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"Cycling Overseas": Care, Commodification, and Stratification in Cross-Border Reproductive Travel

Andrea Whittaker and Amy Speier

Cross-border reproductive travel involves the movement of patients to undertake assisted reproductive treatment through technologies, such as in vitro fertilization and associated procedures otherwise denied to them due to cost, access, or regulatory restrictions. Based on fieldwork in Thailand, the United States, and the Czech Republic, we explore the commodification of reproductive bodies within this trade and the reduction of the nurturing affective labor of reproduction to exchange value. Second, we examine the intensification and globalization of the stratification of reproduction. These inequalities are illustrated though discussion of the trade in poor women's bodies for surrogacy and ova donation. Even reproductive body parts, ova, sperm, and embryos are stratified—marketed according to place of origin, the characteristics of their donors, and gender.

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> Don't accept the high cost of IVF in the United States. Take a trip of a lifetime to beautiful Thailand *and* have IVF while you're there! The cost of IVF at a top-rate Bangkok hospital is a third of what it is in the US, even adjusting for currency fluctuations . . . and with the money you'll be saving, why not get a great trip out of it? . . . Of course, we did our "due diligence," i.e., speaking to a number of friends and family members, several of whom are doctors. But ultimately, *we took a leap of faith* . . . because IVF isn't just about trying to get pregnant. It's about money and time and the highest of hopes. (IVF Thailand 2009. Emphasis in the original.)

Writing of the global spread of assisted reproductive technologies (ARTs), van Balen and Inhorn (2002:27) suggested that "(t)he availability of NRTs (new reproductive technologies) in disparate global sites may create new possibilities, new social imaginaries, and new arenas of cultural production, as well as new contradictions, new dilemmas of agency and new regimes of control." Drawing on field data from clients of clinics in Thailand and the Czech Republic as well as a medical facilitation company in the United States, in this article we explore some of these new imaginaries, contradictions, and dilemmas as couples travel to undertake treatment through IVF (in vitro fertilization), ICSI (intracytoplasmic sperm injection), and associated procedures such as PGD (preimplantation genetic diagnosis) and surrogacy. The prevalence of infertility,[1] the advent of sophisticated clinics across the world, and easy mobility have resulted in a heavily marketed trade and demand for these technologies.

First, we explain what undertaking these treatments overseas entails and the implications of this on our definitions of this travel. We then consider the implications of the marketing of reproductive services as a commodity. The website quoted above suggests that reproduction may be treated as a matter of money and time—a disconnected commodity relying on miracle technology rather than an intimate human experience. We explore some of the tensions of the commodification of reproductive bodies within corporate medicine and the reduction of the nurturing affective labor of reproduction to exchange value. We note the attempts by companies to assert the primacy of affective relationships in their trade, yet the distancing when they describe the economic motivations of surrogates and ova donors.

Second, we examine the intensification and globalization of the stratification of reproduction (Ginsburg and Rapp 1991). Inequalities central to this trade cross familiar divides of class/race, rich/poor, Western/non-Western, elite/subaltern, and developed/less-developed country. The

need to travel also speaks of inequalities and differential access to medical care for patients *within* origin countries (Spar 2006). Except in the few countries with publically funded schemes (e.g., Israel), access to ARTs is restricted to the wealthy. These inequalities are most intensely illustrated in a discussion of the marketing of bioavailability—the trade in poor women's bodies for surrogacy and ova donation (Heng 2007). Even the reproductive body parts, ova, sperm, and embryos are stratified and are marketed according to place of origin, the characteristics of their donors, and gender.

As the articles of this issue attest, a new geography and economy of the body is mapped on the globe, with various locations popular for particular specialties concerning various parts of the body (Kangas 2002:58). Major hubs for reproductive travel in Europe include Spain, Belgium, Cyprus, and the Czech Republic; in the Middle East and Africa include Jordan, Israel, and South Africa; and in Asia include Thailand, India, and South Korea. The United States is still an important destination for commercial surrogacy and ova donation, although its high prices are a barrier for many couples. The destination sites usually have evolved through a combination of sophisticated medical infrastructure and expertise; particular regulatory frameworks (or the lack of them), which enable certain procedures; and lower wage structures, which allow ARTs to be performed at competitive lower costs than in other countries. Good tourist infrastructure such as hotels, government policies supportive of medical travel in general, the common use of English among medical providers, the availability of translators, religious affiliations, and ease of travel and visa requirements all play important roles in determining which countries are popular destinations.

