Chapter 7

Reproduction as a Form of Aspiration: Medicalised Childbirth and the Case of Chinese Birth Tourism in the United States and Canada (1980–2017)

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Abstract

Scholars examining the phenomenon of Chinese birth tourism to North America point to strategic desires tied to citizenship in order to explain why Chinese women give birth outside China. The authors build on these insights by exploring the various meanings of childbirth and post-partum recovery among Chinese birth tourists in Canada and the United States through a historically informed ethnographic analysis. Analysed through a postcolonial feminist lens, the authors interpret archival and ethnographic evidence in order to argue that birth tourism is part of a project that is broadly linked to novel aspirational identities of China's new middle class which have developed in step with significant changes to the One Child Policy and neoliberal economic reforms. First, the authors suggest that imaginaries of childbirth and post-partum care are driven by the pursuit of specific forms of medicalisation which empower mothers to create a plan that conforms to the kinds of birth experiences they expect to have. Second, the authors describe how giving birth in the United States or Canada also bestows social distinctions in the form of foreign citizenship, education and

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business investment opportunities which are symbolically meaningful. Finally, the authors illustrate how birth tourism permits families to partake in consumptive tourist and health practices that are marked with global cosmopolitan value. Insights from this investigation contribute to global, medical humanities and social science perspectives on the study of reproduction, medicalisation, gender and Asian birth tourism.

Keywords: Reproduction; aspiration; gender; birth tourism; China

Introduction

Following the United Nations International Conference on Population and Development (ICPD) in 1994, the Chinese state departed from coercive and punitive One Child Policy (OCP) enforcement to pursuing demographic goals through novel reproductive health discourses and notions of the 'good mother' (Greenhalgh, 2005, p. 237). Buttressed by China's embrace of free-market policies, an emerging environment of consumer items and media technologies oriented towards pregnancy and child-rearing sought to cultivate individualistic mothers who would pursue scientific births and its associated care. This new logic, which resonated deeply with China's new-middle class in the early 2000s, encouraged 'self-interested' and 'enlightened mothers' to have one 'quality' child, defined in genetic, health and sociocultural terms. Among them, some families embraced birth tourism – the practice of travelling to the global north to give birth and observe *zuoyuezi* (*sitting the month*), a month of post-partum recovery.[2] In this chapter, we explore a subset who travelled to the United States and Canada beginning in the late 2000s.

Scholars examining migration coupled with childbirth outline multiple motivations for expectant mothers from China (and their families). While early cases in Hong Kong (and elsewhere) often aimed to circumvent the OCP (Shi, 2017), some were motivated by the prospect of socio-economic benefits and legal entitlements (via residency or citizenship rights), lower taxes and access to free education, public assistance and health care (Yan & Chen, 2014). Similar motivations appear in other studies of Chinese birth tourism (Wang, 2017; Yam, 2016). Although these studies highlight possible instrumental incentives, they often overlook broader 'identity seeking' projects associated with birth tourism (Li, 2016, p. 438). Indeed, feminist reproduction studies stress that the embodied experience of pregnancy is often coupled with larger structures of reproductive governance (Klausen, 2015; Morgan & Roberts, 2012; Suh, 2018). That is, reproduction involves 'questions of state, race, freedom, individuality, and economic prosperity [which connect] the micrological with the transnational via embodiment' (Murphy, 2012, p. 6).

This chapter explores the diverse meanings of pregnancy, childbirth and post-partum recovery among Chinese birth tourists and the practices that support them. We ask: do Chinese families travel abroad seeking access to medicalised pre- and postnatal care and, if so, why might this be desirable? How is

foreign birth – and the material advantages it might afford Chinese children – meaningful and desirable? Drawing on archival and ethnographic evidence, we argue that birth tourism is motivated by a desire for reproductive autonomy from a medical system, mainly run by male doctors and shaped by the bureaucratic imperative of large hospitals, that often devalue the desires of female patients and their families. We suggest that such desires are also linked to novel aspirational identities emerging among China's new middle class in step with significant changes to the OCP and neoliberal economic reforms. We illustrate how imaginaries of childbirth and post-partum care are driven by the pursuit of specific forms of medicalisation which empowers mothers to plan their childbirth and post-partum experiences. We describe how giving birth in the United States or Canada also bestows social distinction through access to foreign citizenship, education and business investment opportunities that hold symbolic value. Finally, we demonstrate how birth tourism permits families to partake in consumptive tourist and health practices marked by global cosmopolitan value.

Below, we begin by reviewing literature on medicalisation, reproduction, racial/cultural difference and China's new middle class. After our research methods section, we historically situate childbirth, travel and the way China's demographic policies have shifted in the post-ICPD period. We then provide a brief history of birth tourism and present our findings. We conclude by reflecting on how Chinese birth tourists respond to developments in the field of birth tourism and the diverse practices and meanings they bring to biomedical childbirth and medicalisation.

