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Fertility Paradoxes

Mexico's Shifting Reproductive Agendas

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"There are fertility clinics in Mexico! But, isn't Mexico a Catholic country? Isn't it overpopulated and poor? Don't they have more pressing health issues to address?" People have been asking me these questions since I began researching assisted reproductive technologies (ARTs) in Mexico in 2006. Many find the existence of ARTs in Mexico to be paradoxical, something absurd given the stereotypes that exist about the country. Explaining this paradox has been the center of my work, unpacking its elements and exploring how the ART industry has flourished in an overpopulated, culturally Catholic country, with 43.9 percent of its population living below the poverty line (CONEVAL 2023) and facing life-threatening conditions such as diabetes, hypertension, and malnutrition. Through a multisited ethnography, I have traced the political, economic, technological, cultural, and emotional entanglements that allowed the Mexican ART industry to develop and flourish (González-Santos 2020).

This chapter focuses on understanding Mexico's ART industry and the reproductive order it has created. I argue that the current reproductive order has been propelled by an aging population, below-replacement fertility rates, an increase in life expectancy, changes in family and gender dynamics, new abortion rights, a decrease in marriages and an increase in divorces, equal rights for same-sex marriages, and changes in women's place in society. These factors combine with stagnant high levels of poverty, a stratified healthcare system, and a neoliberal political economy. They have transformed reproductive medicine into a commodity, clinicians into service providers, and patients into consumers. The current reproductive order has created a

number of fertility figures that sustain the invisibility of the vulnerable and the overvisibility of the elite.

This chapter explores the rise of this new reproductive order. Following a chronological narrative, it examines the *shifting reproductive agendas* key to the growth of the Mexican ART industry. In doing so, it identifies the combination of factors involved in the rapid growth of Mexico's infertility hypermarket and unpacks the dynamics of the current reproductive order. As I define it here, a reproductive agenda is the conjunction of public policies, infrastructures, knowledge sets, targeted populations, objectives, and methods developed and used to enact politics of reproduction by the state and the medical industry. I suggest that the current reproductive agenda includes elements of past agendas, while also being situated in the present. This combination is possible because past and present agendas align with and perpetuate the existing sociopolitical structure, which is extremely classist, racist, and gender unequal.

The Past

In what follows, I describe the agendas of the twentieth-century reproductive order, focusing on their objectives, whom they see as subjects of care and control, the infrastructure they built, and the purpose of their medical interventions. I highlight how they participated in placing infertility, reproduction, and family structure on the table for medical, social, and political discussion and management.

Puericultura and *Esterilología* (1930s–1970s)

After the Mexican Revolution (1910–1917), Mexico launched a national project to (re)build itself into a modern Western nation with a strong and healthy population. The state invested in developing public policies and building institutions designed to promote a pronatalist, eugenic, neo-Lamarkian reproductive agenda. The organizing paradigm was *puericultura*, the medical paradigm, rooted in eugenic ideas, that researched and studied the ways to conserve and improve the human species by focusing on the mother-child dyad from before pregnancy through the first years of a child's life. *Puericultura* became key in the

solidification of gynecology and pediatrics in Mexico, in which managing reproduction was seen as the way to produce healthier individuals and a healthier population. *Puericultura* was central for the establishment of the "*gran familia Mexicana*" (great Mexican family): a family with a healthy mother-child dyad at its core, guided by medicine and overseen by a protective state. This family is captured in the logo of the Mexican Social Security Institute, established in 1943: an oversized eagle, representing the state, is swaddling a mother cradling and breastfeeding her child, representing the nation. There is no father in this fertility figure, only a safeguarding state overlooking a protective mother feeding a growing nation.

Physicians were given the power to evaluate who was "fit-to-marry," hence to reproduce. To get married, a couple had to present a medical certificate testifying that they had been evaluated by a physician, were found healthy enough to have offspring, and had received information about healthy reproductive practices. Physicians could withhold this certificate in cases of infertility, even though the condition was considered curable. *Esterilología* was the medical subspecialty focused on curing infertility.[1]

Puericultura's main subjects of control and care were women, particularly the "unfit-to-reproduce" women. This "unfitness" resulted from a classist and racist mindset, from viewing poor women with indigenous roots as having undesirable biological and social traits, and judging them ignorant because they consulted with midwives and traditional healers, whose ideas were considered remnants of an unhealthy and superstitious past. Eliminating such nonbiomedical ideas about reproduction remains a goal even today (Vega 2018).

