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Reproductive Tourism

Health Care Crisis Reifies Global Stratified Reproduction

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Medical tourism, "the practice of patients seeking lower cost health care procedures abroad, often packaged with travel and sightseeing excursions" (Senate Committee on Aging 2006:1), is a vastly expanding industry that reveals new healthcare-seeking practices. Health care costs in North America have been the primary motivating factors for people seeking care outside of the United States (Connell 2006; McLean and McLean 2007; Turner 2007). Medical tourism reflects the "global networks" (Scheper-Hughes 2000:192–93) of late capitalism, in which markets tend to reduce everything, including body parts, to commodities (Scheper-Hughes 2002:3).

Some scholars have argued that rather than use the term *reproductive tourism*, which connotes pleasurable travel, the term *reproductive exile* better reflects the pain associated with infertility and the fact that couples must evade regulations or high costs that prevent them from accessing treatment at home (Inhorn and Patrizio 2009; Matorras 2005). While to some extent cost exiles North American reproductive patients, they still have the freedom to travel to whatever region they choose, and in some cases they travel back to their "roots." In this way, exile would be a misnomer. The widely accepted term *cross-border reproductive travel* (Pennings 2005) will be used in this chapter. It must be maintained that the extent to which reproductive

travelers do participate in sightseeing and touristic experiences does vary tremendously. Throughout the chapter, the term "patient traveler" will also be used to connote the tension that exists between the leisure of travel and the seriousness of medical treatment being sought.

Spending on average sixty billion dollars annually, one hundred million patients seek health treatment abroad each year (Jones and Keith 2006). While people have always traveled on a "quest for therapy" (Janzen 1978), the speed and scale of travel has dramatically increased over the past twenty years. Furthermore, the ways in which patients make the decision to travel abroad for health care reflects global, neoliberal models of consumer health care (Scheper-Hughes 2002). As American patients are acting as consumers with respect to their health care, we must view this consumption of treatment and body parts as meaningful practice (Becker 2000:10).

This chapter will examine the complex reasons Americans "choose" to travel to the Czech Republic for reproductive care, most often seeking in vitro fertilization (IVF) treatment combined with egg donation. Reproductive travel has grown as one of the main forms of medical tourism, and people who want more affordable or less regulated fertility treatments seek it out. Reproductive travelers may be couples, traditional or nontraditional, or single women. Americans are especially interested in more affordable treatments, since fertility treatment in the United States is generally considered "elective," and each attempt could cost upward of ten thousand dollars.[1] For patient travelers traveling to the Czech Republic, treatment for IVF is roughly U.S. $5,600, and for an egg donor cycle the cost is U.S. $8,000, compared with anything ranging from U.S. $10,000 to U.S. $40,000 in the United States. A couple can make the trip to the Czech Republic for egg donation and stay within a U.S. $10,000 budget.

Reproductive travelers criticize the commodification of fertility treatment in the United States yet fail to extend this critique to the foreign markets serving them. In the Czech Republic, the market of reproductive technologies is rendered invisible, as they are cloaked in the lower prices and altruism of Czech doctors and donors. In this chapter, I frame the politics of reproductive medicine within an international market, exploring the ethical issues surrounding the "choice" of patient travelers and egg donors. Finally, the economic relationship between Czech egg donors and American patient travelers will be explored, ending with a consideration of how to understand the international market of gametes.

METHODS

My informants include company representatives and clients of a medical tourism broker company, which assists couples by arranging fertility

care in the Czech Republic. This company, which I will call IVF Holidays, provides ground transportation, travel tips, suggestions for accommodations, local representatives in the country, transfer of medical records, and the negotiation of rates for service—as do similar medical tourism companies (Turner 2007). Tom and Hana, who also have the help of family in the Czech Republic, own the company. In the summer of 2008, I traveled to their home-based company in the Midwest, where I conducted informal and semistructured interviews with both owners of the company. This company is one of two North American consulting firms that work exclusively with their respective reproductive clinics in the Czech Republic. At the time of this research, their company provided roughly 25 percent of the clientele to the *Klinika Reprodukční Medicíny a gynekologie*—or the Clinic of Reproductive Medicine and Gynecology in Zlín. In addition, 90 percent of IVF Holidays' clientele is American, but they have provided service to Canadians, Australians, Nigerians, and some Europeans as well. Finally, phone and email 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. However, the difficulty of maintaining anonymity when working with public businesses must be acknowledged.

