



MONASH University

TAMING EGG DONORS:
THE PRODUCTION OF THE EGG DONATION
BIOECONOMY IN SPAIN

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A THESIS
submitted for the degree of
Doctor of Philosophy
at Monash University

Faculty of Arts, School of Social and Political Sciences

Melbourne, August, 2021

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ABSTRACT

Taming egg donors is a multi-sited ethnography of the egg donation industry in Spain. It elaborates the politics of decision-making, information, risk perception, labour, and selection that operate in the Spanish context. In this thesis, I delineate the multilevel processes in place to ultimately achieve the stabilisation of bodies and eggs for their entry into the global bio-market circuits. Based on ethnographic fieldwork in Barcelona, I draw on the point of view and experience of both egg donors and clinicians. This polyvocal approach reveals the needs, struggles, and expectations of the participants involved and how they are orchestrated to produce the egg donation bioeconomy.

The main argument of this thesis is that egg donation is a fragile process that needs careful methods of containment to effectively work. It is fragile in the sense that the process can fail at any point: the donor might not follow the rules properly; the drugs might not generate the expected effect; the risks cannot always be contained; the extracted eggs might not be mature enough; or the children born might not meet the expected health standards. I argue that these methods for containing women, which I describe as a process of taming, operate both at the structural level — where institutional discourses, socio-economic factors, and regulations converge — and at the micro level of clinical practices — through the building of particular relationships between clinicians, donors, and their bodies.

First, I argue that the rationalities of becoming an egg donor are intimately linked with the precarious Spanish labour market, which makes egg donation an activity that is very similar to having a job for young women. Second, I show how the combination of the legal framework of egg donation as altruistic and anonymous and the information delivery practices in fertility clinics produce particular sociotechnical imaginaries among egg donors that ultimately prevent debates on reproductive justice. Third, I contend that fertility clinics have taming methods in place to assure that egg donors will make it until the end of the process. These techniques happen at the level of the selection and management of donors and attempt to contain behavioural problems and bodily imbalances. Fourth, I describe how clinics precariously attempt to stabilise donors'

genetic and ethnoracial pasts in objectifiable categories, a process that reveals key aspects of how health and race operate in the fertility industry. Finally, I contend that all these efforts reveal clinicians' imaginaries, struggles, and anxieties in relation to the perceived stressful job of dealing with egg donors. Their uneasy presence in fertility clinics is highlighted by the sociotechnical imaginaries of clinicians about future of assisted reproduction, in which egg donors are expected to 'disappear' thanks to forthcoming technoscientific innovations.

Through these arguments, thus, I analyse how the Spanish egg donation industry is orchestrated to contain women's imaginaries, bodies, biographies, and eggs so that they can be converted and travel across the global bio-market circuits. In doing so, this dissertation contributes to scholarship on tissue economies, reproductive labour, sociotechnical imaginaries, and Spanish extractive industries.

DECLARATION

This thesis is an original work of my research and contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Anna Molas Closas

Date: 14 of August 2021

PUBLICATIONS DURING ENROLMENT

Molas, A & Perler, L 2020, 'Selecting women, taming bodies? Body ontologies in egg donation practices in Spain', *Tapuya: Latin American Science, Technology and Society*, vol. 3, no. 1, pp. 396-414. DOI: 10.1080/25729861.2020.1781371

Molas, A & Whittaker, A 2021, 'Beyond the making of altruism: branding and identity in egg donation websites in Spain', *BioSocieties*. DOI: 10.1057/s41292-020-00218-0

ACKNOWLEDGEMENTS

The last four years configure one of the most intense, inspiring, and challenging periods of my life. The PhD journey did not imply for me only the writing of a thesis, but also a relocation from Spain to Australia, a country that I had never visited before and where I had no first-hand contacts. I owe these lines to a large network of people who, across thousands of kilometres, supported me throughout this process.

On the Southern Hemisphere, the first person that I want to thank is my main supervisor, professor Andrea Whittaker. Any enumeration of the things I am grateful for would be neglecting so many others. Nevertheless, I would like to mention at least four: First, thanks for believing in my project and accepting me as your student, how lucky I feel! Second, thanks for opening the doors of your home (and thanks as well to your family, Bruce, Claire, and Rachel) when I had just arrived in Melbourne and did not have a fix place to stay. Third, thanks for being an excellent mentor, for guiding me throughout this process, and for letting me explore, get lost, and start over again. And finally, thanks for your unconditional support over the last two years of PhD, where I, as so many others, found myself locked not only inside my apartment for several months, but also in Australia, without the possibility of going back to Spain when it was heavily hit by the Covid-19 pandemic.

I want to express my gratitude to Professor Narelle Warren and Dr Paul Mason, who were my second supervisors at different periods of my thesis. Thanks for your disposition, advice, and more important, for your kindness throughout this journey. This path would also have been much harder without the company of my PhD candidate fellows Trang Do and Sarah Hearn, who have been always there for listening, reading, or commenting when the thesis (and life) became too much to handle. Thanks for your friendship. And of course, thanks Ettore, Rudi, Sergio, Marco, Javi, Laura, Cris, David, Helen, Don, and Geraldine for the undisrupted amount of laughter and adventures throughout these years.

Moving now to the Northern hemisphere, across lands, oceans, and seas, I want to first thank to the participants of this thesis, egg donors and IVF practitioners, who

voluntarily decided to take part in the project, who gave me their valuable time, and who had the humility to let their stories be interpreted by a third person. I take your voices as a privilege I am not worth of. Thank you so much.

I want to acknowledge the support of Professor Joan Bestard as well, to whom I owe more than anyone the opportunity to undergo a PhD in the first place. Thanks for, after being my MA supervisor, granting me with all the support that was at hand to prepare a doctoral thesis application. I will never forget those early days. Thanks also for acting as my local supervisor during my fieldwork, for providing me with a space at the University of Barcelona when I needed it, and for integrating me in the postgraduate program activities of the Department of Anthropology.

Thanks to my friend and colleague Laura Perler, with whom I share a strong intellectual and personal bond without which this thesis would probably look very different. And to Berta, Albert, Sara, and Marta, for being there, as always. Thanks to my family, who found a way to be always close to me and to my project despite the distance, time difference, and language barriers: my parents, Marta and Prudenci. My siblings, Mireia, Alba, Joan, and Maria. I could never have made it without you.

Finally, to the person who stayed with me on both sides of the world, who embarked on this uncertain journey away from everyone and everything that we knew, with whom I have lived all the adventures of the past years and hopefully, the ones that are to come: thanks, Albert Cruz Gispert, for everything.

*A la meva mare,
Marta Closas Rins,
i a la meva àvia,
Antonia Rins Recasens*

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ABBREVIATIONS

AI: Artificial insemination

AMH: Anti-Mullerian Hormone

ARTs: Assisted Reproductive Technologies

CBRC: Cross-border reproductive care

ECHR: European Court of Human Rights

ESCs: Embryonic stem cells

ESHRE: European Society of Human Reproduction and Embryology

GnRH: Gonadotropin-releasing hormone antagonists

ICSI: Intra-cytoplasmic sperm injection

INE: Instituto Nacional de Estadística (*National Statistics Institute*)

IUD: Intrauterine device

iPSC: Induced pluripotent stem cells

IVF: In vitro fertilisation

CNRHA: Comisión Nacional de Reproducción Humana Asistida (*National Commission of Human Assisted Reproduction*)

OHSS: Ovarian hyper-stimulation syndrome

PDG: Preimplantation genetic diagnosis

SEF: Sociedad Española de Fertilidad (*Spanish Fertility Association*)

SIRHA: Sistema de Información de Reproducción Humana Asistida (*Information system of human assisted reproduction*)

STS: Science and Technology Studies

TFR: Total Fertility Rate

INTRODUCTION

STABILISING DONORS, EXTRACTING EGGS

It is common knowledge that you get paid to donate eggs in Spain. I am not sure when I heard about it for the first time. During my twenties, my social media profiles were full of advertisements from different clinics inviting me to become a donor. At university in Spain, I remember that the free folder they offered us at the printer shop was branded by a clinic which had basic information on their egg donation program printed on it, a promotion strategy targeting students that continued during my fieldwork. Once I even received an email through the employment portal I was subscribed to when trying to look for a new job: “Donate eggs, REWARD!” said the subject line. The mix of anger and surprise that I felt about that message, which was purposely situated on the borders between an ad and a job offer, was the seed that motivated me to undertake this research.

The participants of this study had similar experiences to me. While some women got incessant advertisements on the Internet, others heard the story of an acquaintance or a friend of a friend who donated eggs, and from whom they learned that “it is like two birds with one stone, I win money and moreover I am helping someone who wants to have a child” (Valentina, 21 years old). Indeed, these advertisements would always point out the altruism of the donation. So, in the same way that everybody knows that you get paid to donate eggs in Spain, everybody knows that you are supposed to do it, at least to some extent, for altruistic reasons.

The aims of this thesis have slightly changed over the course of my investigation, particularly after conducting my fieldwork. My initial main purpose was to explore the

experiences of egg donors, which is still, to this day, the most striking gap in the literature of the growing Spanish (and transnational) fertility industry. However, I quickly realized that centering the thesis on that question was insufficient for making sense of the entanglements that permeate the lives of the so-called “egg donors”. The first problem with this approach was, in fact, departing from the assumption that such thing as “egg donors” exist in Spain.

I am not referring here to the much-debated use of the term egg ‘donation’, which presumes that the people who engage with this practice are motivated by the wish to charitably donate to help other women to become mothers (an issue on which I take a stance on section ‘On nomenclatures and definitions’). My surprise was rather to find out that my participants’ ideas about what egg donation was and did, varied significantly. Their literacy in the medical process it implied, the imaginaries about the possible futures of their eggs, and their knowledge around the realities of the global circulation of ova and patients among Europe, to name some central aspects, revealed the disparity of understandings around egg donation held by my egg donor participants. I soon realized that such disarticulation was not casual and even less innocent. Instead, it was one of the pillars on which the success of the egg donation industry rested. Putting all the focus of this thesis on their motivations and views about the process, therefore, was not enough. Doing so would reveal donors’ particular understandings and imaginaries about the process rather than any valorisation of systems in place in fertility clinics or of the market dynamics that regulate the circulation of their eggs, which most of my participants ignored. This is how, while still placing the experiences of egg donors at the core, the mechanisms in place to bring women to complete extraction cycles came to be the main focus of my research.

The question that all the chapters of this thesis attempt somehow to answer is: *how are bodies stabilized for extraction purposes in the Spanish reproductive bioeconomy?* This shift from motivations and experiences to practices allowed me to undertake a much more stimulating task, which in turn brought more questions to the table: what are the rationalities of women when deciding to undergo egg donation? How do these decisions relate to issues of information and risk perception in and outside the clinic? What kind of

labor is required by women engaging in a donation cycle? Under what conditions is it undertaken? How do clinics select women for extraction purposes? And finally, how do clinicians envisage the future of reproductive medicine in relation to the current practices of egg donation? In this thesis, I am interested in the protocols in fertility clinics that allow this relationship between clinics and donors to work. Through the crossing of their gazes, I will pass through the topics of decision-making, labor, risk perception, selection, and the future.

This thesis starts from the idea that egg donation is a fragile process. It is fragile in the sense that it needs to be carefully handled from the very beginning — the selection process of the donor — until the very end — when the extracted eggs are assigned futures. The process can fail at any point: the donor might not follow the rules properly; the drugs might not generate the expected effect; the risks cannot always be contained; the extracted eggs might not be mature enough; the children born might not meet the expected health standards. The environment of uncertainty, pressure and high competency in which clinicians working on egg donation are usually embedded requires a diverse set of control techniques directed to minimize the associated risks.

The main argument of this thesis is that the whole egg donation system in Spain, both at its structural level (where socio-economic factors as well as regulations converge) and at the micro level of clinical practices (from the personal relationships between clinicians with donors to the drugs they will be prescribed), are orchestrated to contain women's bodies and biographies in order to comply with clinics' extraction purposes. In this thesis, I contend that the process through which these two world orders — the one of fertility clinics and the one of donors — are made ready to operate is a process of *taming*. The central aim of this thesis is, therefore, to delineate the multilevel processes in place to ultimately achieve the stabilization of bodies and eggs as they constitute the condition for their entry to the global bio-market circuits.

Taming donors

The choice of the word *taming* to talk about the standardisation process that takes place in different spheres of the egg donation process allows a new perspective on the relationships and practices that operate in fertility clinics. While the term evokes notions of control through an attempt to domesticate, the semantic charge goes beyond the framework of top-down discipline to account for other forms of ambivalent collaboration that include affective relations and mutuality. Throughout this thesis, I will use this term relying on the use proposed by Anibal Arregui (2020) when discussing animal-human affective intimacies.

In his study, Arregui aims to disentangle the complex affective relationships between the endangered pink river-dolphin or *boto* — a popular character of Amazonian folklore — and the riverine dwellers of the lower Amazon region (Brazil). As he argues, human and dolphins can show mutual hostility in some cases, while in others positive corporal engagements take place. The author's investigation concludes that highly ambivalent relationships take place in this interspecies encounter, that can be both seen as 'wild' and 'tame', and that in either case go much beyond the possibilities that the notion of 'domestication' conceals. Situating his work in a large tradition of scholarship that acknowledges the agency and the potency of non-humans to shape human behaviour (see Ingold 2000; Haraway 2007; Cassidy and Mullin 2007; Tsing 2012, 2015), he argues that "the analytical implications of distinguishing domesticatory processes from relations of taming still remain largely tacit in social sciences scholarship" (p. 824).

Following his line, in this thesis I aim to delve deeper on the possibilities of the concept of *taming* to shed light to the complex, bidirectional relations between egg donors, bodies and eggs, and clinicians. In this exploration, I will illuminate taming relationships based on measures of control but also of care, concern, and affection. As Arregui claims, dolphins can be both "tame" and "wild beasts", which he does not see as static qualities of bodies, but instead *positional relations* that are negotiated. These positional relationships between donors and clinics will take most of the attention of this thesis.

While the taming methods I will outline along this thesis will remind in some parts to the Foucauldian notion of ‘discipline’ (which he explored particularly in *Discipline and Punish* 1975), different empirical findings took me to the decision not to make this concept central. For Foucault, discipline is the technique of power to manage the behaviour of individuals in a society. It is based on a continuous surveillance of the subjects which is in part facilitated by social institutions such as the prison, the hospital, and the school. This thesis will show how egg donors are indeed under surveillance during the egg donation cycle. However, the process of taming is understood here as happening beyond the disciplining of donors as subjects. Instead, it also accounts for the containment of bodies and eggs, who are seen as having the potentiality to exert their agency, or ‘wildness’ and make the egg donation process fail. *Taming* is therefore a notion that encapsulates disciplining measures but that also accounts for the more-than-human aspects in need of control and stabilisation to achieve successful outcomes.

In the following chapters, I address the issue of the taming of egg donors through different perspectives: the taming of the imaginaries of the egg donation system, the taming through the labour of egg donation, the taming through control, discipline and affects, and the taming of the future of the egg cells.

ON NOMENCLATURES AND DEFINITIONS

What is egg donation? Process and risks

As outlined by the European Society of Human Reproduction and Embryology (ESHRE) “[e]gg donation is a fertility treatment directed to women unable to produce their own eggs or at high risk of transmitting a genetic disease. The donated eggs are fertilised with partner [or donor] sperm as in a conventional IVF treatment cycle, and one (or two) [and sometimes three (SEF 2018)] transferred as an embryo for pregnancy” (ESHRE 2017).

The medical process consists of the ovarian stimulation of the donor through self-administered hormonal drugs in form of subcutaneous injections over 8-12 days (Plate 1). The medication acts by producing multiple mature eggs during one menstruation cycle. Once the eggs are mature, they are retrieved from the donor through a surgical procedure of aspiration. The operation requires general anaesthesia and usually lasts between 20 minutes and 1 hour. The number of eggs extracted in the puncture, their maturity and their quality cannot be precisely predicted. However, the latest report from the Spanish Fertility Association (SEF) indicates that the average number of eggs obtained in Spain per extraction cycle in 2018 was 19.4, and the success rate of IVF using donated eggs was 34.2% per cycle (SEF 2018).

Apart from the risks associated with the anaesthesia, egg donation is a procedure that carries some risks and side effects. As the SEF informs in their guidelines for the treatment of infertility (Matorras Weinig and Hernández 2007), the most common is ovarian hyper-stimulation syndrome (OHSS). When occurring in women undergoing egg donation, it consists of an unexpected strong reaction to the stimulation treatment of the ovary. The SEF indicates that the frequency of the pathology varies between 0.6% and 10% of women undergoing ovarian stimulation. It involves a significant growth of the ovaries, liquid accumulation in the abdomen or thorax, and alteration of renal and/or hepatic functions. In severe cases, it can be life-threatening for egg donors, with the possibility of respiratory failure or coagulant alterations. It might require hospitalization and surgical treatment (Matorras Weinig and Hernández 2007). Other risks and complications might include intolerance or side effects due to the medication, abdominoperineal infection, haemorrhage due to an accidental puncture of the blood vessels, abdominal pain, accidental puncture in another part of the body, and ovarian torsion.

While some studies have suggested a correlation between egg donation and certain kinds of cancer, long-term effects remain unknown due to the lack of longitudinal studies (Beeson and Lippman 2006; Pearson 2006; Schneider 2008; Woodriff et al. 2014; Brody 2017; Tober et al. 2021). The use of informed consent itself has been called into question by some who instead “call for more realistic explanations to egg donors about the lack of

knowledge of long-term risks as well as more transparent informed consent documents” (Schneider et al. 2017, p. 480).



Plate 1 - Bag of used syringes of a donor halfway through the egg donation process. Shared by Andrea, 29 years old, two-time egg donor

Donors, providers, or sellers?

The terminology surrounding ova donation is debated (Beeson et al. 2015). While in most countries like Spain egg provision is embedded in the framework of altruistic donation, it seems obvious in most ‘reprohubs’ (Inhorn 2015) that referring to these women as ‘donors’ is a misnomer (Nahman 2008) that hides both the economic interest and the reproductive labour that is embedded. Catherine Waldby and Melinda Cooper (2008) argue that the use of the word donation is "a way to expropriate donors and deny them rights over their bodily material" (p. 67), for which they coined the term ‘clinical labour’, that reflects the precarious working conditions in a globalized bioeconomy (Cooper and Waldby 2014). Following this line, Sara Lafuente-Funes (2019) argues that it is important

to confine the work of egg donors or gestational surrogates from other assisted reproduction practices, and rather talk about ‘Transference of Reproductive Capacity’ (TRCs), which highlights specific power-relations operating in these exchanges by placing them as another step in the expanding feminized global care chains.

However, I observed that in the Spanish context most women who underwent the process, regardless of their motivation and context, used the term ‘egg donation’. Leaving this name behind in order to make a political statement as a researcher would be also abandoning the interesting and productive tensions that this term produces. These tensions are ‘generative nodes’ (Haraway 1991) and allow me to make sense of the participants’ perspectives as well as the logics of the industry. In this thesis, therefore, I decided to respect the emic term ‘egg donation’ used by all the participants, acknowledging (and embracing) its problematic potential.

Ova or eggs?

As the reader will notice, in some parts of this thesis, I use the term ‘eggs’ and, in others, ‘ova’ to refer to female egg cells. The rationale for this is based on several considerations. First, the distinction between egg donation and ova donation does not exist in neither Catalan nor Spanish. The practice is instead always called *donación de óvulos* [literally translated as ‘ova donation’]. The literal translation of ‘egg donation’, instead, would be *donación de huevos*, which sounds ridiculous in the context of Catalan or Spanish, as the term ‘eggs’ is exclusively used to refer to bird eggs. If used in the human context, it is to refer, in a colloquial way, to the testicles [what in English would be called ‘balls’]. Strictly speaking, therefore, it would be more accurate to talk about ‘ova donation’ in the context of this thesis. However, the scientific formality that this term implies in English does not match with the informal tone in which most egg donors in my fieldwork talked about their eggs. For this reason, I choose to talk about ‘egg donation’ when discussing the experiences of (intending) egg donors.

However, the formality of the term ‘ova’ matched well with the way clinicians referred to human egg cells. To play a bit with the semantic distinction of both terms and to highlight the changing meaning of egg cells during the process, I contend that while women arrive to the clinic to provide their ‘eggs’, these have to be transformed into bio-objects (Holmberg et al. 2011) for medical practice, that is ‘ova’, detached of the meanings and entanglements that tied it to their producing subject. Ova, therefore, will be used as a translation for *óvulos* when it is the clinicians who are referring to it.

THEORETICAL DISCUSSION

Ethnographic studies of egg donation

The scarcity of qualitative studies that focus on the voices of egg donors around the world has been repeatedly pointed out by different researchers in the literature of assisted reproductive technologies (e.g., Pollock 2003; Molas 2016; Lafuente-Funes 2017a; Nahman 2018; Smietana et al. 2018; Rivas et al. 2018). The perspectives of egg donors are usually neglected in favour of the voices of IVF patients, clinicians, or the expanding transnational dynamics of reproductive bioeconomies. According to my own experiences, I would speculate that this absence is at least in part linked to a question of access. For example, during my fieldwork, I was not allowed to recruit egg donors through any of the clinics in which I did interviews or observations. The fear of them dropping out if their journey through the clinic was too burdensome was highlighted in clinics’ denials of permission to recruit. This implied for me a laborious process of sticking up recruitment posters in several strategic sites of the city of Barcelona and outskirts, typing WhatsApp chains with information about the study, and the contact with different organisations related to motherhood issues that could disseminate my project on their social media. Although in my case the outcomes were very positive and 25 women reached me to participate, the uncertainty was very high, which is usually not tolerable for academic projects with tight timelines and budgets. As a result, there are relatively few studies that rely on egg donors’ voices in Spain or elsewhere around the globe.

However, the ethnographic studies that do exist framed the lines of the current understandings of egg donors. In the following review, I will first provide an overview of their focus and main findings. I will then highlight the studies that, due to their attention on egg donors' biographies and labour entanglements, resonate more directly with my own approach and focus. And finally, I will situate my own contribution within the existing literature on the broader field of assisted reproductive technologies, science, and technology studies (STS), and third-party reproductive labourers.

One of the first and more influential ethnographies on egg donors (and also on recipient mothers) is Monica Konrad's work *The nameless relations* (2006). Konrad's study, which was based in the UK and conducted prior the ban of anonymous gamete donation in 2005, seeks to challenge the view that extracted eggs are automatically transformed into commodities in an anonymous egg donation system. Instead, she sheds light on the different understandings of the gift created between altruistic egg donors and recipients by highlighting the kind of relation that is "constituted in and through active not-knowing" (p. 243). According to her, even if not accomplishing the three rules of the Maussian gift — giving, receiving, and reciprocating — (Mauss 1969 [1925]), the transfer of ova between anonymous donors and recipients creates new relations and new kinds of relatedness. Establishing links with the findings of anthropologists in the Melanesian context in terms of exchanges and relationships — particularly on Marilyn Strathern's *The gender of the gift* (1988) — Monica Konrad argues in favour of the existence of an anonymous sociality. This study, however, is very different to the approach of my thesis for at least three reasons. First, in terms of time — her fieldwork was conducted in mid-1990s. Second, in terms of the context — she examines the views of egg donors and recipients in an altruistic framework. And third, in terms of her focus — kinship and gift relations created and imagined between egg donors, recipients, and reproductive cells in an anonymous framework. Although the findings of her research are very significant, the differences discussed make her examination of limited use for comparison with my own work.

A similar issue is observable in the ethnographic work on egg donors in Spain, where all the studies before my own contribution are derived from fieldwork that took place in

the decade of 1990s and early years following 2000. In her book, *La búsqueda de la eterna fertilidad. Altruismo y mercantilismo en la donación de semen y óvulos* (2008), Consuelo Álvarez Plaza unpacks the logics of the egg donation system in Spain by triangulating the views of clinicians, recipients, and both sperm and egg donors. In her work, she discloses key aspects of the Spanish fertility industry such as: the use of the anonymity framework as a way to preserve the nuclear family; the matching criteria as tool that places different economic value to phenotypes animating racial distinctions; the gender differences in terms of the meaning of the economic compensation for gamete donation; or the kinship arrangements that operate in this setting. The sixteen years that separate her fieldwork from mine reveal interesting aspects, both for the things that they have in common and for the things that have changed significantly over time. The things that are similar are, for example, the fact that the assisted reproductive health care has very strong private dominance. Another aspect that has remained stable throughout the years is the large number of migrant egg donors in Spanish fertility clinics, as well as the fact that most of them have complicated socioeconomic contexts. Other relevant issues, however, have changed the significantly the dynamics of the industry significantly over time. On the one hand, the number of egg donors — along with the number of private fertility clinic and egg banks — has boomed across the state. While the register from the SEF shows that in 2003 there were 4,625 egg donation cycles (SEF 2003), in the latest report there are 16,355 reported cycles (SEF 2018). Some of the reasons for this increase in donors will be examined throughout this thesis. On the other hand, the possibility to successfully freeze eggs (a technique that was not in practice in 2003) has shifted considerably the everyday practices of fertility clinics and the reproductive bioeconomy more broadly. The changes that this innovation has brought are many and will be discussed in detail in the next chapter. Finally, the routinization of the genetic screening of donors through the genetic carriers' test has generated interesting new issues for both clinic and egg donors that will be examined in this thesis. A final distinction between our studies has not to do with the years that separate our fieldwork, but with the main focus of research. While Álvarez Plaza (2008) was mainly concerned about broader issues of the functioning of fertility clinics and how money and kinship were mobilised for sperm and egg donors, my thesis takes interest in the ways in which women put their bodies to work for extraction purposes and the role of the relationship between clinicians and donors in this endeavour.

The studies of Gemma Orobitg and Carles Salazar (2005) and Orobitg, Salazar and Joan Bestard (2013) studies also draw upon fieldwork undertaken two decades ago, between 1997 and 2000. They put the focus on the ability of egg donors to act as “cultural bricoleurs” (Orobitg and Salazar 2005, p. 49) that emerges when donors have to disentangle the social construction that associates genes with kinship in order to make sense of their act. They demonstrate how economic compensation does not have a major significance for egg donors at first but gains importance once the process starts and the inconveniences become real. The authors point to the central role of the economic compensation for egg donors to objectify and separate themselves from the genetic material. However, they do not examine in depth the financial context and the labour demanded of egg donors when undergoing an extraction cycle. In this regard, my preliminary ethnography, undertaken for my MA thesis after the economic crisis of 2008 (between 2015-2016) as well as the work of this thesis, offer a change of paradigm. My MA Thesis (Molas 2016) and the subsequent published papers (Molas and Bestard 2017; Molas 2017) point out that the meaning of economic compensation for Spanish egg donors is deeply linked to the precarious context of the socioeconomic landscape of the country’s post-economic crisis. While altruism is still important in most egg donors’ interviews, it functions to give a moral meaning to their way of obtaining money and to position themselves within discourses of Spanish ideals of womanhood.

An important body of work has explored different aspects of the Spanish reproductive bioeconomy. While these studies have not focused on egg donors’ experiences, notable contributions looked at issues such as the ontologies of eggs in different settings (fertility clinics, labs, and universities) (Lafuente-Funes 2017a); the role of egg donation in the functioning of fertility clinics and the discourses and practices that sustain it (Lafuente-Funes 2017b); the market design in place to assure the availability of eggs and donors in Spain (Degli Esposti and Pavone 2019); the similarities and differences of the Spanish and the US egg donation system (Tober and Pavone 2018); adoption, surrogacy and egg donation as forms of women’s silenced reproductive work fuelled by the framework of altruism and anonymity (Marre et al. 2018); the altruistic framework of egg donation and the mandatory anonymity as the cornerstones of the Spanish fertility industry, which allows the appropriation of ova by fertility clinics (Rivas et al. 2019); the

history and evolution of assisted reproductive technologies (ARTs) and the contextual and legal causes for the growth of the Spanish bio-industry (Alkorta-Idiakez 2006, 2010, 2021); and the links between egg donation and other types of feminized work configuring global care chains (Lafuente-Funes 2019; Lafuente-Funes and Pérez Orozco 2020). Some of these contributions will be discussed further throughout the following chapters.

Moving again towards ethnographic studies that put egg donors' voices at the core, recent contributions can be found in studies in other parts of the world. The work of Rene Almeling in the United States deserves attention. The author undertook the largest ethnography on gamete donation arrangements in the US to date. In her book, *Sex cells: The Medical Market for Eggs and Sperm* (2011) and related publications, Almeling focuses on gamete donation agencies and donors (Almeling 2006, 2009, 2010, 2014). Through a comparative approach between sperm donation and egg donation arrangements, she concludes that gender matters in the organization of the two markets and the experiences of the participants. While egg donation is usually defined as an altruistic gift, sperm donation is rather framed as a job. As she contends, these discourses — promoted by clinics — reify the traditional ideas of women as caring and dedicated and men as breadwinners. Her work also provides an outstanding examination of how the biological discourses in clinics reproduce social constructions of gender, and how they have consequences on donors' understandings about the money they receive and their imaginary connection with the potential resulting children. Her description of how engaging with egg donation implies gendered clinical discourses and emotional labour (Hochschild 2000, 2003) that ultimately shape egg donor's experiences, narratives, and subjectivities, informs this thesis.

For its special relevance to this thesis, I group together the work of Michal Nahman (2013) in Romania, Polina Vlasenko (2015) in Ukraine, and Laura Perler and Carolin Schurr (2020) in Mexico. Their focus on egg donors' everyday experiences beyond the donation itself as well as the situatedness of their lives in the historical, cultural, and socioeconomic context of a specific (peripheral) location make their work and findings very akin to my own ethnography.

In *Extractions: An ethnography of reproductive tourism* (2013), Michal Nahman explores how the egg donation system in Israel co-produces national politics of identity in order to reproduce “Israeliness” in the context of Israel/Palestine conflict (also in Nahman 2006, 2007). From the interviews with Romanian egg “sellers” (as she calls them), the author highlights their agency in the extraction practices in which they engage. Nahman argues that they are ‘savvy participants’ and ‘theorists of reproduction’ (see also Nahman 2008) who are nevertheless situated within the neoliberal precarious context of post-soviet Romania, where very limited options exist for women to devise a future. Similar to Michal Nahman, Polina Vlansenko (2015) analyses the construction of the ideal Ukrainian egg donor “through the lens of the ideas about race, gender and class that intersect in transnational ova donation arrangements” (p. 214). Through a case study of an egg donor in Ukraine, she claims that the non-recognition of Ukrainian egg donors as labourers reinforces their precarity in a context in which their eggs are increasingly commercialised across borders.

The work of Laura Perler and Carolin Schurr (2020) in the Mexican context consolidates even more the importance of accounting for egg donors’ stories at the conceptual level. Following Nahman’s (2008, 2013) interest in debates of agency and choice among egg donors and with an aim to delve deeper in the concept of ‘bioavailability’ (Cohen 2005) in the egg donation context, they call for a focus on egg donors ‘reproductive biographies’. By this concept they understand “women’s narrations of their reproductive life cycle and the embodied entanglements between their reproductive intimacies with their socio-economic and political environment” (p. 6). As they argue, “reproductive biographies are shaped and framed by a racialized and classist postcolonial biopolitics, the neoliberalization of healthcare, the lack of a social welfare state, machismo and gendered obligations of care” (p. 6). Due to these multiscale and intimate entanglements, they argue that egg donors’ studies need to focus on aspects beyond the donation itself and take interest in their “affective experiences of (unwanted) pregnancies, abortions, family planning, and sexual, physical and obstetric violence” (p. 6). Following their vein, this thesis puts egg donors’ life stories in a privileged position, and through them, issues of risk perception, labour, and the imaginaries around the egg donation industry are unpacked. Having discussed the main ethnographic studies that put

the focus on egg donors' voices, the next section provides an examination of the main theoretical approaches that informed my thesis and how my own contribution speaks to this rich body of literature.

Materialising clinical labour

In their formulation of the concept of 'clinical labour', Melinda Cooper and Catherine Waldby (2014) describe the conditions through which women enter into a particular sphere of work, which emerged following the disintegration of the Fordist era. According to them, the post-Fordist shift stabilised experimental and reproductive forms of value that were previously forms of unpaid work undertaken at the edges of the Fordist factory. The advent of a deregulated and precarious labour market, therefore, created the perfect conditions to convert the unpaid work of the housewife into an "entire service sector (childcare, food preparation) and various horizontal contracts for formally domestic service, including the care and nurture provided by (often undocumented) migrant labor" (Cooper and Waldby 2014, p. 222).

The contributions of Michal Nahman (2013), Laura Perler and Carolin Schurr (2020) and Polina Vlasenko (2015) also take interest in the aspects related to the 'labour' performed by egg donors. As Vlasenko (2015) points out, labour is not usually recognised as such by discursive practices in the fertility industry, which frame egg donation as a gift, reifying the dualism of productive/reproductive work. Similarly, in her Marxist feminist analysis of egg donation in South Africa, Verena Namberger (2019) claims that a significant part of the labour demanded by egg donation is not acknowledged by the dominant narratives that see the body as "an organic whole infused with vitality" (p. 88), whose biovalue can only be extracted by the technological means of fertility clinics. As she contends, this approach undermines the material and immaterial labour that egg donors need to perform "from filling in the donor application form, through the hormonal stimulation and clinic visits to the retrieval of eggs and their fertilisation in the lab" (p. 88). These two studies highlight how the strategic undermining of the labour provided by egg donors is highly profitable for the expanding global bio-markets.

The concept of ‘clinical labour’ offers in this regard a very interesting lens to the studies of egg donation, as it puts the focus on the financial profit or surplus value provided by egg donors labour to the expanding bioeconomies despite their own understandings of the nature of the donation itself or their motivations to undergo the process. In chapters one and two, I will work with this concept to locate it within the context of egg donors’ lives in Spain. To do so, I will describe, on the one hand, the intertwinements between women’s labour lives and decision-making to become donors and; on the other, I will identify and examine the different operations required for egg donors to make themselves ‘bioavailable’ (Cohen 2005). I will show how the precarious Spanish labour market is deeply related to the donors’ motivations to make themselves bioavailable, a process that will require different forms of labour which will, in turn, subjectivise and subjugate women in particular ways.

By analysing these operations in detail, I will demonstrate, on the one hand, that the labour of donorship itself can be regarded as a process of subjectivation, in which egg donors learn about the clinics’ currency and their biocapital in the industry. And on the other, I will show how not only women’s motivation to undergo the process, but also the means and the conditions in which it is undertaken, are precariously articulated along the lines of race and class.

The production of sociotechnical imaginaries

The relevance of studying social imaginaries in order to understand the experience of the social worlds among people has a long tradition in the social sciences (McNeil et al. 2016). The concept of ‘imaginaries’, which is most famously known by the influential essay ‘Imagined communities’ by Benedict Anderson (1983), is currently used to refer to the ways that society builds collective identities that bring a sense of unity, belonging, and difference. The ‘imaginary’, however, had been previously explored in psychoanalysis, particularly by the work of Cornelius Castoriadis (1987 [1975]). The author sought to address the limitations of Marxism in the deterministic description of the functioning of societies, and postulated that the creation of a social institution cannot be explained fully

in terms of material needs. According to Castoriadis, all societies work in relation to flexible arbitrary imaginaries that give structure and purpose to people's lives, and that do not rely on material causes only, but also on socio-cultural and historical grounds.

In the field of Science and Technology Studies (STS), Sheila Jasanoff and Sang-Hyun Kim (2009) point to the relevance of the gaze towards imaginaries in order to “make sense of national policies supporting the development of science and technology”, for which “we need to invoke not only the material and organizational resources that states deploy but also the imaginative resources with which they relate such policies to the public good” (p. 141). To capture this endeavour, the authors coined the term ‘sociotechnical imaginary’. As they contend, this approach is able to show “how different imaginations of social life and order are co-produced along with the goals, priorities, benefits and risks of science and technology” (Jasanoff and Kim 2009, p. 141). In a latter refinement of the concept, Sheila Jasanoff described sociotechnical imaginaries as “collectively held, institutionally stabilized, and publicly performed visions of desirable futures, animated by shared understandings of forms of social life and social order attainable through, and supportive of, advances in science and technology” (Jasanoff 2015, p. 14). As it is visible on her definitions of the concept, regardless of the special place that powerful institutions — such as the state, corporations, the law, and scientific truth — have in the shaping of sociotechnical imaginaries, they cannot be thought through a top-down approach which would imply a causal reception logic. As she states, sociotechnical imaginaries are an entanglement between peoples’ perceptions about the technology and the future, which both shape and are shaped by institutional discourses and collective notions of public good. In other words, sociotechnical imaginaries are *co-produced*, a notion that points to “the ways in which elements of human subjectivity and agency get bound up with technoscientific advances through adjustments in identities, institutions, and discourses that accompany new representations of things” (Jasanoff 2015, p. 14). Sociotechnical imaginaries, therefore, are not so much concerned by the products of scientific disciplines but by the “promotion and reception of science and technology (S&T) by non-scientific actors and institutions” (Jasanoff and Kim 2009, p. 120). The study of sociotechnical imaginaries can reveal not only people’s views about issues related to science and technology, but also how they are bound up with institutional discourses and perceptions,

and the benefits they imply in a particular sociotechnical regime. In this dissertation, a focus on sociotechnical imaginaries will allow me to go beyond the individual motivations and view of my participants, both egg donors and clinicians, and see instead how they were inscribed in broader practices and perceptions around health, biopolitics, social class, market dynamics, and gendered economies.

Some recent examples in the field of STS and reproduction have shown how the concept of sociotechnical imaginaries can be relevant in the field of reproduction studies. Willum Adrian (2017) takes this lens to understand how different imaginaries of sperm donation in Denmark coexist and change over time in order to examine the effects they have on policies and practices. Janne Rothmar Herrmann and Charlotte Kroløkke (2018) use this approach to determine how cryopreservation becomes imagined in Danish regulatory processes and public debates. Both studies highlight the possibilities of a focus on sociotechnical imaginaries to determine not only how they are “at stake as technologies are developed, used, and implemented”, but also how “sociotechnical imaginaries are not innocent” (Adrian 2017, p. 289). In a recent paper, I contribute to this body of literature by examining the sociotechnical imaginaries co-produced by Spanish fertility clinics’ websites directed at egg donors (Molas and Whittaker 2021).

As I will claim throughout the thesis, sociotechnical imaginaries around egg donation in Spain are one of the ways through which both the process of egg donation and egg donors are tamed. Different aspects mingle in this process. In chapter one and two, I will discuss the different aspects that participate in the production of particular sociotechnical imaginaries about the industry. First, I will target the altruistic framework of egg donation in Spain, then, the risk perception of egg donation among my participants, and finally, the information delivery practices in fertility clinics. In sum, I will contend that discursive and material practices are used to produce, control, and spread sociotechnical imaginaries around egg donation, and that their promotion by fertility clinics work to ultimately tame the egg donor subject.

Technologies of control and care: Taming in the clinic

The perception of egg donors as unstable women with complicated biographies permeates the narratives of clinicians in fertility clinics. While they also account for the number of very responsible and motivated donors, they all acknowledge that most of their work with donors is laborious due to the women's unreliability. Departing from the stories of their struggles dealing with them, I argue that the 'reproductive biographies' (Perler and Schurr 2020) of intending egg donors are perceived as in need of taming to enter and successfully deal with the egg donation process (see Molas and Perler 2020). As I will discuss particularly in chapters four and five, the selection and taming techniques in fertility clinic to manage, on the one hand, their behaviour, and on the other, their bodies and eggs, are directed to control them as well as to build relations of reciprocity that ultimately bring them to collaborate. Through the examinations of the selection and management practices in fertility clinics, I will delineate how egg donors are tamed through techniques where the boundaries between control and care get blurred.

That third-party reproductive labourers are subject to disciplinary practices and required to perform emotional labour is not new in reproduction studies. It is actually a logical consequence that is already implied in Melinda Cooper and Catherine Waldby's formulation of 'clinical labour' (2014). This concept is described as labour that has its roots in forms of unpaid gendered work which are supposed to emanate from the natural caring drives of women, whose intimacy becomes increasingly commodified in the advent of global capitalism. This gaze on the discipline and emotional labour demanded of reproductive workers has focused on the one hand, on the mobilisation of feelings that result from the clinical discourse of altruism, which situate participants in complicated dichotomies of good women versus selfish, financially driven or prostitute women (Almeling 2011; Pande 2014; Rudrappa and Collins 2015; Hovav 2019). On the other, on the emotional labour of reproductive workers is disciplined to disentangle affective ties towards resulting children (Teman 2010; Siegl 2018). And finally, studies focus on the management of the relationships (or the absence of thereof) between donors and intending couples (Weis 2017; Whittaker 2018).

In her examination of surrogacy practices in Russia and Ukraine, for example, Veronika Siegl (2018) draws on the concept of ‘technologies of the self’ from Foucault (1988) and ‘emotional labour’ from Hochschild (2003) to formulate what she calls ‘technologies of alignment’. With this term, she refers to the process that “surrogate workers fulfil and are expected to fulfil, in order to find the right balance between care and distance in relation to the child they carry, and not to ‘fall victim’ to their hormonal bodies” (p. 64). In a similar fashion, Christina Weis (2017) observed that, in the Russian context, surrogates subjugate themselves to the ‘rules of the game’ temporarily to achieve their own goals:

The majority of surrogacy workers manifested their agency and pursued their goals of earning a big sum of money in the shortest possible time not by resisting the structure within which they played their ‘serious games’, but by adapting to and temporarily accommodating the imposed rules. More often than changing the rules of the game, they reproduced them (p. 217).

Nevertheless, while these discipline mechanisms are usually described to happen at the discursive level, not many studies have focused on the control in terms of care and affective relations, which are materialised through practices, legal documents, technologies, and drugs, and which generate intimate labour for both reproductive labourers and clinicians. According to Boris and Parrenas (2010), ‘intimate labour’:

[E]ncompasses a range of activities, including bodily and household upkeep, personal and family maintenance, and sexual contact or liaison. It entails touch, whether of children or customers; bodily or emotional closeness or personal familiarity, such as sexual intercourse and bathing another; or close observation of another and knowledge of personal information, such as watching elderly people or advising trainees. Such work occurs in homes, hospitals, hotels, streets, and other public as well as private locations. It exists along a continuum of service and

caring labor, from high-end nursing to low-end housekeeping, and includes sex, domestic, and care work (p. 2).

In other words, intimate labour is about having a tight closeness with another one's body, sensitive personal information, or vital spaces such as the household. As I will show throughout this thesis, clinics become spaces of intimate relationships between donors and clinicians, which will share aims, desires, and usually also struggles, that despite their different positions, they will have to negotiate together. Highlighting how descriptions of 'intimate labour' have focused on its immateriality, I agree with Ariel Ducey (2010) when she argues that technology has been written "out of the story of caring (and affective) labour" (p. 19). According to her,

[C]are can be extended to things, just as people can be treated like tools or commodities. Although objects are not usually considered the focus of concern in institutions and relationships that provide care, the objects that figure in such institutions can arguably become the source of intimate and caring relationships in their own right or the basis of unfolding awareness and what Bruno Latour would call increasingly articulate bodies (p. 20).

Ariel Ducey refers in this quote to Bruno Latour's (2004) proposal to understand bodies beyond the dualism between physiology and phenomenology. As he contends, having a body is a process of articulation in which not only biological, but also artificial and material components take part, and through them we ultimately learn to be affected. Ducey's (2010) reframing of the understanding of care relations to include non-human elements is crucial in my descriptions of the relations between donors and clinics, where discourses but also practices, technologies and substances intervene to shape, mediate, and contain the interactions for a successful outcome.

Understanding 'intimate labour' as encompassing this non-human dimension, I rely on Andrea Whittaker's (2018) proposal to view surrogacy and egg donation as forms of "intimate *and* clinical labour", which "allows for a more nuanced approach that recognizes

the significance of the social, cultural, economic, and political structures that shape it” (p. 52). This focus on intimate and clinical labour allows my ethnography to account not only for the external conditions through which donors enter in the Spanish (transnational) reproductive bioeconomy, but also to attend to the dynamic relationships of taming in the clinic that align and convert certain reproductive biographies into valuable bio-objects (Holmberg et al. 2011) for the global bio-market circuits.

Some work on reproductive labourers has made moves towards this direction, however they can only be found in ethnographies of surrogacy arrangements rather than egg donation. Amrita Pande (2014), for example, explores how surrogacy agencies socialise Indian surrogates through the different steps of the process — from recruitment and contract to their stay in surrogacy hotels, childbirth, and post-partum — in an aim to convert them in the perfect ‘mother-worker’. This process entails discipline and control techniques as well as affects and care towards surrogates. Sharmila Rudrappa (2012) targets this issue in her ethnography on surrogacy in India, where she accounts for relations of reciprocity and power that operate in the agencies and hostels. Both authors highlight how forms of coercive control and discipline are deployed alongside methods of mutual care between staff and reproductive labourers, who participate actively in this relationship contesting, negotiating and sometimes reifying clinics’ discourses in a way that it becomes difficult to trace clear lines between coercion, reciprocity, willingness, and love. As Amrita Pande (2014) puts it in her ethnography:

Surrogates resist the construction of surrogates as “disposable and dirty workers” and as “disposable mothers.” In sharp contrast to the surrogate-prostitute analogy used by the clinic and the media, the surrogates construct themselves as moral and needy mothers. While on the one hand, these alternative constructions of surrogacy by the surrogates affirm their dignity and sense of self-worth, on the other hand, they replicate certain gender hierarchies. Ironically, while the focus of this study has been on surrogacy as labor, most surrogates do not speak of surrogacy as paid work or work that they have chosen. It is almost as if the surrogates do not resist the image of women as

selfless dutiful mothers whose primary role is to serve the family (p. 168).

This thesis will fill this gap in the literature of egg donation by focusing on how control, care relations, and intimate labour materialise in the clinic as yet another form of taming egg donors, who enter in the realm of a the highly emotional space of the fertility clinic, or as Sara Lafuente-Funes (2017a) puts it, a “space of desire and frustration”¹ (p. 141). In this regard, I will focus not only on the emotional labour demanded of egg donors, but also on the intimate labour performed by both donors and clinicians, specially by administrative staff, nurses and psychologists through practices, documents, technologies, and substances. These material and immaterial forms of taming bring to life the interrelations of technoscientific products, state biopolitics, biocapital growth, and medical practice.

Stabilising pasts and futures

Another aspect that needs to be tamed for the egg donation cycle to succeed are the egg cells themselves. Gametes outside bodies are contested matter: they entail ethical debates about their extractions and future use, and they do not stand neither as alive matter, nor as simple objects. Through the means of technological development, frozen gametes can be suspended in time, making it possible to reproduce individuals at different moments (Waldby 2014, 2019); they create dilemmas at the level of storage time and the possibility of posthumous reproduction (Kroløkke and Adrian 2013); and finally, their existence isolated from the bodies, only possible through technoscientific interventions and egg donor’s material and immaterial labour (Namberger 2019), challenges the boundaries of categories making it “matter out of place” in the Mary Douglas (2003 [1966]) sense (see Holmberg et al. 2011). Their ambivalent condition, therefore, will need taming measures to control the dangers and ambiguities it entails. In this regard, egg cells are the perfect example of what Tora Holmberg, Nete Schwennesen and Andrew Webster (2011) and

¹ Original text in Spanish. Fragment translated to English by the author of this thesis.

Ingrid Metzler and Andrew Webster (2011) labelled as ‘bio-objects’. As these authors put it, ‘bio-objects’ are “contested socio-technical objects” (Holmberg et al. 2011, p. 2) which:

tend to disrupt the conventional boundaries and identities of biological forms and categories, such as the boundaries between humans and animals or between the natural and artificial, sitting ambiguously in between those entities that we tend to conceptualize as human subjects and as non-human objects instead, sometimes troubling or even unsettling this very distinction. (Metzler and Webster 2011, p. 649)

Stabilisation is crucial for eggs to enter the circuits of biocapital, as their unsettling nature needs to be converted in promises of particular futures for intending parents. On the one hand, they must assure ethical guarantees (Rose 2007), a process that is done in terms of the informed consent. On the other, they must be assessed in terms of quality through different medical screenings of the donors, with a special focus on genetic diseases transmissible to the offspring. Finally, they must be properly categorised in terms of ethnoracial parameters — or phenotypical features, as the clinics usually put it — in order to make “proper” matchings with intending parents.

This process of conversion is ongoing and does not have a clear ending: on the one hand, because the attempts to classify eggs into stable categories are always contested by the different actors involved; and on the other, because the categories themselves mutate over time with the change of paradigms, imaginaries, political regimes, and scientific novelties. This thesis will show how these processes are never easy to undertake and generate discomfort among clinicians, who are required to make complicated decisions that animate taboo imaginaries of eugenic and race selection. I will also show how, even if thoroughly done, these selection processes are always somehow incomplete, leaving the sense of a thread intact.

Taming genetic pasts

Genetic standardisation for egg donation is achieved through the means of genetic tests of intending egg donors. The lines of what should be screened and what should lead to the discard of a donor are areas with little regulation in the Spanish ART's context, which does not specify on matters of genetic selection. The law only states that the

[egg donors] psychophysical state will have to accomplish the demands of a mandatory protocol of donors' screening which will include their phenotypical and psychological characteristics, as well as the clinical conditions and the needed analytical determinations to prove, according to the state of the art and the existing techniques at the moment of their realisation, that donors do not suffer from genetic, hereditary or infectious diseases transmissible to the offspring (Law 14/2016, p. 5-6)².

The now routinised genetic carriers' test in Spanish fertility clinics has provided new interesting selection logics. As Arribas-Ayllon (2011) states, “genetic testing not only produces knowledge that we are ‘fettered to’”, instead,

new genetic knowledge is continuously negotiated and contested. The laboratory procedure of a ‘genetic test’ is only one dimension that has changed our knowledge of health and disease or our expectations of prevention and treatment. We argue that responsibility for the calculation and management of genetic risk is a situated activity accomplished by local actors (p. 4).

Investigating these dimensions of the genetic knowledge and risk as situated and contested, my dissertation explores the rationalities of clinicians around the genetic carriers' test. As I will outline, clinicians struggle to discard genetic pasts as the process itself gives rise to notions of eugenics that recall the consequences that such discourse

² Original text in Spanish. Fragment translated to English by the author of this thesis.

had in Europe in the twentieth century (Arribas-Ayllon 2011; Wade 2012; Wahlberg and Gammeltoft 2018).

However, market dynamics — the forces that move and direct the present and future of genetic science —, place more value on ‘clean(er) donors’: those who carry no-prevalent genetic diseases and who are, therefore, more easily marketable within different countries regulations. This exploration will make clear how, despite cultural and medical discourses around how genetic pasts should be selected, market dynamics have an important role at the practical level. These dynamics highlight again the logics of ‘liberal eugenics’ as “the unintended consequence of numerous individual choices made under the guise of technical and economic efficiency” (Arribas-Ayllon 2011, p. 54).

Finally, I will examine how the knowledge provided by the genetic carriers’ test impacts on egg donors’ subjectivities who are labelled “genetically at risk” (Novas and Rose 2000). As Arribas-Ayllon (2011) puts it, I will look at:

the ways in which the testing of inherited risk enjoins new forms of social, individual and professional responsibility, and by extension, provides new resources for blame. Families and professionals, entrepreneurs and consumers, and ‘the public’ more generally, are being drawn into discussions and decisions, which are changing the ways in which we think about ourselves and our relations with others, about future risks and how these can be minimised, if not avoided altogether (p. 2).

Indeed, as it has been argued with other kinds of genetic testings such as PGD (e.g., Franklin 2006; Ehrich and Williams 2010; Pavone and Arias 2011; Pavone 2017; Pavone and Lafuente Funes 2018) or DNA Ancestry testing (e.g., Mason 2017; Halovic 2017; Lacaze et al. 2017), the knowledge produced through the genetic carriers testing has implications on both the lives of the tested (egg donors) as well as in the lives of consumers (recipients couples). I will discuss what some of these consequences are in the context of egg donation in Spain.

Taming ethnoracial pasts

The Spanish law on assisted reproduction states that clinics have to provide intending mothers with gamete donors who are the most similar possible to their phenotype (Law 14/2006). The function of the mandatory nature of the phenotypical matching in the context of gamete donation in Spain is to produce ‘plausible’ babies (Thompson 2009), or as Peter Wade puts it, children with ‘race-kinship congruity’ (Wade 2012). That is, babies with the ability to ‘pass’ as biological offspring of the intending couple (Bergmann 2012b, 2014). However, deciding in matters of resemblance is not such an easy task as the law on assisted reproduction seems to imply. As I will unpack in the thesis, phenotypical selection is also a contentious matter for clinicians who, despite their attempt to avoid ‘racist’ dynamics, reanimate racial categories in the matching practices themselves.

As Thompson (2009) asserted when discussing the context of egg donation in the US, “perceiving skin tone always involves its intersection with these other attributes and their wider meanings and histories. This means that skin color is an index of legibility whose chromatic properties are deeply relative” (p. 132). Race is, in this context, enacted rather than discovered in the negotiations between patients and doctors and in the selection of egg donors. Along the same lines, Laura Mamo (2005) highlights how relatedness is never only based on bio-genetic ties and social ties. According to her, “biology and sociality are mobilised to create shared ancestry and the similarities and histories that embodies” (p. 254), something that Charlotte Kroløkke named ‘affective assemblages’ (2014b). What these authors highlight is the inevitable role of ethnoracial imaginaries in the presumed objective phenotypical selection. The attempt to tame ethnoracial pasts into stable categories serves “as a specific context for the fabrication of race” (Bergmann 2015, p. 239).

My thesis will focus on the decision-making process of clinicians when taming egg donors’ ethnoracial pasts or, in other words, when stabilising their phenotypical characteristics to match or to freeze the eggs into the bank for later use. I will explore how these practices enact a particular definition of race which is presented as a consequence of a society with racial prejudices combined with the market dynamics. The

mandatory practice of the phenotypical matching places the clinicians in the interesting and challenging situation of trying to avoid racist dynamics while at the same time, reproducing racial tensions through the tailoring, or ‘curation’ (Moll 2019) of the phenotypical matching.

In sum, this thesis is informed by ethnographic accounts on egg donors and egg donation in Spain and around the globe; specific literature that focuses on reproductive workers, clinical labour, and the way they have pictured control and care relationships in fertility clinics; the emergence of scholarship that highlights the importance of a focus on sociotechnical imaginaries; and literature on how genetic and phenotypical screening shape the selection criteria in fertility clinics. While in this section I have discussed the main body of work upon which my thesis will draw upon, in each of the five findings chapters I bring more specific literature concerning each of the topics discussed.

METHODOLOGY AND EPISTEMOLOGY

A Multi-sited ethnography approach

“Our methodological and epistemological choices are always also ethical and political choices.”

(Harding 2003, p. 130)

The learning approach I used for the data collection of this research is ethnography. Indeed, I have been the primary tool of data collection, basing my research interpretations on the practices of my participants and the meaning they made out of them (Schensul et al. 1999). According to Michael Agar (1986), “[s]uch work requires an intensive personal involvement, an abandonment of traditional scientific control, an improvisational style to meet situations not of the researcher's making, and an ability to learn from a long series of mistakes” (p. 12). Choosing this approach was particularly useful because I have been documenting a process (egg donation) and the subjectivities of the participants at different stages of it (egg donors and clinicians). In this sense, ethnography has served me as a flexible methodological toolkit through which I was able to explore the different questions that drove my thesis. In particular, I used the conceptual approach of the ‘multi-sited ethnography’ (Marcus 1995, 1998) which challenges the conventional conception of a single-site ethnographic research as the main means to achieve in-depth knowledge through intimate face-to-face encounters with communities. As George E. Marcus (1995) claims in his influential contribution on multi-sited ethnography,

any ethnography of a cultural formation in the world system is also an ethnography of the system, and therefore cannot be understood only in terms of the conventional single-site mise-en-scene of ethnographic research, assuming indeed it is the cultural formation, produced in

several different locales, rather than the conditions of a particular set of subjects that is the object of study (p. 99).

As Marcus (1995, 1998) already notes in his germinal essay, multi-sited ethnography has been especially prevalent among cultural studies of science and technology (STS), in which, due to the nature of their research interests, a single-sited fieldwork was not a satisfying option. The approach of researchers such as Bruno Latour or Donna Haraway of “following the thing” in a metaphorical and material sense demands a new way to understand both the site, the subject/object of study, and the researcher itself. Multi-sited ethnography allows for these choreographies as it is “designed around chains, paths, threads, conjunctions, or juxtapositions of locations in which the ethnographer establishes some form of literal, physical presence, with an explicit, posited logic of association or connection among sites” (Marcus 1995, p. 105).

