CHALLENGES FOR ASSISTED REPRODUCTION AND SECONDARY INFERTILITY IN LATIN AMERICA

FLORENCIA LUNA

TRANSLATED BY ALLISON B. WOLF

Joyce 12/3/13 9:53 AM
Comment [1]: Please see queries throughout. There is no abstract; the headings are in outline form and there are too many subcategories, and the notes are numbered incorrectly and need to be reviewed by the author.

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. . . and the feminists understand perfectly that infertility carries a heavy burden for women. However, they have ambivalent feelings in relation to supporting them in their search for treatments that will resolve their infertility because they feel as if they would be contributing to reinforcing traditional gender roles. It is this tension that has strongly framed the relationship between those who are in favor of these assisted reproductive technologies . . . and feminists[.] (Thompson 2002, 19)

Abstract

This essay explores a new way to think about Assisted Reproductive Technologies (ARTs) in the Latin American context. The infertility caused by inadequately treated sexually transmitted diseases and by unsafe or illegal abortions is preventable, neglects women´s sexual health, and disproportionally affects the region's poorest women. I suggest a new logic that revisits ARTs to do justice to the relevance of this type of infertility. I propose to utilize these technologies so as to transform the care of women and open a new discourse. I also suggest we should be more strategic and seek new alliances.

Introduction

In this essay, I want to explore a new way to think about Assisted Reproductive Technologies (ARTs) in the Latin American context. I will consider a type of infertility that is both preventable and that affects the region's poorest women. In Latin America, as in other parts of the developing world, high levels of infertility are caused by inadequately treated sexually transmitted diseases (STDs) and infections or injuries resulting from unsafe or illegal abortions. This type of infertility is referred to as "secondary infertility."[1] Given its prevalence in developing countries and the special circumstances that surround its occurrence, I will explore its potential relationship to ARTs and women's well-being.

In my examination, I will have in mind the sustained development and insertion of ARTs in the region. These technologies are well established in Latin America and are here to stay. As of 2008, there were more than 50,000 procedures performed annually—a figure that is not expected to decrease. These techniques are so prevalent that private clinics not only flourish in the region, based on demand from within their countries, but they also offer reproductive tourism services via the Internet to people living in industrialized nations (Smith et al. 2010). It is also worth noting that in 2001, Costa Rica was brought before the Commission of Interamerican Human Rights for banning almost all ARTs; the Commission subsequently ruled in their favor (Luna 2008; Brena 2012; CIDH 2012). Given these circumstances, the strong presence of ARTs in Latin America, as well as in developing societies more generally, cannot be denied (Ryan 2009).

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Many "progressive" and women's-rights analyses take a strongly critical stance against these technologies.[2] Although this work presents and recognizes the force of many of their arguments, I believe that we may be better off thinking about them by applying a different logic, one that revisits ARTs in order to build them. Such an approach recognizes the relevance of

secondary infertility while at the same time identifies infertility concerns as not splintered off from other feminist claims. I ask myself whether we should involve infertility specialists to a larger degree so that they can endorse a perspective more committed to women's overall health, rather than using just the reductionist one that simply offers these sophisticated technologies. In addition, I suggest that a new perspective on these technologies could align specialists with feminists, to fight against unsafe and illegal abortions as well as against the lack of access to sexual health services. I also think this broader and more holistic approach could help us to acknowledge and address the unresolved issue of secondary infertility. This, in turn, could help produce a more transparent and open dialogue in Latin America and change certain public policies.

In the first part of this article, I explain the impact of secondary infertility and uncover the biased picture that permeates discussions about infertility in Latin America. In the second part, I present some of the arguments about gender and women's rights that are most relevant in Latin America (focusing on those offered in Spanish and Portuguese). I conclude the section by considering the implementation of these technologies in Latin America. In the essay's third part, I speculate about whether it is possible and worth our while to try to "save" ARTs and whether an ethical solution to the problem of infertility as it manifests in Latin America is possible. I will also wonder if we should be more strategic and seek new alliances, utilizing them in a new way so as to transform the care of women and open a new discourse.

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A "relatively" invisible problem

Infertility affects up to 15 percent of couples of reproductive age around the world. While we tend to think that this is a problem primarily affecting those living in industrialized countries,

the highest percentage of infertility occurs in low-income nations with scarce resources.[3] For example, demographic studies from the World Health Organization (WHO) show that more than 30 percent of women between ages twenty-five and forty-nine in Sub-Saharan Africa suffer from secondary infertility (Cui 2010). The causes of this type of infertility vary, but the lack of good and effective treatment for sexually transmitted diseases (STDs), unsafe abortions, HIV/AIDS, and maternal sepsis are the most common.

Globally, 38 percent of infertility cases can be attributed to previously inadequately treated STDs. For example, untreated gonorrhea or chlamydia can invade the pelvic area, thereby infecting the uterus, Fallopian tubes, or ovaries, producing Pelvic Inflammatory Disease (PID). Scar tissue forms around the pelvic organs, generating obstructions and distortions of the Fallopian tubes. As a result, ovum cannot naturally enter the uterus. After the first episode of PID, there is a 15 percent probability of infertility. After the second episode, the probability increases to 38 percent, and, after a third occurrence, it rises to almost 75 percent.

With respect to unsafe abortions, WHO indicates that STDs cause up to 5 million hospitalizations annually around the world. They are responsible for approximately 13 percent of maternal deaths and cause secondary infertility in close to 24 million women. Among other consequences, unsafe abortions lea to lacerations in the cervix from the use of dilating instruments (which then create the predisposition for repeated miscarriages); perforation of the uterus; infections and obstructions of the Fallopian tubes; endometriosis, and so forth. A recent report published in the *Lancet* (Sedgh et al. 2012) shows that the number of unsafe abortions in the world continues to rise. According to that report, in countries with the most restrictive laws relating to abortion, the majority of those that are performed are unsafe (for example, 97 percent of abortions in Africa and 95 percent in Latin America are considered unsafe).[4] In contrast, in

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regions where abortion is widely permitted and tolerated, almost all of the procedures (99 percent) are considered safe. Beyond this, the number of abortions in the industrialized world decreased from 36 percent in 1995 to 26 percent in 2008.