Other scholars (Inhorn 2004; Whittaker and Speier 2010) have noted the difficulty of identifying and recruiting patient travelers. Anthropologists must rely on clinics or such intermediary companies like IVF Holidays to access patients. Some women or couples did not want to participate in interviews because they maintain secrecy about their fertility problems and their attempts at IVF, here or abroad. One patient traveler told me, "In general, I don't share my fertility problems with anyone." One of the IVF Holidays owners, Hana, suggested that some women do not want to talk about the trip they took at all, wanting to forget that it ever occurred. She said, "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 they are pursued overseas. It may also indicate denial on the part of those who use Czech egg donors.

COMMODIFIED TECHNOLOGY, GAMETES, AND HOPE

Scholars have argued that reproductive medicine typifies a consumer model of health care. Becker writes, "The coalescence of business and medicine is nowhere near so obvious to consumers of reproductive medicine" (2000:245). This is compounded by the fact that these procedures are not

fully covered by insurance. Reproductive medicine has been complicit with the commodification of health care, since it is a booming, profitable "baby business" (Spar 2006). Kimbrell (1993:73) has referred to this business as "the human body shop," whereby elements of reproduction are sold. As is the case with biomedicine in general, reproductive medicine reifies body parts, making them into objects, and subsequently commodities (Scheper-Hughes 2002). Kimbrell (1993:73) argues that reproductive medicine "represents the invasion of the market into our most intimate selves."

Reproductive technologies exist fully within the private sector, whereby technologies, gametes, and hope are bought and sold (see also Bonaccorso 2005). Sperm and eggs are bought and sold, often to be used with assisted reproductive technologies. Hence, technology and gametes are in the process commodified. Lock claims, "In order for body parts to be made freely available for exchange they must be first conceptualized as thing-like, as non-self and as detachable from the body without causing irreparable loss or damage to the individual person" (2001:71). In this case, gametes become commodities. It seems that egg and sperm donors distinguish clearly between the gametes they donate and the potential future development of that gamete. A coordinator at the clinic said, "I don't think they think it through."

When Americans come to the Czech Republic for egg donation they are seeking an anonymous donor. They have no desire for contact with their egg donor, and they indicate preferred education level and phenotypes that resemble their own. If Americans are traveling for egg donation, the personal qualities of these "gifts" are denied (Mauss 1922). In addition, Mauss has been criticized for assuming equality between giver and receiver in gift exchange (Lock 2001), which does not exist in the case of Americans coming to Czech clinics for egg donation. Taussig (1987) has written about the differential value attributed to bodies, which do not have universal value. In the case of the reproductive medicine industry, Czech eggs are valued at a much lower price.

For patient travelers, eggs and sperm are fetishized commodities because they promise possible life (Scheper-Hughes 2002). Appadurai (1996) has written about the social meaning and significance of commodities, whereby nothing is fixed or stable about commodities. In the case of global reproductive medicine, there is a clear demand for gametes and reproductive technology, and assisted reproductive technologies may be inciting further demand.

POLITICS OF REPRODUCTIVE MEDICINE

Feminists have shown how new reproductive technologies must be considered "hope" technologies. Hope is closely associated with American

notions of individualism and responsibility for health, and it has become embedded within the process of commodification (Becker 2000:117). Clinical statistics often skew the success rates of reproductive technologies in order to garner business. At the same time, as new medical advances are made, couples inevitably feel "compelled to try" any way possible to have a baby (Sandelowski 1991). Women find themselves continually trying new procedures to get pregnant (Becker 2000; Franklin 1997; Sandelowski 1991). Sandelowski (1991:33) considers how new reproductive technologies exacerbate the extent to which "women feel compelled by their doctors and male partners to undergo medical treatments for infertility because of the strong cultural pressure for married couples to have children and to demonstrate their normality in reproducing." The American Society for Reproductive Medicine has raised concerns about the exploitation of infertility patients.

