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BROCHER SYMPOSIUM: PERSPECTIVES ON ACCESS TO REPRODUCTIVE HEALTHCARE

Unravelling orders in a borderless Europe? Cross-border reproductive care and the paradoxes of assisted reproductive technology policy in Germany and Poland[☆]


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Abstract This article examines assisted reproduction policy and practices in Germany and Poland. Germany is among the most restrictive countries in the European Union (EU) with respect to assisted reproductive technologies. In contrast, Poland only recently passed legislation regulating assisted reproductive technologies. Before this, most practices were unregulated, despite vocal opposition to all forms of IVF from conservative Roman Catholic activists. Germany and Poland differ significantly regarding the cultural narratives and historical experience that impact attitudes toward reproduction. In Germany, discussions on assisted reproduction often invoke concerns about medical intervention in ethically complex matters, due – in part – to the country's National Socialist past. My objectives in this article centre on examining assisted reproduction contexts in each of these two countries, with attention to the framing of debates on reproduction, the anxieties that inform them, and the resulting paradoxes. I consider the unintended consequences of domestic policy and their importance regarding cross-border reproductive care (CBRC). Within the borderless EU, the widespread practice of CBRC demonstrates the ineffectiveness of national policies. Moreover, this shift in location can impact practices and trends found in other accessible, but less restrictive countries. Of particular concern are

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the relocation of risk to 'bioavailable' populations in less affluent countries and the reification of cultural and socio-economic hierarchies.

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Introduction

This article explores policy and practices in Germany and Poland regarding assisted reproductive technologies in the context of the European Union (EU). Markedly different approaches to assisted reproductive technologies have developed in these neighbouring countries, with Germany taking a very restrictive approach and Poland, until recently, having no laws that specifically regulated assisted reproduction. My objectives include examining the framing of national debates, the anxieties that inform them, and paradoxes resulting from current policy and practices. I situate my discussion within the context of global trends concerning cross-border reproductive care (CBRC). A central theme in my study is the ineffectiveness of highly restrictive national policies within the borderless EU, including their role in promoting CBRC.¹ One major concern is the relocation of risk to the newer, and often less restrictive EU countries, as well as countries outside the EU.

Although CBRC is a global phenomenon (Inhorn, 2015; Nygren et al., 2010), its presence across Europe has been especially noted (Schindele, 2007, 2015). One of the most extensive studies, which included six countries, estimates conservatively 24,000–30,000 assisted reproduction IVF cycles, involving 11,000–14,000 CBRC patients performed annually in Europe (Shenfield et al., 2010). Study of the topic is a complex undertaking marked by a dearth of adequate data, the sensitivity of the topic, and the involvement of multiple actors across a range of locations (Inhorn and Gürtin, 2011; Nygren et al., 2010). The complex legal landscape of assisted reproductive technologies in Europe is undoubtedly a major force driving CBRC (Ferraretti et al., 2010; Inhorn and Patrizio, 2012; Pennings, 2005; Shenfield et al., 2010), with many patients travelling to access therapies that are not allowed in their home country or that are inaccessible to particular groups (such as single women or same-sex couples). However, other important reasons include more affordable or better quality care, and a shortage of donor gametes in some countries (Ferraretti et al., 2010; Shenfield et al., 2010).

Materials and methods

My research centres on analysis of both primary and secondary texts, as well as focused interviews and less structured conversations. Primary materials include legal publications,

national press, internet discussions of patients, and comments of assisted reproductive technology specialists in response to my enquiries (Berlin, Leipzig, Szczecin, and Warsaw) and cited in press accounts or internet sites directed at potential patients. In this article, I consider the following questions: How do policy and regulations on assisted reproductive technologies impact practices in Germany and Poland? What discourses inform such policy? How are regulations in these countries connected to CBRC, especially in the context of a borderless Europe? And is Europe, in fact, borderless?

National stories

In examining policy contexts, I consider the 'repro-national choreographies' (Franklin and Inhorn, 2016) or complex histories characterizing assisted reproductive technologies in Germany and Poland. The two states differ significantly regarding cultural narratives and historical experiences that impact attitudes toward reproduction, including gender norms and the role of religion in daily life and discourse. Most Poles are at least nominally Roman Catholic, and the Church continues to play a central role in the Polish political sphere. However, Polish attitudes toward the Church have become more complex since the 1980s, when it functioned as the leading moral authority in opposition to the Communist government (IMAS, 2009). In the present context, polls suggest that the majority disagree with the Church's staunch condemnation of IVF therapies (Boguszewski, 2015). The role of religion in public discourse in Germany is more varied, with both the Roman Catholic and Lutheran churches playing important roles. There are also strong regional variations regarding religious affiliation, or lack thereof. For example, the percentage of nonreligious individuals is much higher among East German inhabitants (Froese and Pfaff, 2009: 136–138). In this case, the impact of the communist era in Germany is in sharp contrast to the situation in Poland, where religious affiliation and expression remained strong, in large part due to the link between religion and national identity.

