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Who Deserves to Reproduce? Latvian State Support for Infertility and Moral Considerations

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Abstract

This article examines how access to state-funded infertility treatment in Latvia is regulated and morally framed. The analysis draws on state regulatory documents concerning sexual and reproductive health in Latvia, as well as six semi-structured interviews with Latvian politicians and reproductive health specialists. The findings reveal that eligibility for treatment is not based solely on biomedical criteria but is also shaped by normative assumptions about gender roles and moral worth. A dominant heteronormative framework positions women as central to reproduction, while men are often marginalised or excluded from state support. Furthermore, infertility treatment is described as a form of economic investment by the state, with an implicit expectation of demographic return. Importantly, reproductive health specialists and politicians do not present reproduction as a neutral or purely biological process, but rather frame it in moral terms, suggesting that there are specific, morally acceptable forms of reproduction.

Keywords

gender; heteronormativity; infertility; Latvia; morality; policy

1. Introduction

One might assume that having children is an entirely private and intimate process, far removed from state regulations. However, today, both the state and medical knowledge have become central forces in shaping kinship and restructuring human relationships (Ross & Moll, 2020, p. 2). As British social anthropologist Jeanette Edwards notes, "states are always invested in the (non)reproduction of their citizens and in regulating specific forms of family through which people should come into being" (Edwards, 2017, p. 155).

Reproductive studies encompass a wide range of topics, including infertility (Almeling, 2015, p. 424), where state involvement and medical knowledge both play important roles. There is extensive research on national policies concerning the diagnosis and treatment of infertility, as well as on how states regulate and fund these services (e.g., Calhaz-Jorge et al., 2020). In parallel, research is expanding on how doctors navigate the ethical and moral dilemmas that emerge with the globalisation of reproductive technologies (e.g., Gammeltoft, 2014).

In this article, I examine the state-funded fertility treatment program in Latvia. First, through an analysis of Latvia's regulatory documents, I explore how the legal framework of state-supported infertility treatment defines eligibility—who is included in state care, and conversely, who is excluded. Second, by analysing statements made by Latvian politicians and reproductive health specialists, I investigate how these actors articulate access to state-funded infertility treatment.

The analysis demonstrates that the dominant understanding of morally appropriate reproduction in Latvia aligns with a strongly heteronormative framework. Women are positioned at the center of reproductive processes, while men are often marginalised or excluded from state support structures. Both doctors and politicians tend to describe state-funded infertility treatment as a form of economic investment, where the state is seen as an investor expecting returns in the form of newborn citizens. Furthermore, discussions around infertility treatment extend beyond medically defined physical criteria. In the statements of doctors and politicians, it is often portrayed as something that should depend on certain moral qualities that individuals are expected to embody. This kind of rhetoric suggests that reproductive support is framed not only as a biomedical necessity but also as a matter of who is considered appropriate or deserving of state-funded care.

2. State Regulation and Moral Framing of Infertility Treatment

The regulation of infertility treatment across different countries varies significantly in both policy approach and moral framing. A growing body of comparative literature reveals that most countries employ mixed regulatory frameworks, combining liberal elements such as broad eligibility and state support, with restrictive features like social or medical limitations tied to relationship status, age, or sexual orientation (Brigham et al., 2013; Ginoza & Isasi, 2020; Thompson, 2021).

Studies highlight the distinction between liberal and conservative healthcare models. In liberal systems, infertility treatment is typically framed as a reproductive right and integrated into national health systems or public funding schemes. Access is broadly available, often underpinned by demographic concerns and pro-natalist policies, particularly evident in the Israeli context, where policies are among the most permissive globally (Birenbaum-Carmeli, 2004; Shalev & Gooldin, 2006). In contrast, conservative or mixed systems introduce eligibility restrictions based on moral or cultural norms, often leading to stratified access (Heidt-Forsythe, 2016; Waldman, 2006).

Key differences in regulation often reflect deeper moral and cultural values. For instance, in more conservative contexts, access to assisted reproductive technologies (ART) is shaped by heteronormative assumptions, religious values, and normative ideas about family and parenthood (Engeli & Allison, 2016; Thompson, 2021). These systems may exclude single women, same-sex couples, or older individuals based on implicit moral criteria, despite public funding availability (Brigham et al., 2013).

Even within mixed models, economic logic frequently intersects with moral framing. Policies may be designed not only to support individuals but also to serve state interests, such as promoting population growth or reinforcing national identity. For example, in Israel, ART policies are driven by a demographic imperative to increase the Jewish population, aligning both liberal access and cultural priorities (Birenbaum-Carmeli, 2004; Shalev & Gooldin, 2006). Moreover, financial models influence who can access care and under what conditions. Countries with fully public systems tend to offer broader access with fewer direct costs to patients, while mixed systems may create economic barriers, even if ART is legally available (Chambers et al., 2009; Dunn et al., 2014).

Finally, moral framing extends to how the state perceives its role in reproduction. In liberal models, the emphasis is often on compassion, autonomy, and reproductive rights. In conservative or mixed contexts, state involvement is more prescriptive, with policies reflecting concerns about social order, cultural continuity, or religious morality (Heidt-Forsythe, 2016; Waldman, 2006).

This article uses these theoretical perspectives to explore how Latvia's infertility policy combines medical criteria with moral reasoning, illustrating how broader norms about gender and reproduction shape access to treatment.

3. Methods

This article draws on an analysis of state regulatory documents regarding sexual and reproductive health, as well as six semi-structured interviews with politicians (3), reproductive health specialists (3) in Latvia. The following chapter outlines the data collection methods and the ethical considerations involved.