I argue that reproductive travel further complicates the "hope" embedded in reproductive technologies, since now patients can travel across the globe in pursuit of reproductive technologies. I asked one patient, Anita, whether she had any misgivings about traveling abroad for treatment, since this constituted her first trip abroad. She said, "I said I was going to do it. I mean, it's worth a try. 'Cause what happens if you don't try and you're always going to have in the back of your mind 'what if'?" Hana said of the patients:

> They're very excited about the possibility of saving a lot of money, having a vacation, and doing the program. You know, after learning how much the prices are in the United States, many people give up their hope. Or like us, say we will have to save for three or four years before we can actually afford this. When they learn, for example, the donor egg cycle is the third of the price that they will be paying in the United States, they are excited.

Aptly, the front cover of the brochure for the clinic reads, "Where hope is turned into happiness . . ."

Bioethics support the "choice" of the consumer, here a "new class" of the medical traveler (Scheper-Hughes 2002:45). Bioethicists tend to argue in favor of the purchasing power of patient travelers, supporting their power to purchase medical treatments where they are available. In the context of reproductive travel, bioethicists support the "choice" of patient travelers to travel for health care. In talking to Tom and Hana, they both said separately in response to my question as to whether they had any restrictions on the type of client they help, "We do not play God." At first, I thought this a fair statement: they were inclusive of couples, women of all ages, and sexual orientation. However, in looking back, I realized that when I asked if there were age limits for those whose travel they would arrange, Hana said that they do not try to stop women from first trying IVF using their own eggs, if that is what they want to pay for. She said,

"That's . . . their decision if they want to spend money." Thus, choice is couched within a consumer framework. Since most American clinics refuse to treat women over the age of forty or forty-five, I think it necessary to reconsider how liberating or empowering this purchasing power may be for the patient traveler in tandem with feminist analysis of patients feeling compelled to try reproductive technologies across the globe. If the women have very little chance of having a healthy pregnancy result in IVF using their own eggs, and if the technologies keep inciting further attempts with little success rate, how positive is this "choice" their money allows them? The reproductive travel industry seems to further extend the promise of cheaper, hence possibly more, chances to conceive. Arguments made by Tom and Hana in favor of the spending power of the patient traveler have been "thoroughly disciplined and brought into alignment with the needs and desires of consumer-oriented globalization" (Scheper-Hughes 2002:31). However, it must be stated that patient travelers are consuming not only reproductive technologies but also a vacation abroad.

THE TOURISTIC EXPERIENCE

There are many parallels between reproductive and adoptive travel, but there are important distinctions to be made as well. While the general flow of travelers from the West for adoption or the use of gametes is the same and touristic elements are roughly the same, the element of disclosure to future children remains a vital distinction. Usually, adoptive parents must tell their children that they were adopted, while some reproductive travelers hope to pretend they never went for treatment using donated egg or sperm or embryos. While adoptive parents travel to particular regions intending to adopt, they are ultimately responsible for their child's memories. Thus, while abroad, they participate in heritage tourism to learn about their child's national heritage (personal communication, Frayda Cohen, June 23, 2010). This element of travel may be missing from reproductive travel.

Another parallel between reproductive travel and adoptive travel is that both groups of travelers are limited in mobility once they are abroad; they tend to stay near the clinic or children's home when they visit particular regions. Thus, reproductive travelers coming to the Czech Republic stay in a small Moravian town, Zlín, which is three hours away from the bustling tourist hot spot that is Prague. The clinic in Zlín does set up its clients' schedules so they have long weekends to travel to nearby cities, including Budapest, Prague, or Vienna. However, while they are in Zlín, they are visiting the Czech clinic daily or every other day. Joan, another client of IVF Holidays, described her visit to the Czech Republic

for fertility treatment. She and her husband were picked up at the Prague airport by IVF Holidays and taken to their hotel. Their first appointment was with the clinic at 9 a.m. Tom and Hana picked them up at their hotel at 8:30, helped them fill out all the paperwork, and walked them through everything. They were told that their donor had been there a day early, and at that point her husband was told to go to the "happy room." They waited five days for a transfer, during which time they traveled to Vienna and Prague. Joan summarized the perks of the trip for me: "I had a ten-day vacation and a donor."

