

**Institutions that Matter: IVF, Abortion and Reproductive Governance in Ecuador**  
**Instituciones con trascendencia: FIV, el aborto y gobernación reproductiva en el Ecuador**

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IVF in Ecuador

- Flourishing industry – 12 private clinics in a poor country of less than 12 million people.
- 25% of IVF patients in Ecuador are *sin* or *bajos recursos*, without much money.
- Catholic Church against IVF because it's akin to abortion.

Sandra's tiny cinder block house in the northern Quito sat near a decaying public hospital. Inside Sandra waited to tell me about her abortions. I came to talk to her about her failed IVF cycle, but the abortions, illegal in Ecuador, needed telling, especially the third one that nearly contributed to her death. She had been young, fifteen, recently migrated to the city from the south to escape the sexual abuse of her mother's new husband. She found work in a canning factory and she met Luis, a truck driver, twelve years her senior. The first and second abortions went fine. The third had been ectopic but the abortionist had no way of knowing that. All seemed well right after the abortion. But within a day she was in terrible pain, and she began to bleed. Luis took her to the Voz Andes, a Christian hospital where the doctors told her she had an ectopic pregnancy and would need surgery. The embryo had lodged in one of her fallopian tubes, instead of her uterus, bursting soon after the abortion, which it turned out, hadn't aborted anything at all. The operation was too expensive at the Voz Andes so Luis got her to a city hospital where Sandra had some social security through her work. (This was the late 1980s

when there were more low income social security benefits). Sandra was sent home a few days after the surgery but had to return immediately when she began bleeding again from a massive infection. Back at the hospital she had more surgery to correct some mistakes the surgeon made the first time. Sandra told me “I regretted everything. I was such a coward. I didn’t think I could have had a baby. It seemed too difficult. I didn’t want to be a single mother.” Soon after she and Luis got married and tried to have a child, but she never got pregnant again. For ten years Sandra took hormones, pills and herbs. But nothing worked.

When Sandra first heard of IVF she wanted to do it right away. It sounded wonderful to her, despite the Churches’ condemnation of IVF, which seemed “antique” to Sandra - “God is giving the scientists a way to make babies.” But she and Luis didn’t have much money. They saved for six years to do the cycle at Dr. Madera’s private clinic. During the cycle Sandra had been so hopeful, dreaming of a baby to keep her company when Luis was gone. She had prayed to the Virgen Del Cisne while she waited. But the IVF cycle didn’t work. Now she wondered if she should try again. They had spent over \$10,000 so far. It would be about \$5000 for another cycle. But their car had been stolen for the second time, and Luis was making about \$600 a month, a good salary, but not much in face of the cost. Maybe they could borrow more money.

I met a lot of women in Ecuador like Sandra, women without much money, who showed up at IVF clinics years after they had undergone abortions gone awry. While in my view abortion’s illegality profoundly shapes women’s experience of the procedure in Ecuador (especially poorer women), most of the women I met did not describe their abortions in terms of legality or illegality or in terms of rights, their “right to choose,” or a fetuses “right to life”. For most of them, abortion was carried out in negotiation with God. For Sandra that negotiation ended badly, in infertility.

Sandra's misfortune was to be young, recently migrated to the city, and without much money or support from her family or the wherewithal to get birth control as a teenage girl. She lived in a nation where abortion is illegal, yet ubiquitous. – (Latin America has highest rates in the world, even though illegal nearly everywhere. Women with money can get very safe clandestine abortions in clinical settings. ) When Sandra did get pregnant the third time she didn't have the means to seek out private clinical care for a clandestine abortion, where a clinician might have used an ultrasound scan to see that her pregnancy was ectopic and prevented the tubal damage she suffered. Sandra's life circumstances gauge how state policies come to rest in certain bodies and not others. Over a decade later these circumstances delivered Sandra into a private and expensive IVF clinic where she became subject to a different form of governance. By walking through the doors of Dr. Madera's private IVF clinic Sandra shifted from a citizen into a client with a patron, Dr. Madera, lord of his own small domain.