Reproduction and Difference

Studies of reproduction, in the more familiar medicalised form, often begin by tracing its emergence in the 19th century, when new forms of anatomical knowledge framed the human body as a set of arranged and interrelated systems (Foucault, 2003). The birth of clinical analysis of the body marked the beginning of a governing ideology in which the body's purpose was to defend against death, disease and – most relevant here – reproduction (Shaw, 2012). With this shift, pregnancy was framed as a pathology requiring clinicians to study aberrant functioning and illness traced to specific bodily systems. No longer was pregnancy 'the fruitful potential of the fluid female body [as it was in early modernity]; instead, it was the result of the mechanical operations of a functioning system' (Shaw, 2012, pp. 121–122). The localisation of pathology made legible reproductive processes, tying them to specific symptoms and fixing them to female reproductive organs. The clinical gaze exerted its analytical power over reproduction by assessing whether the pregnant body conformed to or deviated from a 'normal' pregnancy and justified medical interventions.

Feminist studies of childbirth have long registered resistance to medicalised childbirth, which privileges the expertise of largely male doctors, normative 'standards of care' and 'risk assessments' which structure hospital operations

and, if relevant, private insurance (Arney, 1982; Bonaparte, 2014, 2015; Eakins, 1986; Martin, 1989; Oakley, 1984). Indeed, scholars increasingly suggest that modular understandings of biomedical modernity should be interrogated, particularly in transnational contexts, to reveal the diverse meanings, practices and contexts of medicalisation (Clarke et al., 2010; Decoteau, 2013; Fernández Anderson, 2020; Prasad, 2017; Rajan & Leonelli, 2013; Suh, 2021). As Sarah Brubaker (2007) reminds us: 'the feminist critique of medicalisation, [is] based largely on the experiences of white, middle-class women... [leaving unexplored the] experiences of [women of colour who] actively negotiate aspects of medicalisation to best meet their own needs' (Brubaker, 2007, p. 529). Analysing desires for medicalised reproduction, then, requires attention to how medical objects acquire curative, and associated, meanings and, we add, the practices that animate them (Rabier, 2013).

In this chapter, we situate Chinese birth tourism against the horizon of aspiration and extend scholarship on social mobility and consumption in contemporary China to middle-class reproductive aspirations in a transnational context. By examining the meanings and practices shaping how Chinese subjects navigate biomedicine historically, we illustrate how cultural meanings of medical treatment are informed by economic reforms and struggles for status distinction anchored to social and physical mobility (Greenhalgh, 2005). Informed by urban and rural status hierarchies and the desire to insulate themselves from 'stereotypes of rural backwardness' (Otis, 2012), China's new middle class seek cultural distinction through 'conspicuous consumption,' including large expenditures on education, travel and health (Naftali, 2016, p. 100). Such expenses are justified as benefiting 'the family' and strategically 'link their families to global sources of value' and distinction (Woronov, 2007, p. 40). We suggest that overseas medical treatment and the foreign travel involved in birth tourism project a family's economic success while providing access to North American institutions and services which are perceived to be privileged.

Neoliberal Motherhood in Post-Reform China

Following ICPD in 1994, Chinese population policies increasingly drew on reproductive health discourses (instead of demographic control) (Zhang & Zhang, 2011). To achieve its demographic goals, the state sought to cultivate the notion of the 'good mother' linked to the 'quality child' (Greenhalgh, 2005, p. 237). Urban 'enlightened mothers' were encouraged to pursue scientific births through mandatory gynaecological prenatal and postnatal exams to ensure fitness for motherhood in genetic, health and sociocultural terms. This state-promoted imaginary about reproduction prescribed a medicalised pregnancy and encouraged mothers to nurture their child intellectually and physically (Greenhalgh, 2005). Alongside these policies, a marketplace of pregnancy and child-rearing products developed, which extolled virtuous maternal practices and strategies to achieve a 'healthy' pregnancy and child (Su & Ni, 2022). Emerging forms of conspicuous consumption were coupled with responsible motherhood, and

consuming children's books, clothing, furniture and food – especially prestigious foreign commodities – which together signalled maternal devotion and conferred her privileged social status. The body and its associated consumer products took on special value in this context. As Ann Anagnost argues in her discussion of *suzhi* (quality), the body 'provides a common substrate that underlies…the absorption of the individual in technologies of the self, in which care for the body becomes an obsessive focus of bourgeois consumption – an intensification of the body as a site of investment' (Anagnost, 2008, p. 200). Through consumption practices, the middle-class family was articulated in the realms of education, health and cosmopolitan citizenship through its desire to implant *suzhi* (quality) into the child. In all, the state's reformed strategy promoted the ideal of 'autonomous' and global Chinese citizens who would self-interestedly pursue premium goods and services aligned with sanctioned demographic objectives to augment the 'quality' of the Chinese population (Anagnost, 2004; Fong, 2011; Kipnis, 2007).

The weight of such lofty goals to augment the quality of the Chinese population has fomented anxiety and inner-conflict among middle-class mothers in urban China. As Kuan (2015) illustrates, women are often overwhelmed and unable to reconcile their realities as mothers, wives and workers with the ideals of privileged childrearing discourses (Hanser & Li, 2017; Kuan, 2015). For those privileged enough to consider birth tourism, giving birth abroad promises another way to afford their newborn with the best perceived biomedical, social and future opportunities.

Early Iterations of Birth Tourism

The earliest known cases of Chinese birth tourism in North America date to the 1980s when pregnant Taiwanese and Hong Kongese women gave birth while visiting family (Cheung et al., 2006).[3] As travel restrictions loosened, women from the People's Republic of China followed suit. Many turned to the growing network of month centres in Los Angeles and Vancouver, which were pioneered by Taiwanese birth tourists (Bilefsky, 2018). These centres drew inspiration from the first commercialised month centres developed for elite domestic consumers in Taiwan during the 1970s (Cheung et al., 2006; cf. Dutta, 2016).

