0 (0.0)	0 (0.0)		
	SEPARATED	1 (100.0)	0 (0.0)		
	DIVORCED	2 (50.0)	2 (50.0)		
	WIDOWED	0 (0.0)	0 (0.0)		
	OTHER	3 (50.0)	3 (50.0)		
	NR	1 (50.0)	1 (50.0)		
CHILDREN	0	5 (71.4)	2 (28.6)	.349 (V)	.692
	1	1 (33.3)	2 (66.7)		
	2	5 (56.6)	4 (44.4)		
	3	6 (85.7)	1 (14.3)		
	4	2 (66.7)	1 (33.3)		
	6	1 (100.0)	0 (0.0)		
		NR	1 (50.0)		
EDUCATION LEVEL	COMBINATION	2 (50.0)	2 (50.0)	.678 (V)	.065
	HIGHSCHOOL	1 (50.0)	1 (50.0)		
	SOME COLLEGE	0 (0.0)	3 (100.0)		
	CERT./DIPLOMA	2 (40.0)	3 (60.0)		
	BACHELOR	0 (0.0)	0 (0.0)		
	MASTERS	3 (60.0)	2 (40.0)		
	DOCTORAL	3 (100.0)	0 (0.0)		
	LAWYER	1 (100.0)	0 (0.0)		
	MED. DOCTOR	8 (100.0)	0 (0.0)		
	N.R.	1 (100.0)	0 (0.0)		
RELIGION	NONE	7 (58.3)	5 (41.7)	.362 (V)	.381
	CATHOLIC	0 (0.0)	1 (100.0)		
	PROTESTANT	11 (78.6)	3 (21.4)		
	JEWISH	0 (0.0)	0 (0.0)		
	OTHER	1 (100.0)	0 (0.0)		
		N.R.	2 (50.0)		
RELIGIOSITY	NOT AT ALL	4 (50.0)	4 (50.0)	.379 (V)	.331
	BARELY	4 (66.7)	2 (33.3)		
	SOMEWHAT	8 (72.7)	3 (27.3)		
	EXTREMELY	1 (33.3)	2 (66.7)		
		N.R.	4 (100.0)		
ATTEND RELIGIOUS SERVICES	NEVER	7 (46.7)	8 (53.3)	.447 (V)	.171
	SEVERAL/YR	7 (87.5)	1 (12.5)		
	1-3/MONTH	4 (100.0)	0 (0.0)		
	1/WK +	1 (50.0)	1 (50.0)		
		N.R.	2 (66.7)		

N = 32

\* percentages indicated by ( )

## RATING OF HUMAN EMBRYO RESEARCH

**TABLE 2B**  
**Frequencies and Percentages \***

		BENEFICIAL	DETRIMNTL	CAN BE BOTH	NOT FAMILIAR	NR	ASSOC	SIGNIF
SEX	FEMALE	3 (15.8)	0 (0.0)	7 (36.8)	8 (42.1)	1 (5.3)	.473 (Phi)	.128
	MALE	5 (38.5)	1 (7.7)	6 (46.2)	1 (7.7)	0 (0.0)		
AGE	31 -35	0 (0.0)	0 (0.0)	1 (33.3)	1 (33.3)	1 (33.3)	.518 (V)	.354
	36 - 40	2 (22.2)	0 (0.0)	2 (33.3)	4 (44.4)	0 (0.0)		
	41 - 45	0 (0.0)	0 (0.0)	3 (75.0)	1 (25.0)	0 (0.0)		
	46 -50	4 (66.7)	0 (0.0)	0 (0.0)	2 (33.3)	0 (0.0)		
	51 - 55	0 (0.0)	1 (20.0)	3 (60.0)	1 (20.0)	0 (0.0)		
	56 - 60	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	61 - 65	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)		
	66+	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED						.202 (V)	.994
	MARRIED	5 (26.3)	1 (5.3)	8 (42.1)	4 (21.1)	1 (5.3)		
	COMMON LAW							
	SEPARATED	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		
	DIVORCED	1 (25.0)	0 (0.0)	1 (25.0)	2 (50.0)	0 (0.0)		
	WIDOWED							
	OTHER	2 (33.3)	0 (0.0)	2 (33.3)	2 (33.3)	0 (0.0)		
	NR	0 (0.0)	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)		
CHILDREN	0	4 (57.1)	0 (0.0)	1 (14.3)	2 (28.6)	0 (0.0)	.486 (V)	.177
	1	0 (0.0)	0 (0.0)	1 (33.3)	1 (33.3)	1 (33.3)		
	2	2 (33.3)	0 (0.0)	3 (33.3)	3 (33.3)	0 (0.0)		
	3	1 (14.3)	0 (0.0)	5 (71.4)	1 (14.3)	0 (0.0)		
	4	0 (0.0)	1 (33.3)	1 (33.3)	1 (33.3)	0 (0.0)		
	6	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		
		NR	0 (0.0)	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)	
EDUCATION LEVEL	COMBINATION	0 (0.0)	0 (0.0)	2 (50.0)	2 (50.0)	0 (0.0)	.551 (V)	.190
	HIGHSCHOOL	2 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)	0 (0.0)	0 (0.0)	2 (66.7)	1 (33.3)		
	CERT/DIPLOMA	1 (20.0)	0 (0.0)	1 (20.0)	3 (60.0)	0 (0.0)		
	BACHELOR	1 (20.0)	0 (0.0)	1 (20.0)	3 (60.0)	0 (0.0)		
	MASTERS	0 (0.0)	1 (20.0)	2 (40.0)	2 (40.0)	0 (0.0)		
	DOCTORAL	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		
	MED. DOCTOR	4 (50.0)	0 (0.0)	4 (50.0)	0 (0.0)	0 (0.0)		
		N.R.	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	
RELIGION	NONE	4 (33.3)	0 (0.0)	4 (33.3)	4 (33.3)	0 (0.0)	.230 (V)	.900
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	PROTESTANT	3 (21.4)	1 (7.1)	7 (50.0)	2 (14.3)	1 (7.1)		
	JEWISH							
	OTHER	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		
	N.R.	1 (25.0)	0 (0.0)	1 (25.0)	2 (50.0)	0 (0.0)		
RELIGIOSITY	NOT AT ALL	1 (12.5)	0 (0.0)	4 (50.0)	3 (37.5)	0 (0.0)	.346 (V)	.504
	BARELY	1 (16.7)	0 (0.0)	3 (50.0)	2 (33.3)	0 (0.0)		
	SOMEWHAT	4 (36.4)	0 (0.0)	4 (36.4)	2 (18.2)	1 (9.1)		
	EXTREMELY	1 (33.3)	0 (0.0)	0 (0.0)	2 (66.7)	0 (0.0)		
		N.R.	1 (25.0)	1 (25.0)	2 (50.0)	0 (0.0)	0 (0.0)	
ATTEND RELIGIOUS SERVICES	NEVER	2 (13.3)	0 (0.0)	6 (40.0)	6 (40.0)	1 (6.7)	.438 (V)	.079
	SEVERAL/YR	4 (50.0)	0 (0.0)	3 (37.5)	1 (12.5)	0 (0.0)		
	1-3/MONTH	1 (25.0)	0 (0.0)	3 (75.0)	0 (0.0)	0 (0.0)		
	1/WK +	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)		
		N.R.	1 (33.3)	0 (0.0)	1 (33.3)	1 (33.3)	0 (0.0)	

N = 32

\* percentages indicated by ( )

**POLICY REGARDING HUMAN EMBRYO RESEARCH**

**TABLE 2C**  
**Frequencies and Percentages \***

		ALLOW POLICY	DISALLOW POLICY	NO POLICY	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	2 (10.5)	1 (5.3)	5 (26.3)	1 (5.3)	6 (31.6)	4 (21.1)	.633 (Phi)	.025
	MALE	9 (69.2)	1 (7.7)	1 (7.7)	0 (0.0)	1 (7.7)	1 (7.7)		
AGE	31 -35	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	1 (33.3)	1 (33.3)	.529 (V)	.281
	36 - 40	3 (33.3)	0 (0.0)	2 (22.2)	0 (0.0)	3 (33.3)	2 (22.2)		
	41 - 45	2 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (25.0)	1 (25.0)		
	46 -50	3 (50.0)	0 (0.0)	1 (6.7)	1 (16.7)	1 (16.7)	0 (0.0)		
	51 - 55	2 (40.0)	1 (20.0)	0 (0.0)	0 (0.0)	1 (20.0)	1 (20.0)		
	56 - 60	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	61 - 65	0 (0.0)	0 (0.0)	2 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	66+	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED							.444 (V)	.194
	MARRIED	9 (47.4)	1 (5.3)	3 (15.8)	1 (5.3)	4 (21.1)	1 (5.3)		
	COMMON LAW								
	SEPARATED	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	DIVORCED	0 (0.0)	0 (0.0)	1 (25.0)	0 (0.0)	1 (25.0)	2 (50.0)		
	WIDOWED								
	OTHER	2 (33.3)	1 (16.7)	1 (16.7)	0 (0.0)	2 (33.3)	0 (0.0)		
	NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)		
CHILDREN	0	2 (28.6)	0 (0.0)	3 (42.9)	0 (0.0)	2 (28.6)	0 (0.0)	.512 (V)	.073
	1	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)		
	2	3 (33.3)	1 (11.1)	1 (11.1)	1 (11.1)	1 (11.1)	2 (22.2)		
	3	6 (85.7)	0 (0.0)	0 (0.0)	0 (0.0)	1 (14.3)	0 (0.0)		
	4	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)	1 (33.3)	1 (33.3)		
	6	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
		NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)	
EDUCATION LEVEL	COMBINATION	0 (0.0)	0 (0.0)	2 (50.0)	0 (0.0)		0 (0.0)	.536 (V)	.241
	HIGHSCHOOL	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)		0 (0.0)		
	SOME COLLEGE	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (66.7)		
	CERT. DIPLOMA	0 (0.0)	1 (20.0)	0 (0.0)	1 (20.0)		0 (0.0)		
	BACHELOR	0 (0.0)	1 (20.0)	0 (0.0)	1 (20.0)		0 (0.0)		
	MASTERS	3 (60.0)	1 (20.0)	0 (0.0)	0 (0.0)		0 (0.0)		
	DOCTORAL	2 (66.7)	0 (0.0)	1 (33.3)	0 (0.0)		0 (0.0)		
	LAWYER	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)		
	MED. DOCTOR	4 (50.0)	0 (0.0)	2 (25.0)	0 (0.0)		2 (25.0)		
		N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	
RELIGION	NONE	5 (41.7)	0 (0.0)	4 (33.3)	0 (0.0)		0 (0.0)	.525 (V)	.019
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)		
	PROTESTANT	5 (35.7)	1 (7.1)	2 (14.3)	1 (7.1)		2 (14.3)		
	JEWISH								
	OTHER	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)		
		N.R.	1 (25.0)	0 (0.0)	0 (0.0)	0 (0.0)		3 (75.0)	
RELIGIOSITY	NOT AT ALL	4 (50.0)	0 (0.0)	2 (25.0)	0 (0.0)		1 (12.5)	.445 (V)	.190
	BARELY	2 (33.3)	0 (0.0)	1 (16.7)	0 (0.0)		2 (33.3)		
	SOMEWHAT	4 (36.4)	0 (0.0)	2 (18.2)	1 (9.1)		1 (9.1)		
	EXTREMELY	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		0 (0.0)		
		N.R.	1 (25.0)	2 (50.0)	0 (0.0)	0 (0.0)		1 (25.0)	
ATTEND RELIGIOUS SERVICES	NEVER	5 (33.3)	0 (0.0)	3 (20.0)	0 (0.0)		2 (13.3)	.490 (V)	.059
	SEVERAL/YR	3 (37.5)	0 (0.0)	3 (37.5)	0 (0.0)		1 (12.5)		
	1-3/MONTH	2 (50.0)	1 (25.0)	0 (0.0)	1 (25.0)		0 (0.0)		
	1/WK +	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)		0 (0.0)		
		N.R.	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)		2 (66.7)	

\* percentages indicated by ( )

N = 32

## FUNDING OF HUMAN EMBRYO RESEARCH

**TABLE 2D**  
**Frequencies and Percentages \***

		PUBLIC FUND	PRIVATE FUND	PRIV & PUBLIC	NO FUND	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	3 (15.8)	1 (5.3)	6 (31.6)	1 (5.3)		3 (15.8)	5 (26.3)	.420 (Phi)	.343
	MALE	4 (30.8)	2 (15.4)	5 (38.5)	1 (7.7)		1 (7.7)	0 (0.0)		
AGE	31-35	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)		1 (33.3)	1 (33.3)	.493 (V)	.520
	36-40	2 (22.2)	0 (0.0)	3 (33.3)	0 (0.0)		3 (33.3)	1 (11.1)		
	41-45	1 (25.0)	0 (0.0)	2 (50.0)	0 (0.0)		0 (0.0)	1 (25.0)		
	46-50	1 (16.7)	1 (16.7)	3 (50.0)	0 (0.0)		0 (0.0)	1 (16.7)		
	51-55	1 (20.0)	0 (0.0)	2 (40.0)	1 (20.0)		0 (0.0)	1 (20.0)		
	56-60	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	61-65	1 (50.0)	1 (50.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	66+	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED								.364 (V)	.468
	MARRIED	5 (26.3)	2 (10.5)	7 (36.8)	1 (5.3)		1 (5.3)	3 (15.8)		
	COMMON LAW									
	SEPARATED	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	DIVORCED	0 (0.0)	0 (0.0)	2 (50.0)	0 (0.0)		2 (50.0)	0 (0.0)		
	WIDOWED									
	OTHER	1 (16.7)	0 (0.0)	2 (33.3)	1 (16.7)		1 (16.7)	1 (16.7)		
NR	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (50.0)			
CHILDREN	0	0 (0.0)	0 (0.0)	4 (57.1)	1 (14.3)		1 (14.3)	1 (14.3)	.438 (V)	.434
	1	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)		1 (33.3)	1 (33.3)		
	2	2 (22.2)	2 (22.2)	3 (33.3)	0 (0.0)		2 (22.2)	0 (0.0)		
	3	3 (42.9)	0 (0.0)	3 (42.9)	0 (0.0)		0 (0.0)	1 (14.3)		
	4	0 (0.0)	0 (0.0)	1 (33.3)	1 (33.3)		0 (0.0)	1 (33.3)		
	6	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	NR	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (50.0)		
EDUCATION LEVEL	COMBINATION	1 (25.0)	0 (0.0)	0 (0.0)	1 (25.0)		2 (50.0)	0 (0.0)	.608 (V)	.026
	HIGHSCHOOL	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (33.3)	2 (66.7)		
	CERT/DIPLOMA	0 (0.0)	1 (20.0)	1 (20.0)	0 (0.0)		1 (20.0)	2 (40.0)		
	BACHELOR	0 (0.0)	1 (20.0)	1 (20.0)	0 (0.0)		1 (20.0)	2 (40.0)		
	MASTERS	0 (0.0)	0 (0.0)	3 (60.0)	1 (20.0)		0 (0.0)	1 (20.0)		
	DOCTORAL	3 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	LAWYER	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	MED. DOCTOR	1 (12.5)	1 (25.0)	6 (75.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	RELIGION	NONE	4 (33.3)	1 (8.3)	3 (25.0)	1 (8.3)		2 (16.7)	1 (8.3)	.370 (V)
CATHOLIC		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
PROTESTANT		2 (14.3)	1 (7.1)	7 (50.0)	1 (7.1)		0 (0.0)	3 (21.4)		
JEWISH										
OTHER		0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		0 (0.0)	0 (0.0)		
N.R.		1 (25.0)	1 (25.0)	0 (0.0)	0 (0.0)		1 (25.0)	1 (25.4)		
RELIGIOSITY	NOT AT ALL	4 (50.0)	0 (0.0)	1 (12.5)	1 (12.5)		1 (12.5)	1 (12.5)	.438 (V)	.218
	BARELY	2 (33.3)	0 (0.0)	2 (33.3)	0 (0.0)		2 (33.3)	0 (0.0)		
	SOMEWHAT	0 (0.0)	2 (18.2)	6 (54.5)	0 (0.0)		0 (0.0)	3 (27.3)		
	EXTREMELY	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		1 (33.3)	1 (33.3)		
	N.R.	1 (25.0)	1 (25.0)	1 (25.0)	1 (25.0)		0 (0.0)	0 (0.0)		
ATTEND RELIGIOUS SERVICES	NEVER	4 (26.7)	0 (0.0)	4 (26.7)	1 (6.7)		3 (20.0)	3 (20.0)	.436 (V)	.228
	SEVERAL/YR	2 (25.0)	1 (12.5)	4 (50.0)	0 (0.0)		0 (0.0)	1 (12.5)		
	1-3MONTH	0 (0.0)	1 (25.0)	3 (75.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	1/WK +	0 (0.0)	0 (0.0)	0 (0.0)	1 (50.0)		1 (50.0)	0 (0.0)		
	N.R.	1 (33.3)	1 (33.3)	0 (0.0)	0 (0.0)		0 (0.0)	1 (33.3)		

\* percentages indicated by ( )

N = 32

## KNOWLEDGE OF DONATION

**TABLE 3A**  
Frequencies and Percentages \*

		FAMILIAR	NOT FAMILIAR	ASSOCIATION Phi / V	SIGNIFICANCE
SEX	FEMALE	9 (47.4)	10 (52.6)	.296 (Phi)	.095
	MALE	10 (76.9)	3 (23.1)		
AGE	31 - 35	1 (33.3)	2 (66.7)	.423 (V)	.679
	36 - 40	5 (55.6)	4 (44.4)		
	41 - 45	3 (75.0)	1 (25.0)		
	46 - 50	3 (50.0)	3 (50.0)		
	51 - 55	2 (40.0)	3 (60.0)		
	56 - 60	1 (100.0)	0 (0.0)		
	61 - 65	2 (100.0)	0 (0.0)		
	66+	1 (100.0)	0 (0.0)		
	N.R.	1 (100.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED	0 (0.0)	0 (0.0)	.357 (V)	.397
	MARRIED	10 (52.6)	9 (47.4)		
	COMMON LAW	0 (0.0)	0 (0.0)		
	SEPARATED	1 (100.0)	0 (0.0)		
	DIVORCED	4 (100.0)	0 (0.0)		
	WIDOWED	0 (0.0)	0 (0.0)		
	OTHER	3 (50.0)	3 (50.0)		
	NR	1 (50.0)	1 (50.0)		
CHILDREN	0	3 (42.9)	4 (57.1)	.310 (V)	.799
	1	2 (66.7)	1 (33.3)		
	2	6 (66.7)	3 (33.3)		
	3	5 (71.4)	2 (28.6)		
	4	1 (33.3)	2 (66.7)		
	6	1 (100.0)	0 (0.0)		
	NR	1 (50.0)	1 (50.0)		
EDUCATION LEVEL	COMBINATION	1 (25.0)	3 (75.0)	.702 (V)	.046
	HIGHSCHOOL	1 (50.0)	1 (50.0)		
	SOME COLLEGE	1 (33.3)	2 (66.7)		
	CERT./DIPLOMA	3 (60.0)	2 (40.0)		
	BACHELOR	0 (0.0)	0 (0.0)		
	MASTERS	1 (20.0)	4 (80.0)		
	DOCTORAL	3 (100.0)	0 (0.0)		
	LAWYER	0 (0.0)	1 (100.0)		
	MED. DOCTOR	8 (100.0)	0 (0.0)		
	N.R.	1 (100.0)	0 (0.0)		
RELIGION	NONE	7 (58.3)	5 (41.7)	.284 (V)	.629
	CATHOLIC	0 (0.0)	1 (100.0)		
	PROTESTANT	8 (57.1)	6 (42.9)		
	JEWISH	0 (0.0)	0 (0.0)		
	OTHER	1 (100.0)	0 (0.0)		
	N.R.	3 (75.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	3 (37.5)	5 (62.5)	.575 (V)	.032
	BARELY	6 (100.0)	0 (0.0)		
	SOMEWHAT	7 (63.6)	4 (36.4)		
	EXTREMELY	0 (0.0)	3 (100.0)		
	N.R.	3 (75.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	8 (53.3)	7 (46.7)	.702 (V)	.351
	SEVERAL/YR	6 (75.0)	2 (25.0)		
	1-3/MONTH	3 (75.0)	1 (25.0)		
	1/WK +	0 (0.0)	2 (100.0)		
	N.R.	2 (66.7)	1 (33.3)		

N = 32

\* percentages indicated by ( )

**RATING OF DONATION**

**TABLE 3B**  
**Frequencies and Percentages \***

		BENEFICIAL	DETRIMNTL	CAN BE BOTH	NOT FAMILIAR	NR	ASSOC	SIGNIF
SEX	FEMALE	4 (21.1)	1 (5.3)	4 (21.1)	8 (42.1)	2 (10.5)	.369 (Phi)	.359
	MALE	4(30.8)	0(0.0)	6 (46.2)	2 (15.4)	1 (7.7)		
AGE	31 -35	1 (33.3)	0(0.0)	0(0.0)	1 (33.3)	1 (33.3)	.590 (V)	.070
	36 - 40	2 (22.2)	0(0.0)	3 (33.3)	3 (33.3)	1 (11.1)		
	41 - 45	3 (75.0)	0(0.0)	0(0.0)	1 (25.0)	0(0.0)		
	46 -50	1 (16.7)	0(0.0)	2 (33.3)	3 (50.0)	0(0.0)		
	51 - 55	0(0.0)	0(0.0)	3 (60.0)	2 (40.0)	0(0.0)		
	56 - 60	1 (100.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)		
	61 - 65	0(0.0)	1 (50.0)	1 (50.0)	0(0.0)	0(0.0)		
	66+	0(0.0)	0(0.0)	1 (100.0)	0(0.0)	0(0.0)		
	N.R.	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED						.569 (V)	.0005
	MARRIED	5 (26.3)	0(0.0)	6 (31.6)	6 (31.6)	2 (10.5)		
	COMMON LAW							
	SEPARATED	0(0.0)	1 (100.0)	0(0.0)	0(0.0)	0(0.0)		
	DIVORCED	2 (50.0)	0(0.0)	2 (50.0)	0(0.0)	0(0.0)		
	WIDOWED							
	OTHER	1 (16.7)	0(0.0)	2 (33.3)	3 (50.0)	0(0.0)		
NR	0(0.0)	0(0.0)	0(0.0)	1 (50.0)	1 (50.0)			
CHILDREN	0	1 (14.3)	0(0.0)	2 (28.4)	4 (57.1)	0(0.0)	.603 (V)	.004
	1	1 (33.3)	0(0.0)	1 (33.3)	0(0.0)	1 (33.3)		
	2	3 (33.3)	0(0.0)	3 (33.3)	2 (22.2)	1 (11.1)		
	3	3 (42.9)	0(0.0)	2 (28.6)	2 (28.6)	0(0.0)		
	4	0(0.0)	0(0.0)	2 (66.7)	1 (33.3)	0(0.0)		
	6	0(0.0)	1 (100.0)	0(0.0)	0(0.0)	0(0.0)		
	NR	0(0.0)	0(0.0)	0(0.0)	1 (50.0)	1 (50.0)		
EDUCATION LEVEL	COMBINATION	0(0.0)	1 (25.0)	0(0.0)	3 (75.0)	0(0.0)	.634 (V)	.016
	HIGHSCHOOL	1 (50.0)	0(0.0)	0(0.0)	1 (50.0)	0(0.0)		
	SOME COLLEGE	1 (33.3)	0(0.0)	0(0.0)	1 (33.3)	1 (33.3)		
	CERT./DIPLOMA	0(0.0)	0(0.0)	3 (60.0)	2 (40.0)	0(0.0)		
	BACHELOR	0(0.0)	0(0.0)	3 (60.0)	2 (40.0)	0(0.0)		
	MASTERS	0(0.0)	0(0.0)	2 (40.0)	3 (60.0)	0(0.0)		
	DOCTORAL	2 (66.7)	0(0.0)	1 (33.3)	0(0.0)	0(0.0)		
	LAWYER	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1 (100.0)		
	MED. DOCTOR	4 (50.0)	0(0.0)	4 (50.0)	0(0.0)	0(0.0)		
	N.R.	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1 (100.0)		
RELIGION	NONE	2 (16.7)	1 (8.3)	4 (33.3)	4 (33.3)	1 (8.3)	.279 (V)	.867
	CATHOLIC	0(0.0)	0(0.0)	0(0.0)	1 (100.0)	0(0.0)		
	PROTESTANT	4 (28.6)	0(0.0)	5 (35.7)	4 (28.6)	1 (7.1)		
	JEWISH							
	OTHER	0(0.0)	0(0.0)	1 (100.0)	0(0.0)	0(0.0)		
N.R.	2 (50.0)	0(0.0)	0(0.0)	0(0.0)	1 (25.0)			
RELIGIOSITY	NOT AT ALL	1 (12.5)	1 (12.5)	1 (12.5)	4 (50.0)	1 (12.5)	.389 (V)	.248
	BARELY	3 (50.0)	0(0.0)	3 (50.0)	0(0.0)	0(0.0)		
	SOMEWHAT	3 (27.3)	0(0.0)	4 (36.4)	3 (27.3)	1 (9.1)		
	EXTREMELY	0(0.0)	0(0.0)	0(0.0)	0(0.0)	3 (100.0)		
	N.R.	1 (25.0)	0(0.0)	2 (50.0)	0(0.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	4 (26.7)	1 (6.7)	3 (20.0)	5 (33.3)	2 (13.3)	.298 (V)	.787
	SEVERAL/YR	3 (37.5)	0(0.0)	3 (37.5)	2 (25.0)	0(0.0)		
	1-3MONTH	0(0.0)	0(0.0)	3 (75.0)	1 (25.0)	0(0.0)		
	1/WK +	0(0.0)	0(0.0)	1 (50.0)	1 (50.0)	0(0.0)		
	N.R.	1 (33.3)	0(0.0)	0(0.0)	1 (33.3)	1 (33.3)		

N = 32

\* percentages indicated by ( )