With regard to assisted reproductive technologies, Germany is among the most restrictive countries in the EU, limiting the number of embryos that can be created to three and banning the freezing of embryos unless there are compelling medical reasons for doing so. In addition, approaches that rely on a female third party, namely egg and embryo donation, as well as surrogacy, are illegal. By contrast, in Poland, despite vocal opposition to IVF from conservative Roman Catholic activists, practices that rely on third-party donation are legal, and, prior to November 2015, assisted reproductive technologies were unregulated. This

¹ For an explanation of terminology used to describe patients who travel abroad to seek fertility treatment, see Pennings et al., 2008.

lack of regulation was the result of a gap in policy due to the limited opportunity for assisted reproductive treatment in communist Poland and a lack of interest in the topic by policy makers in the 1990s.²

A lack of clear laws addressing assisted reproductive technologies in Poland resulted in limited accountability and sometimes dubious practices. For example, in 2015 a representative of a family advocacy organization indicated to me that she had received requests for help from distraught women who had been asked to sign consent forms agreeing to share their eggs with other patients while they were still under the influence of anaesthesia after undergoing oocyte retrieval surgery for IVF (conversation, July 6, 2015). Such practices highlight the problems that can emerge in unregulated states. Indeed, the question of how to obtain oocytes in numbers sufficient to meet demand is one of the central dilemmas of assisted reproductive technologies and has resulted in scandals in other contexts (Birenbaum-Carmeli, 2016; Schindele, 2007).

In both Germany and Poland, state governance has failed to adequately address assisted reproduction practices. In the former case, policies are so restrictive that they effectively drive many patients to seek treatment abroad and, in effect, relocate ethical concerns and potential health risks. Within Europe, patients have the right to seek treatment in other countries (Shenfield et al., 2010), facilitating this process and ultimately rendering many national policies ineffective.

In Poland, until 2015 a lack of legislation addressing assisted reproductive technologies created a lax situation in which there were effectively few controls regarding what procedures were available and limited accountability. Ironically, the continual focus on the issue of IVF in Poland as a *bête noir* of conservative Roman Catholic activists prolonged a situation in which standards and practices were largely uncontrolled. New assisted reproductive technologies legislation adopted in June 2015 provides a regulatory framework, although it fails to address some areas of concern, including clear guidelines regarding recruitment of egg donors. In some aspects the law is quite liberal (for example in allowing treatments that rely on a female third party). However, in other ways it demonstrates a socially conservative bias, for example it excludes single women and lesbians from receiving IVF treatment. In addition, the new conservative government elected in October 2015 chose to end government support for IVF through a reimbursement programme that was in place from 2013 to 2016, a decision which will also limit access.

² In Poland, during the last decades of Communist rule, abortion regulations were relatively liberal. The increased role of the Church in Polish politics since the early 1990s led to the enactment of a much more restrictive abortion law in 1993. In the 2000s, IVF also became a target for conservative activists in Poland, who argued that it was inextricably linked to the destruction of embryos. However, such religious objections occurred alongside a context in which more Poles were seeking assisted reproductive treatment, making it more difficult for politicians to muster the political will to enact legislation, which did not occur until 2015. In the current context, in which parties of the right dominate politics, the status of IVF remains uncertain.

Hierarchies, hyperspaces and the unleashing of anomaly

A tendency within Europe to see those countries which are located to the south and east as less advanced (Bakić-Hayden, 1995) also plays a role in conceptualizing and organizing medical care (Knoll, 2012). Depictions of 'backwardness' and economic desperation (both perceived and real) foster a propensity to view the populations of such states as additional resources to be cultivated. However, these processes are complex and cannot be broken down into simple dichotomies. For example, research on peripheralization reveals processes that contribute to regional and class inequalities (Naumann and Fischer-Tahir, 2013), as well as the emergence of new centres in regions that are often conceptualized as peripheral.³ Regarding spatialization and state authority, ethnographic study has demonstrated the limitations of imagining the verticality of state power (as that which is simply stacked at the top of a hierarchical structure), examining the many mundane interactions and contexts on which the legitimization of state power is contingent (Ferguson and Gupta, 2002).

At the same time, CBRC practices contribute to the creation of so-called 'hyperspaces' (Beck, 2012), shifting transnational sites that make it possible for actors to circumvent limitations imposed by states. Indeed, as transnational processes increasingly erode the role of the state in shaping institutions and economic relations, some scholars argue that individuals are encouraged or even pressured to slip the collar of state controls (Wilson and Donnan, 2005). When officially endorsed models of reproductive care are found to be unsatisfactory, some individuals and groups respond by looking for alternatives (M. Murphy, 2012). The prevalence of CBRC and the proliferation of global repro-hubs (Inhorn and Patrizio, 2012) offer a striking example of how restrictive national policies are rendered ineffective.

Moreover, the connection between new medical technologies and the unravelling of orders is a prominent concern as these technologies have the potential to undermine existing cultural and political norms on multiple levels. Aditya Bharadwaj uses the concept of 'bio-crossings', to express the complexity of medical technologies that achieve transformation through 'extraction and insertion of biogenetic substance across multiple terrains ranging from geopolitical borders to areas between biology and machine' (Bharadwaj, 2012a, 2012b: 305, Bharadwaj and Glasner, 2009). Stem-cell research and IVF rely on the creation of new transnational systems, including infrastructures, legal regimes and moral logics (Franklin, 2005; T.F. Murphy, 2012). In examining networks surrounding embryonic stem-cell research in India, Bharadwaj and Glasner employ the concept of a 'liminal third space', which challenges both official governance paradigms and efforts to enact new moral controls on science (2009: 9). Drawing on the anthropology of reproduction, they connect this dynamic to the assertion that the act of reproduction initiates difference (Franklin, 1997; Strathern, 1992) by allowing more forms of alterity, which subverts the binary,

³ In his study of the emergence of biotechnology research in India, Aditya Bharadwaj refers to such phenomena as 'dis-locations', (Bharadwaj, 2012b: 305).

forging 'a third space'. They argue that these processes are open-ended and unpredictable, signalling great opportunity, but also danger (Bharadwaj and Glasner, 2009: 57, 85–86).