Scholars in history, public policy, and medicine have written of the bioethical, regulatory, and financial complexities cross-border reproductive care entails (Pennings 2002, 2004; Heng 2007; Matorras 2005; Deech 2003; Blyth and Farrand 2005; Storrow 2005), but anthropological engagements are only recently emerging. They include a large study of such movement across the Middle East by Inhorn (in press), complementing her extensive work on IVF in Egypt (1994). In her 2003 study in Egypt, she noted that it was typical of elite Egyptian families to attempt IVF overseas and to only seek treatment in Egypt once it had failed. One third of the 41 upper-middle class couples of her study had travelled to Europe and the United States for IVF—what she then termed "therapeutic transnationalism." Those who did not cited logistical and moral concerns as well as cost considerations as factors discouraging them from doing so. Similarly, studies of IVF in Israel by Kahn (2000) noted how the ardently pronatalist religious and social conditions in Israel encourage a trade in ova donors for Israeli couples having difficulty fulfilling rabbinical conditions for ova donations by appropriate non-married donors. This includes the trade in "white" egg donors from

former Soviet countries who fly into Cyprus to supply ova to wealthy couples from Israel and Western Europe (Kahn 2000:132; Nahman 2006). Birenbaum-Carmeli (1998) also wrote of travel by Canadian women to seek reproductive care in Israel. Reflecting on her own experience as a patient and participant-observer, she noted the differences in clinic culture and doctor-patient relationships in the two locations, despite similar technologies. A large sociological study of the experiences of British people who travel overseas for fertility treatment is currently underway (Culley and Hudson 2009).

Other work in progress includes ethnographies of IVF and the surrogacy and ova trade. Such studies highlight the stratified and exploitative relationships involved (Pollock 2003; Spar 2006). For example, poor minority women are recruited as gestational surrogates in the United States (Ragoné 2005; Tober 2002) and poor Indian women are marketed as "wombs for rent" (Vora 2008; Deomampo 2008; Bharadwaj 2008). Bharadwaj (2008) wrote that these journeys breach transnational, human, ethical, scientific, and cultural thresholds as "bio-crossings" and noted how such movements of reproductive bodies and body products result in differing understandings of the nature of donations and are culturally charged with religious, caste, and class notions of appropriateness.

METHODS

Research on reproductive travel poses considerable methodological challenges. Apart from the difficulties in gaining access to IVF clinics (Inhorn 2004), there are difficulties in identifying and recruiting patients to interview. Given population mobility, there is little option but to identify and recruit patients through contact with facilitation companies arranging their travel, through websites, or in the destination infertility clinics. Data for this paper were generated as follows. The first author conducted interviews with patients in four IVF clinics as part of a broader study on IVF in Thailand during seven months of fieldwork in Bangkok in 2007. Initially 10 clinics in Bangkok and Chiang Mai were approached as possible field sites, and preliminary information was gathered regarding caseload and proportions of foreign patients. The four clinics included in this study were Bangkok-based whose heads and staff welcomed the presence of a researcher. Only one clinic had a significant foreign clientele. Thai and foreign patients were initially approached by clinic staff to see if they wanted to participate in the study; they then carried out an informed consent procedure and underwent a face-to-face interview with the first author that lasted approximately 1 hour. Foreign patients were less likely than Thai patients to consent to an

interview, possibly due to the fact that some couples travel in order to keep their treatment confidential. A total of six couples who had travelled from overseas to undertake IVF treatments in Thailand, data from these couples, and interviews with clinic staff informs this paper.

The second author recruited company representatives and clients of a "medical tourism facilitator company" that assists couples by arranging ARTs in the Czech Republic. She traveled to their home-based company in Ohio, where she conducted informal and semi-structured interviews with both owners of the company. This company is one of two North American consulting firms that deals with the Czech Republic, and they work exclusively with the Clinic of Reproductive Medicine in Zlín, Czech Republic. IVF Holidays provide roughly 25 percent of the clinic's clientele; 90 percent of IVF Holidays' clientele is American, but Canadians, Australians, Nigerians, and some Europeans also use its services. In addition, phone and e-mail interviews were conducted with three former clients of this company after obtaining informed consent from both the owners and the clients. Pseudonyms have been used for all informants and the company name, but we acknowledge the difficulty in maintaining anonymity when working with public businesses.

Some couples did not want to participate in interviews because they feared being portrayed in negative ways. One owner, Hana, suggested that some women do not want to talk about the trip they took at all: "Some people when they get pregnant or they deliver the baby, they are doing like they've never been on the trip and they never want to talk about it." This suggests perceived stigma and secrecy attached to infertility and the use of new reproductive technologies, particularly when pursued overseas.