## POLICY REGARDING DONATION

TABLE 3C  
Frequencies and Percentages \*

		ALLOW POLICY	DISALLOW POLICY	NO POLICY	AMBRV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	3 (15.8)	1 (5.3)	3 (15.8)		8 (42.1)	4 (21.1)	.625 (Phi)	.014
	MALE	10 (76.9)	0 (0.0)	0 (0.0)		2 (15.4)	1 (7.7)		
AGE	31 - 35	0 (0.0)	0 (0.0)	0 (0.0)		2 (66.7)	1 (33.3)	.622 (V)	.025
	36 - 40	4 (44.4)	0 (0.0)	1 (11.1)		3 (33.3)	1 (11.1)		
	41 - 45	2 (50.0)	0 (0.0)	0 (0.0)		1 (25.0)	1 (25.0)		
	46 - 50	3 (50.0)	0 (0.0)	1 (16.7)		2 (33.3)	0 (0.0)		
	51 - 55	2 (40.0)	0 (0.0)	0 (0.0)		2 (40.0)	1 (20.0)		
	56 - 60	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	61 - 65	1 (50.0)	0 (0.0)	1 (50.0)		0 (0.0)	0 (0.0)		
	66+	0 (0.0)	1 (100.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED							.523 (V)	.004
	MARRIED	10 (52.6)	0 (0.0)	1 (5.3)		7 (36.8)	1 (5.3)		
	COMMON LAW								
	SEPARATED	0 (0.0)	1 (100.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	DIVORCED	1 (25.0)	0 (0.0)	1 (25.0)		0 (0.0)	2 (50.0)		
	WIDOWED								
	OTHER	2 (33.3)	1 (16.7)	0 (0.0)		3 (50.0)	0 (0.0)		
NR	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	2 (100.0)			
CHILDREN	0	2 (28.6)	0 (0.0)	2 (28.6)		3 (42.9)	0 (0.0)	.516 (V)	.082
	1	2 (66.7)	0 (0.0)	0 (0.0)		1 (33.3)	0 (0.0)		
	2	3 (33.3)	1 (11.1)	0 (0.0)		3 (33.3)	2 (22.2)		
	3	5 (71.4)	0 (0.0)	0 (0.0)		2 (28.6)	0 (0.0)		
	4	1 (33.3)	0 (0.0)	0 (0.0)		1 (33.3)	1 (33.3)		
	6	0 (0.0)	0 (0.0)	1 (100.0)		0 (0.0)	0 (0.0)		
	NR	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	2 (100.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	0 (0.0)	1 (25.0)		3 (75.0)	0 (0.0)	.572 (V)	.113
	HIGHSCHOOL	1 (50.0)	0 (0.0)	1 (50.0)		0 (0.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)	0 (0.0)	0 (0.0)		1 (33.3)	2 (66.7)		
	CERT/DIPLOMA	2 (40.0)	1 (20.0)	0 (0.0)		2 (40.0)	0 (0.0)		
	BACHELOR	2 (40.0)	1 (20.0)	0 (0.0)		2 (40.0)	0 (0.0)		
	MASTERS	2 (40.0)	0 (0.0)	0 (0.0)		3 (60.0)	0 (0.0)		
	DOCTORAL	3 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	MED. DOCTOR	5 (62.5)	0 (0.0)	1 (12.5)		0 (0.0)	2 (25.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
RELIGION	NONE	5 (41.7)	0 (0.0)	0 (0.0)		5 (41.7)	0 (0.0)	.615 (V)	.000
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	PROTESTANT	7 (50.0)	0 (0.0)	0 (0.0)		4 (28.6)	2 (14.3)		
	JEWISH								
	OTHER	0 (0.0)	1 (50.0)	1 (50.0)		0 (0.0)	0 (0.0)		
	N.R.	1 (25.0)	0 (0.0)	0 (0.0)		0 (0.0)	3 (75.0)		
RELIGIOSITY	NOT AT ALL	2 (25.0)	0 (0.0)	1 (12.5)		4 (50.0)	1 (12.5)	.398 (V)	.208
	BARELY	4 (66.7)	0 (0.0)	0 (0.0)		0 (0.0)	2 (33.3)		
	SOMEWHAT	5 (45.5)	0 (0.0)	1 (9.1)		4 (36.4)	1 (9.1)		
	EXTREMELY	0 (0.0)	0 (0.0)	1 (33.3)		2 (66.7)	0 (0.0)		
	N.R.	2 (50.0)	1 (25.0)	0 (0.0)		0 (0.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	4 (26.7)	0 (0.0)	2 (13.3)		7 (46.7)	2 (13.3)	.388(V)	.253
	SEVERAL/YR	5 (62.5)	0 (0.0)	1 (12.5)		1 (12.5)	1 (12.5)		
	1-3MONTH	2 (50.0)	1 (25.0)	0 (0.0)		1 (25.0)	0 (0.0)		
	1/WK +	1 (50.0)	0 (0.0)	0 (0.0)		1 (50.0)	0 (0.0)		
	N.R.	1 (33.3)	0 (0.0)	0 (0.0)		0 (0.0)	2 (66.7)		

N = 32

\* percentages indicated by ( )

## FUNDING OF DONATION

**TABLE 3D**  
Frequencies and Percentages \*

		PUBLIC FUND	PRIVATE FUND	PRIV & PUBLIC	NO FUND	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	3 (15.8)	0 (0.0)	5 (26.3)	1 (5.3)		3 (15.8)	7 (36.8)	.579 (Phi)	.057
	MALE	2 (15.4)	3 (23.1)	6 (46.2)	0 (0.0)		2 (15.4)	0 (0.0)		
AGE	31 -35	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)		1 (33.3)	1 (33.3)		
	36 - 40	1 (11.1)	0 (0.0)	4 (44.4)	0 (0.0)		2 (22.2)	2 (22.2)		
	41 - 45	0 (0.0)	0 (0.0)	3 (75.0)	0 (0.0)		0 (0.0)	1 (25.0)		
	46 - 50	2 (33.3)	1 (16.7)	1 (16.7)	0 (0.0)		1 (16.7)	1 (16.7)		
	51 - 55	0 (0.0)	0 (0.0)	2 (40.0)	0 (0.0)		1 (20.0)	2 (40.0)		
	56 - 60	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	61 - 65	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)		0 (0.0)	0 (0.0)		
	66+	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED								.596 (V)	.001
	MARRIED	2 (10.5)	1 (5.3)	9 (47.4)	0 (0.0)		3 (15.8)	4 (21.1)		
	COMMON LAW									
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		0 (0.0)	0 (0.0)		
	DIVORCED	2 (50.0)	0 (0.0)	1 (25.0)	0 (0.0)		0 (0.0)	1 (25.0)		
	WIDOWED									
	OTHER	1 (16.7)	1 (16.7)	1 (16.7)	0 (0.0)		2 (33.3)	1 (16.7)		
NR	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (50.0)			
CHILDREN	0	1 (14.3)	0 (0.0)	3 (42.9)	0 (0.0)		2 (28.6)	1 (14.3)	.557 (V)	.014
	1	1 (33.3)	0 (0.0)	1 (33.3)	0 (0.0)		0 (0.0)	1 (33.3)		
	2	2 (22.2)	2 (22.2)	2 (22.2)	0 (0.0)		2 (22.2)	1 (11.1)		
	3	1 (14.3)	0 (0.0)	4 (57.1)	0 (0.0)		1 (14.3)	1 (14.3)		
	4	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		0 (0.0)	2 (66.7)		
	6	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		0 (0.0)	0 (0.0)		
	NR	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (50.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	0 (0.0)	0 (0.0)	1 (25.0)		3 (75.0)	0 (0.0)	.593 (V)	.046
	HIGHSCHOOL	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	SOME COLLEGE	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	2 (66.7)		
	CERT/DIPLOMA	2 (40.0)	0 (0.0)	1 (20.0)	0 (0.0)		0 (0.0)	2 (40.0)		
	BACHELOR	2 (40.0)	0 (0.0)	1 (20.0)	0 (0.0)		0 (0.0)	2 (40.0)		
	MASTERS	0 (0.0)	0 (0.0)	2 (40.0)	0 (0.0)		2 (40.0)	1 (20.0)		
	DOCTORAL	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)		0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
	MED. DOCTOR	1 (12.5)	1 (12.5)	5 (62.5)	0 (0.0)		0 (0.0)	1 (12.5)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	RELIGION	NONE	2 (16.7)	2 (16.7)	2 (16.7)	1 (8.3)		3 (25.0)	2 (16.7)	.420 (V)
CATHOLIC		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
PROTESTANT		1 (7.1)	0 (0.0)	8 (57.1)	0 (0.0)		1 (7.1)	4 (28.6)		
JEWISH										
OTHER		0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		0 (0.0)	0 (0.0)		
N.R.		2 (50.0)	1 (25.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	0 (0.0)	1 (12.5)	1 (12.5)	1 (12.5)		3 (37.5)	2 (25.0)	.356 (V)	.702
	BARELY	2 (33.3)	0 (0.0)	3 (50.0)	0 (0.0)		0 (0.0)	1 (16.7)		
	SOMEWHAT	2 (18.2)	1 (9.1)	4 (36.4)	0 (0.0)		0 (0.0)	1 (16.7)		
	EXTREMELY	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		1 (33.3)	1 (33.3)		
	N.R.	1 (25.0)	1 (25.0)	2 (50.0)	0 (0.0)		0 (0.0)	0 (0.0)		
ATTEND RELIGIOUS SERVICES	NEVER	2 (13.3)	1 (6.7)	3 (20.0)	1 (6.7)		3 (20.0)	5 (33.3)	.348 (V)	.746
	SEVERAL/YR	1 (12.5)	1 (12.5)	5 (62.5)	0 (0.0)		0 (0.0)	1 (12.5)		
	1-3/MONTH	1 (25.0)	0 (0.0)	2 (50.0)	0 (0.0)		1 (25.0)	0 (0.0)		
	1/WK +	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)		1 (50.0)	0 (0.0)		
	N.R.	1 (33.3)	1 (33.3)	0 (0.0)	0 (0.0)		0 (0.0)	1 (33.3)		

\* percentages indicated by ( )

N = 32

## ACCESS TO DONATION

TABLE 3E  
Frequencies and Percentages \*

		RESTRD ACCESS	FREE ACCESS	NO ACCESS	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	7 (36.8)	2 (10.5)		4 (21.1)	6 (31.6)	.391 (Phi)	.179
	MALE	5 (38.5)	5 (38.5)		2 (15.4)	1 (7.7)		
AGE	31 -35	1 (33.3)	0 (0.0)		1 (33.3)	1 (33.3)	.422 (V)	.846
	36 - 40	2 (22.2)	3 (33.3)		2 (22.2)	2 (22.2)		
	41 - 45	2 (50.0)	1 (25.0)		1 (25.0)	0 (0.0)		
	46 -50	3 (50.0)	1 (16.7)		1 (16.7)	1 (16.7)		
	51 - 55	3 (60.0)	0 (0.0)		1 (20.0)	1 (20.0)		
	56 - 60	0 (0.0)	1 (100.0)		0 (0.0)	0 (0.0)		
	61 - 65	0 (0.0)	1 (50.0)		0 (0.0)	1 (50.0)		
	66+	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
	N.R.	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED						.420 (V)	.154
	MARRIED	8 (42.1)	5 (26.3)		3 (15.8)	3 (15.8)		
	COMMON LAW							
	SEPARATED	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
	DIVORCED	2 (50.0)	1 (25.0)		0 (0.0)	1 (25.0)		
	WIDOWED							
	OTHER	2 (33.3)	1 (16.7)		3 (50.0)	0 (0.0)		
NR	0 (0.0)	0 (0.0)		0 (0.0)	2 (100.0)			
CHILDREN	0	4 (57.1)	0 (0.0)		3 (42.9)	0 (0.0)	.517 (V)	.108
	1	1 (33.3)	2 (66.7)		0 (0.0)	0 (0.0)		
	2	3 (33.3)	2 (22.2)		1 (11.1)	3 (33.3)		
	3	2 (28.6)	3 (42.9)		1 (14.3)	1 (14.3)		
	4	2 (66.7)	0 (0.0)		1 (33.3)	0 (0.0)		
	6	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
	NR	0 (0.0)	0 (0.0)		0 (0.0)	2 (100.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	0 (0.0)		3 (75.0)	1 (25.0)	.594 (V)	.088
	HIGHSCHOOL	1 (50.0)	1 (50.0)		0 (0.0)	0 (0.0)		
	SOME COLLEGE	1 (33.3)	0 (0.0)		0 (0.0)	2 (66.7)		
	CERT./DIPLOMA	2 (40.0)	1 (20.0)		1 (20.0)	1 (20.0)		
	BACHELOR	2 (40.0)	1 (20.0)		1 (20.0)	1 (20.0)		
	MASTERS	1 (20.0)	1 (20.0)		2 (40.0)	1 (20.0)		
	DOCTORAL	1 (33.3)	2 (66.7)		0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
	MED. DOCTOR	6 (75.0)	2 (25.0)		0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
RELIGION	NONE	3 (25.0)	3 (25.0)		3 (25.0)	3 (25.0)	.424 (V)	.140
	CATHOLIC	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	PROTESTANT	8 (57.1)	3 (21.4)		2 (14.3)	1 (7.1)		
	JEWISH							
	OTHER	1 (100.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (25.0)		0 (0.0)	3 (75.0)		
RELIGIOSITY	NOT AT ALL	1 (12.5)	1 (12.5)		2 (25.0)	4 (50.0)	.406 (V)	.200
	BARELY	2 (33.3)	3 (50.0)		0 (0.0)	1 (16.7)		
	SOMEWHAT	6 (54.5)	2 (18.2)		2 (18.2)	1 (9.1)		
	EXTREMELY	1 (33.3)	0 (0.0)		2 (66.7)	0 (0.0)		
	N.R.	2 (50.0)	1 (25.0)		0 (0.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	5 (33.3)	2 (13.3)		4 (26.7)	4 (26.7)	.354 (V)	.443
	SEVERAL/YR	4 (50.0)	3 (37.5)		0 (0.0)	1 (12.5)		
	1-3/MONTH	2 (50.0)	1 (25.0)		1 (25.0)	0 (0.0)		
	1/WK +	1 (50.0)	0 (0.0)		1 (50.0)	0 (0.0)		
	N.R.	0 (0.0)	(33.3)		0 (0.0)	2 (66.7)		

N = 32

\* percentages indicated by ( )

## KNOWLEDGE OF ALTERNATIVE INSEMINATION

**TABLE 4A**  
**Frequencies and Percentages \***

		FAMILIAR	NOT FAMILIAR	ASSOCIATION Phi / V	SIGNIFICANCE
SEX	FEMALE	18 (94.7)	1 (5.3)	.149 (Phi)	.401
	MALE	13 (100.0)	0 (0.0)		
AGE	31 -35	3 (100.0)	0 (0.0)	.287 (V)	.955
	36 - 40	8 (88.9)	1 (11.1)		
	41 - 45	4 (100.0)	0 (0.0)		
	46 -50	6 (100.0)	0 (0.0)		
	51 - 55	5 (100.0)	0 (0.0)		
	56 - 60	1 (100.0)	0 (0.0)		
	61 - 65	2 (100.0)	0 (0.0)		
	66+	1 (100.0)	0 (0.0)		
	N.R.	1 (100.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED			.696 (V)	.004
	MARRIED	19 (100.0)	0 (0.0)		
	COMMON LAW	0 (0.0)	0 (0.0)		
	SEPARATED	1 (100.0)	0 (0.0)		
	DIVORCED	4 (100.0)	0 (0.0)		
	WIDOWED	0 (0.0)	0 (0.0)		
	OTHER	6 (100.0)	0 (0.0)		
	NR	1 (50.0)	1 (50.0)		
CHILDREN	0	7 (100.0)	0 (0.0)	.696 (V)	.017
	1	3 (100.0)	0 (0.0)		
	2	9 (100.0)	0 (0.0)		
	3	7 (100.0)	0 (0.0)		
	4	3 (100.0)	0 (0.0)		
	6	1 (100.0)	0 (0.0)		
		NR	1 (100.0)		
EDUCATION LEVEL	COMBINATION	4 (100.0)	0 (0.0)	.558 (V)	.267
	HIGHSCHOOL	2 (100.0)	0 (0.0)		
	SOME COLLEGE	2 (66.7)	1 (33.3)		
	CERT./DIPLOMA	5 (100.0)	0 (0.0)		
	BACHELOR	0 (0.0)	0 (0.0)		
	MASTERS	5 (100.0)	0 (0.0)		
	DOCTORAL	3 (100.0)	0 (0.0)		
	LAWYER	1 (100.0)	0 (0.0)		
	MED. DOCTOR	8 (100.0)	0 (0.0)		
		N.R.	1 (100.0)		
RELIGION	NONE	12 (100.0)	0 (0.0)	.475 (V)	.124
	CATHOLIC	1 (100.0)	0 (0.0)		
	PROTESTANT	14 (100.0)	0 (0.0)		
	JEWISH	0 (0.0)	0 (0.0)		
	OTHER	1 (100.0)	0 (0.0)		
	N.R.	3 (75.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	7 (87.5)	1 (12.5)	.311 (V)	.542
	BARELY	6 (100.0)	0 (0.0)		
	SOMEWHAT	11 (100.0)	0 (0.0)		
	EXTREMELY	3 (100.0)	0 (0.0)		
		N.R.	4 (100.0)		
ATTEND RELIGIOUS SERVICES	NEVER	15 (100.0)	0 (0.0)	.558 (V)	.041
	SEVERAL/YR	8 (100.0)	0 (0.0)		
	1-3/MONTH	4 (100.0)	0 (0.0)		
	1/WK +	2 (100.0)	0 (0.0)		
		N.R.	2 (66.7)		

N = 32

\* percentages indicated by ( )

RATING OF ALTERNATIVE INSEMINATION

**TABLE 4B**  
**Frequencies and Percentages \***

		BENEFICIAL	DETRIMNTL	CAN BE BOTH	NOT FAMILIAR	NR	ASSOC	SIGNIF
SEX	FEMALE	9 (47.4)		10 (52.6)		0 (0.0)	.241 (Phi)	.395
	MALE	7 (53.8)		5 (38.5)		1 (7.7)		
AGE	31 -35	2 (66.7)		1 (33.3)		0 (0.0)	.764 (V)	.002
	36 - 40	5 (55.6)		4 (44.4)		0 (0.0)		
	41 - 45	3 (75.0)		1 (25.0)		0 (0.0)		
	46 -50	3 (50.0)		3 (50.0)		0 (0.0)		
	51 - 55	1 (20.0)		4 (80.0)		0 (0.0)		
	56 - 60	1 (100.0)		0 (0.0)		0 (0.0)		
	61 - 65	1 (50.0)		1 (50.0)		0 (0.0)		
	66+	0 (0.0)		1 (100.0)		0 (0.0)		
	N.R.	0 (0.0)		0 (0.0)		1 (100.0)		
MARITAL STATUS	NEVER MARRIED							
	MARRIED	10 (52.6)		9 (47.4)		0 (0.0)	.542 (V)	.016
	COMMON LAW							
	SEPARATED	0 (0.0)		1 (100.0)		0 (0.0)		
	DIVORCED	3 (75.0)		1 (25.0)		0 (0.0)		
	WIDOWED							
	OTHER	2 (33.3)		4 (66.7)		0 (0.0)		
NR	1 (50.0)		0 (0.0)		1 (50.0)			
CHILDREN	0	3 (42.9)		4 (57.1)		0 (0.0)	.532 (V)	.112
	1	2 (66.7)		1 (33.3)		0 (0.0)		
	2	5 (55.6)		4 (44.4)		0 (0.0)		
	3	4 (57.1)		3 (42.9)		0 (0.0)		
	4	1 (33.3)		2 (66.7)		0 (0.0)		
	6	0 (0.0)		1 (100.0)		0 (0.0)		
	NR	1 (50.0)		0 (0.0)		1 (50.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)		4 (100.0)		0 (0.0)	.921 (V)	.000
	HIGHSCHOOL	2 (100.0)		0 (0.0)		0 (0.0)		
	SOME COLLEGE	3 (100.0)		0 (0.0)		0 (0.0)		
	CERT/DIPLOMA	0 (0.0)		5 (100.0)		0 (0.0)		
	BACHELOR	0 (0.0)		5 (100.0)		0 (0.0)		
	MASTERS	1 (20.0)		4 (80.0)		0 (0.0)		
	DOCTORAL	2 (66.7)		1 (33.3)		0 (0.0)		
	LAWYER	1 (100.0)		0 (0.0)		0 (0.0)		
	MED. DOCTOR	7 (87.5)		1 (12.5)		0 (0.0)		
	N.R.	0 (0.0)		0 (0.0)		1 (100.0)		
RELIGION	NONE	5 (41.7)		7 (58.3)		0 (0.0)	.438 (V)	.139
	CATHOLIC	0 (0.0)		1 (100.0)		0 (0.0)		
	PROTESTANT	8 (57.1)		6 (42.9)		0 (0.0)		
	JEWISH							
	OTHER	0 (0.0)		1 (100.0)		0 (0.0)		
N.R.	3 (75.0)		0 (0.0)		1 (25.0)			
RELIGIOSITY	NOT AT ALL	3 (37.5)		5 (62.5)		0 (0.0)	.392 (V)	.277
	BARELY	4 (66.7)		2 (33.3)		0 (0.0)		
	SOMEWHAT	7 (63.6)		4 (36.4)		0 (0.0)		
	EXTREMELY	1 (33.3)		2 (66.7)		0 (0.0)		
	N.R.	1 (25.0)		2 (50.0)		1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	7 (46.7)		8 (53.3)		0 (0.0)	.509 (V)	.035
	SEVERAL/YR	6 (75.0)		2 (25.0)		0 (0.0)		
	1-3/MONTH	1 (25.0)		3 (75.0)		0 (0.0)		
	1/WK +	0 (0.0)		2 (100.0)		0 (0.0)		
	N.R.	2 (66.7)		0 (0.0)		1 (33.3)		

\* percentages indicated by ( )

N = 32

## POLICY REGARDING ALTERNATIVE INSEMINATION

TABLE 4C  
Frequencies and Percentages \*

		ALLOW POLICY	DISALLOW POLICY	NO POLICY	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	11 (57.9)	1 (5.3)	5 (26.3)			2 (10.5)	.412 (Phi)	.142
	MALE	12 (92.3)	0 (0.0)	0 (0.0)			1 (7.7)		
AGE	31-35	1 (33.3)	0 (0.0)	1 (33.3)			1 (33.3)	.737 (V)	.001
	36-40	7 (77.8)	0 (0.0)	2 (22.2)			0 (0.0)		
	41-45	3 (75.0)	0 (0.0)	0 (0.0)			1 (25.0)		
	46-50	5 (83.3)	0 (0.0)	1 (16.7)			0 (0.0)		
	51-55	5 (100.0)	0 (0.0)	0 (0.0)			0 (0.0)		
	56-60	1 (100.0)	0 (0.0)	0 (0.0)			0 (0.0)		
	61-65	1 (50.0)	0 (0.0)	1 (50.0)			0 (0.0)		
	66+	0 (0.0)	1 (100.0)	0 (0.0)			0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)			1 (100.0)		
MARITAL STATUS	NEVER MARRIED							.465 (V)	.054
	MARRIED	17 (89.5)	0 (0.0)	1 (5.3)			1 (5.3)		
	COMMON LAW								
	SEPARATED	0 (0.0)	0 (0.0)	1 (100.0)			0 (0.0)		
	DIVORCED	2 (50.0)	0 (0.0)	1 (25.0)			1 (25.0)		
	WIDOWED								
	OTHER	4 (66.7)	1 (16.7)	1 (16.7)			0 (0.0)		
NR	0 (0.0)	0 (0.0)	1 (50.0)			1 (50.0)			
CHILDREN	0	4 (57.1)	0 (0.0)	3 (42.9)			0 (0.0)	.523 (V)	.093
	1	3 (100.0)	0 (0.0)	0 (0.0)			0 (0.0)		
	2	6 (66.7)	1 (11.1)	0 (0.0)			2 (22.2)		
	3	7 (100.0)	0 (0.0)	0 (0.0)			0 (0.0)		
	4	3 (100.0)	0 (0.0)	0 (0.0)			0 (0.0)		
	5	0 (0.0)	0 (0.0)	1 (100.0)			0 (0.0)		
	6	0 (0.0)	0 (0.0)	1 (50.0)			1 (50.0)		
	NR	0 (0.0)	0 (0.0)	1 (50.0)			1 (50.0)		
EDUCATION LEVEL	COMBINATION	2 (50.0)	0 (0.0)	2 (50.0)			0 (0.0)	.543 (V)	.249
	HIGHSCHOOL	1 (50.0)	0 (0.0)	1 (50.0)			0 (0.0)		
	SOME COLLEGE	1 (33.3)	0 (0.0)	1 (33.3)			1 (33.3)		
	CERT./DIPLOMA	4 (80.0)	1 (20.0)	0 (0.0)			0 (0.0)		
	BACHELOR	4 (80.0)	1 (20.0)	0 (0.0)			0 (0.0)		
	MASTERS	5 (100.0)	0 (0.0)	0 (0.0)			0 (0.0)		
	DOCTORAL	3 (100.0)	0 (0.0)	0 (0.0)			0 (0.0)		
	LAWYER	1 (100.0)	0 (0.0)	0 (0.0)			0 (0.0)		
	MED. DOCTOR	6 (75.0)	0 (0.0)	1 (12.5)			1 (12.5)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)			1 (100.0)		
	NR	0 (0.0)	0 (0.0)	0 (0.0)			1 (100.0)		
RELIGION	NONE	9 (75.0)	0 (0.0)	3 (25.0)			0 (0.0)	.675 (V)	.000
	CATHOLIC	1 (100.0)	0 (0.0)	0 (0.0)			0 (0.0)		
	PROTESTANT	12 (85.7)	0 (0.0)	1 (7.1)			1 (7.1)		
	JEWISH								
	OTHER	0 (0.0)	1 (100.0)	0 (0.0)			0 (0.0)		
	N.R.	1 (25.0)	0 (0.0)	1 (25.0)			2 (50.0)		
RELIGIOSITY	NOT AT ALL	5 (62.5)	0 (0.0)	3 (37.5)			0 (0.0)	.395 (V)	.243
	BARELY	5 (83.3)	0 (0.0)	0 (0.0)			1 (16.7)		
	SOMEWHAT	9 (81.8)	0 (0.0)	1 (9.1)			1 (9.1)		
	EXTREMELY	2 (66.7)	0 (0.0)	1 (33.3)			0 (0.0)		
	N.R.	2 (50.0)	1 (25.0)	0 (0.0)			1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	11 (73.3)	0 (0.0)	3 (20.0)			1 (6.7)	.357 (V)	.428
	SEVERAL/YR	6 (75.0)	0 (0.0)	1 (12.5)			1 (12.5)		
	1-3/MONTH	3 (75.0)	1 (25.0)	0 (0.0)			0 (0.0)		
	1/WK +	2 (100.0)	0 (0.0)	0 (0.0)			0 (0.0)		
	N.R.	1 (33.3)	0 (0.0)	1 (33.3)			1 (33.3)		

