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# "I WANT a BABY; DON'T STOP ME from BEING a MOTHER": AN ETHNOGRAPHIC STUDY on FERTILITY TOURISM and EGG TRADE

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**ABSTRACT** **The increasing demand for human egg cells has led to reproductive tourism and a transnational egg trade. The activity flourishes due to poverty and criminality, as well as medical needs (infertility) and cultural needs (the dream of parenthood). Other factors are fundamental concepts, such as the view of the body as an object of utility and value. This article aims to go behind the normative discussions that usually surround different forms of assisted reproductive technology (ART), fertility tourism, and the egg trade. It further calls for an understanding of how the local, culturally embedded use of reproductive technology is put into practice. The material,**

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**collected from Sweden, Eastern Europe, and the Middle East, consists of observations, in-depth interviews, reports from nongovernmental organizations (NGOs) and authorities in these countries, and global media reporting. I also draw on my previous research on reproductive technology and ongoing organ-trafficking fieldwork.**

KEYWORDS: egg trade, gray zones, ethnography, narrative work

## BACKGROUND

Developments in reproductive medicine have made it possible for many people with reproductive problems to become parents. At the same time, this technology also has created the need for eggs and sperm and various forms of fertility treatments. Today health-care systems in many countries offer assisted reproductive technology (ART) as a standard treatment, along with established clinical treatments. However, there is also an increase in activities taking place internationally, including legal reproductive tourism—women who seek help abroad for treatments not available in their home country but accepted in another country.[1] These activities also include the increasing quasi-legal and entirely illegal trade in human eggs.

I first came in contact with fertility tourism and transnational egg trade during my organ-trafficking field studies in Eastern Europe and the Middle East in 2009 and 2010. I was familiar with the concept owing to my previous studies on ART (Lundin 1996, 1997, 2000).[2] A prosecutor I met in Israel, who worked with several organ-trade cases, put me in touch with both poor organ sellers and people involved in the international fertility business, ranging from legal medical tourism to illegal commerce. These contacts opened the door for meetings with doctors from fertility clinics and meetings with people at the Isha L'Isha–Haifa Feminist Center, and these in turn provided me with interview material from women who had donated, sold, or intended to sell their eggs and with women who wanted to buy eggs.[3]

## PURPOSE AND METHODS

My ambition is to look more closely into the gray zone where fertility medicine, reproductive tourism, and the transnational egg trade meet. By gray zones, I refer to Carolyn Nordstrom's (2004) discussion of global shadow zones and shadow markets—places where regular shadow economies govern existence and where people, goods, weapons, money, bodies, and so on constitute components of the international market.[4] However, I use the term *gray area* or *gray zone* instead of Nordstrom's term *shadows*. The activities in this gray zone flourish for several reasons: medical needs (infertility); cultural needs (the dream of parenthood); socioeconomic structures, where



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welfare interplays with poverty and criminality; and, not least, the medical technology that makes assisted reproduction possible.

The discussion starts in critical cultural and social theory that argues that biomedical technologies are neither morally nor socially neutral but deeply influenced by medical, cultural, and political norms (Lock and Nguyen 2010: 17). Thus the dream of parenthood interacts with people's self-understanding as well as with the view of the body and how this body should be treated in the fertility arena. A broad range of studies on medicine and ART point out that one of the many consequences of being in the intersection of biomedicine and culture is that individuals might be transformed into medical objects (Corea 1985). Another, quite different consequence, to lean on Charis Thompson's discussion of reproductive technology and the construction of the self, is that the research itself that critically describes medicine's objectification of the individual might be regarded from a normative perspective; the analyses produced might consider medical technology only as a locus of discrimination that objectifies the individual and deprives her of agency (cf. Hoeyer 2009; Thompson 2005). In other words, such a perspective divides the empirical field into victims without agency on the one hand and actors and oppressive systems on the other (Agustín 2007; Lundin 2010b).