Although our sample is small and not representative, our interviews provide insight into the motivations and experiences of cross-border reproductive patients. They are supplemented by testimonials from websites and web chat room accounts. The combination of data from two separate field sites – an Asian developing country and a European middle income country – allows us to consider the similarities and differences in the trade, each offering similar services and regulatory freedom, and both part of the global "therapeutic itineraries" (Kangas 2002) of infertile couples.

TO HAVE BABY . . . WILL TRAVEL: "CYCLING" OVERSEAS

Unlike other forms of medical travel described in this special issue, travel for ARTs is usually not a "one-off" procedure but rather a commitment to a range of tests and procedures across the course of a "cycle." For this reason, IVF treatment appears an unlikely candidate as a procedure for medical

travel because of the time and multiple steps involved. Usually only affluent travelers can afford the long stays required. For a woman, a cycle in IVF takes place across approximately 21 to 28 days. It involves suppressing a woman's normal menstrual cycle, inducing ovulation, usually involving daily injections of pituitary hormones to produce a number of eggs, "oocyte retrieval" (the "harvesting" of those eggs using an ultrasonically guided needle), fertilizing those eggs by sperm, growth "in vitro" in the laboratory across a number of days, selection and further testing in the case of PGD, further hormonal stimulation for some women to induce the production of endometrial lining, and transferring (usually two) resulting embryos directly into the uterus. Two weeks later, testing (which may occur back in the home country) reveals whether implantation of the embryo has been successful. Men have less physical involvement. This is so even when male infertility requires procedures such as ICSI, involving testing and sperm collection through masturbation or a surgical procedure. Alternately, a man may have his sperm collected in his home country and couriered overseas for use.

While some tests and procedures may be undertaken in their home countries before travelling overseas, minimally, a woman undergoing IVF must stay for two to three weeks. If she chooses to complete all of her preparation and testing for a cycle in the destination clinic, she may need to stay for up to three months.

Paradoxically, couples with more complex fertility issues who require surrogates and egg donors may need to spend less time in the destination clinic. A woman using a surrogate but her own eggs will undergo most procedures, excluding the transfer of the embryos. When a couple uses donor eggs and a surrogate, a male partner may travel alone to deposit sperm, and further travel occurs only when the couple receives the newborn child.

There are no accurate statistics on the numbers of patients travelling for such services (Nygren et al. 2010). While individual hospitals and clinics may maintain such statistics, few regulators systematically collect data. Data also may differ because of definitions. Some hospitals count patient visits or cycles, not individual patients, and may record nationalities, not place of residence. A report by the European Society of Human Reproduction and Embryology Taskforce for Cross Border Reproductive Care (2009) indicated that each year, 20,000–25,000 treatment cycles take place for women from Britain travelling abroad to European countries to access treatment unavailable to them at home. A survey of Canadian and US fertility service providers found that approximately six percent of the total Canadian IVF volume is leaving the country for treatment (445 out of 6,927 annually), the majority (80%) for anonymous donor eggs. Four percent of the total US IVF treatment involves patients from other countries (Hughes and DeJean 2010).

REPRODUCTIVE TRADE IN THAILAND AND THE CZECH REPUBLIC

Thailand has sophisticated tourism and health care infrastructure and a flourishing trade in medical travel. Over a million patients per year, the majority from Japan, the United States, the United Kingdom, and Middle Eastern countries, seek medical procedures (Chai-aim 2009). Of 30 registered IVF clinics across Thailand (Royal Thai College of Obstetrics and Gynecology [RTCOG] 2008), six clinics in Bangkok and one in Chiang Mai treat the majority of the foreign patients who come for treatment. IVF in Thailand costs approximately 80,000 Baht per cycle (US $2270), one third of the cost of treatment in the United State. However, cost is not the only factor driving the trade in Thailand: access to PGD for sex selection also attracts patients.

ARTs have proliferated in Thailand with little state intervention. An initial Medical Council Order was published in the *Royal Gazette* in January 1998, requiring all clinics to provide counseling to patients to prepare them for possible problems and to appoint an ethics committee to decide on treatments and medications. A draft reproductive health bill, still awaiting ratification by parliament, includes measures to regulate ARTs and surrogacy.[2] Until then, it is up to each clinic and doctor to decide on protocols. Presently ARTs are used in various ways without regulation. This is one of the primary draw cards for reproductive travelers.

