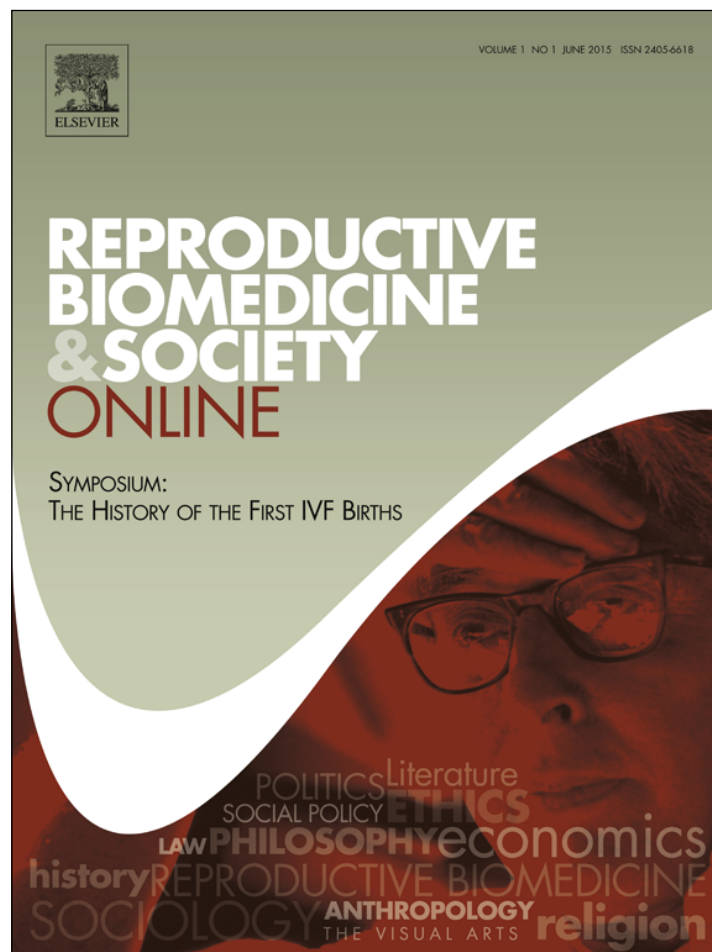


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ARTICLE

Gendered bio-responsibilities and travelling egg providers from South Africa

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Abstract 'Unsuspecting young South African women are heading overseas to donate their eggs to infertile couples and earn a free international holiday in the process. But, at what cost?' This was the voice-over during a news show in South Africa in 2016 that described the phenomenon of young white South African women going abroad to 'donate' their eggs. Through the media, medical professionals sought to warn 'naïve girls' about 'unscrupulous agencies' taking advantage of them, and in doing so putting them at grave medical risks in 'Third World' clinics. Yet owners of agencies and egg providers themselves countered this imagery; here, the egg provider becomes a far more complex biocitizen who finds an opportunity to combine an act of altruism with an opportunity to earn money and travel. Through interviews with travelling egg providers, doctors and egg agencies, and analysis of public and social media, we analyse these competing discourses critically by situating them within the specific context of egg provision in South Africa. We argue that travelling egg providers' defence of their involvement may challenge some gendered assumptions made by the media and medical staff, but at the same time reaffirm what we call 'gendered bio-responsibilities', or the gendered nature of the emphasis on (individual) responsabilization of biological citizens. By focusing on a relatively understudied aspect of the burgeoning literature on biocitizenship, we argue that the project of biocitizenship assists the expansion and normalization of new biomedical technologies, often without proper emphasis on the disproportionate obligations on the women involved.

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Introduction

In April 2016, Julie,¹ a young South African woman, took to Facebook to post her story with the hashtag, #IwasNOTeggsplotted. Julie wrote about travelling to Thailand and India to 'donate' her eggs and, in turn, wanted to share some lessons. 'I urge all young girls interested in becoming egg donors to do their research not only on what the procedure entails but also to do extensive research on the agencies that they choose to go through,' she wrote online. Julie wrote in response to a broadcast on the top South African weekly news programme *Carte Blanche*. In a segment called *Eggsplotted*, journalists and medical professionals described the risks in the growing trend of travelling egg provision from South Africa (i.e. young women crossing borders to provide their eggs for use in in-vitro fertilization (IVF) and commercial surrogacy²). Julie took issue with the portrayal of the practice as inherently dangerous. To her, egg provision³ was only risky if young women did not do the proper research and find the right agency to coordinate the trips.

