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Artificial Reproductive Technology (ART) and Rights of Women in India

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ABSTRACT

Recent developments in the field of reproductive technology have made artificial insemination a practicable alternative to "natural" procreation within the context of a marital relationship. Artificial insemination, in vitro fertilisation, embryo transfer, and surrogate mothering are some of the techniques that have increased the options that are available to an individual who wishes to create a family in which she or he will be the only parent who will be responsible for the child's upbringing. The fact that Indian courts and legislators have already sanctioned the practise of having children via surrogacy lends credence to the notion that they will likely permit access to the novel artificial reproductive technique through artificial womb facility. IVF and related techniques have been transformed too rapidly and easily from experimental to therapy status, despite evidence that suggests considerable caution is warranted. Unfortunately, the widespread diffusion of IVF has preceded rather than followed firm evidence of its value in extending the reproductive rights of women and couples. Resources might better be directed toward prevention of fertility problems and discovering the causes of infertility .

The use of artificial reproductive technology has sparked a significant amount of excitement in western nations. The use of many different approaches as a treatment for infertility issues has gained widespread acceptance in recent years. However, fundamental issues continue to be asked concerning the influence of artificial reproductive technologies (ARTs) on reproductive rights and the distribution of limited medical resources, notwithstanding the fast spread of novel procedures. As a result of this additional shift towards technology-mediated procreation, the challenges we face in terms of law, ethics, and policy will grow much more complex. This article takes a look at these concerns in relation to artificial reproductive technology (ART) known as in vitro fertilisation (IVF), which is a therapy for infertility that receives universal approval.

I. INTRODUCTION

Reproduction with the aid of technology is not a recent development. Yet, the creation and formalisation of arts as a discrete class of methods intended to facilitate conception by treating

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 [ISSN 2581-5369]

or avoiding infertility is a very new development. Doctors Robert G. Edwards and Patrick Steptoe "cared" for Louise Brown, the world's first test-tube child, when she was born in 1978 in Lancashire, United Kingdom; for this, Edwards received the 2010 Nobel Prize in Physiology or Medicine. In-vitro fertilisation, sometimes called as "test-tube baby technology," intracytoplasmic sperm injection (ICSI), which is used exclusively for male factor infertility, embryo freezing, etc., are more recent additions to the current list of ARTS operations. Surrogacy, which makes use of the arts but is still an arrangement and not a technology, is also included.

The idea that technology is fundamentally patriarchal is nevertheless at odds with efforts to provide women more access to and control over it in discussions on gender and technology. While proponents of the first school of thought might hold that reproduction is a "natural" process that men (seek to) exert control over through technology, proponents of the latter might believe that reproductive technology has the power to liberate women by defeating reproductive biology, which has been the primary cause of women's subjugation to the domestic, private sphere of the family. As a result, according to organisations like the Feminists International Network of Resistance to Reproductive and Genetic Engineering (FINRRAGE), these technologies are fundamentally not only sexist but also racist, classist, and deeply eugenic, serving as both traditional and contemporary instruments of population control. Others promote a more nuanced viewpoint and caution against technological determinism, which overemphasises technology's potential for good or bad. This strategy enables us to emphasise the physical environment in which the arts are produced as well as associated problems of social justice, equality, and access.

Motherhood has been under fire for being capitalist and patriarchal, and for accepting power structures that associate motherhood with female rather than challenging them. The seeming profusion of options, in this situation regarding reproduction, does not always imply advancement. The decision to "create" your child's DNA or to terminate a female foetus is neither innocent nor empowered. By their excessive or improper usage, new reproductive and medical technologies—the broader category that includes ultrasound, c-section, arts, and so on—are often put to the service of institutions like heteropatriarchy, marriage, the medical industry, and others. Reproduction (and kinship via reproduction) is subject to destabilisation and re-definition through the usage of the arts. Nonetheless, their practise demonstrates that through restoring the sequential sequence of marriage and childbearing, the arts mostly promote and repair the hetero-patriarchal family. The main justification and selling point of the arts is often the possibility, however remote, that they may bestow biological motherhood (USP).

 [ISSN 2581-5369]

Socially speaking, the value placed on biological parenting within heterosexual marriage is far higher than the value placed on childlessness on one's own will, adoption, or other family arrangements. As a result, the arts are mostly stabilising the conventional family structure, which is threatened by infertility, while nevertheless holding onto the capacity - which is also sometimes realised - to undermine the same[2].

Many see arts as a "hit-and-trial" technology since they circumvent infertility rather than treat it and have dismal success rates. According to the World Health Organization (WHO), infertility is defined as "the inability to conceive following at least one year of unprotected coitus" by the Indian Council for Medical Research (ICMR). This definition is an updated version of the one that was in use before to 1975, when up to five years of unprotected intercourse without pregnancy was considered a cause of infertility. In 1975, this number was reduced to two years, and in 2005, it was further reduced to one year. More and more individuals are included in the definition of infertility as the number of years reduces and the minimal standard to declare a case of infertility increases, turning their infertility into a medical problem that requires treatment.