Scholars have observed the degree to which IVF provokes ambivalence (Franklin, 2013; Strathern, 1992; Thompson, 2005), including among people who are especially invested in the procedure, such as practitioners and patients. Part of this ambivalence may stem from ethical issues that these new technologies raise. However, another component is the potential of IVF to call attention to and destabilize existing concepts of identity, and this suggests another reason why assisted reproduction policy in many states remains contentious. For some observers, such therapies appear to irreparably undermine the natural ordering of things.

Charis Thompson has demonstrated the processes through which people cope with such anomaly, often interpreting their experiences of assisted reproductive technologies as new expressions of old things. She argues that 'naturalization normalizes and domesticates procedures, making them seem like appropriate ways of building a family rather than monstrous innovations' (2005: 141). Reproductive technologies have markedly transformed the potential ways that people conceptualize kinship, forging new forms of relations (Franklin, 2013: 159). However, it is precisely these forms of relationships that some policy makers find objectionable. The concept of motherhood, and the possibility that a child could have more than one mother, has been viewed as especially problematic. Judgements about the 'inviolability of motherhood' (Melhuus, 2012), the notion that it is unnatural for a woman to carry a child with whom she does not share a genetic link, inform Germany's restrictive assisted reproductive legislation, which I discuss in the next section.

Germany, the Embryo Protection Law and 'divided motherhood'

Since 1991, assisted reproductive procedures have been regulated by the German Embryo Protection Law (*Embryonenschutzgesetz*). Germany's unique stress on the protection of embryos is also a result of controversies in the 1980s about embryos being created for research purposes (Robertson, 2004). The result is that Germany (along with Italy) is among the most restrictive countries in the EU regarding assisted reproduction, placing considerable constraints on treatment practices. Sperm donation, artificial insemination and conventional IVF are permitted; however, egg and embryo donation are prohibited. Preimplantation genetic diagnosis (PGD) was previously banned, but since 2011 has been permitted in some cases to reduce severe health risks. The law also limits the number of embryos created through IVF to three and prevents the freezing of embryos after the fusion of male and female nuclei.⁴

⁴ Online patient discussions about experiences of IVF treatment in German clinics suggest that practices may, nevertheless, vary from one facility to another with regard to the number of embryos transferred during IVF cycles and procedures for freezing embryos. The following internet thread discusses a range of experiences regarding the number of embryos transferred and in some cases frozen: <https://www.toytowngermany.com/forum/topic/105133-fertility-treatments-ivf-icsi-in-germany/?page=2> Accessed 3 February, 2017.

The strong emphasis placed on protecting embryos in German law stems, in part, from religious beliefs about the sanctity of human life and, perhaps even more significantly in the case of Germany, also from concerns about avoiding the eugenic practices and general disregard for human life associated with the Nazi era. For these reasons, many people in Germany are wary of medical interventions that generate challenging ethical situations. For example, discussions about embryo donation (also referred to as 'embryo adoption') stress the need to be especially cautious regarding questions in which medical ethics may be ambiguous due to 'experiences from German history'.⁵ This cautionary principle appears to inform many of the restrictions on assisted reproductive practices, including those that address female gamete donation and PGD.

One of the stated aims of the Embryo Protection Law was also to prevent all forms of 'divided motherhood' (*gespaltene Mutterschaft*)⁶ (Keller et al., 1992; Schindele, 2007). In her research on the ban against egg donation in Norway, Marit Melhuus has argued that this decision is connected to concepts of 'mother belonging' and a 'unitary motherhood'. She stresses that eggs and sperm are treated differently under the law, because they are 'embedded in different chains of meaning', in which eggs are seen as 'inalienable', belonging 'where they came from' (Melhuus, 2012:74–75). In Norway and Germany, legislators have argued that denying forms of divided motherhood is in the interests of children created through assisted reproductive technologies. In both countries the law asserts that children have the right to know their genetic ancestry. In the German context, egg and embryo donation were rejected because of the significance of genetic identity to overall identity formation and because policy makers stressed that the role of the mother was viewed as playing a greater role in identity formation than that of the father. In the case of surrogacy, it was argued that the mother–child bonding process would be undermined without the connection developed through pregnancy (Hauser-Schäublin et al., 2008: 151–152). These arguments formed the basis for banning treatments that involve a female third party in Germany. However, as I have discussed above, this does not prevent women from seeking these treatments elsewhere.