3.1. State Regulatory Documents

This study involved the analysis of laws and Cabinet of Ministers regulations that directly address sexual and reproductive health—specifically infertility, its treatment, and the use of medically assisted reproduction (MAR)—as well as broader legislation and regulatory acts relevant to the overall legal and policy framework. The documents analysed included primary legislation such as the Constitution of the Republic of Latvia (Satversmes Sapulce, 1922), the Civil Law (Ministru kabinets, 1937), and the Law on Sexual and Reproductive Health (Saeima, 2002). Cabinet of Ministers regulations included: No. 716, *Procedures for the Organization of Medically Assisted Reproduction and the Establishment of the Register of Infertile Families, the Medically Assisted Reproduction Register, the Unified Gamete Donor Register, and Gamete Donor Banks* (Ministru kabinets, 2003); and No. 1529, *Procedures for the Organization and Financing of Health Care* (Ministru kabinets, 2013). In addition, the policy planning document, Family State Policy Guidelines for 2011–2017 (Labklājības ministrija, 2011), was analyzed. The documents were collected between July and December 2020. A follow-up review was conducted in May 2025 to identify any changes that may have occurred since the original research was carried out in 2020.

3.2. Semi-Structured Interviews

Six semi-structured interviews were conducted between July 17 and December 10, 2020. Due to the medical dimension of the topic, three semi-structured interviews were conducted with reproductive

health specialists: two gynecologists specializing in reproductive medicine and one urologist-andrologist. These doctors were representing two private infertility clinics, out of a total of six in the country, that provide state-funded infertility treatment. Purposive sampling was used to identify relevant actors based on their expertise and institutional role, while convenience sampling determined the final selection based on accessibility.

Interviews were also conducted with three politicians whose work over the past decade in Latvia has been related to sexual and reproductive health policy. First, Anda Čakša represents the centre-right political party New Unity, and from 2016 to 2019, she served as Minister of Health. Second, Linda Ozola, representing the New Conservative Party in the 2020 extraordinary Riga City Council elections, was nominated as the party's lead candidate and became Deputy Chairperson of the Riga City Council. During the pre-election period, the party's published programme pledged that the Riga City Council budget would co-finance an infertility treatment programme for Riga residents and that the age limit for accessing the service would be increased from 37 to 40 years. In 2025, during the next municipal elections, Latvian journalists evaluated the promises made by politicians in 2020. As journalist Evita Puriņa (editor of *Re:Check*) noted, this promise had not been fulfilled (Puriņa, 2025). Politicians concluded that there was no need for additional municipal involvement, since the state was already funding and implementing these services. Third, Imants Parādnieks represents the national-conservative party National Alliance "All for Latvia!–For Fatherland and Freedom" (hereinafter referred to as the National Alliance VL–TB/LNNK) and is one of the most prominent politicians in Latvia working on demographic issues. During the 11th convocation of the Parliament of the Republic of Latvia, which commenced on 17 October 2011, Parādnieks chaired the Subcommittee on Demographic Affairs under the Budget and Finance (Taxation) Committee. Since 2016, he has been the head of the Demographic Affairs Centre. When the government of Krišjānis Kariņš took office in 2019, Parādnieks became the Prime Minister's advisor on demographic issues, a position he held until the end of the government's term in December 2022.

The interviews were conducted both remotely, using the Zoom platform, and in person, in compliance with the epidemiological regulations established in the country during the Covid-19 pandemic. The interviews lasted approximately one hour. All study participants were informed prior to the interview about the purpose of the research and how and where the collected data would be used. Verbal consent to participate in the study and to make an audio recording was obtained from all participants. All names, except those of public figures such as politicians, have been altered to ensure the anonymity of the individuals involved. On July 23, 2020, approval for conducting the study was granted by the Research Ethics Committee of Rīga Stradiņš University.

After the interviews, the audio recordings were manually transcribed in MS Word. Thematic analysis was carried out following a structured, multi-phase approach based on Kuckartz's model (Kuckartz, 2014). An initial reading of the material was performed, during which key passages were highlighted and memos were written. In the next phase, the main thematic categories were developed. This was followed by a first round of coding, during which the data were coded using the established categories. All text segments belonging to each category were then compiled, and sub-categories were developed inductively based on the content. In a second round of coding, the material was re-coded using this more detailed category system. The process concluded with a category-based analysis, and the results were presented accordingly.

4. Characterizing Infertility and State-funded Infertility Treatment in Latvia

According to WHO data, approximately one in every six people of reproductive age experiences infertility at some point in their lives (WHO, 2024). Globally, it is estimated that approximately 15% of heterosexual couples experience infertility, defined as the inability to conceive a child after one year of regular, unprotected sexual intercourse (Sharlip et al., 2002). While this percentage is widely cited in discussions of global infertility, it does not necessarily capture regional or national differences, where infertility rates may be higher or lower (Agarwal et al., 2015).

In Latvia, accurately determining the prevalence of infertility remains challenging. The policy planning document *Family State Policy Guidelines 2011–2017* (Labklājības ministrija, 2011) references a 2006 study conducted by the pharmaceutical company Organon, which, based on a survey of eleven doctors, estimated that there were approximately 15,000–20,000 infertile couples in the country. Data from the Latvian National Health Service (NHS) indicate a gradual increase in infertility among both women and men: from 4,075 women in 2011 to 8,238 in 2023, and from 103 men in 2011 to 468 in 2023 (Ķīvīte-Urtāne et al., 2023, p. 40). In contrast to the NHS data, the Organon study suggested that 60% of these cases in Latvia were attributed to male infertility (Ķīvīte-Urtāne et al., 2023, p. 40).