The industry's expansion in North America was fuelled by several factors. Chief among them was the conferral of citizenship on newborns under the Canadian Citizenship Act and the 14th Amendment. Some Chinese families sought advanced reproductive technologies (ARTs), like in-vitro fertilisation treatment, to circumvent China's OCP.[4] The advent of social media further fuelled the phenomenon by promoting services to a wider audience. Most importantly, these trends coincided with relaxation of the OCP in 2013 and tightened travel restrictions elsewhere (i.e., Hong Kong imposed restrictive measures to halt Chinese birth tourists in 2012 after a fifteen-fold increase between 2003 and 2011) (Legislative Council Secretariat Research Office report [online], 2015). This policy change directed many expectant mothers to the United States and Canada (Legislative Council Secretariat Research Office report [online], 2015; Jiang, 2012).

Reliable statistics of the number of children born in the United States or Canada to Chinese tourists are unavailable. In 2008, when tourism restrictions to the United States were relaxed, estimates suggest 4,200 children were born; by 2012, the figure had reached 10,000 (Cao Dan & Deng, 2014). One birth tourism industry white paper estimated approximately 40,000 such births in the United States in 2013, with projections doubling within 2 years (A-AMSM, 2014, p. 13). In Canada, a 2020 report indicated that non-resident births had tripled since 2013–14 at a hospital in Richmond, British Columbia – a city with a higher proportion of Asian-Canadian residents and visitors (Burns-Pieper & Mayor, 2020).

Sitting the month historically involved a month of recovery typically attended by the mother's mother-in-law. In its modern and commercialised form, it features comprehensive care by *yuesaos* (maternity matrons) who braid together traditional postnatal practices – rest and healthy diet – with medicalised practices involving regular post-delivery check-ups within a clinical-cum-hospitality setting (called a *month centre*). Chinese families sitting the month in North America, however, accentuate their racial difference, which fuelled a veritable frenzy of racist coverage about 'maternity hotels' (Clark & Shen, 2020; Tasci & Nelson, 2013) and led to some centres being raided and 'shut down' by United States Customs and Immigration officials in 2015 under the pretext of safety (Lewin, 2015). Still, birth tourists largely exist within a privileged envelope of the Asian diaspora, in which many of their doctors and all month centre staff are ethnic Chinese, shielding them from intensifying discrimination for racialised persons in North America.

Methods: Accounts of Reproduction

To understand the evolving meanings of reproduction for Chinese women and those associated with birth tourism, we conducted 27 interviews between 2016 and 2017 with 24 middle-class and elite birth tourists and three brokers affiliated with US month centres.[5] We employed convenience and snowball sampling to recruit participants in Beijing and Taiyuan, Shanxi, which allowed us to enlarge and situate our participant pool within the social world of birth tourism (Burawoy, 1998; Patton, 2002). Except for two online interviews, all were conducted in-person in China and lasted approximately one hour. We developed a semi-structured format to guide open-ended questions. Our guiding questions asked about motivations for birth tourism and the role of family, friends, social media and month centre staff in the process. We also explored experiences with hospital-based childbirth, pre- and postnatal care and post-partum recovery, as well as their return to China and future expectations. With permission, interviews were recorded, transcribed and translated; all quotes below employ pseudonyms.

We situated our ethnographic interviews in relation to substantial archival research. We collected and examined immigration policies, newspaper accounts, social media posts and websites pertaining to birth tourism. For Canada, we gathered evidence from Statistics Canada on annual live births, noting parents'

residential status. Together, this documentary evidence allowed us to situate and trace birth tourism temporally and locate it within historically evolving policy and economic currents, as well as in relation to relevant health institutions and organisations. Aligned with our historical ethnographic approach, we independently analysed our archival evidence and transcripts of our ethnographic interviews and identified broad themes from our evidence. We compared each set of identified themes and, after conferring with each other, agreed which ones constituted the closest representations of the meanings of pre- and post-partum care and childbirth expressed by our informants. To address 'digital bias,' we removed 'obvious artefacts' of industry or month centre promotion from our evidence (Marres, 2017, p. 123). We did so by cross-referencing month centre messaging with interviewee testimony to filter out curated narratives intended to promote the birth tourism industry.

Aspiration, Obstetric Care and Childbirth

Birth tourism has been motivated by desires for reproductive autonomy tied to novel aspirational identities among China's new middle class. Imaginaries of childbirth and post-partum care among the new middle class in post-ICPD China have centred on pursuing specific forms of medicalisation that empowered mothers to plan their childbirth and post-partum experiences. Expectant mothers greatly valued access to medical services, including advanced obstetric technology and personalised attention from medical professionals in Canada or the United States. Elsewhere, the pursuit of such medical services might be unremarkable, but we illustrate how being able to determine one's birth plan and post-partum care was both a personal choice and a symbol of respect and status which has been unevenly available in their prior experiences in Chinese hospitals.

