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Sociotechnical Imaginaries and Reproductive Rights in Scandinavia

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Introduction

During the 1990s it became apparent that existing international human rights law was not adequately equipped to address issues related to reproduction. As a result, the concept of reproductive rights was adopted and expanded in the Program of Action developed at the 1994 UN Conference on Population and at the 1995 UN Conference on Women. The concept contained a broad definition of reproductive health embracing certain human rights that were already recognized in national laws and international human rights treaties. Legal scholarship has considered the basis and strength of reproductive rights from a rights' perspective (Dworkin, 1993) and developed the 'reproductive rights as human rights' perspective (Cook, 2003). However, it has been argued that now, 20 years later, the agenda of turning reproductive rights into human rights has failed in many parts of the world. (Halonen, 2013). This paper explores reproductive rights in a first mover region in terms of successful national implementation of reproductive rights. This paper draws inspiration from the concept of sociotechnical imaginaries to analytically grasp reproduction and reproductive rights were imagined in Scandinavian regulatory processes (Jasanoff, 2015, pp. 1–33). Sociotechnical imaginaries can be defined, according to Jasanoff, as "collectively held, institutionally stabilized, and publicly performed visions of desirable futures, animated by shared understandings of forms of social life and social order attainable through, and supportive of, advances in science and technology" (Jasanoff, 2015, p. 4). Following this definition, I examine the legal imaginative work undertaken during different time periods in the Scandinavian regulation of reproduction.

The Scandinavian Welfare States

Scandinavia is in many ways a homogenous region. During 1397-1523 Denmark, Norway and Sweden (including the territories of Finland, Greenland, Pharoe Islands, the German provinces of Slesvig and Holstein, Orkney Islands, Shetland Islands and Iceland) formed the Kalmar Union headed by a single monarch. Not long after Sweden left the Union in 1523, Norway became subject to the Danish Crown until 1814 when Norway was surrendered to the Swedish crown following war defeat. Following a failed attempt for independence, Norway was forced to enter into a Union with Sweden before gaining independence in 1905. Thus a common history and culture has existed for centuries. In the 1800s the ideological movement "Scandinavia-ism" supported the idea of a unified region based on common language, culture and heritage. A modern form of "Scandinavia-ism" reemerged decades later, e.g. through formalized legal collaboration in private law in the early 1900s, the formalized political structure for inter-parliamentary collaboration (The Nordic Council), the national appointment of Ministers responsible for Nordic collaboration, the establishment of the then Scandinavian State-owned Scandinavian Airlines System and a common Nordic football league tournament.

Political dreams of a welfare state appear in the Scandinavian countries during the 1920ies and 1930ies. During that time Denmark and Sweden began to develop welfare state societies, and even though the same political ideas were found in Norway, it was not until the mid-1960ies and early 1970ies that Norway truly became a welfare state: Having been an active opponent to the German invasion, Norway faced a long period of rebuilding in the wake of WW2 as opposed to neutral Sweden and Denmark, which had been a "protectorate" with an official policy of "reasonable collaboration" at least until 1943.

The Scandinavian countries are all socialist-democratic conceived welfare states. A number of Nordic conventions secure free movement within the Scandinavian territory, including the right to live, study and work, the right to social security and the right to speak your own language in other Scandinavian countries. Nonetheless, regulation of abortion, and assisted reproductive technologies and how reproduction was originally perceived in law making differs considerably.

