



# Reproducing whiteness and enacting kin in the Nordic context of transnational egg donation: Matching donors with cross-border traveller recipients in Finland

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## ABSTRACT

The multimillion-euro fertility industry increasingly tailors its treatments to infertile people who are willing to travel across national borders for treatments inaccessible at home, especially reproductive tissue donor treatments. Finland is the Nordic destination for access to donor eggs, particularly for Swedes and Norwegians hoping for a donor match that will achieve a child of phenotypically plausible biological descent. Finns are seen as Nordic kin, and the inheritability of “Nordicness” is reinforced at clinics. Drawing on ethnographic material from three fertility clinics in Finland during 2015–2017, this article discusses how Nordic relatedness and whiteness are enacted in the practices of matching of donors with recipient parents. The analysis shows a selective and exclusionary rationale to matching built around whiteness: matches between donors with dark skin tone and recipients with fair skin tone are rejected, but a match of a donor with fair skin and recipients with dark skin may be made. Within the context of transnational egg donation, the whiteness or Nordicness of Finns is not questioned as it has been in other historical circumstances. Even the establishment of a state donor register offers a guarantee of kin-ness, especially non-Russian kin-ness. It is concluded that the logics of matching protect the “purity” of whiteness but not brownness or blackness, enacting Nordic(kin)ness in ways that are part of broader intra-European histories of racism and post-socialist Othering.

## 1. Introduction

Markets for reproductive healthcare have become increasingly transnational in that people increasingly travel across state borders to access care (e.g. Franklin, 2011; Inhorn, 2010; Thompson, 2011). The multimillion-euro fertility industry increasingly tailors its treatments to infertile people who are willing to travel to receive treatments unavailable or inaccessible at home because of legal barriers, long waiting lists and high prices (ESHRE, 2010). Gamete/embryo donation and gestational surrogacy are part of this trend (Franklin, 2011; Van Hoof et al., 2015; Vora and Iyengar, 2017; Waldby, 2012). People travel mostly to access donor tissue and treatments. Key destinations include Spain, the Czech Republic and South Africa for egg donation; Denmark for sperm; Mexico, the US, and until recently India for commercial surrogacy (Adrian, 2016; Deomampo, 2016; Gunnarsson Payne, 2016; Kroløkke, 2017; Namberger, 2017; Smietana, 2017; Speier, 2016).

This transnational traffic or “reproflows” (Inhorn, 2010) migrates along historical paths of domination and commerce (Bergmann, 2011; Deomampo, 2016; Thompson, 2011; Vora and Iyengar, 2017). Previous research argues that cross-border travel for reproductive care

reproduces global inequalities, colonial legacies and exclusions in terms of gender, economy and race (Vora and Iyengar, 2017). Only a few can become global biocitizens, exiting and entering regulatory systems, while others – especially women – are reproduced as providers of resources and reproductive labour (Franklin, 2011; Namberger, 2017; Waldby, 2012). Moreover, historically racialized notions of the world are also at work when people choose destinations for their reproductive journeys (Kroløkke, 2017; Speier, 2016).

Studies of traffic to/from key destinations show that travellers typically seek reproductive tissue donation that will assure phenotypic resemblance with the infertile intended parent (e.g. Smietana, 2017; Speier, 2016; Thompson, 2011). That is, they wish to be matched with a donor that shares their ethno-racial(ized) background and personal qualities. Such matching allows the intended parents to pass as the genetic parents in public, and thus to be discreet regarding donor use. In many countries, clinics and brokers involved in gamete donation bolster the creation of an ethno-racially matching nuclear family (Deomampo, 2016; Speier, 2016; Thompson, 2009). It is believed that the donor's ethno-racial(ized) characteristics can be genetically passed on to children born from donor treatments.

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The notion of matching intended parents with donors derives from adoption practices (e.g. [Haines and Timms, 1985](#)), and appears to have been embraced uncritically in fertility treatment practices. Studies show how policy and practice of both adoption and donor fertility treatments aim to match intended parents with children/donors on the basis of phenotypical resemblance and/or other personal characteristics ([Andersson, 2016](#); [Deomampo, 2016](#); [Speier, 2016](#); [Thompson, 2009](#)). Policymakers and medical professionals have even regarded the lack of physical or other personal resemblance as a risk to the successful attachment between parents and child ([Andersson, 2016](#); [Thompson, 2009](#); cf. Government Bill HE 3/2006). This risk argument reproduces the ideal of a solid base of genetic kinship. Indeed, according to Thompson (2009, p.144), matching has kept “assisted reproductive technologies (ART) as ‘natural’ as possible, and aid[ed] families in domestic decisions about disclosure regarding donor use”.

Racial or ethnic proximity are not clear or stable categories; nor is their relation to genetics at all clear-cut. I align myself with research that understands race and ethnicity as social categories enacted in historically and culturally situated practices ([Vuolajärvi, 2014](#); [Whitmarsh and Jones, 2010](#)). People are differentiated, and these differences are stabilized into categories of race and ethnicity: people are racialized ([Mulinari et al., 2009](#), p.4). Linking race to biology has a long history that according to writers legitimized colonialism ([Thompson, 2006](#); [Whitmarsh and Jones, 2010](#)). The scientific quest to define human characteristics on the basis of biological race has come a long way since the heyday of biological race theories and eugenics at turn of the 20th century, which relied heavily on colonial attitudes while making classifications on the basis of observed appearances and behaviours. These racist theories were falsified even before the advent of today's genomics and population genetics, which show how impossible it is to distinguish between the biological and the cultural in “race” ([Kemiläinen, 1998](#); [Oikkonen, 2017](#); [Thompson, 2006](#)).