Most respondents described travelling to North America to gain more control over their childbirth experience. Many cited a lack of recognition for the service and medicalised preferences of birth mothers in China.[6] One informant, who emphasised the importance of privacy, explained her frustration with using *guanxi* to reserve a double room during the first childbirth in China because 'there were no rooms available and you had to wait for other people to leave.' More commonly noted, however, was the perceived quality and ready access to medical procedures when desired. Another noted that while anaesthesia in China could take 10–30 minutes to work, 'in America it takes effect in only one minute.' Immediate access was a central concern. One mother described how her request for an epidural was lost in the fray of multiple childbirths taking place in the delivery unit.

According to participants, cost-minimising strategies by private hospitals – increasingly dominating childbirth services in contemporary Chinese cities – have led to inadequately monitored child births and a shortage of attending doctors to order necessary epidurals.

Several interviewees reported feeling ignored by doctors overseeing the delivery of their first child in Chinese hospitals. One described how her doctor

conducted a caesarean despite her wish for a natural birth. Others conveyed that they were denied an epidural during their delivery despite clearly requesting them before going into labour. Many mothers sought to avoid being patronised, dismissed or even insulted by hospital staff, as they had been in China. As Lili clearly articulates:

> I told the Chinese doctors what I wanted to do [i.e., have an epidural], but they didn't accept it. They said no...[So] I went to the U.S. to be able to deliver naturally [with an epidural and] without pain.

Lili's tone underscores her struggle to exercise control over her medicalised childbirth. She resented her physician's open denial of her childbirth choices, a common experience with Chinese obstetricians. At the same time, her decision to go 'to the U.S.' to experience childbirth on her terms reflects her privileged position to self-finance an expensive trip and access personalised medical care abroad.

The mother's age could also influence the decision to give birth abroad. When asked if his wife had considered delivering their third child in China, Liu Chao lamented that:

> the medical technique is not good enough. My wife was 42 years old. This situation isn't considered suitable to have more babies in China, but in the West, it is not a problem...They [Chinese people] think...middle-aged women shouldn't have babies...when we went to pre-natal check-ups, people were so curious...so, we decided to go abroad to have the baby. [We] even thought about going to Canada. We wouldn't do it in China no matter what because we couldn't stand the way people were looking at us.

As this testimony illustrates, limited medical expertise for pregnancies 'later' in life, social stigma and subpar medical professionalism were potent considerations. As one interviewee summed it up: 'the doctors there are more dedicated with a bit more professionalism than here.'

Month centre's social media posts echoed these desires for more control over the childbirth experience. One recurring theme was power struggles with Chinese hospital staff over services and respect. Posts emphasise personalised care and the mother's autonomy.

One post from the *Meibaozhijia* highlighted prenatal check-ups as follows: 'mothers enjoy Dr. Yao's VVIP treatment. This time is exclusively dedicated to professional interactions.' One participant indicated that 'the doctor and patient show mutual respect for each other' (Meibaozhijia Month Centre social media post, 12 March 2017).

The prospect of giving birth in Canada or the United States also fulfils desires for knowledge and learning about pregnancy and infant care. Resonating with the shifting media landscape in China –where mothers are flooded with advice on

nurturing 'a healthy child' (described above) – month centres offer classes on pre- and postnatal health.

According to one post, *Meibao* month centre conducts its educational initiatives in the following manner:

> [We] invited a professional nurse guru to conduct class (*sic*). The class is specifically for pregnant mothers to learn about prenatal and postnatal mother and baby health. From infant protection and postnatal mother protection to breastfeeding, she answers all the mothers' questions. Mothers expressed that before this class they didn't know these things. After an entire afternoon of class, they felt immediately at ease. (Meibaozhijia Month Centre post, 14 March 2018)

Such seminars provide valuable information on how elements of traditional Chinese medicine are incorporated into the individualised pre- and postnatal care environment. They also enhance the status of expectant mothers by subtly modifying power relations with their own mothers or mothers-in-law, who sometimes accompany them at month centres. In another context, Zhang and Hanser (2023) highlight how new Chinese mothers use acquired biomedical knowledge to gain intergenerational autonomy from family authority and cultural expectations. Similarly, Chinese birth tourists transform their travelling mothers and mothers-in-law into tourists and learners of hybrid medical practices, rather than gatekeepers of traditional pre- and postpartum care practices.

Distinctions

The prospect of giving birth abroad resonated with Chinese birth tourists because of various opportunities and symbolic distinctions reflected on the child and family. Scholars rightly identify the political and socio-economic benefits of birthright citizenship as key motivations to engage in birth tourism (Wang, 2017; Yam, 2016). However, we found that giving birth in the global North also positioned Chinese families to pursue 'local status aspirations' (Folse, 2023, p. 13). Specifically, a Canadian or US passport has become an extension of the *hukou* which (Chan & Zhang, 1999) permits access to educational institutions – private, public and international – that are often off-limits to non-local or rural, 'lower-valued' *hukous* in China (Folse, 2023).[7]

Families emphasised that US passports provide children with future 'choices' and shaped their well-being and status. As one participant explained, 'Even if my child doesn't want to stay in the US. . .it's up to my child.' For these families, 'more choices' represent more than physical and social mobility – they signify distinction.