A recent *WHO Report* identifies different patterns of disability according to whether the countries are high, middle, or low income. Its data shows that in the middle-income group, many more people experienced disabilities associated with preventable causes. The *WHO Report* (2011) mentions two such causes: accidents and infertility. But the interesting fact it points out is that the causes of infertility from unsafe abortions or maternal sepsis are 0.8 percent in industrial countries in contrast to 32.5 percent in developing countries. As these statistics demonstrate, completely different realities what is referred to as the "North" and the "South."

Of course, variations exist between distinct parts of the "South." Compared to the situation in Sub-Saharan Africa, for example, Latin America ranks higher, but the numbers are closer to Africa than they are to Europe (Polak 2009, 82). Despite the existing data, however, the deep connection between infertility and low-quality reproductive health care and the fact that infertility has different origins in different regions continues to go unrecognized. As such, it is a problem that is frequently overlooked and is "relatively" invisible (Ryan 2009). I suggest that because the causes of infertility in the "South" (poor access to reproductive health care, lack of adequate treatments for STDs, and policies that continue to promote unsafe abortions) differ from those leading to infertility in the "North," we must develop and adopt distinct strategies for distinct regions of the world. But this has yet to occur.

In Latin America, undoubtedly, these types of problems reflect profound socioeconomic inequities, a certain level of contempt for women who have full sex lives, strong patriarchal structures, and a marked presence of religion in health policies.[5] These questions have

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traditionally been the domain of feminism in Latin America. Feminist books, articles, and anthologies about reproductive issues in the region include discussions of unsafe abortions, the ways in which poverty and economic inequality affect women, and the religious barriers that are prevalent throughout the region (Lamas 2001; Diniz and Costa 2006; Careaga Pérez et al. 1998; Figueroa 2001; Gonzalez Velez 2008; Bianco 2012). Still, there has been very little reflection about abortion, lack of sexual health, secondary infertility, and their connections to ARTs in the region.

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An anachronistic photograph

Before evaluating or considering different reasons and arguments that promote resisting these technologies, let us consider an image that, on my criterion, also generates a special way of thinking about infertility, its users, and its possible solutions. I call this idea or image the logic of "historical photography."

The logic of historical photography refers to the idea that solutions to the problem of infertility still appear to be designed and implemented according to a picture of infertility and reproductive technologies taken when these treatments were first introduced. That is, we model our ideas about ARTs today on images of how infertility has been addressed in industrialized nations. This leads the public to a specific image that permeates bothits reactions to the technologies and its understanding of those who use them.

The fact is that these technologies were originally created in industrialized countries for upper- and middle-class women. Consequently, we almost always imagine the primary user of these treatments as a middle-class, educated, and professional woman who wants to get pregnant later in life. Given this picture, assisted reproduction appears to be only a luxury for certain

women—an option for "selfish" or self-interested women who postpone motherhood in pursuit of other academic or professional goals and achievements—who need these costly interventions because it is now too late to get pregnant without them. This image is bolstered by the fact that a large number of the initial treatments occurr in very expensive private clinics, and thus, only those women and couples who have a certain level of resources could avail themselves of them. The picture is the model that has been exported throughout the world and remains central to the way that decision makers and the general public think about infertility.

The problem is that the data about secondary infertility and the suffering it entails has long demonstrated that this vision, or logic, is anachronistic for developing nations. This image neither covers the extent of the problem's prevalence nor the actual epidemiological reality of who is affected and why. Simultaneously, this logic fails to account for ways that this model generates (or perpetuates) inequalities in developing nations. Nevertheless, this photograph taken in Europe during the 1970s remains the preferred one for the media, for public officials, and for health-care workers in Latin American countries when contemplating public policy about these matters.

These unwanted practices . . .

The conservative positions

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The arguments offered by conservatives are wide ranging and generally connected to religious positions. Their objections span from protesting the lack of "naturalness" of ARTs (or the way that these technologies interfere with the natural process of reproduction) to condemning the manipulation and destruction of embryos (which, since this worldview categorizes embryos as persons, is akin in their minds to manipulating and destroying persons) (Luna 1995, 230;

Ratzinger 2008). This is a "relatively" coherent position in that it also rejects birth control (except some methods that they consider natural) and, of course, completely opposes abortion. Although we could criticize this view, it is understandable within the religious dogma from which it stems and is considered acceptable for those who adhere to these faiths. Unfortunately, in Latin America, these positions have strong political backing; they dominate public policy and legislation that is intended to govern the lives not only of the faithful, but also of the entire population.

Feminist positions

At the risk of stating the obvious, feminist bioethics encompasses a variety of positions.[6] Despite this, one can find common threads in their work. Specifically, feminist analyses examine data with a critical and political lens that focuses on unraveling the power structures inherent to the societies in which we live. This lens exposes the patriarchal influences on that society and challenges the inequalities manifested within it, revealing economic and policy differences related to gender. In this sense, feminist bioethics does not present a simplistic view that exclusively evaluates biomedical phenomenon and the latest technology. Instead, it is an approach that always considers the connection between biomedical issues, technology, and the larger context, such as the social determinants of health (questions that involve socialization, education, poverty,and so forth). Considering this backdrop, I will outline the most relevant arguments that explore the implications of these technologies for women in Latin America.[7] Even if some of these arguments reflect a strong international influence, I will not consider this point here; I will focus on the criticisms and positions that are circulating in Latin America and that have had an impact in the region.

