THE SECULAR ETHICS OF ASSISTED
REPRODUCTIVE TECHNOLOGY

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Introduction

Artificial procreation or artificial fertilization is understood as the different technical procedures directed towards obtaining a human conception in a manner other than the sexual union of man and woman (Abbey, 1991). This Instruction deals with fertilization of an ovum in a test-tube (in vitro fertilization) and artificial insemination through transfer into the woman's genital tracts of previously collected sperm. A preliminary point for the moral evaluation of such technical procedures is constituted by the consideration of the circumstances and consequences which those procedures involve in relation to the respect due the human embryo. Development of the practice of in vitro fertilization has required innumerable fertilizations and destructions of human embryos (Millsap, 1996). Even today the usual practice presupposes a hyper ovulation on the part of the woman: a number of ova are withdrawn, fertilized and then cultivated in vitro for some days. Usually not all are transferred into the genital tracts of the woman; some embryos generally called spare are destroyed or frozen. On occasion some of the implanted embryos are sacrificed for various eugenic economic or psychological reasons. Such deliberate destruction of human beings or their utilization for different purposes to the detriment of their integrity and life is contrary to the doctrine on procured abortion already recalled (Friedman, 1997b).

The connection between in vitro fertilization and the voluntary destruction of human embryos occurs too often. This is significant: through these procedures with apparently contrary purposes life and death are subjected to the decision of man who thus sets himself up as the giver of life and death by decree. This dynamic of violence and domination may remain unnoticed by those very individuals who in wishing to utilize this procedure become subject to it themselves. The facts recorded and the cold logic which links them must be taken into consideration for a moral judgment on IVF and ET (in vitro fertilization and embryo transfer): the abortion-mentality which has made this procedure possible thus leads whether one wants it or not to man's domination over the life and death of his fellow human beings and can lead to a
system of radical eugenics. Nevertheless such abuses do not exempt one from a further and thorough ethical study of the techniques of artificial procreation considered in them abstracting as far as possible from the destruction of embryos produced in vitro (Millsap, 1996). The present Instruction therefore take into consideration in the first place the problems posed by heterologous artificial fertilization and subsequently those linked with homologous artificial fertilization. Before formulating an ethical judgment on each of these procedures the principles and values which determine the moral evaluation of each of them will be considered. By the term heterologous artificial fertilization or procreation, the Instruction means techniques used to obtain a human conception artificially by the use of gametes coming from at least one donor other than the spouses who are joined in marriage. Such techniques can be of two types:

a) Heterologous IVF and ET: the technique used to obtain a human conception through the meeting in vitro of gametes taken from at least one donor other than the two spouses joined in marriage.

b) Heterologous artificial insemination: the technique used to obtain a human conception through the transfer into the genital tracts of the woman of the sperm previously collected from a donor other than the husband.

By artificial homologous fertilization or procreation, the Instruction means the technique used to obtain a human conception using the gametes of the two spouses joined in marriage. Homologous artificial fertilization can be carried out by two different methods:

i) Homologous IVF and ET: the technique used to obtain a human conception through the meeting in vitro of the gametes of the spouses joined in marriage.

ii) Homologous artificial insemination: the technique used to obtain a human conception through the transfer into the genital tracts of a married woman of the sperm previously collected from her husband (Collins, 1994).
An author by the name Karisa D.2016 reviewed by the Baby Center Medical Advisory Board highly recommends on the use assisted reproductive technology that in the 1970s, British doctors began removing eggs from women who had trouble conceiving and fertilized the eggs in a laboratory. Researchers called this experimental procedure in vitro fertilization (IVF), and after many attempts the first test-tube baby was born in 1978. Today assisted reproductive technology (ART) refers to all treatments that involve handling eggs or embryos outside the body, and this includes IVF as well as a few of its variations. These procedures are usually paired with fertility drugs to increase success rates and about 22 percent of ART procedures (or cycles) result in the birth of a baby (Friedman, 1997 b). A bioethicist called William Bay, has categorized the new reproductive technologies as; artificial fertilization artificial insemination invitro fertilization and embryo transfer alternative technology using male and female gamete cells and cloning or gamete reproduction (Evers, 2012).