Puericultura's task was to encourage women to follow a conscious maternity. This meant regularly visiting the hygiene centers where they could consult with healthcare providers trained in Western science and medicine. These centers exhorted women to follow their advice to ensure the health of their future babies. When puericulturists encountered extremely "unfit-to-reproduce" women, they encouraged them to refrain from reproducing or forcibly sterilized them (Castro 2021).

This pronatalist, but inherently racist, reproductive agenda was epitomized in Luis Echeverría's 1969 presidential campaign slogan: "*poblar es gobernar*" (to populate is to govern). *Puericultura* and *esterilología*

were the official, professional pronatalist reproductive agendas of the time. Four years later, the national agenda on reproduction radically changed to endorse a strong family-planning campaign. How and why did this happen?

Family Planning (1960–1990)

By the 1960s, still in the middle of this pronatalist agenda, more than one hundred thousand Mexican peasants were gathering a wild yam called "*barbasco*," from which Mexican and North American scientists were synthesizing progesterone to make contraceptives, which more than two million women in the United States would eventually ingest in their daily contraceptive pill (Soto Laveaga 2009). At this stage, contraception in Mexico was used mostly by wealthy women who accessed it through the private sector.

On the other side of the border, demographers, politicians, and academics were fomenting a new reproductive concern. The Cold War heightened fears that the rapid population growth in less developed countries like Mexico would encourage illegal immigration to the United States, threaten the American way of life, and help socialist and communist ideals spread across Latin America (Stone 1953; Murphy 2017). These demographers, politicians, and academics argued in favor of investing in biomedical and sociological research on contraception and in family-planning campaigns in Mexico as a solution to this "population problem." These campaigns would educate people in reproductive matters, giving them tools to have fewer children. Particularly concerning were the "hyper-fertile-poor-urban" (and usually indigenous) women who were commonly described as "begging in the streets surrounded by little children." This trope is a reiteration of the "unfit-to-reproduce" woman of *puericultura* and continues today as a justification for limiting ART services in the public sector.

By 1974, the Mexican government had adopted the family-planning agenda and begun to establish its infrastructure, in some cases aided by organizations such as the Ford Foundation, the Rockefeller Foundation, and the Population Council. Article 4 of the Constitution and the Ley General of Población were written and amended, giving people the right to decide how many children they wanted to have and how and

when to achieve this. These policies made the state responsible for offering free family-planning services in public institutions and allowed for the advertising and sale of contraceptive methods in public clinics. This constitutional article became central in the configuration of the ART industry in the next century.

Like *puericultura*, family planning involved problematic ways of providing contraception, particularly when it involved women (again) considered "unfit to reproduce." One strategy included systematically offering contraceptive methods at every single consultation with women, even when the visit was not gynecological. Another strategy was incentivizing healthcare providers to perform a minimum number of sterilizations, for which they received extra resources (Gutmann 2009). Sterilization procedures and intrauterine device (IUD) placements were usually performed after childbirth, miscarriage, or abortion, frequently without consent (Zavala de Cosío 1992). In rural areas, women were offered transportation to the nearest health center, where they were fitted with IUDs or sterilized, and then returned to their hometowns, all in the same day.

The government worked with renowned marketing firms and joined forces with the media to develop and broadcast family-planning campaigns designed to transform people's ideas about the ideal family size and the use of contraception. These campaigns appeared in the press, in public spaces, and on television. The advantages of having smaller families were commonly linked to affordability, using slogans such as "¿Pensando en el gasto? La familia pequeña vive mejor" (Thinking about costs? Small families live better lives) or "Pocos hijos para darles mucho" ([Have] fewer children to give them more). Campaigns also encouraged behavioral change. Playing on the idea of becoming fewer in number, they suggested becoming less macho, submissive, or corrupt: "Vámonos haciendo menos . . . machos . . . sumisas . . . corruptos" (Let's become less macho . . . submissive . . . corrupt). The fertility figure of the "small family" was depicted as mother, father, a son, and a daughter, as represented in the icon of the National Population Council.