An international issue is infertility. Involuntary childlessness affects 8 to 12 percent of marriages globally, according to estimates. The rate of primary and secondary infertility varies from 10 to 25% in certain areas, such as the "infertility belt" of sub-Saharan Africa. So, it is not unexpected that the use of assisted reproductive technologies (ART) has spread worldwide. More than 3 million births using ART have been documented worldwide since the first in vitro fertilisation (IVF) birth in Great Britain in 1978, including births in China, India, Asia, Africa, and South America. It is therefore not unusual to find high-tech reproductive clinics establishing in locations with extremely little resources or next to primary healthcare institutions that are already overworked and underfunded, given the thriving fertility sector in the industrial North. Fertility is major business, generating $4 billion in sales annually in the United States alone. Entrepreneurs both within and outside of India see it as the potential new frontier of an ever-expanding ART market[3].

The ethical and societal repercussions of assisted reproduction have received much of bioethicists' attention. The importance of ART for women's reproductive autonomy has caused feminists considerable worry. One need not go too deeply into modern feminist ethical literature

[2] Corea, G (1985): The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs (New York: Harper and Row).
[3] Gupta, J A (2020): New Reproductive Technologies, Women's Health and Autonomy (New Delhi: Sage Publications).

 [ISSN 2581-5369]

to get involved in the often heated discussion about the role of ART in the advancement of women's health and development. However, there hasn't been much sustained reflection on the international spread of ART, either with regard to the systemic issues surrounding the role of Western market forces in the globalisation of ART, or with regard to the more concrete questions of justice regarding access to care and the procedures by which health care priorities are established in different contexts. The linked social, ethical, and economic aspects of infertility and the rise of ART in areas with limited resources have also received scant consideration. The geographic and cultural lens for analysing the significance of ART for women's health is widened by paying attention to the implications of ART for women's empowerment and health in resource-poor places. Taking this approach will successfully challenge prevalent paradigms in the ethical analysis of ART, which presuppose a biomedical explanation of infertility, reduce reproductive agency to individual choice, and undervalue or ignore the influence of social, economic, and political factors as determinants of health and illness. Additionally, examining the implications of the growth of ART for women in the global South brings up a number of issues that lie at the nexus of contemporary development theory and international human rights discourse, including the connections between gender, status, and health; the ability of local and global structural relationships to support or undermine human agency, particularly for the most vulnerable groups in the most vulnerable regions; and the promise and danger of transnationalism[4].

The globalisation of ART serves as the backdrop for this essay's investigation of feminists' rising interest in merging human rights and development views in support of a transnational bioethics. It contends that a dual-lens approach, one that directly draws from the discourses of international human rights and draws attention to structural relationships in the development and distribution of health care goods and services, illuminates ethical features of the globalisation of ART that would be missed in conventional bioethical analyses. The argument for examining the introduction of ART in the global South in light of the unique economic, political, and cultural circumstances that mediate the experience of infertility, particularly for women, is presented in the first section. In this manner, it is made obvious how social and cultural constraints on reproduction mix with business interests in growing the current ART markets. The second part demonstrates how a dual-lens approach expands the ethical concerns surrounding ART in a global market beyond choice and access to consider what types of

[4] ICMR (1984): ICMR Bulletin, Indian Council of Medical Research, October, 14(10). - (2022): National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India (New Delhi: Indian Council of Medical Research).

 [ISSN 2581-5369]

investments might benefit women's health and development when viewed in terms of the various and ever-changing dynamics of power in which they are embedded. Lastly, it links research on ART trends throughout the world to worldwide activism for social and economic fairness[5].

II. BARRENNESS AMID PLENTY: INFERTILITY AND ADVOCACY

The main paradox of infertility is that it often occurs most frequently in regions of the globe with the highest reproductive rates. Reproductive rights were given fresh respect as a part of global human rights initiatives in the 1990s. In the worldwide fight for women's health, the recognition of sexuality and reproduction as "domains to which human rights may and should be applied" is largely considered as a milestone. Women's reproductive autonomy was formally acknowledged as a cornerstone of development beginning with the United Nations 1994 International Conference on Population and Development and continued with the Fourth World Congress on Women in Beijing (1995). There was evidence of an emerging commitment to a lifespan approach, one that moved beyond the almost sole focus on birth control that has characterised decades of population and development policy and towards ensuring access to services for all aspects of sexual and reproductive health, including the prevention and appropriate treatment of infertility. However, there was no political will to implement this approach, despite its emerging commitment in theory. Infertility is still only sometimes acknowledged as a significant public health problem, despite the Beijing Declaration's demand for worldwide investment in reproductive health, encompassing not just the tools for family planning but also the resources for family formation. The issue of infertility has received little attention from reproductive health research projects intended at determining foreign assistance priorities, particularly in economically developing nations[6]. Family planning programmes have received more development assistance than any other area of maternal and child health, despite cuts to Indian budgets since 2001. When the prevalence of infertility in resource-poor nations is acknowledged, it is frequently assumed without being explicitly stated that social investments in overcoming infertility are inappropriate, either because infertility is seen as a natural counterbalance to population pressures (overpopulation being the public health priority for Western donor nations generally) or because infertility services are given a low priority in underfunded and overburdened health care economies. As a consequence of the HIV/AIDS

[5] Klein, R (2008): "From Test-tube Women to Bodies without Women", Women's Studies International Forum, 31(3), 157"75

[6] Ministry of Health and Family Welfare and Indian Council of Medical Research (2023): The Assisted Reproductive Technologies (Regulation) Act 2021.