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The first such argument points to the lack of naturalness involved in these technologies. The difference between this and the conservative position is that, in these cases, the proposal notes the medicalization of women's bodies that these technologies involve. This argument claims that this is especially worrisome given that the technologies are often very invasive and that the "body they must penetrate" is the woman's (even when the source of the fertility problem is the male partner) (Sommer 1994, 45–50).[8]

A second type of argument circulating in the region highlights the continuation of women's reproductive role. More precisely, it suggests that the desire to have a child is antithetical to attaining women's liberation. A version of this argument points out that these technologies oppress women (Ventura 2005). According to this line of thought, reproductive technologies are part of a patriarchal medical system that can, potentially, abuse women.[9] Moreover, by continuing to support these technologies, society encourages maternity through artificial means and, furthermore, seems to do so without limit (not only through the possibility of women freezing their own embryos—a technology that is increasingly perfected and can be utilized by young women without partners or women when they get older—but also through the possibility of becoming pregnant after menopause, as there are now cases of women who are over the age of sixty) (Olivera 2001; Corrêa 2001a, b).[10] Consequently, some feminist thinkers in the region take up North American Second Wave critiques and claim that "the desire to accede to the demands of assisted reproduction is the product of a new form of ideological manipulation of women (Sommer 1993).[11]

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Many Latin American countries exert social pressures to try some of these treatments when women have difficulty becoming pregnant.[12] The technologies are known and have been in place for over thirty years. The public sees them as options that every woman who wants to

become a mother "must" try if the natural process eludes them. The subtle pressure is strong, at least in some cities where the technologies are heavily promoted.[13] As a result, women feel pressured to submit to invasive and costly procedures (costly not only economically but also psychologically and physically).

A version of this argument is cited by those who examine these technologies from a socialist stance. This perspective analyzes the place occupied by procreation, scientific development, and the division of labor demanded in capitalistic societies. Doing so, according to these thinkers, reveals that medical practice puts too much weight on the individual dimension of health and sickness. And, in a society where women are "forced" to have children in order to meet the societal demand that they become mothers, these technologies can be turned against them (Izquierdo 1993).

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A third line of criticism that has weight in Latin America is rooted in Kantian morality and explores the commodification of women. An example is the possibility of poor women selling their eggs for the benefit of wealthy women (egg donation), a process that requires them to undergo egg stimulation and egg extraction. In some cases, this is a way for the women themselves to obtain desired and costly fertility treatments; in other cases, it is merely a sale of services (Viera Cherro 2012, 257). Similar issues arise in the case of surrogate motherhood. With respect to this situation, these thinkers suggest that one cannot accept a contract that requires a gestating woman to give up her child. Moreover, they argue that it has been legally established that no person can be used as an instrument for achieving someone else's ends and that diverse legislation prohibits using one's body (and its individual parts) for financial gain (Ferrajoli 2006). These arguments have been taken up by Latin American thinkers not only interested in Latin American women but also in Indian women as a major source of gestational mothers—a

fact that exposes the intersections between poverty, inequality, and the possibility of exploitation (Amador Jiménez 2010).

A fourth line of criticism formulated by regional thinkers—and one that is related to the nucleus of this article—claims that the new reproductive technologies generate a social justice problem since they are costly but not very effective. Proponents of this argument state that social inequalities are exacerbated when the state finances such technologies, because treating infertility in this way depletes the already limited health-care budget. Moreover, those same funds could be directed toward other areas of health that would be a higher priority to the population (Sommer 1993).[14]

As shown above, in Latin America, numerous critical positions are very suspicious of these treatments. But, of course, some feminists and women's-rights advocates are not critical of these practices.[15] There are liberal feminists who support these technologies, and some think that they "liberate" women from early motherhood by offering women important opportunities, including the chance to develop their intellectual and professional talents and the opportunity to exercise their autonomy by choosing when to have a child. For these thinkers, the technologies represent one more way to satisfy one's desire to become a mother (Gargallo 1993).[16] In addition, middle-ground arguments combine different aspects of the ideas just outlined (Diniz 2002; 2003; Diniz and Buglione 2002).[17] What I would like to emphasize with this rapid enumeration of these various arguments employed in Latin America are both the variety of positions and the fact that not every vision of feminism per se coincides with support for these technologies.

In contrast to the diverse positions on ARTs, the majority of women's-rights advocates are unified in their commitment to social justice and their support of a full sex life, good sexual

education, and adequate birth control (including access to safe and legal abortions) (Cardaci and Sánchez Bringas 2011; Lamas 2001; Diniz and Costa 2006; Careaga Pérez et al. 1998; Figuerosa 2001; Gonzalez Velez 2008; Bianco 2012). Nevertheless, when we identify infertility only with very sophisticated and invasive ARTs and fail to consider that developing nations also have to face secondary infertility, which is preventable and affects women with scarce resources, we seem to overlook some important issues. This oversight could be attributed to the influence of Anglo-Saxon or European feminism (for which defending a full sex life and access to safe and legal abortions are battles already won, even if lately there have been threats from conservative positions).[18] In the industrialized world, criticisms of ARTs do not affect access to safe abortion or arguments for improved care for women's sexual health. But in Latin America, this is not the case. Since these are still unresolved and pending matters, establishing certain dichotomies could bring about counterproductive results. My reflections are intended to reveal how current analyses examine ARTs, and, more importantly, infertility in Latin America, using a dichotomous lens. Such visions presume that ART and infertility are distinct and separable from women's sexual health care. As we will see shortly, I fear that these approaches will lead to counterproductive results.

