



Changing Fertility Landscapes: Exploring the Reproductive Routes and Choices of Fertility Patients from China for Assisted Reproduction in Russia

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Abstract

Global reproductive landscapes and with them cross-border routes are rapidly changing. This paper examines the reproductive routes and choices of fertility travellers from China to Russia as reported by medical professionals and fertility service providers. Providing new empirical data, it raises new ethical questions on the facilitation of cross-border reproductive travel and the commercialisation of reproductive treatment. The relaxation of the one-child policy in 2014 in China, the increasing demand for ART exceeding the capacity of national fertility clinics and the difficulty of accessing treatment with donor eggs concomitant with a growing economic power of the upper-middle class are shaping the ART industry in Asia in new ways. A new development is Chinese citizens increasingly seeking ART treatment in Russia, which has a long-standing practice of ART governed by a liberal legislation. Furthermore, as China prohibits the export of gametes, Chinese fertility travellers rely on acquiring donor gametes once starting treatment abroad. Clinicians in Russia report three strategies amongst their Chinese patients: One group is using donor eggs of women of Asian appearance living in Russia or is hiring women of resembling appearance from third-party countries to donate their eggs in Russia to create resemblance in their offspring. Another group is buying white donor gametes to create Eurasian mixed children and thus ‘enhance’ their offspring. Providing novel empirical data, this article informs ethical deliberation and raises imminent questions for further research in this understudied geographic region and on cross-border reproductive treatment.

Keywords Cross-border reproductive travel · China · Russia · Assisted reproduction · Egg donation · Eurasian

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Introduction

Global reproductive landscapes are rapidly changing, and along with them, the cross-border reproductive flows and routes individuals take seeking to fulfil their procreative desires (Hudson et al. 2011; Whittaker et al. 2019). Catalysts for such changes include legislative changes, local restrictions and technological advances, in particular in the field of assisted reproductive technologies, that allow selective assisted reproduction (Culley et al. 2011; Inhorn and Patrizio 2012; Wahlberg and Gammeltoft 2017). This travel for cross-border reproductive care is part of a global phenomenon of spreading medical consumerism (Cooper and Waldby 2014; Turner 2010).

Scholarship on cross-border reproductive care has highlighted the phenomenon as a significant arena for inequality and stratification, with patients from the global North exploiting their economic and social capital to access fertility treatment, and women from a lower socioeconomic strata offering reproductive labour, such as surrogacy, to provide for themselves and others (Gammeltoft and Wahlberg 2014; Nahman 2011; Rudrappa 2015; Schurr 2017; Weis 2017). A small body of work has explored patient travel for purposes of pre-implantation sex selection (Bhatia 2018; Whittaker 2011), processes of racialisation in assisted reproduction (Cromer 2019; Deomampo 2016; Moll 2019; Nahman 2013; Rich 2020) and the eurocentricity of existing work (Pande 2010; Vertommen 2015; Weis 2017).

Despite this substantial and fast-growing body of empirical and conceptual literature on the changes in global reproductive landscapes and cross-border reproductive travels, scholarship beyond known epicentres and well-travelled routes that have a global reputation for the provision of ART services, such as the reproductive landscapes and flows in countries of the former Soviet Union, remain under-researched. Emerging work on commercial surrogacy and egg donation in former Soviet Union countries demonstrates an increase in cross-border reproductive travel, not least because of the low costs, minimal regulations and neoliberal governmental approaches which are permissive to treatments prohibited elsewhere (Siegl 2018; Vertommen and Reynolds 2019; Vlasenko 2015; Weis 2013, 2017), and thus the need to pay more attention to the developments in these countries.

This exploratory paper addresses the need to expand the scope of scholarship and presents novel empirical data on the changing landscape of fertility treatment in Russia with respect to the fertility travels of Chinese citizens from China to Russia and the experiences of receiving Russian fertility service providers. This paper is concerned with three key issues. Firstly, it outlines the impetus for reproductive travel from China. Second, it maps an emerging route of travellers and of gametes from China to Russia. And third, it presents contradictory desires of the Chinese fertility patients regarding racialised imaginaries of donor gametes. This paper will show how these three issues are intrinsically linked: Structurally squeezed out of the Chinese reproductive health care system, Chinese patients travel to Russia where they need to obtain gametes for treatment on-site. In the absence of Chinese donors in Russia, they turn to other Asian donors, often hiring them from third-party countries, or choose to pursue treatment with white Russian donor gametes to create Eurasian mixed-race children. These developments raise issues regarding the ethics of care in assisted reproduction, in particular the well-being of women travelling to provide eggs and that of the children conceived and complicate the focus on a global North/South divide in reproductive stratifications.