In Latvia, there is no single, unified national registry for infertility diagnoses or patients. But, according to Cabinet Regulation No. 716, *Procedures for the Organization of Medically Assisted Reproduction and the Establishment of the Register of Infertile Families, the Register of Medically Assisted Reproduction, the Unified Gamete Donor Register, and Gamete Donor Banks* (Ministru kabinets, 2003), the register of infertile persons is maintained at each medical institution where MAR is performed (Ķīvīte-Urtāne et al., 2023, p. 40).

4.1. State-Funded Infertility Treatment in Latvia

In Latvia, the beginnings of MAR can be traced back to the early 1990s, following the restoration of independence. A significant milestone occurred in 1995, when Voldemārs Lejiņš became the first gynaecologist in restored independent Latvia to successfully perform in vitro fertilization (IVF) at the Latvian Family Center, resulting in the birth of twins. Lejiņš was also one of the founders of EGV Clinic, which has since become one of the leading reproductive medicine centers in the country.

The next significant step occurred on September 1, 2012, when amendments to the Cabinet of Ministers' regulations, the *Procedures for the Organisation and Financing of Healthcare* (Ministru kabinets, 2013), introduced state budget coverage for both the diagnosis of infertility causes and MAR. In 2018, a centralized waiting list for these procedures was established to improve access to state-funded services by reducing waiting times and enhancing the transparency of information regarding the number of patients in the queue. Since the spring of 2022, the average waiting time for state-funded assisted reproduction services has been approximately one month.

Infertility treatment is organized within the private healthcare sector and is carried out in six institutions contracted by the NHS, which administers the state support programme. The national infertility treatment program states that, "in Latvia, state-funded infertility diagnostics and related healthcare services are available—including specialist consultations, diagnostic examinations, reimbursable medications, and more"

(Nacionālais veselības dienests, 2025). The MAR procedure is state-funded for women up to and including the age of 40 (Nacionālais veselības dienests, 2025). It should be noted that from the program's introduction in 2012 until 2022, this service was available to women up to and including the age of 37. The decision to raise the age limit was based on national demographic policy considerations, international experience, and the fact that the MAR service within the state program was particularly in demand among women aged 37 (Veselības ministrija, 2022). An analysis of the number of state-funded services provided up to 2020 reveals that the highest number of procedures was performed for women aged 37. It should also be noted that in Latvia, the average age at which a woman gives birth to her first child has increased since the program was established (25.9 years in 2011; 28.1 years in 2024; see Oficiālās statistikas portāls, 2025). In Europe, twenty-eight out of twenty-nine countries have set age limits for accessing state-funded fertility treatment, with the age range for women varying between 36 and 49 years, while the maximum age for men is rarely specified (Calhaz-Jorge et al., 2020).

The website of the NHS outlines the steps that must be taken to qualify for state-funded support (Nacionālais veselības dienests, 2025). Before undergoing a MAR procedure, diagnostic tests must be conducted to determine the causes of infertility and establish a diagnosis. If a patient wishes to receive these examinations funded by the state budget, they must consult a physician who has a contract with the state—specifically, with the NHS. Women should see a gynaecologist, while men should consult a urologist. A gynaecologist is considered a direct-access specialist, meaning no referral is needed. However, to see a urologist, a referral from a general practitioner is required. During the visit, the doctor examines the patient and, based on their health condition, determines the necessary tests to identify the causes of infertility and confirm the diagnosis. The doctor also assesses whether only the woman requires diagnostic testing or whether tests are also necessary for the male partner. For women, the following examinations may be performed to diagnose infertility: gynaecological examination, screening for sexually transmitted infections, hormonal evaluation, ultrasound examination (patient co-payment 4.00 EUR), and fallopian tube patency assessment (patient co-payment depends on the method used). For men, the following examinations may be performed: screening for sexually transmitted infections and sperm analysis (spermogram).

Once infertility has been diagnosed, the patient attends a consultation with a gynaecologist, during which the specialist may recommend MAR and place the patient on the centralized waiting list for the service (patient co-payment: 4.00 EUR). When the patient's turn on the waiting list is reached, the NHS sends an invitation to the patient's registered personal email address. Upon receiving the invitation, the following services are provided: pre-procedure gynaecologist consultation (4.00 EUR); ovarian stimulation medications; ovarian puncture for oocyte aspiration (including all necessary gynaecologist consultations, ultrasound examinations, anaesthesiologist consultation, day clinic use, and anaesthesia costs [21.00 EUR]); testicular biopsy (including urologist consultations and ultrasound examinations [21.00 EUR]); intracytoplasmic sperm injection (ICSI) with embryo culture up to day five, or intrauterine insemination with sperm and embryo culture up to day five; embryo freezing (up to five straws) and thawing; embryo transfer (21.00 EUR); post-procedure consultation (4.00 EUR); and ultrasound examination in weeks 4–6 after embryo transfer. The long-term storage of frozen embryos is not covered by the state. The acquisition of donor gametes is not covered by the state and must be paid for by the patient; however, the MAR procedure may still be state-funded if eligibility criteria are met.

A woman is removed from the waiting list if: she has reached the age of 41; she declines MAR; she does not visit a medical institution to undergo the procedure within six months of receiving the invitation; MAR is no longer necessary or is not possible due to medical indications. MAR is not funded by the state in the following cases: (a) if two unsuccessful MAR procedures have already been funded by the state (i.e., no clinically confirmed pregnancy occurred after embryo transfer) and (b) for women over the age of 40, except in cases where ovarian stimulation with medication was initiated before the age of 41 and has been successful, and the MAR process is continued up to the embryo transfer without freezing the embryo.