The website of IVF Holidays has a page devoted to sightseeing excursions. It reads:

> Within your 21 day visit, you will have plenty of time to see exactly what you want and leave with wonderful experiences. We will organize two day trips, one to Prague, the capital of Czech Republic, and the other to Vienna, the capital of Austria. The beauty of these two cities is that everything is within walking distance. There is lots to see . . . and to taste. Some couples even had time to go see Budapest, Krakow, Venice. Feel free to ask us about directions, train schedules and tips from past clients. All of these locations are within several hours away and everybody had such a wonderful time on their trips.

The actual amount that patients travel varies with respect to their budget. Some patient travelers maintain a tight budget and limit themselves to trips to the local zoo and the shopping mall. Others, however, do take advantage of the long weekend to venture further out to nearby Eastern European capitals. The patient travelers receive from IVF Holidays a map of Zlín, a brochure on Moravia, and a list of nearby sights to visit while staying for treatment. Possible day trips range from nearby towns to forests, cemeteries, spas, cathedrals, and zoological gardens.

PATIENT TRAVELERS

When I asked if there was a general socioeconomic status of their clients, Tom said:

> It's been weird, it's been rather bizarre, we've actually had several doctors that have gone. We've had lawyers, nurses, and I was amazed at the amount of people in the medical field that have gone. A lot of teachers. So I would say better than half of our clients are higher educated. When we started doing this, we were thinking people like ourselves, who had money but not a whole lot. That most of the people who have gone seem to have more money than we do. . . . They've traveled more, they know more. So they know the medical situations around the world a little bit, they're a little more research oriented, so they do the research and plan out.

As mentioned, the main reason to travel abroad for fertility treatment is the lower prices, at least for Americans. Tom said, "The main reason would be the money. It doesn't matter how much you make, if you can save fifteen thousand dollars on a procedure and feel confident that it's going to be done in the same manner," then you will do it. But, he adds, "There are a lot of other little reasons that go into that, but I would say the main reason is money."

In 2004, more than one million Americans underwent some form of fertility treatment, participating in what had become a nearly U.S. $3 billion industry (Spar 2006:3). Tom and Hana spoke about how expensive reproductive care is in the United States, as did their clients. Tom said regarding America, "It is most expensive here. Insurance doesn't cover much of anything. I mean, some do, some don't. We've had women that their meds are covered, or partial IVF, little bits and pieces. The ones that have the flex plans have got it good." In addition to the sheer expense, Tom characterized the general experience with American infertility treatment as one that entails endless consumption. He paints a scenario:

> The bottom line is they knew going in, more than likely, is you're going to need IVF. But they end up nickel and diming you with these surgeries. They go to IUIs and all these little things that nickel and dime you and you don't have any money. And oh, fifteen thousand dollars, you've got to do IVF, that's the only way. Say you scrape the money and you do IVF. Well, now you're 38, 39 years old, it doesn't work. Well, you know what, you're getting kind of up there, your egg quality is not quite what it should be. Thirty thousand dollars, egg donor, and it's almost like they're in sales. Out of pure economics, the sky's the limit on that.

Unfortunately, according to Tom, there is no incentive for biomedical clinics in the United States to lower the cost of treatment:

> There are a lot of people out there that can't afford it. . . . Better than half the country. It is still out of their price range for that kind of money. You know as long as they've got 45,000 people that are getting it done and paying them fifteen to thirty thousand dollars, they're going to keep charging them. Even with the people going overseas, I don't think we're stealing patients from them. They're just getting the ones that would never even dream of going abroad. If money dictates whether you can conceive or not, or you spend so much money to conceive that now the kid's born and you lose your house because you've got nothing left. That's problematic.