Opting for a multi-sited ethnography is not a way to be closer to the ‘reality’ of the issue under study. Different sites are not intended here to provide a more complete vision of the picture, but instead to produce a more complex and interconnected one. Far from an aim to fall in the trap of objective representation, by taking several standpoints, I intend to produce knowledge that, if not arbitrary, is deeply situated and embodied. Therefore, I engage with the proposal of Donna Haraway of ‘situated knowledges’ (1991), which accounts for the production and relevance of the embodiment of the researcher as well as the historical and cultural production of the “objects” of study, that she labels as “material-semiotic actors” (p. 200). Precisely because of this complex genealogy that configured the boundaries of such objects/subjects, Haraway concedes them a great deal of agency. As she claims, “accounts of a ‘real’ world do not, then, depend on a logic of ‘discovery’, but on a power-charged social relation of ‘conversation’” (p. 198). This is the way I conceive of the present research, as a situated conversation between me as an embodied sociocultural subject and the material-semiotic actors that came to be the objects/subjects of this research in a series of produced sites.

The field(s)

As stated in the previous section, I engage with the critiques of the field-site as an existing category or place where the researcher can go to extract information. Instead, I conceive field sites as sociocultural and situated productions. As Falzon (2009) argues, “contemporary research has to come to terms with the idea that, logically, if space is produced, there is no reason why the space of ethnography should be exempt. Which puts the processes of this production, and the possibility of alternatives, on the agenda” (p. 4). Matei Candea (2009) goes a step further and provocatively names field-sites “arbitrary location[s]” which might be “more or less productive than others, depending on the subject and aims of the research” (p. 41).

Much before these contributions, Michael Agar (1986) asserted that “ethnographies emerged out of a relationship among the traditions of ethnographer, group, and intended audience” (p. 19). And indeed, a number of contingent issues led my research project to take place primarily in the city of Barcelona, Spain. On the one hand, Catalonia is a significant geographical place for the fertility industry, as it is the most popular destination for cross-border reproductive care (CBRC) across Spain (SEF 2018). On the other hand, as I was a local and had based my previous MA research project there, my knowledge about the history, the social context, and the egg donation assemblage made it easier to make sense of my fieldwork experience in the time limits of my PhD candidature. However, Barcelona was only the point of departure and the physical space in which the observations took place. As stated before, my research was multi-sited in practice, as I not only entered in the realm of different fertility clinics, but I also followed my key participants through the different spaces of their lives, conducting interviews in their hometowns, through the internet or virtually accompanying them in their lives through fragments of diaries, video-recordings or vocal messages they shared with me.

Methods

The multi-sited approach of this thesis materialised with the selections of a diverse number of actors and methods that informed different aspects of the Spanish reproductive bioeconomy. The polyvocal narratives encountered in the diverse field-sites provided me not only with their particular insights but also with the sociotechnical imaginaries operating in fertility clinics and among egg donors. The following table (Table 1) offers a summary of the methods used and the number of participants of this thesis.

METHODS	In-depth interviews Focus group discussion Negotiated interactive observation
EGG DONORS	22 first in-depth interviews (demographic data on Appendix) 9 follow-up in-depth interviews 1 Focus Group Discussion with 3 egg donors
DISCARTEED	3 first in-depth interviews (demographic data on Appendix) 1 follow-up in-depth interview
FERTILITY CLINICS' STAFF	22 in-depth interviews (to 25 professionals as two were group interviews) Participants across 6 different clinics
STAFF BY ROLES	7 biologists 6 gynaecologists 6 international patient coordinators 3 nurses 2 psychologists 1 admin

Table 1 - Methods and participants.

Semi-structured interviews

Semi-structured interviews represented one of the most important sources of information for this research, through which I talked to two broad groups of participants: (intending) egg donors and professionals in fertility clinics.

Interviews with (intending) egg donors

I interviewed a total of 25 women, 22 of whom did at least one cycle and 3 of whom intended to donate eggs but were discarded from the program. They were all recruited into my study using one of the following methods: physical advertisements placed in strategic sites of the city such as universities, public libraries or nearby areas; virtual advertisements spread through WhatsApp chains and Facebook; and snowball sampling (all of the participants were asked at the end of the first interview if they knew more women who might want to participate).

None of the participants of the research were contacts of mine previous to the recruitment and all of them contacted me in the first place after seeing the advertisement or being told about the study by a contact. The interviews were held in a place of convenience for the participant, which usually was a bar nearby their homes, places of study or work. Due to the long distance for some of the participants, five interviews were held on Skype. All participant women were asked if I could tape record the interviews, to which they all agreed. I had two or more follow-up interviews with nine of the participants. In addition, three of them also participated in a focus group (discussed below).

The interviews aimed to achieve detailed information on the experiences of women undergoing egg donation and specifically to identify their understandings around the fertility industry in Spain. The main topics of conversation were: their reasons for wanting to donate eggs; their experiences during the procedure; their opinions regarding the egg donation system in Spain; their family situation and their opinions regarding egg donation; their perception about the information they received in the clinic; and their imaginaries of the future of their extracted eggs.

Interviews with professional in the clinics

I interviewed a total of 22 current or former clinicians of six different fertility clinics. They were recruited through emails that I sent to the clinics when I was looking for participants or through snowball sampling. Among the group, there were gynaecologists, embryologists, lab directors, biologists, psychologists, and administrative and international patient coordination staff. The aim of these interviews was to understand the daily functioning of a fertility clinic with a focus on egg donor management, their daily challenges and dilemmas within their clinical practice, and their visions about the future of egg donation and assisted reproduction more broadly. The topics covered with fertility clinic staff were: their perceptions of the well-being of both recipient couples/women and egg donors; the management practices with egg donors; the role of egg donation treatments in the clinic; their perceptions of the egg donors in their program; the selection procedures; the recruitment strategies; and the challenges for the future of assisted reproduction.

The interviews were usually held in the premises of the clinics they worked in. All participant professionals were asked if the interviews could be tape recorded, to which they all agreed.

Focus group

I organised a focus group with three egg donors (who were previously interviewed at least once) in order to see how a group conversation might change and extend their reflections around egg donation. I considered this method relevant especially because most of my participants had not talked about their experiences with egg donation with other egg donors. The topics proposed for the focus group were: their perceptions of the altruism/financial compensation dichotomy; their perceptions in relation to the information received about the procedure and its risks; their understandings of the presumed benefits of egg donation; and the anonymity of their donation.

The focus group was held in the premises of the University of Barcelona. All of the participants were asked to be tape recorded, to which they all agreed.

(Negotiated interactive) observation

As the title of the section implies, I will not talk about ‘Participant observation’ as a method of this thesis. In his reflective article on doing fieldwork in hospitals, Gitte Wind (2008) explains that it is rare that researchers can actually ‘participate’ in the everyday activities of professionals in highly specialised health care systems. This was particularly true during my observations in a fertility clinic, where I could, at most, be the entertainment of some practitioners when they felt like talking about their work or were excited to share a specific part of their tasks that they found fascinating. I was also the recipient of the complaints of the things that did not work as they should or that could be improved in their practice. Other than that, my role in the clinic was being by the clinicians’ side when they allowed me to, observing, noting, and asking about the things I could not understand, keeping always in mind that not being a burden was the condition for my continued stay there. While this was definitely doing fieldwork, it was not Participant Observation understood in the classical sense of being and living like ‘one of them’, and had little to do with what Bronislaw Malinowski did in the Trobriand Islands or Margaret Mead in Samoa. This is why, following Gitte Wind’s (2008) proposal, I will use instead the term ‘negotiated interactive observation’. While this name still acknowledges the active role of the researcher in the field in generating interactions with the participants and being sensitive to their experiences and feeling, it does not imply that ‘participation’ in a highly specialised medical routine is possible in the sense that it is usually evoked.

One of the clinics contacted through the course of my fieldwork accepted to have me doing observations in the premises of the clinic. This included observations in an IVF lab (one day), at the reception desk of the clinic with the nurse and admin staff (two days), observations in the consultation room with the gynaecologist (two days), and observations in the operation room during four egg extraction’ surgeries (all happening the same day).

Although access was a very difficult aspect of my fieldwork and the time that I could do observations was limited, the quality of information that these experiences provided was very important to my overall understanding of egg donation practices. During that time, I could observe a first informative interview with an egg donor; the communications with egg donors through phone calls, WhatsApp, and in the premises of the clinic; the consent form giving and signing; the matching practices between egg donor-recipient; the egg donors' ultrasound controls; and the procedures and dynamics in extraction surgery settings.

Collateral data collection: pictures, diaries, videos, and vocal messages

Some of the participants of this research shared additional materials with me during the course of the fieldwork. This included, in one case, pictures that a participant had taken of herself during the hormone administration process. Two other participants, shared with me extracts of their diaries where they wrote about their feelings, doubts, and concerns in relation to egg donation. In one case, a participant made a video of herself preparing and injecting the hormonal medication. In some other cases, participants shared with me vocal messages to give me updates of their donation cycles, their communications with the clinics, or about physical reactions after the treatment. This material is very valuable because it provides a much more intimate approach to their relationship with egg donation than what I could get from some of the interviews alone. In all the cases, they gave me permission for displaying this material in the thesis.

Analysis

The data collected for this thesis was thematically analysed (LeCompte and Schensul 2012; Ryan and Bernard 2003) categorised, and coded using the software NVivo 12. The building of the coding book was done inductively, which allowed me to be “more open to being influenced by the data” (Fugard 2020, p. 4). The process of creating codes was

therefore guided by the theory that informed this research, my preliminary research questions, and my intuition. To certify the relevance of the codes created through this approach, I discarded those who, at the end of the coding of all the material, had less than 5 entries. For the purposes of this thesis, I created two different codebooks: one for my (intending) egg donor participants and another for the clinicians interviewed. From the interviews and focus group to (intending) egg donors, I created 57 codes, 7 of which did not reach the minimum level of entries and therefore were discarded. From the interviews to clinicians, I created 42 codes, 8 of which were did not reach the minimum level of entries and therefore were discarded.

While the classification of the data according to codes using NVivo 12 was crucial to understand the patterns and most salient topics of the interviews, I took a holistic approach to the analysis of the material trying not to be too much constricted by the artificial thematical boundaries that the coding classification inevitably traces. In this sense, the field diary helped me keep a global perspective of the ethnographic experience. Coming back to it allowed me to recall and reflect on what Paul Stoller would call “the taste of ethnographic things” (Stoller 1989). These ethnographic details provided me with the bridges that connected the different codes and led me to write a cohesive story.

Notes on language and translation

All the conversations between the participants of this research and myself happened either in Catalan or Spanish, languages in which I am native speaker. I transcribed them in their original languages in Nvivo 12 and later I translated those quotes selected for the thesis to English. Also the field diary was originally written in Catalan and later I translated those specific fragments that I selected to appear in the thesis. This dissertation also contains some official documents (laws, informed consents, and reports) and some academic papers that were originally written in Spanish. The fragments that appear on the thesis have been translated by me and are followed by a foot note indicating the original language of the document. Due to my proficiency in English and as a native speaker of both Catalan and Spanish, I believe I have not incurred any mistakes that compromise the integrity of

the original source. When I had doubts on how to translate certain expressions into English, I asked native speakers to make sure the meaning in the original language was conveyed effectively in the English translation. As the reader will see, in some parts I maintain original terms in Spanish or Catalan, putting its meaning in English in brackets. I did this specially when the translations to English did not provide the full dimension of the term in Spanish or Catalan, which was usually when the participants cursed or when they used idioms.

Chapter outline

This dissertation is comprised of eight chapters. In this first introductory chapter, I have outlined the aims and goals of this thesis as well as the theoretical framework and the methodology used. The next chapter concerns the context of the research, where I provide key information regarding the egg donation industry in Spain as well as aspects of its political and socioeconomic situation. After this, the dissertation has five findings chapters, three of which centre around the experiences of egg donors, and two on the views of clinicians working in fertility clinics.

Chapter 1, “Securing a future through egg donation”, explores women’s decision-making process for undergoing an egg donation cycle with a focus on how the gendered discourse of altruism has effects on women’s imaginaries and narratives. Examining egg donors’ stories in detail, I argue that the decision to become an egg donor is in most cases deeply entangled with women’s desires to secure better futures in the complicated Spanish labour market. Chapter 2, “‘Nothing to lose’: risk perception among egg donors”, revolves around the question of information delivery in fertility clinics and risk perception among egg donors. First, I provide accounts on the conditions and the means through which fertility clinics provide information and get informed consent from intending egg donors. Then, I focus on donors’ risk perception around egg donation and the role that power structures and donors’ experiences of risk have in their perception of trust, danger and benefits. Finally, I discuss how the mandatory anonymity of the donation becomes a means of production and control of the imaginaries around egg donation practices.

Chapter 3, “The labour of donorship”, starts from Lawrence Cohen’s (2005) concepts of ‘bioavailability’ and ‘operability’ to shed light on the steps (‘operations’) that women have to undertake to make themselves ‘bioavailable’ for the global reproductive industry as egg donors. Connecting Cohen’s approach to the concept of ‘clinical labour’ (Cooper and Waldby 2014), I conceptualise these operations as ongoing labour that happens in the physical and emotional spheres before, during, and after the treatment itself. Chapter 4, “Selecting and taming behaviour: control, affects, and care in the fertility clinic”, takes Annemarie Mol’s work on body ontologies (2002) to examine the two body ontologies of egg donors that coexist in fertility clinics. Moving the gaze from egg donors’ experiences to clinicians, I focus on the selection, management, and taming practices in fertility clinics that attempt to regulate the behaviour of egg donors during the cycle. As I argue, the ways in which egg donors are read and managed are linked to imaginaries of class and race. Chapter 5, “Labelling ova: taming genes and race”, continues the examination of egg donor body ontologies by focusing instead on the donor enacted as a site of extractability. I depart here from an understanding of egg cells as ‘bio-objects’ (Holmberg et al. 2011) and examine the difficult process of contention and standardisation of egg donors’ genetic and phenotypical condition. Finally, in the conclusions chapter and the epilogue of this thesis, I provide a discussion of the empirical findings and political implications of this research.

In order to provide an overview of the context of this research, in the following chapter I will first describe some key aspects of the Spanish legislation on assisted reproduction and the functioning of the Spanish fertility industry. Second, I will discuss the European low fertility rates and the issue of ‘cross-border reproductive care’. Finally, I will explore the parallels and imbrications between the Spanish fertility industry and the tourism industry.

CONTEXT OF RESEARCH: THE TRANSNATIONAL OVA INDUSTRY IN SPAIN

SPANISH LEGISLATION ON ASSISTED REPRODUCTION

The first Spanish law on assisted reproduction in 1988 was one of the earliest among European countries. It came into effect under the government of Felipe Gonzalez from the Spanish Socialist Workers' Party (PSOE), the third Prime Minister of Spain after the dictatorship of Francisco Franco (1936-1975). However, different assisted reproductive techniques were being used and normalized much before that. The Spanish Fertility Association (SEF), the most active and influential fertility expert organization in Spain, was founded in 1953 with the aim of grouping different professionals interested in human assisted reproduction to create a speciality in reproductive medicine (Coroleu Lletget 2011). The earliest sperm bank in Spain, for example, was founded eleven years before this first assisted reproduction law, in 1977, and facilitated the birth of thousands of babies within a decade's time. Anna Victoria, the first test tube baby in Spain, was born in 1984 — before the law — in the Instituto Universitario Dexeus, a private clinic in Barcelona. One year after her birth, the first successful IVF treatment using donated eggs resulted in the birth of twins at the same clinic (Coroleu Lletget 2011).

The introduction of the law on assisted reproduction in 1988, therefore, came to mediate the expansion and direction of these techniques, arguing that they were embedded in a “matter of great responsibility” that could no longer be delegated to the

“free choice of scientists”³ (Law 35/1988, p. 33373). Other major scientific achievements took place quickly after the implementation of the law, such as the clinical application of Preimplantation Genetic Diagnosis (PGD) in 1991, the development of the Intra-Cytoplasmic Sperm Injection (ICSI) in 1992, and the first children born from frozen eggs in 2002 (Coroleu Lletget 2011).

The fast emergence of scientific novelties in assisted reproduction during the following decades made the 1988 law quickly obsolete, which was reformed in 2003 (Law 45/2003). The renewed law aimed to expand the framework for the growing research potential and to provide guidance on the problem of ‘supernumerary embryos’⁴. However, this new law also presented important limitations for the development of assisted reproductive medicine. On the one hand, the use of the supernumerary embryos for research purposes was allowed but still very restrictive. On the other, it established a limit of three eggs to be extracted for every reproductive cycle, which “made difficult the ordinary practice of the techniques of assisted reproduction” (Law 14/2006, p. 2).

Consequently, three years later, the law was modified again with substantial changes (Law 14/2006). First, it defined clearly the ‘pre-embryo’⁵ concept, which created an indispensable ground to argue in favour of the supernumerary embryos to be used for research without ethical restriction. Second, it anticipated the proliferation of new technologies and practices, which would be automatically accounted in the law. Finally, it also allowed embryo selection through PGD in order to avoid genetic diseases.

The new law of 2006, which still prevails today, did not just represent the most permissive law in Spain but also in Europe, where regulations in assisted reproduction

³ Original text in Spanish. Fragment translated to English by the author of this thesis.

⁴ I am adopting here the exact terms used by the Spanish laws on assisted reproduction of 2003 and 2006 to refer to the embryos that were created through IVF and cryopreserved instead of used for reproduction. This is usually due to the superior number of embryos produced for IVF that the finally needed to fulfill the reproductive desires of patients.

⁵ Concept that refers to the state of the embryo until the day 14 of development, a limit that was established in the UK in 1984 by the Warnock Committee, designated for the purpose to resolve moral questions around the status of the embryo and its uses for research. Even if the scientific basis of this limit was questioned since its first formulation, it has been deeply influential in many laws and regulations around the world (Piciocchi and Martinbelli 2016). The restrictions in ARTs usually take place in countries where the concept of ‘pre-embryo’ did not penetrate in the legal and bioethical spheres (Melhuus 2015).

continue to vary largely from country to country (Mínguez and García-Velasco 2011; Präg and Mills 2017). A number of intersecting factors make patient access easier and faster in Spain than in most neighbouring European countries (Pennings et al. 2008).

First, the law does not restrict access according to marital status. Single women and lesbian couples can undergo any treatment available, with the requirement for the latter to be married if they wish to be both inscribed as legal mothers in the Civil Register. Second, unlike other European countries, in Spain, third-party gamete donation is anonymous by law, which means that unless extraordinary circumstances the donors will be strictly recruited and selected by the clinic with no future possibility of contact contemplated (Law 14/2006, p. 8).

Finally, Spanish private clinics offer the highest compensation rates for egg donation across Europe (Pennings et al. 2014), which is similar than the minimum professional gross salary per month for a full-time job, at 1,050 euros (Eurostat 2019). The financial compensation for third party providers also changed over time in the Spanish regulations on assisted reproduction. The first law (1988) established that gamete donation had to be free and altruistic with no mention of a possible economic compensation. In 1998, the annual report from the National Commission of Human Assisted Reproduction (CNRHA), argued in favour of economic compensation to avoid the establishment of a black market of eggs and to maintain the high number of donations in the country (CNRHA 1999). The report expressed the potential problem of compensation becoming the main reason for the donation, for which it established an illustrative amount subject to updates according to the inflation rate (Zafra et al. 2012). Nowadays, the possibility of an economic compensation is stated in the law. The amount varies slightly from clinic to clinic ranging from 900 to 1,300 euros (Fieldwork observations).

Rights over embryos and gametes: Ownership and research

In the current law (Law 14/2006), surplus embryos created for reproductive purposes can be used for research only if the couple or woman for whom they were created allows it through an informed consent form (regardless of the origin of the gametes). Through the signing of the informed consent form, women/couples renounce their rights to the possible economic benefits the research might generate (Law 14/2006) (see also Rivas et al. 2019). The gamete surplus from ova or sperm donation belongs to the clinic, who can reuse them for other IVF treatments in the same or other clinics, or for research purposes. Donors only have the right to have their gametes back in case they experience fertility issues and require them for IVF. In this case, the donor would have to reimburse the clinic for the extraction costs when the donation took place. This possibility, of course, exists only if the clinic still had the gametes at the time of the request.

Although the law contemplates research purposes for both embryos and gametes, in practice this research is very rare. During my fieldwork, different practitioners pointed out a problem of embryo storage: while many couples stated that they wanted their supernumerary embryos to be used for research in the informed consent form, no research projects were demanding them. This forces clinics to store thousands of embryos for uncertain periods of time until they can be legally destroyed.

As different clinicians explained to me, the main research uses of eggs and embryos in the past — somatic nuclear cell transfer and stem cell research —, had been mainly replaced by the prominent field of research with induced pluripotent stem cells⁶ (iPSC) (Fieldwork notes). The imaginaries of how this technology could change the fertility industry are discussed in the epilogue of this thesis.

⁶ Induced pluripotent stem cells (iPSCs), are type of pluripotent stem cells which, along with embryonic stem cells (ESCs), have the capacity of self-renewal (that is, to divide indefinitely), and pluripotency (that is, to differentiate in any somatic cell). Contrary to ESCs, iPSCs are not derived from the inner cell mass of preimplantation embryos. Instead, iPSCs are obtained by reverting the differentiation process of adult somatic cells through in vitro technology called cell reprogramming (Romito and Cobellis 2015).

Gamete donors national register

From its first version in 1988, the Spanish law on assisted reproduction stated that the maximum number of children born in Spain from the gametes of the same donor is six. This number is interpreted by professionals as the number of babies from each donor in a single country for which it is allowed to send batches of eggs from the same donor to women or clinics in other countries even if in Spain the number of six children has been reached. While the number was established to avoid consanguinity problems, it has been questioned for the lack of scientific basis (Janssens et al. 2015; Alvarez 2017). To comply with this regulation, the law planned the creation of a national register where clinics would have to enter the donors' identities and the outcomes of the donations so that any other clinic could check it when recruiting new donors.

However, 30 years after its first formulation in 1988, professionals in fertility clinics still have no means to know the number of times a woman had undergone extraction cycles nor whether there were more than six children born from their gametes. During the time I was doing fieldwork (2019), some clinics were participating in the first trial of the register's preliminary version, which was intended to be fully implemented by 2020. Future research on the outcomes of its implementation is therefore needed.

Anonymity in gamete donation

Gamete donation in Spain is anonymous by law since 1988 (Law 35/1988). The current law states that donor-conceived people and their legal representants have the right to know general information about the donor which does not include their identity. The donor must remain anonymous unless serious medical or legal issues requires the release of their identity (Law 14/2006). In Europe, however, there is no supranational regulation on the matter, for which the situation is very diverse across all countries of the European Union. Some other states have been reversing the principle of anonymity over time. Sweden, for example, was the first country to lift the donor anonymity rule in 1984, followed by Austria in 1992, The Netherlands in 2000, the United Kingdom in 2005

(Igareda González 2018), and finally Portugal in 2018. Intermediate situations can be found for example in Belgium, where non-anonymous donation is possible in the case of an agreement between the parts, or in Denmark, where donors can choose whether to donate anonymously or not.

Recent reports and recommendations from bioethics committees in Spain have been pressing for its reversal, pointing out the interest of the children who, according to the article 8 of the European Court of Human Rights (ECHR), should have the right to know their origins as it is considered “an integral part of identity” (ECHR 2020, p. 54). In 2016 the bioethics committee of Catalonia published a report arguing against the anonymity of gamete donation (Terribas et al. 2016). This was later followed by the state-level bioethics committee report on January 2020, which, in the same vein, highlighted some of the current flaws of the practices in assisted reproductions (de Montalvo Jääskeläinen et al. 2020). The latter report, echoed in a number of different media in Spain, provoked the immediate reply from the Spanish Fertility Association (SEF). The SEF posted a statement on their website and Twitter account which summarised the main arguments previously published in their report on their position on the matter of anonymity (Muñoz et al. 2019). This report articulates classical anxieties related to non-anonymous donations, such as the problems of filiation that identity-release donors could generate as well as the genetic essentialism that these claims supposedly reify. The report also states that this change would imply a reduction of the number of gamete donations which would cause an “economic disaster” for private fertility clinics in Spain.

Unlike the bioethical committees mentioned, the Spanish Fertility Association is an association which mainly represents the interests of private fertility sector in Spain. With many of its board of directors working as clinicians in private fertility clinic, its political and divulgatory activity are directed to safeguard the prosperity of the industry.

As some have already pointed out, however, clinics can no longer guarantee the anonymity of the donation to the different parts implicated. The rise of direct-to-consumer ancestry genetic testing and the international genetic databases in which many

people are participating jeopardises this anonymity making possible to be matched with other biological relatives in the database (Harper et al. 2016; Pennings 2019).

PRIVATE/PUBLIC DYNAMICS IN THE SPANISH FERTILITY INDUSTRY

The reproductive industry in Spain has grown and settled within the private sector since its beginnings. The private dominance in reproductive medicine is a reality both in terms of innovation and of number of clinics and treatments (De la Fuente and Requena 2011). In 1988, when the first assisted reproduction law was established, Spain had 14 clinics which offered IVF treatments: four were public. This number boomed to 203 assisted reproduction centres in just 15 years, with 38 public centres versus 165 private clinics (Alkorta-Idiakez 2006). The latest data available reveals that in 2018 Spain had 245 IVF clinics, 45 of which were public and 200 were private.

The reproductive landscape in Spain has always had major differences in the private and the public sectors in terms of treatments available, conditions of use, and waiting lists. The public health system covers in vitro fertilization treatments (with women's own eggs) and artificial insemination (AI). However, the former has a waiting list of more than one year and a half, and the latter, around 6 months. Moreover, unlike in private clinics where there is no official age limit for access, in the public system, women need to be under 40 years old to access these techniques.

Public health care has as well a limit on the number of attempts, which vary slightly from region to region: in Catalonia, it is 3 for IVF and 4 for AI, after which patients will not be able to retry anymore in the public system (Departament de Salut 2016). The public system does not offer the ROPA method (Reception of Oocytes from the Partner), a treatment available for lesbian couples in which one provides the gametes to be fertilized in vitro with donor sperm, and the other has the embryos transferred and carries the pregnancy. Finally, and most important, oocyte donation is generally not offered in public centres due to the impossibility of competing with private clinics for egg donors as a result

of not being able to offer financial compensation (Álvarez Plaza 2008; Pérez Milán 2011; Lafuente-Funes 2017a).

THE ROUTINIZATION OF DONOR EGG BANKING

The proliferation of egg banks in Spain has changed fertility clinics' practice significantly in recent years (Tober and Pavone 2018; Quaas and Pennings 2018; Waldby 2019; Hudson et al. 2020). While sperm has been frozen, stored and shipped for decades in Europe, the much more complex technique of oocyte vitrification has taken longer to be controlled and routinized. This routinization is now visible in the latest Spanish fertility report, which shows that more than 30% of egg donation cycles performed in Spain in 2018 used vitrified donated eggs (SEF 2018).

As I observed during my fieldwork, all of the clinics that had an egg donation program in place had created their own egg bank in the recent years. While some used it solely to meet their own treatment demands, others also used it for shipping ova to local neighbouring clinics who might not recruit egg donors. It is also very common for big clinics to export vitrified donated eggs abroad. It is the case of Ovobank, a branch of a fertility clinic in Marbella that after years of growth and expansion to other cities in Spain, established in 2013 the first commercial egg bank in the state. Ovobank exports eggs around Europe with a special focus in Italy, which has become an important client for Spanish egg banks (Tober and Pavone 2018; Perler and Schurr 2020). According to the interviews with clinicians, the average price per egg is 450 euros, and they are usually distributed in batches of different amounts depending on the preference of the patients or clinics abroad.

The routinization of egg vitrification techniques has many advantages for clinics. On the one hand, it avoids the need to synchronise donors and recipients in space and time, which facilitates both egg donor and patient recruitment and treatment. And on the other, it allows clinics to divide the eggs of a single donation cycle between more than one recipient, reducing waste and significantly increasing the benefits that a single egg

donation cycle can generate. Finally, it has the potential to reduce waiting lists even more, especially for recipients with ‘rare’ phenotypes who might experience difficulties to find a donor that matches with them at the same time they want to undergo the treatment.

Egg banking, however, raises also important questions at the level of local regulations of assisted reproduction technologies (ARTs), which egg shipping can potentially circumvent. Issues such as the economic compensation for egg donors in Spain or the anonymity of the donation, both banned in various European countries, could find a way to enter the legal landscape of other jurisdictions if specific regulations on the matter are not developed⁷.

The routinization of egg shipping can ultimately change cross-border reproductive mobilities in Europe, with the potential of creating a reverse circuit where the eggs, and not women/couples, travel. At the moment of writing, the number of eggs exported abroad from Spain is not accounted for in the SEF registers, for which new reports on cross-border reproductive care (CBRC) could give the misleading impression that the pressure on egg donors in Spain has been alleviated and spread across the European area. I argue that it is urgent that they start to account for these shipments as the practice is likely to increase in the coming years.

EUROPEAN FERTILITY STRUGGLES AND SPANISH EGG DONATION INDUSTRY

The expansion and normalization of reproductive technologies across Europe has an inverse relationship to the decline of total fertility rates (TFR) across the continent (Table 2 and Table 3). Although data on fertility rates and specially on IVF cycles is difficult to trace due to the lack of early registers in some European countries (Präg and Mills 2017),

⁷ The EU Tissue and Cells Directive (2004/23/ED) regulates the cell and tissue obtentions and circulation within the European Union, and states that egg procurement will only be possible for therapeutic reasons without the possibility of commercialisation or inducement to the donation. As it is observed in the case of egg donation, however, the application and interpretation of this directive across the EU varies a lot from country to country.

recent compilation studies can help us have approximate numbers. While in 1980, there were 6.47 million of babies born alive in Europe (EU-28), it dropped to 4.97 in 2018 (Eurostat 2021). Contrary to this trend, in 1997 there were 203,225 treatment cycles reported in Europe, which more than quadrupled in 19 years, reaching the number of 918,159 by 2016 (Wyns et al. 2020)⁸.

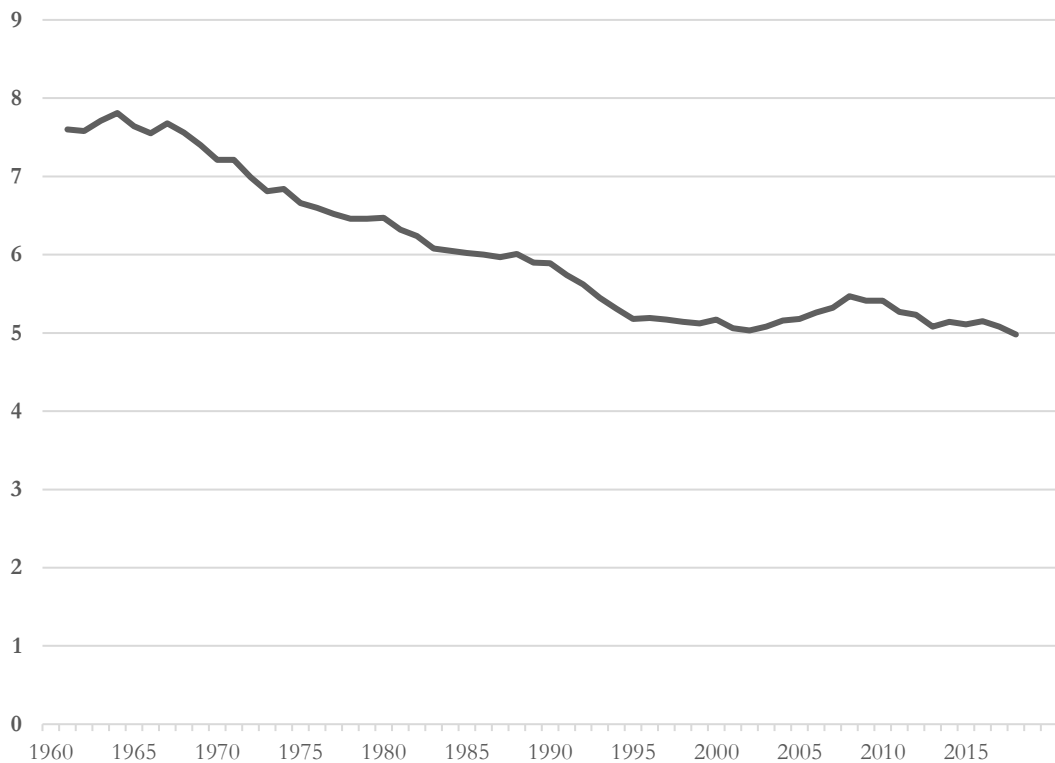


Table 2 - Number of live births, EU-28, 1961-2018. Source: Eurostat 2021.

⁸ It is important to keep in mind that from 1997 not only the number of cycles increased, but also the number of countries reporting data to the European Society of Human Reproduction and Embryology (ESHRE). The most accurate part of the graph is probably from 2013 to 2016, where the number of countries reporting results is the most stable (see Wyns et al. 2016).

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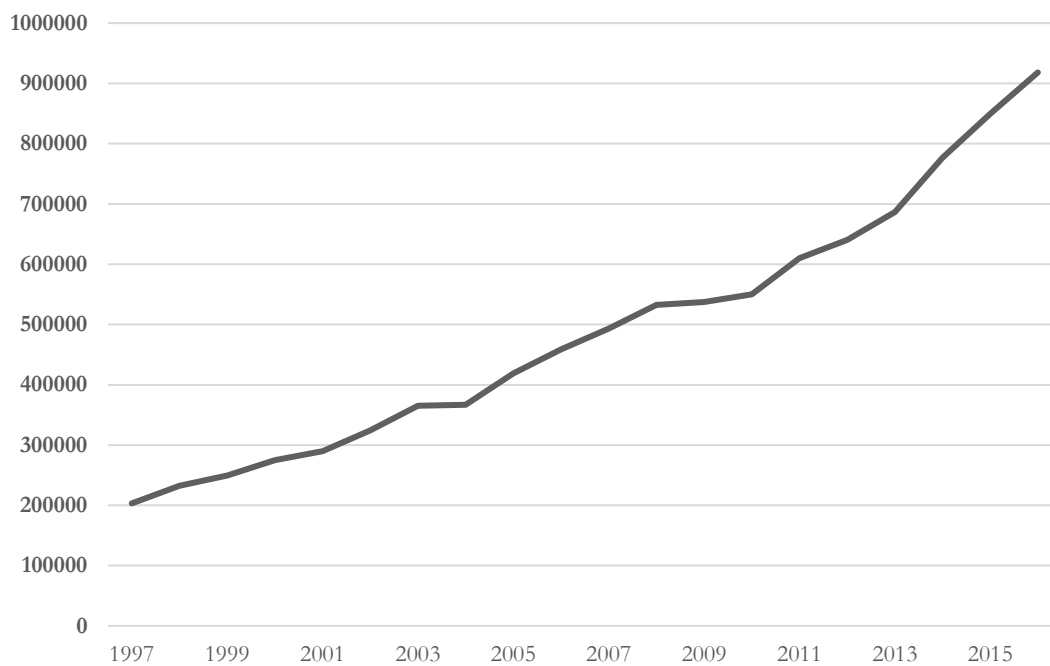


Table 3 - Number of cycles in Europe, 1997-2016. Source: Wyns et al. 2016.

The availability of contraceptive methods in most European countries since the 1960s, and the full introduction of women in the paid labour market (te Velde et al. 2012) are usually emphasised to explain the sharp declines of fertility rates across the continent, a situation leading to what Diana Marre labelled as “structural infertility” (2009, p. 114).

The causes identified as having a direct correlation with low fertility rates and motherhood delay nowadays are the difficulties in balancing work and parenthood due to precarious and inflexible working conditions, limited access to childcare services, the still-large gap between the amount of unpaid work done by men and women, as well as cultural factors related to the social acceptance of childlessness (Tobío Soler 2002; Alkorta-Idiakez 2006, 2010; Sobotka 2017; Matysiak et al. 2021; Inhorn et al. 2018; Waldby 2019).

The consequences of these changes can be seen in some representative trends, such as the raise in first-time mothers over 40 years old both in the US and Europe (Sobotka and Beaujouan 2018). Supporting the correlation between motherhood delay and demand for IVF, the Spanish register of activity indicates that 73.4% of the embryo transfers using

donated egg in Spanish clinics are directed to women over 40 years old (SEF 2018) (Table 4).

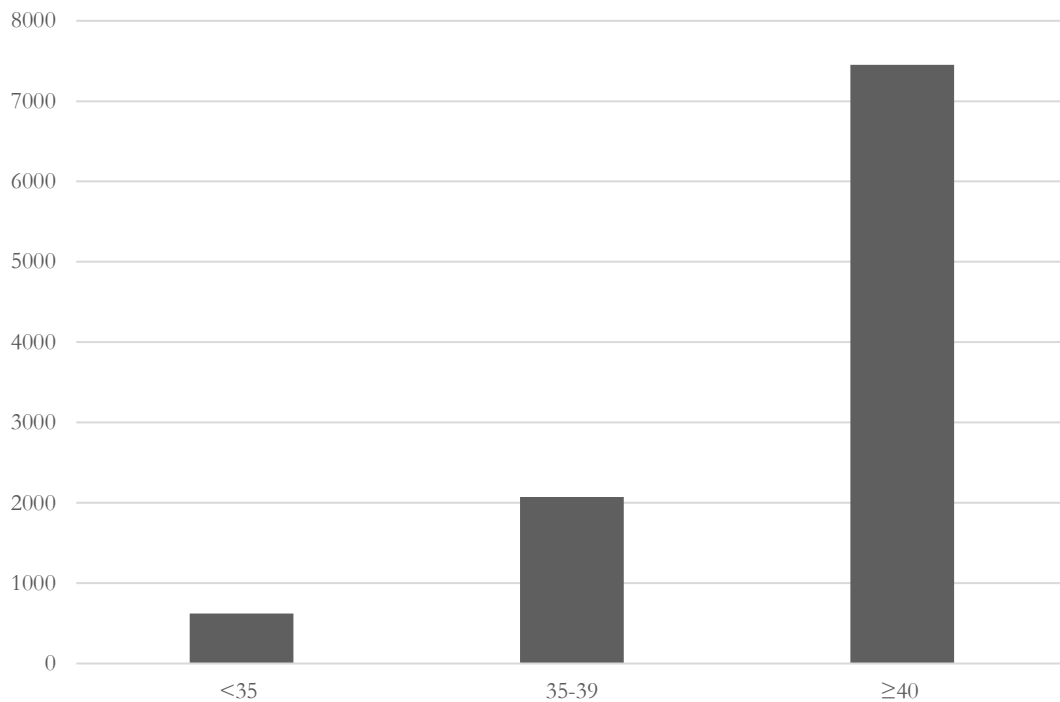


Table 4 - Age of women receiving embryo transfers using egg donation in Spain. This table shows the number of women who received embryo transfers using egg donation per age groups. Source: SEF 2018.

The delay in motherhood due to these intersecting factors has led a major number of couples with difficulties conceiving around Europe, who in turn face barriers in most of their home countries to access the desired assisted reproduction treatment, particularly IVF using donated eggs. This has generated what has been called ‘cross-border reproductive care’ (CBRC) or ‘fertility tourism’ (Präg and Mills 2017; Sobotka et al. 2008; Sobotka 2017; Sobotka and Beaujouan 2018).

The latest data available at the time of writing indicates that in 2018, 15,795 patients from other countries came to Spain to undergo assisted reproduction treatments, of whom 53.7% came to undergo IVF with donated eggs. That year, Spain performed 15,176 egg extractions on women’s bodies, which were used for 16,355 IVF treatments within their 245 fertility clinics. On top of that, 7,909 IVF treatments were performed using vitrified donated eggs, bringing a total of 24,264 treatments.

‘CROSS-BORDER REPRODUCTIVE CARE’ VS. ‘FERTILITY TOURISM’

It seems impossible nowadays to write about people travelling across the borders to gain access to assisted reproductive treatments without facing the question of what name these people deserve. As the debates on this topic prove, this is an area of academic disagreement.

In their review of cross-border reproductive care studies, Hudson et al. (2011) point out that since the phenomenon of people travelling across the borders for fertility treatments was understood “as a variant of the wider trend of medical tourism” (2011, p. 678), the term ‘fertility tourism’ was initially used unproblematically. This term is still largely used today both in media and academia, although in recent academic literature, it usually appears along with ‘cross-border reproductive care’. Nevertheless, a body of work has started to question the word ‘tourism’ for implying “choice, pleasure and relaxation” (2011, p. 678). Along this line, Marcia Inhorn and Pascale Patrizio (2009) point out that the tourism connotation fails to recognise the suffering and stress of those undergoing fertility treatments. Instead, the term ‘reproductive exile’, which highlights the failure of states to meet infertile citizens’ needs, has been proposed by some (Inhorn and Patrizio 2009; Matorras 2005). Following Guido Pennings’ (2005) argument, Marcia Inhorn and Pascale Patrizio (2009) among others advocate for more neutral terms such as ‘reproductive travel’ or ‘cross-border reproductive care’. The latter is the one used by the European Society of Human Reproduction and Embryology (ESHRE) (Pennings et al. 2008).

A question of sensibility towards reproductive travellers is at the core of the debate. Indeed, as it has been repeatedly demonstrated, fertility patients suffer, and most of them travel against their desires for reasons related to legal restrictions and availability of treatments that have little to do with the consumerist values that the concept of ‘tourism’ entails (Pennings et al. 2008). The experiences of couples traveling to Spain to ‘circumvent

laws' (Bergmann 2011) have been the focus of different ethnographic studies to date (Zanini 2013, 2011; Bergmann 2011, 2012a; Kroløkke 2014b, 2014a).

However, I contend that we could continue the discussion by questioning if the term that should define reproductive travellers can or should depend just on patients' intentions, motivations, and feelings. I argue that different types of reproductive circuits might need different names to describe their nature and its particularities, and that these names will have to consider not just the patients' perspective, but also logics embedded and the impact of these mobilities in the recipient country. I will cast doubt as well on the claim that we have to aim for an "objective" term with "no value judgement regarding the movements" (Pennings 2005, p. 3571), as I believe the topic touches sensitive issues that need to be critically addressed by social researchers. But before moving on, I consider the data that shapes my argument.

Spain at the core of CBRC mobilities

The results generated by the European registers of 40 countries in 2016 reported by the ESHRE (Wyns et al. 2020) prove that in Europe, the "objective" (Pennings 2005, p. 3571) term 'cross-border reproductive care' is in practice a much more concrete phenomenon. Although the authors acknowledge that the data provided by these countries have varied levels of completeness, the results still point to interesting trends. Crossing the data from this report with the report of activity of Spanish fertility clinics in 2016 (SEF 2016), we find out that 12,939 of the 19,239 cycles for cross-border patients reported in 10 European countries, were done in Spain, which represents 67% of all the reproductive mobility in Europe. A first thing to recognise, therefore, is that when discussing CBRC in Europe, we are mainly talking about European infertile patients travelling to Spain.

Eggs at the core of CBRC mobilities towards Spain

Departing from the same ESHRE report (Wyns et al. 2020) and matching its data against the report of activity of Spanish fertility clinics in 2016 (SEF 2016), a second interesting

aspect to consider emerges. Forty-six point six (46.6) per cent of these European mobilities occur to gain access to egg donation treatments. If we consider this number in the light of the 6,893 foreign couples that underwent IVF with donated eggs in Spain in 2016, we can conclude that 77% of CBRC egg donation treatments in Europe happened in Spain. A second important consideration, therefore, is that the main motivation to travel abroad for fertility treatment is the availability of ova, which in practice means most European international fertility patients travel to Spain for donated eggs.

Economic precariousness and the egg availability in Spain

Although Spain is the hub of ova extraction in Europe, very little quantitative research has been done to understand the sociodemographic characteristics of women donating their eggs. The biggest survey done to date is a study undertaken by the ESHRE with data from 2011 and 2012 from a total of 449 Spanish egg donors (Pennings et al. 2014). The study concludes that 28% of egg donors in Spain work full-time, while 23.3% work part-time, 23.3% are unemployed, and 24.9% are studying. Forty-six point seven (46.7) per cent of donors have completed secondary studies, while 22.5% have technical studies and 22.5% university studies. The study also questioned former donors regarding their motivations to donate and pointed out that 56.5% claimed to be motivated by both altruism and financial reasons, while 30.4% claimed being motivated only by altruism and 19.1% only for financial reasons. As the study points out, there was a strong correlation between donors' country of origin, age, professional activity, and number of donation cycles with the motivations to donate. Migrants, young women, those without a full-time job, and donating more than once are more likely to be totally or partially economically motivated.

The health authorities of Catalonia also gather details on egg donors' sociodemographic profiles. In its last report with data from 2014, it states that most egg donors are between 18 and 24 years-old (40.6%). It also shows that 24.8% of egg donors were born abroad, which suggests that the oocyte economy in Spain is not just fuelled by

foreign couples circumventing laws, but also by migrant women who participate in large numbers in this industry (FIVCAT.NET 2014). These data, however, is much better understood when analysed alongside the socioeconomic context of young women in Spain. In the following section, I provide an overview of this context.

The Spanish socioeconomic context

The global financial crisis in 2007 hit the country especially hard with unemployment rates reaching 25.7% in 2012 (INE, 2019). This downfall affected the state as a whole but had special impact among women, young adults and elderly people. The austerity measures demanded by the European Union for the management of the crisis resulted in increased precarity of the labour market as well as major cuts in the public services such as health, education, and pensions.

Although the surveys show how, within the last decade, the median salary has been increasing slightly, from 1,563.10 euros per month in 2008 to 1,714.93 euros per month in 2018, this has not been the case for the young population, and more particularly, among young women. The median salary for women from 20 to 24 years old has been stable over the last decade and even slightly lower overall in 2018 at 793 euros per month (INE 2018). Moreover, the data reflects only those young women who are active in the paid labour market, which is not the most common scenario: 46.26% of women aged 16-19 are unemployed, as well as 30.22% of women aged between 20 and 24. Those from 25 to 29 years old have an unemployment rate of 18.65% (INE 2019).

It is also important to note that, while the minimum salary in Spain in 2019 was 1,050 euros, which represented a significant increase in relation to 2018, at 858.55 euros (Eurostat 2019), these amounts reflect the full-time regular contracts of 40 hours per week. It does not include the types of contracts usually held by young people, such as training contracts, in which the salary has to be at least 75% of the official minimum wage during the first year, and 85% from the second year onward. Nor does it account for internship contracts, which are usually unpaid. It is within this context of precarious and

poorly paid employment for young women that the amount of money egg providers receive in Spain needs to be understood as an attractive sum of money.

THE SPANISH EXTRACTIVE TOURISM AND FERTILITY LANDSCAPE

Putting together that most fertility mobilities across Europe are from patients travelling to Spain for the availability of ova, and that egg donors in Spain are mainly young women (both local and migrant), in precarious contexts at least partially driven by the economic compensation, I argue that regardless of whether we call these mobilities ‘cross-border reproductive care’ or ‘fertility tourism’, the fertility and the tourism industry in Spain are intimately related. I propose to think about both industries in a broader manner, focusing on the concepts of extractivism, for which I refer to “the rapid and widespread removal of resources for exchange in global capitalist markets” (Jacka 2018, p. 61), and precarity, “understood as the predicament of those who live at the juncture of unstable contract labour and a loss of state provisioning” (Han 2018, p. 332). As I unpack further in the following paragraphs, both fertility and tourism industries share an unequal distribution across Europe, a transnational business structure, and the provision of poorly paid workers, often migrants and women, who participate in the provision of this labour in large numbers.

Although Spain is the country with the most prominent fertility industry in Europe, the industry’s infrastructure is not spread equally across the territory. One hundred sixty-four out of the 245 fertility clinics in Spain are situated along the Mediterranean coast (Andalucía, Catalonia, the Valencian Community and Murcia), or in Madrid, the capital. All of these locations are among the most visited parts of Spain by tourists (INE 2019) and have important touristic infrastructures, such as airports with low-cost flights connected to most European capitals, many accommodation options as well as services in multiple languages, especially in the big cities where most clinics are based. This is not so much to suggest that patients chose these destinations for their touristic interest, but

rather that this touristic infrastructure is crucial for the European transnational fertility industry to work efficiently.

This intertwinement between tourism and CBRC is especially significant in this research: Barcelona, capital of the region of Catalonia, accounts for the biggest portion of the fertility market (24,28% of all the cycles performed in Spain in 2018) (SEF 2018). In 2019, the city received more than 20 million tourists (Observatori del Turisme a Barcelona 2019), being the most visited city in Spain.

The management of tourism is currently one of the biggest challenges for Spain especially in the cities along the Mediterranean Sea. The negative effects of mass tourism are witnessed every day in Barcelona, such as gentrification, ejection from the local population due to the rising costs of living in their neighbourhoods, labour precariousness, among other infrastructural and environmental effects.

These tangible consequences have provoked different protest actions against the management model of the city since 2017, which are visible in the streets and balconies of some of the most affected neighbourhoods in Barcelona (Plate 2, Plate 3, Plate 4). While big touristic organizations in the state argue against this rejection of tourism, pointing to the economic growth of the territory as well as the creation of employment, other analyses note the standstill of employment and economic growth, particularly in those regions with high touristic pressure such as Barcelona (Fora Alcalde and Espelt Alba 2019).

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Plate 2 - Banner against real estate speculation in a street from the neighbourhood of Raval (Barcelona). Written in Catalan: “Stop!! the real estate speculation that is moving us out of the neighbourhood”. By Anna Molas.



Plate 3 - Graffiti anti-gentrification in the façade of an occupied building (Ca La Trava) in the center of the neighborhood of Gràcia (Barcelona). Written in Catalan: “Stop gentrification”, “No eviction without response”, “Ca La Trava resists”. By Anna Molas.



Plate 4 - Banner against real estate speculation in a street from the neighbourhood of Raval (Barcelona). Written in Catalan: "They are kicking us out of our home. Real estate violence, speculation, build-up of people, dirt, unaffordable rents, mobbing, tourist

SPANISH FERTILITY CLINICS AS TRANSNATIONAL CORPORATIONS

As an industry based on extractivism, it is important to consider the fact that the Spanish reproductive industry is not a local state-based economy. It is rather increasingly part of the multibillion-dollar transnational private health care industry across the world. The laissez-faire politics of the Spanish government in relation to the fertility industry has

acted as a “guarantor of the benefits of the neoliberal system” (Lafuente-Funes 2017a, p. 83) and has driven the Spanish fertility industry, and particularly the Spanish oocyte economy, to become an important part of the prominent reproductive bioeconomy (Cooper and Waldby 2014).

Two of the biggest IVF groups in Spain provide a good example of the ongoing functioning of this prominent bioeconomy increasingly transnationally organized: Eugin is a fertility clinic group founded in 1999 in Barcelona which currently performs the most cycles across the state. After expanding its clinics across Europe and Latin America, it was acquired in 2015 by the biggest private health care group in the United Arab Emirates, NMC Health, which is listed on the London Stock Exchange (Casado 2015). NMC Health later sold Eugin to the German group, Fresenius Helios, owner of the biggest groups of private health care in Spain. Nowadays Eugin has clinics around the world which operate according to the laws of each specific country. A further example is IVI, a private fertility group which has 30 clinics in the main cities of Spain. In 2017, IVI merged with the private reproductive health group from the United States, RMA, becoming the biggest group offering fertility services in the world (Plate 5) (Zafra 2017). After the fusion, IVI-RMA also entered the Stock Exchange market in the USA and Spain.



Plate 5 - Image of the agreement between IVI and RMA. Source: ivi.es

These transnational corporations are controlled by stakeholders who do not necessarily have professional connections with reproductive medicine. For example, one of the stakeholders of IVI-RMA is also the president of a Spanish airline operating flights across Europe (Zafra 2018), a further example of the links between tourism infrastructure and the fertility industry.

Within this globalised bioeconomy, Lorraine Culley and Nicky Hudson (2010) argue that fertility travellers can be theorised as “global consumers, engaged in a worldwide phenomenon which is characterized by the extension of markets into human reproduction; the growing commodification of the body and its parts, and the actions of the state and other political actors in (often indirectly and perversely) aiding the development of a global market in fertility treatment” (p. 142). As they state, cross-border reproductive care is “an expression of the market par excellence” (p. 146; see also Whittaker and Speier 2010). In Spain, the fertility industry operates in a complex dynamic embedded in a neoliberal free market system, which works within the logics of globalisation and is organized transnationally rather than locally through intimate relations with other prominent business industries. Within this framework, patient mobility and the Spanish tourism infrastructure are intrinsically related and fuel each other. Therefore, I contend that reintroducing the term ‘tourism’ in the definition of fertility travel in Europe could have an important function even if it does not reflect the patients’ experiences. Instead, it works to highlight the intimate connections between the fertility mobility and the tourism circuits of Europe, and Spain’s dominance in both. It also provocatively associates the transnational fertility industry with the struggles of touristic cities in Spain, such as Barcelona, where the dynamics of extraction are leading to increase the already significant precarity of citizens.

CONCLUSIONS

In this chapter, I outlined key contextual data to understand the intersecting factors that brought Spain to become the main provider of ova and egg donation treatments around Europe. I first provided details on the past and current legislation and practices around

ARTs in Spain, which have led to the most permissive regulation across Europe. Second, I focused on the low fertility rates in Europe as well as the mobility patterns of patients across borders to access IVF in order to offer an approach to the discussions around the terminology of these movements. By providing key information around the dynamics of the fertility industry and the tourism industry in Spain, I traced similarities and imbrications between the two and argued that both are, in practice, intimately linked.

In the following chapter, I will focus on women's decision-making to become egg donors and the close relationship between this process and the precarious labour market in Spain. I will describe in detail how the dichotomy altruism/economic interest has effects not only on women's narratives around the donation, but also in feelings of ambivalence and shame for not aligning (or not entirely aligning) with the gendered principle of care and solidarity in which egg donation is framed in Spain.

CHAPTER 1: SECURING A FUTURE THROUGH EGG DONATION

INTRODUCTION

Melinda Cooper and Catherine Waldby situate the concept of ‘clinical labour’ as a type of labour that emerged along with the disintegration of the Fordist era. According to them, this disintegration stabilized those experimental and reproductive forms of value that were before “developed in sequestered spaces sharply separated from those of industrial mass production” (Cooper and Waldby 2014, p. 221). The authors refer to the unpaid work that was being undertaken at the margins of the Fordist factory by prisoners forced to participate in mass clinical trials or housewives who had to undertake domestic, affective, and reproductive labour for the household unit. The emergence of a deregulated and precarious labour market, therefore, created the conditions to turn the unpaid work of the housewife into an “entire service sector (childcare, food preparation) and various horizontal contracts for formally domestic service, including the care and nurture provided by (often undocumented) migrant labor” (Cooper and Waldby 2014, p. 222). Scientific innovations played a key role in the creation of this new form of labour based on women’s reproductive capacities, which developed value in the growing reproductive bioeconomy. A bioeconomy that capitalizes upon the difficulties of bearing children within a context of economic precarity at different levels.

Most of the participants of this research fit within Cooper and Waldby's definition and can be described as clinical labourers for whom participation in the global reproductive bioeconomy is situated within a framework of instability and precarity at different levels. Similar to the Indian surrogate mothers in Sharmila Rudrappa's study (2012), many of the examples from my data below show how egg donors flow between unstable, temporary jobs to egg provision, without a clear perception of the two being any different in terms of conditions. As I will show, some even clearly label egg donation as a faster, less exhausting, and more meaningful way to make money. Michal Nahman's (2013) examination of Romanian egg donors points to a similar direction when she claims that the accounts of exploitation and choices "must be taken together with a wider understanding of the kinds of labour (reproductive and otherwise) that are possible and quotidian for people in the context of Romania" (p. 32). Or, as Verena Namberger (2019) puts it when studying the South African egg donation bioeconomy:

For a lot of donors, it is the everyday reality of a regular 40-hour office job, the boredom of stocking shelves at a supermarket or the hardship of unsatisfying, poorly paid occasional jobs, which shapes their notion of normal labour. In comparison, the duties of being a donor stand out as an exciting and meaningful break from the dull routines of daily life and as a possibility to be 'part of something bigger', as many women put it. (p. 99)

What these accounts reveal is the need to understand egg donors' labour lives beyond their passage through the clinic to be able to make sense of their experiences and rationalities for undergoing an egg donation cycle.

In this chapter, I address the ways in which women frame their decision to become egg donors, with a specific focus on its entanglements with the participants labour context. First, I show how the manufactured dichotomy between the altruistic framing of egg donation and the financial interests of egg donors plays out within particular discourses of the participants in my research. Second, I examine how egg donation and the labour market are intimately intertwined through similar logics, being egg donation

for some a way to buy time to look for a job, a job itself, or a way to secure future and financial autonomy in a context of socioeconomic instability. Third, I explore the rationales of egg donors to do another cycle, and how their circumstances can change their decisions over time. I conclude that undergoing egg donation in Spain is an activity intimately linked with having a job, and sometimes even interchangeable. As the examples from my research below show, even if egg donation is not considered work by all participants, the close relation between the labour market and egg donation is present in most stories.

The aim of this chapter is to show how the discourse of altruism become the tool that tames the ambivalent relation between the decision-making to become egg donor and the Spanish labour market. In this sense, altruism provides a specific narrative and imaginary of the exchanges that take place, highlighting stories of reciprocity that draw on women as naturally caring, and which reduce the socioeconomic struggles in which this relation rest.

'EGG DONATION, GOOD OR GIFT?'