(Re)producing the Nation

In the Scandinavian welfare states, the (re)production of families is a major focal point for different reasons: In Denmark reproduction became vital as the notion of a welfare state providing free education and healthcare formed as a political project in the 1920ies, especially in terms of controlling the "quality" of the individuals who would potentially pose a "burden" to society and the public purse. Lene Koch has demonstrated how, in Scandinavia, eugenic practices were adopted by parliamentary majorities on the initiative of the labour (social-democratic) parties and enjoyed wide scientific endorsement (Lene Koch, Racehygiejne, 2nd edition, 2000). Koch's doctoral thesis evidences how eugenics as a political ideal became an integral part of Danish healthcare and social welfare policies, but also how the practical implementation of this ideal was complex and included both elements of coercive legal measures and elements of liberalisation of reproduction. The welfare state project and its adoption of eugenic policies marked the first successful liberalisation of abortion and sterilisation. Even though this liberalisation which made certain abortions legal (in Denmark and Sweden with the adoption of the first Abortion Acts in 1938) had a societal motivation, nonetheless it constituted the very first legal recognition of the individual's own control of reproduction. At the same time the decreasing birth rate was seen as a national crisis, and in Denmark a population commission was therefore tasked with considering social programs relating to motherhood (Brøndum: Det gode moderskab - et biopolitisk perspektiv på dansk moderskab i 1930erne, Kvinder, Køn og Forskning, nr. 4 2012 p. 30-39). The recommendations of the commission only lead to few changes in practice, however. In Sweden the issue of population control was equally pivotal due to what was perceived as a fertility crisis with the lowest number of births in Europe. Even though abortion on eugenic grounds had also been legalized in Sweden in 1938 and eugenic sterilization laws had been adopted in 1934 and 1941, it was also the wider issue of population control (combined with the Scandinavian-wide social-democratic ideology) that encompassed the political ideal of the welfare state. In Sweden the fear of population decline drove several pronatalist welfare initiatives in the reproductive area, including the adoption of a marriage loan reform intended to lengthen the fertile period of women within marriage by making earlier marriages economically feasible, a maternity relief reform provided economic assistance to childbearing women in need and programs on improved housing

for large families were intended to indirectly affect fertility by upgrading conditions for families that were to serve as examples of appropriate family patterns (Kalvemark: More children of better quality? Aspects on Swedish population policy in the 1930's, Uppsala Universitet, Uppsala, 1980). In this way the programs also had an intention of being socially engineering and these intrusions into intimate life were justified by an instrumental rationalism. To produce more than one child was seen as rational behaviour just like good dental hygiene and thus actively promoted for this reason[1]. In Norway, just after WW2 all parties had announced a common program that would introduce a rights-based welfare state model centering equality as opposed to social welfare dependency on hand outs and alms. But unlike most European countries, rationing continued well into the 1950ies demonstrating a prolonged period of rebuilding the Norwegian economy and country. The major welfare state legislation came with the introduction of social security in laws of 1964, 1966 and 1971. Support for unmarried mothers followed in 1981 and salaried maternity leave followed during 1987-93. Having been established decades later, and not in the context of a perceived national crisis relating to decreased population numbers, the underlying message of the Norwegian welfare state is not about encouraging women to have more children, but rather about creating the necessary societal framework to support women/couples in having the number of children they chose to have.
However, in her new year's address to the Norwegian people in 2019, the Norwegian Prime Minister called for Norwegian women to have more children to counterbalance the increase in pensioners, so that the weight of the welfare state might be distributed on more shoulders. Even in 2019 reproduction in the welfare state connects to collective and societal interests, although the spirit of the Norwegian regulation emphasizes support of autonomous wishes more so than the historical imaginaries behind the Danish and Swedish regulation.

The Nordic welfare states are redistributive and provide a wide range of benefits and services as citizens' entitlements with the aim of creating more egalitarian societies (Leira 2002, 32). This includes, but is not limited to, paid parental leave, free health care, affordable childcare , and child support to single parents or lower-income families: typically parents are entitled to up to 1 year of parental leave to share between them with the state providing an income based on previous salary (often capped at the same level as unemployment benefits, with some employers providing the remainder of the normal salary for some of the months), prenatal care, birth and child/parent health check ups after birth in the home are free as is fertility treatment subject to certain conditions. Childcare is heavily subsidised, meaning that parents pay approximately $ 300 a month for childcare, most families receive a cash financial subsidy from the state with single parents receiving more, for example in Denmark a couple would receive $ 2760 in cash subsidy yearly for a 0-2 year old dropping to $ 1700 for 17 year olds, whereas single parents receive another $ 5500 yearly in addition.
In the welfare state, women must dutifully manage their reproductive abilities in order to reproduce not only the family but, in fact, the nation.