 [ISSN 2581-5369]

epidemic, the condition of infertility is particularly precarious since financing for all areas of women's health has either been reduced or, at best, modestly increased due to competition for scarce public health dollars[7].

For a variety of reasons, activists for women's health and reproductive rights seldom list treating infertility as one of their top objectives. The widespread and direct link between infertility and ART is one reason for its relative obscurity. According to Indian government, general feminist ambivalence about the role of assisted reproductive technology (ART) in the empowerment of women is heightened in regions with a history of externally or hierarchically imposed family planning programmes; in these settings, the contradictory possibilities of ART as a therapeutic tool and a tool for control are particularly evident. The fact that in certain places (like India) IVF has been administered specifically to facilitate the acceptance of sterilization has women's rights groups worried that ART may further submit women to the control of the state[8].

Another reason is the concern that bringing up infertility as a women's rights problem might reinforce long-standing ideologies linking motherhood to the feminine character and heighten pressure to procreate, especially in nations with strong patriarchal and pronatalist values. The fact that the social meaning of infertility frequently plays both sides of the table in discussions about whether ART increases or decreases women's age raises additional feminist concerns. Both parties who support the expansion of ART and those who oppose it invoke the same set of societal and cultural norms. ART draws attention to, and thereby gives voice to, the complex field of expectations and values concerning motherhood and childbearing that shape assisted reproduction as a social practice, whether it is lauded as a hopeful cure for the suffering experienced by infertile women or denounced as a tool for the further manipulation of women's bodies[9].

The necessity to establish strategic goals for action, particularly in countries where activists think that real and immediate challenges to women's safety and autonomy continue, marginalizes infertility. The impact of population control measures on women's bodies and lives, as well as sex (pre)selection and sex determination followed by abortion of the female fetus, have been the major focus of feminists and women's health organizations in India. For her, this is not so much an ideological preoccupation as it is a practical one: while if campaigners

[7] Mukherjee, M (2008): "Engineering Family Values: Assisted Reproductive Technologies and Kinship in West Bengal", PhD thesis, Jawaharlal Nehru University.
[8] Netscribes (India) (2008): Medical Tourism in India: Research and Markets, viewed on 2 April 2023 (www.researchandmarkets.com).
[9] Rapp, R (2001): "Gender, Body, Biomedicine: How Some Feminist Concerns Dragged Reproduction to the Centre of Social Theory", Medical Anthropology Quarterly - International Journal for the Analysis of Health, 15(4), 466-77

 [ISSN 2581-5369]

acknowledge the significance of infertility-related policies for women's health in a perfect world, there is only so much political energy that can be mobilized. Advocates for women's health throughout the globe have comparable rights to concerns including gender-based domestic and sexual abuse, unsafe abortion, STDs, HIV/AIDS susceptibility, female genital mutilation, and sex trafficking. Yet, omitting to acknowledge infertility as a problem affecting women's health or restricting reproductive health to the availability of effective contraception greatly oversimplifies the problem of infertility, particularly in regions of the global South. The fact that "problematic high fertility occurs in a relationship of tension and contrast to problematic high infertility," as it is well known, is ignored. Reproductive-tract infections, STDs, and medical treatments (postpartum and post-abortion) performed in unclean settings are the main avoidable causes of secondary infertility (the inability to conceive or bring to term after a prior delivery). The disproportionally high rates of secondary infertility in economically underdeveloped nations (for instance, secondary infertility affects more than 25% of all couples in 14 of the 23 countries in sub-Saharan Africa; rates in Egypt, Turkey, Bolivia, and Peru range from 15% to 20%) are a result of the interaction between social and cultural values regarding reproduction (including, in some cases, strong societal pressures to reproduce) and the accessibility of reproductive technologies. In many places, choosing intrauterine devices over barrier techniques or choosing not to use contraception due to a desire for children, a fear of social shame, or a lack of access dramatically increases women's chances of developing STDs, including HIV/AIDS. In fact, "infertility together with HIV constitutes twin risks of depopulation in certain locations," notably in Africa[10].

Lack of knowledge of the culturally and geographically distinct causes of infertility is one result of the inability to include infertility in a global health agenda. For the reasons outlined above, it will be difficult to understand risk factors for infertility in the global South using Eurocentric analyses of causality in infertility, which have given special attention to lifestyle factors like age, smoking, and alcohol consumption and take primary infertility as their context. Assessing arguments for investments in various forms of treatment, such as low-tech interventions like artificial insemination or drug therapy that are likely to be ineffective for the majority of cases of infertility in this context versus high-tech interventions like IVF that are more likely to be effective, requires identifying the factors that account for the majority of infertility cases in resource-poor or economically underdeveloped regions such as sub-Saharan Africa. More importantly, examining the geographically specific factors that contribute to the prevalence of

[10] Sarojini, N and Vrinda Marwah (2011): "Shake Her, She Is Like the Tree That Grows Money!: Contests and Critiques in Surrogacy"?

