Research Summary—EUCE Fieldwork Grant

"Biology and kinship in fertile marketplaces: Czech and Spanish fertility clinics in a globalized market of care"

Skye Miner, McGill University

Introduction: The World Health Organization estimates that one in six couples will experience infertility. This increase in the recognition of infertility as a disease has been accompanied by an increase in medical technologies and practices used to treat infertility. However, not all people have access to all assisted reproductive technologies—access is dependent on a combination of personal resources and public policies, which make some treatments available in certain areas and not in others. For example, the European Union Directive 2004/23/EC prohibits the payment of egg and sperm donors. At the same time, the directive does not explicitly prohibit or allow certain types of treatment. Various interpretations of this directive by different member states has created "fertility markets" in countries such as the Czech Republic and Spain. I use the term "fertility market" to indicate the creation of a specific location for the purpose of "reproductive tourism"—the traveling of patients across borders to receive fertility treatment such as *in vitro fertilization* (IVF) (Bergmann 2010). This market creation is often driven by the relatively low costs of treatment, liberal policies surrounding fertility treatment, and the availability of "advanced" fertility technologies. The Czech Republic and Spain are two such countries where there is a strong fertility market that attracts both EU citizens and Canadians. My research focuses on these two specific European fertility markets and how they have become popular places for Canadian's to receive infertility treatment using egg donors (Blyth 2010).

Canadian's have become reproductive travelers as they attempt to avert waiting times and obtain treatment that is restricted by Canada's Assisted Human Reproduction Act (AHR). Like the European Union Directive 2004/23/EC, the AHR also prohibits paying women to be egg donors. Canada like many EU countries (e.g. France) have interpreted these statements conservatively, meaning that only direct compensation—reimbursement for medical expenses—is allowed. This type of direct compensation means that in Canada the egg donor is not receiving any "extra" money for compensation as this money is considered by the AHR "payment," thus illegal. The inability to compensate egg donors beyond medical costs has created a perceived "shortage" of eggs in Canada. One survey finds that of the six percent of Canadian infertile women (445 out of 6,927) who seek IVF in another country, 80% of these women were in search of donor eggs (Hughes and deJean 2010). Although many EU countries interpret the 2004 EU directive in the same way as Canada, only allowing compensation for medical expenses, some countries, including the Czech Republic and Spain, have a more liberal compensation policy, creating a large number of donors. The large donor database coupled with the low cost of treatment potentially attracts Canadians to the Czech Republic and Spain for IVF treatment involving egg donors.

Objectives: This study examine the development of the Czech Republic and Spain as a site of international fertility tourism specifically for Canadian patients. Since international fertility care is dependent on fertility care providers, I will use fertility care providers' experiences treating Canadian patients in order to better understand how they treat international patients in the face of international and national regulation. The main objectives of this research study are:

- to understand how fertility clinics create international markets of care to craft families from donated eggs;

- to understand how international fertility markets are produced through the actions and relations of patients and health care providers; and
- to understand how international recommendations and national regulations are interpreted in order to create global medical markets.

Methodology and Timeline: The EUCE fieldwork grant has allowed me to conduct semi-structured interviews with Czech and Spanish fertility clinics. Additionally, I have collected ethnographic data at a conference on reproductive tourism. Currently, I have conducted interviews with seven fertility clinics, five clinics in the Czech Republic and two clinics in Spain. I will be traveling back to both of these countries in the spring to conduct an additional ten interviews. I have spoken with directors of these fertility clinics as well as egg donor coordinators who have direct contact with international fertility patients. My ethnographic data consists of observations and interviews with bioethics, fertility lawyers and physicians who were in attendance at a week-long summit surrounding cross-border fertility care. These observations and interviews will be used to provide policy context to the interview data that I have collected with the Czech and Spanish fertility clinics. Currently, I am in the process of analyzing the data that I have already collected and planning my upcoming trip. I hope to prepare a publication of my results by the end of Summer of 2017.

Preliminary Results: I found that Czech and Spanish fertility markets are dependent on two affordable economies, the compensation of egg donors, and the anonymization of egg donors. Both Czech and Spanish fertility treatments using egg donation are cheaper than other countries in Europe as well as the Canadian system. The low cost of these procedures is coupled with the relatively low costs of accommodation and travel to these countries. Thus, for some patients, the cost of procedure and the travel to these countries is still cheaper than the costs of obtaining in treatment of their home countries. Clinics routinely talked about how their clients could experience a vacation and fertility treatment at low cost and created packages that allowed for their clients to book everything with the clinic making travel to the clinic simple. Not only was the cost of treatment affordable, but the clinics in these countries were able to compensate their donors, something that is not allowed in Canada nor in many European countries. The ability to compensate donors was not seen as against the EU regulations as the compensation was discussed in relationship to the expenses that the egg donors incurred during treatment. Additionally, egg donors in both countries were promised anonymity in that neither the future child nor the intended parents would not have access to identifying information about the donor.

Conclusion: My research shows how policies surrounding medical care are not specific to one country, but instead affect the health of other citizens as patients easily and affordably travel across borders to obtain the health care they need/want. As policies are created to regulate health care markets, policy makers should be attentive to how their specific country policies may either create barriers for their own patients or draw-in outsiders. While the EU directive on assisted reproductive technologies does attempt to create standardization in fertility treatment involving egg donation across countries, the lack of clear definitions surrounding what is and is not considered payment for gametes has created disparate country policies. I suggest that the EU with other countries, including Canada, establish clear compensation guidelines in order to provide for equitable access to egg donation across states as well as ensure that potential egg donors will be treated equally and fairly across country borders.