When patients find they have limited or no options left regarding fertility treatments that can be pursued in Germany, there are also differences in how German reproductive specialists advise them. Some doctors mention treatment options available in other countries, sometimes even making informal referrals. Others do not mention such options, suggesting simply that a patient has no options left (Bergmann, 2012). In internet forums, some patients express frustration with constraints placed on assisted reproduction in Germany, mentioning their success in seeking treatment

⁵ See for example, Harmsen, 2012. „Das Leben nehmen, wie es kommt“ (Interview with Susanne Breit-Keßler). *Sonntagsblatt* 7.10.2012. Breit-Keßler's original German phrase is „die Erfahrungen aus der deutschen Geschichte lehren uns große Bedachtsamkeit.“ http://www.sonntagsblatt.de/news/aktuell/2012_41_01_02.htm Accessed 14 February, 2017.

⁶ This term is sometimes translated as 'gestational motherhood'; however, *gespaltene* literally means 'split' or 'divided', and I believe this more literal translation sheds more light on objections to multiple forms of motherhood.

abroad and urging others to consider this avenue as a means of accessing more therapy options.⁷

German reproductive specialists have criticized the Embryo Protection Law as outdated (Krüssel cited in Narloch, 2013). Some doctors express dissatisfaction at the current state of German law on assisted reproductive technologies, such as the ban on donating embryos to other patients seeking fertility treatment. Under current law, embryos remaining after treatment must be destroyed, a seeming contradiction to the Embryo Protection Law. In this context some experts have called for a new public debate regarding embryo donation (Thorn et al., 2012: 4). Many reproductive specialists are also critical of the current prohibition on egg donation that drives women to seek treatment in the Czech Republic, Poland, Spain and Ukraine, claiming that both donors and recipients would be better off receiving treatment in Germany due to the country's high standards of care. However, this issue appears to be a low priority for political parties in power. The leading Christian Democratic Union (CDU) underscores its position that the current ban on egg donation protects women from exploitation and upholds concern for the welfare of potential children resulting from assisted reproductive treatment who have a right to know their origins. The co-governing Social Democratic Party (SPD) has also not been eager to take up reform of the Embryo Protection Law. The Free Democratic Party (FDP) has been the only political party in recent years to publicly endorse legal reform regarding assisted reproduction (Central FM, 2014). In January 2017, the FDP renewed its position on the need to modernize the Embryo Protection Law to legalize egg donation (Föst, 2017). However, this statement does not address embryo donation and restrictions on the freezing of embryos. Moreover, the FDP currently holds no seats in the Bundestag.

The Embryo Protection Law has been subject to criticism for both ethical repercussions and for hindering effective treatment. The European Society of Human Reproduction and Embryology (ESHRE) released figures in 2007 asserting that the law had the unintended effect of increasing the number of embryos and fetuses destroyed after fertility treatment. The society refers to higher rates of fetal reductions performed in Germany due to pressures to transfer three embryos per cycle, resulting in more risky multiple order pregnancies (ESHRE, 2007). In addition, restrictions on the freezing of embryos runs counter to current research regarding most effective treatment practices. For example, researchers have demonstrated that freezing embryos after fresh IVF cycles for use in later cycles greatly increases pregnancy rates (ESHRE, 2007). More recent studies, in fact, suggest that previously frozen embryos actually develop better than fresh embryos in IVF cycles (Maheshwari et al., 2012), a finding which has been noted in German language discussions addressing fertility treatments.⁸

⁷ See, for example, posts at [Babyclub.de](http://www.babyclub.de), *Erfahrungsberichte Künstliche Befruchtung* <http://www.babyclub.de/mybabyclub/forum/themen/11528136.erfahrungsberichte-kuenstliche-befruchtung.html>, Accessed 29 May, 2015.

⁸ See for example, „Eingefrorene IVF-Embryonen entwickeln sich besser: Schwangerschaftsablauf optimaler als bei herkömmlicher Methode“, *Presstext*. September 6, 2012. <http://www.pressetext.com/news/20120906012> Accessed May 29, 2015; see also, *Frische oder gefrorene Embryonen – was ist besser? Der Fruchtbarkeit Blog*, <http://www.der-fruchtbarkeit-blog.com/frische-oder-gefrorene-embryonen-was-ist-besser/> Accessed May 29, 2015.

Access to such information and the awareness of other options facilitates CBRC.

A further policy-related reason that more Germans in recent years may have opted for treatment abroad is a significant reduction in state-sponsored support for IVF cycles. Since 2004, patients must cover at least 50% of the cost, and insurance no longer covers women over 40 and men over 50 (ESHRE, 2007). Patients therefore may decide that the relatively low cost and high quality of medical services in some other countries are a more feasible option when they are faced with financing fertility treatment themselves. In addition, people belonging to ethnic minority groups in Germany may be dissatisfied with the degree of cultural sensitivity that they experience in seeking fertility treatment (Vanderlinden, 2009), leading some to seek medical care abroad.

Some patients have multiple reasons for seeking treatment outside Germany. For example, internet discussions among patients suggest that those considering travel from Germany to Szczecin, a Polish city a two-hour drive from Berlin, often consider this option due to lower costs and relatively close proximity, with some patients also mentioning improved options for freezing embryos for further treatment.⁹ The fact that a high percentage of German patients travelling to the Czech Republic and Spain seek egg or embryo donation (Shenfield et al., 2010) demonstrates the limitations of the restrictive legal situation regarding assisted reproduction. Many Germans ultimately decide to go abroad for treatment, especially to more easily accessible EU countries, as a means of accessing options unavailable at home.