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Some problems with implementation

The individualist doctor and the status quo

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When feminists resist these technologies, they do not do so capriciously. They are often left in the cold when defending women's rights and their importance, such as in cases of fighting for legalizing abortion. In Latin America, few physicians or infertility specialists are also willing to be identified with progressive positions or women's rights.[19] To the contrary, a vast majority

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of these providers hide behind photos of beautiful, healthy babies and try to identify with happy motherhood and the success of overcoming barriers to achieving long-awaited pregnancies. They are not ready either to advocate for full sexual and reproductive health services for women or for the decriminalization of abortion.

Similarly, they do not recognize some problematic aspects of their activities. Among these are selective abortion, embryonic selection, and the discarding of embryos. These practices are frequently minimized and obscured in a mantle of ambiguity when practitioners refuse to call things by their name. For example, they use ad hoc terminology such as "embryonic reduction" when they should call this procedure selective abortion or "egg donation" when they mean a sale of eggs (Luna 2001).[20] The use of this terminology is especially relevant in Latin America where the presence of the Catholic Church is very strong and there is a high valorization of embryos (Luna and Salles 2010). This environment generates different legal responses to the practices just described, as seen in Argentina's creation of the position of "The Guardian of the Embryos,"[21] or Costa Rica's attempts to prohibit ARTs absolutely. These responses do not go unnoticed and are not innocuous.[22] To the contrary, they exhibit the resistance, force, and pressure that some conservative and religious groups are ready to exert in the face of these technologies (Luna and Salles 2010).

The circumstances described above help explain why the medical community has chosen to implement these technologies in a private and discrete manner. With the exception of Costa Rica, most Latin American countries do not have specific prohibitions against ARTs in place. These practices are allowed because they are not explicitly forbidden. To prevent altering the status quo, providers have tried to avoid acting in ways that could raise concerns or mistrust. This response, however, not only promotes a false, compartmentalized vision of women's sexual

and reproductive health (as if pregnancy and motherhood had no relation to a full sex life), but also implies a strong degree of hypocrisy and contradiction. It is a response that rejects transparency and shirks away from accepting all that these technologies imply (i.e., abortions, embryo destruction). It encourages a lack of commitment to fight for issues that affect women, and supports a double standard that is prevalent in Latin America (it is one thing what people say they do, and quite another what they actually do).

It is necessary, then, to state explicitly that feminists and others who defend women's rights have hardly encountered allies in many specialists in the ART field. These professionals are happy to grow strong businesses using women's bodies but do not accept their own responsibilities or the paradoxes of their activities. As such, they are neither ready nor willing to support women's fights.

Privatization and excessive over-treatment

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Another potential source of resistance to ARTs is found in the way these technologies have been implemented. With few exceptions, the majority of clinics and centers that offer ARTs, especially in Latin America, do so in a private setting.[23] Delivering these services in this context involves very high economic costs with questionable success rates (given the low fertility rate of the human species as such). In general, those who are interested in pursuing this path begin with the most simple technologies (ovarian stimulation and artificial insemination) and then move toward more complicated, invasive, and costly procedures (in vitro, Intracytoplasmic Sperm Injection [ICSI]). It is then often the case that several treatment cycles are required for a viable pregnancy to be achieved that terminates with the birth of a healthy baby. For this reason, the relatively true perception exists that these infertility clinics receive

juicy dividends for practices that do not necessarily guarantee the long-awaited success that they promise. And, in this sense, the criticisms dealing with economics and the equitable distribution of resources that some local thinkers proffer are relevant (Sommer 1993).

In addition, administering these treatments in the private sphere makes it more difficult to place limits on the desires of the woman or the couple. When treatments are offered through the public health-care system, their use can be regulated; limitations are placed on providers and clients by the state. In the private sphere, by contrast, there are no regulations or strict guidelines stipulating the limits of the treatments (for example, the number of cycles permitted). Instead, the client's "wish" appears to impose itself or direct the process. In many cases, it seems that only economic limitations or the exhaustion and disillusionment of the couple place an endpoint to the process. Beyond this, in the private sphere couples can easily change providers (which encourages providers to accede to the demands of the women or couples). This process, and the lack of appropriate regulation of ARTs in particular, creates vulnerability for the couple and the woman and leads to excessive spending as well as overtreatment. However, it is also true that the lack of regulation results from failing to conceptualize the problem of infertility as a serious public-health issue (in the same sense in which the region has not debated the thorny issue of the status of embryos) (Luna and Salles 2010).

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Now, it is true that some countries in the region allow access to some of these treatments through the public health-care system. This has been the case in Argentina since June 2013, with the new National Law 26.862. Although this may seem like a plausible response to the issue, I do not think that simply making these services available through the public system is adequate for Latin America; we cannot deal with this issue by simply copying the European model of public health[24] or by uncritically adopting the private practice to the public system. Instead, I think that

we must go much further than this and deepen the proposal. It is precisely because the sexual health problems and type of infertility from which people suffer in Latin America are caused by different factors (than in industrialized nations) that we must adopt a public-health focus that uses a different and wider lens.

The logic of "Copy now, think later . . ."

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In addition to the arguments against ARTs already outlined, ideas that go beyond particular ideologies appear to spark resistance to the insertion of these new technologies into our society. I will not label these ideas or reasoning an "argument," as they do not withstand critical analysis or contain a clear argumental structure. Nonetheless, they do seem to function as a hidden logic that, I think, allows us to understand why the current approach to infertility functions as it does.