Standard local health insurance plans in Latvia generally exclude infertility treatments. Some insurance companies might cover co-payment of the state-covered MAR services.

Over the years, both the allocated funding and the number of births have increased in Latvia. Over a ten-year period, a total of 7,473,485.50 EUR has been allocated to this initiative. According to NHS data, starting from 2012, when state support began, and 2021, a total of 5,516 MAR procedures were performed, resulting in 2,165 births. Nevertheless, this data remains incomplete, as some individuals seek infertility treatment privately or do not turn to medical institutions at all. To grasp the larger picture, one can look at the newborn registry in the Health Statistics Database. Over 12 years (2010–2021), 3,451 births were recorded with a note indicating the use of IVF, ICSI, or intrauterine insemination (Veselības statistikas datubāze, n.d.). It is important to emphasize that not all uses of these technologies are related to infertility—MAR is also utilized by same-sex couples wishing to have children, and both state-funded and privately funded procedures are included.

It is analytically valuable to situate this aspect within a broader demographic context, particularly considering ongoing concerns about population decline and reproductive trends. The demographic situation in Latvia in 2025 indicates a continued population decline, primarily driven by low birth rates and high mortality. In 2024, a total of 12,571 newborns were registered in Latvia, which is 13.2% or 1,919 fewer than in 2023 (Oficiālās statistikas portāls, 2025). This represents the lowest number of births in the past 100 years. The total fertility rate in 2023 was 1.36, which is below the European Union average of 1.46 and significantly lower than the replacement level of 2.1–2.2 (Oficiālās statistikas portāls, 2025). Births following the use of MAR account for 0.8–2.5% of all births in Latvia each year (Ķīvīte-Urtāne et al., 2023, p. 41).

According to data provided by specialists from clinics in 2018, the success rate of MAR procedures in Latvia was 45%, referring to the number of children born as a result of these procedures (Nacionālais veselības dienests, 2019). Compared to other countries, such as the United Kingdom, this is considered a very high rate (Nacionālais veselības dienests, 2019). Doctors interviewed for this study also expressed a favourable view of the state program. One of the interviewed gynecologist-reproductologists commented: "It's [the program] very good. I would be truly happy if I could help even more couples." She explained that Latvia's high success rate can be attributed to several factors. A key element is the close cooperation between doctors and patients: "We always share our personal phone numbers." Clinics also can swiftly acquire the latest technologies without being hindered by complex bureaucratic procedures. Furthermore, continuous learning and the regular updating of professional knowledge allow medical practitioners to make decisions based on the most current global scientific evidence.

5. "It's More Complicated With Men": (Re)Producing Heteronormativity

When describing the clients of the clinic, one of the interviewed gynecologist-reproductologists explains that her clients include heterosexual women without partners and homosexual women, because "any woman has the right to want a child. It's more complicated with men." Why is it "more complicated with men"? And what does this reveal about who is considered eligible for state support in situations where reproduction requires both technological and state assistance? To answer these questions, this subsection examines how heteronormativity is embedded in legal regulations and the rhetoric of politicians and doctors when discussing the state-funded infertility treatment program.

Almeling, in her comprehensive article on reproduction research in the social sciences, concludes that "men are almost completely absent in research on reproduction, reinforcing the notion that this is a 'women's issue,'" (Almeling, 2015, p. 424). At the same time, Almeling, referring to Edin and Nelson (2013), argues that "only recently has this gap attracted sustained attention, with in-depth historical and qualitative studies on men's experiences of conception." The concept of "reproductive masculinity" was developed by Daniels (2006, pp. 6–7), encompassing "the associated cultural beliefs that men are secondary to reproduction, their bodies are invulnerable to reproductive harm, and they are far removed from the health problems of their children."

Heteronormativity—the assumption that heterosexuality is natural and superior to other forms of human sexuality—is embedded in the Latvia's Sexual and Reproductive Health Law (Saeima, 2002), where infertility is defined as "the inability of two opposite-sex individuals who have reached reproductive age to conceive a child within a year while engaging in regular sexual intercourse without contraception." This definition relates to that of the WHO, which defines infertility as a disease of the reproductive system in either a man or a woman, determined by the failure to conceive after twelve months or more of regular, unprotected sexual intercourse (WHO, 2024). This definition relies on the implicit assumption that such intercourse occurs between a cis-woman and a cis-man. The heteronormativity is also embedded in the way infertility diagnosis and treatment are covered by state budget funds for both women and men. Only women can be admitted to the queue for state-supported infertility treatment administered by the NHS (Nacionālais veselības dienests, 2025).

Heteronormativity is also evident in how access to MAR services in general is regulated in Latvia. Article 13, Section 2 of the Sexual and Reproductive Health Law states: "Medical fertilization is performed at the request of a heterosexual couple or a woman, based on a written application submitted to a medical institution by a heterosexual couple or a woman" (Saeima, 2002). The law prioritizes one form of sexuality but does not define a woman's sexual orientation or partnership status. As a result, this service is available in Latvia not only to heterosexual women but also to homosexual women and women without a partner.

A paradoxical fact emerges. On the one hand, it is impossible to register a same-sex marriage (civil unions were legalized in 2023, taking effect from July 2024) in Latvia, but on the other hand, MAR regulations allow, for example, same-sex female couples to have children. However, it is important to note that this regulation explicitly excludes not only homosexual men but also heterosexual men without a partner. This reproductive inequality is also pointed out by a gynecologist-reproductive specialist, whose quote opens this subsection. She confirmed her clinic serves both heterosexual women without partners and homosexual women:

Every woman is entitled to the desire for a child, but when it comes to men, the situation becomes more complex.

