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Medicine and the State

The Medicalization of Reproduction in Israel*

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Introduction

Feminist and sociological researchers in Israel over the last two decades have consistently claimed that Israeli reproductive policy has always been, and remains, an expression of the State's nation-building efforts. Within this framework, two main contentions are made: (a) Israel's "reproductive policy" primarily aims at winning a "demographic race" against the Palestinian Arabs and is, therefore, pronatalist¹ and (b) Israel, although pronatalist, is equally concerned with the reproduction of the "New Jew", who exhibits physical and/or cultural attributes that fit Westernized/modernistic qualitative demands.²

These two contentions take for granted that as a profession, medicine has assumed the role of an obedient servant of the State, lending its expert skills to the Jewish nation-building project. Further, Israeli scholarship in the field has sometimes understood gynecologists to be agents of progressive processes that allow women to

gain wider control over their reproduction.³ Thus, medicine as a profession has not only been portrayed as the loyal servant of the State in its nation-building project, but also as the servant of women in need of rescue, and reproductive possibilities. Critical sociological research, on the most part, has therefore neglected gynecology as a subject of independent analysis.⁴

In this chapter, I wish to trace the medicalization of reproduction in Israel by pointing at and tracking gynecologists' interests. I shall argue that beyond national, political, cultural and ideological agendas, the medical establishment in Israel has also acted in its *own* interests in increasing its professional power and influence by ever deepening the medicalization of reproduction. From this perspective, ideological justification structures were instrumental, nurturing the medical establishment's ever growing power position. I will suggest that Israeli medicine cannot be understood as a mere tool used by a presumably homogenous State to promote a coherent political agenda or reflect a clear value system. As this chapter aims to expose, Israeli physicians have their own interests, which they try to promote within or *vis-a-vis* the State. Since it is my understanding that cultural explanations, such as pronatalism, have often worked to cloud rather than clarify the understanding of such processes, this chapter will focus on more "structural" dimensions, i.e., the negotiation between Israeli medicine and the State over resource allocation and legislation regarding reproduction.

Working within the generally accepted frameworks of Foucauldian analyses of state power and doctors' professional power, my emphasis is on the continuous negotiation over state resources taking place between state agencies, and non-state actors who can potentially use bio-power and population control discourses as vehicles for obtaining professional resources (Fligstein 2001). According to this view, professionals employed as administrators within state apparati facilitate the production of a common language which eventually directs state agencies to embrace professional interests in their decisions and policies. This understanding applies to medical professionals as well, who in their negotiation with state agencies, and while acting from within state agencies, frequently manage to rely on scientific language to

achieve almost full autonomy over the practice and funding of their professional domain (Abbott 1991).

In the domain of gynecology, professionalization and the very inclusion in the field of medicine largely pivoted on the medicalization of pregnancy during the second half of the 20th century. Barker (2003) describes how in the United States, a network of state officials and medical professionals directed state action toward establishing medical knowledge as the exclusive source of authority and jurisdiction in matters of reproduction, gradually rendering other professionals and sources of knowledge irrelevant. In other countries, medicalization has taken the aura of a national enterprise, depending on and aiming for public legitimacy, constituting itself as a vehicle in the service of national objectives. At the same time, physicians and particularly gynecologists came to occupy state administrative positions with an active role in decision-making processes (Abbott 1991).

In this chapter, my aim is to point to the professional interests that doctors and gynecologists have had in specific directions of evolution and change in Israel's reproductive policy over the years. In other words, I hope to underscore the role of doctors and medical researchers in the shaping of legislation and resource allocation. My focus is on three historical moments in the medicalization of reproduction in Israel.

Section one will examine population regulation between the 1950s and the 1970s, focusing on the issue of contraception use. Whereas traditional sociological literature has emphasized the state's ideological motivation to minimize the use of contraception as a means of population regulation, this section will suggest the medical interest in expanding the use of medical contraception, thereby creating a clientele for experimentation, while taking part in a larger debate over the appropriate size of families in Israel.

Section two will examine the medicalization of pregnancy termination, as it developed during the 1970s. This section reveals the abortion debate as an arena for legitimizing an existing medical practice, as well as furthering the medicalization of pregnancy and reproduction in general.

Section three examines the converging debates over human cloning, stem cell research and oocyte donation that are currently underway in Israel. It reveals the major influence that the medical community has had on legislative processes in this

area, particularly the effort to ensure scientific access to human oocytes and to remove legal hindrances to scientific cloning research.

Interestingly, these processes, and medical pressure aimed to influence legislations in general, are not necessarily covert. Indeed, the Israeli Medical Association (IMA) openly lists this sphere of activity as part of its role and mission.⁵

I: Reproductive medicine and population regulation in Israel

In the 1960s and 1970s, population regulation was discussed by various state-appointed professional bodies in Israel. Although it is traditionally thought that the Arab-Jewish "demographic race" was the major focal point of these discussions, my study shows that the diversity within the Jewish population and the state population policy with regards to the various Jewish groups was at least equally important in most professional deliberations, in which doctors played an active integral part (Hashash 2004).

The national family planning program was among the major issues that were discussed. Research has usually commented on the scarcity of family planning in Israel, interpreted by researchers as an expression of the State's pronatalist policy (Portugese 1998). In contrast to that approach, I shall analyze not the absence, but rather the presence of family planning in Israel, in order to explore its medicalized characteristics, and the medical influences on its shaping.

