

**A FEMINIST POLITICAL ECONOMY ANALYSIS OF MEDICAL BROKER
AND FERTILITY CLINIC WEBSITES**

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ABSTRACT

This dissertation studies the ways in which market-based reproductive health services are advertised and virtually represented on a global scale. I detail the implicit values and assumptions found in the content of reproductive tourism websites. In doing so, I show how medical broker and fertility clinic websites reproduce dominant ideologies and how these websites portray reproductive tourists, egg providers and surrogates. Using a feminist political economy approach, I situate the practice of reproductive tourism within particular historical, economic and political contexts, including both domestic and global neoliberal healthcare reforms. The findings of this thesis reveal that the websites portray neoliberal policies that emphasize consumerism, individual responsibility for one's healthcare and that position reproductive tourists as empowered consumers capable of making informed choices in purchasing new reproductive technologies (NRTs). The marketing of reproductive tourism on these websites also ignores the physical and emotional labour of women who are egg providers and surrogates and minimizes the unequal power relationships that exist between reproductive tourists and egg providers and surrogates. Their experiences are erased from view and their bodies objectified and fragmented for market consumption.

Dedication

To the women who are egg providers and surrogates and whose care and labour are often marginalized and erased from view. And to the children born from the use of new reproductive technologies, may we hear your voices and experiences.

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Chapter One: Introduction

Reproductive tourism (Knoppers and LeBris 1991) refers to individuals traveling from one country or jurisdiction to another in order to obtain fertility treatments that may not be available in their own jurisdiction. The travel for health purposes is not new. Women have traveled to different countries to access reproductive health services (Bennett 2006). Today, cheaper transportation to other countries, with increased incomes, has enabled people to travel. The Internet has made gathering and researching information on reproductive tourism easier. This thesis is about the medical broker and fertility clinic websites that advertise to the people who travel to become parents and seek to participate in the practice of reproductive tourism.

My work experience and MA thesis shaped my research interest in reproductive tourism. First, my MA research explored Newfoundland women's embodied experiences of infertility as they maneuvered through the complex diagnosis and treatment of their infertility. I was interested in studying how they made sense of their lives and bodies after receiving a diagnosis and confronting the assumption that when the time was right, their bodies would be able to carry a pregnancy to term and have a child.

At the time of writing my MA thesis, individuals wanting to use in vitro fertilization or IVF would have to leave the province because the only fertility clinic in Newfoundland did not perform IVF. This meant, couples needed to travel out of province. The nearest fertility clinic was in Halifax, NS. In a sense, couples who chose to travel to Halifax to obtain IVF were participating in reproductive tourism, across provincial jurisdictions. A

few years later, while working in Jamaica as a policy analyst and researching reproductive health services in Jamaica, I discovered a fertility clinic advertising NRTs to foreign patients on a website—they could obtain a variety of fertility treatments and stay at one of the local five-star resorts in Ocho Rios and Montego Bay. This was the first time I observed a fertility clinic abroad advertise its services to Canadians. The fertility clinic noted its cheaper prices and shorter wait times for accessing fertility treatments as compared to Canada. Whereas in the past, Canadians might travel across provincial jurisdictions, now, Canadians had the option to travel abroad to other countries to seek viable options to build their families.

I wanted to learn more about these websites and the companies behind them, including how fertility clinics around the globe were advertising their services to foreign patients. I also wanted to know how Canadians connected with the fertility clinics and medical brokers abroad, what information was available and how this phenomenon would push the boundaries of feminist theory. The medical broker and fertility clinic websites created a virtual space where various social actors including medical brokers, fertility specialists, travel agents, lawyers, hospital personnel and hospitality workers interact with each other across borders. These websites also bring together reproductive tourists who purchase the biological material and the emotional labour of women who are egg providers and surrogates. For me reproductive tourism raised concerns about health equity and the need to situate these websites within the larger context of globalization, privatization of health services, neoliberal policies and commercialization of women's bodies and new reproductive technologies (NRTs).

It also raised a number of questions for me and shaped the research questions for this study. For instance, would there be a negative impact on the Jamaican healthcare system when foreign patients obtain NRTs at private clinics while the public health care system was struggling to be funded and staffed adequately? Whose needs were being privileged? How were the relations between private medicine and government structured? How are health services such as fertility treatments represented on these websites? How does reproductive tourism work and who are the key stakeholders in this new niche market? Medical sociologists have made sense of current and historical transformations in medicine with terms such as biomedicalization (Clarke et al. 2003) and information-based medicine (Nettleton 2004). Saukko et al. (2010: 746) argues that “biomedicalization is characterized by increasing privatization and commodification of medical research and services, which expands biomedical jurisdiction into ever new areas of life”. Current research on reproductive tourism has primarily focused on the broader biomedical and ethical debates of this phenomenon.

My PhD thesis explores ways in which market-based reproductive health services are advertised and virtually represented on a global scale. I am particularly interested in how the fertility clinic and medical broker websites advertise their services, how they define their role in reproductive tourism and how they define the reproductive tourist. Also, how are women who choose to become surrogates and egg providers portrayed on the websites? What are the means used to construct these portrayals and how are unequal power relationships represented in these portrayals? I uncover the implicit and taken for granted values and assumptions of seemingly neutral media content and how these medical representations reflect dominant ideologies and power

in their discourses. I am particularly interested in uncovering the taken for granted values and representations of these market transactions. A study of the underlying assumptions and ideologies used to virtually market NRTs on these websites can reveal the implications of marketing women's bodies and their reproductive capacities on a global scale.

These websites present NRTs in a specific discursive story which emphasizes the normalization of reproductive tourism and the benefits of receiving healthcare services within a private, for-profit healthcare system. The medical broker and fertility clinic websites blur the boundaries between health information on NRTs and direct-to-consumer advertising to reproductive tourists and often present travelling to another jurisdiction to obtain NRTs in simplistic linear steps. This creates a website space that incorporates medical and non-medical information in the form of a promotional material for Canadian patients to maneuver through and make sense of. I argue that the websites portray neoliberal policies that emphasize consumerism, individual responsibility for one's healthcare and reproductive tourists as empowered consumers capable of making informed choices in purchasing NRTs. The marketing of reproductive tourism on these websites also ignores the physical and emotional labour of women who are egg providers and surrogates and minimizes the unequal power relationships that exists between reproductive tourists and egg providers and surrogates. Their experiences are erased from view and their bodies objectified and fragmented for market consumption.

Chapter Descriptions

This dissertation is composed of eight chapters. The first two chapters lay the groundwork for understanding my research, reproductive tourism, and the nature of medical brokers and fertility clinics. In chapter one, I discuss why and how Canadians enter into the reproductive tourism market. I then explore how many Canadians go abroad for fertility treatments as well as the tensions surrounding the use of the term, reproductive tourism. I end this chapter with a brief discussion of the contextual nature of reproductive tourism.

In chapter three I discuss feminist political economy, offering my understanding of this theory and how it relates to reproductive tourism. A feminist political economy approach allows me to situate these websites in a particular historical, economic and political context. Feminist political economists argue that healthcare policies are not neutral, rather they result from particular social and historical processes and are based on particular values about responsibility and rights to healthcare (Corburn 2001). Specifically, this theoretical framework allows me to locate NRTs with a global marketplace, noting the differences of national policies of reproductive technologies and consumer desires and hopes. I also explain the research methods used in this study, how I chose the websites to study and how I analyzed the different media on the websites, such as digital images and videos. In chapter four, I offer an analysis of the Canadian healthcare system from a feminist political economy framework, paying particular attention to the neoliberal reforms in healthcare which helped shape the development of reproductive tourism. I also detail the regulatory framework of NRTs in Canada. The majority of NRTs have developed under neoliberalism and are primarily delivered in private for-profit medical clinics.

Chapters five, six and seven analyzes the data from the websites. In chapter five, I explore how the websites use and incorporate neoliberal healthcare discourses of personalized healthcare services and patients as empowered consumers capable of making informed decisions about their healthcare needs. I argue that the medical broker and fertility clinic websites use healthcare discourses of patient-centred care and empowerment to normalize Canadian's participation in travelling to another jurisdiction for fertility treatments. I also document how the medical broker and fertility clinic websites link receiving fertility treatments with going on a luxury vacation. In chapter six, I focus on the use of patient testimonials to market health and non-health care services to prospective reproductive tourists. These testimonials provide an emotional connection for others considering going abroad for fertility treatments. I argue that these patient testimonials help prospective reproductive tourists to identify with other 'infertility journeys' and offer a possible solution to their childlessness. The medical broker companies and fertility clinics also use the patient testimonials as a marketing strategy to attract new consumers.

In chapter seven, I analyze what is strategically missing from these websites, documenting the short-term and long-term side effects of NRTs, the use of unpaid labour by caregivers who travel abroad with reproductive tourists, and the narratives and experiences of egg providers and surrogates. I argue that the websites use specific discursive strategies both visually and textually to objectify women's bodies and erase their physical and emotional labour from view. For instance, I document how the labour egg providers and surrogates perform for reproductive tourists is depicted as a natural extension of women's altruism and care work, how the websites minimize the health

risks of women undergoing NRTs, and how the images and videos of medical procedures commodify and fragment women's body parts in terms of wombs, uteruses, and eggs.

I end this dissertation with an explanation of how my findings contribute more broadly to the literature on feminist political economy. I also suggest important directions for future research and offer recommendations for individuals participating in reproductive tourism. It is important to note that throughout this dissertation, I use the term reproductive tourism to draw attention to the non-medical goods and services that travelers consume as they cross borders and jurisdictions, as well as to the marketing of services by fertility clinics and medical brokers who explicitly advertise their medical services as part of a vacation. In fact, my data chapters detail how the medical broker and fertility clinic websites evoke the images of "white sandy beaches" and "exotic locations" to reproductive tourists as well as the ease of traveling and obtaining NRTs in other countries.

Chapter Two: The Subject

Introduction

This chapter discusses the subject of reproductive tourism and why and how Canadians travel abroad for fertility treatments. I document the multiple stakeholders involved in reproductive tourism, the number of Canadians travelling abroad for NRTs, and both the social and ethical concerns surrounding reproductive tourism. At the end of the chapter, I discuss the tensions surrounding using the term, reproductive tourism.

Reproductive tourism is a phenomenon with multiple stakeholders and entry points. A long list of participants is a part of the global market in fertility services. These include health care providers, hospitality service workers, lawyers, healthcare facilities such as fertility clinics and hospitals, medical brokers, and the men and women who provide gametes (egg and sperm) and the women who are surrogates (Ikemoto 2009). Fertility clinics and medical brokers have sprung up across the globe and those seeking parenthood travel thousands of miles from their home countries and jurisdictions to seek NRTs in other countries.

Reproductive tourists may travel abroad for a variety of reasons: moral and religious codes that bar unmarried people and gays, transgendered and lesbians from NRTs; long wait lists in their jurisdiction; the high financial cost of NRTs to be paid by individuals in their countries; and regulations that ban certain practices such as sex selection, paid surrogacy and preimplantation genetic diagnosis (PGD) (Harrison 2014). As a result of such barriers, “developing” countries with lax or non-existent regulations and cheap labour have increasingly become destinations for fertility treatments. For example, the 2013 regulations restricting surrogacy in India to married heterosexual

couples pushed all cases of LGBTQ surrogacy to Thailand (Martin 2015). Also, after a high-profile surrogacy scandal in Thailand, that country banned cross-border surrogacy in 2014 and only married heterosexuals with at least one Thai partner are allowed to use surrogates (Pande 2017). Some LGBTQ surrogacy clients excluded from India in 2013 sought treatment in another neighbouring country, Nepal, for surrogacy agreements (Martin 2015).

Reproductive tourism may include individuals travelling from “developed” countries to other “developed” countries (Canada to the United States); individuals travelling from “developed” countries to “developing” countries (Canada to Africa); individuals traveling from “developing” countries to “developed” countries (India to Canada); and individuals travelling from “developing” countries to other “developing” countries (Thailand to Malaysia). Horsfall, Lunt and Hanefeld (2014) contend that the most popular countries participating in reproductive tourism are in Asia (Malaysia, Thailand and Singapore), Eastern European (Hungary, Romania, Poland and Czechoslovakia), Mediterranean (Malta and Cyprus), Africa (South Africa), and South and Central America (Costa Rica, Mexico, Brazil and Argentina).

These countries allow travelers to obtain a wide range of new reproductive technologies. NRTs refers to “those technologies which facilitate, manage or prevent reproduction” (Throsby 2004:9). The term came into use during the 1980’s among feminist researchers studying the developments in the field of reproductive science and medicine. The technologies that fall under the rubric of NRTs are extensive. They include: donor insemination, in vitro fertilization (IVF), surrogacy, egg and sperm (gamete) donation, egg freezing, amniocentesis, embryo transfer and freezing,

ultrasonography, sex pre-selection, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ICSI) and pre-implantation genetic diagnosis (PGD). This list is by no means exhaustive. The term is somewhat misleading given that not all of the technologies which fall under its rubric are new. For example, donor insemination (DI) or what is also called artificial insemination (AI) has a long history stretching back several decades (Throsby 2004).

What is new, however, is access to information through the Internet. The types of NRTs reproductive tourists may access in other countries include in vitro fertilization (IVF), gamete (egg and sperm) donation, sex selection, surrogacy arrangements and embryonic diagnosis. Reproductive tourism is often referred to individuals traveling outside their home jurisdiction to access new reproductive technologies in another country.

Entry Points into the Reproductive Tourism Market

There are two entry points for individuals to research and obtain NRTs abroad using the Internet. One is through the websites of fertility clinics located in hospitals and the other is through those of medical broker companies who act as intermediaries linking patients to hospitals in other countries and arranging for their stay while attending a fertility clinic for NRTs. Located in both “developed” and “underdeveloped” countries, medical broker companies are privately owned. Their websites advertise that they employ medical staff (nurses, physicians), travel agents and other personnel who have worked in the healthcare field such as policy analysts and IT specialists.

Although reproductive tourism may go in many directions, the transnational flow of reproductive tourists usually occurs from “developed” countries to “developing” countries. For this study, I focus on analyzing medical broker and fertility clinic websites that help Canadians travel to “developing” countries to obtain fertility treatments. Canadians can choose to use the services of medical brokers located in Canada (British Columbia, Alberta, Ontario and Quebec), in the US, who facilitate travel to “developing” countries or medical brokers located in “developing” countries such as Argentina, Romania, Czechoslovakia, India, Barbados and Turkey just to name a few. I chose to include US medical brokers in this study because their advertising on these websites targets Canadians and they help Canadians to travel to “developing” countries, even though they themselves are located in the US. I also included US medical broker websites that specialize in egg provider and surrogacy arrangements in this study because they advertise their services to North American clients, including Canadians. The medical brokers located in Canada usually have ties with larger private hospitals, such as the one Surgical Tourism Canada has with Apollo hospitals in India (Mulay and Gibson 2006). Canadians may also contact medical broker companies located in “developing” countries which have ties to specific fertility clinics. These medical broker companies advertise that they have intimate knowledge of the local culture and the healthcare system in a particular “developing” country.

Medical brokers advertise their services on the Internet detailing hotel accommodations, airfare rates, arranging of visas, transferring of patient’s medical records, facilitating contact with fertility specialists in other countries and booking tourist packages which highlight the unique sight-seeing opportunities of that particular

country. The Internet websites often provide information about various fertility treatments offered for a third of what they would cost in “developed” countries and highlight their success rates of NRTs such as IVF and surrogacy. After browsing through a medical broker’s website, Canadians can contact a particular company by telephone, email, instant message and Skype to ask questions or hire the medical broker to facilitate their travel to another country. Canadians pay an all-inclusive price which includes the fee of the medical broker services, the cost of NRTs including fertility drugs and treatment, fees paid to gamete providers and surrogates, costs of hotels and airfare and any tourist activities. Those travelling abroad for NRTs can choose which surrogate or egg provider they want based on profiles sent by the medical broker of fertility clinic.

Instead of using a medical broker company, Canadians can directly contact a fertility clinic located in another jurisdiction (country) in which they wish to travel to and obtain fertility treatments. The fertility clinics are privately owned and are located in for-profit private hospitals and usually employ health (nurses, fertility specialists) personnel and non-health personnel such as travel agents, customer service representatives and administrative assistants. The fertility clinic websites have the same features as medical broker websites in that they advertise their services detailing hotel accommodations, airfare rates, arrangement of visas, transferring of patient’s medical records, facilitating contact with fertility specialists and booking tourist packages. Canadians also pay an all-inclusive fee to the fertility clinic to arrange all their medical and travel requirements and the costs of all fertility treatments.

The financial cost of traveling abroad (whether using a medical broker or fertility clinic) to obtain NRTs varies and depends on the type of fertility treatments Canadians purchase, which country they travel to and how long they need to stay abroad. Women who receive IVF may need to stay abroad up to four weeks while Canadians who are paying for surrogacy arrangements may spend less time abroad. A further discussion of the physical and emotional work involved with fertility treatments are discussed in chapter seven.

Number of Canadians Travelling Abroad for NRTs

The exact number of Canadians traveling abroad for NRTs is not known. Many individuals do not wish to discuss intimate details of their infertility and may fear disclosing going abroad for NRTs due to stigmatization about leaving Canada in search for unregulated fertility treatments. Although there is considerable discussion of the extent of reproductive tourism in the literature, much of the current knowledge of incidence is based on a very small number of surveys that are diverse in their methodological approaches. One such study conducted by Hughes and DeJean (2010) mailed a survey to Canadian and American fertility clinics asking them how many individuals they referred out of the country. There were 28 responses from 34 Canadian clinics for a response rate of 82%. The most common reason for reproductive travel (80%) was access to anonymous eggs. The response, as reported by the authors, is that “365 Canadian patients per year went abroad for anonymous eggs” (Hughes and DeJean 2010: 17). However, these numbers are estimates given that reproductive tourists may not contact a local Canadian fertility clinic first but may choose to go

abroad for NRTs without the fertility clinic's knowledge. This survey research also did not ask Canadian patients which countries they traveled to for fertility treatments.

Researchers who study medical tourism suggest that caution should be made about prevalence rates because in some cases, the data are based on estimates (Hughes and DeJean 2010; Nygren et al. 2010), contain missing data or have gaps which make "extrapolation difficult" (Infertility Network UK 2008; Pennings et al. 2009: 3109) or "contain too few data from which to draw firm conclusions" (Blyth 2010:13). Additionally, what reporting there has been of recent qualitative studies is based on a small number of participants (Whittaker and Speier 2010).

Those in the reproductive tourism industry, including medical brokers and fertility clinics, are faced with the task of not only selling their individual product or service, but also promoting the wider industry and normalizing the idea about travelling abroad for fertility treatments. Most of the data on reproductive tourism regarding patient numbers, patient profiles and patient flows and financial scale come from the industry itself. As Lunt, Smith, Horsfall, Exworthy, Hanefeld and Mannion (2014: 603) note, "the problem of course is that such information may be hard to corroborate and stakeholders have a vested interest in presenting a picture of a vibrant and growing [reproductive tourism] industry."

Representation of Health and Illness on Medical Websites and Social/ Ethical Concerns of Reproductive Tourism

The representations of health and illness in the mass media have been studied by sociologists interested in the role of culture in illness/disease experience (Seale 2005). While traditional print media have been critically studied for their representation

of the illness experience, studies of health information on the Internet have tended to be centred on assessing medical accuracy and quality, and on the potential of the electronic medium to transform relations with healthcare consumers.

For instance, the American Medical Association (AMA) has published guidelines for medical and health information websites to guide the development of web content, regulate online advertising and protect the privacy of healthcare consumers (Huang, Discepola, and Al-Fozan 2005). The AMA states that regarding the quality of website content, most fertility websites lack descriptions of the “editorial process, the source of specific contents, the proper citations of reference sources, the dates on which the contents were posted, revised, and updated, and relevant financial disclosures of authors and content producers” (Huang, Discepola, Al-Fozan 2005: 540). Yet, the AMA study does not provide any in-depth analysis of how medical brokers and fertility clinics market their services to prospective consumers nor do they analyze how reproductive tourism is represented on these websites.

In their analysis of commercial and US government websites on health West and Miller (2009) argue that commercial websites have different incentives for online content and advertising and often have sponsors selling products on these websites which aids in the financial cost of maintaining the websites. Little work has been done to critically examine representations of health and illness on the Internet or the marketing strategies used to sell healthcare services. It should be noted that I do not define infertility as an illness; however, within biomedicine, infertility is seen as a medical condition requiring medical intervention to cure the infertile body.

Increasingly, individuals are taking an active role in enhancing their health and illness knowledge a variety of media, including the Internet, online support groups and healthcare organizations. The term of “cyber medicine” has been coined to represent “the science of applying Internet and global networking technologies to medicine and public health, of studying the impact of the Internet, and of evaluating the opportunities and the challenges for health care” (Eysenbach, Ryoung and Dipgen 1999: 1296). General practitioners, hospital specialists and nurses from “developed” countries are utilizing online medical resources to assist them in hospital and clinic settings. As Eysenback, Sa, and Diepgan (1999: 2) argue, healthcare consumers “will have a crucial role in being a major force for clinicians to ‘go online’”.

Whittaker (2008) further contends that our understanding of fertility treatments and patient expectations is being fed by social media. Reproductive tourists “constitute a new form of biological citizen, the “global biological citizen”, transnationally seeking medical treatment, embodying a neoliberal dream of mobile global capital flows, choice and competition” (Whittaker 2008: 283). The contribution of my PhD research to this literature is that it highlights how privatization and commodification happen through the creation of new marketing strategies on a virtual, global scale linking NRTs, medicine and consumer culture.

As previously stated, wealthy citizens can buy healthcare services, while poorer citizens cannot (Turner 2007). These wealthy citizens can also leave their own countries and travel to another country where NRTs are not regulated or have minimal regulation and potentially participate in law evasion where their own countries have more restricted laws that regulate NRTs (Pennings, Cohen and Devroey 2006). NRTs often rely on third

parties who provide gametes or women who are surrogates. The class, racial, gender and national differences among reproductive tourists and egg providers and surrogates speak to equality concerns and whether these women who are selling their services have been exploited in providing gametes or agreeing to become surrogates.

Conversely, researchers have noted that reproductive tourism can be an economic win-win arrangement for both the reproductive tourists, egg providers and surrogates and for countries participating in these practices, specifically for developing countries. Bookman and Bookman (2007) and Chambers and McIntosh (2008) argue that reproductive tourism and medical tourism can improve public health. In other words, paying reproductive tourists can exist with improvements in basic healthcare and social services. Reproductive tourism is seen as a “*strategy for economic growth, focusing on how revenue from international patients translates into output, jobs and income, et cetera*” (Bookman and Bookman 2007:9).

Sociologists and other researchers have also debated the policy of regulating reproductive tourism (Smith, Berrmann, Martin and Williams-Jones 2009; Pennings 2008; Ikemoto 2009; Inhorn 2009). Researchers examine the tensions between state regulations and the global marketplace for reproductive health services, “paying attention to the patchwork of national policies regarding reproductive technologies in the face of multilateral trade agreements, technological development and forces of global capital” (Martin 2009: 250).

Definition of Reproductive Tourism

Researchers, academics and bioethicists writing on reproductive tourism do not agree on the use of the term “reproductive tourism” to describe individuals leaving their jurisdiction and traveling abroad for fertility treatment(s). A variety of terminology is used within academic and popular culture references to reproductive tourism. The terms used by those writing about reproductive tourism, whether in popular media, or in medical, legal or policy documents are typically presented as if they were neutral (Beeson et al. 2015). They may reflect an attempt to legitimize or promote the practice or to invoke an opposition to the practice. According to Beeson et al. (2015:810) individuals who try to be neutral “simply adopt the language they assume is most commonly used and therefore most likely to be understood.” It is important to note that word choice reflects a particular perspective on an issue reflecting a set of values and beliefs. For example, individuals participating in reproductive tourism have been described as “procreative tourists”, individuals seeking “healthcare without borders”, or seeking “health care beyond boundaries,” or “travel ART,” and “cross border reproductive care” which emphasizes the practice of reproductive tourism in neutral terms. The practice of individuals traveling for fertility treatments abroad has also been referred to as “reproductive outsourcing”, “reproductive exile” and “reproductive trafficking” which seeks to draw attention to the unequal power relationships between reproductive tourists and egg providers and surrogates as well as noting the potential exploitation of women who choose to become egg providers and surrogates (Ikemoto 2009).

According to Smith-Cavros (2009), the representations of reproductive tourism portray medical treatments as effortless and even relaxing. Pennings et al. (2008) argues that this term (reproductive tourism) is inappropriate because it ignores the cost,

seriousness, and emotional and physical risk of fertility treatments. Pennings et al. (2008) prefers to use a more neutral “term like ‘cross-border reproductive care’ to avoid the negative connotations associated with reproductive tourism” (2008: 2182).

Inhorn and Pasquale in Smith-Carvos (2010: 467) note that reproductive tourism is more like “reproductive exile than tourism”. Rather than experiencing rest and relaxation associated with a vacation, Inhorn and Pasquale in Smith-Carvos (2010) argues, it is likely that intended parents feel pressured to travel for fertility treatments due to restrictive laws in their home countries and extensive, waiting times for treatments. Ikemoto (2009) argues that the most serious concern with reproductive tourism is the purchasing of gametes and hiring of surrogates. The strongest opponents of reproductive tourism use the term trafficking to draw attention to the illegal trafficking of human organs across the globe. Some feminist academics who write on surrogacy agreements in the “developing” world have advocated for viewing surrogacy as an “extension of care labour” (Bailey 2009:10). Bailey (2009:10) argues that this term acknowledges the “impact of outsourcing surrogacy, is attentive to surrogate worker’s agency, fleshes out the material dimensions of surrogate worker’s lived experiences and does not rely on Western moral frameworks.”

The purpose of the above discussion about the disagreement around using reproductive tourism to describe individuals traveling abroad for fertility treatments and the bioethical debates surrounding reproductive tourism is to draw attention to the complexity of defining reproductive tourism and researching this phenomenon. By using the term “reproductive tourism and replacing it with something as benign as cross

border reproductive care, we lose its linguistic and analytic link to the already-established phenomenon of medical tourism” (Martin 2015: 9).

The Context

The social, medical and ethical implications of the global marketing of NRTs and the commodification of women’s bodies are profoundly dependent on context. Reproductive tourism intersects many different issues such as governmental/state regulations of NRTs, the privatization and commercialization of health services, the global spread of medical technologies to other countries, the unequal power relationships between reproductive tourists and egg providers and surrogates. Intended parents are not merely traveling to obtain NRTs; they are using their socioeconomic status to purchase the reproductive labour of others in addition to the non-medical goods and services they consume in other countries such as transportation, accommodations, food, and entertainment. (Martin 2014). Reproductive tourism frequently involves political and not merely economic motives. The home countries of intended parents may forbid, discourage or ban certain NRTs. And as a result, intended parents travel to other jurisdictions to meet their reproductive desires. Reproductive tourists rely upon a global infrastructure of medical providers, attorneys, egg and sperm donors, surrogates, instant communication and information on the Internet and travel services. Here, I use feminist political economy to discuss the context, while I later expand on how it helps guide my analysis of the websites. This includes how gendered and racialized discourses are reproduced on the medical broker and fertility clinic websites.