Social media posts we analysed generally framed giving birth in North America through a common narrative structure: beginning with the benefits of United States' citizenship then moving to themes of child-rearing, investment

and security. One widely viewed post compared the costs of an American-based month centre with an estimate of an American-born child's future educational and career opportunities. It boldly claimed: 'It only takes 100,000 to go to the United States to give birth, and you can get an American baby worth 9.8 million!' (Meibaozhijia Month Centre post, 8 July 2013). While giving birth in the United States or Canada often costs more than doing so at top Chinese hospitals, posts rationalise the expense by comparing them to the investor visa and emphasising future benefits[8]: free public-school education, lower college tuition (compared to international students), employment and retirement benefits, visa-free travel and easier re-entry to North America. Affirming these advantages, one couple indicated:

> I think it [i.e., birth tourism's principal benefit] is education. I went to school in China and also abroad... Our belief is that a good education is very important for children...My child will have many options in the future. He will have both Chinese and American identities...he will be more competitive.[9]

Beyond valuing pedagogies employed in the United States, this couple believed childbirth in the United States provided social and cultural capital that has a cosmopolitan valence among China's new middle class. Most interviewees viewed American citizenship as a pathway to future college education. This couple's testimony also underlines a belief that foreign credentials carry much higher distinction than domestic ones (Reinhardt, 2018).

The quest for social distinction extends to pre- and postnatal care, which is perceived as superior and healthier in the 'unpolluted' natural environment of Canada or the United States. As Hammer (2003) notes, 'nature' plays a powerful role in Chinese health imaginaries. Anchored in Daoist beliefs, these imaginaries privilege intimate relationships with nature which fosters 'optimal moral and physical health' (Hammer, 2003, p. 16). As industrialisation has rapidly accelerated in Chinese cities, many among the Chinese middle- and upper-middle class urgently desire a 'pollution-free' environment. Pre- and postnatal health, along with childbirth itself, are incorporated into this imaginary of the natural environment and reproduction's symbiotic relationship. Consider the observations of Dai Yuanyuan on her upcoming US trip:

> My husband and I will take this time as a family vacation. The environment for having a baby is better. I had my first baby at the Women's Hospital, which is a good hospital in Beijing. But there are too many people. Every time I went, it was a lot of trouble to stand in line. And the weather...smog... When I did examinations...I was enrolled in a study on smog's effects on new-borns. From their research, we know smog definitely affects babies.

Despite impressive material gains from manufacturing, this informant – whose class status affords her mobility – worries that increased air pollution will

harm her child's health. Dai Yuanyuan evokes travelling to the United States and staying in a month centre – framed as 'a vacation for the family' – as a privileged alternative offering a 'cleaner' environment for childbirth.

Cosmopolitan Experiences and Publics

Framed through leisure, health and tourism, giving birth in North America has signalled conspicuous consumption and cosmopolitan experiences. Consider the Meibao agent who linked her decision to become a broker with a desire to access elite networks and social belonging:

> I started this to create a circle around me of people who wanted to give birth abroad. Now I know many people. We are friends. Our children can get documents and attend school together. That was my initial motivation.

Interviewed with her husband, she emphasised how their US childbirth experiences, plus his US education, enhanced their consultancy. He explained, 'I can tell them about life there – schools, majors…where Chinese people like to stay, what to eat and enjoy there.' Their familiarity with foreign systems was attractive to families seeking entry into cosmopolitan circuits of distinction.

Zhao Guangming and his wife viewed the trip as a fun family adventure, including their oldest child and his grandmother. Month centres facilitate leisure and tourism experiences beyond childbirth and 'sitting the month' by offering services and amenities akin to high-end hotels. One Jiayoumeibao post describes the 'community environment' complete with a pool, playground and basketball court. An accompanying photo shows fathers playing basketball together with Americans and playfully claims they had 'completely fit in with the locals' lives' abroad. Some centres provide life and wellness courses and services coupled with leisure or personal development. For example, The Baoma Inn in Richmond, Canada, offers 'breast massages to promote lactation… lectures on childbirth with other Chinese mothers-to-be and excursions for high tea' (Bilefsky, 2018).

Month centres have blended commercial hospitality and luxury hotel services with Chinese practices of hiring a *yuesao* (maternity matron). Emerging from the commercialisation of sitting the month, yuesaos attend to the mother and new-born during the post-partum recovery month. Song Lili describes her observation of month centre accommodations and care:

> Month centres [in the United States] have grown with more people hiring *yuesaos*. We didn't used to hire *yuesaos*. We thought they were so expensive… why would I hire a *yuesao*? But now more families, even middle-income families, hire *yuesaos* to ensure new mothers receive good care and service. Sitting the month is very important.

Song Lili's testimony braids the health benefits of sitting the month *and* expectations of its commercial iteration (i.e., 'good service'). Hiring a *yuesao* is both a form of care and hospitality offered through premium services. The value of month centres was summed up by one broker: 'month centres are easy. You only have to worry about giving birth.' Several respondents echoed this, including one father who described the 'main difference' between giving birth in China and the United States as its 'relaxing' nature, thanks to the *ayi* [*yuesao*] caring for the newborn: 'Every night the *ayi* took the baby to another room to sleep, and I'd just shuttle the baby back for feedings. In China, we didn't have this. There were children crying nearby, which was fine, but the US was much more relaxing.'

The 'relaxing' presence of *yuesaos* has permitted travelling grandmothers to support and observe rather than provide caretaking.[10] An Lapangbaba post about a Zhejiang resident who gave birth in the United States noted that 'her mother-in-law brought the oldest child to accompany the mother while awaiting to give birth, [and] the delivering mother's mother arrived on the day of birth to care for her daughter. Congratulations' (Lapangbaba, 12 December 2016). This reflects a role reversal, with the paternal grandmother minding the grandchild rather than attending to her daughter-in-law, while the maternal grandmother casually arrives on delivery day. Such testimonies showcase grandmothers enjoying global travel, unencumbered by traditional expectations of reproductive labour.