Again, women were the main targets of these campaigns, which now situated them as active, responsible individuals, with opinions and ideas and capable of changing and improving their own and their families' lives. They were encouraged to plan their pregnancies, to wait until they were in

stable emotional and economic relationships, and to have no more than two children, well spaced. Ironically, women were later told that they were infertile because they had waited until they had stable relationships and jobs and had prioritized their careers over motherhood. Placing women in charge of their reproduction was not always received positively by men; some felt they were being left out of the reproductive decisions. Hence, campaigns were redesigned to portray family planning as a couple's decision. Within the clinical context, physicians abandoned the interest in curing infertility, as suggested by *esterlilología*, and adopted the ideas of reproductive biology, which sought to control the hormones involved in reproduction. Reproductive biology, developed within the context of family planning, became the epistemological grounds for ARTs.

Present

The following reproductive agendas spanning the new millennium frame biomedical knowledge and technology as ways to manage, control, and, now, assist reproduction. They continue to include infertility, reproduction, and family structure in the medical, social, and political discussion. But they now occur in the context of globalization, rampant consumerism, free trade agreements, important political shifts, the Internet, and neoliberalism.

Globalization and Neoliberalism (1990s–2010s)

After twenty-five years of economic growth and infrastructure development, Mexico underwent repeated devaluations (in 1976, 1982, and 1994). This led the country to adopt a new import-export-based political economy, which required a profound adjustment of Mexicans' habits. A population of "weak consumers" had to be taught to buy, dispose, and consume (Morton 2003). A workforce accustomed to catering to its internal market now had to compete and satisfy the foreign consumer. A government that had spent years looking inward for stability and growth was now, for the first time, associating a better future with better relations with Washington (Fuentes 1993).

This radical shift was inscribed in the signing of the North American Free Trade Agreement (NAFTA) in 1993. Immediately, Mexico was

overtaken by a tsunami of foreign influence through goods and television programs promoting ideas of individuality and consumerism. The neoliberalism that was being fashioned in Mexico defended individual liberty and protected the market, favoring private investments and industries while discouraging the welfare state, the protection of public goods, and the improvement of public services. For example, state investment in healthcare was reduced by 47 percent, and federal laws and regulations were adapted to facilitate foreign private insurance companies' and health services' participation in the national market; this boosted the growth of the private medical sector (Tamez González and Valle Arcos 2005).

Globalization and neoliberalism also influenced the reproductive agenda. In the past, the focus had been on the welfare of the nation, then on the well-being of the family. Now, the focus shifted toward the interests of the individual. Slogans emphasized new values—individualism, responsibility, empowerment, human rights, and gender equality—stressing the fact that family planning was an individual's decision and a good option to improve living standards (Nazar-Beutelspacher, Zapata-Martelo, and Vázquez-García 2004). Men became subjects of reproductive care and control in the late 1980s and early 1990s through campaigns promoting vasectomy as a contraceptive method and encouraging monogamy and the use of condoms to avoid HIV contagion. This was the first time the word "condom" was used in the media (Rico, Bronfman, and Chiriboga 1995; Gutmann 2009). Influenced by different social movements, the reproductive agenda began to expand beyond reproductive health, bringing in ideas and policies on reproductive rights in addition to concerns about maternal and child health, infertility, and sexually transmitted diseases. Although the reproductive agenda expanded beyond the notion of the "woman-of-reproductive-age-in-a-relationship" to include adolescents, young adults, and men, this fertility figure is still used within government documents in spite of its heteronormative, conservative implications and the bias this produces (Secretaría de Salud 2008).