A CRITICAL APPROACH TO WOMEN'S MOTIVATIONS

Although it is possible to discern some patterns, it is difficult to generalise when talking about how providers make sense of their donation and the particular way in which they organise the discourse around the presumed altruism and the money received in exchange. It is true, however, that the explanation on whether they were more 'altruistic' or 'financially-motivated' was one of the first questions the participants were prepared to answer.

In April 2019, when I was 4 months into my fieldwork in Barcelona, I was invited to take part in a panel on reproductive markets organized by the Universidad Complutense de Madrid. The name of the round-table discussion in which I participated was called 'Gamete donation in Spain: good or gift?'. The title, of course, was intended to provoke

a vivid discussion of gamete configurations in Spain, because it encapsulated the static frame within which the debate has been stuck for years. Good or gift?

This is the question to which egg donors are confronted all the time. “So, do they do it for money or is it really altruistic?”, I was asked repeatedly by friends and family during my fieldwork. The answer to this question is presumed to have the capacity to reveal the legitimacy of the whole industry and the true nature of the donor. “Selling yourself for 1,000 euros?”, someone said to one of my participants, “you don’t love yourself”. This framework resonates in media approaches to the topic as well as in academia.

Guido Pennings et al. (2014) published a paper titled: “Socio-demographic and fertility-related characteristics and motivations of oocyte donors in eleven European countries”. The results of the paper indicated that egg donors in Spain were mostly motivated by “a combination of altruistic and financial reasons” (p. 1084), with 56.5% of a sample of 449 donors marking this option (30% indicated “just for altruism” and 19.1% “just for money”). Within a framework that legitimises egg donation to the extent that egg providers are altruistically motivated, the results of this research are promising, especially for fertility clinics. As they see it, most donors actually wanted to help, for which all issues related to a possible exploitation of women or unfair inducement through the economic compensation get somehow dissipated. This is how some fertility clinics decided to read and market Pennings et al. (2014) findings, with many including content on their websites targeting recipient couples in which they highlighted the altruistic motivations of egg donors. I observed this marketing during my fieldwork too. In a talk on fertility options organised by a fertility clinic in Barcelona for the Spanish association entitled *Single mother by choice* (Madres Solteras por Elección), a slide indicated that the motivation of egg donors was altruism and generosity.

In a critique of this manufactured binary model of thinking, Sara Lafuente-Funes (2017b) argues that focusing on the motivation of women obscures the functioning and profit of the industry in favour of individual moral questions. She notes that looking at egg providers’ subjective perceptions in this way places “the motivations of donors at the core of the definition of the process (and not the motivation of the clinics, for instance)

and separating the procedure from the idea of eggs sale or exploitation of women”⁹ (Lafuente-Funes 2017a, p. 259). Following her argument, I contend that asking ‘Who are the egg donors?’ or ‘What do they think?’ from identity frameworks has the risk of exotizing the women who participate in this process just because they do, suggesting that they are somehow different from any other random group of young women in Spain.

Similarly, Laura Perler and Carlo Schurr (2020) contend that the altruism/exploitation dichotomy when considering egg donors’ motivations is a Eurocentric conceptualization of choice and agency. They argue instead that women’s choices must be analysed “against the backdrop of their [egg providers’] reproductive biographies” (p. 3) to understand the entanglements between the global bioeconomy, state biopolitics, and women’s intimate lives. As Andrea Whittaker (2015) puts it: “The critical issue for feminists is not so much the content of women’s choices but the conditions under which they are made” (p. 266).

Following their propositions, I contend that the focus on this dichotomy is suppressing important questions on the collective and individual contexts in which these decisions are made. Moving away from static frameworks of motivations, this research aims to uncover the sociotechnical entanglements within which egg donation takes place in Spain. To do this, I focus on egg donors’ experiences in the light of discursive, moral, legislative contexts, and in particular, the precarious Spanish labour market.

FRAMING A WISH FOR MONEY IN GENDERED ECONOMIES

Among the participants of my research, very few described their donations as a *purely altruistic* matter. Only 3 out of 25 claimed that they did not have a financial motivation. The main drivers for each of them were different. Andrea, for example, saw the donation as an opportunity to find out whether she had any fertility problems, as her mother did,

⁹ Original thesis in Spanish. Fragment translated to English by the author of this thesis.

while at the same time she was helping other women like her mum, who had struggled to have her. Maria, on the other hand, was a midwife who claimed to be “enthusiastic about motherhood-related issues” and said becoming an egg donor had been on her to-do list since she was very young. She did the donation when she was 32 and tried to choose the “less commercial place”, for which she selected a private clinic associated with a public hospital in Barcelona. Finally, Stella claimed she donated out of “scientific curiosity” and a desire to help. We met one morning in a cafeteria for the interview, and she did not let me pay for her breakfast, highlighting that she was there to help me with the research, and “not for you to pay me anything”. On reflection, I understood that her reaction was a way to state what she had come to tell me: she did not donate eggs for money, and it was important for her that I understood that. She assured me that she thought they paid around 500 euros, which she wanted to donate to the NGO *Doctors without Borders*. When she found out the payment was actually double that amount, she decided to keep half of it for herself to pay the rent that month.

For the rest of the twenty-two participants I spoke to, financial compensation was the driver of their decision to donate. Eleven women told a story where empathy with women was also important, while ten others only highlighted the particular reason why they wanted the money and how it took them to consider egg donation. In the former group, the division between financial motivation and the so-called ‘altruistic reasons’ or the ‘moral part’ was blurred. In many of the stories, the two went hand in hand, fuelling each other. As I argued elsewhere and was clear again in this fieldwork, for some participants egg donation is seen as a ‘win-win situation’ (Molas and Bestard 2017) where their wish for money can be covered in the best possible way, by helping others. The perception of what they win and their perception of the price they pay for it will be examined throughout the thesis.

Helena, 27 years old, spoke to me for a long time about how her step-grandmother’s experience of infertility was an important factor in her decision to donate eggs. However, later in the interview, when asked about how she found out about the possibility to donate, she said:

So, a friend... I went to see a friend who was ill and so on [...] and she told me “I will do this thing of the eggs as they give me cash”. And I thought “what do you mean by *this thing of the eggs?*”, and she told me broadly. Then I... I am very stubborn. So, I went home and I started to look it up and look it up and I thought, “okay, so I’ll do it”.

Indeed, in many stories, accommodating the ‘altruistic factor’ in the equation of their discourse seemed to be a later operation. The case study of one of my participants, Mica, provides a clear example of the impossibility of grasping the context in which women are becoming egg providers by just asking about their motivation in a single survey question. Had she taken part in Pennings et al.’s (2014) survey, she would have answered that her motivation was both economic and altruistic, and yet that would have told us nothing about herself or the egg donation arrangements operating in Spain. The story she told me in the encounters we had underscores the multiple layers that need to be considered in any study of the egg donation bioeconomy in Spain:

I have a friend who has donated several times. Some went well, others worse, and so it scared me a bit. And well, I have relatives, not blood relatives, but who can’t... who needed to adopt, who can’t have children and all of that. Not here but... just for the fact that they couldn’t have children... it gave me strength to do it. Because as I can do it, as I can help... And then during the months of August... July, August, September... I had a lot of free time. [...] I mean I am young; I need 1,000 euros; I want to help...

(Mica, 22 years old, two-time egg donor)

Certainly, Mica had free time and could use 1,000 euros. Her family migrated from Uruguay to Spain when she was 11 years old and struggled for years to reach some financial stability. Living in a 30 square meter apartment, her mum worked in a supermarket and her father in a factory, which later closed and left him unemployed and depressed. Mica’s marks at school were low, and her brother suffered from strong anger

attacks. Finally, her father decided to go back to Uruguay, which, as Mica claimed, improved both her marks and her brother's attacks. However, shortly after that, her mum started a new relationship with a man which was not well received by any of the children, and everyday fights started again. Therefore, when she was 16 years old, Mica decided to return to Uruguay with her father:

With my father, we were always at the threshold of poverty. I mean, it was even hard to buy toilet paper. My dad did not work so much, but the main thing is that everything there is very expensive. Everything is a sacrifice. It was always rice with mayonnaise... buying a burger was like "wow!", everything is uphill. [...] And I had to study in the university in Montevideo that was one hour and a half journey away, but I couldn't afford the ticket, plus the universities are crowded because they are public, and I said, "Okay, I need to leave".

She came back to Catalonia with her boyfriend from Uruguay, to whom she married so he could get the documentation to live and work in Spain. However, her plans to start university in Catalonia proved more difficult than she expected. She needed recognition of her studies in Uruguay, which took months to come through, a time in which she did not know whether she would be able to continue studying or if she would miss one year.

Since she was back in Spain in November, she worked full-time as a waitress while she was waiting to go back to studying again. Her partner could not work because the documentation after their marriage also took several months to come through. Meanwhile, she alone paid for their portion of the rent to her mother, as well as the expenses of both. The situation worsened when the cafeteria she was working in went bankrupt and, by the month of July, she was unemployed: "So the situation was a bit like this. I was going to start studying, Roberto didn't have a job and I didn't work 40 hours anymore, and so the money [for the egg donation] was welcomed to pay bills".

The case study of Mica provides an example of the complex entanglement of experiences, life stories, circumstances, and desires that can make a woman consider egg

donation. In her case, a migration story, job struggles, and family economic instability all played a role in her decision to become an egg donor. However, the story of her infertile non-blood relatives was not mentioned further in any of the conversations we had afterwards, nor the messages that we exchanged throughout my fieldwork.

Indeed, admitting they were donating (at least to some extent) for money was not easy for some participants and sometimes caused mixed feelings. It was the case of Júlia, a participant that for the first time in the university cafeteria of the faculty of psychology. With her round face, blue eyes and with her hair shaved on one side, she clearly looked older than the average bachelor student. She told me that she was 34 years old and that she had recently started university studies for the first time. “I’d always had a very altruistic personality”, she said when I asked her about how she decided to donate her eggs. But she also told me that she had her first son when she was 16, the second when she was 22 who she raised on her own, and that she really needed a bit of extra cash. She already had different strategies in her life in order to make ends meet which mostly involved caring for children. She went one hour a day to clean her children’s school lunchroom, for which she would get food leftovers in return. As for work, she had many spontaneous temporary jobs that she combined with the babysitting of multiple babies. Among laughs, she recalled the time when she was babysitting three babies from different families at the same time. She used to take the smallest one (4-months-old), who apparently cried a lot, on her chest with a baby carrier wrap, another one (8-months-old) in a baby toddler backpack, and the third one in the baby carriage. “The tourists took pictures of me”, she said amused. This continued until the night she dreamed she was spilling breastmilk and realised, when she woke up, that she had actually lactated again six years after having stopped breastfeeding her daughter. She then decided to stop babysitting the 4-month-old baby.

Júlia expressed her ambivalence between the presumed altruistic motivation of the donation and her need of money in the following way:

It was a moment that... first, this wish collaborate that I had, because it is true that I thought about it, right? I had also met people who had

difficulties and who had to turn to this, right? To donor eggs. And well, for me motherhood had always been something that... well, in that time, it was something I was enjoying a lot, right? Like I could empathise, right? [...] And there was also an economic need. This was very hard, right? Because during the process, I started to have like a lot of doubts, like “it is not good if I am doing this for the money”, to myself, you know? And “if it is for this economic reason, I don’t feel good because I am not doing this because I want to help, or not entirely”, right? And this made me feel very anxious.

One of the cases that better pictures the uncomfortable feelings that a wish for money can generate in this setting was my interview with Sara, who was 25 years old and who had donated her eggs twice. After an hour of interviewing, she finally told me about the reason for her two donations when she was 19. She warned me before starting: “I mean, this is really tough, okay?”, and then she told me she used the money from the donations to pay for the orthodontic treatment she needed to stop the strong migraines she was having. As she told me, these had started after her family was evicted from the place they were living because her father, working in construction, had to shut down his business following the economic crisis in 2008. Again, what started as a story of empathy towards a friend of her aunt who had to undergo IVF to conceive, finished with a “tough” story of personal hardship involving an eviction, loss of family business, and an investment in her health care.

Mireia, a participant who donated eggs 5 years before our interview, reflected on her motivation acknowledging that what she really wanted when she claimed herself as “wanting to help” was in fact helping herself:

In a certain way, all the thoughts that I had of “yes, okay, I want to help someone”, it was a bit to comfort myself because I knew that the base of my ideas was that I had financial need. Then yes, all the rest were additional things. And it is true that it is something that in that moment made me feel bad, like “you are saying something and you say yes, that

you think is very good, that you are doing that for another person, but in reality you are doing this to help yourself’, right?

(Mireia, 28 years old, egg donor)

The case of another participant, Berta, provides a contrasting example. While most donors began with stories where altruism had a central role, Berta considered herself a victim of the system who was forced to donate because of her family economic problems.

While Berta’s case might seem a contradiction with the others examined, I claim that the logics are the same. Narratives with doses of epics are used to justify their choices to donate. In an extract of her diary, she shared with me, she pictures herself as a valiant victim of poverty forced to “sell” her body to overcome the adversities in an ambivalent narrative in which she “loses her principles”:

She goes out on the street early in the morning and thinks about how when she was little, everything was easier, or so she thought, being unaware of all the problems that happened around her and worrying only about asking for 10 euros from her mum to go to the cinema with her friends.

Now instead she is the one who must bring the money home, and she is totally aware of the things that happen around her. Reality made her grow up all of a sudden with a slap on the face, because when you are lower class, this is what happens. You grow up fast along with the strikes life gives you without you really being aware of what’s happening.

That morning, with that reflection in her mind, she was walking distracted, not paying much attention to the people around her. It wasn’t like other mornings. That day she felt totally confronted by her thoughts.

It wasn’t the first time she was going to that place, but this time her feelings were different. This time they were more visceral and totally opposed to those who accompanied her the first time.

She felt sad and with a huge rage inside. She also felt that her principles got lost on the way to the clinic... but on the other hand, she thought of her family and the immediate need of having a plate on the table which wasn't given by the crumbs of a system and an administration that oppresses us and that makes us their dependant slaves. Which makes us kneel for a meal, a house, or a piece of cloth not to be cold.

*She had seen her mum ask for things so basic as aids to pay the school or food and being refused them. She had seen her mum cry inconsolably so many times out of the rage she felt for being in that situation, that she had the need and the obligation to do whatever it was to take them out of that position, so that they could live for a while without depending on anyone. And if that meant that she had to sell her body for some weeks, she would do it, being aware of all the hormonal processes she would have to undertake, the poking, the mood changes, the restrictions... finally, of not being herself during the process and to be the "perfect" woman so everything went well. Not to mention, of course, the emotional process that starts the moment she thinks of walking the path, which does not finish in the operation room, but it is with her during the following months when she sees a little child, a pregnant woman or even when she has her period. [...]*¹⁰

(Extract from Berta's diary, 21 years old, two-time egg donor)

The guilty feelings that both Júlia and Mireia experienced as well as the need for Berta to explain her decision in terms of desperation provide a good understanding of the material consequences of framing egg donation as an act of love and empathy towards others. As it has been argued, the oocyte market is part of the new markets of clinical reproductive labour which are "developing in close synergy with pre-existing transnational economies of feminised labour (domestic, sexual and maternal)" (Waldby and Cooper 2008, p. 64) in which the labour they imply is usually difficult to properly quantify. The idea that reproductive work is somehow emanating from a natural predisposition of women towards the care of others has historically made it very difficult to monetise,

¹⁰ Although she is talking about her experience, this fragment is in third person because Berta wrote it this way in the original version in Catalan.

configuring different kinds of feminised precarious markets (see Lafuente-Funes and Orozco 2020 for a detailed account of the synergies between egg donation and care work in the Spanish context).

The fertility clinic as an active agent in the making of altruism and therefore, in the making of gendered expectation towards third-party reproductive workers, has been reported by different researchers (Álvarez Plaza 2008; Curtis 2010; Almeling 2011; Pande 2014; Rudrappa and Collins 2015; Jacobson 2016; Lafuente-Funes 2017b; Marre et al. 2018; Degli Esposti and Pavone 2019; Hovav 2019). However, the examples of Júlia and Mireia make clear that the institutional framework of egg donation in Spain does not only constitute a discursive apparatus that assists clinics to create and promote ‘biodesirable’ donors for infertile patients (Gunnarsson Payne 2015), as well as obedient women (Lafuente-Funes 2017a; Rivas et al. 2019; Molas and Perler 2020). These mechanisms also carry embodied consequences for egg providers, which translate into anxiety and guilty feelings for not complying with the gendered expectations to be caring rather than financially motivated.

In the following section, I examine the rationales of the participants for engaging with egg donation, which I classify in three groups: egg donation to buy time to find a job, egg donation as a job, and egg donation to invest in future jobs. I argue that although these examples are different, they all emanate from a same problem: the precarious and unstable Spanish labour market.

FLUIDITY BETWEEN EGG DONATION AND THE LABOUR MARKET IN SPAIN

Buying time to look for a job

For some participants, becoming an egg provider was not a job itself, but rather a way to obtain extra money when the former was lacking. It was a way to buy some time to keep

looking for a job for a bit longer. The decision of Mireia to become an egg provider, for example, was framed by her struggle to find a job to ensure she could continue her studies. The economic compensation from egg donation substituted for the income that used to come from her job, as she explained in the interview:

After my first year of university, I had worked for a while... I worked here by the coast, I had always worked to pay for my studies, right? So, I finished my first year at the university and I had applied for the scholarship¹¹, I did the first term of the second year but then... I didn't know yet if... whether I was going to have the scholarship again or not, right? Then I finished the first term in December, and by January, I didn't have money at all to be honest. [...] So, I worked for 6 months in nightclubs and restaurants, making money to go back to the university in September and continue my studies. During that summer, one of my colleagues told me that her sister had done an egg donation and that it went very well. She also did it for a matter of money and so on, and it was something that I thought "*hostia*" [damn it]. Also my sister had my first niece and it was something that I had never thought about at the personal level, I always thought, "Wow, I don't know if I want to have children" and so on. But with the experience of being an aunt, I had this awakening much more, right? Like "*Hosti*, I do like children", right? "I do have something there". [...] I had to ask for financial help from my parents, for two months, which I didn't like, and I saw myself quite suffocated and then I... the idea came to my mind again, right?

(Mireia, 28 years old, egg donor)

Mireia's purpose was to continue her university education, something that, due to her socioeconomic context, she could only do with external income. The idea of donating

¹¹ She refers to an existing scholarship directed to low-income students to help them pay the fees and that sometimes goes along with a small stipend.

eggs seduced her when she was struggling to find a job and needed to ask for financial help from her parents. She also indicated the need to have a moral reason to do it, which in her case was the realisation that she actually liked children when she became an aunt.

Another participant, Merche, shows still another way in which egg donation and the precarious labour market are intrinsically linked. As she told me, at 19 years old, after five months of looking for a job “day and night”, she decided to schedule a donation cycle “to have a [financial] cushion”:

From June to October, I was looking to a job day and night. I signed in for Infojobs¹², Adecco, Randstad¹³, I went to the SOC [Public Employment Service] and to a local institution in my town where they help you look for a job and they also do training. I did the typical training on how to do résumés, how to do job interviews, I mean everything, I did everything I could to find a job. I went to business after business with my résumé. I went to Barcelona to get them, I moved heaven and earth. But of course, it reached a point to say, “Okay, my idea was to start studying, now I can’t, I can’t save money, I can’t do anything. In February, the campaign to sign in for the university will start again for next year, I will have wasted an entire year, I can’t find a job,” you know? I was also feeling very stressed, right? I found myself a bit stressed in that moment. The money [from the donation] was not to pay the university, but to have something there just in case, and I don’t know, if I couldn’t find a job, I could put it there. Which was good for me to be honest. [...] I mean, want it or not, the transport and the print of my CVs... [...] I saw myself in a moment where I was spending a lot of money and not winning any. That is why I wanted to have a little [financial] cushion.

¹² Employment website.

¹³ Temporary work agencies.

For Merche, the donation is related to her work in the way that it boosts her chances of finding a job and therefore, starting university the next school year. With the money of the donation, she was able to print more CVs, pay for transport tickets, and have a little bit more time to keep looking for employment.

As discussed in the literature review, egg donation treatments sell time not only to the recipients who cannot have children with their own eggs for age reasons, but also to egg providers who attempt to reach their goals with laborious but secure injections of income into their fragile personal economies. It provides an amount of money that allows both Mireia and Merche to be financially independent for some time and aspire to something more than immediate subsistence.

Egg donation as a *chosen* job

Some participants, on the other hand, conceptualized egg donation and the money from economic compensation explicitly as a job. Through calculations and comparisons in terms of money and effort, egg provision becomes preferable than being in the regular labour market. The stories of Martina and Lucía provide a clear picture of the realities of the job opportunities and conditions in Spain and the positioning of young labourers within it.

Martina moved to Barcelona when she was 18 years old. She was starting a degree in Criminology and was leaving her parental house and moving to a big city for the first time in her life. Her parents paid the university fees and the rent of the shared flat she was living in:

My parents are both teachers. I mean, don't think that... [...] it is not so easy for them. I mean, they are making an effort to pay for my education here and if I waste it, I am very aware that here I'm not on holidays, they will turn off the tap. I mean, I have this very clear.

For the rest of her expenses, she relied on the money she could save up while working as a waitress in Port Aventura, a theme park located in Tarragona (one-hour south of Barcelona) in the summer, where she earned 700 euros per month for a full-time contract. However, as she explains, this saving could not cover more than her basic needs in the city:

Sure, the groceries, the metro for example, the Bicing¹⁴, I pay all of this myself with the money from the summer. And it covers it, but it doesn't cover, for example, going out every Friday to take some beers... paying a ticket to a concert, a ticket to the cinema twice per month... It is not like I have a very cool social life, don't think that I go out dinner every night or... partying. It is not my lifestyle, but I mean... with the money from Port Aventura it was not enough. [...] So... if I hadn't been able to donate eggs, I would have had to accept it. I mean, I would have thought, "Okay, so this is my reality and I have to adapt and accept it as it is", but... there was this option of *doing more things*. I mean... my life didn't depend on going to Bling Bling on a Thursday, to Razzmatazz¹⁵, to the concert of Love of Lesbian¹⁶... I am saying things that I have done recently, okay? Things like that. Or to visit my friend who is studying in London. Well, this is already an extra [...] All of these are not needs. They were whims or extras that escaped my summer salary. It didn't cover everything. And as this possibility, fast and easy, existed, I considered it. And well, it was a bit like that. I mean, damn it... I feel like super cold when I say it out loud but... well, I don't think you will judge me.

Indeed, in one of those early days of her new life in Barcelona, she heard the story of someone who had donated eggs, where she learned for the first time about the money she could get. Since her first donation when she was 20, until the fourth donation, which

¹⁴ Public biking network in Barcelona.

¹⁵ Bling Bling and Razzmatazz are night clubs in Barcelona.

¹⁶ Spanish indie-pop band.

happened a couple of months before the interview took place, egg donation has been her primary source of income to cover all the *other things* she considered *caprichos* (whims):

This has been my salary during these 4 years in Barcelona. [...] I remember that a girl in my class worked at Nostrum¹⁷ and she said, “This is so good, because this way I will be able to pay whatever”, and I thought “Yes sure, I also can work before Easter for three months...” and then I thought “Oh, no way... I can donate eggs and in one month I have more than two salaries”, because adding my salary of Port Aventura of July and August I earn the same as donating eggs once. So, it is like... I am sorry to say it like this, but it is an easy way to... [...]. So, if you compare it, I work two months in the summer or during the weekends, or I am poking for two weeks these hormones to my body, of course, according to the way I am, my personality, my experience, I *choose* to donate eggs and have this economic compensation.

(Martina, 22 years old, four-time egg donor)

For Martina, egg donation was the job she chose in the light of the possibilities available to her. While she thought that she could work part-time during the week like her friend, she quickly concluded that egg donation gives her a much higher rate of money per time invested. The way she assessed the possible risk of the donation will be discussed in the following chapter. Her discourse also speaks about the symbolic effect of egg donation being an option available in a young woman’s life in Spain. If that did not exist, she believes, she would have had to accept her impoverished economic position. However, egg donation gave her something to aspire to: a more comfortable and fun life. With a notable amount of guilt and shame, she states that egg donation allowed her to fulfil her “whims”, which highlights the framework of what she considers basic.

In a similar manner, the economic compensation was for Lucía a way to achieve a kind of life out of her reach. When she wanted emancipation from her parents to move

¹⁷ Take-away food company.

out and live with her partner, she found in egg donation the job that would allow her to accomplish her goal in the fastest way:

I was broke, so I started to work as a waitress in a job where they would call me, and I worked by hours. More like events and so on. So, of course, my salary was very small, and I wanted to have a certain economic independence, so I didn't have to depend so much on my partner. Because at the end of the day, I was depending on my partner, right? A I didn't... like it very much. So, this way I had a complement of 1,000 euros, so I calculated those 1,000 euros would last me more or less for 3 months [...]. Like, I don't know, to be able to go on holidays a weekend, you know? These things. It was always purely an economic motivation, I tell you. And at that time, it was emancipation [...] I always say that the thing is that it takes me between 10 to 15 days to do all the processes and, in this time, I win 1,000 euros. There is no job where I can get the same. So, basically, for me in these moments, it is like a job. It was like a job.

(Lucía, 22 years old, four-times egg donor)

As Lucía makes clear, the proximity and in most cases the exchangeability of egg donation and the labour market are not just evident in terms of their experiences in both sectors, but also at the material level. As noted earlier, egg donation pays 1,000 euros, which is a superior to what most of the participants could aspire to earn in a month if they had a full-time job.

Securing a future job

Another thing that was often mentioned by women when talking about how they would direct the money earned through egg donation was unpaid internships: most degrees in Spain have the requirement to undergo a certain number of hours of internship in order to acquire the qualification. The students usually choose among different organizations,

some of which will pay a small amount of money. However, most of the internships in high demand, usually at important organizations of each sector, will not pay their internees. This issue creates an inequality between the students who can afford to be working for free part-time and doing classes the rest of the day (that means no having any income at all) and those who cannot afford that for their personal situation.

In order to be able to acquire the more promising internships, some my research participants decided to undergo a donation cycle. That is, paradoxically, they underwent donation to pay for an unpaid job, in hope this will boost their future opportunities. Nancy, for example, had been selected to take part in an exciting internship program where they would send her to Portugal for three months. However, there was no stipend:

I thought that I needed the money, that was it. Because as I was going to start an internship... I'm going for 3 months to do an internship. These are 3 months where I will not gain any money, Because this is not a paid internship. They pay the travel, the food, the accommodation but they don't pay the work itself. I mean, all the rest is paid but the internship is not. So, of course, if I want to spend something there, I won't have anything. And I don't want to depend on my parents either.

(Nancy, 22 years old, discarded from the egg donation program¹⁸)

The situation of Helena was very similar:

The first time it was more personal, for what I told you, and the second it was... well, they gave me an economic compensation of 1,000 euros and I... I was in the third year of Uni and my dream was to go to Argentina during the fourth year to do the internship there, so it was like, "I donate one more time and... and I go". [...] It was very good, and yes, I could leave with a [financial] cushion, that is the truth.

¹⁸ The reasons why she was discarded will be detailed later in chapter three.

Because economically, it is not like I was precisely wealthy, but... if I wanted to achieve this dream, I had to get it from somewhere.

(Helena, 27 years old, two-times egg donor)

Being able to do these internships was seen as opening up an opportunity to their future. Helena even labelled going to Argentina as the “dream” she had, for which she needed to get the money. Like Merche and Mireia, for whom egg donation was related to their access to university, Nancy and Helena invest in their future careers by funding their period of working for free in exciting environments, experiences that were thought to improve their CVs and therefore their future employability.

As I discussed in the introduction and as I will continue to discuss in the following two chapters, the stories of most of my participants, egg donation cycles are tightly intertwined within their roles within the labour market. Participants jump from one to another, sometimes using one to boost the possibilities to get the other or simply interchanging them for some time. This fluidity between the two highlights the precarity and the lack of opportunities in the labour market in Spain, particularly for young women. In a context of embedded and accepted precariousness, egg donation appears as a good alternative to poorly paid service jobs which, moreover, are not easy to find.

Lucía, a four-time egg donor, provided a good example of this. While she acknowledges that she would have never done a donation cycle had she had better socioeconomic conditions, rather than being angry for feeling somehow pushed to do it, she was happy that at least there was this option on the table for people who, like her, were in need of money:

Well, I think that I would have liked not to ever have needed the money to the point of having to donate eggs, right? To the point of thinking about the possibility. If I had never needed it, I wouldn't have done it, of course. But I think that given the situation, that you need money, it is a viable option, and that is it... I wouldn't reject it and I don't think it is wrong, neither ethically nor physically. So, I think it is positive that

the possibility exists for people like me, who have needed it. However, if I had, I don't know, a basic income, then I wouldn't have done it, right? I mean, if there were other possibilities that would have granted me better economic stability, I wouldn't have done it, of course not.

(Lucía, 22 years old, four-times egg donor)

This fragment speaks about the general accepted precarity among most of the participants of this research –precarity that is embedded in their lives and that most of them do not question. Instead, struggling for money and stability in Spain is seen as the norm. Investing in the future is seen as a privilege, and therefore, as long as their donation cycle was not directed to fix basic subsistence needs such as food, women did not consider themselves *that poor*.

Money of one's own

Another desire emanated from most of the stories told by most of my participants: economic independence. Indeed, egg providers usually express their desire to stop depending on other peoples' money. In the diary extract from Berta, she explains how fed up she is on depending on what she calls “the crumbs of a system and an administration that oppresses us”. In a similar manner, both Mireia and Lucía wanted to stop depending on the money from their close relationships, the former from her parents and the latter from her boyfriend. In contrast, for Mica and Merche, being helped was not even an option, for which they had to make their own money “cushions” in order to face adversities in uncertain times. It is interesting to observe here how the intergenerational relations play out in this choreography. While young women find themselves in this situation in part derived from a lack of inheritance of wealth from previous generations, they ironically become the means of reproduction for older women. The question remains whether they will be able to find some economic stability when they wish to start a family or if it will be too late for them to do so.

The way women looked to produce some money they could consider ‘their own’ resonates with the problems of women that Viviana Zelizer describes in her book, *The Social Meaning of Money* (1994). As she explains, at the beginning of the twentieth century, American women without access to the labour market performed all kind of strategies in order to gain money of their own. Even the wives of wealthy husbands felt poor in the sense that they not only depended on their husbands financially, but because, in most cases, they were not even assigned a fixed amount of money from their husbands’ salary. Instead, they had to ask for it every time, which meant the continuous control of women’s expenses. Zelizer talks about the unforeseen ways in which women tried to gain some money they could consider their own, such as stealing from their husbands, asking dressmakers, shoemakers, and sellers in general to inflate the bill so they could keep the surplus, or even sexual abstinences until the husband would agree to give a fixed amount of money to his wife. Similar to the women Zelizer describes in her essay, I argue that egg donation in Spain can be understood as a feminine subsistence strategy to achieve goals that are mostly directed to accomplish a higher degree of personal autonomy.

Doing another cycle?

Considering whether to undergo another egg donation in the future is part of the task of becoming an egg donor. This is not because everybody feels eager to repeat, but rather because it is very common that if the cycle is successful from the clinic’s point of view (that is, if the donor produced between 15 and 25 mature eggs), the clinics contact women multiple times enquiring whether they would like to repeat their donation. But the fact is that having to give an answer to the clinic makes women develop a rationale on why they would or would not donate again. While empathy and solidarity were embedded in most of the discourses of the egg donors of this research, it vanished completely when they considered if they would do it again. On this question, there was a large homogeneity in the donors’ responses: they would consider it only if they needed money.

At the moment, I haven't thought of doing it again. [...] At the end of the day now, I work more, I have some extra income, which is not 1,500 euros, but still.

(Ángela, 22 years old, two-time egg donor)

Ángela's rationale is that she is now working a bit more, having more income, and therefore, donating is no longer a necessity. Similarly, Berta doesn't reject the possibility, but would only do so if she had a strong need of money.

The last time, I also said, "I won't do it again". Right now I am at the point of, "I won't do it again", but I don't know how things will go. I don't know. I can't say a yes or a no that is 100% sure, because I don't know. I don't plan to, and maybe at the personal level is not something that I'd say, "look, I will go to the clinic and do it", but it also depends on the economic situation I am in.

(Berta, 21 years old, two-time egg donor)

My experience in the field was that vows not to donate again were frequently broken under further economic pressures. Lucía, for example, said that the need of money and the time between donations made her "forget" about the bad experience she had in her second donation: "It was for economic need, and as enough time had passed so as to forget about the pain I had felt the second time... [laughs]. I forgot about the pain and that's it, right? So, I did it."

This "forgetting" was not unique to Lucía's story, Emily also seemed to experience it when deciding to donate a second time. She was 23 years old when I met her, and she was in her third year of studying anthropology at university. She was doing her final dissertation on mental health issues, a topic to which she could relate a lot, she told me, as she herself had suffered depression some time ago. The dissertation was about mental health and stigma, a topic that motivated her to the point of considering undergoing a master's degree and maybe even a PhD. We chatted about it and I gave her my experience

in the PhD journey. We met for the first time just one month after she did her first donation cycle, and in general she was pretty happy about the outcome and keen to repeat:

So look, I thought it was going to be a much worse experience. It is true that I had some pain and discomfort, but they were pretty... I mean yes, it was hard to do things, but I could do them. So, I don't know, there was a limitation, but well. And then also because... the same as I told you before, I think about the money they will give me, so it is true that sometimes I think that it should be more money, but the money that they give me is already good for me. So, well... as it is not a process that has disrupted me so much... and the money is good for me, so I focus on that. So, it is very... pragmatic, right?

However, just a couple of weeks after we met, she told me she had not been feeling well. Her level of anxiety was very high, and she had relapsed into depression. She didn't know what was going on but after her counselling session with her psychiatrist, "everything started to make sense". She had had a car accident just before the donation, which she did not have time to process. So, her explanation was that she was suffering from post-traumatic syndrome and that the hormones of the egg donation had further unbalanced her state of mind. She had to stop going to university for some weeks, during which we stayed in touch via text messages and voice notes. She told me about her slow recovery, and a month later I met her again on campus.

She was looking weak, but she said she was happy to start slowly going back to classes. "I think that the hormones have a lot to do with this", she told me, "I mean, it is a bomb that you put in your body and somehow it has to affect you". To my surprise, however, a few weeks after that second encounter, she texted me to tell me that she had agreed to undergo another cycle at the same clinic. She said she needed the money again, although she did not tell me exactly why. She said that this time she knew what the process was, and that therefore she was more prepared for it. I suggested that she might keep a diary to record the different phases of the process, to which she agreed and later shared with me. In one of the sections, she wrote this:

The truth is that the injections are bearable. At the beginning, I don't mind them but as the days go passing, my body is heavier and more sensitive. I can't wait for the moment of the extraction. It is hard to walk or to do physical effort. My belly is bloating, and I almost have to walk with the legs opened so that my ovaries don't hurt when I walk. I wonder during the whole process how it is possible that I agreed to do it again. I wonder if sometimes I am too lax with these things and I start to feel a bit guilty. I think that in part I am selling myself to the system and the reproduction market, but at the same time, I think what I would do if I wanted to be a mother and I couldn't for whatever reasons. I can't avoid thinking that I feel sold but how important it is for some people to have children. Why is it? Would I be able to continue with my life if they told me that I have problems to conceive or that I won't be able to be a mother? How might women who, for whatever reason, socialisation, etc, they have the profound desire to be mothers? Am I doing well? Am I contributing to a system that exploits reproduction? I have the feeling of taking part in something I don't know a lot of things about, and that provokes a bit of anguish. Not to mention the medication and its effects on the body. Even though I try to deal with it the best I can, it scares me a bit that so many hormones might trigger more anxiety as the last time, even though it is not the same situation.

(Emily, 23 years old, two-time egg donor)

Her reflection raises the issues of the labour the donation implies, the lack of information received, her risk perception, the imaginaries around the recipients, and how this all relates to the legal framework of egg donation in Spain. These topics will be discussed in the next two chapters.

CONCLUSIONS

In this chapter, I discussed the intimate relationship between egg donation and the precarious labour market in Spain. I argued that a framework that uses the dichotomy of altruism/economic motivation is not useful to provide an understanding of the ways egg

donors make sense of their actions. Focusing on my participants, I contended that while, for most, the altruism of the donation has a function in the articulation of their stories and framing their narratives, economic compensation appears as the foremost driver to undergo donations. The dichotomous framework has effects beyond the discursive practices and materialises in their stories as feelings of ambivalence, guilt, and shame. It highlights the gendered expectations of women as being altruistic rather than financially motivated, which is also promoted by the clinics' discourse.

In examining the stories of my participants with egg donation, I argued that most of them depart from a common source: the precarious labour market in Spain. In this sense, I identified three drivers for choosing to donate eggs. The first driver was donating eggs to “buy time” to look for a job. In the two examples selected, participants needed to get a job in order to be able to pay for their studies. As finding a job was very difficult, after some time, they despaired over their lack of money, lack of time, and the barriers these presented to their aspirations of studying at university, as the semester was approaching without them having been able to save money. In this sense, egg donation became an opportunity to give them a break in a stressful time.

Second, some participants highlighted that egg donation was, for them, a job that they preferred over their other possibilities in the labour market. The participants who spoke of this driver highlighted how egg donation provided a relation between time, effort invested, and money that no other job they could imagine could give. Moreover, for women in this group, egg donation was a way to upgrade to a slightly more comfortable life where they could have things other than ‘basic needs’ covered. Examples included: going out for dinner, going to the cinema or concerts, or moving out from the parental house. It could be summarised as a modest means to participate in the dynamics of consumption and socialisation in a city like Barcelona. Egg donation becomes, in this context, a conscientious ‘choice’ among the range of precarious, lower paid and the more time-consuming labour options, although given the difficulty in finding any employment in Barcelona's depressed economy, few other options actually presented themselves.

Third, some participants highlighted that egg donation was for them a means to secure better opportunities for the future. The examples displayed focused on a common phenomenon in Spain: the mandatory internships required for most degrees, which are mostly unpaid. I argued that young people struggle to juggle them with the studies they need to undertake as this implies, in most cases, not having income at all for several months. At the same time, however, internships are regarded as important opportunities to enter into the complicated competitive labour market. That is the reason why, for these participants, doing a donation cycle was a way to pay for the time they would be working for free, without any other source of income. It provided a chance to take exciting opportunities directed to secure better futures. Finally, I pointed out the way in which many of the participants' reasons to donate eggs are related to their aim to become, at least for some time, financially independent from their close relatives or intimate partners. Here I highlighted the intergenerational choreography in place, where the lack of wealth transfer of previous generations makes young women become ironically the means for their reproduction.

In the last section of the chapter, I examined the rationales of the participants around undergoing or not more donation cycles in the future. Coinciding with the previous arguments, repeating an egg donation cycle was only an option for most if they were in need of money. Having stable jobs and sufficient income to pass the months with some security usually dissipated the interest in egg donation. Bad experiences with egg donation get "forgotten" when economic pressure increased, and some donors reversed their decisions not to undergo another donation and ultimately underwent another cycle.

Overall, in this chapter, I highlighted the entanglements between the precarious labour market in Spain and the participants' decision-making to donate eggs. I showed that even though the gendered framework of altruism permeates and tames the narratives of egg donors, the different strategies through which egg donation is used (buying time, upgrading life possibilities, and securing a future and economic independence) stress the level of entanglement between economic conditions and aspirations in women's egg donation stories.

In the following chapter, I will discuss in detail the problems related to the available information on egg donation. I will also explore egg donors' risk perceptions, the imaginaries around the recipient women and the industry, and how it all relates to the anonymous framework of egg donation.

CHAPTER 2: 'NOTHING TO LOSE': RISK PERCEPTION AMONG EGG DONORS

INTRODUCTION

Well, in general, we asked our friend what we had to do, what steps we had to follow and so on. [...] And well, that's it, we started to talk, I said "well, so let's do it". I have *nothing to lose* I guess, one more experience. [...] Plus, it was because I wanted to continue my studies, so I said, "let's go, *why not?*".

(Laia, 26 years old, two-time egg donor)

At the end of the day, I don't know, it is for the science, or to help people or whatever. So, if it does not imply any risks for you, *why not?*

(Stella, 20 years old, one-time egg donor)

Contemporary debates on egg donation arrangements around the world are increasingly focusing on questions of information delivery, informed consent, and understanding. These discussions point out the existing problems in providing informed consent for egg donation when the long-term risks remain unknown (See the 'What is egg donation? Process and risks' section in the Introduction for more insights on these debates).

Sharing the interest and concerns this reality gives rise to, this chapter sheds light on the information provided by Spanish fertility clinics to egg donors, the reception of this information by my participants, and the resulting imaginaries it produces. Relying on field observations and interviews, I argue, on the one hand, that the information delivery practices of fertility clinics to egg donors can be described as highly problematic due to the partial or total lack of quality of information as well as the poor conditions in which it is delivered. On the other hand, however, I also argue that misinformation cannot explain by itself the willingness to donate eggs, sometimes in multiple occasions, for which I highlight the role of *risk perception*. As I will discuss, risk perception is not only linked to the amount of detailed information one might receive about a treatment, but also to the trust in power structures such as regulation, government, and medical expert figures, and to the experiences of risk in the lives of egg donors. Finally, I will focus on the imaginaries of egg donors about the outcomes of their donation, how they resemble or differ from the Spanish egg donation market dynamics, and the crucial role that the legal framework of anonymity has in the control of those imaginaries.

The aim of this chapter is to highlight the problems with egg donation information delivery, which are exacerbated when we consider how the risk perception of egg donors is shaped by age, cultural level, and financial insecurity. On the other hand, this chapter also aims to show how misleading or partial information narratives, as well as the Spanish anonymity framework, have a role in the shaping of imaginaries among egg donors, obscuring the implications, aims, and outcomes of their donations. Information delivery patterns are read as a means to tame egg donors by alienating them from their product value, by reinforcing the narrative of altruism, and by asserting the transfer of ownership on their eggs, which are converted into bio-objects with commercial potential.

NAVIGATING PAPERWORK AND GIVING CONSENT

Fertility clinics invest significant effort in building their corporative identity in the websites directed to egg donors (Molas and Whittaker 2021). While many of them count with multiple taps, big colourful pictures, and messages highlighting the progressive spirit and empowerment of women who decide to donate eggs (Plate 5), detailed information about the medical process, the risks, and the side effects it implies is harder to find. Instead, clinics updated regularly their blogs and social media profiles directed to egg donors, through which “websites create a complete sociotechnical imaginary in which to donate eggs would not just be an act of solidarity but would also imply belonging to a community of progressive empowered women, in control over their bodies, with modern consumption capacity” (p. 23). In that study, I aimed to show the production of a particular sociotechnical imaginary (Jasanoff 2015) through the practices of information and promotion on egg donation websites.



Plate 6 - Home page of the egg donation website of IVI fertility clinic. On the image in Spanish: “Being supportive means being unstoppable”. Source: ividona.es

Once women approach a clinic, they receive further information with a view to giving informed consent. According to my field observations and interviews with both egg donors and clinicians, I argue that while the way women are informed about egg donation

varies slightly from clinic to clinic, the overall logics share many aspects with those found online.

In this section, I describe the information practices in place for intending egg donors and the reception of this information by my participants. Focusing on the notion of risk perception, I argue that while the information practices in fertility clinics are problematic, this discussion needs to take into account the entanglements of policy, government and expert knowledge, and the experiences of risk in the lives of egg donors within the Spanish (post) 2008 economic crisis context. To start the argument, I will provide insights from a first informative interview I attended in a fertility clinic.

First informative interview

Notes from fieldwork diary, May 2019:

Around 5.30pm, a young woman arrives to the clinic for the first appointment. She is a friend of a “very good donor”, Núria (nurse) had told me before. The woman, Catalina, is from Argentina, and arrived at Barcelona only two months ago. After a brief oral questionnaire about her phenotypes and the ones of her family, we soon move from the reception desk to a consultation room for the first informative interview. I sit on one side of the table on a stool next to Núria. Catalina is in front of us. With a PowerPoint that contains only images, Núria starts explaining that egg donation is needed by “many different kinds of women”. Representing the donors, we see a group of women displaying different phenotypes who have their thumbs up and are smiling. Next to them, there are images of other women: some with a man representing the male member of the couple and some with another woman, representing the female couple. Catalina supports her head with the arm and goes nodding in silence. Núria says that egg donation is a “voluntary act”, which means that “you don’t come here because someone is making you do it, this is altruistic”. But as it is a process that “has costs”, Núria continues, such as going to the visits, injecting the medication, and undergoing surgery, there is an economic compensation

that in the clinic is 1,100 euros. Núria highlights that this is given if “everything goes alright”, and then she specifies: “We understand ‘everything goes right’ as: coming to the appointments, taking the medications, etc”. She also tells Catalina that the donation will not have consequences for her future fertility, because “we are going to take what would be disposed of anyway”. As for medical checks, she says, Catalina will have to undergo a blood test and a genetic test to find out if she is carrying genetic diseases. “This is not a test that people would usually do”, says Núria almost proudly. Núria also mentions the extraction, where she points out that it is “simple and short”. About the risks and secondary effects, she says that they are not extraordinary, “bloating like in a period, but stronger”. She rapidly mentions the most common complications, for which she mentions ovarian hyperstimulation (and specifies that this has never happened in the clinic) and ovarian torsion. With a reassuring look, she tells Catalina that if she follows the prescriptions from the beginning, there shouldn’t be any problem. I am surprised that she is linking the risks of egg donation to her behaviour during the treatment. The last slide of the presentation is titled, ‘FAQ for interested women’ which, are related to the effects of egg donation to fertility, gaining weight, and having acne. All of them, she says, are myths. “This does not affect you at all the day you want to be a mother”, Núria restates. “At all?”, asks Catalina. “No”, says Nuria

I had long wanted to be present in an informative appointment for intending egg donors, and once it was over, it was hard to believe it had been so short. This was supposed to be the only specific appointment intending egg donors had to get informed about the whole process, its implications, and its purpose. Yet it had briefly focused on the steps in terms of the treatment and the operation, the conditions in which they would receive the compensation, and reassuring Catalina about the unlikely possibility of anything going wrong.

The downplaying of the risks and the lack of detailed medical information observed both in this first interview and on the egg donation clinics’ websites resonates with studies in other locations in the world. Andrea D. Gurmankin (2001), for example, investigated the risk information provided by 19 egg donation programs in the US in a preliminary

phone call inquiry. The study concludes that many clinics would not disclose risk information unless they were explicitly asked. When information was disclosed, however, in many programs, it would be incomplete, inaccurate or even false. Pointing out the ethical implications of the pilot study, the author highlights the problems of these findings when regarded in the light of the large financial compensation given to oocyte donors. Likewise, Alberta *et al.* (2014) noted that risk disclosure on online recruitment advertisements for egg donation in the US is rare while, in contrast, financial compensation is listed in most of them. She concluded that women, particularly those from families of low economic status, are influenced by higher financial compensation and are significantly more likely to contact egg donation agencies.

In the end, Catalina was not accepted into the program because she had been in Latin America during the last three months, for which the effects of Hepatitis B could still appear. If she were infected, the disease could be transmitted through her eggs. Had Catalina passed her screening, however, the next step would have been the reading and completing of different documents and informed consents. I discuss these in the following section.

Informed consent arrangements

An important stage of the process to become an egg donor is the filling and signing of the multiple documents clinics usually provide on the day of the first appointment. These documents include a data protection informed consent (1 page), the egg donation informed consent (8 pages), a questionnaire about the woman's demographic and medical history (4 pages), the genetic testing informed consent (7 pages), and the psychological test (a multiple-choice questionnaire of 144 questions)¹⁹. The filling and signing of these documents is usually followed with a first blood test or ultrasound scan all in the same day.

¹⁹ Data from one fertility clinic in Barcelona, there might be slight variations across clinics.

The multiple documents intending egg donors receive in the first appointment need to be analysed as material objects that carry symbolic value by materialising the relationship between the donor and the clinic. While, on the one hand, they serve to foster transparency, on the other, they are also “material manifestations of the power of state actors to produce knowledge of populations, which in turn become a ‘reference for truth or authenticity’” (Borrelli and Lindberg 2019, p. 52). As I will explore further in this section, these documents do not ‘reflect’ a reality, but rather they produce an official one that looks objective and despoiled of human participation (Bierschenk 2019).

In the context of the proliferation and growth of bioeconomies, Nikolas Rose (2007) asserted that “as biotech companies seek to commodify products — DNA sequences, tissues, stem cells, organs — it is clear that ethics has a crucial function in market creation. Products that do not come with appropriate ethical guarantees, notably assurances as to the ‘informed consent’ of donors, will not find it easy to travel around the circuits of biocapital. It is also clear that the routinization of ethical concerns in the bureaucratic procedures of research governance can serve to insulate researchers rather than to constrain them” (p. 30). With this powerful statement, the author is pointing out the instrumentalization of informed consents as bureaucratic tools to assist the commercialisation of bio-products rather than an asset to assure rights and safeguard vulnerabilities. In a similar vein, Waldby and Mitchell (2006) claim that, “[i]nformed consent is the mechanism that transforms a gift into property” and “serves to regulate and formalize the transfer of possession from donor to recipient” (p. 71). This is a process that Verena Namberger (2019) labels as a “contemporary form of dispossession” (p. 110) as it alienates the provider from her genetic/biomaterial. The role of experts and the current legal framework in the definition and delimitation of risk, risk perception, and trust will be explored in this section to highlight “the double face of bureaucracy, as a form of domination and oppression as well as of protection and liberation, and all the ambivalences this dialectic entails” (Bierschenk 2019, p. 117).

The informed consent forms for egg donation I had access to during my fieldwork followed the exact or very similar format of the recommended template proposed by the Spanish Fertility Association. The risks stated in the document include ovarian hyper-

stimulation syndrome (OHSS); intolerance or side effects due to the medication; abdominoperineal infection; haemorrhage due to an accidental puncture of the blood vessels; abdominal pain; accidental puncture in another part of the body; and ovarian torsion. Similar to what I observed in the description of the risks in the online information on egg donation, in the informed consent forms the language emphasises the unlikely possibility of these problems occurring. Words such as ‘only’, ‘just’, ‘very rarely’ abound in narratives that stress the ability of clinics to manage them. As in other geographical locations such as United States, clinics in Spain do not mention the lack of studies on long-term risks, nor the potential risks highlighted in case study literature such as endometriosis and certain kinds of cancer (Kalfoglou and Geller 2000; Kramer et al. 2009; Beeson and Lippman 2006; Schneider 2008; Woodriff et al. 2014; Schneider et al. 2017).

Bioethical literature has focused on the debates around the naturally limited ability of participants to fully understand informed consents for biomedical research (Beskow and Weinfurt 2019), from which some have attempted to provide guidelines and strategies for the writing and delivering of informed consent to gamete providers (Cattapan 2016; Beskow et al. 2020). The largest study to date to focus on egg donors’ perceptions of informed consent in the US concluded that while most participants felt informed about the short-term risks, more than half of them did not feel well informed about potential long-term risks (Tober et al. 2021). This conclusion aligns with the current debates about the lack of longitudinal studies on risks of egg donation. In relation to the Spanish context, in this chapter I focus on egg donors’ experiences to shed light on the conditions in which donors are given the informed consent and explanatory statements, and how risk perception relates to their assessment and decision-making.

According to my observations in the clinic and to the experiences of most of my informants, egg donors are usually not allowed to take the many consent forms and questionnaires home for reading, considering, and signing. Documents must be filled in the clinic and are given usually the day of the first appointment.

The first appointment with the doctor, I remember that he was a man... not really friendly and it was... it made me doubt a lot. I don’t

know, he was explaining it as if everything was very beautiful, and you always need to watch out, right? Because obviously they are trying to sell a service and of course, they say it in a way... it was very commercial. He was a very commercial man, and everything was perfect, everything was beautiful, and everything you were going to do there was great. So, when I started to make those questions, the details, right? Like “yes but this has risks”, he was like “yes but don’t worry, whatever”, and he made me... I mean, he made you sign the documents in the same consultation room. I told him no, that I wanted to take them home to sign them there. And he said no, that I had to sign them there because they were the documents of the procedure... well, there were a lot of documents, a test, and so on. And I told him, “okay, so no problem, I stay here”, and I stayed like two entire hours.

(Andrea, 29 years old, two-time egg donor)

Similar to Andrea, Nancy also highlighted the number of documents she was required to read and sign in the waiting room the first day she stepped into the clinic. In her case, she didn’t even have a ‘first interview’ before reading and signing the informed consents:

I mean, they came to me and gave me like a notebook with a lot of pages and told me about it broadly... Well, she told me that I had to read all of that and that she had marked the boxes where I had to sign. But of course, I had to read all that information on my own. I was there a lot of time reading it all and so on.

(Nancy, 22 years old, discarded from the donation program)

But while Andrea and Nancy assured that they were committed to reading and understanding all the documents before signing, this was not the case for everybody. Several other examples pointed out that understanding women’s decision-making requires a frame that moves away from an individualistic reception logic and that highlights the structural and specific contexts of egg donors.

RISK PERCEPTION: TRUST, HEALTH LITERACY, AGE, AND INTIMATE LIVES

They told me the pros and cons and so on, but of course, I was 19 years old. As long as they didn't say that I was going to die... you know?

(Alba, 25 years old, one-time egg donor)

In that moment, I experienced it in a... [she exhales] in a very dispassionate way to be honest. I mean, I think they gave me a pen drive with a PowerPoint, but I remember that I didn't pay attention to it at all, I mean... I was in a situation when I was with a partner that abused me psychologically. Then it was, "I am doing this and that's it". And I don't know if they called me and I said "yes, yes, everything is fine", like very impersonal from my part, you know? Then I lived it like, "let's do it, let's do it" and I was totally unaware. And even the day they did the intervention, I put that injection in the wrong way and everything was a drama. Everything was full of blood, and so on but I mean, I was in that mood, you know?

(Lidia, one-time egg donor, 27 years old)

But at the end of the day, you have some money on the table, you have a contract that says that yes, you can have an haemorrhage and so on, but then the doctor is telling you that this happens once in so many cases. Of course, you see that the risk is very small, that you have money and it is like, "I don't mind what you tell me, I sign it and I do it". Then here I think that there is a part... the ethical part, right?

Because when you show money to someone that needs it... how many people sell their body for need and not for pleasure?

(Andrea, 29 years old, two-time egg donor)

Different experiences and reflections of the participants in this thesis highlight problems of consent in egg donation that go beyond misinformation. I witnessed how, even when clear and complete the information of the process and risks, both known and unknown, was disclosed, the risk perception was not necessarily affected to a big extent. This was the case of Mica. In the two interviews we had, she stated several times that she would not donate again. The problems she had injecting the medication in a train station at night (explained later in chapter three) as well as the physical pain she felt the days after the donation, discouraged her from ever donating again. However, four months after our last interview, she sent me a WhatsApp message. She said that she was thinking of doing another cycle and asked me if I could provide her with a list of the “secondary effects, consequences and so on”. She said that she had a new boyfriend and that he wanted to know what the risks of egg donation were. I worked an email as carefully and clearly as I could. I wrote that the most important thing to understand was that there were not studies on the long-term risks of egg donation. I recommended her a New York Times article by Jane E. Brody (2017) that had been translated to Spanish, titled “Do Egg Donors Face Long-Term Risks?”, which precisely tackled the issue of the lack of studies. Then, I listed the risks stated by the Spanish Fertility Association. I ended the message asking her if she could tell me her final decision and why she was thinking of doing another cycle.

She replied shortly after with a vocal message:

Hey lovely, well, so now I have a part-time job and I start the classes again and then I am looking for... Well now they will hire me for a second job so I might not do the thing of the eggs, but I wanted this money that... Well, we know how it is, it is pretty fast, and then it would allow me to have a [financial] cushion for the school fees, the books, the T]ove [public transport ticket], the transport costs...

Everything that starting the school year in September implies. So... I thought about doing it and I commented about it to my new boyfriend and well, as it usually happens, he didn't really like it. However, he doesn't know deeply about the process, so I told him that I had talked to you and so on, to see if you could send me this list, which has been very useful to know about the secondary effects or about what could happen or go wrong. And well, he still doesn't agree that I do it for the issue of... as they don't quite know in the long-term how it affects so... but I still haven't resolved it. Next week, I will start in this second job and I would do it [the donation cycle] in September, October... but well, if I do it, I will let you know!

(Mica, 22 years old, two-time egg donor)

In the beginning of October, she wrote to me again to tell me that she had just started a new cycle. Indeed, although having provided her with important information that most donors do not have and having herself had a tough experience in her first cycle, she still chose to do it one more time. As her voice message implied, the purpose of the list of risks was not to decide herself, but to convince her partner that he should not worry. Even if my reply probably did not help her in this endeavour, it did not seem to change her will to go on with the process one more time.

While many examples highlight how the means and the context in which information on egg donation is given in the Spanish context is problematic, in egg donors' accounts, information is not the only decisive factor in choosing whether to donate. I argue that the debate needs to shift to include the entanglements that co-produce risk perception. In the following section I provide a brief conceptual framework around the notion of risk and its connections with power dynamics.