N = 32

\* percentages indicated by ( )

### FUNDING OF ALTERNATIVE INSEMINATION

**TABLE 4D**  
Frequencies and Percentages \*

		PUBLIC FUND	PRIVATE FUND	PRIV & PUBLIC	NOFUND	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	8 (42.1)	1 (5.3)	8 (42.1)				2 (10.5)	266 (Phi)	.519
	MALE	5 (38.5)	2 (15.4)	6 (46.2)				0 (0.0)		
AGE	31-35	1 (33.3)	0 (0.0)	2 (66.7)				0 (0.0)	475 (V)	.599
	36-40	3 (33.3)	1 (11.1)	4 (44.4)				1 (11.1)		
	41-45	1 (25.0)	0 (0.0)	2 (50.0)				1 (25.0)		
	46-50	3 (50.0)	1 (16.7)	2 (33.3)				0 (0.0)		
	51-55	2 (40.0)	0 (0.0)	3 (60.0)				0 (0.0)		
	56-60	1 (100.0)	0 (0.0)	0 (0.0)				0 (0.0)		
	61-65	2 (100.0)	0 (0.0)	0 (0.0)				0 (0.0)		
	66+	0 (0.0)	0 (0.0)	1 (100.0)				0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)				0 (0.0)		
MARITAL STATUS	NEVER MARRIED									
	MARRIED	9 (47.4)	1 (5.3)	9 (47.4)				0 (0.0)	428 (V)	.128
	COMMON LAW									
	SEPARATED	1 (100.0)	0 (0.0)	0 (0.0)				0 (0.0)		
	DIVORCED	2 (50.0)	0 (0.0)	2 (50.0)				0 (0.0)		
	WIDOWED									
	OTHER	1 (16.7)	1 (16.7)	3 (50.0)				1 (16.7)		
NR	0 (0.0)	1 (50.0)	0 (0.0)				0 (0.0)			
CHILDREN	0	2 (28.6)	0 (0.0)	4 (57.1)				1 (14.3)	472 (V)	.258
	1	1 (33.3)	0 (0.0)	2 (66.7)				0 (0.0)		
	2	5 (55.6)	2 (22.2)	2 (22.2)				0 (0.0)		
	3	3 (42.9)	0 (0.0)	4 (57.1)				0 (0.0)		
	4	1 (33.3)	0 (0.0)	2 (66.7)				0 (0.0)		
	6	1 (100.0)	0 (0.0)	0 (0.0)				0 (0.0)		
	NR	0 (0.0)	1 (50.0)	0 (0.0)				1 (50.0)		
EDUCATION LEVEL	COMBINATION	2 (50.0)	0 (0.0)	2 (50.0)				0 (0.0)	621 (Phi)	.044
	HIGHSCHOOL	0 (0.0)	1 (50.0)	1 (50.0)				0 (0.0)		
	SOME COLLEGE	1 (33.3)	0 (0.0)	1 (33.3)				1 (33.3)		
	CERT/DIPLOMA	4 (80.0)	0 (0.0)	1 (20.0)				0 (0.0)		
	BACHELOR	4 (80.0)	0 (0.0)	1 (20.0)				0 (0.0)		
	MASTERS	1 (20.0)	0 (0.0)	3 (60.0)				1 (20.0)		
	DOCTORAL	1 (33.3)	0 (0.0)	2 (66.7)				0 (0.0)		
	LAWYER	0 (0.0)	1 (100.0)	0 (0.0)				0 (0.0)		
	MED. DOCTOR	4 (50.0)	0 (0.0)	4 (50.0)				0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)				0 (0.0)		
RELIGION	NONE	5 (41.7)	2 (16.7)	4 (33.3)				1 (8.3)	347 (V)	.483
	CATHOLIC	0 (0.0)	0 (0.0)	1 (100.0)				0 (0.0)		
	PROTESTANT	6 (42.9)	0 (0.0)	8 (57.1)				0 (0.0)		
	JEWISH									
	OTHER	0 (0.0)	0 (0.0)	1 (100.0)				0 (0.0)		
	N.R.	2 (50.0)	1 (25.0)	0 (0.0)				1 (25.0)		
RELIGIOSITY	NOT AT ALL	2 (25.0)	2 (25.0)	3 (37.5)				1 (12.5)	389 (V)	.270
	BARELY	3 (50.0)	0 (0.0)	3 (50.0)				0 (0.0)		
	SOMEWHAT	7 (63.3)	0 (0.0)	4 (36.4)				0 (0.0)		
	EXTREMELY	0 (0.0)	0 (0.0)	2 (66.7)				1 (33.3)		
	N.R.	1 (25.0)	1 (25.0)	2 (50.0)				0 (0.0)		
ATTEND RELIGIOUS SERVICES	NEVER	5 (33.3)	2 (13.3)	7 (46.7)				1 (6.7)	365 (V)	.386
	SEVERAL/YR	5 (62.5)	0 (0.0)	3 (37.5)				0 (0.0)		
	1-3MONTH	2 (50.0)	0 (0.0)	3 (37.5)				0 (0.0)		
	1/WK +	0 (0.0)	0 (0.0)	2 (100.0)				0 (0.0)		
	N.R.	1 (33.3)	1 (33.3)	0 (0.0)				1 (33.3)		

\* percentages indicated by ( )

N = 32

**ACCESS TO ALTERNATIVE INSEMINATION****TABLE 4E**  
**Frequencies and Percentages \***

		RESTRD ACCESS	FREE ACCESS	NO ACCESS	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	8 (42.1)	9 (47.4)	1 (5.3)		1 (5.3)	.163 (Phi)	.838
	MALE	5 (38.5)	7 (53.8)	0 (0.0)		1 (7.7)		
AGE	31 -35	1 (33.3)	2 (66.7)	0 (0.0)		0 (0.0)	.603 (V)	.069
	36 -40	4 (44.4)	5 (55.6)	0 (0.0)		0 (0.0)		
	41 -45	1 (25.0)	2 (50.0)	1 (25.0)		0 (0.0)		
	46 -50	4 (66.7)	2 (33.3)	0 (0.0)		0 (0.0)		
	51 -55	2 (40.0)	3 (60.0)	0 (0.0)		0 (0.0)		
	56 -60	0 (0.0)	1 (100.0)	0 (0.0)		0 (0.0)		
	61 -65	0 (0.0)	1 (50.0)	0 (0.0)		1 (50.0)		
	66+	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)		
MARITAL STATUS	NEVER MARRIED						.516 (V)	.013
	MARRIED	9 (47.4)	9 (47.4)	1 (5.3)		0 (0.0)		
	COMMON LAW							
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)		
	DIVORCED	1 (25.0)	3 (75.0)	0 (0.0)		0 (0.0)		
	WIDOWED							
	OTHER	3 (50.0)	3 (50.0)	0 (0.0)		0 (0.0)		
NR	0 (0.0)	1 (50.0)	0 (0.0)		0 (0.0)			
CHILDREN	0	5 (71.4)	2 (28.6)	0 (0.0)		0 (0.0)	.559 (V)	.038
	1	1 (33.3)	2 (66.7)	0 (0.0)		0 (0.0)		
	2	4 (44.4)	4 (44.4)	1 (11.1)		0 (0.0)		
	3	2 (28.6)	5 (71.4)	0 (0.0)		0 (0.0)		
	4	1 (33.3)	2 (66.7)	0 (0.0)		0 (0.0)		
	6	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)		
	NR	0 (0.0)	1 (50.0)	0 (0.0)		1 (50.0)		
EDUCATION LEVEL	COMBINATION	2 (50.0)	1 (25.0)	0 (0.0)		1 (25.0)	.535 (V)	.284
	HIGHSCHOOL	1 (50.0)	1 (50.0)	0 (0.0)		0 (0.0)		
	SOME COLLEGE	1 (33.3)	2 (66.7)	0 (0.0)		0 (0.0)		
	CERT./DIPLOMA	3 (60.0)	2 (40.0)	0 (0.0)		0 (0.0)		
	BACHELOR	3 (60.0)	2 (40.0)	0 (0.0)		0 (0.0)		
	MASTERS	4 (40.0)	3 (60.0)	0 (0.0)		0 (0.0)		
	DOCTORAL	0 (0.0)	3 (100.0)	0 (0.0)		0 (0.0)		
	LAWYER	0 (0.0)	1 (100.0)	0 (0.0)		0 (0.0)		
	MED. DOCTOR	4 (50.0)	3 (37.5)	1 (12.5)		0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)		
RELIGION	NONE	4 (33.3)	7 (58.3)	0 (0.0)		1 (8.3)	.327 (V)	.594
	CATHOLIC	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)		
	PROTESTANT	7 (50.0)	6 (42.9)	1 (7.1)		0 (0.0)		
	JEWISH							
	OTHER	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)		
	N.R.	0 (0.0)	3 (75.0)	0 (0.0)		1 (25.0)		
RELIGIOSITY	NOT AT ALL	2 (25.0)	5 (62.5)	0 (0.0)		1 (12.5)	.339 (V)	.528
	BARELY	1 (16.7)	5 (83.3)	0 (0.0)		0 (0.0)		
	SOMEWHAT	6 (54.5)	4 (36.4)	1 (9.1)		0 (0.0)		
	EXTREMELY	2 (66.7)	1 (33.3)	0 (0.0)		0 (0.0)		
	N.R.	2 (50.0)	1 (25.0)	0 (0.0)		1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	5 (33.3)	9 (60.0)	0 (0.0)		1 (6.7)	.361 (V)	.404
	SEVERAL/YR	4 (50.0)	3 (37.5)	1 (12.5)		0 (0.0)		
	1-3/MONTH	2 (50.0)	2 (50.0)	0 (0.0)		0 (0.0)		
	1/WK +	2 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)		
	N.R.	0 (0.0)	2 (66.7)	0 (0.0)		1 (33.3)		

N = 32

\* percentages indicated by ( )

## KNOWLEDGE OF CRYOPRESERVATION

**TABLE 5A**  
**Frequencies and Percentages \***

		FAMILIAR	NOT FAMILIAR	ASSOCIATION Phi / V	SIGNIFICANCE
SEX	FEMALE	12 (63.2)	7 (36.8)	.234 (Phi)	.185
	MALE	11 (84.6)	2 (15.4)		
AGE	31 -35	2 (66.7)	1 (33.3)	.383 (V)	.791
	36 - 40	5 (55.6)	4 (44.4)		
	41 - 45	2 (50.0)	2 (50.0)		
	46 -50	5 (83.3)	1 (16.7)		
	51 - 55	4 (80.0)	1 (20.0)		
	56 - 60	1 (100.0)	0 (0.0)		
	61 - 65	2 (100.0)	0 (0.0)		
	66+	1 (100.0)	0 (0.0)		
	N.R.	1 (100.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED	0 (0.0)	0 (0.0)	.264 (V)	.693
	MARRIED	14 (73.7)	5 (26.3)		
	COMMON LAW	0 (0.0)	0 (0.0)		
	SEPARATED	1 (100.0)	0 (0.0)		
	DIVORCED	2 (50.0)	2 (50.0)		
	WIDOWED	0 (0.0)	0 (0.0)		
	OTHER	4 (66.7)	2 (33.3)		
NR	2 (100.0)	0 (0.0)			
CHILDREN	0	5 (71.4)	2 (28.6)	.207 (V)	.967
	1	2 (66.7)	1 (33.3)		
	2	6 (66.7)	3 (33.3)		
	3	5 (71.4)	2 (28.6)		
	4	2 (66.7)	1 (33.3)		
	6	1 (100.0)	0 (0.0)		
	NR	2 (100.0)	0 (0.0)		
EDUCATION LEVEL	COMBINATION	2 (50.0)	2 (50.0)	.546 (V)	.299
	HIGHSCHOOL	2 (100.0)	0 (0.0)		
	SOME COLLEGE	2 (66.7)	1 (33.3)		
	CERT./DIPLOMA	2 (40.0)	3 (60.0)		
	BACHELOR	0 (0.0)	0 (0.0)		
	MASTERS	4 (80.0)	1 (20.0)		
	DOCTORAL	3 (100.0)	0 (0.0)		
	LAWYER	0 (0.0)	1 (100.0)		
	MED. DOCTOR	7 (87.5)	1 (12.5)		
	N.R.	1 (100.0)	0 (0.0)		
RELIGION	NONE	8 (66.7)	4 (33.3)	.328 (V)	.487
	CATHOLIC	0 (0.0)	1 (100.0)		
	PROTESTANT	11 (78.6)	3 (21.4)		
	JEWISH	0 (0.0)	0 (0.0)		
	OTHER	1 (100.0)	0 (0.0)		
	N.R.	3 (75.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	6 (75.0)	2 (25.0)	.349 (V)	.421
	BARELY	4 (66.7)	2 (33.3)		
	SOMEWHAT	8 (72.7)	3 (27.3)		
	EXTREMELY	1 (33.3)	2 (66.7)		
	N.R.	4 (100.0)	0 (0.0)		
ATTEND RELIGIOUS SERVICES	NEVER	8 (53.3)	7 (46.7)	.459 (V)	.151
	SEVERAL/YR	7 (87.5)	1 (12.5)		
	1-3/MONTH	4 (100.0)	0 (0.0)		
	1/WK +	1 (50.0)	1 (50.0)		
	N.R.	3 (100.0)	0 (0.0)		

N = 32

## RATING OF CRYOPRESERVATION

**TABLE 5B**  
Frequencies and Percentages \*

		BENEFICIAL	DETRIMNTL	CAN BE BOTH	NOT FAMILIAR	NR	ASSOC	SIGNIF
SEX	FEMALE	3 (15.8)		8 (42.1)	7 (36.8)	1 (5.3)	.452 (Phi)	.088
	MALE	7 (53.8)		4 (30.8)	1 (7.7)	1 (7.7)		
AGE	31 - 35	1 (33.3)		1 (33.3)	1 (33.3)	0 (0.0)	.562 (V)	.174
	36 - 40	2 (22.2)		2 (22.2)	4 (44.4)	1 (11.1)		
	41 - 45	3 (75.0)		0 (0.0)	1 (25.0)	0 (0.0)		
	46 - 50	1 (16.7)		4 (66.7)	1 (16.7)	0 (0.0)		
	51 - 55	1 (20.0)		3 (60.0)	1 (20.0)	0 (0.0)		
	56 - 60	1 (100.0)		0 (0.0)	0 (0.0)	0 (0.0)		
	61 - 65	1 (50.0)		1 (50.0)	0 (0.0)	0 (0.0)		
	66+	0 (0.0)		1 (100.0)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)		0 (0.0)	0 (0.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED							
	MARRIED	9 (47.7)		6 (31.6)	3 (15.8)	1 (5.3)	.408 (V)	.193
	COMMON LAW							
	SEPARATED	0 (0.0)		1 (100.0)	0 (0.0)	0 (0.0)		
	DIVORCED	0 (0.0)		2 (50.0)	2 (50.0)	0 (0.0)		
	WIDOWED							
	OTHER	1 (16.7)		3 (50.0)	2 (33.3)	0 (0.0)		
	NR	0 (0.0)		0 (0.0)	1 (50.0)	1 (50.0)		
CHILDREN	0	1 (14.3)		4 (57.1)	2 (28.6)	0 (0.0)		
	1	2 (66.7)		0 (0.0)	1 (33.3)	0 (0.0)		
	2	3 (33.3)		3 (33.3)	2 (22.2)	1 (11.1)		
	3	4 (57.1)		2 (28.6)	1 (14.3)	0 (0.0)		
	4	0 (0.0)		2 (66.7)	1 (33.3)	0 (0.0)		
	6	0 (0.0)		1 (100.0)	0 (0.0)	0 (0.0)		
		NR	0 (0.0)		0 (0.0)	1 (50.0)	1 (50.0)	
EDUCATION LEVEL	COMBINATION	0 (0.0)		2 (50.0)	2 (50.0)	0 (0.0)	.720 (V)	.002
	HIGHSCHOOL	1 (50.0)		1 (50.0)	0 (0.0)	0 (0.0)		
	SOME COLLEGE	1 (33.3)		0 (0.0)	2 (66.7)	0 (0.0)		
	CERT/DIPLOMA	0 (0.0)		2 (40.0)	3 (60.0)	0 (0.0)		
	BACHELOR	0 (0.0)		2 (40.0)	3 (60.0)	0 (0.0)		
	MASTERS	1 (20.0)		3 (60.0)	1 (20.0)	0 (0.0)		
	DOCTORAL	2 (66.7)		1 (33.3)	0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)		0 (0.0)	0 (0.0)	1 (100.0)		
	MED. DOCTOR	5 (62.5)		3 (37.5)	0 (0.0)	0 (0.0)		
		N.R.	0 (0.0)		0 (0.0)	0 (0.0)	1 (100.0)	
RELIGION	NONE	2 (16.7)		6 (50.0)	3 (25.0)	1 (8.3)	.381 (V)	.303
	CATHOLIC	0 (0.0)		0 (0.0)	1 (100.0)	0 (0.0)		
	PROTESTANT	7 (50.0)		5 (35.7)	2 (14.3)	0 (0.0)		
	JEWISH							
	OTHER	0 (0.0)		1 (100.0)	0 (0.0)	0 (0.0)		
	N.R.	1 (25.0)		0 (0.0)	2 (50.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	1 (12.5)		4 (50.0)	2 (25.0)	1 (12.5)	.353 (V)	.450
	BARELY	3 (50.0)		1 (16.7)	2 (33.3)	0 (0.0)		
	SOMEWHAT	5 (45.5)		4 (36.4)	2 (18.2)	0 (0.0)		
	EXTREMELY	0 (0.0)		1 (33.3)	2 (66.7)	0 (0.0)		
		N.R.	1 (25.0)		2 (50.0)	0 (0.0)	1 (25.0)	
ATTEND RELIGIOUS SERVICES	NEVER	3 (20.0)		6 (40.0)	5 (33.3)	1 (6.7)	.379 (V)	.317
	SEVERAL/YR	5 (62.5)		2 (25.0)	1 (12.5)	0 (0.0)		
	1-3/MONTH	1 (25.0)		3 (75.0)	0 (0.0)	0 (0.0)		
	1/WK +	0 (0.0)		1 (50.0)	1 (50.0)	0 (0.0)		
		N.R.	1 (33.3)		0 (0.0)	1 (33.3)	1 (33.3)	

N = 32

\* percentages indicated by ( )

## POLICY REGARDING CRYOPRESERVATION

TABLE 5C  
Frequencies and Percentages \*

		ALLOW POLICY	DISALLOW POLICY	NO POLICY	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	5 (26.3)	1 (5.3)	4 (21.1)		6 (31.6)	3 (15.8)	.450 (Phi)	.166
	MALE	9 (69.2)	0 (0.0)	2 (15.4)		1 (7.7)	1 (7.7)		
AGE	31 -35	1 (33.3)	0 (0.0)	1 (33.3)		0 (0.0)	1 (33.3)	.631 (V)	.018
	36 -40	2 (22.2)	0 (0.0)	2 (22.2)		4 (44.4)	1 (11.1)		
	41 -45	2 (50.0)	0 (0.0)	0 (0.0)		1 (25.0)	1 (25.0)		
	46 -50	4 (66.7)	0 (0.0)	1 (16.7)		1 (16.7)	0 (0.0)		
	51 -55	3 (60.0)	0 (0.0)	1 (20.0)		1 (20.0)	0 (0.0)		
	56 -60	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	61 -65	1 (50.0)	0 (0.0)	1 (50.0)		0 (0.0)	0 (0.0)		
	66+	0 (0.0)	1 (100.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED							.455 (V)	.047
	MARRIED	11 (57.9)	0 (0.0)	3 (15.8)		4 (21.1)	1 (5.3)		
	COMMON LAW								
	SEPARATED	0 (0.0)	0 (0.0)	1 (100.0)		0 (0.0)	0 (0.0)		
	DIVORCED	1 (25.0)	0 (0.0)	1 (25.0)		1 (25.0)	1 (25.0)		
	WIDOWED								
	OTHER	2 (33.3)	1 (16.7)	1 (16.7)		2 (33.3)	0 (0.0)		
	NR	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	2 (100.0)		
CHILDREN	0	1 (14.3)	0 (0.0)	4 (57.1)		2 (28.6)	0 (0.0)	.533 (V)	.050
	1	2 (66.7)	0 (0.0)	0 (0.0)		1 (33.3)	0 (0.0)		
	2	4 (44.4)	1 (11.1)	0 (0.0)		2 (22.2)	2 (22.2)		
	3	5 (71.4)	0 (0.0)	1 (14.3)		1 (14.3)	0 (0.0)		
	4	2 (66.7)	0 (0.0)	0 (0.0)		1 (33.3)	0 (0.0)		
	6	0 (0.0)	0 (0.0)	1 (100.0)		0 (0.0)	0 (0.0)		
		NR	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)	
EDUCATION LEVEL	COMBINATION	0 (0.0)	0 (0.0)	2 (50.0)		2 (50.0)	0 (0.0)	.590 (V)	.069
	HIGHSCHOOL	1 (50.0)	0 (0.0)	1 (50.0)		0 (0.0)	0 (0.0)		
	SOME COLLEGE	1 (33.3)	0 (0.0)	0 (0.0)		0 (0.0)	2 (66.7)		
	CERT/DIPLOMA	1 (20.0)	1 (20.0)	0 (0.0)		3 (60.0)	0 (0.0)		
	BACHELOR	1 (20.0)	1 (20.0)	0 (0.0)		3 (60.0)	0 (0.0)		
	MASTERS	3 (60.0)	0 (0.0)	1 (20.0)		1 (20.0)	0 (0.0)		
	DOCTORAL	3 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	MED. DOCTOR	5 (62.5)	0 (0.0)	2 (25.0)		0 (0.0)	1 (12.5)		
		N.R.	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)	
RELIGION	NONE	5 (41.7)	0 (0.0)	3 (25.0)		4 (33.3)	0 (0.0)	.648 (V)	.000
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	PROTESTANT	8 (57.1)	0 (0.0)	3 (21.4)		2 (14.3)	1 (7.1)		
	JEWISH								
	OTHER	0 (0.0)	1 (100.0)	0 (0.0)		0 (0.0)	0 (0.0)		
		N.R.	1 (25.0)	0 (0.0)	0 (0.0)		0 (0.0)	3 (75.0)	
RELIGIOSITY	NOT AT ALL	3 (37.5)	0 (0.0)	2 (25.0)		2 (25.0)	1 (12.5)	.341 (V)	.531
	BARELY	3 (50.0)	0 (0.0)	1 (16.7)		1 (16.7)	1 (16.7)		
	SOMEWHAT	6 (54.5)	0 (0.0)	2 (18.2)		2 (18.2)	1 (9.1)		
	EXTREMELY	0 (0.0)	0 (0.0)	1 (33.3)		2 (66.7)	0 (0.0)		
		N.R.	2 (50.0)	1 (25.0)	0 (0.0)		0 (0.0)	1 (25.0)	
ATTEND RELIGIOUS SERVICES	NEVER	6 (40.0)	0 (0.0)	3 (20.0)		5 (33.3)	1 (6.7)	.397 (V)	.215
	SEVERAL/YR	4 (50.0)	0 (0.0)	2 (25.0)		1 (12.5)	1 (12.5)		
	1-3MONTH	2 (50.0)	1 (25.0)	1 (25.0)		0 (0.0)	0 (0.0)		
	1WK +	1 (50.0)	0 (0.0)	0 (0.0)		1 (50.0)	0 (0.0)		
		N.R.	1 (33.3)	0 (0.0)	0 (0.0)		0 (0.0)	2 (66.7)	

N = 32

\* percentages indicated by ( )

**FUNDING OF CRYOPRESERVATION**

**TABLE 5D**  
**Frequencies and Percentages \***

		PUBLIC FUND	PRIVATE FUND	PRIV & PUBLIC	NOFUND	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	1 (5.3)	3 (15.8)	6 (31.6)	2 (10.5)		3 (15.8)	4 (21.1)	.469 (Ph)	.217
	MALE	2 (15.4)	5 (38.5)	5 (38.5)	0 (0.0)		1 (7.7)	0 (0.0)		
AGE	31 - 35	0 (0.0)	1 (33.3)	1 (33.3)	0 (0.0)		1 (33.3)	0 (0.0)	.500 (V)	.470
	36 - 40	0 (0.0)	0 (0.0)	4 (44.4)	1 (11.1)		3 (33.3)	1 (11.1)		
	41 - 45	1 (25.0)	1 (25.0)	1 (25.0)	0 (0.0)		0 (0.0)	1 (25.0)		
	46 - 50	1 (16.7)	3 (50.0)	1 (16.7)	0 (0.0)		0 (0.0)	1 (16.7)		
	51 - 55	0 (0.0)	1 (20.0)	3 (60.0)	0 (0.0)		0 (0.0)	1 (20.0)		
	56 - 60	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	61 - 65	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)		0 (0.0)	0 (0.0)		
	66+	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED								.516 (V)	.026
	MARRIED	2 (10.5)	5 (26.3)	8 (42.1)	0 (0.0)		1 (5.3)	3 (15.8)		
	COMMON LAW									
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		0 (0.0)	0 (0.0)		
	DIVORCED	0 (0.0)	0 (0.0)	2 (50.0)	0 (0.0)		2 (50.0)	0 (0.0)		
	WIDOWED									
	OTHER	1 (16.7)	2 (33.3)	1 (16.7)	0 (0.0)		1 (16.7)	1 (16.7)		
NR	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)		0 (0.0)	0 (0.0)			
CHILDREN	0	1 (14.3)	2 (28.6)	2 (28.6)	0 (0.0)		1 (14.3)	1 (14.3)	.464 (V)	.263
	1	0 (0.0)	0 (0.0)	2 (66.7)	0 (0.0)		1 (33.3)	0 (0.0)		
	2	1 (11.1)	3 (33.3)	2 (22.2)	0 (0.0)		2 (22.2)	1 (11.1)		
	3	1 (14.3)	2 (28.6)	3 (42.9)	0 (0.0)		0 (0.0)	1 (14.3)		
	4	0 (0.0)	0 (0.0)	2 (66.7)	0 (0.0)		0 (0.0)	1 (33.3)		
	6	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		0 (0.0)	0 (0.0)		
	NR	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)		0 (0.0)	0 (0.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	1 (25.0)	0 (0.0)	1 (25.0)		2 (50.0)	0 (0.0)	.555 (V)	.149
	HIGH SCHOOL	0 (0.0)	2 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)	0 (0.0)	1 (33.3)	1 (33.3)		1 (33.3)	0 (0.0)		
	CERT/DIPLOMA	0 (0.0)	1 (20.0)	1 (20.0)	0 (0.0)		1 (20.0)	2 (40.0)		
	BACHELOR	0 (0.0)	1 (20.0)	1 (20.0)	0 (0.0)		1 (20.0)	2 (40.0)		
	MASTERS	0 (0.0)	0 (0.0)	4 (80.0)	0 (0.0)		0 (0.0)	1 (20.0)		
	DOCTORAL	1 (33.3)	1 (33.3)	1 (33.3)	0 (0.0)		0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
	MED. DOCTOR	2 (25.0)	2 (25.0)	4 (50.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
RELIGION	NONE	1 (8.3)	4 (33.3)	2 (16.7)	1 (8.3)		2 (16.7)	2 (16.7)	.408 (V)	.377
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	PROTESTANT	1 (7.1)	3 (21.4)	8 (57.1)	0 (0.0)		0 (0.0)	2 (14.3)		
	JEWISH									
	OTHER	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		0 (0.0)	0 (0.0)		
NR	1 (25.0)	1 (25.0)	0 (0.0)	1 (25.0)		1 (25.0)	0 (0.0)			
RELIGIOSITY	NOT AT ALL	0 (0.0)	3 (37.5)	1 (12.5)	2 (25.0)		1 (12.5)	1 (12.5)	.408 (V)	.378
	BARELY	0 (0.0)	1 (16.7)	3 (50.0)	0 (0.0)		2 (33.3)	0 (0.0)		
	SOMEWHAT	2 (18.2)	2 (18.2)	5 (45.5)	0 (0.0)		0 (0.0)	2 (18.2)		
	EXTREMELY	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)		1 (33.3)	1 (33.3)		
	N.R.	1 (25.0)	1 (25.0)	2 (50.0)	0 (0.0)		0 (0.0)	0 (0.0)		
ATTEND RELIGIOUS SERVICES	NEVER	0 (0.0)	3 (20.0)	5 (33.3)	1 (6.7)		3 (20.0)	3 (20.0)	.409 (V)	.373
	SEVERAL/YR	2 (25.0)	3 (37.5)	2 (25.0)	0 (0.0)		0 (0.0)	1 (12.5)		
	1-3/MONTH	0 (0.0)	1 (25.0)	3 (75.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	1/WK +	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)		1 (50.0)	0 (0.0)		
	N.R.	1 (33.3)	1 (33.3)	0 (0.0)	1 (33.3)		0 (0.0)	0 (0.0)		