The first ART services were established around 1985 in Mexico City (one private and one public) and Monterrey (one private), and they began reporting successful births in 1988. These clinics were central to the establishment and growth of the ART community. They published

papers, organized conferences, invited foreign experts, and trained subsequent generations of ART specialists. NAFTA established favorable conditions for foreign clinics to consider Mexico as a potential market. Soon, a few clinics from the United States and Spain opened branches in Mexico or partnered with local ones. Although their organization and marketing strategies were unusual for Mexicans, local clinics ended up adopting these strategies, propelling the marketization and commodification of ART services in Mexico. These marketing strategies involved advertising on radio and television, in public spaces (billboards), and in the press, offering discounts, and working with banks for tailored loans. When the Internet arrived, clinics opened websites and, later, Facebook pages. The topic also inspired telenovelas as well as interviews with former users and stories of the rich and famous, all highlighting how the "ART-mother-to-be" endured everything to become a mother. Characterizing the ART woman as a "mother-at-all-costs" endorsed the Mexican mandate that women must be selfless and sacrificing mothers, wives, and daughters (Saldaña-Tejeda, Venegas Aguilera, and Davids 2017). These developments helped construct infertility as a common problem and ARTs as an acceptable solution (González-Santos 2020).

The first adopters of ARTs ventured into an unknown field with little information and support. This motivated them to create what they called a "fertility community," uniting patients, psychologists, and physicians. They set up websites and online support groups, and they organized events where practitioners and patients could meet. One of these early adopters took this idea one step further by organizing a trade show, Expofertilidad, held five times between 2007 and 2012 at the Mexican World Trade Center. These events offered a safe space where users and practitioners gave and received support and advice, experimented with resignifying what constitutes a family and what establishes kinship, and searched for the validation that their reproductive decisions were correct. This is where those using donated gametes would repeat, almost mantra-like, "S/he might not have your eyes, but s/he will have your gaze; s/he might not have your mouth, but s/he will have your smile."

Until this time, advertising healthcare, in the media or anywhere, was unprecedented in Mexico. Several physicians shared with me their discomfort with these marketing strategies. They were unsettled by the ways in which patients were transformed into clients, searching for

the best deal, and physicians into salespeople, hawking their products. Nonetheless, this commercial edge engulfed the field of assisted reproduction, transforming it profoundly by the 2010s.

Current Reproductive Order

The year 2000 was significant for Mexicans, who participated in their first democratic election and had, for the first time in seven decades, a new governing party in office. Since then, three different parties have taken office, all favoring globalization, consumerism, and neoliberalism. The first two periods were won by the conservative party; this meant a cutback on the presence of family-planning campaigns in the media. Consequently, people were less informed about their contraceptive options and where to get contraceptives. Paradoxically, the struggle to legalize abortion also began in the year 2000, eventually succeeding in 2023. Abortion is now legal and free across Mexico in cases of pregnancy resulting from rape, and in ten of the thirty-two states it is legal without having to provide any justification, up to the twelfth week of pregnancy.

The struggle to legalize abortion occurred within a context in which teenage pregnancies were increasing. More than half of them involved sexual violence, and many included sexually transmitted diseases (Secretaría de Salud 2008, 2021). This rise in teenage pregnancy could also have been the result of a combination of a stigmatization of nonheterosexual forms of relationships (i.e., same-sex relationships) and sexual activity outside a formal union, with the availability of misleading information circulating in social media. This mixture erects barriers to acquiring and using contraception and having abortions, placing adolescents and queer individuals in vulnerable positions (Villalobos et al. 2020; Secretaría de Salud 2008, 2013, 2021).

For the past twenty years, each new administration has reported that the previous one reduced its investment in family-planning campaigns (Secretaría de Salud 2008, 2013, 2021).[2] These reports suggest that controlling fertility is no longer a matter of governmental interest. Mexico has arrived at the desired fertility rate—1.9 children per woman in 2020—so the perception is that there is no need for further action. While Mexicans have become fewer, they have also become older, with a median age of twenty-nine. Mexicans are living with chronic

degenerative diseases like hypertension and diabetes; they marry less and divorce more; and more people work in jobs that do not offer social security. All this is transforming the way families can cope with caring for children, the elderly, and the sick (Myers and Vargas 2023). In the past, the extended family helped with these tasks, but this becomes more complicated as families shrink and age.