The initial metaphor of the historical photograph—the image of infertility treatments being offered in private clinics to help middle- and upper-class, professional, educated women have a child in their forties—can now be complemented with an "argument" that I will name "copy now, think later." The mechanism of "copy now, think later" consists of the tendency to copy "imported solutions" from the North and apply them to our own situations in many developing countries. Since, traditionally, these technologies are developed in industrialized nations, much of the technology utilized in the developing world tends to be "copied" as a matter of course. Many times, being "modern and sophisticated" is identified with employing the technology as it was implemented in its nations of origin (bringing the latest equipment and most recently developed treatment options). The problem with this approach is the lack of reflection about how we should execute the move of this technology from the industrialized setting in

which it was developed to our nations. How should one employ technologies imported from abroad in a new context?

The problem is even more serious when the social, cultural, and economic conditions in different regions vary widely. In these cases, great changes must be made in order to adapt the technologies adequately to the new social reality in which they are now being utilized. The social reality at the end of the 1970s was very different in Europe and the United States than it was in Latin America (and this continues to be the case). Starting in the 1960s, many European and North American countries had approved birth control pills and certain types of abortions. And, in 1978, the first test-tube baby was born.[25] Although strong debates and controversies about abortion continue today, the procedure is still legal in practically all industrialized nations, while in Latin America, it is almost always prohibited. The few exceptions that are permitted are those interpreted through a very conservative lens. This policy promotes unsafe abortions that not only harm women and leave them infertile, but also often kill them. This illustrates that the social context in which these technologies are used is very different in different nations. But, “copy now, think later” does not acknowledge this. And, those who pay the price of the prominence of this type of thinking as well as the existence of the historical image detailed previously are not—as popular imagination continues to suggest—middle- and upper-class women who are definitely able to afford such technologies in private clinics. Instead, they are the women in the most vulnerable situations.

To summarize, different questions about ARTs arise in the Latin American context than in the industrialized world. First, the epidemiological profile of the infertile women in developing nations differs from that in industrialized nations. Second, the state of sexual and reproductive rights and liberties in Latin America is far from the reality that existed in the late

1970s or that which currently exists in Europe or the United States. In light of these differences, the provision and implementation of these technologies must be modified to fit the context. Therefore, these decisions should neither continue to be in private hands at great costs, nor be based in anachronistic photographs or on models copied without reflection.

A new agenda including infertility

Given the situation just described, we find ourselves at a crossroads. On the one hand, we have seen that there are a series of theoretical and practical arguments in Latin America that oppose ARTs. On the other hand, the existence of secondary infertility affects poor women in the region and puts its prevention and treatment in the spotlight. The question is: should we consider including infertility and access to ARTs as a related strategy?

Without a doubt, secondary infertility is wedded to many serious issues that have not yet been resolved. Its prevalence is connected to poverty as well as to neglecting the most basic social determinants of health for those who have the least. It also exhibits an underlying devaluation of women who have a full sex life.[26] Latin America is a region with great inequalities and strongly patriarchal societies. Defenders of women's rights have exposed and denounced these circumstances countless times. At the same time, they have been advocating for profound changes and respect for full reproductive rights.[27] This is, undoubtedly, a slow and difficult path that requires a long-term strategy, but it is one that cannot be abandoned.

It is also true that ARTs have gained great prominence and lobbying power in the region.[28] Given this, couldn't we utilize them for the benefit of our own women? I suggest we could think about these technologies in another way: instead of rejecting ARTs outright, could we think about implementing them differently in order to address better the needs of Latin

American women? Obviously, this would not resolve the deeper issues—the true causes of secondary infertility—but perhaps it could be a medium- or short-term strategy that could help change the status quo.

One factor that must be kept in mind about secondary infertility is that its origin is dissociated from its later manifestation. That is, the causes of the infertility can be traced to the woman's past when she did not want to have a child rather than to something in her current situation. This circumstance favors a compartmentalized approach to the problem. For the fertility specialist who arrives on the scene, many years later, the infertility is a fait accompli, an established fact. So, she or he sees no reason to examine the causes of the problem since what matters now is restoring the woman's fertility, which requires costly and invasive treatments. Despite this common way of interpreting the issue, we need not approach infertility in thismanner. On the contrary, cases of secondary infertility are precisely the situations that could be prevented in a simpler, more ethical, and more economical way by trying to avoid some of its causes.

Placing secondary infertility on the agenda, then, both reveals a new way of understanding infertility and provides a broader profile of the women who suffer from it. In order to construct an ethical approach to infertility that will address the needs of these women, we must leave behind the idea of infertility being exclusively associated with complicated and sophisticated technology. Instead, we should use a gendered lens to reconceptualize it as a public-health issue that requires responses aimed, fundamentally, at its prevention and also—but not only—to treatment. Doing so will not only improve responses to infertility, but will also, in a roundabout way, help address other issues that feminists in Latin America have long been fighting for with respect to providing adequate attention to the sexual health of women. Failing

to do so, however, will mean that women traditionally stripped of their rights and resources will escape our vision again and continue to be invisible.

It must be acknowledged that my suggestion goes against the “logic” of these treatments. This is because, for the majority of private clinics, it is easier to work with the established case of infertility. These clinics are structured in such a way that they can only begin to treat the person once the “problem” appears (i.e., when the woman or the couple has fertility problems). The issue is that the logic of this structure is flawed; clinics should be structured to begin with women’s sexual health (rather than with women already infertile). Those using a gendered lens would advocate to strengthen primary health systems or create new types of fertility clinics equipped to prevent secondary infertility. They could offer a range of services that would include adequate treatment of STDs, birth control, and access to safe abortions in order to avoid unwanted pregnancies.[29] In addition, they could educate young women on what kind of care is necessary to achieve a later or subsequent pregnancy (from adequate nutrition, folic acid supplements, all the way to determining the best times to get pregnant). Finally, they could offer a realistic view with respect to the successes and limits of reproductive technologies. Rather than offering women and couples unlimited access to whatever type and number of treatments they could afford, the number of cycles and embryo transfers, the specific technologies that can be used based on age and specific circumstances, an accurate estimation of the costs, and other factors would all be delineated.