As feminist political economists argue, “healthcare systems are not neutral or random. Rather, they result from particular social and historical processes that are context-specific and based on particular values about governments and individuals’ responsibilities and rights to care” (Armstrong and Armstrong 2010; Aronson and Neysmith 1997; Corburn 2001; Vosko 2003 as cited in Grigorovich 2014: 7). It directs attention to whose voices and experiences are missing from the websites. In particular, this approach argues that gender and gender relations influence, and are in turn, influenced by socio-economic and political structures and ideologies and that these are important for understanding individual’s choices and access to resources. A discussion of the Canadian context of healthcare reforms shaping reproductive tourism and the current Canadian regulatory landscape of NRTs is further discussed in Chapter three. The next chapter outlines my theoretical framework, feminist political economy as it relates to reproductive tourism as well as detailing my research methods.

Chapter Three: Theoretical and Methodological Framework of Thesis

Introduction

In the previous chapter, I discussed why and how Canadians travel to other jurisdictions to obtain NRTs, the tension(s) surrounding using the term reproductive tourism, outlined the literature on reproductive tourism and briefly highlighted the contextual landscape of reproductive tourism. In this chapter, I discuss the theoretical framework of this dissertation, feminist political economy and my research methods. I argue, along with other feminist scholars, that we need to analyze the work of egg providers and surrogates in terms of affective/emotional labour or care work and to document the unequal power relationships among reproductive tourists and egg providers and surrogates. The marketing of reproductive tourism on the medical broker and fertility clinic websites ignores the care work these women perform and the unequal power relationships that exists between reproductive tourists and egg providers and surrogates. Instead, these websites discursively frame egg donation and surrogacy as women helping women across national borders and erase their labour and experiences from view. This is further discussed in chapter seven.

Feminist Political Economy Perspective

Feminist political economy's framework came from a critique of political economy which explored how politics, economics and ideology were interconnected and shaped social relations. Capitalism, from a political economy perspective, is organized by a profit driven logic that is not viewed as natural but as "socially constructed set of relations that are historically specific" and produced economic inequalities among individuals (Armstrong et al. 2001: 45). Political economist theorists question who

benefits from the existing set of social relations and viewed inequality from the perspective of class and economic relations and not in terms of unequal gendered relations. Women's domestic labour and their participation in the paid labour force were rendered invisible and any gendered analysis of the wage gap between men and women or the precarious employment of women were dismissed (Armstrong 1983). For feminist political economists, the invisibility of gendered relations in the analysis of capitalism, the state and market forces were incomplete. They argued that the analysis of capitalism, the state and market forces required a critical lens of how the formal economy relied on the unpaid labour of women in the home (Armstrong and Armstrong 1983).

In addition, a feminist political economy approach viewed social relations, capitalism and the state as a means to oppress women (Armstrong and Connelly 1999). The state regulates the household and also shapes how paid and unpaid labour is organized along gender lines. Feminist political economy theorists developed the concept of social reproduction to discuss the ways in which paid and unpaid work are influenced by the state, the market and gender (Luxton 2006). The concept of social reproduction entails more than the physical reproduction of a population; it encompasses transmitting of values and knowledge across generations and cultures (Luxton 2006). Social reproduction refers to the care work necessary for biological reproduction and reproduction of human labour to participate in the market economy. This work is primarily undertaken by women and much of it unwaged.

Feminist Political Economy and Intersectionality

According to a feminist political economy approach, intersectionality is a theoretical and methodological approach exploring how complex systems of power impact the interconnected experiences of individuals and group identities and social locations. Researchers taking an intersectionality lens highlight how multiple social locations such as race, gender, socioeconomic status, age, nationality, language, ability, sexual orientation interact and inform inequalities and differences in health, health services, access and patient experiences (Hankivsky 2012; Hankivsky 2014).

A central tenant of intersectionality theory is that social locations are “relational and interactive; they are not mutually exclusive and do not operate in isolation of each other” (Hankivsky 2014: 255). Using an intersectionality approach directs the researcher’s focus to the multiple social locations individuals have and their access to resources (Hankivsky 2014). This approach provides a more nuanced understandings of health inequalities when developing models of care that are shaped by the experiences of different sub populations and communities. Exploring the narrative representations of reproductive tourists and women who are egg donors and surrogates on the medical broker and fertility clinic websites recognizes that reproductive tourists and women are not a homogenous group and any program and policy designed to address the treatment and non-medical needs of these women, caregivers and reproductive tourists is influenced by their multiple and interacting social locations and identities.

Feminist Political Economy and Reproductive Tourism

The medical broker and fertility clinics’ marketing strategy on the Internet creates a new social space for products and services between medicine and consumer culture

to occur (Saukko, Britten and Hogarth 2010). Reproductive travel involves not only bodies that move across borders, but also technologies as well as dreams, images, and hopes (Krolokke 2015). Many of the medical facilities and fertility clinics are located in lower income nations in “developing” countries. These countries have low wages, cheap real estate, low currency exchange rates that can appeal to reproductive tourists from ‘developed’ countries (Chelliah 2012). The prospect of low-cost fertility treatments attracts reproductive tourists from such countries as the United States, Canada, United Kingdom and Australia. As Spar (2006:10) contends, “we need to understand reproductive medicine in a more familiar context, a commercial context” in which competing fertility clinics, medical brokers and fertility specialists use technology to meet their consumers’ needs.

The emergence of reproductive tourism ties the “commodification of gametes and wombs to a globalized landscape in which technologies, people, money and beliefs about family and kinship ties flow in multiple directions” (Inhorn as cited in Harrison 2014:146). Intended parents research the most favourable pricing and regulatory environments that align to their reproductive goals. In order to view reproductive tourism as a business which operates within neo-liberal thinking, abetted by the erosion of state barriers and, which allows the free flow of people, capital, and medical services, I need a theory that is concerned with the interaction of economic processes and power relations, on a global scale and questions the economic inequity between reproductive tourists and those women providing eggs and surrogacy as third-party participants. The rapid growth of global capitalism and consumerism has created “new regimes of consumption”, with individuals as well infertility specialists, fertility clinics, medical

brokers and “research scientists trading in reproductive bodies and body parts for profit-making” (Gupta 2009:5). In the words of Hochschild (2003: 63), there is a “commercialization of intimate life”.

A feminist political economy approach is focused on questioning how care became associated with women and femininity. Armstrong and Armstrong (2004: 10) argue that, “caring can be understood as women’s work only within the unequal relationships, structures and processes that help create women as carers and undervalue this caring work.” Additionally, Hochschild’s (1983) work on emotional labour analyzes the ways in which women skills in the physical reproduction of a population are being transformed into labour within the new global economy. Since then, terms such as care labour (Fisher 1990 and Duffy 2005) emotional or affective labour (Weeks 2007) have been used by feminists to discuss work that is feminized and involves the nurturing of others.

As previously noted, reproductive tourists can purchase gametes (egg and sperm) and enter into commercial, contractual relationships with women who are hired as surrogates. Women who provide their eggs or become surrogates for reproductive tourists allocate their time, energy, attention, labour and care for their bodies to produce a child by paid legal contract. As a paid legal service, commercial surrogacy is imagined on the websites as a “contractual usage of a women’s otherwise unused uterus as a space in which to gestate a fetus that is understood as someone’s else’s property and progeny” (Vora 2015: 10).

The care and labour that egg providers and surrogates provide can be viewed as the social reproduction of society. As Vora (2012) notes, “social reproduction is the care and energy put into making sure the person doing productive labour is able to return to work each day [...] By providing support to the biological reproduction of the worker’s body and strength as well as a replacement worker in the form of child rearing [and childbearing]” (Vora 2012: 688-689).

The feminization of work that reproduces life is work that often involves care and remains undervalued. I argue, along with others, that women who provide their biological material or become surrogates are engaged in a form of labour, even though the terminology of labour is not used in these contexts. It leads us to ask, what stakes are involved when egg providers’ and surrogates’ labour “occurs primarily through biological and affective processes and that are subject to capitalist labour power” (Vora 2012: 682)?

Waldby and Cooper (2008; 2010) further argue that women who provide eggs and become surrogates are part a larger bio-economy in which women’s reproductive biology has become part of biomedical research and global commercialization of women’s bodies. For Waldby and Cooper (2006; 2008; 2010) reproductive labour includes all the physical and nurturing labour that women are involved in when they provide their eggs or become surrogates for reproductive tourists.:

The Body as a Machine and the Commodification of Body Parts

New medical advancements “have made far-reaching interventions on the body possible, extending the boundaries of a single body beyond its skin, tissues and organs

[...] Human beings have become an assemblage of body parts, where they are exchanged, denoted or traded” (Gupta and Richter 2008: 239). The metaphor of the body as a machine composed as an assemblage of parts is reinforced. The human body is fragmented both “metaphorically and literary through language, visual imagery or the actual surgical reconstruction, removal or replacement of specific body parts” (Sharp 2007: 385). Lock (1993) asserts that the medicalized body is isolated, decontextualized and abstracted from the actual geographical location and social space. The body can be operated upon in any geographical region regardless of the context and space in which bodies live, work and play.

Gupta and Richters refer to Braidotti to discuss the discourses of biosciences which “in taking the organism as its object, also takes the body as a mosaic of detachable pieces. Under biotechnological gaze which penetrates in three ways, x-rays (ultrasounds), steel (instruments) and chemistry (biochemical), living organisms are reduced to an infinitesimal scale and lose all reference to the being as a whole” (Gupta and Richters 2008: 240). Reproductive medicine intervenes in the body from larger to smaller parts of the body such as the womb, eggs to microscopic parts such as cells, and also from semen to a single sperm. Scheper-Hughes (2005) further proposes that free market economy requires a fragmented body that can be purchased for medical consumption. The technologies for pre-natal screening such as ultrasound create a division between the pregnant woman and the fetus, often privileging the later (Rothman 1986). Within reproductive medicine, there is an increasing tendency to view women as wombs and childbearing machines instead of whole persons.

The female body is commodified within a healthcare market economy (Gupta and Richters 2008). Commodification happens when the boundary of what can or cannot be sold is removed. This is shown by the current healthcare markets for gametes, tissues and reproductive body parts that cater to a medical marketplace. Commodities are “freed’ from a direct relationship between producers and consumers; they are bought and sold and they can circulate in broader, even global networks” (Gupta and Richters 2008: 241). According to Gupta and Richters (2008: 245), with the emerging “biotechnology industry, human bodies have become biological capital that is deposited in bio-technological banks (blood banks, sperm banks, tissue banks and core blood banks) from which the public can draw.”

Increasingly, bodies and their parts are seen as economic capital under conditions of economic globalization where they can be bought and sold (Scheper-Hughes 2001). In the healthcare market economy, body parts, gametes, and individual and private business interests come together. Gupta and Richters (2008: 242) note that while the sale of organs is illegal in most countries around the globe, the sale of gametes do not fall under the current laws “because they are regenerative.”

It is also important to note that reproductive tourism and NRTs rely on the use of women’s bodies and therefore NRTs are a gendered technology. NRTs need to be understood within a context of unequal, gendered socio-economic relations. This means beginning with the contexts in which these medical technologies are developed and used. These contexts are characterized by financial and human inequalities, gendered technologies (Balka et. al. 2009). Regardless of the cause of infertility, it is the woman who is seen as infertile (Ikemoto 2009). Often, womanhood is socially constructed

around motherhood and failure to produce a child may be seen in a negative light and may lead to questioning what it means to be a woman. Moreover, pregnancy is proof of fertility; its absence marks the woman as infertile. In addition, most treatments are administered to women even in the case of male infertility. For example, intracytoplasmic sperm injection (ICSI) is used to overcome a common cause of infertility-low sperm motility. ICSI is a specialized form of IVF that involves the injection of a single sperm directly into a mature egg. Nevertheless, it is the woman who undergoes IVF in order to retrieve the eggs that are injected with sperm, and who undergoes egg transfer to achieve pregnancy. Thus, women bear most of the health risks, as egg providers, IVF patients and surrogates.

Globalization, Women and Care work

In addition, the processes of reproduction have been deregulated, privatized and made available for financial investment (Waldby and Cooper 2008). Women's participation in the sale of eggs and surrogacy involves a "very literal form of bodily, reproductive labour, a kind of labour that has been traditionally available to women but which has recently been medicalized and standardized to an extent where it can be organized on a global scale" (Waldby and Cooper 2006: 8). Egg selling and surrogacy can be also be understood as "new forms of biomedical or clinical labour for example participation in clinical trials or the selling of organs and other bodily tissues as a means of livelihood" (Waldby and Cooper 2006: 8).

The process of care work and labour is further disrupted as "global care chains" emerge in the reproductive health services (Krolokke, Foss and Pant 2012). Hochschild (2000) developed the concept of global care chains to discuss the experience of migrant

women who are paid domestic workers. Hochschild defined global care chains as “a series of personal links between people across the globe based on the paid or unpaid work of caring” (2000:13). Migrant domestic workers cross international borders to act as caregivers for other women’s children (Krolokke, Foss and Pant 2012).

Yeates (2005) further reworked the concept of global care chains to illustrate how traveling in search of reproductive services is embedded in a hierarchical labour market. According to Yeates (2005: 373),

Global care chains do more than demonstrate the connections between personal lives and global politics; they elucidate the structures and processes that reflect and perpetuate the unequal distribution of resources globally. Global care chains reflect a basic inequality of access to material resources arising from unequal development globally but they also reinforce global inequalities by redistributing care resources, particularly emotional care labour, from those in poorer countries for consumption by those in rich ones.

Therefore, if care is understood as of both biological and social reproduction, then paid egg providers and surrogates who donate their eggs and give birth for reproductive tourists can also be viewed as a global care chain network. In the case of transnational surrogacy and egg donation, this network consists of medical brokers and fertility clinics that manage the reproductive tourists’ trip abroad, sight- seeing tours, book hotel rooms, and obtain visa requirements. This network is highly gendered. As Krolokke, Foss and Pant (2010: 275-276) propose, within it, women are “engaged most[ly] in physical and emotional labor, while clinics and legal [departments] stand apart, in a

more conventional masculine pose, engaged in forms of labor that are positioned as distanced, objective and prescriptive.”

Furthermore, Waldby and Cooper (2008) argue, reproductive, biomedical and clinical labour lies at the heart of neoliberalism where individuals are encouraged to sell their own labour, pursue their desires and participate in the global free market economy. In terms of reproductive tourism, women in the “developing” countries are viewed as cheap labour and suppliers of reproductive services (selling of gametes and surrogates) for the Global North.

Across the globe, more women have moved into the labour market and countries that have traditionally provided paid childcare, have now opened to migrant domestic workers who work as caregivers and are defined “along the lines of racial, geographical and class difference” (Waldby and Cooper 2008:63). Reproductive tourism has also opened spaces where women in ‘developing’ nations are becoming egg providers and surrogates for women in the Global North.

Women living in the Global South may seek out or “be forced to invent new productive niches in the so-called informal economy” (Davis 2006 as cited in Waldby and Cooper 2008: 63) due to the structural adjustment policies imposed by the International Monetary fund. Many countries in the Global South were forced to privatize their publicly funded programs such as healthcare and education and this impacted women’s access to regular employment.

Also, if we want to talk about gendered and racialized bodies, not all bodies have equal access to healthcare and social services. The patterns of “global poverty and

disease impact in differential ways and in particular, on women and children” (Bennett 2006: 268). Globalization offers new financial opportunities while at the same time, reproduces structural inequalities. Studies on transnationalization of reproduction, illustrate different patterns of female migration, labour and childbearing that empowers those already privileged by gender, race, class, nationality and immigration status (Ehrenreich and Hochschild 2004; Ginsburg and Rapp 1995). Kempadoo (1996: 72) further argues that the neoliberal restructuring of “developing” economies “imposed by the World Bank and the IMF, entailed the recolonization of women’s bodies as women were forced into sex work as a survival strategy in places such as the Caribbean and into new forms of transnational labour often as domestic workers in wealthier countries.” A problem arises when the interests of individuals clash with the state policies. It is at the opposing juncture of wants that reproductive tourism enters. The globalization of assisted reproductive technologies “forces us to push the levels of analysis up, beyond the state. The use of NRTs has already been turned into an act of consumption and globalization widens the market, pushing reproductive decision making onto the global stage” (Martin 2009: 253). Reproductive tourism is a rapidly shifting set of practices that mix the “commercial and intimate in a wide variety of settings that literally span the globe” (Ikemoto 2009: 189).

While most previous feminist research on NRTs--including surrogacy and egg donation study gender, much less attention has been paid to the issues of class, race and the state. Feminist theorists (Collins 1990: Crenshaw 1989) who study NRTs have noted that race, class and state along with gender are all essential to understanding reproductive debates, politics and experiences (Beisel and Kay 2004; Roberts 1997;

Markens 2011). Countries such as India, Thailand, Nepal, Mexico and Romania are looking to reproductive labour of their population “as a means of inserting themselves into the global exchange of scientific and biomedical knowledge and appear to be positioning themselves as both developers of new biotechnologies and suppliers of reproductive tissues” (Waldby and Cooper 2008: 64).

For instance, a significant number of physicians and nurses from “developing” countries train in North America, Western Europe and Australia and bring back their new skills to their country of birth, creating an increase in medical expertise and technical skills. Hospitals and fertility clinics in “developing” countries are able to attract patients from around the globe. According to Jenner (2008), healthcare globalization manifests itself in several ways, including the standardization of medical knowledge and practices to meet the fertility tourist’s expectations from the U.S., Canada and Western Europe. Healthcare globalization includes “the exchange of ideas about medical science, particularly the scientific cannon, as well as about technological processes in medical innovations... [which] easily cross borders” (Bjorkman and Altenstetter as cited in Jenner 2008: 243).

The international market for gametes and surrogacy has also been fueled by recent moves to privatize healthcare in several “developing” countries (Jenner 2008). This move has further fueled the consumerism of medical services and technologies. As previously stated, governments of many countries are actively pursuing reproductive tourism as a new source of economic development (Jenner 2008). As Jenner (2008) notes, the globalization of healthcare represents a shift from local, community-based healthcare providers and hospitals, which delivered healthcare for the local population,

to a more global healthcare system. Healthcare is transforming into a “system controlled by large mega healthcare corporations, consumer demand, government offices of economic development and, increasingly, insurers” (Jenner 2008:241).

Furthermore, a number of feminist theorists have referred to the history of female reproductive labour in the colonial world as a way of thinking about the contemporary rise of informal female labour and its relationship to the globalization. According to Kempadoo’s (1999) analysis, the neoliberal reforms imposed by the World Bank and IMF have led to a process of re-colonization, which overwhelmingly impacted female care work. The importance of Kempadoo’s (1999) work is that it directs our attentions to the transnational nature of the political economy and gendered division of labour involved in reproductive tourism. Whereas most early feminist work on reproductive labour tended to focus on a Western notion of the nuclear family (Delphy 1984), this literature focuses on the care work women perform under global capitalism. It makes clear that care work women perform is inseparable from issues of race, colonialism and unequal power relations that exist among women. In particular, it offers important insight into the way the “market value of bodies and their labour is determined not merely as a function of economic consideration but also a function of desire, fantasy and hope” (Barnett and Smith 2006: 4). In terms of reproductive tourism, it is important to note that women who sell their eggs or become surrogates are not passive victims but have agency. Viewing their participation in reproductive tourism as labour and care work opens up the possibility that relations between these women and reproductive tourists, fertility specialists and medical brokers may be subject to resistance.

For instance, reproductive labour is increasingly contractualized, removed from the space of the home and located in the medical and fertility clinic. Yet, research by (Parry 2015), tells us that although reproductive labour occurs within a neoliberal discourse, we cannot divorce it from different types of labour and care work. To do so has the effect of “erasing key aspects of their lived experience and it invites the reader to assume all reproductive labourers occupy similar positions within the bioeconomy” (Parry 2015: 46). Recent ethnographic accounts of surrogacy in India detail how Indian surrogates are placed in hostels away from their families and social networks in order to monitor their pregnant bodies. However, Indian surrogates use these same hostels to establish friendships with other women and come together as a whole to renegotiate their surrogate contracts (Parry 2015; Pande 2010). As Pande (2010) argues, focusing on labour allows researchers to move beyond a binary framework of exploitation versus empowerment and instead explore the lived experiences of women who participate in egg donation and surrogacy. Surrogacy may also reflect an appealing employment alternative to other labour options. In a study of surrogates in Bengaluru India, Rudrappa (2014) found that potential surrogates in this region were mostly recruited from garment manufacturing where low pay and harsh working conditions are the norm.

In sum, using a feminist political approach allows me to view reproductive tourism at the growing intersection of medical and information technology, the bio-economy, neoliberal government policies, unequal power relations, privatization and the commercialization of medical services. Reproductive tourism will play a role in shaping the future of medical care both globally and locally. My PhD research provides an entry point into exploring these new medical and global patterns by documenting the novel

ways in which market-based reproductive health services are marketed on a global scale. The next section of this chapter discusses my research methods.

Research Methods

As previously discussed, potential patients can find out about fertility services in other jurisdictions through self-referral directly via fertility clinic websites and through a growing number of medical broker websites. As I began conducting research on analyzing websites that use blogs, Skype, instant message boards, patient narratives, text, images and videos to market NRTs and commodify women's bodies, it became apparent that there was a gap in the literature that detailed "how to" deconstruct these websites.

A few research studies (Connolly 2014; Turner 2012; Culley et al. 2013) used content analysis to examine medical brokers in the United States. Researchers counted the number of pictures which depicted tourist activities, hospital facilities abroad and the prevalence of White, heterosexual couples holding their babies and noted the frequency of tourist language used to market medical tourism. Yet, few studies documented how researchers analyze the different media used on the websites, such as images, videos, texts, and hyperlinks or how unequal power relations and discourses are represented within these mediums.

A feminist political economy perspective notes that political and economic power are deeply interconnected and it is necessary to examine gender and gender relations within different socioeconomic and political structures and discourses (Armstrong, Armstrong and Coburn 2001). Feminist political economy links reproduction and care

work to production and attends to women's voices and experiences. This is a particularly useful theoretical framework for examining reproductive tourism, as it supports a critical investigation of dominant neoliberal assumptions that are embedded in healthcare policies and systems. These assumptions include the belief that healthcare should be managed and organized based on a for-profit business model and that health is an individual responsibility where the healthcare consumers can make informed decisions about their care.

Furthermore, my research is firmly centred on understanding the particular historical, economic and political context in which these websites are located. How are the unequal power relations represented in the text, images and videos on the medical broker and fertility clinic websites? Whose voices are featured prominently while others are marginalized? Smith (1990), a feminist political economist views power relations as operating in ways that maintain dominant ideologies and sustain unequal social relations. Relations of ruling designate "the complex of extra-local relations that provide in contemporary societies a specialization of organization, control and initiative. They are the forms that we know as bureaucracy, administration, management, professional organization and the media and discourse" (Smith 1990:6). This research explores the unequal power relations of women who are egg providers and surrogates and how their care work is rendered invisible in their discursive narratives on these websites.

Smith's Concept of Discourse and Text

Smith's concept of discourse and text can be seen as bridges between theory and practices. As Griffith and Smith (2005) noted, texts are not just statements, they are the products of relationships and interchanges among researchers, public

institutions, popular media, and texts of popular culture. Feminist political economy helps locate these relationships and Smith's concepts help me to further analyze the websites.

Theorists such as Smith (1990, 1999), Fairclough (2001, 2003), Lazar (2007) and Wodak (2002) view texts as distinct phenomena for sociological investigation. Discourse is commonly understood as language-in-use and reflective of social relations. In other words, discourse is concerned not only with the nature of a particular communication but also with the organizations that shape daily activities. Smith and these other theorists are not only concerned with what texts say, but also with what texts do. For Smith (2001: 46), texts are not "solely sources of information about organizations but rather, are seen as coordinating people's local activities/ practices such as writing, drawing, and reading and watching". Texts are definite forms of "words, numbers, symbols and images that exist in a material form which can be replicable across sites...reproduce[ing] them across time and space and among people diversely located" (Smith 2001: 46-47). Whether the text is printed or electronically produced, it is read, watched and listened to in particular local settings by specific people. In this way, reproductive tourists research different medical broker and fertility clinics on the Internet—watch videos, talk with medical broker facilitators and fertility specialists and write their own patient testimonials on these websites. According to Smith, (2001) people's activities in local settings are in this way connected into social relations organized by the text. Texts are "key devices in hooking people's activities in specific settings into the transcending institutions and organizations" (Smith 2001:48).

Smith's concept of discourse also incorporates an active presence of people creating, consuming and reproducing discourse. Smith (1999: 84) builds upon Foucault's (1978) concept of discourse; however, she criticized his work for displacing the subject as "passively cowed by texts, rather than as a knower and actor, actively engaged in mediating discourses". Discourse refers to "translocal relations coordinating the practices of individuals talking, writing, and reading, watching in particular local places at particular times. People actively participate in discourse and their participation reproduces it" (Smith 1999: 45). Griffith and Smith further explain (2005: 34),

we use the term discourse somewhat as Foucault [1978] does... though the notion of *discourse* that we work with here shifts from discourse conceived simply as forms of signification or meaning to emphasize discourse as the local practices of translocally organized social relations...people participating actively and embodied in a conversation mediated by written and printed materials.

By emphasizing discourse as "the active, local practices of people (watching, reading, writing, and listening), mediated by written, printed and watched materials", Smith (2001: 48) is drawing attention to the need to view discourse as actually happening and preformed. The consequence of "this definition of discourse is that people are always present in its creation and consumption and provide its dynamic" (Smith 1999: 145).

Drawing from Bakhtin, Smith (1999) argues that discourse is an active dialogue between what people are trying to get said and get done at any given moment. As reproductive tourists search for medical broker and fertility clinic websites on the Internet, compare prices of NRTs offered by various fertility clinics, success rates at

fertility clinics, costs of hotels stay, and interact with both health and non-health professionals: all of these activities are not apart from the virtual texts. Texts are activated in these activities as local events and coordinate the local practices of these individuals (Smith 1999).

Discourses can be viewed as elements of social phenomenon that can have effects. Discourses can bring about changes in our knowledge, beliefs and values and have long-term effects (Fairclough 2003). For instance, being exposed to advertising can contribute to shaping people's identities as consumers or their gender identities. Documents and their discourses can "have social, political cognitive, moral and material consequences and effects, and that it is vital to understand these consequences and effects if we are to raise moral and political questions about contemporary societies" (Fairclough 2003: 14). For example, texts and their discourses are generated in different settings such as "government systems of collecting statistics, social scientific research in universities, policy making in government and mass media are coordinated conceptually, producing an internally consistent picture of the world and providing the terms of policy language and decisions" (Smith 1999: 157). According to Smith (1999), there are ideological codes that organize texts across settings that can focus on different issues, often targeting specific audiences. For instance, describing someone as a healthcare consumer connects a local moment into the discursive relations organized by neoliberal ideology.

