A limited market: the recruitment of gay men as surrogacy clients by the infertility industry in the USA

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Abstract Gestational surrogacy via egg donation is an expensive – and sometimes ambivalently undertaken – but increasingly popular route to planned fatherhood for some gay men. The surrogacy market in the USA plays an important role for gay men with the financial resources to access these services, as it is currently the only stable, commercial market in which there are legal protections for openly gay men. While a small, ethnographic and qualitative literature on the experiences of gay fathers via surrogacy exists, less is known about the state of the surrogacy industry towards gay men as clients. Here I investigate the surrogacy industry in the USA to ask how welcome gay men are in this market. I do so via a content analysis of patient/client recruitment on infertility clinic and surrogacy agency websites. Content analysis of 547 websites indicates that the majority of infertility clinics (62%) and 42% of surrogacy agencies do not directly advertise or appear to be welcoming to gay men. A minority of gay-friendly clinics and agencies, which cluster geographically, actively recruit gay men, creating a limited but niche market. The unequal recruitment of gay men as infertility clients reflects how normative ideas about gender, sexuality and social class are reproduced in the infertility industry. This, in turn, may impact gay men’s procreative consciousness and decision-making about parenting, and exacerbate inequalities around their access to intentional genetic parenthood.

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Introduction

Gestational surrogacy via egg donation in US-based infertility clinics is understood to be an increasingly popular route to planned fatherhood for gay men able to afford these services (Berkowitz and Marsiglio, 2007; Dempsey, 2013; Greenfeld, 2007). For some men, this method is more attractive than others, such as adoption or co-parenting with women, as it seemingly permits more control over the process and allows for genetic exclusive parenthood (i.e. one in which they and/or their gay male partner contribute sperm, without the
involvement of an intended mother\textsuperscript{1}) (Berkowitz, 2012; Blake et al., 2017; Goldberg et al., 2014; Greenfeld, 2015). With gestational surrogacy, a gay male couple is able to arrange for the creation of a child as a couple, within the boundaries of their relationship, allowing for genetic fatherhood for at least one of the men and an intentional fatherhood for both men.

Genetic exclusive parenthood motivates, at least initially, other surrogacy clients in the USA (Jacobson, 2016). A preference for genetic parenthood is not unique to surrogacy or to gay men. Many in the USA understand genetic relatedness as the standard and preferred route to parenthood (Cahn, 2013; Jacobson, 2008; Nelson et al., 2013). This cultural preference for genetic parenthood is reflected in and reinforced by social institutions in the USA, such as the legal system. Genetic parenthood confers automatic legal rights and responsibilities in the USA in ways that other forms of parenting do not. As such, genetic parenthood offers a safety net of legal protections, which might be particularly significant for gay men for whom legally recognized status as (gay) parents has been historically tenuous (Park et al., 2016).

Surrogacy, along with other forms of assisted reproduction, has the potential to be transformative in opening up a path to genetic exclusive parenthood for different populations of people. As Charis Thompson (2005: 274) notes, ‘ARTs have a huge potential to tolerate multiple family forms and to contribute to the demise of reproductive and kinship discrimination against single, gay, and lesbian would-be parents’. There is a small, rich, qualitative and ethnographic literature on the lived experience of contemporary gestational surrogacy (Berend, 2016; Jacobson, 2016), and specifically on gay men and surrogacy (Bergman et al., 2010; Berkowitz, 2012; Berkowitz and Marsiglio, 2007; Blake et al., 2016, 2017; Dempsey, 2013; Goodfellow, 2015; Lewin, 2009; Mitchell and Green, 2007; Murphy, 2013; Smietana, 2017; Tuazon-McCheyne, 2010). Those familiar with this literature and/or the organization of surrogacy in the USA might have an understanding of some men’s experiences accessing surrogacy services and/or know of certain clinics and surrogacy agencies that cater to gay men. But what of the industry as a whole? How welcome are gay men currently in infertility clinics and surrogacy agencies around the country? Are surrogacy services limited nationally for gay men, or do they have the same access as other clients able to afford these services? There is a dearth of national data on gay men as surrogacy clients in the USA; one outcome of an absence of national demographic data on surrogacy (which is not federally regulated or tracked by any federal agencies or organizations). In this paper, I examine the contemporary infertility industry in the USA in order to investigate how the market may be encouraging (or discouraging) gay men as surrogacy consumers via an investigation of client recruitment for gay men across infertility clinics and surrogacy agencies in the USA. In doing so, I add national data to the literature on surrogacy. I ultimately argue that the structure and practice of commercial surrogacy in the USA, reflecting normative ideas about gender and sexuality, has created a limited yet niche market for wealthy gay men. I provide empirical evidence for this niche market, and speculate that it has the potential to lead to unintended consequences for gay family formation.