The Moral Welfare State
During the 1960ies and 1970ies, Denmark became one of the first countries in the Western world to legalize abortion. It happened in 1973 by statutory law (the same year as abortions rights were

[1] Jeanne Freiburg: Review: Counting Bodies: The Politics of Reproduction in the Swedish Welfare State, Scandinavian Studies Vol. 65, No. 2 (Spring 1993), p. 228

established by the Supreme Court in the US in Row v. Wade). Sweden followed in 1975 and Norway in 1978. The Scandinavian abortion debates began among youth organisations arguing for motherhood to be set free, and for women to gain to control over their own bodies. At the time legal abortions had to be approved by specially mandated public bodies (Lennerhed, 2017; Andersen Nexø 2005). However, at least in the Danish law and its preparatory comments, the values of autonomy and emancipation are almost non-existing. Even though these values had been at the forefront in the public debates, the actual Bill reflects visions of the Moral State as a caretaker citing that the number of unsafe, back alley abortions was high, leaving many families at risk of losing their mother. It was accepted that a large number of abortions in the Danish society were clandestine and unsafe, the move towards an autonomy-based right to abortion in the first trimester would secure medical safety for that group of women.

The Moralistic Welfare State

The Moral State showed its concern again in the reproductive area in 1983 which marked a fundamental change in available fertility treatments in Denmark. Fertility treatment, which had previously consisted of hormonal medication, surgery and insemination, was revolutionized with the introduction of in vitro fertilization (IVF) and consequently the birth of the first Danish IVF baby. The media called the baby boy a miracle. However, his birth also initiated regulatory interest in reproduction. Up until that point, *assisted* reproduction had not been subject to regulation and the introduction of IVF as a treatment had thus been purely a medical decision even bypassing the (non-binding) research ethics evaluation that would have been a stepping stone had IVF not been introduced directly as a treatment by the medical professionals.

A few months after the birth of the first Danish IVF baby, the Minister for Interior formed a working group to consider the ethical and legal ramifications. These issues were not on the public agenda at the time. It was very much a decision based on the Minister's personal troubles as a regular citizen in making head or tail of the technologies that were dawning on the horizon. Difficulties sparked inter alia by a conference organized by members of the scientific community inviting the Minister and the public to become aware of the emerging ethical issues. In October 1984, the working group published their report "The Price of Progress." The cover of the report depicted Adam and Eve holding the forbidden apple in the Garden of Eden, thus signalling the seriousness of what was at stake – the technology of assisted reproduction was a potential snake that offered forbidden temptation. The report stated that the issues at stake were central facets of our culture that transgressed normal disciplinary delineations and involved the public. As such ethical considerations had to be balanced against scientific knowledge and the group recommended the establishment of a National Council of Ethics. It seems that the working group envisaged a body resembling the UK Human Fertilisation and Embryology Authority. The Danish Parliament debated the report on April 10, 1985; the Socialists and the Christians in particular were sceptical of ART. The government at the time consisted of the Conservatives, the Liberals, the Christians and the Social-Liberals, and no one in the opposition was against subjecting ART to ethical reflection and subsequent regulation. In 1987, a Council of Ethics was established by Parliament with *inter alia* the task of considering ART, their ethical and legal implications and what regulatory measures were needed to protect fertilized eggs. Rather than

being a regulatory or licensing body, the Council was to make recommendations to Parliament and initiate debate and dialogue with the public.