Intertextuality

Intertextuality refers to the relationships among texts. Kristeva introduced the term "inter-textuality" in the early 1980s to popularize, in Europe, the work of Mikhail

Bakhtin. A basic tenet of this concept is that no text is unique. It is a product of, and refers to “other texts, and these references, these inter-relationships among texts, govern their meaning in that any text is the absorption and transformation of another” (Kristeva 1984: 35). Smith (1999) insists that a text cannot be read in detachment from other texts that it references. A text is embedded and connected to a set of hierarchical texts, including institutional texts which can frame how lower-level texts are read (Smith 1999). In other words, intertextuality looks at how texts draw upon and incorporate other texts (Fairclough 2003).

Intertextuality is also partly a matter of assumptions people make when they speak or write. According to Fairclough (2003: 17), “what is said in a text is always said against the background of what is unsaid”. An important question in using intertextuality as an analytic tool is asking which texts and voices are included and which are excluded. In terms of the medical broker and fertility clinic websites, I documented what information was included, which information was excluded, and any gaps in the information. And were there any differences and similarities between the medical broker and fertility clinic websites in terms of information provide and images used? I asked, “how other voices are textured in relation to the authorial voice, and in relation to each other and are attributed voices directly reported (quoted), or indirectly reported” (Fairclough 2003: 217).

In this study, attending to the intertextual relationships between medical brokers/fertility clinic personnel, reproductive tourism research, reproductive tourists’ desires, and public and medical institutions provides insights into the political economy of this marketing strategy. The paths along which fertility treatments become consumer

services to be bought were an important consideration in this thesis, particularly as the scale and extent of the marketing of reproductive tourism and its links with global corporate capital have increased over the years. Following my feminist political economy approach, I was also interested in exploring how the relations between private medicine and government were structured.

Another important rationale for using Smith's concept of intertextuality is the set of inherent characteristics of websites as texts. Websites and their virtual texts are set apart from traditional texts by their overt intertextuality. Unlike print texts, the virtual text offers the opportunity to connect various virtual texts with specific hyperlinks which allow the reader to move from one text to another in an effortless manner (Cohen 2010). The ability to use links to move from one point in a particular text to another text is a unique feature of the virtual text. According to Cohen (2010: 229), Internet text is "self-consciously intertextual, constantly inviting the reader to move to another textual mode. The presumption of reading to the end is replaced by the expectation that the reader will explore the links that appear in the text." The nonlinear text, invites the reader to a more active role in the reading and meaning making process. The hyperlinks on the homepage of the website calls for "exploration and the meaning produced by selecting one series of hyperlinks which could produce a very different meaning from selecting an alternative series of hyperlinks" (Cohen 2010: 230). Also, following Smith's argument, the forms of text-mediated social organization may differ because which sites a reproductive tourist has access to or reads may, in turn, influence which medical broker he or she uses, as well as which fertility clinic abroad he or she uses. In this context, the reader becomes the author because it is the reader who is the agent who actively

selects the hyperlinks to follow (Cohen 2010). Smith's concept of discourse, text and intertextuality all emphasize the active presence of people creating, consuming and reproducing discourses and texts. The reproductive tourist is actively involved in selecting which texts to view and in which order to view them.

The virtual texts with the help of website designers, can also combine written words with pictures, audiovisual images and videos which may not follow a linear story or path (Papson 2004). However, it is important to note that website developers use "three elements, an aesthetic (the use of repetition, proximity and contrast), images and videos, and a system navigation. These three factors frame the substance of the site and [to serve] as visual makers that guide the view through both the page and the site" (Papson 2004: 1625). Although the use of hypertext on these websites does increase user agency, the reproductive tourist still navigates within a self-contained website. According to Papson et al. (2004), the user/viewer must be able to recognize that they are within the website. The next two sections of this chapter detail how I selected the websites to include in my research study and how I analyzed the written texts with pictures, videos and multiple voices on the fertility clinic and medical broker websites.

The Selection of Websites/Texts

It is important to note that we never neutrally engage with documents and its discourses; we always engaged with them in a specific local context and we read or use them in a specific way. Krippendorff (2006) suggests researchers need to acknowledge that all texts are produced and read by others and are expected to be significant to them, not just to the researcher. As a researcher, it is important to provide the reader with a roadmap of my decisions because we do not engage with texts (websites)

neutrally. My rationale for the selection of websites will shape the context in which I analyze them.

Using Google and Yahoo search engines I conducted a keyword search to locate medical broker and fertility clinic websites on the Internet. Keywords included terms such as Canada and medical broker, medical tourism and Canada, reproductive tourism, cross border reproductive care, fertility tourism, transnational surrogacy and egg donation, international surrogacy and IVF. The rationale for this approach is to simulate the search methods that a Canadian patient might use to search for fertility tourism services. The medical broker and fertility clinic websites in this study met two criteria. First, they had to be published in English. Second, they had to convey their marketing message to Canadians. Websites using symbols such as the Canadian flag or specifically stating they cater to Canadians or discussing how their services can alleviate Canadian wait times by providing Canadians the means of purchasing fertility services abroad were included in the research study. My study is based on ten Canadian medical broker websites, nine United States medical broker websites which provide fertility treatments in “developing” countries, six international medical brokers located outside North America which provide fertility treatments in “developing” countries and eight fertility clinic websites from Barbados, South Africa, India, Thailand, Turkey, Argentina, United States, Romania and Czechoslovakia that market to Canadians. Below is a list of all the websites included this study. They include:

Canadian Brokers

- www.ihcproviders.com
- www.timelymedical.com

- www.surgicaltourism.ca
- www.medextra.com
- www.meditours.com
- www.magellangh.com
- www.choicemedicalservices.com
- www.worldassist.com
- www.firstchoicemedical.com
- www.medexpress.com

U.S. Medical Brokers

- www.passportmedical.com
- www.elite-ivf.com
- www.planethospital.com
- www.patientbeyondborders.com
- www.eggdonation.com
- www.eggdonorcenter.com
- www.newgeneticsgloballimited.com
- www.renewfertility.com
- www.medicaltourismco.com

International Medical Brokers

- www.ivfmiraclebaby.com
- www.myivfalternative.com
- www.surgicalbliss.com
- www.thailandfertility.com
- www.surogacyabroad.com
- www.scmmedicaltravel.co.uk

Fertility Clinics

- www.turkey-ivf.com

- www.barbadosivf.com
- www.fertilityargentina.com
- www.ivf.co.il
- www.pragueivf.com
- www.sdfertility.com
- www.ivfnj.com
- www.newlifeindia.com

Before data collection, I defined a website as the unit of analysis. For the purpose of this study the term *website* is defined from a lay perspective as a collection of pages or files linked together and available on the Internet. The unit of analysis was the home page and all the other internal pages directly connected to the home webpage. Medical broker and fertility clinic websites were further defined as websites intended to sell comprehensive medical travel services, which include not only clinical services but also transportation, accommodations, and visa requirements.

The medical broker and fertility clinic websites have a generic structure of a home page, mission/value statement, list of contact information and travel accommodations as well as other elements that vary among the websites. Within this website structure there is also a mixing of genres. For instance, news reports may be displayed alongside individual patient testimonials in video format, or videos and images of fertility treatment procedures may be presented alongside images of tourist attractions. As Gover and Go (2005: 75) contend, in marketing a destination country on these websites there is a “tension between the desires to project imagery that provides an authentic identity of place but at the same time, commoditizes it for tourist consumption reflecting desirable experiences”.

The object of qualitative research is not generalizability but transferability, i.e., a judgement about whether findings from one context are applicable to another. Thus, sampling texts of the websites does not need to ensure that all websites being analyzed have an equal probability of being included in the sample. Instead, the sample is purposive (White and Marsh 2006). Including new fertility clinic and medical broker websites “continued until no new patterns or findings in relation to the concepts under analysis become apparent in the coding process, that is, until saturation had been reached” (White and Marsh 2006: 23).

Thus far, I have solely discussed the analysis of written texts and its discourses and the selection criteria of the websites. However, the medical broker and fertility clinic websites are virtual texts—containing digital photographs and videos. The written text, digital photographs and videos on these websites are all utilized to construct reproductive tourism discourses and identities. My analysis of these websites would not be complete without documenting how the photographs and videos are used to structure, produce, organize and sustain particular discourses. The section below highlights the methods used to analyze digital images and videos on the websites.

Images and Videos

Historically, analyses of visual images (digital photographs and videos) have been on the margins in sociology. Turner (1984) attributed this marginality in sociology to the removal of the body as an analytic category from mainstream social theory. With the advent of feminist theorists and the writings of Foucault and post-modernist theorists, we see a resurgence of the body in sociological theory. Without a serious

engagement with visual modes both digital photographs and videos, it becomes difficult to tease out the complexity of ideologies and discourses embedded in virtual texts.

It is important to note that with respect to visual images¹ (here, I am including digital photographs and videos) there is a wide agreement among visual researchers that the meaning of a visual image is constructed by the maker and the viewer, both of whom bring their social positions and interests to bear on the image (Bailey et al. 2009). Therefore, people may read the same image in different ways, often depending on their identity, their life experiences and the subject positions they adopt. While I am treating visual images as texts which can be analyzed for ideological and discourse themes, I am also approaching the images as indicators. That is, as “sources of visual information about abstract concepts and processes which are central to understanding every day social life” that is not only read by reproductive tourists but are also read by myself using a feminist political economy perspective (Emmison and Smith 2000: 87). For instance, how do the images and text come together to portray the medical broker, fertility clinic personnel, the reproductive tourist, the egg donor and the surrogate? What language, terms, images and videos do the medical broker and fertility clinic websites use to discuss reproductive tourism?

Since some forms of visual data such as advertisements are based on stereotypical constructions, researchers should view them as offering insight into “the idealized character of relationships between groups or institutions rather than ‘true’ and

¹ There are no pictures of websites included in this dissertation due to the medical brokers and fertility clinics not giving permission to use trade marketed (licensed) pictures. Even though these websites are in the public domain, on advice from a copyright lawyer, no pictures are included. Instead, I have described the pictures and videos that are discussed in the dissertation.

accurate representations about behaviours or lifestyles” (Emmison and Smith 2000: 88). For instance, with the medical broker and fertility clinic websites, the researcher can ask what are the changing structural relationships being depicted between the doctors and patients and between human reproduction and technology in these digital images and advertisements? What gender relations are being portrayed here?

Smith et al. (1995) also argues that the standardization of images can organize the local activities of individuals. Images that are distributed by media (in my case websites) are constant for every local setting in which they occur in virtual form. For women and men, wherever they live, the standardized and normalized image is the same as it is for other women and men anywhere within reach of the Internet (Smith 1999). The normalized images are a “uniform point of reference for women and men in widely differing settings, in different economic and social circumstances, with different bodies” (Smith et al. 1995: 175). Regardless of the complexities of the “social relations that their working lives may create, their relations to one another are mediated by the standardization of visual norms organized by the discourse” (Smith 2001: 176). Here, I am interested in analyzing the normalized images of the reproductive tourist, the egg donor, the surrogate along with the medical broker and fertility specialist.

I first approached the websites with its written text, digital images and videos openly in order to respond to their content holistically. Prosser and Schwartz (1996: 119) call this initial experience listening to the “visual voice of the imagery” where “the researcher responds with all their senses open so that they may be more deeply affected by the content.” In terms of producing the thematic codes for the texts, images and videos on the websites, this initial stage was as inclusive as possible. I looked at

the medical broker and fertility clinic websites to determine the typical information listed on the websites, noting any similarities or differences in comparison with other websites. I looked at the digital images and videos by themselves and in relation to the written texts. For instance, I documented how pictures of 4-or-5-star hotels on fertility clinic and medical broker websites related to the text description of the medical services offered. I documented the differences and similarities across the virtual texts (written, digital and video) as well as noting which “understanding of the world was taken for granted and which were not recognized” (Phillip and Jorgensen 2002: 11). Textual analysis calls for interpretation that “goes beyond mere counting of occurrences and instead analyzes more subtle aspects of textual construction, layout and content” (White and Marsh 2006: 32).

My general questions about the process of reproductive tourism and the use of medical broker/fertility clinic websites to advertise fertility treatments abroad were used to guide my initial inquiry into the data. However, as I analyzed and compared the data, my codes and themes became more refined. As my textual analysis developed and I made new interpretations and connections between visual, verbal and written texts, I also documented how one image or video might later be invested with new meanings. This occurred when I analyzed the images of egg providers and surrogates on the websites and documented how the care work these women perform were erased from view.

As I observed the images and videos on these websites more closely and in relation to the written texts, I adopted key concepts in visual sociology from Emmison and Smith (2000) to aid in the analysis. A useful starting point in analyzing the images

and videos is to identify and describe individuals, objects, places or events in an image. For instance, photographs of pregnant women tend to use well-known devices such as “cropping, focus and camera angle which together create the nucleus—the element which is foregrounded and the mood for the photograph” (Emmison and Smith 2000: 35). As Emmison and Smith (2000: 35) note, “expected mothers typically appear in photographs in side profile emphasizing the change in contours of their bodies. Photographs are frequently cropped to focus attention on the abdomen and shot in soft light.”

The digital image and/or video may make use of binary oppositions to convey another layer of meaning. Binary oppositions are “signifiers which are arranged in pairing, but are opposed to each other, such as man/woman and light/dark etc.” (Emmison and Smith 2000: 36). Next in the analysis of the image or video is documenting the frames used in the images. Frames “are the contexts within which an image or part of an image is presented to the viewer. Since interpretation involves relationships between the part and the whole, these frames often have an impact on how an image is read. Images and videos are also analyzed and classified in terms of genres” Emmison and Smith 2000: 11). Genres are categories that the researcher’s use to classify “cultural objects into groups with similar properties or themes” Emmison and Smith 2000: 11). In terms of digital images, we can think of genres as pregnancy photos or tourist landscape photos to market a particular country such as white sandy beaches. In terms of a website narrative, this may involve the story line of a series the images such as pictures of a 4-star or 5-star hotels that reproductive tourists may stay

in during their fertility treatments and an image of what is going to happen next, a picture of a positive pregnancy test.

As I observed and read the virtual texts (written, digital images and videos) I began to note key phrases and text segments that corresponded to my questions, noting others that seem important, unexpected and similar. The overall process allowed new questions to emerge that were not part of the initial analysis. Glaser and Straus (1967) refer to the constant comparison approach to data analysis, in which the emerging relationships and categories are continually refined and compared.

Throughout this process, I returned to the websites between September 2010 and September 2016 in order to capture any changes in information, digital images and videos. Such changes could be the text, digital images and videos posted on the webpages. These websites are constantly changing in content and are not static in their layout. Because “the world wide web is a fast-moving medium” (Sobo et al. 2011: 123) each website’s pages were printed for static storage and data stability, with colour and animation information noted. However, it is important to note that I did not conduct a longitudinal study of the websites, I only documented the changes in content from the time I did the original study.

The final analytic section of this chapter is devoted to discussing the importance of incorporating the social location of the researcher in the analytic process as well as documenting the context in which the websites were analyzed. The researcher’s social location can and does shape how the texts are read, framed and analyzed.

Social Locations and Contexts

While the social location of the researcher is considered an important feature of the interpretive lens in qualitative research methodologies, this issue is somewhat overlooked in discourse and textual analysis research (Rogers et al. 2011). It is important in shaping research interpretations because a key aspect of critical discourse and textual analysis is that texts are political and the analysis I make of the writers and readers of medical broker and fertility clinic websites is no less so.

Documenting my social location as well as the process of my study of the medical broker and fertility clinic websites was central to my analysis. As Smith (1999) notes, I am an active creator in consuming and reproducing texts and discourses, specifically when I actively choose the order in which to study the websites and the order in which I studied the internal links/pages on a particular website. The order in which I selected the virtual texts and interpretation might be different from another social researchers. First, I looked at the Canadian medical broker websites, followed by the U. S. medical broker sites and finally I studied the fertility clinic websites. For consistency, I followed the same order of the internal links/pages for every website. I began my analysis with studying the webpage's URL name, followed by looking at the home page which usually gave their mission statement and values.

Next, I studied the medical and non-medical services they offered, which usually linked with specific hospitals and hotels abroad and then analyzed how the websites documented the financial costs of the services they provided. Finally, in order to document how the patients conceptualized the services they received, I examined the patient testimonial section of the websites which detailed patients' satisfaction of the medical and non-medical services they received. It is important to note that I do not

know how other individuals read the medical broker and fertility clinic websites; therefore, my study is limited to reading the texts from the perspective of feminist political economy which may not be shared by everyone. The feminist political economy perspective develops a connection between gender, the nation state and mobile transnational capital from a particular perspective.

I documented the context within which the websites and texts were examined. As Krippendorff (2006) suggests, the researcher needs to construct a world in which the text and images make sense and can answer the researchers' questions. Researchers have to know the conditions under which they "obtain their texts/documents and which processes they are applying to the come to their conclusions, and also what the world looks like in which their analyses and their own readings make sense to other researchers" (Krippendorff 2006:23). As Phillips and Jorgenson (2002: 70) state, the study of discourse is "three dimensional" in the sense that it "connects texts to discourses, locating them in a historical and social context, by which we refer to particular actors, relationships and practices that characterize the situation under study." Situating discourse analysis within a broader historical, economic, social and political terrain is a central component of feminist political economy. I situated the development of the medical broker and fertility clinic websites within the broader historical, economic, social, and political context, considering the global flows in information, technology and capital as well as the influence of neoliberal policies on healthcare and its services in Canada. The next chapter I discuss the neoliberal health reforms and the Canadian regulatory landscape of NRTs which shaped the conditions in which reproductive tourism developed.

Chapter Four: Healthcare Reforms in Canada and the Regulation of NRTs

Introduction

While this study focuses on reproductive tourism and the marketing of NRTs globally, reproductive tourism continues to be shaped by regulations and the restructuring that occurs in multiple levels of government and organizations. As a result, it is necessary to situate the present study of reproductive tourism within the context of broader Canadian healthcare reforms and regulations. I begin this section on context by providing an analysis of the neoliberal reforms in Canada's healthcare system from a feminist political economy perspective and outlining the shift to viewing the patient as healthcare consumer who is capable of making informed choices. Next, I discuss the historical regulatory framework of NRTs in Canada and the influence of feminist perspectives on the current legislation. As I illustrate throughout this chapter, the neoliberal reforms in healthcare have shaped how reproductive tourism developed and became a viable option for Canadians seeking desirable fertility treatments abroad.

Neoliberal Reform of Health care

Prior to the 1970's, healthcare in Canada was under a welfare state model in which healthcare and healthcare services were viewed as a human right and it was the government's responsibility to provide these services for all Canadians (Grigorovich 2011). However, in the late 1970s the welfare state model began to unravel and neoliberalism began to take hold across Canada (Armstrong 2001; Cohen 2011).

Neoliberal ideology developed in opposition to socialism (Braedley and Luxton 2010). Neoliberals oppose collectivism and economic redistribution of wealth.

According to Bradley and Luxton (2010: 5), neoliberals “believe that individual freedom of choice is maximized through competition. Competition is perceived as a naturally occurring social good, and the best method of social organization, enacted primarily through the mechanism of price.” Here, neoliberalism is “understood not just as a political and economic reality, but also as a political project intent on re-regulating society through the rationality of the market” (Schild 2007: 180)). In relation to social services, in this case, healthcare, “citizens are no longer assumed to have entitlements; rather, health services come to be viewed as goods to be accessed through market-like relations” (Schild 2007:180). Neoliberals view that market forces should distribute goods and services rather than the state (Meghani 2011). The “economic inequality resulting from the free play of market forces will motivate individuals” (Meghani 2011: 20). Globally, neoliberalism entails countries to participate in free trade with open borders, have no tariffs and only those companies that “offer goods and services at the most competitive price will survive, benefiting consumers” (Meghani 2011: 20).

Neoliberal reforms have shaped how healthcare is organized in Canada and have increased its privatization. Examples include “the downsizing of care within public institutions such as hospitals, the contracting out of health services to private for-profit companies, the shifting of more responsibility for care to [women] and families” (Grigorovich 2014: 8) and the adoption public private partnerships in education, healthcare and transportation services (Armstrong et al. 2000).

This paradigm shift has allowed the federal and provincial governments to push successfully for healthcare reforms based on the idea that healthcare costs need to be better managed in order to increase the system’s efficiency and to make it more cost-

effective. (Armstrong et al. 2001; Daly 2007; England 2010). One rationale for neoliberal healthcare reform is that healthcare consumers would not wish to waste medical resources but value them as they would be personally paying for them. Moreover, healthcare as part of the economy would generate “profits for individuals and businesses resourceful enough to be part of the medical goods and services industry” (Meghani 2011:10).

The Healthcare Consumer

In healthcare, neoliberal ideology has also influenced how we view patients. The change in terminology from patient to consumer corresponded with the emergence of a new active neoliberal subject. According to Giddens as cited in Adams (2011: 1070), late modernity is characterized by “the influence of multinational corporations have on the everyday activities of individuals and thus “shaping how individuals understand themselves” and how individuals are expected to take responsibility for the decisions that impact [their lives].”

Giddens (1991) associates consumerism with the development of modernity. The social construction of modern patients as independent consumers is used by society to argue for change in the interests of a public (Giddens 1991). Individualization, consumerism and “other symbols of modernity are presented as taken for granted facts that shape the expectations of healthcare” (Newman and Vidler 2006:200).

Reflexivity refers to how people, both “individually and as members of social groups, actively draw on available knowledge in order to monitor their actions and the

contexts in which these take place” (Adams et al. 2011:110). Whereas the term patient suggests passivity and diminished capacity for independent decision making, the term consumer implies a capacity for independent decision making and acting on behalf of their beliefs and values. Health consumers are understood to be “self-actualizing, self-activated, autonomous social agents who cannot be subordinated to the professionals, and are capable, with adequate information, of formulating their own intentions, deciding their own preferences and wants, and making rational choices about their health” (Irvine 2002:35). In other words, reproductive tourists must understand their infertility situation, work with fertility specialists to obtain the best care and engage in self-improvement (e.g., reduce stress, eat healthily, stop smoking and adapt healthy lifestyle choices) to increase the chances of having a child.

Neoliberal ideology promotes consumerism and individualism. It assumes that all individuals should exercise choice, freedom, empowerment and personal responsibility. Structural inequalities defined by race, class, immigration status and gender are rendered invisible, and the individual is viewed as fully responsible for her or his own success or failure (Moran and Lee 2001). This has resulted in an emphasis on free choice that is expressed through consumptive practices (Leve et al. 2012).

Health consumerism individualizes the morality of action. However, as Irvine (2002:36) notes, “to fix the health consumer merely in terms of a set of behavioural traits against which actual behaviour can be assessed reduces this complex term to a one-dimensional concept.” Health consumer discourse does not simply convey personal experiences; it plays a part in socially constructing subjects in relation to political discourses. For example, health consumer discourse often obscures

government policies for reduced spending in healthcare and shifts the burden of care to families as well as transforming self-care practices into personal responsibilities.

As previously noted, neoliberal discourses about health and healthcare emphasize personal responsibility for one's own health. This is achieved by positioning citizens as consumers who, empowered by information, are "expected to choose their way to good health through the acquisition of health knowledge or expertise that enables health-helping behaviours" (Irvine 2002:35). In terms of reproductive tourism, the Canadian federal government perpetuates the discourse of personal responsibility and the importance of conducting research before traveling abroad for fertility treatments. The Government of Canada notes,

it is your responsibility to research the standards of the foreign health care facility and the licensing of the health care provider in your destination country. Find out how the medical services and facilities are accredited and how they are regulated. Verify the licensing of the facility or health professional and study any complaints, comments, reports and evaluations.

www.travel.gc.ca/travelling/health-safety/care-abroad 2015

Consumers, "as a category of people, are not a natural and effortless response to the spread of markets but have been made through [...] specific historic, cultural and economic conditions" (Schild 2007:180). In relation to social goods in this case, healthcare, citizens are no longer assumed to have entitlements but are instead encouraged to relate to the healthcare system as services that are accessed through the market (Schild 2007). The assumption with this discourse is that individuals have

become “used to flexible, responsive user-centred services delivered in the marketplace and want the same when they come to the [public healthcare system]” (Griffith and Smith 2005: 197.).

Similarly, “neoliberal ideology promotes the idea that (in)fertile individuals should take personal responsibility for their fertility and make behavioural and lifestyle choices that maximize their chances of pregnancy and upward mobility, while simultaneously turning reproductive matter [gametes, embryos] into particular types of commodities” (Krolokke and Pants 2012: 234). Under neoliberalism, reproductive tourists, surrogates, egg and sperm providers are seen as making rational choices in a market economy (Ross 1999).

Regulatory Framework of NRTs

Having developed during a period of neoliberal rise, the vast majority of fertility treatments are delivered in private, for-profit clinics and is privately financed in Canada. Usually, private financing means that individuals will have to cover the cost of fertility treatments out of their own pocket since private health insurance companies in Canada generally do not cover new reproductive technologies (NRTs) and only some are covered by provincial/territorial plans. Quebec became the notable exception in August 2010, when the province moved to provide public funding for three cycles of in vitro fertilization (IVF) (McGill Reproductive Centre 2010). Ontario also provides funding for one cycle of IVF (Ontario Ministry of Health 2016) and Manitoba provides a tax credit of up to \$8000.00 for IVF.

In the field of NRTs, the potential exploitation of women has been a matter of concern since the advent of in vitro fertilization in the mid-1970s. In Canada, NRTs have been regulated to provide “restrictions against the commodification of sexual and reproductive labour [...] and to defend against the potential exploitation of vulnerable women and their bodies” (Cattapan 2014:362). In response to feminist demands, the *Royal Commission on New Reproductive Technologies* (1993) was created by the federal government in 1989 to study the ethical, social and legal implications of NRTs in Canada. The Royal Commission published its report in 1993 entitled, *Proceed with Care*. This report listed the non-commercialization of reproductive technologies as one of the Commission’s eight guiding principles and stated that commercialized reproduction was exploitative (Sherwin 1998; Fulfer 2017).

Fulfer (2017) further proposes that non-commercialization of women’s bodies is a feminist value. Women are “disproportionately affected by the use of NRTs and exploitation in reproductive care becomes a feminist concern when women’s labour and bodies, which are necessary for reproduction, become subject to the control of other forces.” (Fulfer 2017: 229). It is important to note that the non-commercialization commitment in the *Proceed with Care* report was influenced by Canadian feminist groups who wrote briefs for the Commission’s deliberations. However, it is worth noting that during the Commission’s deliberations there were various feminist arguments surrounding NRTs. At times, heated debates took place surrounding theoretical assumptions about the female body, technology and power. Broadly speaking, there were two main feminist arguments on NRTs: 1) new reproductive technologies provide individuals with more choices in having a child, and treating infertility, and these

technologies have the capacity to free women from the confines of the biological family; and 2) new reproductive technologies further medicalize women's reproductive capacities and increase the control over women's bodies by a predominately white, male medical profession, thus expanding patriarchal power over women's bodies.