Why is it "more complicated with men"? What do the examples described above reveal about the way childbearing is perceived in Latvia? First, a woman not only has the "right to want a child" but can also practically realize this wish, whether alone or with a partner. Second, heterosexual men without a partner and homosexual men face greater difficulty in accessing infertility treatment and childbearing in general. Their reproductive desires cannot be fulfilled independently of a woman. Thus, men's position in reproduction can be described as secondary, subordinate, and unequal.

This asymmetry, as defined by Strathern, can be explained through historical perceptions of motherhood and fatherhood (Strathern, 1992, p. 148). Historically, in so-called Western societies, motherhood was considered a natural phenomenon, whereas fatherhood was viewed as social or cultural—in this sense, artificial. For a long time, it was believed that there was certainty about the former (with childbirth as proof) and internal uncertainty about the latter (paternity could only be assumed; see Strathern, 1992, p. 148).

Strathern refers to Sybil Wolfram, who, describing English law, notes that "a husband is presumed to be the father of any child born to his wife unless it can be proven that he is not the biological father" (Strathern, 1992, p. 148). A child's mother was considered the woman who gave birth, whereas a father was determined by his social bond (marriage) with the mother—"the mother is linked to the child, while the father is linked to the mother" (Strathern, 1992, p. 148). This principle is still present in Latvia. Article 146 of the Civil Law states that "the mother of a child is recognized as the woman who gave birth to the child" (Ministru kabinets, 1937), whereas the father is recognized as the man married to the woman who gave birth to the child.

Both the way the state defines men's and women's roles in reproduction align with research on fatherhood in Latvia. Studies have concluded that the core unit of a family, by default, consists of women and children, while men's involvement is subject to possible variability (Sedlenieks & Rolle, 2016, p. 3). That is, fathers are perceived as helpers or assistants rather than equal parents.

Heteronormativity is also part of the bigger picture in Latvia. The assumption that gender is binary and that the most appropriate type of relationship is between people of the opposite sex is reflected in Article 110 of the Latvian Constitution, which states: "The state protects and supports marriage—a union between a man and a woman" (Satversmes Sapulce, 1922).

Men in Latvia enter the state's sphere of attention and concern mainly once they become fathers. This is evidenced by various state regulations and initiatives by non-governmental organizations. Since 2023, each parent of a newborn in Latvia is required to take at least two months of parental leave. The main goal of this legislative measure is to involve both parents in the care of the child. Indirectly, this legislative change aims to increase fathers' involvement in the care of their children during the first months of the child's life. Since 2009, Father's Day has been celebrated on the second Sunday of September in Latvia. There are several non-governmental organizations in Latvia aimed at promoting fatherhood. For example, the Latvian organization "Tēvi" promotes active fatherhood by conducting research, raising public awareness, organizing support groups and educational activities for fathers, training professionals, and advocating for policy changes that strengthen the role of fathers in families and society (Tēvi, n.d.).

6. "The State is Interested in Paying to Get Results'": State Support for Infertility Treatment

"The state is interested in paying to get results," said one of the interviewed gynecologists-reproductologists, clearly indicating that the state's involvement in infertility treatment is driven by the logic of market economics. In this subsection, I examine how politicians and reproductive health specialists, when discussing infertility treatment and state support, articulate who can be included within the scope of state care.

6.1. The Logic of Market Economy

In several interviews with doctors and politicians, the logic of the market economy becomes evident: the state is framed as an investor allocating funds with the expectation of a return. In this context, the anticipated return is an increase in childbirth rates, which is seen as a means of ensuring the country's future economic growth. One of the interviewed gynecologists and reproductive health specialists explicitly refers to this economic rationale:

> You have to understand that this is a business at the national level. The state gives you money so that you can generate a return on that money for the state.

Similar views are expressed by politician Imants Parādnieks from the National Alliance VL-TB/LNNK party, who has long worked on demographic issues:

> There must be sufficient state support, investments. Let's put it this way: The economic logic is that each child born contributes approximately one million euros to our economy….If people want to have children, and the state provides support to help bring these children into the world, then no matter how much we invest—within reason, of course—it benefits the country's growth and economy.

Social anthropologist Mileiko (2018, p. 138) also points to the economic logic of fertility management in Latvia, concluding that the allocation of state budget funds for citizens' reproductive health legitimizes the state's authority to determine who qualifies for state support and who is excluded.

6.2. Body Mass Index

Fertility can be influenced by various factors, including a woman's body mass index (BMI). Studies show that a high BMI is positively correlated with fertility problems (Mena et al., 2020), while a low BMI can also negatively affect fertility (Foucaut et al., 2019). Both doctors and politicians who participated in the research acknowledged that, in the future, the state-defined criteria for women seeking state-funded infertility treatment could be expanded. They suggested that BMI should be included as an additional criterion, as both high and low BMI can negatively affect the chances of a successful pregnancy. One of the gynecologist-reproductologists expressed his concerns:

> Legally, I can't refuse her on that basis, but it's money wasted….The next step is that, legally, I should be able to say: "Dear girl, your BMI is completely off." You know what's interesting? When that girl adjusts her BMI, she gets pregnant. That's the issue. We need to say that we can't just hand out money.

A similar view was expressed by another interviewee, a gynecologist-reproductologist.

> There are only age limits, but no BMI restrictions….Honestly, we waste resources. These young women keep coming back again and again. The state process ends when the embryo is transferred. For a particular woman, we spend fifteen thousand euros….She knows—we've told her everything—that it won't work, but she has the legal right to demand: "Let's keep going, I pay taxes, after all." And we are paying for money to be thrown away.

