

- Perspective. In: Arda, V. Rispler-Chaim (eds). *Islam and Bioethics*. B. Ankara University Turkey; 2012.
29. Murray T. *The Worth of a Child*. Berkeley: University of California Press; 1996:1–214.
 30. Nelson J. Parental obligations and the ethics of surrogacy: A causal perspective. *Public Affairs Quarterly*. 1991;5:49–61.
 31. Matrimonial Causes Act. Cap M7, Laws of the Federation of Nigeria, 2004.
 32. Brake E, Millum J. Parenthood and procreation. In: Edward N (ed). *The Stanford Encyclopedia of Philosophy*; 2016 [cited 2016 Sep 26]. Available from: <http://plato.stanford.edu/archives/fall2016/entries/parenthood/>
 33. Hamilton B, McManus B. Infertility treatment markets: The effects of competition and policy. *Unpublished Manuscript, Olin School of Business, Washington University, St. Louis*, 2005.
 34. Sherwin S. Feminist ethics and in vitro fertilization. *Canadian Journal of Philosophy*. 1987;10(1):74–103.
 35. Warnock Committee, *Report of the Committee of Inquiry into Human Fertilization and Embryology*, Cmnd 9314, 1985, London: HMSO (the Warnock Report).
 36. Meribe v Egwu.(1976) 1 ALL NLR 266.
 37. Status of Children Act, 1974, Act 8602 of 1974, amended Jan 1, 2015. Section 10C. Available from: [http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/LTObject_Store/ltobjst9.nsf/DDE300B846EED9C7CA257616000A3571/1ECD00FACECAC2A8CA257DBD007A3C7F/\\$FILE/74-8602aa040%20authorised.pdf](http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/LTObject_Store/ltobjst9.nsf/DDE300B846EED9C7CA257616000A3571/1ECD00FACECAC2A8CA257DBD007A3C7F/$FILE/74-8602aa040%20authorised.pdf)
 38. Swain ME. Oocyte donation: legal aspects. In: *Third-Party Reproduction*. 2014: Springer New York. (pp. 31–39).
 39. Human Fertilisation and Embryology Act, 1990. Available from <https://www.legislation.gov.uk/ukpga/1990/37>

Invisible women in reproductive technologies: Critical reflections

PIYALI MITRA

Abstract

The recent spectacular progress in assisted reproductive technologies (ARTs) has resulted in new ethical dilemmas. Though women occupy a central role in the reproductive process, within the ART paradigm, the importance accorded to the embryo commonly surpasses that given to the mother. This commentary questions the increasing tendency to position the embryonic subject in an antagonistic relation with the mother. I examine how the mother's reproductive autonomy is compromised in relation to that of her embryo and argue in favour of doing away with the subject-object dyad between them, particularly in the contexts of surrogacy and abortion. I also engage with the Surrogacy (Regulation) Bill, 2016. A critical discussion of the privacy judgment passed by the Supreme Court of India helps examine how personal autonomy of the body and mind extends to include the reproductive autonomy of women as well.

Introduction

“Putravati Bhava” – May you be blessed with progeny – is traditionally an extremely coveted blessing for a woman. Progeny is highly prized for most and childlessness appears to be a curse for couples. The essence of female autonomy, particularly in male-dominated societies, lies in women's ability to control their own fertility, and reproductive autonomy provides women with a model for personal autonomy. However, the different reproductive technologies that abound in the contemporary world tend to scale women down to

secondary positions, or even, at times erase them. The question may arise as to whether the increasing subjectification of the embryo reduces women to the position of an antagonist. In the first part of this commentary I examine whether the alleged “primacy” of the embryo has in any way contributed to the marginalisation/erasure of women.

While discussing the subject-object dichotomy between the embryo and the mother, the commentary moves from the concept of motherhood to a theorisation of maternal subjectivity. It does not deny the potential of childbearing as a meaningful activity but denies that childbearing is a necessary part of women's nature. There are many women who are not able-bodied and lack the capacity to get pregnant and give birth naturally. If motherhood is viewed as synonymous with womanhood, would women who are infertile, homosexual, or not able to get pregnant naturally, not be considered women? They are women as well, though in a developing context such as India, infertility is commonly viewed as some sort of disability (1: p 117). The situation of infertile women in India is aggravated by their being negatively limited in their social and political participation (1: pp 113,117-119). Infertility may result from delayed pregnancy, sexually transmitted infections, or abortions conducted in unhygienic conditions (2: p 165). Advancements in medical science have made it possible for clinics providing assisted reproductive services, ie, the ART clinics, to promote their services as offering a chance to negotiate infertility. India has more than 1000 in-vitro fertilisation (IVF) clinics offering a range of services including surrogacy (3). Despite the debates and the recommended ban on commercial gestational surrogacy, the demand for surrogacy has scarcely waned; and yet sections of society continue to consider it a taboo (4). This commentary examines how reproductive autonomy and privacy get compromised for women in India; it critically reflects on the abortion and surrogacy debates, especially in the light of the recent verdict on privacy passed by the Supreme Court of India on August 24, 2017.