This paper concerns what Lynn Morgan and I call *reproductive governance* – meaning the mechanisms through which different historical configurations of actors, such as state institutions, churches, hacienda owners, private doctors, donor agencies and NGOs use legislative controls, personal interactions, economic inducements, moral injunctions, and ethical incitements to produce, monitor, manage and control reproductive behaviors and practices (2008). From the abortions to her IVF cycle Sandra was subject to two forms of governance - that of state institutions and laws as member of the subjugated urban proletariat and that of the private medical clinic which is one of the several elite domains in Ecuador that have historically appeared to stand outside of state oversight.

Women like Sandra are the subject of greater reproductive governances by the state than wealthier women who don't make use of state services. The laws against abortion are constantly flouted by women of all classes but it women *sin recursos*, who are more greatly affected by the law

because of their difficulty in accessing private or safe clandestine clinical abortion. When Sandra began to bleed, from what she thought was a botched abortion, her care was mishandled in the public city hospital which they had tried to avoid by going to a private Christian hospital. Deborah Poole argues that, in the Andes, sites of interface, where the state demands payment or distributes services are where poor and indigenous citizen subjects are made to learn the “gap between membership and belonging” (Poole 2004, 17). The multitudes are disciplined to the inequities of standing in line for unequal resources while the connected jump ahead or are ushered in to back rooms, or don’t require these services at all. To stand in line is assume the position of the masses, whose only recourse is the law. Ecuadorians from all classes try to avoid state institutions. It’s the relatively wealthy, who tend to be able to do this with success, an ability with deep reaching historical precedent. Those who do not have to interact with the state in Ecuador are elite by definition, and can make their own forms of freedoms outside the law. For those *sin recourses* the consequences for circumventing the state can be quite high, as they were for Sandra.

Ecuadorian IVF clinical directors like Dr Madera are in many ways similar to agrarian *hacendados* who have always been able to circumvent the law because they were its makers. These elite men maintained their hierarchical and authoritarian approach to governance and the administration of subjugated populations into the republican state era. Ecuador had the highest percentage of Indians of all the new Andean republics, what politicians at the time called “the Indian problem”. The interplay of liberalism, and perceived radical otherness in the Andes fostered the creation of exclusionary, nineteenth century, "republics without citizens" (Larson 2004). The solution to the Indian Problem was to officially hand over the designated pastoral care of Indian groups, to *hacendados*, who were themselves lawmakers and state actors (Guerrero 2003). This hand over in part had the effect of making “the state’ and these *hacendados* seem separate, simultaneously codifying the state as autonomous from elite control,

and producing domains where the state did not intrude. On the haciendas Indians became *hausipungeros* and were managed through the patrimonial care of the *hacendados*.

The forms of governance developed on haciendas as domains separate from the state resonant with the relations found in Ecuadorian IVF clinics today. Historically physicians came from elite families and also became state authorities and elected officials. Within their private clinical walls doctors have nearly complete autonomy to oversee their patients, just as the *hacendados* who controlled and managed the lives of their *hasuipungeros*. And just like on the haciendas clinic relations have nothing to do with the dialectic between the individual and the state, the particular and the universal. Interchanges between patients and doctors are personal not bureaucratic, and while these interchanges involve intimate forms of care with all patients, the relations between poorer patients and the IVF physicians are highly unequal.

The IVF clinic director's ability to circumvent state institutions and the law manifested after the passing of a new civil code in 2003 that prohibited the manipulation of human life after conception. Article 20 of The Child and Adolescent Civil Code states:

Boys and girls and adolescents have the right to life from their conception....  
Experiments and medical and genetic manipulations are prohibited from the fertilization of the egg until birth.

Some of the common tertiary techniques of an IVF cycle, especially embryo cryopreservation, could be interpreted as medical manipulation after fertilization.