The harsh economic reality of reproductive medicine in the United States, it seems, exiles many women and couples to seek treatment abroad.

The reproductive travelers who go to the Czech Republic have tried minimal procedures in the United States before traveling abroad. Kay, a

client of IVF Holidays, said that she spent U.S. $28,000 in two years' time doing several different treatments for her infertility in the United States before she decided to go abroad. She and her husband had insurance, but it didn't cover infertility. For her, the main reason she traveled was cost. She said, in comparing the price of the United States and the Czech Republic, "Three failed cycles in Zlín have cost us roughly U.S. $18,000, while one failed cycle in St. Louis would have cost more than twice that amount." Joan, another client, said that her insurance would not cover any more after one trigger shot. She told me at that point they went right to the donor egg option. "Here [the United States], reproductive medicine is a business," she explained.

Tom and Hana can also be considered reproductive exiles (Matorras 2005), since they found the cost of fertility treatments to be prohibitive. They first went through fertility treatment in the Czech Republic. Hana is Czech, and Tom is American. As they were seeking treatment, they both had the idea of helping other couples. As I talked to them, they described how wonderful their personal relationships were with their clients. Their words minimized the entrepreneurial aspect of their company. Hana talked about their first time going through treatment, as they also hosted their first two clients. She said, "Once you see them over there, you just become more like a friend than a formal client, you know, business relationship." Tom said, "A lot of us share a lot of our personal information about ourselves, you know. So people feel more comfortable. We wanted to make it a little more personal, we didn't want it to be the big professional, because we want people to realize that we were just like they are." Tom and Hana avoid advertising their own cases of successful IVF treatment by having television networks like CNN and Fox interview their clients. At the top of their website, they write, "See the latest interview of one of our clients and their babies on CNN.com," and they provide a direct link to several news clips, ranging from MSNBC to mommy blogs that recount successful trips to the Czech Republic that resulted in babies. Those patient travelers who are willing to talk tend to share the details of their experiences continuously on the IVF Holidays website, on blogs, and with the media, as well as with the anthropologist. Thus, their stories are continuously recirculated.

In my conversations with Tom and Hana, as well as with the patient travelers, they often contrasted their experiences at the Clinic of Reproductive Medicine in Zlín to their experiences in the United States. Czech doctors were characterized as kind, patient, and not looking for money. Tom said the Czech doctors are "stunned that they can charge so much money in the United States for what they're doing, because it's minimally invasive. It's just stunning. I mean . . . 30,000 dollars for a donor cycle?" Despite the dismay of Czech doctors at the amounts of money American

doctors make, Czech doctors are profiting from American patient travelers coming to their private clinics.

The patient travelers with whom I spoke viewed American medical practice as a business profiting from their hopes; their views of medicine shifted as they began to see themselves as consumers rather than patients (Becker 2000:129). In the case of patient travelers in the Czech Republic, they seemed to criticize the American medical system as commodified but praised the Czech system as gratuitous. However, the clinic in Zlín is still profiting from their business; they are simply keeping costs down because they can pay egg donors U.S. $800 as opposed to U.S. $5,000 to U.S. $10,000, the amount they receive in the United States.[2]

Czech doctors give patient travelers attentive care, and thus their emotions seem more authentic in contrast to the bureaucratic nature of medical treatment in the United States. One patient traveler, Kay, said about her care in the United States, "I never felt like a patient, just a checkbook. The treatment was never discussed with me, I was just told what to do and when that didn't work, there was no discussion of why, [I was] just told to write another check and come back for cycle day 2 monitoring." She said of the Czech doctor that he was "warm, friendly and truly interested in getting his patients pregnant." I argue the individualized, more affordable care that patient travelers receive directly from Czech doctors, and not just nurses, is interpreted as compassion.

