Assisted Reproductive Technologies : Issues and Ongoing debates

Modern contraceptive technology has developed so much that it gives us the choice to have or not have children and also to plan the spacing of children. Methods which vary from simple technologies such as artificial insemination to high tech options such as in vitro fertilization in all its variations are used in many instances to assist couples with problems of infertility.

Infertility is defined as inability to conceive after one year of unprotected coitus. Any treatment for suspected infertility should be preceded by a clinical examination of partners, a medical history and a diagnosis tests ruling out infection, hormonal disorders and other health problems. This includes tests of sperm quality for men and to establish that women experiences regular ovulation and her fallopian tubes are functional. Once the problem is identified, treatment can include elementary advice leads to drug therapy and corrective surgical procedures. The assisted reproductive technologies are referred as conceptive technologies. They were originally developed to help with tubal pathologies or in the case of husband for idiopathic or unexplained fertility. These may include such low technologies as Artificial Insemination (AI) or In-Vitro Fertilization (IVF), more popularly, through mistakenly known as test tube method in all its variations. Also techniques such as microscopic tuboplasty are used to help women with tubal pathologies to conceive.

In artificial insemination, woman is inseminated with man's sperm, produced after masturbation, without having sexual intercourse. It is simple procedure entailing sperm being deposited in a women's vagina close to the cervix. The sperm used could be that of her husband or partner – referred to as artificial insemination by husband's sperm; or that of a donor, referred as artificial insemination by donor. The latter is resorted as when the husband partner is infertile, as a low sperm count or a genetic disorder which the parents do not want to pass to the offspring. The Roman Catholic Church and Vatican are opposed to artificial insemination altogether viewing masturbation as sinful. Islam also prohibits artificial insemination (Gupta,2000).

The IVF procedure consists of several laboratory and medical procedures which include psychological and psychiatric assessment. Generally women should be under 40 years of age, married or a long standing heterosexual relationship. Except for supplying the sperm, in some cases the male partners have no other role. Procedure starts with stimulate the ovaries, to produce more eggs. Women must take hormones everyday from the second or third day of menstruation. Later in the cycle, around the ninth day, they must have hormone injections which help to egg cells to ripen. There will be series of blood and urine tests vaginal ultra sound scan etc. When the largest follicle is about 18 mm in diameter, women given an injection of hormone which induces ovulation. Within 24-38 hours the egg cells which have developed are sucked out of the follicles – this is known as egg-cell puncture – by technique called trans vaginal ultrasound directed oocyte recovery. In this, eggs are harvested through the vagina. This includes risks like pain, bleeding, damage to internal organs, swelling in the pelvic area and infections in the vagina and bladder. The eggs cells are kept for a few days at 37 degree Celsius to incubate. A few hours after egg cell puncture, the egg is out together with sperm in a petri dish in a culture medium so that fertilization can take place. Once the fertilized egg splits from a single cell into a two to four to eight cell stage it is ready to be replaced or transferred into a women's uterus, where normal gestation follows. It is a very short period when egg cells can be fertilized, therefore to improve the chance of successful fertility, more eggs cells are retrieved, fertilized and usually multiple embryos are replaced. In principle the fertilized eggs can be replaced in another women's body rather than the one from whom the eggs were taken; that women is referred to as a 'surrogate'. A surrogate mother

carries the child for a couple who contributed the sperm and perhaps the egg with the understanding that once the child is born she will hand over the contracting couple who will raise it.

Surrogacy embryo transfer was first carried out in cows. The method used in the early years was to stimulate the cow with hormones and then remove the eggs or inseminate the cow and then flush out the fertilized eggs. Now with improved techniques for developing freezing and implanting embryos, the possibilities of making the technique widely available have increased. In the latest development, scientist collect ova (immature eggs) from slaughtered cows, bring them to maturity in the laboratory, fertilize them and freeze them as seven day old embryos, which can be transferred later to recipient cows. This has become a routine technique. It is now possible to apply the technique in women as well. The cycles of both women are simultaneous by administering hormones. After artificial insemination or five days after natural fertilization, the embryo is flushed out before it has had a chance to attach itself to the uterine wall and implanted in the recipient women. There are different kinds of surrogacy. In genetic surrogacy, the woman is inseminated with the sperm of the commissioning father known as classical surrogacy. In gestational surrogacy, the woman receives an embryo from somewhere else(Gupta,2000).

Recent advances in freezing and storage of sperm and ova have made different variations on the IVF procedure possible. With these procedures the implantation rate is 40-50 higher than the traditional IVF in single cycle. Some of these techniques are

1. Micro manipulation of sperm and eggs
2. MIST – micro insemination; sperm transfer
3. Direct injection of spermatozoa to the cytoplasm of the oocyte (DISCO)
4. intra uterine insemination (IUI)
5. Intra peritoneal fertilization (IPF)
6. Gamate Intra Fallopian Transfer (GIFT)
7. Zygote Intra fallopian trasfer (ZIFT)
8. Transport IVF

None of these techniques cures infertility. They simply assist in producing offspring technically, in spite of existing sterility. This means that the whole procedure has to repeated in case more children are desired.