Author: **Piyali Mitra** (piyalimitra94@gmail.com), Ph.D Student, Department of Philosophy, University of Calcutta, 1, Reformatory Street, Alipore, Kolkata -700 027, INDIA

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The mother and her embryo: a subject-object dyad

New reproductive technologies are rarely controlled by those who seek them. Women are urged to believe that their lives would be incomplete if they do not have children. Such a framework reduces mothers to objects. The mother as a woman, an agent in her own right, remains largely absent in such discourses; further, the subjective meaning a woman gives to the lived experience of mothering a child gets overshadowed. Within the praxis imagined by the ARTs, women are increasingly objectified. ARTs involve privately contracting a biogenetically curated pregnancy using IVF. The aspect of a woman's choice is sidelined. Women have to undergo painful hormonal stimulation; the egg retrieval process involves risk to women's health. The rights and safety of women are now more at stake. With ARTs they are reduced to commodified means to solve the infertility problem. This tendency to objectify women gets aggravated when we accord higher value to the embryo as a subject at the cost of objectifying the gestating woman. This leads to the woman being represented as an interchangeable object rather than a unique subject.

Does default maternal subjectivity lie in the process and act of a woman becoming a mother? One may say that mothers are subjects in the sense that they have experience – of gestating, giving birth, breastfeeding, mothering, where each experience is both unique and also dovetails into another, overdetermining each other. But to be a subject one must not only have experience or live through experience, but also one must *author* the meaning of that experience and be able to exercise autonomy in the process, regenerate new meanings that are adapted to one's own situation and history. Others would argue that motherhood connotes a natural state or condition which functions as an empty category into which the needs of the embryo, ie, the future child, can be placed. While talking of maternal subjectivity, Stone points out that, mothers are often not properly recognised as subjects by others around them. Indeed, mothers often experience the transition to motherhood in terms of just this loss of recognition (5: p 2). With pregnancy a woman, who has been formerly viewed as an agent of her own life and been treated by others as a centre of agency, is suddenly perceived as largely subservient to the embryo she is nurturing. Thus, with pregnancy, women begin to lose control of their lives; they feel that in entering the realm of the maternal body they have fallen into a formless realm that excludes meaning and autonomy. Mothers do strive to regain subjectivity where it has been compromised, but this cannot be the usual kind of subjectivity grounded on separation from the maternal body. It can only be subjectivity of a new kind, arising from their place in maternal body relations.

In fact, institutionalised "regard" for human embryos has been captured in various forms in laws around the world, adversely impacting gestating mothers. Ethical policies have been motivated by a belief in the innate sanctity or value of the life of human embryos which extend to prevent the destruction of the embryo through a range of measures (6: p 71). These laws

completely override women's decision making. The choices of women – whether to use the embryo (especially when pre-implanted) for one's own pregnancy, or donate it for the reproductive use of another woman, or freeze it for future use, or donate it for research purposes, or destroy it – are not prioritised within such a framework. When we accord a moral status to the pre-implanted human embryo, there is an overall acceptance that it is an entity of social and ethical significance from conception onwards and its inception into human life. This idea implies that embryos are of abstract significance to society at large, rather than of specific importance to the woman undertaking infertility treatment. The importance of the embryo is concentrated in its potential for life rather than its representation of the myriad potentialities and desires to the mother herself (both in potentiality and actuality). There is a general tendency to represent women as wombs and child bearing operators, instead of composite persons (7: p 240).

Feminist theorists began to query the romanticised version of self-effacing motherhood (8). The painful maternal experiences of ambivalence have remained under-explored. During pregnancy, a woman contains at least two beings within her body; however, women are absorbed by a sense of the "otherness" besides her own self existing in the maternal body. Whether interpreted as mystical "communion" or nightmarish exploitation, the reciprocal exchange through the placenta which transfers nutrients in one direction and waste-products in the other, continues as a physiologically intimate and integral process. With advancing pregnancy, the uncontrollable nature of the "other" occupying the maternal body becomes increasingly evident. Far from an idyllic "communion", pregnancy is often accompanied by a sense of invasion from a parasite sapping the resources of the host body (8: p 9). It becomes an ethical imperative to shift the subjectivity from the "embryo" to the "mother". Karpin suggests that a feminist regulatory response might be initiated by challenging the primacy of the disembodied embryo – disembodied because the embryo hovers between having a materiality in terms of mass and weight, and a simultaneous lack of personhood. Indeed, it would challenge both its physical detachment from the female body and its social detachment from the parental relation. The next step would be the replacement of the "phantasmic preominitional [sic] embryo with an alternate phantasm: that of the *not yet pregnant* pregnant woman." Within the ambit of the feminist regulatory response, the "not yet pregnant" pregnant woman would be accorded legislative visibility and centrality, not the embryo (9: p 621). Millbank proposes a relational sense of the embryo that centres the woman and values the "intensely personal and infinitely variable" meaning to her. This framework of relational sense of the embryo centering the woman not only allows us to consider a woman's decision making concerning her embryo as part of a broader political and social context, but also accepts that this experience incorporates an individualised, fluid and variable sense of kinship and belonging, in which the embryo may but not necessarily be regarded as part (6: pp 85-86).