This article aims to go behind the normative discussions that usually center on different forms of ART, fertility tourism, and egg trade. Thus my ambition is not primarily to reveal victimized people and oppressive actors; rather, I want to understand how the system, maintained by a variety of players with quite different reasons for their actions, works. One way to approach this task is to see how the people involved in the system describe what happened to them and how they talk about the dilemmas that appear when fertility medicine involving a third party is put into practice in the gray-zone arena.

I have chosen, when talking in general terms about individuals selling and buying eggs, to use the words *provider* and *recipient*, with the aim to define them in more morally neutral terms.[5] The discussion revolves around the women involved in the fertility business, and I present some of these women, focusing on their narratives to understand the meanings they assign to the events in which they took part (Frank 1995; Zeiler, Guntram, and Lennerling 2010).[6] To discuss providing eggs, I present a case in the reproductive tourism industry in Romania; the case follows, through narrated experiences, some Romanian and Israeli women who sold their eggs. The next section describes how involuntarily childless women, the recipients, describe the strategies they use to achieve parenthood and the accompanying moral concerns—strategies that are sometimes within the law but sometimes also in a legal and moral gray zone. I will use the concepts of narratives to understand how people talk about their experiences and decisions (Frank 1995).



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The discussion relies on ethnography, making use of observations and in-depth interviews that are essential to ethnographic work. In my discussion, I draw on my previous research on reproductive technology starting in the early 1990s to give a longtime perspective (Lundin 1996, 1997, 2000) and from ongoing research on reproductive tourism and egg and organ trade (Lundin 2010b). I also glean from other researchers' ethnographies and from reports by various NGOs, authorities, and global media reports. The empirical data were gathered from Eastern Europe, the Middle East, and Sweden.

## PROVIDING EGGS

In 2009 Romanian authorities raided the Sabyc Fertility Clinic in Bucharest. Thirty people—buyers and sellers of human eggs—were detained. Among those arrested were doctors accused of being at the center of these illegal transactions. Three of the doctors were Romanian, and two others were from Israel. The incident has been dubbed the Romanian egg affair, and it is an illustrative example of the workings of the burgeoning reproductive tourism industry. It is by no means unique, either internationally or in Eastern Europe and the Middle East, as suggested by similar events in 2003, at the Romanian Global ART Clinic and at Global Med Rom. But police intervention at the Sabyc Fertility Clinic made the business public and further revealed in several countries the activities of medical fertility centers arranging foreign travel for women trying to purchase fertilized egg cells and have them implanted in their wombs (Darnovsky 2009; Shay et al. 2010). The providers at the Romanian clinics, the women from whom egg cells were taken, were mostly poor Eastern Europeans, including university students who wanted to pay for their studies and illiterate young Romanian women.

One of the doctors, designated as a participant in the Romanian fertility business, is the Israeli Dr. NN.[7] Besides being a respected and successful gynecologist, Dr. NN also has been associated with some gray-zone activities in Israel and in Eastern Europe, specifically at the Global ART Clinic and Global Med Rom in Bucharest. I was made aware of Dr. NN through my contacts at the Haifa Feminist Center. When I interviewed him at his fertility clinic in Tel Aviv in 2010, he denied all accusations against him and tried to turn our conversation to other topics, such as the Israeli health policy and the country's positive approach to fertility treatments, as well as his own commitment to improving infertile people's access to various forms of ART.

Regardless of his denials, the allegations against the doctor do exist, and one was mentioned by Romanian lawyer George Magureanu in a speech to the European Parliament. On June 30, 2005, the lawyer addressed the European Parliament in Brussels with these words: "I come here today to bring to your attention a very pressing matter regarding egg donation, egg harvesting, and especially a growing business in Romania, egg commerce" (Magureanu 2005).