N = 32

\* percentages indicated by ( )

## ACCESS TO CRYOPRESERVATION

TABLE 5E  
Frequencies and Percentages \*

		RESTRD ACCESS	FREE ACCESS	NO ACCESS	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	6 (31.6)	3 (15.8)	2 (10.5)	4 (21.1)	4 (21.1)	.458 (Phi)	.152
	MALE	4 (30.8)	7 (53.8)	0 (0.0)	1 (7.7)	1 (7.7)		
AGE	31 -35	1 (33.3)	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)		
	36 -40	1 (11.1)	3 (33.3)	0 (0.0)	3 (33.3)	2 (22.2)		
	41 -45	1 (25.0)	1 (25.0)	1 (25.0)	1 (25.0)	0 (0.0)		
	46 -50	3 (50.0)	1 (16.7)	1 (16.7)	1 (16.7)	0 (0.0)		
	51 -55	3 (60.0)	1 (20.0)	0 (0.0)	0 (0.0)	1 (20.0)		
	56 -60	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	61 -65	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	1 (50.0)		
	66+	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED						.447 (V)	.060
	MARRIED	5 (26.3)	8 (42.1)	2 (10.5)	2 (10.5)	2 (10.5)		
	COMMON LAW							
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
	DIVORCED	3 (75.0)	0 (0.0)	0 (0.0)	1 (25.0)	0 (0.0)		
	WIDOWED							
	OTHER	2 (33.3)	2 (33.3)	0 (0.0)	2 (33.3)	0 (0.0)		
NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)			
CHILDREN	0	2 (28.6)	2 (28.6)	1 (14.3)	2 (28.6)	0 (0.0)	.484 (V)	.186
	1	0 (0.0)	2 (66.7)	0 (0.0)	1 (33.3)	0 (0.0)		
	2	4 (44.4)	2 (22.2)	1 (11.1)	1 (11.1)	1 (11.1)		
	3	2 (28.6)	4 (57.1)	0 (0.0)	0 (0.0)	1 (14.3)		
	4	2 (66.7)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		
	6	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
	NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	1 (25.0)	0 (0.0)	2 (50.0)	1 (25.0)	.532 (V)	.280
	HIGHSCHOOL	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)	0 (0.0)		
	SOME COLLEGE	1 (33.3)	1 (33.3)	0 (0.0)	0 (0.0)	1 (33.3)		
	CERT./DIPLOMA	2 (40.0)	0 (0.0)	0 (0.0)	2 (40.0)	1 (20.0)		
	BACHELOR	2 (40.0)	0 (0.0)	0 (0.0)	2 (40.0)	1 (20.0)		
	MASTERS	2 (40.0)	2 (40.0)	0 (0.0)	1 (20.0)	0 (0.0)		
	DOCTORAL	1 (33.3)	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
	MED. DOCTOR	4 (50.0)	3 (37.5)	1 (12.5)	0 (0.0)	0 (0.0)		
N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
RELIGION	NONE	4 (33.3)	3 (25.0)	0 (0.0)	3 (25.0)	2 (16.7)	.360 (V)	.414
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	PROTESTANT	4 (28.6)	6 (42.9)	2 (14.3)	1 (7.1)	1 (7.1)		
	JEWISH							
	OTHER	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
N.R.	1 (25.0)	1 (25.0)	0 (0.0)	0 (0.0)	2 (50.0)			
RELIGIOSITY	NOT AT ALL	2 (25.0)	2 (25.0)	0 (0.0)	1 (12.5)	3 (37.5)	.381 (V)	.290
	BARELY	2 (33.3)	3 (50.0)	0 (0.0)	1 (16.7)	0 (0.0)		
	SOMEWHAT	4 (36.4)	4 (36.4)	1 (9.1)	1 (9.1)	1 (9.1)		
	EXTREMELY	0 (0.0)	0 (0.0)	1 (33.3)	2 (66.7)	0 (0.0)		
	N.R.	2 (50.0)	1 (25.0)	0 (0.0)	0 (0.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	6 (40.0)	3 (20.0)	0 (0.0)	4 (26.4)	2 (13.3)	.420 (V)	.127
	SEVERAL YR	1 (12.5)	4 (50.0)	2 (25.0)	0 (0.0)	1 (12.5)		
	1-3/MONTH	2 (50.0)	2 (50.0)	2 (25.0)	0 (0.0)	1 (12.5)		
	1/WK +	1 (50.0)	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)	2 (66.7)		

N = 32

\* percentages indicated by ( )

## KNOWLEDGE OF PARTHENOGENESIS

**TABLE 6A**  
Frequencies and Percentages \*

		FAMILIAR	NOT FAMILIAR	ASSOCIATION Phi / V	SIGNIFICANCE
SEX	FEMALE	5 (26.3)	14 (73.7)	.279 (Phi)	.114
	MALE	7 (53.8)	6 (46.2)		
AGE	31 -35	1 (33.3)	2 (66.7)	.416 (V)	.698
	36 - 40	3 (33.3)	6 (66.7)		
	41 - 45	2 (50.0)	2 (50.0)		
	46 -50	1 (16.7)	5 (83.3)		
	51 - 55	2 (40.0)	3 (60.0)		
	56 - 60	1 (100.0)	0 (0.0)		
	61 - 65	1 (100.0)	0 (0.0)		
	66+	0 (0.0)	1 (100.0)		
	N.R.	1 (100.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED	0 (0.0)	0 (0.0)	.507 (V)	.083
	MARRIED	9 (47.4)	10 (52.6)		
	COMMON LAW	0 (0.0)	0 (0.0)		
	SEPARATED	0 (0.0)	1 (100.0)		
	DIVORCED	0 (0.0)	4 (100.0)		
	WIDOWED	0 (0.0)	0 (0.0)		
	OTHER	1 (16.7)	5 (83.3)		
	NR	2 (100.0)	0 (0.0)		
CHILDREN	0	2 (28.6)	5 (71.4)	.369 (V)	.627
	1	1 (33.3)	2 (66.7)		
	2	3 (33.3)	6 (66.7)		
	3	3 (42.9)	4 (57.1)		
	4	1 (33.3)	2 (66.7)		
	6	0 (0.0)	1 (100.0)		
		NR	2 (100.0)		
EDUCATION LEVEL	COMBINATION	1 (25.0)	3 (75.0)	.575 (V)	.226
	HIGHSCHOOL	0 (0.0)	2 (100.0)		
	SOME COLLEGE	1 (33.3)	2 (66.7)		
	CERT./DIPLOMA	1 (20.0)	4 (80.0)		
	BACHELOR	0 (0.0)	0 (0.0)		
	MASTERS	1 (20.0)	4 (80.0)		
	DOCTORAL	3 (100.0)	0 (0.0)		
	LAWYER	0 (0.0)	1 (100.0)		
	MED. DOCTOR	4 (50.0)	4 (50.0)		
	N.R.	1 (100.0)	0 (0.0)		
RELIGION	NONE	3 (25.0)	9 (75.0)	.378 (V)	.278
	CATHOLIC	0 (0.0)	1 (100.0)		
	PROTESTANT	6 (42.9)	8 (57.1)		
	JEWISH	0 (0.0)	0 (0.0)		
	OTHER	0 (0.0)	1 (100.0)		
	N.R.	3 (75.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	3 (37.5)	5 (62.5)	.399 (V)	.278
	BARELY	3 (50.0)	3 (50.0)		
	SOMEWHAT	3 (27.3)	8 (72.7)		
	EXTREMELY	0 (0.0)	3 (100.0)		
		N.R.	3 (75.0)		
ATTEND RELIGIOUS SERVICES	NEVER	2 (13.3)	13 (86.7)	.593 (V)	.024
	SEVERAL/YR	5 (62.5)	3 (37.5)		
	1-3/MONTH	1 (25.0)	3 (75.0)		
	1/WK +	1 (50.0)	1 (50.0)		
		N.R.	3 (100.0)		

N = 32

\* percentages indicated by ( )

**RATING OF PARTHENOGENESIS**

**TABLE 6B**  
**Frequencies and Percentages \***

		BENEFICIAL	DETRIMNTL	CAN BE BOTH	NOT FAMILIAR	NR	ASSOC	SIGNIF
SEX	FEMALE		2 (10.5)	1 (5.3)	14 (73.7)	2 (10.5)	.352 (Phi)	.266
	MALE		5 (38.5)	0 (0.0)	7 (53.8)	1 (7.7)		
AGE	31 -35		0 (0.0)	1 (33.3)	1 (33.3)	1 (33.3)	.579 (V)	.124
	36 - 40		1 (11.1)	0 (0.0)	7 (77.8)	1 (11.1)		
	41 - 45		2 (50.0)	0 (0.0)	2 (50.0)	0 (0.0)		
	46 -50		1 (16.7)	0 (0.0)	5 (83.3)	0 (0.0)		
	51 - 55		2 (40.0)	0 (0.0)	3 (60.0)	0 (0.0)		
	56 - 60		0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
	61 - 65		0 (0.0)	0 (0.0)	2 (100.0)	0 (0.0)		
	66+		0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	N.R.		1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED						.355 (V)	.440
	MARRIED		6 (31.6)	0 (0.0)	10 (52.6)	3 (15.8)		
	COMMON LAW							
	SEPARATED		0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	DIVORCED		0 (0.0)	0 (0.0)	4 (100.0)	0 (0.0)		
	WIDOWED							
	OTHER		0 (0.0)	1 (16.7)	5 (83.3)	0 (0.0)		
NR		1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)			
CHILDREN	0		1 (14.3)	1 (14.3)	5 (71.4)	0 (0.0)	.311 (V)	.952
	1		0 (0.0)	0 (0.0)	2 (66.7)	1 (33.3)		
	2		2 (22.2)	0 (0.0)	6 (66.7)	1 (11.1)		
	3		2 (28.6)	0 (0.0)	4 (57.1)	1 (14.3)		
	4		1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)		
	6		0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	NR		1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)		
EDUCATION LEVEL	COMBINATION		0 (0.0)	1 (25.0)	3 (75.0)	0 (0.0)	.563 (V)	.173
	HIGHSCHOOL		0 (0.0)	0 (0.0)	2 (100.0)	0 (0.0)		
	SOME COLLEGE		0 (0.0)	0 (0.0)	2 (66.7)	1 (33.3)		
	CERT./DIPLOMA		1 (20.0)	0 (0.0)	4 (80.0)	0 (0.0)		
	BACHELOR		1 (20.0)	0 (0.0)	4 (80.0)	0 (0.0)		
	MASTERS		1 (20.0)	0 (0.0)	4 (80.0)	0 (0.0)		
	DOCTORAL		1 (33.3)	0 (0.0)	1 (33.3)	1 (33.3)		
	LAWYER		0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
	MED. DOCTOR		3 (37.5)	0 (0.0)	5 (62.5)	0 (0.0)		
N.R.		1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)			
RELIGION	NONE		1 (8.3)	1 (8.3)	9 (75.0)	1 (8.3)	.260 (V)	.889
	CATHOLIC		0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	PROTESTANT		5 (35.7)	0 (0.0)	8 (57.1)	1 (7.1)		
	JEWISH							
	OTHER		0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	N.R.		1 (25.0)	0 (0.0)	2 (50.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL		1 (12.5)	1 (12.5)	5 (62.5)	1 (12.5)	.314 (V)	.663
	BARELY		2 (33.3)	0 (0.0)	4 (66.7)	0 (0.0)		
	SOMEWHAT		2 (18.2)	0 (0.0)	8 (72.7)	1 (9.1)		
	EXTREMELY		0 (0.0)	0 (0.0)	3 (100.0)	0 (0.0)		
	N.R.		2 (50.0)	0 (0.0)	1 (25.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER		1 (6.7)	1 (6.7)	11 (73.3)	2 (13.3)	.301 (V)	.738
	SEVERAL/YR		3 (37.5)	0 (0.0)	5 (62.5)	0 (0.0)		
	1-3/MONTH		1 (25.0)	0 (0.0)	3 (75.0)	0 (0.0)		
	1/WK +		1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)		
	N.R.		1 (33.3)	0 (0.0)	1 (33.3)	1 (33.3)		

N = 32

\* percentages indicated by ( )

**POLICY REGARDING PARTHENOGENESIS**

**TABLE 6C**  
**Frequencies and Percentages \***

		ALLOW POLICY	DISALLOW POLICY	NO POLICY	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	0 (0.0)	2 (10.5)	2 (10.5)		11 (57.9)	4 (21.1)	.303 (Phi)	.389
	MALE	1 (7.7)	4 (30.8)	0 (0.0)		6 (46.2)	2 (15.4)		
AGE	31-35	0 (0.0)	0 (0.0)	1 (33.3)		1 (33.3)	1 (33.3)	.550 (V)	.193
	36-40	0 (0.0)	1 (11.1)	0 (0.0)		6 (66.7)	2 (22.2)		
	41-45	1 (25.0)	1 (25.0)	0 (0.0)		1 (25.0)	1 (25.0)		
	46-50	0 (0.0)	1 (16.7)	0 (0.0)		5 (83.3)	0 (0.0)		
	51-55	0 (0.0)	3 (60.0)	0 (0.0)		2 (40.0)	0 (0.0)		
	56-60	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
	61-65	0 (0.0)	0 (0.0)	1 (50.0)		1 (50.0)	0 (0.0)		
	66+	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED							.491 (V)	.014
	MARRIED	1 (5.3)	5 (26.3)	0 (0.0)		10 (52.6)	3 (15.8)		
	COMMON LAW								
	SEPARATED	0 (0.0)	0 (0.0)	1 (100.0)		0 (0.0)	0 (0.0)		
	DIVORCED	0 (0.0)	1 (25.0)	0 (0.0)		2 (50.0)	1 (25.0)		
	WIDOWED								
	OTHER	0 (0.0)	0 (0.0)	1 (16.7)		5 (83.3)	0 (0.0)		
NR	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	2 (100.0)			
CHILDREN	0	0 (0.0)	1 (14.3)	1 (14.3)		5 (71.4)	0 (0.0)	.037 (V)	.543
	1	0 (0.0)	0 (0.0)	0 (0.0)		2 (66.7)	1 (33.3)		
	2	0 (0.0)	1 (11.1)	0 (0.0)		6 (66.7)	2 (22.2)		
	3	1 (14.3)	2 (28.6)	0 (0.0)		3 (42.9)	1 (14.3)		
	4	0 (0.0)	2 (66.7)	0 (0.0)		1 (33.3)	0 (0.0)		
	6	0 (0.0)	0 (0.0)	1 (100.0)		0 (0.0)	0 (0.0)		
	NR	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	2 (100.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	0 (0.0)	2 (50.0)		2 (50.0)	0 (0.0)	.562 (V)	.145
	HIGHSCHOOL	0 (0.0)	0 (0.0)	0 (0.0)		2 (100.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)	0 (0.0)	0 (0.0)		1 (33.3)	2 (66.7)		
	CERT/DIPLOMA	0 (0.0)	1 (20.0)	0 (0.0)		4 (80.0)	0 (0.0)		
	BACHELOR	0 (0.0)	1 (20.0)	0 (0.0)		4 (80.0)	0 (0.0)		
	MASTERS	0 (0.0)	1 (20.0)	0 (0.0)		4 (80.0)	0 (0.0)		
	DOCTORAL	0 (0.0)	1 (33.3)	0 (0.0)		0 (0.0)	2 (66.7)		
	LAWYER	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	MED. DOCTOR	1 (12.5)	3 (37.5)	0 (0.0)		3 (37.5)	1 (12.5)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
RELIGION	NONE	0 (0.0)	1 (8.3)	2 (16.7)		9 (75.0)	0 (0.0)	.482 (V)	.019
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	PROTESTANT	1 (7.1)	5 (35.7)	0 (0.0)		6 (42.9)	2 (14.3)		
	JEWISH								
	OTHER	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
N.R.	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	4 (100.0)			
RELIGIOSITY	NOT AT ALL	0 (0.0)	1 (12.5)	2 (25.0)		4 (50.0)	1 (12.5)	.401 (V)	.195
	BARELY	0 (0.0)	3 (50.0)	0 (0.0)		1 (16.7)	2 (33.3)		
	SOMEWHAT	1 (9.1)	1 (9.1)	0 (0.0)		8 (72.7)	1 (9.1)		
	EXTREMELY	0 (0.0)	0 (0.0)	0 (0.0)		3 (100.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (25.0)	0 (0.0)		1 (25.0)	2 (50.0)		
ATTEND RELIGIOUS SERVICES	NEVER	1 (6.7)	2 (13.3)	2 (13.3)		9 (60.0)	1 (6.7)	.401 (V)	.194
	SEVERAL/YR	0 (0.0)	2 (25.0)	0 (0.0)		4 (50.0)	2 (25.0)		
	1-3/MONTH	0 (0.0)	1 (12.5)	0 (0.0)		3 (75.0)	0 (0.0)		
	1/WK +	0 (0.0)	1 (50.0)	0 (0.0)		1 (50.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	3 (100.0)		

\* percentages indicated by ( )

N = 32

## FUNDING OF PARTHENOGENESIS

**TABLE 6D**  
**Frequencies and Percentages \***

		PUBLIC FUND	PRIVATE FUND	PRIV & PUBLIC	NOFUND	AMBIV	NOT FAM	NR	ASSOC	SIGNIF	
SEX	FEMALE	0 (0.0)	0 (0.0)	2 (10.5)	1 (5.3)		9 (47.4)	7 (36.8)	.529 (Phi)	.112	
	MALE	1 (7.7)	1 (7.7)	0 (0.0)	3 (23.1)		7 (53.8)	1 (7.7)			
AGE	31-35	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		1 (33.3)	1 (33.3)	.605 (V)	.029	
	36-40	0 (0.0)	0 (0.0)	0 (0.0)	2 (22.2)		5 (55.6)	2 (22.2)			
	41-45	1 (25.0)	0 (0.0)	1 (25.0)	0 (0.0)		1 (25.0)	1 (25.0)			
	46-50	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		4 (66.7)	2 (33.3)			
	51-55	0 (0.0)	0 (0.0)	0 (0.0)	2 (40.0)		2 (40.0)	1 (20.0)			
	56-60	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)			
	61-65	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (100.0)	0 (0.0)			
	66+	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)			
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)			
MARITAL STATUS	NEVER MARRIED								.472 (V)	.099	
	MARRIED	1 (5.3)	0 (0.0)	1 (5.3)	3 (15.8)		7 (36.8)	3 (36.8)			
	COMMON LAW										
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)			
	DIVORCED	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		4 (100.0)	0 (0.0)			
	WIDOWED										
	OTHER	0 (0.0)	0 (0.0)	1 (16.7)	0 (0.0)		4 (66.7)	1 (16.7)			
	NR	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)		0 (0.0)	0 (0.0)			
CHILDREN	0	0 (0.0)	0 (0.0)	1 (14.3)	1 (14.3)		4 (57.1)	1 (14.3)	.443 (V)	.398	
	1	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (33.3)	2 (66.7)			
	2	0 (0.0)	0 (0.0)	1 (11.1)	0 (0.0)		6 (66.7)	2 (22.2)			
	3	1 (14.3)	0 (0.0)	0 (0.0)	1 (14.3)		3 (42.9)	2 (28.6)			
	4	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)		1 (33.3)	1 (33.3)			
	6	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)			
		NR	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)		0 (0.0)	0 (0.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	0 (0.0)	1 (25.0)	0 (0.0)		3 (75.0)	0 (0.0)	.598 (V)	.038	
	HIGHSCHOOL	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (100.0)	0 (0.0)			
	SOME COLLEGE	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)		1 (33.3)	1 (33.3)			
	CERT./DIPLOMA	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (40.0)	3 (60.0)			
	BACHELOR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (40.0)	3 (60.0)			
	MASTERS	0 (0.0)	0 (0.0)	0 (0.0)	1 (20.0)		3 (60.0)	1 (20.0)			
	DOCTORAL	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)		0 (0.0)	2 (66.7)			
	LAWYER	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)			
	MED. DOCTOR	1 (12.5)	0 (0.0)	1 (12.5)	1 (12.5)		5 (62.5)	0 (0.0)			
		N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	RELIGION	NONE	0 (0.0)	0 (0.0)	1 (8.3)	1 (8.3)		8 (66.7)	2 (16.7)	.330 (V)	.834
CATHOLIC		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)			
PROTESTANT		1 (7.1)	0 (0.0)	1 (7.1)	2 (14.3)		5 (35.7)	5 (35.7)			
JEWISH											
OTHER		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)			
		N.R.	0 (0.0)	1 (25.0)	0 (0.0)	1 (25.0)		1 (25.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	0 (0.0)	0 (0.0)	1 (12.5)	2 (25.0)		4 (50.0)	1 (12.5)	.377 (V)	.577	
	BARELY	1 (16.7)	0 (0.0)	0 (0.0)	1 (16.7)		3 (50.0)	1 (16.7)			
	SOMEWHAT	0 (0.0)	0 (0.0)	1 (9.1)	0 (0.0)		3 (50.0)	1 (16.7)			
	EXTREMELY	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (66.7)	1 (33.3)			
		N.R.	0 (0.0)	1 (25.0)	0 (0.0)	1 (25.0)		1 (25.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	0 (0.0)	0 (0.0)	1 (6.7)	1 (6.7)		9 (60.0)	4 (26.7)	.406 (V)	.392	
	SEVERAL/YR	1 (12.5)	0 (0.0)	1 (12.5)	1 (12.5)		3 (37.5)	2 (25.0)			
	1-3/MONTH	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		3 (75.0)	1 (25.0)			
	1/WK +	0 (0.0)	0 (0.0)	0 (0.0)	1 (50.0)		1 (50.0)	0 (0.0)			
		N.R.	0 (0.0)	1 (33.3)	0 (0.0)	1 (33.3)		0 (0.0)	1 (33.3)		

N = 32

\* percentages indicated by ( )

## ACCESS TO PARTHENOGENESIS

TABLE 6E  
Frequencies and Percentages \*

		RESTRD ACCESS	FREE ACCESS	NO ACCESS	NOT FAM	NR	ASSOC	SIGNIF	
SEX	FEMALE	0 (0.0)	1 (5.3)	2 (10.5)	8 (42.1)	8 (42.1)	.439 (Phi)	.186	
	MALE	2 (15.4)	0 (0.0)	3 (23.1)	6 (46.2)	2 (15.4)			
AGE	31 - 35	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)	2 (66.7)	.545 (V)	.212	
	36 - 40	0 (0.0)	0 (0.0)	1 (11.1)	5 (55.6)	3 (33.3)			
	41 - 45	2 (50.0)	0 (0.0)	1 (25.0)	1 (25.0)	0 (0.0)			
	46 - 50	0 (0.0)	0 (0.0)	1 (16.7)	4 (66.7)	1 (16.7)			
	51 - 55	0 (0.0)	0 (0.0)	2 (40.0)	2 (40.0)	1 (20.0)			
	56 - 60	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
	61 - 65	0 (0.0)	0 (0.0)	0 (0.0)	1 (50.0)	1 (50.0)			
	66+	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)			
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
MARITAL STATUS	NEVER MARRIED						.401 (V)	.195	
	MARRIED	2 (10.5)	0 (0.0)	5 (26.3)	6 (31.6)	6 (31.6)			
	COMMON LAW								
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
	DIVORCED	0 (0.0)	0 (0.0)	0 (0.0)	3 (75.0)	1 (25.0)			
	WIDOWED								
	OTHER	0 (0.0)	1 (16.7)	0 (0.0)	5 (83.5)	0 (0.0)			
	NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)			
CHILDREN	0	0 (0.0)	1 (14.3)	1 (14.3)	5 (71.4)	0 (0.0)	.440 (V)	.419	
	1	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)	2 (66.7)			
	2	0 (0.0)	0 (0.0)	2 (22.2)	4 (44.4)	3 (33.3)			
	3	2 (28.6)	0 (0.0)	1 (14.3)	2 (28.6)	2 (28.6)			
	4	0 (0.0)	0 (0.0)	1 (33.3)	2 (66.7)	0 (0.0)			
	6	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
		NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	1 (25.0)	0 (0.0)	2 (50.0)	1 (25.0)	.505 (V)	.376	
	HIGHSCHOOL	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)	0 (0.0)			
	SOME COLLEGE	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	3 (100.0)			
	CERT./DIPLOMA	0 (0.0)	0 (0.0)	1 (20.0)	3 (60.0)	1 (20.0)			
	BACHELOR	0 (0.0)	0 (0.0)	1 (20.0)	3 (60.0)	1 (20.0)			
	MASTERS	0 (0.0)	0 (0.0)	1 (20.0)	3 (60.0)	1 (20.0)			
	DOCTORAL	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	2 (66.7)			
	LAWYER	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
	MED. DOCTOR	2 (25.0)	0 (0.0)	2 (25.0)	4 (50.0)	0 (0.0)			
		N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
RELIGION	NONE	0 (0.0)	1 (8.3)	1 (8.3)	7 (58.3)	3 (25.0)	.378 (V)	.305	
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)			
	PROTESTANT	2 (14.3)	0 (0.0)	4 (28.6)	5 (35.7)	3 (21.4)			
	JEWISH								
		OTHER	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	4 (100.0)			
RELIGIOSITY	NOT AT ALL	0 (0.0)	1 (12.5)	1 (12.5)	2 (25.0)	4 (50.0)	.311 (V)	.717	
	BARELY	1 (16.7)	0 (0.0)	1 (16.7)	2 (33.3)	2 (33.3)			
	SOMEWHAT	1 (9.1)	0 (0.0)	2 (18.2)	6 (54.5)	2 (18.2)			
	EXTREMELY	0 (0.0)	0 (0.0)	0 (0.0)	3 (100.0)	0 (0.0)			
		N.R.	0 (0.0)	0 (0.0)	1 (25.0)	1 (25.0)	2 (50.0)		
ATTEND RELIGIOUS SERVICES	NEVER	1 (6.7)	1 (6.7)	1 (6.7)	7 (46.7)	5 (33.3)	.336 (V)	.563	
	SEVERAL YR	1 (12.5)	0 (0.0)	2 (25.0)	3 (37.5)	2 (25.0)			
	1-3/MONTH	0 (0.0)	0 (0.0)	1 (25.0)	3 (75.0)	0 (0.0)			
	1/WK +	0 (0.0)	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)			
		N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	3 (100.0)		