During the 1950s, the first decade of the Israeli State, population regulation was a major concern for many countries in the West, as well as for other population policy-makers globally. Different population policies that were endorsed were motivated by either strong eugenic objectives, or aspirations for social reform. Medical establishments responded to population regulation policies by offering medical means to implement state policies, as well as medical opinions as to the healthy size of a family and the medically-recommended time interval between pregnancies.

The interest in population regulation programs was crucial for the development of the medicalization of reproduction, primarily because it constructed a legitimate working field for practitioners. But its importance was also conceptual. Population regulation encapsulated the very idea of planning, which is the basic tool of any professional intervention. As such, the idea of planning future fertility trends or family size constitutes a favorable *a priori* for anyone who wishes to legitimize a professional intervention in that field.

Israeli doctors were quick to join the developing field of medical contraception. The Hebrew-language professional magazine *Harefu'ah* [Medicine] reported that an Israeli gynecological study had become one of two pioneering publications in the area of contraception as early as 1959 (Vego & Shapira 1968). However, Israeli doctors' interest in the subject was not necessarily national; indeed, it was at least partly related to the activity of international bodies, such as the Population Council established by Rockefeller in the United States in 1952. In order to address global population growth, the Council worked to encourage research on contraception in various places around the world. In 1963, it included Israel in its statistical assessment of IUD clinical data worldwide (Schindler 2007; Vego & Shapira 1968). The U.S. Department of Health was also interested in funding family planning programs and research in Israel. With the help of American funding, Israeli gynecologists were able to take part in the newest research on medical contraception that was being conducted in several clinics and hospitals throughout the country during the 1960s.⁶

Although there was already medical interest, a legitimate clientele under medically supervised contraception was still lacking. Hence, doctors negotiated with the State, which, in the mid-1960s, was still ignorant of these developments.⁷ This was soon to change, but not before global interests would be translated into the rhetoric of national concerns.

Israel is an immigrant society. Between 1948--the year of its establishment--and 1960, about one million Jews immigrated to Israel from different countries in Eastern Europe, South West Asia and North Africa. The non-European immigrants were referred to as belonging to Mizrahi (Oriental) communities. These communities were culturally and economically marginalized by the hegemonic Ashkenazi (mostly East European) society and government. In the early 1960s, it became clear that Mizrahi Jews were beginning to form a demographic majority within the Jewish population of Israel.⁸

In 1962, demographer Professor Roberto Bachi was appointed as director of the Natality Committee (NC), which was to advise the government on aiding large families, most of whom were Mizrahi, as well as on addressing the issue of the allegedly low Jewish fertility rate.⁹ The fertility discussions, as I have argued elsewhere, were not necessarily designed to solve any demographic issue. The NC

defined its goal as a one of regulation intended to equate fertility rates between the different Jewish ethnic groups and to create a homogenous fertility pattern. Yet, as was well known to the experts in the committee, a homogenous fertility pattern was already rapidly forming with no governmental intervention, with Mizrahi fertility declining from nearly 6 to roughly 3 children per woman over the decade after immigration, and Ashkenazi fertility registering a slight, yet consistent increase. It is therefore my contention that fertility discussions were used to address issues of the State's economic and cultural makeup, and were a site where professionals and representatives of the middle class Ashkenazi public fought over the allocation of State's resources (Hashash 2004).

The NC, whose seven members included the director-general of the Health Ministry and a senior doctor from Israel's largest HMO (*Kupat Holim*), suggested that public funds allocated to enhance Jewish fertility rates should be directed only to smaller, better-off families that were economically and “culturally” able to afford a third or a fourth child, but whose own financial calculations made them reluctant to have this birth. This reluctance, it was claimed, might change with proper public support.¹⁰ The committee explained that larger families do not plan the size of their families and, therefore, should not be eligible for birth incentives (NC Report 1966: 39). The NC also advised the government to distribute information on family planning as a social justice agenda (*ibid*: 50).

Thus, it was the NC that was in charge of officially introducing family planning as a recommended means of fighting poverty, eventually recommending how to supplement small families' income.¹¹ In that way, it contributed to the creation of a legitimate clientele for new medical contraceptives. The cautious yet clear dictum of applying family planning as a major weapon to fight poverty and to prevent deterioration in the quality of the population resonated with the American Population Council agenda, enabling doctors to openly engage in medical contraceptive research and practice with a legitimate target population: women of Middle Eastern descent with several children.

The head of the Gynecology and Obstetrics ward of Rehovot Hospital, for example, published an article in which he explained that the IUD was primarily suited to "women who have given birth, and in particular women who finished giving birth and were of low educational level." The pill, he tried to point out, was suitable

to all "but primitive women who are not able to take it responsibly every day" (Lancet 1970: 69).

The establishment of the Demographic Center in 1968 worked to expand this process. The Demographic Center's propaganda campaign was designed to mobilize "families with two children to increase their families to 3-4 children, and advise large families on family planning." The Center's active committee members frequently referred to the national threat of burdening the public with population growth in the lower strata.¹²

The NC and the Demographic Center helped in creating a legitimate clientele for medical contraception. But, concrete state apparatus was still amiss if family planning would be established as a nation-wide practice that was medically managed. From their power position as participants in state apparatus that addressed population regulation issues, fertility doctors worked to influence decision making towards a national, medically managed family planning program.