Politician Imants Parādnieks, who has worked on demographic issues in Latvia for many years, emphasizes that BMI is not only about the physical condition of the person who wants to receive state support, but it also indicates a person's moral character.

> If a person is not willing to invest the effort to meet the minimum requirements—for example, regarding BMI, and I'm not saying everyone should look like a bundle of sticks—then the question arises: What kind of parent will this person be? If they behave irresponsibly toward their own body, we are only increasing the number of irresponsible parents. Do we need that? No, we don't. What we need are responsible people.

Parādnieks' statement suggests that body weight reflects a person's moral qualities and potentially indicates whether they can be a responsible parent. In this idealized vision, the state is composed of individuals who consciously care for their physical well-being and are thus capable of being responsible not only for themselves but also for their future children. It is through this responsible attitude—embodied in a well-maintained and disciplined body—that the state can continue to function successfully.

By discussing the need for additional eligibility criteria, doctors position themselves as responsible managers of state resources and as intermediaries between the state and individuals. Through their participation in the state-supported infertility treatment program, doctors actively implement the country's natalist policies. Social anthropologist Elīna Kursīte has examined ideas and practices related to childlessness in Latvia and concludes that a natalist ideology is present (Kursīte, 2014). According to her, this ideology is maintained through various state regulations and policy measures aimed at increasing the national birth rate.

6.3. Legal Status of a Relationship

Politician Imants Parādnieks also argues that not only a properly maintained body but also marriage—as a formalized relationship between two heterosexual individuals—is a morally appropriate foundation for responsible parenthood. As he states:

> It confirms that you are responsible to each other and to the child, so that the child has the best possible place—a family, where they can grow up to become a decent person.

In the context of infertility treatment, he sees marriage as serving several functions. First, it signals potentially responsible behavior in the creation and upbringing of children. Second, marriage allows the state to regard individuals as responsible partners in their relationship with the state, thereby justifying their inclusion within the state's sphere of care.

In some countries, in addition to gender, age, and diagnosis, relationship status is also a criterion for accessing state-funded MAR. For example, in Germany, only married heterosexual couples are eligible, and public health insurance only provides reimbursement for them (Milewski et al., 2025). This requirement is based on the idea of a "proper" family model in which a child should grow up in a family with two married biological parents. In Latvia, no such requirement exists. However, politician Imants Parādnieks supports the German approach. He believes that the state-defined union of individuals in the form of marriage is a mark of a responsible and upstanding person—someone who, by extension, can be expected to act responsibly when having children.

Overall, these statements from doctors and politicians about BMI and marriage as potential state criteria reveal the type of people they believe should receive support for having children. Beyond physical criteria, their remarks highlight a moral dimension—responsibility for one's body and partner.

7. Conclusion

Infertility—its diagnosis, treatment, and the broader use of medical technologies—serves as a lens through which to examine how morally acceptable reproductive processes are perceived in Latvia. It sheds light on who can (and cannot) be diagnosed with infertility, who qualifies (or does not qualify) for MAR, and who receives (or is denied) state support for infertility treatment, ultimately shaping the boundaries of inclusion and exclusion within the state's sphere of care.

It can be concluded that the way infertility is defined and state support for its treatment is structured, both in legal documents and in the statements of research participants (politicians and doctors), reflects the prevailing heteronormativity in reproductive matters. In Latvia, women are positioned as the primary managers of reproductive processes. Only a woman diagnosed with infertility can be placed on the waiting list for state-supported infertility treatment. Meanwhile, a man's health examinations and treatment are only possible in connection with a female partner, effectively making her the "gatekeeper" of reproductive processes.

The heteronormative framework embedded in state support programs not only excludes certain groups from state care (heterosexual men without partners and homosexual men) but also continues to concentrate reproductive responsibility on women. In contrast, men only enter the state's sphere of attention and concern once they become fathers. This is evidenced by various state regulations (such as amendments to the parental leave law) and initiatives by non-governmental organizations (such as events dedicated to fathers, support groups).

In everyday life, reproductive policies are maintained and implemented by private medical institutions. Clinic staff perceive themselves as responsible managers of both state resources and human bodies. By participating in the state-supported infertility treatment program, clinics act as intermediaries between the state and women, effectively forming a practical and symbolic agreement with the state regarding childbirth.

Both politicians and doctors in Latvia argue that it is not enough for children simply to be born. There is also an expectation that children should be conceived through a morally appropriate process and brought into a morally acceptable environment. The statements from doctors and politicians about BMI and marriage

as potential state criteria reveal the type of people they believe should receive support for having children. Beyond physical criteria, their remarks highlight a moral dimension—responsibility for one's body and partner. The research participants' responses suggest that, in an ideal scenario, the state should consist of people who consciously take care of their bodies, live in registered relationships, and are responsible not only for themselves but also for future generations, thereby contributing to a stable and morally grounded society.

Latvia's infertility policy combines biomedical eligibility with moral criteria shaped by heteronormative and demographic values. Viewed in a broader comparative perspective, this case shows how policies that appear inclusive on the surface can still produce unequal access through culturally embedded ideas about who is morally deserving of state-supported reproduction.

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Conflict of Interests

The author declares no conflict of interests.

Data Availability

Data that support the findings in this article are available from the author upon reasonable request.

LLMs Disclosure

ChatGPT (GPT-4) was used to refine the English language and improve readability. The intellectual content and interpretations remain entirely my own.