Joyce 12/2/13 11:15 AM
Comment [26]: Sentence is awkward.

This entire vision and proposal implies a public-health perspective organizing women’s sexual and reproductive health in a way that makes using costly and invasive reproductive technologies a last resort. In this sense, my suggestion is to distance ourselves from the U.S. model of private practice and the European model of public health that is centered around ARTs.

The main difference is that, in order for this vision to make sense, at least for Latin America, ARTs should not be the point of departure or the center of attention. Instead, prevention and integrated sexual and reproductive health care for women should take center stage. In this integrated conception of women's sexual and reproductive health, ARTs are just the last step in a series of public policies aimed at preventing infertility, as well as unwanted fertility. Furthermore, my proposal tries to lead to the following: if infertility is included in the agenda as a public-health problem, the state should necessarily assume its responsibility for secondary infertility indirectly caused by it (either through the state failing to provide adequate sexual and reproductive health care and/or by state prohibitions on sexual and reproductive rights). The solutions suggested by exploring infertility through public-health and gendered lenses, then, seem ethically required and respond to various needs that go unmet in Latin America.

New alliances? Recognizing icebergs

In order to adopt this new perspective—in order to leave aside the current view that compartmentalizes sexual and reproductive health and rapidly responds to problems by offering sophisticated, technological solutions—one not only needs a different understanding of sexual health and ARTs, but also different alliances. In this case, we should seek new alliances among fertility specialists and women's-rights advocates.

With respect to physicians, those who offer assisted reproduction need to adopt a gender-sensitive perspective. They should note the seriousness and prevalence of secondary infertility, the importance of women having access to good sexual health care, and should acknowledge all of the costs involved with infertility (not only physical, psychological, and economic costs for the woman, but also the social costs involved). Beyond this, they should explain—whenever

possible—that there are large numbers of women suffering from secondary infertility in the region and, as such, should emphasize that the issue cannot be avoided. Finally, these specialists should abandon the double standard most of them actually endorse, and take a more transparent position with respect to their own practices. They should recognize that they, themselves, on occasion, utilize procedures that imply or require abortions. A transparent discourse about ARTs, embryos, and abortions would be a significant step forward and would imply a much more logical, ethical, and equitable approach to the problem.

On the other side, instead of continuing to distance ourselves from ARTS, I wonder whether feminists should start exploring new strategies regarding ARTs and infertility, as these physicians could be natural allies in fights concerning sexual and reproductive health care. Even if we do not approve of these technologies, they are already well-entrenched parts of our societies and are supported by a strong lobby. Perhaps feminists should leave aside animosities and critiques and recognize that the Latin American situation is far from that which is depicted by the "historical photograph." This would mean examining the larger panoramic picture of the actual reality in Latin America. Feminists may support physicians and infertility specialists if they could explain the dangers and injuries that are inherent to certain practices, if they could help eliminate some of the "veils of holiness" that surround embryos and fetuses in Latin America, and offer objective information that could help influence health-care policy decision making at the legislative level. Moreover, we could move forward toward a dialogue that is more frank, transparent, and, perhaps, could even help break barriers in the discussion about abortion in the region.

This proposal, which, at first glance, may seem trivial or obvious, is actually far from it in a region decimated by double standards and a lack of solidarity with poor women. A transparent

discourse on the part of specialists would be extremely important for the society as a whole and would be a great help to feminists and women's-rights advocates in particular. We must get to a point where the fertility specialists and other health-care providers visualize infertility as if it were an "iceberg" and openly recognize that many of its causes (e.g., poor sexual health care, unsafe abortions) are under the water, invisible. This enormous but invisible mass of ice requires our attention. It is true that, at first glance, this new approach may not seem very tempting for these specialists; they could feel that they may lose part of their juicy profits and that they are being asked to enter turbulent waters. However, it is also true that not all of these specialists feel comfortable with the double standard already described and that some are aware that permitting conservative public policies with respect to, say, abortion, could, at any moment, boomerang and turn against them.

Beyond this, some specialists are already sensitive to these issues and could help open a new path.[30] They should call on their colleagues to be more strategic and more generous. They should call on them to recognize the importance of prevention and of taking a holistic view of the problem that recognizes that, even if their sophisticated technologies would not be the first approach or the priority, they could, otherwise, be part of a larger, gender-sensitive, and ethical approach. And, if they heeded this call, they could have the support of many feminists who seek an effective strategy for women's health (and not only from liberal feminists).[31]

In addition to the reasons detailed above for bringing these groups together, I think that we find ourselves at a crucial moment and must evaluate the risk of losing this "opportunity" to form these alliances. In fact, dangerously, in Argentina a new law is proposing to think in a dichotomous way about embryos. The draft of the new Civil Code[32] distinguishes between embryos *in utero,* who are considered persons, and embryos *ex utero*, which are not considered

equally, so that they can be used in ARTs (Luna 2012).[33] A similar path was made by the Interamerican Human Rights Court regarding embryos in the case against Costa Rica. In addition, as explained, a few months ago, just in June 2013 publicly funded treatments for ARTs should be provided;[34] so new services in public hospitals should be designed. What are the implications of these proposals? The answer is that ARTs will continue to progress toward legalization and established implementation while abortions will continue to be illegal and those who promote them will be persecuted. Unfortunately, this situation closes off opportunities and makes the path to decriminalizing abortion even more difficult. If we keep in mind these legal maneuvers and the dangers that they could create, it seems even more important to begin working with a new gendered lens in relation to ARTs to try to gain new allies.