Thus we find that Dr. Polishuk, head of the Women and Labor Ward at Hadassah Hospital in Jerusalem and member of the Demographic Center, recommends, in a letter from 1968 to Dr. Gajevin, the Director-General of the Health Ministry and himself a member of both the NC and the Demographic Center, a plan to add family planning and pregnancy-supervision programs to maternity care centers so that women who should not get pregnant due to medical and social difficulties could be given an IUD or hormonal contraception, so that these women "and their reproductive organs" could be monitored. The plan, Polishuk suggested, would attract U.S. Department of Health funding.¹³

Perhaps the most enthusiastic medical advocate of family planning was Professor Yitzhak Halbrecht, a leading gynecologist and fertility researcher,¹⁴ who was a member of the Demographic Center's Council. In the late 1960s, Halbrecht gathered a group of gynecologists and started the Family Planning Association. In 1974, he obtained funding from the International Planned Parenthood Society and turned the small association into the Israeli Family Planning Association (Zafirir 1981). Through this association he advocated the American idea of "each child a wanted child" and stressed the health hazards to those who were not careful to space their pregnancies by a period of 2-2.5 years. At the Demographic Center, which

supported his project (Zafirir 1981), Halbrecht had strongly advocated family planning, stating that "it is doubtful that unplanned and therefore unwanted children would be wanted by the state" (CEPA Report 1974: 491).

In 1974 the NC and Demographic Center family planning advocates received support from the opposite side of the political spectrum: the Katz Committee. The Katz Committee (officially named the Prime Minister's Committee for Youth in Distress) was appointed by the government following ethnic and social riots that spread from Jerusalem to the entire country. The Black Panthers, as they called themselves after the American movement, protested against the discrimination of Mizrahi population and accused the government of encouraging social gaps based on ethnic criteria. Unlike the NC, The Katz Report that was submitted in 1974 advised the government on allocating budgets for welfare, education and cultural activities in underprivileged neighborhoods and townships in the country. Like the NC, it linked between poverty and a large number of children, and advised the establishment of a national family planning program as a remedy. That same year, the Health Ministry decided to cooperate with Halbrecht's association, and to incorporate family planning services into already-existing medical services--maternity care centers and gynecology wards (Zafirir 1981)--giving a governmental push to the medicalization of family planning.

So, while several political agendas were at work--the NC's quasi-eugenic one, and the Katz Committee's social one--it was medical professional interest that could be mobilized through and for the convergence of global and local interests. Thus, local social concerns were defined in terms of quality and quantity, as coined by foreign institutions (e.g., the Population Council; the Planned Parenthood Association), so as to contribute to the growing local medical expertise in the field of contraception, and to facilitate local participation in the research and development of medical contraceptives. Non-medical considerations were put under the umbrella of medical jurisdiction, and social reasons were cited in order to mobilize research funds.¹⁵

The medicalized character of family planning has further been strengthened through the following decades, so much so that in her 1996 survey on the availability of contraceptives in Israel, Larissa Remmenick (1996: 26) reported that:

This topic [birth regulation] in Israel is based on medicine, probably to a larger extent than in other countries... Modern contraceptives are represented in reproductive clinics by 3-5 types of pills and a similar number of IUDs, while popular non-medical contraceptives are not perceived by doctors as relevant to their profession.... The potential of some of these non-medical measures, like the diaphragm and the condom combined with spermicides, is not properly used, as doctors have no incentive to recommend them.

II: Induced abortion

The previous section explored doctors' role in introducing and shaping family planning in Israel. It has been suggested that the inner logic of gynecology as a profession required dissemination of the idea of planning in order to justify medical intervention in reproductive processes. Medical attempts to influence the public demand for such intervention were also explored. Approaching the medical establishment as a site of power with a significant degree of autonomy allows us to re-examine pregnancy terminations as well, and explore their role in the medical process. The conceptual acceptance of the possibility to terminate a pregnancy is a vital component in the medicalization of reproduction. This section will follow the medical establishment's efforts to legalize abortion under medicalized conditions, and the construction of the abortion debate as a site for advocating further medicalization in the future.

Amir has systematically examined the politics of induced abortion in Israel (Amir 1989; Amir and Benjamin 1992). In her accounts of the various political forces struggling over a local resolution that would enable a relatively consensual practice, gynecologists are rarely seen as political agents. Instead, they are depicted as either progressive in relation to women's interests or neutral in relation to the political debate. Despite her reference to physicians as her informants for the various organizations that have contributed to the shaping the practicalities of abortion, Amir (1989) virtually never dwells on the possibility that the gynecologists could have been using their power positions in state administration or in the local health care system to promote some vested interests of their own.

In 1972, the Health Ministry established the Committee for Examining Prohibitions on Abortion (CEPA). Similar to other state regulations concerning reproduction that have benefited doctors' interests, the CEPA may also be viewed as having advanced the distinct interests of the medical establishment.

Up until the early 1970s, the Abortion Law was legally based on a British Mandate law from 1936, which was enforced along lines drawn by the Israeli attorney general in 1952. The law stated that a prosecution could take place only if the abortion was performed against the woman's will, caused her death, was

performed negligibly, or was performed by anyone other than a licensed physician. The issue was discussed by a gynecologists' sub-committee of the NC, which advised the NC that abortion was a risky medical procedure and therefore should not be allowed unless conducted under medically accepted criteria. Similarly, the 1974 CEPA report argued forcibly for the need to make abortion a legal medical procedure, and for the need to prohibit it under any other circumstances. The bill it proposed recommended the following (CEPA Report 1974: 432):

No charges of criminal responsibility will be brought against the person performing the abortion if the procedure was carried out in a **recognized institution** receiving the written **approval of a medical committee** [my emphasis] on the grounds of one of the following reasons:

- a) Continuing the pregnancy could cause risk to the pregnant woman's life.
- b) Continuing the pregnancy could cause the woman mental or physical damage.
- c) There is a risk that if born, the offspring would have physical or cognitive impairments.
- d) Conception occurred as a result of rape or incest.
- e) The woman is under the legal age for marriage or over 45 years old.
- f) Severe damage might be caused to the woman or her children because of extreme social conditions, including a large number of children in the household.