N = 32

\* percentages indicated by ( )

## KNOWLEDGE OF SEX PRE SELECTION

**TABLE 7A**  
**Frequencies and Percentages \***

		FAMILIAR	NOT FAMILIAR	ASSOCIATION Phi / V	SIGNIFICANCE
SEX	FEMALE	13 (68.4)	6 (31.6)	.093 (Phi)	.599
	MALE	10 (76.9)	3 (23.1)		
AGE	31 - 35	2 (66.7)	1 (33.3)		
	36 - 40	7 (77.8)	2 (22.2)		
	41 - 45	3 (75.0)	1 (25.0)		
	46 - 50	4 (66.7)	2 (33.3)		
	51 - 55	3 (60.0)	2 (40.0)		
	56 - 60	1 (100.0)	0 (0.0)		
	61 - 65	1 (50.0)	1 (50.0)		
	66+	1 (100.0)	0 (0.0)		
	N.R.	1 (100.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED	0 (0.0)	0 (0.0)	.472 (V)	.123
	MARRIED	16 (84.2)	3 (15.8)		
	COMMON LAW	0 (0.0)	0 (0.0)		
	SEPARATED	0 (0.0)	1 (100.0)		
	DIVORCED	2 (50.0)	2 (50.0)		
	WIDOWED	0 (0.0)	0 (0.0)		
	OTHER	3 (50.0)	3 (50.0)		
	NR	2 (100.0)	0 (0.0)		
CHILDREN	0	5 (71.4)	2 (28.6)	.447 (V)	.379
	1	2 (66.7)	1 (33.3)		
	2	7 (77.8)	2 (22.2)		
	3	6 (85.7)	1 (14.3)		
	4	1 (33.3)	2 (66.7)		
	6	0 (0.0)	1 (100.0)		
		NR	2 (100.0)	0 (0.0)	
EDUCATION LEVEL	COMBINATION	2 (50.0)	2 (50.0)	.542 (V)	.309
	HIGHSCHOOL	1 (50.0)	1 (50.0)		
	SOME COLLEGE	2 (66.7)	1 (33.3)		
	CERT /DIPLOMA	2 (40.0)	3 (60.0)		
	BACHELOR	0 (0.0)	0 (0.0)		
	MASTERS	3 (60.0)	2 (40.0)		
	DOCTORAL	3 (100.0)	0 (0.0)		
	LAWYER	1 (100.0)	0 (0.0)		
	MED. DOCTOR	8 (100.0)	0 (0.0)		
		N.R.	1 (100.0)	0 (0.0)	
RELIGION	NONE	8 (66.7)	4 (33.3)	.327 (V)	.487
	CATHOLIC	0 (0.0)	1 (100.0)		
	PROTESTANT	11 (78.6)	3 (21.4)		
	JEWISH	0 (0.0)	0 (0.0)		
	OTHER	1 (100.0)	0 (0.0)		
	N.R.	3 (75.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	6 (75.0)	2 (25.0)	.300 (V)	.578
	BARELY	4 (66.7)	2 (33.3)		
	SOMEWHAT	9 (81.8)	2 (18.2)		
	EXTREMELY	1 (33.3)	2 (66.7)		
		N.R.	3 (75.0)	1 (25.0)	
ATTEND RELIGIOUS SERVICES	NEVER	9 (60.0)	6 (40.0)	.555	.043
	SEVERAL/YR	7 (87.5)	1 (12.5)		
	1-3/MONTH	4 (100.0)	0 (0.0)		
	1/WK +	0 (0.0)	2 (100.0)		
		N.R.	3 (100.0)	0 (0.0)	

N = 32

\* percentages indicated by ( )

### RATING OF SEX PRE SELECTION

**TABLE 7B**  
**Frequencies and Percentages \***

		BENEFICIAL	DETRIMNTL	CAN BE BOTH	NOT FAMILIAR	NR	ASSOC	SIGNIF
SEX	FEMALE	0 (0.0)	6 (31.6)	8 (42.1)	5 (26.3)		.397 (Phi)	.168
	MALE	2 (15.4)	6 (46.2)	4 (30.8)	1 (7.7)			
AGE	31 - 35	0 (0.0)	2 (66.7)	1 (33.3)	0 (0.0)			
	36 - 40	0 (0.0)	2 (22.2)	5 (55.6)	2 (22.2)			
	41 - 45	0 (0.0)	2 (50.0)	1 (25.0)	1 (25.0)			
	46 - 50	1 (16.7)	2 (33.3)	2 (33.3)	1 (66.7)			
	51 - 55	1 (20.0)	1 (20.0)	2 (40.0)	1 (20.0)			
	56 - 60	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)			
	61 - 65	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)			
	66+	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)			
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)			
MARITAL STATUS	NEVER MARRIED						.390 (V)	.264
	MARRIED	1 (5.3)	6 (31.6)	10 (52.6)	2 (10.5)			
	COMMON LAW							
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
	DIVORCED	0 (0.0)	1 (25.0)	2 (50.0)	1 (25.0)			
	WIDOWED							
	OTHER	1 (16.7)	3 (50.0)	0 (0.0)	2 (33.3)			
NR	0 (0.0)	2 (100.0)	0 (0.0)	0 (0.0)				
CHILDREN	0	0 (0.0)	2 (28.6)	3 (42.9)	2 (28.6)		.401 (V)	.634
	1	0 (0.0)	0 (0.0)	2 (66.7)	1 (33.3)			
	2	1 (11.1)	5 (55.6)	3 (33.3)	0 (0.0)			
	3	1 (14.3)	2 (28.6)	3 (42.9)	1 (14.3)			
	4	0 (0.0)	1 (33.3)	1 (33.3)	1 (33.3)			
	6	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
	NR	0 (0.0)	2 (100.0)	0 (0.0)	0 (0.0)			
EDUCATION LEVEL	COMBINATION	0 (0.0)	2 (50.0)	0 (0.0)	2 (50.0)		.581 (V)	.116
	HIGHSCHOOL	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)			
	SOME COLLEGE	0 (0.0)	2 (66.7)	1 (33.3)	0 (0.0)			
	CERT/DIPLOMA	0 (0.0)	2 (40.0)	0 (0.0)	3 (60.0)			
	BACHELOR	0 (0.0)	2 (40.0)	0 (0.0)	3 (60.0)			
	MASTERS	1 (20.0)	1 (20.0)	2 (40.0)	1 (20.0)			
	DOCTORAL	0 (0.0)	0 (0.0)	3 (100.0)	0 (0.0)			
	LAWYER	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)			
	MED. DOCTOR	0 (0.0)	4 (50.0)	4 (50.0)	0 (0.0)			
N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)				
RELIGION	NONE	1 (8.3)	4 (33.3)	4 (33.3)	3 (25.0)		.325 (V)	.602
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
	PROTESTANT	1 (7.1)	4 (28.6)	7 (50.0)	0 (0.0)			
	JEWISH							
	OTHER	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)			
N.R.	0 (0.0)	3 (75.0)	1 (25.0)	0 (0.0)				
RELIGIOSITY	NOT AT ALL	1 (12.5)	3 (37.5)	3 (37.5)	1 (12.5)		.309 (V)	.690
	BARELY	0 (0.0)	2 (33.3)	3 (50.0)	1 (16.7)			
	SOMEWHAT	1 (9.1)	4 (36.4)	4 (36.4)	2 (18.2)			
	EXTREMELY	0 (0.0)	0 (0.0)	1 (33.3)	2 (66.7)			
	N.R.	0 (0.0)	3 (75.0)	1 (25.0)	0 (0.0)			
ATTEND RELIGIOUS SERVICES	NEVER	1 (6.7)	4 (26.7)	6 (40.0)	4 (26.7)		.302 (V)	.722
	SEVERAL/YR	0 (0.0)	3 (37.5)	4 (50.0)	1 (12.5)			
	1-3/MONTH	1 (25.0)	2 (50.0)	1 (25.0)	0 (0.0)			
	1/WK +	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)			
	N.R.	0 (0.0)	2 (66.7)	1 (33.3)	0 (0.0)			

N = 32

\* percentages indicated by ( )

**POLICY REGARDING SEX PRE SELECTION**

**TABLE 7C**  
**Frequencies and Percentages \***

		ALLOW POLICY	DISALLOW POLICY	NO POLICY	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	4 (21.1)	3 (15.8)	5 (26.3)	1 (5.3)	4 (21.1)	2 (10.5)	279 (Phi)	.778
	MALE	5 (38.5)	3 (23.1)	2 (15.4)	1 (4.7)	1 (7.7)	1 (7.7)		
AGE	31 -35	1 (33.3)	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)	1 (33.3)	.464 (V)	.715
	36 - 40	2 (22.2)	2 (22.2)	3 (33.3)	0 (0.0)	2 (22.2)	0 (0.0)		
	41 - 45	1 (25.0)	0 (0.0)	0 (0.0)	1 (25.0)	1 (25.0)	1 (25.0)		
	46 -50	3 (50.0)	1 (16.7)	1 (16.7)	0 (0.0)	1 (16.7)	0 (0.0)		
	51 - 55	1 (20.0)	1 (20.0)	1 (20.0)	1 (20.0)	1 (20.0)	0 (0.0)		
	56 - 60	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	61 - 65	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	66+	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED							.398 (V)	.442
	MARRIED	8 (42.1)	3 (15.8)	4 (21.1)	1 (5.3)	2 (10.5)	1 (5.3)		
	COMMON LAW								
	SEPARATED	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	DIVORCED	0 (0.0)	0 (0.0)	1 (25.0)	1 (25.0)	1 (25.0)	1 (25.0)		
	WIDOWED								
CHILDREN	OTHER	1 (16.7)	2 (33.3)	1 (16.7)	0 (0.0)	2 (33.3)	0 (0.0)		
	NR	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (50.0)		
	0	0 (0.0)	1 (14.3)	4 (57.1)	0 (0.0)	2 (28.6)	0 (0.0)		
	1	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		
	2	3 (33.3)	3 (33.3)	1 (11.1)	0 (0.0)	0 (0.0)	2 (22.2)		
	3	4 (57.1)	0 (0.0)	1 (14.3)	1 (14.3)	1 (14.3)	0 (0.0)		
	4	0 (0.0)	1 (33.3)	0 (0.0)	1 (33.3)	1 (33.3)	0 (0.0)		
	6	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
NR	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (50.0)			
EDUCATION LEVEL	COMBINATION	0 (0.0)	1 (25.0)	2 (50.0)	0 (0.0)	1 (25.0)	0 (0.0)	.537 (V)	.234
	HIGHSCHOOL	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	SOME COLLEGE	1 (33.3)	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)		
	CERT./DIPLOMA	1 (20.0)	1 (20.0)	0 (0.0)	0 (0.0)	3 (60.0)	0 (0.0)		
	BACHELOR	1 (20.0)	1 (20.0)	0 (0.0)	0 (0.0)	3 (60.0)	0 (0.0)		
	MASTERS	2 (40.0)	1 (20.0)	1 (20.0)	0 (0.0)	1 (20.0)	0 (0.0)		
	DOCTORAL	3 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	MED. DOCTOR	1 (12.5)	2 (25.0)	2 (25.0)	2 (25.0)	0 (0.0)	1 (12.5)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
RELIGION	NONE	3 (25.0)	3 (25.0)	4 (33.3)	0 (0.0)	2 (16.7)	0 (0.0)	.436 (V)	.228
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	PROTESTANT	5 (35.7)	1 (7.1)	3 (21.4)	2 (14.3)	2 (14.3)	1 (7.1)		
	JEWISH								
	OTHER	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
RELIGIOSITY	N.R.	1 (25.0)	1 (25.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (50.0)		
	NOT AT ALL	3 (37.5)	2 (25.0)	3 (37.5)	0 (0.0)	0 (0.0)	0 (0.0)	.448 (V)	.176
	BARELY	1 (16.7)	0 (0.0)	1 (16.7)	2 (33.3)	1 (16.7)	1 (16.7)		
	SOMEWHAT	4 (36.4)	2 (18.2)	2 (18.2)	0 (0.0)	2 (18.2)	1 (9.1)		
	EXTREMELY	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)		
ATTEND RELIGIOUS SERVICES	N.R.	1 (25.0)	2 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (25.0)		
	NEVER	5 (33.3)	1 (6.7)	4 (26.7)	1 (6.7)	3 (20.0)	1 (6.7)	.315 (V)	.889
	SEVERAL/YR	1 (12.5)	2 (25.0)	2 (25.0)	1 (12.5)	1 (12.5)	1 (12.5)		
	1-3/MONTH	2 (50.0)	1 (25.0)	1 (25.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	1WK +	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)		
N.R.	1 (33.3)	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)			

N = 32

\* percentages indicated by ( )

**FUNDING OF SEX PRE SELECTION**

**TABLE 7D**  
**Frequencies and Percentages \***

		PUBLIC FUND	PRIVATE FUND	PRIV & PUBLIC	NO FUND	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	4 (21.1)	1 (5.3)	2 (10.5)	5 (26.3)		3 (15.8)	4 (21.1)	408 (Ph)	.379
	MALE	3 (23.1)	3 (23.1)	2 (15.4)	4 (30.8)		1 (7.7)	0 (0.0)		
AGE	31-35	1 (33.3)	0 (0.0)	0 (0.0)	2 (66.7)		0 (0.0)	0 (0.0)	.470 (V)	.682
	36-40	2 (22.2)	1 (11.1)	2 (22.2)	1 (11.1)		3 (33.3)	0 (0.0)		
	41-45	2 (50.0)	0 (0.0)	0 (0.0)	1 (25.0)		0 (0.0)	1 (25.0)		
	46-50	0 (0.0)	1 (16.7)	1 (16.7)	2 (33.3)		0 (0.0)	2 (33.3)		
	51-55	1 (20.0)	1 (20.0)	1 (20.0)	1 (20.0)		0 (0.0)	1 (20.0)		
	56-60	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	61-65	0 (0.0)	0 (0.0)	0 (0.0)	1 (50.0)		1 (50.0)	0 (0.0)		
	66+	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED								.380 (V)	.556
	MARRIED	6 (31.6)	2 (10.5)	3 (15.8)	4 (21.1)		1 (5.3)	3 (15.8)		
	COMMON LAW									
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	DIVORCED	1 (25.0)	0 (0.0)	1 (25.0)	1 (25.0)		1 (25.0)	0 (0.0)		
	WIDOWED									
	OTHER	0 (0.0)	1 (16.7)	0 (0.0)	3 (50.0)		1 (16.7)	1 (16.7)		
NR	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)		0 (0.0)	0 (0.0)			
CHILDREN	0	1 (14.3)	0 (0.0)	1 (14.3)	3 (42.9)		1 (14.3)	1 (14.3)	.394 (V)	.733
	1	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)		1 (33.3)	0 (0.0)		
	2	1 (11.1)	2 (22.2)	1 (11.1)	3 (33.3)		1 (11.1)	1 (11.1)		
	3	2 (28.6)	1 (14.3)	2 (28.6)	1 (14.3)		0 (0.0)	1 (14.3)		
	4	1 (33.3)	0 (0.0)	0 (0.0)	1 (33.3)		0 (0.0)	1 (33.3)		
	6	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	NR	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)		0 (0.0)	0 (0.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	0 (0.0)	0 (0.0)	1 (25.0)		3 (75.0)	0 (0.0)	.637 (V)	.008
	HIGH SCHOOL	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)		0 (0.0)	0 (0.0)		
	SOME COLLEGE	1 (33.3)	0 (0.0)	0 (0.0)	2 (66.7)		0 (0.0)	0 (0.0)		
	CERT/DIPLOMA	0 (0.0)	0 (0.0)	0 (0.0)	1 (20.0)		1 (20.0)	3 (60.0)		
	BACHELOR	0 (0.0)	0 (0.0)	0 (0.0)	1 (20.0)		1 (20.0)	3 (60.0)		
	MASTERS	0 (0.0)	1 (20.0)	2 (40.0)	1 (20.0)		0 (0.0)	1 (20.0)		
	DOCTORAL	2 (66.7)	0 (0.0)	1 (33.3)	0 (0.0)		0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	MED. DOCTOR	4 (50.0)	0 (0.0)	1 (12.5)	3 (37.5)		0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	RELIGION	NONE	0 (0.0)	2 (16.7)	3 (25.0)	3 (25.0)		3 (25.0)	1 (8.3)	.438 (V)
CATHOLIC		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
PROTESTANT		6 (42.9)	1 (7.1)	1 (7.1)	3 (21.4)		0 (0.0)	3 (21.4)		
JEWISH										
OTHER		0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		0 (0.0)	0 (0.0)		
N.R.		1 (25.0)	1 (25.0)	0 (0.0)	2 (50.0)		0 (0.0)	0 (0.0)		
RELIGIOSITY	NOT AT ALL	0 (0.0)	2 (25.0)	2 (25.0)	2 (25.0)		2 (25.0)	0 (0.0)	.403 (V)	.411
	BARELY	3 (50.0)	0 (0.0)	0 (0.0)	2 (33.3)		1 (16.7)	0 (0.0)		
	SOMEWHAT	3 (27.3)	1 (9.1)	2 (18.2)	2 (18.2)		0 (0.0)	3 (27.3)		
	EXTREMELY	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)		1 (33.3)	1 (33.3)		
	N.R.	1 (25.0)	1 (25.0)	0 (0.0)	2 (50.0)		0 (0.0)	0 (0.0)		
ATTEND RELIGIOUS SERVICES	NEVER	3 (20.0)	2 (13.3)	3 (20.0)	2 (13.3)		3 (20.0)	2 (13.3)	.363 (V)	.662
	SEVERAL/YR	3 (37.5)	0 (0.0)	0 (0.0)	4 (50.0)		0 (0.0)	1 (12.5)		
	1-3/MONTH	0 (0.0)	1 (25.0)	1 (25.0)	1 (25.0)		0 (0.0)	1 (25.0)		
	1/WK +	0 (0.0)	0 (0.0)	0 (0.0)	1 (50.0)		1 (50.0)	0 (0.0)		
	N.R.	1 (33.3)	1 (33.3)	0 (0.0)	1 (33.3)		0 (0.0)	0 (0.0)		

N = 32

\* percentages indicated by ( )

**ACCESS TO SEX PRE SELECTION**

**TABLE 7E**  
**Frequencies and Percentages \***

		RESTRD ACCESS	FREE ACCESS	NO ACCESS	NOTFAM	NR	ASSOC	SIGNIF	
SEX	FEMALE	6 (31.6)	1 (5.3)	7 (36.8)	3 (15.8)	2 (10.5)	.514 (Phi)	.076	
	MALE	1 (7.7)	6 (46.2)	4 (30.8)	1 (7.7)	1 (7.7)			
AGE	31 -35	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)	0 (0.0)	.486 (V)	.557	
	36 -40	2 (22.2)	3 (33.3)	2 (22.2)	2 (22.2)	0 (0.0)			
	41 -45	1 (25.0)	0 (0.0)	2 (50.0)	1 (25.0)	0 (0.0)			
	46 -50	2 (33.3)	1 (16.7)	2 (33.3)	1 (16.7)	0 (0.0)			
	51 -55	1 (20.0)	2 (40.0)	1 (20.0)	0 (0.0)	1 (20.0)			
	56 -60	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)			
	61 -65	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)			
	66+	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)			
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
MARITAL STATUS	NEVER MARRIED						.436 (V)	.082	
	MARRIED	5 (26.3)	6 (31.6)	6 (31.6)	1 (5.3)	1 (5.3)			
	COMMON LAW								
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
	DIVORCED	2 (50.0)	0 (0.0)	1 (25.0)	1 (25.0)	0 (0.0)			
	WIDOWED								
	OTHER	0 (0.0)	1 (16.7)	3 (50.0)	2 (33.3)	0 (0.0)			
	NR	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)			
CHILDREN	0	1 (14.3)	1 (14.3)	3 (42.9)	2 (28.6)	0 (0.0)	.517 (V)	.082	
	1	2 (66.7)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)			
	2	2 (22.2)	2 (22.2)	5 (55.6)	0 (0.0)	0 (0.0)			
	3	1 (14.3)	4 (57.1)	1 (14.3)	0 (0.0)	1 (14.3)			
	4	1 (33.3)	0 (0.0)	1 (33.3)	1 (33.3)	0 (0.0)			
	6	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
		NR	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	0 (0.0)	2 (50.0)	1 (25.0)	1 (25.0)	.530 (V)	.291	
	HIGHSCHOOL	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)	0 (0.0)			
	SOME COLLEGE	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)	0 (0.0)			
	CERT./DIPLOMA	1 (20.0)	0 (0.0)	1 (20.0)	2 (40.0)	1 (20.0)			
	BACHELOR	1 (20.0)	0 (0.0)	1 (20.0)	2 (40.0)	1 (20.0)			
	MASTERS	1 (20.0)	2 (40.0)	1 (20.0)	1 (20.0)	0 (0.0)			
	DOCTORAL	1 (33.3)	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)			
	LAWYER	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)			
	MED. DOCTOR	3 (37.5)	1 (12.5)	4 (50.0)	0 (0.0)	0 (0.0)			
		N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
RELIGION	NONE	2 (16.7)	3 (25.0)	4 (33.3)	2 (16.7)	1 (8.3)	.328 (V)	.616	
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)			
	PROTESTANT	5 (35.7)	3 (21.4)	4 (28.6)	1 (7.1)	1 (7.1)			
	JEWISH								
	OTHER	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)			
	N.R.	0 (0.0)	1 (25.0)	2 (50.0)	0 (0.0)	1 (25.0)			
RELIGIOSITY	NOT AT ALL	1 (12.5)	3 (37.5)	3 (37.5)	0 (0.0)	1 (12.5)	.355 (V)	.443	
	BARELY	2 (33.3)	1 (16.7)	2 (33.3)	1 (16.7)	0 (0.0)			
	SOMEWHAT	4 (36.4)	2 (18.2)	3 (27.3)	1 (9.1)	1 (9.1)			
	EXTREMELY	0 (0.0)	0 (0.0)	1 (33.3)	2 (66.7)	0 (0.0)			
		N.R.	0 (0.0)	1 (25.0)	2 (50.0)	0 (0.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	5 (33.3)	3 (20.0)	3 (20.0)	3 (20.0)	1 (6.7)	.344 (V)	.515	
	SEVERAL/YR	1 (12.5)	1 (12.5)	5 (62.5)	0 (0.0)	1 (12.5)			
	1-3/MONTH	1 (12.5)	2 (50.0)	1 (25.0)	0 (0.0)	0 (0.0)			
	1/WK +	0 (0.0)	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)			
		N.R.	0 (0.0)	1 (33.3)	1 (33.3)	0 (0.0)	1 (33.3)		

N = 32

\* percentages indicated by ( )

**KNOWLEDGE OF CONTRACT MOTHERHOOD****TABLE 8A**  
**Frequencies and Percentages \***

		FAMILIAR	NOT FAMILIAR	ASSOCIATION Phi / V	SIGNIFICANCE
SEX	FEMALE	16 (84.2)	3 (15.8)	.266 (Phi)	.132
	MALE	13 (100.0)	0 (0.0)		
AGE	31 -35	3 (100.0)	0 (0.0)	.389 (V)	.772
	36 -40	7 (77.8)	2 (22.2)		
	41 -45	3 (75.0)	0 (0.0)		
	46 -50	6 (100.0)	0 (0.0)		
	51 -55	5 (100.0)	0 (0.0)		
	56 -60	1 (100.0)	0 (0.0)		
	61 -65	2 (100.0)	0 (0.0)		
	66+	1 (100.0)	0 (0.0)		
	N.R.	1 (100.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED	0 (0.0)	0 (0.0)	.483 (V)	.113
	MARRIED	19 (100.0)	0 (0.0)		
	COMMON LAW	0 (0.0)	0 (0.0)		
	SEPARATED	1 (100.0)	0 (0.0)		
	DIVORCED	3 (75.0)	1 (25.0)		
	WIDOWED	0 (0.0)	0 (0.0)		
	OTHER	5 (83.3)	1 (16.7)		
	NR	1 (50.0)	1 (50.0)		
CHILDREN	0	6 (85.7)	1 (14.3)		
	1	2 (66.7)	1 (33.3)		
	2	9 (100.0)	0 (0.0)		
	3	7 (100.0)	0 (0.0)		
	4	3 (100.0)	0 (0.0)		
	6	1 (100.0)	0 (0.0)		
		NR	1 (50.0)	1 (50.0)	
EDUCATION LEVEL	COMBINATION	4 (100.0)	0 (0.0)	.408 (V)	.723
	HIGHSCHOOL	2 (100.0)	0 (0.0)		
	SOME COLLEGE	2 (66.7)	1 (33.3)		
	CERT./DIPLOMA	4 (80.0)	1 (20.0)		
	BACHELOR	3 (100.0)	0 (0.0)		
	MASTERS	1 (100.0)	0 (0.0)		
	DOCTORAL	3 (100.0)	0 (0.0)		
	LAWYER	1 (100.0)	0 (0.0)		
	MED. DOCTOR	8 (100.0)	0 (0.0)		
		N.R.	1 (100.0)	0 (0.0)	
RELIGION	NONE	10 (83.3)	2 (16.7)	.333 (V)	.469
	CATHOLIC	1 (100.0)	0 (0.0)		
	PROTESTANT	14 (100.0)	0 (0.0)		
	JEWISH	0 (0.0)	0 (0.0)		
	OTHER	1 (100.0)	0 (0.0)		
	N.R.	3 (75.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	7 (87.5)	1 (12.5)	.356 (V)	.399
	BARELY	5 (83.3)	1 (16.7)		
	SOMEWHAT	11 (100.0)	0 (0.0)		
	EXTREMELY	2 (66.7)	1 (33.3)		
		N.R.	4 (100.0)	0 (0.0)	
ATTEND RELIGIOUS SERVICES	NEVER	13 (86.7)	2 (13.3)	.342 (V)	.441
	SEVERAL/YR	8 (100.0)	0 (0.0)		
	1-3/MONTH	4 (100.0)	0 (0.0)		
	1/WK +	2 (100.0)	0 (0.0)		
		N.R.	2 (66.7)	1 (33.3)	