The landscape of surrogacy for gay men

My curiosity about the infertility industry’s recruitment of gay men as clients was sparked by a comment made to me by a nurse at a small clinic as I was collecting ethnographic data for a larger research project on embryo fate. During our conversation, this nurse noted that she sees gay male clients as ‘more optimistic’ than heterosexual couples or single women as they have not experienced infertility. This idea of gay male infertility clients being different from others resonated with ethnographic data I had from surrogates. As I detail in my book, Labor of Love: Gestational Surrogacy and the Work of Making Babies (Jacobson, 2016: 91), there are surrogates in the USA who prefer to match with gay men in order to avoid working with intended mothers, who, they told me, might have lingering feelings of loss due to infertility. These surrogates wish to work with gay men because of what they see as gay men’s positivity, as loss of fertility is not necessarily a part of the surrogacy equation. Other surrogates prefer working with gay men because of their support for gay rights and non-traditional routes to parenthood. There are surrogates, however, who refuse to match with gay men. These women do not see same-sex couples as forming ‘good families’, often citing religious objections, and were direct with me in their preference for heterosexual married couples. There are clinicians too who told me they prefer not to provide services for gay men, while others have shown me their robust practices in which they directly court members of the gay community as clients.

My experiences collecting ethnographic data in the infertility service field drew me to consider the way in which gay men’s use of surrogacy in the USA may be facilitated by certain practitioners and limited by others, and to seek empirical national data on client recruitment. I find this data particularly important as the acceptance of gay men in US infertility clinics and surrogacy agencies is central to the access of these services for gay men globally. The USA is not only the epicentre of surrogacy in general, it is currently the only stable, global, commercial, gestational surrogacy market in which there are legal protections for openly gay men (Smietana, 2017). Historically, the reproductive rights of men not partnered with women (i.e. single or gay partnered men) have been constrained as they have experienced legal, social and cultural barriers to planned independent fatherhood (Murphy, 2013; Powell et al., 2010; Smietana, 2017; Weston, 1991). This impediment can be tied to the ways in which cultural understandings of gender and its understood meaning in child rearing have been coupled with discriminatory practices against gay men, and enacted and sustained by social institutions, including medicine and social services (Appleby et al., 2012; Bergstrom-Lynch, 2015; Berkowitz and Marsiglio, 2007; Biblarz and Savci, 2010). Although gay men ‘have been living in family and kin arrangements that include children for as long as there have been gay men’, the restrictions against the open formation of their families did not begin to shift until the 1980s, at the same time as developments in assisted reproductive technology (ART) began to make the open formation of exclusive

\textsuperscript{1} A woman is involved, of course, but according to the ‘rules’ of commercial surrogacy in the USA, the surrogate is not considered nor is she intending to be a social parent to the child (Jacobson, 2016).
genetic gay fatherhood possible (Goodfellow, 2015: 2). Since the 1980s, more gay men have been choosing to openly create families and experiencing increased social and legal support in their pursuits (Bergman et al., 2010; Goldberg et al., 2014; Lewin, 2009). These shifts are part of a larger campaign of activism over the course of the last several decades, which has included access to legal protections and social services related to and supportive of alternative family formation and queer families (Gamson, 2015).

As this paper focuses on the acceptance of a minority group that has historically experienced social and legal restrictions to family formation, a reproductive justice lens is helpful in framing this project. Reproductive justice centres reproductive rights (including health and parenting concerns) as social justice issues, and is both a movement and platform for activism and academic enquiry begun by black women in the USA (Briggs, 2017; Ross, 2017). This lens is useful as it contextualizes assisted reproduction and gay men’s position(s) within a larger historical framework of stratified reproduction. It encourages an examination of the stratified market, including who participates in this industry as clients, patients, ‘donors’ and workers (Greil et al., 2011; Solinger, 2013; Spar, 2006). In proposing this lens, I follow Laura Mamo and Alston-Stepnitz (2015: 521) in their call to ‘queer reproductive justice’ in their thinking that ‘LGBTQ participation [in fertility biomedicine] is a rights and justice issue that intersects with and takes shape within broader and multiple reproductive rights and justice issues’.

A reproductive justice frame shines light on the deep history of stratified reproduction policies and services in the USA, which have enabled and coerced reproduction among certain populations while disabling or discouraging that of others (Colen, 1995; Luna and Luker, 2015; Roberts, 1997; Solinger, 2005; Thompson, 2005). I posit that how gay men fit into the shifting landscape of biomedicine as consumers is part of that history, and an important area for enquiry. Reproductive services, as Charis Thompson (2016: 130) notes, intersect with other systems of stratification to create unequal access for marginalized groups in the USA. Lower-income potential patients, for example, are often priced out of the more expensive procedures and services, while systems of stratification sometimes encourage their participation as donors or workers (Bell, 2014; Speier, 2016). This is the case with commercial gestational surrogacy, among the most expensive of procedures in the USA. A single commercial surrogacy ‘journey’ (in industry parlance) can cost upwards of $150,000 in the USA, and few intended parents have comprehensive fertility insurance coverage that would pay for the full range of surrogacy services which are often needed for extended time periods (Berkowitz, 2012; Jacobson, 2016; Thompson, 2016). Market recruitment for wealthy infertility clients intersects with racial stratification, to the exclusion of women of colour – especially working class and poor women of colour – although empirical evidence points to increased rates of infertility among this population (Briggs, 2017; Greil et al., 2011; King and Harrington Meyer, 1997; Luna and Luker, 2015; Roberts, 1997).