Reproductive Health

The World Health Organization (WHO) has popularized the understanding of health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Along the same conceptual path, reproductive and sexual health can be understood as a state of complete physical, mental, and social wellbeing in the domain of reproduction and sexual activity (Frederick, 2013). Such a definition is evidently an ideal standard, necessary as the target of aspirations and practical projects; in practice it is hardly achievable for all members of any society or human community (Abraham, 2000). The actual over-all state of health of any individual at any given point in time will always be less than complete or perfect. In fact, at the individual level, even if such a state of complete or perfect mental, physical, and social well-being were achieved, one could hardly know for certain that it had been achieved; human ambitions and aspirations will, understandably, always stay ahead of the status quo or what is actually achievable, because human beings are by nature aspiring but limited beings.
Millsap, 1996). Be that as it may, while reproductive health has been a perennial concern from time immemorial in all societies and cultures, it is only in recent times that it has received the focal attention of medical researchers and research funders.

Programmes/projects and associations now abound which are making a great impact globally on reproductive health. Furthermore, assisted reproduction technologies (ARTs) and assisted conception are making reproduction not only possible for those for whom it would otherwise have been impossible but safer and healthier than in the past (Collins, 1994). Except for very sophisticated methods, like ICSI (cytoplasmic sperm injection) and EF (embryo freezing), nearly all the other ARTs are already available in Africa, although in terms of demand there is a clear preference for artificial insemination using a husband’s sperm (AIH) rather than other possible options. But economic factors will likely ensure increasing resort to the other methods of ART (Millsap, 1996). Economic determinism is already leading to both a delay in the assumption of the burdens of parenthood and a reduction in family size for many Africans. Delayed parenthood will come with difficulties in achieving conception normally or naturally, making resort to ARTs inevitable.

**Sexual Health**

The idea of sexual health as a separate and independent value was almost completely absent in traditional African societies. For a long time sexual health has been accepted as an integral part of reproductive health, it is only recently that sexual health has emerged as a clearly separate and independent value. Many factors are responsible for the increasing importance of sexuality as a separate and independent concern irrespective of reproduction (Abraham, 2000). These include besides those already enumerated such phenomena as voluntarily childless marriage much earlier discovery or introduction to sexuality, increasing rates of sexually transmitted infections particularly of HIV/AIDS increasing recognition or acceptance of homosexuality, the impact of biotechnologies on reproduction, etc.
The WHO has already announced the imminent publication of a number of very important studies focusing exclusively on sexual health such as: Defining sexual health: Report of a Technical Consultation on Sexual Health; Wood K. and Eagleton P., A conceptual framework for sexual health programming; and Integrating sexual health interventions into reproductive health programs experiences from developing countries (Evers, 2012). Cook, Dickens and Fathala have characterized sexual health as including the ability to enjoy mutually fulfilling sexual relationships freedom from sexual abuse, coercion or harassment, safety from sexually transmitted diseases and success in achieving or in preventing pregnancy. In the context of Africa where traditional ways of thinking, attitudes, habits and practices still hold sway this understanding of sexual health in its comprehensiveness involves a call to a different way of looking at things and developing new attitudes habits and practices in as much as the idea of sexual pleasure within the traditional world-view was simply a welcome by-product of a process aimed at fecundation in which the idea of preventing pregnancy would have been self-contradictory (Millsap, 1996). Even the idea of fertility regulation in that context boiled down to child spacing and the person seeking permanent sterilization would have been looked upon as indeed odd if not downright evil.

It is against such background also that the various forms of marriage in Africa especially family-arranged marriages can properly be understood. In some cases the bride and groom could be meeting for the first time on their wedding night. In arranging a marriage, the family was always less concerned about the physical beauty or sexual attractiveness (which admittedly are in the eye of the beholder) of the marriage partner and more concerned about such other qualities as good family background general physical and mental health, reliability, honesty, hard work and above all, likelihood of being fertile. In that setting it was extremely difficult to find convincing reasons for say refusal of a potential spouse on grounds connected with mere personal preference/choice or for divorce of any marriage, which had been blessed with at least an offspring (Frederick, 2013). A woman who had borne offspring with the husband knew very well that her place in the patri-lineage was more secure than that of her husband who could always be reminded that the woman was not his wife alone but the wife of the entire lineage (Millsap, 1996).
This situation as sketched above, is in a state of rapid mutation and change under the powerful influences of contact with Western culture and Western religions, the emergence of sundry epidemics connected with sexuality the phenomenon of globalization increased migration the information revolution etc.