TRANSLOCAL REPRODUCTIVE CLINICS

The Czech Republic has a large medical travel industry worth over U.S. $182,000,000 in 2006 (Warner 2009). The services of a number of reproductive clinics, counting twenty-three centers[3] (Donovan 2006), are advertised in Prague and surrounding provinces. Czech clinics seem to market especially for those who are seeking ova donation. Clinic websites advertise in English, German, Italian, and Russian, stressing the ready availability of student ova donors with only a three-month waiting period. The profitability of the Czech clinic is from the ready supply of Czech eggs for patient traveler consumption. The clinic has five hundred women on the books who are egg donors, according to the coordinator at the clinic, Lenka. Most of the egg donors are university students, while some are younger local women who have already had their own children. Patient travelers seek, as they do in the United States, relatively well-educated, blonde-haired, and blue-eyed donors, as well as women who have proven fertile by conceiving their own child. Tom and Hana work with a clinic in Zlín; however, they do not have a contract with the clinic. They repeatedly told me that they work for the patient traveler.

The clinic in Zlín is a manifestation of global biomedical technoculture, with similar clinical procedures and routines, roles, and technology as those found in the United States. The clinic is the same one Tom and Hana used when they went for fertility treatments, since it is close to Hana's natal home. The destination sites for fertility treatment usually have evolved through a combination of sophisticated medical infrastructure and expertise, particular regulatory frameworks (or the lack of them) that enable certain procedures, and lower-wage structures that allow reproductive technologies to be performed at competitive lower costs than in other countries. Good traveler infrastructures, 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. Many point to the fact that, unlike its Catholic neighbors Slovakia and Poland, the Czech Republic is predominantly atheist, which allows loose regulatory frameworks regarding assisted reproductive technologies. The Czech government is quite liberal in terms of regulations, allowing egg, sperm, and embryo donation, all anonymous by law, and preimplantation genetic diagnosis (PGD) (Slepičková and Fučík 2009).

The advent of a market oriented toward relatively wealthy foreign patient travelers 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. However, it does encourage the brain drain from public hospitals into private clinics. The clinic in Zlín treats both Czech and foreign patients—who have separate schedules at the clinic—and the enforcement of regulatory standards seems to shift just slightly depending on the patient and the situation.[4] For Czechs, the tests to determine infertility are fully covered by national Czech health insurance (www.sanitoriumhelios.cz). It is estimated that 15 percent of Czech couples suffer infertility (Slepičková and Fučík 2009), and 7 to 10 percent of Czech babies are born via assisted reproduction. Three treatments of egg removal from ovaries, fertilized in a lab and transplanted back to the uterus, are all covered by Czech insurance, and a woman may receive up to three cycles if she is under the age of thirty-nine.

The clinic in Zlín has assisted couples in having over a thousand babies in the nine years since it opened in 2001. According to Tom, Americans who are even older than Czech patients have a higher success rate. Some attribute this to the way patient travelers are on "vacation" and are more relaxed. Tom said, "They do our patients a little differently than they do the Czech patients. 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." Thus, even if Americans are saving

money by traveling to the Czech Republic, their money privileges them above Czech patients who are receiving treatment covered by insurance. Their economic status becomes tied to personal rates of success.

Becker states that "new reproductive technologies are a global phenomenon characterized by hierarchical relations and power constellations" (Becker 2000:21). Medical travel intensifies the global stratification of reproduction (Ginsburg and Rapp 1995). Inequalities empower certain categories of people to reproduce and nurture but disempower others. In this case it may privilege the reproduction of elites across wealth and nations. Cross-border reproductive trade parallels the international divisions of hosts and guests within the travel trade.

The globalization of reproductive biotechnologies has created even newer tastes and desires, inciting desire for the bodies of "others" (though their difference is suppressed) (Cohen 2002). These inequalities are most intensely illustrated in a consideration of the marketing of bioavailability—the trade in poor women's bodies for ova donation (Heng 2006, 2007). Even the reproductive body parts—ova, sperm, and embryos—are stratified, marketed according to place of origin, the characteristics of their donors, and gender. The IVF Holidays website claims, "The doctors who interview the donors accept only intelligent and attractive donors." Patient travelers traveling to the Czech Republic are, according to Hana, seeking "white" babies from Czech egg or sperm donors. Hana characterized their general client: "Most clients are in need of donor eggs. I would say 85 percent of our clients are interested in the donor egg option. Most of the women are over 40, most of the women are looking for a blue-eyed, blonde-haired donor."