Liberal feminists contend the NRTs increased the choices of individuals wanting to have a child (Parks 2009). Liberal feminists "emphasize choice, autonomy and informed consent" (Storror 2005: 309). Surrogacy and egg donation are viewed as non-exploitative when women are fully told about all medical, social and legal consequences of NRTs (Storror 2005). Also, the use of "IVF or artificial insemination by lesbians and disabled, single, minority and post-menopausal women alters traditional family formations and raises the average age of women's reproduction [and thereby] extended reproduction to women who have historically been denied access because of their difference" (Parks 2009: 21). Also, gay and transgender couples and people with disabilities have contracted women to become surrogates for them, allowing for family formation that might not otherwise be achieved.

However, some feminist writers (Corea 1985; Williams 1986; Waldby 1990; Spallone 1989; Klein 1989; Shewrin 1992; Stanworth 1987; and Miles and Finn 1989) have noted that technological reproduction does not neutralize the patriarchal power structure but it inverts it. It appropriates the reproductive power of women and places it in the hands of men who control reproductive technologies. As Tong (1989: 28) notes, "far from liberating women, reproductive technology will further consolidate men's power over women." It is argued that NRTs increase the medicalization of women's bodies and therefore, women's monthly cycles, pregnancies and menopauses become controlled

by a predominately white, male medical profession. These men may pursue research directions which they feel are important and which many or may not be beneficial to women (Williams 1986). Physicians controlling these technologies could restrict access to only those women who meet physicians' criteria for good mothers, criteria that may emphasize race, age, heterosexual relationships and middle-class life style.

Concerns about women's exploitation in paid egg donation are associated with them taking significant physical and emotional risk in exchange for paid compensation (Cattapan 2014). In terms of surrogacy an embryo is implanted into a woman's the uterus "with the intention that she will not raise any resulting child and will, instead, cede guardianship to the intended social parent(s) at birth" (Cattapan 2014: 364). Concerns about exploitation in commercial surrogacy are centred around "the potential for bonding between the surrogate and the child, informed consent of the surrogate and the idea that women's reproductive capacity as well as their behaviours in pregnancy may be governed and controlled through legal commercial contracts and agreements" (Cattapan 2014: 364). The opportunity to use these technologies has political and social meanings and consequences regarding the role of women and men, and how women and children are viewed in society (Rodin and Collins 1991). Feminist theorists have noted that NRTs exist within a specific cultural, historical and medical context which shapes the development of these technologies (Smart 1996; Armstrong 1995; Rodin and Collins 1991; Jordanova 1980; and Oakley 1984).

Still other feminist theorists have questioned the unilateral characterization of medical technology and its effects on the body as being oppressive; they point out that a woman's body can also be a site of resistance, agency and empowerment (Rapp

1991; Martin 1989; Humm 1989; and Woolett 1996). Writing from her own experiences of infertility, Humm (1989: 45) notes:

Infertility is problematic because of the ways in which it has been technologized by male-dominated medicine. Yet, an experience of infertility must be kept problematic, must deliberately not cohere, if the individual who brings it forward is to see the contradictions honestly. But to rely on the apparent passivity of infertile women as a basis for feminist explanation for the development medical technology is the narrowest kind of rationalization.

Feminists such as Martin and Rapp have noted the complex relationship between viewing women as either victims or as agents in regards to reproductive technologies. Rapp (1991) goes beyond the medical-control component of reproduction by documenting women's resistance to genetic testing. Similarly, Martin (1989) notes that young black women in birthing centres are devoted to the creation of new birth imagery and women-centred birthing practices, providing resistance to dominant birth practices in hospitals. The complex and often contradictory relationships of women to NRTs are even documented in relation to the use of imaging technologies such as ultrasounds. Although these imaging technologies increase the medical control over women's bodies and assist in discrediting women's experience of pregnancy, one must also note the positive aspect of these technologies such as women's pleasure in seeing their fetus and increased knowledge of their own bodies (Marcus 1990).

Nonetheless, *The Proceed with Care* report adopted the feminist values surrounding the exploitation and commercialization of women's bodies and labour with

the use of NRTs. It was this report that later served the basis for the federal statute, the *Assisted Human Reproduction Act (AHR Act)* which was passed by Parliament in 2004 and was fully in force by 2007 (Downie and Baylis 2013). The Act introduced a system of licensing, monitoring, inspection and enforcement designed to protect and promote the health, safety, and rights of Canadians who use or are born of assisted human reproductive technology. The AHR Act banned commercial surrogacy and egg donation in part to protect women from exploitation. However, the Government of Canada did introduce a non-payment provision of the Assisted Human Reproduction Act in order to limit the commodification of human life and reproductive capacity (McLellan 2002). This legislation was written in such a way that many sections of the Act require the development and publication of regulations in order to come into force. Health Canada has been responsible for writing and implementing of this regulatory framework.

It is important to note that at the time of writing this dissertation the reimbursement of expenses to donors and surrogates can only occur in the accordance with regulations to be written (Hughes, Sawyer, DeJean and Adamson 2016). There is a provision in the AHR Act that allows for the reimbursement for egg donation and surrogacy for some medical expenses and potential lost wages, however, clear and detailed regulations are yet to be written. What remains is a legal and regulatory framework in which no payment to egg providers or surrogates is allowed.

Also, “shortly after the AHR Act was passed [by parliament], Quebec challenged the constitutionality of the legislation; it argued that several sections of AHR Act were beyond the federal government legislative authority” (Baylis 2011: 317) because NRTs fall under the delivery of healthcare services which are a provincial responsibility. On

December 22, 2010, the Supreme Court of Canada (SCC) released its decision. The SCC held that some, but not all, of the contested sections were indeed unconstitutional. The federal prohibitions against “human cloning, creating in vitro embryos for research purposes, manipulating embryos to increase the probability of a particular sex, payment for surrogacy or for the purchase of egg and sperm (gamete) remain in force [...] each province is free to regulate (or not) the delivery of reproductive services and the conduct of research in this area” (Baylis 2011: 318). As a result, Canada has a province-by-province approach to the regulation of NRTs. For instance, the “altering, manipulating, treating, obtaining, storing, transferring, destroying, importing or exporting human reproductive material or in vitro embryos are no longer federally regulated activities. Provinces and territories can choose to regulate these activities, or not to” (Downie and Baylis 2013: 230).

When Canadians travel abroad for fertility treatments including IVF, purchasing of gametes and surrogacy, there is a problem with inconsistency. Because Canada does not enforce the AHR Act for reproductive tourism, the non-commercialization values and protections apply only in Canada. Surrogates and egg providers outside of Canada are not considered to be covered by the ethical protections offered by the AHR Act (Fulfer 2017). It should be noted that the relationship between citizens and consumers is established separately for each particular biomedical technology, including NRTs. For example, an individual cannot be a consumer of human organs because buying an organ on the free market is against the law in most countries. The majority of fertility treatments are not available to individuals simply because they are citizens, but because these treatments are not publicly funded and there are laws

preventing some practices in Canada, for example, paid egg donation and paid surrogacy. It is not difficult, however, to become a consumer of fertility treatments (buying eggs, sperm, embryos and wombs) “for a price elsewhere—this is regarded as a matter of individual choice” (Lock and Farquhar 2007: 145).

This model of autonomy as choice is at work within neoliberal context of reproductive tourism. Reproductive tourists can search out desirable fertility treatments on medical broker and fertility clinic websites and choose from a variety of healthcare services from around the world. In essence, reproductive tourists can purchase fertility treatments outside of Canada and circumvent its regulatory framework governing NRTs. Reproductive tourism allows a “certain class of people—those with social and economic means to travel to escape the restraints of the law” (Pande 2017:53). Furthermore, within a neoliberal context, reproductive tourists are viewed as healthcare consumers who are autonomous social agents and not subordinate to healthcare professionals. They are capable of formulating their own healthcare decisions and travel abroad for fertility treatments. Fertility clinics and medical brokers have opened in countries with no regulations surrounding NRTs to accommodate reproductive tourist’s desires and wants (Waldby and Cooper 2008). Some transnational feminists have argued that the availability of NRTs abroad allows governments to enact stricter laws at home than they might otherwise have the political will to enact (Pande 2017; Das Gupta and Das Gupta 2010). They argue that strict national laws, in turn, exports this industry to other countries and jurisdictions, often a country in the “developing” world (Pande 2017; Pande 2016).

Conclusion

In sum, NRTs are taking place within what Hartouni (1997:2) calls a “shifting reproductive landscape” where these technologies exist within social and cultural norms and contexts that are not static and unchanging. The neoliberal reforms in healthcare that increasingly see healthcare services as goods to be bought and accessed through market-like relations and views patients as consumers. It then stands to reason that if reproductive tourists cannot access fertility treatments in Canada due to the regulatory framework and lack of public funding, they can buy healthcare services and NRTs abroad. The social phenomenon of reproductive tourism is also challenging and expanding previous feminist arguments surrounding NRTs in terms of commodification and exploitation of women’s bodies and their labour. The following three chapters discuss my research findings.

Chapter Five: The Marketing of Medical Broker and Fertility Clinic Services

Introduction

In the previous chapter, I reviewed the neoliberal reforms in healthcare, the evolution of the patient into a consumer of healthcare services as well as the regulatory framework of NRTs in Canada. The following three chapters of the thesis focus on my data chapters. I detail the forms of representation that aim to encourage readers to obtain NRTs in other countries. I show how the medical broker and fertility clinic websites use the multi-media features of texts, images, videos and flash animation to create a phenomenological virtual space that invites readers to respond with all their senses (use of colour, sound and scenery) with the potential effects of attracting reproductive tourists to the websites and keeping them there. These websites use this multi-media virtual space to manipulate, reshape and assemble different discourses and texts to market their services.

In order to analyze how these websites, portray different discourses in the texts, images and videos, I separate the content of the websites among themes. For instance, I analyze how medical brokers and fertility clinics use personalization of healthcare services to create an imagery of the healthcare consumer as never being alone in the medical encounter or the use of patient testimonials to facilitate the reader to self-identify with others. Also, I specifically analyze a text, image or video by itself to clearly illustrate which discourses are being portrayed and how. In addition, I analyze text, images and videos together on the websites to document the overall theme being portrayed on the webpage to illustrate how the designers of the website hook people in

and inviting reproductive tourists to stay and maneuver through their website and potentially purchase medical and non-medical services.

I employ what Armstrong and Armstrong (2004: 10) call “lumping and slicing: looking at what is [represented] in common and what is not.” All the websites have the common structure in terms of having a mission or values statement, a health services offered page and a patient testimonials page, just to name a few. However, the websites use text, images, and videos in various ways to portray different discourses. This chapter explores how medical broker and fertility clinic websites use neoliberal health discourses to advertise their services to prospective reproductive tourists. First, I explain how the healthcare consumer discourse is used to sell health services and then discuss how Web 2.0 technology is presented as increasing patient choice and empowering reproductive tourists. Next, I explore how personalized and patient-centred care is represented on the websites. Finally, I discuss how the Canadian healthcare system is viewed on these websites in terms of the differences between publicly funded healthcare system and a private, for-profit healthcare system.

Healthcare Consumer

Healthcare consumers’ access to health information on the Internet is framed in terms of its role to inform and empower patients. By providing access to information via the Internet, healthcare is expected to become more open and democratic, as doctors and patients are supposed to become collaborating partners. Physicians and patients are expected to share information while patients are responsible for researching appropriate medical information to make informed decisions about their medical care with the support of the physician (Gieryn 1999).

Medical Tourism Corporation (MTC), a US medical broker which markets surrogacy and egg donation in “developing” countries, highlights the importance of giving the reproductive tourist all the necessary information to make his/her decision to go abroad. On its website’s homepage, the company states,

Medical Tourism Corporation (MTC) facilitates contact with overseas doctors and hospitals and presents their credentials to prospective clients. We also provide information to these clients about various medical procedures and recuperation packages. The information we provide is often used by our clients to make their own decisions, as to where they want to have the medical care (2014).

On Passport Medical’s homepage, a US medical broker with ties to fertility clinics in India, Mexico and Thailand, emphasizes in the quote below that an informed Canadian patient is satisfied. The owner argues,

Passport Medical is here to help you through the entire process and to make sure you are informed. It is important to us that you make an educated decision, whether or not, medical travel is right for you. The patient experience has been paramount to our success over the years and we feel that an informed patient is a satisfied patient...At any time, if you have a question, please feel free to start a live chat with us. You can do this in the lower right corner of your screen, or you can call us anytime.

www.passportmedical.com (2015).

The above quotes from medical brokers illustrate a marketing genre, an appeal to healthcare consumerism in which self-empowered consumers make savvy choices,

actively self-managing their care. The information provided on medical broker and fertility clinic websites “empower you to take charge of your health” (passportmedical.com 2011) and facilitates “you to make an informed decision” (www.surgicaltourism.ca 2011). Medical brokers and fertility clinics sell a medical experience that is rendered familiar through operating as patient advocates and travel agents. They do this by casting the patient as a consumer, which commodifies the medical experience and gives patients more power to control it by deciding where they want to go, and what amenities or logistical support they need. By making patients consumers, medical brokers and fertility clinics move “choice into the foreground and emphasize that if they are provided with the right information, clients are supposed to be able to make the best decisions about their healthcare” (Dalstrom 2013: 29). The consumer’s choice drives the medical travel booking instead of the physician’s advice. Neoliberalism elevates consumer choice to the level of a right: “it is the rights of each individual to spend his/her own resources as he/she chooses and the responsibility to research all possible risks to one’s health” (Henderson and Peterson 2002:26).

In their mission statements, a number of fertility clinic websites emphasize the benefits of increasing the number of choices for reproductive tourists (consumers) on a global scale. For instance, Elite-IVF, an US fertility clinic that sends Canadian reproductive tourists to Mexico, Panama City and Cyprus for surrogacy, IVF and egg donation, argues on their homepage that one of the best

things about being a global IVF agency is that we are not restricted to any one location, but have, instead, a wealth of options to offer our intended parents.

Consumers should have a world of opportunities to choose from---not a handful.

Elite IVF has a network of partner clinic, donors, surrogates, and expertise around the globe ready to provide consumers with an array of options. This allows us to provide a custom, tailored donor search for an international ethnically diverse donor pool.

www.elite-ivf.com (2014)

In addition, a Turkish fertility clinic notes on its home page that by

working closely with your fertility center doctor, you will map out a strategy and an infertility treatment plan that fits your goals, your schedule, and your values...[We] celebrates individuals' needs and desires. Treatment cycles are coordinated around a patient's requests...We offer personalized treatment protocols that are developed between the physicians and the patient.

www.turkey-ivf.com (2014).

The expansion of the Internet has allowed fertility treatments to be marketed directly to consumers (Petersen, Davis, Fraser and Lindsay 2010).

The reproductive tourist (health consumer) also aligns with Petryna's (2004: 250) concept of "biological citizenship", which Rose and Novas use in their writings (2005; 2007). By this term, the Rose and Novas refer to a social identity that "encompass[es] all those citizenship projects [that link to] to beliefs about the biological existence of human beings, as individuals, as families and lineages, as communities, as population and races, and as a species" (Rose and Novas 2005: 440). Such citizens use "biological-colored languages to describe aspects of themselves or their identities and

to articulate their feelings of unhappiness, ailments and predicaments” (Rose and Novas 2005: 445-446). Biological citizenship can move beyond the self-motivated individual to take on an active role “wherein people align with others who share similar biological conditions, advocate advancing their position, and may see governments or medical authorities as allies or as antagonists” (Rabinow 1996:43).

People with infertility conditions or those unable to have children on their own for social reasons have started online support groups, which some of the medical broker and fertility clinic websites support and/or belong to. Involvement in these organizations can be an enactment of biological citizenship. Rose, who emphasizes activist biocitizenry, writes “biological citizenship requires those with investments in their biology to become political” (2007: 18). However, political actions may not be conscious. Those who cross jurisdictions in order to obtain fertility services may or may not be involved with any advocacy organizations, but the very act of engaging in reproductive tourism has political nuances, especially when it occurs as a means to enact one’s personal reproductive autonomy in the face of restrictive laws. This interpretation of biological citizenship relates to Ong’s (1999: 113) concept of “flexible citizenship” which includes “the localizing strategies of subjects who, through a variety of familial and economic practices, seek to evade, deflect, and take advantage of political and economic conditions in different parts of the world.”

Health consumer and empowerment discourse distorts the perception of medicine as a social, public good to a commodity that can be bought and sold. Informing the health consumer is central to the marketing of health, where patients are positioned as consumers of healthcare services. (Harris, Wathen and Wyatt 2010). As

Conrad and Lieter (2004:160) state “when medical products, services, or treatments are promoted to consumers to improve their health, appearance, or well-being, we see the development of medical markets” such as NRTs. The commercialization of NRTs has transformed the notion of choice where the linkage between choice and autonomy has been reworked and transformed into an understanding of reproductive choice as an aspect of free-market individualism (Ikemoto 2009). The use of NRTs has extended opportunities for previously infertile people who can afford them, but the uncritical use of the rhetoric choice has enabled the fertility industry to develop. The next section of the chapter discusses how the websites owners’ and developers use Web 2.0 technology in ways that enhance the neoliberal model of autonomy of choice and consumerism.

Consumer Choice and Web 2.0 Technology in Healthcare

The neoliberal model of autonomy of choice is said to be enhanced by adopting Web 2.0 technology in healthcare (Felt et.al. 2009). The Internet increases the opportunity to access unlimited information which can direct reproductive tourists and other consumers in a variety of ways. As Sheehan and Burns (2007:69) states,

the Internet differs from other media channels in that unlimited amounts of information can be presented for consumer perusal. Multiple page websites present information in a nonlinear manner fashion that allows consumers to navigate the information in any way they choose.

The internet allows consumers to link with medical providers in other countries, thus geographically minimizing space between the medical consumer and the physician.

The medical broker and fertility clinic websites actively use Web 2.0 technology to sell their services to prospective reproductive tourists. Web 2.0 is viewed as the second stage of development of the World Wide Web (Witteman and Zikmund-Fisher 2012). The main characteristics of Web 2.0 technologies include the new role of users, users' networks and user-generated content (Witteman and Zikmund-Fisher 2012). User participation refers to allowing individuals to engage with a segment of information by commenting on it or sharing it with others. Openness implies that information is displayed in a way that allows engagement to occur in which people can change, use or build upon existing texts. Network effects refer to using the power of crowds, where information on the website becomes richer as more people interact with it (Witteman and Zikmund-Fisher 2012). The goal of web designers using Web 2.0 technology is to integrate all other media forms such as printed text, visual images, videos and flash animation (Papson et al. 2004). The use of various forms of media is marketed as creating an open and unbounded system of information that can be assembled in new and unexpected ways by the healthcare consumer.

It is argued that, in making medical knowledge accessible to consumers over the Internet, Web 2.0 technology can open new avenues for patient-centred medicine and claims to enable evidence-based medicine. Evidence-based medicine is the linking of clinical expertise and knowledge, patient values and the best evidence into the decision-making process for patient care. Clinical expertise refers to the physicians' cumulated experience, education and clinical skills. The patient brings to the encounter her or his own concerns, expectations and values. The best evidence is claimed to be found in "clinically-relevant research that has been conducted using sound methodology"

(Sackett 2002:363). For example, in their patient portal on their website, a medical broker in Canada that facilitates Canadians to travel to India, states

in the same spirit of advanced information technology solutions, we've now developed and launched [...] an evolving collection of online fertility resources shared between researchers, patients and fertility professionals for knowledge support and continued advancement of the most complete reproductive healthcare available...[It] is a customizable set of processes for providing thousands of scenarios and information related solutions in fertility and reproductive medicine. Our site of information technology solutions has evolved in response to the real-life clinical information needs of practitioners, their patients and business partners.

www.surgicaltourism.ca (2011)

The web resource portal on its website is meant to highlight how the medical broker and fertility clinic websites uses Web 2.0 technology to provide consumers with the necessary information they need to make decisions surrounding their fertility treatments. The discourse on consumer participation and informed decision-making "is rooted in the very idea of a knowledge society, where rational decision making should be based on the right to techno-scientific knowledge, which is, like the technology itself, conceptualized as neutral" (Stehr as cited in Felt et al., 2009: 25). This discourse reinforces the image of technology, such as Web 2.0 technology, as "independent instruments that can simply be inserted and diffused in healthcare without changing what care is all about" (Oudshoorn 2011: 10).

However, the Web 2.0 architecture that enables the interaction among medical broker and fertility clinic companies and consumers should not be seen as producing a simple, static website containing text, images and hypertexts or a website with connected blogs interacting with patients. Rather, Web 2.0 architecture is a confusing combination of different hyperlinks, discussion groups, patient testimonials and blogs, in which the boundaries among patients' experiences, company presentations, advertisements and scientific information are blurred.

For instance, all the medical broker and fertility clinic websites analyzed displayed a homepage with a confusing combination of hyperlinks that contain links to patient testimonials, the different treatment options offered and prices, access to blogs written by reproductive tourists or website staff such as patient coordinators, travel agents and physicians. Next to these hyperlinks on the home page are pictures of fertility clinics or hospitals overseas, images of luxury, five-star hotels and resorts with white sandy beaches and blue sky, and images of White, blonde blue-eyed babies. Further down on the medical broker and fertility clinic website are videos of fertility treatments, usually the procedure of in vitro fertilization narrated by a fertility specialist. At the end of these videos, a list of medical qualifications of fertility specialists are displayed on the screen which includes where they obtained their training, a sample of peer-reviewed articles written by the fertility specialist and a list of any current medical research.

Subsequently, the homepage of these websites is not static but rather is an interactive maze of medical and non-medical information presented for reproductive tourists in a variety of mediums as texts, images and videos. The reproductive tourist

actively engages with these websites by clicking on different hyperlinks, watching videos describing fertility treatments, reading about reproductive tourist experiences in another jurisdiction, writing their own experiences and participating in on-line discussions boards supported by the website and facilitated by a patient coordinator.

Web 2.0 technology creates new spaces in which consumers can search for their own information during and after a medical encounter and disclose their experiences with healthcare providers and others. The notion of the medical consumer fits within a vision of a future which re-organizes health practices and views the patient as a technologically-empowered citizen who engages in new forms of participation and collaboration. This individual is empowered in that he or she makes informed choices and produces and shares medical information. Personal experiences and knowledge are produced and circulated in ways that enable consumers to interact with healthcare professionals in new ways. Website users including reproductive tourists become information producers, changing the current roles from “message recipients to message senders and creating room for new information users to emerge—the blending of consumption and production” (Snyder et al. 2011:10).

For instance, a Canadian medical broker tells prospective reproductive tourist consumers that

Magellan Global Health mission is to build and operate a consumer driven, interactive, global telehealth and patient assistance system that facilitates the safest, most cost effective and most efficient patient care worldwide...Our Navigators provide clients with the best interpersonal high touch experience,

while using our proprietary Virtual Clinic—an interactive telemedicine online clinic for patient care...We use the best of online techniques and technology to deliver care online and by mobile phone extension—anytime, anywhere...provide you with care on a continuing basis empowering your access to information, helping you chose the right path for you and ensuring that you remain informed and in control.

www.magellanglobalhealth.com (2011)

Similarly, a US medical broker that helps Canadians travel to India, Thailand and Mexico states,

We believe in borderless medicine and patient empowerment... A patient should have the freedom to choose where they get their healthcare whether it is across state lines or across the globe...A patient should have the right to the latest innovations in medicine without being constrained by regulations that might exist to prevent competition rather than harm.

www.planethospital.com (2011)

Medical brokers argue that it is necessary to adopt Web 2.0 technology so that they can improve access of information to consumers. It is important to note that I am not arguing that there is something wrong with offering people reliable information about their health and encouraging people to keep themselves healthy. Nor am I arguing that there is anything wrong with supporting people taking an active role in their own health by being informed. Rather, I am drawing attention to the processes in which these ideas are and reshaped to support other ideas, agendas and discourses that may not

necessarily have been designed or developed in the interests of patients. The medical consumer or reproductive tourist is

an individualized role that shifts attention away from the quality problem in healthcare and toward the quality of the person as a medical consumer who is characterized to be optimistic, proactive, rational, responsible and informed in order to 'take charge' of their own healthcare and the care of their families receive and away from equity or care as a human right (Sulik and Eich-Krohnm 2008:3).

Additionally, the medical broker and fertility clinic websites emphasize the benefits of new scientific and biomedical developments and "overrate and over hype high-tech solutions" (Parrott and Condit as cited in Michelle 2007: 653). The discourse surrounding biomedical technology is seen as a good and progressive. Medical and scientific research on NRTs is seen as offering hope for those who want a baby. A common thematic frame illustrated on these websites is a description of the procedure of in vitro fertilization, expressed by showing images or video of an egg in a petri dish being fertilized by the use of a needle that inserts a single sperm. Right beside the images of in vitro fertilization is the end product, usually a picture of a white heterosexual couple holding their healthy and happy baby.

There is an overarching discourse of technology-whether medical, scientific or Web 2.0 as progressive, positive and beneficial to health consumers and healthcare systems. The medical brokers and fertility specialists often over select optimistic scientific claims made by researchers which emphasize the importance of their work

rather than highlighting the potential medical side effects of fertility treatments and NRTs (Michelle 2007).

These websites often highlight how NRTs and other biogenetic technologies are state-of-the-art, world class and technologically advanced. A fertility clinic in Turkey states that IVF techniques are

much more advanced than the techniques used in North American hospitals and cost a fraction of the price. Doctors can implant up to 3 embryos per IVF treatment whereas in the US doctors can only transfer one embryo per treatment.

www.ivfturkey.com (2011).

Also, a medical broker in Thailand claims that their

state-of-the-art laboratory uses the very latest advances in fertility treatment and offers you the best opportunity to have your own children.

www.ivfmircalebaby.com (2011).

Finally, a fertility clinic in Barbados advertises their fertility treatment services as

one of the largest and most successful facilities in the Caribbean and continues to be at the forefront of IVF and egg donor/donation technology, offering the latest in reproductive care in a warm and compassionate environment...At

Columbia University where our physicians trained, they enjoyed the benefit of an Ivy league institution, leading-edge facilities, great minds and the resources to be leaders in reproductive medicine.

www.barbadosivf.com (2011).

The websites are designed to market reproductive tourism and attract patients from around the world (Mulay and Gibson 2006). The notion of the empowered, well-informed consumer is central to how the medical broker and fertility clinic websites market their services. One of the main goals of the websites, according to the sites, is to provide accurate information on all options for having a baby. In order to increase the choice for reproductive tourists and other medical consumers, there is a perceived need for a “diversity of providers, and this typically has been interpreted as a justification for creating market entry by the private sector healthcare providers” (Tritter, Koivosalo, Ollila and Dorfman 2009: 5). The medical broker and fertility clinic websites depict the reproductive tourist consumer as empowered, educated and capable of making rational choices about their reproductive health. The reproductive tourist consumer remains informed and in control within a healthcare environment that is both “high tech” (having the latest NRTs available to them) and “high touch” (having a patient-centred care approach).