Risk and power

Anthony Giddens, in his canonical work, *The consequences of Modernity* (1990), argued that the emergence of the concept of risk can be traced back to European Enlightenment and is deeply related to a secular ideology which, through the means of the major technoscientific advances, displaced world views of fatalism, destiny, and God as the ultimate deciding force. In its place, a perspective of human agency and its capacity to act through rational and pragmatic modes to interfere and create futures emerged along with the notion of risk as something quantifiable and manageable (Bernstein 1996; van Loon 2002; Lupton 2013; Boholm 2015).

In deep resonance with Giddens work (1990, 1991), Ulrich Beck (1992) claimed that given the increase in the dependence of society's future on decision-making, we have entered into a new mode of social organization, *risk society*. Anthropological and sociological accounts on risk have asserted that risk and risk perception are complex situated notions. As Åsa Boholm (2015) notes, ethnographic tradition has explored risk as "embedded in local contexts, taking into account the ways in which culturally framed experience and knowledge shape how risk is understood, managed, negotiated and contested in terms of power, identity and social belonging." (2015, p. 10). The influential study by Mary Douglas in *Risk and Culture* (1983) already notes the role of particular cultural local contexts in the perception of risk of different groups, for which she argues that risk is a culturally-specific notion.

The definitions, classifications, and management strategies of risks, however, are to a great extent in the hands of the authority of 'experts'. As Boholm puts it:

In the modern discourse of risk, knowledge of contingency is delegated to the realm of expertise. When deploying the concept of risk, an expert approaches uncertainty as a dimension that can be analytically separated from its immediate context. An expert on risk analysis today is a scientific specialist and not a merchant, gambler or military

campaigner, and such specialised expertise provides a privileged knowledge position in modern society... (2015, p. 6).

In the field of biomedicine, the emergence of experts of all kinds is perhaps especially notable. Describing the novel form of biopolitics that operated in the twenty-first century, Nikolas Rose (2007) claimed that it “is concerned with our growing capacities to control, manage, engineer, reshape, and modulate the very vital capacities of human beings as living creatures” (p. 3), for which new forms of authority and expertise have emerged in the last decades as “pastoral experts” (Rose 2007, p. 6). Experts are therefore needed to navigate the decisions of the new ‘biological citizenships’ (Rose and Novas 2005) which are expected to take responsibility about their health and their futures (Franklin and Lock 2003; Rose 2007). As Sheila Jasanoff (1999) points out, paraphrasing Winner (1986), in this dialectic, experts have a privileged position: “Risk-talk implicitly empowers some people as experts and excludes others as inarticulate, irrelevant or incompetent” (Jasanoff 1999, p. 137). As research has claimed, and as is particularly true when examining the egg donation assemblage in Spain, it is important to highlight that risk perception is therefore always deeply influenced by the role of states, policies and institutions (Jasanoff 1999; Caplan 2000; van Loon 2002; Boholm 2015).

In this sense, the first thing to consider when thinking about risk perception around egg donation is that, despite the level of information provided or neglected in fertility clinics, egg donation is a legal practice in Spain. This fact alone has already to be regarded as an important aspect in the building of trust among women wanting to enrol. In a field involving high tech procedures and biomedical expert knowledge intermediaries, the legal condition in a welfare state such as Spain is perceived by some as a trust guarantee. My fieldwork provided examples of this when some donors were surprised and worried when they found out, usually during the interview itself, that egg donation was actually not a practice that was legal in all European countries. The legal framework had an important role in their perceptions of trust in the clinics and doctors. This was especially true among donors whose knowledge about the egg donation bioeconomy was delimited by the information provided by the clinics; others, instead, had started to challenge the official assumptions before the interview.

Contesting knowledge and cultural capital

The ability to challenge official discourses promoted by biomedical institutions and supported by the state is rarely possible by any single individual within society. As it is already implicit in the influential work from Carlos Novas on patient activism and the political economy of hope (2006), cultural capital is needed to articulate, organise, and coordinate communities to contest biomedical discourses and practices. This was also reflected in my fieldwork, where participants with higher education levels and who were older in age were usually the ones who questioned clinics' narratives and had issues related to information arrangements. Andrea put it clearly during her interview. Her account was powerful because she described herself as someone who had socially and culturally "escalated" in the recent years. Having quit her studies to work in a call centre where she earned 600 euros in a full-time contract, she finally decided to start university when she was 26, which she described as a life-changing experience. She highlighted the dangers of deciding to donate when reliable information sources were hard to discern:

Of course, because according to the information they give you there, everything is very beautiful, like... "No, it is alright, a lot of girls come here, we have never had a case of...", and surely they have had cases of haemorrhage and problems, but they're like "we have never had a case, whatever...". They decrease the risk really, right? Then I don't know, I think it lacks... I was looking for information on the internet and you find information... but then, which sources do you find? Who is behind that information? Because you can find very good information and also very bad information, but there should be like a reliable source. But then you think "who is looking up for this information?", "What level, maybe cultural, you need to have to know that this source...". They are not at the reach of everybody, right? It is like that. I mean, me for example, if I had done the donation when I was 18, I didn't even know that there was a thing such as "reliable sources", and that maybe that forum I was reading was... think of *Foro*

*Femenino*²⁰ or whatever, so probably the clinics are in there, right? The ones who make those comments. And that is what could happen to my friend for example, that she doesn't know about this, and maybe I tell her and she says, "come on Andrea, what you are saying is not true". And now that I went to the university and that I am studying a degree and acquiring this knowledge level, I can see that maybe putting a profile picture doesn't mean anything, because in a forum, who is behind? "Anonymous says whatever". Right, who is anonymous? This clinic or the one next door? You know what I mean? [...] So, it is this lack of information that I think is really important, because then there are girls of 18 whose parents don't give [them] any money and they go there and maybe it says [in the informed consent] that you can have an internal haemorrhage during the intervention, but if the doctor, *a doctor*, is telling you "don't worry, stay calm, this has never happened here". Maybe they had 10 cases or more, but what will he say? "Oh yes, yesterday a girl got sterile because I did the extraction wrong, but don't worry, this won't happen to you". This is the ethical part let's say, isn't it?

(Andrea, 29 years old, two-time egg donor)

Apart from the point she makes in relation to the 'cultural level' needed to find and make sense of the information, Andrea highlights as well as the relevance of the age at which decision-making takes place. This aspect was raised by other participants as well, specially by those who had done the donation years ago. For most of them, their personal situation had changed significantly, usually having now more stable working conditions, higher education levels, and in some cases, families of their own. In the interview, most of them claimed to have acquired a more critical approach over time and questioned their ability to understand and consent at a much younger age, when they did the cycles. I discuss the role of temporality in the next section.

²⁰ Popular online forum in Spain directed to discuss women's issues.

Temporality and subjectivity shifts:

'Try to imagine how many *niñas* did it like this

Alba was one of the participants who highlighted her inability to fully understand and choose in an informed way when she was 19 years old. She said:

So when you are that age and they tell that, for doing nothing, they will give you 1,000 euros and that moreover you are protected and so on... and if you are thinking that you will make someone happy, it is superb, isn't it? So, you do it. I don't know, they recruit you, it is not that you do it because you want it. They end up catching you, and of course there will be so many people that went because, "my friend did it, so I am doing it as well". Try to imagine how many *niñas* [little girls] did it like this. [...] Yes, they gave me the information and made me sign so that I had understood. Obviously, I hadn't understood anything. [...] what I was supposed to understand, I couldn't understand it at that time.

(Alba, 25 years old, one-time egg donor)

Alba was interviewed six years after the donation, and as she told me, in the recent years she had been thinking more about the donation. She confessed that the donation was something that she "couldn't quite reconcile 100%" from a feminist point of view. Similarly, Sonia had the interview 10 years after she did the donation, at the age of 21. At that moment, her mother had just been fired, and so she did not want to put more financial pressure upon the family and decided she would find the way to pay for her studies by herself. She did the donation in secret:

It is aggressive, it is an aggressive method and this... They don't tell you that at the clinic. They didn't give me any information obviously. Well, I expected that already. Well no, I didn't expect it, I mean, I couldn't imagine it. You don't imagine anything. You trust in people,

don't you? Because they are doctors, they are experts or whatever, and you don't imagine that this might cause you... that this can have secondary effects. Even less at 21. Now I might have a more critical view about the world, and I would think about it twice. In that moment, no... I had faith that nothing would happen.

(Sonia, 31 years old, egg donor)

What these accounts share is the relevance of temporality in egg donation stories in Spain. First, as some of the participants claim, their ability to assess risk at a particularly young age is seen as difficult in narratives that point to the need of a certain level of 'maturity' and 'education' to take responsibility for this decision. Second, however, it is particularly in this timespan when they are eligible to donate eggs in Spain, between 18 and 35 — although most clinics cut this number at 29 to assure optimized cycles. Finally, it is also at this time when they feel the most financially vulnerable. While most of them are not fully economically independent yet, they have expenses and responsibilities for which they cannot or do not want to be externally supported.

Tempting luck: balancing speculative future risks and present needs

Still related to the relevance of temporality, a last crucial aspect to consider is that risk is a way to quantify and manage uncertainty (Rosa 1998; Jasanoff 1999; Caplan 2000; Lupton 2013; Boholm 2015). In other words, risk is itself a temporal concept, an assessment for a better future. Thinking about the risks means thinking about the future. The notions of risk and risk perception gives rise to some questions: who is in the position to make choices directed to prevent worse futures? Who can invest in the future in spite of the present?

Coming back to the case study of Mica, despite the new information I gave her about the possibility of unknown future effects, the reality was that in her experience with egg

donation, pain lasted for *only* one week. She had a lot of expenses, and it is not hard to imagine how stressed she might have been starting the second year of a full-time course and working in two different jobs at the same time. From her point of view, while the future risks were unstudied and therefore speculative, there was no doubt that she needed a certain amount of money to face all the expenses of the beginning of the year. Her choice was directed to the present because the urgency she was facing was also situated in the present or immediate future.

The case of Mica resonated with one other participant. Martina told me in the interview that she did not want to pay much attention to the risks, precisely, because she *didn't want* to pull out. She was counting on the compensation money and, although she believed to some extent that the whole thing could bring her consequences, she still chose to do it. She described her position of deliberate ignorance in this way:

So, it is like... I feel bad saying this, but it is a fast way... but, of course, I repeat, I have never been aware, any of the four times, because I didn't look it up, I didn't really take interest on what I was doing. Well, I knew it because they had told me, but to what level? To what point? I always... I don't know, these two last times it was like "come on, I want money, I do it". Like very honest, I mean... I sometimes felt bad to do this to my body. I mean, it is not like I am killing it... but maybe yes. I don't know.

(Martina, 22 years old, four-time egg donor)

Just like Mica highlighted in her voice message, Martina points out to the rapidity of the process, referring again to the urgency of the present despite the possible slow "killing" of the body she sometimes feels guilty about. The balance between the unknown but somehow imagined future risks and the financial outcomes desired for the present was nicely articulated by Lucía:

Anna: Do you think you will do more cycles?

Lucía: No. No. No, because I think that four times is... quite a lot. I mean, for an issue of health I feel that... I have already tempted luck too many times.

(Lucía, 22 years old, four-time egg donor)

The notion of ‘tempting luck’ is an interesting one, because it gives a very clear image on how many egg donors assess and manage risk. Egg donation appears as an option that entails risks, and every cycle is perceived as taking a turn to spin the wheel of a roulette. Being affected by them is a matter of luck, where the chances to have complications increase at every turn. On the other hand, egg donation is a reliable source of money. The amount of money, the time invested, and the efforts expected are usually the same, and get optimised if they donate more than once (as they do not have to undergo some of the medical checks and tests). The number of times they will turn the wheel will be assessed against other variables such as the level of need and pressure they experience. Mica thought she had enough with one cycle; however, when facing financial stress later again, she decided to take the risk of a second. Lucía, on the other hand, felt she needed to stop, as her spell might end after four “successful” goes. However, as not many of them know, the outcomes may take years to be revealed.

ANONYMITY, IMAGINARIES, AND CONTROL

So far, I have discussed the ethics of information delivery in egg donation considering only the information regarding the risks, side effects, and the risk perceptions of my participants. However, given the transnational dimension of the lucrative Spanish fertility industry, the question remains: what should be considered ‘relevant information’ for intending egg donors? What should we actually be expecting to know about egg donation? Following previous research, I contend that given the industry arrangements in which egg donation happens, not only the risk and side effects, but also the possible futures of their eggs and the exchange value they will acquire once they are outside their bodies are crucial

questions to disclose if we aim for 'informed decisions' (Cattapan 2016; Rivas et al. 2019; Niemiec and Howard 2020; Tober et al. 2021).

This omission of information is propelled by both the altruistic and the anonymous framework of egg donation in Spain, which results in the alienation of egg donors from their product value and helps maintain low production prices. In other words, the imaginaries of egg donation, managed and promoted by the clinic, play a role in the functioning on the industry (see Marre et al. 2018). As Rivas, Lores and Jociles (2019) argue:

Anonymity as information control has been extended not only to the non-identifying data of the donor, but to other data on which the law does not say anything or it is ambiguous about, and those are relegated to clinics decisions; for example, the information about the number of eggs extracted, their use for one or several recipients, the use in fresh or their cryopreservation, the number of pre-embryos obtained after the insemination of the eggs, the success or fail in the transference, the number of births in national territory or outside the state, [or] the destiny of the unassigned eggs/embryos.²¹ (p. 634)

Confirming the concerns this quote raises, the participants of this research had little information about the outcomes of their cycles and the market dynamics of fertility clinics. This sometimes made interviews delicate conversations where I, as a researcher with privileged information, had to decide whether to intervene when women expressed wrong assertions about their donation. This occurred when I asked participants: How do you imagine the recipient(s) of your eggs? Have you ever thought of the possibility of there being more than one recipient of your donation? Have you ever considered the possibility of the recipients being from other countries?

²¹ Original paper in Spanish. Fragment translated to English by the author of this thesis.

The responses to these questions provided very different answers, which highlighted the fragmentation of the knowledges among women donating eggs,

Imagining outcomes in an anonymous context

They told me that more or less they would take between 3-4 eggs. Then, the rest were left there. And then, in the lab, they would check which one was the best to make a... Before that I had seen a documentary where the woman would get the most ideal egg and the rest, in some places, they would freeze them, and in others, they would get rid of them. So, of course, I don't know exactly what they did with the rest, I don't even know how many they took. I know that it was between 3-4... and that they chose the most ideal and so on. And I suppose that the rest have been frozen or put in the bin. I don't exactly know what happened with the rest of the eggs.

(Stella, 20 years old, one-time egg donor)

Anna: Did they tell you if your eggs were going to be for one or more recipients?

Emily: No. But I don't know if more women can use them. I think there is a law that says that you can't... I mean... or can you? [...] In theory... well they didn't say anything in relation to this. And in the documents that I read it didn't say it either. They talked about *the* recipient; I know that.

(Emily, 23 years old, two-time egg donor)

Anna: What do you think that has happened to your eggs? Did you ever considered they may be assigned to a foreign recipient?

Lidia: [...] I had never imagined, never ever, that he could be in another country. Not this.

(Lidia, 27 years old, one-time egg donor)

Anna: Have you always thought your eggs were in Spain?

Lucía: No. No, because in the clinic where I went, almost all the people who were there, all the couples who came to receive, they were almost all tourists. I think it was people who came on purpose to do it, the *in vitro* fertilisation. In fact, the girls who were at the reception desk, which were four, they spoke like 6 or 7 languages each. Because I saw that they were talking to a lot of people. I mean, that is super international, so I imagine him [the baby] from any place in the world. So, the probabilities that I see one of these babies of mine... [laughs].

(Lucía, 22 years old, four-time egg donor)

Anna: Have you ever thought of the possibility that the couple could be from another country?

Sonia: No, no! [laughs]. Now that you say it, yes, yes, it could be, of course, but no, no. I mean, it was not the image that came to my head, no. I had the image of someone from here, from Barcelona.

(Sonia, 31 years old, one-time egg donor)

As the examples demonstrate, the imaginaries in relation to the future of their eggs varies a lot from donor to donor. However, these different imaginaries usually were not related to the information they were given in the clinic, but rather to the information they could grasp by observing during their appointments or, on some occasions, the information they found in the media.

Most of the participants were not told the number of eggs that had been extracted, the number of couples that might be able to receive them, their recipients' country of origin, the reasons for the recipients to demand eggs, or whether their eggs would be frozen to be shipped abroad — options that most donors did not even know existed. The most common imaginary was a single baby born in a family which lived nearby, who for medical reasons, using donated egg was their only chance to become pregnant. In the following section, I will shed light on the perspectives and rationalities of clinicians when providing information about egg donation.

***'Ella al final ni pincha ni corta'*: tracing knowledge boundaries through altruism and anonymity**

The interviews with clinicians in relation to informative practices aligned very well with what I found by talking to egg donors. They indeed highlighted that detailed information of the outcomes of the donation was not communicated. However, they could let donors know if the donation had *led to pregnancy*. As Aina and Neus, gynaecologists, explained, while the number of eggs the clinic finally extracts is not communicated, donors are instead encouraged to ask, *if they helped*. As seen in the previous section, this practice reinforces once again a narrative in which not only altruism is at the centre, but also the imaginary of the single family they are assisting at.

Anna: What information can a donor have? I mean, can she know if the treatment worked? How many eggs were extracted?

Neus: If they ask for it, “did I help?”, we tell them if they led to a pregnancy or not, because this gives them information about their own fertility. [...] The number of eggs by default is not disclosed, but some of them ask “and how many follicles... how many little rounds do I have?” and sometimes you tell them, “Look, you have very healthy ovaries” or “we are a bit at the limit, but we’ll see how...”. Usually, they are not given exact data, but they are told “look, your ovaries have a big reserve”, or, “not so much”. Obviously if they have a low reserve, we tell them.

(Neus, Gynaecologist and Clinic Manager)

Anna: When you are doing controls to the donors and so on, what can the donor know about the process she is having?

Aina: If her donation has led to gestations. If the donor asks, we can tell her. It is like... especially the ones who do it... in an altruistic way, they are interested and they ask you “do you know if the recipient was able to get pregnant?” And you can tell them this.

Anna: And what about more technical things such as how many follicles she is producing and so on?

Aina: How many eggs, right?

Anna: Yes. Would you say it in a ultrasound control for example?

Aina: Oh, in a control they see it, because they can see it in the screen and they say “oh, so many!” and so on, and many ask for it and you go explaining how the stimulation is going, poor things. There are some who are educated, in the sense that they have... that they are studying,

we even have medicine students, and you go explaining it. And they love it. What is not really told is how many eggs were extracted because... At least here they [the management] don't like much that we say it. I don't know why. I guess not to give so much detailed information... At the end of the day, she *ni pincha ni corta* [she has no clout/power]

(Aina, gynaecologist)

By using the Spanish expression “*ni pincha ni corta*”²² (she has no clout/power), Aina expresses that egg donors' participation and relation to her eggs is finished right after the extraction. The number of eggs is considered information which is no longer her business and is now commercial in-confidence. However, whether someone got pregnant out of her eggs is information that she is encouraged to ask. I argue that the obscurement of this information is intended to prevent debates on retributive justice and to maintain the roles of the participants. The rationality for letting her know if a pregnancy took place but not the number of eggs extracted, reaffirms the gendered logic of altruism and traces the limits of her appropriate interest in her donation, a strategy that I have named ‘discursive recycling’ (Molas and Whittaker 2021).

Many times, the logics of clinicians not to provide information about the outcome of the donation were related to the legal framework of anonymity. Indeed, the fact that donors cannot have information about the recipient couples or the resulting children of their donations, serves as a pretext to obscure all the aspects related to the results of the cycle. Nevertheless, other rationalities emerged during the fieldwork. Virginia, egg donation program coordinator, made an interesting reflection on the vulnerabilities of giving donors information on the results of her cycle. According to her, the information could negatively affect their future reproductive life:

²² Literally translated as “[something or someone] neither stabs nor cuts”, the idiom is used to highlight that something or someone does not have any power or influence in an issue. In this context, Aina stressed that donors do not have sociotechnical power or influence in the decision making of the destiny of their eggs after the extraction, for which giving them information appears as pointless.

Virginia: For example, if you discard her, you have to tell her the reason, okay? However, are you obligated to tell her how many eggs you have obtained or if the patient is pregnant or not? No, this is not written anywhere. It seems a bit counter-productive to give this information. I think it is information that... it is not because I want to oppose transparency, as I am the kind that thinks that everything should be transparent. Everything, okay? I could even bet for the non-anonymity. Although I think this is a society that is not ready for non-anonymity and moreover... from the business point of view everything would sink, okay? But I am not speaking as business, I am speaking about my convictions which do not necessary fit with... [laughs]

Anna: With the business goals?

Virginia: Exactly. These are two different things, and I work, and I earn a salary... like everyone else, right? But my convictions can go on another direction. Okay, so going back to the point, although I stand for transparency, there is a point that I don't see quite clearly about a donor knowing everything that is happening. I tell you why, because if you are a young girl, and you have made a donation, and I tell you that we didn't get a pregnancy, maybe this will block you in regards of your future motherhood plans. You can think that it won't work, that your eggs don't work... okay? Psychologically this can affect you. And if I tell you that it went alright, it can also affect you psychologically. It can affect you because when you have children you can get obsessed thinking that you have stepsiblings, that your children have stepsiblings around the world, okay? Around the whole world moreover [laughs]. Or it can affect you if you can't have children and you know that there are children who are biologically yours. Okay?

(Virginia, Biologist and egg donation program coordinator)

Virginia's reflection brings to the table a topic that needs further reflection: how the information of an egg donor's cycle can affect her life and future. As I show throughout this thesis, this debate is not exclusive to the results of the cycle itself (i.e., how many eggs extracted or how many children born), but also to the results of the different tests she will undergo as part of the screening process, notably the anti-Müllerian test²³ and the carrier genetic test²⁴. I argue, however, that this is not necessarily in opposition to give information on the egg donation industry more broadly. What I suggest needs to be discussed is the importance of the knowledge of the systems in place, value exchange, and possible futures, not only of their own eggs but of the eggs of any given donor in Spain. This shift would broaden the scope, deindividualize the perspective of egg donors, and allow informed reflections at a collective level.

I contend, therefore, that there are at least four debates intertwined in this discussion: one has to do with the quality of information delivery practices. The second has to do with ethics of disclosing personal medical information to egg donors. The third is related to the discussion around the anonymity of egg donors. And the fourth, with the ethics of disclosing information about the egg donation bioeconomy, especially when in Spain donation is framed as an altruistic act.

While the debate concerning the anonymity of donation in Spain has been on the table for years (see Context of research chapter), the debates on the quality of the information provided, the possible negative effects for the donor due to information being disclosed or withheld, and whether information regarding the business model of donation is required as part of informed choice, need to have their own space. At present, secrecy and avoidance is the alternate for the four debates, ultimately benefiting clinics' business goals.

²³ Test currently done to all intending donors as part of the screening process. Anti-Müllerian Hormone (AMH) is a hormone secreted by cells in developing follicles. The level of AMH in a woman's blood is generally a good indicator of her ovarian reserve.

²⁴ Explored in chapter five.

CONCLUSIONS

In this chapter, I addressed the problems with the availability of information about egg donation in Spain. Within clinic informed consent arrangements, I described the short informative interviews, where emphasis is placed upon the definition of egg donation as an altruistic act instead of the medical procedure involved. I also highlighted the consent form delivery practices, where I pointed out that clinics give women all the informative documents and consent forms to sign the first day that they come to the clinic without any possibility to take them home. I argued that an examination of the quality and the means of information delivery is not sufficient to understand egg donors' reception logics and decision-making. In this sense, I drew on the experiences of several participants that highlighted that other issues such as trust in the doctors, cultural capital, and age had an important role. By using the notion of 'risk perception', I analysed both the structural and individual arrangements related to risk assessment and perception. Drawing on the notion of temporality, I discussed how risk assessment is related to an ability to think and invest in the future — an ability which was restricted by the circumstances of many of the donors in this research.

Finally, I outlined an important debate on egg donation practices both in and outside Spain: the relevance of having information about the market exchange dynamics of egg donation. I showed how the imaginaries of egg donors in relation to the future of their eggs differed significantly among participants and were, in many cases, quite far from the realities of the everyday egg donation bioeconomy. I argued that accurate information on the possible outcomes of the donation is crucial if we aim for 'informed decisions', as this knowledge provides ground for collective reflection about egg donation arrangements in Spain.

Informative practices in fertility clinics result in the fragmentation of understandings around the process and its outcomes as well as the risks involved, which depend on different aspects of their lives such as cultural level, labour experiences, reproductive literacy, age, and their financial situation. Along with the lack of transparency on the egg donation market dynamics in Spain, I argue that these arrangements can be understood

as a means to delimit the participation and knowledge of egg donors, separate them from their product value, and use their eggs as bio-objects owned by the clinic whose futures will depend on market dynamics. I read the information arrangement for egg donors as ultimately aimed to tame a potential debate on retributive justice and assert ownership on the eggs extracted.

On the following chapter, I will continue the discussion by focusing on the ‘operations’ required by intending egg donors to make themselves ‘bioavailable’ (Cohen 2005). I will contend that ‘the labour of donorship’ goes beyond the actual medication and extraction surgery, for which I will explore the processes of choosing a clinic, of learning about one’s biocapital in the reproductive industry, of organising when and who will administrate the injections, of managing pain and discomfort, and how this is all juggled with their other life commitments.

CHAPTER 3: THE LABOUR OF DONORSHIP

INTRODUCTION

Lawrence Cohen (2005) proposed the concepts of ‘bioavailability’ and ‘operability’ in his examination of kidney donation in India. In his study, he explores the social apparatus that governs kidney redistribution in South India. According to him, to be bioavailable “is to be available for the selective disaggregation of one’s cells or tissues and their reincorporation into another body (or machine)” (p. 83). The bioavailability of large populations is necessary for the creation of global forms of organ and tissue circulation across different expanding global bio-markets. However, the process of bioavailability does not come naturally. As he argues, subjects aimed to become bioavailable will need to be situated within a specific technoscientific regime allowing and underpinning the transformation of some subjects (usually the poor and marginal). These subjects, in turn, will have to embrace these transformations often framed in progressive discourses embedded in neoliberal ideas of entrepreneurship, care, and decision-making — a process that Cohen (2005) names ‘operability’. As the author puts it, ‘operability’ “is thus necessary to remake one’s mindful body in accordance with the demands of developmental modernity, to remake one *as if* one were modern. If the operation becomes a form through which constitutively marginal, pre-modern subjects can secure some form of modern participation in the nation-state, it may become a critical desideratum” (Cohen 2005, p. 87).

The concepts of ‘bioavailability’ and ‘operability’ are used in the context of this thesis to shed light on the steps (‘operations’) that women have to undertake to make themselves ‘bioavailable’ for the global reproductive industry. This analysis of operability as a process through which individuals from marginal backgrounds can actively engage with modern society resonates with the findings of this research, where women find in egg donation a way to secure themselves a future or a better participation in their present lives in an industrialised post-Fordist context. Connecting Cohen’s approach to the link between women’s decision to become egg donors and their position in the labour market explored in chapter two, I conceptualise these operations not so much as steps for the clinical labour to begin, but as labour themselves. In other words, I contend that becoming an egg donor in Spain is a laborious ongoing process — both physical and emotional — that takes place before, during, and after the treatment itself.

In describing these operations, I first discuss how intending egg donors choose a clinic to undergo their cycle, where I show how the perceptions of prestige and luxury associated with private fertility clinics emerge as indicators of safety and care. Second, I address the realisation of intending egg donors that they might not be able to choose in which clinic they will undergo the procedure. By focusing on the experiences of participants who were rejected from a donation program, I highlight how the clinics’ selection criteria make women think of themselves in terms of biocapital for the reproductive bioeconomy. Third, I discuss the self-medication and work arrangements egg donors organise during the cycle, where I point out how they are rarely directed to increase their own comfort during the process but rather to juggle their jobs and other commitments with the donation. Finally, I explore how egg donors manage the pain and discomfort experienced during the process, where I challenge fertility clinics’ dismissing the pain as “similar to menstruation, but stronger”.

CHOOSING A CLINIC: LUXURY AND SAFETY IN THE PRIVATE CLINIC

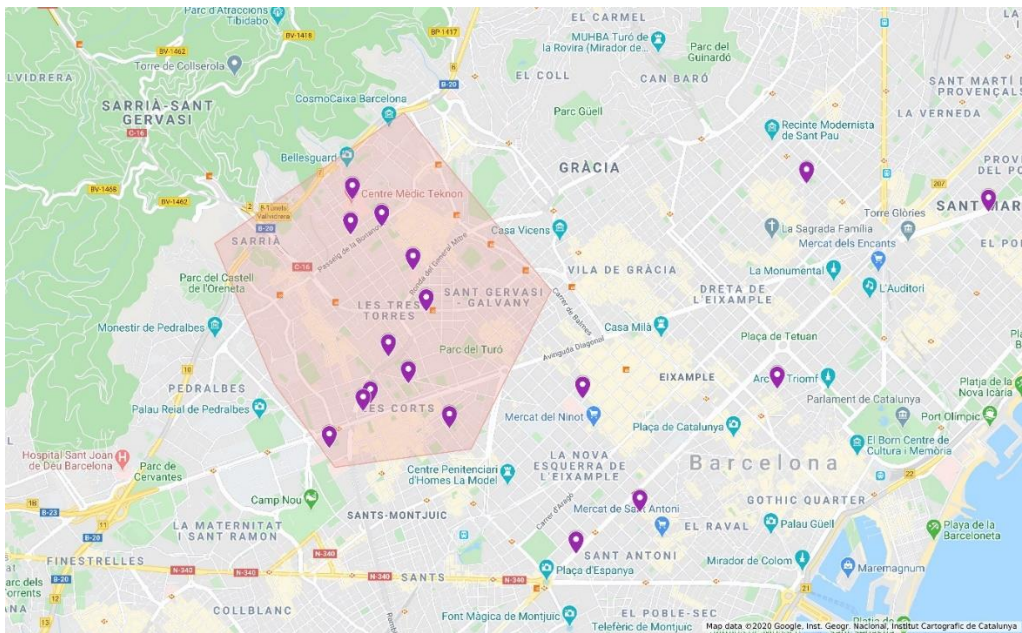
Notes from fieldwork diary, January 2019:

Out of three small waiting rooms, placed one after the other and connected by a corridor, the one that is the furthest away is the most impressive. I am in a high-up floor and the views from the windows of the room offer a stunning landscape. On the right side, I see the skyline of Barcelona, delimited by the sea, with the Mapfre towers emerging above the rest. I am right in the middle of Diagonal Avenue, where I can appreciate the buildings of bank corporations, commercial centres, and organizations. But as this floor is even higher than all these buildings, my eyes overcome the mountains of luxury and I can also appreciate a more real city, less bright. Across from the sea, I observe a hill full of irregular constructions: the hill of El Carmel. Indeed, from this height, one can appreciate the many faces of the city. The doctor arrives. She doesn't call my name though, but the one of the couple next to me, who switch from this panoramic view to the scientific concretion of the reasons why they can't conceive a child, the name of the drugs they will have to use, or to perhaps meet the gown she will have to wear for the surgery. (Plate 7)



Plate 7 - View from the waiting room of a fertility clinic located in the upper side of Barcelona. By Anna Molas.

Doing fieldwork for my thesis involved walking around a particular part of Barcelona very often. The area from Francesc Macià Square to Maria Cristina Square and connected by Diagonal Avenue, is home of the majority of fertility clinics in Barcelona as well as the headquarter of big corporations, banks, private hospitals, and hotels. Surrounded by the four wealthiest neighbourhoods of the city: Les Corts, Sant Gervasi, Sarrià, and Pedralbes, this part of Diagonal is like a valley surrounded by high buildings, new and old, which act as borders for one of the fanciest showcases of the city (Map 1). Women intending to donate their eggs will usually have to stroll around these streets for some time.



Map 1 - Map of Barcelona. On purple, the fertility clinics located in the city. Coloured in red, the clinics that are located in the upper side of the city.

The same clinic ‘where the king of Spain is going’

I went there because it was like “Institut Marques”, “Pedralbes”, I mean... there are a lot of things with that, right? You need to be careful; it is also something that affects your body very much. It affected me a lot at the hormonal level, then I also found out that they did it through Sanitas²⁵ and so on, and that also helped me... I really liked that, right?

(Andrea, 29 years old, two-time egg donor)

The ascension, both real and symbolic, to this part of the city shapes egg donors’ experiences in different ways. For most of them, who do not live nearby and sometimes not even in the city, this will become a pleasant liminal space which will allow them to briefly taste the delights of a luxurious industry who will invest in their attention and care for a while.

²⁵ Private health insurance.

The region of Catalonia has more than 30 fertility clinics, most of them in the city of Barcelona (SEF 2018). Choosing a clinic to undergo the egg donation will be one of the first operations that the donorship labour will demand. Interestingly, even those donors who showed complete alignment with the clinics' discourse of good faith and claimed themselves as altruistic struggled when it came to choose a clinic. The impression that they needed to "be careful" about where to do their donation, as Andrea said, reveals the perceived shadows around the industry despite the narratives and motivations of women.

Jokes about the donors' concerns that doctors might take their kidney as well were commonly made by both donors and clinicians. Indeed, the imaginary that some clinics did not perform ethically was shared by most of the participants and was the reason why most women took significant steps and time to select a clinic perceived to be "safe". The most important factors to consider usually appeared to be money, location, and safety. But as the amount of money paid under the name of economic compensation does not vary much from clinic to clinic, and as in Barcelona most of the clinics are in the same area, having the feeling of being in a safe place was usually the most important thing to consider in the decision-making process. Consequently, personally knowing someone who had a good experience in a clinic was a very decisive aspect.

Well, it was... I looked up on the internet and there were a lot of clinics, but of course, I wasn't going to... It was something that concerned me a bit, right? Then finally I talked to the friend who told me about it for the first time and I asked her about the clinic where her sister went.

(Mireia, 28 years old, one-time egg donor)

Interestingly, the ideas around safety were usually intertwined with perceptions of luxury and prestige of the clinics. The fact that the egg donation sector is privatized in Spain made the imaginaries of quality and safety assumed with the brands of private clinics emerge, with many donors wanting to undergo the cycle in clinics that "have a name".

I remember very well looking a lot on the Internet, right? I checked the places where I could do it, what clinics did it, which one was close to the university... and which one was paying the most fundamentally, because there are some that pay more and others that pay less. Then I finally choose CEFER clinic. In fact, I visited a lot of websites and they started to call me from different places, because when you start looking, they already start to call you and...²⁶ Finally, I was keen on CEFER clinic. I don't know exactly why. I think it was because I got the impression that, being the Instituto Teknon²⁷... right? So, it gave me the feeling that it was better in the sense that it was not a small clinic. Because there are some clinics that are smaller, right? So, I don't know, that gave me a kind of security.

(Lucía, 22 years old, four-time egg donor)

I will be honest, as they were doing this to me... I would choose the one that would give more money, right? It was a personal thing, yes, but I am not silly. I won't go to a clinic that would give 300 euros when there were others that gave 1,000²⁸ euros, right? So, of course, I searched, and I saw Dexeus and I said "wow, it is the one that has more renown". I decided that I would do it in Dexeus because... I was [deciding] between Dexeus and Teknon and I decided Dexeus because there were always ads on the TV and things like... that focused on motherhood issues, to women, right? I don't know, it is the impression

²⁶ Most egg donation clinics' websites have a form on the home page for intending egg donors to leave their contact details so that the clinic can contact them.

²⁷ Private hospital in Barcelona since 1994 famous for its luxurious installations, the advances in medical technology, and for attending celebrities.

²⁸ This was an exaggeration that she employed to make her point. All private clinics in Barcelona give between 900 and 1.300 euros.

that I had, right? Most football players or the famous people in Barcelona give birth there, right?

(Helena, 27 years old, two-time egg donor)

Similarly, Angela (22 years old, two-time egg donor), highlighted that the clinic where she did the first donation was the one “where the king of Spain was going”.

Indeed, regardless of their main motivation to undergo the donation, it was in egg donors’ imaginary that they needed to take charge of this decision in a self-conscious manner in order to avoid abuses implicitly perceived to be usual. These concerns can be read as a means to take some control in a process that generates concerns and a sense of vulnerability (Warren et al. 2013).

The possibility for accessing these spaces located in a particular part of the city, as well as becoming the centre of attention of staff in the clinic, was noted by many donors who, for some weeks, were in the position to receive deep care, attention, and luxury. Participants usually talked about the beautiful settings of the clinics and, the comfort they always found there, highlighting details such as having free food and coffee, all of which helped them feel reassured about their decision.

‘Benchmark professionals’: perceptions of reproductive health care services

Along the same lines, the prestige of the doctors in assisted reproductive medicine was brought up by one of the participants. Maria, a 34-year-old midwife, had an unwanted pregnancy a month after the donation, which was in part due to the hormonal alteration from the IVF medication. She worked as a midwife in the public health system, and with strong feelings of guilt and anger at herself, she told me how screwed up she was when she found out:

Hostia puta [f*cking hell], I mean, I had already had a period after that [the extraction], so I counted that that extra fertility was over, but in reality, it put my cycle out of order in a way that I ovulated when I didn't expect to, and I got pregnant. And that was like, "fuck it", right? I mean, the bitter part of all of this, because I... of course it was my responsibility, but it was a bit because of this hormonal unbalance due to the process.

As she explained, she was very knowledgeable of her cycles and her fertile days, which had been her contraceptive method for some periods of her life. She decided to terminate the pregnancy. However, she chose a private clinic instead of a public hospital. When I asked about this decision, she explained that being herself a health care professional in the public system, any time that a colleague would open her medical history on the computer for a prescription or any other reason, they would see that "stain" in her profile:

Hostia, I mean, I am a midwife, you control all of this, this stain cannot be in your file. I didn't want this chapter of my life in my medical history, right? A voluntary abortion because you haven't controlled your fertility as you should have, right? You spend the day advising people not to have unprotected relations and now it is you who had them and so on, right?

She decided, therefore, to undergo the termination in a private clinic for a price of around 400 euros, "so finally part of the money from the egg donation went to pay my abortion", she said ironically. Maria stressed the differences she perceived between the settings and professionals of the fertility clinic and the abortion clinic.

If we compare it with abortion clinics, come on, I have the impression that they also move a lot of money and still they have very seedy clinics. In contrast, here [in the fertility clinic] the installations, the means... I don't mean that the chairs are cool, but the ultrasound scanner is very good too. Or the professionals, right? The prestige they have, their

careers. I can't say all, but in many assisted reproduction clinics, the careers of their professionals have nothing to do with the ones who end up in pregnancy termination. [...] There are no benchmark professionals that work in termination of pregnancy. [...] The social status of the gynaecologists that are in assisted reproduction has nothing to do with the ones in termination of pregnancy. Usually, they end up being gynaecologists who don't have their title validated and that come from South America and end up [working] in termination of pregnancy clinics, isn't it? Instead, the ones in assisted reproduction are another vibe. They are professionals that work in the private [sector] but also in the public [sector] and end up being benchmark professionals, they are professors at the university... I mean, it is totally another kind of professional. [...] They are both moving a lot of money a priori if you think it from the outside, right? But one seems that is investing the money and in the other [abortion clinics] probably there is a *capo* [mafia boss] behind it all that is taking profit, but the professionals are not taking much profit of it, no, no. Because I don't hesitate that someone is taking profit from the money from abortions, there is a lot of money moving... where is it?

(Maria, 34 years old, one-time egg donor)

Her experience provides an interesting example of the differences between the reproductive health systems available for women in the private sector, as well as the perceptions around them. While she experiences care, luxury, and a perceived high level of expertise when undergoing donorship, she encounters a seedy space when instead she needs a reproductive treatment for herself, an abortion. If pregnancy is a huge achievement in fertility clinics, where money, time, reproductive and emotional labour are directed, in abortions clinics, shabby installations and a sense of lower professionalism is perceived. What is extremely valuable in one context becomes total waste in the other one (Table 5).

ABORTION CLINICS	FERTILITY CLINICS
Low profile professionals	High profile professionals
Unwanted pregnancies	Highly desired pregnancies
Seedy clinics	Luxurious clinics
Morally problematic	Morally good
Dubious financial structure	Wealth distributed and invested in the care of the users

Table 5 - Perception on the different reproductive services in place in the private health sector by Maria (34 years old, one-time egg donor)

We see here how women reproductive capabilities and bodily fluids have an enormous different social value in one setting compared with the other. A value that, as Charlotte Kroløkke (2018) puts it, is “intertwined with the cultural values in which reproductive parts and social relations are embedded” (p. 3). The social relations embedded in the Spanish private sector of abortion and assisted reproduction become clear in Maria’s story. The services related to the termination of pregnancy, are regarded as morally ambiguous both for the practices underlying them and for the kind of professionals working in there. Instead, assisted reproduction services are imbued with the hope and excitement their high-tech and scientifically sophisticated innovations bring.

What traditionally has rendered abortion a morally problematic practice has been the understanding that a human life is being destroyed. However, this would be a feature that, a priori, would be shared with fertility clinics, through the production of supernumerary embryos that in most cases are later destroyed. Nevertheless, as it is visible in Maria’s story, fertility clinics have escaped from this perception to embrace other attributes deemed morally good. According to my observations, I argue that fertility clinics animate sociotechnical imaginaries that point to the life they will create rather than the life that will be destroyed in the process. Ideas of family, motherhood, and the reproduction of a social class get coordinated to perceive the clinicians of these industries as ‘benchmark professionals’.

UNDERSTANDING ONE'S BIOCAPITAL

If, as previously mentioned, the process of selecting a clinic was the first stage in the making of a donor, the realisation that they might actually not be able to choose was definitely the second. For most egg donors, it was something that they would understand as soon as they started receiving calls from the clinics, which happened as soon as they left their personal details in their web pages. What usually started as an assessment to determine which clinics offered the best combination of perceived safety, money, and convenience, sometimes ended in a quest to find a clinic that would accept them at all. The rejection of donors has to do with different issues that will be described in detail later (in chapters 4 and 5) but could be summarised as having phenotypes “in surplus” (usually used by clinicians to refer to Latin American women with visible Amerindian features) or not accomplishing the basic health, genetic, and psychosocial quality standards of the clinic.

The selection criteria of IVF clinics raised a number of issues which were previously not perceived to be a problem by most of the participants, which is why I claim they constitute an avenue to think about their bodies and their health in a new form: in terms of biocapital, desirability and future reproductive potentialities. When answering the questions of clinicians and undergoing the multiple screenings required, egg donors start to grasp the biocapital they possess in the clinic and then they try to find means to convert it.

This process became evident when I observed how some women did not just accept one clinic's rejection. Instead, many participants called other clinics if they were rejected in the first one they had applied to. Some did it to refute the clinic's criteria for rejection, considering baseless, which usually happened when the refusal was a matter of height or weight. Others, however, would have a second try at becoming an egg donor in another clinic by deleting the information that became the reason of their rejection, such their own or their families' health histories.

Mica: And I called, and they rejected me because of my height, I remember. [...] Because I'm 1.56 [meters] and they said "no", that I was very small, that they thanked me a lot. And I said, "what?"

Anna: How did the conversation go?

Mica: No, I mean, it was straightforward, they said "hi, how are you?" and I, "good, I'm interested, whatever" and they, "and what do you look like?" and I, "I'm blond, normal constitution, green eyes...", "how tall are you? How much do you weigh?" [...] "oh, okay thanks, let it go". I mean everything was very correct but basically, they hung up. And I thought, "but there are many women who are...", I mean, my height is nothing crazy, my boyfriend is 1.40 [meters], I mean... and that is it. They rejected me like this, very fast. After that, I talked to a friend... [...] and she said "I don't think they will reject you in CEFER". And in CEFER, they didn't have any problem with it. They said that it was okay so...

(Mica, 22 years old, two-time egg donor)

In a similar manner, Berta, a 21-year-old, two-time egg donor, opted to have her first visit at a private clinic attached to a famous private hospital in Barcelona. After filling in both the clinic's questionnaire and the psychological test, she was informed on the phone that she could not be a donor due to her mental health issues. By this, the clinicians meant Berta's aunt's diagnosis of a borderline personality disorder. Angry and frustrated by the outcome, Berta decided, far from giving up, to continue her search. Apparently, the second clinic she went to did not check so exhaustively on family history on mental health and she was accepted. Emily had a similar experience:

Emily: Well, I looked for information, I started looking for clinics... for a week or so. I started to read what the process was about, how long it lasted... and then the demands of each clinic, because... that was another topic. Each clinic had different demands, at least the one

where I was, I had the impression that they were not as strict in terms of... For example, they call you and one of the first things they ask you is the weight and the height. Then the first clinic that called me they told me that I couldn't do it because for my weight and my height, it was complicated. They told me that in terms of the anaesthesia it could be complicated. [...]

Anna: Too short?

Emily: Too small, yes. And with a weight... well, that was at the limit of the body-mass index, so they said no. But then they called me from another clinic after some days and in this one, they said yes. And they also asked me for the weight and the height in the first place. I thought, "what's wrong here? Is it that in this clinic they are not strict?". Because at the end of the day, it is a medical and health matter, isn't it? Then presumably they should have more or less the same rules. If it is dangerous in one clinic it is also dangerous in another, isn't it? So, in the end, I stayed with this doubt.

(Emily, 23 years old, two-time egg donor)

Racial biocapital

For some participants, the selection criteria of fertility clinics also implied a new understanding of themselves as racial beings. In this new definition they were confronted with, race did not only imply certain visible features. Even if not physically perceptible, within fertility clinics, race was understood as a potential, hidden in their genetic past, threatening the future of intending parents and children. In chapter five, I devote a section on the definition of race that is enacted in the clinics and how it impacts selection processes. In this section, instead, I focus not so much on how race is delimited but on how intending donors come to understand themselves through this lens.

Valentina, an intending egg donor from Colombia who had been living in Spain with her mother for 11 years, tried to donate eggs when she was 18 years old. As she told me, she was surprised about the interest of the clinic not just of her origins but also those of her parents.

Valentina: [...] If I'm not wrong, they asked me about my family's origins. From where my family came from, where I had been born. [...] But I remember it was the looks that interested them the most.

Anna: Did you have to answer questions because your family was from Colombia?

Valentina: Well, they asked about the origin of my mum and my dad, from where exactly...

Anna: From where exactly in Colombia?

Valentina: From where and what part of Colombia. I think they asked for the physical aspect of my parents as well. Mmh... I don't know if also about my sister. I remember that one time, the girl [nurse] was there and she commented that... I don't remember exactly how, but something like "well, you don't really look like a Latin-American". I am white, I have fair hair... It was just a comment, I mean, that's it. I don't know if it was something good [...], because of course, if I was *morenita* (brownish), small eyes, straight hair... I don't know if that, for example, is also an obstacle or if it is something that the clinic is not interested in because the parents are not interested... but yes, [...] I think they commented that sometimes they asked for the looks of the parents, because many times the son is not like his parents, but like his grandparents. Of course, if it is from my parents, especially my mum, she has some very characteristic features. I mean, they are more visible of... a person from Latin America.

Valentina came to understand that visible “Latin-American features”, as Núria, a (nurse) put it, were an obstacle in the reproductive industry, and further that this represented a risk that was inscribed in herself through the heritage of her parents. So, even if she did not display such features, as was the case, she was conceptualised as a potential carrier. After that phone call, she still was invited to have a first appointment in the clinic but was finally discarded anyway on the pretext of her height, which was 1.55 meters. The narrative around the rejection was not related to the risks with anaesthesia, as for Emily, but on the differences between Colombian and Spanish features.

She said it politely, she said “listen, it is not that there is any problem, it is not that we are not interested, but you need to understand that the process of extracting eggs is expensive”, and basically, she kind of told me that it was not worth it to extract my eggs if the possibilities of someone choosing them to have a child were low. Because, of course, this means maintaining the eggs knowing that they won’t choose me or that the probabilities are very low. So, it was when she said, “well, it is not for any health related issue, it wouldn’t have any bad effect on you, but the thing is that basically many times mums want a donor a bit taller”. And I think she wanted to be conciliatory, think that they want them to look like them physically, and physically the medium height of mums in Spain is 1,60 [meters]. In Colombia, I am medium, I am normal. There everybody is short, but here it is not like that.

(Valentina, 21 years old, discarded from the egg donation program)

Through both the questions about her family’s origins and features and the statements on Spanish women’s medium height, Valentina was constructed as risky and less desirable than Spanish donors, or than donors with a whiter and taller heritage in general. As she told me, after one year she was contacted again by the clinic saying they found a recipient “who didn’t care, or who was also short, I don’t even know”. However, at that time she was anaemic and, therefore, not medically able to undergo a cycle. Her racial biocapital in the fertility clinic, which she fully understood once she underwent the screening, would

not let her choose when to do the donation. Neither whether she would be able to do it at all.

A similar thing happened to Nancy, a participant who was born and raised in Peru until she was 8 years old, and then moved to Spain with her family. She was 22 when, following the example of two of her friends (also participants of this research, Mica and Lucía), she tried to become an egg donor. After reading many documents and signing informed consents, filling in forms on her personal information and health history, undergoing a check on her weight and height, having a picture taken, and completing the psychological test (which, as I explained in the previous chapter, were all filled in the first appointment), her ethnic features were again the reason for the rejection.

Nancy: There was a very messed up question that said, “what is your race?”. Something like that. And I thought, “I don’t know” [laughs] I mean, my skin is brown but... I thought that this was very... unnecessary in part. Because of course I thought that this was more like an altruistic thing. You go there and you donate if you want to. Like when you donate blood. No one asks you, I don’t know, if your blood is too brown or... very fair red, right? And of course, they asked these things about my physical characteristics, so it was hard. I mean, it wasn’t hard, but I thought it wasn’t nice really. And they asked it to me like this, “what is your race?” [...].

Anna: What options did you have?

Nancy: There were no options. I mean, you had to write what you were, and I thought, “what am I?”. And of course, I asked her, and she told me, “Don’t worry, we will write it down ourselves”. I guess that she had seen me and that she was going to write something down.

Just the day after she completed all these forms, tests, and checks, she received a call from the clinic.

They called me and told me that it was better to cancel the appointment because there weren't people who wanted my profile... for my features... well, for my ethnic features I guess, that it was better not to do all the process... because of course, these cells, my eggs, would stay there for months, and of course they didn't want to do it for now in case no one wanted those eggs and they were there with nothing to do, you know? They told me that in case someone would want my eggs, then they would call me to start the process, etc. Then the appointment ended up in nothing, and that's it. That was all I did.

Nancy's understanding after undergoing the screening was that the desirability of her phenotypes was lower than the cost of the process itself. Or, in other words, the transformation of her bodily capabilities into marketable commodities was not considered economically worth the investment. The response of the nurse telling her they were not confident anyone would demand her eggs made it clear that they were the ones setting the definitions according to agendas that intending donors sometimes got to grasp during their donation process. It was through such conversations that egg donors understood themselves in terms of biocapital in the Spanish fertility industry.

ORGANISING WHO, WHERE, AND WHEN TO INJECT THE MEDICATION

Some of the participants of this research reported finding it easy to get to the clinic, as a few hundreds of meters down the fancy avenue from where most clinics are located, lies what is called 'Zona Universitaria', a 500 square-meter area that hosts more than 10 university faculties. However, not all donors came from universities, and for many of them, getting to the clinic was an arrangement to be thoroughly planned for it to not affect other commitments. This was the case for Mica (Plate 8, Plate 9, Plate 10, Plate 11), who donated eggs in a clinic in the area when she was 22 years old. She lived in a town 27 kilometres away from the clinic, for which she had to take the train, the railway, a bus,

and walk uphill for 10 minutes in a journey that, in the best of the situations, lasted 1 hour and 15 minutes. After the appointment to the clinic, however, she also had to go to the centre where she was studying her higher education degree, which took her another hour of public transport. Then, at 9pm, it was time to go home, which was almost another hour by train. This ritual was repeated every day she had to go to the clinic to undergo tests, ultrasound controls, or take medication home. Towards the end of the process, however, something disrupted her fragile organisation of things.

Mica: One day, the train was delayed, and I had to get home. I had gone to the clinic, I had all the needles with me, and I had to prepare all the *show* [referring to the preparation of the injections]. So, I went down in Sant Adrià station [a suburb in Barcelona, some stations before her own stop] because I had to put it at 10pm, I had to be very punctual. And I couldn't inject it myself. My body couldn't... the hand stopped every time. I was going to poke myself and at the last moment... I had to poke myself here [she points out the side of her belly] and at the last moment the hand stopped. It was like my head going "poke", but my body didn't want to do it anymore. It was the last one [the last injection of the medication process], I was very hormonal. I think the day after, or the following, I was having the extraction, and this is what I remember the most... I don't know if I would do it again really because my body was rejecting it, I mean, my hand couldn't go down completely. My hand stopped and I tried again and again but at the last moment... and then I poked but of course the needle couldn't really get it and I started to feel bad, because this was a very, very specific injection. For the rest of them, if you do it 5 minutes late it is not a big deal, but this one... and I remember getting home and saying [she exhales] "my body doesn't want this, and I don't want..." I mean, everything is alright until my body says it is enough. My body didn't want it. It was exactly like this, because I grabbed myself like this [she pinches the side of her belly with the thumb and index finger] and at the last moment... "no, no, don't do it".

Anna: But did you finally manage?

Mica: Yes, at the end... because also I was in Sant Adrià, which is an area that at 10pm... and I had a lot of needles!

Anna: Like people thinking that you were...

Mica: Exactly! And there was a group of guys around and I started to cry... because of course I was very hormonal with all of this. And with the needle in my hand and all, I remember that I had my mom, her boyfriend, and my boyfriend on the phone speaker telling me to calm down, “it is okay, it is okay, if you go over some minutes it is okay, calm down, breath in, you’ll see how you can do it”. And, at the end, I had a lot of little pokes in the belly but I could poke myself there, like very rough, and I did it right. [...] I think this is the strongest feeling that I lived. The body... no, no, the hand wouldn’t go down. Plus, I am not fussy with needles or anything, I don’t have any dread to poke myself, having blood extracted, nothing. But in that moment... I was okay when I went down in Sant Adrià, but when I saw that I had to poke but the hand wouldn’t go down... and I tried three times, there I started to get nervous, “No Mica, it is enough”.

Mica’s daily commitments were difficult to balance with the requirement of egg donation. When it became too much, her body was the one to put a stop to it, who is described by her as a separate entity who talks to her in a desperate manner. Her story accounts for a strong dissociation of her body during the process, which communicates with her by unexpectedly not obeying the order of injecting the medication. Similar to the experiences of the surrogates in Elly Teman’s ethnography (2010) in Israel, for some donors, putting themselves at the disposition of fertility clinics for a period of time served as a means to suspend the communications with their own bodies, which therefore needed to find different ways to express themselves. For Teman (2010), these bodily reactions “may thus be considered symbolic expressions of the lack of freedom and structural

powerlessness under the restrictive contract and surveillance of the body politic, medical institution, and contracting people” (p. 45).



Plate 8 - Mica handles the medication in the preparation of the last injection of her second cycle.



Plate 9 - Mica handles the medication in the preparation of the last injection of her second cycle.



Plate 10 - Mica handles the medication in the preparation of the last injection of her second cycle.



Plate 11 - Mica injects the last jab of her second egg donation cycle.

In this section, I consider the level of coordination and organisation required to be able to attend to the appointments, inject the medication, and juggle it all with their other daily life commitments. Mireia, a 28-year-old participant (22 when she underwent the cycle), struggled a lot to balance the medication process with her studies and her work:

It was crazy. I mean, I was all day up to my eyeballs, sincerely. Luckily, well luckily... I have to say that at the university, I've always been the phantom student, right? As I worked and many days. I went out late to the restaurant [where she worked], then I skipped the first hours and so on. I was going to classes very irregularly, you know? Then the truth is that, of course, I had to think very well about the schedule of the injections, right? Because I don't really remember how it was, but they had to be always at the same time. Of course, I had very unstable schedules, but then I realised that an hour before going to work was a good moment. During that week, I checked very well my schedules and so on to try to do it always at the same time and to be able to be at home, because I had to keep the product to inject in the fridge. Luckily, it was just one week, but it drove me crazy to have to go to the clinic, to go home, to jab me, to go to classes...

As Mireia said, the when and where to inject the medication was usually a matter to be studied beforehand, but for some donors, especially first timers, *who* would inject the medication for them also needed to be thoroughly planned. Martina, for example, relied on her flatmate to inject the medication, which involved feelings of anxiety on her part as she was afraid he might forget to be home for it.

I didn't feel panic about needles because for example I had donated blood before, or tests and so on, but to jab myself... The truth is that it made me feel... I hadn't thought about it till I had the needle on my hand and I had to inject it. Until that moment I didn't say "shit", I hadn't realised that I had to do it. Luckily, I lived with a guy who was physiotherapist, so he jabbed me. [...] The problem was that he always had to be at home at the right time, I mean, I asked him to. That really was a bit annoying, like "Pablo, when will you get home?" or "Please, don't go out dinner today" and so on.

(Martina, 22 years old, four-time egg donor)

But indeed, the people who they relied on sometimes forgot or just disappeared when they needed to be jabbed, which caused fear and concerns about doing it wrong. This was the experience for Lúdia, who relied on her boyfriend to inject the medication.