In terms of other reasons patients want to travel to the Czech Republic, as mentioned previously, egg and sperm donation are anonymous. Many patient travelers want to maintain anonymity. Tom said:

> Donor wise, women are happy that it's an anonymous donor. You don't want to have to worry about someone knocking on your door. They can feel comfortable being in the no-tell camp, knowing that the donor doesn't even know if there is a birth, and the only thing she knows about them is that they exist. They don't know where you're from, they don't know how old you are, you exist. There's a woman out there who wants your eggs, and that's all they know and that's all they ever know.

Sacrifice of the egg donor is invisible with anonymity. Services of reproductive clinics cater to buyers' desire to choose (Spar 2006:46). The fertility trade functions like medical trade in general; the people do not see themselves as participating in a commercial relationship, while fertility is emphatically a for-profit endeavor (Spar 2006:49).

DONOR EGGS

There is a class structure in the reproductive industry, in which individuals are ranked and considered appropriate for different reproductive tasks (Heng 2006, 2007; Tober 2002:157). The regional and global circulation of reproductive gametes (ova, sperm) brings stratification into sharp relief. Countries such as the Czech Republic trade on their ready supply of a bioavailable population of ova and gamete donors. Czech donors are "available for the selective disaggregation of one's cells or tissues and their reincorporation into another body" (Cohen 2005:83).

In June 2006, the Czech Republic passed Legislative Act No. 227/2006 Col., which governs sperm and egg donation. Under this legislation, donation is legal but must be voluntary, gratuitous, and anonymous. Donors cannot be paid, but are offered attractive "compensatory payments" for the discomfort involved in ovarian stimulation and egg retrieval. In a region where the average monthly salary is U.S. $1,085, these young women receive U.S. $800 per egg donation. So we return to the question: Is the egg a gift, a commodity, a scarce commodity, or a commodity of last resort? Scholars and lay people have wondered if it is ethical for a woman to be paid for her eggs. Those who claim that a woman should not be paid for her eggs are attempting to frame egg donation in altruistic terms. However, Almeling (2007) writes that egg and sperm donation is not as altruistic as blood or organ donation because the donors do receive financial compensation.

While bioethicists wholeheartedly support the purchasing power and consumer choice of reproductive travelers, the question remains: How much individual autonomy and choice do the egg donors have? Tom anticipated a common response when I asked how much Czech donors are paid: "People say that is just not that much and they get so much here. Well, when you consider the fact that if you're working in a shop, like a grocery, you're going to make 250 or 300 dollars a month. So it's roughly three months' wages for a girl." Lenka said that none of the donors talked about it as a gift; they were only interested in the money. While critics tend to denounce financial motivations of egg donors, students tend to have a bit more leeway when they are financially motivated (Almeling 2006:153). As is the case with sperm donation, the clinic advertises for egg donors in Zlín, with many recruited from the local university. Tom claims:

> A lot of these girls get accepted into college, they get married, they get pregnant, and then while they're going to school, grandma watches the kids [because they all live in an extended family]. She can go to school to better her life still, 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. Plus, insurance is free.

He fails to problematize their class position within an international travel framework. Is selling their eggs a mode of empowerment, or is it a sacrifice disguised by the language of altruism? The language of gift disguises the sacrifice of egg donors, rendered even more invisible with the anonymity of gamete donation. The dichotomy between gift and commodity is collapsed when discussing sperm and egg donation (Tober 2002). Scheper-Hughes (2000:192) writes that the global market for organs, similar to the global market for gametes, blends altruism and choice, magic and science, gift and barter.

If we consider the market of eggs, the clinic in Zlín has many more donors than it needs. Lenka claims that they categorize donors as A, B, or C, and, "A is perfect, pass, more than average, B is average, and C is not very good . . . and because we have so many donors, we really do not have a need. They are in the database. We have some C's, but I do not have a need to call her because I still have enough A's and B's." She has donors calling all the time to see if they can be used. As in the case of North America, there is an "oversupply of women willing to be egg donors . . . far outstripping recipient demand. Despite this abundance, egg donor fees hold steady and are often calibrated by staff perceptions of a woman's characteristics and a recipient's wealth" (Almeling 2007:336).