 [ISSN 2581-5369]

infertility reveals potential synergies between various public health priorities, such as addressing infertility and preventing STDs, enhancing adolescent reproductive health, and lowering infant and maternal mortality[11].

Ignorance to the incidence and impact of infertility in economically undeveloped regions also obscures factors that raise infertile women's risk of marginalization and makes the experience of infertile men and women in certain regions of the globe invisible (or inconsequential). The inability to conceive or carry children is widely acknowledged as a profound human loss, a source of very tremendous grief, particularly for women. Feminists and others may dispute on the causes, though. However, in some parts of the global South, particularly in high-fertility, pronatalist societies, an infertile woman is at high risk for domestic violence (either at the hands of a partner or her extended family), abandonment and/or divorce, and infidelity. The risk of social stigma or ostracism varies greatly across regions. In certain circumstances, they are not allowed to inherit their husbands' property or be buried in family graves; others are anticipated to enter polygamous relationships as second wives. In countries where the elderly are traditionally supported and nursed till death by their adult offspring, childless women "are especially vulnerable in their old age"[12].

African women are often subjected to "enormous demands from family, community, and society to conform to the existing gender and reproductive conventions, as well as internalized pledges to behave responsibly towards others" while making reproductive choices. So, for instance, childless women are not only not allowed to participate in their prescribed social role (and thus not allowed to achieve social status and identity) but also not allowed to perform their reproductive work for the family, which makes them ineligible for burial rites among the Indians.

Arguments in favour of ART that mention gender-related pain or stigma associated with infertility as if such suffering or stigma required no deconstruction have drawn the suspicion of feminists, and for good reason. However, ignoring the social, cultural, and economic significance of having children and childbearing and their connection to women's status and well-being in communities, particularly in high-fertility, pronatalist societies, runs the risk of undermining not only the lived experiences of women in many areas of the world but also the forces that propel the growth of ART. Understanding why infertile individuals and couples go

[11] Sarojini, N, Vrinda Marwah and Anjali Shenoi (2011): "Globalisation of Birth Markets: A Case Study of Assisted Reproductive Technologies in India", Globalisation and Health, 7:27.
[12] Shore, C (1992): "Virgin Births and Sterile Debates: Anthropology and the New Reproductive Technologies", Current Anthropology, 33(3), 295-3

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to great lengths to overcome infertility, in some cases putting their lives and financial stability at risk, or why difficulty conceiving is the most common reason for seeking medical care in many areas of the global South (from both traditional healers and the formal medical system), requires understanding the value placed on childbearing and the pressure to reproduce in a given society. Understanding how this is the case in a particular context is essential for evaluating the importance, particularly for women, of the worldwide development of ART. Societal norms and cultural forces surrounding reproduction also cross with financial goals in extending current markets for ART.

III. ASSISTED REPRODUCTIVE TECHNOLOGY (REGULATION) ACT, 2021

The first test-tube baby to be born in India, Kanupriya alias Durga, was born in Kolkata in 1978, marking the beginning of a complicated and protracted relationship with assisted reproductive technology (ART). With this, the multimillion dollar reproductive tourism business started to expand. Despite the absence of an appropriate regulatory or legal structure to guide it, the sector expanded enormously.

A conservative estimate puts the number of ART clinics in the nation at over 40,000. This resulted in a variety of legal, moral, and social problems that called for standardised procedure. With the publication of the National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India in 2005—the first-ever national guidelines for establishing standards of conduct for surrogacy in India—the Indian Council of Medical Research (ICMR) attempted to fill the legislative gap. Moreover, the Ministry of Home Affairs has occasionally released surrogacy regulation guidelines. The Law Commission suggested passing legislation in 2009 in its 228th report to ease the proper use of ART and legalise surrogacy.

In light of this, on December 8, 2021, Parliament approved the Assisted Reproductive Technologies (Regulation) Act, 2021, which the President signed on December 18, 2021. The Act's objectives include the regulation and oversight of ART clinics and banks, the avoidance of abuse, and the safe and moral provision of ART services.

The Surrogacy (Regulation) Act, 2021, which only recognises altruistic surrogacy as lawful, is introduced concurrently with this Act. While the Acts eventually regulate the sector, they also raise a variety of legal issues, including as rights, technological advancements, international surrogacy, duties, and moral conundrums[13].

[13] Srinivasan, S, ed. (2022): Making Babies: Birth Markets and Assisted Reproductive Technologies in India (New Delhi: Zubaan Books

(A) Important highlights of the ART Act

Every ART clinic and bank is required by the Act to be listed in the National Register of Banks and Clinics of India. This Registry, which consists of scientific and technical personnel, will serve as a central database for all institutions in India that provide ART treatments. State governments must select individuals to expedite the registration procedure. In order to perform ART operations, a person, clinic, or bank must be registered with the Registry.