Under the impact of these phenomena, it is evident that the traditional African family and traditional African marriage, ideas, attitudes and practices related to sexuality and procreation can no longer be wholly sustained. Nowadays sexual debut is occurring much earlier than in the traditional setting and increased urbanization and the HIV/AIDS epidemic have violently jolted traditional attitudes and ways of thinking (Collins, 1994). Change is inevitable and almost complete on many issues at the ideational level but is still to impact completely on attitudes and practices. For example many Africans today readily accept the idea of individual choice as a consequence of individual autonomy of say a marriage partner but this still has to be reconciled and harmonized with attitudes and practices that emphasized community and group values over individual ones. Nor is it a matter of either/or in the exclusive sense.

The two sets of values (which summarily can be described as communal and individual) are reconcilable and harmonize-able although the result to be expected will surely be heavily shaped and colored by context and perspective. Nearly all traditional African communities affirm by varying degrees and conceptual appellations the philosophy of Ubuntu which in actual fact is a balance between individual autonomy and communal values; establishing a dialectic relationship between them by means of which alone each finds meaning (Frederick, 2013). John Mbiti has popularized this philosophy with the epigram: “I am because we are; and since we are, therefore I am”. Traditional Marriage among the Africans for example Marriage is a particularly important area where traditional African customs, laws, and ethics seem to coalesce perfectly. Marriage of course is a cultural universal, in the sense that even though marriage-less societies have been advocated in Plato’s Republic for example no actual culture has ever succeeded in doing without it. But the form and shape marriage takes is culture bound, a cultural particular. In Western cultures, marriage is generally understood as a legal union between two individuals to the exclusion of all others, till death or legal divorce do they part. In traditional African cultures
marriage is understood mainly in extended familial terms as the inclusion rather than exclusion of many others as marriage typically turns two hitherto indifferent lineages into significant others of each other. But to be married at all was to assume sexual responsibility.

A married person was not expected to engage in casual or opportunistic sex, which was tantamount to wasting a precious procreative treasure (Evers, 2012). If a married man proved sexually insatiable and medication failed to help, the wife would be the first person to initiate the search for a co-wife or co-wives for him. If a married woman proved sexually insatiable the situation was much more complex but two frequent results were either separation or she could seek sexual satisfaction outside the home with the covert approval of the husband but in any case, any children she bore traditionally belonged to the husband as long as there had been no divorce (Millsap, 1996). Among the Africans both polygamous and monogamous marriages exist, although polygamy is preponderantly for the rich while the vast majority of ordinary people are monogamists. For ordinary citizens there were before the recent introduction of civil status marriage there were two types’ recognized valid marriages monogamous or polygamous. A father arranged the marriage of the first wife of each of his sons (Frederick, 2013).

A peculiarity of African marriage vis-a-vis marriage amongst other African peoples is that there is bride price/wealth or dowry. Ceremonial gifts are, however, exchanged at prescribed times with the proviso that the total value of marriage gifts received on behalf of a girl should not exceed the total value of the gifts that were given on behalf of her mother. A lot of time and attention are however devoted to checking the familial background of the prospective spouses to make sure that there is no blood relationship between them and that there exists no old and unsettled grudge, quarrel or feud between the two family lineages (Abraham, 2000). The prospect of marriage is also an occasion and an incentive for the ritual settlement of persisting differences, grudges and problems between families, lineages and communities (Klein, 1989). But once the marriage ceremonies and rituals have been performed, the two families/lineages now become in-laws committed to coming to each other’s assistance in times of need, such as tilling,
harvesting, building, birth, marriage, installation, death etc. In unorthodox marriage, a man takes unto himself a wife and a woman a husband without the above formalities of orthodox marriage; they simply ‘move-in together’ (Farmer, 1999). Though recognized and tolerated, this form of marriage was not at all encouraged. This was a great disincentive and constraining factor for this form of marriage.