Culinary experiences are threaded through the care associated with birth abroad. Jiayoumeibao advertised:

> Here come nutritious meals at our comfortable villa. Daily meals are a combination of meat and vegetables and can be cooked according to mom's tastes. We guarantee mothers' nutritional needs and that they enjoy their food. We also offer free sea cucumber and swallow's nest soup once a week. (Jiayoumeibao Month Centre post, 6 July 2017)

The culinary dimension of birth tourism is both 'healthy' and a moment to enjoy delicacies and China's eight regional cuisines. Month centres claim to orient their menus to birth mothers' regional taste. While regional sensitivities were supported by our informants, one clarified that post-partum meals were mostly bland and tasteless for health reasons:

> Liver tomato noodles, without salt, do you think that's tasty? While eating, I was just thinking this is for my health and that my body needed it. . .Every day during the month, we all had to eat a lot of soup to guarantee we produced enough milk.

This response suggests that the post-partum nutritional focus, rooted in Traditional Chinese Medicine, often takes precedence over flavour.

Food experiences offer a way to conspicuously celebrate events both in-person and through social media. Month centres render their services more intimate and personalised by organising birthdays and other gift giving occasions, which can be important for older children who might feel anxious or marginalised by the new-born. Such occasions are deliberately publicised. For example, a Huameibaobao month centre post shares photographs of a birthday party (including gifts and cake) hosted for one mother with newly made 'family' and 'friends,' consisting of month centre employees and other clients. It reads, 'Our Huameibaobao mothers come from all over China, yet they're just like one big family happily sitting together eating seafood' (Huamei Baobao Month Centre post, 10 July 2017).

Indeed, the community formed in month centres performs normative understandings of China's multi-ethnic nation, often favouring Han regional identities. Captioned photographs and messages about 'good times' with other foreign travellers abroad are circulated through social networks to broadcast their cosmopolitan experiences and project family status to the publics in which they are embedded.

These events and their representations further reify the birth tourist family's privileged status through social media. While attempting to project an inclusive community, these communications subtly convey how families are *served* by staff. One Huameibaobao month centre post described how a driver assigned to a resident family not only sent flowers to the hospital after a client's delivery but also brought a Lightning McQueen toy car for the newborn's 'big brother'. The post explains that staff 'inadvertently learnt' the boy yearned for the toy by monitoring the mother's social media (Huamei Baobao Month Centre post, 11 July 2017). Refracted through social media, such interactions and gestures convey the privileged arrangement birth tourist families enjoy with attentive month centre staff.

No trip to America is complete without visits to boutiques and malls. Month centres are often located near shopping, restaurants and medical services. One facility noted that 'shopping malls, cinemas, parks and golf courses' were within 10 minutes, with 10 Asian restaurants nearby, and listed driving times to each hospital: Fountain Valley (7-minutes), Garden (9-minutes) and Garfield (40-minutes) (A-AMSM, 2014, p. 16).

Beyond convenience, significant emphasis is placed on the prestige of the neighbourhood where month centres are situated. Establishing facilities in high-end areas of Los Angeles County enables birth tourists to avail themselves of much desired American goods and services in some of the most prestigious west coast localities known to the global Chinese community.

For mothers with school-age children, another consideration is temporary access to the schools with English instruction. Posts highlight access to schools while explaining the school system and enrolment requirements (i.e., needing only a utility bill in one's name to enrol). In a WeChat exchange shared by one informant detailing her conversation with a prospective month centre, she first expressed concerns about her parents' US visa applications, then immediately inquired about enrolling her 4-year-old in a local kindergarten.

Malls, schools and medical offices are vital publics where birth tourists connect and form social ties. These publics also provide opportunities to challenge the images of birth tourism perpetuated by for-profit agencies. Birth tourists were not unaware of the stigma attached to these facilities fuelled by reports of fraud and poor services at some organisations. Perhaps due to anxieties over whether they were receiving premium accommodations and care, many sought each other out to share information. One informant recounted:

> At the doctor's, I talked to some pregnant women who were cheated by the month centres they initially stayed at. They were put on top of a hill, and the medical clinic was actually opened by the month centre. They were unprofessional so the women didn't receive adequate and professional care.

Chinese birth tourists seek connections with each other while they circulate through cosmopolitan sites (i.e. American and Canadian medical facilities, month centres and malls) which form a circuit of public spaces and institutions expected to accommodate their desires, practices and presence. Many, as the Meibao agent noted as her motivation for entering the industry, create social 'circles' and continue interacting after returning to China through social media.