I never really poked myself because in reality I was scared about it. Well, it is something for which you need to be mentally very solid. [...] Anyway, specifically that day [the day of the last injection], I don't know for what goddamn reason, my partner disappeared, and I had to do it on my own. And I had all the fears in the world of seeing me alone at the moment of truth. The following day, I had the intervention. I couldn't let air get in. I wasn't sure if I was doing it right... maybe if I had had someone with me, I would have been calmer. Someone who said, "good, good, good, I think you are doing it well", and that's it, you know? It really was... It is cool to talk about it because I have never told anyone. It was like an evening that I spent doing that for one hour. One hour of nerves. I did the first shot wrong... I mean, I remember being so stressed... and maybe because... I also had inside a feeling of "I'm not sure of what I'm doing", right? "But I have to do it because..." I found myself doing something that maybe... doing something without thinking, and then when you are in the middle of it you realise that you hadn't actually meditated about it a lot. And well, I got it, yes. But the problem is that I was so nervous that I did it wrong... and in fact jabbing myself was very hard. I tried to jab, and I said "okay, I can't". I waited a bit, I laid down, but I had to do it yes or yes. And I jabbed myself... What a drama right?

(Lúdia, 27 years old, one-time egg donor)

The arrangements women have to organise in order to medicate correctly and on time are part of the labour of donorship. As Emily framed it, the required organisation, the restrictions during the medication process such as staying around for the

examinations, no drinking alcohol, and no sexual intercourse, made egg donation “like a job”:

It is like a job. Because when you go there, they give you a paper telling you about the indications on how you have to apply the medication. And then you choose a time. You have a time slot, and you pick up a time for you to put the medication. Of course, it was a bit limiting because it was Christmas, and sometimes I wanted to go out at night, but I couldn't go out because I had to stay at home... I mean, or I had to get there before or I had to take the medication with me or I don't know what, so that I could jab myself at the time that I had to. So, it was quite constricting in that way, right?

Moreover, for most participants this “job” overlapped with their other jobs, for which more decisions had to be made. Telling their bosses and colleagues about the donation or taking (or not) a couple of free days after the extraction were more issues they needed to resolve. As the following paragraphs reveal, their choices speak once again about the position of some of these women in their labour lives making their vulnerabilities emerge.

JUGGLING THE LABOUR OF EGG DONATION WITH ONES' JOB AND STUDIES

Shortly after the incident at the train station, Mica had her extraction appointment on a Friday morning. Her mother drove her to the clinic and dropped her and her boyfriend two streets from the entrance. Walking those hundreds of meters, however, was harder than she expected: “I remember that we had to walk two streets and that I could hardly move. I had to walk very slow and I always... even if I was late today [for the interview], I am always very punctual. Specially that day, I wanted to be punctual. My boyfriend had to take me because I was very, very bloated”.

However, the extraction surgery was fast and soon she found herself in the hospital cafeteria eating “for free”, with 1,000 euros in her pocket, and feeling “*super bien*” [really good]. “How did they give them to you?”, I asked.

In an envelope. I was thinking [laughs] it looks like I donated an organ. The girl told me, “Come here for a sec”, and she took me to a small room and goes “here you go, next time it will be 1,100 euros and the following 1,200 euros”. And I was like, “calm down, I’ve just finished with this one”. [...] I remember that, on Friday, I thought “well, if I continue like this, I’ll do it more times”, you know? And well, on Saturday, I was feeling a bit worse, and then on Sunday, it was the worst.

Mica started to feel bad the day after the extraction, and although clinics usually recommend resting, she went to work. “I should have rested from 24 to 48 hours as they recommend. But it was my second weekend of work in that hotel. And then, of course, I really wanted that job, and as I was going to be sitting, I said, ‘I take the risk and go’. I worked from 8 am to 1 pm, until I couldn’t bear it, and... I was in pain, bloated...”.

While she could still finish her shift on Saturday, on Sunday she woke up and the pain was stronger, and even if she did go to the hotel in the morning to see if the pain eased, as soon as she arrived, she told their colleagues and boss she could not face a workday like that. The matter was delicate as she had not told her boss about the real reason why she did not come on Friday. The only colleague she told about the donation said things that made her feel bad: “It was like ‘How do you do that with your body? You don’t love yourself, whatever’, and well, I explained my reasons to her, and she said, ‘how much do they pay you?’, I said ‘1,000 euros’, and she exhaled and said, ‘Giving your body for 1,000 euros, they have no shame, whatever’”.

The case of Mica is not unique. Although clinics recommendations advise to rest for 24-48 hours after the extraction, most of the participants worked right after that day, and some of them even the same day, in their afternoon shift. It was the case of Oliva, a three-

time egg donor whom I met in the clinic during my observations and who worked in a supermarket. She came to the ovarian ultrasound control in the company of her 4-year-old son and stated to the doctor that she was ‘*molida*’ [ground down] because of work. When I chatted with her again the day of the extraction, after a difficult recovery which involved yelling and sobbing, she told me that at 4pm, she was starting her shift at the supermarket. In most of the cases, the reasons for choosing to go to work seemed in part to be related to the money they would lose if they had the day off, but even more with the fear of being fired in the unstable work conditions of most of them.

Merche (26 years old, 19 when she did the donation) also went to work the same day of the ovarian puncture. As I explained in chapter one, she had been looking for a job “day and night” for five months and finally decided to schedule for the donation cycle “to have a [financial] cushion”. But just when she started the hormonal process, she finally found a job in a shoe shop. “It must have been karma”, she joked. The extraction was in the morning, and she had the afternoon shift:

They recommended not to go to work that day, but I had just found that job recently... It was like starting the process and getting the job. I thought, “ain’t I lucky?” [ironical]. And even more in a shop. And precisely they scheduled the extraction on a Saturday morning. I thought, “How can I tell them, just after one week working there, that I’m not going to go on a Saturday afternoon because I have...?”

Luckily, she managed to be in the counter where she could be sitting most of the afternoon, which allowed her to work for the whole shift.

In many cases, egg donors choose not to inform their workplaces about the surgery to avoid possible problems, hoping to be able to bear the pain and do their shifts without showing pain or discomfort. Their choices speak about precarious work relationships in Spain which are characterised by a strong sense of insecurity. As I discussed in chapter one, we can also read from their stories the multiple struggles they face to find a job at

their young age and how disposable they feel when they choose not to tell they had an elective surgery.

The findings of this section highlight that while the money received from the donation is legally conceptualised as ‘economic compensation’ to cover the expenses and inconveniences of the process, this is not the use that it has for many donors. Most of my participants, instead of using it to have an easier, trouble-free process, they squeezed their schedules to the maximum to fit the process without disrupting their work life and avoiding any extra expenses during the process.

In the following sections, I focus on the management of pain and discomfort during egg donation, which will show how this too requires labour from the donors.

EXTRACTIONS: FEAR AND LONELINESS IN THE CLINIC

During my observations, I was allowed to be present at four egg extractions, all happening the same day. The following fragment belongs to my field diary that I wrote that same afternoon.

Notes from fieldwork diary, June 2019:

Last night, I was quite nervous thinking about the surgery. I thought that it would be hard to fall asleep. I thought about the four women who had the extraction in the morning, and I felt a strange kind of empathy. I thought about them, and about how nervous they would be, much more than me. In the morning, I still felt the same way. I could eat something; I took a coffee. I was a bit afraid of feeling dizzy in the operation room. And then I thought about them, and the fact that they could not eat. And that maybe they were coming from outside Barcelona in public transport with nothing on their stomach, and with all the nerves.

[Almost getting to the clinic]

I have mixed of feelings, nervous and wanting to cry. I think that maybe this is because I heard many women's stories about the day of the puncture and the crying. And it makes me experience it myself a bit.

Paula (nurse) opens the door. We say hello, and she tells me that the donors have not arrived yet. As soon as one of them arrives, I go to the waiting room with her to introduce myself and the study. She remembers me from the ultrasound control, and I remember her: she is Lola. I tell her about the study more in detail and I ask her whether she is nervous, and she says she is not. It is the second time she donates in this clinic. She agrees to me being present during the extraction and about chatting a bit with me afterwards. Paula (nurse) cuts us saying that we must go upstairs already. I put on the surgery clothes she gives me. I am surprised to see myself like that.

Although Lola arrived first, they will do the surgery first to the second donor to arrive, who was in fact scheduled before Lola. In the meantime, Lola will wait on a stretcher, all changed for the operation, in the room where all donors will wait before the extraction, and also after, during their recovery. [...] Soon I meet the woman who will have the extraction first. I remember her too from the ovarian control I observed some days ago. She is Olivia, the one who took her little boy with her that day. I tell her about the study when she is in the changing room. She looks very tired, like the day I saw her in the ultrasound control. She puts her hands on her ovaries and tells me that they hurt. It is very hot in the room, and I can feel both of us sweating. I feel bad for talking to her about the study in this scenario. She tells me that she is okay with me being in the operation room. Once she is ready, they quickly take her to the operation room. The anaesthetist introduces himself and talks fast about what he will do. The nurse inserts in an intravenous line. The doctor comes in and they start talking about the newly released movie Aladdin. The doctor highlights the acting of Will Smith and the fact that the little girl with whom she went to the cinema, her granddaughter I assume, got sick afterwards. In the background the radio is on, Freddy Mercury through the speakers. Olivia is looking at the ceiling, still, serious. She doesn't smile at any time, nor does she show

connection with the conversation. I think about the fact that she has a 4-year-old son and that maybe she could actually participate in the discussion of the movie. No one looks at her and she doesn't make any move to be included in the animated conversation. When they put the electrodes and her heartbeat starts to be heard in the room, I see in the monitor that she is at 114 beats/minute. She is nervous, I think. At some point, she falls asleep. I didn't see the anaesthetist putting the medication in the intravenous line, but he did, and as he tells me later, in 16 seconds it makes the loop from the arm to the brain and makes her sleep.

The doctor puts the ultrasound scanner and the needle through her vagina, and I see on the screen the follicles, and when I pay closer attention, I also see the needle which gets in them and suckles out the follicular liquid. The anaesthetist talks about the incredible end of year party that was organized at her daughter's school. "Not surprising it was incredible, with all that you are paying!" says Paula (nurse) meanly. The two biologists in the room laugh and so does the doctor, and he looks a bit disconcerted. Later in the conversation, I understand that her daughter is going to the German school. As the anaesthetist talks, he holds Olivia's oxygen mask in a way that he covers almost all her face with the hand. The biologists put the liquids the doctor goes sucking in little pots. In some of them, the liquid is more yellowish, in others, more reddish, mixed with blood. Paula tags the pots with a black marker and puts them in a container that keeps them at a stable temperature. Later, in the lab, they will check them to see how many eggs they contain. And after a bit more they will be able to see how many of them are mature, that is, suitable for IVF.

One of the things that shocks me the most is the end of the intervention. They switch on the lights and quickly the anaesthetist takes Olivia's mask off and starts to call her name out loud. In a second, she starts moving. At some point, she opens her eyes and looks around the room. When her eyes meet mine, I give a hint of a smile with the aim that she feels some warmth, that she doesn't feel alone. Now the anaesthetist, the nurse, and the doctor, all at the same time, are shouting close to her face for her to wake up. She moves the head forth, as if she wanted to sit up, and the anaesthetist

pushes it down resulting in her hitting the stretcher with the head in a way that I feel violent.

Finally, they take her to the pre- (and post-) operation room where Lola waits. The stretcher passes in front of Lola as they put it next to her, just separated by a blue plastic curtain. Olivia grumbles a lot. She says that she is very dizzy. That she is very sleepy. She grumbles in a way that it looks like she will start to cry. She looks at me in the eyes and says things that I don't understand. Lola seems affected and inhibited. When, at some point, I find myself alone in the room with both, I ask Lola how she is feeling, "Fine, freaking out with this". Now, unlike before, she looks scared. I think I try to say something to lower the tension, maybe that probably this is normal because of the anaesthesia. But soon I remember that, even if it is hard, it is not my role to make that clinic look like a warmer place. But, on the other hand, I think that given that I am there I can keep her company, even if it is just allowing her to share her feelings. Just like Olivia, Lola came to the clinic alone. Lola asks me to tell her whether she does something similar when she wakes up from the anaesthesia, she wants to know what she will say under the effects of the sedative drugs. I tell her that if she says something, I will definitely tell her.

The extraction is the moment of the process that aroused the most conflicted feelings, according to my participants. One thing reported, especially for first timers, was the anxiety they experienced before the extraction. As my field observations revealed, for some of them, the extraction represents a kind of awakening about the complexity of the process they are involved in. The common fear experienced before the operation becomes both a realisation of the little amount of control they have in the process and a reminder of their bodily reality and its vulnerability. Nerves provoke bodily reactions such as stomach pain and uncontrollable shaking.

I was... well I was a "flan" [jelly-like dessert in Spain, the expression means 'shaking like a leaf'], I mean super nervous. Of course, never in my life have I had any broken bones, never in my life was I hospitalized for anything, never in my life have I been in that situation. And the first

time I was super nervous, it was 7am. I was... with no breakfast, with nothing in my body, like a flan, but I mean shivering, right?

(Sara, 25 years old, two-time egg donor)

Shitting myself. I was shitting myself; I was very afraid, a lot of nerves. I hadn't been slept before, for anything. And I think I haven't done it ever again [laughs]. [...] And yes of course, nervous, nervous.

(Sonia, 31 years old, egg donor)

I was nervous... I was going crazy all alone, I was thinking "Oh my god, but what are you doing?" and they gave me a Valium, I arrived there super high.

(Arlet, 27 years old, egg donor)

I was very nervous, and between the nerves, the fact that you don't eat anything, your tummy makes noises... and of course, you get in a hospital, and I don't know if people feel the same way, but... the hospital smells like a hospital [laughs], all white, all doctors, all running... I mean, you find yourself a bit bewildered. But luckily a friend went with me, and you don't feel so alone."

(Merche, 26 years old, egg donor)

But while Merche highlights the importance of being with a friend that day, company was not an option for all participants. Indeed, just as some donors go to work the same

day of the extraction, some come and go to the surgery by themselves, against the recommendations of the clinic. I was surprised during my fieldwork to see that although the staff in the clinics stressed the importance that donors came with someone the day of the extraction, during the observations that I made, only one out of four came with someone to the clinic the day of the surgery. All the rest arrived at the clinic and left it unaccompanied. This was the case of Júlia (34 years-old, egg donor). Her main concerns with egg donation were not related to the risks or side effects but rather with the fear of having to undergo anaesthesia for the extraction.

I started to relate it with the sexual abuses that I suffered when I was a child, and how they modified my behaviour. It was like I always had to protect myself. Also, I had grown up in a family where my parents didn't take care of us the way they should have, and since I was a child, I had to take care of myself, right? It affected me for example in my adolescence, when my friends got drunk, I saw them like crazy, right? "How can people be there like this? They can do anything to them. Aren't they afraid of not being able to care for themselves?". For me, losing control, for example, is something that causes me panic. So, one of the reasons [not to do it] was the idea that they had to sedate me and that I would lose this control. It is something that makes me panic at all the levels of my life. So, for this reason, I rejected the idea of egg donation, plus this sensation that they were going to extract my eggs, which was very related with the genitalia, you are asleep... This loss of control for me it was too much, right? And I let it go.

After some time, however, the money struggles she claimed to have always endured became very hard to handle, and she decided to start the process. And despite her having organized with someone to accompany her beforehand, the day of the extraction she found out that she would have to go to the clinic and leave it all by herself.

I talked to my sister, who long ago had said "Yes, I'll go with you", but the night before she said she couldn't come. And I was like "Oh my

god, I have to go alone”, and with my personal issue like “always when I have to do something that scares me, I am alone”. Like very obsessed with this: “Why every time I need to do something that scares me there is nobody by my side?”. So, I went in the morning, and I started crying as soon as I was out of my place, but crying... in the metro at 7am, right? I went to the clinic and as I was closer, I cried more and more. And I am quite sensitive and emotional but at the same time I am like very cold, when I have to control my emotions I do, you know? And this thing of crying everywhere or that they received me there and I was crying, I mean that was like very strange, right? I arrived there crying and the girl that was there received me like “Oh, oh, come on, we will go fast with you because I see that you are feeling terrible”.

Anna: Because they saw you like this?

Júlia: Yes, of course. Plus, when I cry it is like I have allergy to my own tears. My face gets terrible. [...] And of course, they... here you see that what they are interested in are your eggs, because instead of checking what is wrong with that person, it is like, “Come on, we’ll do it fast because you are having a hard time and we get rid of it”. Instead of seeing what is happening. And nothing, they put me in a room, “Put that on”, and in the waiting area when I was alone, I cried. I didn’t know why I cried. Because well, I don’t know, maybe also all the hormones that I had on me they were doing this effect, and nothing, they put me in the operation room. And the doctor tells me I don’t know what and she pokes me and so on. Which is quite a painful poke that one. And you fall asleep and that is it. That is it. You don’t feel anything, you don’t know what happens in that time, you don’t know for how long you’ve been like this and you start to wake up.

Once awake, however, the feelings came back again, and she cried still some more. While she thought she was under the effect of the hormones, she was surprised to find herself still down and sad days after the extraction.

After that, I was sad for some weeks, if not more... but specially the first weeks very... very, very hard, I couldn't stop crying and crying and crying. And I went on the bus, and I cried. I went wherever, and cried and cried and cried all day. After it slowly eased, but that sensation... plus the sensation was of... I don't know, the questioning of what had happened during that time, and I was asleep, I don't know. Like a pile of things and... I don't know I was like very down, I cried a lot, I remember an experience like... (she exhales) I don't know.

For Júlia, the extraction was a very delicate subject, as she would relate the anaesthesia and intervention with the feeling of vulnerability she had experienced with the sexual abuses she suffered as a child. And although in Júlia's case, the association of the extraction with unconsented touching was clearly related to her experience, other participants also talked about the strange feeling of being “remenada” (a Catalan word that literally translates as “stirred”) without them being aware, which also evoked feelings of lost control and revulsion.

Labouring discomfort and pain

Similar to the way in which egg donation is framed as a simple process to use, “all those eggs that would be thrown away by the body itself²⁹, bodily reactions and pain are usually undermined by fertility clinics when they claim they are “like the ones of a period but stronger” (Núria, nurse). In this way, clinics equate this pain to something close to natural and, therefore, almost not to be accounted for as a consequence of the donation process.

²⁹ IVI clinic's website.

Waldby and Mitchell (2006) largely discussed how the discourse of “waste” is a way to disentangle tissues from the “personal relations that produced it, and from its significance as a potentially implantable entity, a possible future child” (p. 70). As they argue, this is a necessary process to turn tissues into bio-objects ready to enter the global circuits of biocapital. Similarly, Kalindi Vora (2016) highlights that the labelling of something (labour, tissue, or in this case, cells) as “unnecessary” *where* (and, I would add, *when*) they are currently located is a necessary operation before they can be mobilised and outsourced. As she claims:

[L]abor, like human vital organs, can be understood as a specific portion of a person’s body and life that can be made free to travel by being constructed as “extra” or not needed where it is currently located. Before a human kidney or a given task or type of labor can become seemingly unnecessary in its immediate context and therefore available for outsourcing, it must be the object of specific cultural and material practices that establish it as unnecessary (p. 2).

According to the clinics’ discourse, pain, like eggs, goes to waste in every menstruation cycle. Egg donation, instead, gives a useful outcome to all these natural processes that are going to happen anyway. This disentangling, therefore, erases not only the labour required by donors for its production, but also the sociotechnical and socioeconomic relations that made it possible (see Waldby and Mitchell 2006; Neimanis 2014; Shaw 2017; Kroløkke 2018). While most of the existing literature has focused on the construction of the eggs as “waste”, in this section, I challenge the construction of pain and discomfort as simple amplification of menstruation bloating and cramps with the help of empirical examples of some of my participants.

In contrast to clinics’ discourses, the management of the pain and discomfort experienced by egg donors are considered here as part of the operations needed to become bioavailable, or in other words, part of the labour that donorship implies. As I describe, unlike any form of “natural” pain due to the menstruation, egg providers have to endure new forms of physical and emotional pain when undergoing an egg extraction

cycle. Mica's story of the jabbing at the train station provides a compelling example of how the subjugation of the body for egg donation can lead to unexpected strong bodily reactions. Other participants had similar milder experiences, where unexpected bodily sensations disrupted their carefully tailored disassociation from their bodies:

I didn't like it at all, not a bit, not a bit... and now that I am thinking about it, maybe I would have liked some more preparation for when you wake up, the sensation that you have. Because for me... it was 15 minutes, right? Apparently, it is just a moment, but they keep telling you "Now you will fall asleep" and I think that I was not aware that I really wouldn't be aware of anything, you literally fall asleep, and I woke up feeling that I had been fully stirred. And I didn't like it at all. I remember that they put like a diaper on me, you know? Like a very big pad. They stirred you and you are losing a bit of blood... and suddenly you say "Wow, it hurts a bit" just a tiny bit I mean, right? And I didn't like that. Because... right? It is like when you are asleep and think "Wow, they touched me, and I didn't realise". But they can't do it any other way. And I remember that that sensation was very weird. "This morning they have been touching me, in my [sexual] parts and I wasn't... I was aware but I didn't notice".

(Arlet, 27 years old, one-time egg donor)

Sara described her feeling inside the vagina as if "they took a condom, filled it with ice and they put it inside of me".

They didn't hurt me or anything I mean... but what I did feel during the extraction was a very cold sensation here in the vagina, I mean, inside. Not on the clitoris or... it was inside. As if... I don't know, I was asleep, because I was asleep, but I was like dreaming that I had a super strong, cold sensation. As if they took a condom, they put ice inside, and they put it into you... I mean, a sensation of cold that almost

burnt. I mean, that was very strange, the first time it didn't happen. I don't know if it was that the anaesthesia didn't have a strong effect on me, I don't know. And when I woke up, I told the doctor "Wow, I felt a very strong cold". He told me that they put helium... helium, is it possible? To open the area and don't leave any scratch... to be more careful.

(Sara, 25 years old, two-time egg donor)

One of the cases that struck me the most was the bloating of Andrea, who assured me that her belly prior the extraction looked like a 7-month pregnant belly:

Well, after this, it is true that I noticed many hormonal problems. Afterwards, moreover... I will look for the picture because I must have it. My belly became like a 7-month pregnant belly. Two days before I couldn't move. I had a very hard time during the process. But horrendous, right? A belly that... impressive. I had a very bad time. But well, of course, the needles, you must poke yourself every day. Obviously, it was my mum who did it, because for me it was impossible. [...] You have sensations... I guess that like when you are pregnant, of course I have never been pregnant, but you have craving feelings, the feeling that you are very full, very heavy... you also feel very strong hormonal waves, like ups and downs.

(Andrea, 29 years old, one-time egg donor)

The pregnant comparison was not just merely a metaphor, as can be seen in pictures Andrea shared with me after the interview, where her belly was swollen as if she was pregnant (Plate 12, Plate 13, Plate 14).



Plate 12 - Andrea's selfie of her belly during the medication process.



Plate 13 - Andrea's selfie of her belly during the medication process.



Plate 14 - Andrea's selfie of her belly during the medication process.

These examples also provide clarity on a common issue for many participants: the difficulty to make sense of their bodily reactions. As I argue in the following chapters, this visceral way through which a certain kind of resistance is expressed through the body is tightly related to the discursive and material practices of the fertility clinics, who work to separate and tame the donors enacted as subjects from the donors enacted as objects.

CONCLUSIONS

In this chapter, I discussed the different operations required for intending egg donors to make themselves 'bioavailable' (Cohen 2005) claiming that each of them configures the labour of donorship. I first examined the process of choosing a clinic to undergo the extraction cycle, where I claimed that donors engage in the imaginaries of the brands of the private fertility clinics in Barcelona as well as their aesthetic aspects in order to assure safety and professionalism. Choosing clinics that are renowned is seen as a way to feel safe amid the perception that some clinics may not perform ethically and be more dangerous.

However, I argued that while choosing a clinic becomes the first step for intending egg donors to assert agency and control, the realisation that they might not be able to choose is the second. In this part of the process, donors will start to understand clinics' requirements, and therefore, their biocapital in the fertility industry. Women come to understand how physiological aspects such as weight and height as well as phenotypical features affect their potential value in the eyes of the clinic.

A third aspect analysed were the arrangements that intending egg donors must accommodate to carry on with the process. In this section, I focused on the self-medication arrangements as well as the work arrangements, where I showed the difficulties they encounter to manage the injections and go to the appointments at the same time as they attend to other commitments in their lives. In this sense, I highlighted that, in most cases, egg donors try to juggle work and/or studies with the extraction cycle so that the latter does not affect the former in any sense. I argued that while the economic compensation is legally conceptualised as a way to compensate possible loss of income, it is not managed that way by egg providers, who mostly try to end the process with the whole amount of the compensation as additional income. Finally, I focused on the pain and discomfort egg donors endure throughout the process and how, contrary to the discourse of fertility clinics which describe it as similar to a menstruation cycle, women undertake exceptional amounts of emotional and physical labour that needs to be managed before, during, and after the extraction.

In this chapter, I showed how the different operations that donorship implies become a subjectivation process for egg donors in which they will learn about their value in the industry and their scope of action during the cycle — a process through which they will get tamed and aligned to clinics purposes.

In the next chapter, I will switch the gaze from egg donors to fertility clinics and clinicians to examine the selection practices and taming techniques in fertility clinics to control donors' behaviour throughout the process.

CHAPTER 4: SELECTING AND TAMING BEHAVIOUR: CONTROL, AFFECTS, AND CARE IN THE FERTILITY CLINIC

INTRODUCTION

In her influential exploration of the ways in which “medicine enacts the objects of its concern and treatment” (p. xii), Annemarie Mol (2002) described the different practices that transform a single object to be more than one (multiple). Drawing on her fieldwork in a Dutch hospital, the author focuses on the different coexisting ontologies around atherosclerosis enacted by the different actors who — from different standpoints and with different aims — must interact with the disease.

In my observations and interviews with the staff of fertility clinics, the body of donors was also multiple. Two main ontologies of donors emerged as stable across different clinics and professionals. The site of exploration where they were the most evident was in the selection and screening practice that intending donors had to undergo to enter in the egg donation program. As the aim of egg donation for reproduction purposes is to make a woman pregnant, it would be expected that selection practices in fertility were directed towards selecting fertile bodies able to reproduce marketable phenotypes and health standards. While this is true, a range of other important factors in

the selection process emerged in my fieldwork conforming to at least two different donors' bodies that were screened and tamed in different ways.

As many clinicians highlighted, the demands that the egg donation process implied (attending all the ultrasound controls; self-injecting the hormonal medication daily for 8 to 10 days; abstaining from sexual relations and the consumption of alcohol or drugs during the process; enduring the pain; and persisting until the day of the surgery for the extraction) made it very important to assess aspects beyond the reproducible capabilities of egg donors' bodies. Selecting women who were deemed as responsible was as important as ensuring that their eggs would have a commercial output.

In this chapter, I first situate the contexts in which the donor as *biographical subject* emerges. By providing fieldwork examples, I discuss the problems that clinicians deal with when treating egg donors and how imaginaries of class and race intersect in their rationalities. In this endeavour, I demonstrate how egg donors are perceived as having an "excess" of reproduction that clinics redirect to parents and families deemed as more desirable to reproduce. Second, I focus on the criteria clinical psychologists use to select women perceived as responsible and ultimately likely to follow the rules and bring the process to extraction surgery. Here, I delve deeper in the intersections with class and race and will explore the importance of women's motivations in this assessment. Third, I show how even if the selection protocols are strict, clinics have mechanisms in place to assure that donors bring the donation to completion once they start, which I discuss as taming techniques directed to assure trouble-free cycles. In this category, I distinguish between taming techniques directed to *control* donors' behaviour through more or less coercive methods, from the taming techniques based on the *care* of egg donors, which ultimately are directed to create a relationship of intimacy and moral obligations between the donors and the clinic.

The goal of this chapter is to provide insight into the ways women are read, selected, and managed in the clinical setting as well as to explore what these discourses and practices tell us about broader Spanish biopolitics. This chapter also intends to portray

the carefully designed methods that clinics have in place to contain and manage egg donors' agency for them to ultimately comply with clinics' business aims.

In an earlier article (Molas and Perler 2020), we examined these multiple [donor] bodies emerging in fertility clinics to highlight the rationalities underpinning selection practices and taming techniques. In this chapter, I flesh out and supplement some of the concepts used for that earlier work, where we proposed the terms, *biographical subject*, *body object* and *taming*.

We coined the term *biographical subject* to refer to the donor enacted as a subject with agency which will have to be tamed throughout the donation process in order for the cycle to arrive to completion. With this term, we aimed to link it to the concept of “reproductive biographies” (Perler and Schurr 2020), which is used to highlight the entanglements between the global bioeconomy, state biopolitics, and women's intimate lives. With the term *body object*, we referred to the donor enacted as a site of extractability. With this concept, we pointed out the privileged conversations that take place between donors' bodies and medical experts which, as I will unpack in the next chapter, are not translated to the donor as a biographical subject.

Finally, we described the mechanisms in place to manage egg donors in the clinic by using the term “taming.” With this concept, we referred to “the set of disciplining, control and contention techniques in place to manage egg donors' minds and bodies to achieve a successful egg retrieval” (Molas and Perler 2020, p. 4). Relying on the use proposed by Anibal Arregui (2020) while discussing animal-human affective intimacies, the term “tame” acknowledges the complex, bidirectional relation between those taming and those being tamed. As we wrote, this is “a relation that in its power relations is similar to those of a tamer dealing with a wild animal, where power relations are clearly in favour of the tamer but where the notion of risk and bidirectionality remains tangible” (Molas and Perler 2020, p. 4). More detailed information of how I conceptualise the notion of taming in the context of this thesis can be found in the introduction of this thesis.

While the paper we wrote had ethnographic examples from both Laura Perler and me, this chapter contains only interviews and field observations from my fieldwork in Barcelona. Moreover, this chapter discusses not only the methods in place to control egg donors as a means to align them with the process, but also how there is a big investment by clinics in care and affection which works to create relations of mutuality, reciprocity, and of moral obligation. In this chapter, I focus on the selection and taming techniques of egg donors as *biographical subjects*. The relationship between medical experts and donors enacted as *body objects* will be discussed in chapter five.

‘SUFFERING EGG DONORS’: TRACING THE DESIRABLE DONOR

On my way to leave a fertility clinic after an interview with Laura, its lab director, she took the opportunity to introduce me the reception staff, comprised of Núria and Paula (nurses), and Roser (administrative worker), whom I would interview the day after. “They are the ones who suffer the donors”, Laura said, and the three of them smiled ironically and nodded. “*Suffering them* is a good way to put it”, Laura reaffirmed.

Indeed, the struggles, difficulties, and desperation of the professionals in charge of dealing with egg donors was expressed by professionals across different clinics. Qualities such as patience, taking it philosophically, breathing deeply and even doing meditation were identified, usually among laughs, as necessary be able to handle this apparently very stressful job.

Then what is really important is how they are, right? Because if they are not responsible... there is a very irresponsible profile of donors and this is a chaos, because if they don't medicate correctly... We don't classify them as good or bad, or beautiful and less beautiful in generic, but in terms of responsibility. A chick who does a good donation, but then two bad ones because she hasn't medicated correctly, then another good one... This is terrible in terms of numbers. It is crazy in terms of

numbers and of emotional cost for the recipients, because all that it involves a donation that doesn't work out is chaos, right? Both in terms of management and in terms of the patient.

(Montse, Lab Director)

As Montse puts it, the level of responsibility of a woman is a crucial aspect to assess when selecting egg donors. The fear that they might not return the investment in tests, drugs, and time makes the work of the whole team, and specially of those who have the first encounters with donors such as reception staff, nurses and psychologists, crucial. Similar to Montse, in the interview that I had with Paula, Núria, and Roser, they highlighted the great burden that working with egg donors implied. Paying close attention to the narratives describing the chaos that donors presumably generated in the clinic, a particular picture of the average donor emerged. In this picture, their perceived profile of irresponsibility and untrustworthy women was usually related to their social class and country of origin. As she described it, the hardship of their job implied dealing with the messiness of egg donors' lives — or more accurately, of a particular social stratum.

“These ones get pregnant as often as I go to the supermarket”: Class, race, and reproductive waste

Paula: The first issue is whether they come.

Roser: Whether they attend.

Núria: Punctuality above all, because out of 10, 8 are unpunctual. [...] Or they say “yes, I am leaving home now, I am coming and so on” and then she doesn't come, and you think, “well then don't tell me and that's it”. It is a bit that you don't really believe what they say.

[...]

Paula: Let's see, the ones who need and the ones who offer their eggs, they are already two different profiles of people, I mean, a donor... I come early, okay? They are... in most cases, okay? They don't have much education of... of... I mean, they are a segment very... I don't know, who had a bit of a difficult childhood, a complicated adolescence. They are not very stable financially. [...] [After describing the steps of first medical check-up] if everything is inside the normal parameters, she continues with the process. Which would be to give her all the documents that Roser was mentioning, informed consents...

Roser: Which they don't even read.

Paula: Which they don't even read, exactly.

Núria: Well, a bit broadly...

Roser: The QCarrier³⁰ they don't read it for sure.

Paula: We give her an informed consent [form] to do a genetic analysis, and many of them don't read it, or they don't fill it because they don't read it, or they sign it directly and sometimes they don't even put their names on it.

Núria: They have many pages on genetic diseases and so on and come on, they don't read it for sure.

[...]

Paula: And afterwards, we also give them the psychological test, which many don't pass either. Because they don't read it properly... It is what we were saying. They do it fast or they have a family history or personal issues that you think, "no wonder they don't pass it", or because...

³⁰ Carrier screening genetic test.

their IQ, poor things, is... a bit short to understand certain questions [...]. Of course, also the level... What I was telling you, the intellectual level is important. When you see them a bit lost in thought, you think, "she won't do it right because she is not understanding anything". I am telling her this, but she is not understanding anything. I mean, you see them with a poker face like saying, "what the hell are you talking about?", you know? I mean, not even if I explained in pictures, right? She is not understanding anything. And of course, you think, "doing a treatment with this person doesn't make sense, because... it is very difficult that she will do it right". The truth is that most of the times that they do it wrong it is because of this. They fail because they couldn't make the dissolution, "I forgot to put the medication that was due", "I was..." whatever, "I was daydreaming and I didn't stop taking the pill...". One thousand stories because of what we were saying, you don't see them engaged. They think it like, "I am going to do a soft perm at the hairdresser and that's it", and you say "no, no, no, it doesn't work like that". So, many say, "I can come that day" [mocking high pitch voice] "because I am free...", and you say, this doesn't work like that, this is not "I'm going to have my manicure done".

Disorganised, with complicated backgrounds, financially unstable, and with low levels of education/IQ were some of the aspects referred by Paula (nurse) to describe most of the women that came to their clinic to donate. During my observations with them at the reception desk of the clinic, I was able to see a clear example of the way they read egg donors and how social class played a crucial role in it. Two young women entered through the door of the clinic one morning, similarly dressed in tight clothes and displaying a large amount of cleavage. Both of them had big tattoos, one on the breast and the other on the arms. They came from outside the city, but I failed to hear from where exactly. One of them was coming to do an ultrasound control since she was already injecting the medication, and the other to receive the results of the genetic carrier testing, which would determine whether she could start the stimulation cycle. The one that was already in the medication process told them that just before starting with the injections, she had a delay

with her period, for which she thought she might be pregnant. She explained in great detail what a fright she had thinking she was pregnant, which fortunately was not the case at the end. Núria and Roser listened in to her story without intervening in a rather serious demeanour. Once they were both sent to the doctor's consultation room, Roser looked at me with a sarcastic expression and said: "These ones get pregnant as often as I go to the supermarket".

The fact that she was highlighting how easily and irresponsibly "these ones" (of course referring to low-class young women) could fall pregnant was very significant in the context of a fertility clinic. The limits and boundaries of the desirable way to reproduce were suddenly clear in her sentence. While the sexuality and reproduction of lower-class women was conceived as surplus, involuntary and excessive, the reproduction for patients in fertility clinics, middle-upper class, was rather framed as a blessing, a way to make dreams come true, and to 'make families' in a controlled and responsible way. The ideas about the desirable subject to be reproduced in this setting are clearly entangled with conceptions of class, and as seen in the following paragraphs, also of race.

Conceptions of race and the migrant status of many intending donors was also brought up by Paula, who was convinced that there were differences between them and local egg donors. Migrant women from Latin American and Eastern European countries (the vast majority of all foreign egg donors according to all the clinics I spoke to) were perceived to be irresponsible not only in their personal lives, but also because they become egg donors "without thinking too much", which they mocked even though this is useful for the clinic. Ideas about the easy and careless ways these women reproduced appeared again in their narratives as they unfolded colonial imaginaries of migrant women as hypersexualised, extra fertile, informal, and lazy.

Paula: There are a lot of Latinas. Most of them have a mindset of, "there is nothing wrong with being an egg donor", they are Latinas... Latin Americans are like, "I donate this like I donate blood...". They don't have... especially because of course, they are mothers much younger than Mediterraneans. Then it is like, "Look, I am mother of

two, of three, of four, whatever, and now I donate eggs and help other people and, moreover, I am financially compensated". It is like... they have this much more assimilated than Mediterraneans, right? Caucasians are like, "What do you mean donate eggs? What does it imply?", right? They are like more reticent. There is a culture that is not... don't you think?

Núria: There are also many Russian donors.

Roser: I think it is because what we are saying, it is for the money. Many come here and they don't have papers to work so they need income. They need money somehow. And some of them are more capable to think and so on... but others, they go directly to this, right? [...] Of course, until they claim the papers, they can't find a job and so on. So, the ones that are from here, generally they work or study, then it is different, right? Because their intellectual level is different, their level of education they might have is different, and all the status they have. [...] But these ones [the migrants], it is another world, another level, I mean, they don't even think, they just go with the flow. According to the circumstances... not of life, but of that same day, on what they have, on what happens to them, "Well, I do that, I help someone, they give me money, and, in the meantime, I look for a job around or I go to the beach".

To understand the context in which these racialized imaginaries are situated, it is important to highlight that since the first wave of migrant women came to Spain in the early 90's in a government strategy to cover job positions that the country could not fill with its population, migrant women — mainly from its former colonies — have been the visible face of the domestic work in Spain (Marre and Gaggiotti 2004; see also Marre et al. 2018). Even though many live in situations of irregularity and abuse, their presence in the country has been the main reason why the fertility rate has not totally collapsed. However, similar to Milena Marchesi's (2012) findings in her study of reproductive

biopolitics in Italy, migrant women are scrutinized and mocked in this context for their excessive reproduction, which “is construed as a problematic and even dangerous contribution to the nation” (p. 173). In this context, the clinic becomes the place where this Transference of Reproductive Capacity (Lafuente-Funes 2019) from less desirable subjects to those deemed more appropriate is practiced.

These racist and classist dynamics tie into the discussion around waste from chapter three. The clinical discourse frames egg donors as wasting their reproductive capabilities, their cycles, their eggs, which become revalued and redistributed in IVF clinics to reproduce other more desirable values, couples, family ideals, and a specific social class more broadly. In the following figures (Diagram 1, Diagram 2), I compare the different imaginaries around egg donors and recipients according to the clinicians I interviewed.

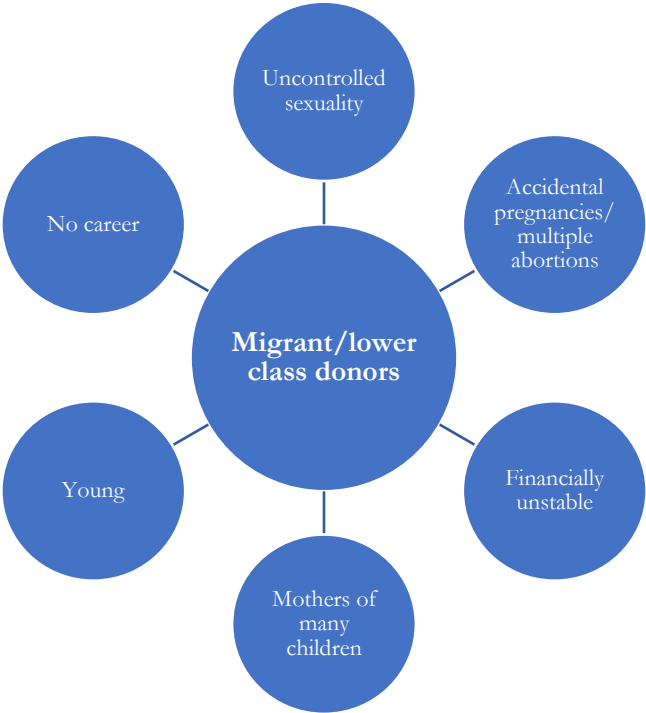


Diagram 1 - Imaginaries of donors according to clinicians.

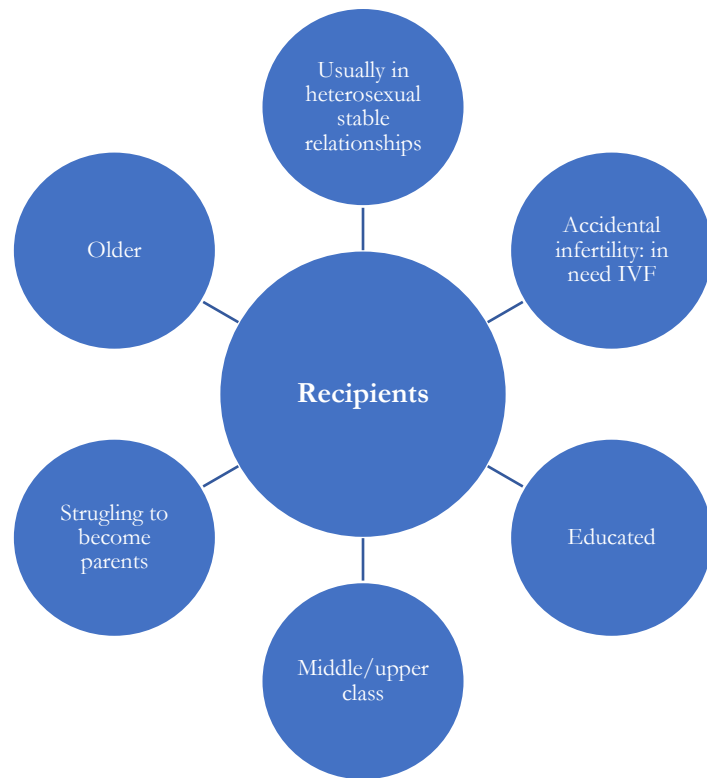


Diagram 2 - Imaginaries of recipients according to clinicians.

'You need to swallow because you need her'

Donors are perceived as subjects that embody the risk of unreliably exerting their freedom and agency by, for example, deciding to drop out or by committing mistakes in the medication process. The issue with clinics, which they openly recognised, is that they completely rely on them. Therefore, treating, negotiating, and taking care of egg donors is viewed as a great burden but one from which they cannot escape. At least *not yet*.

Those who have this bit of irresponsibility, well, not irresponsibility but lack of responsibility, it is very difficult for you to modulate, they are like this and that is it. But what happens? That sometimes they have uncommon physical characteristics, blond, blue eyes, green eyes, so we are interested even if they are messy and... you are interested in doing

another cycle with her even if she gave you headaches because she was not on time for the visits and so on.

(Aina, Gynaecologist)

Moreover, the donors know that the clinics need them, right? So, this also relaxes them a lot. It is like “well, if you don’t do it, I will go to another place”. And unfortunately, many times they are right. I mean, you need to swallow because you need her.

(Laura, Lab Director)

They go to the one next door. It is exactly like this. Now with all the thing of the SIRHA³¹... the SIRHA is the platform that theoretically since... The law says that the donors should be controlled and now they are not controlled. And the SIRHA won’t allow that you are in two clinics as donors. Because now it is like trading. When we set the clinic in Barcelona, it was chaotic, like: “What will you give me?” “But I want to start next month because otherwise I will go to the clinic next door” and so on.

(Montse, Lab Director)

In Aina’s quote, she emphasised that the level of patience staff were willing to have with egg donors was related to the level of desirability of their phenotype, highlighting again the relevance biocapital among egg donors. While many clinicians had the impression that egg donors took advantage of knowing that they were so highly needed

³¹ SIRHA is the abbreviation of Sistema de Información de Reproducción Humana Asistida (Information System of Human Assisted Reproduction), which is the name of the donors’ register that was in its trial version at the time of my fieldwork.

by clinics, clinicians also acknowledged that there was nothing they could do to escape from having to deal with them. Interestingly, some of them believed this dependency would eventually come to an end. In the epilogue of this thesis, I will explore how many clinicians dream about the day where they will not need to treat egg donors anymore, as egg cells will be created from pluripotent stem cells from patients.

SELECTING A RESPONSIBLE BIOGRAPHICAL SUBJECT

In the middle of this “chaotic” pool of women, selecting appropriate donors became one of the most crucial tasks for fertility clinics. One interesting figure of the egg donation screening procedure in Spanish private fertility clinics was the clinical psychologist, who in most clinics would have at least one formal interview with the egg donors before they were accepted into the program. As two psychologists explained to me, their function was twofold: on the one hand, they had to determine if the donors were at risk of transmitting hereditary diseases. And on the other hand, they had to make sure that donors would act obediently throughout the process, medicate correctly, and attend to all the controls. The way psychologists and other staff in the clinic assessed their reliability is the object of this section.

It is especially interesting to see her life habits, right? What they do, if there is emotional stability, work stability... if there is social stability, right? Sometimes we see a lot of people who come from abroad, women from other countries come here to donate. Maybe they are women that have been here only a few months and because of their economic need they look for something to get money. And they come here, then we have to see how their adaptation to society is. Where they live, if they have friends, if they don't... I mean, there are a lot of things that you can see in the person, right? But above all, we want them to be honest, okay? That they are honest. That really the life that they are having is the healthiest possible, okay? That she has an interest in life. Sometimes they are mothers, so check the care that she is giving to her

little ones. Sometimes they are girls who are separated, which come from a process of separation, and then we check how they are carrying on this separation from their husbands. Sometimes we have people who have received physical abuse, right? So, we check how she has been able to get out of that, to look for resources to get out of that by herself from this situation. Above all, what we look for is to see people... well, with a certain emotional balance and with an adaptation to society. Their health and nutrition habits as well, if she practices sport... that they are active in their free time... We also look for people who are active, right? And who are healthy.

(Gemma, Psychologist)

Adaptation to society, an active social life, emotional balance, practising sports, being a 'good' mother, and taking good care of one's diet are identified as traits to predict the overall commitment an intending egg donor will have during the egg donation process. When highlighting a special assessment for migrant women who donate for economic reasons or women who have received physical abuse by their partners, psychologists, and clinicians more broadly, implicitly provide a picture of the dangers associated with a specific social class.

It is true that you see the vibe of a person, right? Then, if for example she is a person who doesn't have any kind of rules at home... who has come in and out of jobs because she has been fired, because she didn't arrive on time. Or she didn't follow the rules, who maybe has many relations every week with a different person. Of course, these are signs of people that don't have the responsibility that we have to demand for such a treatment, because she doesn't commit with anything, right? This commitment... You see the commitment, you see it, you see the commitment she has in her life, in her goals, and you see that she doesn't commit with anything. The friendships, she might have some but well, if it goes alright, great, and if it doesn't, also great. That maybe

her family is not so important to her, right? These are little things that make you see that she won't be able to stick to this commitment. Or they tell me "I wake up and I go to the park, then I go to a bar and then maybe I clean a house, but if I don't want to, I tell them that I will go tomorrow". That means that this personal commitment is not there.

(Gemma, Psychologist)

As she describes, unemployment and lack of motivation in her life along with the job example she provides (cleaning houses) clearly draw the preference for donors with economic stability versus women who are socially excluded. As already highlighted by Sara Lafuente-Funes (2017b), clinicians in Spanish fertility clinics "show a clear preference towards having donors that behave in particular ways: altruistic, calm, responsible, and discreet" (p. 264). Indeed, choosing bodies able to produce eggs through trouble-free cycles will, therefore, need the selection of subjects perceived as malleable, obedient, and responsible. Motivation is one important variable. As implied in the preceding quotes, women perceived as being only interested in the money are perceived as more at risk to quit throughout the process. The connection between the motivation (more or less based on the compensation or the desire to help) and the behaviour is in turn perceived to be related to having a lower-class egg donor candidate versus a middle-class egg donor candidate.

Raquel: In that first interview... the most important thing when they come here, the first thing is honesty. Honesty. Afterwards, obviously, well, if they look at you into the eyes, what she is telling you... why they come to donate, the why. [...] But I think that the first thing, in the first minute, the most important thing is to see the response that she has, what she is looking for, how she looks at you... There are many women who come and the first thing that they tell you is that they have family members who had fertility problems or "my sister just had a baby and I thought that I could transmit this happiness", right? "And I am young, and I can transmit it". Then well... you are already

seeing that there is this family thing, of generosity... that they want to help. [...]

Anna: Why is it important that they want to help when they come to donate?

Raquel: Yes, it is important because... it is true that you can find people who are less altruistic and that care more about the money. If they come very, very eager to help, the process that they have is also more beautiful. Calmer. The insides are also more relaxed, the endometrium is like more relaxed [laughs].

Anna: Really?

Raquel: I can't assure you because I haven't made the study, but they are more respectful when it comes to coming to the clinic, the punctuality... They bail on you less in the appointments. Because they have this idea that they want to help and their goal is to help, they feel good doing this. They feel good doing this. Then, for us, it is important maybe as facilitation, right? Also for all the processes that they will undergo, and because of the fact that they want to help... It is not that it confirms it, but it gives you an idea that they will come like very honest.

(Raquel, Psychologist)

Pointing out to similar things, Irene, the egg donation coordinator of the same clinic as Raquel, claimed the following:

It is like in real life, there are hunches, right? For example, last week there was one that had something that I didn't like... You can't really say what it is, right? That they don't look into your eyes when they speak, that you feel that they are thinking of something else, that they

are not paying attention. At the end of the day, you are explaining to them some risks, although it is true that they are not huge, but you need to be aware, right? [...] You see that they are not attentive, or you see that they want to go to the point and say: “No, I am not so interested on how the surgery will be”, and they directly ask you for the compensation. [...] This doesn’t necessarily mean that she will not do the treatment with us, but you take it into account when you... you say “well, this girl can be used to do a deferred treatment or for egg freezing”, so that she doesn’t have a recipient waiting, right? At the same time, you try to control it.

As Irene stated, the results of this team group assessment of the egg donors in terms of their background and social status not always resulted in the discarding of the donor, but sometimes would determine the type of treatment they would receive. If a donor with desirable phenotypes for the clinic displayed unwanted behaviours or troubling hints about her life, they might choose to do a cycle to freeze all her extracted eggs and put them in the bank, instead of using them for a fresh cycle in which a recipient has to be synchronised. This method assured that there would not be no consequences for the recipient — and therefore for the clinic — should the donor dropped out of the process halfway or committed any mistake.

TAMING EGG DONORS THROUGH CONTROL AND CARE

Despite the efforts of clinicians to select women likely to have smooth and trouble-free cycles, clinics have different forms of taming techniques in place to address women’s behaviour and performance throughout the process. In the following subsections, I will delineate the two different taming techniques in fertility clinics: those which are directed to *control* egg donors throughout the process, and those which are directed to *care* for them.

Control: tests, money, and medication

“Hooking donors” with fast medical screenings

First, as stated in chapter two, it was common that when donors were interested in the donation after the first informative appointment, they were immediately given the informed consent form and start the medical check-ups that same day. As different clinicians confirmed, this was part of a strategy to motivate donors to come back to the clinic a second time.

When they come to be informed [...] there are many clinics that, before they go home, they already make them do a blood test. Because this is a way to make them want to come back to know the results or to find out about her blood type. It is a way to hook her. So, in the second visit, you do her an ultrasound scan, or even in the first visit... The thing is to do everything fast so they don't unhook and that they want to know the results.

(Magalí, Biologist)

Threatening with not paying

A second broad and widespread way to manage donors' behaviour was by threatening to cut a part of the compensation or not paying it at all. In this regard, different clinics were observed to perform differently following their own protocol. While some would pay donors only if they got to the extraction, others would consider paying a small amount if her cycle had to be cancelled halfway through for medical reasons (such as her body not reacting as expected with the stimulation medication).

They are sacred [the ultrasound controls] but sometimes also... there are some who don't come, right? But... it depends a bit on the person.

If the person is a bit flaky, you need to be insisting a lot. A lot. And at the end, the sentence that motivates them the most is, “if you don’t come, you won’t receive the compensation”, and then yes, many of them take short time to be back, you know? Then you say, “Okay, so the donation was altruistic, right?” [laughs], but well, it is like this.

(Laura, Lab Director)

Think that the compensation is not given until the eggs are extracted. Until you have passed through the surgery room, they don’t give you anything. Because, if at the first visit, they give you 200 euros, everybody would come, would take the 200 euros and goodbye. No. Then, until you don’t get to a surgery room, or if they can’t extract you the egg for medical reasons, you are not paid. Even if you have done everything. I mean... they make you hold on a lot.

(Magalí, Biologist)

We give a partial compensation because she has not made it to the end. I mean, what is compensated are the inconveniences, so of course, the main inconvenience is the extraction, apart from the daily injections. Depending on the moment when they are cancelled, we have a protocol that... obviously if it was a negligence from her, I mean, that she hasn’t put the medication, that she has lost it... then the compensation is minimal or can even be non-existent if she has stopped coming to the [ultrasound] controls. [...] And well, it depends on the moment when the process is cancelled. If they do it all correctly and they are committed people and they didn’t do it on [purpose]... then it is almost complete. It depends a bit.

(Neus, Gynaecologist)

Reimbursement

Third, donors were not just threatened with the possibility of not being paid, but also with the possibility of having to reimburse the money of their treatment should they want to leave the process halfway through. As stated in the template of the egg donation contract offered by the SEF, “[i]f the extraction does not proceed for withdrawal, negligence or bad faith of the donor, the centre will also be able to claim that she refunds the expenses of the explorations and the treatments that might have occurred”³². Although different professionals stated that they had never enacted this clause, it is possible that this coercion through money is the reason why some donors disappeared when they were in the middle of the process and never again contacted the clinic. A situation that was relatively common, according to the clinicians I spoke to.

WhatsApp

Fourth, the communications with the donors during the process provide ingenious ways of controlling egg donors when they are not in the clinics. On the one hand, they can control whether they have read their messages through the double blue check³³. On the other hand, it can assist them to make a first phenotypical screening through the profile picture, in which, if the donor has “very pronounced Latin American features”, she might be discarded before the interview (Núria, nurse, in an informal conversation in the clinic). Another clinic also reported that communication via instant messaging was useful to control whether and when the last medication (the one to trigger ovulation) had been injected. This was done by making donors send a screenshot of their phone at the moment when they put the injection, so as to have proof of the time.

During my observations in the clinic, Núria, Paula and Roser let me have a look at the specific smartphone they had to communicate only with egg donors. It caught my

³² Original text in Spanish. Fragment translated to English by the author of this thesis.

³³ On the instant messaging application WhatsApp, it is possible to know if the recipient of a message has read it because a double blue check appears under each message when they open it. While it is possible to change it for it not to appear, the double blue check is a default function of the application.

attention that most contacts were saved like “Leticia, *amiga de Rosana*” [friend of]. When I asked Núria about it, she told me that knowing from whom that donor came from gave them a lot of information about what to expect. If the ones who recommended had been ‘good’ donors, they felt more secure about the new one. It was also useful, they told me, because in case a donor disappeared in the middle of the process, they could always get in contact with the person who recommended the clinic to ask what was going on.

Elomva

Finally, donors are sometimes managed through the medications. Corifollitropin alfa (distributed under the commercial name of *Elomva*) is a long-acting stimulation drug that can substitute up to six days of daily medications with only one shot that is injected in the clinic. As the price for this medication is higher than the other drug requiring daily injections, it was usually reserved for women perceived to be more irresponsible and for donors with highly desired phenotypes for which the clinic did not want to risk a cycle cancellation due to misadministration.

There is a medication which is the most expensive and that not all donors can have, but it is one shot and that’s it. After that, they need to have more injections, but at least we would do this first recapture fine. And this one, they put in here [the clinic]. Then many times you say [to the doctor] “prescribe her this one because I think it will be the only way to do it correctly”.

(Paula, Nurse)

Virginia, a biologist and the coordinator of the egg donation program of a fertility clinic in Barcelona, also pointed out the increased benefits that the implementation of this medication provided:

So, with this hormone, you are already avoiding mistakes for five days.
[...] So, the hormone diminishes... In fact, since we started using it,

the percentage of bad responses has lowered a lot. Before we reached a discard of the seven, eight percent [of potential donors]. Now we have a discard of a two percent of donors, okay?