Poland, new legislation and IVF as a national threat

In 2004, Poland's eastern border became the eastern border of the EU. Its status as a borderland state carries significance regarding policies, practices and flows connected to assisted reproduction. Within a borderless Europe, complex ethical situations and potential risks can be more easily relocated to 'newer' EU states. These risks include potential exploitation of women serving as third parties in certain treatments such as egg donation. One concern is the lack of controls on the flow of human eggs across borders, both within the EU and also across its eastern border. One report notes that Polish customs officials have confirmed a rise in the import of donor eggs from the Czech Republic, but also from non-EU countries, such as Ukraine and Moldova (Omachel and Bruździak, 2013).

Many Polish reproductive specialists are eager to stress that the medical facilities and practices in Poland are run to the highest standards and achieve proven positive outcomes. However, in reality there have been great disparities in practices across clinics in Poland and limited transparency. In addition, in 2014 the European Union Court of Justice sanctioned Poland for its failure to implement the EU Tissue and Cells Directive (Cosić, 2014). Such gaps in legislation and implementation have prompted concerns about a general lack of accountability in Polish assisted reproductive procedures (Lisowska, 2014). In addition, a scandal involving the mixing up of patient gametes convinced many observers

⁹ For example, <http://www.klein-putz.net/forum/viewtopic.php?t=69244> Accessed August 6, 2016.

of a need for better regulation (Klinger and Wittenberg, 2015). This case received considerable attention as it involved an error concerning a retrieved egg that was erroneously fertilized and subsequently transferred into a patient for whom it was not intended, compounded by the fact that the IVF cycle resulted in the birth of a child with a genetic disorder (Adamowska, 2015). Representatives of the Fertility and Sterility section of the Polish Gynecological Society (*Sekcja Płodności i Niepłodności Polskiego Towarzystwa Ginekologicznego* or SPiN) argued that such errors also indicate a need for a national regulatory body (Ramowska, 2015).

From 2013 to 2015, efforts to create specific legislation addressing assisted reproduction in Poland occurred in a climate of intense public discussion in which IVF became a special target for conservative Roman Catholic activists. In a context in which women's reproductive rights have generally deteriorated in post-communist Poland, and in which the controversies over IVF coalesce with the controversial issue of abortion (Mishtal, 2015), the discursive strategies of such conservative activists often depict IVF as an immoral procedure and a threat to the Polish nation (Korolczuk, 2014; Radkowska-Walkowicz, 2014).

In this context, negative portrayals of IVF invoke both a fear of eugenics (Korolczuk, 2014) and promote images of children born using IVF as monsters with pronounced physical deformity and illness, psychological and social problems, as well as lives burdened by guilt that their birth was derived from the deaths of other embryos (Radkowska-Walkowicz, 2012). Conservative Roman Catholic efforts to influence reproductive rights, including access to IVF, politicize religion and strongly impact, or even impede processes of public deliberation (Gozdecka, 2012). The staunch opposition of conservative activists to all forms of IVF and the perceived strength of the Church in influencing public opinion has meant that Polish politicians often waiver in their positions on the procedure.

In an effort to counter the portrayals made by conservative politicians and activists, physicians' associations, especially reproductive specialists, have publicly condemned the vilification of IVF technologies, stressing how many families they have helped. In addition, patient advocacy groups have attempted to counter conservative depictions, sometimes collaborating with physicians' associations.

After several failed attempts due to the contentious atmosphere of public debate, in June 2015 the out-going government succeeded in passing legislation regulating assisted reproductive technologies, which became effective on 1 November 2015. In some national contexts, scandals have led to the adoption of more restrictive assisted reproductive laws (Inhorn, 2016). However, despite heated debate over IVF and a scandal demonstrating a lack of accountability, more kinds of reproductive therapies continue to be available in Poland, including gamete and embryo donation, than in other countries where religious activists are less vocal. These examples point to areas where popular discourse and medical practices diverge sharply. At the same time, despite the dominance of anti-IVF voices in public discourse, surveys indicate that, in fact, most Poles support access to in-vitro technologies (Boguszewski, 2015).

Yet the new law does impose significant restrictions, some of which have been influenced by religious positions (Mishtal, 2015). Most notably, it excludes single women and women in same-sex relationships from receiving IVF treatment, as is the

case in several other European countries, including Austria, France and Germany. In addition, the government chose not to extend the public financing programme for IVF which had been in place from 2013 to 2016. These two changes will make it more difficult for many patients seeking treatment to receive it, thereby increasing 'reproductive stratification' (Colen, 1995), with those with fewer resources, or groups who are stigmatized as inappropriate parents, having diminished access to care.

Eastern Europe, policy and relocation of risk

The widespread practice of CBRC demonstrates the presence of extensive transnational connections and suggests that policies in one country may create new markets and impact practices found in other accessible, but less restrictive, countries. Policies may be restrictive in some states due to moral or religious opposition, desires to avoid complicated ethical situations or concern about health or psychological risks to those involved.