The Czech Republic also has a large medical travel industry worth over US $182,000,000 to the Czech economy in 2006 (Warner 2009). The services of a number of reproductive clinics are advertised in Prague and surrounding provinces. The Czech Republic has 23 centers of assisted reproduction (Donovan 2006), especially targeting patients requiring ova donation. Websites advertise in English, German, Italian, and Russian, stressing the ready availability of student ova donors and only a three-month waiting period. Treatment is not as cheap as in Thailand, but it is still less expensive than in the United States (US $3000 for IVF, US $4000 for an egg donor cycle). In June 2006, Legislative Act No. 227/2006 Col. was passed governing sperm and oocyte donation. Under this legislation, donation is legal but must be voluntary, gratuitous, and anonymous. Donors cannot be paid, but are offered attractive "compensatory payments" of approximately US $800 (the equivalent of three-months' salary) for the discomfort involved in ovarian stimulation and oocyte retrieval.

The clinic in Zlin attended by the interviewees was described by one as "a Soviet era factory building, and there was a freight elevator .... But once you stepped off the elevator, it was like any clinic, immaculate." Patients describe clinics as "like any clinic"—manifestations of global biomedical technoculture, with similar clinical procedures and routines, roles and

technology. This is emphasized in all medical travel marketing. The foreign patients in Thai clinics also described the clinic as "the same" as other IVF clinics, but "more comfortable." The clinic is in a popular tourist area of Bangkok, a multi-storey modern building with plush décor and seating, offering a "one-stop shop" with all lab facilities, counseling rooms, surgeries, and a maternity center in-house. Short-term accommodation in several hotels and apartments are nearby.

Cultural differences in the doctor-patient relationship and expectations are effaced in these descriptions. Place is relegated to an exotic backdrop, picturesque scenes and stereotypes to be experienced at leisure, stripped of history, context, or relationship. Moments of encounter with local cultural differences can be unsettling (as in the reminder to the patient of a Soviet past) or experienced as an added unexpected dimension of special significance. For example, at the Thai clinic, patients noted the presence of a shrine at the front of the clinic as a reassuring example of the "deep spirituality" of Thais.

CROSS-BORDER REPRODUCTIVE TRAVEL, REPRODUCTIVE TOURISM, OR REPRODUCTIVE EXILE?

Consistent with the other papers in this issue, we use the term "cross-border reproductive travel" rather than "reproductive tourism" or "infertility tourism" to describe the movement of patients for reproductive treatments (Pennings 2005). The difficulties over appropriate neutral definitions point to the variability within the population of people travelling for such care. Reproductive tourism carries intimations of hedonism discordant with the anxiety, hope, and pain often associated with these treatments. However, unlike some other forms of medical travel, IVF treatment *can* lend itself to a combination of treatment and tourism between appointments. There may be several days between medical appointments, and patients are otherwise in good health. Sightseeing usually occurs before embryo transfer, not after.

Fieldwork in different sites reveals differing patterns. No couples interviewed in Thailand undertook touristic activities (although one had planned to do so). As explained by one informant, Pranee (40 years): "Because travelling for doing this [is] not travelling like a tourist, you know, I mean, but because we want to have a baby, we just, I'm gonna do it, I want to do it, I have to do it." Florence suggested she and her partner would "at least try to see a crocodile and elephant show" while in Thailand. In contrast, a number of couples in the Czech Republic undertook side trips to local attractions and spas, reflecting their recruitment through a company that specifically promotes "IVF Holidays." Chris, an owner of IVF Holidays, thinks it is beneficial to do IVF abroad: "it's bad enough when you do it in the States,

you gotta go to work, there's more stress at work, you have that going against you, plus you're trying to do these shots, and you're thinking about your upcoming donor cycle. I think it really helps a lot that it's a true vacation."

In opposition to the use of the term "medical tourism," Matorras (2005) described cross-border patients as "reproductive exiles"—victims of the failures and inequalities of their own medical systems to provide care and treatment for infertility (see also Inhorn and Patrizio 2009). Unmarried couples and same-sex couples may find themselves precluded from treatment in their home country. Other couples may face age restrictions on publically funded treatment or long waiting periods jeopardizing their chances of success. For many, the source of exile is the cost, which under the privatized US system is beyond the reach of many of its citizens. IVF is rarely covered by US health insurance schemes because it is defined as an "elective" procedure.

The notion of exile also evokes dislocation from home, family, and the familiar—a consequence of the global mobility experienced by reproductive travelers. A number of couples we spoke to had travelled before to other locations. For example, Florence and Joaquim had undergone treatment in South Africa before treatment in Thailand. Tom (48 years) and Pranee (40 years) had sought treatment in Australia, Thailand, Belgium, and birthed in Malaysia. The owner of IVF Holidays spoke of their many repeat customers to the Czech Republic.