Care: “Here we treat them like princesses”: Affective capital in the private clinic

When I started knocking the doors of different private clinics in Barcelona, I quickly got the impression that my fieldwork plan was going to be difficult to accomplish. This was not unexpected. However, the narrative behind their denials was surprising. While I thought that the main problem clinics would have would be related to the fear of donors potentially speaking critically of the clinic and perhaps of me seeing and hearing about the precarious background of most donors, I was surprised to see that this generated less discomfort than I expected. As I described before, most medical clinicians spoke openly about the obvious economic motivations of most of egg donors as well as the fact that, for example, a large number of them were migrant women from Latin American and Eastern European countries. However, every time that a potential contact with donors was raised, they referred to them as very delicate subjects.

Notes from fieldwork diary, January 2019:

I talked again to Doctor Moran. Today she was different. She told me she has talked to the staff and that the psychologist said she doesn't like the research project. That they will not let me give the survey myself, nor talk to the donors outside of the clinic, nor, obviously, be in the consulting room with them. She spoke sentences that I don't want to forget: “Here we treat them like princesses”, “Like our daughters”, she said. The thing is that apparently, as she highlighted many times, out of the number of girls who call for a first appointment, only a ratio of 30% actually come to the clinic at the end, so I assume that they don't want to lose them. She told me that the donors are like “stop bugging me”.

Notes from fieldwork diary, February 2019:

When Virginia talked about the donors she said, “well, the donors are a group that...” and she exhaled looking at the ceiling. Then she told me that there were many couples, local and foreign, who came here for that [egg donation treatments], and that this was why they “took great care of the donors”. She told me that the research studies that were very demanding to egg donors usually didn’t pass the clinic’s committee. She was telling me all of this with silences, breaks and taking her time to look for the appropriate words. She told me that the vision in the clinic was that of “let’s not bug the donors”. It is amazing that these are exactly the same words doctor Moran used. Obviously, I got the impression that, again, she was referring to a fear of them dropping out if the process became too tiresome.

From their explanations, I came to understand that their relationships with donors during their time in the clinic were a carefully considered matter and that clinics did not wish to do anything that might jeopardise women’s willingness to donate. In my observations and interviews with both practitioners and egg donors, I realised that other equally important taming techniques were taking place in the clinic which instead were based on the investment of a significant amount of affective capital in egg donors. In this section, I will delineate and discuss each of the methods in place with the aim of situating the care offered to donors as yet another taming technique for a successful egg donation cycle.

“At a time when there are more than 30 private fertility clinics in Barcelona, how can you make sure they will be going to your clinic?” I asked clinics’ staff in our interviews. The answers I got from my participants, who were mostly practitioners in medium-sized clinics, were usually in the same line as that of Dolores, a nurse who had been in charge of the egg donation program of the clinic for years:

Big clinics have the advantage that they have a great economic capacity and they can do a lot of advertising through radio, TV, the buses, and you see it everywhere. Instead, small clinics, we don’t have this

possibility. For us, a donor must be treated *super bé* [super good]. You need to make it as easy as possible for her and that she feels well attended. That when they come, they know who they will find and that they see that you know their name and that she is treated in a very personalised way. That she is not a sheep, okay? She is not a number. And we tell them that if they liked it and they want to tell that to other people or... and the truth is that there are girls that come and say, “yes because so-and-so told me and...”. I suppose that it happens to other clinics as well but for us this is important.

Anna: The fact that they come because a friend recommended?

Dolors: Because a friend did the treatment here, yes. In fact, there are girls that tell you that they did donations in other places and then you ask them why they’ve changed, and it is because they were not happy in the other place. They tell you, right? And you say, well so even more reason to spoil them, take care of them and put them at ease...

“Spoiling donors” and making it “as easy as possible” materialised in a set of different strategies that clinics had been developing throughout the last 10 years, as more and more clinics were established and the competition for donors became tougher.

Women carers as capital

Dolors’ clinic, for example, had hired one specific young woman, Irene, to deal with the issues related to egg donors, and reported that “the investment”, as they themselves referred to it, was a success. Gerard, who had been the main gynaecologist of another private fertility clinic for years, told me how hiring women to do these caring tasks was not uncommon:

There are places where there is specific staff who deals with the donors, I don’t know, women doctors, more like girls, young, cooler... trying

to make the ambience less medical. Even if, in reality, you are doing a medical procedure. That the patient perceives it like, “Well cool, this is not too serious,” like, “I feel comfortable and this is not too, too, too serious”. Like a middle point between being professional but not too serious. And yes, it is usually externalized to a specific department.

(Gerard, Gynaecologist)

This investment in care for donors was well received by some participants in this research, who regardless of the concerns they might have around the industry, usually agreed that the manners were very good. Alexia, for example, expressed how the fact that she was going to be treated by women was an important aspect of her decision-making.

And well.... it was always quite good. I guess that the fact that they were women influenced, because if it was men, it would have been more... because the person that answered my email was a man, his name was Jordi and I felt like, “watch out”. But then they told me, “We’ve assigned you a woman doctor”. Actually, almost all were female nurses which, want it or not, has an influence. And I don’t know, they were all very kind like... this kind of people that are very cute like “ooh...” [putting a sweet soft voice], and that also... the personality of people makes you want to come back or not.

(Alexia 21 years old, one-time egg donor)

Clinics generate chains of capital from women based on what Boris and Parrenas (2010) termed “intimate labour”. With this term, the authors refer to “embodied and affective interactions in the service of social reproduction” (p. 12). Female nurses or coordinators are in charge of caring for donors, who are asked in turn to care for themselves during the process in order to care for the recipient woman waiting for their eggs. In this manner, female affective care and biocapital is converted into financial capital and profit for clinics.

Continuous communication

A second investment clinics did to care for donors was to maintain intensive and continuous communication with them throughout the process. While this included phone calls from time to time, in most cases donors were given a phone number to talk through Whatsapp to the nurses. In the observations in the clinic, I saw that they had a specific android cell phone that they used exclusively to talk to egg donors. While, as mentioned before, this allows clinics more than just mere communication, for most donors this measure created a sense of proximity and security.

I've always had the same nurses and the same doctors. At the end, I was going there, and they said, "hello Martina, how are you doing?". The ones from the secretary office they knew me as well, and bear in mind that, in the morning, there were different people than in the afternoon. I mean, yes, the faces were the same. It is not like in a hospital that there are many doctors, right? There it was them and I knew them and... they also do something that makes you feel very close, which is that they give you... well, they have a WhatsApp number through which they ask you, "How do you feel after the extraction? Have you already had your period? How do you feel?". This also makes it very close, the fact that you see that there is like a real follow-up also made me feel that I wasn't putting my body at risk. I mean, I know that I was putting it at risk, right? But I mean you also put your body at risk when you cross Diagonal Avenue with all the cars. Well, I don't know, this is a stupid comparison, sorry.

(Martina, 22 years old, 4-time egg donor)

Very few egg donors I interviewed had ever experienced private health care before they became egg donors. As I discussed in chapter 3, most of them were middle to lower class and not used to such levels of personalised care in medical settings. The young age of many of my participants at the time of the donation meant that, for most of them, the

extraction cycle was by far the longest medical intervention they ever had, with some of them even stating that it represented their first appointment ever with a gynaecologist. Additionally, in some cases, egg donation was done secretly from families, which shows how the investment in affective capital in the clinic is key in egg donors' management and engagement.

For example, Merche decided to donate eggs when she was 19 years old. She had just declined her admission to the public university because she could not afford the fees. After 5 months of looking for a job without success, she decided to do an egg donation cycle (more details on her case in chapter one). Her mom, who was raising Merche and her brother alone and had long shifts at the kitchen of a hospital, was not aware of her daughters' decision. Therefore, Merche managed the injections alone in the bathroom and hid the medication in the fridge pretending it was her allergy medication. The exhaustive care and attention from the clinic helped her to cope with it all.

It is not the same now at 26 than then at 19, I tell you that. When I found myself with the needles, in the bathroom... plus my family didn't know anything. Because maybe their mindset was not like mine. This is the first thing. And also, maybe they thought, "she is doing this for money or why is she doing that? She has other options..." or things like that. Then I hadn't said anything, and it was a bit... I found myself at 19 years old in the bathroom with the syringes and I was like "okay... what am I doing?" [laughs]. But once you do it the first time, you go getting the drift, plus during all this time your *medicas* [female doctors] are always in contact with you, they call you, you go, they also do some gynaecological appointments in the meantime. They ask you during the process how you are doing with the medication, how you are, whether you feel alright... So, there is always contact. It's not like they give you the drugs and forget about it. There is always a contact between the clinic and you.

Medical care benefits

A third taming care investment involved doing little favours to current or recent donors such as providing some medical services for free during their time as donors. As Neus, Gynaecologist and Clinic Manager, stated clinicians saw themselves as helping women from lower social strata to successfully navigate health services.

Neus: Even after [the extraction], if some donor tells you, “Oh, I need to put in an IUD, could you put it in me?” I say, “get it, get it and I will put it in”. I mean, we do... we try to make a follow-up because some of them come from some social strata that they struggle to have an appointment at the outpatient clinic and so on, and well, “so if you get to buy an IUD, we put it in you”. I mean, many times we continue with the medical service afterwards.

Irene: There is an accompanying beyond the donation itself.

Neus: If we find an altered cytology, we insist, “Have you been to the outpatient clinic? Have you been there to check it out?”. We try to perform the role of base gynaecologist while they are doing the process or....

Irene: Or between donation and donation, yes.

Neus: Now, if it's been three years since they donated and they come to me with an IUD, then maybe not, right? But while they are in the process of... we consider that they are patients and that we have to take care of them.

(Neus, Gynaecologist and Clinic Manager, and Irene, egg donation program coordinator)

Another example of these favours that clinics provide are free ultrasounds for recent egg donors. This was the case for Maria, who found herself involuntarily pregnant a month after the donation (case study in chapter three), called the clinic, and the staff offered her to come for an ultrasound for free.

Specific staff for 'Russians'

A fourth way in which this care materialises is in the resources in place for migrant donors, especially Russians who might not be proficient in Spanish or English. The clinic where I did observations had the egg donors' informed consents in four languages: Catalan, Spanish, English and Russian. That same clinic also had a specific person who was exclusively in charge to recruit and accompany Russian donors through their time in the clinic. The following field diary fragment is from the day that I went to the clinic to observe extraction surgeries and my encounters with Katia, a Ukrainian egg donor, and Masha, the clinic coordinator in charge of accompanying Russian donors (or Russian-speaking donors) in her journey through the clinic.

Notes from fieldwork diary, June 2019:

Paula (nurse) informs me that Katia, a donor, has arrived, so that I can inform her about my research and ask whether she agrees with me being in the operation room. She warns me that she is Russian and not very proficient in Spanish.

I find her alone in the waiting room. She is blond, slim, and pale. I introduce myself and I start explaining my research. At a certain point, she stops me, making me a gesture to indicate that she is not understanding. I continue much slower. I keep asking if she can follow from time to time, and she says that she is, with a rather shy smile. She finally agrees to have me in the operation room and signs the informed consent. While talking to her I find out that in fact she is not from Russia, as Paula had said, but from Ukraine. However, she lets me know that she speaks Russian. I ask whether it has been long since she came from Ukraine, assuming this is the case according to her basic level of Spanish. To my surprise, she says that she has

been in Spain for four years already. She tells me that, as she spends most of the time at home caring for her 4-year-old son, she doesn't have many chances to practice.

I ask her how she is feeling. She struggles to find the words in Spanish but finally tells me that she has "nauseas". She tells me that it is the third time that she has undergone a cycle but that she doesn't want to do it anymore: all the hormones that she must inject "scare" her. Soon, a woman with a nurse outfit enters in the waiting room. She introduces herself as Masha, a clinic coordinator who is in charge of the management of Russian patients and donors. She says something to Katia in Russian, to which she stands up and goes to the room next door to get changed for the operation.

[...]

When Katia's extraction is over, Masha enters the post-operation room, sits next to her, and starts talking in Russian. At some point, Masha tells me that she tries to be with them [Russian' donors] all the time, although she abstains from being in the surgery room, as once she fainted in the middle of an extraction. She can't stand blood. As Masha keeps talking to Katia, I wonder if this role exists in other clinics. And I wonder as well how someone like Katia ended up in the clinic. Someone who barely speaks Spanish and who, as she herself told me, barely leaves the house.

[...]

When she takes Katia downstairs to give her the last documents and the compensation, I go down with them as well. Masha is still next to her talking fast. Roser (administration staff) gives her 1,000 euros in cash in 50-euro notes inside an envelope. I see it because they make her count before putting it in her bag. Katia leaves the clinic alone. Once she has left and Masha is back to her office, I ask Roser if she knows how Katia, who doesn't really speak Spanish, ended up in the clinic. "Some Russian mafia", she says in a tone that does not sound like a joke. Then she tells me that she doesn't know, that the Russian coordinators must have contacts, and the thing of the "Russian mafia" is mentioned at least a couple more

times. She tells me as if trusting me with a secret that she also feels is strange, because sometimes they come to the clinic, “and maybe it’s been only one or two days since they have arrived from Russia”.

After some time, a young woman enters the clinic. Masha comes down again to receive her. Just like with Katia, she sticks close to her and starts talking in Russian. The new woman came to pick up the medication. In the time she is there with Masha and Roser, who gives her the bag with the drugs, the only thing that I hear her say in Spanish is “Adios” [goodbye]. I ask Masha if she would have some minutes to talk to me about her work, to which she agrees and comes down to the reception desk a bit later. I ask her how someone like Katia arrives to the clinic to donate eggs. She tells me that there are many who come “by recommendation” and that there are also networks of Russians who live in Spain to which the coordinators of the clinic inform about the clinic’s existence. I ask her if these are cultural centres. She says no, that they rather find these groups through social media. She tells me that the fact that herself (Masha) is in the clinic is a guarantee for Russian donors that everything will be alright and that the doctors will not hurt them. That of course, coming to the clinic without speaking the language and so on, many were afraid that doctors would take their organs. Again, I do not notice a hint of a joke in her voice. She also tells me that as the “economic issue” is the first reason to donate, they tell each other and come “by recommendation”.

As many clinicians told me, having Eastern European donors is a great asset for a fertility clinic. It allows them to match blond and fair eyes phenotypes which are in great demand and more difficult to cover with Spanish donors only. Having staff whose job is to exclusively establish links between Russian speaking women and the clinic is an example of how care work is an important part of the investment that egg donors require for a competitive fertility clinic.

Part of this investment in care for donors materialises in the hiring of women staff whose role is precisely to create a more calm, caring, and comforting experience. This practice is directed to reassure the donors that the risks are under control or that, as Masha

put it, no one will take their organs. This work is especially important when considering the backdrop of egg donors' experiences, who as I discussed, are usually very young, are doing the donation in secret and sometimes even in foreign country.

Space segregation

A fifth way in which clinicians claim to be caring for egg donors is through the separation of the spaces between egg donors and recipients. This practice has been increasing in the last years as many big and middle-sized clinics have opened specific centres for egg donors. Some other smaller clinics have built different waiting rooms and, in some cases, even different doors to access and leave the clinic. While some clinicians stated that separating egg donors from recipients was a way to make them both feel more comfortable and to maintain their privacy, space segregation also allows clinics to do other things. The segregation of spaces allows clinics to maintain its image of professionalism and luxury, which is challenged by the uneasy presence of donors in the waiting rooms, who often embody markers of class and age.

Gerard: Well... there are donors that I think, "if the recipient saw her, she wouldn't want her". Not physically, because she can be very cute or look very alike [to the recipient]. But because... she is very sloppy or full of piercings or... for example, smoking habits, toxics, these are not exclusion criteria. The fact that a donor smokes is not exclusive. There are donors who smoke like a chimney and so on, who are party animals, who arrive late to the appointments because they come from partying and so on... mmh... and sometimes there are recipients that you think: "wow, if the recipient saw this donor she really wouldn't want her", she thinks the donors is a perfect *bomboncito* [sweetie] who studies at Cambridge, you know? And sporty, and healthy, and so on. And it is not always like that. And sometimes there are donors that I think, "If the recipient saw her, she couldn't want her". But not

physically... I mean, she accomplishes objective medical criteria, she accomplishes them. But in terms of behaviour or... well.

Anna: Do you think this is why the contact is avoided a bit?

Gerard: Yes, the contact is avoided because of that, so that they don't judge them and so on. So, the donors don't feel uncomfortable either, so they are in a more friendly environment and so on, and so that the recipients... Well, because as the most frequent indication for the treatment is age, it is very frequent that at the waiting room people look at each other like: "you are a donor", "you are a recipient", so that no one feels uncomfortable, because it is very clear the one who is 44 years old and the one who is 19. In a waiting room, it is like you see it clearly... you would see the 19-year-old chewing gum, tobacco smelling, half sprawled in a corner and so on... I am exaggerating, but sometimes is like that, right? And the 44-year-old, I don't know, super posh and so on, reading the newspaper... and then it would notice a lot. [...] Because there are many donors that... the clinic does not want that what is seen in waiting rooms is *that*.

(Gerard, Gynaecologist)

The image of the donor who actually comes to the clinic is replaced by a blurry imaginary of a distant young woman, responsible, well-intentioned, intelligent, and healthy. Removing the donors from the central clinic is yet another strategy to remove eggs from their present and their past and to control the imaginaries of the other part in both sides.

Appealing to donors' feelings and moral obligations

Finally, both my observations and the interviews with egg donors showed how clinics try to manage egg donors by creating close relations that are imbued with moral obligations. In my observations in the clinic during the ultrasounds, for example, it was interesting to observe Valentina (Gynaecologist) talk to egg donors. While she did not give them explicit information on the progress of the cycle, she used to cheer them up by using sentences such as “you are a genius”, “you are going so well”, and referring to them as *cariño* [honey], *corazón* [heart] or joke about the small piece of gown they had to wear for the vaginal ultrasound, which covered only the front part leaving the backside naked, by calling it *faldita hawaiana* [little Hawaiian skirt].

In the Spanish context this language is usually reserved for very close affective relations and thus aims to create a sense of familiarity and intimacy. This had consequences in the way egg donors navigated their journey in the clinic. Arlet, for example, told me that when she was having her first informative appointment, the doctor almost broke into tears after receiving a call which, as she explained to Arlet, informed her that after a long time a 47-year-old patient had had a positive pregnancy test. “I don’t know if she was acting”, admitted Arlet, “but it worked”. Similarly, Alexia told me that for her last donation, the clinic had contacted her via WhatsApp to tell her that a donor had dropped out and that they needed a replacement as soon as possible. They highlighted the pain of the recipient who was already waiting for the eggs. She accepted. After the second donation was done, she kept receiving messages from the coordinator of the program three more times, which she found too persistent:

I don’t know, the insistence was a bit like... stop it, right? And I don’t know, I guess this is the thing that was more... I mean, I didn’t... I didn’t feel obligated to do it at any time or anything, everything was because I wanted, but well... Maybe I felt that the insistence was a bit too much when I had already told them no, I told them that I was going to go overseas. Which was a lie, obviously, but well... I said it because... I don’t know.

(Alexia, 21 years old, two-time egg donor)

Faced with the insistence of the clinic, Alexia finally decided to lie so they would stop texting her. The fact that she said that she was going overseas instead of saying that she did not want to do it anymore illustrated of the emotional strings attached between donors and clinics. Another example was the one of Raquel (Psychologist) who, in an illustration of their good care of donors, told me that some donors would run to hold her when they saw her in the corridor of the clinic.

They hold you and say: “This is so good, I am happy!”. And they are injecting! Right? And they say: “And you know what they told me, Raquel? They told me that from the last one [the last donation], the baby is born, he is born!”.

(Raquel, Psychologist)

The fact that the ideal of a good donor-clinic relationship is that of a donor running through the corridors to hug the psychologist gives an idea of the level of emotional involvement that is desired from donors: a donor who commits to the cause and the clinic on a personal level, whom the clinic can trust and count on if there are any problems or mishaps.

While this rapport is claimed to be intended to make the donor feel comfortable and safe, it is also used to get the donors to comply and collaborate by appealing to their empathy. Indeed, clinicians might tell donors about their problems or successes in the clinic embedding them in highly emotional narratives where, as observed, saying no might not be an easy task.

Moments of realisation

While, as I showed, many donors thought that the relationship they had with the clinic was very good, some of them also described different moments in which they felt waking

up from the comfortable universe tailored by fertility clinic. These feelings usually appeared when they got the chance to see the reaction of the clinic when the process failed at some point. With no aim to imply that all donors had moment of realisation at some point, in the following paragraphs I give voice to some of these bad experiences.

Diana, who started to experience a lot of pain the night after the surgery, also experienced a moment of awaking. When she called the clinic to let them know that she had a fever and that she was feeling unwell, she was told to go the check it at a public hospital:

Then, the day after, I had a fever. I called the clinics because of course, I had a bit of a fever, and they told me to go the Hospital Clinic [public hospital in Barcelona], you know? Because they didn't want to take charge. I told them that I wouldn't go, that they did it [the surgery] to me and that I was going to the clinic. I told them that I wanted the gynaecologist in the clinic to check on me. So, then they gave me antibiotic and so on. The gynaecologist that examined me was the emergencies one and of course, he didn't have anything to do with the assisted reproduction unit³⁴, and he was like shocked, you know? Like a bit "well, this can be... you can have an ovarian torsion, you know?". I mean... that I could have problems afterwards, right? So, I think they [the clinicians] did it [the extraction] quite rough, I don't know.

(Diana, 24 years old, one-time egg donor)

The story of Diana brings to attention another interesting private/public dynamic generated by private fertility clinic. When there are complications derived from the treatment that require a wider check-ups or hospitalisation, patients are told to attend instead a public hospital. So, while the procedure and the benefits of the cycles are performed and distributed within the private fertility clinic, the costs of health

³⁴ The fertility clinic to which Diana attended was adhered to a private hospital, which was where she was sent after her refusal to go to the emergencies of the public hospital.

complications are usually assumed by the public health system. As different clinicians told me, this was the case not only with egg donors, but also with fertility patients, who very usually required further specific medical assistance derived from the risks that an IVF pregnancy to people over 40 years old inevitably implies.

In these situations, the participants often felt that the care they had received through the process was interested. As Emily explained, after having experienced a lot of pain after the extraction, she felt that the last call from the clinic checking if she was okay was insufficient:

Then I had a very bad time with the anaesthesia because it made me feel terrible. I had nauseas and I spend all day long vomiting. Then they call you, and that was the last call I received from them [smiles ironically]. It is like very pragmatic, right? While you are there, they will call you as many times as they need to, until you accomplish with your function. But once you have completed it, “I don’t know anything about you”. And that was the last call. They asked how I was feeling, if the anaesthesia was going out and... that’s it. They haven’t called me again.

(Emily, 23 years old, two-time egg donor)

Another participant, Berta (21 years old, two-time egg donors), also had a moment of realisation at the end of her second donation. The gift they offered her along with the economic compensation made her grasp the different ways her body was at work in the fertility clinic. She shared her experience during the focus group that I organised with two other participants: Alba and Lía.

Berta: I went there [to the clinic] for the last time in January. I mean, it was very surreal. They gave me the money and afterward they told me that because I had done it [the cycle] around Christmas... they gave me a voucher for free fake eyelashes.

Lidia: Oh, what are you saying?

Alba: Really?

Lidia: Together with the money, right?

Berta: I mean, they asked me if I wanted it, and I said no. And then I was like, “well, give them to me...”, but I mean...

Alba: I thought you were going to say, I don’t know, a free medical check...

Berta: A voucher... for fake eyelashes.

Alba: Nothing more feminine, do you realise?

Berta: They are there, in an envelope at home. I don’t know if it has an expiry date. [...] I haven’t even opened it, I mean, I don’t want fake eyelashes! I mean, exactly, if it was a voucher for a medical check or... I don’t know man, it doesn’t matter [they all laugh]. A spa, a voucher to go to a spa to relax. Look, this would have made more sense to me, right? After all that a donation implies. Fake eyelashes...

Alba: And well, I don’t know if it was a coincidence or not, but it is very sexist that they precisely give you this.

Berta: Exactly, yes, yes, yes. It is super sexist, it is like, “wow”, I mean...

Alba: Like, “you are a woman, you have to like fake eyelashes, for sure”.

Receiving a voucher to have fake eyelashes implanted was perceived by Berta, Alba, and Lidia as a kind of humiliation. As if the clinic was implying that they could be appealed

by what was perceived as a gendered gift implying superficiality and material interest. A sense of objectivation emerged and they felt defined in terms that pervert the narrative of the donation. Furthermore, establishing this link between the reproductive and the beauty industry (which in the case of some clinics is real)³⁵, worked to disconnect ARTs from the realm of the medical, and to reconnect it to the realm of body enhancement. If providing eggs enacted her femaleness through the body in narratives that highlighted solidarity among women, one thousand euros cash in an envelope and a voucher for fake eyelashes enact their femaleness as well but in a different way: the body is in this occasion a site for aesthetical physical enhancement to highlight femininity through beauty and materialism. Again, a sense of betrayal serves as a moment of realisation where the feelings of deep care and importance are broken. In those moments, they feel they are reminded of their position in the fertility industry.

CONCLUSIONS

In this chapter, I have proposed an ontological duality of egg donors enacted in fertility clinics. Focusing on the practices and discourses in this setting, and departing from Annemarie Mol's conceptualisation on multiplicity (2002), I have distinguished between the *biographical subject* and the *body object*. This chapter has focused on the delimitation, the selection and the taming practices of the biographical subject, for which I referred to the donor enacted as a subject with agency which will have to be contained throughout the donation process in order for the cycle to be completed. In other words, clinics aim to select a responsible biographical subject who obeys professionals' instructions throughout the process in order to make the body object accessible for the clinics' extraction purposes (see Molas and Perler 2020).

I first showed how dealing with egg donors was experienced as a troublesome and exhausting job that required dealing with women with complicated biographies. As I explained, both the imaginaries of class and race intertwined with staffs' perceptions about

³⁵ Eva Clinics, a rapidly expanding Spanish fertility group, belongs to the Grupo CC which also has plastic surgery clinics (Dorsia) that usually share establishment and part of the staff.

the donors highlight the boundaries and contours of the desirable reproducible subject. While many egg donors were labelled as disorganised, financially unstable, uneducated and with irresponsible sexual and reproductive patterns, the clinic becomes the place to transfer this “excess” of reproduction towards more desirable parents, which are usually defined in opposition to egg donors: older, middle-upper class, educated, and responsible in terms of family planning.

Second, I focused on the selection practices of the biographical subject stressing the role of the clinical psychologist in the recruitment of egg donors perceived as reliable and therefore, likely to bring the donation cycle to completion. Here again, I showed how the delimitation of the responsible subject was imbued with ideas of class and race, social life, alimentation habits, and sexual and reproductive patterns. Psychologists argued that the motivation of egg donors in this context is an important indicator of their obedience and performance during the treatment, as altruistic egg donors are usually read as higher class than donors who do the donation motivated by the money they will receive.

Third, I highlighted that despite the efforts of clinicians to assess the level of responsibility and commitment of a donor, biographical subjects are always perceived at risk to abandon the process or causing cancellations due to maladministration of medication. Therefore, clinics have taming techniques in place to assure donors will continue to the end of the process.

The techniques described can be separated in two groups, those directed to *control* egg donors and those directed to *care* for them and therefore prevent from dropping out. In the first group, I described the strategy of having a fast first screening which preferably includes some test without immediate results to “hook” donors from the beginning of the process. I also highlighted the different ways of coercing them with the economic compensation, which involved both threatening them with not paying a part or the whole sum or even with the idea that they might have to reimburse the clinic for tests, appointments, and drugs should they want to drop out for non-medical reasons. I also described how the routinisation of the use of Whatsapp allows for different kinds of control. Finally, I also described how clinics control donors with the medication itself.

Clinics might prescribe a more expensive medication which substituted six days of injection for only one shot to desirable donors perceived at risk of mis-administrating the medication.

The second group of taming techniques relied on the caring for egg donors. I first discussed the strategy to appoint women staff on the frontline to treat and deal with egg donors with the aim to create an environment of security and trust. Consequently, female affective care converts into financial capital and profit for clinics. Second, I demonstrated how another taming caring technique used in clinics occurs through keeping continuous communication with donors, which especially helps those who are very young and who are doing it in secret from their families. Third, I highlighted how providing little favours in the form of medical care benefits while they are in the process of the donation or in between donations is common and is part of a gift relationship that will be later asked to be reciprocated. Fourth, I showed that another way to invest in care for donors implies having specific staff to attend the large number of donors who come from Russia and who, therefore, might not be proficient in Catalan or Spanish. Fifth, I explained how the segregation of spaces between donors and recipients is increasingly used in clinics to both make donors comfortable and to maintain the image of professionalism that is allegedly challenged by the donors' markers of class and age. Finally, an issue that includes all the techniques explored, I shed light on the ways in which clinics create close affective relations with egg donors that allow them to generate certain moral obligations. On a last note, I highlighted the experiences of some egg donors that felt that these relations of care got broken at some point, revealing their place in the fertility industry.

In conclusion, this chapter has highlighted how clinics understand donors as *biographical subjects* touched by instability at different levels who will have to be carefully selected and tamed to make the extraction cycle work. These taming techniques include both methods of control and coercion as well as a significant investment in affective capital to make donors feel at ease and cared for. These complex relationships of control but also care and mutuality are built through discourses, contracts, technologies, and substances. In the following chapter, I will focus on the donor enacted as *body object*, selected for its capacity to reproduce health standards and desirable phenotypes.

CHAPTER 5: LABELLING OVA: TAMING GENES AND RACE

INTRODUCTION

Selecting bodies able to reproduce desirable health standards is an obligation for clinics according to the Spanish law on assisted reproduction (Law 14/2006). However, the legislation is rather vague when it comes to explain what it is exactly that clinicians should be screening for. More specifically, the law states that donors have to be “in good psychophysical health” and that IVF clinics have to ensure that donors “do not suffer from genetic or infectious hereditary diseases transmissible to the offspring” (Law 14/2006). However, the questions of what “good” psychophysical health is, what the “transmissible diseases” are, and what counts as disease all remain unanswered. Rather, the law states that this screening will be done “according to the state of the art of science and the existing techniques at the moment of its realisation” (Law 14/2006, p. 5). Amid these blurry rules and definitions, this chapter explores how clinicians select bodies to take part in egg donation programs. As I show, while clinicians aim to base their decision on scientific criteria that helps them transform donors into objective stable categories, this process is always contested and shaped by social and cultural norms, and as I demonstrate, also by commercial ones. As Wahlberg and Gammeltoft (2018) claim, selective reproductive technologies “are shaped by cultural values and social norms around notions of what ‘high quality’ or ‘good quality’” is (p. 8), rather than by ‘objective’ medical criteria.

The guidelines which regulate this screening have been agreed by the SEF, which published recommendations for clinics in 2007 (Matorras Weinig and Hernández 2007). In order to guarantee that the donors are in good psychophysical health the SEF states that clinics should screen the donor's blood group and Rhesus factor (Rh), test for Hepatitis B, Hepatitis C, and HIV, and conduct a clinical examination to detect toxoplasmosis, rubella, herpes virus, and cytomegalovirus. They should also undergo tests for *Neisseria gonorrhoeae* and *Chlamydia trachomatis* (Matorras Weinig and Hernández 2007, p. 353). In the same document, the SEF states that clinicians should check that the family and the personal health history has no “genetic diseases or history of cardiovascular diseases, blindness, severe arthritis, youth diabetes, alcoholism, schizophrenia, depression, epilepsy, Alzheimer diseases, etc.” (Matorras Weinig and Hernández 2007, p. 353).

How imaginaries of social class and race affect the notions of the hereditary and transmissible when clinicians try to trace the boundaries between the ‘biological’ and the ‘social’ has been discussed by Laura Perler and myself elsewhere (Molas and Perler 2020). Similarly to these earlier findings, in this chapter I explore genetic carriers’ testing and the selection and management of donors’ phenotypes. This examination provides an illustrative example of what Sarah Franklin (2013) has termed ‘technological ambivalence’. By this concept, she describes the contradiction that ARTs generate when, intending to reproduce the ‘natural’ order (i.e., normative) they need to undertake a number of choreographies that precisely reveal the ‘unnatural’ social norms and the cultural charge they are imbued with. Indeed, while at first sight the aim of IVF might be to produce a pregnancy that results in a born baby, fertility clinic endeavours go beyond combining of eggs and sperm in a petri dish and animate a large range of sociocultural imaginaries about reproduction.

Starting from an understanding of egg cells as ‘bio-objects’ (Holmberg et al. 2011), in this chapter I am concerned with the difficult process of contention and standardisation of the egg donors genetic and phenotypical condition of egg donors in order to control their eggs’ capabilities and future outcomes. This process of ‘bio-identification’, to use a term from Holmberg et al. (2011), has the aim of standardizing the genetic and racial past of ova in databases, which inevitably involves a twofold task: assigning new identities to

eggs as well as erasing past affective entanglements, so that they can be distributed and commercialised as purified neutral materials (Théry 2009).

In this chapter, I first focus on the means, the challenges, and the consequences of the routinization of the genetic carriers' test for egg donors. I show how the entanglements between vague guidelines, the market forces of competition between labs, and the commercial dynamics of the global circulation of eggs are leading towards specific approaches to reproductive selection. Second, I shed light on how egg donors are transformed into phenotype samples for fertility clinics' egg banks, which try to assert certain futures to intending parents by controlling and stabilising donors' racial pasts. I claim that in this context, 'phenotype matching' inevitably leads to a constant negotiation of what 'resemblance' means in a process that is racializing by definition. Finally, I focus on the mechanisms in place to tame the *body object*. I stress how the body object is managed as a site restricted to medical expertise with whom clinicians establish an intimate conversation that is not translated to the *biographical subject*. The role of the donors at this point is to obey clinicians' instructions for a smooth and trouble-free cycle.

After having discussed in the previous chapter the importance of egg donors' biographies in the selection process, my goal in this chapter is to highlight how they are afterwards enacted as *body objects*. I argue that clinicians manage these body objects with the goal to extract ova that can be converted into objective categories. The forms of discipline, control, and containment of the body that this process entails will leave the biographical subject out of the conversation.

GENETIC CARRIERS' TEST

The genetic carriers' test in egg donation was standardised and routinized in Spanish fertility clinics around 2015, along with their expansion and affordability (Field notes). The logics and consequences the tests results bring to the selection of egg donor varies across clinics. These differences across clinics are due to the ambiguity in the current law

on assisted reproduction. In the following paragraphs, I discuss the problems and challenges that the normalisation of these tests brought to private fertility clinics in Spain.

As explained in more detail in the context chapter, one of the main innovations the current Spanish law (Law 14/2006) on assisted reproduction introduced was that it anticipated the proliferation of new techniques due to scientific progress, which would be accounted in the law automatically. The law states that the psychophysical condition of the donors will be assessed through: “a mandatory protocol of donors’ screening which will include phenotypical characteristics and the necessary analytical results to prove, *according to the state of the art of science and the existing techniques at the moment of its realisation*, that donors do not suffer from genetic, hereditary, or infectious diseases to the offspring” (Law 14/2006, p. 5-6 [emphasis added]). The current law leaves the screening techniques open to technoscientific advances. In relation to the genetic testing, this means that in practice implies it is the expanding market of genetic tests, and not the fertility clinics, who are defining what should be observed.

The genetic carriers’ test allows clinics to know the recessive diseases that intending donors carry to later use this information for the matching process with the intending father or sperm donor. However, this genetic test also entails the possibility to discover pathologies that might appear later in life or information with unclear diagnoses, which means that scientific knowledge cannot determine whether a disease is associated it or not. The implications of this fact will be unpacked later in the section “Discarded donors, future patients?”.

The selection protocol of genetic carriers’ diseases announced in the law in 2006, however, was not enacted until mid-2019, when the first guideline was published by the SEF (Abellán-García et al. 2019). The document explains basic concepts of genetics and carrier diseases and establishes guidelines for clinics to proceed. My fieldwork, however, was conducted in the months just before the publishing of this document, so I cannot comment on the degree to which the report may have changed clinical practices.

Instead, in this section, I focus on the different problems that these tests generate for both clinics and egg donors. I first focus on the different understandings of how carriers' genetic tests should be used in assisted reproduction. Second, I demonstrate how the new marketing options of egg shipping abroad unintentionally are leading to a non-risk approach in which 'clean(er)' eggs become more easily marketable. Third, I pay attention to the feelings of disorientation shared by many practitioners who feel they lack the knowledge to make sense of the rapid novelties these tests introduce. And finally, I outline the usually neglected consequences of the routinization of these tests among egg donors, which result in new subjectivities and responsibilities.

Discarding genetic diseases: avoiding eugenics versus market dynamics

It is not about eradicating cystic fibrosis from society, okay? Instead, it is about avoiding that if both the man and the donor are carriers, the son is sick. But if a donor is a carrier but the man is not, I mean, that child will not be sick. The child will only be a carrier like the donor, and she is healthy, or the man, and he is healthy. I mean, it is about avoiding that the disease appears, not about discarding this girl because she is carrying this disease.

(Virginia, Biologist, and egg donation program coordinator)

We are strict in the sense that if she [the donor] is a carrier of any important mutation we don't accept her. And I know that there are other clinics where they accept them and they do the matching with the recipient, and if the recipient is not carrying congenital deafness, they assign the donor anyway. We wouldn't accept a donor with congenital deafness.

Anna: Just in case? Because even if the couple doesn't have it there are possibilities that the offspring...?

Aina: No, no. That first generation would be carriers at most, but for the following, if that baby is carrier of the mutation and gets together with another person who is carrier of the mutation, they have 25% chance of having a sick baby by that mutation, a baby that is born with deafness. Well, we are quite... We do it quite well in this regard.

Anna: And what about other more common things such as cystic fibrosis and so on, would that be the same or would it depend?

Aina: We would not accept them for sure.

(Aina, Gynaecologist)

As the quotes make clear, amid the grey lines and dilemmas genetic tests generate, different clinics were observed to perform in different ways. While most clinicians stated that the aim of the test was not to eliminate diseases from the population, which many see as a form of eugenics, but to give birth to "healthy children", others asserted their ethics by precisely being stricter with carriers of high prevalence diseases such as cystic fibrosis and congenital deafness. Discarding them would presumably protect not only the present generation of intending parents but also the future ones. While the latter is an open statement in favour of eugenics, the former underpins an interesting rationality in which, although eliminating the disease is unthinkable and unethical, the birth of someone affected by the disease is so as well. This, therefore, implicitly means that the offspring of those carriers as well as their partners would have to successively undergo the genetic carriers' test (and maybe IVF to undergo preimplantation genetic diagnosis [PGD]) to avoid the birth of a potentially affected child in each generation. Like Virginia, other clinicians carefully avoided associations of their practice with eugenics. This notion represents a serious taboo especially within the European context, where it brings imaginaries of the disastrous consequences of the Second World War (Wade 2012;

Wahlberg and Gammeltoft 2018). However, as I will discuss throughout, moral dilemmas in genetic selection are resolved instead by market dynamics.

Regardless of Aina's statement, it was obvious that for most clinics there was no point in discarding donors carrying prevalent genetic diseases, because this would imply discarding a high number of donors who could be used by careful matching them with the sperm provider. However, different factors made the stock of 'clean(er) egg donors' very valuable. On the one hand, because while all donors are nowadays required to undergo the genetic carriers test, intending fathers have the option not to have it done, which makes the treatment a bit cheaper. This makes clinics classify their donors as "apt" (for donors carrying no or very uncommon genetic diseases), "apt with matching" (for carriers of prevalent genetic diseases) or "non-apt" (for carriers of transmissible genetic diseases – usually those who need only one copy of the mutated gene for the offspring to be affected³⁶) (Field observations).

A couple might then prefer to save the money knowing that in the case they choose not to undergo the test, the clinic would assign a 'clean(er)' egg donor, that is, a donor without the most prevalent diseases in that population group. In this regard, 'clean(er)' donors are more easily marketable.

Another reason for the preference or high value of 'clear(er)' egg donors lies in the expansion of egg banks that ship eggs across Europe. The different regulations regarding donor genetic selection requirements makes 'clean(er)' eggs more easily distributed across the continent. That is why I contend that although the definitions of what a healthy baby is avoid eugenic narratives, local and international market circuits place higher value to eggs with no prevalent genetic diseases. The following chart (Diagram 3) offers a visual representation of the different paths that the eggs of screened donors might take:

³⁶ This pattern of inheritance is called Autosomal Dominant and refers to when one altered copy of the gene in each cell is enough for the offspring to be affected by a genetic disorder. In some cases, an affected person inherits the condition from an affected parent. In others, the condition results from a new variant in the gene and occurs in people with no history of the disorder in their family. Some examples of this disorders are: Huntington disease, neurofibromatosis, or Marfan syndrome. (Medline Plus, 2021)

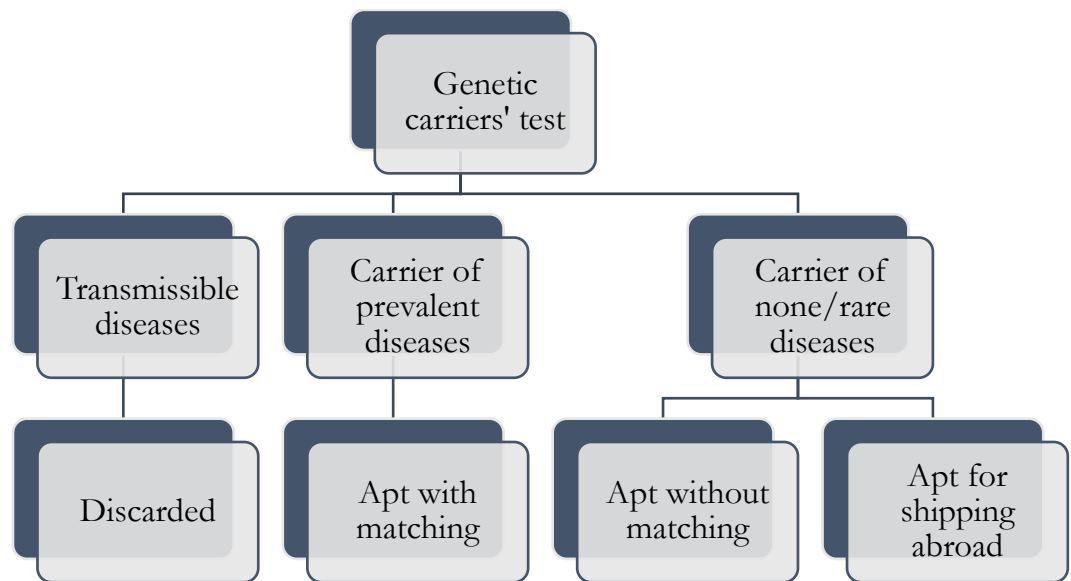


Diagram 3 - Possible classifications of donors after the results of the genetic carriers' test.

Reproduction under quality control

An important point to understand the context of clinicians when they deal with the genetic carriers' test is that most of the genetic labs performing these tests are external to the clinic. The clinics are, therefore, clients of these private labs. Criticisms of the logics and practices of genetic labs were raised by clinicians, who reported feeling trapped in both the competition between clinics and between the new genetic tests that continuously popped up. They also argued that the promises that genetic testing gave to intending parents were tricky and even unethical.

The ethical issue is: 'Well, where do we stop?'. Because nowadays there are around 7,000 and 10,000 known genetic diseases. Then, do we have to do a screening for all of them? Because of course, the tests that we do here in Spain analyse around 500 diseases. Then you will look at these 500, but what if she had the 501? Okay, then we are introducing this sensation of fake security to the progenitors. [...] We are looking at 0.5% of the possibilities, so we can't guarantee this certainty, right? This is on the one hand. On the other hand, the other debate is: and

why only [test] the donors? Why don't we do it among couples as well? Right? To see if they are compatible, and if they are not, look for a donor. Or if they are not, then do a preimplantation diagnosis to see if at the end the two abnormal genes have coincided, right? So, we move on one more step, no? Sometimes I joke with this topic and say, "at the end we will have an app in the phone that will tell us which are our genetic diseases, and we will check with who we do *matching* and with who we don't", right? Like a Tinder, these apps to flirt, and they will say "well maybe you are good for a sporadic relationship because reproducing is not really advisable, because we coincide in two or three", right? Well, it is a bit of a caricature, but we are moving on with this idea of the reproduction being almost under quality control.

(Emilio, Biologist and Bioethicist)

At the end of the day all of this... as the possibility to do it exists, the possibility is corrupted to make it a need. Because the day after tomorrow, if you have a couple and you want to have a child, you know that there is the possibility to undergo genetic testings to see if you are compatible. So, maybe in some years you will see it as a need because it will be the logical thing to do, to get genetically tested. Then at the end this is a business. And they create this need. There might be cases where this will be great because there will be couples who are not compatible or that have the risk of a disease. So, that couple that was going to have this child in a natural way, and who had a risk of the 25% to have a sick child, will end up doing an IVF cycle with a genetic diagnosis and so on. And maybe that child would have been healthy, right? They won't know. Or maybe he would have been sick, and this is f*cked up. But maybe she has a healthy baby and she has a hypoxia at labour, and he ends up worst, you know? That is why I say that at

the end you can't control it all, even if it seems like you can. And well, these are possibilities that will become needs.

(Laura, Lab Director)

The idea of having a quality assurance process for reproduction was criticized but inevitably embraced by some clinicians who tried to assert an ethical performance by trying to make clear that other bigger risks that were out of their control could also carry problems for the desired baby. Indeed, some clinicians pointed out that the highest risk IVF patients faced was not a genetic disease, but problems during pregnancy and birth, information that some believed it was necessary to give.

What happens? That all genetic tests have improved brutally in these last three, four years, and the prices are going down... very much, which means that with affordable prices you can do many tests. Afterwards it is crazy, because you never know where the limit is. And people also need to understand that even though you look at many genetic things, no one can tell you that you won't have a problem at birth and that you may have hypoxia and the child... [...] You can't make them believe that she will have zero risk of having a child with problems when unfortunately there are things that are not in our hands. We are doing IVF to people of more than 48 years old, who many times have premature births because their womb is old and doesn't work correctly. And all of this needs to be well explained. [...] Having so many tests at reach, it is also very important that we know the limits of all of this. [...] As there has been this explosion of sequencing techniques and a very big slope of the prices we don't know... we all don't know if we are doing too much, if we are doing too little... I think that nowadays we are all doing too much because we have been caught by... As always, the techniques are faster than the organization and the labelling of things, right? We are all a bit lost, but everyone is

very eager for this to be organised, right? We talk about it a lot in the congresses.

(Montse, Lab Director)

In the same line, Gerard (Gynaecologist) talked about the power that clinicians had when informing intending parents about this test. According to him, the pressure from private fertility clinics to sell more expensive IVF packages could lead to the easy manipulation of the intending parents. When I asked him if he believed that couples were well informed when choosing to undergo an extensive genetic test to both their donor and the intending father, he said the following:

You never tell any lies. My view, however, is that the truth can be seen from many different angles. I mean, you as a doctor can manipulate the patient a lot without saying any lies. It depends very much on how you present the things, okay? I mean, without saying a lie, I can say... I put an example, I can tell you “this is a disease that affects almost no one, one every 10,000”. Or I can tell you “*hostia*, I’d better do this test because *hostia*, it is 1 every 10,000, right?”. Just because of the way I say it, the answer will be “okay, okay doctor”. So just the way I say it will condition you to do it or not to do it, and in any of the cases... In both cases I said the same thing, right?

(Gerard, Gynaecologist)

Similarly, Emilio highlighted how private clinics asserted their superiority in relation to the public health system by precisely selling the presumed security generated by this test:

There is a dialectic between the public and the private, right? In a way that is not innocent, if not directly malevolent. What is the message of the private clinics? “Come with us because we will give you wider screening and you will have more security that everything will be

alright. If you go the public system, as they don't have money, they won't do this screening and then you will assume the risks". And we are talking about something that is not banal, right? We are talking about how your children will be, I mean, this is it a very important aspect, right? "Look, if you need 5,000 euros take a loan". The message is this. [...] There is a discussion... The law is ambiguous because it says that you must do all the available tests, so of course, you can do many.

(Emilio, Biologist and Bioethicist)

The routinization of the genetic carriers' test in gamete donation has placed fertility clinics in the uncomfortable position of having to make decisions without clear scientific or ethical guidelines, mainly driven by the strong competition between clinics. Amidst this confusing ground, some clinicians believe the best way to assert an ethical performance is to inform the patients properly about the real benefits and risk of the test, and of IVF more broadly. Doing this or not, however, relies on the ethics of each practitioner, or maybe more accurately, of the politics of each clinic.

DISCARDED DONORS, FUTURE PATIENTS?

As I commented before, another important aspect of the genetic carrier test is that it can determine not only the chances of having a child affected by a genetic disease, but also unintentionally discover pathologies of later appearance or information with an unclear diagnosis. The problems that such discoveries might generate for the people tested are not unique to the genetic carriers' test. Other genetic tests such as the Ancestry DNA test (Halovic 2017; Lacaze et al. 2017; Mason 2017) have generated concerns in terms of the pre and post-test information delivery practices, which have been described as particularly problematic in the context of the increasing direct-to-costumer genetic tests (Borry et al. 2011; Arribas-Ayllon 2011; Savard 2013). While I do not have data of donors who had

been informed about these discoveries, some of the participants were informed that they were carriers of prevalent genetic diseases.

‘Safer than a normal pregnancy’

Despite the obvious consequences that the test might have for intending egg donors, clinicians usually did not see that as a problem. Testing women was always seen as an opportunity for egg donors to make the right choices in the future. When a donor was discarded because she was found to be a carrier of a prevalent genetic disease, she was advised to undergo genetic counselling and potentially IVF with PGD should she want to form a family in the future. This was, for example, the view of Pablo (Gynaecologist and Clinic Manager):

The QCarrier [one brand of the genetic carriers’ test] looks for around 4,000 mutations and more than 200 recessive genetic diseases. No woman who wants to have children is doing this. Therefore, I would say that in this moment the donation... Genetically, egg donation is much safer than any other spontaneous pregnancy, this has to be very clear. Every month we have one or several young girls who are carriers of genetic diseases incompatible with the donation, and they don’t know. And we are doing them a big favour to some of them, because some of them are at risk of having children with intellectual neurological deficiency, haematological [problems], and serious diseases which we discard when they come to offer their ova. So, they take the genetic information which will be of use for their future children, because we forbid them, we tell them that they shouldn’t have children without consulting beforehand with a gynaecologist or a genetic counsellor in order to have her own children. Specially diseases tied to the X chromosome, right? Fragile X, which are diseases that have a 25% of probability of having an affected child and so on. Serious illnesses which... and all of this means that every time egg donation is

safer. And without any doubt, safer than a normal pregnancy. Everybody is a carrier of recessive genetic diseases which they don't know about, and that if they don't do the genetic analysis, which now is easy to do, they will never know. And sometimes there are Cystic Fibrosis, Retinitis Pigmentosa, Muscular Degeneration, Fragile X, neurological deficits, things that really... you know? And which will make it so that all women who have been discarded will directly benefit from this information.

(Pablo, Gynaecologist and Clinic Manager)

Creating future patients

This notion of a “benefit” reinforces the widespread idea of the importance of having a genetically “healthy baby” (Ehrich and Williams 2010) as well as the patient responsibility for this to happen. This was also understood in positive terms by many egg donors themselves, who saw in egg donation the opportunity to have information that otherwise they would have never had. Indeed, many donors valued the opportunity to undergo a “very expensive” test for free with valuable information for their future, again evoking the pleasures of temporarily accessing luxurious private health. This was the case of Stella, who was informed that she had variations associated with two diseases: Cystic fibrosis and congenital bilateral absence of the vas deferens, both labelled at high risk of transmission if the sperm provider did not have the genetic test done (1/6,452 possibilities of an affected child for the former and 1/295 for the latter).

They did a blood test to see if I had any genetic disease which could be... which could be transmitted ehm... I think they analysed 200 different pathologies or something like that. In fact, I have the documents, which they give you [she shows them to me]. You give consent and they give you the tests which... and really, they are very expensive the genetic tests. And then I had an interview with the geneticist who explained the tests to me. She said I was quite alright,

that I didn't have any disease out of the common as for not being able to donate, and said that if the day after tomorrow I want to have children, the tests could be shown to a geneticist or... because they found two pathologies, two diseases that were transmissible. Then they would only affect the child if my partner had them as well. So, they gave me the documents so that I could go the day after tomorrow if I was interested in having children, to see how to do it and solve the problem.

(Stella, 20 years old, one-time egg donor)

As Stella states, undergoing the test meant for her a new important duty in the future: “solve the problem” by visiting a genetic counsellor to have her partner tested, and maybe even undergoing IVF and PGD herself should the partner carry the same genetic disease. A new subjectivity is therefore created among donors who are discarded for genetic reasons or found to carry prevalent genetic diseases: they are women ‘genetically at risk’ (Novas and Rose 2000) of giving birth to unhealthy babies, and now that they know, they should do something about it. In other words, to put it in Rose’s (2007) terms, they become ‘pre-patients’ of the fertility and genetic medicine industry. I contend, therefore, that egg donation does not only create donors but is also able to recruit future patients of these services once they are engaged with the narratives of quality, risk prevention, and responsibility. The violence that such advice might represent in the usual contexts of financial insecurity of egg donors should also be considered.

Changing the view to observe how phenotypes are selected, managed, and classified, the next section will shed light on how race is constructed and delimited in the clinic.

'WHAT IS A CARIBBEAN?': RACE IN THE MAKING IN THE CLINIC

Notes from fieldwork diary March 2019:

Nervous and excited in equal parts, I entered the clinic for my first day of observations. My contact and interviewee was Montse, the Lab Director and Submanager of the clinic, who after our interview introduced me to the lab team on duty: two men, Joan and Hector, and a woman, Fina, all seemingly young, around 35 years old I thought.

I promised that I would not be a burden, to which they told me not to worry. Apparently, it was not a busy day. And Montse reassured me: "Don't worry, these ones like to talk, you'll see". Joan and Hector informed me that Fina loved to talk about "all these kind of issues" as apparently, she liked bioethics. And it turned out to be true. She told me she was very interested in the debates around surrogacy and altruism. She also wanted to talk about the racial categories they were using to match egg donors and recipients, because maybe I, "as an anthropologist", could assist them.

Soon a debate started in the lab after she told me that "of course, this thing of the races is actually not useful", because sometimes they didn't know how to classify people. "What is a Caribbean?" she asked me. Joan joined the discussion and they ended up having an argument about the racial category for Egyptians: "Because of course, an Egyptian is Caucasian", said Fina. "No, let's see... it is not really Caucasian, is more like Arab", Joan replied. "No, but technically they are Caucasians, like Mediterraneans, like us", went Fina.

"What do you think?", they both asked me.

Notes from fieldwork diary (later that same) March 2019:

I met Gerard in the public hospital where he worked as a Gynaecologist, a position he had just started after several years in a private fertility clinic in Barcelona. He told me early in the conversation that he now earned half of what he used to, but he would not change it for anything:

I find more sense in it now that my work does not depend on the market. I mean, I'm not selling treatments. In the private [clinic] at the end you do your doctor-work as good as you can, and medicine is done well, but you can't forget that you eat from what you do. Then sometimes your medical decisions can be a bit corrupted... It is not in my case, but it is true that at the business level you sometimes do unnecessary treatments. You overdemand diagnostic tests that generate more expenses and that are not always necessary for a process. It is a private company.

I tell him more about my research and that I love assisted reproduction because although it is a high-tech medical field, it is embedded in many deep social issues. He agrees and tells me that actually they could use an anthropologist in their unit as they face "many ethical dilemmas everyday". As an example, he tells me that very recently they had a couple from Bolivia who needed donor sperm. They could only offer them "Mexican or Colombian sperm", which in the clinic was under the same label, "Amerindians". However, he continued, for the patients there were differences, and they did not want any of them. They told the doctors that with those options on the table, they would rather have Caucasian sperm which would help with the integration of their child (who was going to live in Spain). He tells me that he empathised with the couple and that "if indeed that would help that child, why deny it?" However, another doctor apparently was absolutely against.

As these field vignettes show, matching the donor and the recipient is perceived as a challenging part of clinicians' work. Both Gerard and Fina felt that they needed of assistance to face what they perceive as "ethical challenges", which would be more suited to an "anthropologist's expertise" than their own as doctors and biologists in fertility clinics. However, this was legally their responsibility. Indeed, the Spanish law on assisted reproduction states that fertility clinics have to provide intending mothers a gamete donor who is as similar as possible to her phenotype (Law 14/2006). But who gets to decide on this matter of resemblance? What categories stand when exact matching is impossible (as it is by definition in gamete donation arrangements)? And in the middle of these grey areas, how do clinicians try to work appropriately and morally? In this section, I delve into these questions to understand how race is constructed in fertility clinics and how it materialises in egg donor selection practices.