The paper is based on an analysis of literature together with online research on Russian clinical and agency websites for fertility treatment, news reportage on medical travel in Russia and China and interviews with medical professionals, fertility agents and entrepreneurs in the sector of assisted reproductive technology (ART) in Russia, Ukraine and Kazakhstan. The empirical data comprise 15 semi-structured interviews with ten research participants, conducted between January 2019 and May 2020¹: three surrogacy agency managers (of which two are operating in Russia and one in Kazakhstan); one courier working for a Ukraine-based gamete shipping company that moves gametes from China to clinics in countries in the former Soviet Union; a Russian logistics manager and five embryologists working in private fertility clinics in St Petersburg and Vladivostok, Russia. Four interviews have been conducted in person at a medical tradeshow, 10 over Skype and one over WhatsApp messages and voice recordings on request for convenience of the research participant. Participant recruitment was facilitated over existing research networks with Russian clinicians stemming from previous research (Weis 2017), snowball-sampling and direct contacting.²

Racialised Logics and Imaginaries in Gamete Provision

When individuals undergo assisted reproductive treatment, yet especially when they therefore travel to other countries or even continents and their treatment involves donor gametes, ethnicised and racialised imaginaries and desires are at stake amongst the providers and recipients of donor gametes (Deomampo 2016; Krolokke 2014; Speier 2016; Thompson 2005).

Empirical research on the practice of gamete donation and matching shows a diverging trend: on the one hand, recipients and professionals display desire and intention to match by physical resemblance, including a shared ‘ethno-racial(ized) background’ (Homanen 2018; Becker et al. 2005; Bergmann 2011; Cromer 2019; Krolokke 2014; Moll 2019; Speier 2016) yet, on the other hand, a more recent trend shows a desire to lighten/‘whiten’ offspring conceived through donor gametes (Marway 2018; Moll 2019; Nahman 2018). In ‘Fertility Holidays’, Speier (2016) refers to the fertility travellers’ intrinsic hope for white babies as the ‘reproduction of whiteness’. Also Deomampo (2016), researching transnational surrogacy in India, shows how some ‘white’ US-American clients seek the service of Indian surrogate mothers, yet rely on ‘white’ South African egg donors to ‘reproduce’ their ‘whiteness’ and create a ‘white’ resemblance in the child. In her study on transnational egg donation and Nordic fertility travellers, Homanen (2018) found that talking about ‘Finish’, ‘Scandinavian’ and ‘Nordic’ donors implies desired ‘white Nordic’ looks, making Finland a desired destination to access the desired ‘white Nordic’ look in offspring. In Spain, Europe’s most prolific egg donation country, ‘white’ oocytes are highly in demand by fertility travellers (Krolokke 2014). In order to provide the desired gametes, Spanish clinics are recruiting Eastern European donors (Bergmann 2011;

¹ One doctor and one surrogacy agency manager gave follow-up interviews, prior to and during COVID-19 which impacted the fertility service provision.

² Ethical approval has been given by the Faculty of Health and Life Sciences Ethics Committee of De Montfort University.

Nahman 2018) and are enforcing a more thorough ‘background check’ on potential white donors from countries known for racial hybridity, such as Brazil, by asking them to outline up to three generations of ‘whiteness’ in order to qualify (Krolokke 2014, 59). Krolokke (2014) and Speier (2016) further show how gamete recipients are not shy of ‘reiterating [their] racialized desire for whiteness’ (Krolokke 2014, 63).

In the USA, Becker et al. (2005, 1300) show the challenges parents of donor children experience when facing ‘resemblance talk’, ‘the ongoing threat that comments about physical appearance could stigmatize their children or cast doubt on the legitimacy of their family structure’, enticing parents to make ethnicity an important matching criterion to avoid being questioned. However, along with a quest of resemblance, research has shown a trend of lightening (Homanen 2018) with a ‘desire for “racial improvement”’ (Pande and Moll 2018).