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Magureanu was serving as the spokesman for two women, Alina and Raluca, who sold their eggs to the Global Art Clinic and Global Med Rom. These women were just two of many egg sellers involved, but the fear of being identified in the public arena made the other women silent. The payment for each so-called egg donation was US$250, while the recipients' cost was around US$11,000–$13,000. The difference was profit for the clinic. In his talk to the European Parliament, Magureanu claimed that the clinics, Global ART Clinic and Global Med Rom, were part of an international chain directed by the Israeli Dr. NN, whose purpose was to make a profit.

Alina and Raluca, the women who testified against the doctors, worked at a factory in Bucharest, where they earned US$100 a month. At the time, Alina was nineteen years old, single, and planning to marry. She had limited financial resources and a minimal level of education. She found out about the Global ART Clinic from a work colleague who had sold her eggs, and Alina's lack of money caused her to contact the clinic as a way to cover her wedding expenses. Following the egg harvesting, she had serious health problems. According to Magureanu, Alina suffered severe pain and abdominal inflammation. Further, she had frequently suffered from nausea and vomiting, calcium deficiency, cardiac instability, and depression. Raluca, the other Romanian woman, was twenty-four and had a four-year-old daughter. Like Alina, she came from a very poor background and had a low level of education. Raluca worked in the same factory as Alina and suffered medical problems in connection with the in vitro fertilization (IVF). She sold eggs twice, and after the second time it appeared that she was too weak to continue the program. Both women understood written and spoken Romanian but not well enough to fully grasp the complex medical terms being used in the information they received from the doctors.

Magureanu's efforts to help the two women and to stop Dr. NN yielded no legal results but led to several organizations and the media becoming aware of the events. The task force, Women and Medical Technologies, operating under the auspices of the Isha L'Isha–Haifa Feminist Center, was one NGO that paid attention. This NGO had preexisting information that Israeli doctors, among them Dr. NN, were involved in the Romanian fertility business and that Israeli women were illegally flown to Cyprus to have their eggs removed in exchange for payment. They decided to investigate the truth of the allegations and sent an Israeli student, Moran, to Dr. NN. Moran pretended to be willing to provide her eggs for financial compensation. This event took place when Israel's law on ART permitted egg donation, but solely in connection with IVF—when a woman is undergoing infertility treatment and then decides to donate her remaining eggs. The new 2010 law is less restrictive, allowing donations for payment without IVF treatment—that is, an out-and-out sale—but still only within the country.



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It turned out that Moran, like Alina and Raluca, received insufficient information about the treatment involved in and the legal situation surrounding egg donation. During the conversation with the doctor, which was recorded without his knowledge, the following exchange occurred:

> I said: "I want to sell my eggs and I'm doing it because I need the money." At first, he asked a lot about my health, at what age I got my period, if I smoked, drank alcohol, if I had been pregnant before, weight, blood type—all of these questions. And he asked why I wanted to donate eggs—they call it donate even if they get money—and I said: "Money, I need money. But I don't want to hurt my health." (Shay et al. 2010)[8]

When Moran hesitated, arguing that she was afraid of the discomfort that might be associated with the treatment, the doctor tried to downplay the possible risks. And when she insisted on having written information, he gave her an informed consent sheet in English, even though she had told him that she read only Hebrew.

The lack of proper information and the feeling of being part of a shady transaction also concerned Anat, another Israeli woman. Anat had no connection to the Women and Medical Technologies task force. Wanting to make money to pay for her studies, she responded to an advertisement published on the Internet:

> My studies are costly. Budget-wise, I don't have any funding. . . . I have no one to turn to, and suddenly I saw this ad on the Internet and they said they would pay a lot. It's very tempting. They told me that it wouldn't hurt, just like a blood donation, like having sex with a boyfriend when there are no problems with it. They pay for the hotel, which is even better, I can just make time for it and they will fly me to the treatment center. It sounded good and I started it. (Lundin 2009)[9]

When meeting the recipient, Anat was uncomfortable with the situation; she felt that the couple was too pushy when they wanted to fly her abroad to a treatment center. Anat did not know that egg retrieval outside the country was illegal and classified as trafficking, but she suspected that she would be cheated. What finally convinced her was that the couple, as Dr. NN had done in his meeting with Moran, waved away all questions about the IVF process and whether she would suffer from any side effects. Instead, they presented the egg retrieval as very simple and similar to a blood donation. Anat decided to find out more about the process of egg donation and ultimately decided not to complete the process when she realized how physically and physiologically stressful the process was.