The Council's 1989 report on the protection of human gametes, embryos, pre-embryos and foetuses became part of the preparatory work that shaped the Bill on Biomedical Research Ethics Committees (1991) which regulated some elements of ART when they were still considered experimental and thereafter the Bill on Artificial Fertilisation that would later be adopted. One of the raised issues related to storage of gametes and embryos (for subsequent self-donation). The Council observed that viability of gametes and embryos was hard to preserve and accordingly recommended a time limit for cryopreservation. A majority of the Council found "that cryopreservation of eggs should be allowed subject to the same conditions applicable to sperm, i.e. that cryopreservation should be allowed for a limited time and had to be destroyed at the time of the depositor's death" (p. 81). However, in the section dedicated to considerations on the cryopreservation of sperm, the Council found that the duration of storing of sperm should not be subject to any limitations except what medical or administrative grounds would call for as long as the sperm was destroyed when the depositor died (p. 60-61). Whereas male gametes had no storage limit, women's eggs were to be restricted in regards to the number of years that they could be cryopreserved. As this fed into adopted policies, the imaginary of the Moral State became highly gendered in its desire to control reproduction.

Most of the issues considered by the Council of Ethics did not spark immediate regulatory response. The initial impact of the Council of Ethics' report was simply that it formed part of the background material for the 1991 Act on Biomedical Research Ethics Committees, which lifted the research ban on fertilized eggs in order to ensure an adequate quality in the provision of fertility treatments. IVF was slowly becoming a recognized clinical treatment, which meant that research – as was the case in all other treatments offered – was integral in ensuring good quality. Thus, initially the dominant perspective was on the research aspect of ART. However, section 14 of the Act did address treatment aspects in that it authorized the Health Minister to issue a ministerial order regulating donation and cryopreservation of human eggs. In the travaux préparatoires to the authorization of the minister, the government stated that the authorization provided the basis for the regulation of questions of a more medical/scientific nature raised by the application of ART. This included first and foremost requirements regarding establishing egg banks and cryopreservation. But the authorization was in reality not solely for regulation of technical questions. A normative issue was intended to fall within the authorization reflected in the fact that the government explicitly stated that it presupposed a maximum cryopreservation period of 12 months for eggs and embryos, but no reasoning for the limit was given in the comments included in the Bill.[2] In this manner, eggs and embryos were regulated in ways that sperm was not[3] and the first regulation of ART was thus included in an Act otherwise predominantly concerned with creating a legally binding framework with respect to research ethics.

[2] L59 (23 October 1991) available at https://pro.karnovgroup.dk/document/7000281373/1

[3] The gendered implications are discussed more in depth in Herrmann & Kroløkke (2018).

The general regulation in medical law at the time was characterized by a high degree of professional self-regulation and covered primarily the legal and administrative framework for the healthcare system, some educational demands regarding healthcare personnel and issues of malpractice, torts and complaints as well as the duty to provide information to patients. As a result fertility treatment had also been left to develop within the healthcare system without regulatory interference. A working group on fertility treatment set up by the Minister of Health in 1992[4] argued that there was overall no need for special regulation "because the practice of insemination had evolved in such a way that it did not give rise to any worries". Insemination was performed by gynaecologists and other medical specialists and as such the working group was satisfied that the standard of care met professional medical standards and that adverse risk of transferal of diseases through donation was managed in an appropriate manner.

However, the public was increasingly concerned that the medical community had introduced IVF as a treatment and that access to treatment was not based on medical criteria only but also on whether or not the couple had any common children[5] In 1993, the government issued a press release outlining its intent to regulate ART. The headline of the government's paper outlining its intent to regulate ART seemingly offers reassurance: "clear guidelines for artificial fertilization" and stated that the Minister had asked the National Board of Health to issue guidelines based on the government's "comprehensive initiative to regulate". The initiative included limiting the maximum number of embryos to be implanted after IVF, a requirement to use cryopreserved sperm only in case of donation (for safety reasons, since cryopreservation would ensure adequate testing for HIV), to implement a national reporting system allowing the Board of Health to "*control retrieved eggs*" and supervise the quality of treatment and to set in place guidelines which "mirrored women's natural ability to bear children". Having in mind that the said ability could end unnaturally early in some women (premature menopause), ART could always be offered to women up to 40 years of age. But on account of the maintenance and upbringing of the child, 45 years was to be the upper limit for women to receive fertility treatment, while no age limit existed for men. In a response to the parliamentary Committee for Health, the Minister added that the increased risk in pregnancy and at birth for older women was also to be considered in setting the upper limit at 45 years. This was the first step in subjecting fertility treatments to various guidelines and instructions.[6] Subsequent legal interpretation would also rely on the intention to *control* as the basis for denying eggs transnational mobility.