The Changing Fertility Landscape in China

China is known for its stringent population politics of controlling population growth through the ‘one-child policy’, which was enforced in 1979. As Wahlberg (2016, 1) points out ‘there is an almost precise coincidence of timing in the birth of Louise Brown in July 1979 and the implementation of China’s restrictive family planning policy a few months later.’ In their struggle to secure funding, Chinese reproductive scientists framed their endeavour of succeeding in IVF as the potential to improve population quality, claiming that ‘IVF was a technique that would contribute to “superior births”’ (Wahlberg 2016, 7). Since their research led them to the birth of the first Chinese IVF baby Zheng Mengzu in March 1988 in Beijing, Wahlberg (2016, 1) estimates IVF has led to the birth of over 200,000 IVF babies in China while the concurrent one-child policy prevented the birth of approximately 140 million babies.

In 2015, the one-child policy was abolished with the attempt to address the detrimental socioeconomic impact this policy had. Yet, despite this, the National Bureau of Statistics announced that China’s 2019 birth rate was the lowest since 1949 when the People’s Republic’s current state was founded (National Bureau of Statistics in China, 2020), leaving China to continue to be one of the world’s fastest ageing populations. Though practised with increasing success throughout the 1990s, assisted reproductive technology was only legalised and thus authorised in China in 2003, as to Ministry of Health officials, helping couples to have babies felt at odds with the government’s ‘systematic efforts to bring down fertility rates’ (Wahlberg 2016, 7).³ Access to assisted reproductive technologies, including (donor) insemination and IVF, is restricted to married heterosexual couples; the use of donor gametes is restricted to donor sperm, though China reports an acute sperm donor shortage (Wahlberg 2018); in the case of donor eggs, their use is restricted to that of unused eggs of women undergoing IVF and willing to donate their remaining eggs (Cai et al. 2012). In such a case, the gametes or resulting embryos are quarantined for 6 months prior to transfer

³ Qiao and Feng (2014) report that while the practice of IVF has to comply with the Ministry of Health’s requirements, the permission of transplanting up to three embryos in IVF procedures, including for surrogacy, gave affluent individuals unintentional higher chances of having twins or even triplets and thus the opportunity to bypass the ‘one-child-policy’, as multiple births were exempted.

(Qiao and Feng 2014). Furthermore, embryo donation, cytoplasmic and nuclear transfer, and sex selection are prohibited (Qiao and Feng 2014). Finally, gestational surrogacy finds itself in legal grey zone, as it is neither explicitly prohibited nor permitted, leading to a large-scale underground surrogacy market and lawsuits over contract validity and parenthood disputes (Ding 2015).

In the last decade, China has recorded an increasing demand for assisted reproduction (Heng and Xiao 2007), fostered by an increasing purchasing power of the growing middle class, yet that cannot be met by local fertility centres (Wahlberg 2018). As a consequence of a growing demand for fertility treatment and the restriction of what forms of treatment can be accessed in China, and by who, Chinese citizens have increasingly sought fertility treatment abroad. These cross-border reproductive travellers present as a highly stratified group. Those financially advantaged may seek treatment in the USA (Qiao and Feng 2014), whereas those with a more restricted budget have resorted to India (Pande and Moll 2018), Cambodia and other countries in Southeast Asia (Whittaker 2018). According to Hu Yuwei (2018), in Cambodia's market in surrogacy, Chinese cross-border reproductive travellers account for approximately 80% of the clientele.

These cross-border reproductive travellers are active consumers in the global medical marketplace who are “offshoring themselves” (Turner 2010) to seek parenthood, and in the past few years, an entire service industry has been established by independent entrepreneurs to facilitate the cross-border reproductive travels of Chinese citizens, including arranging visas, accommodation and itineraries, medical appointments and translation services, legal assistance and the coordination between various service providers.

One particularly popular destination as of 2015 is Russia, and in particular Moscow and St. Petersburg (Nikitina and Strielkowski 2018; Pan and Moreira 2018). In the following sections, I draw on interviews and online research to sketch how these new reproductive flows from China to Russia are beginning to map out, how (medical) service providers are responding to these demands and what ethical questions these developments raise.