Conclusions

Social scientists studying childbirth practices and medicalisation among racialised subjects in North America and in the Global South note how subjects actively negotiate medicalisation in relation to imaginaries of health, social privilege and transnationalism (Almeling, 2015; Brubaker, 2007; Clarke et al., 2010; Decoteau, 2013). This chapter reveals how privileged Chinese families navigated pregnancy, childbirth and post-partum recovery amid changing fertility and travel policies, shifting conceptions of child rearing and motherhood and evolving middle-class aspirations. Framed as a culturally informed reproductive project, shaped by Chinese women and their families in a transformed economic environment, we demonstrate how aspirations to overcome domestic inequalities informed their experiences and assigned meanings of childbirth, post-partum care and travel. Giving birth and receiving post-partum care in North American cities, in addition to engaging in related consumption experiences, fulfil Chinese families' aspirations to overcome material and symbolic inequalities dating back to the Cultural Revolution. Strikingly, these experiences are not simply individual or biomedical choices but are embedded within family-based logics of care, responsibility and intergenerational investment. In this way, the experiences of birth tourism we analysed often mobilise entire family units, particularly grandmothers and spouses, whose labour, financial support and caregiving facilitate the mother's – and her family's – transnational reproductive project. While gendered hierarchies within families also surface, involving expectations of intensive mothering that might be driven by notions of

middle-class femininity, for example, mothers engaging in birth tourism have also been able to exercise a modicum of agency by availing themselves of the amenities and services of month centres which fulfil roles they might traditionally be expected to play. We would be remiss if we did not also acknowledge how such gendered hierarchies might be extended outside the family to female caregivers as with the example of the *yuesao* (maternity matron) who, as we described, might be hired to care for the mother and newborn.

Since 2020, the period following our analysis, Chinese birth tourism has undergone marked changes. As some month centre operators predicted and as our study confirmed, many birth tourists are turning to a Do-It Yourself, 'DIY' arrangements, whereby families independently organise travel, accommodations and medical services without relying on a month centre. This likely involves the distribution of feminised labour of reproduction across family networks, especially as it concerns mothers and mothers-in-law, the latter of whom have historically played key roles in 'sitting the month' practices. In North American medical contexts however, such practices may unfold with limited knowledge or institutional support because the enterprise is organised independently.

Perhaps unsurprisingly, our Meibao research participant criticised DIY, suggesting it stemmed from an inability to 'afford good care.' She described a prospective client who, after choosing DIY to save money and bringing her mother to assist, later admitted that she 'didn't sit a good month.' The agent concluded: 'you get what you pay for.' In our study, we find evidence linking experience and confidence to DIY and challenging this assertion. Specifically, of the two birth tourists who returned to the United States for a second birth, one managed the process independently and the other hired a month centre after arriving. These shifting practices suggest a growing negotiation of risk, thrift and autonomy and intergenerational strategies of care among transnational families.

Whether motivated by saving money or asserting independence, more birth tourists are turning to DIY. As the head of Gedao Life Agency noted:

> I think the demand for our services will start to diminish. They will find their own accommodation through Airbnb and apply for their own visas. I have a new business plan to introduce Chinese patients to doctors from around the world, not just obstetricians in the U.S., but also specialists in other areas... (Pak, 2019).

While needing less support with travel and maternity arrangements, Chinese birth tourists continue to seek autonomy in choosing medical services and accessing premium medical care, as our study demonstrated. These adaptations in practices of birth tourism unfold not only across national borders but also along gendered and familial lines, revealing how women's reproductive decisions are interwoven with broader household strategies aimed at maximising symbolic and material capital.

By our estimation, the DIY field has continued to evolve since the period of our analysis. Major world events have introduced new obstacles to North American birth tourism, including souring Sino-US relations and the COVID-19

pandemic, both of which have reduced the number of Chinese tourists. In late 2020, the Trump administration's hostility towards China prompted amendments to B-1 and B-2 visitor visa regulations by the State Department, specifically targeting 'birth tourism' in the policy change (White House Press Secretary statement 2020). In 2025, birth right citizenship was put into question by an executive order.

Is the question of Chinese birth tourism in Canada or the United States merely a case of biomedical personalisation? Nikolas Rose (2001) suggests that in late modernity, clinical practices no longer focus on treating pathologies based on medical necessity. Instead, biomedical customisation and personalisation – often aimed at enhancement (e.g., gender reassignment or limb lengthening) – have become central (Rose, 2009). We do not view Chinese birth tourism in North America as a case of biomedical customisation or personalisation because desires for medicalised treatment need not be coupled with the promised outcomes of biotechnological enhancement alone.

Indeed, insights from medical sociologists and anthropologists underscore that the telos of modern medicine, in which medicalisation is necessarily prior to the availability of exploratory biotechnological treatments, is an assumption derived primarily from the experience of privileged subjects in the North (Fernández Anderson, 2020; Prasad, 2017; Rajan, 2013; Suh, 2021).

Technoscience scholars stress the need to interrogate modular understandings of biomedical modernity, particularly in transnational or Global South contexts, to reveal diverse meanings, practices and contexts of medicalisation. Decoteau (2013) has demonstrated that Black South Africans with HIV often combine biomedicine and 'traditional' healing practices to treat the virus. Despite warnings about blending anti-retrovirals with traditional healing interventions, Decoteau's informants rejected a 'monotherapeutic ideology,' as indigenous approaches to disease and cure accommodate biomedicine rather than reject it outright (Decoteau, 2013, p. 266; Digby, 2006, p. 346). Her concept of 'health pluralism' (Decoteau, 2013, p. 265) – referring to the ways subjects navigate disempowerment within biomedicine resonates with our analysis of the heterogeneous post-partum practices Chinese birth tourists bring to the experience of childbirth, which also adopts biomedical practices. Our account further underscores what historians of science call the 'plurals' of birth tourism as a hybrid practice, consisting of 'always already internally pluralised' tradition of post-partum recovery that blends notions of 'pastness' and modernity, as demonstrated in our review of the history of 'sitting the month' and how the practice has incorporated shifting notions of motherhood in post-reform China (Brooks et al., 2020, p. 5; Mukharji, 2016, p. 24; Zhang & Hanser, 2023). This hybridisation might also interweave interpretations of roles for the family that are central to medicalised childbirth, particularly those that are thought to be from the past and those that are 'modern' in which Chinese birth tourists navigate care through intergenerational support, gendered roles, paid labour and transnational resources.