N = 32

\* percentages indicated by ( )

**RATING OF CONTRACT MOTHERHOOD**

**TABLE 8B**  
**Frequencies and Percentages \***

		BENEFICIAL	DETRIMNTL	CAN BE BOTH	NOT FAMILIAR	NR	ASSOC	SIGNIF
SEX	FEMALE	1 (5.3)	5 (26.3)	11 (57.9)	2 (10.5)	0 (0.0)	.304 (Phi)	.567
	MALE	1 (7.7)	3 (23.1)	8 (61.5)	0 (0.0)	1 (7.7)		
AGE	31-35	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)	0 (0.0)	.479 (V)	.600
	36-40	0 (0.0)	0 (0.0)	8 (88.9)	1 (11.1)	0 (0.0)		
	41-45	0 (0.0)	1 (25.0)	1 (25.0)	1 (25.0)	1 (25.0)		
	46-50	1 (16.7)	2 (33.3)	3 (50.0)	0 (0.0)	0 (0.0)		
	51-55	0 (0.0)	2 (40.0)	3 (60.0)	0 (0.0)	0 (0.0)		
	56-60	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		
	61-65	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)	0 (0.0)		
	66+	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED						.345 (V)	.509
	MARRIED	0 (0.0)	4 (21.1)	14 (73.7)	0 (0.0)	1 (5.3)		
	COMMON LAW							
	SEPARATED	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	DIVORCED	1 (25.0)	1 (25.0)	1 (25.0)	1 (25.0)	0 (0.0)		
	WIDOWED							
	OTHER	1 (16.7)	1 (16.7)	3 (50.0)	1 (16.7)	0 (0.0)		
NR	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)	0 (0.0)			
CHILDREN	0	0 (0.0)	0 (0.0)	6 (85.7)	1 (14.3)	0 (0.0)	.429 (V)	.488
	1	0 (0.0)	0 (0.0)	2 (66.7)	1 (33.3)	0 (0.0)		
	2	2 (22.2)	2 (22.2)	5 (55.6)	0 (0.0)	0 (0.0)		
	3	0 (0.0)	2 (28.6)	4 (57.1)	0 (0.0)	1 (14.3)		
	4	0 (0.0)	2 (66.7)	1 (33.3)	0 (0.0)	0 (0.0)		
	6	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	NR	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)	0 (0.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	1 (25.0)	3 (75.0)	0 (0.0)	0 (0.0)		
	HIGHSCHOOL	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)		
	SOME COLLEGE	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)	0 (0.0)		
	CERT./DIPLOMA	0 (0.0)	3 (60.0)	1 (20.0)	1 (20.0)	0 (0.0)		
	BACHELOR	0 (0.0)	3 (60.0)	1 (20.0)	1 (20.0)	0 (0.0)		
	MASTERS	0 (0.0)	1 (20.0)	3 (60.0)	1 (20.0)	0 (0.0)		
	DOCTORAL	0 (0.0)	0 (0.0)	3 (100.0)	0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		
	MED. DOCTOR	0 (0.0)	2 (25.0)	5 (62.5)	0 (0.0)	1 (12.5)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
RELIGION	NONE	1 (8.3)	1 (8.3)	8 (66.7)	2 (16.7)	0 (0.0)	.325 (V)	.634
	CATHOLIC	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		
	PROTESTANT	0 (0.0)	5 (35.7)	8 (57.1)	0 (0.0)	1 (7.1)		
	JEWISH							
	OTHER	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	1 (25.0)	1 (25.0)	2 (50.0)	0 (0.0)	0 (0.0)		
RELIGIOSITY	NOT AT ALL	1 (12.5)	1 (12.5)	6 (75.0)	0 (0.0)	0 (0.0)	.332 (V)	.588
	BARELY	1 (16.7)	2 (33.3)	2 (33.3)	1 (16.7)	0 (0.0)		
	SOMEWHAT	0 (0.0)	3 (27.3)	7 (63.6)	0 (0.0)	1 (9.1)		
	EXTREMELY	0 (0.0)	0 (0.0)	2 (66.7)	1 (33.3)	0 (0.0)		
	N.R.	0 (0.0)	2 (50.0)	2 (50.0)	0 (0.0)	0 (0.0)		
ATTEND RELIGIOUS SERVICES	NEVER	2 (13.3)	3 (20.0)	7 (46.7)	2 (13.3)	1 (6.7)	.328 (V)	.617
	SEVERAL/YR	0 (0.0)	1 (12.5)	7 (87.5)	0 (0.0)	0 (0.0)		
	1-3/MONTH	0 (0.0)	3 (75.0)	1 (25.0)	0 (0.0)	0 (0.0)		
	1/WK +	0 (0.0)	0 (0.0)	2 (100.0)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (33.3)	2 (66.7)	0 (0.0)	0 (0.0)		

N = 32

\* percentages indicated by ( )

**POLICY REGARDING CONTRACT MOTHERHOOD****TABLE 8C**  
**Frequencies and Percentages \***

		ALLOW POLICY	DISALLOW POLICY	NO POLICY	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	6 (31.6)	5 (26.3)	3 (15.8)	2 (10.5)	2 (10.5)	1 (5.3)	.451 (Ph)	.261
	MALE	8 (61.5)	4 (30.8)	0 (0.0)	0 (0.0)	0 (0.0)	1 (7.7)		
AGE	31-35	2 (66.7)	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)	.536 (V)	.226
	36-40	6 (66.7)	0 (0.0)	1 (11.1)	1 (11.1)	1 (11.1)	0 (0.0)		
	41-45	1 (25.0)	1 (25.0)	0 (0.0)	0 (0.0)	1 (25.0)	1 (25.0)		
	46-50	1 (16.7)	4 (66.7)	0 (0.0)	1 (16.7)	0 (0.0)	0 (0.0)		
	51-55	3 (60.0)	2 (40.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	56-60	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	61-65	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	66+	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED							.516 (V)	.025
	MARRIED	11 (57.9)	6 (31.6)	0 (0.0)	1 (5.3)	0 (0.0)	1 (5.3)		
	COMMON LAW								
	SEPARATED	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	DIVORCED	1 (25.0)	1 (25.0)	1 (25.0)	0 (0.0)	1 (25.0)	0 (0.0)		
	WIDOWED								
	OTHER	2 (33.3)	2 (33.3)	1 (16.7)	0 (0.0)	1 (16.7)	0 (0.0)		
NR	0 (0.0)	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)			
CHILDREN	0	2 (28.6)	2 (28.6)	2 (28.6)	0 (0.0)	1 (14.3)	0 (0.0)	.510 (V)	.077
	1	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		
	2	4 (44.4)	3 (33.3)	0 (0.0)	1 (11.1)	0 (0.0)	1 (11.1)		
	3	5 (71.4)	2 (28.6)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	4	1 (33.3)	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	6	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	NR	0 (0.0)	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)		
EDUCATION LEVEL	COMBINATION	2 (50.0)	0 (0.0)	2 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	.128 (V)	.181
	HIGHSCHOOL	1 (50.0)	1 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	SOME COLLEGE	2 (66.7)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)		
	CERT/DIPLOMA	1 (20.0)	3 (60.0)	0 (0.0)	0 (0.0)	1 (20.0)	0 (0.0)		
	BACHELOR	1 (20.0)	3 (60.0)	0 (0.0)	0 (0.0)	1 (20.0)	0 (0.0)		
	MASTERS	2 (40.0)	1 (20.0)	0 (0.0)	1 (20.0)	1 (20.0)	0 (0.0)		
	DOCTORAL	3 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	LAWYER	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	MED DOCTOR	2 (25.0)	4 (50.0)	1 (12.5)	0 (0.0)	0 (0.0)	1 (12.5)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
RELIGION	NONE	4 (33.3)	2 (16.7)	3 (25.0)	1 (8.3)	2 (16.7)	0 (0.0)	.408 (V)	.379
	CATHOLIC	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	PROTESTANT	7 (50.0)	6 (42.9)	0 (0.0)	0 (0.0)	0 (0.0)	1 (7.1)		
	JEWISH								
	OTHER	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	2 (50.0)	0 (0.0)	0 (0.0)	1 (25.0)	0 (0.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	4 (50.0)	0 (0.0)	2 (25.0)	2 (25.0)	0 (0.0)	0 (0.0)	.421 (V)	.306
	BARELY	3 (50.0)	2 (33.3)	0 (0.0)	0 (0.0)	1 (16.7)	0 (0.0)		
	SOMEWHAT	4 (36.4)	5 (45.5)	1 (9.1)	0 (0.0)	0 (0.0)	1 (9.1)		
	EXTREMELY	1 (33.3)	1 (33.3)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		
	N.R.	2 (50.0)	1 (25.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	7 (46.7)	2 (13.3)	3 (20.0)	1 (6.7)	2 (13.3)	0 (0.0)	.437 (V)	.225
	SEVERAL/YR	3 (37.5)	4 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (12.5)		
	1-3/MONTH	1 (25.0)	3 (75.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	1/WK +	2 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	1 (33.3)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	1 (33.3)		

N = 32

\* percentages indicated by ( )

**FUNDING OF CONTRACT MOTHERHOOD**

**TABLE 8D**  
**Frequencies and Percentages \***

		PUBLIC FUND	PRIVATE FUND	PRIV & PUBLIC	NO FUND	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	1 (5.3)	7 (36.8)	1 (5.3)	5 (26.3)	1 (5.3)	1 (5.3)	3 (15.8)	.373 (Ph)	.615
	MALE	1 (7.7)	5 (35.5)	1 (7.7)	6 (46.2)	0 (0.0)	0 (0.0)	0 (0.0)		
AGE	31-35	0 (0.0)	3 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	.500 (V)	.472
	36-40	1 (11.1)	3 (33.3)	2 (22.2)	1 (11.1)	0 (0.0)	1 (11.1)	1 (11.1)		
	41-45	0 (0.0)	0 (0.0)	0 (0.0)	3 (75.0)	0 (0.0)	0 (0.0)	1 (25.0)		
	46-50	0 (0.0)	1 (16.7)	0 (0.0)	3 (50.0)	1 (16.7)	0 (0.0)	1 (16.7)		
	51-55	0 (0.0)	3 (60.0)	0 (0.0)	2 (40.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	56-60	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	61-65	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	66+	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED								.391 (V)	.724
	MARRIED	2 (10.5)	7 (36.8)	1 (5.3)	7 (36.8)	1 (5.3)	0 (0.0)	1 (5.3)		
	COMMON LAW									
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	DIVORCED	0 (0.0)	1 (25.0)	1 (25.0)	1 (25.0)	0 (0.0)	1 (25.0)	0 (0.0)		
	WIDOWED									
	OTHER	0 (0.0)	3 (50.0)	0 (0.0)	2 (33.3)	0 (0.0)	0 (0.0)	1 (16.7)		
NR	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (50.0)			
CHILDREN	0	0 (0.0)	2 (28.6)	1 (14.3)	3 (42.9)	0 (0.0)	0 (0.0)	1 (14.3)	.382 (V)	.826
	1	0 (0.0)	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		
	2	1 (11.1)	4 (44.4)	0 (0.0)	2 (22.2)	1 (11.1)	0 (0.0)	1 (11.1)		
	3	1 (14.3)	2 (28.6)	1 (14.3)	3 (42.9)	0 (0.0)	0 (0.0)	0 (0.0)		
	4	0 (0.0)	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)		
	6	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	NR	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (50.0)		
EDUCATION LEVEL	COMBINATION	1 (25.0)	1 (25.0)	0 (0.0)	2 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	.452 (V)	.013
	HIGHSCHOOL	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)		
	CERT/DIPLOMA	0 (0.0)	2 (40.0)	0 (0.0)	1 (20.0)	0 (0.0)	1 (20.0)	1 (20.0)		
	BACHELOR	0 (0.0)	2 (40.0)	0 (0.0)	1 (20.0)	0 (0.0)	1 (20.0)	1 (20.0)		
	MASTERS	0 (0.0)	1 (20.0)	1 (20.0)	1 (20.0)	1 (20.0)	0 (0.0)	1 (20.0)		
	DOCTORAL	1 (33.3)	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	MED. DOCTOR	0 (0.0)	1 (12.5)	1 (12.5)	6 (75.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
RELIGION	NONE	1 (8.3)	4 (33.3)	1 (8.3)	3 (25.0)	1 (8.3)	1 (8.3)	1 (8.3)	.335 (V)	.938
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	PROTESTANT	0 (0.0)	5 (35.7)	1 (7.1)	7 (50.0)	0 (0.0)	0 (0.0)	1 (7.1)		
	JEWISH									
	OTHER	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	1 (25.0)	2 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	1 (12.5)	4 (50.0)	0 (0.0)	1 (12.5)	1 (12.5)	0 (0.0)	1 (12.5)	.459 (V)	.304
	BARELY	0 (0.0)	3 (50.0)	0 (0.0)	2 (33.3)	0 (0.0)	1 (16.7)	0 (0.0)		
	SOMEWHAT	0 (0.0)	2 (18.2)	2 (18.2)	6 (54.5)	0 (0.0)	0 (0.0)	1 (9.1)		
	EXTREMELY	0 (0.0)	0 (0.0)	0 (0.0)	2 (66.7)	0 (0.0)	0 (0.0)	1 (33.3)		
	N.R.	1 (25.0)	3 (75.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
ATTEND RELIGIOUS SERVICES	NEVER	1 (6.7)	6 (40.0)	1 (6.7)	4 (26.7)	1 (6.7)	1 (6.7)	1 (6.7)	.368 (V)	.834
	SEVERAL/YR	0 (0.0)	3 (37.5)	0 (0.0)	5 (62.5)	0 (0.0)	0 (0.0)	0 (0.0)		
	1-3/MONTH	0 (0.0)	1 (25.0)	1 (25.0)	1 (25.0)	0 (0.0)	0 (0.0)	1 (25.0)		
	1/WK +	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	1 (33.3)	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)		

N = 32

\* percentages indicated by ( )

**ACCESS TO CONTRACT MOTHERHOOD****TABLE 8E**  
**Frequencies and Percentages \***

		RESTRD ACCESS	FREE ACCESS	NO ACCESS	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	8 (42.1)	2 (10.5)	5 (26.3)	2 (10.5)	2 (10.5)	.328 (Phi)	.487
	MALE	4 (30.8)	4 (30.8)	4 (30.8)	0 (0.0)	1 (7.7)		
AGE	31 -35	2 (66.7)	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)	.543 (V)	.226
	36 - 40	4 (44.4)	3 (33.3)	0 (0.0)	1 (11.1)	1 (11.1)		
	41 - 45	1 (25.0)	0 (0.0)	2 (50.0)	1 (25.0)	0 (0.0)		
	46 -50	2 (33.3)	0 (0.0)	4 (66.7)	0 (0.0)	0 (0.0)		
	51 - 55	2 (40.0)	1 (20.0)	2 (40.0)	0 (0.0)	0 (0.0)		
	56 - 60	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	61 - 65	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)		
	66+	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED						.551 (V)	.001
	MARRIED	8 (42.1)	4 (21.1)	7 (36.8)	0 (0.0)	0 (0.0)		
	COMMON LAW							
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
	DIVORCED	2 (50.0)	0 (0.0)	1 (25.0)	1 (25.0)	0 (0.0)		
	WIDOWED							
	OTHER	2 (33.3)	2 (33.3)	1 (16.7)	1 (16.7)	0 (0.0)		
NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)			
CHILDREN	0	2 (28.6)	2 (28.6)	2 (28.6)	1 (14.3)	0 (0.0)	.595 (V)	.005
	1	2 (66.7)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		
	2	5 (55.6)	1 (11.1)	3 (33.3)	0 (0.0)	0 (0.0)		
	3	2 (28.6)	3 (42.9)	2 (28.6)	0 (0.0)	0 (0.0)		
	4	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)	0 (0.0)		
	6	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
	NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
EDUCATION LEVEL	COMBINATION	1 (25.0)	2 (50.0)	0 (0.0)	0 (0.0)	1 (25.0)	.561 (V)	.149
	HIGHSCHOOL	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)		
	SOME COLLEGE	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)		
	CERT./DIPLOMA	2 (40.0)	0 (0.0)	2 (40.0)	1 (20.0)	0 (0.0)		
	BACHELOR	2 (40.0)	0 (0.0)	2 (40.0)	1 (20.0)	0 (0.0)		
	MASTERS	2 (40.0)	1 (20.0)	1 (20.0)	1 (20.0)	0 (0.0)		
	DOCTORAL	1 (33.3)	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	MED. DOCTOR	3 (37.5)	0 (0.0)	5 (62.5)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
RELIGION	NONE	4 (33.3)	3 (25.0)	2 (16.7)	2 (16.7)	1 (8.3)	.427 (V)	.106
	CATHOLIC	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	PROTESTANT	6 (42.9)	1 (7.1)	7 (50.0)	0 (0.0)	0 (0.0)		
	JEWISH							
	OTHER	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
NR	1 (25.0)	1 (25.0)	0 (0.0)	0 (0.0)	2 (50.0)			
RELIGIOSITY	NOT AT ALL	3 (37.5)	3 (37.5)	0 (0.0)	0 (0.0)	2 (25.0)	.418 (V)	.133
	BARELY	3 (50.0)	0 (0.0)	2 (33.3)	1 (16.7)	0 (0.0)		
	SOMEWHAT	4 (36.4)	1 (9.1)	6 (54.5)	0 (0.0)	0 (0.0)		
	EXTREMELY	0 (0.0)	1 (33.3)	1 (33.3)	1 (33.3)	0 (0.0)		
	N.R.	2 (50.0)	1 (25.0)	0 (0.0)	0 (0.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	7 (46.7)	3 (20.0)	2 (13.3)	2 (13.3)	1 (6.7)	.446 (V)	.061
	SEVERAL/YR	3 (37.5)	0 (0.0)	5 (62.5)	0 (0.0)	0 (0.0)		
	1-3/MONTH	1 (25.0)	1 (25.0)	2 (50.0)	0 (0.0)	0 (0.0)		
	1/WK +	1 (50.0)	1 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)	2 (66.7)		

N = 32

\* percentages indicated by ( )

**KNOWLEDGE OF ARTIFICIAL WOMB TECHNOLOGY**

**TABLE 9A**  
**Frequencies and Percentages \***

		FAMILIAR	NOT FAMILIAR	ASSOCIATION Phi / V	SIGNIFICANCE
SEX	FEMALE	2 (10.5)	17 (89.5)	.541 (Phi)	.002
	MALE	8 (61.5)	5 (38.5)		
AGE	31 -35	1 (33.3)	2 (66.7)	.439 (V)	.629
	36 - 40	3 (33.3)	6 (66.7)		
	41 - 45	1 (25.0)	3 (75.0)		
	46 -50	2 (33.3)	4 (66.7)		
	51 - 55	1 (20.0)	4 (80.0)		
	56 - 60	1 (100.0)	0 (0.0)		
	61 - 65	0 (0.0)	2 (100.0)		
	66+	0 (0.0)	1 (100.0)		
	N.R.	1 (100.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED	0 (0.0)	0 (0.0)	.335 (V)	.465
	MARRIED	6 (31.6)	13 (68.4)		
	COMMON LAW	0 (0.0)	0 (0.0)		
	SEPARATED	0 (0.0)	1 (100.0)		
	DIVORCED	0 (0.0)	4 (100.0)		
	WIDOWED	0 (0.0)	0 (0.0)		
	OTHER	3 (50.0)	3 (50.0)		
	NR	1 (50.0)	1 (50.0)		
CHILDREN	0	3 (42.9)	4 (57.1)	.449 (V)	.372
	1	1 (33.3)	2 (66.7)		
	2	1 (11.1)	8 (88.9)		
	3	4 (57.1)	3 (42.9)		
	4	0 (0.0)	3 (100.0)		
	6	0 (0.0)	1 (100.0)		
		NR	1 (50.0)	1 (50.0)	
EDUCATION LEVEL	COMBINATION	1 (25.0)	3 (75.0)	.523 (V)	.362
	HIGHSCHOOL	1 (50.0)	1 (50.0)		
	SOME COLLEGE	0 (0.0)	3 (100.0)		
	CERT./DIPLOMA	0 (0.0)	5 (100.0)		
	BACHELOR	0 (0.0)	0 (0.0)		
	MASTERS	2 (40.0)	3 (60.0)		
	DOCTORAL	2 (66.7)	1 (33.3)		
	LAWYER	0 (0.0)	1 (100.0)		
	MED. DOCTOR	3 (37.5)	5 (62.5)		
	N.R.	1 (100.0)	0 (0.0)		
RELIGION	NONE	3 (25.0)	9 (75.0)	.244 (V)	.752
	CATHOLIC	0 (0.0)	1 (100.0)		
	PROTESTANT	5 (35.7)	9 (64.3)		
	JEWISH	0 (0.0)	0 (0.0)		
	OTHER	0 (0.0)	1 (100.0)		
		N.R.	2 (50.0)	2 (50.0)	
RELIGIOSITY	NOT AT ALL	2 (25.0)	6 (75.0)	.318 (V)	.521
	BARELY	3 (50.0)	3 (50.0)		
	SOMEWHAT	3 (27.3)	8 (72.7)		
	EXTREMELY	0 (0.0)	3 (100.0)		
		N.R.	2 (50.0)	2 (50.0)	
ATTEND RELIGIOUS SERVICES	NEVER	2 (13.3)	13 (86.7)	.463 (V)	.143
	SEVERAL/YR	4 (50.0)	4 (50.0)		
	1-3/MONTH	2 (50.0)	2 (50.0)		
	1/WK +	0 (0.0)	2 (100.0)		
		N.R.	2 (66.7)	1 (33.3)	

N = 32

\* percentages indicated by ( )

**RATING OF ARTIFICIAL WOMB TECHNOLOGY**

**TABLE 9B**  
**Frequencies and Percentages \***

		BENEFICIAL	DETRIMNTL	CAN BE BOTH	NOT FAMILIAR	NR	ASSOC	SIGNIF
SEX	FEMALE	2 (10.5)	0 (0.0)	2 (10.5)	12 (63.2)	3 (15.8)		.243
	MALE	3 (23.1)	1 (7.7)	3 (23.1)	6 (46.2)	0 (0.0)		
AGE	31 -35	0 (0.0)	0 (0.0)	1 (33.3)	1 (33.3)	1 (33.3)	.656 (V)	.067
	36 - 40	0 (0.0)	0 (0.0)	3 (33.3)	5 (55.6)	1 (11.1)		
	41 - 45	0 (0.0)	0 (0.0)	1 (25.0)	3 (75.0)	0 (0.0)		
	46 -50	3 (50.0)	0 (0.0)	0 (0.0)	3 (50.0)	0 (0.0)		
	51 - 55	1 (20.0)	0 (0.0)	0 (0.0)	3 (60.0)	1 (20.0)		
	56 - 60	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	61 - 65	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)	0 (0.0)		
	66+	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED						.403 (V)	.186
	MARRIED	4 (21.1)	0 (0.0)	4 (21.1)	9 (47.4)	2 (10.5)		
	COMMON LAW							
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	DIVORCED	0 (0.0)	0 (0.0)	0 (0.0)	3 (75.0)	1 (25.0)		
	WIDOWED							
	OTHER	1 (16.7)	0 (0.0)	1 (16.7)	4 (66.7)	0 (0.0)		
NR	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)			
CHILDREN	0	1 (14.3)	0 (0.0)	2 (28.6)	4 (57.1)	0 (0.0)	.470 (V)	.250
	1	0 (0.0)	0 (0.0)	1 (33.3)	1 (33.3)	1 (33.3)		
	2	2 (22.2)	0 (0.0)	0 (0.0)	6 (66.7)	1 (11.1)		
	3	2 (28.6)	0 (0.0)	2 (28.6)	3 (42.9)	0 (0.0)		
	4	0 (0.0)	0 (0.0)	0 (0.0)	2 (66.7)	1 (33.3)		
	6	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	NR	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	0 (0.0)	1 (25.0)	3 (75.0)	0 (0.0)	.700 (V)	.001
	HIGHSCHOOL	2 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)	0 (0.0)	0 (0.0)	2 (66.7)	1 (33.3)		
	CERT/DIPLOMA	1 (20.0)	0 (0.0)	0 (0.0)	4 (80.0)	0 (0.0)		
	BACHELOR	1 (20.0)	0 (0.0)	0 (0.0)	4 (80.0)	0 (0.0)		
	MASTERS	1 (20.0)	0 (0.0)	1 (20.0)	3 (60.0)	0 (0.0)		
	DOCTORAL	1 (33.3)	0 (0.0)	1 (33.3)	1 (33.3)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
	MED. DOCTOR	0 (0.0)	0 (0.0)	2 (25.0)	5 (62.5)	1 (12.5)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
RELIGION	NONE	1 (8.3)	0 (0.0)	1 (8.3)	9 (75.0)	1 (8.3)	.337 (V)	.559
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	PROTESTANT	3 (21.4)	0 (0.0)	4 (28.6)	5 (35.7)	2 (14.3)		
	JEWISH							
	OTHER	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	N.R.	1 (25.0)	1 (25.0)	0 (0.0)	2 (50.0)	0 (0.0)		
RELIGIOSITY	NOT AT ALL	1 (12.5)	0 (0.0)	1 (12.5)	5 (62.5)	1 (12.5)	.362 (V)	.403
	BARELY	0 (0.0)	0 (0.0)	3 (50.0)	2 (33.3)	1 (16.7)		
	SOMEWHAT	2 (18.2)	0 (0.0)	1 (9.1)	7 (63.6)	1 (9.1)		
	EXTREMELY	1 (33.3)	0 (0.0)	0 (0.0)	2 (66.7)	0 (0.0)		
	N.R.	1 (25.0)	1 (25.0)	0 (0.0)	2 (50.0)	0 (0.0)		
ATTEND RELIGIOUS SERVICES	NEVER	1 (6.7)	0 (0.0)	1 (6.7)	10 (66.7)	3 (20.0)	.433 (V)	.089
	SEVERAL/YR	1 (12.5)	0 (0.0)	3 (37.5)	4 (50.0)	0 (0.0)		
	1-3/MONTH	2 (50.0)	0 (0.0)	1 (25.0)	1 (25.0)	0 (0.0)		
	1/WK +	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)	0 (0.0)		
	N.R.	1 (33.3)	1 (33.3)	0 (0.0)	1 (33.3)	0 (0.0)		