Modern lifestyles are reported to have increased incidences of infertility around the globe. A survey done by World Health Organization, on the incidence of infertility in different countries in the world put the incidence of infertile women in India at 3 percent. According to the report, about 10 percent of the couples in India suffer from the problems of in fertility. Nearly 16 million couples or 32 million individuals in the age of 18-35 year of age group is affected by the problem, making infertility one of the most wide spread conditions in the country (Katiyar, 1993).

But many argue that the infertility figures for India are grossly overestimated. Sandhya Srinivasan argues that the prevalence of infertility is constantly overestimated and it is not common in India. She put forward the evidences from census and NFHS data. Health Researcher Shireen Jeejeebhoy by quoting the 1981 Census data, says that between 4 and 6 percent of current married women over the 40 year of age are childless. Demographer Malini Karkal supports it by 1992-1993 NFHS data, that only 2.4 percent of the currently married women aged between 45 – 49 (and 3.7 percent of all women of same age) have never given birth to a child (Srinivasan 2004). It may not be far from truth to say that

this grossly underestimated figure justifies existence of infertility clinics and related industries in the country.

While expensive infertility clinics abound in the country, the state of infertility treatment in the government hospitals is in a pitiable situation. The research and Promotion of Assisted reproductive Technologies was undertaken in India as a government initiative, but it eventually discontinued the programme. The treatment of infertility in government hospitals is very insufficient with the lack of infrastructure and specialists in the field. These state affairs aided the boom of private institutions which eventually developed into an industry.

Infertility treatments of all types have been widely publicized in the press since the first In Vitro Fertilization (IVF) baby in India received extra ordinary publicity in 1986. Hoardings advertising infertility clinics have since proliferated in many public spaces such as bus stops and railway stations. There, and the crowded clinics themselves testify the widespread availability, and use of infertility treatment in the country. An expanding and unregulated private sector fosters the proliferation of infertility related technologies trough out the country. Their customers vary from urban slum dwellers to wealthiest of the wealthy. These patients are ready to go for any tests without any consideration of its cost and ready to spend their all time and money for getting a child of their own. societal pressure to have a child makes these couple desperate enough even to sell land and to borrow money at cut throat rates.

The need of a son is unavoidable especially in Hindu culture. Hindu belief is that son will help the father to attain 'moksha'. The problem of infertility affects both couples but it affects women more than men. She is the one who get cursed more by family members especially by in laws and others. The status of wife increases when she became a mother. If she is not, she faces many forms of humiliation and unacceptability. In a study of married childless women in rural Andhra pradesh, 30 percent of respondents reports that their husbands had a second wife or spoke of taking one or asked for a divorce. These pressures are not only from husbands but also from other family members. These wives are treated as inauspicious and bad omen in families. This kind of behavior makes them to seek treatment for infertility and to ignore many serious health problems that can result from the treatment. (Srinivasan, 2004).

There are a number of potential health risks for women and children associated with IVF include hyper stimulation syndrome, spontaneous abortion or miscarriage, ectopic pregnancy, multiple births, difficult labour and cesareans, premature births, low weight at birth, perinatal and neonatal mortality, and genetic disorders/ defects. Whether IVF carries long term health risks such as ovarian cancer and early menopause is still under debate. An Australian study suggests that children born through this technique show relatively slow mental development; also they are likely to have inherited infertility/sub-fertility from their fathers (Gupta, 2000).

Women bodies are treated as defective machines in need of improvement and control, which is constantly blamed for their inability to operate correctly or in demand; they are even stubborn after medical intervention. Women who do not succeed in bearing a child through IVF feel they have not only failed themselves and their husbands, but also failed technology.(the same was true in the case of contraceptives which do not suit certain women). They experience infertility as a painful life crisis. They feel a sense of lack of control, which they hope to get through an IVF programme. However, few gain that. Many feel used as laboratory animals, as guinea pigs (Klein, 1989). Many feminists dismissed the idea of new reproductive technologies contributing to women's choice in any way since women have no choice in other areas of life, subject as they are to patriarchal control and used as instruments of population control. Women's role as producers/workers is negated and undermined and their maternal role is reinforced through these technologies.