Similar to the circumstances surrounding family planning, abortions were in this way to be accepted under limited, medically supervised instances, allowing non-medical issues to be captured within a medical veneer.

The proposed bill argued for the enforcement of a controlled space to carry out abortions, as this would ensure "that abortions will be performed only by those who have the special expert skills required for this medical procedure." Whereas the requirement for "expert skills" can be accepted at face value, the bill did not explain why the procedure had to be conducted in hospitals only and why the decision regarding each specific case depended on institutional medical approval. One of the main features of the bill was the immunity from state interference or potential legal

liability that it endowed those possessing the "expert skills." It also legalized a procedure already practiced by physicians.

Beyond the abortion procedure, the CEPA also strove to institutionalize the decision-making process leading to an abortion as primarily a medical procedure. The nature of the guidelines proposed by the CEPA, of which only the first three involve medical considerations, raises a question. If alternative procedures can easily be used to certify that the relevant medical considerations are taken into account, why should the committee be a medical one? Amir and Benjamin (1992) suggest that the importance of this directive lies primarily in ushering gynecologists into non-medical issues. The committee exerted symbolic control over women asking for an abortion. Noticeably, the committee, which was designed to interrogate the woman on her misuse of contraception, approved almost every request for abortion, and thus had no real influence on the actual decision to abort.

But, the CEPA could have achieved more than the medicalization of abortion and the exertion of symbolic power over women who sought its approval. It could form the abortion debate as an infrastructure for future medicalization processes. In an addendum to the NC's 1974 report, Halbrecht, then head of the women's ward at Hasharon Hospital, proposed to set up a comprehensive center for controlling all reproductive-related processes: pre-pregnancy, during the course of pregnancy, during birth, and after the birth. The opening statement of Halbrecht's document (CEPA Report 1974: 490) reads:

The future of the State of Israel depends on its number of citizens and their quality – both aspects depend on the magnitude of immigration from various countries of origin on the one hand and the natural increase of the local population. To these two foundations we need to add the need to care for our people's physical and mental well being and health. The health of our people who come to this country from all over the world, will be critical for our fate in our war for survival, facing multiple dangers from without and within.

Halbrecht thus positioned the medical establishment as one of the main national forces in the war for the survival of the Jewish people and the State of Israel. The set of practical suggestions he lists is much less national and much more medical in nature: constructing a comprehensive family health center that would handle problems like family-planning counseling, eugenic and genetic counseling, diagnosis of inherited diseases before and during pregnancy, monitoring pregnancy and the effects of environmental factors on its quality, conduct amniotic fluid tests for the

detection of fetal defects and inherited diseases during pregnancy, treat infertility, and finally, treat sexual deviance. Connecting this range of medical reproductive activities to national goals, Halbrecht (*ibid*: 494) summarized his suggestions as follows:

The duty to heighten our efforts and exploit our resources and the immense potential to improve mothers' and children's health--is ours to shoulder. We need to act to continue the trend of a decrease in maternal death and infant mortality as well as improving our ability to prevent thousands of children from the suffering caused by damage occurring during abnormal pregnancies and births--turning them to invalids crippled for life as well as into a heavy burden on the family and society.

By hinting at the mutual interests of the individual, the family and the State, Halbrecht positioned himself and other doctors as possessing the professional knowledge and skill to serve these mutual interests.

Halbrecht's vision had a concrete aspect. In 1974, the same year the CEPA was established, he established the Institute for Reproductive Research and Embryo Development at Hasharon Hospital. It was his plan to further develop this institute into the comprehensive center that he portrayed in the NC report. Although he himself retired in 1975, the model whose foundations he had laid mirrored the medical establishment's professional ambitions in reproductive health, and reproductive centers that would spring up later on and would include all of the elements he had portrayed and more.

Upon concluding this section, it needs to be reiterated that doctors' control over both family planning and abortion could not have been accomplished without acceptance of the notion of pregnancy planning or termination, which imply approval of human intervention in the reproductive process.

III: Stem cell research, cloning and oocyte donation

The last site I wish to visit enables us to follow closely both overt and tacit medical and scientific influence on policy-making processes through a study of the debates that took place in the Science and Technology Committee of the Knesset regarding cloning and oocyte donation. The following sub-section will depict the convergence of two legislative processes that took place in Israel since the late 1990s. The first is the law that regulates human cloning; the second is the oocyte donation bill.

In November 1998, Thomson et. al. published an article on their success in producing the first embryonic stem cell line.¹⁶ Using fertilized oocytes derived from an IVF procedure, the scientists were able to create a line of unspecialized cells and induce them to regenerate. The potential was immense: in principle, these unspecialized cells were able to differentiate into any of the specialized embryonic tissues and be useful in "drug discovery, and transplantation medicine" (Thomson et. al. 1998: 1146-1147).

There are two sources of embryonic stem cells: the first is from embryos cultivated *in-vitro* through the insemination of an oocyte. The second is through a method known as therapeutic, or research, cloning.¹⁷ Both methods require female oocytes, and each attempt to create such a line consumes large numbers of oocytes.