Like Anat, an Israeli woman named Smadar had financial motives when she contacted a well-known and well-established medical



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center in the United States. She knew that the clinic treated childless Jewish women and that the sum paid for the eggs was very high. Unlike Anat, many egg vendors at the Sabyc Fertility Clinic in Bucharest, and those in the growing surrogacy industry in India who are involved in what may be called "selling reproduction," Smadar "never regretted it." She says:

> They [the clinic] talked to me about the risks, one by one, and told me that I had a limited number of eggs and that I needed to be aware of that. I admit that, perhaps because of my age, I didn't quite get what the risks were about, but I trusted that they were reliable and professional, so I wasn't afraid to do it. What bugged me was loading my body with so many hormones. You put foreign substances into your body and that's not a simple thing to do. If it wasn't for the incredible embracing approach of the medical staff, who always told me how much I helped the recipient, and how important I was, nothing would have happened. (Lundin 2010a)[10]

The phenomenon of people trying to improve their lives by acting as vendors for financial gain is not only relevant for reproductive medicine but also significant for almost all commerce in human body parts (Lundin 2010b; Scheper-Hughes 2008). Whether it concerns eggs or organs, the vendors' actions lead to questions about society's view of the individual and her body, concerns that are also found in the experiences of the women who provided their eggs. There are similarities as well as differences in the narratives of the Romanian and Israeli women. What unites them is their intention to make money. What sets them apart is their interpretations of these experiences. Whereas Alina and Raluca from Romania and Anat and Moran from Israel describe their experiences as if they were more or less abused, Smadar emphasizes that she did something altruistic. It would be tempting to describe the women's different approaches as a matter of different legal contexts. Certainly, the fact that some were involved in quasi-legal events and others were part of a legal clinical situation determined how they were treated and the amount of information they received about the process. To understand the variations in their narrated experiences, it is necessary to look closely at the relationship between the individual and the system requiring the eggs (Shay et al. 2010; Sharp 1995).

Thompson's concepts of ontological choreography and the multiplicity of the self are useful tools to use to approach how the providers assign a meaning to the events in which they took part. Thompson (2005) argues that the subject is dependent on an ontological entwining between self and environment and that this ontological choreography—the dynamic coordination of the technical, scientific, gender, legal, political, and financial aspects that characterize most spheres of human activity, including that of ART—influences self-



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understanding. Further, and most important, this ontological entwining requires flexibility. This means that intelligible self-narratives are built on ontological heterogeneity and produce a multiplicity of selves (Thompson 2005: 179–82). It is against this background that we can consider how people involved in the fertility business interpret their experiences.

Women who sell their eggs, who undergo hormone treatments and often are defined as biological containers and egg producers, certainly are being objectified. This objectification of the body can, as has been discussed in many studies, lead to alienation (Arditti, Duelli-Klein, and Minden 1984). At the same time, however, the objectification does not necessarily reduce women's ability to act—to make them feel used or victimized. It also can be a basis for creating a meaningful conception of the self. The stories of the Israeli women Anat and Smadar illustrate how they accepted their objectification as a way of reaching certain goals and how they activated various self-images. Anat presents herself as a person with academic ambitions who has chosen to finance her studies by selling her eggs. When she suspected that she would be cheated, she dropped out of the program, to avoid what she refers to as the risk of exploitation. Smadar's story also has many layers. She also was interested in egg donation for primarily financial reasons, but she presents her selling of eggs, more or less, as an altruistic act, where the dangerous IVF treatment is compensated by the knowledge of "helping the recipient."