The ART industry has taken advantage of the government's loss of interest in fertility by controlling the conversation. For one, it has not made information accessible. It has been nearly forty years since the first clinics were established, and still unknown are the exact number of clinics that exist, the types of procedures they perform, and their outcomes. The Mexican Medical Association of Reproductive Medicine (AMMR), whose members are ART specialists, has never published this information. The National Sanitary Risk Commission (COFEPRIS), which inspects ART clinics in order to grant them licenses, has an unclear and difficult-to-access database, where clinics are not even listed by their commercial names. The Mexican Council of Gynecologists and Obstetricians should have a database of the ART specialists they certify, but having a certification is not the same as having a clinic. RedLara gathers information offered voluntarily by affiliated clinics,[3] but not all clinics are part of the network. Their latest report states that 188 clinics, located throughout fifteen countries, reported a total of 93,600 procedures; of these, thirty-eight were Mexican (sixty-three were in Brazil and twenty-eight in Argentina), and they performed 15,789 procedures (Brazil reported 39,142 and Argentina 20,054) (Zegers-Hochschild et al. 2020). This number contrasts with the 130 clinics COFEPRIS has listed and with the "80,000 procedures [that] are performed annually in Mexico," according to an ART specialist (Sánchez Cordero 2019).

The ART industry has helped to maintain the regulatory patchwork under which ART services operate. The first legislative bill was presented in 1999, and by 2020 there were more than thirty. Yet, not one has passed; thus there still is no federal law concerning ARTs. Currently, each clinic follows its own criteria concerning who is eligible for these services, what services are offered, and the content and structure of the consent forms and contracts (López et al. 2021). It is worth noting that not one bill has suggested prohibiting ART services. Most of them justify allowing ART services by appealing to Article 4 of the

Constitution, which stipulates that everyone has the right to form a family and to have access to health services. The objective of these bills has been to stipulate the criteria for who can access these services and for which reason (e.g., sex selection, avoiding genetic diseases, or social reasons). Presently, only some states have local regulations. Mexico City's regulation, for example, allows genetic manipulation to avoid the inheritance of undesirable genetic conditions, while Puebla's prohibits embryo selection, even if it is to avoid heritable diseases (González-Santos and Saldaña-Tejeda 2023).

After having many conversations with the policymakers and physicians involved in drafting some of these bills and after sitting in on the discussion over how to regulate ARTs, I see that regulating ARTs is not a priority. Currently, there is no clear advantage for the government nor the industry. Some of my interlocutors pointed out that one of the problems is the lack of resources to implement these laws (e.g., qualified staff); others told me that the religious lobby is against some parts of these bills, thus exerting pressure to hold back their approval; others say that it is not the right political time (Semmex 2022); and many simply agree that there is no interest or political gain. This uneven regulatory landscape contributes to the stratification of ART services and, with the advent of surrogacy, it is producing problematic scenarios for service providers and users (Saldaña-Tejeda et al. 2022). Surrogacy agencies, which proliferated in the past decade, are taking advantage of this regulatory patchwork and lack of oversight on fertility clinics. They act as translators between the Mexican legal and medical system (including the ART specialists, the gamete donors, and the surrogates) and their clients (Olavarría Patiño 2018).

The ART industry has also taken advantage of the difficulties of implementing laws concerning health-related advertisements, particularly when it comes to social media. In their first websites, clinics posted information about their staff's qualifications and basic information about infertility and the procedures they offered. With the emergence of social media, their online presence intensified, and their messages became more promotional, offering guarantee packages, assuring 100 percent success "or your money back," and narrating ARTs as almost risk free. They back up these claims with testimonies constructed through pictures and videos of former users. The pictures commonly have the

(usually male) physician at the center, holding the baby or standing next to the mother with the baby. More recently, ART users have begun to chronicle their reproductive journeys through social media, turning into critics, evaluators, and promoters of these services. Although their stories tend to be more complex, showing the ups and downs, contrasting with the straightforward narrative told by clinics, they still commonly offer hope (that the procedure will eventually succeed) and rarely explore other ways of reproduction and kinship. They are now ART influencers, and some are now official spokespeople for the clinics where they achieved their goals.

The ART industry has also taken advantage of the marriage and reproductive rights granted to the LGTBQ+ community and the changes in family structure (more single parents), incorporating them into their client portfolios. For example, clinics now advertise egg freezing for young working women and sperm banks for single mothers-to-be; they offer lesbian couples a procedure called ROPA,[4] and they offer surrogacy to gay couples. Mexico is considered an attractive place to seek these services, particularly for North American customers, because it offers high-quality procedures at lower prices than those in the United States and because Mexico already has a history of being a destination for medical tourism. However, given the patchy laws and the particular way bureaucracy works in Mexico, (mainly foreign) intended parents commonly face unimagined (although documented) bureaucratic hurdles when trying to issue the newborn's identity papers. This has sparked negative press, legal battles, and bad experiences. It has also inspired media discussions concerning the autonomy of the women who are hired as surrogates and egg donors, contrasting their economic precarity with the affluence of those seeking their services, who are presented as wealthy, white, and foreign (GIRE 2015; Olavarría Patiño 2018).