N = 32

\* percentages indicated by ( )

**POLICY REGARDING ARTIFICIAL WOMB TECHNOLOGY**

**TABLE 9C**  
**Frequencies and Percentages \***

		ALLOW POLICY	DISALLOW POLICY	NO POLICY	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	1 (5.3)		4 (21.1)		11 (57.9)	3 (15.8)	.493 (Phi)	.051
	MALE	6 (46.2)		1 (7.7)		5 (38.5)	1 (7.7)		
AGE	31 -35	0 (0.0)		1 (33.3)		1 (33.3)	1 (33.3)	.493 (V)	.503
	36 - 40	2 (22.2)		1 (11.1)		5 (55.6)	1 (11.1)		
	41 - 45	2 (50.0)		0 (0.0)		1 (25.0)	1 (25.0)		
	46 -50	2 (33.3)		1 (16.7)		3 (50.0)	0 (0.0)		
	51 - 55	0 (0.0)		1 (20.0)		4 (80.0)	0 (0.0)		
	56 - 60	1 (100.0)		0 (0.0)		0 (0.0)	0 (0.0)		
	61 - 65	0 (0.0)		1 (50.0)		1 (50.0)	0 (0.0)		
	66+	0 (0.0)		0 (0.0)		1 (100.0)	0 (0.0)		
	N.R.	0 (0.0)		0 (0.0)		0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED							.507 (V)	.016
	MARRIED	6 (31.6)		3 (15.8)		9 (47.4)	1 (5.3)		
	COMMON LAW								
	SEPARATED	0 (0.0)		1 (100.0)		0 (0.0)	0 (0.0)		
	DIVORCED	0 (0.0)		0 (0.0)		3 (75.0)	1 (25.0)		
	WIDOWED								
	OTHER	1 (16.7)		1 (16.7)		4 (66.7)	0 (0.0)		
NR	0 (0.0)		0 (0.0)		0 (0.0)	2 (100.0)			
CHILDREN	0	1 (14.3)		2 (28.6)		4 (57.1)	0 (0.0)	.593 (V)	.014
	1	0 (0.0)		1 (33.3)		2 (66.7)	0 (0.0)		
	2	2 (22.2)		0 (0.0)		5 (55.6)	2 (22.2)		
	3	4 (57.1)		1 (14.3)		2 (28.6)	0 (0.0)		
	4	0 (0.0)		0 (0.0)		3 (100.0)	0 (0.0)		
	6	0 (0.0)		1 (100.0)		0 (0.0)	0 (0.0)		
	NR	0 (0.0)		0 (0.0)		0 (0.0)	2 (100.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)		2 (50.0)		2 (50.0)	0 (0.0)	.566 (V)	.160
	HIGHSCHOOL	1 (50.0)		1 (50.0)		0 (0.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)		0 (0.0)		1 (33.3)	2 (66.7)		
	CERT./DIPLOMA	1 (20.0)		0 (0.0)		4 (80.0)	0 (0.0)		
	BACHELOR	1 (20.0)		0 (0.0)		4 (80.0)	0 (0.0)		
	MASTERS	1 (20.0)		1 (20.0)		3 (60.0)	0 (0.0)		
	DOCTORAL	1 (33.3)		1 (33.3)		1 (33.3)	0 (0.0)		
	LAWYER	0 (0.0)		0 (0.0)		1 (100.0)	0 (0.0)		
	MED. DOCTOR	3 (37.5)		0 (0.0)		4 (50.0)	1 (12.5)		
	N.R.	0 (0.0)		0 (0.0)		0 (0.0)	1 (100.0)		
RELIGION	NONE	1 (8.3)		3 (16.7)		9 (75.0)	0 (0.0)	.496 (V)	.023
	CATHOLIC	0 (0.0)		0 (0.0)		1 (100.0)	0 (0.0)		
	PROTESTANT	5 (35.7)		3 (21.4)		5 (35.7)	1 (7.1)		
	JEWISH								
	OTHER	0 (0.0)		0 (0.0)		1 (100.0)	0 (0.0)		
N.R.	1 (25.0)		0 (0.0)		0 (0.0)	3 (75.0)			
RELIGIOSITY	NOT AT ALL	1 (12.5)		2 (25.0)		4 (50.0)	.230 (V)	.955	
	BARELY	2 (33.3)		1 (16.7)		2 (33.3)	1 (16.7)		
	SOMEWHAT	3 (27.3)		1 (9.1)		6 (54.5)	1 (9.1)		
	EXTREMELY	0 (0.0)		1 (33.3)		2 (66.7)	0 (0.0)		
	N.R.	1 (25.0)		0 (0.0)		2 (50.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	2 (13.3)		2 (13.3)		10 (66.7)	1 (6.7)	.413 (V)	.174
	SEVERAL/YR	2 (25.0)		2 (25.0)		3 (37.5)	1 (12.5)		
	1-3/MONTH	2 (50.0)		1 (25.0)		1 (25.0)	0 (0.0)		
	1/WK +	0 (0.0)		0 (0.0)		2 (100.0)	0 (0.0)		
	N.R.	1 (33.3)		0 (0.0)		0 (0.0)	2 (66.7)		

N = 32

\* percentages indicated by ( )

**FUNDING OF ARTIFICIAL WOMB TECHNOLOGY**

**TABLE 9D**  
**Frequencies and Percentages \***

		PUBLIC FUND	PRIVATE FUND	PRIV & PUBLIC	NOFUND	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	1 (5.3)	0 (0.0)	1 (5.3)	0 (0.0)		10 (52.6)	7 (36.8)		.108
	MALE	2 (15.4)	1 (7.7)	2 (15.4)	2 (15.4)		5 (38.5)	1 (7.7)		
AGE	31 - 35	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		1 (33.3)	1 (33.3)	.550 (V)	.172
	36 - 40	1 (11.1)	0 (0.0)	1 (11.1)	1 (11.1)		4 (44.4)	2 (22.2)		
	41 - 45	1 (25.0)	0 (0.0)	0 (0.0)	1 (25.0)		1 (25.0)	1 (25.0)		
	46 - 50	0 (0.0)	0 (0.0)	1 (16.7)	0 (0.0)		3 (50.0)	2 (33.3)		
	51 - 55	1 (20.0)	0 (0.0)	0 (0.0)	0 (0.0)		3 (60.0)	1 (20.0)		
	56 - 60	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
	61 - 65	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (100.0)	0 (0.0)		
	66+	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED								.482 (V)	.075
	MARRIED	3 (15.8)	0 (0.0)	1 (5.3)	2 (10.5)		7 (36.8)	6 (31.6)		
	COMMON LAW									
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	DIVORCED	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		4 (100.0)	0 (0.0)		
	WIDOWED									
	OTHER	0 (0.0)	0 (0.0)	2 (33.3)	0 (0.0)		3 (50.0)	1 (16.7)		
NR	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (50.0)			
CHILDREN	0	0 (0.0)	0 (0.0)	1 (14.3)	1 (14.3)		4 (57.1)	1 (14.3)	.441 (V)	.408
	1	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)		1 (33.3)	1 (33.3)		
	2	0 (0.0)	0 (0.0)	1 (11.1)	0 (0.0)		6 (66.7)	2 (22.2)		
	3	2 (28.6)	0 (0.0)	1 (14.3)	1 (14.3)		1 (14.3)	2 (28.6)		
	4	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (66.7)	1 (33.3)		
	6	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	NR	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (50.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	0 (0.0)	1 (25.0)	0 (0.0)		3 (75.0)	0 (0.0)	.618 (V)	.017
	HIGHSCHOOL	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)		1 (50.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (33.3)	2 (66.7)		
	CERT./DIPLOMA	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (40.0)	3 (60.0)		
	BACHELOR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (40.0)	3 (60.0)		
	MASTERS	1 (20.0)	0 (0.0)	1 (20.0)	0 (0.0)		2 (40.0)	1 (20.0)		
	DOCTORAL	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)		1 (33.3)	1 (33.3)		
	LAWYER	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
	MED. DOCTOR	1 (12.5)	0 (0.0)	0 (0.0)	2 (25.0)		5 (62.5)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
RELIGION	NONE	0 (0.0)	0 (0.0)	2 (16.7)	0 (0.0)		8 (66.7)	2 (16.7)	.398 (V)	.441
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	PROTESTANT	3 (21.4)	0 (0.0)	1 (7.1)	2 (14.3)		4 (28.6)	4 (28.6)		
	JEWISH									
	OTHER	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (25.0)	0 (0.0)	0 (0.0)		1 (25.0)	2 (50.0)		
RELIGIOSITY	NOT AT ALL	0 (0.0)	0 (0.0)	2 (25.0)	0 (0.0)		4 (50.0)	2 (25.0)	.397 (V)	.445
	BARELY	2 (33.3)	0 (0.0)	0 (0.0)	1 (16.7)		3 (50.0)	0 (0.0)		
	SOMEWHAT	1 (9.1)	0 (0.0)	1 (9.1)	1 (9.1)		4 (36.4)	4 (36.4)		
	EXTREMELY	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (66.7)	1 (33.3)		
	N.R.	0 (0.0)	1 (25.0)	0 (0.0)	0 (0.0)		2 (50.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	0 (0.0)	0 (0.0)	2 (13.3)	1 (6.7)		8 (53.3)	4 (26.7)	.438 (V)	.221
	SEVERAL/YR	2 (25.0)	0 (0.0)	0 (0.0)	1 (12.5)		4 (50.0)	1 (12.5)		
	1-3/MONTH	1 (25.0)	0 (0.0)	1 (25.0)	0 (0.0)		1 (25.0)	1 (25.0)		
	1/WK +	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (100.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)		0 (0.0)	2 (66.7)		

N = 32

\* percentages indicated by ( )

## ACCESS TO ARTIFICIAL WOMB TECHNOLOGY

TABLE 9E  
Frequencies and Percentages \*

		RESTRD ACCESS	FREE ACCESS	NO ACCESS	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	2 (10.5)	1 (5.3)		9 (47.4)	7 (36.8)	.360 (Phi)	.247
	MALE	3 (23.1)	3 (23.1)		5 (38.5)	2 (15.4)		
AGE	31 -35	0 (0.0)	1 (33.3)		1 (33.3)	1 (33.3)	.404 (V)	.899
	36 -40	2 (22.2)	1 (11.1)		4 (44.4)	2 (22.2)		
	41 -45	2 (50.0)	0 (0.0)		2 (50.0)	0 (0.0)		
	46 -50	1 (16.7)	1 (16.7)		3 (50.0)	1 (16.7)		
	51 -55	0 (0.0)	1 (20.0)		2 (40.0)	2 (40.0)		
	56 -60	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
	61 -65	0 (0.0)	0 (0.0)		1 (50.0)	1 (50.0)		
	66+	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED						.418 (V)	.157
	MARRIED	5 (26.3)	2 (10.5)		7 (36.8)	5 (26.3)		
	COMMON LAW							
	SEPARATED	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
	DIVORCED	0 (0.0)	0 (0.0)		3 (75.0)	1 (25.0)		
	WIDOWED							
	OTHER	0 (0.0)	2 (33.3)		4 (66.7)	0 (0.0)		
NR	0 (0.0)	0 (0.0)		0 (0.0)	2 (100.0)			
CHILDREN	0	1 (14.3)	1 (14.3)		5 (71.4)	0 (0.0)	.425 (V)	.501
	1	1 (33.3)	0 (0.0)		1 (33.3)	1 (33.3)		
	2	1 (11.1)	1 (11.1)		5 (55.6)	2 (22.2)		
	3	2 (28.6)	2 (28.6)		1 (14.3)	2 (28.6)		
	4	0 (0.0)	0 (0.0)		2 (66.7)	1 (33.3)		
	6	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
	NR	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	1 (25.0)		2 (50.0)	1 (25.0)	.482 (V)	.563
	HIGHSCHOOL	0 (0.0)	1 (50.0)		1 (50.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)	0 (0.0)		1 (33.3)	2 (66.7)		
	CERT./DIPLOMA	1 (20.0)	0 (0.0)		3 (60.0)	1 (20.0)		
	BACHELOR	1 (20.0)	0 (0.0)		3 (60.0)	1 (20.0)		
	MASTERS	0 (0.0)	2 (40.0)		2 (40.0)	1 (20.0)		
	DOCTORAL	1 (33.3)	0 (0.0)		1 (33.3)	1 (33.3)		
	LAWYER	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
	MED. DOCTOR	3 (37.5)	0 (0.0)		4 (50.0)	1 (12.5)		
	N.R.	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
RELIGION	NONE	0 (0.0)	2 (16.7)		7 (58.3)	3 (25.0)	.388 (V)	.275
	CATHOLIC	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	PROTESTANT	5 (35.7)	2 (14.3)		4 (28.6)	3 (21.4)		
	JEWISH							
	OTHER	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
N.R.	0 (0.0)	0 (0.0)		1 (25.0)	3 (75.0)			
RELIGIOSITY	NOT AT ALL	0 (0.0)	2 (25.0)		2 (25.0)	4 (50.0)	.413 (V)	.174
	BARELY	3 (50.0)	0 (0.0)		2 (33.3)	1 (16.7)		
	SOMEWHAT	2 (18.2)	2 (18.2)		5 (45.5)	2 (18.2)		
	EXTREMELY	0 (0.0)	0 (0.0)		3 (100.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)		2 (50.0)	2 (50.0)		
ATTEND RELIGIOUS SERVICES	NEVER	1 (6.7)	2 (13.3)		7 (46.7)	5 (33.3)	.474	.043
	SEVERAL/YR	3 (37.5)	0 (0.0)		4 (50.0)	1 (12.5)		
	1-3/MONTH	1 (25.0)	2 (50.0)		1 (25.0)	0 (0.0)		
	1/WK +	0 (0.0)	0 (0.0)		2 (100.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)		0 (0.0)	3 (100.0)		

N = 32

\* percentages indicated by ( )

**KNOWLEDGE OF RU 486 PILL****TABLE 10A**  
**Frequencies and Percentages \***

		FAMILIAR	NOT FAMILIAR	ASSOCIATION Phi / V	SIGNIFICANCE
SEX	FEMALE	8 (42.1)	11 (57.9)	.191 (Phi)	.280
	MALE	8 (61.5)	5 (38.5)		
AGE	31 -35	1 (33.3)	2 (66.7)	.589 (V)	.196
	36 - 40	4 (44.4)	5 (55.6)		
	41 - 45	2 (50.0)	2 (50.0)		
	46 -50	2 (33.3)	4 (66.7)		
	51 - 55	5 (100.0)	0 (0.0)		
	56 - 60	1 (100.0)	0 (0.0)		
	61 - 65	0 (0.0)	2 (100.0)		
	66+	0 (0.0)	1 (100.0)		
	N.R.	1 (100.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED	0 (0.0)	0 (0.0)	.395 (V)	.289
	MARRIED	12 (63.2)	7 (36.8)		
	COMMON LAW	0 (0.0)	0 (0.0)		
	SEPARATED	0 (0.0)	1 (100.0)		
	DIVORCED	2 (50.0)	2 (50.0)		
	WIDOWED	0 (0.0)	0 (0.0)		
	OTHER	1 (16.7)	5 (83.3)		
	NR	1 (50.0)	1 (50.0)		
CHILDREN	0	4 (57.1)	3 (42.9)	.649 (V)	.036
	1	1 (33.3)	2 (66.7)		
	2	1 (11.1)	8 (88.9)		
	3	6 (85.7)	1 (14.3)		
	4	3 (100.0)	0 (0.0)		
	6	0 (0.0)	1 (100.0)		
		NR	1 (50.0)	1 (50.0)	
EDUCATION LEVEL	COMBINATION	1 (25.0)	3 (75.0)	.556 (V)	.272
	HIGHSCHOOL	1 (50.0)	1 (50.0)		
	SOME COLLEGE	0 (0.0)	3 (100.0)		
	CERT./DIPLOMA	2 (40.0)	3 (60.0)		
	BACHELOR	3 (60.0)	2 (40.0)		
	MASTERS	0 (0.0)	0 (0.0)		
	DOCTORAL	3 (100.0)	0 (0.0)		
	LAWYER	0 (0.0)	1 (100.0)		
	MED. DOCTOR	5 (62.5)	3 (37.5)		
		N.R.	1 (100.0)	0 (0.0)	
RELIGION	NONE	3 (25.0)	9 (75.0)	.547 (V)	.048
	CATHOLIC	0 (0.0)	1 (100.0)		
	PROTESTANT	11 (78.6)	3 (21.4)		
	JEWISH	0 (0.0)	0 (0.0)		
	OTHER	0 (0.0)	1 (100.0)		
	N.R.	2 (50.0)	2 (50.0)		
RELIGIOSITY	NOT AT ALL	2 (25.0)	6 (75.0)	.358 (V)	.394
	BARELY	4 (66.7)	2 (33.3)		
	SOMEWHAT	6 (54.5)	5 (45.5)		
	EXTREMELY	1 (33.3)	2 (66.7)		
		N.R.	3 (75.0)	1 (25.0)	
ATTEND RELIGIOUS SERVICES	NEVER	5 (33.3)	10 (66.7)	.354 (V)	.406
	SEVERAL/YR	6 (75.0)	2 (25.0)		
	1-3/MONTH	2 (50.0)	2 (50.0)		
	1/WK +	1 (50.0)	1 (50.0)		
		N.R.	2 (66.7)	1 (33.3)	

N = 32

\* percentages indicated by ( )

**RATING OF RU 486 PILL**

**TABLE 10B**  
**Frequencies and Percentages \***

		BENEFICIAL	DETRIMNTL	CAN BE BOTH	NOT FAMILIAR	NR	ASSOC	SIGNIF
SEX	FEMALE	9 (47.4)	0 (0.0)	0 (0.0)	8 (42.1)	2 (10.5)	.44 (Phi)	.178
	MALE	4 (30.8)	1 (7.7)	2 (15.4)	6 (46.2)	0 (0.0)		
AGE	31 - 35	1 (33.3)	0 (0.0)	0 (0.0)	1 (33.3)	1 (33.3)	.445 (V)	.792
	36 - 40	3 (33.3)	0 (0.0)	0 (0.0)	5 (55.6)	1 (11.1)		
	41 - 45	1 (25.0)	0 (0.0)	1 (25.0)	2 (50.0)	0 (0.0)		
	46 - 50	3 (50.0)	0 (0.0)	0 (0.0)	3 (50.0)	0 (0.0)		
	51 - 55	3 (60.0)	1 (20.0)	1 (20.0)	0 (0.0)	0 (0.0)		
	56 - 60	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	61 - 65	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)	0 (0.0)		
	66+	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	N.R.	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED						.269 (V)	.902
	MARRIED	9 (47.4)	1 (5.3)	2 (10.5)	5 (26.3)	2 (10.5)		
	COMMON LAW							
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	DIVORCED	2 (50.0)	0 (0.0)	0 (0.0)	2 (50.0)	0 (0.0)		
	WIDOWED							
	OTHER	1 (16.7)	0 (0.0)	0 (0.0)	5 (83.3)	0 (0.0)		
NR	1 (50.0)	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)			
CHILDREN	0	4 (57.1)	0 (0.0)	0 (0.0)	3 (42.9)	0 (0.0)	.465 (V)	.272
	1	1 (33.3)	0 (0.0)	0 (0.0)	1 (33.3)	1 (33.3)		
	2	2 (22.2)	0 (0.0)	0 (0.0)	6 (66.7)	1 (11.1)		
	3	3 (42.9)	0 (0.0)	2 (28.6)	2 (28.6)	0 (0.0)		
	4	2 (66.7)	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)		
	6	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	NR	1 (50.0)	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)		
EDUCATION LEVEL	COMBINATION	1 (25.0)	0 (0.0)	0 (0.0)	3 (75.0)	0 (0.0)	.547 (V)	.204
	HIGHSCHOOL	1 (50.0)	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)	0 (0.0)	0 (0.0)	2 (66.7)	1 (33.3)		
	CERT /DIPLOMA	3 (60.0)	0 (0.0)	0 (0.0)	2 (40.0)	0 (0.0)		
	BACHELOR	3 (60.0)	0 (0.0)	0 (0.0)	2 (40.0)	0 (0.0)		
	MASTERS	1 (20.0)	1 (20.0)	0 (0.0)	3 (60.0)	0 (0.0)		
	DOCTORAL	2 (66.7)	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
	MED. DOCTOR	4 (50.0)	0 (0.0)	1 (12.5)	3 (37.5)	0 (0.0)		
	N.R.	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
RELIGION	NONE	2 (16.7)	0 (0.0)	1 (8.3)	8 (66.7)	1 (8.3)	.312 (V)	.712
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	PROTESTANT	9 (64.3)	1 (7.1)	1 (7.1)	2 (14.3)	1 (7.1)		
	JEWISH							
	OTHER	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	N.R.	2 (50.0)	0 (0.0)	0 (0.0)	2 (50.0)	0 (0.0)		
RELIGIOSITY	NOT AT ALL	1 (12.5)	0 (0.0)	1 (12.5)	5 (62.5)	1 (12.5)	.434 (V)	.520
	BARELY	3 (50.0)	0 (0.0)	1 (16.7)	2 (33.3)	0 (0.0)		
	SOMEWHAT	6 (54.5)	0 (0.0)	0 (0.0)	4 (36.4)	1 (9.1)		
	EXTREMELY	1 (33.3)	0 (0.0)	0 (0.0)	2 (66.7)	0 (0.0)		
	N.R.	2 (50.0)	1 (25.0)	0 (0.0)	1 (25.0)	0 (0.0)		
ATTEND RELIGIOUS SERVICES	NEVER	4 (26.7)	0 (0.0)	1 (6.7)	8 (53.3)	2 (13.3)	.419 (V)	.128
	SEVERAL/YR	5 (62.5)	0 (0.0)	1 (12.5)	2 (25.0)	0 (0.0)		
	1-3/MONTH	2 (50.0)	0 (0.0)	0 (0.0)	2 (50.0)	0 (0.0)		
	1/WK +	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)		
	N.R.	2 (66.7)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		

N = 32

\* percentages indicated by ( )

**POLICY REGARDING RU 486 PILL**

**TABLE 10C**  
**Frequencies and Percentages \***

		ALLOW POLICY	DISALLOW POLICY	NO POLICY	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	2 (10.5)	0 (0.0)	6 (31.6)	1 (5.3)	3 (36.8)	3 (15.8)	376 (Phi)	478
	MALE	4 (30.8)	1 (7.7)	3 (23.1)	0 (0.0)	4 (30.0)	1 (7.7)		
AGE	31-35	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	1 (33.3)	1 (33.3)	.461 (V)	.736
	36-40	1 (11.1)	0 (0.0)	3 (33.3)	0 (0.0)	4 (44.4)	1 (11.1)		
	41-45	2 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (25.0)		
	46-50	2 (33.3)	0 (0.0)	1 (16.7)	0 (0.0)	3 (50.0)	0 (0.0)		
	51-55	1 (20.0)	1 (20.0)	2 (40.0)	1 (20.0)	0 (0.0)	0 (0.0)		
	56-60	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	61-65	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)		
	66+	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED							.520 (V)	.022
	MARRIED	6 (31.6)	1 (5.3)	6 (31.6)	0 (0.0)	5 (26.3)	1 (5.3)		
	COMMON LAW								
	SEPARATED	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	DIVORCED	0 (0.0)	0 (0.0)	1 (25.0)	1 (25.0)	1 (25.0)	1 (25.0)		
	WIDOWED								
	OTHER	0 (0.0)	0 (0.0)	1 (16.7)	0 (0.0)	5 (83.3)	0 (0.0)		
NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)			
CHILDREN	0	0 (0.0)	0 (0.0)	4 (57.1)	0 (0.0)	3 (42.9)	0 (0.0)	.613 (V)	.001
	1	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)		
	2	1 (11.1)	0 (0.0)	0 (0.0)	0 (0.0)	6 (66.7)	2 (22.2)		
	3	4 (57.1)	0 (0.0)	3 (42.9)	0 (0.0)	0 (0.0)	0 (0.0)		
	4	1 (33.3)	1 (33.3)	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)		
	6	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	0 (0.0)	2 (50.0)	0 (0.0)	2 (50.0)	0 (0.0)	.471 (V)	.674
	HIGHSCHOOL	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)	2 (66.7)		
	CERT./DIPLOMA	2 (40.0)	0 (0.0)	1 (20.0)	0 (0.0)	2 (40.0)	0 (0.0)		
	BACHELOR	2 (40.0)	0 (0.0)	1 (20.0)	0 (0.0)	2 (40.0)	0 (0.0)		
	MASTERS	1 (20.0)	1 (20.0)	1 (20.0)	0 (0.0)	2 (40.0)	0 (0.0)		
	DOCTORAL	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	MED. DOCTOR	2 (25.0)	0 (0.0)	2 (25.0)	1 (12.5)	2 (25.0)	1 (12.5)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
RELIGION	NONE	1 (8.3)	0 (0.0)	3 (25.0)	0 (0.0)	8 (66.7)	0 (0.0)	.504 (V)	.038
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	PROTESTANT	5 (35.7)	1 (7.1)	5 (35.7)	1 (7.1)	1 (7.1)	1 (7.1)		
	JEWISH								
	OTHER	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
NR	0 (0.0)	0 (0.0)	1 (25.0)	0 (0.0)	0 (0.0)	3 (75.0)			
RELIGIOSITY	NOT AT ALL	1 (12.5)	0 (0.0)	2 (25.0)	0 (0.0)	4 (50.0)	1 (12.5)	.376 (V)	.579
	BARELY	1 (16.7)	0 (0.0)	2 (33.3)	1 (16.7)	1 (16.7)	1 (16.7)		
	SOMEWHAT	4 (36.4)	0 (0.0)	3 (27.3)	0 (0.0)	3 (27.3)	1 (9.1)		
	EXTREMELY	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)		
	N.R.	0 (0.0)	1 (25.0)	1 (25.0)	0 (0.0)	1 (25.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	3 (20.0)	0 (0.0)	3 (20.0)	1 (6.7)	7 (46.7)	1 (6.7)	.500 (V)	.043
	SEVERAL/YR	1 (12.5)	0 (0.0)	4 (50.0)	0 (0.0)	2 (25.0)	1 (12.5)		
	1-3/MONTH	2 (50.0)	0 (0.0)	1 (25.0)	0 (0.0)	1 (25.0)	0 (0.0)		
	1/WK +	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)	2 (66.7)		

