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COMMENTARY

Is global access to infertility care realistic? The Walking Egg Project

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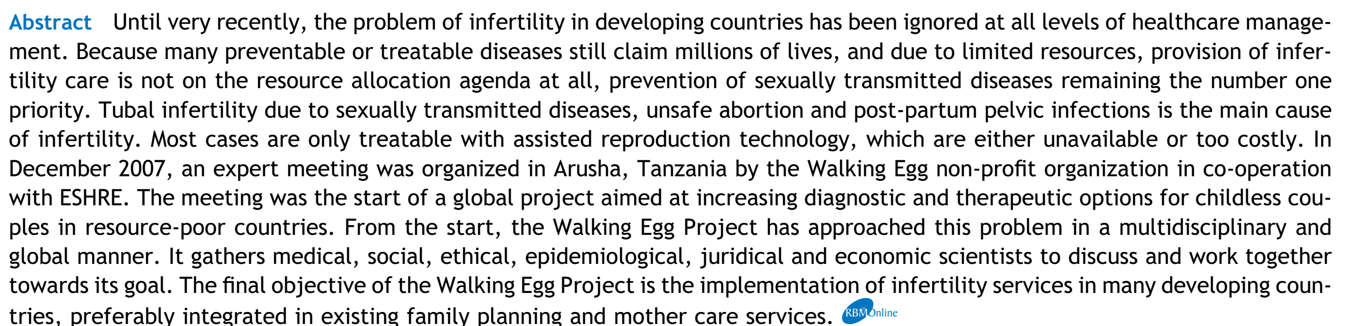

Abstract Until very recently, the problem of infertility in developing countries has been ignored at all levels of healthcare management. Because many preventable or treatable diseases still claim millions of lives, and due to limited resources, provision of infertility care is not on the resource allocation agenda at all, prevention of sexually transmitted diseases remaining the number one priority. Tubal infertility due to sexually transmitted diseases, unsafe abortion and post-partum pelvic infections is the main cause of infertility. Most cases are only treatable with assisted reproduction technology, which are either unavailable or too costly. In December 2007, an expert meeting was organized in Arusha, Tanzania by the Walking Egg non-profit organization in co-operation with ESHRE. The meeting was the start of a global project aimed at increasing diagnostic and therapeutic options for childless couples in resource-poor countries. From the start, the Walking Egg Project has approached this problem in a multidisciplinary and global manner. It gathers medical, social, ethical, epidemiological, juridical and economic scientists to discuss and work together towards its goal. The final objective of the Walking Egg Project is the implementation of infertility services in many developing countries, preferably integrated in existing family planning and mother care services.

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Infertility is a global reproductive health problem. Recent data on the worldwide prevalence of involuntary childlessness indicate that 52.6–72.4 million couples could benefit from some form of medical intervention to achieve a pregnancy (Mascarenthas et al., 2012), the 12-month infertility prevalence rate in less-developed countries ranging from 6.9% to 9.3% (Boivin et al., 2007). The consequences of involuntary childlessness are usually more dramatic in developing countries when compared with Western societies, particularly for women, an observation explicable by differences in: (i) sociocultural values surrounding procreation and infertility; (ii) the economic impact of being childless; and (iii) the availability and affordability of infertility treatments. These negative consequences include stigmatisation, isolation, being ostracized, disinherited and neglected by the entire family and even the local community (Dyer et al., 2007; Gerrits and Shaw, 2010; Ombelet et al., 2008; Van Balen and Gerrits, 2001). Many families in developing countries depend completely on children for economic survival and so childlessness can be regarded as an important social and public health issue (Dhont et al., 2011; Dyer et al., 2007; Ombelet et al., 2008).

The most important reasons for infertility in developing countries are the high incidence of sexually transmitted diseases (STD), which affects both men and women, and pregnancy-related infections, due to unsafe abortions and home deliveries in unhygienic circumstances, mainly in rural areas. The high prevalence of genital infections in developing countries is commonly compounded by a

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complete lack of diagnosis together with incomplete, inappropriate or no intervention at all. Yet, severe male infertility due to STD and female infertility as a result of tubal block can only be treated by 'expensive' assisted reproduction technologies, which are not available at all or only within reach of those who can afford it (the fortunate few), mostly in private settings (Ombelet et al., 2008). On top of this, marital instability and polygamy, as reactions to infertility and childlessness within the conjugal relationship, may increase the spread of HIV1 infections (and STD) (Dhont et al., 2011).