References

Agarwal, A., Mulgund, A., Hamada, A., & Chyatte, M. R. (2015). A unique view on male infertility around the globe. *Reproductive Biology and Endocrinology*, *13*, Article 37. https://doi.org/10.1186/s12958-015-0032-1

Almeling, R. (2015). Reproduction. *Annual Review of Sociology*, *41*, 423–442. https://doi.org/10.1146/annurev-soc-073014-112258

Birenbaum-Carmeli, D. (2004). 'Cheaper than a newcomer': On the social production of IVF policy in Israel. *Sociology of Health & Illness*, *26*(7), 897–924. https://doi.org/10.1111/j.0141-9889.2004.00422.x

Brigham, K. B., Cadier, B., & Chevreul, K. (2013). The diversity of regulation and public financing of IVF in Europe and its impact on utilization. *Human Reproduction*, *28*(3), 666–675. https://doi.org/10.1093/humrep/des418

Calhaz-Jorge, C., de Geyter, C. H., Kupka, M. S., Wyns, C., Mocanu, E., Motrenko, T., Scaravelli, G., Smeenk, J., Vidakovic, S., & Goossens, V. (2020). Survey on ART and IUI: Legislation, regulation, funding and registries in European Countries: The European IVF Monitoring Consortium (EIM) for the European Society of Human Reproduction and Embryology (ESHRE). *Human Reproduction Open*, *2020*(1), Article hoz044. https://doi.org/10.1093/hropen/hoz044

Chambers, G. M., Sullivan, E. A., Ishihara, O., Chapman, M. G., & Adamson, G. D. (2009). The economic impact of assisted reproductive technology: A review of selected developed countries. *Fertility and Sterility*, *91*(6), 2281–2294. http://doi.org/10.1016/j.fertnstert.2009.04.029

Daniels, C. R. (2006). *Exposing men: The science and politics of male reproduction*. Oxford University Press.

Dunn, A. L., Stafinski, T., & Menon, D. (2014). An international survey of assisted reproductive technologies (ARTs) policies and the effects of these policies on costs, utilization, and health outcomes. *Health Policy*, *116*(2/3), 238–263. https://doi.org/10.1016/j.healthpol.2014.03.006

Edin, K., & Nelson, T. J. (2013). *Doing the best I can: Fatherhood in the inner city*. University of California Press.

Edwards, J. (2017). The politics of "see-through" kinship. In T. Thelen & E. Alber (Eds.), *Reconnecting state and kinship* (pp. 155–177). University of Pennsylvania Press. https://doi.org/10.9783/9780812294415-007

Engeli, I., & Allison, C. R. (2016). Governing new reproductive technologies across Western Europe: The gender dimension. In M. Lie & N. Lykke (Eds.), *Assisted reproduction across borders: Feminist perspectives on normalizations, disruptions and transmissions* (pp. 87–99). Routledge. https://doi.org/10.4324/9781315561219

Foucaut, A. M., Faure, C., Julia, C., Czernichow, S., Levy, R., Dupont, C., & ALIFERT collaborative group (2019). Sedentary behavior, physical inactivity and body composition in relation to idiopathic infertility among men and women. *PLoS ONE*, *14*(4), Article 0210770. https://doi.org/10.1371/journal.pone.0210770

Gammeltoft, T. M. (2014). *Haunting images: A cultural account of selective reproduction in Vietnam*. University of California Press.

Ginoza, M. E. C., & Isasi, R. (2020). Regulating preimplantation genetic testing across the world: A comparison of international policy and ethical perspectives. *Cold Spring Harbor Perspectives in Medicine*, *10*(5), Article 036681. https://doi.org/10.1101/cshperspect.a036681

Heidt-Forsythe, E. (2016). Morals or markets? Regulating assisted reproductive technologies as morality or economic policies in the states. *AJOB Empirical Bioethics*, *8*(1), 58–67. https://doi.org/10.1080/23294515.2016.1209595

Ķīvīte-Urtāne, A., Lazdāne, G., Demčenko, K., Gobiņa, I., Isajeva, L., Ivanovs, A., Kezika, S., Kursīte, M., Libora, I., Miķelsone, A. I., Ozoliņa, K., Penka, E., Rakša, V., Štolcere, I. E., & Zīverte, M. L. (2023). *Pētījums par Latvijas iedzīvotāju seksuālās un reproduktīvās veselības ietekmējošiem faktoriem un paradumiem*. LR Veselības ministrija. https://www.esparveselibu.lv/sites/default/files/2023-11/Pētījuma%20gala%20ziņojums.pdf

Kuckartz, U. (2014). *Qualitative text analysis: A guide to methods, practice & using software*. Sage.

Kursīte, E. (2014). *Brīvprātīgās bezbērnu sievietes Latvijā*. Rīgas Stradiņa universitāte.

Labklājības ministrija. (2011). *Ģimenes valsts politikas pamatnostādnes 2011.–2017.gadam*. https://www.google.com/url?sa=t&source=web&rct=j&opi=89978449&url=https://www.lm.gov.lv/lv/media/964/download&ved=2ahUKEwjC8Oui2uKNAxUkExAIHZqMN2QQFnoECBcQAQ&usg=AOvVaw26epaRZ0RwYQD_bwAJutpM

Mena, G. P., Mielke, G. I., & Brown, W. J. (2020). Do physical activity, sitting time and body mass index affect fertility over a 15-year period in women? Data from a large population-based cohort study. *Human Reproduction*, *35*(3), 676–683. https://doi.org/10.1093/humrep/dez300

Mileiko, I. (2018). *Auglība tradicionālajā un mūsdienu kultūrā Latvijā*. Latvijas Universitāte.