‘All IVF Clinics in St. Petersburg now have Patients from China’: Reproductive Travel from China to Russia

‘In China they queue for IVF, and if you are not standard, you are out. It is *your* problem, solve your problem’, explains Dr Andrey,⁴ a renowned Russian embryologist. By ‘not standard’ he referred to women with underlying health conditions, advanced age and in need of donor eggs, as well as same-sex couples. His clinic, like most private fertility centres in St. Petersburg and Moscow, has seen a sharp increase in Chinese patients since 2015.⁵ According to him and other fertility doctors in St. Petersburg,

⁴ All names are pseudonyms.

⁵ This noticeable increase of Chinese fertility patients in Russia as of 2015 is part of a general increase in medical and cultural tourism from China (Gaiva 2017) which started with the devaluation of the Russian currency in the winter of 2014, making private treatment in Russia more economical. According to the Russian Medical Tourism Association, in 2017, the number of medical tourists from Southeast Asia that are seeking medical care in Russia more than doubled in a year, with fertility treatment being particularly popular amongst medical travellers from China (IMTJ 2017).

fertility centres in China are overwhelmed by the demand for treatment and working at the limit of their capacity (see also Wahlberg 2018).

According to my research participants, one of the main reasons for choosing Russia for fertility treatment, besides the more affordable treatment costs and close geographic proximity, is Russia's liberal ART legislation that permits treatment with donor gametes, the import and export of donor gametes, commercial surrogacy and posthumous reproduction. Unmarried couples, same-sex couples and single individuals⁶ can gain access to ART treatment. There appears to be a high demand from Chinese patients for preimplantation genetic diagnosis which also allows the determination of the embryo's sex.

In addition, despite the practice violating the Russian Federal Law no. 323 on surrogacy, Russian private clinics have earned themselves the reputation of implementing surrogacy without medical indication. As Dr Victoria, an embryologist based in St. Petersburg, commented, when women request such 'social surrogacy' arrangements, 'we try to do it without any indication'. As the Russian law is not robust, Dr Victoria reports that 'We [can note down] any reason, for example age - if these women are in their 40s, I can write "[her age] is a reason for surrogacy."' In Russia's private fertility sector, the patient as the consumer of private services sets the tone. Likewise, when it comes to choosing donor gametes, Dr Lydia ditto reported 'We do not actually counsel [patients] in terms of [who to consider as a donor], it is the right of the patient to choose the donor they prefer, we do not persuade them or we do not reject [demands]. We do not refuse anyone in any kind of donor scheme, it is the right of the [patient].'

The increasing demand for fertility treatment by Chinese clients has prompted changes in the receiving clinics in Russia. Medical and administrative staff have been prompted to work with translators or resort to English where possible and appropriate, yet medical staff deplore the negative impact language barriers and unavoidable occasional misunderstandings have on the quality of the consultation. Doctors in Russia described Chinese patients as highly demanding in their expectation of elite donors, and their interactions as challenging due to the cultural differences. In Dr Victoria's words 'The Chinese are very difficult [sighs]. They are very difficult and very different, in my opinion, and there are large divides in the society and different laws on different levels between themselves. Difficult. (...) It is difficult to translate [all nuances during the consultation sessions].'

Some fertility centres initially hesitated opening to the Chinese clientele, but as the demand increased and competitors embraced the new market, even reluctant clinics had to open their doors to Chinese patients as management feared not accepting Chinese patients would impact negatively on the reputation of their clinics. Other clinics proactively sent their representatives to medical conferences and exhibitions in China to advertise. Dr Lydia recalls:

Actually, when I first went to China for the exhibitions three years ago, I met only two or three other colleagues, a year ago it was like 20 or 30 of my colleagues. And all of them presented their own either agencies or clinics or labs, so I guess

⁶ Single men and male same-sex couples are not explicitly listed as eligible for surrogacy in Russia, but clinics and agencies refer these men to specialised lawyers who represent them in court to win paternity rights.

the China market is so big - it's incredibly big. Even if everyone, every doctor has its own patients from China there will be enough for everyone.

Chinese clients in Russia's fertility clinics are bringing new opportunities and new demands. While previous transnational fertility travellers had mainly been Russian expats or come from Scandinavian countries (Weis 2017), and were able to either ship their gametes from previous cycles or find a matching donor in Russian egg and sperm banks, the 'new' reproductive travellers from China who come for IVF treatment and rely on third-party donor gametes cannot easily import gametes from China because of the doubtful legality of this transit (see below). They therefore need to rely on local or travelling gamete providers.