This chapter advances scholarship on medicalised childbirth among Chinese women in North America by contributing a transnational perspective from women and families in the Global South (Brubaker, 2007; Litt, 2000). We argue

that Chinese birth tourism extends extant insights of medicalisation by illustrating the diverse practices subjects might use to navigate biomedicine. Rather than jettisoning obstetric technologies and procedures (e.g. natural childbirth or epidurals) for limiting maternal agency, Chinese birth tourists and the industry which services them recombined and re-appropriated these tools. This, we argue, underscores how disempowerment in medicalised childbirth may not always result in outright rejection of biomedicine, as some feminist scholars emphasise (Arney, 1982; Eakins, 1986; Martin, 1989; Oakley, 1984). Instead, Chinese families normatively reconstructed medicalised reproduction by traveling internationally to secure obstetric services which were situated in a newly imagined, cosmopolitan iteration of the traditional practice of 'sitting the month'.

Still, several limitations of our findings must be noted. First, as with many studies of 'hidden populations,' our relatively small, networked sample – due to the legal grey zone in which birth tourists operate – may not be representative of the larger Chinese birth tourism cohort (Hanson & Theis, 2024). Second, our evidence was collected before COVID-19 and significant shifts in Sino-US relations, both of which drastically impacted travel between the two countries. In addition to more prospective birth tourists adopting 'DIY' strategies, many may have forgone the practice altogether due to structural constraints that reduced the feasibility of travel and medical procedures. These shifts have altered both the symbolic and institutional value of US citizenship for Chinese families and their ability to maintain quasi-dual citizenship (Folse, 2023).

These limitations and uncertainties provide opportunities for further research on the social implications of this phenomenon. For example, some of our respondents noted that few doctors in North America understood Chinese approaches to the body and health, despite the autonomy they gained during childbirth. Future studies might examine how birth tourist mothers, even with class privilege, experience marginalisation and structural racism in health, and the historical context of these experiences, similar to other medical-seeking racialised communities in Canada and the United States (Valiani et al., 2023). Researchers might also historically trace the impact of US citizenship on the children of birth tourists, many now approaching adulthood. Like other children born in contexts which blur territorial boundaries and citizenship claims (Choi & Lai, 2022), they may have faced challenges navigating their unique citizenship statuses, identity and emotional belonging and intensifying global anti-migration rhetoric over the first two decades of their lives.

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Notes

1. The authors are listed alphabetically, and the labour required to produce this manuscript was shared equally between the co-authors.
2. In late imperial China, 'sitting the month' involved seclusion at home where new mothers would be sheltered from 'the harmful influences of weather, demon, and human alike… rest in bed… [and were] plied them with foods and drugs that were seen as "warming" and fortifying. …' (Wu, 2010).
3. Traveling to the United States to give birth is a practice stemming from at least in the 1950s involving parents who were Indian, Pakistani or Turkish among other countries. Approximately 30 countries now offer 'birthright citizenship' (Bilefsky, 2018). The derogatory term 'anchor baby' had been used repeatedly in the late 1990s to describe these newborns and exaggerated accounts of pursuing birthright citizenship have been invoked to create controversy often around general elections in the United States.
4. For example, The Mayo Clinic in Rochester (New York) reported that double the number of Chinese patients sought reproductive services from the Clinic between 2014 and 2015 (just prior to the official end to the OCP) (Tatum, M. (2020). China's fertility treatment boom. *The Lancet (British edition), 396* (10263), 1622–1623. https://doi.org/10.1016/S0140-6736(20)32475-2).
5. The four primary month centre organizations are Lapangbaba (La Fat Dad), Meibaozhijia (American Baby Home), Jiayoumeibao (Home Has American Baby) and Huameibaobao (Chinese American Baby).
6. Though we do not specify it below, at each mention of childbirth, the Chinese mothers we interviewed did not object to having medicalised childbirths but that they were not able to avail themselves of specific medicalised procedures as they had requested in advance.
7. Folse (2023) concludes that the acquisition of US citizenship through birth has come to be known as 'the American hukou' in China.
8. As the reader will notice, some interviewees' claims could be inaccurate or exaggerated. Nevertheless, these estimates do not detract from our argument that childbirth in the United States constitutes a project of reproduction tied to the pursuit of social forms of distinction by middle-class Chinese birth tourists.
9. Comparisons between China and the United States that our informants made should not be read as cultural generalisations which the authors endorse. Our informants' views were perceptions that intersected with aspirations about their children's future for which childbirth in the United States was a crucial point of departure.
10. The majority of expectant mothers we interviewed travelled to the United States with their own mothers and mothers-in-laws. However, the two women who did not use month centres, choosing to stay in private accommodations instead, were the only informants whose mothers and/or mothers-in-laws cooked and cared for them during the post-partum period.

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