Another way to frame egg donation is to ask how similar and dissimilar it is to sperm donation. Tober (2002) claims sperm donors are sex workers, in a sense, while I find this to be a stretch. I prefer Almeling's (2007:324) label of "reproductive service workers." Eggs are more controversial than sperm, there is greater complication in finding donors, and the long-term implications for donors are not known (Spar 2006:41–43). Since eggs are a limited supply and it is more difficult to donate eggs, we can say, "Eggs are a scarce resource compared to sperm, and thus women's donation of eggs will be more highly valued than men's donation of sperm" (Almeling 2007:323). Furthermore, since it is a riskier endeavor, egg donors are compensated with more money than sperm donors. "Egg donation has features that make it more exploitative than sperm donation . . . at U.S. $2,000 per donation, ova donors are more subject to outright economic coercion than are sperm donors" (Kimbrell 1993:86–87). The market of eggs obviously parallels the market of sperm (Almeling 2007:320). However, Almeling (2007:320) shows how eggs are also more highly valued because of "economic definitions of scarcity and gendered cultural norms of motherhood and fatherhood." Almeling (2007:328) writes, "Women

are perceived as more closely connected to their eggs than men are to their sperm." According to Almeling, gametes are gendered, and eggs are more highly valued since they contribute to the motherhood project.

We also see an international market structure that determines different valuations depending on the regional context of the reproductive medical industry. Thus, we must complicate the issue of "choice" of Czech egg donors, as we did for reproductive travelers. Although egg donors are university students, not living in below-poverty conditions, their "choice" is not unproblematic. They are embedded within socioeconomic and political constraints of the international market. The valuation of their eggs reflects the stratification of reproduction reflecting global inequalities when it comes to differential values of body parts.

We need to problematize the commodification of health care and body parts on a global scale, as we complicate the consumer and seller choices made by patient travelers and egg donors. Although Czech egg donors may not legally be monetarily compensated, they are given money for their "time," blurring the distinction between profit and altruistic motivation. Egg donors are seeking the financial rewards of egg donation. Lenka bluntly said to me, "I never met a donor who would do that from my point of view from just altruistic reasons. It is all about money, and they are not as sensitive as I should say they should be . . . they just ask when they get the money and that's why I don't think that they really realize what they are doing."

CONCLUSION

The expansion of the market in reproductive services in the Czech Republic has provided opportunities for many international couples to access treatments and produce families—opportunities often denied to them by the costly treatment options in the United States. The challenge as anthropologists is to study the advent of global reproductive travel with compassion and respect, while casting a critical eye over the political economy of the trade and the relations of power it entails. This research reveals how medical travel complicates the "compulsion" to try for couples or women regarding their infertility, rather than simply democratizing access to treatment.

The expansion of reproductive travel possibilities has created new demands and 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 use 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 who have 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 market forces cull undesirable qualities.

NOTES

1. Insurance coverage for fertility treatment varies state by state. Five states are mandated, in that insurance companies must provide coverage for IVF cycles. All states have at least one company that has some form of coverage. However, it varies greatly.

2. The Society for Assisted Reproductive Technologies has stated that egg donors may be paid $5,000 to $10,000, but any amount more than $5,000 must be explained, and sums over $10,000 are not appropriate (Egg Donation, Inc. 2011).

3. Since the time of conducting this research, at the time of writing this chapter, there are now thirty centers of assisted reproduction in the Czech Republic. This reveals the extent to which a country with a population of ten million has a fiercely competitive field of reproductive medicine, increasingly vying for foreign patients.

4. Surrogacy is a shady topic, since it involves egg donation. Czech law stipulates that the woman who gives birth is the mother, and then the intended parent must adopt the child. The clinic in Zlín is beginning to help Czech couples with surrogacy but will not help foreign patients, although I think there may be some room to negotiate.

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