Medical research policies intended to protect patients in one country often result in relocating risk to low- and mid-income countries, including states in Eastern Europe (Petryna, 2007). The increased globalization of medical infrastructure has launched valid concerns about private industries relocating risk to the 'bioavailable' poor (Cohen, 2007; Janes and Corbett, 2009; Jarrin, 2012; Whittaker, 2008). Indeed, in a climate in which many government healthcare policies are increasingly shaped by neo-liberal ideology, CBRC plays a role in 'recycling' poorer citizens deemed unproductive into 'reproductive viability' (Bharadwaj, 2012a, 2012b: 159).

These claims are relevant because fears about exploitation are often used to justify restrictive assisted reproduction policies, and countries where there are limited or no regulations may indeed provide contexts that facilitate abuse. As many patients from highly restrictive countries seek treatment in places that have few or no restrictions, ethically complex situations are not resolved, but merely relocated and often exacerbated.

In particular, issues of human rights have been raised regarding gamete donation and surrogacy. One often-cited risk is the potential for exploitation of egg donors due to the more invasive nature of retrieval, health risks associated with the practice, and potential for exploitation of women seeking financial remuneration. Within Europe, this fear is often directed at women in less wealthy EU countries and in countries outside the EU such as Ukraine and India, which have become sites for CBRC. Moreover, ethnographic studies have raised concerns about inequalities in CBRC practices and the potential to reify existing racial and national hierarchies (Knoll, 2005, 2012; Nahman, 2012; Whittaker and Speier, 2010). Some scholars have drawn parallels between women whose bodies are employed in the service of assisted reproduction and cases in which impoverished women from Eastern Europe become prostitutes serving western clients (Storrow, 2005; Whittaker and Speier, 2010).

Potential exploitation is certainly a valid concern; however, one problem is that such discussions often take the category of 'East European' as self-evident, suggesting that conditions in all former communist countries are similar, when in fact great disparities exist between those countries labelled 'East

European', and often within the same country. This complexity should be examined rather than invoking an image of the victimized East European woman—a common trope in western media (Williams, 2014).¹⁰ Such images are reinforced by associations of 'backwardness', which have also been critiqued in recent decades (Todorova, 2005; Wolff, 1994). These portrayals often overlook the fact that the CBRC phenomenon includes women from Eastern countries travelling to other countries in the region where certain therapies are considered to provide better quality, pointing to social inequalities within East Central Europe. For example, a fertility clinic owner in Warsaw whom I interviewed indicated that she had received enquiries from potential patients in Russia and that she knows of other local clinics that have treated patients from Ukraine (focused interview, Warsaw, October 20, 2015). Therefore, at the same time as many poorer women from Russia and Ukraine are among those who may be at a higher risk of exploitive practices, other, wealthier women from these countries have the means to seek treatment abroad and provide a market for CBRC.

In addition to risks to gamete donors, health policy specialists also stress that CBRC poses increased risks to incoming fertility patients (Ferraretti et al., 2010; Pennings, 2009; Pennings et al., 2008; Shenfield et al., 2011). One concern addresses the screening of donors. In countries with few or no regulations, it is difficult to ensure appropriate standards. Additionally, women who find themselves in dire economic conditions may be less forthcoming in disclosing negative information about their health or their family health history.

However, one of the main risks to patients who travel abroad, especially to countries outside the EU, appears to be an increased chance of multiple-order pregnancies (which bring decidedly more health risks to mothers and babies), as some physicians are willing to transfer up to four embryos at a time (Lawrance, 2010). Indeed, in May of 2015 the case of a 65-year-old German woman who gave birth to premature quadruplets was a major focus of news accounts. Reports indicate that the woman became pregnant after seeking treatment in Ukraine (Köhler, 2015). Some German politicians accused this patient of acting irresponsibly (Medick and Mieritz, 2015); however, such comments overlook the need for a broader debate about domestic policies that induce individuals to travel abroad for treatment. The highly restrictive nature of German policy regulating assisted reproduction, especially the ban on egg and embryo donation, induces many patients to seek treatment abroad, putting some at risk to injudicious practices.

CBRC landscapes: Germany and Poland

Although the topic of CBRC is less often a focus of media discourse in Poland, Polish fertility clinics are also destinations for patients from outside Poland. Polish clinics report significant numbers of patients visiting from the United Kingdom, Ireland,

¹⁰ Sex-worker organizations are often critical of other groups who claim to speak on their behalf, claiming to protect women without consulting those whom are most affected by policy changes (see, for example, Kempadoo and Doezema, 1998). More qualitative research on egg donors is needed before presuming that they have no agency regarding their role as donors, although a lack of legal regulation and enforcement that exists in some countries, especially outside the EU, creates climates that facilitate exploitation.

Russia, Sweden, and the United States (Górska, 2009). However, due to a lack of transparency and clear reporting requirements, it is difficult to establish accurate numbers.

The fact that Germany and Poland are neighbouring countries and that assisted reproduction policies are relatively strict in the former and generally permissive in the latter, has led some Germans to travel to Poland for treatment. Polish reproductive specialists assert that their success rates are higher than those in Germany, stressing that many German patients come to them through word of mouth (Pezda, 2007). However, fertility clinics in Spain and the Czech Republic are especially frequent destinations for German fertility patients (Bergmann, 2011) and also have relatively high and well-documented success rates.¹¹ One reason may be that there are more contacts between German fertility specialists and Spanish and Czech clinics and more infrastructures catering to German visitors in these countries. However, more research is needed on the constellations of actors and networks that exist within countries and across borders, including policy makers, physicians, patients, donors, surrogates and advocacy organizations.