Racist patients, moderating clinicians

As reported by the clinicians that I interviewed in the middle-sized clinics, the challenges during the matching process generated were mainly caused by the pressure put by patients who, apparently, were very concerned about this part of the process and displayed "racist" preferences. Indeed, as I showed earlier in the narratives of clinicians around the purposes of the genetic carriers' test, also when it comes to matching, the taboos around racism and eugenics reemerge provoking feelings of discomfort among the clinicians. As it has been argued, the use of the term "phenotypical" (instead of racial) represents an effort to acknowledge and avoid endorsing the racist understandings that led to past violence and discrimination. But despite the clinicians themselves, racial categories "become reanimated" (see also Bergmann 2015, p. 238; Russell 2018) in matching practice. While clinicians aimed to perform objective medical-based matchings, in their practice, they fumbled with intending parents to disentangle phenotypical screening and classification from ethnoracial imaginaries. As Thompson (2009) discussed in the context of egg donation in the US, "perceiving skin tone always involves its intersection with these other attributes and their wider meanings and histories. This means that skin color is an index of legibility whose chromatic properties are deeply relative" (p. 132). The matching,

therefore, serves “as a specific context for the fabrication of race” (Bergmann 2015, p. 239), which is enacted rather than discovered in the negotiations between patients and doctors and in the screening and selection of egg donors.

While discussing this topic with the clinicians, I usually sensed an urge to make clear that not only they were not racist, but that they made efforts for it to not be materialised in the clinic, highlighting their struggles when the recipients made unsettling demands:

So, what do our foreign egg donation patients want? Look, what they look for... and here their true intentions will become evident, right? But look, it is how it is. They want it to work fast, that the donor is pretty, and if she can be blond with blue eyes even better, regardless how the patient looks like. Even if she [the patient] is dark-haired with brown eyes like you and me, all of them want blonds with blue eyes. It is amazing. All Maghrebians suddenly are the only brunettes of their family. “Because in my family everyone is blond”, and you say, “yes sure, the world is full of Berbers, tell me another story”, right? The stereotype of the Moroccan is blond with blue eyes and 1.95 [meters], everybody knows! [...] I remember an Arab who said, “the most important thing is that she is not Jewish”, like “the donor cannot be Jewish”. Excuse me? Do the ova pray? What? “If she is Jewish, I don’t want her”. And you say, “Sure, you know what? In Spain we don’t distinguish for creed, so we don’t ask for the religion of the donor, of course”. And that was a real conversation, right? “So you don’t know if my donor is Jewish?”, she said. “Neither yours, nor any donor”, I replied. “Well, so how do we do it?” and me, “We don’t do it”. I won’t ask anyone... In Spain this is an invasion of one’s privacy, I won’t ask it.

(Ada, International Patient Coordinator)

Ada's narrative of patients demands was not an exception. In conversations with clinicians in other clinics they usually highlighted the 'racist' demands of patients. In front of this, clinicians asserted themselves as moderators ultimately aiming to stop this racism from materialising in patient-donor matching. However, and resonating with the results of other studies on matching practices in Spain and western fertility clinics (Lafuente-Funes 2017b; Homanen 2018; Moll 2019), this purpose of avoiding racism was more specially highlighted for those phenotypes classified in a category other than Caucasian that wanted to move towards a lighter phenotype. "In general people are very demanding with the donors. I mean, people want prettier people, taller, blonder, fairer, more fantastic. I mean, everybody wants at least how they are or better" (Gerard, Gynaecologist).

As Gerard makes clear, 'better' is always understood as a wish to upgrade to phenotypes associated with higher social status, which might mean different combinations in different regions of the world. Here again, Gerard highlights the pressure patients put on clinicians to maintain at least their racial status, if not 'upgrade' it. Coming back to the story he told me at the beginning of our conversation, I asked him what their final decision was with the couple from Bolivia.

She was Bolivian, then we classify the donors as Amerindians, like, American indigenous. But of course, for them it is not the same a Bolivian than a Colombian because... and it is true, they are quite different. And for them it is offensive because they say, "it is not the same, I want one from my country", so you... and the law says that within the possibilities of that moment you have to offer the most similar donor. So, if at that moment you don't have Bolivians, but you have Mexicans or Colombians, as they are considered the same ethnic group... [...]

Anna: So then, what happens when he or she expresses her desire of, "I rather take a Caucasian than a Mexican", what do you do then?

Gerard: Strictly, if at that moment you have the option, you should make matching with what is most similar to her ethnic group, you should give the same ethnic group, not what she asks for. If she says “no, no, I like Swedish”, “No, you are Amerindian, and I have Amerindians. If you don’t like it, we don’t do it”. But as they are private companies, many times... you are more flexible and you say, okay. But strictly you should adjust to the maximum to her phenotype.

Interestingly, “adjusting the maximum to her phenotype” in this context represents enabling certain kind of movements while denying others. In the case presented by Gerard, a couple from Bolivia was directed to Mexican and Colombian donors when Bolivian donors with indigenous features were lacking. However, moving to a donor classified as Caucasian was only considered if they did not have any other American Indigenous donors. This means that while the move from Bolivia to Mexico and Colombia was perceived as quasi-equal, the move from Bolivia to Swedish was perceived as a means to allow racism and eugenics. ‘Amerindian’ in this context becomes a social status category rather than a phenotypical one, while whiteness appears as a resource of power to be protected under the pretext of preventing the racism of those more “racially” marginal. The access to this resource, however, is mediated by a private-public dynamic, in which, as Gerard states, patients from private clinics will benefit from more flexibility in their demands.

Protecting whiteness and avoiding unthinkable matches

As it has been reported, the goal of phenotypical matching is to produce ‘plausible’ babies (Thompson 2009) for intending parents, or as Peter Wade puts it, children with ‘race-kinship congruity’ (Wade 2012). In other words, the aim is to give birth to children able to ‘pass’ as biological relatives of the intending families (Bergmann 2014, 2012b). This is a matter that is especially salient for heterosexual couples, who have the chance to pass as a “normal” family. The quest for resemblance is therefore a quest for the freedom to

keep the donation secret if they wish to, without being confronted by the more than likely 'resemblance talk' (Becker et al. 2005) that usually takes place when a baby is born. However, resemblance is always understood as something much wider than the phenotype. As Joan Bestard (2004) states, through kinship we "relate people to other people and we build the idea of community, we relate bodies to other bodies to each other and we build the idea of resemblance, we connect ancestors and offspring, and we establish genealogies"³⁷ (p. 13). Similarly, as Diana Marre and Joan Bestard (2009) put it, "it is a way of constructing relations in a network of already existing relatives, a way of placing the new body into the group of the family body and constructing the new individual body as a family member" (p. 65).

The ideas of what is inheritable transcends scientific understandings to embrace a range of other imaginaries related to a symbolical belonging to a shared thick past. As Laura Mamo (2005) puts it, "[t]his construction of relatedness is not based solely on biogenetic ties nor is it based on social ties. Here, biology and sociality are mobilised to create shared ancestry and the similarities and histories that embodies" (p. 254). An example of the notions that phenotypical matching mobilises is also visible in Michal Nahman's (2013) examination of how the Israel-Palestinian conflict materialises in the fertility clinic. As she notes, in rejecting the origin of certain eggs and selecting others, "borders and national selves are made and unmade" (p. 127).

According to the clinicians, in the case of Spanish recipients, this intertwinement was especially visible in their rejection of donors from Latin America. Although the narratives of these patients are that of rejecting donors from certain countries in an aim to assure the continuation of their white lineage, I contend that the colonial imaginaries associated with Latin American women also play a role in their rejection. As we will see in the following quote, even if the donors are white, the perception of a 'Latino' thread remains tangible.

I have to say that it is curious, and it is a topic to study from the sociological point of view, that Spanish, and Catalans inside the

³⁷ Original text in Spanish, translated by the author.

Spanish, they don't accept donors from other countries. I mean, non-European countries, because I almost don't have European donors. I can have some French who is... working here, some Italian, but this is not common, okay? Donors are either from here or from Latin America, some girls from northern Europe... well Northern... from Russia, Ukraine... but I have to say that we don't specialise in these countries, okay? I tell you this because there are clinics where you go and all of them are from Russia or from Ukraine. It is not our case, okay? Here basically there are Spanish, and when they are not Spanish, there are many who are from Latin America. Venezuela... Venezuela is a country which is easier for patients to accept, but Spanish don't, okay? Colombia, Brazil, it depends, because in Brazil there is a lot of diversity, right? Argentina, okay? Chile it depends, okay? Then, what is really hard is Ecuador, Honduras, El Salvador, Venezuela... not to mention Dominican Republic, okay? Because Dominican Republic has a lot of mulata population, black... so the patients from here they don't accept it. Maybe the African patients, because they know that there are no African donors... [...]

Anna: Till what point you need to say it? Let's imagine that you have a donor from Brazil, Argentina or Ecuador with white ancestors?

Virginia: I say it. Because of course, she is from Ecuador, I can see her very white, but I don't know what she has behind.

(Virginia, Biologist and egg donation program coordinator)

As Virginia clearly puts it, even if displaying whiteness, the ancestral past of donors from Latin American countries is perceived as a threat to the future of recipient patients. In this context, as Gerard makes clear, the fear of patients to downgrade their racial status becomes their own fear as professionals, which set the precautions they will take.

For example, there are clinics who don't want South American donors from some countries. No one wants indigenous South American donors. No one wants Bolivians, no one wants Peruvians. No one. Even the Peruvian recipients, the Bolivians, they want an Argentinian or Venezuelan donor. This is interesting.

Anna: It is! Tell me more about this please.

Gerard: Donors... I mean, for example, a Spanish recipient doesn't want a Latin donor under any circumstance. No matter how amazingly pretty or white-skinned she is. Because... if she has possibilities of having ancestors like grandparents and so on who are very brown, they don't want them. So, you are a Spanish recipient, I give you a donor who is super white, very cute... exactly like you but Argentinean, then they don't want her. Because they say, "Maybe her uncle is from Brazil" and so on, so they are concerned that they will have a black baby, right? These are stupid things, but it is very important. Then ethnic backgrounds, for example, depending on what clinics, if you go "I want to be a donor" and you are clearly Amerindian Bolivian, like indigenous, they say "thanks, but no". [...] It is not that they will be discarded, right? But many times, clinics have a surplus of that because there is less demand. So, in general there is more demand of white donors with fair eyes and so on... in this country.

(Gerard, Gynaecologist)

The meaning of 'downgrading' from a Spanish recipient point of view is well understood by clinicians, who are familiar (and embedded with) local recipients' racial imaginaries and 'affective assemblages' (Kroløkke 2014b) and therefore, know what to avoid. But this becomes more difficult with recipients from other countries and ethnic backgrounds. Indeed, as many clinicians highlighted, working in gamete donation made them learn about 'interracial racism'.

There was a patient recently... [laughs] a black woman who told me... I said, “would you mind if your donor is mulata?”, “but please, as long as she is not islander, okay? They are very lazy” [laughs] of course, then there is the interracial racism, not from the white to all the rest, which is what we are used to, but that the Japanese don’t want Chinese, that Chinese don’t want anything that is not Chinese, that the black is like “be careful from what country you bring her”... you say *hostias*, of course here we are not used to other types of racism.

(Ada, International Patient Coordinator)

Of course, the same way we notice the blond and the brunette they notice... the black tone from Nigeria and the black tone from Senegal. Which is different, one is darker than the other. And one is taller, and the others are shorter... but we don’t know so much. I am learning that African high lineage people they won’t accept anything that is not from their region and so on, so of course, they go looking [further] because here it is very complicated.

(Neus, Gynaecologist)

Interestingly, performing ‘ethically’ in these practices will imply telling the recipients the truth when an exact ethnic match cannot be done, which usually will be informing and negotiating over which traits the recipients is willing to ‘downgrade’ and which to prioritise. This negotiation shows once again the ‘race in the making’ or ‘racialisation’ that the matching process inevitably entails.

We have problem specially with mixed race. Of course. You start to pull out, what about your father? Your grandpa? Your uncle? Your children? Of course, you cannot risk it because you think... from both sides. You think, okay, mixed race with what? With an Indian? A

Chinese? With a Maghrebi? With a Hindu? I mean... It is a bit complicated this topic. To try to see how you do it in order not to f*ck it up.

(Paula, Nurse)

Underpinning the argument I have made so far, we see how Paula mixes territories (Maghreb), religions (Hindu), and nationalities (Indian and Chinese) when explaining the difficulties of achieving racial certainty on 'mixed-raced' donors. Although again she framed her performance as aiming to prevent racism, this 'interracial racism' expertise will be required in order not to 'f*ck it up' and make unthinkable matches.

Race as a market driven assemblage?

Interestingly, while the narratives of patients are labelled as racist, the consequences they have in the selection protocols of clinics are not. Instead, they are considered effects of a society with racial prejudices combined with the market dynamic, a definition that evoked the concept of 'liberal eugenics' (Braun 2007; Rose 2007). With a business approach in mind, clinics will put their efforts in the selection of donors that have possibilities to make a match with the patients and that, therefore, imply benefits for the clinic.

At the end of the day, it is a source of income for them, and therefore they want to be donors. The thing is that if we don't have compatible recipients, then to what point are we interested in making the studies? You know? This happens sometimes, a donor comes, and you say "well, when we have a compatible recipient, we will let you know and make you the tests", because at the end of the day doing all the screening of the donor is an economic investment for the clinic, it costs money. If she will not have an outlet, you won't take her.

(Laura, Lab Director)

Along the same line, Irene (egg donation program coordinator) and Neus (Gynaecologist and Clinic Manager) reveal their purpose of having a good sampling of all kinds of phenotypes so that they can accept a diverse range of patients.

Irene: We have a bank so... if a phenotype appears through the door...

Neus: If an oriental shows up we automatically freeze her. That is, rare phenotypes, a red-haired with green eyes. We freeze her automatically, or... a blond with blue eyes who... usually they start the treatment straight away, but if in that moment there is not a blond blue-eyed recipient, we freeze her. We always freeze unusual phenotypes.

Irene: I believe that we have some... some vitrification of all phenotypes.

Neus: A sampling.

The way the doctor puts it (“we automatically freeze her”) provides a good example of how donors are read through multiple gazes once they are in the clinic. In the fast scanning of an intending donor with valuable phenotypes, she is directly pictured as frozen eggs in their bank filling a phenotypical gap. Their ability to select and tame egg donors as *biographical subjects* will determine whether this goal is achieved or not. Their statement also highlights how the selection criteria appears to be more flexible with “rare phenotypes”. Along the same line, Magalí further explicitly explains how the phenotypical desirability of donors will have effects on the kind of treatment received in the clinic, reinforcing the findings from chapter three in relation to women’s racial biocapital.

Of course, everything depends on what you look for because... I don’t know, for example you have many... with many donors we would freeze it all. Because what happens? That maybe you always have the typical Spanish Caucasians, brown, a bit like you. White skin, brown hair, brown eyes or... you know? And of course, if the recipient is

Swedish with blue eyes and almost white hair, you are interested in donors like this. Then what you do is that when a girl shows up to be informed and she is different than the ones you usually to have, you are crazy for her to stay. You give her coffee; you give her whatever she wants [laughs]. It is true. Or for example, you have a recipient who is black. And there are not many black donors, at least here. Then... or B negatives, which are rare blood types. If a girl comes and you say, "do you know your blood type?", "B negative", we already glance at each other [laughs]. It is like "this one comes home with us!". This is what is done.

(Magalí, Biologist)

Similar to what Daisy Deomampo (2019) found in the context of egg donation in the United States, Magalí statement makes clear that the matching dynamics in fertility clinics do not only enact race, but also concede capital value to eggs because of their presumed racial transmissible capabilities. Within this narrative, again it is not the clinicians or the clinic who are 'racist' but the market dynamics to which they depend on, which puts value to certain racial imaginaries and labels others as surplus or waste.

The obligatory nature of the phenotypical matching between recipients and donors reveals how race is not a stable category and that any ideas around the concept of resemblance will always be contested by different actors across different regions of the world. With the principle of protecting whiteness and avoiding patients to 'downgrade' to phenotypes associated with lower social status (a notion that is always local and contextual), clinicians find themselves in the position of becoming experts in racial anxieties between people around the world with the aim to achieve patient satisfaction without crossing 'unthinkable' boundaries. The fertility clinic becomes therefore a site of negotiation, contestation and ultimately, reproduction of racial tensions.

CONTAINING THE BODY

If in the last sections I discussed the problems of trying to assign women and eggs in stable categories, in this next section I focus on the way clinicians deal with egg donors' bodies — that is, with the donor enacted as a *body object*. The *body object* is understood in the clinic as a site restricted to medical expertise. Once the *biographical subject* has been selected and contained, doctors start their intimate conversation with egg donors' bodies in order to achieve a successful egg retrieval. These bodies, however, are not understood as lifeless matter. On the contrary, they are understood as organisms with agency which the doctors will have to 'get to know' in order to treat effectively. Indeed, for this taming process, doctors will have to discipline the 'natural' raw potential of the body through stimulative medication, monitor its reactions through ultrasound controls, and contain or correct any misbalance in this tense equilibrium between optimization and risk control (see Molas and Perler 2020).

In this subsection, I discuss how the body object becomes a site restricted to medical expertise where egg donors as *biographical subjects* will not have access. I also unpack how risk control is approached by clinicians. Finally, I focus on a specific example of body contention through the implementation of gonadotropin-releasing hormone (GnRH) antagonist drugs, and how this substance becomes both a tool for optimization, risk control, and relaxation for clinicians in fertility clinics.

Silent controls

As I mentioned before, it was common that Claudia, the gynaecologist who did all the ultrasound controls I could observe, used words such as “cariño” [could be translated as *dear*] or “corazón” [could be translated as *sweetheart*] to talk to donors when they were in the consultation room. One of the things that struck me the most was that in these controls, where the doctor conducted a vaginal ultrasound to check the evolution of the stimulation process, usually happened in silence. When donors asked how it was going, she would usually answer with single words such as: “Super!”. During those observations

I saw how, for example, Claudia decided that a donor had to change the medication plan they had prescribed her at the beginning of the cycle without explaining to the donor the reason why. Or how she found a cyst when doing the control, and even if she then wrote this down in the computer to take it into account for the surgery³⁸, she would not tell the donor what she had seen. When I asked her about it, she told me that it was a normal effect of the medication and that it would probably go away in the following days. However, she did not tell me why she would not explain the same to the donor.

Giving no detailed medical information during the cycle was common practice among the different clinicians I interviewed. The rationale for not doing so were entangled with the realities they found in the clinic among egg donors. When asked, many of them assured me that there was no bad faith in withholding information. The issue seemed to be more related to the presumable uselessness of explaining these technicalities to donors, most of whom, according to them, were basically interested in the money and did not care so much about the medical process. In some of their explanations it seemed clear that it was also about not ‘bugging the donors’ (as I unpacked in chapter four) with complicated explanations when they perceived their aim was to get the money as smoothly and fast as possible.

I think that one of the things that you have to care about the most in an egg donation cycle is the donor. Because she is exposed to everything and is suffering everything for nothing. I mean, not for nothing, for the money, but they are not aware that we are putting all the hormones and so on. I mean, theoretically you explain to her that there is no study to date that proves that these hormones are related to any kind of cancer, you have to explain it a little, but there are many donors who are not even interested in that, I mean, they want what they want so... It is like “I come, and it is already hard for me to come to this control as to have you explaining nonsenses about what the

³⁸ As explained by the doctor, the formation of a cyst in the ovaries during a stimulation cycle was not uncommon and usually not dangerous, as it will usually disappear on its own after the extraction. However, it was important to take them into account in order to avoid puncturing them during the extraction surgery, which could provoke an excess of bleeding.

hormones do or don't do or whatever", you know? It depends. It depends a bit on the type of patient – you will explain a bit more or a bit less. How the cycle is going, what you are trying to do, how she will respond, and so on.

(Eva, Gynaecologist)

Indeed, as I discussed before, the perception of the donor as someone who had a low reproductive health literacy and who was mainly interested in the money was widespread across clinics and was confirmed in some of the interviews and observations I did with both donors and clinicians. However, I contend that other reasons not related to the comfort of a particular egg donor also played a role. The fear of them dropping out if the process became tiresome (for having to engage with too much expert information) or worrying (if they were informed that they had a cyst or that the medication was not having the expected effect) were also reasons why these encounters between doctors and donors always lasted the least time possible.

Clinicians, therefore, tame the *body object* with the drugs itself, through which they attempt to find an equilibrium between optimisation and risk control. Both edges of this tension are equally important and can be translated in financial gain or loss. As I will outline in the next subsection, taking an 'ecological approach' is labelled as desirable by a clinic manager, who made evident the gaze towards the donor as an object of extraction and highlights the importance of having a long-term perspective.

An "ecological" approach to egg harvesting

Neus: Let's see, our standard is that the donors do not leave bloated like a balloon and that if she wants, she can donate again. We prefer two donations rather than one donation of 50 ova that will leave you... So, for us, the standard is between 10 and 15, as if it was one IVF. I know that there are clinics where they drug them to get 50 or 30, because you can do it, but these girls cannot walk for a week after the

donation, if there are no complications... Of course, there are more surgical complications, these are more vascular ovaries, there are more risks of haemorrhage, I mean, you take more risks in everything of course. Obviously, the benefit is very high, but we try that donors leave the same way they entered. I mean, with two ovaries and without much pain. This means not taking them to the limit.

Irene: They all feel quite well when they leave, you see them... The other day, I saw one when she was leaving, and she said, "I didn't expect that I would feel so well".

Neus: This is our philosophy until we can stand it. If egg banks start to... it is like anything else, right? Sardine fishing... I don't want to be... you know? But it is like anything else. If we despoil the seas, at the end we won't have fish anymore, so it is a bit the same... In this aspect we are kind of ecological... The donor isn't... the donor is a luxury, right? She is a luxury patient, not an egg machine.

Neus (Gynaecologist and Clinic Manager) and Irene (egg donation program coordinator).

Controlling egg donors' bodies, therefore, is not just a risk control measure, but also a project in optimisation in the long term. The 'ecological' approach, clearly stated by Neus but also referred in other ways by professionals in other clinics, makes clear that having a low-risk policy is also a sustainable way to persuade donors to repeat. Along with the efforts to invest in affective capital that I discussed in chapter four, minimising risks is seen as a patient satisfaction measure which should return the investment in the form of a second cycle.

The way to assure this control is mostly done through the medication itself. In the following paragraph, I focus on the use of gonadotropin-releasing hormone (GnRH) antagonist drugs. However, other forms of control were done through contraceptive pills (cycle control by the clinic), antibiotics (administered through pills or as a prophylactic

right before the surgery to avoid any infections), or anxiety pills (prescribed in some centres to be take the night before the extraction to assure a good night's sleep and an adequate response to the sedation administrated the day of the surgery).

Antagonists

Probably one of the drug developments that resulted in the biggest change for the egg donation industry was the use of the antagonists. Scientifically known as Gonadotropin-releasing hormone antagonists (GnRH), these are a class of medications usually administered during the late-follicular phase in ovarian stimulation treatments to prevent a premature rise in serum luteinizing hormone (LH) levels and a premature ovulation (Tarlantzis et al. 2006). As different doctors stated, their discovery and implementation resulted in a drastic improvement of the functioning of fertility clinics given their ability to reduce the chances of hyperstimulation syndrome. According to Montse, this allowed doctors to increase medication at a much lower level of risk of hyperstimulation:

Of course, doctors push them more, they push them more without fear. Before pushing them was “Oh, I’ve crossed the line!” I’ve crossed the line means that she has reacted a lot with this dose that I gave her, right? Yes, I think now doctors they are much more... well, they live much more relaxed. Because that was a constant worry. I mean, I don’t even want to talk or think about how we would be in here with the number of donors we have, because we would have constant donors with low hyperstimulation. It would be constant. Instead, now... we don’t even talk about it, right? It is something that has gone down to history.

(Montse, Lab Director)

Indeed, the advancement of IVF drugs has allowed a more relaxed way of working for clinics, which have seen one of the most important risks of eggs donation, ovarian hyperstimulation syndrome, drop to imperceptible levels. In this fragment Montse

provides a very eloquent example of the sociotechnical dimension of the advancements in medicine in IVF. A drug with the availability to restrain the body to hyper react to the stimulation medication becomes a tool for clinics to “push them more without fear” and for doctors to “live much more relaxed”. GnRH antagonists become in this way, a tool of optimisation, risk control, and relaxation for doctors in fertility clinics.

CONCLUSIONS

Delving deeper into the argument on the ontological duality of egg donors in fertility clinics started in chapter four, this chapter has focused on the delimitation, the selection, and the taming practices of the donor as a *body object*, for which I referred to the donor enacted as an object of extraction which, nevertheless, has agency that will have to be contained.

First, I explored the way in which the genetic carriers’ test is managed in fertility clinics. I argued that the law stating that clinics should screen according to the current state of science and the techniques available is problematic, as it gives license and justification to a highly profitable relationship between clinics and genetic labs. According to my observation, the genetic screening of egg donors results in the higher valuation of those eggs carrying non- or non-prevalent genetic diseases. Second, I explored the consequences that the results of the genetic carriers’ test have for egg donors. Relying on fieldwork examples, I explained how undergoing this test can create new subjectivities and responsibilities when prevalent genetic diseases are found. The effects that come with the routinisation of this test need to be considered in any discussion on information, risk perception, and informed consent.

Third, I explored how the phenotypical matching is navigated in the fertility clinic, where I documented the concerns of clinics’ staff who are divided between the patients demands and their aim to prevent racism in matching practices. I discussed, on the one hand, how in the search of the similarity mandated by the law, certain kind of choreographies are allowed while some others are denied. I argued that this process makes

obvious the special protection around whiteness and the ethnoracial imaginaries that are at stake when deciding which eggs can be used for the matching process. I claimed that the phenotypical matching practices convert the fertility clinic into a site of negotiation, contestation, and reproduction of racial tensions.

Finally, I described the taming techniques in place to contain the *body object* in order to achieve successful egg donation cycles. Here, I explained how the body of donors is understood as a site restricted to medical expertise. Doctors will get to know and start an intimate conversation with donors' anatomies that will not be translated to the biographical subject. In this sense, I first discussed the rationalities behind not giving details to donors about the course of the cycle, where I detected an aim to make the whole process fast and worry-free. Following the same line, another taming method was observed in the rationalities of clinicians on how much to trigger donors' bodies during the stimulation process, where an 'ecological' ethics was endorsed in order to increase the possibilities of the donors to repeat a cycle. Lastly, I focused on the narratives around the revolution that the implementation of gonadotropin-releasing hormone (GnRH) antagonists represented for the Spanish fertility industry. With the ability to reduce to a minimum the possibility of hyperstimulation in donors, the drugs are at the same time a method of body regulation, a means of optimisation, and a source of relaxation for doctors, who no longer need to stress so much about donors' bodily reactions.

In conclusion, in this chapter I have highlighted how clinics understand donors as *body objects* which will have to be properly selected and carefully tamed for a successful IVF cycle. In doing so, I have focused on the difficult process of contention and standardisation of donor eggs' genetic and phenotypic condition that are in place to control their capabilities and future outcomes. The impossibility of standardising any of those categories has brought relevant information on the social issues that are imbued in any selective reproductive technology. In this context, I have shown how these selection practices ultimately reproduce racial imaginaries and ideas of quality assurance. In the following chapter, I will provide a discussion of the main findings and implications of the thesis in the light of the sociotechnical imaginaries about the future of fertility clinics evoked by practitioners.

CONCLUSIONS

The increasing value of donated eggs for the growth of the fertility industry worldwide has led to specific systems that attempt to automatise its availability, production, and extraction from bioavailable women. Ontologically constructed through different interests and desires, donated eggs are at the same time substances of hope for people seeking to create families, promissory bio-objects for fertility clinics, and temporary economic relief for young women, who, if passing the standards of clinics, can put their bodily functions at the disposition of the industry. The ways in which these desires are orchestrated to effectively operate in the egg donation bioeconomy in Spain has been the object of this research.

In this thesis, I have argued that egg donation is a fragile process that needs a series of careful methods in place for it to effectively work. It is fragile in the sense that it can fail at any time and that, therefore, it needs to be monitored and controlled throughout all its steps for a successful outcome. The image of the industry at the public level, the selection of egg donors, their behaviour throughout the process, the reaction of their bodies, the quality of the extracted eggs, and its proper categorisation are all crucial aspects for the functioning of fertility clinics. The focus of this research has been the operability process of egg donors and eggs. I asked: How are bodies stabilized for extraction purposes in the Spanish reproductive bioeconomy? As I have argued, these methods of containment of women go beyond fertility clinics and operate both at the structural level – where institutional discourses, socio-economic factors, and regulations converge – and

at the micro level of clinical practices – through the relationships established between clinicians, donors, and their bodies during the process.

I described these different methods of control as a process of *taming* (Arregui 2020), which has allowed me to offer a new approach to the relations between donors and clinics, moving away from a perspective of top-down discipline from clinics to donors. The word *tame*, instead, highlights the more complex interaction between the two, accounting not only for the dynamics of control and coercion but also of care, reciprocity, and mutuality. In this thesis, therefore, I have acknowledged the power imbalance in the clinic while still accounting for the agency of donors' minds, bodies, and eggs — donor women are perceived by clinicians as agents who contest rules, restrictions and categorisations. Taking this approach, I delineated the multilevel processes that operate to ultimately achieve the stabilization of donors for their eggs' entry to the global bio-market circuits.

This thesis has drawn on the points of view and experience of both egg donors and clinicians. This polyvocal approach has revealed the needs, struggles, and expectations of both and how they were orchestrated to fuel the egg donation bioeconomy in Spain. For this research, I have undertaken a multi-sited ethnographic approach with its main centre in the city of Barcelona, where I have carried out interviews with (intending) egg donors (25) and professionals working in assisted reproduction (25) across different fertility clinics (6). I have also undertaken (negotiated interactive) observations in a fertility clinic.

In the two first chapters, I targeted the role of information delivery, institutional discourses, and socioeconomic backgrounds on women's rationalities to donate eggs. In the first one, I focused on women's decision-making process, while in the second, I captured issues related to risk perception and imaginaries around the donation. In the third chapter, I provided a detailed account of the actual labour that donorship implies in opposition to the discourses that label it as a 'natural' process that is only slightly pushed by the hormonal medication. In the fourth and fifth chapters, I moved towards the perspectives of clinicians, and I discussed how the selection and management of egg donors is organised to both contain and align them with the clinics' extraction purposes. Here I showed how egg donors' biographical backgrounds, socioeconomic contexts, and

countries of origin are read as providing hints of their overall behaviour during the process, which will determine the taming methods that will be used. While in the fourth chapter I focused on how donors are selected and tamed as *biographical subjects* – that is, as subjects with agency and ability to negotiate and contest – in the fifth I centred on how the donor is enacted as a *body object* – that is, as a site of extractability whose genetic and phenotypical information will have to be standardised into stable categories.

This conclusions chapter discusses the main findings of this thesis together with its broader contributions to the field. The socio-political implications of the empirical results will be discussed in my epilogue of the thesis, featuring the imaginaries of clinicians about the future of reproduction.

A FIELD WITHOUT COMMUNITY: EGG DONORS AND DISPARITY OF KNOWLEDGES

There are very few things that sustain the identity of ‘egg donors’. One of the things that generates this identity instability is the fact that egg donation has a specific limited temporality that prevents women from donating eggs throughout all their lives. In Spain, for example, women can only donate when they are between 18 and 35 years old, although many clinics reduce this age to 29 years old (field observations). For this reason, egg donation, is usually one more activity that women undertake to obtain some extra money, but not the only one and the creation of an identity as an egg donor is brief and transitory.

The existence of such subjectivity is produced and fragile. The aim of doing ethnography with ‘egg donors’ is therefore in itself illusory, for which I claim that this field of study is *a field without community*. Unlike other ethnographic research field sites, where there is a physical or virtual place where the researcher can go to explore how meanings and experiences have been constructed collectively by a group or groups of people, egg donors rarely know many other women who have undergone the process. In this sense, although women who initiate the so-called “egg donation process” are subject to similar practices and discourses, the way they will make sense of them will be related

to their own background, reproductive literacy, the knowledge about the reproductive industry they have, their age, their cultural capital, and other aspects of their personal life paths. Asking “Who are the egg donors?” or “What do they think?” from identity frameworks, therefore, carries the risk of exoticizing the people who participate in these processes.

In this thesis, I have concluded that the individualisation of the experiences and understandings of egg donors is not innocent. It is shaped, instead, by mechanisms that go beyond fertility clinics themselves but that nevertheless benefit their activity. Most notably is the stigma related to embodied labour and money, which makes many women keep the donation secret even from their families in fear that they would judge their aims and interests in money. The legal framework of egg donation as altruistic reinforces this stigma and encourages women to build narratives around their acts that reaffirm their gendered responsibilities of care while at the same time generates feelings of guilt when they feel their motivations for the donation do not align with social expectations. The moral weight of this dichotomy between altruism and economic interest was obvious in my interviews with egg donors, who usually came ready to answer the question that they thought would interest me the most: whether they did it for money or for altruism.

The function of framing third-party reproductive participation under this dichotomy and its effects upon the subjectification of egg donors and surrogates has been documented by many researchers to date (e.g., Almeling 2011; Pande 2014; Rudrappa and Collins 2015; Jacobson 2016; Lafuente-Funes 2017b; Hovav 2019). These studies agree with the fact that this discourse is related to the production of compliant, docile workers with limited margin for negotiations, as their work is defined as emanating from their ‘natural’ female inclinations towards the caring of others. Contesting the conditions in which these exchanges happen implies questioning the noble intentions in which, in theory, they had when entering in the clinic in the first place. However, as the interviews with egg donors went on and beyond the question of motivation, several other topics emerged, some of which they had never thought about before.

The knowledge around how the medical process worked, the risks it implied, the number of eggs that were extracted, to whom or where the eggs would go once outside their bodies and so on, varied to a large extent from woman to woman. Any enquiries in relation to their motivations to undergo the process, therefore, revealed more about the particular imaginaries on which their experience was built than in any valorisation of the systems in place in fertility clinics nor the current dynamics of global bio-markets through which their eggs circulated. For this reason, I argue that egg donors should not be seen as independent agents containing the truth or the legitimisation of the egg donation industry. Instead, they are inserted in a network of knowledges, expert discourses, desires, experiences, and structural conditions that co-produce their subjectivity, which is not stable, but rather subject to changes throughout the course of their lives.

In the first and second chapter of this thesis, I have claimed that egg donors' decision-making process is shaped by these different knowledges and discourses that ultimately produce certain kinds of imaginaries about what egg donation is and does. In the first chapter, I have argued that egg donors can be considered clinical labourers in the sense that Cooper and Waldby (2014) proposed. For most of them, the entry to the reproductive bioeconomy is determined by a context of instability and precarity that expands across different levels, and where the boundaries between clinical labour and other kinds of precarious labour (inside or at the margins of the labour market) are blurry. For many of them, egg donation was a means to achieve their own goals, usually related to securing a better future for themselves in the complicated Spanish labour market.

In the second chapter, I have contended that egg donors are tamed through a particular sociotechnical imaginary about the future of their donated eggs and its recipients, which are usually believed to be one single local couple who, due to medically related infertility issues, need the donation. This idea, however, is far from the reality of current practices, where the main reason for access is age, where more than half of the egg donation treatments in Spain are directed to foreign couples, and where the eggs of a single cycle are divided, if possible, between multiple recipients.

CONCLUSIONS

I have argued that this imaginary is not so much (or not only) spread through active misinformation, but rather through a lack of information about the processes that take place after the extraction surgery – in particular, the quantity and value of their eggs in the reproductive bioeconomy markets and the possible futures they might be assigned. The anonymity framework in Spain serves this purpose in a particular way: through the legal requirement that donors, recipients, and offspring should remain anonymous, not only their identity remains obscured, but also the number of eggs extracted, the number of cycles the eggs will be used for, and their individual value in the global reproduction bioeconomy.

The information practices in fertility clinics are a means to tame egg donors in other ways: as I have showed, while the level of information received in the clinic is problematic both in terms of the content and the means through which it is delivered, other aspects are crucial to the understanding of risk perception among egg donors in Spain. Cultural capital and a certain level of maturity (which many claimed they couldn't have at the young age at which they donated eggs) were pointed out as needed to make sense of the information received. A question around temporality emerges here when we consider that a young age is a condition of participation to egg donation.

At the same time, it is precisely at a young age where women find themselves the most vulnerable in Spain, where access to the labour market is particularly limited and the wages are among the worst paid across all population groups. Moreover, it is in this moment where many women are aiming to gain some level of economic independence, either for a desire to upgrade to a more comfortable life, or because their families cannot longer sustain them. The ability for egg donors to give consent is in question when the targeted women are by definition in vulnerable positions within the Spanish context. The level of embodied risk that they already experience in their everyday lives and jobs for a limited amount of money makes egg donation appear as a valid option, and in some cases, a better one.

ACCOUNTING FOR EGG DONORS' LABOUR

Egg donation is not considered work in the official discourse in Spain. For the same reason, the payment received is not labelled as a salary. In the current law on assisted reproduction (Law 14/2006), it is defined as a donation for which economic compensation is allowed. Clinics adopt this discourse not only through avoidance to frame egg donation as a job but also by describing it as a series of bodily reactions that would happen anyway during a menstruation cycle and which clinics only trigger and further facilitate. Starting from this institutional definition, in chapter three, I have contested this framework, that ultimately makes invisible the physical and emotional labour of egg donors, by providing a detailed account of what the labour of donorship actually implies for women.

Engaging with Lawrence Cohen's (2005) concepts of operability and bioavailability, I have argued that women have to undergo a number of laborious operations to make themselves bioavailable for the fertility industry. These operations concomitantly carry a subjectification process where women learn about their biocapital in the industry in relation to their physical capabilities (in particular height, weight, and phenotype), as well as how to invest it. The arrangements that women need to accommodate during the cycle include how and when to inject the medication, how to juggle the process with their other commitments, and the management of pain and bodily changes throughout the cycle. As I have claimed, they all are part of the unaccounted labour of donorship.

In this chapter, I have examined the difficulty of women to make sense of their feelings and bodily reactions. The body appears as a separate entity from the donors. As I have claimed, this separation between the subject and the body is connected to the discursive and material practices of the fertility clinics, whose selection and management techniques split the donors as *biographical subjects* and as *body objects*.

The findings of this chapter raise questions about the vulnerability of egg donors when focusing on the actual use of the economic compensation throughout the process. As I have observed, most egg donors are not interested in using the economic

compensation for the purpose for which it is conceived, such as the transport costs to go to the clinic or the salary loss for the absences throughout the treatment. Instead, most women squeeze their schedules to the maximum, avoid expenses in their visits to the clinic, and go to work the same day of the extraction to both avoid losing days of work in fear they could be fired, and to keep the whole amount of money as additional income.

CONTAINING THE CHAOS OF A SOCIAL STRATA

As I have shown in chapters four and five, while one would expect that selecting women to become egg donors would be related to selecting bodies complying with certain health standards and able to reproduce desirable phenotypes, equally or more important is to select a donor perceived to be responsible and who would obey doctors' instructions throughout the process. Centring this time on the voices of clinicians, in these chapters, I have argued that egg donors are enacted as multiple bodies in fertility clinics. Following Annemarie Mol's (2002) investigation on body ontologies, I have showed how selection and taming practices of egg donors in fertility clinics reveal the way egg donors are enacted as two different entities. On the one hand, they are enacted as *biographical subjects*; that is, the donor understood in terms of background and behaviour, and on the other, as *body objects*; that is, the donor understood in terms of extractability and of genetic and ethnoracial reproducible capabilities.

The selection of egg donors as *biographical subjects* is directed to anticipate and control the behaviour of egg donors throughout the process. Clinicians, and more specifically those at the frontline of the selection process such as administration staff and nurses, described many of their donors as disorganised and untrustworthy. They usually related these assets to their complicated socioeconomic background and their country of origin, making imaginaries of class and race to emerge strongly in this context. As they explained, their practice was challenging precisely because of the chaos that egg donors generated in the clinic when not following doctors' instructions. As I have argued, that is why clinics have a set of containment techniques to make sure that women make it until the day of the extraction. While some of these techniques imply threatening them with not paying

or with the possibility of having to reimburse the costs of the treatment, other techniques are directed to retain donors by providing personalised attention and building intimate relationships that later would create moral obligations and dynamics of reciprocity.

Here, following Andrea Whittaker's (2018) approach, I have claimed that egg donation is a form of both intimate and clinical labour. This has allowed me to account for not only control and coercion taming measures, but also for those that rely on the caring of egg donors throughout the process. These dynamic relationships of taming aim to convert the labour of egg donors into valuable bio-objects for the global reproductive bioeconomy. In chapters four and five, I have argued that clinicians and donors establish complex relationships of control but also care and mutuality that are built through discourses and contracts as well as technologies and substances.

As clinicians argued, spoiling and caring for egg donors was perceived as necessary in a context where egg donors had many clinics to choose from to undergo the donation. The level of care and patience they were willing to provide was, therefore, related to the level of desirability of each donor.

STABILISING GENETIC AND ETHNORACIAL PASTS

Finally, in chapter five, I have examined how egg cells as bio-objects are tamed to control the dangers and ambiguities their existence *ex-vivo* entails (Holmberg et al. 2011). With a focus on the genetic carriers' test and the phenotypical (or ethnoracial) screening and selection practices, I have observed how clinicians attempt to classify egg donors according to objectifiable categories in order to stabilise their heritable capabilities. I have argued that this process is needed for donated eggs to be neutralised from their pasts so that they can be commercialised as 'clean' cells that can promise specific futures. Focusing on the routinisation of the genetic carriers' test, I have observed how, even though the official discourse highlights its anti-eugenic approach where intending donors would only be screened to make sure that a particular mutation did not coincide with the sperm provider, in practice it was clear how egg donors with no prevalent diseases had more

value in the clinics, as they could be assigned to any couple and shipped abroad to other countries with different screening requirements.

Similarly, when examining the management of phenotypical matching in the clinic, I have observed that even though clinicians highlight that they want to avoid racist dynamics in the clinic, they ultimately reproduce a particular definition of race as well as racial tensions when attempting to achieve patient satisfaction. This enactment of race happens in the negotiation of what resemblance and difference means in the context of phenotypical traits. Ethnoracial pasts are therefore contained to assure certain racial futures to intending parents.

Taken together, these five chapters provide a picture of how women's biographies and reproductive capabilities are set to effectively guarantee successful egg retrievals that can promise specific genetic and ethnoracial futures and qualities. This taming is directed to control the perceived traits of a particular social and racial strata in order to smooth the process for a successful egg donation cycle. These taming methods are present: at the discursive level, where a particular framing of egg donation as altruistic and anonymous generates certain kinds of imaginaries among donors; at the level of information delivery in the clinic as well as the lack of it with the obscurement of the transnational market dynamics in which egg donation is embedded; at the level of the selection and management of egg donors biographical profiles, where different control and caring techniques will attempt to keep them in track; and at the level of their bodily reproductive capabilities, where their genetic and phenotypical information will be precariously stabilised in objectifiable categories. This process ultimately undermines the participation and labour of egg donors and makes them disappear from egg donation treatments, transforming their eggs in bio-objects ready to enter the reproductive bioeconomy circuits.

In this thesis I have shown the carefully tailored methods in place to align systems, bodies, and desires with the interests of the growing reproductive bioeconomy. The experiences of clinicians in this endeavour highlight the complications embedded in both the presence of and dependence on human subjects for the supply of raw materials. This

is a shared problem with other types of third-party reproductive/medical participation, such as surrogacy, womb transplantation, or organ donation. Clinicians' struggles were particularly evident in their hopes and expectations for the future which, they believed, would offer a more comfortable world for reproductive medicine: a world without donors.

In the epilogue of the thesis, I discuss clinicians' imaginaries about the future. Mindful of the fragility of the egg donation process and the challenges that stabilising eggs and women carry, the clinicians impatiently waited for the time where technoscientific innovation effectively removed egg donors from the equation of fertility treatments.

EPILOGUE: A WORLD WITHOUT DONORS

Emilio and I were at his office room at the university where he taught when I asked about his thoughts on the debate on anonymity of egg donation in Spain. Looking a bit bored with my question, he told me that he thought that those arguing for its release were genetic essentialists and that this was an old discussion on the table since the latest Spanish law on assisted reproduction appeared in 2006. The debate, however, was about to expire, and technology would be the way to put an end to it.

I think this debate has an expiry date. And it will be technology who will solve it, because we won't need donors anymore. In an horizon of maybe... I don't know because I don't have a crystal ball, right? But between 10 and 20 years from now, probably donors will stop being necessary, because the techniques to derive gametes from human pluripotent cells are close to success. Which means that if you don't have ovaries or testicles, it doesn't matter. They will take your cells from the skin, they will make an iPSC³⁹, they will make pluripotent stem cells, and with them they will be able to derive gametes, for example spermatozoids or oocytes, and therefore this debate will be over.

(Emilio, Biologist and Bioethicist)

³⁹ Definition of iPSC in footnote 6, p.43.

The idea that donors would no longer be necessary in a near future was invoked as a hopeful future across professionals in different clinics. In this epilogue, I argue that clinicians' hopes and desires for the future reveal their present worries and anxieties. To put an end to these concerns they only need to wait for further technoscientific advances, which should come up with the definitive solution, moving donors away from the scheme.

As I have examined throughout this thesis, dealing with donors was experienced as a tiresome burden, for which many clinicians did not feel sufficiently trained. The practices of hiring specific people (often without medical training) to deal with donors, or segregating recipients and donors in different spaces to hide donors' markers of class and maintain the professional image of the clinic, portrays the ambivalent relationship between donors and clinics – they are both necessary and troublesome. Among the systems in place to assure egg donors will bring the donation to fruition, I have portrayed how egg donors are also converted into different bodies which are selected and tamed through a series of specific sociotechnical techniques. The elevated price of the drugs and tests they undergo, and the possibility that donors simply 'disappear' in the middle of the process, positions clinicians in a place of dependence in relation to them. But most importantly, donors not only require a large investment of material and structural resources from the clinics, but they also bring with them many ethical dilemmas threatening the continuous growth of the reproductive industry. Debates on the anonymity of donors, on the late arrival of the register to control the number of donations and its outcomes, and around whether egg donors are exploited keep emerging in media from time to time (Gómez 2019; Remacha 2019; Zafra 2019; Sellés 2020; Virgili 2020).

For Emilio, the solution to the problem of donor anonymity, for example, is not at the policy level, nor within the political sphere. The solution is technoscientific, for which he and other clinicians just have to wait a bit. In this way, important issues affecting egg donors and the whole population are more broadly perceived as 'liminal', for which there is little cause for debate. The fantasised future landscape looks much more sophisticated. Such fantasies evoke a moment when clinics would finally be only for intended parents, and where professionals would be able to exercise their medical

expertise fully rather than having to deal and care for bothersome donors with complicated biographies.

AN EXPIRING SYSTEM: THE (MUCH AWAITED) ENDING OF EGG DONATION

But how does the *near* future look like? I asked my participants. According to them, everything seems to indicate that the market for eggs will further expand. In this sense, egg banks are expected to grow in number, and the practices of shipping abroad to become much more routinized and common. Some clinicians also highlighted the potential of social egg freezing as an increasingly popular technique. However, most of them were not very optimistic about its potential to solve the problems of egg availability. As Laura (Lab Director) claimed, the problem was that the motivation to undergo social egg freezing usually came at a time when women were at the limits of their oocyte quality.

The girls who are 20 and who freeze their eggs are a minority, right? The number of 20-year-old who think “maybe I will want to have children in the future, and maybe I won’t be able to”, they are very little, very little. They come from 35 onwards. So, it has already passed. Genetically and at the oocyte level you are already late. Then I think that society is pushing in this direction when instead it should push to make it easier for women to have children earlier.

(Laura, Lab Director)

The ‘improvement’ of the genetic tests, the legalisation of genomic edition of embryos as well as less invasive PGD screening, which would bring “more genetic security” (Aina, Gynaecologist), were also believed to be issues that would deeply transform assisted reproductive medicine in the short-term.

Other clinicians also pointed out that Spain soon would have to come to terms with surrogacy. The debate on legalizing surrogacy in Spain has been in the public and political agenda for several years now, with parliamentary groups sustaining diametrically opposing views (Noriega 2019; Boussarie 2021). Many clinicians in this research were in favour of making surrogacy legal.

Nevertheless, as Emilio and others stated, a much more promising and less ethically challenging future awaits in 20 to 50 years from now: a future without donors (and without surrogates as well).

EGG DONATION AS 'THE PREHISTORY OF GENETICS'

Well, and now they are going to... and you will see with this, ha! This thing of the artificial wombs and so on. This, and also, they are trying to create pluripotent cells in order to make eggs from them. Directly, right? I mean, you take a cell from anywhere that is already specific. You take it back so it can be pluripotent, and you push it to be an egg. So, you don't depend on the ovarian reserve, I mean, from the ovaries of that woman. Instead, you will be able to create an egg of hers from another cell. Well, this is where all this thing of reproduction will go at the end.

(Eva, Gynaecologist)

And where is reproduction going in the mid- to long-term? According to many clinicians as Eva, the rules of the game are about to change. The new playing board promises to finally get rid of third-party IVF participants, and with it, a big part of the current public and bioethical debates.

One of the most interesting conversations that I had on the topic was one with Pablo, Gynaecologist and Manager of a middle-sized clinic in Catalonia. After a first day

undertaking observations in the lab, I had the chance to interview him. Enthusiastic about sharing his views on the history of assisted reproduction, its current moment, and its future avenues, we talked for almost two hours. Just like Emilio, Pablo evoked a hopeful future where the “botched job” of replacing the eggs of one woman with the eggs of another one would come to an end, a practice that in the future would be seen as “the prehistory of genetics”.

The thing is that I think that the donation will last some years, I don't know if 10, 15, 20, 30, but there will be a moment in which with stem cells we won't probably need eggs to generate an embryo, but it will be these same stem cells that will generate the egg so that we can make an embryo without donation. [...] We won't need an egg bank because our reproduction clinics will have transformed, right? There will be... no doubt there will be eggs, but generated not by a donor but by a lab, right? Therefore, we won't need a woman to donate eggs anymore. [...] Imagine all this cell manipulation used in reproduction, right? This is the future of reproduction clinics in 30, 40 or 50 years. In which we will take a cell of yours, even if you are menopausal, we will transform it to an egg, okay? We will fertilise it, maybe with a sperm which does not come from a sperm bank, but from a masculine cell transformed, and from that, those eggs transformed from a stem cell and with that sperm transformed from a stem cell, which will have not come from a testicle nor an ovary, we will make an embryo. This is the future, okay? And we won't need an egg bank nor a sperm bank. Instead, reproduction clinics will be genetic banks which will transform cells. [...] Therefore, I will transmit your genetic information, which is what people want. What you want is to perpetuate your genetics. Now we are in this in between [phase] where what we are doing is a botched job, okay? By putting the genetics of another person because we are not able to transform the genetics of a cell to another one. [...] Those who will have to live in 100, 200, 300 years, they will say “these people

used to take eggs of other women to get another one pregnant”, this will be obsolete. This will be the prehistory of genetics.

(Pablo, Gynaecologist, and Clinic Manager)

According to Pablo’s futuristic perspective, the present is already an obsolete past. The present becomes then a dead time, or ‘posthumous’, following Marina Garcés (2017) conceptualisation of the ‘posthumous condition’. As Garcés states, this concept refers to “the rupture of the eternal present and the beginning of a no-time” (p. 23), “the posthumous condition is the afterwards of a death that is not our real death, but a historical death caused by the dominant discourse of our time” (p. 26)⁴⁰. Transposing her argument to my fieldwork, I content that the present time is understood in the clinic as a deferral after a death that has already been announced for years in conferences and papers. This perspective poses important problems when it comes to the present debates on the table, as the imaginary of a unique linear time make waiting for the future seems like a plausible option.

There is another fantasy tightly connected to this one: Not only will egg donors disappear from the scheme, but also surrogacy will be obsolete. The advances on artificial wombs will put an end to that discussion as well. In the last part of my interview with Pablo, Montse (Lab Director) joined us and joked about how Pablo loved to talk about these topics. “I’m sure no one so far gave you his perspective”, she laughed. “The reproduction clinics will be genetic clinics, right? Of cell cultivation and reproduction, okay? So, the same way that you sell eggs, somehow you will sell cells...” continues Pablo, to which Montse intervenes with a half-smile correcting his language, “you *distribute* eggs, you *distribute* them...”.

Pablo: So, we can all be eunuchs, we can castrate them all, right? And all menopausal, but they will still have children. Because moreover,

⁴⁰ Original book in Spanish. Fragment translated to English by the author of this thesis.

what is the issue? Surrogate mothers will exist, so you won't need to have...

Montse: The womb, they already have the womb... There is already an artificial womb. Nowadays there is a prototype of... In fact, it is not an artificial womb but for pregnancy problems at the very early stages, so they take out the baby even if it is not yet...

Pablo: All of this is on YouTube, I will look it up for you.

Montse: It is very creepy, I warn you. Because it is like a vacuum closed bag with the little one inside. So, the problem of the gestation before the lungs are developed is basically a breathing problem. Until the end of the pregnancy the lungs are not mature enough. So, what is totally unfeasible with the children born at 20 weeks is basically a breathing issue, right Pablo?

Pablo: Yes, yes. [Still looking for the video on the Internet]

Montse: So, if [the foetus] doesn't breathe properly he cannot develop the rest of the things. So, this system is... they put them in a closed vacuum bag...

Pablo: I tell you about this because from the anthropological point of view, I like it...

Anna: Of course.

Pablo: [with the video ready to show on his computer screen] You will freak out, okay? This is the experiment they made with a lamb calf, okay?

Montse: But this can be done... This is already happening, right?

Pablo: Well, but this is a first thing, but we are talking of about 50 years, right? Or 25.

Montse: No, for this you are talking much less, maybe 5 years, right? It is very developed.

Pablo: Yes, yes, but this is an experimental artificial womb, this is a lamb calf, there are many things but...

Montse: So, it is a pre-incubator.

[We start to watch the video as we keep talking. Plate 15]



Plate 15 - Frame of the YouTube video: “Desarrollan un útero artificial” [An artificial womb is developed] — <https://www.youtube.com/watch?v=0XMdAFsg4FI>

Pablo: I remember when I was working at a public hospital in Barcelona, they started to talk about... There were some comments, about the uterine transplant, okay? And getting her pregnant afterwards. There are children born like that already. I mean, you are

born without a womb, you are compatible with your mum, they take the womb from your mum, they put it to you, you get pregnant, you have children, and the same day or the day after they take it out again. If you had told me 25 years ago that there would be uterine transplants that would result in pregnancies I would have said “come on, this is impossible”, because when you do a uterine transplant, you have to give her anti-rejection medication. This anti-rejection medication is usually incompatible with the foetus.

Montse: Well, and the chemos that they are doing now to pregnant women which don't affect the little one...

Pablo: This seemed impossible but... of course. [...] like foetal surgery, okay? You take it out or you do fetoscopy. You operate it and you put it back inside, you stitch, and the pregnancy continues. This seemed impossible 50 years ago. And we are doing it. What they will do in reproduction in 50 years, I tell you, we will start from the cellular part, but we will go much further. [...]

Montse: It is very creepy. [watching the image of the lamb in the artificial womb on the screen]

Pablo: I freaked out, and I've been a gynaecologist for 30 years.

Montse: To me this image that looks like they are vacuum closed gives me the creeps... then when I look at it from the other side I think, “*Hostia* [damn it], but this is what is needed, right?”

Pablo: I can have a bag, I take the artery, the umbilical veins, I connect them to a machine that is extracorporeal, which oxygenates the blood, and I stick in liquid, I stick in nutrients, and that guy lives outside... that foetus, 4, 5, 6 weeks. Of course, if they told you that 30 years ago

you would have said, “This is impossible”, right? But no, nothing is impossible, I tell you that.

The mix of fear and excitement that Pablo and Montse expressed in our conversation was a common feeling among other clinicians. While they had been practitioners in these clinics for a long time, they were rather passive witnesses of the new technoscientific advances that were presented annually to the congresses they attended. And while the possibilities that these advances could bring, such as the end of ethical dilemmas with third-party participants, were emphasised, the drawbacks of these techniques were also highlighted. Laura (Lab Director), who was pregnant at the time of the interview, pointed out to the repercussions this could have at the business level.

So, I think, the day that artificial wombs are developed, the reproduction as we know it will change. All the obstetric complications won't exist. I wouldn't like it, okay? I think that... the thought that a machine will give birth for me... I wouldn't like it. I understand that humankind at the end needs to go through a lot of things, good and bad experiences in the cycle of life. But if you think it from the business point of view for example, there wouldn't be maternity leave, women wouldn't have problems... Of course, this would make the eyes of businessmen spark. I mean that... I don't know, I mean, you can do so many things... Biotechnology also allows this. They generate hybrids between biological tissue and nanotechnology, you know? At the end... Well, I don't even know.

(Laura, Lab Director)

Fertility clinics inhabit an imagined and fantasised future, which is clear, brighter, and better. The present is portrayed as a “botched job”, an obsolete past waiting for the technoscientific future. Therefore, debates on the liminal practices undertaken in this already dead time, such as egg donation, lack of interest and relevance.

The iPSCs application in fertility medicine resolves the problem of genetic reproduction and is expected to facilitate to a great extent fertility clinics' practices thanks to the end of the participation of donors. As in many other industries, the technoscientific innovations progressively allow to manage without the first-line employees without giving a solution to the precarious context of these flexible workers situated in a post-Fordist context. If the iPSCs prophecy becomes true, the question remains: what other niches will appear for women who, like the participants of this research, look for means to secure a better future?