To illustrate these processes, I draw on observations during an international reproductive technology tradeshow in Western Europe and interviews with medical professionals, fertility agents and entrepreneurs to describe the entrepreneurial ambitions of fertility service providers to enter the 'gamete trade' and export gametes from China for fertility treatment in a chosen country. I will then discuss how Russian fertility service providers described two of the choices made by their Chinese patients who had treatment with donor eggs. Based on the presented scenarios, I raise questions for future research and ethical deliberations.

Shipping Gametes from China to Russia

Exporting gametes from China for treatment in another country is prohibited by the Chinese government, with exceptions for research (Rosemann et al. 2017). In response to the growing overseas cycles of Chinese citizens, reproductive entrepreneurs and courier services are searching for gaps in the legislation or other circumventive routes to bring gametes remaining from previous treatment in China to clinics abroad. At an international reproductive technology tradeshow, Ivan, an employee in a Ukrainian clinic's logistics department, confirmed the export prohibition and, leading me away from his clinic's exposition stall, added with a hushed voice 'only Hong Kong.' When I asked him to elaborate, he explained that gametes can be transported between licensed clinics within China, including Hong Kong—and 'from Hong Kong they can ship [gametes] out to other countries'. At the time of the conversation in June 2019, Ivan estimated that his clinic received shipments from China through Hong Kong once or twice a month; most shipments were embryos for surrogacy arrangements. Likewise, Ewelina, logistics manager of another company facilitating global courier services, was aware of the Hong Kong route, but was aiming higher: She was confident to soon export directly from mainland China to fertility clinics worldwide. Key for that is 'to have a connection with any Chinese clinic who can give us permission for internal shipment (...). If we have this clinic [she laughs] we will do the rest. (...) [Laughs again.] But we need this friendly and polite Chinese clinic to help us'. 'Friendly and polite' are euphemisms for 'cooperative and discreet' as this clinic would operate at the gamete export port for worldwide shipment. '[Our local Chinese collaborators] have already discussed with airports in Guangzhou, Beijing and Shanghai for permission to take our cryo-shipping containers on board. So, we can do it. But we need to release [the gametes] from one clinic, and we need this paper from this friendly Chinese clinic

that we will accept their embryos.’ On my question on how this may be managed within the Chinese law, she replied that ‘it is a small secret, ok.’ The added ‘ok’ was to mark the end of the discussion. ‘So it is not exactly according to the law’, I summed up with the intention to provoke a further comment, and Ewelina added: ‘Ahm, not everything in shipment business and shipment of IVF samples runs according to the law in all countries.’

The initiatives and planning of the above-mentioned intermediaries show that they are active players and planners in the shifting reproductive landscapes and reproductive flows. More research is needed to determine the role such agents play in directing the volume and directions of such flows.

Seeking Egg Donors in Russia

For most Chinese patients in Russia, gametes cannot (yet) be shipped from China to Russia and those individuals who do rely on donor eggs for their treatment have to resort to acquire donor eggs in Russia. Because of the phenotypical differences in appearance amongst most Russians and Chinese, commercial egg banks in Russia have already broadened their recruitment to include women from ethnic minority groups within Russia’s borders to offer eggs with phenotypical resemblance to fertility travellers.

These ethnic minority women ‘of Asian appearance’ in Russia, in the words of embryologist Dr Lyudmila, ‘are *our* women, such as Kazakh, Kalmyk, Buryat, or Yakut’. She emphasised ‘our’ to remind of Russia’s multi-ethnic composition that in fact is now seen as a beneficial asset to the recent developments in the Russian fertility industry: the local availability of ethnic minority women who can act as donors offers a local supply of gametes to create resemblance in the offspring of Asian fertility patients who need donor eggs. It is important to note ethnic minority women with distinct Asian features for the longest time were shunned in the Russian markets in assisted reproduction. Until this recent demand for ‘Asian eggs’, ethnic minority women were required neither as donors nor as surrogacy workers. The rejection of their reproductive labour and reproductive capacities is grounded on the prevailing racism in the reproductive industry that depicts their bodies and labour as lower quality than that of ethnic Russian women, and thus undesired to assist their reproduction (Weis 2017).

However, the accounts of Russian fertility service providers suggest that Chinese patients may make contrasting choices of donors. In the next section, I discuss some of the patients’ choices and their racialised imaginaries.