Stem cell research is conducted worldwide, and in accordance with the particular laws of each country, which either limit or encourage it. Israeli legislation concerning stem cell research is included in the law that prohibits genetic intervention. Barbara Prainsack (2006), who analyzed the legislative processes dealing with cloning and embryonic stem cell research in Israel, depicts the law here as so permissive—it allows practically everything, except for the actual cloning of a fully developed human being—it sometimes draws comments from bioethics counterparts in Europe and the USA as being immoral. Prainsack suggests that this liberal legislation reflects a specific value system, rather than a lack of values. It is a system that draws on two cultural-political factors that jointly explain the State's permissive attitude toward genetic research. The first factor, according to Prainsack, is Jewish law, in which, unlike Christian teachings, an embryo outside the uterus has little status, and human attempts to intervene with nature are not condemned but encouraged. The second factor is the demographic-pronatalist explanation. The

pronatalist discourse in Israel is discreet and yet internalized by civilians, who exhibit Foucauldian self-governing and interpret the “creation of new individual bodies” as “saving the collective body” (Prainsack 2006: 188). These two factors, Prainsack, claims, define the discursive range of the permissible and the prohibited regarding reproduction technologies.

While rejecting Prainsack's conclusions, I find her data supportive of my argument. In March 1997, an expert body--the National Council for Research and Development--was convened to discuss ethical issues concerning cloning. Prainsack describes the way scientific experts repeatedly approached a politician who had initiated a bill for State control in the field—MP Hagai Merom—informing him in a friendly, respectful manner of his lack of understanding in science and his confusion regarding science and morals. Merom wished to ban human cloning altogether, and to restrict cloning research, while the scientists insisted that his restrictive proposals hampered scientific attempts to help humanity. As a result of this pressure, Mr. Merom changed his mind, and the law that was finally approved granted vast research autonomy to medical experts, thus making the Israeli law in this field one of the least restrictive in the world. The cloning of a full human being was only prohibited for a five-year moratorium, and not altogether. Prainsack quotes Merom in the aftermath as saying that these frequent meetings with scientists and physicians persuaded him that any restriction would impede genetic research.

At the end of 2003, the five-year moratorium was about to expire, and the The Knesset's Science and Technology (S&T) Committee had convened several times to discuss the re-approval of the genetic intervention prohibition bill. The need for oocytes that enable cloning research was also debated. I now turn to follow closely the debates and eventual legislation concerning these two distinct yet related issues: the extension of the 5 year moratorium on cloning, and the oocyte donation bill.

A. Contesting politicians: the battle for the moratorium

The central question in the discussions of the genetic intervention prohibition bill was whether to prohibit the cloning of a human entirely or to prolong the moratorium that the 1999 law enacted. The Knesset members (MKs) varied in their stance on the question, whereas the scientific community's representatives all objected to a total

prohibition and advocated prolonging the moratorium. The issue of cloning research, and the need for women's oocytes for that research, arose from time to time during these discussions.

Nearly all of the committee's meetings were characterized by a high attendance from the scientific community: stem cell scientists, managers of genetic institutions or wards, fertility doctors, etc. In fact, at most of these meetings, the scientists outnumbered the MKs. Following the pattern that Praisnack describes, the scientists dismissed some of the MK's and other participant's concerns as stemming from a non-scientific, moral, and emotional attitude that might jeopardize scientific progress.¹⁸

The meeting of 12 November 2003 drew the presence of Professor Bolslav Goldman, who was head of large Sheba Medical Center, chairman of the Supreme Helsinki Committee for Genetic Experiments on Humans, and manager of a genetic institution. A reading of the protocols of this and other meetings that Goldman attended shows that his main concern over the legislation was to ensure that Israeli scientific development would not be hampered, although his other professional positions might have called for a more complex set of concerns. "We have gone a long way to enable this law," he said, and continued:

My fear is that once you start making changes, they can go in all kinds of directions, and may put on hold and delay a development that to me and most of my friends in the scientific-medical world is a most important one.¹⁹

When relating to ethical questions that other participants of the meeting raised, Goldman said:

I was very disturbed by the apocalyptic picture that was presented here: man's dignity, woman's dignity, oocyte and all these issues....[A]ccording to this position we must stay still and do nothing.²⁰

Carmel Shalev, a member of the Supreme Helsinki Committee and a researcher of gender and reproductive health, as well as Meira Weiss, a professor of cultural anthropology and sociology at the Hebrew University, tried to raise such ethical questions in the next meeting. Weiss claimed that cloning and scientific progress could not be addressed without looking into Israel's position on human organ trafficking and the trade in oocytes. Organs are being taken from the poorer populations all over the world in order to meet the needs of the affluent, Weiss said. "Israel's involvement in purchasing oocytes from young, poor women...makes me

very worried," she continued, claiming that the State has not dealt at all with the issue of oocyte donors.²¹ Such practices, Weiss advised, contribute to Israel's isolation in the world. Professor Joseph Itskovitz, a leading stem cell scientist, commented that if the researchers were left alone to research, instead of being intimidated by the "slippery slope," they hoped to be able to clone oocytes, so that they would no longer need to extract them from women.

Shalev proposed that cloning research be prohibited for a year, since Israel had not yet regulated the field and lacked monitoring bodies and regulations. Michel Revel, Head of the National Bioethics Council, warned that this position might hurt science and, specifically, the international scientific connections that Israel enjoyed. Like Goldman, Revel took the position of a science guardian, putting all other bioethical dilemmas aside. Furthermore, his role as a bioethicist was used to reassure concerned MKs. During the meeting of 31 December 2003, for example, the issue of prohibiting the in-vitro development of an embryo after the 14th day arose. Michel Revel asked that the law not specify a certain day, because "science keeps finding out new things" that should not be limited by legislation. MK Peaness felt uneasy, saying he had heard only supporters of the bill. Revel tried to reassure him that "there are representatives of bioethics committees, the Helsinki Committee, and the Health Ministry that do nothing but supervise research, and we have considered the matter, not as users of the methods but as supervisors of the ethics of science."