With the development in reproductive technology, doctors – especially in big cities of India – are offering some of the latest and most sophisticated techniques to infertile couples. In India now there is total of 200,000 clinics across country offer artificial insemination, IVF and surrogacy[1]. Many young doctors set up clinics and with the advanced expensive equipments and most of them have completed their studies abroad. They are naturally very keen to recover their capital in a short span of time; hence the treatments tend to become very costly. Some of the simpler procedures such as AIH and AID, ovulation cycle study, semen analysis are performed by these gynecologist themselves and hence included in the doctor's fee is shown as tests done outside and charges are collected separately.. However, couples required IVF and more complicated services are referred to special infertility clinics which have latest imported equipments. The economic liberalization policies of the government in 1990s are likely to made imports even easier and resulted increase in number of clinics. A few states have passed laws requiring clinics offering infertility services to register themselves, but there is so no authorized government agency which monitors the quality of the services provided. The infertility industry is only one part of an unregulated private health care system which is based on profitability rather than need.... as in other situations these health services are capitalized on cultural demands and on peoples poverty., comments Dr Amar jesani, Coordinator of the Center for Inquiry into Health and Allied Themes and editor of the Journal of Medical Ethics.

IVF treatments are extremely expensive, anything from 50,000 to 100,000 or US$ 1500- 3000 (although cheaper). However Compared to other developed countries health care is cheaper in India. The lower cost of treatment and accommodation in a nursing home in India made it an attractive factor for people abroad to come to India for treatment. Many couples from abroad come to India for treatment. The reproductive tourism became a luminous industry by the increasing number of foreign couples.

A qualitative study conducted by Sama – Resource Group for Women and Health, a Delhi based women's working group on health from 2004 to 2006 on medical, social and ethical implications of ART came with many portraits of lives of childless women. The study was guided by the understanding that a in a patriarchal society, the proliferation of ART can impose double burdens: the burden of a social system that restricts women's role to that of child bearing, and the burden created by what might be described as the medicalisation of everyday life. The study highlights a number of issues surroundings ARTs: the social implication of childlessness and the importance of motherhood; the fragmented nature of information imparted to the women on the treatment's success rates, side effects, etc.(Sama team, 2007).

Infertility clinics pander to the socitical value behind the idea of biological motherhood where by a patriarchical family can pass its property to its own "son" leading to a situation where none speaks adoption as an option for childlessness. Adoption is not favored by infertile couples or their families as they suspect that the child may carry the genes of, let us say a rapist. Adoption law in India is different for the different religious communities according to their independent personal laws. Under Hindu Adoption and Maintenance Act of 1956 secures equally the interests of the parent and the child. Adoption under Wards and Guardianship act of 1890, which is open to all religious communities, does not ensure rights of insurance or succession to the child, nor security of adoptive parents. Three separate attempts to pass the Indian Adoption Act failed due to the objections from the minority communities on the basis of their personal laws[2] which do not support adoption and give primacy to

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1 http:southasia.oneworld.net accessed on 22 November 2008

2 Anklesaria, Shahnaz, storm over Adoption-1 who interprets religious precepts? The statesman26 July 1983

biological motherhood. This supports the IVF and surrogacy. The interesting fact is that same communities reject artificial insemination as a method of cure for infertility and supports biological motherhood only.

Surrogacy might be seen as another cotton industry where women number most as workers. It is soaring in India, with a number of surrogate mothers nearly doubling a year. Women in financial need having their own children, are likely to be excellent recruits as their circumstances would guarantee the surrender of the child. In 2006, 290 surrogacy cases were reported compared to 158 in 2005. In 2004, there were 50 odd cases, according to the data collected from the 116 fertility centers in a study by national ART Registry of India survey conducted by the Federation of Obstetrics and Gynecological Societies of India and Indian Society for Assisted reproduction (HT, 2008). According to the data, Gujarat recorded the highest number of surrogacy at nearly 110 cases with the eastern region contributing the least. In most of the industries nowadays pregnant and women with children are rejected; this is the one industry welcomes them.

There was no law in India governing surrogacy. It was governed by a 126 page document by Indian Council of Medical Research. The new coming law on regulating ART in India is a welcoming effort. But its shortcomings need to rectify before passing it as an act.

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Between Justice and Pathologisation: Juxtapositions of Epistemic and Material Violence in Transnational Migration and Domestic Violence Research

This paper addresses ethical-political dilemmas encountered within a recent transnational action research project (conducted under my supervision) concerned with service provision to Pakistani women asylum seekers, whose asylum status had arisen by virtue of domestic violence. It considers the conduct of this work in the context of not only the colonial relationship between Britain and Pakistan but as also intensified by the current climate of Islamophobia and xenophobia. The chapter draws upon feminist critiques of liberal multiculturalism which show how this works to privilege discourses of 'culture' and 'cultural respect' over gender, and so reinstates the public-private split that secures women's oppression. Yet the practical-political context of generating documentary support to inform better decision-making around asylum claims pressurises accounts towards a 'victim'-focus that limits conceptions of women's agency, alongside the potential for demonisation of the national, cultural and religious contexts that the women are escaping. The paper offers a rationale for and key examples of strategies for returning the problematising gaze from those 'other' arenas to the normalized but equally potent cultural, national and religious context of Britain/the North.