In this paper, I shift the lens to gay men, asking how gender and sexuality intersect with market recruitment. Existing research points to screening against lesbian or gay-identified patients in reproductive clinic settings (Berkowitz, 2012; Berkowitz and Marsiglio, 2007; Dempsey, 2013; Greenfeld, 2007, 2015; Greenfeld and Seli, 2011; Gurmankin et al., 2005; Johnson, 2012). The potential for such discriminatory practices towards the lesbian, gay, bisexual, trans, queer/questioning and others (LGBTQ+) community has been recognized as an issue by the Ethics Committee of the American Society for Reproductive Medicine (ASRM) (2013: 1524) as it identifies ‘denial of access to fertility services on the basis of marital status or sexual orientation’ as problematic in the field. Although ASRM (2013: 1524) acknowledges that ‘professional autonomy in deciding who to treat is also an important value’, it concludes that it is an ‘ethical obligation’ of physicians ‘to treat all persons equally, regardless of their marital status or sexual orientation’. This statement by ASRM reflects the fact that the infertility industry in the USA is a privatized market, undergirded by neoliberal principles, and physicians can choose who to treat, what services to offer and who to recruit as patients (Hawkins, 2013; Johnson, 2012; Spar, 2006). In this paper, I analyse national data on the recruitment of gay men as surrogacy clients in order to add to the growing dialogue on the stratification of ART and the ways in which gender, sexuality and social class shape the infertility industry.

Methods

In order to examine the receptivity of the infertility industry to gay men, I analyse patient/client recruitment for surrogacy. I focus on recruitment for several reasons. First, we cannot look to numbers of surrogacies by gay men in the USA as an indication of gay men’s access to third-party reproduction, as such data do not exist. Surrogacy is not federally regulated in the USA. National comprehensive numbers of these arrangements are not collected, and neither are demographic data on surrogates or intended parents. Without comprehensive numbers, I use recruitment of clients as a valuable tool to examine the orientation of particular clinics and agencies regarding their service provision for gay men. Recruitment data are available on services provided to gay men via the advertising of clinics and agencies. I examine an important (perhaps the primary) method of information dissemination and client recruitment for many industries in the USA today: online recruitment.

When intended parents begin on their path to parenthood, they often start by researching, via the internet, infertility clinics and surrogacy agencies to gain information about fertility care (Haagen et al., 2003; Huang et al., 2003; Weissman et al., 2007, 2015; Greenfeld and Seli, 2011; Gurmankin et al., 2005; Johnson, 2012). The potential for such discriminatory practices towards the lesbian, gay, bisexual, trans, queer/questioning and others (LGBTQ+) community has been recognized as an issue by the Ethics Committee of the American Society for Reproductive Medicine (ASRM) (2013: 1524) as it identifies ‘denial of access to fertility services on the basis of marital status or sexual orientation’ as problematic in the field. Although ASRM (2013: 1524) acknowledges that ‘professional autonomy in deciding who to treat is also an important value’, it concludes that it is an ‘ethical obligation’ of physicians ‘to treat all persons equally, regardless of their marital status or sexual orientation’. This statement by ASRM reflects the fact that the infertility industry in the USA is a privatized market, undergirded by neoliberal principles, and physicians can choose who to treat, what services to offer and who to recruit as patients (Hawkins, 2013; Johnson, 2012; Spar, 2006). In this paper, I analyse national data on the recruitment of gay men as surrogacy clients in order to add to the growing dialogue on the stratification of ART and the ways in which gender, sexuality and social class shape the infertility industry.

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2 The Centers for Disease Control and Prevention (CDC) does collect data on ART procedures. In 2014, the latest year for which full CDC ART reports are available, 3% of the 208,604 ART cycles performed in the USA involved a surrogate in a fresh non-donor cycle (CDC, 2016: 52). This equates to approximately 6258 transfers using a surrogate. This figure only covers fresh non-donor cycles, not frozen embryo transfers or embryos (either fresh or frozen) created using donor eggs. This is, therefore, not a comprehensive number of surrogacy cycles in the USA, and does not include surrogacies involving gay intended fathers.