Technological advancements in the sphere of health, especially women's health, have come to (re)shape conventional scripts of sexuality, pregnancy, childbirth and parenting. But these advancements have not led to the recognition of women's choice and agency. In India, having a genetic child is of fundamental importance in upholding the validity of the institution of the family. Thus, ARTs began to play a vital role in addressing such concerns, in order to preserve caste and community as they enable people across the board to have genetically related children. ARTs provide technological solutions to produce a child that bears the genetic imprint of oneself. Not having one's own genetic child is a social impediment, for genes are one of the ways families are made (10: p 2). Families are assumed to be an essential social unit and support for people. Families preserve and perpetuate caste and community through maintaining the genetic lineage of heterosexual couples (11). Commissioning couples availing of an IVF service may express a preference for a surrogate belonging to a particular caste or religious community (12: p 6). Thus, ARTs have a big role in the preservation of caste and community. Infertile married Indian women are stigmatised by the socio-cultural normative framework of society. For these women then, resorting to ARTs in order to realise their desire for motherhood becomes the only viable option to "cure" their infertility. But there is need for more research and dialogue on ethical issues related to women's health and bodies with regard to invasive ARTs and surrogacy.

The following sections address how the question of women's autonomy was debated in the issues on abortion and surrogacy in India.

ARTs in India

The Indian Council of Medical Research (ICMR) developed research guidelines for the development of testing reproductive technologies (13,14). The ICMR recognises that women should have equal right to participate in research and should not be deprived arbitrarily of the opportunity to benefit from research; however, sometimes women's autonomy is compromised because researchers have to abide by the requirements of local cultural practices in order not to disturb the harmony in the household or community (13: Sec. 6.4, p 60).

A key aspect of reproductive autonomy is reproductive rights, which include the right to make sexual and reproductive decisions, as recognised by the 1994 United Nation International Conference on Population and Development (15). These rights include contraceptive rights, the right to undergo legal and safe abortion, the right to make decisions pertaining to reproduction free of coercion, discrimination and violence. The Indian perspective on reproductive rights takes account of several inequalities and contradictions in society. In 2009, the Supreme Court recognised women's reproductive autonomy as a fundamental right, stating that "There is no doubt that a woman's right to make reproductive choices is also a dimension of 'personal liberty' as understood under Article 21." (16) Needless to say, reproductive rights extend to surrogacy as well.

Surrogacy is a complex issue which raises multiple ethical and legal issues including definitions of parenthood and custody of children. Surrogacy may be commercial or altruistic in nature. In India commercial surrogacy was legalised in 2002 and soon acquired an internal market as several foreign couples came to India to commission surrogacy at costs much lower than in their own countries. The debate on commercial surrogacy was sparked off in India by a controversial case in 2008 (17,18), where the Indian judiciary had to resolve legal issues relating to the "statelessness" of children born via surrogacy. Over time, numerous cases of abandonment of babies, exploitation of surrogates and egg donors, and non-payment of promised monetary compensation were reported (19).

It has been argued that surrogacy depersonalises reproduction (20: p 2). There is social stigma and ostracism attached to surrogacy in India's social structure (21: p 975, 4: p 1). The socially conservative culture of India treats the surrogate mother as a disposable object. Despite this, commercial surrogacy in India has moved far beyond myth (3). The factors conducive to commercial surrogacy in India such as comparatively lower costs, availability of a large pool of women ready to become surrogates, and lack of regulation have consequently turned India, until recently, into the most sought-after destination for reproductive tourism and womb renting (4).