The last two sessions of the S&T Committee on the cloning law were stormy. Chairwoman Moli Polishuk, who considered herself "pro-scientist", felt herself attacked because of her categorical objection to cloning a human being:

As to what the three committee experts have decided. I want to say that... these are the same people on the three committees, so you can relate to them as one group of scientists.... I have also heard from some of the [non-scientific] people that sit on the committees ... that those who had a different opinion were hushed up. I myself repeatedly felt how those who think differently are being silenced. I have never seen in the Science Committee's meetings so much passion generated and pressure exerted by one particular group on another as in this matter.... To say that it's not interest driven, maybe; ideological concern for research purposes, maybe.... I felt very bad and think it is improper... when you speak of different views that people hold and say...that they are moral and not based on knowledge, when I have reiterated so many times that not the slightest harm is being done to research.²²

Although some of the MKs said they would favor a permanent prohibition, others declared their faith in the scientists. Ultimately, the committee voted on 1 March

2004 to recommend the extension of the five year moratorium on the cloning of a full scale human being.

B. Contesting politicians: In search of oocytes

With the extension of the moratorium, which ensured the legality of cloning research, doctors and researchers could finally make their case for oocyte donation, which meant adding research as a legitimate ground for oocyte donation. Thus, two legislative processes converged here.²³

Several oocyte donation bills have been forwarded by different MKs since 1999. A special experts committee was assigned to discuss oocyte donations, issuing the Halperin report. However, those suggested bills, as well as the Halperin Committee's report, never involved donations for research. Furthermore, some measures were taken to protect the health of the donors and to supervise the operating medical staff.²⁴

The debate among the scientific community's delegates, parliamentarians, and others present at meetings of the S&T Committee reveals the use of rhetoric embedded in different value systems to overcome objections to oocyte donations for research. It also reveals the ways in which rhetoric created an inaccurate impression.

On 24 March 2004, Prof. Itskovitz appeared before the S&T Committee to lobby for legislation that would allow women not going through IVF treatment to donate oocytes for research. Itskovitz, the director of the Obstetrics and Gynecology Department at the Rambam Medical Center in Haifa, established its IVF section in the 1980s. He is also director of the Stem Cell Research Center, which he initiated in 1998, and was a member of the first team in the world to extract an embryonic stem cell line.²⁵

During the meeting, Itskovitz stressed that current Israeli legislation was "killing" all prospects of research, whereas science elsewhere in the world was developing rapidly. What research really needs, he said, is not surplus oocytes, but new, unfertilized, and high-quality oocytes. He suggested that any woman who wished to contribute to science should have freedom of choice to do so. He stressed ("I guarantee") that the oocyte extraction procedure today is simple, safe, and gentle, and downplayed any medical risks that may be involved in subjugating women to

intensive hormonal treatments. Superfluous donations did not even begin to satisfy research needs, Itskovitz stated. He then went on to stress the national motivation: "We should not conceal that bio-technological developments are a national-state goal, and not only a personal goal for the researcher who will take the 'stash' and go home."

In a meeting held at the end of the following year, Prof. Reubinof, a leading stem cell researcher and head of the Stem Cell Research Center at Hadassah Hospital, presented the S&T Committee with a review of global developments on cloning.²⁶ "The first problem I wish to emphasize," Reubinof said,

...is the availability of human oocytes for the process.... It is clear that the availability of human oocytes for the procedure of somatic cell transplant...is a crucial phase.... These developments can only occur in countries that allow the donation of oocytes for research.... In our opinion, the donation of oocytes for research into advanced and effective treatment of severe diseases has an ethical justification no less than ... for fertility....There will be many women who will be interested in contributing to science and not to fertility.

The committee chairman asked for ethical remarks. Professor Michel Revel responded: "Oocyte donation belongs to the domain of organs donation ... and can be seen as an altruistic deed for the health of another person."²⁷

"Is an oocyte defined as an organ?" the chairman asked. Stressing the fertility rather than the research need for oocytes, Revel answered: "It is also a contribution to the improvement of health and life. If you look at infertility as a disease, you can certainly look at an oocyte donation, which allows another woman to give birth, as an organ donation for her health." The bill that the committee then suggested was, however, very far from the organ donation legislation that forbade anonymous donation and put strict supervision in order to avoid trafficking.

Nira Lamai of the Future Generations Commission insisted: "But an organ donation bill has just been passed. It never mentioned oocytes." In reply, Revel encouraged her to look at stem cell research as a life saver, thus justifying the donation ethically. Lamai was not pleased. She insisted that the issues arising from cloning should not be handled exclusively by the scientific community. "The question should be referred to the Health and Justice Ministries," she advised. "Have you estimated at all what would happen if you allowed oocyte donations? How many women will come forward? What are the possibilities of the development of illegal trafficking, of a black market?"

Again, Revel played a soothing role: "We have in Israel bioethics institutions... a very strong ethical basis... several committees.... I think we all want a good society."

Eventually, the Knesset passed an oocyte donation bill on its first reading on 8 May 2007. The bill lacked supervision over doctors and reduced the protection for donors that was available in previously proposed bills.