3 Three government agencies monitor and collect data on the medical procedures, laboratory testing, drugs and devices used in ART in the USA: CDC, Food and Drug Administration, and Center for Medicare and Medicaid Services (ASRM, 2010). None of these agencies, however, regulate, monitor or collect comprehensive data on surrogacy per se (Jacobson, 2016).
Internet research plays an important role in third-party reproductive care as prospective clients use it to compare program characteristics, such as number of available donors, approach to anonymity, cost, and screening requirements. They preselect a program on the basis of this research (Hawkins, 2013; Omurtag et al., 2012; Woodward, 2015: 526). For infertility clients, the internet is ‘highly influential’ in choosing a clinic (Marcus et al., 2005; Omurtag et al., 2012: 2). Of course, intended parents also use other means to gather information about possible clinics and agencies, including tapping into their personal networks and seeking advice from medical staff and organizations that disseminate information on the industry (Jacobson, 2016). Murphy (2013: 1112) posits, however, that websites are not only primary sources of information on programmes for many people, but are particularly important for gay men as they ‘inspire potential users by constructing a particular image of surrogacy that affirms the aspirations of gay men to become parents’. Gay men’s procreative consciousness is encouraged, in other words, by seeing images and reading text supportive of gay fatherhood on clinic and agency websites.

Prior research on clinic websites, however, has found a lack of consistent information and support for gays and lesbians. Others studying clinic websites have examined them specifically for LGBT content generally (Wu et al., 2017), patient information for same-sex couples (Jin and Dasgupta, 2016), and support for lesbians and single women (Johnson, 2012). Many clinic websites, as found by Jin and Dasgupta (2016: 2283), did not contain patient education information for same-sex couples. Likewise, Wu et al. (2017) found that only slightly more than half of the clinic websites they surveyed contained LGBT content, with larger clinic size and geographic location as predictive factors.

In this paper, I provide a combined content analysis of clinic websites and surrogacy websites, which, to my knowledge, has not been published previously, in order to gain a broader understanding of the landscape faced by gay men pursuing surrogacy. I analyse publically available information on surrogacy agency and infertility clinic websites to examine the recruitment of gay men as potential clients. My goal with this analysis is not to determine definitively whether or not a particular clinic or agency services gay men, but rather if the clinic or agency presents itself on its website as actively welcoming and recruiting gay men.

I also focus my analysis specifically on gay men, not the LGBTQ+ community in general. As others have noted, there is a need for further research on the fertility experiences of men (Almeling and Waggoner, 2013; Barnes, 2014; Culley et al., 2013; Daniels, 2006). The focus on men was important in my research as I found the differentiation between gay men and the LGBTQ+ community (including lesbians, bisexual women and transsexuals with female reproductive organs) to be an important distinction. I posit that gay men have a distinct experience in the US surrogacy shop compared with women (of any sexual orientation or marital status) due to their status both as gay and as men. This perspective is informed by other scholars who have studied male reproduction or infertility, and have found important ways in which understandings of gender shape the infertility industry and individuals’ experiences within it (Almeling, 2011; Barnes, 2014; Daniels, 2006; Thompson, 2005).

Analysis for this paper began with data from the Centers for Disease Control and Prevention (CDC). Although CDC does not collect comprehensive data on surrogacy, they do collect data on ART procedures and success rates in the USA. Along with reporting clinics (listed by name, address and physician), they also publish reports that list the names and addresses of clinics that did not submit information but were ‘known to be in operation’ (CDC, 2016: 1). In total, 471 clinics were listed in the latest published data: the 2015 Clinic Data Set 4 (CDC, 2017). Of those 471 clinics, 27 were closed, did not have websites or had website issues (the website had been hacked or could not be opened). I surveyed the remaining 444 websites, looking specifically for culturally intelligible icons (such as the rainbow flag), images (such as two men with a child) and specific language (such as ‘same-sex families’) indicating the acceptance of gay men at each clinic and agency. I noted whether or not such indications were present, and how easy it was to view them (i.e. were they on the initial homepage or did they require clicking on various links within the website to find them? Did the clinic use direct language to indicate that gay men were welcome or did they use more subtle, ambiguous text, such as ‘modern families’?). I recorded the presence of specific language that indicated (or could be interpreted to indicate), as I explain below, that gay men would not be welcome in the clinic or agency.

In addition to surveying clinic websites, I also analysed the websites of 103 surrogacy agencies in the USA. Surrogacy agencies provide matching and support services, something that clinics may or may not do. It is important to include surrogacy agency websites in this analysis as agencies can be the initial contact into surrogacy service provision, especially for gay men. Heterosexual couples or single women who arrive at surrogacy are often established infertility patients, and many receive referrals for surrogacy through their physicians (Jacobson, 2016). Most gay men, on the other hand, arrive at surrogacy without previous treatment in an infertility clinic. Surrogacy agencies may, therefore, be the first point of contact for gay men to the provision of ART services. As such, I found it important to include surrogacy agencies in my analysis.

Unlike infertility clinics, no listing is available via CDC or other government organizations for surrogacy agencies in the USA. Therefore, I created a list of all agencies via Google searching ‘surrogacy agencies in the United States’ and ‘surrogacy agencies’ by state (i.e. ‘surrogacy agencies in Alabama’, ‘surrogacy agencies in Alaska’). The 103 agencies I surveyed were all separate entities that engaged in matching services between surrogates and intended parents.