Many Polish fertility clinics use their websites as a tool in recruiting egg donors. Some feminist scholars have criticized the discrepancy between the growing commercialization of the Polish assisted reproduction market and altruistic rhetoric, including the language of gift-giving used to recruit donors, as revealing the hypocrisy of many Polish clinics (Alichniewicz and Michatowska, 2015). In addition to fertility clinics, at least one agency in Warsaw functions as a broker, providing egg donors and surrogates for international clients in a process that includes the recruitment and travel of Polish donors to distant countries. The agency's website includes testimonials of egg donors recounting their positive experiences of travelling to Cambodia, India, Thailand and Mexico. The fact that these descriptions are provided in English suggests that the intended audience is patients from outside Poland seeking donors who may be more persuaded by upbeat accounts that paint a positive picture of the donor experience. The website also mentions that the agency offers a large pool of potential donors from countries other than Poland, including Georgia, India, Thailand and Ukraine.¹²

Although it is difficult to assess how many Polish women have been recruited by this agency, its Polish-language Facebook site mentions that 'several dozen' women have already participated in its egg donor programme and advertises that donors can receive 1500 USD for their donation. The same site indicates that surrogate mothers can receive 12,000 euros.¹³ The agency urges young Polish women to help others

¹¹ For example, in the Czech Republic, clinics claim success rates ranging from 34 to 75% (<http://www.fertilityclinicsabroad.com/> Accessed November 30, 2015). However, success rates are difficult to compare, as there is great disparity regarding type of treatment and the age of patients receiving treatment. Some clinics report positive numbers based on pregnancy tests, others from confirmed fetal heartbeat, or from percentages of live births. In addition, many international patients do not report their outcomes to clinics, making results more difficult to track.

¹² The agency, *New Life Poland* is a branch of a parent agency founded in the Republic of Georgia, *New Life Global Network* http://www.newlifepoland.net/New_Life_Poland Accessed 1 November 2015.

¹³ *New Life Poland* <https://www.facebook.com/pages/New-Life-Poland/131845123639980> Accessed 28 November 2015.

who are struggling to have a child and promises exciting trips to exotic locations, providing photographs of luxury hotels where donors are housed. It may be that many young women have positive experiences as donors. Nevertheless, such advertisements call attention to the brokering of travelling egg donors – a sphere that is especially difficult for national policies to address and a practice that raises concerns about exploitation of women (Storrow, 2005).

Exploitation is often referred to in discussions of CBRC and offered as a reason to ban certain practices such as egg donation and surrogacy. However, as I argued above, banning procedures does not make them go away. Instead they are removed to other sites, often to places where assisted reproduction is largely unregulated and where there are greater risks of exploitation.

In Poland, awareness of CBRC is still emerging. Negative depictions of IVF as a profit-hungry business and as a treatment sought mainly by the wealthy (Radkowska-Walkowicz, 2012: 35) are sometimes extended to include images of wealthy westerners seeking treatment in Poland (Krzyżak and Filiks, 2015). In Germany there is occasional condemnation of patients who seek treatment abroad, but not enough serious debate about the impacts of its restrictive policies. In both countries, public discussions of CBRC have been inadequate.

Instead, moral and religious declarations are invoked in place of undertaking more meaningful public debate of the topic as it connects to consequences on the ground. Polish conservative activists voice concern over the fate of embryos, but there is no significant discussion of the potential for exploitation surrounding unregulated recruitment of egg donors and the dubious trade of oocytes across borders. In Germany, where assisted reproduction is regulated by the Embryo Protection Law, this same law requires that embryos that remain after patients decide not to pursue further treatment are destroyed rather than allowing them to be donated to other patients. Moreover, arguments invoked about the detrimental impact of ‘divided motherhood’ on mother–child relationships are not borne out by research on family and child development (Golombok et al., 2004; Söderström-Anttila et al., 2001); and research on the well-being of donor-conceived adolescents, while more complicated, does not indicate that they are less well adjusted than naturally conceived or adopted children (Golombok et al., 2002). Indeed, a renewed and concerted public discussion of national policies of assisted reproduction and CBRC would also draw attention to the increased use of genetic databases, which some researchers have argued will effectively bring about the end of anonymous gamete donation (Harper et al., 2016). This trend increases the likelihood that donor-conceived individuals may learn of their lack of genetic ties to one or potentially both of their parents, even if they are not told by their family. This possibility serves as a further argument in favour of openness and early disclosure to children.

CBRC in a borderless Europe

Addressing assisted reproduction policy within the context of the EU has become a thorny matter. Those countries with more restrictive policies, such as Germany, have often pushed for increased harmonization (Pennings, 2009: 3).