The reproductive agenda sketched out by President López-Obrador's administration (2018–2024) was the latest example of how family planning has lost political priority. This agenda shifted from centering on family planning and contraception to dealing with sexual and reproductive health. Infertility became just one more line item in a list of concerns: sexual health, menstrual health, peri-/postmenopause, sexual dysfunctions, sexually transmitted diseases, cancers, and adolescent pregnancies (Secretaría de Salud 2021).

Reflections on Mexico's Reproductive Agendas

Physicians often told me that ARTs and contraception are two sides of the same coin. Exploring this perspective, I found that *esterilología* and reproductive biology (contraception) share an interest in understanding hormones and the processes involved in conception, in order to cure infertility and control fertility. However, as I see it, the ART industry promotes other intentions. Up until the 1980s, infertility had been constructed as a public health problem, with economic and social implications, that required public policy and state-financed research and institutions. The state first addressed underpopulation and then overpopulation, always framing its approach as beneficial for the nation. Then, influenced by globalization and neoliberalism, the idea of controlling fertility was reshaped by ideas of individual rights and desires, techno-fixes, and consumerism. Infertility became an individual, private, and personal matter. The ART sector abandoned the goal of curing infertility and now aims to give clients what they desire: children.

Three things unite these reproductive agendas. First, they use Western science to control fertility and exclude other forms of understanding reproduction held by many Mexicans (even when these are part of their culture) (Vega 2018). Second, they share a strong foreign influence, inspired by academics, politicians, and demographers from the United States, by alliances with foreign ART clinics and professionals, and by international surrogacy agencies. Third—and most important—they all invoke Article 4 of the Mexican Constitution: the right to have the desired family configuration. The shift from a health matter to a rights matter was accompanied by a shift in who controls reproduction. As described in the last section, in the twenty-first century the government lost interest in fertility matters, and the ART industry leaped into this vacuum by creating a market-favorable setting. This setting has allowed for the dissemination of false and exaggerated advertisement that cannot be critically read in the absence of trustworthy information regarding, for example, the number of ART cycles performed annually and the success rates of each clinic.

This market-favorable setting has intensified the stratification of ART services. Although ART services began simultaneously in the public and the private sectors, the former did not develop beyond a few services

justified as training facilities, while the latter grew in size and scope. This made ARTs affordable for only a segment of the population, especially when the ART industry became part of the global and neoliberal cross-border healthcare market (particularly with the United States and Canada). The unequal access to ART services is displayed throughout private and public spaces, testimony to Mexico's class tensions. Two key examples illustrate this disparity. First, on the wall of a low-income house, located near a private hospital in a low-income neighborhood, hangs a billboard advertising a private ART clinic. People living in this house earn some extra money by renting their wall to an ART clinic whose services they could not afford. Second, wealthy ART users often turn to household employees for help with acquiring, managing, and administering fertility treatments, yet these employees could never afford these treatments for themselves. These homes are spaces where economic poverty and economic opulence clash, where those without access to certain goods and treatments are in direct contact with the healthcare they cannot afford. ARTs reveal the intermingling of economic disparities that sustains Mexico and that produces contained contempt, fear, resentment, and hatred but also wealth, opportunity, care practices, and an enigmatic and problematic stability.