In sum, I visited the websites of all 444 infertility clinics and 103 surrogacy agencies in the USA. The publically available information on clinic and agency websites was analysed for its presentation of surrogacy, specifically the terminology and images used, especially that referring to intended parents and the described processes, for its inclusivity or exclusivity of gay men. I noted the types of text, icons and images present on the

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1 Data on clinics in Puerto Rico were not included.

2 While gay male parented families exist in multiple forms, such as single or multiracial families, in this analysis, I was searching for images that would clearly indicate a same-sex sexual orientation of potential male clients, which translated into searching for images of same-sex male couples.
Websites, where on the websites these items were placed, and where in the nation the agencies or clinics were located. In examining these 547 websites, I searched for indications that gay men were welcome as surrogacy clients.

Website recruitment of gay men as clients

My content analysis of the 444 infertility clinics in the USA reveals that the majority (273/444) do not recruit gay men as clients via their websites. These clinics gave no indication whether or not they work with gay men. These sites are devoid of images (such as two men and a baby), icons (such as the rainbow flag) or text (such as ‘LGBT family building’ or ‘gay couples’) – either implicit or direct – that welcome gay men as patients. This does not necessarily mean that these clinics do not service gay men, but rather that this client population is not part of their online recruitment campaign.

I found no clinics which included statements indicating that they refuse to work with gay men (e.g. ‘gay men not welcome’); however, the language used on the majority of these websites is exclusionary. For example, when describing patients for whom surrogacy is indicated, many of these websites did not include men or gay couples, but rather listed women with a variety of conditions (i.e. ‘women with premature ovarian failure’ and ‘women who have had their uterus removed’). Many clinics also use language in their explanations of surrogacy that locate it as an arrangement exclusive to heterosexual couples. For example, when describing the process of gestational surrogacy, many websites state something akin to that found on one website which read: ‘embryos created in the laboratory from the couple’s sperm and eggs are transferred to the gestational carrier, making the baby a genetic offspring of the couple’. These websites only included images of opposite-sex couples or single women and children, with no images of same-sex couples. In these ways, these 273 websites demonstrate their recruitment of women and of heterosexuals, but give no indication that they are welcoming to gay men.

In contrast, there were 151 clinic websites recruiting gay men as clients. More than half (80/151) of these gay-friendly clinics had some visible indication on their homepage signalling that gay men were being actively recruited. These included rainbow icons, pictures of two men and a child, text describing their services for gay men, testimonials from gay couples, or a visible link, such as ‘same sex parenting’ or ‘gay family building’, that led to a description of services for gay men.

The other half (71/151) of the gay-friendly sites had some indication that services were provided to gay men; however, it often took two or three clicks to find. Most of these websites gave the impression that heterosexual couples were the primary clients (due to the amount of text and images about them), with gay men as a small specialized subset of their practice. Therefore, although they provided services for gay men, these clinics did not appear to be actively recruiting them.

There were 20 clinic websites I characterize as ambiguous when it came to the recruitment of gay men as clients. These websites contained either text or images indicating that they serviced ‘same-sex clients’, but the described procedures, images or language focused specifically on lesbians, not gay men. So, while these clinics appeared to be lesbian-friendly, there were no descriptions, images or text about surrogacy or egg donation services including gay men as potential clients.

The majority of US infertility clinics (62%) do not appear to be welcoming or recruiting gay men. This contrasts with surrogacy agencies. Over half (60) of the 103 surrogacy agencies I surveyed had language on their websites indicating that they provide services for gay men. The majority (44/60) of these gay-friendly surrogacy agencies featured their support for gay male clients directly on their homepage, thus appearing to be actively recruiting these men as potential customers. Four of these agencies indicated that gay men were not only welcome, but were their primary clients. The supportive language or images for the remaining 16 gay-friendly agencies were found deeper into the websites, requiring clicks on one, two or sometimes three links to find. Forty-three surrogacy websites gave no indication that they worked with gay men, but rather, through the text and images used, focused exclusively on recruiting women and heterosexual couples.

In summary, as can be seen in Fig. 1, the majority of US infertility clinics do not recruit gay men on their websites. This is in contrast to US surrogacy agencies, where 60 of 103 agencies do recruit gay men on their websites. However, the majority of both infertility clinics and surrogacy agencies do not participate in active recruitment of gay men, as demonstrated via direct images, text or icons on a website’s homepage.

The geography of surrogacy

When surveying infertility clinics and surrogacy websites by state, it became obvious that infertility services (in general) in the USA cluster geographically. In 2015, there were 4716 clinics providing ART procedures in the 50 states and the District of Columbia (CDC, 2017). Nearly half of those clinics (234/471) were located in just six states: California (n = 74), Texas (n = 44), New York (n = 38), Florida (n = 30), Illinois (n = 28) and New Jersey (n = 20). Two states in the nation (Alaska and Wyoming) have no infertility clinics, while 36 states have 10 clinics or fewer.