Yet the term "exile" is also a misnomer. Reproductive travelers can return home, hopefully with a child in arms. For many, the trip is not to an unfamiliar destination; a significant number appear to be expatriates returning to their countries of origin for treatment. For example, the owner of IVF Holidays reported that two clients were of Czech descent, and a number of Thai clinics who were phone surveyed claimed Thai expatriate women married to Westerners formed the bulk of their "foreign" couples (Whittaker 2009). Indeed, many clinics classify such women as "Thais" not "foreigners," adding confusion to statistics of the numbers of medical travelers when many hospitals collect statistics on nationality not residence. Three couples interviewed in the Thai clinics were Thai-*Farang* (Westerner) couples.[3] The South Asian diaspora is likewise an important source of medical and reproductive travelers to India (Bharadwaj 2008). Couples seek reproductive treatment where they are familiar with the language and the medical system, and they may have existing kinship ties.

A MEDICAL FACILITATION COMPANY: "MADE US FEEL LIKE CLOSE FRIENDS"

A number of medical facilitation companies act as intermediaries for patients by organizing contacts with medical facilities; arranging travel,

accommodation, and concierge services; accompanying the patients to clinics; facilitating their treatment; and supplying translation services. In some cases these are large travel agencies that have built relationships with particular hospitals (such as Diethelm Travel and Bumrungrad Hospital in Thailand); others are stand-alone specialists in medical travel.

As described previously, IVF Holidays connects US couples with ARTs in the Czech Republic. The owners call themselves "IVF coordinators." As with most medical facilitation companies, they use the Internet as their means of marketing their services. One owner explained,

> [We] provide communication between the clinic and the client... transportation from Prague airport to Zlin, to the hotel and back. We pick them up at the hotel and take them to their appointments, and we are there with them to translate or help them with any needs.... We basically guide them through the whole process; we try to make the trip as easy as possible. The only decision to make is if [they] want to take a day trip to Budapest or Prague.

The owners started the company following their own treatment to "help others come to Czech Republic." They explain on their website: "As a fertility challenged couple, we understand the frustration and experience of trying to conceive... we're not only presidents of the company, we are also clients." In their first year in 2006, the company facilitated the travel and treatment of only two couples, but business has grown exponentially. By February 2009, a total of 220 couples had used their services. Ninety-four babies had been born—fifty percent were twins. IVF treatment costs quoted on the website in 2009 are US $3316, which includes all medications, and an additional IVF Holidays service fee of $1500. IVF with egg donation is quoted at US $4056, with a service fee of $2500. The entire cost of a trip to the Czech Republic is estimated as: "in winter, $10,000 for everything including [air] tickets for two people." This compares favorably to the cost of treatment in the United States. One client, Kathy, was quoted $38,000 per cycle in St. Louis, which did not cover medication or the donor fee.

During an interview, one owner emphasized the affective labor involved in their work: "It's so great how you get attached to people and when you talk to them... you just become more like a friend than a formal client, you know, business relationship." Patients concur in their website testimonials: "[They]... are honest, sincere, good natured people who immediately made us feel like close friends rather than clients or customers." Companies such as these reinsert the discourse of affective labor, care, and nurturing within a reproductive experience that is otherwise devoid of all familiar relationships. This supports Spar's (2006) observation of the reproductive medical

industry's attempts in the United States to distance itself from references to the market, since people do not want to refer to children as commodities. Similarly, we argue that there is an effort to assert the affective nature of reproductive travel by companies and clinics to reassert a discourse of nurture within the commercial relationship. In an experience dislocated from family, place, language, and culture, the "IVF facilitator" de-emphasizes the commodification of reproduction and reasserts the emotional relationship, a striving for reproductive normalization of the experience.

COMMODIFICATION AND CARE

The tensions between commodification and care are evident not only in marketing but in patients' own testimonies. Descriptions of foreign clinics often draw on national and ethnic stereotypes. Thai clinics are "In the Land of Smiles," and in their promotional material they emphasize special Asian service values (see also Aizura, this issue). European clinics emphasize the fact that they are *not* developing countries. Patients, too, tend to romanticize the level of care and the relationships with their practitioners despite the language and cultural divides. In testimonials describing her experience in the Czech clinic, one woman wrote,

> the doctors and nurses are everything you dream of in a health care provider. They are so nice and really dedicate their time to you. I have come to hate the doctors here [US] because they treat me like a piece of meat, and make me feel as if all they want is my money.