The egg providers' narratives work in different ways. To begin with, they make sense to the narrators themselves. In addition, these women are able to make the narratives meaningful to others. In other words, by means of their statements, they present themselves as intelligible moral subjects. That narratives are culturally embedded adds another piece to the picture; there is an ethical norm at work regarding how medical treatments, such as ART and transplantations involving other individuals, should be conducted—namely, exclusively through donation and as part of a gift economy (Cohen 2003). Most countries reject the idea of commercializing the body and do not sanction egg donation. This normative line of thinking is probably one of the reasons that commercial clinics insist on using the morally loaded terms *donation* and *paid donation*, which are culturally preferred to the term *selling*. Moral concepts appear, then, to influence the women's different approaches and narrations—as seen in Smadar's statement that she did not regret selling her eggs to the American clinic and was happy to be described as a donor.

The witnesses in the Romanian case describe different situations. As vendors, these women were not part of a morally accepted gift economy but rather were part of the questionable transaction of selling their body parts (cf. Agustín 2007). At the same time, they were part of a corrupt system—Romania's exploitation of vulnerable citizens and its turning a blind eye to the growing quasi-legal and



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illegal fertility tourism industry. This sheds light on the role of the Romanian egg vendors in the sense that corruption breeds distrust of the medical system, making people feel negative about altruistic donation and positive about personal ownership of the body and the selling of body parts (Demeny 2009; Lundin 2010b). The testimonies of the women at the Sabyc Fertility Clinic in Bucharest is thus characterized primarily not by the shame of having committed a moral fault—having sold their bodies or parts of their bodies—but by anger and disappointment at having been maltreated and cheated out of money.

The stories of the providers from Israel and Romania—who talk about their experiences on a scale from very poor to satisfactory—illustrate how the local use of reproductive technology is put into practice in light of cultural values and structural forces (cf. Lock and Nguyen 2010). The concept of dirty work, invoked by Everett Hughes (1951) and elaborated by many scholars, such as Amrita Pande (2009: 155) in her study on surrogates, refers to occupations that are rejected by society and thus require individuals' remedial work to neutralize the stigma associated with their actions. The self-narratives of some of the providers give examples of such remedial narrative work (Goffman 1963; Pande 2009: 155). The next section looks at the other party—those who are infertile and who hope to conceive with the help of medicine and other people's bodies.

## RECIPIENTS BUYING EGGS

For recipients, reproduction is interwoven with an important identity construction—parenthood. It is not just parents who create children; children also create parents, thus transforming women into mothers and men into fathers (Edwards et al. 1993; Lundin 2000). Treatment with ART is a solution for many childless individuals. However, it is not a solution for all, as there is no guarantee of success with ART (Harris and Daniluk 2010). Long waiting lists, high costs in the couple's home country, or the unavailability of a specific treatment owing to lack of expertise or equipment are other reasons why ART is not always an option (Ferraretti et al. 2010). Legal grounds are also a factor in many countries, as infertile citizens face restrictions on their choice of particular types of infertility treatment. Thus crossing borders to seek help for infertility is one of many strategies employed by involuntarily childless people. The cultural concept of parenthood leads to legal travel to countries with less restrictive reproduction laws (Storrow 2006) and also triggers the use of quasi-legal or illegal fertility treatments outside as well as inside the country.