The study of the protocols of the S&T Knesset Committee reveals that physicians exerted constant pressure on politicians to pass the bill in order to establish legitimate procedures of oocyte donation and a legal infrastructure for future scientific development. To this end, they used their status as professionals, and as members of national committees, to further their own interests. Though cloaked in national ("bio-technological developments are a national state goal"), humanitarian ("It is also a contribution to the improvement of health and life"), or even gender-equality terms (women's right to choose to donate), these demands have unfailingly been compatible with medicalization, and the needs of bio-medical research of reproduction. What has been consistently downplayed, and mostly ignored, is the physical toll on women, as well as the ethical and social consequences of their objectification.

Subsequent to these debates, the S&T Committee approved a new version of the oocyte donation bill. That version lacked any safeguards for the donors. At the same time, it allowed doctors to extract oocyte without any state regulation. The Knesset has approved this bill and it now awaits its 2nd and 3rd calls.

By way of conclusion

The preceding accounts have illustrated the role of the medical establishment and the scientific community in Israel as the initiators of developments, rather than executors of pre-deliberated State policy: Family-planning concerns began in hospital wards; a comprehensive State program of prenatal and natal care was suggested by physicians; legislation for oocyte donations for research was written to meet scientific demands.

The medical establishment has been shown to negotiate state facilitation of its professional interests through their integration into Israeli local value systems. In

addition, the interest in medical advances has been shown in its connection to an agenda much wider than the national agenda, whether it was the American interest in population control or the global race for new therapies and drugs based on human embryonic stem cell research. Aside from the appropriation of non-medical areas into the medical realm, the medical establishment has constantly used negotiation with the State to build an infrastructure for future growth. We have seen this “expansive” attitude in Halbrecht's vision, as well as in the pressure exerted by scientists to prolong the cloning moratorium, and in Revel's insistence on avoiding specific clauses in legislation that might limit future developments.

We have also seen that gynecologists and scientists have been in a position to influence legislation through the central role they play in different public committees. The success of the scientific community's negotiations with the State depends to a large extent on the existence of a close network of professionals and administrators who are either scientists or doctors themselves, or who otherwise share common interests. Cooperation with other state professional officials, such as the head of the NC in the case of family planning, or the legal advisor to the Health Ministry in the case of cloning legislation, has also been a factor.

The state, as Fligstein has proposed, is a complex entity, comprised of different agencies that continuously negotiate among themselves as well as with other non-state actors. The extent to which the state "hands over" the reproduction of its citizens to the medical profession depends upon the ability of medicine to negotiate the scope of its domain and to promote its interests through being incorporated into various administrative capacities. It also depends, as Abbot has remarked, on its competitive ability to assume authority in the field. In order to better compete, medicine had to win public legitimacy and so had to take on social and national agendas. It also had to be part of the state's decision making apparatus. Gynecologists' ability to achieve a great measure of autonomy is ubiquitous, and is a subject of growing literature. It also has its particular history and context dependent power configurations, as this chapter has tried to depict.

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¹ See for example Portugese (1998) and Berkovitch (1997).

² See for example Melamed (2002) and Remennick (2006).

³ Amir (1989), for example, implied the existence of such a progressive role by referring to gynecologists as "liberal" when practicing abortions.

4. Smadar Sharon (2006) has suggested that architects and city planners were equally motivated to serve the hegemony as well as to work in accordance with their field's inner logic, the outlines of which are more often drawn outside of Israel. A scrutiny of the medical establishment concerning reproduction can be found to an extent in Carmeli & Birenbaum- Carmeli (2000), Shalev & Gooldin (2006), and Remenick (2006). However, these analyses are deeply entrenched in cultural interpretations.

⁵ "The Israeli Medical Association represents doctors in the legislative house [...] The IMA's activity in the Knesset focuses on proposing bills on its behalf, overseeing the process and promoting it. IMA representatives participate regularly in sessions taking place in Knesset committees, present its view on the matters at hand and work to promote doctors' welfare, health and medicine in Israel.... The committee of scientific and technological R&D promotes research issues, science and technology, against the backdrop of the rapid development of these issues in the world... and the IMA is a partner to all the bills discussed in this committee" (Israel Medical Association N.D.).

⁶ In 1963, a Dr. Einhorn concentrated on experiments in IUD at the Tel-Aviv City Council clinic. In 1965, the gynecology departments of Ashkelon Hospital and Beer-Sheva's Soroka Hospital received vast supplies of IUDs from an American agency – the Pathfinder Foundation. According to Avraham Doron, studies in this area were conducted that year at other hospitals in Israel as well (Doron 1976:19-22). Since the devices were quite new, their implementation caused various degrees of inconvenience to the women taking part in the research, 5.4% of whom experienced severe disturbances requiring extraction of the device, and others suffering "minor" disturbances, such as irregularity in their periods, bleeding, or stomach aversion (Vego and Shapira, 1968: 252-254).

⁷ Correspondence with the Israeli Health Ministry reveals that there was little awareness of medical contraception in that ministry in the mid-1960s; see Israel State Archive, Gal 2091/1: To Dr. Rivlin from Dr. H.S. Halevi, on family planning, 9.6.1964; To Optex from Dr. Tuastein, on IUD, 5 July 1964

⁸ Professor Roberto Bachi, the country's chief demographer at the time, issued a demographic report stating that "the percentage of children in families from Europe has decreased greatly while the percentage of children of Asian and African descent has risen, so that today, they are the majority of the children being born in Israel." As a result, Bachi continued, most children are being born to "un-educated and culturally inferior mothers" (ISA, Gimel 2976/14, "A review of current demographic trends in the world, the Jewish People and Israel").