Julie's egg provision was part of the growing international market in assisted reproductive technology (ART) that, in 2015, generated revenue worth USD 2 billion in the USA and USD 22.3 billion globally (*Global Market Insights Report, 2016; Grandview Research Report, 2016*). While human oocytes (or eggs) have become a central resource⁴ in this market, the growth in demand has not been without controversy, most recently in South Africa, a country that supplies an increasing number of eggs for patients abroad. Egg provision, in general, raises far more concerns than, for example, sperm provision. First among them are concerns around the risk of physical harm to the provider, as egg extraction involves an invasive process that includes the stimulation of ovaries through hormone injections and a short surgical procedure. Scholars and women's health activists have argued that the data around

the long-term impacts of ART are sparse, particularly for egg providers who are often anonymized with little follow-up (*Jain, 2013*). Furthermore, critics say that many egg providers are not adequately informed of the potential risks involved, such as the effect on future fertility, on children borne out of these technologies, and the effects of repeat cycles (*Woodruff, 2017*). Others have argued that egg provision is morally reprehensible, a 'trade in female's body', or that it is exploitative in extracting surplus value from the bodies of women (*Pfeiffer, 2011; Widdows, 2009*). These general anxieties around egg provision become compounded by the cross-border nature of the provision. First, some worry that egg providers are likely to be exploited because brokers have an incentive to skirt national laws and disregard the safety and well-being of women. Second and relatedly, there is a fear that economic pressures and a lack of alternative ways to make an income, especially for women from relatively resource-poor countries, may coerce egg providers' decisions.

Many of these anxieties were evident in the public broadcast and ensuing social media debate. The media, medical professionals, egg provision agencies and providers themselves sought to assert specific subjectivities of the 'travelling egg provider' (TEP) as at-risk victims of greedy foreign clinics, as naïve girls, and as rational and altruistic figures. This paper analyses these discourses critically by situating them within the specific context of egg provision in South Africa, a nation arguably both an 'advanced liberal society' (*Rose, 2007*) and its corollary. These multiple discourses, we argue, reaffirm the gendered responsabilization of biological citizens – the gendered nature and consequences of individual responsibility. This is a relatively understudied aspect of the burgeoning literature on biocitizenship. A gendered analysis reveals that the project of biocitizenship assists the expansion and normalization of new biomedical technologies, often without proper emphasis on the disproportionate obligations on the women involved.

Global markets for egg provision

Scholarly interest in what is variously called 'cross-border reproductive care' or simply 'reproductive travel' has increased in the last decade, part of a growing body of work on medical travel and the global structural inequalities underpinning, fuelling and heightened in these processes (*Inhorn and Gürtin, 2011; Roberts and Scheper-Hughes, 2011; Scheper-Hughes, 2000*). In the case of reproductive travel, geopolitical factors that shape circuits of resources, patients and technologies include non-availability of technology and procedures at home (such as the ban on egg provision in Germany), legal restrictions on certain demographic groups (such as single women, lesbian and gay couples), high costs (such as in the USA) and long waiting lists for procedures. Patients' preference for anonymous egg provision, coupled with increasing legislation against the practice (resulting in only non-anonymous egg provision in UK, Australia and the Netherlands), has also fuelled cross-border travel for IVF with third-party gametes.

Research on reproductive travel typically focuses on those seeking ART treatment – the clients or intended parents and, in the recent decade, on surrogate or gestational mothers – in reception countries (*Pande, 2014; Speier, 2016*). The

¹ All names have been changed to protect the anonymity of participants.

² IVF is increasingly utilized for third-party reproduction practices (sperm and egg cell provision and surrogacy) in cases of medical infertility in heterosexual couples, and also for 'non-medical' reasons (e.g. for single people and same-sex couples).