Based on the recommendations of the Law Commission of India, the Union Cabinet approved the Surrogacy (Regulation) Bill in 2016 (22). The Bill had been introduced to prevent commercialisation of surrogacy, prohibit potential exploitation of surrogate mothers and of children born through surrogacy. However, the Bill questions the reproductive rights of women. The right to life enshrines the right to reproductive autonomy, inclusive of the right to procreation as an exclusive right, free of the state's interference. The decision on the mode of parenthood should lie with an individual and not with the state. The Bill hinges on the paternalistic imperative to protect the surrogate against exploitation, as seen in commercial surrogacy, and to permit surrogacy only involving a "near relative" and for altruistic reasons. It proposes to bring in the greatest utility for the greatest number of women, but surprisingly the Bill has disregarded the ethical issue of whether "altruism" within patriarchal familial contexts can be free of coercion, given the social premium placed on motherhood. Besides this, it recommended conditional surrogacy to married Indian couples, disqualifying others on the basis of nationality, marital status, sexual orientation or age – decisions which do not appear to pass the test of equality as described under Article 14 of the Indian Constitution (23), or of being a reasonable classification, satisfying the very objective it seeks to achieve. The Bill severely limits the autonomy of potential surrogates with stringent conditions and requirements of eligibility certificates.

The Parliamentary Standing Committee Report (2017) on the Surrogacy (Regulation) Bill reckoned that coercing a married couple to come out in the open about their infertility breaches privacy, especially given the stigma often attached

to infertility (3). The Report raises similar concerns regarding the surrogates whose identity would be disclosed and privacy compromised. The Bill had also left unanswered the question of ensuring protection of health of the surrogate mother; it prohibited homosexual couples from opting for surrogacy services because the Indian state does not recognise homosexual persons as legal citizens. While the Delhi High Court ruled down Article 377 of the IPC in 2009, granting same-sex relationships a legal status, the Supreme Court of India set aside the High Court's ruling in 2013 (24). By limiting surrogacy only to those physically incapable of maintaining a pregnancy, so-called "socially infertile" women are disqualified under the 2016 Bill.

The use of reproductive technologies and surrogacy arrangements needs to be regulated. The law should promote transparency by incorporating the principle of accountability. Ethical practices should be encouraged. There is definitely a need for regulation. But the blanket restriction proposed in the 2016 Surrogacy Bill is akin to capping a volcano. While there is a need for regulation, we cannot wish away the advances in medical science and the subsequent impact on surrogacy. We need to have a legislation which, while dealing with the problems associated with surrogacy does not interfere with the reproductive rights and freedom of choice of women. The use of biomedical technologies enables a simultaneous focus on women's bodies as sources of both reproductive power and value, and away from their bodies exclusively as vessels for the "vansh" or progeny for their families. Future research ought to highlight the inequalities and ethical complexities both in national and transnational reproductive transfers.

Abortion and reproductive autonomy

The attitude of the Indian judiciary to the right to reproductive choice is garnered from decisions that handled issues concerning abortion in controversial situations. The question that has been posed before Indian courts most often is whether abortion without spousal consent amounts to cruelty, which is recognised as a reason for divorce in India (25: p. 85). The Indian judiciary's attitude expressed a complete disregard of the woman's right to privacy, and her right to make independent reproductive choices (26). But on 24 August, 2017, there was a historic judgment (27) which specifically recognised the constitutional right of women to make reproductive choices as a part of personal liberty under Article 21 of the Indian Constitution. The bench recognised privacy as an inalienable right, based on values such as dignity that underlies all our fundamental rights, and it categorically located privacy in the individual. While the judges phrased their conceptions of privacy differently, the bench held in common that privacy encompasses personal autonomy concerning body and mind and making choices, as well as informational privacy. The draft of the National Policy for Women (2016) aims to protect the rights of women adopting reproductive technologies (28).

In the Puttaswamy judgment (27), the bench reiterated the position adopted by the three-judge bench in the Suchita Srivastava case (16) which upheld that reproductive rights include the woman's right to privacy, dignity and bodily integrity. The Suchita Srivastava case arose in the context of the Medical Termination of Pregnancy Act (1971) (MTP Act) (29); this Act governs abortions in India. The MTP Act permits abortion where the continuance of the pregnancy will cause "grave injury to mental or physical health." The Act recognises the anguish caused by the "grave injury to mental health" in pregnancy as a consequence of the failure of contraception. Strangely enough, the anguish caused by a pregnancy applies only to married women and does not recognise the anguish caused to an unmarried woman by an unwanted pregnancy. It reveals that "the Act was motivated not by libertarian ideals but by the need to promote abortion as a family planning tool" (26: p. 77).

Further, the MTP Act does not leave the decision to abort with the woman. Section 3 of the Act states that only registered medical practitioners can terminate a woman's pregnancy provided that the doctor believes in good faith that continuing the pregnancy would be a risk to the woman's life or that the child would be born with serious physical or mental abnormalities. If the woman has been pregnant for 12 weeks, the permission of one medical practitioner is required, and if the pregnancy extends between 12 and 20 weeks, the permission of two medical practitioners is mandatory. The Act was not envisaged as a tool for women to control their reproductive choices. The Act grants veto power to a third person, viz the medical practitioner. Thus, abortion laws in India reflect that policy makers consider abortion a tool for controlling population growth, rather than an expression of women's right to control their bodies. It has met with opposition over the years for its restrictive nature and for not being able to accommodate the growing technological advancements in medicine¹.