Childlessness often raises complex questions about everything from gender identity and parental identity to ideas about the link between sexuality and reproduction. Many of the women who go through fertility treatments, which may stretch over many years, are focused on their personal needs and defined by the desire for a child (Franklin 1997; Strathern 1992). Those I interviewed told me that during their wait for ART or in the midst of it their bodies became



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increasingly important in their lives. A middle-aged Swedish woman, Lisa, said that her body was "always a top priority—what I ate, how I took care of the body, when it was time for sex, how long I should be sleeping. I was nothing more than body!" (Lundin 1995). Furthermore, motherhood, or rather the quest for biological authenticity that motherhood guarantees, has become the essence of their female identity. Despite their childlessness, the women I interviewed in the 1990s as well as those from the early 2010s were more or less convinced of their inherent motherhood; they simply saw it as hidden deep inside them. A Swedish woman, Karin, whom I met in 1995, put it this way: "I always knew I was destined to become a mother; a small 'defect' in my body didn't matter. And when we heard about IVF we felt it was quite obviously something we wanted to try . . . just like helping nature along the way . . . to realize my 'true self'!" (Lundin 1995).

The search to realize their identities as mothers is common among recipients, as is the idea that this quest requires a correction of the body, as with ART (cf. Strathern 1992). However, what sets these women apart are the ways they define the strategies—ranging from legal to illegal—that are morally defensible to reach their goals. A Swedish woman, Sonja, who went to Finland to purchase a treatment prohibited in her country but legal in Finland and who gave birth to a girl through egg donation, repeatedly pointed out the importance of doing "everything in my power to have a child, to be a mother" (Lundin 2010b). At the same time, she had concerns about whether her actions were morally right: "I'm thinking of what it means to, how shall I put it . . . to make use of a donor. . . . I saw this documentary about egg donors and surrogates in India and it was terrible how they were used" (Lundin 2010a).[11] A slightly different view, also with clear moral concerns, is offered by Michal, who was interviewed at the Haifa Feminist Center and for whom the need for motherhood seemed to overshadow all else: Michal had been involuntarily childless for many years and tried a number of different treatments. In a discussion about egg commerce in Romania and what means are ethically defensible to have a child, she said:

> I think that if I had gotten to a point where I was told, "Your only chance of having a child, of becoming a mother, is to go to Romania and receive an egg from somebody who would get a dollar for it," I mean, like something she could buy a coat and boots with, and that it's really not healthy for her . . . I mean, I'm pretty convinced that, God forgive me, I would have done it. I'd bring a life into this world on account of . . . it's not like I want a bigger house, it's not that I want . . . I don't know . . . it's bringing life into this world. (Lundin 2009)[12]

Another woman, Nira from Israel, who went to Kiev several times for egg donation, with no results, had similar experiences and arguments. She finally asked her local doctor to help. She stated: *"We*



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*pressured him, we had a way to do it, which I don't want to talk about, and he did it, ASAP. Just like that, he found eggs for me"* (Shay et al. 2010). The Israeli woman Rahel seemed to have significantly fewer concerns about infertility and ART. She declared: "[I would not hesitate to] do anything to be a mother, otherwise I would be a sick and worthless woman. You must understand, I want a baby; don't stop me from being a mother!" (Lundin 2009).

Many studies point to the historically and globally rooted importance of motherhood for the female identity, and the narrations of the (potential) recipients of eggs could, to some extent, be understood against such a background (Lock and Nguyen 2010). Simultaneously, the narrations give information about national and sociocultural differences, which might have relevance for the recipients' moral considerations and, in the end, their actions.

In Sweden, ART must abide by many restrictions in the health-care system. Additionally, the health policy has been characterized by a pronounced ideological principle concerning the medical treatment that involves third parties—such as ART, transplantations, and cell transfer—meaning that all forms of financial compensation are prohibited and only donations are allowed. Swedish citizens like Sonja and the other women I met who have concerns about donations in the medical gray zones have been socialized into norms that affirm altruism, which makes the involvement of third parties who are against payment morally problematic (cf. Koch 1998; Lundin 2008).