Milewski, N., Passet-Wittig, J., & Bujard, M. (2025). Infertility and seeking medical help to have a child vary across migrant origin groups in Germany. *Population Research and Policy Review*, *44*, Article 25. https://doi.org/10.1007/s11113-024-09921-3

Ministru kabinets. (1937). *Civillikums*. https://likumi.lv/ta/id/225418-civillikums

Ministru kabinets. (2003). *Medicīniskās apaugļošanas organizatoriskā kārtība un neauglīgo ģimeņu reģistra, medicīniskās apaugļošanas reģistra, vienotā dzimumšūnu donoru reģistra un donoru dzimumšūnu banku*

izveidošanas kārtība (Regulation No. 716). https://likumi.lv/ta/id/82281-mediciniskas-apauglosanas-organizatoriska-kartiba-un-neaugligo-gimenuregistra-mediciniskas-apauglosanas-registra-dzimumsunu-donoru-registra-un-donoru-dzimumsunu-banku-izveidosanas-kartiba

Ministru kabinets. (2013). *Veselības aprūpes organizēšanas un finansēšanas kārtība* (Regulation No. 1529). https://likumi.lv/ta/id/263457-veselibas-aprupes-organizesanas-un-finansesanas-kartiba

Nacionālais veselības dienests. (2019, February 14). *Atzinīgi novērtē valsts apmaksātas medicīniskās apaugļošanas rindas centralizēšanu* [Press release]. https://www.vmnvd.gov.lv/lv/jaunums/atzinigi-noverte-valsts-apmaksatas-mediciniskas-apauglosanas-rindas-centralizesanu

Nacionālais veselības dienests. (2025). *Medicīniskā apaugļošana*. https://www.vmnvd.gov.lv/lv/mediciniska-apauglosana?utm_source=https%3A%2F%2Fwww.google.com%2F

Oficiālās statistikas portāls. (2025, February 14). *2024. gadā dzimstība turpināja samazināties* [Press release]. https://stat.gov.lv/lv/statistikas-temas/iedzivotaji/iedzivotaju-skaits/preses-relizes/22346-iedzivotaju-skaits-un

Puriņa, E. (2025). *Bērnudārzu rindas atrisina demogrāfiskā situācija, īres dzīvokļu nav. Kādi Rīgas koalīcijas solījumi palikuši uz papīra?* LSM.LV. https://www.lsm.lv/raksts/zinas/latvija/15.05.2025-bernudarzu-rindas-atrisina-demografiska-situacija-ires-dzivoklu-nav-kadi-rigas-koalicijas-solijumi-palikusi-uz-papira.a599041

Ross, F. C., & Moll, T. (2020). Assisted reproduction: Politics, ethics and anthropological futures. *Medical Anthropology*, *39*(6), 553–562. https://doi.org/10.1080/01459740.2019.1695130

Saeima. (2002). *Seksuālās un reproduktīvās veselības likums*. https://likumi.lv/ta/id/58982-seksualas-un-reproduktivas-veselibas-likums

Satversmes Sapulce. (1922). *Latvijas Republikas Satversme*. https://likumi.lv/ta/id/57980-latvijas-republikas-satversme

Sedlenieks, K., & Rolle, K. (2016). *Palīdzēt un atbalstīt: Latvijas tēvi ģimenes dzīvē*. Nodibinājums "Tēvi." https://tevi.lv/wp-content/uploads/2017/03/Tevi_ka_paligi_Petijums_3.pdf

Shalev, C., & Gooldin, S. (2006). The uses and misuses of in vitro fertilization in Israel: Some sociological and ethical considerations. *Nashim: A Journal of Jewish Women's Studies & Gender Issues*, *12*, 151–176. http://doi.org/10.1353/nsh.2006.0032

Sharlip, I. D., Jarow, J. P., Belker, A. M., Lipshultz, L. I., Sigman, M., Thomas, A. J., Schlegel, P. N., Howards, S. S., Nehra, A., Damewood, M. D., Overstreet, J. W., & Sadovsky, R. (2002). Best practice policies for male infertility. *Fertility and Sterility*, *77*(5), 873–882. https://doi.org/10.1016/S0015-0282(02)03105-9

Strathern, M. (1992). *Reproducing the future: Essays on anthropology, kinship, and the new reproductive technologies*. Routledge.

Tēvi. (n.d.). *Par mums*. https://tevi.lv/lv/par-mums

Thompson, C. (2021). Reprotech in France and the United States: Comparisons, reproductive technology and migrapolitics. *Reproductive Biomedicine & Society Online*, *11*, 104–105. https://doi.org/10.1016/j.rbms.2021.02.002

Veselības ministrija. (2022). *Uzlabojumi valsts apmaksāto medicīnas pakalpojumu saņemšanā*. https://www.vm.gov.lv/lv/jaunums/uzlabojumi-valsts-apmaksato-medicinas-pakalpojumu-sanemsana

Veselības statistikas datubāze. (n.d.). *MCH080. Mātes slimības, grūtniecības un dzemdību sarežģījumi*. https://statistika.spkc.gov.lv/pxweb/lv/Health/Health__Mates_berna_veseliba/MCH080_Mates_slimibas_sarezgijumi.px/table/tableViewLayout2

Waldman, E. A. (2006). Cultural priorities revealed: The development and regulation of assisted reproduction in the United States and Israel. *Health Matrix: Journal of Law-Medicine*, *16*, 65–106. https://ssrn.com/abstract=918802

WHO. (2024). *Infertility*. https://www.who.int/news-room/fact-sheets/detail/infertility

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