Another patient testimonial declared: "I didn't feel like just a wallet to him [the Czech doctor]." In such descriptions, the lower-cost health care of the Czech Republic is interpreted as a form of altruism. As Scheper-Hughes and Wacquant (2002) noted, in the new global economy, capitalized economic relations involving human bodies are often masked in other forms, such as altruism. In stark contrast, the frank commercial interests of medical care in the United States are criticized, with American doctors portrayed as profit seekers.

TRANSNATIONAL STRATIFIED REPRODUCTION

The global dissemination of technologies for assisted reproduction poses new examples of "stratified reproduction" (Ginsburg and Rapp 1991). Inequalities empower certain categories of people to reproduce and nurture,

but disempower others. In this case it privileges the reproduction of elites across wealth and nations.

The trade also speaks of the inequalities and differential access to treatment experienced within patients' countries of origins. Deprived of state subsidized health systems in countries such as the United States, middle class couples have little choice but to cross national boundaries to seek affordable treatment. In Britain, long waiting times for appointments and regulations restricting publically funded treatment to those younger than 40 years may make treatment in Thailand the only possibility. Laws restricting fertility treatments for same-sex couples or single women also may encourage movement to less regulated environments.

Regardless of their origins and difficulties in accessing treatment in their home countries, reproductive travelers by definition are affluent enough to travel overseas and pay the fees involved. One owner of IVF Holidays explained, "They're the ones with money . . . and they can travel, the Americans, the Canadians, and the British and Australians."

Because they are paying customers, different clinical criteria may be used in the treatment of foreign patients. In the clinic used by IVF Holidays in the Czech Republic, different age standards apply for American and Czech patients. For Czech women, treatment is only available up to 38 years of age. As the IVF Holidays owner explained,

> They do our patients a little differently than they do the Czech patients . . . . Look, people are flying halfway around the world to come over here, they're spending all this money, we need to do what we can to get their successes as best we can . . . . The women who are coming over from the United States or from the world, they shouldn't be over 51 years old, and then it depends on how they follow the rules more or less.

In Thailand, although doctors say they discourage treatment with IVF for women over 40 years, older women with financial resources can easily find treatment.

The trade also affects the access of local patients to assisted reproductive technologies within destination countries. ARTs tend not to be publically subsidized, and so stratification of access occurs. Poorer local infertile couples are offered basic inexpensive treatments such as medications and IUI (Intra-uterine insemination); only those who can afford it are offered access to IVF. The advent of a market oriented toward wealthy foreign patients has encouraged the development of clinics with access to the latest technology and procedures and has created an incentive for IVF specialists to remain in these countries. Yet it has also produced a division of elite clinics oriented to foreigners and the wealthiest local patients and other locally

oriented clinics with crowded facilities, heavy caseloads, and poorer lab facilities. Patients themselves question the ethics of differential access. One chat room participant asked: "Is it, well, ethical to take advantage of another country's health care system? And what about using an egg donor from a country where many people are poor? It is opportunistic?" (Conceiveonline.com 2006).

OVA AND SURROGACY: STRATIFICATION AND THE GLOBAL MARKETING OF BIOAVAILABILITY

The regional and global circulation of reproductive gametes (ova, sperm), embryos, and the reproductive bodies of surrogates brings stratification in sharp relief. Cohen (2005:83) used the term "bioavailability" to describe the wide range of bodily exchanges and their incorporation into another body (or machine). Countries such as India, Thailand, and the Czech Republic trade on their ready supply of a bioavailable population of ova and gamete donors and surrogates. The trade also involves the transnational movement of surrogates and egg donors. For example, patients in Thai clinics report that Vietnamese women travel on tourist visas to Thailand to act as sources of ova or wombs for wealthier Thai couples. Transnational companies facilitate the movements of surrogates, such as the Singapore-based company "Asian Surrogates," which arranges for surrogates from throughout the region to travel to clinics, charging approximately S $45,000 (US $30,380), of which approximately half is paid to the surrogate. The owner of Asian Surrogates has another company, "Ivimed," which buys ova from donors for S $6000 per retrieval for sale in the region (Robles 2009).

Most clients travelling to the Czech clinics are seeking ova donors. Czech egg donors get US $800 in compensation. One IVF Holidays founder noted in an interview,

> if you're [a Czech woman] working in a shop, like a grocery, you're going to make two hundred and fifty or three hundred dollars a month, so it's roughly three months wages for a girl . . . a lot of these girls get accepted into college, they get married, they get pregnant, and then while they're going to school, and because they all live in an extended family, grandma watches the kids, she can go to school to better her life . . . . School is free, she's getting paid, so she can concentrate on her studies, and then she donates eggs on the side, she's an approved donor because she has a healthy child, she can donate up to three times . . . . I mean, that's nine months salary just for doing egg donation while she's going to school for extra money.