The privacy judgment significantly bolsters calls for reform, paving ways for Sections 3 and 5 of the MTP Act to be contested. Section 5 of the Act is applicable in the case of termination of pregnancy beyond 20 weeks, where the doctors believe that abortion is an immediate requirement in order to save the woman's life. In 2017, the SC clarified that abortion at 24 weeks is legal in the case of anencephaly, which is a fatal foetal impairment that also puts the mother's life at risk, stating that her rights to bodily integrity and reproductive autonomy allow her to "preserve her own life against the avoidable danger to it" (30). The law recognises only medical reasons and risks to allow abortion, delegitimising all other reasons for a woman to seek abortion. A woman is coerced to carry a pregnancy to full term unless it poses a grave risk to her life, even if other grounds of physical and mental anomalies in the foetus are satisfied as per Section 3. So, sections 3 and 5 evidently infringe women's rights to make reproductive choices which the bench affirmed as part of the right to privacy. The law hardly leaves room for non-medical concerns over the economic burden of child-rearing, effects on career, or

other personal reasons. In fact, the Act turns a blind eye to the plight of married women who are forced to conceive and carry the pregnancy to term against their will. This is grounded in the reason that the marital rape of women older than 15 years does not legally amount to rape².

It is to be noted that fundamental rights are placed under limitations by the state, but these limitations need to pass tests outlined in constitutional jurisprudence. The bench affirmed that any curb on privacy will be tested according to the fundamental rights which it infringes and the established jurisprudence on those rights. The bench distinctly focused on Article 21, which guarantees the fundamental right to life and personal liberty, and entails a “just, reasonable, and fair” test (31), that is, any law curbing Article 21 must be “just, reasonable, and fair” to remain constitutionally valid.

The MTP (Amendment) Bill 2014 (32) seeks to broaden the reproductive rights under the Act. Most importantly for privacy concerns, the bill allows abortion on the “request” of a woman up to 12 weeks of pregnancy without having to justify the woman’s needs. The Abortion Assessments Project also revealed that doctors in public sector hospitals sometimes refuse to perform abortions unless women undergo sterilisation concurrently (33). Through Section 2(d), the Bill aims to improve access to abortion by giving access to “registered healthcare providers.” Section 5A of the Bill mandates that no registered healthcare provider shall disclose the name and other details of the woman about to undergo abortion. However, the amended Bill may not satisfactorily address all privacy concerns with the Act’s restrictions on abortions.

It is to be noted that though the newly amended MTP Bill (32) permits abortion beyond 12 weeks at the request of the woman, yet women still have to prove that it was an unplanned pregnancy or that contraceptive measures have failed, which still considerably restricts their power to exercise their reproductive choice in this issue. The state does not merely have a negative duty not to infringe privacy, but also has the positive obligation to uphold reproductive autonomy and take steps to sustain an individual’s privacy as held in the Puttaswamy judgment (27). Apart from the privacy judgment, in the 2016 case of *High Court on its Own Motion v State of Maharashtra* (34), the Bombay High Court ruled in favour of improving the access of women prisoners to abortion and strongly affirmed women’s rights to abortion as a part of the fundamental right conforming to the right to live with dignity under Article 21 of the Indian Constitution. The judgment recognises that unwanted pregnancies are disproportionately cumbersome to the woman and to force her to carry a pregnancy to term represents a violation of the woman’s bodily integrity and aggravates her mental trauma thus being harmful to her mental health condition. Even when the judiciary does give access to abortion beyond 20 weeks, the fact that women have to move the court highlights a further restriction on their access to safe and legal abortions, thus hindering their reproductive autonomy. In a country where

9 to 20% of maternal deaths occur due to unsafe abortions (35) there is an urgent requirement to align the provisions of the MTP Act with these judgments. From the above decisions, it appears as if the Supreme Court supports reproductive autonomy, but when it comes to abortion, women are not given any real control, though the most recent Supreme Court and Bombay High Court decisions (27, 34) may be an indication of progress.

The court applies the protection of privacy to those rights it deems implicit in the concept of ordered liberty, fundamentally affecting a person, or so significant that they need to continue to be inviolable. In fact, the right to privacy has spawned discussions on the right to integrity of one’s personality, and the right to “selfhood” (36: p. 330). A woman’s security in her own body is fundamental to her intellectual, psychological development. But this security of women again gets compromised with the implementation of reproductive technologies, especially in surrogacy. The privacy judgment did not explicitly refer to surrogacy, but it affirmed existing jurisprudence on privacy, which has considered personal decisions about birth and babies as being part of reproductive autonomy (37).