Quest for Resemblance: Seeking an Asian Donor

According to the embryologist Dr Victoria, a majority of her Chinese patients want an ‘Asian donor’, and for these clients, ‘appearance [is important] first of all, followed by their education’. With ‘Asian’, the clinicians I interviewed referred interchangeably to Chinese⁷ as well as to individuals from outside the territory of the former Soviet Union

⁷ Further to conflating the Chinese patients/clients as Asian, no differentiation regarding ethnic identifications amongst Chinese citizens was made.

with Asian physical appearance, such as Taiwanese, Filipino and Cambodian, and to individuals from within the territory of the former Soviet Union, such as Kazakh, Kyrgyz and Mongolian, including the above-mentioned ethnic minorities resident within Russia. However, unless clinicians personally treated their patients' egg providers to facilitate the egg retrieval for a fresh IVF cycle, they did not know the origins of the eggs or showed little interest.

Clinicians in Russia reported that some patients chose their 'Asian donor' from egg banks in Russia, while patients who specifically wanted 'Chinese donor eggs' had them shipped from American eggs banks.⁸ As a third option, clinicians reported patients' choosing to bring their own donor of choice from a third country to Russia with the help of intermediaries. The clinicians in my sample could not answer why their Chinese patients did not recruit an egg donor from China or whether it is legal. The option of hiring a donor from a third country is becoming increasingly popular amongst Chinese patients in Russia. In those cases, the egg donors are commonly stimulated in their country of origin and travel to Russia for the retrieval, in some cases, arriving on the morning of the procedure and departing on the same day. Dr Lydia, who routinely works with Chinese patients coming to St. Petersburg, illustrated the latter with a recent case from spring 2020:

The Chinese couple found [their] egg donor in the Philippines, and this lady was examined locally. She was provided with a kind of initial administration of injections, so she arrived [in St Petersburg] already stimulated. (...) And she arrived early in the morning with already quite big follicle inside, around 16-17 millimetres, it's quite painful if you can imagine, those ovaries are quite big already. So we just had a final ultrasound examination and gave her a trigger [shot]. And if she was stimulated here for example, I would have done this trigger two days earlier already.

All doctors who worked with travelling egg donors confirmed that these women stayed as short a time as possible, often on short-stay visas, as their recipients sought to minimise expenses on their behalf. 'Being here for five days or for two days is quite a big difference in terms of accommodation costs. So most of the patients decide that the donor just needs to arrive in the morning to have the egg retrieval, and fly back home the next evening' (Dr Lydia). Raising my concerns over the donors' welfare and the lack of aftercare with Dr Victoria, she reassured me that in her clinic 'luckily, we didn't have any such episodes [laughs]. But, for real, we conduct the [cycles] sufficiently free of danger, (...) there is a replacement trigger which prevents the development of OHSS [ovarian hyperstimulation syndrome]. This replacement trigger works sufficiently well, and it is not dangerous.' Yet, she added she would personally prefer keeping the donors in the country for a few days 'because there could be any complications, but they have short visas. So with the visa, that's what happens.' However, she and other clinicians explained they only meet the donors in their capacity as clinicians overseeing the

⁸ With over 40 million Chinese living outside of China (Poston and Wong 2016), such gamete pathways, whereby young, healthy and well-educated Chinese (Han and other ethnicities) are making themselves bioavailable by becoming donors for other Chinese living or travelling abroad for fertility treatment, may be on the increase. (Thank you to an anonymous reviewer for pointing this out to me.)

medical aspects of the arrangement without influence on the wider travel arrangements, a practice common in transnational arrangements (Majumdar 2018).

The practice of hiring egg donors from a third country, recruited by intermediaries, stimulated in their home country, sent to Russia for the retrieval and sent back possibly on the same day, raises significant ethical questions. These young women may experience complications while travelling in either direction, or after return to their home countries where access to aftercare may not be available or affordable. The young women's reproductive work might be illegal or stigmatised in their countries of residence, or a decision to not disclose complication and not seek aftercare governed by other reasons. It was not evident that the clinics in Russia or agencies in China took any responsibility for any medical complications immediately or in the longer term or that doctors considered their practice as a violation of medical ethics.⁹ There was little evidence of any follow-up care for donors. Nor was it clear what would happen if complications arose during treatment in Russia and a visa overstay occurred, or what would happen if complications occurred on the travel to Russia or if they missed connecting flights and, consequently, their appointment. Finally, while Nahman (2008) reminds us to not think of egg donors as victims but as savvy agents in this neoliberal economy, the clandestine nature of the operation appears to thrive on a network of unethical, profit-driven operator.