Personalization of HealthCare Services

Businesses in healthcare use the personalization of health services to sell their goods and services and to generate profit. It is important to note that “personalized healthcare” has various meanings. Personalized healthcare can be used to describe a medical model that proposes to customize healthcare by using genetic testing and tailoring medical decisions to individual patients. In this model, diagnostic testing is often employed to select appropriate and optimal therapies based on the context of a patient’s genetic content. This use of genetic information has played a major role in personalized medicine (e.g., pharmacogenetics). Pharmacogenetics is the study of

genetic differences in metabolic pathways that can affect an individual's response to drugs, both in terms of therapeutic effects as well as adverse effects (Hedgecoe and Martin 2003).

Personalization of healthcare services can also be defined as a more general term that proposes to ensure choice and control for the health consumer, instead of emphasizing a one-size-fits-all model of service delivery. The original goals of patient-centred care or personalized care were quite modest and very specifically focused on helping clinicians recognize their patients as “real people living messy lives” (Harris, Wathen and Wyatt 2010: 15). The focus on patient-centred care came from a critique of viewing the human body as fragmented body parts and in need of repair due to an illness or disease (Armstrong and Armstrong 2014). The care for the human body often occurred in isolation, away from the social and environmental contexts in which it exists. Reconceptualizations of care that focus on the whole messy lives of individuals have been an important critique of body-focused medical model of care.

According to Beresford (2009), the personalization of healthcare services initially focused on individualizing budgets for persons with disabilities, by allocating money to eligible individuals, who could then decide to spend it as they wish on a package of support (e.g., home care workers). Individualized budgets were “designed to give persons with disabilities the choice of home care workers and provide more control over their care” (Beresford 2009: 10). Leadbetter as cited in Cutler (2007) discusses the changes that enabled patients to personalize their care. There is a focus on five items: “providing people with a consumer-friendly interface; giving users more say in navigating their way through services; giving users more direct say over how money is

spent; defining users as co-producers and co-designers of services; and creating technological platforms to allow healthcare professionals and consumers to decide on treatment options together” (2007: 849). Personalization of services can mean anything from “the tailoring of services to meet individual needs and wants or, it can mean the collaboration between the consumer and healthcare provider to develop a health service” (Leadbetter as cited in Cutler 2007: 849). Throughout this thesis, personalization of healthcare services refers to the tailoring of services to meet individual’s needs and wants and the collaboration of both the medical consumer and healthcare provider to develop a health service plan. Where tensions begin, however, is in the expanding scope of sharing power and responsibility between the healthcare provider and patient. As the discourse of empowerment and patient education started to gain influence, increasingly complex interventions were developed to support processes designed to increase patient centered care. This included the progression from simple techniques such as having a face-to-face conversation with a patient, to more technologically- mediated methods such as computer-assisted decision aids tools. Today, consumers of healthcare have the duty to participate individually in the planning and implementation of their healthcare.

The medical broker and fertility clinic websites advertise their health and non-health services as personalized medical packages to meet the reproductive tourist’s every need and offer “medical hospitality at its best” (www.meditours.org 2011), personalizing their medical services “in order to treat you like family” (www.ihcproviders.com 2011). One example of framing fertility treatments in terms of

personalized services comes from a US medical broker that facilitates Canadians' travel to 'developing' countries such as India. The owner states,

if you have previous experiences in your home country with IVF fertility treatment, you have experienced being treated like a number, not a patient in a fragile state. You likely found it hard to get face time with doctors or nurses, were passed amongst a team, no one really knowing your story. Our doctors are dedicated to this goal and have been chosen for this [...] We provide timely options for Canadians who endure long wait times and often unavailable medical options.

www.passportmedical.com (2011).

Additionally, a fertility clinic in Argentina argues that it is uniquely positioned to offer reproductive tourists exceptional care because it is not affiliated with any larger medical institution that would hamper patient-centred care. Instead, it can offer "cutting edge reproductive technology" and creative financial plans. The fertility specialist states,

we celebrate individuals' needs and desires. Treatment cycles are coordinated around a patient's requests. Unlike some fertility practices, we do not "batch" or group treatment cycles for the convenience of the center but rather, personalized treatment protocols are developed between the physician and the patient [...]

This approach provides our patients with a well-coordinated, well-executed, holistic experience and some of the best success rates worldwide. Our clinic operates independently. We are unique in our not being affiliated with a larger institution so our patient care and attention is unprecedented.

www.fertilityargentina.com (2015)

Decisions to promote or adopt a specific media frame, in this case personalization of healthcare services, are informed by an underlying economic need to attract reproductive tourist readers to websites, to keep them reading, and to gain future consumers.

However, it is important to note that with the advent of personalized healthcare services within medicine, the consumer is still located within a dominant paradigm that views the body as a machine with fragmented body parts and the choice of fertility treatment options as within a biomedical model. Researchers have noted that patients' conceptualizations of their roles in healthcare encounters vary according to many factors, including age, levels of education and information literacy, with more advantaged patients more likely to perceive that they are entitled to be involved (Sinding 2014; Henwood et al., 2003 and Smith et al. 2011). The social capital necessary to engage effectively in healthcare discourses and practices is also linked to social position; the ability to take charge of one's care is inequitably distributed, with patients with high socioeconomic status able to do so (Mykhalovskiy 2002; Smith et al., 2011). Also, patients cannot take charge as they desire. The extent of patient involvement in care practice is determined by healthcare providers who are not always able to or respond positively to patients' efforts to involve themselves (Sinding 2014).

Moreover, patient empowerment is typically framed by biomedical perspectives. According to Fox et al. (2005), these framings obscure other ways of involvement where what may appear as enabling patient empowerment in the patient-physician visit can

involve patients taking up constraining medical perspectives. For example, the medical broker and fertility clinic websites predominantly market medical treatments for infertility such as IVF, surrogacy and artificial insemination, which are located under a “service offered” hyperlink. Once a reproductive tourist clicks on this hyperlink, a separate web page opens with a list of medical treatment options. The language of patient involvement and empowerment is also engaged in contexts where tasks traditionally undertaken by healthcare professionals are delegated to patients. Scholars have increasingly highlighted the emphasis in patient-directed health information on shifting responsibility for health and healthcare from the collective to the individual (Harris, Wathen and Wyatt 2010). They point to instances in which health information is replacing giving care to patients (Henwood, Harris and Spoel 2011; Sinding 2014).

Linked with the critique of patient empowerment “is a critique of healthcare professionals’ disinvolvement” (Sinding 2014: 58). Here, the focus is on neoliberal structural and discursive changes in healthcare, which “reconfigure the identities and responsibilities of providers of healthcare and effect a ‘disappearance’ of providers from particular aspects of care” (Sinding 2014: 59). Patient empowerment is a valued goal. However, under neoliberalism, health care professionals are “no longer encouraged, nor have the discretion, to provide the care they once did, and thus patients, who are now positioned as consumers, must be involved if they are to receive adequate care” (Sinding 2014:59). Harris et. al. (2010: 130) also contend that when health is constructed as personal choice that is private, public attention is “is diverted away from health concerns posed by social and environmental conditions such as poverty and

pollution, which require remedies beyond the responses of single individuals [and the actions by the state]”.

It is also important to note that with discourses of patient-centred, personalized healthcare, patients do not necessarily have a personal role in shaping how healthcare services are delivered. According to Harris, Wathen and Wyatt (2010), patient-centred care in the context of neoliberalism means, it is the patient who manages her/his illness and disease by incorporating instructions from healthcare providers. It is assumed that information transferred from fertility specialists and medical brokers to reproductive tourists will be used by them as an educational information by which they will be empowered to act upon. For instance, fertility specialists may relay instructions explaining how women must daily inject a fertility drug into their muscle in their thigh in order to prepare their bodies for ovulation induction and harvesting of their eggs. I discuss this medical procedure further in chapter seven. Thus, the health consumer does not shape service but learns how to manage it in terms of existing medical instruction and practice guidelines.

This discourse illustrates what Mol “refers to the logic of choice, a model of care that emphasizes the importance of choice and consumerism as the foundation of improving healthcare” (as cited in Dalstrom 2013: 25). The medical brokers and fertility clinics are providing a sense of choice for reproductive tourists by adopting a consumer language. Canadians traveling abroad for fertility treatments and circumventing domestic regulation can be a part of a larger struggle in Canadian society. According to Humphreys and Quinn (2013), this struggle pits collectivist responsibility against a neoliberal ideology that frames healthcare as a commodity. Advocates of this latter view

of care aim to liberalize Canadian healthcare by privatizing various components of the healthcare system, such as the public financing that serves to control costs and universalize access to healthcare for all citizens (Steinbrook 2006; Barua, Esmail and Jackson 2014). This perspective argues that individual Canadians are unjustly denied the freedom to address their healthcare needs by using their own resources to meet them (Temenos and Johnston 2016).

Leaving the Canadian Healthcare System: Public versus Private Healthcare

Another discursive frame used by medical brokers and fertility clinics, whether in Canada or abroad, to keep Canadian reproductive tourists reading their websites is to portray the Canadian healthcare system as dysfunctional. The medical broker and fertility clinic websites produce a narrative that juxtaposes private-for-profit hospitals in other countries, positioned as offering personalized healthcare services, against the Canadian healthcare system, positioned as so overwhelmed with wait times that the reproductive tourist is unlikely to receive good care. In advertising its services, a medical broker notes the lengthy wait times faced by Canadians and proposes that traveling to a “developing” country can save money and decrease wait times. He notes,

out-of-pocket medical costs of critical and elective procedures continue to rise, while nations offering universal care, like Canada, are faced with ever increasing resource burdens. These drivers are forcing patients to pursue cross border healthcare options either to save money or to avoid long waits for treatments.

www.patientbeyondborders.com (2011)

Another medical broker argues that

a patient should have the right to the latest innovations in medicine without being constrained by regulations that might exist to prevent competition rather than harm. A patient should be able to receive healthcare in a timely manner rather than be limited by rationing.

www.planethospital.com (2011)

Similarly, a Canadian medical broker specifically marketing egg donation and surrogacy arrangements in India states,

we are a full-service egg donor agency whose speedy time to treatment is typically 60 days, in some cases less. Having a strong global network in place ensures that our intended parents will wait as little as possible for their treatments. We have partner clinics around the globe to accommodate our patients' needs, including Canadians. We have a 70% pregnancy success rate with egg donation.

www.surgicaltourism.ca (2011)

The above quotes actively market to Canadians considering going abroad for fertility treatments. Medical tourist companies emphasize their services will meet every consumer need and that the reproductive tourist will be treated as an individual with unique needs, rather than just a number. It is important to note that the medical brokers specifically highlight Canadians' perceived frustration with their healthcare system's long wait times and unavailable medical options.

Canadian medical broker websites discuss the Canadian healthcare system by making reference to “scores of Canadians dying on long wait lists for needed surgery” (www.timelymedical.ca 2011), or to an “inefficient, over-burdened healthcare system” (www.choicemedicalservices.ca 2011).” One claims that “countries who support a universal healthcare system like Canada are now realizing they can no longer afford these programs” (www.choicemedicalservices.ca 2011). One Canadian medical broker even states that Medicare cannot offer the most advanced care to Canadians. On their front page of its website, MedExtra argues,

while Canada’s Medicare excels at providing service to everyone, it is not able to offer the world’s most advanced care to everyone. Which means it cannot offer it to anyone: there simply aren’t enough dollars. The system was designed to be egalitarian—for good or sometimes, ill. Often it is not until something goes wrong that individuals appreciate the freedom of being able to choose the best. That’s where MedExtra steps in.

www.medextra.com 2011

Canadian consumers can travel to another country to access “much needed medical care promptly, where there is no long waiting list, such as is the case of socialized healthcare in Canada” (www.passportmedical.com 2011). Throughout the sample of medical broker websites, all descriptions of the Canadian healthcare system are located on the front page, above their mission statement. Marketed as a solution to the restrictive public healthcare system, medical travel is claimed to enable reproductive tourists to choose the type of fertility treatments “they want, the location, time, and the

amenities” (Dalstrom 2013:25). Medical travel offers a menu of unregulated NRTs, which medical brokers and fertility clinics argue democratizes healthcare. This claim is based on the notion that healthcare is a commodity and that reproductive tourists can act as rational consumers to choose a fertility clinic that offers less expensive NRTs, without excessive regulation. Also, crossing jurisdictions for fertility treatments entails disassociations that might start even before reproductive tourists travel abroad. Ormond and Sothern (2012) describe in their analysis of medical travel guide books how readers are invited to come to view their home healthcare system as impersonal and dysfunctional. Likewise, Inhorn and Patrizio (2009) state that reproductive tourists go abroad because they come to see their home healthcare system as ignoring their needs.

It is important to note that while medical brokers and fertility clinics highlight the “inefficient, over-burdened Canadian healthcare system”, it is to this same healthcare system those reproductive tourists return to in order to receive follow-up care and address any medical complications that occurred abroad while receiving fertility treatments and, potentially giving birth. The medical broker and fertility clinic websites acknowledge follow-up care only in terms of informing reproductive tourists that it is their responsibility to receive proper follow-up care from Canadian physicians or fertility specialists as the medical brokers can provide information only about locating a physician in Canada. As Snyder, Crooks and Johnston (2012) argue the depiction of concern for the lengthy wait times of medical procedures in Canada on the websites may contribute to unrealistic expectations about the availability of follow up care. Objections about the availability of care and access to new medical procedures

surrounding NRTS may ignore the “human and financial implications of making these procedures available in a publicly-funded system like Canada’s” (Snyder et al. 2012: 235).

Reproductive Tourism and a Luxury Vacation

Another genre that medical brokers and fertility specialists use to market their services is weaving together the notion of taking a vacation with obtaining ‘first class’ fertility treatments. One such example is a video from passport medical (www.passportmedical.com 2011), which appears on the front page of the website, next to the mission statement. This video markets a fertility clinic in Barbados. The script and imagery are as follows,

Frame 1: Tired of Negative Results.... There is a solution (white woman holding up a negative pregnancy test).

Frame 2: Take an IVF vacation (airplane landing during sunset, with palm trees in the background).

Frame 3: Relax in Paradise (picture of a white sandy beach, with clear blue water).

Frame 4: Save thousands of dollars (small globe with a stethoscope wrapped around it).

Frame 5: First class healthcare (picture of white man wearing white coat with a stethoscope around his neck).

Frame 6: One-on-one doctor consultations (white man wearing white coat with a stethoscope talking with a white heterosexual couple).

Frame 7: Taking time for yourself (white woman lying on a beach with palm trees).

Frame 8: Unique site-seeing (picture of brightly, multi-coloured parrot).

Frame 9: The procedure (egg being pricked by a needle in a petri dish).

Frame 10: Later that day (picture of hammock on the beach).

Frame 11: Few weeks later...Success? (white heterosexual couple holding up a positive pregnancy test).

Frame 12: Internationally trained doctors (picture of ethnically diverse male doctors).

Frame 13: Exciting...first ultrasound (picture of white woman receiving an ultrasound on her belly and then showing a picture of a fetus on the computer screen).

Frame 14: Just enjoy the next nine months (picture of white heterosexual couple on the beach gazing into each other's eyes).

Frame 15: Enjoy every day (white woman lying on the grass with her naked pregnant belly exposed).

Frame 16: The new addition arrives (picture of a white baby).

Frame 17: The gift of life is remarkable (picture of mother and child together).

Frame 18: Priceless (picture of white baby, blue eyed and blond hair).

Frame 19: See you soon (Same picture of baby as described above).

The images portrayed in this video include highlighting the previous failed attempts at a successful pregnancy and the negative results the reproductive tourists experienced in their home countries, while offering a unique solution: taking an IVF vacation where one

can relax in paradise of white sandy beaches. The video also emphasizes the importance of “taking time for oneself” while receiving fertility treatments (in this case IVF) in the hope that the medical treatment is successful. The video is ambiguous in terms of whether the heterosexual couple receives the good news of positive pregnancy test while vacationing in Barbados or after they return to their home country. It is up to the viewer of the video to interpret this ambiguity. Yet, it is clear that the video juxtaposes the image of saving thousands of dollars with images of receiving first class healthcare that uses the latest medical technology. Reproductive tourists will receive personalized care, one-on-one doctor consultations on their journey to have a baby, a baby which is a “priceless gift.” The text and videos provide a way for individuals to understand their infertility and to imagine the ways in which the medical brokers and fertility specialists can solve their fertility concerns.

Also, the combining of “highly rated medical care or first-class healthcare” by medical brokers with pleasurable, stress-free travel is no simple comparison or accident; medical brokers and fertility clinics shape their promotional advertisements by designing exclusive images, texts and videos to brand their specific destinations (Bookman and Bookman 2007). In their study of medical tourism in the English-speaking Caribbean, Chambers and McIntosh (2008) observe that the region could not easily compete in the global medical market, given the wide spread of international available health services with appealing natural environment. The Caribbean region consequently brands its distinctiveness in special ways, by advertising its tropical beaches and five-star resorts.

For instance, a fertility clinic in Barbados displays white sandy beaches, crystal clear blue water and a heterosexual couple walking in the distance holding hands on the front page of its website. The Barbados fertility clinic stresses its idyllic, stress-free environment, paired with holistic medicine that increases the success rate of achieving a pregnancy by IVF. The Barbados website reads

in between your appointments, you have constant access to our team of experts by cellular phone but with the freedom of being on a holiday. You can enjoy the soothing sound of the lapping Caribbean Sea, go for a long romantic walk along the white sandy beaches and then enjoy the tantalizing tastes of Caribbean cuisine.

www.barbadosivf.com (2011)

Medical brokers in South Africa, state that reproductive tourists can go on “exotic safaris” and enjoy the breath-taking scenery from their hotel suites. Surgicalbliss.com (2012) notes reproductive tourists can recover in an

authentic bush styled accommodation. Book into Shamwari Game Reserve, one of the biggest game reserves in the Eastern Cape [...] Experience the best that nature offers and go on a personalized game drive and view indigenous animals from the big five, plus exotic birds and lush and green trees [...] Surgical bliss works with some of the most cutting-edge fertility clinics in the world.

Beside this caption is a picture of a safari vehicle parked by a dirt road with White individuals taking pictures of lions and giraffes. Through the use of images, texts and videos, the medical brokers and fertility specialists use the website to persuade

reproductive tourists to abandon uncertainty and trust overseas hospitals and healthcare providers in a different country (Connell 2013).

All medical broker and fertility clinic websites have a “services offered” page which discusses not only the fertility treatments offered, but also the variety of travel resources and tourist information for reproductive tourists. Tourist information on these websites include a list of five-star resorts and hotels, list of sight-seeing tours, gourmet restaurants and descriptions of the local culture. Beside the text descriptions of these amenities are pictures of resorts, landscape photos of idyllic natural surroundings and restaurants. Reproductive tourists can also choose from special tourist packages that merge receiving fertility treatments with participating in spa, golf, garden/nature and safari packages with an all-inclusive price listing. Medical broker and fertility clinic websites also offer supplementary programs such as the “healthy mind and body program” which includes massage, acupuncture, reflexology, and reiki and one-to-one sessions with a trained counselor dealing with the emotions associated with receiving fertility treatments. Most websites have a toll-free number so that reproductive tourists can speak to a travel agent employed by the medical broker and fertility clinic. Or, reproductive tourists can contact the patient facilitator online by instant messaging or by Skype and discuss details of purchasing NRTs and book tourist travel packages.

Additionally, the websites link personalized health care services in hospitals with the image of luxury. Medical brokers and fertility specialists claim to offer reproductive tourists the luxury of private rooms in which to heal and recuperate. For example, in one fertility clinic in Barbados, “all rooms have an ocean view [and] this area is ideal for your recovery” (www.barbadosivf.com 2011). In another fertility clinic, one may “relax and

recuperate in idyllic surroundings” (www.ivfturkey.com 2011). The images of hospitals and fertility clinics portrayed on these websites depict hospitals as taking on elements of elite hotels with grand foyers and shopping malls. For example, Passport Medical, a medical broker advertises the international hospitals to which they send reproductive tourists, as offering “five-star recovery facilities that would be the envy in North America. One of our hospitals has a movie theatre for patients, an art gallery and a museum in addition to shops and recovery center that allows music therapy, aromatherapy, and art therapy” (www.passportmedical 2014).

According to research done by Turner (2010; 2015) most medical brokers have specific international hospitals and fertility clinics where they work and these medical brokers may receive a financial payment from these institutions depending on how many reproductive tourists receive fertility treatments at those specific medical facilities. These private, elite hospitals are advertised as having enhanced biomedical technology, five-star rooms and restaurants that provide respite from hospital food. This type of setting is sold as fostering a stress-free environment where healing and pregnancy can take place, as opposed to the website discourse which portrays North American and European healthcare systems as having a rushed recovery process, unpleasant surroundings, a “high probability of iatrogenic infections, and delayed or troubled access to nurses and other clinicians” (Sobo et al. 2011:76). Research by Han and Hyun (2015) suggest that if consumers are deciding to travel abroad for medical treatments, they will likely pay attention to the cost of receiving care abroad as well as the amenities they can access.

The Role of the Patient Advocate

The medical broker and fertility clinic websites also highlight their unique position in offering specialized medical personnel to assist and accompany the reproductive tourist's journey towards parenthood in another jurisdiction. All medical broker websites advertise their qualifications for helping the reproductive tourist travel to another country, setting up medical appointments, ensuring language interpreters are available, coordinating travel within the host country and confirming that medical records are transferred to the fertility clinic. As one international medical broker discussed,

Every patient is assigned a Personal Medical Assistant to be the patient's expert advocate and guide—from diagnosis to recovery—in a personalized, first-class medical environment. You are never alone in any decision you have to make. You are provided with a comprehensive, individualized tailored medical treatment plan, containing primary options and with the data you need to make an informed decision regarding your choice of global physician, facility and medical travel destination.

www.gcmmed.com (2011).

A Canadian medical broker argues that

learning complicated medical jargon is hard enough, but when you are stressed, it is twice as hard to learn and understand [...] How are you going to be sure you ask the right questions? Wouldn't it be great if there was someone beside you, who already understood medicine? Who could ask the right questions, and get the right answers? That's MedExtra Medical accompaniment. Your MedExtra Care Manager will prepare for the appointment with you and establish with you what needs to be addressed. MedExtra's Care Managers engage the physicians

as medical professionals and ensure that all aspects of care are discussed. After the appointment, you will receive a detailed report and the Care Manager is available as often as you wish to answer your questions or clarify anything with you.

www.medextra.com (2011)

Similarly, a U.S. medical broker, marketing to Canadians, who specializes in IVF and surrogacy in India and Thailand states,

our patients have one job and one job only-to show up for treatment, leaving the rest for [our] cross-border case management team. Let us take on your stress so that you can stay focused on yourself and what matters most to you---your treatment. We handle everything and are ready to serve every need.

www.elite-ivf.com (2013)

One interesting aspect of these quotes is how medical brokers depict patients' encounters with health professionals. In the traditional setting of healthcare delivery such as Canada, the patient is constructed as being ignored, alienated and alone in making healthcare decisions in an overburdened and impersonal setting. However, patients (consumers) who purchases fertility treatments outside their jurisdiction are portrayed as being surrounded by a team of individuals who are attentive to their special needs. The medical consumer can escape the confines of the overburdened and impersonal healthcare system and travel abroad and receive the needed care. The owners of medical broker and fertility clinic websites use the word "facilitator", "care manager", or "personal medical assistant" to characterize their roles as important.

These terms evoke the image of helper, someone making life easier, while the term “broker” brings to mind the world of business and money making. Moreover, as Penney et al. (2011: 7) argue, the terms of facilitator, personal medical assistant or care manager “may be seen more to have the patient’s interests at heart, thus reducing risks, while ‘broker’ might be seen as engaging in more mercenary, risk-taking behaviour, making the broker’s perceived role as an important element in the communication and understanding risk.”.

Contradictions in Medical Broker and Fertility Clinic Messaging

There are also many contradictions in how the healthcare consumer is portrayed on these websites. A consumer of a publicly-funded healthcare system is depicted as alienated and alone in making decisions about the care they receive because the healthcare system is overburdened due to lengthy wait times. In contrast, the site claims that a consumer who travels abroad for medical treatments from a for-profit private hospital will receive immediate, personalized and individualized care. Although the healthcare consumers are portrayed as empowered to make medical decisions on their own, a patient advocate will be assigned to reproductive tourists to help them make decisions surrounding their fertility treatments and to ensure a worry-free experience of traveling travelling abroad for NRTs. As consumer-tourists, they will be pampered and looked after not only medically but in terms of a vacation experience as well.

The apparent contradiction of the image of medical consumer may be lessened due to the placement of different discourses on the websites. For instance, the narrative of the Canadian healthcare system as overburdened and impersonal occurs on the front page of the websites. However, the narrative of the consumer as being empowered and

the various personalized services offered by the medical brokers and fertility clinics are detailed under a “services offered” link, which requires the reproductive tourist to navigate to another page on the website. This provides a visual separation from the previous narrative where the reproductive tourist can now focus on reading about all the services offered by the medical broker and fertility clinics. Here, reproductive tourists can read about how the medical facilities are equivalent to those at home (e.g., in terms of clinical training and accreditation standards) and how a patient advocate will be assigned to them to ensure a “worry free experience” while receiving medical care and participating in tourist activities abroad. It is also important to note that while reproductive tourists read about how fertility clinics are equivalent to those in Canada, these websites specifically highlight the fact they operate in countries where NRTs are unregulated.

Given that NRTs are unregulated, these websites argue that reproductive tourists have more choice and freedom in obtaining the fertility treatments they desire, without the confines of both a publicly funded healthcare system and a highly regulated market of NRTs. The increase of competition among medical brokers and fertility clinics can facilitate the reduction in prices and the savvy healthcare consumer can shop around for the best possible prices of NRTs. Reproductive tourists are depicted as needing to escape the health structures (regulations and laws) limiting their agency while, at the same time, are required to purchase fertility treatments under a set of structured rules that “ensure quality of care, certified physicians and accredited hospitals” (Perfetto and Dholakia 2010: 413). In other words, “the quest for freedom to choose a healthcare facility and its services coexists in sharp contradiction with the desire to be free from

harm resulting from medical malpractice” (Perfetto and Dholakia 2010: 413).

Reproductive tourists are positioned to desire to be free from the constraints of the Canadian healthcare system and this is associated with a larger ideology. It is an ideology built upon taken-for-granted neoliberal beliefs that people are able to act individually to change their own circumstances. However, at the same time, the regulatory constraints of NRTs in Canada are also depicted as part of a larger healthcare system that assures quality, lowers risks surrounding the use of fertility treatments, and limits the commodification and exploitation of women’s bodies.

Overseas clinicians are portrayed on the websites as able to spend significant high- quality clinical time with each patient, constantly checking in and making themselves available. The level of service in terms of nursing care is portrayed as being “second to none with nurse-to-health consumer ratios approaching one-to-one” (Sobo et al. 2011: 331). Further, communication with healthcare professionals will be in “fluent English or if not, via fluent interpreters” ([www.passportmedical](http://www.passportmedical.com) 2011). Accesses to Western amenities (e.g., television channels, coffee makers, in-room safes, familiar foods) are advertised as being assured.