Geographic differences by state are even starker for surrogacy agencies. One-third (n = 34) of the 103 surrogacy agencies are located in just one state: California. There are no surrogacy agencies in 23 states, and 12 states only have one agency. The 15 remaining states have between two and nine agencies.

While infertility clinics and surrogacy agencies providing services to any client cluster geographically, the geographic concentration of service providers for gay men is even more pronounced. Perhaps not surprisingly, California leads the nation in the numbers of clinics and surrogacy agencies actively recruiting gay men. California has always been at the forefront of assisted reproduction for same-sex couples (Stacey, 2006). With the amendment of the California Family Code from 1 January 2013, gestational surrogacy arrangements are legally protected in the state (when adhering to certain procedures), regardless of the marital status or sexual orientation of the

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6 This figure includes the 27 clinics that did not have working websites for website content analysis.

7 There were 74 clinics in California in 2015 performing ART services. Eight of those clinics were either out of business or their websites were non-existent or inaccessible.
intended parents (Legislative Counsel of California, n.d.). More than half of the Californian clinics (35/66) and surrogacy agencies (19/33) recruit gay men on their websites. The majority of these supporting Californian clinics (21/35) and agencies (15/19) actively recruit gay men directly on their main homepage.

Despite the strong-hold that California maintains, there are other geographical pockets of clinics and agencies supportive of gay men as clients. These include the greater New York/New Jersey area, with a combined 24 clinics and seven surrogacy agencies, and Texas with 11 clinics and three agencies, all advertising for gay men on their websites. The concentration of reproductive services in California, New York/New Jersey and Texas contrasts with the situation in many states in the country wherein there is a dearth of any clinics or agencies, and even fewer that appear to service gay men.8

The limited market for gay men

My content analysis of clinic and surrogacy agency websites indicates a limited market of providers recruiting gay men. My work joins existing research to point to potential screening against gay-identified patients in clinic settings (Berkowitz, 2012; Berkowitz and Marsiglio, 2007; Dempsey, 2013; Greenfeld, 2007, 2015; Greenfeld and Seli, 2011; Gurmankin et al., 2005; Johnson, 2012). The majority of US infertility clinics (243/444) and a sizeable minority of surrogacy agencies (43/103) do not advertise services for gay men or give any indication that they are welcome. Of the 444 clinic websites surveyed, only 80 advertised for gay men on their homepage, compared with 44 of the 103 surrogacy agencies. An additional 71 clinics and 16 agencies buried information for gay men deeper on their websites, indicating that while gay men were serviced, they were not the primary clients for recruitment. The 43 remaining agencies focused their online recruitment efforts towards women and heterosexual couples. Of the 293 remaining clinics, 20 had ambiguous information on their websites (e.g. text recruiting ‘same-sex couples’ but only including information on services for lesbians) while 273 only recruited women and heterosexual couples.

The contrast between seemingly unsupportive clinics and agencies and those appearing to actively recruit gay men as clients is stark. Gay-friendly clinics and agencies use icons, images and text to implicitly and explicitly communicate to potential clients that they not only welcome gay men but are courting them as clients. Gay-friendly clinics appear to invest effort recruiting gay men. On their websites, many advertise their in-house egg donation programmes and surrogacy screening and matching services which allow a ‘one-stop surrogacy shop’ for gay men. They use images of two men and children on their sites, and include testimonials from same-sex couples. Their websites project a gay-friendly clinic or agency, and they use inclusive language in their recruitment and educational materials. This contrasts with the language and images available on websites that do not recruit gay men, which is exclusionary (i.e. only use images of women or heterosexual couples and children, testimonials from women and heterosexual couples alone, descriptions of clients and their motivations for services exclusive to heterosexuals and women). The images and text used on the non-gay-friendly websites, which comprise 62% of the clinics and 42% of the agencies in the nation, give the impression that these clinics and agencies are oriented solely towards providing services for women and their male partners.

This limited surrogacy market for gay men is further compounded by the geographic clustering of reproductive services. Reproductive services for gay men are not universally available in the USA, but centre on certain regions and urban locations. These findings are consistent with other research.

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7 There were 74 clinics in California in 2015 performing ART services. Eight of those clinics were either out of business or their websites were non-existent or inaccessible.