N = 32

\* percentages indicated by ( )

**FUNDING OF RU 486 PILL**

**TABLE 10D**  
**Frequencies and Percentages \***

		PUBLIC FUND	PRIVATE FUND	PRIV & PUBLIC	NO FUND	AMBIV	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	5 (26.3)	0 (0.0)	3 (15.8)	0 (0.0)		6 (31.6)	5 (26.3)	.553 (Phi)	.081
	MALE	2 (15.4)	2 (15.4)	2 (15.4)	2 (15.4)		5 (38.5)	0 (0.0)		
AGE	31 - 35	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)		1 (33.3)	1 (33.3)	.542 (V)	.206
	36 - 40	1 (11.1)	0 (0.0)	3 (33.3)	0 (0.0)		3 (33.3)	2 (22.2)		
	41 - 45	1 (25.0)	1 (25.0)	0 (0.0)	0 (0.0)		1 (25.0)	1 (25.0)		
	46 - 50	1 (16.7)	0 (0.0)	1 (16.7)	0 (0.0)		3 (50.0)	1 (16.7)		
	51 - 55	2 (40.0)	0 (0.0)	1 (20.0)	2 (40.0)		0 (0.0)	0 (0.0)		
	56 - 60	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	61 - 65	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (100.0)	0 (0.0)		
	66+	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
MARITAL STATUS	NEVER MARRIED								.380 (V)	.558
	MARRIED	5 (26.3)	1 (5.3)	4 (21.1)	2 (10.5)		4 (21.1)	3 (15.8)		
	COMMON LAW									
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	DIVORCED	1 (25.0)	0 (0.0)	1 (25.0)	0 (0.0)		2 (50.0)	0 (0.0)		
	WIDOWED									
	OTHER	1 (16.7)	0 (0.0)	0 (0.0)	0 (0.0)		4 (66.7)	1 (16.7)		
NR	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (50.0)			
CHILDREN	0	2 (28.6)	0 (0.0)	2 (28.6)	0 (0.0)		2 (28.6)	1 (14.3)	.460 (V)	.286
	1	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		1 (33.3)	1 (33.3)		
	2	1 (11.1)	0 (0.0)	0 (0.0)	0 (0.0)		6 (66.7)	2 (22.2)		
	3	2 (28.6)	1 (14.3)	2 (28.6)	1 (14.3)		1 (14.3)	0 (0.0)		
	4	2 (66.7)	0 (0.0)	0 (0.0)	1 (33.3)		0 (0.0)	0 (0.0)		
	6	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
	NR	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (50.0)		
EDUCATION LEVEL	COMBINATION	1 (25.0)	0 (0.0)	0 (0.0)	0 (0.0)		3 (75.0)	0 (0.0)	.595 (V)	.042
	HIGHSCHOOL	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)		1 (50.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (33.3)	2 (66.7)		
	CERT/DIPLOMA	2 (40.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (40.0)	1 (20.0)		
	BACHELOR	2 (40.0)	0 (0.0)	0 (0.0)	0 (0.0)		2 (40.0)	1 (20.0)		
	MASTERS	0 (0.0)	0 (0.0)	1 (20.0)	2 (40.0)		1 (20.0)	1 (20.0)		
	DOCTORAL	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)		0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)	1 (100.0)		
	MED. DOCTOR	3 (37.5)	1 (12.5)	1 (12.5)	0 (0.0)		3 (37.5)	0 (0.0)		
	N.R.	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)		0 (0.0)	0 (0.0)		
	RELIGION	NONE	1 (8.3)	0 (0.0)	2 (16.7)	0 (0.0)		7 (58.3)	2 (16.7)	.373 (V)
CATHOLIC		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
PROTESTANT		5 (35.7)	1 (7.1)	3 (21.4)	2 (14.3)		1 (7.1)	2 (14.3)		
JEWISH										
OTHER		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		1 (100.0)	0 (0.0)		
N.R.		1 (25.0)	1 (25.0)	0 (0.0)	0 (0.0)		1 (25.0)	1 (25.0)		
RELIGIOSITY	NOT AT ALL	1 (12.5)	0 (0.0)	1 (12.5)	0 (0.0)		4 (50.0)	2 (25.0)	.336 (V)	.807
	BARELY	2 (33.3)	1 (16.7)	1 (16.7)	0 (0.0)		2 (33.3)	0 (0.0)		
	SOMEWHAT	3 (27.3)	0 (0.0)	2 (18.2)	1 (9.1)		3 (27.3)	2 (18.2)		
	EXTREMELY	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)		1 (33.3)	1 (33.3)		
	N.R.	1 (25.0)	1 (25.0)	0 (0.0)	1 (25.0)		1 (25.0)	0 (0.0)		
ATTEND RELIGIOUS SERVICES	NEVER	3 (20.0)	0 (0.0)	2 (13.3)	0 (0.0)		7 (46.7)	3 (20.0)	.433 (V)	.244
	SEVERAL/YR	3 (37.5)	1 (12.5)	2 (25.0)	0 (0.0)		2 (25.0)	0 (0.0)		
	1-3/MONTH	0 (0.0)	0 (0.0)	1 (25.0)	1 (25.0)		1 (25.0)	1 (25.0)		
	1/WK +	0 (0.0)	0 (0.0)	0 (0.0)	1 (50.0)		1 (50.0)	0 (0.0)		
	N.R.	1 (33.3)	1 (33.3)	0 (0.0)	0 (0.0)		0 (0.0)	1 (33.3)		

\* percentages indicated by ( )

N = 32

## ACCESS TO RU 486 PILL

TABLE 10E  
Frequencies and Percentages \*

		RESTRD ACCESS	FREE ACCESS	NO ACCESS	NOT FAM	NR	ASSOC	SIGNIF
SEX	FEMALE	4 (21.1)	5 (26.3)	0 (0.0)	5 (26.3)	5 (26.3)	.307 (Phi)	.556
	MALE	3 (23.1)	4 (30.8)	1 (7.7)	4 (30.8)	1 (7.7)		
AGE	31 -35	0 (0.0)	1 (33.3)	0 (0.0)	1 (33.3)	1 (33.3)	.502 (V)	.454
	36 - 40	0 (0.0)	4 (44.4)	0 (0.0)	3 (33.3)	2 (22.2)		
	41 - 45	3 (75.0)	0 (0.0)	0 (0.0)	1 (25.0)	0 (0.0)		
	46 -50	2 (33.3)	1 (16.7)	0 (0.0)	2 (33.3)	1 (16.7)		
	51 - 55	2 (40.0)	2 (40.0)	1 (20.0)	0 (0.0)	0 (0.0)		
	56 - 60	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)		
	61 - 65	0 (0.0)	0 (0.0)	0 (0.0)	1 (50.0)	1 (50.0)		
	66+	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
MARITAL STATUS	NEVER MARRIED						.484 (V)	.018
	MARRIED	7 (36.8)	6 (31.6)	1 (5.3)	2 (10.5)	3 (15.8)		
	COMMON LAW							
	SEPARATED	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
	DIVORCED	0 (0.0)	2 (50.0)	0 (0.0)	2 (50.0)	0 (0.0)		
	WIDOWED							
	OTHER	0 (0.0)	1 (16.7)	0 (0.0)	5 (83.3)	0 (0.0)		
NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)			
CHILDREN	0	1 (14.3)	3 (42.9)	0 (0.0)	3 (42.9)	0 (0.0)	.577 (V)	.011
	1	0 (0.0)	1 (33.3)	0 (0.0)	1 (33.3)	1 (33.3)		
	2	2 (22.2)	0 (0.0)	0 (0.0)	5 (55.6)	2 (22.2)		
	3	4 (57.1)	3 (42.9)	0 (0.0)	0 (0.0)	0 (0.0)		
	4	0 (0.0)	2 (66.7)	1 (33.3)	0 (0.0)	0 (0.0)		
	6	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
	NR	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)		
EDUCATION LEVEL	COMBINATION	0 (0.0)	1 (25.0)	0 (0.0)	2 (50.0)	1 (25.0)	.502 (V)	.456
	HIGHSCHOOL	1 (50.0)	0 (0.0)	0 (0.0)	1 (50.0)	0 (0.0)		
	SOME COLLEGE	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)	2 (66.7)		
	CERT./DIPLOMA	2 (40.0)	1 (20.0)	0 (0.0)	2 (40.0)	0 (0.0)		
	BACHELOR	2 (40.0)	1 (20.0)	0 (0.0)	2 (40.0)	0 (0.0)		
	MASTERS	0 (0.0)	2 (40.0)	1 (20.0)	1 (20.0)	1 (20.0)		
	DOCTORAL	1 (33.3)	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)		
	LAWYER	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)		
	MED. DOCTOR	3 (37.5)	3 (37.5)	0 (0.0)	2 (25.0)	0 (0.0)		
N.R.	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)			
RELIGION	NONE	1 (8.3)	2 (16.7)	0 (0.0)	6 (50.0)	3 (25.0)	.415 (V)	.143
	CATHOLIC	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
	PROTESTANT	6 (42.9)	6 (42.9)	1 (7.1)	0 (0.0)	1 (7.1)		
	JEWISH							
	OTHER	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	0 (0.0)		
N.R.	0 (0.0)	1 (25.0)	0 (0.0)	1 (25.0)	2 (50.0)			
RELIGIOSITY	NOT AT ALL	1 (12.5)	1 (12.5)	0 (0.0)	2 (25.0)	4 (50.0)	.404 (V)	.182
	BARELY	1 (16.7)	3 (50.0)	0 (0.0)	2 (33.3)	0 (0.0)		
	SOMEWHAT	4 (36.4)	4 (36.4)	0 (0.0)	2 (18.2)	1 (9.1)		
	EXTREMELY	1 (33.3)	0 (0.0)	0 (0.0)	2 (66.7)	0 (0.0)		
	N.R.	0 (0.0)	1 (25.0)	1 (25.0)	1 (25.0)	1 (25.0)		
ATTEND RELIGIOUS SERVICES	NEVER	2 (13.3)	4 (26.7)	0 (0.0)	5 (33.3)	4 (26.7)	.476 (V)	.024
	SEVERAL/YR	4 (50.0)	2 (25.0)	0 (0.0)	2 (25.0)	0 (0.0)		
	1-3/MONTH	1 (25.0)	2 (50.0)	0 (0.0)	1 (25.0)	0 (0.0)		
	1/WK +	0 (0.0)	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)		
	N.R.	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)	2 (66.7)		

N = 32

\* percentages indicated by ( )

MATRIX  
TABLE 1  
MAJOR STAKEHOLDERS IN REPRODUCTIVE TECHNOLOGIES  
Frequencies and Percentages\*

Technology/ Stakeholder Categories	In Vitro Fertilization	Human Embryo Research	Donation	Cryo- pres- ervation	Artificial insemination	Partheno- genesis	Sex Pre- selection	Surrogate motherhood	Artificial Womb technology	RU-486 Pill
Heterosexual Women	9 (47.4)	5 (26.3)	6 (31.6)	6 (31.6)	13 (68.4)	0 (0.0)	4 (21.1)	5 (26.3)	2 (10.5)	7 (36.8)
Heterosexual Men	7 (36.8)	5 (26.3)	4 (21.1)	5 (26.3)	7 (36.8)	0 (0.0)	4 (21.1)	5 (26.3)	1 (5.3)	1 (5.3)
The unborn	3 (15.8)	5 (26.3)	2 (10.5)	2 (10.5)	7 (36.8)	1 (5.3)	6 (31.6)	3 (15.8)	4 (21.1)	1 (5.3)
Infertile heterosexual couples	14 (73.7)	3 (15.8)	6 (31.6)	6 (31.6)	14 (73.7)	0 (0.0)	1 (5.3)	10 (52.6)	3 (15.8)	1 (5.3)
Infertile women	14 (73.7)	3 (15.8)	6 (31.6)	4 (21.1)	11 (57.9)	1 (5.3)	1 (5.3)	10 (52.6)	3 (15.8)	2 (10.5)
Infertile men	7 (36.8)	3 (15.8)	6 (31.6)	5 (26.3)	13 (68.4)	0 (0.0)	0 (0.0)	6 (31.6)	1 (5.3)	1 (5.3)
Racial minorities	4 (21.1)	4 (21.1)	2 (10.5)	1 (5.3)	5 (26.3)	0 (0.0)	2 (10.5)	2 (10.5)	1 (5.3)	2 (10.5)
Surrogate mothers	2 (10.5)	2 (10.5)	3 (15.8)	2 (10.5)	6 (31.6)	0 (0.0)	0 (0.0)	11 (57.9)	1 (5.3)	2 (10.5)
Homosexual couples	3 (15.8)	2 (10.5)	2 (10.5)	1 (5.3)	8 (42.1)	1 (5.3)	1 (5.3)	4 (21.1)	1 (5.3)	1 (5.3)
Homosexual women	4 (21.1)	2 (10.5)	4 (21.1)	1 (5.3)	12 (63.2)	1 (5.3)	1 (5.3)	1 (5.3)	1 (5.3)	4 (21.1)
Homosexual men	2 (10.5)	2 (10.5)	1 (5.3)	1 (5.3)	2 (10.5)	1 (5.3)	0 (0.0)	3 (15.8)	0 (0.0)	0 (0.0)
Donors	7 (36.8)	4 (21.1)	9 (47.4)	4 (21.1)	14 (73.7)	0 (0.0)	1 (5.3)	4 (21.1)	2 (10.5)	0 (0.0)
Children	4 (21.1)	4 (21.1)	4 (21.1)	1 (5.3)	9 (47.4)	1 (5.3)	4 (21.1)	4 (21.1)	0 (0.0)	0 (0.0)
Lawyers	4 (21.1)	4 (21.1)	5 (26.3)	5 (26.3)	8 (42.1)	2 (10.5)	2 (10.5)	10 (52.6)	4 (21.1)	1 (5.3)
Doctors	13 (68.4)	7 (36.8)	5 (26.3)	6 (31.6)	11 (57.9)	2 (10.5)	5 (26.3)	5 (26.3)	4 (21.1)	7 (36.8)
Others (please specify)	2 (10.5)	2 (10.5)	2 (10.5)	2 (10.5)	1 (5.3)	0 (0.0)	0 (0.0)	0 (0.0)	2 (10.5)	0 (0.0)

\*percentages indicated by ( )

MATRIX  
 TABLE 2  
 PERCEPTIONS OF CONSULTATIONS REGARDING REPRODUCTIVE TECHNOLOGIES  
 Frequencies and Percentages\*

Stakeholder Categories/Technology	Heterosexual Women	Heterosexual Men	The unborn	Infertile hetero couples	Infertile women	Infertile men	Racial minorities	Surrogate mothers	Homosexual couples	Homosexual women	Homosexual men	Donors	Children	Lawyers	Doctors	Others (specify)
In vitro Fertilization	9 (47.4)	8 (42.1)	2 (10.5)	14 (73.7)	14 (73.7)	10 (52.6)	7 (36.8)	3 (15.8)	5 (26.3)	6 (31.6)	5 (26.3)	10 (52.6)	4 (21.1)	10 (52.6)	14 (73.7)	2 (10.5)
Human embryo research	9 (47.4)	8 (42.1)	2 (10.5)	6 (31.6)	6 (31.6)	5 (26.3)	8 (42.1)	3 (15.8)	4 (21.1)	6 (31.6)	5 (26.3)	5 (26.3)	4 (21.1)	7 (36.8)	9 (47.4)	2 (10.5)
Donation	7 (36.8)	7 (36.8)	1 (5.3)	8 (42.1)	8 (42.1)	8 (42.1)	5 (26.3)	4 (21.1)	5 (26.3)	6 (31.6)	4 (21.1)	8 (42.1)	3 (15.8)	4 (21.1)	6 (31.6)	2 (10.5)
Cryopreservation	7 (36.8)	6 (31.6)	2 (10.5)	6 (31.6)	7 (36.8)	6 (31.6)	4 (21.1)	2 (10.5)	3 (15.8)	3 (15.8)	2 (10.5)	7 (36.8)	2 (10.5)	6 (31.6)	8 (42.1)	1 (5.3)
Artificial insemination	10 (52.6)	10 (52.6)	2 (10.5)	15 (78.9)	13 (68.4)	15 (78.9)	8 (42.1)	7 (36.8)	7 (36.8)	11 (57.9)	6 (31.6)	14 (73.7)	6 (31.6)	8 (42.1)	13 (68.4)	2 (10.5)
Parthenogenesis	3 (15.8)	2 (10.5)	2 (10.5)	1 (5.3)	1 (5.3)	1 (5.3)	2 (10.5)	1 (5.3)	3 (15.8)	2 (10.5)	2 (10.5)	1 (5.3)	1 (5.3)	2 (10.5)	2 (10.5)	0 (0.0)
Sex preselection	8 (42.1)	7 (36.8)	2 (10.5)	4 (21.1)	4 (21.1)	4 (21.1)	6 (31.6)	5 (26.3)	5 (26.3)	5 (26.3)	4 (21.1)	4 (21.1)	3 (15.8)	7 (36.8)	8 (42.1)	2 (10.5)
Surrogate motherhood	8 (42.1)	7 (36.8)	1 (5.3)	10 (52.6)	10 (52.6)	7 (36.8)	6 (31.6)	11 (57.9)	6 (31.6)	5 (26.3)	4 (21.1)	5 (26.3)	2 (10.5)	11 (57.9)	10 (52.6)	1 (5.3)
Artificial womb technology	5 (26.3)	4 (21.1)	2 (10.5)	2 (10.5)	3 (15.8)	2 (10.5)	4 (21.1)	2 (10.5)	4 (21.1)	3 (15.8)	2 (10.5)	2 (10.5)	1 (5.3)	3 (15.8)	5 (26.3)	2 (10.5)
RU-488 pill	10 (52.6)	4 (21.1)	1 (5.3)	2 (10.5)	2 (10.5)	2 (10.5)	5 (26.3)	3 (15.8)	1 (5.3)	5 (26.3)	1 (5.3)	1 (5.3)	1 (5.3)	5 (26.3)	9 (47.4)	0 (0.0)

\*percentages indicated by ( )

MATRIX  
TABLE 3  
MAJOR STAKEHOLDERS IN REPRODUCTIVE TECHNOLOGIES  
Frequencies and Percentages\*

Technology/ Stakeholder Categories	In Vitro Fertilization	Human Embryo Research	Donation	Cryo- pres- ervation	Artificial insemination	Partheno- genesis	Sex Pre- selection	Surrogate motherhood	Artificial Womb technology	RU-486 Pill
Heterosexual Women	6 (46.2)	4 (30.8)	5 (38.5)	5 (38.5)	6 (46.2)	0 (0.0)	5 (38.5)	5 (38.5)	3 (23.1)	4 (30.8)
Heterosexual Men	7 (53.8)	4 (30.8)	4 (30.8)	4 (30.8)	5 (38.5)	0 (0.0)	5 (38.5)	4 (30.8)	2 (15.4)	3 (23.1)
The unborn	7 (53.8)	6 (46.2)	6 (46.2)	6 (46.2)	6 (46.2)	3 (23.1)	6 (46.2)	9 (69.2)	5 (38.5)	5 (38.5)
Infertile heterosexual couples	11 (84.6)	4 (30.8)	8 (61.5)	6 (46.2)	11 (84.6)	0 (0.0)	4 (30.8)	11 (84.6)	4 (30.8)	1 (7.7)
Infertile women	11 (84.6)	4 (30.8)	8 (61.5)	6 (46.2)	7 (53.8)	0 (0.0)	4 (30.8)	10 (76.9)	5 (38.5)	1 (7.7)
Infertile men	7 (53.8)	4 (30.8)	8 (61.5)	6 (46.2)	10 (76.9)	0 (0.0)	4 (30.8)	5 (38.5)	1 (7.7)	1 (7.7)
Racial minorities	2 (15.4)	1 (7.7)	1 (7.7)	1 (7.7)	1 (7.7)	0 (0.0)	3 (23.1)	2 (15.4)	1 (7.7)	0 (0.0)
Surrogate mothers	6 (46.2)	3 (23.1)	7 (53.8)	2 (15.4)	8 (61.5)	0 (0.0)	2 (15.4)	11 (84.6)	1 (7.7)	1 (7.7)
Homosexual couples	3 (23.1)	2 (15.4)	5 (38.5)	2 (15.4)	5 (38.5)	1 (7.7)	3 (23.1)	3 (23.1)	2 (15.4)	1 (7.7)
Homosexual women	4 (30.8)	2 (15.4)	5 (38.5)	3 (23.1)	5 (38.5)	1 (7.7)	3 (23.1)	2 (15.4)	2 (15.4)	1 (7.7)
Homosexual men	3 (23.1)	2 (15.4)	2 (15.4)	1 (7.7)	2 (15.4)	1 (7.7)	1 (7.7)	2 (15.4)	3 (23.1)	1 (7.7)
Donors	7 (53.8)	4 (30.8)	8 (61.5)	7 (53.8)	9 (69.2)	0 (0.0)	2 (15.4)	8 (61.5)	3 (23.1)	1 (7.7)
Children	6 (46.2)	6 (46.2)	5 (38.5)	5 (38.5)	5 (38.5)	2 (15.4)	4 (30.8)	6 (46.2)	3 (23.1)	3 (23.1)
Lawyers	1 (7.7)	2 (15.4)	2 (15.4)	2 (15.4)	1 (7.7)	0 (0.0)	1 (7.7)	5 (38.5)	2 (15.4)	2 (15.4)
Doctors	5 (38.5)	6 (46.2)	3 (23.1)	3 (23.1)	5 (38.5)	2 (15.4)	3 (23.1)	5 (38.5)	3 (23.1)	5 (38.5)
Others (please specify)	1 (7.7)	2 (15.4)	1 (7.7)	2 (15.4)	1 (7.7)	1 (7.7)	1 (7.7)	1 (7.7)	2 (15.4)	1 (7.7)

\*percentages indicated by ( )

MATRIX  
TABLE 4  
PERCEPTIONS OF CONSULTATIONS REGARDING REPRODUCTIVE TECHNOLOGIES  
Frequencies and Percentages\*

Stakeholder Categories/Technology	Heterosexual Women	Heterosexual Men	The unborn	Infertile hetero couples	Infertile women	Infertile men	Racial minorities	Surrogate mothers	Homosexual couples	Homosexual women	Homosexual men	Donors	Children	Lawyers	Doctors	Others (specify)
In vitro Fertilization	9 (69.2)	9 (69.2)	3 (23.1)	10 (76.9)	10 (76.9)	9 (69.2)	5 (38.5)	5 (38.5)	7 (53.8)	8 (61.5)	7 (53.8)	8 (61.5)	4 (30.8)	6 (46.2)	9 (69.2)	3 (23.1)
Human embryo research	8 (61.5)	8 (61.5)	2 (15.4)	8 (61.5)	8 (61.5)	8 (61.5)	5 (38.5)	4 (30.8)	7 (53.8)	8 (61.5)	8 (61.5)	8 (61.5)	3 (23.1)	8 (61.5)	8 (61.5)	3 (23.1)
Donation	8 (61.5)	8 (61.5)	2 (15.4)	9 (69.2)	9 (69.2)	8 (61.5)	6 (46.2)	5 (38.5)	7 (53.8)	8 (61.5)	8 (61.5)	8 (61.5)	3 (23.1)	6 (46.2)	7 (53.8)	3 (23.1)
Cryopreservation	8 (61.5)	8 (61.5)	3 (23.1)	7 (53.8)	8 (61.5)	7 (53.8)	6 (46.2)	2 (15.4)	7 (53.8)	8 (61.5)	7 (53.8)	7 (53.8)	2 (15.4)	7 (53.8)	9 (69.2)	3 (23.1)
Artificial insemination	8 (61.5)	8 (61.5)	3 (23.1)	10 (76.9)	8 (61.5)	8 (61.5)	6 (46.2)	7 (53.8)	8 (61.5)	8 (61.5)	7 (53.8)	8 (61.5)	3 (23.1)	8 (61.5)	9 (69.2)	3 (23.1)
Parthenogenesis	3 (23.1)	3 (23.1)	1 (7.7)	1 (7.7)	1 (7.7)	1 (7.7)	2 (15.4)	0 (0.0)	2 (15.4)	3 (23.1)	3 (23.1)	2 (15.4)	2 (15.4)	3 (23.1)	3 (23.1)	1 (7.7)
Sex preselction	8 (61.5)	8 (61.5)	3 (23.1)	6 (46.2)	6 (46.2)	6 (46.2)	5 (38.5)	3 (23.1)	6 (46.2)	7 (53.8)	7 (53.8)	3 (23.1)	3 (23.1)	5 (38.5)	7 (53.8)	3 (23.1)
Surrogate motherhood	8 (61.5)	8 (61.5)	3 (23.1)	10 (76.9)	9 (69.2)	6 (46.2)	5 (38.5)	9 (69.2)	6 (46.2)	7 (53.8)	7 (53.8)	6 (46.2)	4 (30.8)	9 (69.2)	7 (53.8)	3 (23.1)
Artificial womb technology	6 (46.2)	6 (46.2)	2 (15.4)	7 (53.8)	7 (53.8)	6 (46.2)	5 (38.5)	2 (15.4)	5 (38.5)	6 (46.2)	6 (46.2)	5 (38.5)	2 (15.4)	5 (38.5)	6 (46.2)	2 (15.4)
RU-486 pill	6 (46.2)	5 (38.5)	3 (23.1)	3 (23.1)	4 (30.8)	4 (30.8)	4 (30.8)	3 (23.1)	4 (30.8)	5 (38.5)	4 (30.8)	3 (23.1)	3 (23.1)	4 (30.8)	6 (46.2)	2 (15.4)

\*percentages indicated by ( )

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Issues Concerning Reproductive Technologies.

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