Conclusion: issues that need to be resolved

A brief examination of the legislative viewpoint in the country, with regard to the right of reproductive autonomy of women, reveals its notion of deep-rooted patriarchy. Social change is the most difficult but also the most crucial element of overcoming the influence of biologism and pronatalism on patients’ reproductive autonomy. The framework for our collective convictions and ideologies needs to be more accommodating and sensitive towards the condition of women. These social changes may help to challenge the assumptions that all women want children, that biological connections are better than social connections and moreover, that those who fail to meet the pronatalist or biologicistic stereotypes are deficient in some ways. Undoubtedly, personal, medical and social contexts in which these technologies are delivered would have a far-reaching effect on the extent to which these reproductive options may challenge or support the autonomy of both individual women and women as a group.

Reproductive autonomy is a basic right. Women see this as necessary because pregnancy and child rearing are for all practical purposes, the sole responsibility of women. Women should therefore have the right to choose when and under what circumstances they will bring a child into the world, for women should be able to control what happens to their bodies and lives. The right to safe and legal abortion is also an essential right of self-determination. The privacy judgment has rekindled the debate around abortion. The judgment enabled the restoring of the reproductive autonomy of women and providing impetus to the better amendment of the long pending MTP (Amendment) Bill. This will help in reducing the social pressure and stigma attached to procurement of abortion. It needs to be understood that not every woman

wants to abort the foetus. However, the choice must be free of coercion so that she may decide her future course of action concerning her pregnancy.

The autonomy of the individual is conditioned by the individual's relationship with the rest of society. Those relationships may and do often pose questions to autonomy and free choice. The overarching presence of state and non-state actors regulates aspects of social existence which bear upon the freedom of the individual. In India women continue to experience significant obstacles in their full enjoyment of reproductive rights including denial of women's decision-making authority. For long, reproductive health-based laws and policies in India have failed to take a women's rights-based approach; instead they have focused on demographic targets, such as population control, while also implicitly or explicitly undermining women's reproductive autonomy through discriminatory provisions such as spousal consent requirements for access to reproductive health services. The issue of spousal consent involves a balancing of the woman's right to privacy and personal autonomy and the spouse's interests in the life of the unborn child.

Finally, the goal of reproductive research is not only to respect the autonomy of women, but also to expand reproductive freedom. To this end, there must be more equal participation in medical research by women and members of minority groups. Modern technology and gender relations are deeply intertwined; therefore, a feminist critique of philosophies of technology in the context of a feminist understanding of infertility brought women together to evaluate this matter. I believe that as rational beings and informed and competent decision-makers, women are strongly placed to decide what is beneficial for them. We should leave women to decide whether the reproductive technologies enrich and enlarge our lives as women or whether in accepting and abetting these technologies we are forcing ourselves in serving to accept a misogynist ideal of freedom. If there be any coercive element behind these reproductive interventions, then we should try and eliminate the coercive element, not the technologies.

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Notes

- ¹ One specific advance that requires mention here relates to the detection of cardiac anomalies only after 22 weeks of pregnancy. The National Commission for Women (NCW) recommended that the Union Health Ministry extend the time limit from 20 to 24 weeks, acknowledging the present developments in medical diagnostic technologies, in addition to the social scenario. The MTP Amendment Bill of 2014 also changed the time limit from 20 to 24 weeks in keeping with the recommendation of the NCW.
- ² In light of the privacy judgment, a two-judge SC bench recently read down the exception for marital rape and held that forced sex with all minor wives and not just wives under 15 years, would constitute rape. The larger exception for marital rape is expected to be debated further.