Racialised Imaginaries and Desirabilities in White Donor Eggs

Another group amongst the Chinese patients were instrumentalising the travel to Russia as an opportunity to access 'white'/Slavic donor eggs to create Eurasian children deemed more beautiful or healthier, as reported by the interviewed clinicians and surrogacy agency managers. Dr Lydia for instance stated that amongst those patients that 'request Slavic type/European type donors (...) some patients absolutely honestly tell us that they just want to have more beautiful kids', and Malvina, a surrogacy agency manager, reported how her clients asked for Russian donors as they wanted children '[with] a white face, and big blue eyes, like [a] Russian', Dr Victoria rendered her patients' preferences as:

(...) you know, [my Chinese clients], they particularly *like* the Russian phenotype. For them – [pauses]. When I was in China – [pauses]. Those [patients] who come here they don't talk about that, but when I was in China, what they say sounds like that: the Russian, he is such a big white warrior. Do you understand? He is such a big white warrior, so strong, he comes and conquers all. Somehow, they appreciate this style - and that's why they choose Russian sperm donors, for example, even though the banks are full of European donors (...). But they for some reason choose in particular this phenotype, dated maybe, - I don't know. It is difficult to say.

Dr Lydia explained how she routinely explains to her patients that children resulting of mixing Chinese and 'Slavic' gametes will as a matter of fact 'not be *absolutely* Slavic'

⁹ To my knowledge, the Russian legislation governing egg donation does not give guidance on incoming reproductive travellers.

in their appearance, but that ‘Asian genes dominate’. Without knowing the intention of the patients, whether they *wanted* their child to look more ‘Slavic’ or ‘European’ or whether they were *accepting* such outcomes because of a more readily availability of white donor gametes in Russia, Dr Lydia tried to ensure that her patients understood that when mixing ‘white’ and ‘Asian gametes’, the Asian phenotype would remain visible.

However, she personally had her suspicion that a number of Chinese patients proactively sought out Russia for their treatment in order to access white donor gametes, and furthermore, that more than seeking to create ‘more beautiful kids’ by mixing their gametes with white donor gametes, these Chinese patients ‘[were] planning something for the very far future’. She elaborated:

Some of my patients, they are honestly telling us that for example they would prefer to avoid some kind of genetic diseases. Each race has lots of different [genetic diseases] and unfortunately it is inherited [sic] (...). So they, in this way, are using egg donation right, for -, well, it is a good aim.

Thus, Dr Lydia perceives her patients’ motivation for choosing ‘white’/‘Slavic’ eggs going beyond an intent to enhance the appearance of their offspring (Mak 2007). She suggests a deliberate move to ‘enhance’ their offspring’s gene pool to lead to the births of a superior population, which has been reported as an inherent desire in the development of IVF in China (Handwerker 1995; Sleeboom-Faulkner 2010; Wahlberg 2016), and is most recently reflected in the increasing demand for preimplantation genetic diagnosis (PGD) in China to eradicate diseases in future generations (Cyranski 2017). Cyranski (2017) notes, *yousheng*, the Mandarin term for eugenics, carries predominantly positive connotations. Scholars critical of the ‘reproduction of whiteness’ however argue that such imaginaries reproduce white supremacy (Twine 2012).

Bioethicists have raised numerous concerns about the desire for children of ‘better quality’ (De Wert et al. 2014; Gillam 1999). In China, licensed fertility clinics are restricted to employ PGD only to avoid serious disease (Cyranski 2017). Clinicians in my sample in Russia however reported implementing PGD in every IVF cycle for their Chinese patients. In Russia’s private fertility sector, governed by a neoliberal market ideology with minimal government limitations (Weis 2017), combining the access to PGD and donor gametes with a different gene pool and the potential promise of a lighter complexion may present itself as the opportunity to reap several goals of improving ones’ offspring. In light of the growing demand of PGD for the creation of ‘better quality’ children, the positive connotations of eugenics/*yousheng* and the availability of PGD and ‘white’ gametes in Russia, ethical concerns need to be re-evaluated within the Chinese cultural context, as the positive connotations of *yousheng* may sideline concerns and caution over negative consequences. Furthermore, bioethicists are called to consider how fertility industries could be held accountable for advancing eugenic options a consumer good.