The Act also calls for the creation of a National Reproductive Technology and Surrogacy Board, which would establish a code of conduct for employees of ART clinics and banks as well as minimum requirements for their physical facilities, laboratory and diagnostic equipment, and expert staffing levels. The Board will also keep an eye on how the Registry is run.

The Act also specifies the obligations that must be met by ART banks and clinics, including ensuring that the commissioning couple, woman, and donor are qualified to receive ART services; mandating that clinics obtain donors' gametes from banks, which must ensure that the donor has been examined for disease; offering counselling to commissioning couples and women regarding the implications of ART; and upholding children's rights. Clinics and banks are required to establish a grievance redressal cell and to preserve the confidentiality of information pertaining to commissioning couples and women. The Act also gives the Central government the authority to establish regulations to implement its provisions as and when necessary.

Moreover, if any of its terms are violated, the Act lays forth severe penalties. For repeated offences, the offender may get a term of 8 to 12 years in jail as well as a fine of 10 to 12 lakh rupees. First-time offenders may be subject to fines between 5 lakh and 10 lakh rupees. Owners of clinics or banks that sell or advertise sex selective ART run the risk of receiving a 5- to 10-year jail sentence, a fine of 10- to 25-lakh rupees, or both.

(B) Shortcomings of the ART Act

Although the Act is a significant and decisive step towards reducing the threat of unlicensed and illegal ART facilities and towards protecting donors and women undergoing ART from the health consequences associated with risky and unlawful treatments, it falls short of fully addressing several grave concerns.

The Act prohibits unmarried males, divorced men, widower men, heterosexual couples who are not married but are cohabiting, transgender people, and gay couples (whether married or cohabiting) from receiving ART services. This exclusion is significant since the Surrogacy Act also prohibits the aforementioned individuals from using surrogacy as a means of reproduction.

 [ISSN 2581-5369]

However, the Act is only applicable to commissioning couples who have been unable to conceive after one year of unprotected coitus. Its applicability is thus restricted, and individuals who are disqualified have fewer options when it comes to becoming pregnant. Finally, the costs of the services are not controlled; this may be fixed with a few simple instructions.

IV. A MATTER OF JUSTICE?

Feminists of India have been debating the importance of reproductive technologies for women's health and the contribution these technologies make to the feminist goals of justice, empowerment, and gender equality for more than twenty years.

It is evident that NRTs (new reproductive technologies) have given some women "new freedoms" in the form of opportunities, such as the ability to prevent unwanted pregnancies and births through contraception and abortion; to a certain extent, the ability to prevent the birth of unwanted children (of the "wrong" sex or "unhealthy") through prenatal diagnosis technologies; and the ability to become mothers for infertile women/couples, single women, and lesbian women through artificial insemination also, they have introduced "new dependencies" on service providers and technology[14].

The employment of these technologies has resulted in some women's transformation from "objects" and "victims" to "knowing subjects" and "agents" of power over their own bodies, while for others, it has increased outside control and expropriation.

Nonetheless, certain similar themes and worries arise when we look at ART in the context of the potential for treating infertility, particularly with regard to the experience of women in poor regions of the globe. One may be referred to as the "myth of choice" that is ingrained in the language of the growing IVF business. Many feminists and women's health advocates in the global South find it very difficult to accept arguments for the introduction or creation of access to ART that are based on liberal feminist conceptions of reproductive autonomy. Many contends that for poor women of colour, the idea of a "woman's freedom to choose" to have children has always been mediated by a coercive, racist state, recalling memories of race- and class-based population control. For many women of colour, the foundation for [coalitions across racial and class lines] must be reproductive rights defined in their fullest sense, in terms of family male-female interactions but also, and more importantly, in terms of institutional ties and state policy. According to this viewpoint, it is important to pay attention to the various, fluid relations of power that not only structure choice but also place women in relation to one another and other

[14] Ginsburg, F.Y. and K. Kapp (eds.). 1995. Conceiving the new world order: The Global politics of reproduction. Berkley: University of California Press.

actors when examining the circumstances under which ART can promote or protect women's capacities to make and realise decisions about reproduction. In situations where ART is openly or covertly used as a tool of population control, such as when sex-selection practices are used to ensure male births in response to restrictive reproductive policies or strong social preferences, such power relations (and women's strategies of resistance to them) are clearly evident. The many, fluid dynamics of power at play in the international commerce in women's reproductive labour are less obvious but much more significant. In addition, the globalisation of ART produces "new regimes of consumption," "new types of market and quasi-market interactions," and "repositions women in new systems of inequality" by reflecting long-standing power inequalities at play in the international migrations of children via adoption[15].