Yet the concept and practice of race persist. That is why it is important to continue the discussion in terms of race and not just its more politically neutral cultural counterpart, ethnicity. For example, biological racialization is often part of the transnational and domestic stratification of gamete and embryo markets ([Ong and Collier, 2005](#); [Thompson, 2006](#)). While East European populations are rarely thought of as kin nationals by North Americans or Nordics, countries such as the Czech Republic and Estonia are destinations for white travellers from those regions seeking access to donor eggs to ensure racial stability in their families ([Gunnarsson Payne, 2016](#); [Speier, 2016](#)). This situation reproduces whiteness by “creating and sustaining geographies of relatedness that both depend on and displace the significance of blood relations” ([Nash, 2003](#), p.181).

Drawing on my research using ethnographic material collected from three infertility clinics, this article discusses Finland as a destination for donor eggs, mainly for other Nordic travellers. By analysing how healthcare personnel – in collaboration with intended parents – match donors with recipients, I show how (Nordic) whiteness is reproduced and national relatedness/kin enacted in everyday care practices. The Finnish case reveals hierarchies within understandings and practices of whiteness in Nordic countries, and how it is possible to “climb” those hierarchies. Racial categories have internal hierarchies, and their borders shift over time. Some people are perceived as more securely white – the racial category that carries the greatest sociocultural privilege – than others ([Ahmed, 2007](#); [Dyer, 1997](#); [Vuolajärvi, 2014](#)). Historically, Finns have not always been considered true Europeans or part of the “white race”, but have been spoken of as a dark people of Asian and Mongolian origin – even though Finns are among the world's blondest populations ([Kemiläinen, 1998](#); [Vuolajärvi, 2014](#)). Within the context of transnational egg donation, however, it seems that Finnish genetic material is good enough to be included in the Nordic kin(d). Before analysing this in detail, I present a short description of my project and methodology.

## 2. Researching the everyday care practices of enacting whiteness and kin

This article is part of a bigger research project concerned with the constitution of interconnected social relations, such as kin, class, gender and race/ethnicity, in reproductive healthcare practices in the context of healthcare marketization. As the markets for reproductive healthcare have become more transnational, the research has also included cross-border travel for care. During fieldwork it soon became clear that the matching of cross-border recipients and local donors was constitutive of national and ethnic kin and whiteness. Thus, I decided to focus on matching more deeply.

To look directly at care processes and practices, I used ethnographic methods ([Harbers et al., 2002](#)). After obtaining formal permission for fieldwork from the Ethics Committee for the Social Sciences and Humanities at the University of Tampere, and consent from healthcare personnel, I conducted approximately two months' fieldwork between late spring 2015 and spring 2017 at three different clinics. Consent to participate was sought separately from all the intended parents.

By choosing three clinics I aimed to capture a diversity of care practices that could not be explained away by, for instance, specific clinics' or professionals' styles. At the time of my fieldwork, ten private (and nine public) clinics in Finland offered the in vitro fertilization (IVF) required in egg donation treatments. A head doctor I talked to at the beginning of my project alerted me to these three particular clinics as those that received the most cross-border travellers. The clinics were situated in three big cities in Finland, all easily reached from abroad by air, land and sea.

Fieldwork was conducted in periods from a few days to two weeks at a time, depending on the clinics' wishes. After two months I concluded the fieldwork, as it seemed that my observations and video recordings had covered all the different activities, settings and temporal cycles involved in fertility treatment care. While two months is a relatively short period in research influenced by ethnographic methodology, through video recordings I was able to collect a large amount of data-intensive material relatively quickly.

The material comprises videotapes from appointments (63 videos) and procedures (42). Appointments include initial interviews, planning of the care cycle, and ultrasound screenings to determine the development of the endometrium and/or ovarian follicles with doctors. Nurses and embryologists also meet the intended parents: nurses give instructions on taking medication and preparing for procedures, and embryologists discuss embryo development and selection. The egg donation treatment coordinator – usually one of the most experienced nurses – is primarily in charge of donor/recipient matching, correspondence with recipients, and treatment contracts. There are usually one or two coordinators per clinic. The procedures comprise inseminations, egg retrievals and embryo transfers with doctors, nurses and embryologists. Appointments vary from 60 to 90 min for initial interviews to 15–20 min for ultrasound screenings and instructions. Procedures take around 15–30 min. Of all my video recordings, 23 were of appointments and procedures with fertility travellers who were not Finnish residents.

Observations were also conducted in meeting rooms, clinic common areas, and the IVF laboratory where all the reproductive cells were stored, oocytes fertilized and embryos cultured. I also collected interview data from 18 healthcare professionals working at the clinics, including doctors, nurses, embryologists and coordinators, to cover their experience-based knowledge of doing fertility treatments. Intended parents were not interviewed – an obvious shortcoming of the study. Their voices, however, can be heard in my fieldnotes on my chats with them and video recordings of appointments.

Handouts distributed to intended parents, and local and nationwide care guideline materials, were also collected. The professionals identified this material as documents they used in their work.

The videos and interviews were fully transcribed. I also wrote

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