⁹ "Allegedly", since the actual data shows quite clearly that after immigrating to Israel, European Jews were slightly, but consistently raising their fertility rates, while Sephardic women were largely and consistently lowering it, thus creating a consistent Israeli fertility trend that was much higher than in the West (Halevi 1959; for more on Bachi's manipulation of demographic data, see Hashash [2004]).

¹⁰ The smaller families that have a "reasonable income [and] proper lifestyle" and "live cultural lives" were felt to be the ones that would benefit society "immensely" by reconsidering their family planning (Knesset Archive, Sixth Knesset, a meeting of the Public Services Committee, 26 November 1968).

¹¹ Programs for direct payments to large families were considered by the NC to be an undesirable method that would "reduce the will to work" (NC Report 1966: 39-40); at the same time, tax breaks designed to benefit the upper strata were enthusiastically recommended and eventually accepted by the government (NC Report 1966: 48, 51-52; ISA g/6/2091, Prime Minister Eshkol's speech to the Knesset on pronatal measures).

¹² For example, Ziona Peled, a member of the Demographic Center's Council, warned, "If we push the public to create larger families to solve the demographic problem we will entrust our existence to a public that may be bigger but lower in quality, much like that of the countries that surround us" (Minutes of the Demographic Center's Council, Vol. 4, p. 40).

¹³ ISA, Gal/2077/3, "A plan to change the content of work in maternal care centers," to Dr. Gajevin from Dr. Polishuk, 4 March 1968.

¹⁴ As chairman of Kupat Holim's Medicine Council from 1947-1967 and head of its research committee, Prof. Yitzhak Halbrecht founded the Getaniu Reproduction Research Center and the Israeli Society for Fertility Research. In 1968, he presided over the 6th World Conference for Fertility

Research, which hosted 1500 researchers from all over the world. He was an advisor to the International Health Organization (IHO) on reproduction from 1968-1974, and a member of its Special Committee on Congenital Defects in 1972.

¹⁵ An extreme example is the studies conducted by Adler and colleagues in Beer Sheva, a southern town in Israel. The writers stated that their major concern was the welfare of humanity and the need to reduce its population-growth hazards. They also stated that it was necessary to implement family planning in specific populations. Their specific population consisted of North African Jewish women. In their 3-year study, the doctors received over 1000 women in 2 clinics: a psychiatric clinic and a gynecology center. Their patients were mostly mothers of 4-8 children who suffered from various gynecological problems that were regarded by the researchers as psychosomatic in nature and resulting from too many pregnancies. They saw themselves responsible, as doctors, for family-planning education, and recommended contraception to all their patients. In particular, they stressed the value of implanting IUDs to alleviate mental dysfunctions, such as depression and psychosomatic pain, as well as a variety of gynecological problems (Adler et al. 1975).

¹⁶ "Stem cells are immature unspecialized cells that renew themselves for long periods through cell division. Under certain conditions, they can be induced to become mature cells with special functions, such as the beating cells of the heart muscle or the insulin-producing cells of the pancreas" (Hadassah Medical Organization N.D.).

¹⁷ Research cloning refers to a process in which a nucleus from an adult donor cell is inserted into a recipient oocyte from which the nucleus has been removed. The nucleus provides all of the necessary genetic information, in the form of DNA, for a cell to function and divide. The cell is then stimulated to divide, resulting in embryonic stem cells that are genetically identical to the adult donor cell. These can potentially evolve into a cloned human being

¹⁸ The delegates of the scientific community were comprised of scientists from the private sector, as well as state appointed specialists or public sector scientists, some affiliating to both.

¹⁹ Meeting of the Science and Technology Committee of the Knesset, 12 November 2003. (All references to the Science and Technology Committee of the Knesset can be found at the Knesset's website: <http://www.knesset.gov.il/protocols/search.asp>)

²⁰ Meeting of the Science and Technology Committee of the Knesset, 12 November 2003, on examining the need to extend the law on genetic intervention..

²¹ 8 December 2003 meeting.

²² 12 January 2004 meeting.

²³ In theory, the transplanting of somatic cells into a human oocyte was not outlawed. However, the law clearly prohibited the extraction of oocytes for any purpose other than fertility, and in that respect was unfriendly to researchers who wished to engage in cloning research. The Israeli law also prohibits women who are not going through fertility treatment from donating oocytes because of the risk of hyperstimulation and the procedure's purported connection with cancer. Two reports were prepared by the Knesset's research center on the risks in extracting oocytes. The most common risk is Hyperstimulation of the Ovaries Syndrome, suffered statistically by 25% of women. The syndrome can result in severe disturbance requiring hospitalization, but it rarely causes death (in 0.1-0.2% of the cases). The more aggressive the treatment, the likelier women are to be subject to hyperstimulation, hence the need to avoid a conflict of interests.

²⁴ For a comparison of the government's 2007 bill and the Halperin recommendations, see Kanyon, Mishori, and Hashash (2007). For an analysis of the protocols of the Halperin Committee and the construction of donors and recipients of donation as different types of women see Bassan (2006).

²⁵ Itzkovitz also holds several lines and has submitted three patent requests to the U.S. patent registry.

²⁶ November 22, 2005.

²⁷ Revel's remark is puzzling, since he had always been one of the advocates of oocyte donations for research, which means that oocytes are regarded as human tissues, and not like organs. Organ donation requires much stricter rules and is not allowed to be made anonymously.

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