The role of ART in efforts to ensure comprehensive support for women's sexual and reproductive health and rights is another area of concern. This support should encompass not only readily available and efficient family planning, which is linked to the prevention of infertility, but also easily accessible public health systems, high-quality pre- and postnatal care, emergency obstetrics, the prevention of HIV/AIDS, gender equality in the home, and protection from sexual and domestic violence. In at least two respects, the development of ART as a medical sector has the potential to compete with and distract efforts towards these all-encompassing aims. Secondly, ART provides a biological solution to infertility; as such, it engages in social progress ideologies that prioritise scientific or technology interventions above socioeconomic, cultural, and political improvements. The most important causes of infertility in many parts of the world, such as untreated STDs, genital tuberculosis, pelvic inflammatory disease associated with contraception, post-abortive and postpartum infections, and the long-term effects of environmental and occupational toxins on male and female reproductive health, are thus not addressed by specialised technologies in this case. Moreover, the ART industry privatises infertility, adding to the already complex and uneven healthcare systems. Also, the focus of the Indian government has been on enhancing public-private partnerships for the provision of maternity services, building on existing health care reform initiatives and structural adjustment policies intended to move services from the public to the private sector. Taking care of a variety of non-medical issues, such as housing, employment, drinking water, and nutrition, is necessary to reduce maternal mortality over time. The need to "address economic, caste, religious, racial, and gender inequity that breeds poor health among young girls and women" is

[15] Hardee, K. J. Gay, A.K. Blanc et al. 2012. 'Maternal Morbidity: A Neglected Dimension of Safe Motherhood in the Developing World', Journal of Research, Policy and Practice, Vol. 7(6): 603-61

 [ISSN 2581-5369]

more crucial[16].

The third and last topic that arises in consideration of what ART means for women in India is the indivisibility of reproductive autonomy from the "everyday efforts of women's agency,". The single-issue policies and philosophies that fail to consider the intersection of poverty, gender inequality, and cultural/religious norms underlying challenges to sexual and reproductive health and structuring alternatives for responding have drawn criticism from feminists working in economically underdeveloped areas. On the advancement of women's sexual and reproductive health and rights in India argues that women are made vulnerable in all facets of life when deeply ingrained patriarchal ideals prevent them from making choices about their own wellbeing. For instance, greater rates of illiteracy, exclusion from property ownership, which increases the risk of financial and physical insecurity and lack of access to health information and services, are just a few examples of how women are disproportionately vulnerable. They are all important factors of women's health since they are key markers of women's social standing. Indian feminists have argued that it is foolish to believe that reproductive self determination leads to self determination in other areas, although acknowledging the significance of control over reproduction for women's autonomy generally. Instead, when women "have re-established their positions in other domains of life, they may be able to assert and demand sexual and reproductive autonomy from actors who want to regulate it. They will be in a good position to bargain when it comes to sexuality and fertility[17].

Putting the cart before the horse with regard to ART has the effect of making analyses of risks and solutions to infertility ineffective unless they explicitly consider the role of gender in the fundamental issues (poverty, low socioeconomic status, inadequate health infrastructure, unfavorable cultural norms, and weak social support systems) that put women in developing nations at a higher risk of infertility (especially secondary infertility), limit their ability to reproduce, and impede their ability to access ART. In other words, it's just as crucial to comprehend the circumstances in which women may feel forced or powerless to decline IVF or other types of ART as it is to comprehend the causes of and circumstances surrounding their search for these technologies. Another conclusion is that women's participation in and entry into the global as well as local economic and political spheres will have a significant impact on the advocacy for a complete and comprehensive reproductive health and rights agenda[18].

[16] Human Fertilisation and Embryology Agency. 1984. (www.hfea.gov.uk/docsAVarnock_Report_of_the_Comm _into_Human_Fertilisation_and_Embryology_1984 pdf) Accessed on November 12th 2022

[17] Indian Council of Medical Research (2005) National Guid Supervision and Regulation of ART clinics in India (http://icmr.nic.in/art/Prilim_Pages.pdf) (accessed on 15 January 2023)

[18] Inhorn, M. 2009. 'Right to Assisted Reproductive Technology in Low Resource Countries', International Journal

V. Lessons in artificial reproduction technology and feminist bioethics

India "Towards Transnational Feminisms" to consider the prospects for female solidarity in an era of globalization. Might the increased cross-border interchange of goods and services create new opportunities for collaboration amongst women in very different economic situations? If the requirements of getting informed consent and safeguarding parties, in particular surrogates and egg donors, from explicit exploitation, can be satisfied, the answer would be yes according to many bioethicists and some feminists. Nevertheless, such response ignores the larger systems of power that govern the prices of products and the terms of trade. So, India only erroneously saw the market interaction between fertile women giving a "product" for sale and infertile women demanding or "needing" eggs as a neutral or equal relationship of producer and consumer. In order to see that women are equally involved in the capitalist global economy, which needs women but marginalizes their labour as both producers and reproducers in search of profit, one must instead view transactions in the global gamete market against the devaluation of women's labour under capitalism. India contends that transnational feminism must be based on a "politics of solidarity" that includes "mutuality, accountability, and the recognition of common interests as the basis for relationships among diverse communities" rather than on easily appropriated global market relationships. According to this perspective, solidarity is built on a willingness to compare one's connection to and interactions within the many, overlapping, and distinct oppressions that women experience rather than on the false equality of free will. In the context of the expanding reproductive supermarket, this involves not only recognizing a priori disparities in power between consumers and producers and exposing the particular pressures that influence decisions to buy or sell gametes but also resisting the prevailing market ethos in which persons become the sum of "saleable and disposable parts". A vision for women's health based on shared opposition to the commoditization of reproduction (and opposition to the commoditization of women's bodies generally) and a shared commitment to what might be described as a civic rather than a consumerist global health care system becomes apparent as the fruit of solidarity[19].