A different picture is shown in Israel, where the medical community gives full support to the use of fertility technology. Consequently, Israel has more fertility clinics per capita than any other country, and ART is subsidized by health insurance plans, giving every woman access to unlimited rounds of treatment until two live children have been born (Kahn 2000: 71).[13] The culturally and politically embedded positive attitude toward ART makes many Israeli women view motherhood through ART as a personal right to be enforced at any cost, as the case of Rahel shows.[14] In Romania the importance of creating a family with numerous children is deeply rooted in the country's culture, as it is in Israel. Even if legislation does not sanction the trade of eggs for money, Romania, along with other countries in Eastern Europe, such as Latvia, the Czech Republic, and Ukraine, is a so-called hot spot for fertility tourism, including the gray area of quasi-legal and illegal ART treatments (Demeny 2009; Lock and Nguyen 2010). This has, as discussed above, consequences not only for a positive attitude toward individual ownership of the body and the selling of body parts but also for the purchasing of eggs by infertile women.

There are many indications that the potential recipients act from a feeling of desperation about female identity and societal normality (cf. Franklin 1990). Their narrations give an understanding for, to return to Thompson (2005), the ontological entwining between self and environment. In previous studies on medicine and self-under-



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standing, I have discussed how today's society is characterized by a search for identity, where the quest for authenticity seems to be highly prioritized (Lundin 1996, 1997, 2008). To be true to oneself, as Karin from Sweden and many others describe it, is a reflexive project linked to the idea of responsibility for bodies and ultimately for finding one's authentic self. To be true to oneself thus means creating and finding oneself, but since, to borrow Anthony Giddens's discussion about self-identity, "there is an active process of self-construction it has to be informed by overall goals" (1991: 79), such as achieving fulfillment through motherhood. From such a perspective, it is understandable that the women's narratives are permeated with reflections about fertility treatments involving third parties and with an arsenal of moral arguments to legitimize their actions. Additionally, to understand how the moral aspects of methods of achieving motherhood can be defined differently by women who seem to have the same need and experience some sort of identity crisis, it is worth returning to the cultural concept of donation versus commercialization and reification.

Parallel to the idea of altruism, which assumes that the individual is unique in him- or herself and should never become a tool for others, there currently exists a user perspective on the body (Cohen 2003; Radcliffe-Richards 2003). This perspective, also rooted in the neoliberal economy, is a condition for the development of and increase in treatments involving various body parts, as well as of medical tourism and the black market in tissues, egg cells, and organs (Haimes 2003; Scheper-Hughes 2008; Waldby 2002). When regenerative body parts can be transferred to ill or infertile people, the organs are transformed from being parts of the individual's self to being valuable objects for other individuals (cf. Sharp 1995). The two culturally embedded approaches, the unique individual and the individual as a (commercial) resource, are contradictory but nevertheless interact with each other. It is against this background that we have to understand the arguments and choices made by women who go abroad into quasi-legal situations to look for eggs or surrogacy (Lundin 2010a, 2010b).

## CONCLUSION

The cases presented above, of providers and recipients, reveal that technologies such as ART are deeply embedded in societies' local practices. Even though normalization is at work in reproductive fertility practices everywhere, as Margaret Lock and Vinh-Kim Nguyen point out, it is clear that societal "interests and values are implicated as powerful forces constituting and repetitively reinscribing what is normal" (2010: 280). Some of the normative aspects that are essential for both recipients and providers include the importance of parenthood and the idea of the regenerative body, as well as the view of the body as an authentic self-alternative and an object of utility. These cultural concepts have extremely concrete effects. One impact



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is that developments in ART make it possible for infertile people to become parents and to have a "normal" family. However, this increases the need for various forms of ART, which, not least, forms a market in which people sell and buy eggs (cf. Inhorn 2003). This process also can be described in terms of how the economics of hope interact with the reproductive market's monopoly of desperation.[15] Without the assumption of demand (people risk staying childless without ART) and supply (eggs, wombs, etc.), neither a legal nor an illegal fertility treatment system would exist.