However, the European Court of Human Rights has stressed in its rulings that no clear consensus exists among member states regarding regulation and assisted reproduction practices (Gozdecka, 2012; S.H. and Others v. Austria, 2010). In most EU countries, national policies regulate reproductive therapies with wide disparities across states regarding which practices are permitted. Neither German nor Polish policy makers have made specific attempts to address CBRC in ways that resolve the ethical and practical dilemmas that it raises. EU law on the freedom of movement makes it difficult to constrain fertility-related travel, and prosecution of such individuals would be seen by many as overly drastic. States have, however, taken more measured actions, such as denying reimbursement for procedures not allowed in the home country or by withholding recognition of parental rights obtained abroad, for example in surrogacy cases (Koffeman, 2014: 9–10).

The prevalence of CBRC suggests that dilemmas and risks are not removed by strict legislation, but are instead relocated. In fact, German policy could be seen to effectively outsource some forms of assisted reproductive technologies to other states with more permissive legal structures, removing pressures for change. This tactic tends to stall activity in legislating bodies regarding assisted reproductive technologies, which has indeed occurred in Germany. Having the option to seek treatment abroad provides a ‘safety valve’, making it unnecessary to move towards legal harmonization, which could impose limits on cultural and ethical pluralism (Pennings, 2004). However, the other side of this process is that the availability of CBRC also hinders healthy deliberation. When patients know they can go elsewhere, they are less likely to protest against overly strict legislation and legislators who find certain procedures objectionable may be more likely to enact or maintain overly restrictive regulations (Storrow, 2010). Within a borderless Europe in which citizens are legally granted the right to seek treatment abroad and where medical infrastructures support this process, many citizens opt to seek treatment elsewhere rather than take the pains to challenge laws in their own country. With regard to assisted reproduction, this tendency is further compounded by patient awareness that statistically positive outcomes often decline with age.

In sharp contrast, the previously unregulated status of assisted reproduction in Poland created a more permissible context, but also one in which there was limited accountability and potentially more opportunities for exploitation. The passing of assisted reproduction legislation (Fertility Treatment Act of June 25, 2015/USTAWA z dnia 25 czerwca 2015 r. o leczeniu niepłodności), which became effective in November 2015, should improve transparency and accountability. However, gaps remain regarding the absence of requirements for psychological consultation and provisions addressing donor recruitment, travelling donors and the import of oocytes. Legislation can also be undermined by political opposition through direct changes to the law or through a lack of funding or implementation. For example, the withdrawal of support for government reimbursement in 2016 means that fewer people now have the resources to pursue fertility treatment.

Discussions about assisted reproduction in Germany are often framed in terms that caution against the use of medical research and technologies that tread in ethical grey zones. Germany’s National Socialist past, in particular, has

resulted in many Germans' discomfort with such ethical ambiguity. In fact, the threat of eugenics is invoked in both Germany and Poland. However, in Poland paradoxical arguments often exist, cautioning against IVF as leading to the dangers of eugenics on one hand, while on the other hand instilling a fear of 'in-vitro children' as malformed humans which eugenic practices are intended to prevent. These anxieties, and the uneasiness with the prospect of 'divided motherhood', which surrounded the debate regarding the German Embryo Protection Law, are linked to the capacity of assisted reproduction to unleash the anomalous. Yet despite these fears, assisted reproduction has already covered considerable ground in becoming normalized as part of our medical, social and cultural repertoires (Franklin, 2013). Across Europe, this technology has come to be expected.

Legislating for assisted reproduction is an especially complicated matter as states must attempt to strike a balance between the moral and cultural perspectives of their citizens and the consequences of regulations. This is no easy task. However, national policies cannot be considered in isolation and especially not in the current context in which there is free movement of patients across EU borders. The examples of Germany and Poland indicate that both highly restricted and largely unrestricted approaches to assisted reproduction pose dilemmas. In particular, Germany's practice of banning egg and embryo donation is only tenable because of other countries which are both accessible and provide affordable alternatives, and because infrastructure is often available to facilitate CBRC.

At the same time, CBRC encompasses complex processes. For example, some patients may travel to Poland for fertility treatment; however, since the new Polish law became effective, single women and those in same-sex relationships from Poland will now be more compelled to seek treatment abroad. The movement of patients within a borderless Europe underscores the degree to which national policies shape, but do not determine, assisted reproductive practices, demonstrating a further way that the EU encroaches on the power of the nation-state (albeit perhaps unintentionally). Such flows also indicate a need for countries to consider how their policies impact practices, not only at home, but also increasingly across borders.

But is Europe really borderless? Perhaps this is a question worth asking. Certainly there is (mostly) uncontrolled border crossing across most EU countries, though some controls have re-emerged in recent years, especially in response to the recent refugee crisis. Although it is not feasible for governments to attempt to control the movements of patients seeking CBRC in this context, some borders still remain. Perhaps the most significant ones have to do with language and culture and the fact that most people would prefer to receive fertility treatment at home (Inhorn and Patrizio, 2012). Undergoing reproductive treatment is stressful, and many patients report that having to travel to seek care increases this burden. Indeed, this is one reason that some scholars have suggested that CBRC is an expression of the failure of states to provide for the reproductive needs of their citizens (Inhorn, 2015) and that 'reproductive exile' (Inhorn and Patrizio, 2009; Matorras, 2005) may be a more fitting term. The concept of a borderless Europe, therefore, aptly describes the freedom of movement and the right of EU citizens to access healthcare in other countries. However, some boundaries remain, crossing them presents significant

challenges, and it is not a decision that most CBRC patients treat lightly.

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