**Human Rights and Reproductive/Sexual Health**

The idea of human rights may be a purely heuristic device but in practice, it is a quite powerful means of effecting positive changes in systems otherwise highly recalcitrant to change. Human rights have such a strong appeal around the globe that their profession constitutes the highest form of political correctness in the contemporary world while their violation draws the automatic condemnation of all and sundry (Laird, 1995). Human rights are of course not provable and cannot be philosophically justified without either logical circularity or reference to the most general assumptions, postulates or axioms of ethical principles. As (Mann, et al 2013), have rightly stated: Modern human rights is a civilization achievement, a historic effort to identify and agree upon what governments should not do to people and what they should assure to all. Human rights are non-provable statements that derive their legitimacy from having been developed, voted upon and adopted by the nations of the world and having been incorporated into the domain of international law; they do not achieve their status from divine inspiration or religion. But even though human rights are not directly derivable from religious doctrines, they are quite compatible with religious worldviews (Farmer, 1999).

The Universal Declaration of Human Rights is the touchstone document for human rights discourses is of course a purely secular document aimed at providing protections in the public domain particularly. Its focus is on societal-level conditions and determinants of well-being, including health and related issues and concerns. There is no religion or culture for which human well-being and the pre-conditions of its attainment are not a central concern. Without belaboring the issue putative human rights can be
recognized by applying the test of reasonableness (McElroy, 1991 b). What is unreasonable cannot be a human right. In public health the central concern is that of ensuring the conditions in which citizens can live healthy lives, avoiding preventable disease, disability and premature death. Intensive international travel and communication, coupled with the emergence of some highly infectious diseases, give public health concerns in our day a global and urgent dimension. In present day Africa, there are arguably more infectious and epidemic diseases than have ever been seen in the past. Public health is the particular responsibility of civil authorities and governments (Collins, 1994). For that reason, human rights concerns in public health focus primarily on governmental actions/inactions and how they impact on human health, human well-being and other rights enshrined in international human rights law. Public health targets populations rather than individuals and in this way has clear affinities with traditional African attitudes that prioritized communal over individual values (Farmer, 1999).

The concept of human rights provides an important imperative for monitoring governmental responsibility and accountability relative to fundamental rights affecting human health. Violations of human rights, such as unjustified discrimination, torture and other forms of physical and psychological abuse impact directly on health and well-being. These considerations relevant and applicable to all countries are critical for African countries in their present situation where traditional ways of life and governance have been displaced with as yet nothing definite and firm enough to replace them and where civil war, poverty, disease, dictatorship and make-believe democracy are the order of the day. Public Health And Human Rights Are Natural Allies (Miall, 1989).

Public health goals and human rights norms when combined complement each other and lead to more effective and sustained health policies and programs. As already mentioned, human rights are non-provable but they do not derive their legitimacy solely from the fact of having been developed, voted upon and adopted by the nations of the world and having been incorporated into the domain of international law. Certainly human rights have been greatly empowered by such procedures and acts that
ensure that they will be respected and not violated with impunity. But such empowerment notwithstanding whatever can be canvassed as a human right can also independently be established and justified, using only common sense and the most general of moral principles, although the justification of morality itself remains irremediably problematic and the cause of interminable controversies, as there is no antidote to extreme moral skepticism or immoralist (Miall, 1989).

Legislation also tends to put issues in a straitjacket whereas the very rapid evolution of our thinking and attitudes in an age of information revolution and globalization calls for constant reappraisal and revision of our accepted ideas, attitudes and practices. The delivery of healthcare, particularly in reproductive and sexual health, is fraught with quandaries and dilemmas for both the provider and the receiver in which the generally accepted fundamental bioethical principles of autonomy, beneficence non-malfeasance and justice are either in conflict or need delicate balancing. Dealing with adolescents, HIV-positive people, polygamists, homosexuals, prostitutes, wives of physically abusive men, husbands of verbally abusive women, etc., for example pose peculiar ethical problems in each case. Take for instance the principle of autonomy which imposes on health workers or care providers the duty of respect for persons and their privacy or confidentiality (Collins, 1994). But there will be circumstances in which breaching confidentiality may seem ethically correct to protect the health of the public at large or even to protect the well-being and future interest of the very person whose confidentiality is being breached.

An adolescent, for instance, seeking, say an abortion or permanent sterilization creates a situation in which many ethical dilemmas must be faced by both herself and her healthcare provider (Miall, 1989). In such a case, can her health-seeking behavior be helped without very careful counseling or without the knowledge and consent of the parents? Such and many other similar ethical dilemmas in the African context concern basic issues that need to be carefully thought through in the prospect or process of using legislation grounded on ethics and human rights to effect changes in the traditional systems of Africa.
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