In this account, Czech donors are depicted as poor "girl" students seeking to better themselves through a college education. Tober (2002) noted how in the United States, ova donors are usually described as intellectually privileged students requiring economic assistance with college fees. The pain and risks involved for egg donors are minimized; emphasis is placed on commercial motivation and need. This carries paternalistic and racist undercurrents. It also suggests that "compensatory payments" offered by clinics make a mockery of the Czech Republic legislation requiring donors to be gratuitous; these are commercial exchanges in all but name. The purchaser of eggs is positioned by such rationalizations as patrons financing women's economic advancement. Those patients who come for treatment are described and addressed as intended mothers undertaking special efforts to conceive, motivated by an intense desire to parent, while ova donors are distanced from their reproductive capacities as "less than mothers" through the discourses and practices of the clinics. Ova donation is framed purely in distant commercial terms, with little acknowledgement of local frameworks of meanings of such donations for either the donor or the contracting couple. More ethnographic research is needed with egg donors regarding their motivations and their interpretations of egg donation.

The relationship between surrogates, ova donors, and the intended parents is complex and cannot be readily reduced to a mere economic relationship (e.g., Roberts 1998). It involves another form of global chain of care, linking families in wealthy nations to families in poorer nations. It involves the displacement and trade in both fertility and emotional surplus value (Hochschild 2000).

For this reason, the anonymity required under Czech law is described as advantageous, maintaining emotional distance between surrogates, donors, and clients. The IVF Holidays website promotes the fact that donors are anonymous. Chris said,

> a lot of women are happy that it's an anonymous donor, you don't want to have to worry about someone knocking on your door. They [the patient] can feel comfortable being in the "no tell" camp . . .. The only thing she [the donor] knows is that you exist, they don't know where you're from, they don't know how old you are. There is a woman out there who wants your eggs, and that's all they know and that's all they'll ever know.

The attitudes of individual women toward their donors are complex. We might expect such donations to be framed as altruistic "gifts" by women who have purchased them, as in the case of semen and ova donations described by Tober (2002). While oocyte donors provide eggs only, stripped of any affective ties to the outcomes of her genetic contribution, there is a

sense that the donor could be potentially threatening, ''knocking on your door.''

Surrogacy in India (Vora 2008; Deomampo 2008) highlights similar processes of distancing, minimalizing emotional links, and emphasizing the commercial motivation in relationships between surrogates and contracting parents. Surrogacy raises questions regarding the rights of Indian surrogates and the processes that condition the alienation and commodification of their wombs. Women who act as surrogates tend to be very poor and are often illiterate; indeed these women are preferred by clinics for surrogacy (Deomampo). They are paid a fixed rate (approximately 300,000 Rupees—US $7500); in many cases, women remain at dormitories during their pregnancies to enable careful monitoring and to provide secrecy over their involvement from their communities. For some this involves separation from their own children. Indian surrogates are socialized into considering their surrogacy as akin to ''renting out a spare room in their house,'' with the baby as a guest separate from rather than part of the woman's body, emphasizing motivation purely for the money, minimizing the nurturing, risks, bodily contribution, and emotional labor involved in carrying a pregnancy to term and giving birth (Vora).

Some Indian clinics do allow the contracting parents to meet their surrogate. In others, strict anonymity is maintained; the surrogate and contracting parents never make contact and the surrogate may never know that she is supplying a baby for a foreign couple (Vora 2008). However, despite efforts by the clinics to formulate surrogacy as mere ''renting,'' a number of surrogates describe future responsibility on the part of the client to the surrogate and her family corresponding to local notions of familial duty. This highlights the different moral economies surrounding reproduction, mothering, organ donation, notions of life, and family embedded within this trade.

Ova donation and surrogacy epitomize how ARTs and Western medical culture disaggregate the work of motherhood into the provision of an ova, the gestation of a fetus, and the work and care of child rearing and ''procreative intent,'' and differentially value and distribute these across class, wealth, and now national (and ethnic and caste) lines (Vora 2008, Ragoné 2005).