With regard to the globalization of ART, India's notion raises the possibility of transnational feminist movements as well as the beginnings of a transnational feminist bioethics. Recent publications have advocated for the need of incorporating discourses of global human rights

Obstetrics. 106: 172-174.

[19] Kothari, Bela. 2012. 'Perception and Work Ethos of Medical Experts Dealing with Infertile Couples: A Study in Medical Sociology', Sociological Bulletin , 61(1): 144-158.

 [ISSN 2581-5369]

and development into bioethical analysis in order to face the issue of globalization for feminist bioethics. In incorporating this discourse, feminist bioethicists have made an effort to learn from the strategies and terminologies of local and global movements that advocate for women's sexual and reproductive rights all over the world. These movements have been crucial in putting the demand for women's rights as human rights on the international political agenda and insisting on the importance of sexual and reproductive health and rights for development initiatives. In the context of global advocacy movements, there are apparent risks associated with arguing for social change based on appeals to a shared humanity or the intrinsic dignity of all people, such as the propensity to accept culturally particular actions or beliefs as normative or universal. To name the dehumanization and privation experienced by certain people or groups, however, as well as to hold communities, organizations, and institutions accountable and responsible, the language of human rights has proved to be crucial. Invoking women's rights as human rights has been more than just a defensive tactic for grassroots activists to draw attention to how vulnerable women are to different power structures or too many women's daily struggles for survival; it has also been a claim for a new political vision and a call for deliberate political action[20].

In addition, there has been a renewed focus on the connections between gender, social position, and health in the aftermath of the AIDS epidemic, as well as the contribution that investments in women's health make to supporting economic development and security. The significance of gender as a dimension of social, economic, and political power relations has been highlighted by feminist critical scholarship, which has challenged traditional development paradigms by moving beyond reliance on a narrow set of economic indicators to illuminate the links between access to resources and the capacity to articulate and realize fundamental human capabilities. Feminists have also pushed for development objectives in women's health that go beyond a simple list of health outcomes and instead emphasize the connections between inequities in access to healthcare and other forms of social and economic injustice. From this perspective, it is not enough to support policies or programmes aimed at delivering basic resources or meeting critical health care needs; rather, women's structural disempowerment calls for development approaches with "transformatory or redistributive potential," that is, approaches that transform the conditions under which women make choices for themselves and their families by building up the "infrastructures essential for the process of self-empowerment". The promise of a dual-

[20] NCMH. 2022. National Commission on Macroeconomics and Health. New Delhi: Ministry of Health and Family Welfare, Government of India (www.int/macrrohealth/.../Report%200f%20the%National%20Commission.Pd f) (accessed on 15 January 2023).

lens feminist bioethics, one that draws from and integrates both human rights principles and attention to the implications of policies and practices for international development, is revealed by critical attention to the factors that drive the globalization of ART on the one hand and marginalize infertility in public health and international aid programmes on the other. As a result, it pays explicit attention to the role of non-medical factors (such as geography, social status, race, or gender) as determinants of health and illness. Applying a human rights paradigm to analysis and response casts both in biological and individual terms as well as social, economic, and political terms. In this way, it fights the inclination to separate reproductive health and agency from all other prerequisites for women's agency, such as having access to education, having a stable job, having access to clean water and adequate nutrition, and not having to deal with gendered violence or discrimination. A human rights paradigm broadens the criticism of power dynamics in medicine (and in the politics of science, medicine, and technology) to include structural factors that shape both decision and consequence, such as the interplay between poverty, gender, and sickness. Because of this, the responsibilities associated with this strategy "are more extensive than utility maximization, more democratic than paternalism, more mutual than informed consent, and more responsive to social inequities than are consumer preference satisfaction and caveat emptor"[21]. A human rights perspective also raises health as a common or public good, upholds the importance of preventative and community-based methods, and calls attention to intersecting power structures (local, national, and worldwide) that govern the distribution of health care products and services. According to this viewpoint, the growing calls for the privatization of reproductive health care and the emphasis on treating infertility with highly technical procedures like IVF are gravely troubling, especially in light of the significant problems with access, quality, and continuity of care that are the root of the high rates of secondary infertility in parts of the global South.