At first none of the IVF practitioners paid attention and when they finally did, they all decided to ignore it. The gap between the new civil code prohibiting manipulation after conception and a flourishing IVF industry seemed resonant with abortion which is illegal and yet widespread, except that the civil code has had very little actual effect since IVF practitioners as elite doctors are able to circumvent state restrictions without consequences. Several IVF

doctors complained about the new law and they also used it as an opportunity to complain about the failure of the state to govern the domain of life and health.

Dra. Castro –The people of the congress and the legal system have done almost nothing in this country for 400 years. Here the people have very little vision. We prefer to avoid pressuring –the state- so that things continue stagnant, like always, so that all continues in silence like it has always been. This is more or less how we function. There could be laws but here everyone *passes above the law*. This is how we are, in this phase of maturation.

Dra. Castro talked about the law as something that can be passed over, a realm of governance that can be avoided, and she like all the IVF practitioners I met was quite willing to continue circumventing the law while overseeing and managing the reproductive lives of her patient clients in her clinics.

Unlike abortion, which is illegal in almost all cases in Ecuador, IVF inhabits a murky legal terrain given that its practitioners are elites who are typically not the objects of governance in Ecuador. This has not necessarily the case everywhere in Latin America. In Costa Rica Catholic lawmakers have succeeded in dismantling the IVF industry by outlawing the practice. Costa Rica is now the only country in the world with such a ban (Poblete 2002). In Chile and Argentina, home to large IVF industries, IVF clinicians have responded by policing themselves in order to conform to and appease the intertwined powers of church and state (in Chile, IVF doctor's term two to three day old embryos, "pre-embryos" to exempt them from legislative debates). These IVF practitioners conduct themselves in such a way as to prevent IVF from becoming *overly* problematic in relation to the Church/State, as it did in Costa Rica.

Unlike clinicians in these other Latin American nations, Ecuadorian IVF practitioners do almost nothing to ward off the regulative powers of church and state. Except for getting supplies and equipment through state customs, and passing a perfunctory yearly sanitation inspection by the

ministry of health, overt state or other forms of institutional regulation -spatial, material or imagined - rarely surface in the clinics. There is no Ecuadorian school of medicine that can issue and revoke licenses to practice. IVF physicians could think of no instance of ever being scrutinized for more than sanitation. The documents they sign with patients are not legally binding, and they are not scrutinized by insurance companies since patients pay out of pocket and since they don't carry malpractice insurance. These elite doctors have a sense that their medical practice can and should remain unhampered by state surveillance of regulation. This allows the majority of IVF doctors to ignore Article 20 of The Adolescent and Child Civil Code and to continue freezing embryos.

IVF practitioner's separation from state governance also allows them latitude that would not be possible in more regulated environments. In a few clinics some practitioners told me that the clinical director had directed the laboratory biologist to use patient's eggs in the cycle of another patient without the first patient knowing. The ability to move a woman's eggs to another woman without her knowing it also requires a sense on the part of practitioners that they are able to make these kinds of decisions for their patient's. Relationships of paternalism and personalism facilitated these surreptitious exchanges, instead of bureaucratic relational forms of informed consent, and patient's rights.

While rights discourses aren't at play within Ecuadorian IVF clinics they permeate current forms of reproductive governance across Latin America. Recent policies tend to be framed through the rhetoric of "reproductive rights" of individuals, which are often made to come up against the "right to life" of the unborn. Both forms of rights discourses are at play in Ecuador along with other Andean nation where abortion laws and policies have become more restrictive at the same time that free maternity laws have been enacted under the banner of the right to reproductive health. In Ecuador that has not necessarily translated into the actual availability of free or low cost maternity or health care in the last decades which has also seen the proliferation of private health care, including a flourishing

assisted reproduction industry that serves anyone who can pay, a consumer. (We will see if Correa's regime will change health care provisioning.) But neither Sandra nor Dr. Madera understand her as a consumer with rights. Instead, Sandra moved from a devalued citizen affected by abortion laws and sub-par social services, to a client enmeshed in and managed through personalistic relations within the clinic, a domain that propagates elite governance outside of and in tandem with state institutions.