Furthermore, at the same time as Chinese patients allegedly revealed their desire for ‘superior babies’ to their doctors in Russia, doctors reported that their patients who chose ‘white’ gametes had no intention to disclose their donor conception to their children. Dr Victoria for instance expressed her discontent that ‘I never heard a clear position from anyone.’ These preliminary empirical insights provide a starting point to

inform ethical deliberation on the future well-being of children with regard to their rights to know their (genetic) origin (Frith 2001). A further point to deliberate is the roles and responsibilities of the clinics in providing counselling, and whether counselling with regard to the choice of the donor gametes to create resemblance or a desired phenotypical appearance in the offspring should be mandatory.

Concluding Remarks

As the global reproductive landscape is changing, reproductive flows are changing in their destinations and intensity. One such ‘new flow’ is that of Chinese citizens who, structurally squeezed out of fertility treatment in China, are coming to Russia for treatment, where clinics have begun catering for their needs, especially their demand for donor eggs. While patients’ primary motivation for cross-border reproductive travel is getting access to treatment restricted or unavailable in China, Russian doctors and intermediaries working with Chinese patients also report of two opposite trends that have emerged with regard to their choices of donor gametes.

Some Chinese patients prefer a donor of Asian origin to create phenotypical resemblance in the child. These patients choose their donor from Russian or overseas gamete banks or hire agencies to recruit donors who are flown to Russia for the egg retrieval and a subsequent fresh IVF cycle. Other Chinese patients prefer to select a ‘white’ donor of Russian origin to ‘lighten’ the complexion of their child, and, as the interviewed clinicians suggest, to ‘enhance’ their children’s and thus their nation’s gene pool. This development also suggests that once patients are engaging in technologically assisted fertility treatment, they might begin to scope and seek their options what to add on or in to optimise their chances of having a successful, or even ‘superior’ birth.

The reported opposite trends raise new questions for empirical research, such as on the desires, experiences and intentions of travelling Chinese fertility patients, how racialised imaginaries configure cross-border reproductive travel amongst Chinese fertility patients and what we can learn about changing dynamics of cross-border reproductive flows from this case study. Furthermore, the trend of purposefully selecting ‘white’ donor gametes to ‘enhance’ the offspring may suggest that IVF is undergoing a new change, from a solution to involuntary infertility to a novel form of optimisation via utilising and capitalising on whiteness along with racialised imaginaries and desirabilities.

Moreover, these first empirical findings raise a number of issues for further ethical deliberations, in particular the well-being of donors and the well-being of the offspring. The growing demand for donor eggs demands a rethinking of global gamete provision with the well-being and safety of gamete providers in mind (Thompson 2011). The reports by the Russian clinicians on the economising of expenses when bringing egg donors into Russia while accepting potential risks to their donors’ health suggests a new immunity towards the inherent inequalities in global reproductive care chains. As travelling for egg provision is becoming more and more frequent (Pande 2020), we need to think about the ethics of care to ensure donors’ well-being (Shalev 2012). Furthermore, the trend towards using ART not only to overcome involuntary infertility, but also create children of a certain, preferably ‘better’ kind continues to raise ethical questions. Furthermore, the reported preference of Chinese patients to not disclose their

donor conception to their children raises especial concerns in the cases where children have been conceived with ‘white’ donor gametes and will more likely raise questions about their appearance and identity in the future.

The presented preliminary data acknowledges the following limitations. First, the limited sample size of $n = 10$ participants recruited via previous research networks snowball-sampling and face-to-face recruitment, and through online contact. Second, without data from Chinese patients on their choices and underlying reasons, it is not expedient or appropriate to consider the clinicians’ perception as an accurate representation of the facts. Nevertheless, the preliminary data raise important research questions. Third, medical professionals were requested to act as gatekeepers to Chinese fertility travellers to interview them about their experiences but declined. Finally, the global spread of Covid-19, subsequent travel restrictions and the halting of fertility treatment in Russia as non-essential treatment further impacted this study as planned fieldwork in Russia had to be cancelled.

The preliminary data nevertheless raises important questions that future empirical and bioethical research needs to address.

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Compliance with Ethical Standards

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