The websites also present the process of travelling abroad for fertility treatments in simplistic, linear steps. For instance, the websites use taglines like “what to expect as a medical travel: 10 easy steps” (www.worldmedassist.com 2011), “allow us to connect you to the care you deserve...We make it as easy as possible for you! Three easy steps.” (www.ihcproviders.com 2011) and “you simply select a procedure, choose a surgeon, upload medical records and then book flights” (www.planethospital.com 2014). These “easy” steps involve assessing the reproductive tourist’s medical situation and

gathering information, sending the information to a medical team in the host country, advising the reproductive tourist on the recommended treatments and costs, making the travel arrangements and then departing for the host country for the desired fertility treatment(s). Similarly, the message that reproductive tourism is easy and pleasant is reinforced with close-up shots of White couples looking positive, confident, relaxed on a beach, not as though they are about to undergo fertility treatments. For example, they are portrayed as tasting exotic local cultural foods, viewing serene natural surroundings of beaches and forests, recuperating in luxury hotels and hospitals and receiving spa treatments associated with luxury vacations. In these images, the processes involved in fertility treatments are backgrounded and notions of hope, success, transformation and freedom are foregrounded. The effect is to gloss over the practicalities, seriousness and risks of fertility treatments, constructing reproductive tourism as a straightforward endeavor and easy (Casey et al. 2013). Researchers have also argued that references to medical tourism on the websites may represent a purposive strategy to minimize consumer's fears regarding post-surgical recovery. Thinking of an operation, for instance, as something to be followed quickly and comfortably with a trip to sun-soaked sandy beaches, a trip to the Taj Mahal or an overnight safari may, in fact, feed patient consumer optimism about fertility treatments without paying attention to the potential medical risks, pain, nausea and exhaustion (Sobo et al. 2011; Inhorn and Patrizio 2009; Kangas 2010). A further discussion of the seriousness and risks involved traveling overseas will be discussed in chapter six.

Conclusion

This chapter provided a snapshot of how medical broker and fertility clinic websites use and enact neoliberal discourses of the health consumerism and personalization of care in marketing their health and non-health services to reproductive tourists. The use of Web 2.0 architecture creates a virtual space of different hyperlinks, texts, images and videos, in which the boundaries among patient's experiences, company presentations, advertisements and scientific information and imagery are systematically blurred. The sensible ideals of viewing patients as whole persons, being nice to them and allowing them some say in their care, have been appropriated by medical brokers and fertility clinics to market their services to reproductive tourists. The social capital necessary to engage effectively with medical discourses and practices is linked to social positioning. The medical broker and fertility clinic websites position the reproductive tourist as a 'patient' and as partaking of a luxury environment where they will be looked after and pampered both medically and in terms of comforts, and embodied sensuous experiences. The next chapter documents how medical broker and fertility specialists rely extensively on patient testimonials to market their services and portray a common thematic discourse of hope and renewal.

Chapter Six: Patient Testimonials of Reproductive Tourists

Introduction

Web 2.0 architecture plays a key role in the process of shaping patient narratives on medical broker and fertility clinic websites. The Web 2.0. technology enables patient narratives to take many different forms such as videos, images and texts. These stories become elements of data to which readers read and view on the medical broker and fertility clinic websites. This chapter examines patient testimonials on these websites and how they use a common thematic thread of hope and renewal that facilitates the marketing of NRTs abroad. I argue that the use of patient testimonials by medical broker and fertility clinic websites act as a direct-to-consumer marketing strategy. Potential reproductive tourists can emotionally identify with these successful parenthood stories and the websites offer an avenue for those seeking assistance to achieve their desires for parenthood. The patient testimonials are not neutral forms of information but are social constructions that have material effects in terms of offering hope for those who may have none.

Patient Testimonials

When individuals upload their infertility journeys to the websites, they must conform to listed rules and conditions. Reproductive tourists do not have control over their stories when they share their experiences on the websites. As Lupton (2014: 856) notes, “patients’ opinions and illness narratives may be expressed in more diverse and accessible forums than ever before, but simultaneously they have become exploited in novel ways in the era of digital health.” This has become what Lupton (2014: 858) terms, the “digital patient experience economy”, where patients’ testimonials are valued

not only for the support and information, they offer to other reproductive tourists but also for the potential they have for increasing the commercial value of medical brokers and fertility clinics. The patient testimonials are treated

as another form of digital intellectual property, owned not by the patients themselves but by the developers of the platforms who encourage patients to upload their experiences. The data archives thus produced are owned by the developers and they are therefore able to profit from the harvesting of these data, including by on-selling the data to their clients (Lupton 2014: 858).

According to Horgan and Sweeney (2012), medical broker and fertility specialists use patient testimonials as part of a word-of-mouth marketing strategy that helps to reduce the advertising and promotional spending and is considered a powerful marketing tool. I am approaching these patient testimonials as discursive representations of a specific story which normalizes reproductive tourism and emphasizes hope for others in building their families and not necessarily as 'true' representations of patient experiences. These patient testimonials may not be written by patients themselves and may be screened by medical brokers and fertility specialists to highlight the positive experiences of travelling abroad for fertility treatments. Nevertheless, this patient testimonials represent a discursive story used to market reproductive tourism to highlight the benefits of traveling abroad and experiencing a vacation as well as the success rates of NRTs.

The patient testimonials have the effect of making a personal and emotional connection to the reader and portray reproductive tourism as a normal and safe way to

achieve parenthood. Reproductive tourists are left largely on their own in a fertility market that presents them with choices that offer hope in the form of the technological promise of NRTs.

Word of mouth marketing has been noted as an important factor in studies of surgical patient-decision making (Hawker et. al. 2001; Al-Hinai, Al-Busaidi and Al-Busaidi 2011). Similarly, Johnston, Crooks, and Snyder (2012) have noted that Canadian medical tourists traveling abroad for various medical procedures rely on patient testimonials as primary considerations when deciding whether to go abroad for medical treatments. As these researchers argue, within the Canadian healthcare system healthcare providers serve as a resource in patients' understanding their illness or disease (Johnston, Crooks and Snyder 2012). But, despite healthcare providers educating patients about their care, more value is placed upon patient testimonials of medical tourists for patients to make their decision(s) to go abroad (Johnston, Crooks and Snyder 2012).

Personal narratives can be seen as credible and convincing to reproductive tourists if they can relate to similar experiences in which they are reading about or watching-- even when evidence-based medicine (EBM) is seen as a gold standard, one based on scientific research and viewed as reliable and valid. And, although the medical broker and fertility clinic websites cite peer-reviewed journal articles of employed fertility specialists that illustrate medical competency, it is the patient testimonials that are given prominence on the websites. Individuals tend to give a great weight to first person accounts when making healthcare decisions for themselves or their families (Ubel 2002; Vera, Herr, Mandato et al. 2012 and Snyder et al. 2013).

All the medical broker and fertility clinic websites have a hyperlink to patient testimonials on their home pages. Once a potential reproductive tourist clicks on the hyperlink, another page appears with all the patient testimonials from individuals who successfully had children whether through IVF, gamete donation or surrogacy. All the patient testimonials are grouped together under a single hyperlink, which permits them to be read in succession. This allows potential reproductive tourists to read multiple successful stories of achieving parenthood, portraying NRTs as being highly successful in other jurisdictions.

Patients' narratives are told through the use of blogs, lengthy text stories and videos depicting the happy couple holding their precious gift—a baby. The patient testimonials displayed on the websites have a common narrative flow. Each story describes their difficulty having children, discussions of an emotional roller coaster ride with sadness, uncertainty and anxiousness followed by a description of the solution (generally through NRTs), and a happy ending. Reproductive tourists may describe their interaction with the fertility specialists, doctors and nurses at the fertility clinics and tourist activities, such as describing the restaurants they went to, resorts or hotels where they stayed and, the places they visited. Below are examples of patient testimonials viewed on the websites. I present these testimonials in succession to illustrate what readers encounter on the websites and to invite an understanding of how reading them one after the other reinforces the image that participating in reproductive tourism is both normal and safe and is highly successful way for individuals to achieve their dreams of parenthood. I also want to draw attention to how the discourses of hope

and consumer empowerment are enacted in the testimonials. For instance, a couple from the United States writes,

After getting married in 2005, my husband and I spent the next five years trying to conceive, eventually trying three rounds of artificial insemination (IUI) without success. After consulting a fertility clinic, they told me the idea of IVF with my own eggs was impossible. I was devastated. It was a dark time for me, filled with questions and tears. A few months later, I discovered the My IVF Alternative website. The testimonials were amazing, and I realized that I was not alone, that so many others were struggling along with me. The idea of an IVF vacation seemed the perfect solution, and it was one-third of the cost of the donor egg IVF procedure in the US. We decided to make some inquiries, and after my initial conversation with Mag, I was introduced to Sue Taylor, the donor egg IVF coordinator. She had a blend of compassion and technical knowledge that I relate to, since I had a Masters in Science and has spent twelve years doing tissue culture in the lab. After some months of planning and coordination, we took our trip to Czech Republic in June, and had a wonderful time. We had two clinic visits, and both times we were impressed with the professionalism and friendliness of the doctors and staff. The clinic was modern and had state-of-the-art equipment. We felt like we were in great hands, especially with our caring coordinator Barbara, and our excellent doctor (Dr. Marcel). The embryo transfer went smoothly and I felt very peaceful and calm. We are home now and I am happy to say that I am pregnant with twins! I never thought this day would come

after such a long struggle, but we are proof that this process can work. Thanks to MyIVFAlternative, we're on our way to our dreams of having a family.

www.myivfalternative.com (2012)

A Black couple from the US states,

I want to say thank you for what you do. You give hope to others who have been struggling for years to conceive. You've been through the same heart ache a lot of us are going through. I know you understand all the ups and downs of infertility.

It is an amazing experience to be able to vacation in a beautiful country and do fertility treatments at the same time. It helps out a lot when you are able to relax and it gets your mind off your troubles. The most relaxing thing we did was the Salt Caves. WOW! I wish we had that here in the US, it is so relaxing. Brno is such an amazing city; there are lots of things to keep you busy like the Zoo, Castles, Churches and all the different types of food and grocery stores. There is a lot of history to explore. We were glad to be able to experience the different cultures and the different ways of living. We even lost weight while we were there.

It's been a long journey for us; we've been trying for six years and had four failed pregnancies. We were so discouraged and got tired of hearing "it will happen, you just need to relax." We discovered that I had an auto immune disease called Antiphospholipid Syndrome, which causes miscarriages. My husband and I almost gave up and we knew for sure that God had plans for us to use a

surrogate to carry our baby. My fertility doctor here in the states recommended us to try IVF at least one time; we knew there was no way we could afford that. A friend suggested going abroad to do the treatments. We did a lot of researching and your clinic was a perfect fit. Mag was awesome and very thorough; she had to be that way to be able to work with me. I wanted to know everything. We had peace about this journey and stepped out into faith. The doctors at the clinic knew how to treat my auto immune disease and suggested several treatments during the process. They were wonderful and our coordinator, Eva, was a great help. She made sure we were well taken care of. The doctors were very informative and went over each step with us. We ended with 2 little healthy embryos of our own. What a blessing. Currently, we are pregnant and everything is going just perfect! We heard our baby's heartbeat and we just fell in love. We've made special memories and also the best gift of all...a baby. I would love to answer any questions you may have and will share our experience along with pictures of our vacation/fertility journey.

www.passportmedical.com (2012)

And finally, a couple from Canada who travelled to the Czech Republic noted,

As many people do, my wife and I decided we wanted to take that next step and start a family. Our hope was high, and then came our first miscarriage! It was devastating for us both, but we quickly put the experience behind us and tried again. Again, my wife became pregnant and again our hope and dreams came crashing down around us as my wonderful wife experienced another miscarriage.

After the third miscarriage, we sought help of specialists in the field to both help us obtain our dreams of a baby and understand what was going wrong. Well, they found a number of problems, some with me and some with my wife.

We listened and learned that thru medical techniques available today, our hopes and aspirations for bringing a child into the world were still possible. Now, came the overwhelming task of finding the doctor and the facility. After numerous consultations with doctors, geneticists and financial consultants and scouring the Internet for hours and hours we found "My IVF Alternative" and let us to Mag and Jeremy which have changed our lives. My wife was the first to talk with Mag and after her initial conversation she was filled with hope. My wife felt so comfortable with her and become her best friend during this emotional rollercoaster.

I remember coming home that night finding my wife so excited and wanting me to call and talk with Mag. I'm by nature a skeptical, so I called that night with apprehension but after a 20-minute phone call with Mag who was friendly and knowledgeable, and answered all my questions, including one very important question for my wife and I, which was, can we use our own sperm and egg. The answer was ABSOLUTELY! We wanted this option. After the call that night with Mag, I too began thinking maybe this too is what we have been looking for. We continued to research the program, read testimonials and of course called some of the people who have participated in the program. We received great feedback. My wife and I agreed this was for us, our chance to start a family. We flew off to Europe to a beautiful little town full of history, art and atmosphere. (Flying with

meds was no problem at all). It was like a vacation! The medical facilities were exceptional, the doctors were highly educated and the experience and the care giving of the staff was top notch. Almost everyone in the clinic spoke English, which was a huge help! The procedure took a total of 14 days, visiting the clinic 3 times during that stay, 1st for the initial consultation, 2nd for the egg retrieval and sperm sample and 3rd for the transfer. It's been 11 weeks and my wife and I are expecting twins. We both are so happy and grateful to Mag and to the My IVF Alternative program. We hope that more couples will find and experience this life changing program. Mag helped us with the travel arrangements and even arranged to have English speaking representatives pick us at the airport bring us to our IVF appointments and guide and give advice. We are truly grateful and so pleased and happy with Mag and the program. Thank you, Mag and Jeremy, for all you have done, you have truly changed our lives. We'll send pictures of the twins!

www.myivfalternative.com (2012).

The extensive use of patient narratives on the medical broker and fertility clinic websites gives an optimistic portrayal of NRTs, offering hope to those who are assumed to have little or none. All patient testimonials discuss the quality and compassionate care they receive abroad while on a relaxing vacation. The enactment of the patient as an empowered, knowledgeable healthcare consumer, stresses that patients can indeed make informed decisions for often medically complex conditions. Reproductive tourism creates a space where reproductive tourists conduct their own research on the Internet, evaluate patient testimonials, make their decisions regarding their personal medical

needs and decide on the most appropriate medical provider for NRTs rather than consulting an expert clinician before receiving fertility treatments. From the perspective of the medical brokers and fertility clinics, offering such services promotes consumer choice by giving clients access to procedures that they wish to undergo. The patient narratives illustrate a specific construction of self: namely a reproductive tourist, who is potentially desperate and open to new and promising treatment, empowered to make their own decisions and capable of achieving his/her dream of parenthood based on the ability to pay and buy the service (Petersen and Seear 2011).

Patient Testimonials and the Concept of the Self

The concept of the self is something that individuals continually work on as a basis for making sense of their world and relationships. For Holstein and Gubrium (2000: 125) self-construction is an “on-going, practical, every day and context-based interpretive practice”. A discursive theme in the patient testimonials is the idea of hope and the reconstruction of self. It is the reframing of the socially and medically defined infertile body into a fertile authentic self. This may be achieved through the use of NRTs including the use of IVF and surrogacy for both heterosexual and LGBTQ couples or single individuals. It is important to note that not all reproductive tourists view themselves as infertile or have been medically defined as such. However, the patient testimonials do portray a positive imagery of using NRTs to achieve the patients’ desire to have a genetically-related child.

Reproductive tourists have their own embodied experiences and they may focus on challenging the biological clock (Cook 2010). According to Cook (2010) individuals participating in reproductive tourism are desiring a future where their infertility is

addressed. As she notes, “the everyday body, with its difficult restrictive realities, travels with the [reproductive] tourist” (2010: 146). It is a journey of discovery that involves medical treatment, emotional and physical pain, recovery and having a baby. When women and men are telling their infertility stories, they are narrating in a way that makes sense to them while also trying to make their stories meaningful to others. They are “offering a story in which they stand as intelligible moral subjects and as individuals with the ability to act” (Thompson 2005 as cited in Lundin 2012: 339).

The Political Economy of Hope

This process can also be described in terms of how the economics of hope interact with the reproductive market’s monopoly of desperation. Without the assumption of demand (people risk staying childless without NRTs) and supply (eggs, sperm, womb etc.), neither a legal nor an illegal NRTs business would exist (Inhorn 2003). To a fertility clinic, reproductive tourists are seen as commercial revenue units as much as people. Fertility treatments, such as ovulation induction, often requires repeated tries in order to find the correct dose of the fertility drug to stimulate ovulation. The treatment process can stretch over a number of years because ovulation induction occurs at a particular point in the monthly menstrual cycle and it may require women to take a break between treatment cycles to minimize side effects of the fertility drugs. The fertility specialist may figure out what dosage of the fertility drug would work based on what did not work in the previous IVF cycle. Therefore, women may feel a need to go for another treatment cycle in order to find the correct dosage of a fertility drug.

The expectations that surround biomedical technologies have developed to the extent that those who do not pursue tests and treatments that are made available to

them are at risk of being judged as irresponsible (Petersen et al. 2017). In terms of revenue and profitability, the more NRTs sold to reproductive tourists by fertility specialists and medical brokers, the better. Presenting numerous patient testimonials about successfully having a baby through the use of new reproductive technologies gives hope to other individuals to try this avenue, thus fueling the demand for travel abroad.

The power of hope also fuels the expectation that NRTs are more successful than they are, bringing into the forefront the rise of fertility clinics and medical brokers around the world. Presenting positive depictions of fertility treatment and care those reproductive tourists receive abroad offers information as only a snapshot in time, which operates to de-contextualize the treatment, reinforcing the seemingly miraculous qualities of NRTs. Through a discourse of hope and healthcare rights, these websites market NRTs as both a human right and a therapy of hope. Regardless of whether such treatments will work becomes secondary as fertility treatments come to be marketed as a form of hopeful technology (Petersen and Seear 2011).

Petersen et al. (2013) notes that Novas and Rose use the term “political economy of hope” to discuss the activities which individuals engage in while obtaining their health goals. As empowered consumers, reproductive tourists are portrayed as adopting healthy activities, using the Internet and using various sources of information to inform themselves about their infertility and avail of NRTs. The active aspect of hopefulness “is not mere wishful thinking and anticipating but rather it postulates a certain achievable and desirable future, which requires action in the present for its realization” (Rose as cited in Petersen et al. 2013: 148). The “political economy of hope

is an area of possibility and anticipation that requires action and awareness of the present in order to realize a range of potential futures” (Rose and Novas 2005: 452). For instance, positive patient testimonials of fertility treatments are used to provide a way for individuals to understand their infertility at a biomedical level in terms of blocked fallopian tubes, sperm mobility, miscarriages, and hormone imbalances as well as ways to imagine how going abroad for NRTs can overcome these biomedical difficulties. As stated previously, a key feature of the websites is to not only provide information to potential reproductive tourists but also to link them to self-narratives written by patients. These accounts offer a means of overcoming the heartache and despair of infertility and practical ways of achieving the goal of parenthood.

Conclusion

In sum, the women and men telling their infertility journeys abroad are story telling in a way that fits with the organizational structure of the websites and makes their stories meaningful to others. Potential reproductive tourists can self-identify with these stories of loss, miscarriages and heartache. The patient narratives also offer a possible action plan for achieving their desires of parenthood: travelling internationally for NRTs. In essence, these narratives of hope, renewal and successfully having a child by seeking fertility treatments abroad target reproductive tourists with the necessary social and financial capital, which, in turn, helps to fuel demand for new reproductive technologies. The next chapter documents the information gaps on these websites in terms of detailing the complicated process of traveling abroad for fertility treatments, recognizing the unpaid care work of family members, friends, and partners who travel

abroad with the reproductive tourist, and the medical side effects of NRTs for the reproductive tourist, egg donor and surrogate.

Chapter Seven: Reproductive tourism in Rhetoric versus Reality: Missing Narratives, Missing Subjects

Introduction

In this chapter I discuss what is systematically missing from the medical broker and fertility clinic websites in terms of the potential medical risks of NRTs and of participating in reproductive tourism. I also address the physical and emotional care work of women who are egg providers and of surrogates who perform in this market transaction both in “developed” and “developing” countries. I document how different forms of labour and care work that are performed by caregivers, reproductive tourists, egg providers and surrogates are ignored and discursively erased from view through the use of texts, images and videos. I argue that through the use of specific, gendered and classed textual and visual representations, the experiences and bodies of egg providers and surrogates are rendered invisible and objectified.

Reproductive Tourism: Complications, Unpaid Labour and Unclear Success Rates

As mentioned in chapter five, the medical broker and fertility clinic websites often portray the process of travelling abroad for fertility treatments in easy linear steps. However, these websites do not highlight the complexities of receiving fertility treatments abroad or the non-linear trajectories these consumers take while trying to have a child. And although reproductive tourists working with a medical broker or fertility specialist will typically be given additional information beyond what is available online, these websites do help form their first impression of traveling abroad for fertility treatments (Penney et.al. 2011). The websites do not highlight, let alone present clear and accessible information for prospective reproductive tourists concerning the financial

implications of their treatments such as the real costs including travel and staying abroad, wait times and the expected time they will have to spend outside their country. The websites also do not include the possible side effects of fertility treatments and legal conflicts, especially with surrogacy and the rights of parents or the cost of aftercare.

The websites rarely offer discussions of anonymity, legal rights and obligations of all parties. For example, personal conflicts may occur regarding the identities of the egg providers. In some countries, fertility clinics are legislated by the government to provide the identity of egg providers while other countries favour anonymity for egg providers. Some individuals receiving eggs may prefer or opt for the anonymous arrangement but return after treatment to their home country, where the law is different. This can cause legal difficulties for Canadian parents because Canada requires genetic testing to ensure that a child born abroad is biologically linked to a parent in order to grant citizenship to the child. Additionally, whether children have access to information about their gamete providers and these providers' medical histories may face hurdles, depending on laws of the country in which the donation occurred. Children attempting to locate their gamete providers and medical histories abroad may face greater hurdles than their domestically conceived counterparts (ASRM 2013).

The positive patient testimonials and supplementary information on the websites provide crucial data because these are among the first sites from which reproductive tourists begin their investigation for going abroad. Johnston et al. (2012:10) argues that the numerous positive testimonials on medical tourism websites tend to "skew interpretation of surgical risk, resulting in a disproportionate weighting of the potential

positive outcomes even when they are presented with the statistical likelihood of the potential negative outcomes”. Therefore, if reproductive tourists solely rely on these websites for information about fertility treatment options and success rates, they may not be able to provide informed consent which includes understanding all the medical risks of NRTs. To give informed consent means that reproductive tourists comprehend “all the relevant facts possible, possible complications, potential risks and benefits, duration, cost of the treatment as well as expected outcomes and follow-up” (Kruizinga 2016: 388).

Going abroad for medical care may also entail new risks for consumers. Flying with a serious medical condition or “flying post-operatively increases patients’ susceptibility to deep vein thrombosis” (Crooks et al. 2010: 7). Reproductive tourists receiving medical care abroad may also be at an increased risk of contracting an infection in fertility clinics and hospitals there and participating in tourist activities or travelling to their home countries might strain their post-operative recovery. In addition, reproductive tourism can undermine continuity of care: when care is administered internationally, medical records are often not transferred to the patient’s home physician. Also, if medical complications happen, the reproductive tourist, once home, may have problems communicating with the fertility clinics and hospitals abroad where they received care. (Bookman and Bookman 2007; Hohm and Snyder 2015; and Johnston, Crooks, and Snyder 2012). On the websites, reproductive tourists are also offered numerous reassurances about the safety of treatments and the promise of being able to gain control over their lives and succeed in fulfilling their desire to have a baby. The depiction of fertility treatments as safe and of clinical staff as competent and

credentialed is reinforced through the use of various images (Petersen and Sear 2011). This includes “images of pristine and hygienic clinics and offices; photographs of medical equipment, accompanied by language describing these enterprises as world class, state-of-the art, at the forefront of cutting-edge science and [highlighting fertility specialists’ social networks]” (Petersen and Sear 2011: 340).

Medical broker and fertility clinic websites also market quality hospitals by stating that the hospital or fertility clinic located abroad is accredited by one of two standard setting bodies: the International Organization for Standardization (ISO) or the Joint Commission International (JCI). The ISO is an international organization setting quality standards in a wide variety of industrial and commercial areas including healthcare while the JCI is a predominantly United States-based body which operates voluntary accreditation programs in healthcare settings (Gurtin et al. 2014). For a fee, the JCI will accredit a hospital indicating that it has reviewed the hospital and deemed it safe in terms of patient safety standards. The websites may also market foreign-trained fertility specialists who have been deemed qualified to practice in the US, UK, Canada and Australia, as well as highlight any collaborations with US medical centres. Kleefield (2016: 231) argues that, “while such considerations can identify positive characteristics of a hospital, there is limited available research showing that these are correlated with best patient outcomes”. The growing access of NRTs via the Internet has enabled providers of fertility treatments to advertise their services directly to reproductive tourists unimpeded by Canadian regulations and laws. Since there is no regulatory oversight of quality or common safety practices, reproductive tourists are only able to make partially informed decisions about choosing the right fertility clinic for their treatment.

If reproductive tourists have concerns about the safety of NRTs, all the websites use a “frequently-ask questions” (FAQ) or question and answer (Q & A) webpage, which is advertised as addressing the concerns of reproductive tourists. The Q & A or FAQ sections of the websites are positioned next to the patient testimonials links. Questions typically refer to the nature of fertility treatments, the services offered by the medical broker and fertility specialist, and how payments for the treatment can be made. Most of the answers offer “reassurances about the safety and efficacy of the [treatments and depict fertility clinics and hospitals] as safe, competent, and caring” (Petersen and Seear 2011: 341).

All websites offer contact details allowing reproductive tourists to send an inquiry along with personal details and information with their struggles with infertility. All websites offer a “Disclaimers or Disclosures” link, stating, that the information presented on the websites is for educational purposes only and that the reproductive tourist should contact a healthcare provider (Peterson and Seear 2011). As Petersen and Seear 2011: 342) note, “these disclaimers presumably serve to protect the providers from any legal action that may arise as a consequence of promises unfulfilled or harms incurred”. Some medical broker and fertility websites also require the reproductive tourist to sign a waiver before receiving any medical services from them. Again, the waiver states that the information is provided for educational and information purposes only and that “you access this service at your own risk. Surgical Tourism Canada Inc. can accept no responsibility or liability whatsoever for medical procedures, advice, opinions and services provided by others” (www.surgicaltourism.ca 2013). However, it is important to note that the “Disclaimers or Disclosures” link and the waiver form appear as a

hyperlink on the homepage, which does not give them prominence. What are given prominence are the positive patient testimonials and visual imagery of couples embracing their babies which reinforce the message that the medical brokers and fertility clinics are “credible, ethical, trustworthy, accessible and strongly committed to the welfare of patients” (Petersen and Sear 2011: 342).