Finally, the fertility figures produced over the years have transformed yet are still reproducing the invisibility of the vulnerable and the overvisibility of the elite. During the pronatalist period, the notion of the "*gran familia mexicana*," a heteronormative family that produced and raised several healthy children who would grow into hard-working citizens, predominated. This ideal family evolved into "*la familia pequeña vive mejor*," a heteronormative family with only two children. Then, during the twenty-first century, the notion of family became flexible enough to accept a variety of configurations, not only the heteronormative. All reproductive agendas have highlighted a set of contrasting figures: the poor-urban/rural-indigenous woman described as "hyperfertile" yet "unfit to reproduce," and the "fit-to-reproduce-young-urban-working-white woman," who needs to preserve her fertility by freezing her eggs. This categorization, still present today, is the epitome of the classist and racist disposition of Mexican political, economic, and social structures. A third set emerged within the neoliberal market when the patient-physician duo transformed into the "consumer-seller": the "ART

influencer," the YouTuber, Instagrammer, and TikToker who documents and broadcasts their ART journey. These fertility figures co-inhabit the nascent global ART market, where skilled cheap laborers work alongside artificial intelligence technologies, all engrained in automated embryo assembly lines (González-Santos 2024).

Yet, the question remains: How could Mexico, being mostly Catholic, accept these reproductive agendas when they clearly go against the Catholic Church's mandates regarding reproduction? It is important to remember that in 1860, the Reform Laws (promulgated by Benito Juarez) took away many rights and duties held by the Catholic Church (such as marriage and birth certificates), denied Catholic clergy the right to vote, and expropriated their land and buildings. This was reiterated, first in the 1917 Constitution and then again during the Cristero Wars in the 1920s. Hence, throughout most of the twentieth century, Mexico's official relationship with the Catholic Church and the Vatican was practically nonexistent. This never meant that people could not practice religion; it simply meant that state and church were separate and the latter could not meddle in matters of the former. This started to change when, in 1992, President Carlos Salinas de Gortari reestablished official relations with the Vatican and changed the Constitution to allow clergy to vote. Since 2000, the presence and influence of the Catholic Church has slowly grown, but the laws that limit the church's official participation in the government are still in place. This does not mean that Catholic morality has no influence on policy, as the church sometimes adopts the path of pressuring conservative groups within the middle and upper economic segments of the population. In addition, it is important to note that assisted reproduction helps women become mothers, and it builds families. As I argue, this is central to Mexican life and belief systems; hence, it trumps the Vatican's prohibitions (González-Santos 2020).

Conclusion

The story I tell in this chapter leaves important things untouched.[5] It does not consider the number of families that are migrating so their teenage children will not grow up in the context of violence. It does not consider the number of maternal deaths that happen mostly in rural

and indigenous communities. It does not consider the number of cases of obstetric violence instigated by discrimination, racism, and classism and that result in infertility. It does not consider the number of births overturned by femicides, the number of families broken by violence, or the number of children left orphans when their parents were forcibly removed. The part of the story I have told in this chapter addresses a reproductive agenda that presupposes life and that takes place in the context of biomedicine and biotechnology. But there is another side, one that lives in death and violence. Both sides make up Mexico's new reproductive order.

Mexico's new reproductive order is thus structured by a reproductive agenda based on life and a reproductive scenario based on death. It is a stratified order that brings together those who are unable to access even the basic elements of reproductive health (such as an IUD, a Pap smear, or an ultrasound) and those with access to the most innovative ARTs. It is an order that fits into the global ART market just as the Mexican industry fits into NAFTA, tailoring specific services for local consumers and others for foreign ones. It is an order guided by a market that works within a legal patchwork. It is an order that looks into the technological future, one with automated clinics with embryo assembly lines, mixing artificial intelligence and cheap labor. It is a neoliberal order that perpetuates racist, classist, and individualistic values and policies. It is an order that I still struggle to understand.

NOTES

1 This medical subspecialty was developed by a group of Mexican physicians concerned with infertility. They created the Mexican Association for the Study of Sterility, published a journal, and laid the groundwork for what would later be the Mexican Association of Reproductive Medicine, the association of ART experts.

2 At the beginning of every presidential term, the Ministry of Health publishes its specific plans of action to tackle health issues deemed a priority; this includes an evaluation of the situation left by the previous administration.

3 RedLara annually produces a report registering the number and type of procedures carried out by the subscribing clinics. These reports are published simultaneously in *Reproductive BioMedicine Online* and in the *Brazilian Journal of Reproductive Medicine*.

4 ROPA stands for Reception of Partner's Oocyte, where one becomes the genetic mother and the other the gestational mother.

5 I thank Abril Saldaña Tejeda for bringing this to my attention.

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