''IT'S THE SKIN COLOR''

In cross-border transactions, the ova, sperm, and embryos also become culturally charged; they carry ethnic, caste, and racial values (Bharadwaj 2008). Websites offer donors of particular ethnicities. For example, apart from its

slightly lower cost, the availability of "Asian" donors for ova has made South Korea an increasingly popular choice for Japanese couples. Skin "whiteness" is traded as a valuable commodity for ova donors throughout East Asia and South Asia. In Thailand, "white skinned" sperm and ova donors are preferred, and urban myths circulate of Thai people using expensive Caucasian donors to produce the highly valued *luk krung* (half-Caucasian, half-Thai child). India is popular as a source of Asian ova and sperm, particularly for couples from the South Asian diaspora, which faces a shortage of "appropriate" sperm donors. Here appropriate may include considerations of caste, class, and ethnicity (Bharadwaj).

> Eastern European sites such as the Czech Republic have a "market advantage" because of, Caucasian donors, it's the skin color, I think because the donors are all from the Czech Republic . . . it's very similar to American, so this is what they're looking for, you can't get that in Thailand. I guess they do have white donors, I should say Caucasian, in Africa.

Hana from IVF Holidays elaborated: "Eighty-five percent of our clients are interested in the donor egg options. Most of the women are over 40, most of the women are looking for blue eyed, blond haired donors." Apart from racial characteristics, couples seeking fertility treatment can state preferences for sperm and ova donors in terms of hair color, eye color, etc., often aiming for "family resemblance." The Czech clinic claims to use "the best and highest quality sperm" and its sperm and ova donors as "healthy, attractive and intelligent"—eugenic claims common to gamete donation agencies (Tober 2002). Sex selection of embryos through procedures such as PGD, a procedure that removes an embryonic cell while in vitro for genetic testing prior to implantation (Rapp and Ginsburg 2007) has also become an important driver of the trade in countries such as Spain, Cyprus, Belgium, and Thailand where such restrictions on its "non-medical use" do not apply (McArthur 2008).

CONCLUSIONS

The expansion of the market in reproductive services in Thailand and the Czech Republic has provided opportunities for many international couples to access treatments and produce families—opportunities often denied to them by the inadequacies or discrimination within their own health systems. Thailand and the Czech Republic represent two variants of this trade—other sites may differ in their reproductive specializations, regulatory setting, the organization of personnel, doctor-patient interactions, and

gender relations assumed and encountered during treatment. Clinics are presented as manifestations of global biomedical technoculture, effacing differences in culture, language, doctor-patient relationships, and expectations. Yet two major characteristics of this trade are common: the commodification of the body and its reproductive parts and the intensification of the stratification of reproductive bodies and their ova, sperm, and embryos. Uneasy tensions between notions of care and commodification proliferate within the discourses surrounding the trade and in the practices of clinics. In contrast, paternalistic discourses and practices surrounding "reproductive assistors" (ova donors and surrogates) serve to deny their emotional involvement and assert the primacy of their commercial interests.

We have discussed the imbrication of reproductive travel with capitalist relations of power and their divisions across class, race, and gender. The Czech Republic and Thailand are two sites in a complex mobile network of global capital, clinics, laboratories, personnel, medical corporations, and biotechnologies, trading in treatments, ova, sperm, embryos, and embryonic stem cells. The expansion of reproductive travel possibilities has created new demands and has invented needs for the reproductive capacities and genetic body products of women and men from these sites. Unable to acquire treatment in their home countries, patients utilize the health systems and trained medical staff of less developed countries to do so. Throughout these transactions is the division between those able to reproduce and those who cannot, and those with the money to reproduce and those who do not. Divisions based on race, whiteness, class, and wealth are the culture medium supporting the growth of global in vitro babies. Even choices of clinic, ova and sperm donors, and embryos carry considerations of race, whiteness, sex, class, and eugenic potential as undesirable qualities are culled by market forces.

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NOTES

1. Recent estimates suggests that women have rates of primary infertility of 7.7 percent and secondary infertility rates of 8.5 percent in developed countries and primary infertility of 4.4 percent and secondary infertility rates of 13.4 percent in developing countries (Boivin et al. 2009).
2. The proposed draft legislation would strictly regulate the use of ARTs. It would prohibit pre-implantation genetic diagnosis for non-medical sex selection purposes and commercial surrogacy. The draft legislation clarifies parental status so that when using donor gametes the woman who carries the pregnancy and her husband (not the biological donors) will be the legal parents. In surrogacy, however, the social parents (i.e., not the surrogate) are the legal parents. No written contracts are allowed (Thai Law Forum 2007).
3. No data are available of the percentage of Thai-foreign clients at these clinics. Access to caseload records would clarify this point.
4. For example, the IVF Holiday website claims 60 percent success in using donor eggs and 50 percent success in using IVF (www.ivfvacation.com/Testimonials2.html, accessed October 11, 2010). No information is provided on how these figures should be interpreted.

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