8 Of the 27 states with at least one surrogacy agency, nine have no agencies recruiting gay men on their websites, and seven have only one agency.
In their analysis of infertility clinics, Wu et al. (2017) also found geography to be important, with the existence of LGBT content on clinic websites more likely in the Northeast and the West. These geographic differences in clinic and agency support for surrogacy (in general) and gay surrogacy (specifically) reflect the politics of different regions in the nation as seen in state legislation or case law. Surrogacy legislation and restrictions are handled at state level in the USA, resulting in a varying – and seemingly constantly shifting – legal landscape (Jacobson, 2016; Markens, 2007). A sizeable minority of states (n = 20), as I wrote in Labor of Love (Jacobson, 2016: 18–19), ‘have no case law or statutes on surrogacy. Surrogacy takes place in those states as there is no law to prohibit it, but the legality of the arrangements has not been tested. Of the states that do have statutes, most are supportive of surrogacy.’ There are states (Arizona, Indiana, Nebraska, New York, Michigan, Washington and the District of Columbia), however, that have regulation or statutes unsupportive of surrogacy (Creative Family Connections, n.d.).

Sometimes, an interesting mix of the variables that shape the landscape of surrogacy for gay men exist at state level. For example, Texas, a strong-hold of Republicanism and conservativism in the Bible belt, is also a pro-industry state that has enforceable surrogacy-friendly legislation protecting legally married intended parents9 (Texas Family Code, n.d.; Jacobson, 2016). New York, a more liberal state with pro-LGBT laws, bans commercial gestational surrogacy (New York Consolidated Laws, n.d.), although it has the third largest number of infertility clinics in the nation (after California and Texas), with 14 of these appearing to welcome gay men. The proximity of New Jersey (with seven surrogacy agencies that advertise for gay men) and Maryland (with four agencies), however, enables gay men to use New York-based infertility clinics and surrogacy agencies in neighbouring states. Oregon, a state where two of the three infertility clinics advertise for gay men, has five surrogacy agencies that match gay men (out of five agencies in the state), and one which lists gay men as their primary clientele.

According to my data, surrogacy agencies have higher rates of advertising to gay men than infertility clinics. I see this as a reflection of the more limited services provided by agencies, which primarily focus on matching surrogates with intended parents. In contrast, infertility clinics perform a range of services, not only gestational surrogacy in-vitro fertilization. However, while there is a higher rate of gay-friendly surrogacy agencies (compared with clinics), agencies are more highly clustered geographically than clinics. Thirty states do not have any surrogacy agencies, and an additional nine states have at least one agency but none that recruit gay men. One-third of all surrogacy agencies in total are located in California, as are one-third of all gay-friendly agencies.

Gay men have few options for genetic exclusive parenthood (the route culturally privileged and preferred by many in the USA) without access to surrogacy. This places gay men at a disadvantage compared with heterosexual men, and women (of any sexual orientation), as their ability to achieve exclusive genetic parenthood is currently entirely reliant on a market. Moreover, as my research has shown, there are fewer clinics and agencies that appear to welcome them. The geographically clustered surrogacy market for gay intended fathers and the cost associated with these services further compound this disadvantage. Future ethnographic research could explore empirically what this geographically limited market means for individual gay men, especially those outside of surrogacy-saturated markets and of lower socio-economic status.

Unintended consequences of the limited market

According to my content analysis, the surrogacy market for gay men is limited. Outside of any individual practitioner decision-making, I propose that this limited market is primarily the outcome of two inter-related social factors. The first are the ways in which normative ideas about gender, sexuality and reproduction shape the industry. Reproduction, as others have articulated, is largely characterized as the purview of women and infertility as a ‘women’s issue’ (Almeling and Waggoner, 2013; Barnes, 2014). Despite the fact that male factor infertility is understood to be as common as that experienced by women, there is a deep history of the conceptualization of infertility as a problem for and about women (ASRM, n.d.; Culley et al., 2013; Greil et al., 2011). The infertility industry is not immune from this cultural conception. The infertility clinic in the USA is a gendered space in which the biomedicalization of women and women’s bodies are primary (Barnes, 2014; Thompson, 2005). According to my content analysis of websites, women (with or without male partners) are the primary clients being recruited at infertility clinics and at most surrogacy agencies. The tight focus on women and women’s bodies in the field of reproduction is reflected in clinical practices, academic research and cultural understandings (Almeling and Waggoner, 2013; Culley et al., 2013). As my research has shown, this results in a stratified market with the majority of clinics focusing their online recruitment campaigns towards women. In other words, gay men may not be recruited because they are men, and men are not the primary market for infertility services in the USA.

Another social factor I see shaping gay men’s restricted access to surrogacy is the way in which biological constraints play out in the organization of the privatized USA ART market. While women without male partners (e.g. single women and lesbians) can access relatively low-tech assistance to reproduce (if they are not experiencing infertility issues), men without female partners require intensive and expensive ART services (egg donors and surrogates) to achieve exclusive genetic parenthood (even if they are fertile). Not all infertility clinics provide such services (although, according to CDC summary data, 91% of reporting clinics perform donor egg services and 87% work with gestational carriers [CDC, 2018]). Sometimes, as I was told by some physicians in the field, the lack of such services for gay men is reflective of practitioners’ ideological or religious positions, but not necessarily. Although, for some clinics, gay men may represent an untapped profitable market [especially as, according to CDC data (CDC, 2018), success rates with donor eggs are higher than those with non-donor eggs], combined egg donor and surrogacy services marketed to gay men require an involved infrastructure that is perhaps simply beyond the time, energy, money and personnel capabilities of some clinics. As others have noted, the reproductive service clinic is often a very busy place (Franklin and Roberts, 2006; Rapp, 2000). Perhaps, as the

