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SYMPOSIUM: IVF - GLOBAL HISTORIES

Resources and race: assisted reproduction in Ecuador

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Abstract This article considers the early period of development of IVF in Ecuador, focusing on factors that shaped the decade after the nation's first successful IVF birth (1992–2002). It describes how a poorly resourced public healthcare sector compelled Ecuadorians towards private-sector medicine, which included assisted reproduction treatment, and how IVF clinics drew patients through the pervasive racial inequalities that characterise post-colonial Ecuadorian society. More generally, the development of assisted reproduction treatment in Ecuador exemplifies themes in 20th century healthcare provisioning and inequality in Latin America, making it essential to understand this larger picture when considering Ecuador's IVF industry both within the region and also internationally.

KEYWORDS: Ecuador, health care systems, IVF, Latin America, private sector health care, race

Introduction

In the years leading up to the birth of Ecuador's first test-tube baby in 1992, the mainstream media publicised the possibility of locally produced 'test-tube babies' as a sign of successful scientific and national progress (Bustamante, 1989; Gomez, 1991). However, this breathless praise of Ecuadorian biomedicine contrasted with the experience of IVF practitioners, who, in the decade after the birth of the first Ecuadorean IVF baby, constantly lamented the difficulties of conducting 'peripheral' biomedicine, especially in regard to obtaining equipment and supplies for this resource-intensive activity. Media commentary about 'technological progress' also contrasted with the experience of women, and their supporters, undergoing IVF. IVF patients in Ecuador, about a third of whom were working class, often experienced the IVF process positively, not because of its scientific modernity, but because their time in private IVF clinics involved highly desirable, personal and paternalistic levels of care conspicuously absent in Ecuador's under-resourced public healthcare

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settings. Within Ecuador's unequal racial history, this kind of personal care allowed patients and their children to become 'whiter' in a terrain where race is not an essential state, but a dynamic process shaped by access to resources, like medicine, education and employment (as discussed in 'Resources and race', below). Thus while IVF practitioners bemoaned their technological shortcomings, the paternalistic care they offered in their clinics attracted patients through the promise of whitening, reinforcing Ecuador's longstanding racial hierarchies.

This article considers the early period of IVF in Ecuador (1992–2002), focusing in particular on how the nation's longstanding racial hierarchy and lack of resources shaped its development. In my ethnographic fieldwork carried out from 2000 to 2007 in six of Ecuador's eight IVF clinics, I traced how a poorly resourced public healthcare sector compelled Ecuadorians towards resource-rich, private-sector medicine, including assisted reproduction treatment (Roberts, 2012a, 2012b). Ethnographic observations of daily life in Ecuador during this period also provided context for how resource access exacerbated pervasive racial inequalities that characterised post-colonial Ecuadorian society. Thus IVF clinics attracted patients partly through their ability to whiten patients and their potential offspring through resources. More generally, the trajectory of assisted reproduction treatment in Ecuador exemplifies the development of 20th century healthcare provision in highly unequal and underdeveloped Latin American nations, making it essential to understand this larger picture when considering Ecuador's IVF industry within the region and around the globe.

Throughout the 20th century, several Latin American nations, particularly Mexico, Colombia, Brazil, Chile, Costa Rica, Uruguay and Argentina, nations with a well-developed state apparatus, developed excellent public healthcare and social security systems based on progressive models of social welfare (Molina et al., 2001). While access to healthcare in these nations tended not to be universal, often linked only to formal-sector employment, marriage or residency in urban areas, the governments of these nations nonetheless created and sustained relatively robust public healthcare systems and healthcare education infrastructures. The so-called neoliberal turn towards the end of the 20th century, characterised by internationally mandated austerity measures and the privatisation of healthcare across Latin America, roughly coincided with the introduction of IVF technology, and consequently most of the early development of assisted reproduction treatment in the region occurred within private medical facilities. However, it was the nations with histories of strong public healthcare infrastructures where the largest and most comprehensive Latin American IVF industries developed, such as in Brazil, Colombia and Argentina, locations that also became hubs for 'elective' forms of healthcare, such as plastic surgery. Thus, growth and innovation within these privatised industries was made possible through the earlier resources allotted to public health provisioning that involved well-organised medical training and robust supply chains for pharmaceuticals and equipment – a fact that is often unacknowledged in the celebration of privatisation and for-profit medical services such as assisted reproduction treatment, plastic surgery, and also medical tourism (Wilson, 2011).

The nations with strong public healthcare systems in Latin America were historically the most prosperous (Huber and Solt, 2004). Poorer Latin American nations, those with a much larger percentage of surviving indigenous peoples after the conquest, especially in Central America and the Andes, tended to have progressive constitutions and laws guaranteeing public health services, similar to more prosperous nations. But these healthcare services were rarely delivered as promised (Coronil, 1988; Roberts, 2012b). This history of under-performing health sectors rendered the neoliberal austerity measures imposed during the 1990s and 2000s somewhat redundant because there had never been a viable social welfare system that could be 'rolled back' to reduce public expenditure. In these nations, the lack of public health provisioning led directly to the development of an IVF industry that was under-resourced from the outset.

The division between relatively prosperous and relatively poor nations in terms of infrastructure and state presence also affected the ability of the Catholic Church to influence IVF practice across Latin America. The Catholic Church is the only major world religion that absolutely condemns all forms of assisted reproduction. The nations in Latin America with relatively robust IVF industries that emerged out of strong state-organised healthcare systems were also the nations with a stronger 'rule of law' than the nations where the Church had a more tangible presence in influencing legislatures and shaping policy. In Costa Rica for example, which had a robust nation state, excellent healthcare infrastructure and strong Church presence, IVF was banned from 2000 to 2015. In my own ethnographic encounters with assisted reproduction treatment practitioners from Chile and Argentina at Latin American assisted reproduction treatment conferences, they described their strategies to deflect the twin attentions of clergy and lawmakers; e.g. promoting GIFT (gamete intrafallopian transfer) or ZIFT (zygote intrafallopian transfer) in clinic publicity or minimising embryo freezing. This concern did not emerge in my work with practitioners in Ecuador who regularly asserted that neither Church censure nor any resultant legal regulation of IVF would affect their clinical practice.

Ecuador's healthcare landscape

Ecuador was one of the Latin American nations with poor public health provisioning and IVF developed within this context. This weak healthcare infrastructure was partially shaped by Ecuador's late 20th century's political instability. From 1996 to 2004, Ecuador had nine presidents, almost all overthrown, some within days of the start of their presidency. In this period urban poverty increased from 19% to 30% (Clark and Becker, 2007; Gerlach, 2003; Sawyer, 2004). During this time, people increasingly avoided interacting with state representatives and services, avoidance made possible by the flourishing of private medicine, along with private education and private security.

Throughout the late 1990s and early 2000s Ecuador had some of the leading indicators of poor health in Latin America (Crandall et al., 2005), and only 2% of Ecuador's annual budget was allocated to public health, with only Haiti spending less (Vos et al., 2004). The Ecuadorian constitution