References

1. Shah K, Batzer F. Infertility in the developing world: The combined role for feminists and disability rights. *International Journal of Feminist Approaches to Bioethics*. 2010; 3(2):109-25. doi: 10.2979/fab.2010.3.2.109
2. Gomez VR, Unisa S. *Surrogacy from a reproductive rights perspective: the case of India*. Autrepap. 2014; 70:165-183. doi:10.3917/autr.070.0185
3. Department-Related Parliamentary Standing Committee on Health and Family Welfare. One Hundred Second Report on The Surrogacy (Regulation) Bill, 2016. New Delhi: Rajya Sabha Secretariat; 2017. Report No. 102. [cited 2018 Mar 06] Available from: [http://www.prsindia.org/uploads/media/Surrogacy/Surrogacy%20\(Regulation\)%20Bill,%202016.pdf](http://www.prsindia.org/uploads/media/Surrogacy/Surrogacy%20(Regulation)%20Bill,%202016.pdf) [Published in Gazette of India Extraordinary Part II Section 2, November 21, 2016.]
4. Arvidsson A, Vauqueline P, Johnsdotter S, Essen B. Surrogate mother-praiseworthy or stigmatized: a qualitative study on perceptions of surrogacy in Assam, India. *Global Health Action*. 2017; 10(1): 1-10. [cited 2018 March 06] Available from <https://doi.org/10.1080/16549716.2017.1328890>
5. Stone A. *Feminism, Psychoanalysis, and Maternal Subjectivity*. New York: Routledge; 2012. p.2.
6. Millbank J. Reflecting the 'human nature' of IVF embryos: disappearing women in ethics, law, and fertility practice. *J Law Biosc*. 2016; 70-93; doi:10.1093/jlb/lsw058. [cited 2017 Nov 10]. Available from https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2876369
7. Gupta JA, Richters A. Embodied subjects and fragmented objects: women's bodies, assisted reproduction technologies and the right to self-determination. *Bioethical Inquiry*. 2008; 5: 239-49.
8. Raphael-Leff J. Healthy maternal ambivalence. *Studies in the Maternal*. 2010; 2(1); doi: 10.16995/sim.97 [cited 2018 February 2]. Available from <https://www.mamsie.bbk.ac.uk/articles/abstract/10.16995/sim.97/>
9. Karpin IA. The uncanny embryos: legal limits to the human and reproduction without women. *Sydney Law Review*. 2006; 28(4): 599-623.
10. Shah C. Regulate technology, not lives: a critique of the draft ART (Regulation) Bill. *Indian J Med Ethics*. 2009; 6(1):32-5 [cited 2018 Mar 13]. Available from: <http://ijme.in/articles/regulate-technology-not-lives-a-critique-of-the-draft-art-regulation-bill/?galley=html>
11. The baby market: gendered implications of assisted reproductive technologies and the surrogacy industry in India. *Gender and Economic Policy Discussion Forum*. 03 August, 2017, Forum-XXIII, Briefing Note:24, Institute of Social Studies Trust/Heinrich Böll Stiftung. [cited 2018 March 06] Available from https://in.boell.org/sites/default/files/uploads/2013/10/gender_brouchure_xxiii_02_may_2017.pdf
12. Sama Resource Group for Women and Health. *Surrogacy Information Brief*. SAMA-Resource Group for Women and Health, India. 2014 [cited 2018 March 07] Available from <http://india.unfpa.org/sites/default/files/pub-pdf/SurrogacyInfobrief-1.pdf>
13. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. New Delhi: Indian Council of Medical Research; 2017. [cited 2017 November 15]. Available from http://www.icmr.nic.in/guidelines/ICMR_Ethical_Guidelines_2017.pdf
14. National Guidelines for Stem Cell Research. New Delhi: Indian Council of Medical Research & Department of Biotechnology; 2017.
15. Program of Action adopted at the International Conference on Population Development. Cairo: UNPF; 1994 Sep [cited 2018 Mar 14]. Available from: https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf
16. *Suchita Srivastava & Anr v Chandigarh Administration*, (2009) 11 S.C.C. 409. Available from: <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Reproductive-Rights-Indian-Courts-Web.pdf>
17. *Baby Manji Yamada v. Union of India and Anr* [2008] INSC 1656. Available from: <https://indiankanon.org/doc/854968/>
18. Commercial Surrogacy and Fertility Tourism in India: The Case of Baby Manji: The Kenan Institute for Ethics at Duke University. [cited 2018 Mar 15]. Available from: <https://web.duke.edu/kenanethics/CaseStudies/BabyManji.pdf>
19. Ghosh A, Khaitan N A. Womb of one's own: Privacy and reproductive rights. *Econ Pol Wkly*. 2017; 52(42-43).
20. Lewis S. International solidarity in reproductive justice: surrogacy and gender-inclusive polymaterialism. *Gender, Place & Culture: A Journal of Feminist Geography*. 1-21 [cited 2018 March 11] Available from <https://>