When the dream of parenthood cannot be fulfilled at home, thoughts turn toward other countries' treatments and other people's bodies. This often involves turning to extremely poor countries and people in the hope that these treatments and these bodies can be bought. Medical tourism for transplantations and reproductive technology treatment is one manifestation of the kind of approach in which buyers use a market that is accessible to them and where others see the opportunity to make money through their bodies (Lundin 2010a, 2010b, 2010c). In these practices and attitudes, more than in biomedical development itself, the fundamental and normative effect of biotechnology becomes visible. It is here that the opportunities of biomedicine, as ART, are transformed into moral concerns, which affect both the recipients and the providers. It is also here that narrative work is conducted.

The women involved in the fertility business are doing narrative moral work by telling their stories 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 (cf. Thompson 2005). Their narrative constructions of self-worth and their handling of the dilemma that the fertility market raises have several consequences, not least for maintaining the half-legal and downright illegal systems. One consequence, deriving from the fact that the market has a variety of players with different reasons for their actions, is the existence of several different "true" stories. This means that the narrative moral work of providers and recipients who claim to give a true picture of the fertility business certainly legitimizes their actions. Simultaneously, however, the narratives also make what is going on in the global gray zone of reproductive medicine invisible.

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## NOTES

1. Fertility tourism occurs when infertile individuals or couples travel abroad to obtain medical treatment for their infertility. Fertility tourism may also occur in the opposite direction, when



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infertile individuals or couples import the third party necessary for their fertility treatment (Storrow 2006: 300). Anna Pia Ferrarretti et al. (2010) suggest that "cross-border reproductive care" is a more appropriate term for this phenomenon. Charlotte Krolløkke (2011) talks about the overall concept *biotourism*. However, none of the terms are sufficient: *fertility tourism* leads to thoughts of pleasure, and *cross-border care* leads to thoughts of only the couples seeking treatment, not the donors/vendors. Nevertheless, I choose to use the term *fertility tourism*.

2. My research on involuntary childlessness and ART started in 1993 with the project "Transformations of the Body" (Swedish Council for Planning and Coordination of Research). My research on organ trade started in 2008 and formed part of the project "The Body as Gift, Resource, and Commodity: Organ Transplantation in the Baltic Region," and in 2010 my research field expanded to include fertility tourism and the egg trade (Östersjostiftelsen 2011).
3. This nongovernmental organization (NGO) aims to develop public involvement with issues combining science and society (Isha L'Isha–Haifa Feminist Center 2010).
4. Nordstrom uses the term *shadow*—instead of *criminal* or *illegal*—because "the transactions defining these networks aren't confined solely to criminal, illicit, or illegal activities, but cross various divides between legal, quasi-legal, and downright illegal activities" (2004: 106).
5. The interviewed women are involved mainly as providers and recipients of eggs; only exceptionally is it about surrogacy.
6. For a discussion on infertility and male identities, see Lundin 2000.
7. Dr. NN is a pseudonym.
8. The quotation comes from an interview conducted with Moran at the Haifa Feminist Center.
9. Anat is quoted also in the Haifa Feminist Center's Report, Shay et al. 2010.
10. Smadar is quoted also in the Haifa Feminist Center's Report, Shay et al. 2010.
11. The practice of renting a womb and getting a child is like outsourcing pregnancy. This trade's business volume is estimated to be worth US$500 million, and the number of cases of surrogacy is believed to be increasing. On the outsourcing of surrogacy to India, see the film *Made in India* (2010).
12. Michal is quoted also in Shay et al. 2010.
13. This full range of ART stands in striking contrast to the fact that family-planning facilities in Israel do not receive state support and are funded on a charitable basis (Lock and Nguyen 2010: 274).
14. This view further attracts patients from other countries to Israel.



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15. There is a broad discussion on the concept of economics of hope in Koch and Hoeyer 2007, Lundin 2005, and Novas 2006. Infertility and desperateness is discussed by Sarah Franklin (1990) and developed by Thompson (2005) in connection with the fertility market.

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