Joyce 10/31/13 11:30 AM
Comment [27]: This sentence is confusing.

With this new way of looking at the issue, we would try to accomplish the following. First, we would offer a vision of infertility that accords with the situation in Latin America (as well as with many developing nations in other parts of the world). Second, we would include women who are invisible through the actual implementation of ARTs. Third, this approach would indirectly expose the great shortcomings of the health-care systems and their unresolved problems with respect to sexual and reproductive health—continuing the larger feminist battle from a different angle. Fourth, we would move toward a discourse on how abortions are conducted in the region that is more ethical and transparent. And, finally, we could get more "allies" who, instead of promoting only the most sophisticated and costly ARTs as the primary solution to the problem, could commit themselves to a unique and coherent discourse with respect to women's fertility and infertility in ways that offer credibility to feminist claims. For all of these reasons, the alliance between women's-rights advocates and infertility specialists could

present the problem of sexual and reproductive health differently and offer decision makers the same monolithic advice.[33] As a result, such an alliance could have a major impact.

Conclusion

This proposal does not follow the usual views of public health with respect to assisted reproduction (models such as those in Belgium, England, or Sweden). I suggest that the traditional model is inadequate, at least for Latin America, because it fails to recognize the existence and impact of secondary infertility. We must move on from the traditional view and instead formulate a much broader approach to infertility. Doing this through primary health-care systems or by means of “Women’s Health Clinics” or via some other mechanism would be the work for public-health specialists. My point here is not to develop and specify these models. Instead, my intention is just to suggest a new challenge and warning to those who are seriously interested in women’s sexual and reproductive health in Latin America.

Giventhis, the approach outlined could be one in which everyone wins. In general, women win by achieving a more realistic and relevant vision and response to the problems from which they suffer (avoiding costly and invasive treatments by preventing the occurrence of infertility). The health-care system would win because it would avoid being drained by expensive treatments. As a result, health-care systems could offer more equitable and logical solutions to women and their partners. Women’s-rights advocates would win because they could count on more “allies” to support their fights for improved women’s sexual and reproductive health care (for example, in having the power to demonstrate the importance of legalizing abortions). And infertility specialists would win because they would have the ability to operate under a more coherent and transparent view that does not limit certain kinds of their practices.

Now, I must recognize that, in my proposal, infertility specialists could lose some possible clients. It is also true that these specialists would have to "sacrifice" the aura of "holiness" that they try to give their practices, recognizing the dark edges that, traditionally, they have tried to minimize. However, if their arguments are more transparent, infertility specialists could do their jobs with more peace, without fearing possible "Guardians of the Embryos"[34] or worrying about having to close their practices because of pseudo-scientific issues.[35] Therefore, they too would win with this strategy.

Perhaps we have arrived at the time to abandon anachronistic photographs, consider the size of the iceberg that we face, and think strategically about an extremely complex present.

Acknowledgments

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Notes

Joyce 12/3/13 10:11 AM
Comment [28]: Notes need attention for numbering issues.

1. There are two ways of understanding the term *secondary infertility.* The first refers to pregnant women who have spontaneous abortions and who were unable to conceive after that initial pregnancy. The second meaning alludes to the infertility that results from infections or unsafe abortions. I will focus on the second meaning. See Luna (2008, 5).

2. How to define *progressive* is very complicated; see Salles (2012). In this article, I only consider *progressivism* as it manifests itself in Latin America. In very general terms, one could say that it deals with visions defending the rights of women and LBGTQA individuals (i.e., with regard to marriage equality, respecting sexual identity).

3. A fantasy suggests that developing countries lack major issues of infertility. In general, people assume that these nations are overpopulated, and that the population is young. It is true that many women have children from a young age; hence, infertility does not appear to be a widespread problem. This is not the case; many women have fertility problems.

4. In Latin America, the statistics vary. In the Caribbean in 2008, there were thirty-eight procedures for every thousand women, of which 46 percent were considered unsafe. However, in Central and South America, there were twenty-nine and thirty-two procedures per thousand women respectively, and *100 percent of those were considered unsafe* (Sedgh et al. 2012). It is likely that the explanation of the difference results from policies with respect to abortion in Cuba, one of the few countries in which abortion is legal.

5. Blocking access to contraception and safe abortions (even when not punishable), resisting health policy by arguing for conscientious objections, among others.

Kate Caras 12/12/13 8:27 AM
Comment [29]: This is a sentence fragment.

6. Within the extensive feminist bioethical literature, the following are just a few international works on this topic: Tong (1997 and 1989); Sherwin (1992); Donchin and Purdy (1999); Jaggar and Young (1998). On feminist thinking in Latin America, see Femenías (2002 and 2005). And, with respect to the diverse feminist positions regarding ARTs, see Puigpelat Marti (2004).

7. In what follows, I complement the work done by Cardaci and Sánchez Bringas (2009) with my own research on the topic.

8. One could argue that unintentionally with a strategy that tries to protect women, this analysis again depends on the idea of the natural as the good. However, this argument is not really based in ideas of "the natural," but rather is fundamentally an argument against the medicalization of women's bodies. While in the conservative argument everything that is not natural is condemned, the feminist argument primarily condemns the inequality in medical technology, illustrating how it often invades women's bodies without restriction and, many times, without respect. I am grateful to Julieta Arosteguy for this point.

9. This follows a similar line of thought as FINRRAGE (*Feminist International Network of Resistance to Reproductive Genetic Engineering*). Brazil also has a strongly critical feminist movement. See Corréa (2001); Ferreira et al. (2007); Puigpelat Marti (2004, 73–75).

10. One must also note that these technologies can be used in cases of immunological disease, and in cancer prior to chemotherapy or radiology.

11. Translator's Note: "El deseo de acceder a la reproducción asistida es producto de una nueva forma de manipulación ideológica de las mujeres."