Reproductive rights in the Scandinavian welfare state

The United Nations' framing of reproductive rights spans the same duality as their framing in the Scandinavian welfare states. They relate to both population control and women's rights, reflected

[4] Behandling af ufrivillig barnløshed, en rapport afgivet af en arbejdsgruppe nedsat af sundhedsministeriet (Treatment of involuntary infertility, a report submitted by a working group under the Ministry of Health), Copenhagen, 1992.

[5] Ester Larsen (2007) Et tilbageblik på Etisk Råd og dets samspil med Christiansborg in Kappel & Lykkeskov (eds.): Etik i tiden. 20 år med Det Etiske Råd. Copenhagen p. 72.

[6] in the form of The Health Board's guidelines no. 15120 of 22 December 1993 on physicians' use of artificial fertilization and other forms of fertility enhancing treatments and The Health Board's circular no. 108 of 13 June 1994 and guidelines no. 109 of the same date both on the introduction of new treatment methods within reproductive technologies.

in the fact that reproductive rights as a concept was adopted and expanded in the Programme of Action developed at the UN Cairo Conference on Population and Development of 1994 and at the UN Beijing Conference on Women of 1995. The concept contained a very broad definition of reproductive health embracing certain human rights that were already recognized in national laws, international human rights documents and other consensus documents. Reproductive rights were thus situated as being part of the existing universal and inalienable human rights. More than 20 years have now passed and in many parts of the world reproductive rights have declined highlighting the claim that the Cairo agenda is unfinished (Halonen, 2013; Policy Recommendations for the ICPD Beyond, 2014). Even in Europe, the concept of reproductive rights has not been developed quite as full-bodied in legal practice as intended in the United Nations platforms. The case-law of the European Court of Human Rights demonstrate that in fact only the negative aspect of the right to reproduce has been developed and even then only partly. The fact that reproductive rights as a concept emerged from two very different UN conferences could in itself explain some inherent tensions; were reproductive rights imagined as a population control tool as opposed to an autonomy project? Positive rights have been even more controversial than negative ones; the ECtHR has dismissed that there is a right to reproduce (S.H. & others v. Austria and Sijakova v. Macedonia). It is clear from the Scandinavian case, that population control is heavily entangled with regulation of reproductive rights. Although women's rights were at the absolute forefront of public debate, the imaginary of the morally responsible state continues to be dominant in the evolution of reproductive rights in the Scandinavian context.

Whereas the US case Roe v Wade saw pregnancy in the first trimester as pertaining to a woman's private life and therefore off limits for government interference, the European human rights system in its first ever decision on abortion , found the opposite to be true: "the claim to respect for private life is automatically reduced to the extent that the individual himself brings his private life into contact with public life or into close connection with other protected interests…pregnancy cannot be said to pertain uniquely to the sphere of private life. Whenever a woman is pregnant her private life becomes closely connected with the developing foetus." Consequently, regulation of pregnancy and abortion did not necessarily infringe on a woman's privacy interests. This corresponds with the observation that Scandinavian and European jurisprudence is more focused on family formation and family life. Consequently, reason-giving is still a focus in Scandinavia when it comes to abortions after the first trimester (week 18 in Sweden).

The overall motor of change in reproductive rights in Scandinavia has thus been a societal interest in family formation as both an individual and collective concern.