³ In this paper, we use the terms 'egg provision' and 'egg provider', instead of 'egg donor' or 'egg seller', partly to avoid the binary of sale versus donation and to recognize that women provide eggs for a variety of reasons (*Lundin, 2012*). However, we also use the term to highlight the fact that egg cells have become a primary resource for the fertility industry. The choice of a 'neutral' label, however, should not downplay the contradictions in the frames used within the industry. While the circulation of egg cells is in line with systems of global capital and the commodification of these egg cells, the industry (and some egg providers) insists on framing the act as altruistic and thus a 'selfless donation'.

⁴ Using the term 'resource' for 'white' South African eggs comes with its own set of questions that we are unable to fully unpack in one article. We are instead focusing on the gendered consequences. The market in gametes, and its correlation with race and whiteness, is a rather understudied topic, and has been analysed by only a handful of scholars. For instance, geographer *Schurr (2017)* explores this in the context of surrogacy in Mexico. Separately in other works, the authors are considering the term 'resource' and the racialization of the gamete markets in South Africa.

cross-border travel of egg providers, although an integral part of the industry in reproductive travel and related scholarship, has received less attention and differs in specific ways. TEPs are not patients seeking treatment like many other medical travellers. Instead, they are engaging in travel to provide a resource for others to use in IVF or surrogacy. TEPs get involved in the circuit of migration as providers of 'bodily service' for 'patients' or clients of biomedical reproduction. However, despite this difference, or perhaps because of it, the topic of egg provision has not escaped controversy.

It is not surprising that young women travelling to 'sell' their gametes garners media attention. It evokes the frame of medical trafficking and comparisons with organ donation, clinical trial subjects and, most recently, gestational surrogates, wherein, allegedly, a certain class of providers, often those in marginality (class, gender and/or political marginality), are induced to become biological resources for the wealthy (Cohen, 2005; Thompson, 2011). Sensationalist reporting, however, does little to unravel the contradictory political economy of the egg industry. The global political economy of TEPs, for instance, is quite different from that of gestational surrogacy. Unlike with gestational surrogacy, countries in the Global South are not currently the primary destination for (non-surrogacy) IVF with donor eggs; rather, the biggest players are countries classified as high income (e.g. USA, Spain, Belgium and Czech Republic), and a handful of middle-income countries, especially in the former Soviet bloc (e.g. Russia and Ukraine).⁵ Some countries in the Global South, for instance Barbados, India, Mexico and Thailand (Deveaux, 2016), have become players in the egg provision market as an ancillary to the cross-border surrogacy industry. For instance, India, Thailand and Mexico have a limited market for egg provision for clients of non-Indian heritage, primarily because recipients demand a race or phenotype match. Patients of non-Indian heritage that go to India for IVF or fertility treatment generally use eggs from providers based in their own, or else a third, country. An exception is South Africa which, for a variety of reasons (e.g. its stratified health care and racial composition of the population), has emerged as a node for global egg provision in the Global South.

While Eastern European and North American cross-border egg providers have been the focus of some studies (Bergmann, 2011; Dickenson, 2002; Gupta, 2006; Nahman, 2008; Waldby and Cooper, 2008; Waldby and Mitchell, 2006), egg provision and TEPs in South Africa have yet to be studied outside of sensationalist media portrayals.⁶ The media attention and

subsequent controversies, however, have been pivotal in highlighting some of the underlying structural inequities in the egg provision industry. On one hand is a group of older, overwhelmingly male, fertility specialists struggling to gain control of a situation they found medically and morally problematic. On the other hand are the egg providers, overwhelmingly young, white South African women – classified as the naïve or greedy 'girls' of this industry – who are seeking to assert complicated and contradictory forms of autonomy. The *Carte Blanche* television special exemplified the popular framing of the debate: agencies taking advantage of young South African women, commodifying their bodies, and putting them at grave medical risk in 'Third World' clinics that lack proper medical ethics or even basic hygiene. However, interviews with agencies and egg providers themselves counter this imagery; here, the egg provider becomes a rational 'repreneur' (Kroløkke and Pant, 2012) who found an opportunity to combine an act of altruism with an opportunity to earn money and travel. In this paper, we use a gendered lens to analyse this complicated counter-imagery of the TEP as a responsible, rational and altruistic biological citizen.