Joyce 11/27/13 11:13 PM
Comment [30]: OK to have this?

12. Puigpelat (2004) also explains that these technologies are patriarchal cultural instruments (74).

13. For example, through women's magazines as well as in mass media communication via soap operas whose characters seek out these treatments, or in discussions of similar cases that have enormous degrees of controversy.

Kate Caras 12/12/13 8:30 AM
Comment [31]: Again, this is a sentence fragment.

14. This argument is especially relevant when the private model of health care is translated directly to the public health-care system.

15. It is important to clarify that these are just general lines of argument and that, in addition to these, each of the technologies (artificial insemination, in vitro fertilization, ICSI,

paying a gestational surrogate, etc.) creates its own specific questions and arguments. See Luna and Salles (1995).

16. This variant of feminism is also known as *liberal feminism* (as opposed to the socialist feminism mentioned earlier).

17. Various Latin America feminists, like Debora Diniz, accept these practices in general while still proposing objections to certain specific aspects.

18. I am aware that in some industrialized countries, abortion, even though it is accepted, continues to generate controversy and debate. This is especially relevant in the United States.

19. Of course, notable exceptions exist as well. Here I am referring to the most common and widespread position in the region.

20. This procedure is done when there is a multiple-embryo pregnancy; some of the implanted embryos are aborted so as to let one embryo develop.

21. In Buenos Aires, the legal system invented the figure of the “Guardian of the Embryos” (*Tutor de los embriones*) in 2004. This justice official must watch over the embryos to ensure that fertility clinics do not discard them. Although in recent years the person in charge has changed and the situation has calmed, this figure still legally exists. See Cano (2006).

22. For example, in Argentina until 2011 it was impossible to pass a law regulating these practices because the topic of embryos is so provocative. The majority of projects were very restrictive and interfered with the medical decision, or lacked support and could not generate a minimum consensus.

23. However, this is changing in Argentina: the province of Buenos Aires instituted Law 14.208 in December 2011 and National Law 26.862 in June 2013. Both laws require the public system as well as all health insurers to offer ARTs.

24. Not all European countries function in the same way; here I am thinking of models in countries such as Belgium, Switzerland, England, or France, that provide these services as part of the public health-care system.

25. In 1973, the case of *Roe v. Wade* in the United States permitted abortions by trimester.

Joyce 12/2/13 11:24 AM
Comment [32]: Not clear what this means.

26. Consider that several Latin American countries forbid abortions under any circumstances. For example, Chile prohibits *all* abortions, even if the life of the women is in danger or if she was raped.

27. I will only mention a few works from an extensive list that reflects these concerns and positions: Cardaci y Sanchez Bringas (2011, 257–65); Lamas (2001); Diniz y Costa (2006); Careaga Pérez et al. (1998); Figueroa (2001); Gonzalez Velez (2008); Bianco (2012).

28. See note 23.

29. Of course, some teenage pregnancies cannot be prevented through providing information and birth control; the pregnancies have roots in deeper problems such as dogmatism, or in the idea that motherhood provides a complete valorization of women. We have already mentioned deep societal inequalities. But if safe abortions could exist, those women who do not want to continue the pregnancy would not have to face sequelae because of unsafe abortions. On this point, I am grateful to the comments of an anonymous reviewer.

Joyce 12/2/13 11:29 AM
Comment [33]: Word ok?

30. Fertility specialist Polak de Fried denounces this type of infertility and its causes, recognizing that prevention and education continue to be the most important objectives in relation to infertility in developing nations. She emphasizes prevention and then moves on to diagnostics and treatment, suggesting that all of these steps be included in health-care clinics. See Polak de Fried (2009, 85).

31. See note 16. This should not be taken to imply that it would lead to an abandoning of fundamental fights against domestic violence, feminicide, sexual violence, the second shift, or safe and legal abortions.

Joyce 12/2/13 11:30 AM
Comment [34]: Word ok?

32. See Article 19 of Proyecto de Código Civil y Comercial de la Nación 2012. One must keep in mind that in the French legal tradition, this document is fundamental; it structures and legislates a large part of daily practice.

33. For a criticism about this dichotomous way of approaching embryos, see Luna (2012). At the time of composition, the distinction between types of embryos still is not accepted, and embryos continue to be considered persons. This shows again how there is still an enormous pressure of conservative positions.

33. In fact, a somehow similar strategy was used by Mexican feminists from Mexico City in order to achieve legalized abortion. They united with recognized physicians, gynecologists, and researchers in order to support their demands. These alliances gave more credibility and force to their proposals.

Joyce 12/3/13 9:52 AM
Comment [35]: There are two notes numbered 33.

34. See note 21.

35. See the case against Costa Rica in Luna (2008); Brena (2012); CIDH (2012).

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Joyce 11/28/13 9:41 AM
Comment [36]: Spell out.

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Joyce 11/28/13 9:43 AM
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Joyce 11/28/13 9:43 AM
Comment [38]: Mexico City?

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Joyce 12/2/13 11:33 AM
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Joyce 11/28/13 9:52 AM
Comment [40]: Country or state?

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Joyce 12/2/13 11:32 AM
Comment [43]: Page numbers do not make sense.

Joyce 11/28/13 9:57 AM
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Joyce 11/28/13 9:59 AM
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Joyce 11/28/13 10:00 AM
Comment [48]: Please add other names.

Joyce 11/28/13 10:02 AM
Comment [49]: Page numbers.

Kate Caras 12/12/13 8:39 AM
Comment [50]: Joyce: Shouldn't this be Frank Van Balen and Marcia Inhorn?

Joyce 11/28/13 10:04 AM
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Joyce 11/28/13 10:04 AM
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