When development discourses are also taken into consideration, attention to dynamics and structures of power as a component of bioethical study becomes sharper. Making explicit the importance of monetary changes, trade ties, and patterns of economic growth in the production of women's sexuality and reproductive autonomy is conceivable, for example, within the setting of development relations. The fact that "sexuality and reproductive behaviour are at the centre of extraordinarily strong economies" comes into focus when seen through this perspective. As a result, a feminist may see much more than just consent issues at play in elite, wealthy women's

[21] Qadeer, Imrana. 2022. 'New Reproductive Technologies and India's Transitional Health System', in Srinivasan, Sandhya (ed). Making Babies: Birth Markets and Assisted Reproductive Technologies in India. Delhi: Zuban, pp. 1-22

 [ISSN 2581-5369]

bioethical transactions involving eggs and wombs. The association between gender-related economic uncertainty, pressure to barter sex for money and the chance of developing an STD is only one example of the economic variables that contribute to women's unique susceptibility to health hazards. The meaning of advocating for women's health is expanded by highlighting the organic link between civil/political rights and social/economic rights and by making explicit the relationship of gender to fundamental conditions like poverty, poor socioeconomic status, poor health infrastructure, detrimental cultural practices, and weak social support systems that put women in developing countries at high risk of infertility (particularly secondary infertility) and restrict options for responding. The cost of structural adjustment and international debt servicing policies on health care in the poorest nations only becomes an ethical issue rather than just an accepted reality of global economics if the structural components of infertility and the globalization of ART are acknowledged[22].

In order to empower women in the many, interrelated domains of social, political, and economic activity, a gendered approach to development encourages and supports locally developed programmes and policies. As we've seen, this strategy relates investments in basic healthcare to better access to training and education, microcredit programmes, and the preservation of property and other civil rights. Yet, India's prior warning should be reiterated: from this viewpoint, it is necessary to embrace strategies for enhancing women's health that have "transformatory or redistributive potential," not only for the goals or results themselves. The impact of ART on women's health and status generally understood, as well as its role in changing (or ratifying) the circumstances under which women make decisions about their health, sexuality, and reproductive choices, must therefore be taken into account when analysing the introduction of ART in resource-poor areas[23].

Lastly, a dual-lens bioethics goes farther than just studying or recognising problems with reproductive health in low-resource nations. Instead, this bio-ethics encourages participation in global action in collaboration with people who are most adversely impacted by the negative effects of globalisation. Notwithstanding its flaws, the language of human rights is one of the most effective ways to turn political and strategic assertions about social injustices into public consciousness. What theologians often refer to as an option for the poor is further grounded in activity by a development viewpoint. According to this viewpoint, inequalities are manifestations of systemic violence, and policies, programmes, and practices are evaluated

[22] SAMA: Resource Group for women and health. 2007. 'Assisted Reproductive Technologies in India: Implications for Women', Economic and Political Weekly, 42 (23): 2184-2189.
[23] Sudha, G., Reddy, K.S in infertile couples Science Vol III (1): 90-101

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according on their capacity to liberate the least fortunate. This approach broadens feminist activism for women's health far beyond the occasionally limited focus on reproductive choice it has had in the past, making new forms of international and intercultural partnership possible. It does this by attending directly to the intersection of poverty, gender inequality, and repressive cultural/religious norms as structural factors in generating and maintaining threats to sexual and reproductive health in the global South[24].

VI. CONCLUSION

There is a lot more that could be written about what it would entail for feminist bioethics to embrace a human rights perspective and give ongoing development theory disputes serious attention. Building on the success of transnational women's advocacy movements for women's sexual and reproductive health and rights, however, requires acknowledging the importance of human rights considerations for advancing women's health and comprehending the varied experiences of infertility, especially in light of the expanding globalization. Using a human rights framework for feminist bioethics should not entail embracing a commitment to ethical universals or the extension of individual freedom as the paramount ideal, despite the fact that rights rhetoric has proved contentious. As a result, feminist bioethics draws from women's advocacy traditions that assert that international human rights are a continuous and evolving discourse that "provides multiple spaces where women and other actors (excluded or misplaced by the social contract black, ethnic, indigenous groups, sexual dissidents) gain individual and collective agency and raise their voices to challenge states and private corporations." Feminist bioethics are not bound by donor-defined, woman-as-object models of international development in the field of women's health, nor are they by discussions of development theory. In contrast to conventional economic measures of social progress and well-being, feminist contributions to development theory place an emphasis on participative, locally defined, dialogic, and open-ended methods for defining and pursuing development objectives. Yet while considering issues like the globalization of ART via a dual lens, three important considerations are kept in mind: Second, promoting social and economic rights (rights of development) for the marginalized recognizes explicitly that all debates over medicine, science, and technology take place on uneven playing fields. Using that perspective, we are less likely to overlook the fact that "global capitalism lays its narrative on the bodies and lives of women and girls from the Third World/South the Two-Thirds World in particular." while doing my study of ART.

[24] SAMA: Resource Group for women and health. 2022. Unravelling the lniertility industry: Challenges and strategies for movement building: A Report available at http://www.samawomenshealth.org/downloads/Final%20Consultation%20Rep ort.pdf

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The ART Act is definitely a step in the right direction, particularly considering that India is one of the biggest centres of these abuses. But, there must be a dynamic supervision in order to guarantee that the law remains relevant in the face of constantly advancing technology, shifting expectations of morality, and altering cultural norms. It is without a doubt going to be necessary to do extensive follow-up investigations on this piece of legislation over the course of some period of time in order to evaluate its effects, as well as its advantages and disadvantages. It is undeniably a ground-breaking piece of legislation that will not only chart the route for future development in this area but also reflect its overall trajectory.

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