The medical broker and fertility clinic websites are clearly designed to sell Brokers’ services and fertility treatments to potential reproductive tourists. Companies that choose to employ these advertisements strategies over others also “tend to observe better short and long-term profits thus, creating sustainable and better growth rates” (Yeoh, Othman and Ahmad 2013:198). It can be concluded that the information provided on these websites is framed more towards promotional and marketing materials than to informing reproductive tourists of the potential risks of traveling abroad for fertility treatments. This asymmetrical portrayal of risks and benefits leaves an overall impression that reproductive tourism and fertility treatments are safe and readily available to individuals who can afford them and that these treatments have a high success rate. Thus, unless prospective reproductive tourists and other healthcare consumers do additional research beyond the scope of the information provided on these websites, they may make healthcare decisions without adequately weighing the risks of reproductive tourism against its benefits.

The Visual and Textual Representations of Fertility Treatments

None of the medical broker and fertility clinic websites mention the medical maze women go through, such as the continuous measurement of body temperature, regulated and carefully-timed sexual intercourse and frequent examinations by one or

more medical experts (McNeil 2008). The patient testimonials offer a rather sterilized version of NRTs. This includes IVF treatment, a process which in its most basic form, involves hormonal stimulation of ovulation to produce several eggs, retrieval of these eggs from a woman's ovary, mixing them with sperm in a culture medium in a laboratory, and then placing some of them back into a woman's womb. This is a typical technical account of IVF on the websites.

For instance, the medical broker, My IVF alternative uses a video to describe an embryo transfer into a woman's womb. The video begins depicting a White woman lying on a hospital bed, legs placed in stirrups and a thin blue blanket draped over her stomach and upper thighs. A caption reads, "the most exciting part of your IVF treatment. Your partner, mother or a friend can be by your side." Lights are dimmed in the medical room and classical music begins playing on the video. A male fertility specialist points to a TV screen on the wall which depicts two embryos. The male fertility specialist then says, "it's two boys". The fertility specialist suctions up the embryos into a catheter and then inserts the catheter into the woman's uterus. A caption on the video reads, "the transfer is not painful." Next, the video shows the woman lying in bed, with a huge smile on her face. Another caption states, "after your embryo transfer is complete, you will rest for 10-15 minutes and relax. See you soon". The video ends. Beside this video a text reads,

Please read the following stories of our IVF patients who wanted to share their struggles, offer hope and encouragement for the journey you are considering.

Our patients are regular couples just like you and I. At My IVF Alternative we also had the privilege to help medical doctors, attorneys, military personnel, business

owners from around the world and a few celebrities as well who just said NO MORE to high cost and limited medical service and YES to savings, great medical care and IVF vacation.

www.myivfalternative.com (2011).

The video depicts the embryo transfer as painless and make no references to the numerous medical procedures performed on a woman's body before the embryo transfer takes place or the potential medical side effects of IVF treatment. The placement of the successful embryo transfer video directly beside the successful patient testimonials of having a baby reinforces the image of NRTs as being successful for everyone and of using medical brokers' services is a route to this desired goal. When medical risks were discussed in the patient testimonials, it was in a way that showcases how they would not occur if a medical broker was used. The patient testimonials examined on both the medical broker and fertility clinic websites made no reference to the potential risk or harm that may arise from engaging in these practices. If former patients talk about any fears they had with having a fertility treatment done in a foreign country, they minimized these fears by mentioning the medical broker agency or facilitator at the fertility clinic they used and of how the highly-trained medical personnel in the facilities that they accessed were available to address all their personalized needs.

In contrast to the website's depiction of IVF and embryo transfer process, all women using their own eggs for IVF treatment will undergo ovulation induction. Ovulation induction is a procedure in which injectable fertility drugs are taken daily, at

the same time of day, to stimulate ovarian activity. It should also be noted that women who provide their eggs to other individuals go through the same procedure. This procedure can last a month, during which women are injected daily with fertility drugs to suppress and then stimulated ovaries to produce follicles. In general terms, "one cycle of egg production and retrieval involves an estimated total of fifty-six hours of interviews, counselling and medical procedures (i.e. screening, hormonal stimulation and egg retrieval)" (Leve 2013:131). During this time, women are monitored using blood tests and vaginal ultrasounds to track the growth of the follicle. The medical side effects can include, "hot flashes, breast tenderness, mood swings, cramping, nausea, dizziness, nasal congestion, fatigue, bloating and headaches" (Curtis 2010: 91). There is also a risk of hyperstimulation of the ovaries which can "result in severe pain, permanent injury, and in rare cases death" (Borrero 2002: 169). The long-term side risks of ovulation induction have not been sufficiently researched (Curtis 2010).

Approximately, 7 to 12 days after taking the injectable fertility drugs, egg retrieval happens. The fertility specialist

retrieves the eggs by a transvaginal oocyte recovery, inserting a needle through the vaginal wall and amassing eggs by sucking them into a needle. Because [women] receive a general anesthetic, they must cancel their usual activities for the day and have a friend or family member take them home or back to the hotel room. [Women] cannot exercise for two weeks prior to and following the retrieval to avoid the potential for ovarian contortion (Leve 2013: 279).

It is important to note that the travel for NRTs is not a onetime procedure, but rather requires a series of tests and procedures across the course of a cycle, which is approximately 21 to 28 days. Although some tests and procedures may be undertaken in their home countries before travelling overseas, at a minimum, a woman undergoing ovulation induction must stay abroad for two to three weeks (Speier 2011). Women are usually able to find a fertility specialist or clinic in Canada who can help them complete initial tests and obtain the necessary fertility drugs. However, if they choose to complete all of their preparation, testing and their ovulation induction in another country, they can stay for up to three months. Individuals with more complex fertility issues and who must use egg and sperm donors, may need to spend less time at the abroad clinic. The above-mentioned video of the embryo transfer on the medical broker website is void of any discussion of the ovulation induction procedure, which is necessary to create embryos to be transferred into a woman's womb and it does not discuss any of the possible medical side effects of this treatment or the length of time she is needed to stay at the fertility clinic overseas.

In addition, it is important to note that although the success rates of NRTs have improved over the last two decades, failure remains a significant feature of their use. According to Canadian Fertility Andrology Society (CFAS 2012), the live birth rates per IVF cycle by age of the mother are 33% for women under 35 years old; 24% for women aged 35-39 years; and 10% for women 40 years old and over. Most IVF cycles still end in failure and this means that there are many more negative features to the IVF treatment than these websites' successful stories of parenthood (McNeil 2008). In fact, none of the medical broker or fertility clinic websites display any negative patient

testimonials that illustrate an unsuccessful outcome. If the websites do list a success rate of NRTs, there is no universal standard definition of success. For instance, a fertility clinic may count an embryo transfer as part of its success rate, however, if a woman then has a miscarriage, this is not included in the website statistics. For most parents, a successful outcome is the healthy birth of their baby, not whether an embryo is successfully transferred into the uterus.

Missing Narratives: Caregivers' Role in Reproductive Tourism

Although medical broker and fertility clinic websites do acknowledge that reproductive tourists may travel with a companion such as a family member, friend or partner, they do not acknowledge the unpaid care work that these individuals perform. Research by Casey et al. (2013) and Turner (2013) and written narratives by medical tourists (Grace et al. 2007; Rose 2009) detail instances where family members, friends or partners perform unpaid care work while abroad. These informal caregiving responsibilities include:

making decisions on behalf of the patient; liaising with formal healthcare providers; coordinating appointment schedules; offering hands on-medical care; asking question about prescription medication; care options and advice for discharge; providing emotional support and taking responsibility for managing care-related finances (Casey et al. 2013: 95).

These authors researched the first-hand accounts of medical tourists, informal caregivers and those who have worked closely with them in a professional capacity, such as international patient facilitators who provided non-medical assistance to the

medical tourists. Casey et al. (2013) found that the informal caregivers facilitated the transfer of information between the medical tourist and formal healthcare providers as well as with other staff members at medical tourism facilities.

Similarly, Whittaker (2015:490) interviewed friends, family members and partners who travelled with medical tourists and showed that they “provided constant informal and emotional care for the patient. They monitored the patient’s symptoms, nurses’ care and doctors’ interventions, assisted with logistic support, liaising with the international staff and were intermediaries between the patient and family back home”. The experience for these patients and their partners, as Whittaker (2015) argues, is not filled with the tourist pleasures promoted in the medical tourism websites. Family members and patients describe “living in suspension, away from their homes, jobs, and routines and being dominated by the daily medical treatment regimes, visits from specialists and nursing staff” (Whittaker 2015: 490).

Informal, unpaid caregivers also help reproductive tourists to follow clinical instructions such as for taking medications. Women wanting IVF treatment may begin the hormonal drug treatment to induce multiple egg release a month or two before the IVF procedure is performed. An overseas fertility clinic can deliver injectable fertility drugs to the woman’s home with instructions, where a family member, friend or partner can administer the medication daily.

A family member, friend or partner may also act in companion roles, by creating a feeling of emotional safety and security for the reproductive tourist. These informal caregivers are familiar to reproductive tourists and are trusted by them. These qualities

put them in a unique position to offer better emotional support than the strangers who staff fertility clinics and hospitals. Informal caregivers may provide additional support by being a familiar person in a foreign city “away from family and friends” (Casey et al. 2013: 5).

These informal caregivers, “are effectively overlooked ‘shadow workers’, unpaid, untrained and largely unrecognized care providers in what is often reported as a highly lucrative industry” (Casey et al. 2013: 8). As Armstrong and Kits (2004) notes, caregiving is not a simple act but rather a complex social relationship and recent healthcare reforms have transformed this care. New technologies, combined with healthcare reforms focused on “privatization and cost-cutting, have not only increased the number of people cared for in households but also transformed the nature of care provided where informal care givers are increasingly burdened with care work that was once designated to health professionals” (Armstrong and Kits 2004:60).

Furthermore, Martin (2015) interviewed fertility specialists who provided fertility treatments to reproductive tourists in the United States. They acknowledged that the care they provide is often sped up when compared to the amount of time they spend with their local clients. According to Martin (2015), this is because fertility specialists are often trying to make the amount of time their foreign clients need to spend in the U.S. as short as possible. Most of the support and consultations that reproductive tourists receive is over the phone and by Skype. In some instances, this kind of virtual communication can strain relationships between fertility specialists and reproductive tourists “because they have less of an in-person, real-time relationship” (Martin 2015: 108). As Martin (2015) notes, domestic clients may work with one clinic throughout their

experience, but reproductive tourists may work with one in their home country and another in the US. Yet, these same, medical broker and fertility clinic websites advertise and market personalized, patient-centred care, in which the fertility specialist or nurse is available for the reproductive tourist around the clock, diminishing the integral roles family members, friends, partners and others play in the reproductive tourists' care. In essence, the caregiver's role in reproductive tourism is erased and their experiences and narratives are missing from the websites' account of receiving NRTs abroad.

Missing Narratives and the Medically-Surveilled Gendered Body: Egg Providers and Surrogates

Other missing, detailed narratives from the medical broker and fertility clinic websites are from egg providers and surrogates. The narratives from egg providers and surrogates are viewed as discursive representations of a specific story which downplays the potential medical side effects of NRTs and the care and labour involved in becoming an egg provider or surrogate and not necessarily as "true" representations of their experiences. As Michelle (2006) notes, potential disadvantages and side effects of NRTs are either ignored or provide only a minor sub-theme in the stories of women who are egg providers and surrogates for other individuals. Often, the websites do not acknowledge the short-term or long-term side effects for women who are egg providers and surrogates. The websites also ignore the emotional and physical labour that the process requires. For instance, Anisa, an egg provider writes,

the donating procedure can seem intimidating if you've never previously donated; however, the satisfaction you receive from giving the gift of life to a deserving

couple is worth every moment. The changes your body goes through are very minor and I was surprised at how simple the process is. I was also fortunate to be part of a very supportive and caring donation agency which makes a difference. Thank you so much. I might not be someone who goes sky diving or climbing Mount Everest to collect money for charity, but this is my Mount Everest. Donating eggs to another woman is one of my greatest achievements, memories and experiences in my life. A candle loses nothing by lighting another candle.

www.eggdonation.com (2011).

The above expert from Anisa's egg provider narrative minimizes the impact of NRTs on her body and states how simple the egg donation procedure is. She highlights that providing eggs to a couple is a great achievement in her life and a gift worth giving. It is important to note that the egg provider's narratives, work in a somewhat different way from the reproductive tourist's narratives. The egg provider's narratives are culturally embedded and reference an ethical norm regarding how egg donation and surrogacy should be conducted—namely, part as a gift economy. This normative line of thinking is one of the explanations that commercial fertility clinics and medical brokers offer by using terms of donation and paid donation instead of the term selling (Lundin 2012). Terms like donor, donor eggs or donation mask the financial transactions and portray the traditional ideals of femininity, such as being selfless, caring and nurturing. In the privatized for-profit industry of reproductive tourism, it is inaccurate to speak of donations when reproductive tourists are providing payments above and beyond basic expenses to those who provide eggs and/or agree to become surrogates. Payments to egg providers and surrogates are unique, especially compared to organ donation within

North America where monetary payments are condemned. For example, despite their “life-saving potential and limited availability, human organs are not sold as commodities because [this could be] exploitative” (Daniels and Heidt-Forsythe 2012: 735-736). The gift of blood is also historically associated with building of nations (Titmuss 1971). Researchers of donation have stressed that “an altruistic system is best for distributing human body products (see, e.g., Titmuss 1971), [because] this system affirms the respect for human life over individual choice to buy and sell objects” (Daniels and Heidt-Forsythe 2012: 736-737).

In his book, the *Gift Relationship: From Human Blood to Social Policy*, Titmuss (1971: 314) anticipated the dilemmas raised by the global market for gametes. He stated:

the commercialization of blood and donor relationships represses the expression of altruism. It erodes the sense of community, lowers scientific standards, limits both personal and professional freedoms, sanctions the making of profits in hospitals and clinical laboratories [...] subjects critical areas of medicine to the marketplace.

The values attributed to human tissues are always dependent on the particular cultural, historical and social factors of different actors such as donors, recipients, family members and healthcare staff (Waldby and Mitchell 2006). Egg donation may make women the object of another person’s reproductive agency and this objectification may not always translate into exploitation because donors may be making an active choice

about the care work they are performing even when the economic conditions under which they are performing their labour can potentially compromise their care and health.

When an egg provider or surrogate narrative does mention the work involved, the pain during the procedure, or the emotions surrogates may experience when they give up a baby to the intended parents, these are always minimized. One narrative that weaves this together is from Kathy who is surrogate for a medical broker in the US that specializes in egg donation and surrogacy arrangements. She states,

You and your staff have given me the chance to do something so amazing. You have found me the most wonderful, kindest and perfect couple to do this for. Going into this a lot of people asked questions like “How can you do this?” “How do you just give up a baby?” “How will you feel afterwards?” To see their faces when they got to hold their baby boy for the first time, to see the miracle I helped them make, will be a gift I will hold in my heart forever. I went through my own tummy problems, had broken ribs was in a lot of pain at times. BUT, it was all worth it. I only had about 6 months of pain. My couple went through years of trying to have a baby and it not working and with that comes pain. So my pain was really nothing compared to theirs. So I know that answer to that question. I feel GREAT. I have found a new family, they may not be blood but they will be just as close and without you and your staff this all would have never happened. You all are truly the Angels. You are women I look up to and admire, working every day to help new and wonderful people come together and develop bonds for life.

www.eggdonation.com (2011).

Kathy minimizes the physical pain she experienced while pregnant due to tummy problems and broken ribs. She compares her pain with that of the couple who have been trying for years to have a baby, noting that her pain was nothing compared to the couple's. Also, throughout the narrative, Kathy frames her work as a gift that she will hold in her heart forever. It is important to note that childbearing is not like any other care work; pregnancy involves hormonal changes that generates feelings that can make surrendering the child difficult. As Ghosh (2006) notes, some surrogates mourn for the babies they have surrendered. In this market transaction, the surrogate is expected not to become attached to the child she is carrying, but, at the same time, the intended parent(s) do want her to feel attached to the pregnancy in order to take care of the fetus in her womb (Ghosh 2006). An owner of a medical broker company, specializing in egg donation and surrogacy focuses on the benefits of becoming a surrogate. The owner notes,

So many components go into making miracles. Are the planets aligned just so? Is a star falling at just the right trajectory to clear through the planets, which can open a space for this magical energy to be created? Is the will of the angels so powerful that it can help us see beyond the scope of normal human experience? I like to think that a miracle is found in love, one heart reaching out to another. Surrogacy and the blessing of a child is just that sort of a miracle. Much like a fireman rushes into rescue a victim from a burning building; a surrogate mother sees the crisis of an infertile couple and longs to take away their pain. This is the selfless love that occurs...If you are interested in finding out more about

surrogacy or want to secure your own ticket to heaven, please contact the surrogacy program.

www.eggdonation.com (2011).

A framing of surrogacy and egg donation that highlights altruistic motives counters the image of commodified reproduction. Gendered motivations of altruism focusing on the desire to assist those who cannot have their own children are provided by surrogates and egg providers. The medical broker and fertility clinic websites that market egg donation and surrogates often depict these women as angels, displaying young, White and attractive women with angel wings on their unclad backs. Religious language of miracles such as in the quotes above are often used by egg provider and surrogate testimonials to describe fertility treatments as “a spiritual process” (www.eggdonation.com 2011). By minimizing the amount of compensation received and emphasizing that it does not serve as the primary motivation, the surrogate and egg provider process becomes framed less as financial transaction than as “family-building endeavor” (Markens 2011: 2). The patient testimonials of egg providers and surrogates reinforce the naturalness of using NRTs and the benefits of being an egg provider or surrogate, regardless of the medical side effects and physical and emotional care work involved. Care work is often associated with women and afforded low status (Fine and Glendinni 2005). This is underscored by the fact that only women can provide eggs and become surrogates for others. Women are positioned biologically able to provide their eggs or become surrogates for couples and discursively portrayed as natural caregivers, self-sacrificing and altruistic in their desire to help others.

Additionally, when medical brokers and fertility specialists screen a woman applying to become an egg provider or surrogate, they frame this process solely in terms of easing the concerns of the intended parents and ensuring they are purchasing high quality eggs and hiring a caring surrogate who is healthy enough to give birth to a baby. All medical broker and fertility clinics that have egg donor or surrogacy programs advertise that potential egg providers and surrogates go through an extensive medical and psychological exam before they are admitted to the program. For instance, Surrogacy Abroad (2011) states that their “information gathering processes are effective” and surrogates go through an “extensive medical and psychological history about herself and her family” so that the agency “may gain insight into their personality and medical problems”. Thailand Fertility (2012) advertises their surrogacy program as having “a very high success rate thanks to a careful assessment of potential surrogates.”

Globally, all potential surrogates and egg providers undergo an intensive screening process with a very detailed questionnaire. This includes questions concerning their physical appearance (i.e., face shape, skin colour, body weight), educational background, personal attributes, reproductive history (i.e., date of first period, past pregnancies, and/or abortion), talents, number of sexual partners, medical illnesses, alcohol/drug abuse, and family health/illness history. This is followed by a medical examination including testing for infectious diseases such as HIV and Hepatitis B and C, and drug use. ELITE IVF (2012) also ensures,

that our donors are prescreened and evaluated for their medical, social, and psychological features, and must be found clear of any genetic or infectious

diseases. Donors must be in excellent health and of **proven fertility potential** (my emphasis) in order to provide the intended parents with the maximum advantage for reaching a pregnancy and ELITE IVF ensures that a great focus is placed on donor quality.

www.elite-ivf.com (2011).

A woman's ability to produce multiple eggs is stressed on the medical broker and fertility clinic websites in order to guarantee reproductive tourists that they are purchasing high quality eggs. Similarly, www.eggdonation.com (2014) notes,

Intended parents frequently thank us for presenting them with such spectacular donors...the number of donors who qualify for this program is limited because we choose only **super donors** (my emphasis) with outstanding fertility who make a large number of **high-quality blastocysts** and have **extremely desirable qualifications** (my emphasis).

Other qualities the fertility clinic and medical brokers screen for include, "an attractive, intelligent, accomplished young woman", and a "person who has a kind and caring heart and wants to help a loving family" (www.eggdonation.com 2011). Similarly, Egg donation Inc. website describes the perfect qualities of an egg donor as "a bright and attractive woman between ages of 20 and 30 yrs, of any ethnic background, preferably having earned a college degree or presently pursuing a college degree and is in excellent health."

Most medical broker and fertility clinic websites depict hegemonic norms of femininity (youthful, polite and altruistic). Other fertility clinics extend these norms of

femininity, assuming that good women donors only have heterosexual partners. For instance, the Egg Donor Centre requires that donors have specific sexual practices and attitudes. Egg providers “must not have had any sexual contact with homosexual, bisexual men or women at this time or any time in the past” and are advised by fertility clinic staff “to be extremely polite to the nursing staff and to be on-time for your appointments.” These non-medical requirements define a good egg provider as women who have stereotypically feminine traits of obedience, passivity, and good-naturedness. Research by Almeling (2008) also found that the ways in which egg donation is marketed reinforces assumptions about gender roles and ideologies. She noted that class, education, gender and sexual orientation played a role in the monetary value of eggs. For instance, the fee that U.S. egg providers are paid vary according to their experience and level of education.

In egg donation, reproductive tourists can buy gametes based on the physical and social characteristics of egg providers, which can include the women’s age, body shape, and ethnicity. Reproductive tourists make choices about the egg providers who are “socially classified on the basis of the presumed genetic heritage, skin colour, body type, height, class background, age, educational achievement and the physical appearance of children they have produced” (Twine 2015: 39). Daniels and Heidt-Forsythe (2012: 720) further contend that the “unregulated free market in [NRTs] has produced a form of gendered eugenics that compromises choice for donors and exacerbates hierarchies of human value based on stratified norms of race, ethnicity, economic class and gender”. Gendered eugenics is defined as the “social practice of ascribing superior human traits to those who most closely match Western ideals of

masculinity and femininity for the purpose of human reproduction” (Daniels and Heidt-Forsythe 2012:720). In creating an individual description of the egg provider based on genetic and non-genetic characteristics, the medical broker and fertility clinic screening process surveils and objectifies each egg provider as an individual case. The fertility clinics and medical brokers seek to gain knowledge about and judge the potential egg provider, producing a normative subject whose description can be marketed and consumed.

According to Twine (2011), national and colonial histories are a part of the selection process used by reproductive tourists in selecting women who are egg donors. Even though gametes do not “possess skin colour, their value is interpreted within hierarchies that privilege specific social characteristics” (2015:39). Researchers have noted that skin colour “is a form of symbolic capital that has exchange value” (Twine 2015: 39). For example, light or white skin colour of women who are egg providers can be viewed as having a high socioeconomic status.

The websites that market egg donation often collapse genetic and non-genetic traits such as religion, hobbies, values, likes and dislikes, educational level and occupation into a package that can be purchased by reproductive tourists. Reproductive tourists, medical brokers, fertility specialists and medical staff are invested in what Rapp (2001: 43) calls “geneticization” or “the extreme reduction of all problematic differences to an individual and genetic basis.” Therefore, genes are held “accountable for a vast array of individual attributes including physical features as well as more amorphous qualities” (Harrison 2012:127). Describing egg providers by their lifestyle behaviours and perceived attractiveness produces a hierarchy of desirability

among egg providers. Reproductive tourists are able to make their own assumptions of the egg provider's desirability based on their access to the narratives, images and videos on the medical broker and fertility clinic websites.

Egg providers and surrogates from India, Thailand, Turkey and Eastern European countries are also screened for appearance and medical and psychological illnesses. A fertility clinic in India advertises the criteria for selection of surrogates.

They note,

the surrogate mother should be no smaller than 1.60 meters (5'3" and should weigh between 50 and 60 kilograms (110 and 132pounds). She should be married, have her own children and a regular period, be free of sexually transmitted and hereditary diseases, be tested for ovarian problems and chromosomal analyses, be emotionally stable (Schulz 2008: 5).

Indian, Thai and Turkish surrogates must also have children of their own to show that they can carry a pregnancy to term and be nurturant mothers as well as showing the intended parents that they have their own children and do not wish to keep the child. As Pande (2010: 976) argues,

the surrogate is expected to be a [docile], disciplined contract worker who will give the baby away immediately after delivery without creating a fuss. But she is simultaneously expected to be a nurturing mother attached to the baby and a selfless mother who will not treat surrogacy as a financial contract or a business.

Therefore, the perfect surrogate is a woman who is constantly aware of her contract obligations to the intended parents and also emotionally bonds with the fetus.

Furthermore, once a woman is screened into an egg donor or surrogacy programs, her body and behaviour are extensively monitored. For instance, ELITE IVF (2012), a medical broker maintains that

once a pregnancy is attained, the surrogate is closely monitored throughout her pregnancy. She attends all ultrasounds and tests, as previously determined in her agreement with the intended parents. Her continued health and over all care is of the utmost importance and the surrogate is continually monitored to ensure that her pregnancy is carrying well.

Questions about diet, lifestyle and exercise routine are common in surrogacy applications and they are often followed by specific questions about drug and alcohol use. These questions assume that the surrogate has the potential to affect the fetus through the environment of the womb. Many feminist scholars have drawn connections between representations of the womb as an “environment and the erasure of the woman as the primary agent and patient in a pregnancy” (Harrison 2016: 148).

Surrogates from India, Thailand and Turkey just to name a few, also have their pregnant bodies monitored. Ethnographic research done by Pande (2010) and Bailey (2011) note that Indian surrogacy workers experience little to no autonomy during their contract pregnancies. Some Indian fertility clinics have hostels where nurses and nutritionists attend to surrogates’ daily needs. By signing a contract with the fertility clinic, the surrogate worker agrees to move into the hostel and avoid sexual intercourse with her husband during the pregnancy. While women have fewer work responsibilities in the hostels, their daily activities are monitored and they follow a strict daily routine.

When surrogate Indian mothers are expected to live separately from their families, “their own desires—to be near loved ones, to walk around their neighbourhoods are devalued against the risk of any behaviour that may harm the fetus” (Pande 2011: 622). While Western reproductive tourists pursuing surrogacy in India may expect the surrogacy agency to provide housing and assume the surrogate will enjoy living in new a new city and home, Deomampo’s (2016) research revealed that many women experience higher levels of stress and anxiety because of restrictions on their mobility and separation from their families. According to Pande as cited in Bailey (2011: 721), “surrogate dormitories do serve a regulative and disciplinary function to produce [...] a healthy, docile, mother-worker subject.”

In surrogacy, both in North America and abroad, reproductive tourists and fertility specialists’ temporarily own a woman’s body. The woman is specifically referred to as a gestational carrier not as a woman and her legal rights are subservient to that of the genetic parents. For example, a medical broker in the United States who facilitates the commercial contracts between reproductive tourists and surrogates in India emphasizes consumer choice among reproductive tourists in terms of offering embryo reductions and impregnating multiple surrogates. This website states “it is up to you [reproductive tourist] to decide what you wish to do, you can choose to have all the children which will cost slightly more of course...or you can request an embryo reduction.” This medical broker also advertises an “Indian Bundle” which involves impregnating two surrogates at the same time to increase “the odds of pregnancy by more than 60 per cent” (www.passportmedical.com 2012). If both surrogates become pregnant, the reproductive tourists have the option to decide if they want all the babies or an abortion.