Despite the severe burden associated with childlessness in developing countries, infertility care remains a low priority for local healthcare providers and community leaders (Fathalla et al., 2006; Ombelet et al., 2008). A shift in attitude towards providing infertility care in developing countries has resulted in attempts to explore low-cost treatments suitable in resource-poor settings, a positive and crucial development. According to Vayena (2009), future steps should consider studies on national infertility needs, the position of infertility services within comprehensive reproductive health programmes and equitable access to infertility care.

Promises, promises, promises ...

'Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to raise a family'. This statement was adopted 65 years ago in the 1948 UN Universal Declaration of Human Rights. Relevant reading of this 'right' shows that people should not have (legal) barriers to founding and raising a family. Whether this right also generates a duty to states to offer a particular type of service remains debatable. The human rights argument was used to argue for lifting the prohibition on offering IVF to the population in the recent case brought against Costa Rica (Zegers-Hochschild et al., 2013). Thus, the Inter-American Court of Human Rights (the Court) has ruled that Costa Rica's Supreme Court judgment in 2000 prohibiting IVF violated the human right to private and family life, the human right to found and raise a family and the human right to non-discrimination on grounds of disability, financial means or gender. The jurisdiction of the Court is widely accepted in Latin America, and legal systems of member states of the American Convention are inclined to defer to its rulings. The Inter-American Court's landmark human rights decision, structured upon robust scientific evidence, directs states and governments on the reproductive rights they must provide and must not ban. This may open new pathways in the defense of women's rights worldwide (Zegers-Hochschild et al., 2013).

At the United Nations International Conference on Population and Development in Cairo in 1994, the following statement was made 'Reproductive health therefore implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so ... and to have the information and the means to do so ...'. In 2004, the World Health Assembly proposed five core statements, including 'the provision of high-quality services for family-planning, including infertility services' (World Health Assembly, 2004). Political statements and commitments require appropriate actions, but progress towards the attainment of these goals with regard to infertility in developing countries remains almost non-existent. The reasons are multiple and include; (i) the problem of 'brain drain'; (ii) the lack of collaboration between non-governmental organizations, civil society groups, the government and the research community; (iii) budgetary constraints; and (iv) lack of political commitment (Fathalla et al., 2006). The most important international non-profit organizations (NPOs) including Family Health International, World Health Organization (WHO), International Planned Parenthood Federation and The Population Council still focus on safe motherhood, the reduction of unsafe abortions, and the prevention of STD and HIV/AIDS. The implementation of infertility treatment in developing countries is not a priority for these organizations, which means that provision of infertility care and providing assisted reproduction services are not on the resource allocation agenda (Vayena et al., 2009).

Milestones

The first important initiative to highlight the implications of childlessness in developing countries was a meeting, 'Medical, Ethical and Social Aspects of Assisted Reproduction', organized by the WHO in 2001 (Vayena et al., 2002). Among many different recommendations it was stated that; (i) infertility should be recognized as a public health issue worldwide, including in developing countries; (ii) policy makers and health staff should give attention to infertility and the needs of infertile patients; (iii) infertility management should be integrated into national reproductive health education programmes and services; and (iv) assisted reproduction treatment should be complementary to other ethically acceptable, social and cultural solutions to infertility. However, progress towards the attainment of these goals remains slow. Infertility prevention remains the main objective of the WHO and the budget for infertility-related reproductive health programmes is even now very limited. A second milestone was the foundation of a Special Task Force on 'developing countries and infertility' by European Society of Human Reproduction and Embryology (ESHRE) in 2006. This initiative was important in convincing many infertility specialists of the need for accessible infertility care in developing countries.

The Walking Egg: a non-profit organization

As described above, there are plenty of reasons for starting a project to emphasize the magnitude of the problem, to raise awareness of the suffering caused by infertility, and to seek solutions, which can be accepted and adopted by politicians and healthcare providers. This is why The Walking Egg NPO was founded. The main goal of the Walking Egg Project is to make infertility care in all its aspects widely available and accessible and, from the outset, the Walking Egg NPO has opted for a multidisciplinary and global approach towards the problem of infertility in developing countries. This project can only succeed if the calculus of infertility care in terms of availability, affordability and

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