- doi.org/10.1080/0966369X.2018.1425286
21. Pande A. Commercial surrogacy in India: Manufacturing a perfect mother-worker. *Culture and Society*. 2010; 35(4): 969-992.
 22. Department of Health Research. The Surrogacy (Regulation) Bill, 2016. New Delhi: Ministry of Health and Welfare, Government of India; 2016. Bill No. 257.
 23. Constitution of India. Amended up to 2006. Available from: <https://www.india.gov.in/my-government/constitution-india/constitution-india-full-text>
 24. Venkatesan J. Supreme Court sets aside Delhi HC verdict decriminalising gay sex. *The Hindu*. 2013 Dec 11. Available from: <http://www.thehindu.com/news/national/supreme-court-sets-aside-delhi-hc-verdict-decriminalising-gay-sex/article5446939.ece>
 25. Bhattacharyya R. Draft Surrogacy (Regulation) Bill 2016: Rhetoric or surrogate-centric? *Space and Culture, India*. 2016; 4(2): 9-21; doi: <http://dx.doi.org/10.20896/saci.v4i2.219>
 26. George SR. Reproductive rights: a comparative study of constitutional jurisprudence, judicial attitudes and state policies in India and the U.S. *Student Bar Review*. 2006; 18(1): 69-92.
 27. *Justice K S Puttaswamy v Union of India* WP(C) No.494/2012. Available from: <https://indiankanoon.org/doc/91938676/>
 28. Ministry of Women and Child Development. Draft National Policy of Women, 2016. New Delhi: MWCD; 2016 [cited 2018 March 13]. Available from: http://wcd.nic.in/sites/default/files/draft%20national%20policy%20for%20women%202016_0.pdf
 29. Medical Termination of Pregnancy Act, 1971. No.34 of 1971 [10th August, 1971]. Available from: <http://www.health.mp.gov.in/acts/mtp%20Act.pdf>
 30. *Meera Santosh Pal & Others v Union of India & Others*, (2017) W.P. (C) No. 17. Available from: <http://www.advocatekhaj.com/library/judgments/announcement.php>
 31. *Maneka Gandhi v Union of India* [1978] AIR 597, 1978 SCR (2) 621. Available from: <https://indiankanoon.org/doc/1766147/>
 32. Ministry of Health and Family Welfare (Department of Health and Family Welfare). Medical Termination of Pregnancy Amendment Bill. Government of India 2014 October 29 [cited 2018 Mar 13] Available from: <http://www.prsindia.org/uploads/media/draft/Draft%20Medical%20Termination%20of%20Pregnancy%20Amendment%20Bill%202014.pdf>
 33. Duggal R, Ramachandran V. The abortion assessment project –India: Key findings and recommendations. *Reprod Health Matters*. 2004; 12(24) Suppl: 122-9. 21.
 34. *High Court on its Own Motion v State of Maharashtra*, WP (CRL) No.1/2016, Maharashtra H.C. Reproductive Rights in Indian Courts- Fundamental and Human Rights in India-Centre for Reproductive Rights. Available from: <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/RR-Indian-Courts-Web.pdf>
 35. Sebastian MP, Khan ME, Sebastian D. *Unintended pregnancy and abortion in India: Country profile report with focus on Bihar, Madhya Pradesh and Orissa*. New Delhi: Population Council; 2017 [cited 2017 Nov 10] Available from https://www.popcouncil.org/uploads/pdfs/2014STEPUP_IndiaCountryProfile.pdf.
 36. Neff CL. Woman, womb, and bodily integrity. *Yale Journal of Law & Feminism*. 1990; 3(2): 327-53.
 37. *B K Parthasarathi v Government of Andhra Pradesh* [2000] ALD 199, AP, 1. Available from: <https://indiankanoon.org/doc/708608/>

ARTs and the problematic conceptualisation of declining reproduction

ANINDITA MAJUMDAR

Abstract

The routinisation of assisted reproduction in India has led to its proliferation and the easy identification of infertility. However, clinical and popular discourse tends to focus primarily on age-related deficiencies in reproduction. Here, both the “dangers” of declining reproduction as well as the facilitation of delayed reproduction are areas of focus and eulogisation. Bringing together the diverse elements of the medico-social conversation, the aim of this commentary is to examine the ways in which the ARTs are used to make sense of declining reproduction.

Background

In its representation in academic literature and in life, ageing is seen as a state of decline and debilitation. Its physical markers are associated with regression and a slowing down of the “normal” body. In the process, more often than not, ageing has conceptually also been compared to a pathological,

diseased state of being. This is especially so in relation to women’s bodies, where the idea of ageing within biomedicine is associated with progressive reproductive decline (1,2). This conceptualisation of ageing and its association with reproduction is the most provocative in contemporary medical practice and ideology.

In this commentary, I discuss how ageing and aged bodies become signifiers of failed and resurrected reproduction. This is particularly evident in the case of assisted reproduction through the use of technologies such as in-vitro fertilisation (IVF) and/or intracytoplasmic sperm injection (ICSI), besides other assisted reproductive technologies (ARTs) that are becoming popular in the “curing of infertility” as an emerging health problem. The paradoxical position that ARTs occupy within the socio-medical discourse on infertility is seen in the ways in which the failure of the technology to “cure” is often projected on to issues of age (3), just as the technology promises to alleviate the obstacles of age in seeking infertility treatment. However, the recent public fear of the ticking “biological clock,” especially with regard to working women in their 30s with no children - and the associated fanfare surrounding the birth of children to 70-year-old women through IVF (4) - has led to questions regarding how infertility and ARTs are marking ageing and reproduction in India.

Author: **Anindita Majumdar** (anindita@iith.ac.in), Assistant Professor of Sociology, Department of Liberal Arts, Indian Institute of Technology, Hyderabad, INDIA

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