Surrogates do not have any control of the embryo transfer and as a result of contracts, forfeit the independent ability to terminate or continue pregnancies.

Often, women deciding to donate their eggs or become surrogates is not based on having all the information about the medical side effects of the fertility treatments nor made “in absolute freedom” (Gupta 2012: 46). The decision to become a surrogate or egg donor is made in a context of “limited possibilities for oneself due to rising unemployment, lack of financial resources and circumstances not under one’s control” (Pande 2010: 980). As Scheper-Hughes (2001:5) propose,

those living at the margins of the global economy, who are daily assaulted by disease, hunger and premature death and by degrading living and working conditions and for whom the experiences of bodily alienation is already a defining feature of their daily lives, the possibility of selling [body parts] seems like an act of empowerment.

NRTs and reproductive tourism are challenging the notion of choice as a central tenet of reproductive rights. The right to control or choose one’s fertility is very different than applying more commercial notions of choice (Gupta 2006). Considering the class, race and geographical divisions between women who benefit from reproductive tourism and those who are exploited by it, the arguments about the right to sell body parts and labour are based on Western notion of individual choice. The social and economic contexts that “make the ‘choice’ to sell eggs or become a surrogate in an urban slum of India or Thailand is anything ‘free’ and ‘autonomous’ one” (Mohanty 2013: 43). The idea

of consent is problematic for women who may have no option other than to sell their eggs or become surrogates due to financial constraints.

Some individuals are able to achieve their desires of genetic parenthood, often through reproductive tourism while others cannot. Poverty and the lack of economic resources may limit access to NRTs and fertility clinics. The playing field of NRTs is uneven in term of the political and economic power those different nations wield in the global market. Inhorn and Van Balen (2002) argue that women in “developed” nations frequently fail to appreciate the extent to which they contribute to the economic and political oppression of women and men in “developing” nations. Also, the production of a tourism culture functions differently for North American and European tourists and has different implications for women according to their racial, class, ability, and national status in “developing” countries. It also differs among those who are hospital workers, chambermaids, domestic workers, cooks, sight-seeing guides and who become egg providers and surrogates for reproductive tourists. Women do not have the same opportunities as men for making money. Women with low education, low or no income or in low-paying, low status jobs, may choose to become surrogates or sell their eggs in order to monetarily sustain themselves and their families both in North America and abroad. For instance, women living in the United States may legally participate in surrogacy arrangements and sell their eggs in order to provide financially for themselves and for their families or to pay for their post-secondary education. For the most part, “developed” countries remain the consumer, while “developing” countries continue to be the main source of gametes and supplier of services such as the case of transnational surrogacy and egg providers.

To mask the unequal power relations that exist between women from “developed” countries and those from “developing” countries, egg donation and transnational surrogacy is often framed on these websites as an opportunity for gendered empowerment whereby becoming a surrogate can vastly improve Indian, Thai, Turkish and Eastern European women’s and their families’ lives. Transnational surrogacy is framed as mutually beneficial to all parties involved. This language raises the contractual and financial transaction beyond the scope of services bought and sold and into the realm of a gift exchanged (donation) between women who are helping one another. Depicting transnational surrogacy in terms of women helping women across borders masks the labour that is involved for these women and masks the unequal global power relations between women. The strategic use of gift (donation) and women helping women narrative obscures disparities of wealth and power between women.

Visual Representations of Egg Providers and Surrogates

The visual imagery of egg providers and surrogates on the medical broker and fertility clinic websites is distinctively different among North American and Indian, Thai and Turkish websites. North American egg donors and surrogates are depicted as young and attractive women whose entire body, from head to toe, is framed against a light blue or pink background. Beside their picture is usually a short caption stating how “lucky and proud” they are about their role.

The egg provider profiles on the North American websites also have multiple pictures where reproductive tourists can compare the “description of the donors to their pictures as a way to verify the information that the donors present and also imaging how these characteristics could take form in their own future children” (Harrison 2012: 139).

As Petchesky (1987:269) notes, images “have the capacity to assume two distinct meanings, often simultaneously: empirical and mythical meaning.” For example, visual images of egg providers provide proof of the physical features of egg providers and provide an idea of what a future child may look like.

One unforgettable image is from a surrogate on an US medical broker website. The surrogates’ body is positioned in the foreground against a dusty rose background. Her left arm covers her exposed naked breasts while a pale pink silk fabric is draped across her exposed swollen, round belly. Her long wavy brunette hair is tucked behind her ear with a white daisy. She looks seductively into the camera. Beside this image of the surrogate are pictures of her with her family (partner and children) as well as late-term pregnancy photos with a vast swollen belly. According to Harrison (2016), images of the surrogate with her family may frame her claims of altruism because the discursive imagery of motherhood as being self-sacrificing is seen as going hand in hand. Visual images of surrogates as good, altruistic and self-sacrificing mothers emphasize the discourse of women helping women and well as being nurturant and caring mothers which naturalizes the surrogacy process.

On the other hand, the pictures of Indian, Turkish, Thai and Eastern European surrogate women do not show their faces and the pictures are usually cropped in to focus specifically on their naked pregnant bellies against a white background. Indian, Turkish, Eastern European and Thai surrogates are not shown with their families or where they live. One particular photo of Indian surrogate women depicts five women standing in a row facing the camera. We do not see their faces; in fact, we do not see their entire body, only different shades of naked brown pregnant bellies. Other images

of Indian surrogates are focused on belly shots, where they are wearing colourful red and golden saris, exposing their naked swollen bellies, leaving their heads out of the picture. One possible reason the image only shows pregnant bellies is due to India's stigmatization of surrogacy. Pande (2010) argues that women who become surrogates experience a high degree of stigma and as a consequence, the women may choose to keep their surrogacy a secret from their community. DasGupta and Dasgupta (2010: 76) further contend, such images "encourage in the viewer to gaze the pregnant woman with Orientalist possibilities in which the faceless body of the pregnant surrogate is very literally unable to look back."

The female body is constructed as a commodity in terms of images of decontextualized body parts which encourage women to consider their own bodies as assemblages and fragments (Speier 2016). For instance, four websites present a set of images, each of an isolated body part set against a blue or black background as if floating in space. Clicking on an image leads to a specific group of options such as clicking on an image of a woman's torso reveals a group of fertility treatments including IVF, GIFT and surrogacy. The decontextualized images work together with rhetoric of free choice and individualism to create an illusion that using NRTs is both normal and an expression of one's own freedom. Furthermore, we cannot look at the labour and care these women perform in isolation from their social, economic and cultural context which shapes their experiences (Parry 2015).

The idealized image of the egg provider and surrogate as young, attractive and compliant is also detached from local contexts of meaning. As Smith (1993) notes, the same meaning of the image can occur simultaneously in multiple and temporally

disjoined settings. The types of clothing, hairstyling, makeup and the lighting and background take on textual properties. They are to be “read, interpreted and not merely seen by the viewer” (Smith 1993:131). The soft tone background of the image, the pink and white flowers worn by the egg donor and surrogate, the delicate silk fabric draped across the pregnant belly of the surrogate, the angel’s wings positioned on the naked back of the egg providers, the red and gold saris worn by Indian surrogates are to be read as feminine. The range of colours, the pinks, whites, creams and the softness of the silk fabric that blurs boundaries and surfaces all code for femininity (Smith 1993). In fact, the terms I draw upon to describe these pictures is knowledge of a code. The softness in the discourse of femininity expresses “a tenet of its doctrine—the feminine woman is yielding, pliant and compliant” (Smith 1993:132).

The images of egg providers and surrogates distributed throughout the websites are virtually consistent for every local site in which they occur. For women and men, wherever they are, with their different social locations, different economic circumstances, and with their different bodies, the normative images are the same as it is for women and men anywhere the medical broker and fertility clinic websites reach. Regardless of the “complexities of the relations that their working lives may create, their relations to one another and to men are mediated by the standardized of visual norms organized by this discourse” (Smith 1993:131). In other words, the discourse of femininity portrayed by visual images of egg providers and surrogates act a normative reference point for the reproductive tourists. The egg provider and surrogate are conceptualized in a highly feminized way— compliant, yielding, self-sacrificing, nurturant and attractive. The idealized image of an egg provider and surrogate

constructs an appearance of the “woman who is desirable; not the woman who desires” (Smith 1993: 131). The woman is as an object to the viewer and the reproductive tourist, and she is an object that can be marketed and purchased.

Conceiving the discourse of femininity as actual activities arising in specific local contexts and under specific economic conditions, rather than solely in the realm of meaning, directs our attention to the political economy (Smith 1993). Femininity can be explored as a set of relations arising in local settings without segregating it from the economic and social relations in which it is embedded. The medical broker and fertility clinic websites work as a commodified, virtual global marketplace which offers standardized images of the surrogate and egg provider, portraying them as having attractive bodies and as compliant caring labourers with the hopes and desires of reproductive tourists of wanting a baby.

The gap between the standardized discursive images of the egg donor and surrogate as fertile bodies (egg production and healthy womb) and the imperfect infertile bodies of the reproductive tourists as discussed with the patient testimonials generates a story of hope and desire. The images of egg providers and surrogates acts as a reminder for reproductive tourists of their own imperfect bodies and childlessness and as empowered consumers, reproductive tourists can take action toward achieving their desire for a child. The standardized discursive images of egg providers and surrogates displayed beside the written narratives of the egg providers and surrogates on the medical broker and fertility clinic websites act together to reassure reproductive tourists that their main motivation is altruistic, a desire to help childless couples and any physical or emotional harm experienced by these women is diminished because a

“candle loses nothing by lighting another candle” (www.eggdonation.com 2013).

Reproductive tourists enter the “discursive organization of desire, now they have an objective where before they had only a defect” (Smith 1993:131). Reproductive tourists can return again and again as consumers to medical brokers and fertility clinic websites in the hopes that the medical broker and/or fertility specialist will remedy their childlessness. It is a global market of body parts, gametes, surrogates, egg providers, hospitals, medical brokers, fertility specialists, reproductive tourists, hotels, restaurants, tourist and pharmaceutical companies.

Dominant Discursive Framing of NRTs

Despite their highly personalized and often intimate forms, most website patient testimonials and visual images by women who provide their eggs and surrogates project a voice of every woman, with little or no attention to the geographical locations of individuals and the context of their lives (McNeil 2007). These stories presuppose and mobilize a discourse—a universal desire to reproduce and there is never any questioning of that desire. The use of NRTs is structured around the personal choice of individuals and couples for whom genetic parenthood is a right and they are considered as having a legitimate need for assistance (Michele 2007). The egg provider and surrogate testimonials and images highlight the gendered altruistic experiences of these women with no reference to the labour they perform or the potential short- and long-term medical side effects of egg donation and surrogacy. In fact, the highly intrusive questionnaires and medical procedures egg providers and surrogates must go through and the surveillance of their behaviour and bodies by the fertility clinics along with the standardized images of egg providers and surrogates all erase these women as

subjects. Their desires, hopes and daily experiences are erased from view. What are dominantly framed throughout these websites are the needs, desires and social contexts of reproductive tourists. The narratives of reproductive tourists focus on the plight of infertile couples, their heartaches and the enormous amount of money they have already spent pursuing fertility treatments, while the “surrogate and egg provider are made invisible and their subjectivity subverted” (Das Gupta and Das Dagupta 2014: 43). I have documented, how at every level of inquiry and in each questionnaire and each medical procedure, the usage of standardized discursive images of egg providers and surrogates and their narratives produce different levels of erasures of women who provide eggs and become surrogates.

The websites actively frame issues in ways that legitimate particular understanding, while simultaneously excluding or downplaying other possible explanations, thereby narrowing the scope of public debate. For example, a medical broker in the US notes, “surrogacy is clouded with controversy. We here at New Genetics Global Limited are not here to debate the ethics, but rather to present safe and viable parenthood alternatives” (www.newgeneticsgloballimited.com 2016). As Sarah Franklin (1993: 524) writes, “dominant cultural representations...have become key sites of struggles over the meanings through which reproductive politics are defined.” Larger debates about the ethical concerns of traveling to another country for fertility treatments are crowded out by the focus on real life stories of individuals struggling to overcome infertility or to gain access to services currently unavailable in their home jurisdictions. The highly personalized patient testimonial format makes it possible for reproductive

tourists to identify with other 'infertile' journeys and offer possible solution to achieving their desires of having a child.

Having universalized the personal experiences of a few in this way, the medical broker and fertility clinic websites imply that the only relevant concerns is that of how such technologies might benefit these particular individuals and couples and scarcely acknowledge the women who provide their labour and biological/genetic material for NRTs. They are subsequently erased from view. Michelle (2007) argues that one consequence of this portrayal is that it emphasizes infertility and childlessness as primarily a financial constraint rather than a failure of NRTs which "continues to have a relatively low success rates among many, particularly older women" (2007: 651). Also, questions surrounding the economic and political contexts in which these medical services are promoted and marketed are ignored. The context of healthcare reform during the last 30 years such as underfunding of the public health care systems, increased privatization, and the increase commercialization and personalization of health care services are not discussed on the websites, except as reasons to use these clinics.

Conclusion

The medical broker and fertility clinics' marketing strategy on the Internet creates a new social space for products and services between medicine and consumer culture. The ability for the reproductive tourist to make an informed choice to go abroad for fertility treatments is hampered because these websites portray going abroad for NRTs in simplistic linear steps without discussing the complexities of travelling abroad, such as the short-term and long-term side effects of fertility treatments and the unpaid labour

of caregivers. While, these consumer- friendly websites provide reassurances about the quality of treatments and qualifications of clinicians through the use of patient testimonials, questions-and-answer links, pictures and videos of pristine, technologically advanced fertility clinics, these websites remain largely unregulated. This approach serves to gloss over the practicalities, seriousness and risks of fertility treatments for reproductive tourists and the women who provide their labour and biological/genetic material for NRTs. These websites ignore the unequal global, economic power imbalances between reproductive tourists and egg providers and surrogates and the exploitation and oppression of these women. Larger debates about the ethical concerns of traveling to another country for fertility treatments are crowded out by the focus on real life stories of individuals struggling to overcome loss or gain access to new reproductive services currently unavailable or illegal in their home countries. Reproductive tourism is constructed as a straightforward endeavor, ignoring the ethical, economic and political contexts in which these medical services and reproductive technologies are promoted and marketed.

Chapter Eight: Conclusion

Addressing the Research Challenges: Strengths and Opportunities of the Study

My dissertation research seeks to understand the ways in which market-based reproductive health services are advertised and virtually represented on a global scale. I also explore the implicit values and assumptions of the reproductive tourism's website content. In doing so, I show how medical broker and fertility clinic websites reproduce dominant ideologies and how these websites portray reproductive tourists, egg providers and surrogates. Using a feminist political economy approach, I situate the practice of reproductive tourism within particular historical, economic and political contexts stressing the neoliberal healthcare reforms both domestically and globally.

Neoliberal economic reforms have resulted in the movement of care work and NRTs across borders, entrenching global economic inequalities as wealthy nations recruit cheaper workers. Global economic reforms and trade agreements seek to protect and expand capital, encouraging privatization and commercialization of health and care. In the Canadian context, the vast majority of fertility treatments including NRTs have developed under neoliberalism and are primarily delivered in private for-profit medical clinics, where the cost of fertility treatments is high compared to those offered in "developing" countries. The neoliberal ideological influence in healthcare also shapes how we view patients. The change in terminology from patient to consumer corresponded with the emergence of a new active subject. Health consumers are portrayed as self-actualizing, autonomous social agents who cannot be subordinated to the health professionals and "are capable, with adequate information, of formulating their own intentions, deciding their own preferences and wants and making choices

about their health” (Rose 2006:21). As feminist political economists argue, healthcare systems and policies are not neutral or random, rather they result from particular social and historical processes and are based on particular values about governments as well as about individual responsibility and rights to care (Armstrong and Armstrong 2010; Corburn 2001; Vosko 2003). Individuals traveling abroad for fertility treatments are seen as consumers using the Internet to research the best options for obtaining NRTs abroad. In relations to social goods in this case, healthcare, citizens are no longer assumed to have rights but are viewed as consumers of services to be accessed through market-like relations.

I have also argued that the use of Web 2.0 technologies by website owners and developers creates a confusing virtual space of different hyperlinks, texts, images and videos in which the boundaries among patient’s experiences, company presentations, advertisements and scientific information are systematically blurred. These websites are specifically designed to sell their health and non-health services to prospective consumers. They assemble a glossy promotional package of medical treatments that includes staying at 5-star resorts and taking in local tourist attractions. These websites produce a discursive narrative that juxtaposes private for-profit hospitals in other countries as offering reproductive tourists personalized, patient-centred care compared to a Canadian health system that is overwhelmed and impersonal. The sensible ideas of viewing patients as whole persons, being attentive to their needs and allowing them some say in their care have been appropriated by medical brokers and fertility clinics to market their services to reproductive tourists. The social capital necessary to engage effectively with the medical discourse and practices is linked to the social positioning of

reproductive tourists; the capacity to take charge of one's health is inequitably distributed, accruing in particular consumers with class privilege.

Furthermore, the extensive use of patient testimonials gives an optimistic portrayal of NRTs, offering hope to those who are assumed to have little or none. The power of hope fuels expectations for NRTs to solve individual's childlessness. The inclusion of positive depictions of fertility treatments and care reproductive tourists receive abroad only provides a snapshot in time that works to decontextualize fertility treatments and reinforces the seemingly miraculous qualities of NRTs. The information provided on these websites is geared more towards promotional and marketing ends rather than to helping inform patients of potential short-term and long-term risks of receiving fertility treatments abroad. This asymmetrical portrayal of risks and benefits leaves an overall impression that reproductive tourism and fertility treatments are safe and readily available to individuals who can afford them and that the NRTs have a high success rate.

Interrelated with such issues of choice and decision-making are fundamental questions of how trust and the credibility of information are established and maintained in light of the risks and uncertainty with regards to seeking fertility treatments abroad. Given that informed consent requires a comprehensive understanding of their condition, the success rate of a given NRT, the treatment options and the risks of complications prior to their fertility treatment, these websites raise concerns about whether reproductive tourists are always in a position to give informed consent to the medical procedures and care they receive abroad based on the information portrayed on these

websites. This approach serves to gloss over the practicalities, seriousness and risks of fertility treatments for reproductive tourists.

The information provided to potential egg donors and surrogates on these websites also does not discuss the complexity of these medical procedures or address the conditions under which they provide their labour and biological, genetic material for NRTs. The websites studied for this dissertation do not address any ethical and social concerns surrounding the exploitation and commodification of women's bodies or the unequal power relationships between reproductive tourists in the global North and these women in the global South. I argue that the gap between the standardized discursive image of egg providers and surrogates as highly fertile bodies (egg production and healthy wombs) and the imperfect bodies of the reproductive tourists generates hope and desire among reproductive tourists. The standardized discursive images of egg providers and surrogates act as a reminder for reproductive tourists of their own imperfect bodies and tell them that as empowered consumers, reproductive tourists can take action towards achieving their desire for a child. The written narratives of egg providers and surrogates further reassure reproductive tourists that the main motivation of the providers is altruistic and any physical or emotional harm experienced by these women are diminished.

Significance and Contributions of my Research Findings

My research offers some important contributions to prior research and scholarship. First, while traditional print media have been critically studied for their representation of the illness experience, studies of health and illness on the Internet have tended to focus on personal blogs, online support groups and other virtual

communities as a source of textual and narrative analysis. However, little research has detailed the marketing strategies of medical broker and fertility clinic websites and how they incorporated healthcare discourses. My research highlights how neoliberal healthcare reforms at both the local and global level contribute to the privatization of and commodification of NRTs, particularly as they are portrayed on a virtual global scale, linking medicine and consumer culture.

Second, my research study contributes to existing feminist literature on NRTs in terms of the exploitation and commodification of women's bodies in this new global, medical marketplace. My research adds to the growing body of literature on transnational feminism and on feminist political economy to understand how the social reproduction of life through labour, care and biology on one side of the world can serve to support life abroad. Studies on transnationalization of reproduction, for example, reveal new patterns of female migration, kinship structures, labour and childbearing that empowers those already privileged by gender, race, class, nationality and immigration status at the expense and exploitation of others. My research shows how globalization forces us to push the levels of analysis up, beyond the state and to link these developments to individuals seeking NRTs.

Increasingly women's bodies are seen as economic capital under conditions of neoliberal economic globalization. I demonstrate how this is achieved by looking at the representation of the egg providers and surrogates on the websites and looking at how egg providers and surrogates' labour is largely invisible part of this biological reproduction. I argue, along with others, that women who provide their biological material and become surrogates are engaged in a form of labour, even though the term

labour is not used in these contexts. It leads me to explore the stakes involved in understanding egg providers and surrogates whose labour occurs primarily through biological and care work processes as capitalist labour power. What are the social and ethical consequence of dominate discursive narratives which effectively erase the labour and care these women perform on a daily basis? The websites actively frame issues in ways that legitimate particular understanding of NRTs, while simultaneously excluding or down playing other possible explanations, thereby narrowing the scope of public debate. The use of NRTs has been turned into an act of consumption and globalization widens the market and pushes reproductive decision-making into a global stage.

Third, my dissertation makes a contribution to the limited methodological literature by using Smith's (1995) concepts of discourse, text and intertextuality to study websites. A strength of Smith's analysis is that texts and its discourses are viewed apart of social life, located in our daily activities and routines and "such analysis has the capacity to show the power relations of apparently neutral and visual discourses artifacts" (Luke 1997:51). Discourse can bring about change in our beliefs, values and activities. One can also argue that prolonged exposure and experiences of advertising and other commercial texts contributes to shaping peoples' identities as consumers and to their gender identities. Since reproductive tourists' first engagement with reproductive tourism is likely through information provided on the medical broker and fertility clinic websites, it is important to explore how their identities as well as the identities of egg providers and surrogates are constructed there. The language, images and videos used to portray these various actors can enter into the language and text of

government policies and popular culture. In essence, these discursive constructions can shape how we view and talk about reproductive tourism. Additionally, I became very aware that there was limited research documenting how one goes about analyzing the text of websites with its multimedia platform and numerous hyperlinks. It was difficult to locate other studies that detailed how to critically engage with images and videos on websites and their various uses of colours, framing and sound. I hope that my dissertation research offers a modest contribution to this literature and provides a roadmap for future studies.

There are also limitations to my research. Since the object of qualitative research is not generalizability but transferability, sampling texts, images and videos of the websites does not need to ensure that all websites being analyzed have an equal or predictable probability of being introduced in the sample. In my thesis, I do not claim to represent the entire ways in which NRTs are virtually marketed on a global scale. However, what I can offer is a snapshot into how NRTs are marketed on specific websites and how medical brokers and fertility clinic personnel on these websites use and appropriate healthcare and neoliberal discourse to market their services, viewing them through a feminist political economy lens. I also do not know how reproductive tourists interpret or make sense of the information provided on the websites or the order in which they view these texts in terms of utilizing different hyperlinks to read about patient testimonials, the mission statements or the health and non-health services offered by medical brokers and fertility clinics. The goal of my analysis was to situate these websites within specific social, economic, political and historical contexts and as such I do not claim to generalize my findings to tourist's own viewings.

Future Directions and Recommendations

An increasing number of Canadians are turning to NRTs to grow and build their families. A 2012 Canadian study (Brushnik, Crook, Tough and Collins 2012) found that infertility is on the rise in Canada, with roughly 16% of heterosexual couples experiencing it. In addition to rising infertility, the trend of delaying marriage and parenthood, scientific advances in cryopreserving ova (eggs) and the increasing use of NRTs by LGBTQ2 couples and single parents to build a family are all contributing to an increase in the use of NRTs. And now, there is an option for Canadians is to travel abroad to seek out viable options to building their families.

First, I have demonstrated that these medical broker and fertility clinics websites based in North America and around the world present a sterilized picture of the complexities of travelling abroad for fertility treatments in terms of the medical side effects of NRTs and the actual success rates of these technologies while understating the amount of time, energy, labour and care necessary to travel abroad. If patients are indeed viewed as empowered consumers able to take charge of their healthcare needs, it is imperative that the information presented on these websites is presented accurately and that universally defined success rates of NRTs are agreed upon among fertility clinics in order for reproductive tourists to compare success rates across clinics and borders. Furthermore, while other researchers (Turner 2010; 2012 and Culley, Hudson, Blyth, Pacey and Rapport 2013) have discussed the development of global standards/guidelines of NRTs, it may be difficult to achieve given the variability of regulations of NRTs. At a minimum, guidelines should be put in place to ensure that informed consent is given by egg providers, surrogates and reproductive tourists. All

parties involved in this market transaction should have third-party representation or consult with physicians who are not connected to the medical brokers or fertility clinics. The amount of medical literacy needed to engage with these websites and research treatment options in other countries is immense. An open dialogue among individuals choosing to go abroad and healthcare professionals in Canada is needed to address the gaps in information about what it is actually like to go abroad for fertility treatments. This open dialogue on reproductive tourism should also include the social and ethical concerns around the conditions in which women who are egg providers and surrogates perform their labour and care.

Second, although my dissertation addresses the regulatory framework of NRTs in Canada and discussed how these websites used positive language to advocate for a deregulatory market for NRTs globally, I have not discussed the legal issues individuals may face in terms of obtaining citizenship status for their genetically-linked children born outside of Canada. Further research is necessary to highlight these difficulties. Also, there is little research on how many Canadians travel abroad for NRTs and the follow-up care they receive in Canada. Because most of the literature focuses on Canadians going aboard for medical treatment and not on reproductive tourism, more research is needed to document the social and economic conditions under which Canadians travel for NRTs and the impact of their follow-up care on the Canadian healthcare system.

Third, a few provinces in Canada such as Manitoba, Quebec and Ontario either offer tax rebates for in vitro fertilization (IVF) or fund one cycle of IVF under provincial healthcare insurance plans. As previously stated, there is a trend in Canada to delay parenthood due to pressures such as financial concerns and accessing affordable

childcare. According to the biomedical literature, as women and men age, their chances of having biological children decreases. Therefore, other government policies can address issues of delayed parenthood by introducing, for example, comprehensive affordable childcare plans and increasing the childcare spaces offered across Canada.

Finally, reproductive tourism and the marketing strategies used by medical brokers and fertility clinics on these websites do not occur in a vacuum and are part of the social, economic and political fabric of Canadian society, including the healthcare system. Further research can address how the same marketing practices are being introduced and used to argue for the further privatization of the healthcare system in Canada. For instance, there are private companies in British Columbia, Ontario and Quebec offering Canadians boutique healthcare services where, for an annual fee, Canadians can have continual access to a family physical or registered practical nurse through the use of apps and online services. Private companies are selling their services as patient advocates helping Canadians maneuver through the healthcare system, attend specialist appointments and consult on a variety of healthcare concerns. However, if we are truly committed to supporting individuals' health and their ability to start families, the findings of this thesis suggest that instead of focusing on ways to privatize healthcare and offering personalized boutique medicine, we need to increase public investment in healthcare and recognize the messy context of peoples' lives and provide care that addresses this complexity.

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