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9 Texas surrogacy legislation was passed prior to 2015 (when the Supreme Court ruled on same-sex marriage).
nurse whose comment began the research for this paper felt, gay men are understood to be qualitatively different from the usual clientele (i.e. women and heterosexual couples) in the clinic and, therefore, practitioners understand them to need their own special programme, which might be beyond the clinics’ capabilities or not appear to make financial sense. In other words, gay men may not be recruited because they are gay, and, as such, they require intensive and expensive treatment to achieve genetic fatherhood. Ethnographic research on individual clinicians’ decision-making about which patients to treat and recruit for surrogacy services would be useful for further understanding the situation for gay men.

The unequal recruitment of gay men by clinics and agencies is demonstrative of the intersection of gender and sexuality in the infertility market. I speculate that gay men are marginalized both because they are men and because they are gay. This limited recruitment may have several potential unintended consequences. First, it may impact gay men’s procreative consciousness and decision-making about parenting. As noted earlier, websites are not only primary sources of information on reproductive services, but, as Murphy (2013) argues, are especially important for inspiring gay men to think of themselves as (potential) parents. Having clinics and agencies in one's community that are supportive of gay family formation may enable gay men to contemplate becoming fathers, and to pursue parenthood within their own city, region or state. The role of local surrogacy providers on the procreative consciousness and parenting intent for gay men would also be an interesting area for further exploration via ethnographic research.

A second unintended consequence of the limited recruitment of gay men as surrogacy clients is the creation of a geographically exclusive niche market. This niche market (as niche markets are sometimes apt to do) may exacerbate the economic and geographic inequality that underlie the infertility industry in the USA. Some gay men might face more challenges finding practitioners willing to work with them not only compared with heterosexual couples or women but also compared with other gay men. This might be especially problematic for gay men of lower socio-economic status in areas of the country with few gay-friendly service providers. While wealthy gay men in southern California should feel supported by the local ART community, and have little trouble accessing clinics and agencies catering to their needs, gay men of lower socio-economic status in middle America may have no local options to support the formation of their families via surrogacy. I speculate that the reduced market has a potential, therefore, to have a material impact on the ability of some gay men – especially gay men of lower socio-economic status in areas outside of surrogacy-saturated markets – to access not only reproductive services but, in turn, genetic exclusive parenthood.

A third potential unintended consequence of the limited gay-friendly surrogacy market relates to solidarity among gay men, and activism around gay family formation and gay family rights. I propose that the economic inequality evident in the infertility industry as a whole, exacerbated by a geographically limited niche market for gay men, has the potential to undermine solidarity between wealthy gay men and working class or poor gay men. As gestational surrogacy is available to wealthy gay men, and only available locally to men in certain areas of the country, is access to this route to fatherhood an issue for gay activism? In other words, does the niche market disable conceptualizations of access to gay-friendly surrogacy providers as a reproductive justice issue for all gay men precisely because it enables such access for wealthy gay men (whose voices may be most heard due to the ways in which wealth and privilege intersect)? Using a reproductive justice lens to frame the data on surrogacy recruitment necessarily raises these questions as it highlights the uneven landscape for gay men’s access to reproductive services and exclusive genetic parenthood compared with women, heterosexual couples and other gay men.

While the medical procedures exist, and legal restrictions against openly gay fatherhood have relaxed over the course of the last 30 years, with same-sex marriage legal in the USA and support for gays and lesbians more expansive, my research demonstrates the ways in which gay men might not have equal access to services to support their only available route to exclusive genetic fatherhood. Some might argue that as long as there is a thriving niche market that caters for gay men, unequal recruitment across the industry as a whole is not problematic. They might even argue that a niche market of professionals specializing in gay surrogacy might make the process smoother for gay men, as it is catering specifically to their needs. However, my research adds to that of others (Murphy, 2013) cautioning the ways in which limited recruitment across the industry could potentially result in not only discouraging a procreative consciousness among potential gay intended fathers, but in the actual exclusion of some gay men from the market – especially financially constrained men from areas of the country without access to geographically close gay-friendly service providers. The marginalization of men in general and financially constrained gay men specifically from the realm of reproduction reflects the intersectionality of gender, sexuality and social class in the organization of the infertility industry in the USA. Gay men, while welcomed as potential infertility clients in certain clinics and agencies in certain parts of the country, still face disparities in their recruitment into reproductive services. While wealthy gay men may be able to circumnavigate these constraints to access the niche market catering to their needs, working class and poor gay men may struggle to find providers, even more so than their heterosexual counterparts, due to their economic constraints being compounded by both the gendering of the infertility clinic and geographic limitations.

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