The linear and unique version of the future carries with it a deterministic logic where action in the present is seen as irrelevant, as if the trajectory of events was already tangible and immutable. In opposition to this discourse, I refuse to think about this thesis as a historical report, documenting the remains of a zombie system waiting for the light of a new day to come. On the contrary, I argue that confronting this version of the story requires being able to grasp the logics and rationalities of the present to open space for further debates: what will mean to reproduce in the future? Through which discourses will be the ideas of health and security built? Who will mediate these increasingly technological conceptions and births? This space can lead us to create niches in this dead present to imagine other futures, or even better, other presents.

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APPENDIX: (INTENDING) EGG DONOR PARTICIPANTS' BIOGRAPHIES

In this appendix, I provide short biographies of the (intending) egg donors who participated in my research. I outline their situation in the two temporalities relevant to this thesis: the time they underwent egg donation cycle(s) and the time when the interview took place. All are referred to by pseudonym and they appear here in alphabetic order. I also provide a table summarising the basic information in each biography at the time they underwent the cycle.

Alba was 19 years old when she underwent an egg donation cycle. At that time, she was studying a degree in communication at the university and was living with her parents.

She was 25 years old time at the time of the interview and had recently started working in the marketing department of a business consultancy. She was living with her parents.

Alexia was 21 years old at the time of our interview and aged 20 when she underwent the first egg donation cycle. She did a second cycle a few months after the first one. She was studying for a degree in Sociology and was sharing a flat with three people.

Andrea was 29 years old at the time of the interview and 27 when she underwent two egg donation cycles (she did not finish the first one due to the low response she had to the hormonal medication). She was studying towards a degree in Business and was working as an administrator of a local newspaper. She was living with her parents.

Ángela was 22 years old at the time of the interview and 20 when she underwent her first egg donation cycle. She did a second one a year later. She was studying for a degree in Psychology and working casually as a waitress and as a hostess in events. She was sharing a flat with three other people.

Arlet was 21 years old when she underwent an egg donation cycle. She was studying for a degree in Psychology and working part-time at the dining room of a primary school, making sure the children ate and behaved properly at lunchtime. She was living with her mother and her brother.

She was 27 years old at the time of the interview and was working as a pedagogic coordinator of extracurricular English classes. She had recently moved in with her partner.

Berta was 21 years old at the time of the interview and 20 when she underwent two egg donation cycles. She was studying for her vocational degree in Pathological Anatomy and was earning an unemployment subsidy. She was sharing a flat with a friend.

Diana was 24 years old at the time of the interview and 22 when she underwent an egg donation cycle. She had recently finished her studies in Interior Design and was looking for a job. She was living with her partner.

Emily was 23 years old at the time of the interview and when she did two egg donation cycles. She was from Ecuador and has been living in Spain for more than 10 years. She was studying towards a degree in Anthropology. She was living with her parents and her brother.

Helena was 20 years old when she underwent an egg donation cycle. She was studying towards a degree in Social Education and was working part-time as a youth recreational leader. She underwent a second cycle six months later. She was living with her parents.

She was 27 years old at the time of the interview and was working in socio-educational intervention for teenagers from vulnerable milieus. She was living with her parents.

Júlia was 27 years old when she underwent an egg donation cycle. She going to night classes to get her Secondary Education degree and working full-time as a waitress in a catering company. She was living with her son and sharing the flat with another person who was renting a room.

She was 34 years old at the time of the interview. She was studying for her degree in Psychology and was earning an unemployment subsidy. She was living with her son and her daughter, and sharing the house with another person who was renting a room.

Laia was 21 years old when she underwent the first egg donation cycle. She did a second cycle shortly after, in the same clinic. She was studying for a degree in Business and for a vocational degree on Sports Education. She was occasionally working in the weekend in different jobs that included private tutor for high school students, youth recreational leader, and at a bakery. She was living with her parents.

She was 26 at the time of the interview and was living in Thailand where she was studying to become Dive Master, while working casually in different jobs. She was living with her partner, who was from Thailand.

Lidia was 20 years old when she underwent an egg donation cycle. She was studying towards a degree in Music and working casually as a music teacher once or twice a week. She was living with her partner.

She was 27 at the time of the interview and was working as a musician performing in shows and teaching in a music school. She was living in a share flat.

Lucía was 22 years old at the time of the interview and 18 when she underwent her first egg donation cycle, which was followed by three more cycles in the next three years. She was from Uruguay and had been living in Spain for more than 15 years. She was studying towards a degree in Sociology and was working part-time in a call centre as a donor recruiter for an NGO. She was living with her partner.

Maria was 34 years old at the time of the interview and 32 when she underwent an egg donation cycle. She was working as a midwife in the public sector and was living with her husband and her two sons.

Martina was 22 years old at the time of the interview and 20 when she underwent her first egg donation cycle, which was followed by 3 more cycles in two years. She was studying for a degree in Criminology and was working in the summers as a waitress in a theme park. She was sharing a flat with four friends.

Merche was 19 years old when she underwent an egg donation cycle. She was looking for a job at a store at the time, which she found at the end of her donation cycle. She was living with her brother and her mother.

She was 26 at the time of the interview. She was studying for a degree in Labour Relations. She was working part-time at a shoe shop and was living with her mother and her brother.

Mica was 22 years old at the time of the interview and when she underwent two egg donation cycles. She was from Uruguay and had been living in Spain for more than 10 years. She was studying for a vocational degree in International Commerce and was working part-time as a receptionist at a hotel. She was living with her mother, her partner, and her mother's partner.

Mireia was 22 years old when she underwent an egg donation cycle. She was studying for a degree in Farming Engineering and was working part-time as a waitress in a night club. She was sharing a flat with a friend.

She was 28 years old at the time of the interview. She was working as a farming technician. She was living by herself.

Nancy was 22 years old at the time of the interview and when she intended to undergo an egg donation cycle, for which she was discarded. She was from Peru and had been living in Spain for 9 years. She had just finished her degree in Mathematics and was working casually as a private tutor for high school students and as a waitress. She was living with her parents and her brother.

Noemí was 22 at the time of the interview and 18 when she tried to undergo an egg donation cycle, for which she was discarded. She was unemployed when she tried to become an egg donor. She was working at a make-up store at the time of the interview.

Rocío was 19 years old when she underwent her first egg donation cycle. She was studying for a vocational degree in international commerce and working in the kitchen of a fast-food pizza company. She attempted to donate again two years later but could not finish the cycle because she had a low response to the hormonal medication. She was living with her mother and her sister.

She was 28 years old at the time of the interview and was working as a coordinator at the airport for a low-cost flight company. She was married and had recently had a baby.

Sara was 19 years old when she underwent her first egg donation cycle. Two years after, she underwent a second one. She was studying and working part-time in a shoe shop. She was living with her parents.

She was 25 years old at the time of the interview. She was finishing a degree in Psychology and was doing an internship in a public employment seeking service. She was living with her partner.

Sonia was 21 years old when she underwent an egg donation cycle. She was studying for a vocational degree in Environmental Chemistry and looking for a job. She was living with her mother.

Stella was 20 years old at the time of the interview and when she underwent an egg donation cycle. She was from Argentina and had been living in Spain for 18 years. She had recently finished her vocational degree in Design and was working part-time in a call centre. She was sharing a flat with three other people.

Valentina was 21 years old and 18 when she intended to do an egg donation cycle, for which she was discarded. She was from Colombia and had been living in Spain for 11 years. She was studying towards a degree in Anthropology, for which she was receiving a stipend. She worked part-time in her uncle's business. She was living with her parents.

She was 31 years old at the time of the interview. She was voluntarily unemployed and finishing a degree in Anthropology. She was living with her daughter and her partner.

Name	Age at the interview (Age at the first donation)	Country of origin	Studying / Employment status	Highest level of education completed	Civil status	Donation cycles
Alba	25 (19)	Spain	Bachelor student	Secondary	Single	1
Alexia	21 (20)	Spain	Bachelor student	Secondary	Single	1
Andrea	29 (27)	Spain	Bachelor student / working part time	Secondary	Single	2

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Ángela	22 (20)	Spain	Bachelor student / casual worker	Secondary	Single	2
Arlet	27 (21)	Spain	Bachelor student / working part time	Secondary	Single	1
Berta	21 (20)	Spain	Vocational degree student / unemployed	Secondary	Single	2
Diana	24 (22)	Spain	Unemployed	Secondary	Single	1
Emily	23 (23)	Ecuador	Bachelor student	Secondary	Single	2
Helena	27 (20)	Spain	Bachelor student / working part time	Secondary	Single	2
Júlia	34 (27)	Spain	High school student / working full time	Primary	Single	2
Laia	26 (21)	Spain	Bachelor student / various casual jobs	Secondary	Single	2
Lidia	27 (20)	Spain	Bachelor student / casual worker	Secondary	Single	1
Lucía	22 (18)	Uruguay	Bachelor student	Secondary	Single	4
Maria	34 (32)	Spain	Working full time	Bachelor's degree	Married	1
Martina	22 (20)	Spain	Bachelor student / casual worker	Secondary	Single	4
Merche	26 (19)	Spain	Looking for a job	Secondary	Single	1
Mica	22 (22)	Uruguay	Vocational degree student / working part time	Secondary	Married	2

APPENDIX: (INTENDING) EGG DONOR PARTICIPANTS' BIOGRAPHIES

Mireia	28 (22)	Spain	Bachelor student / working part time	Secondary	Single	1
Nancy	22 (22)	Peru	Casual worker	Bachelor's degree	Single	0
Noemí	22 (18)	Spain	Unemployed	Secondary	Single	0
Rocío	28 (19)	Spain	Vocational degree student / working part time	Secondary	Single	1
Sara	25 (19)	Spain	Bachelor student / working part time	Secondary	Single	2
Sonia	21 (21)	Spain	Bachelor student / unemployed	Secondary	Single	1
Stella	20 (18)	Argentina	Vocational degree student / working part time	Secondary	Single	1
Valentina	21 (18)	Colombia	Bachelor student / working part time	Secondary	Single	0

Table 6 - (Intending) egg donor participants summary table at the time of the donation cycle(s).

ANNEXES

[SPANISH] RESUMEN

Taming egg donors es una etnografía multi-situada sobre la industria de la donación de óvulos en España. Analiza los distintos factores que influyen la decisión de las donantes de óvulos, la información en las clínicas de fertilidad, la percepción del riesgo entre donantes, el trabajo que implica la donación de óvulos y las lógicas de selección que operan en el contexto español de la reproducción asistida. En esta tesis, describo los procesos que existen a distintos niveles para lograr en última instancia la estabilización de cuerpos y óvulos para su entrada en los circuitos de los mercados reproductivos globales. Partiendo de un trabajo de campo etnográfico en Barcelona, esta tesis recoge el punto de vista y las experiencias tanto de las donantes de óvulos como de los profesionales de las clínicas de fertilidad. Este enfoque plurivocal revela las necesidades, dificultades y expectativas de los actores involucrados y cómo estos se orquestan para dar forma a la bioeconomía de la donación de óvulos en España.

El argumento principal de esta tesis es que la donación de óvulos es un proceso frágil que necesita métodos de contención cuidadosos para funcionar eficazmente. Es frágil en el sentido de que el proceso puede fallar en cualquier momento: la donante puede no seguir las pautas correctamente; los medicamentos pueden no generar el efecto esperado en el cuerpo; los riesgos no siempre se pueden contener; es posible que los óvulos extraídos no estén lo suficientemente maduros; o que los niños nacidos no cumplan con los estándares de salud esperados. Sostengo que estos métodos para modelar a las mujeres, que describo como un proceso de *taming*⁴¹, operan tanto a nivel estructural —donde convergen discursos institucionales, factores socioeconómicos y regulaciones— como a

⁴¹ La traducción literal de la palabra en inglés *tame* es domesticar o amansar. En este texto, sin embargo, he preferido mantener el término en inglés ya que las connotaciones de la traducción literal en castellano están relacionadas en su mayoría con el reino animal. Mientras este sentido lo tiene también en inglés, *tame* va más allá de este marco y abraza otros significados figurados como el de *controlar*, *educar* o *moldear* a personas o fenómenos que se rigen por sus propias normas.

nivel micro de las prácticas clínicas —a través de la construcción de relaciones específicas entre médicos, donantes y sus cuerpos.

En primer lugar, argumento que los motivos para hacerse donante de óvulos están íntimamente enlazados con el precario mercado laboral español, que hace de la donación de óvulos un recurso muy similar a tener un trabajo para mujeres jóvenes. En segundo lugar, muestro cómo la combinación del marco legal de la donación de óvulos como altruista y anónima y las prácticas informativas en las clínicas de fertilidad producen imaginarios sociotécnicos específicos entre las donantes de óvulos que, en última instancia, impiden debates sobre la justicia reproductiva y retributiva. En tercer lugar, sostengo que las clínicas de fertilidad tienen métodos de *taming* para asegurar que las donantes de óvulos lleven a cabo el proceso hasta el final. Estas técnicas se dan a nivel de selección y gestión de donantes e intentan contener posibles problemas de comportamiento durante el ciclo, así como posibles desequilibrios a nivel corporal. En cuarto lugar, describo cómo las clínicas intentan estabilizar los pasados genéticos y etnoraciales de las donantes en categorías objetivables: un proceso que revela las definiciones de salud y raza que operan en la industria de la fertilidad. Por último, sostengo que todos estos esfuerzos hacen visibles los imaginarios, las dificultades y las ansiedades de los profesionales en relación con el trabajo de tratar con donantes de óvulos, que perciben como estresante. Su incómoda presencia se hace evidente en los imaginarios sociotécnicos del personal de las clínicas de fertilidad sobre el futuro de la reproducción asistida, en el que se espera que las donantes de óvulos "desaparezcan" gracias futuras innovaciones tecnocientíficas.

En resumen, a través de estos argumentos analizo cómo se articula la industria española de la donación de óvulos para contener los imaginarios, cuerpos, biografías y óvulos de las mujeres para que estos últimos puedan moverse por los circuitos de los mercados reproductivos globales. En este sentido, esta tesis contribuye en los campos de estudio de las economías de los tejidos biológicos (*tissue economies*), trabajo reproductivo, imaginarios sociotécnicos e industrias extractivas españolas.

[SPANISH] CONCLUSIONES

El valor creciente de los óvulos para la industria de la fertilidad ha dado lugar a la implementación de sistemas que intentan automatizar su disponibilidad, su producción y su extracción en mujeres ‘biodisponibles’ (Cohen 2005). Definidos ontológicamente a partir de distintos intereses y deseos, los óvulos donados son al mismo tiempo sustancias de esperanza para las personas que buscan crear familias, bio-objetos de gran valor para las clínicas de fertilidad, y un alivio económico temporal para mujeres jóvenes, que, si pasan los criterios de selección de las clínicas, pueden poner sus cuerpos a disposición de la industria. La manera en que estos deseos se articulan para el correcto funcionamiento de la bioeconomía de la donación de óvulos en España ha sido el objeto de esta investigación.

En esta tesis he sostenido que la donación de óvulos es un proceso frágil que necesita de una serie de métodos cuidadosos para que funcione eficazmente. Es frágil en el sentido de que puede fallar en cualquier momento y que, por lo tanto, tiene que ser supervisado y controlado a lo largo de todo el proceso. Aspectos como la imagen de la industria a nivel público, la selección de las donantes de óvulos, su comportamiento a lo largo del proceso, la reacción de su cuerpo, la calidad de los óvulos extraídos y su correcta categorización son cruciales para el funcionamiento de las clínicas de fertilidad. El foco principal de esta investigación ha sido el proceso de ‘operatividad’ (Cohen 2005) de las donantes y de los óvulos, por lo que me he preguntado: ¿Cómo se estabilizan los cuerpos de las donantes para que puedan ser objeto de extracción en la bioeconomía reproductiva española? Tal y como explico en la tesis, los distintos métodos de contención de donantes van más allá de las clínicas de fertilidad y operan tanto a nivel estructural — donde confluyen discursos institucionales, factores socioeconómicos y regulaciones — como a nivel de las prácticas clínicas — a través de la construcción de ciertas relaciones entre el personal de la clínica, las donantes y sus cuerpos.

Conceptualicé estos métodos de control como un proceso de *taming*⁴² (Arregui 2020), lo que me ofreció un nuevo enfoque para observar las relaciones entre donantes y clínicas. Este nuevo enfoque me permitió, entre otras cosas, alejarme de una perspectiva de disciplina vertical (de las clínicas hacia las donantes). El término *tame*, en cambio, da paso al reconocimiento de una interacción más compleja entre ambas, dando cuenta no sólo de las dinámicas de control y coerción, sino también de las dinámicas de cuidado, reciprocidad y mutualidad. En este sentido, en esta tesis he visibilizado la desigualdad de poder en la clínica sin dejar de tener en cuenta la capacidad de acción de las donantes, sus cuerpos y sus óvulos. Tal y como he detallado en esta tesis, estos agentes son percibidos por los profesionales como actores que se oponen a las normas, las restricciones y las categorizaciones. Con este enfoque, he delineado los procesos que buscan conseguir la estabilización de las donantes para que sus óvulos puedan entrar en los circuitos globales de los mercados reproductivos.

Esta tesis se ha basado en los puntos de vista y las experiencias de donantes de óvulos y de profesionales de clínicas privadas de reproducción asistida. Este enfoque plural ha mostrado las necesidades, problemas y expectativas de ambos y la forma en que estos se orquestan para impulsar la bioeconomía de la donación de óvulos en España. Para esta investigación, llevé a cabo un trabajo de campo etnográfico multi-situado con su centro principal en la ciudad de Barcelona. Allí hice entrevistas a donantes de óvulos (25) y a profesionales en el campo de la reproducción asistida (25) que trabajaban en diferentes clínicas de fertilidad (6). También realicé observaciones en una de ellas.

En los dos primeros capítulos, observé las razones de mis participantes para donar óvulos, y vi que estaban influenciadas por la información que se da en las clínicas de fertilidad, los discursos institucionales y sus contextos socioeconómicos. En el primer capítulo, me centré en el proceso de toma de decisiones de estas mujeres, mientras que, en el segundo, me interesé por cuestiones relacionadas con la percepción del riesgo de las

⁴² La traducción literal del término en inglés *tame* es domesticar o amansar. En este texto, sin embargo, he preferido traducirlo por *moldear* o *controlar* (dejando el término en inglés entre paréntesis) o simplemente mantener el término en inglés en cursiva sin traducción. He tomado esta decisión porque las connotaciones de la traducción literal en castellano están relacionadas en su mayoría con el reino animal. Mientras este sentido lo tiene también en inglés, *tame* va más allá de este marco y abraza otros significados figurados como el de *controlar*, *educar* o *moldear* a personas o fenómenos que se rigen por sus propias normas.

donantes de óvulos y en los imaginarios en torno a la donación. En el tercer capítulo, detallé minuciosamente el trabajo que implica la donación de óvulos en contraposición a los discursos clínicos que la describen como un proceso natural (como un ciclo menstrual) ampliado ligeramente por la medicación hormonal. En el cuarto y quinto capítulo, cambié el foco central hacia el personal de las clínicas y analicé cómo se lleva a cabo la selección y la gestión de las donantes de óvulos para que puedan ser contenidas y alineadas con los fines de extracción de las clínicas. Aquí mostré cómo las clínicas leen los antecedentes biográficos de las donantes, sus contextos socioeconómicos y sus países de origen como indicios de su comportamiento durante el proceso. Esta evaluación inicial determinará los métodos de *taming* que se utilizarán en la clínica. Por un lado, en el cuarto capítulo me centré en cómo se seleccionan y moldean las donantes como *sujetos biográficos* -es decir, como sujetos con agencia y capacidad de negociación y contestación-, por otro lado, en el quinto, describí cómo se gestionan las donantes como *objetos corporales* -es decir, como terreno de extractabilidad cuya información genética y fenotípica tendrá que ser estandarizada en categorías estables para que los óvulos pueda entrar en los circuitos globales del mercado reproductivo.

En este capítulo de conclusiones analizo los hallazgos más importantes de esta tesis junto con las contribuciones que hace en el campo de estudio en el que se enmarcan. Las implicaciones sociopolíticas de los resultados se discutirán en el epílogo de la tesis, junto con una discusión alrededor de los imaginarios de los profesionales de reproducción asistida sobre el futuro de la reproducción.

Un campo sin comunidad: donantes de óvulos y disparidad de conocimientos

Hay muy pocas cosas que sostengan la identidad de las "donantes de óvulos". Una de ellas que genera la inestabilidad de esta supuesta identidad es el hecho de que la donación de óvulos tiene una temporalidad concreta que impide que se pueda donar óvulos durante toda la vida. En España, por ejemplo, sólo se puede donar entre los 18 y los 35 años, aunque muchas clínicas limitan la edad a los 29 años (observaciones de campo). Por ello,

la donación de óvulos, más que una subjetividad, suele ser una actividad entre tantas que se realiza para obtener un dinero extra.

La existencia de dicha subjetividad es fabricada y frágil. Por esta razón, el propósito de hacer etnografía con "donantes de óvulos" es en sí mismo ilusorio. En este sentido, sostengo que mi campo de estudio es *un campo sin comunidad*. A diferencia de otros campos de investigación etnográfica en los que existe un lugar físico o virtual al que el investigador puede ir para explorar el modo en que los significados y las experiencias se han construido colectivamente por un grupo de personas, las donantes de óvulos raramente conocen a otras mujeres que hayan pasado por el mismo proceso. En este sentido, aunque las personas que inician el llamado "proceso de donación de óvulos" están sometidas a prácticas y discursos similares, la forma en que les darán sentido estará relacionada con su propia formación, su conocimiento sobre reproducción y la industria reproductiva, su edad, su capital cultural y otros aspectos de sus trayectorias vitales. Por ello, preguntar ¿quiénes son las donantes de óvulos? o ¿qué piensan? desde marcos identitarios conlleva el riesgo de exotizar a las personas que participan en estos procesos.

En esta tesis he mostrado que la individualización de las experiencias y conocimientos de las donantes de óvulos no es inocente. Al contrario, esta individualización está impulsada por mecanismos que van más allá de las propias clínicas de fertilidad pero que, sin embargo, benefician su actividad. El más destacable es el estigma relacionado con el trabajo reproductivo y el dinero, que hace que muchas mujeres mantengan la donación en secreto, incluso a sus familias, por miedo a que juzguen sus objetivos e intereses económicos. El marco legal que define la donación de óvulos como altruista refuerza este estigma y anima a las mujeres a construir narrativas en torno a sus actos que reafirmen sus responsabilidades de género en materia de cuidados. Al mismo tiempo este marco genera sentimientos de culpa cuando las donantes sienten que sus motivaciones no son las esperadas. El peso moral de esta dicotomía entre altruismo y el interés económico se ha visto claramente en mis entrevistas con las participantes de esta investigación, que normalmente venían preparadas para responder a la pregunta que creían que más interesaba: si lo hacían por dinero o por altruismo.

La función de enmarcar la participación de las donantes bajo esta dicotomía, así como sus efectos en la subjetivación de las donantes de óvulos y las gestantes por sustitución (o madres de alquiler), ha sido documentada por varias investigadoras hasta la fecha (por ejemplo, Almeling 2011; Pande 2014; Rudrappa and Collins 2015; Jacobson 2016; Lafuente-Funes 2017b; Hovav 2019). Todas coinciden en el hecho de que este discurso está relacionado con la producción estratégica de trabajadoras obedientes, dóciles y con poco margen para negociar, ya que se considera que su trabajo emana de sus inclinaciones naturales como mujer hacia el cuidado de los demás. Impugnar las condiciones en las que se producen estos intercambios implica, al mismo tiempo, cuestionar las nobles intenciones con las que en teoría una decide llevar a cabo estas prácticas en primer lugar. Sin embargo, a medida que avanzaban mis entrevistas con las donantes surgían otros temas, algunos de los cuales nunca había pensado antes.

Las percepciones de otros temas como proceso médico, los riesgos de la donación de óvulos, el número de óvulos que se extraen, a quién o a dónde van a ir una vez fuera del cuerpo, entre otros, eran muy distintas de donante a donante. Fue así como me di cuenta de que investigar sus motivaciones para someterse al proceso, revelaba más cosas sobre los conocimientos particulares sobre los que se construía su experiencia que sobre su opinión en relación con el funcionamiento de la industria. En este sentido, entiendo a las participantes de esta investigación, no como agentes independientes con la verdad o la legitimación de la industria de la donación de óvulos, sino como insertadas en una red de saberes, discursos técnicos, deseos, experiencias y condiciones estructurales que determinan sus percepciones sobre el proceso, que no son siempre las mismas, sino que pueden cambiar a lo largo de su vida.

En el primer y el segundo capítulo de la tesis he afirmado que el proceso de toma de decisiones de las donantes de óvulos se basa en estos distintos conocimientos y discursos que, en última instancia, producen cierto tipo de imaginarios sobre lo que es y qué hace la donación de óvulos. En el primer capítulo, he argumentado que las donantes de óvulos pueden considerarse trabajadoras clínicas (*clinical labourers*) en el sentido que propusieron Melinda Cooper y Catherine Waldby (2014). La incorporación de la mayoría de las donantes en la bioeconomía reproductiva está determinada por un contexto de

inestabilidad y precariedad a distintos niveles de modo que las fronteras entre el trabajo clínico (*clinical labor*) y su participación en otros tipos de trabajo precario son difusos. Para muchas de ellas, la donación de óvulos es un medio para lograr sus propios objetivos, generalmente relacionados con conseguir un futuro mejor dentro del mercado laboral español.

En el segundo capítulo, he sostenido que las donantes de óvulos son moldeadas (*tamed*) a través de un imaginario sociotécnico sobre el destino que tendrán sus óvulos y sobre cómo son los receptores. Generalmente las donantes piensan que los receptores de sus óvulos son una sola pareja local que, debido a problemas médicos de infertilidad, necesitan óvulos donados. Esta idea, sin embargo, se aleja de las prácticas reales, donde el principal motivo de acceso a tratamientos con óvulos donados es la edad elevada, donde más de la mitad de los tratamientos se dirigen a parejas extranjeras, y donde a menudo se dividen los óvulos extraídos en un ciclo de estimulación entre varias receptoras.

Este imaginario no se difunde (o no solo) a través de la información en la clínica, sino más bien a través de la falta de información en relación con los procesos que tienen lugar después de la extracción. En particular, a través de la falta de información sobre el número de óvulos extraídos, a dónde van a ir a parar, y su valor monetario una vez entran en los circuitos globales de los mercados reproductivos. El anonimato de las donaciones de gametos en España contribuye a crear estas percepciones de una manera particular: a través del requisito legal de que donantes, receptores y descendencia deben permanecer en el anonimato, no solo su identidad, sino también el número de óvulos extraídos, el número de ciclos para los que se utilizarán y su valor en la bioeconomía de la reproducción permanece oculto.

Sin embargo, tal y como he mostrado en esta tesis, mientras que la calidad de información que dan las clínicas a las donantes es problemática tanto en términos del contenido como en términos de los medios en los que se entrega, otros aspectos son cruciales para entender la percepción del riesgo entre las donantes de óvulos en España. Un cierto nivel de capital cultural y de madurez (que muchas afirman que no tenían en la

temprana edad en la que donaron óvulos) aparecen como necesarios para comprender la información recibida.

Al mismo tiempo, son precisamente las mujeres jóvenes las que son más vulnerables socioeconómicamente en España, donde el acceso al mercado laboral es particularmente limitado y los salarios se encuentran entre los peor pagados de todos los grupos de población. Por último, es también en este momento en el que muchas mujeres aspiran a obtener algún nivel de independencia económica, ya sea por el deseo de tener una vida más cómoda o porque sus familias ya no pueden mantenerlas. La capacidad de las donantes de óvulos para dar su consentimiento queda en entredicho cuando vemos que se encuentran, por definición, en posiciones vulnerables en el contexto español. El nivel de riesgo que ya aceptan en sus vidas a cambio de una cantidad pequeña de dinero hace que la donación de óvulos aparezca como una opción válida y, en algunos casos, mejor que otros trabajos precarios.

Cuantificar el trabajo de las donantes de óvulos

La donación de óvulos no se considera un trabajo en el discurso oficial español. Por la misma razón, el pago recibido por ello no se considera un salario. En la ley actual de reproducción asistida (Ley 14/2006), la provisión de óvulos se define como una donación por la que se permite una compensación económica. A través de este discurso, las clínicas evitan la asociación entre la donación de óvulos y un trabajo, a la vez que la describen como una serie de reacciones corporales naturales (como las de un ciclo menstrual) que las clínicas únicamente aumentan un poco más a través de la medicación hormonal. En el capítulo tres he cuestionado esta definición, que en última instancia invisibiliza el trabajo físico y emocional de las donantes de óvulos, a partir de una descripción exhaustiva de las implicaciones del proceso.

Basándome en los conceptos de operabilidad (*operability*) y biodisponibilidad (*bioavailability*) de Lawrence Cohen (2005), en el capítulo 3 he concluido que las mujeres que entran en el proceso de donar óvulos deben llevar a cabo una serie de operaciones

laboriosas para convertirse en biodisponibles para la industria de la fertilidad. Estas operaciones conllevan un proceso de subjetivación donde las mujeres se dan cuenta de su biocapital en la industria reproductiva, el cual viene determinado por sus condiciones físicas (en particular por la altura, el peso y el fenotipo). Las gestiones que las donantes deben llevar a cabo para sobrellevar el ciclo son diversas e incluyen: decidir cuándo y cómo se va a inyectar la medicación hormonal, conciliar el ciclo con sus otros compromisos laborales o de estudios, y tolerar el dolor y las molestias provocadas por los cambios corporales a lo largo del proceso. Tal y como afirmo en la tesis, todos estos pasos son parte del trabajo no contabilizado que implica donar óvulos.

En este capítulo, he examinado también la dificultad de las mujeres para dar sentido a sus sentimientos y a sus reacciones corporales durante la donación. El cuerpo es percibido durante el proceso como una entidad separada de las donantes. Esta separación entre el sujeto y el cuerpo está relacionada con las prácticas discursivas y materiales de las clínicas de fertilidad, cuyas técnicas de selección y gestión separan a las donantes como *sujetos biográficos* y como *objetos corporales*.

Los hallazgos de este capítulo plantean preguntas sobre la vulnerabilidad de las donantes de óvulos también cuando nos fijamos en el uso que dan a la compensación económica que reciben al final del proceso. Tal y como he observado, a la mayoría de las donantes de óvulos no les interesa usar la compensación económica para la finalidad para la que está concebida, es decir, para cubrir los gastos de transporte para acudir a la clínica o la pérdida de salario por las ausencias al trabajo durante el tratamiento. Por lo contrario, la mayoría de las mujeres exprimen al máximo sus horarios, evitan tener gastos de cualquier tipo en sus visitas a la clínica, y a menudo van a trabajar el mismo día de la extracción para no perder días de trabajo por temor a ser despedidas, y para mantener la cantidad total de dinero como ingreso adicional.

Controlar el caos de un estrato social

Como he explicado en los capítulos cuatro y cinco, si bien uno podría esperar que la selección de mujeres para que se conviertan en donantes de óvulos estaría relacionada con la selección de cuerpos que cumplan con estándares de salud y sean capaces de reproducir fenotipos comercializables, igual o más importante es seleccionar donantes percibidas como responsables y obedientes. Centrándome esta vez en las perspectivas de los médicos, en estos capítulos he concluido que las donantes de óvulos se perciben como entidades duales en las clínicas de fertilidad. Siguiendo la investigación de Annemarie Mol (2002) que se interesa por las ontologías corporales en el campo de la medicina, he mostrado cómo las prácticas de selección y de *taming* de las donantes de óvulos en las clínicas de fertilidad revelan el modo en que estas son percibidas como dos entidades distintas. Por un lado, se perciben como *sujetos biográficos*; es decir, en términos de antecedentes y comportamiento. Y por otro, como *objetos corporales*; es decir, en términos de extractabilidad y de condiciones genéticas y etnoraciales.

La selección de donantes de óvulos como *sujetos biográficos* está dirigida a anticipar y controlar el comportamiento de las donantes de óvulos a lo largo del proceso. El personal de la clínica, y más específicamente, las personas que están en la primera fila del proceso de selección (como el personal de administración y las enfermeras), describen a muchas de sus donantes como desorganizadas y poco fiables. A menudo relacionan estas características con su complicado contexto socioeconómico y con su país de origen. De este modo que sus percepciones sobre las donantes como *sujetos biográficos* están marcadas por ideas raciales y de clase. Según me explicaron, el trabajo de estas profesionales era difícil precisamente por el caos que generaban las donantes de óvulos cuando no seguían las instrucciones que se les daban. Es por eso por lo que las clínicas disponen de una serie de técnicas de contención para asegurarse de que las donantes aguantarían hasta el día de la extracción. Si bien algunas de estas técnicas implican amenazarlas con no pagarles o con la posibilidad de tener que reembolsar los costes del tratamiento, otras están dirigidas a retenerlas mediante atención personalizada y construyendo relaciones íntimas con ellas que luego transformarían en obligaciones morales y dinámicas de reciprocidad.

Por ello, siguiendo el enfoque de Andrea Whittaker (2018), he afirmado que la donación de óvulos es una forma de *trabajo íntimo y clínico*. Esta óptica me ha permitido dar cuenta no solo de las medidas de control y coerción, sino también de las relaciones dinámicas de *taming* en las clínicas de fertilidad que tienen el objetivo de alinear y convertir ciertos sujetos biográficos en bio-objetos de gran valor para los mercados reproductivos. En los capítulos cuatro y cinco, he argumentado que los profesionales y las donantes establecen relaciones complejas de control, pero también de cuidado y reciprocidad que se construyen a través de discursos, contratos, tecnologías y sustancias.

En esta investigación he examinado tanto las técnicas de control como las de cuidado para que las donantes cumplan con los términos de la donación. Como me explicaron distintos profesionales, mimar y cuidar a las donantes de óvulos se ve como necesario en un contexto en el que las donantes de óvulos disponen de muchas clínicas para elegir donde realizar el proceso. El nivel de atención y paciencia que los profesionales están dispuestos a tener viene determinado por el nivel de interés que tienen en cada donante.

Estabilizar pasados genéticos y etnoraciales

Finalmente, en el capítulo cinco, he examinado cómo los óvulos como bio-objetos son moldeados (*tamed*) para controlar los peligros y ambigüedades que su existencia *ex vivo* conlleva (Holmberg et al. 2011). Centrándome en el test genético de portadores y en las prácticas de cribado y selección fenotípica (o etnoracial), he observado cómo los médicos buscan clasificar a las donantes de óvulos en categorías objetivas con tal de controlar lo que sus cuerpos pueden reproducir. He argumentado que este proceso es necesario para invisibilizar el origen de los óvulos, y poder comercializarlos como células 'limpias' que prometan futuros ciertos a los receptores. En relación con el test genético de portadores, he observado cómo, a pesar de que el discurso de la clínica intenta desmarcarse de prácticas que se asocian con la eugenesia, las dinámicas comerciales acaban dando más valor a los óvulos que no tienen ninguna enfermedad genética recesiva prevalente, ya que pueden asignarse a cualquier pareja y enviarse a países con diferentes marcos legales en materia de cribado genético.

De manera similar, al examinar las prácticas de *matching* fenotípico en la clínica observé que, a pesar de los esfuerzos de los profesionales por evitar el racismo, en la práctica, el proceso del *matching* reproduce ideas y tensiones raciales. Este aspecto se hacía evidente en las negociaciones entre profesionales y receptores sobre el significado de semejanza en el contexto de rasgos fenotípicos, que inevitablemente trae consigo los imaginarios etnoraciales asociados a distintos rasgos y lugares del mundo.

Tomados en conjunto, estos cinco capítulos ofrecen una imagen de cómo las donantes y sus capacidades reproductivas se controlan (*are tamed*) para la obtención de óvulos capaces de prometer ciertos futuros, cualidades genéticas y etnoraciales. Este proceso está dirigido a controlar los rasgos relacionados con una clase social y racial con el fin de tener ciclos de estimulación exitosos.

Estos métodos de *taming* están presentes tanto a nivel discursivo como informativo. Por un lado, la definición de la donación de óvulos como altruista y anónima trae consigo unas expectativas de comportamiento y motivación que colocan a las donantes en una posición donde es difícil negociar las condiciones de la donación. Por otro lado, la opacidad de las dinámicas del mercado transnacional de los óvulos donados, impulsada justamente por el altruismo y el anonimato, genera cierto tipo de imaginarios entre las donantes que a menudo están lejos de las prácticas comerciales actuales. Estos métodos de *taming* también están presentes a nivel de selección y gestión de las donantes, donde diferentes técnicas de control y cuidados se dirigen a hacerlas llegar hasta el final del proceso. Finalmente, vemos estos métodos también a nivel de sus condiciones biológicas. En este sentido, la información genética y fenotípica de las donantes de óvulos se intenta estabilizar en categorías objetivas y estables para que los óvulos extraídos puedan asegurar ciertos futuros. Este proceso invisibiliza la participación y el trabajo de las donantes de óvulos y las hace desaparecer de los tratamientos de reproducción.

Esta tesis ha mostrado los métodos cuidadosamente diseñados para alinear sistemas, cuerpos y deseos con los intereses de la creciente bioeconomía reproductiva. Las experiencias de los profesionales en sus intentos por conseguir este alineamiento hacen emerger las complicaciones implícitas en la presencia y dependencia de sujetos humanos

para el suministro de materias primas (en este caso los óvulos). Este es un problema que la donación de óvulos comparte con otros tipos de participación reproductiva/médica de terceros, como la gestación subrogada, el trasplante de útero, o la donación de órganos.

En el epílogo de la tesis hablo de los imaginarios sobre el futuro de la reproducción por parte de los profesionales, quienes, conscientes de la fragilidad del proceso de donación de óvulos y los desafíos que conlleva la estabilización de óvulos y mujeres, aguardan con impaciencia el momento en que la innovación tecnocientífica borre finalmente a las donantes de óvulos de la ecuación de los tratamientos de fertilidad.

[SPANISH] EPÍLOGO: UN MUNDO SIN DONANTES

Emilio (biólogo y bioético) y yo estábamos en el despacho de la universidad donde da clases cuando le pregunté su opinión en relación con el debate del anonimato en la donación de óvulos en España. Un poco aburrido por mi pregunta, me dijo que pensaba que quienes abogaban por su anulación eran esencialistas genéticos y que se trataba de un viejo debate, sobre la mesa desde que apareció la última ley española sobre reproducción asistida en 2006. El debate, sin embargo, estaba a punto de caducar, y la tecnología sería la que le pondría punto final.

Creo que este debate tiene fecha de caducidad. Y será la tecnología la que lo solucionará, porque ya no necesitaremos donantes. En un horizonte de quizás... no lo sé porque no tengo una bola de cristal, ¿no? Pero entre 10 y 20 años, probablemente las donantes dejarán de ser necesarias, porque las técnicas para derivar gametos a partir de células pluripotentes humanas están cerca del éxito. Lo que significa que, si no tienes ovarios o testículos, no importa. Te sacarán células de la piel, te harán una iPSC⁴³, fabricarán células madre pluripotentes y con ellas podrán derivar gametos, por ejemplo, espermatozoides u ovocitos, y por tanto este debate habrá terminado.

(Emili, biólogo y bioético)

La idea de que los donantes ya no serían necesarios en un futuro cercano fue evocada como una fantasía esperanzadora entre los profesionales de diferentes clínicas. En este epílogo sostengo que las esperanzas y deseos de los médicos para el futuro revelan sus preocupaciones y ansiedades presentes. Curiosamente, para poner fin a estas

⁴³ Las células madre pluripotentes inducidas (iPSCs), son un tipo de células madre pluripotentes que, junto con las células madre embrionarias (ESCs), tienen la capacidad de autorrenovación (es decir, de dividirse indefinidamente) y de pluripotencia (es decir, de diferenciarse en cualquier célula somática). A diferencia de las ESCs, las iPSCs no se derivan de la masa celular interna de los embriones previos al implante. Sino que las iPSCs se obtienen revirtiendo el proceso de diferenciación de las células somáticas adultas mediante una tecnología in vitro llamada reprogramación celular (Romito and Cobellis 2015).

preocupaciones, solo necesitan esperar más avances tecnocientíficos, que deberán dar la solución definitiva, apartando a las donantes de la ecuación.

Como se constata a lo largo de la tesis, tratar con las donantes se vive como una carga difícil para la que muchos profesionales no se sienten capacitados. La práctica de contratar personal específico (a menudo sin formación médica) para tratar con ellas, o separar receptores y donantes en diferentes espacios con el fin de ocultar los marcadores de clase de las donantes y mantener la imagen de profesionalidad de la clínica, son ejemplos de la relación ambivalente que las clínicas tienen con las donantes: necesarias y a la vez, problemáticas. Entre los métodos establecidos para asegurar que las donantes llevarán a cabo la donación, describí cómo son divididas en distintas categorías (o cuerpos) que son seleccionados y moldeados (*tamed*) a través de una serie de técnicas específicas. El precio elevado de los medicamentos y las pruebas a las que se someten y la posibilidad de que las donantes simplemente "desaparezcan" en medio del proceso, coloca a los profesionales en un lugar de dependencia con respecto a ellas. Pero lo más importante es que las donantes no solo generan una gran inversión de recursos materiales por parte de las clínicas, sino que también traen consigo varios dilemas éticos que amenazan el crecimiento de la industria reproductiva. Los debates sobre el anonimato de los donantes, la ausencia del registro para controlar el número de donaciones y sus resultados, así como las discusiones sobre la explotación de los donantes de óvulos siguen surgiendo de vez en cuando en los medios (Gómez 2019; Remacha 2019; Zafra 2019; Sellés 2020; Virgili 2020).

Para Emilio, la solución al problema del anonimato de los donantes, por ejemplo, no está a nivel político. La solución es tecnocientífica, por lo que él y el resto de los profesionales de la reproducción asistida solo tienen que esperar un poco. De esta manera, las cuestiones importantes que afectan a las donantes de óvulos y a toda la población en general se perciben como "liminales", por lo que hay pocos motivos de debate. El paisaje del futuro fantaseado se ve mucho más sofisticado. Tales fantasías evocan un momento en el que las clínicas finalmente serán solo para los futuros padres, y donde los profesionales podrán ejercer plenamente su práctica médica en lugar de tener que lidiar y cuidar a donantes molestas con biografías complicadas.

Un sistema que se acaba: el (esperado) final de la donación de óvulos

Pero ¿cómo se ve el futuro cercano? Le pregunté a mis participantes. Según ellos, todo parece apuntar a que el mercado de los óvulos se expandirá aún más. En este sentido, se espera que los bancos de óvulos aumenten en número y que las prácticas de envío al exterior se vuelvan mucho más cotidianas. Algunos médicos también subrayan el potencial de la congelación de óvulos propios como una técnica que es cada vez más popular. Sin embargo, la mayoría no se mostró muy optimista acerca de su potencial para resolver los problemas de disponibilidad de óvulos. Como afirmó Laura, directora del laboratorio, el problema es que la motivación para someterse a la congelación de óvulos propios por lo general llegaba en un momento en que las mujeres ya estaban en los límites de su calidad ovocitaria.

Las chicas de 20 años que se congelan los óvulos son una minoría, ¿no? La joven de 20 años que piensa que quizás quiero tener hijos en el futuro y no puedo, son muy pocas, muy pocas. Vienen a partir de los 35 años. Entonces ya pasó. Genéticamente y a nivel de ovocitos ya llegas tarde. Entonces creo que la sociedad intenta tirar en esta dirección cuando, en cambio, debería presionar para que sea más fácil para las mujeres tener hijos antes.

(Laura, directora de laboratorio)

Muchos también pensaban que la 'mejora' de las pruebas genéticas, la legalización de la edición genómica de los embriones, así como un DGP menos invasivo, traería “más seguridad genética” (Aina, ginecóloga), y transformarían profundamente la reproducción asistida a corto plazo.

Otros médicos también señalaron que España pronto tendría que aceptar la gestación subrogada. Esta cuestión ha estado en el debate público y político desde hace varios años, con grupos parlamentarios que sostienen puntos de vista diametralmente opuestos

(Noriega 2019; Boussarie 2021). Muchos de los profesionales que participaron en esta investigación estaban a favor de legalizarla.

Sin embargo, como afirmaron Emilio y otros, un futuro mucho más prometedor y menos desafiante a nivel ético nos aguarda en 20 a 50 años: un futuro sin donantes (y también sin madres de alquiler).

La donación de óvulos como ‘la prehistoria de la genética’

Bueno, y ahora van a... y ya verás con esto, ¡ja! Esta cosa de los úteros artificiales y demás. Esto, y también, están tratando de crear células pluripotentes para producir óvulos a partir de ellas. Directamente, ¿sabes? Quiero decir, tomas una célula de cualquier lugar que ya sea específica. La vuelves atrás para que sea pluripotente y la empujas para que sea un óvulo. Así no dependes de la reserva ovárica, quiero decir, de los ovarios de esa mujer, sino que podrás crear un óvulo suyo a partir de otra célula. Bueno, allí es donde todo esto de la reproducción irá al final.

(Eva, ginecóloga)

¿Hacia dónde va la reproducción a medio y largo plazo? Según muchos, al igual que Eva, las reglas del juego están a punto de cambiar. El nuevo tablero promete deshacerse por fin de las terceras partes en los tratamientos de FIV y, con ello, de la mayoría de los debates bioéticos actuales.

Una de las conversaciones más interesantes que tuve sobre el tema fue con Pablo, ginecólogo y director de una clínica en Cataluña. Después de un día realizando observaciones en el laboratorio, tuve la oportunidad de hacerle una entrevista. Entusiasmado por compartir su punto de vista sobre la historia de la reproducción asistida, su momento actual y su futuro, conversamos durante casi dos horas. Montse,

directora del laboratorio, se unió a nosotros en la última parte de la entrevista. Al igual que Emilio, Pablo también evocaba un futuro esperanzador donde el “trabajo chapucero” de reemplazar los óvulos de una mujer por los óvulos de otra llegaría a su fin, una práctica que en el futuro se vería como “la prehistoria de la genética”.

Es que yo creo que la donación va a durar unos años, no sé si 10, 15, 20, 30 pero habrá un momento en el que con las células madre probablemente no necesitemos óvulos para generar un embrión, sino que serán estas mismas células madre las que generarán el óvulo para que podamos tener un embrión sin donación. [...] No necesitaremos un banco de óvulos porque nuestras clínicas de reproducción se habrán transformado, ¿verdad? Habrá... sin duda habrá óvulos, pero no generados por una donante sino por un laboratorio, ¿sabes? Por lo tanto, ya no necesitaremos que una mujer done óvulos. [...] Imagina toda esta manipulación celular utilizada en reproducción, ¿no? Éste es el futuro de las clínicas de reproducción en 30, 40 o 50 años. En el que cogemos una célula tuya, aunque seas menopáusica, y la transformaremos en un óvulo, ¿vale? Lo fertilizaremos, tal vez con un espermatozoide que no provenga de un banco de esperma, sino de una célula masculina transformada, y de ahí esos óvulos transformados a partir de una célula madre y con ese esperma transformado a partir de una célula madre, que no han venido ni de un testículo ni de un ovario, haremos un embrión. Éste es el futuro, ¿vale? Y no necesitaremos un banco de óvulos ni de esperma. Sino que las clínicas de reproducción serán bancos genéticos que transformarán las células. [...] Por lo tanto, transmitiré tu información genética, que es lo que la gente quiere. Lo que quieres es perpetuar tu genética. Ahora estamos en este intermedio en el que lo que estamos haciendo es algo chapucero, ¿de acuerdo? Poniendo la genética de otra porque no somos capaces de transformar la genética de una célula en otra. [...] Los que tendrán que vivir dentro de 100, 200, 300 años, dirán “esta gente solía sacar óvulos de otras

mujeres para embarazar a otras”, esto estará obsoleto. Esto será la prehistoria de la genética.

(Pablo, ginecólogo y director de clínica)

Según Pablo el presente ya es un pasado obsoleto porque el punto desde donde observa es el futuro. El presente se convierte así en un tiempo ya muerto, o “póstumo”, siguiendo la conceptualización de Marina Garcés (2017) sobre la “condición póstuma”. Como afirma Garcés, este concepto se refiere a “la quiebra del presente eterno y la puesta en marcha de un no tiempo” (p. 23), “[l]a condición póstuma es el después de una muerte que no es nuestra muerte real, sino una muerte histórica producida por el relato dominante de nuestro tiempo” (p. 26). Transponiendo su argumento a mi trabajo de campo, sostengo que el presente se entiende en la clínica como una prórroga tras una muerte que ya ha sido anunciada desde hace años en congresos y ponencias. Esta perspectiva plantea importantes problemas a la hora de tratar los debates actuales, ya que el imaginario de un tiempo lineal único hace que la espera del futuro parezca la opción plausible. Estrechamente conectada a esta fantasía hay otra. No solo las donantes de óvulos desaparecerán del esquema, sino que también la subrogación quedará obsoleta. Los avances científicos en úteros artificiales también pondrán fin a esa discusión.

En la última parte de la entrevista, Montse (directora del laboratorio) se unió a nosotros y bromeó sobre cómo a Pablo le encantaba hablar sobre estos temas. "Estoy segura de que nadie te ha dado su perspectiva", me dijo con una sonrisa. “Las clínicas de reproducción serán clínicas genéticas, ¿no? De cultivo y reproducción celular, ¿de acuerdo? Entonces de la misma manera que vendes óvulos, de alguna manera venderás celdas...”, continúa Pablo, a lo que Montse interviene con una media sonrisa corrigiendo su lenguaje, “*distribuyes* óvulos, los *distribuyes*...”.

Pablo: Entonces podemos ser todos eunucos, podemos castrarlos a todos, ¿no? Y todas menopáusicas, pero aún así tendrán hijos. Porque, además, ¿cuál es el problema? La madre de alquiler existirá, por lo que no necesitarás tener...

Montse: El útero, ya tienen el útero... Ya hay un útero artificial. Hoy en día existe un prototipo de... De hecho, no es un útero artificial sino para problemas de embarazo en etapas muy tempranas, por lo que sacan al bebé, aunque aún no esté...

Pablo: Todo esto está en YouTube, te lo busco.

Montse: Da mucha angustia, ¿eh? Porque es como una bolsa cerrada al vacío con la criatura dentro. Entonces, el problema de la gestación antes de que se desarrollen los pulmones es básicamente un problema respiratorio. Hasta el final del embarazo, los pulmones no están lo suficientemente maduros. Entonces, lo que es totalmente inviable con los niños nacidos a las 20 semanas es básicamente un problema respiratorio, ¿verdad Pablo?

Pablo: Sí, sí. [Todavía buscando el video en Internet]

Montse: Entonces, si [el feto] no respira bien, no puede desarrollar el resto de las cosas. Entonces este sistema es... lo ponen en una bolsa cerrada al vacío...

Pablo: Te cuento esto porque desde el punto de vista antropológico me gusta...

Anna: Por supuesto.

Pablo: [con el video listo para mostrar en la pantalla de su ordenador] Vas a flipar, ¿eh? Este es el experimento que hicieron con un cordero, ¿de acuerdo?

Montse: Pero esto se puede hacer... Esto ya está pasando, ¿no?

Pablo: Bueno, pero esto es una primera cosa, pero estamos hablando de más de 50 años, ¿no? O 25.

Montse: No, de eso hablas mucho menos, quizás 5, ¿no? Está muy desarrollado.

Pablo: Sí, sí, pero esto es un útero artificial experimental, esto es un cordero, hay muchas cosas, pero...

Montse: Entonces es una preincubadora.

[Empezamos a ver el video mientras seguimos hablando]



Imagen. Fotograma del video de YouTube: “Desarrollan un útero artificial”.

<https://www.youtube.com/watch?v=0XMdAFsg4FI>

Pablo: Recuerdo que cuando estaba trabajando en un hospital público de Barcelona, empezaron a hablar de... Había algunos comentarios, del trasplante de útero, ¿vale? Y dejarla embarazada después. Ya hay niños nacidos así. Quiero decir, naces sin útero, eres compatible con tu mamá, le quitan el útero a tu mamá, te lo ponen a ti, te quedas embarazada, tienes hijos, y el mismo día o al día siguiente te lo sacan.

Si me hubieran dicho hace 25 años que habría trasplantes de útero que llevarían a embarazos, habría dicho “venga, esto es imposible”, porque cuando haces un trasplante de útero hay que dar medicación antirrechazo. Este medicamento contra el rechazo suele ser incompatible con el feto.

Montse: Bueno, y las quimios que están haciendo ahora a las embarazadas que no afectan a la criatura...

Pablo: Parecía imposible, pero... claro. [...] Como una cirugía fetal, ¿de acuerdo? Lo sacas, le haces fetoscopia, lo operas y lo vuelves a poner adentro. La suturas y el embarazo continúa. Esto parecía imposible hace 50 años. Y lo estamos haciendo. Lo que harán en reproducción en 50 años, ya te digo, empezaremos por la parte celular, pero iremos mucho más allá. [...]

Montse: Da mucha angustia. [viendo la imagen del cordero en el útero artificial en la pantalla]

Pablo: Yo flipé y soy ginecólogo desde hace 30 años.

Montse: Para mí esta imagen que parece que está cerrada al vacío me da mucha angustia... luego cuando lo miro desde el otro lado pienso, "Hostia, pero esto es lo que se necesita, ¿no?"

Pablo: Puedo tener una bolsa, cojo la arteria, las venas umbilicales, las conecto a una máquina que es extracorpórea, que oxigena la sangre y le meto líquido, le meto nutrientes, y ese tío vive afuera... ese feto de 4, 5, 6 semanas. Claro, si te explican esto hace 30 años, dices: “Esto es imposible”, ¿verdad? Pero no, nada es imposible, ya te lo digo.

La mezcla de miedo y emoción que Pablo y Montse expresaron en nuestra conversación era un sentimiento común entre otros profesionales. Si bien habían ejercido

en estas clínicas durante mucho tiempo, eran más bien testigos pasivos de los nuevos avances tecnocientíficos que se presentaban anualmente en los congresos a los que asistían. Y si bien muchos enfatizaban las posibilidades que estos avances podrían traer, como el fin de los dilemas éticos con terceras partes (donantes y madres de alquiler), Laura (directora de laboratorio) también destacó los inconvenientes de estas técnicas. Ella, que estaba embarazada en el momento de la entrevista, señaló las repercusiones que esto podría tener a nivel empresarial.

Así que creo que el día en que se desarrollen los úteros artificiales, la reproducción tal como la conocemos cambiará. Todas las complicaciones obstétricas no existirán. A mí no me gustaría, ¿vale? Creo que... la idea de que una máquina dé a luz por mí... no me gustaría. Entiendo que la humanidad al final necesita pasar por muchas experiencias, buenas y malas, en el ciclo de la vida. Pero si lo piensas desde el punto de vista empresarial, por ejemplo, no habría bajas por maternidad, las mujeres no tendrían problemas... Por supuesto, esto haría brillar los ojos de los empresarios. Quiero decir que... no sé, quiero decir que puedes hacer tantas cosas... La biotecnología también te permite esto. Generan híbridos entre tejido biológico y nanotecnología, ¿sabes? Al final... Bueno, yo que sé.

(Laura, directora de laboratorio)

Las clínicas de fertilidad habitan el futuro imaginado y fantaseado, que es cierto, más prometedor y, en definitiva, mejor. El presente se dibuja como una “chapuza”, un pasado obsoleto que espera el futuro tecnocientífico. Por lo tanto, debates sobre las prácticas liminales que se llevan a cabo en este tiempo ya muerto, como la donación de óvulos, carecen de interés y relevancia.

La aplicación de iPSCs en medicina reproductiva resuelve el problema de la transmisión genética y puede facilitar en gran medida las prácticas de las clínicas de fertilidad gracias al fin de la participación de las donantes. Como en muchos otros

sectores, los avances tecnocientíficos permiten prescindir de los empleados en los estratos más bajos, sin resolver los contextos precarios de las vidas de estas trabajadoras flexibles en un contexto posfordista. Si la profecía de las iPSCs se hace realidad, la pregunta queda: ¿qué otras opciones aparecerán para las mujeres que, como las participantes de esta investigación, buscan medios para asegurar un futuro mejor?

La versión lineal y única del futuro lleva consigo una lógica determinista donde la acción al presente se ve como irrelevante, como si la trayectoria de los eventos ya fuera tangible e inmutable. En oposición a este discurso, me niego a pensar en esta tesis como un informe histórico, que documenta los restos de un sistema zombi que espera la luz de un nuevo día. Por el contrario, sostengo que rebelarse contra esta versión única de futuro requiere ser capaz de captar las lógicas del presente para abrir espacios a nuevos debates: ¿qué va a significar la reproducción en el futuro? ¿A través de qué discursos vamos a construir ideas de salud y seguridad? ¿Por quién estarán mediadas estas concepciones y nacimientos cada vez más tecnificados? Estos espacios pueden llevarnos a crear grietas en este presente muerto para imaginar otros futuros, o mejor aún, otros presentes.