Gender, responsibility and biocitizenship

Medical anthropologist Petryna (2002) first used the term 'biological citizens' in her book *Life Exposed: Biological Citizens After Chernobyl* to highlight the individual and collective claims made by a 'biologically damaged population' (Cooter, 2008). Nikolas Rose and Carlos Novas took the concept a step further to theorize biological citizenship as a novel moment of biopolitics that is enacted through individual consumer choice, and wherein individuals, as moral, rational and responsible actors, 'draw on science to articulate their own judgements and political claims' (Raman and Tutton, 2010: 716). Such enactment deploys a 'moral economy of hope' (Rose and Novas, 2005) through which individuals stake claims for citizenship. What is key in Rose and Novas' (2005) conception of biological citizenship is the dispersal of responsibilities. Rather than an incursion of power from the state and from above, the new era of biopolitical power involves a dispersed 'regime of the self', whereby individuals are 'empowered' and concurrently compelled to act 'rationally' towards optimizing health and managing and minimizing risks. There is responsibility and prudence engendered within the 'proper' biological citizen:

Such a prudential norm introduces new distinctions between good and bad subjects of ethical choice and biological susceptibility

[(Rose and Novas, 2005: 441)]

Some recent scholarship pays attention to individual responsibilities embedded within projects of biological citizenship in neoliberal contexts, and particularly how these take gendered forms. Charles (2013), for instance, argues for the use of biological citizenship as a tool of modern biopolitics that imposes unprecedented obligations on the citizenry. How can we account for forms of fear, risk and despair still deployed within discourses of health promotion, she asks? Charles analyses how the promotion of the human papilloma virus vaccine in Canada reconfigured forms of gendered and

⁵ Arguably, here too a similar thesis of exploitation or undue inducement operates since the differences in currency exchange rates, purchasing power parity and living standards means that a '£250 compensation for egg donors (SEED Report, 2005) proposed by the Human Fertilization and Embryology Authority in the UK would appear to be a paltry sum by UK standards. However, to young working women in some Eastern European countries and the former Soviet Union, this could very well represent a couple of weeks' wages' (Heng, 2005).

⁶ A notable exception is the recent work by gender studies scholar Verena Namberger, one of the first to start the conversation on the "bioeconomic dimension of egg donation" in South Africa. Although Namberger focuses on the local industry and not its cross-border component, her analysis is a necessary impetus to further work on egg provision in this region, as technologies "embedded in local socio-cultural contexts and power relations" based on race and class (2017: 81).

responsible biological citizenship. Promotion of the vaccine gains traction specifically through the use of gendered forms of responsibility – as mothers, wives and sisters – and thus constitutes a form of biopolitical burden (Charles, 2013). In a very different context, Colvin et al. (2010) track another use of gendered responsibility – human immunodeficiency virus activists in Cape Town engaging in ‘responsibilization talk’. The study reveals the ‘messiness’ of state–citizen interactions and its effects on health outcomes by highlighting how traditional notions of entrepreneurial, responsible masculinity blend with the individual responsabilization mandated by the state. ‘Their notion of responsibility “as men”,’ the authors conclude (Colvin et al., 2010: 1192), ‘provides a local vernacular for the state’s neoliberal language of responsible ARV adherence’. In this paper, we extend this idea of gendered prudential norm and responsible biocitizen in the context of travelling egg provision from South Africa. The next few sections provide the background to this study: the history of egg provision and travelling egg provision in South Africa and our research methods. We then describe the narratives of ‘paternal protectionism’ by medical professionals and in the media – an attempt to ‘save the girls’ from excessive commodification, exploitation by agencies and the ‘Third World’. In direct response to this are the narratives of ‘responsible altruism’ by the providers themselves and of ‘responsible maternalism’ by the agency managers. We argue that while these narratives challenge gendered assumptions made about the naivety and ultimate victimhood of TEPs, they simultaneously reaffirm the notion of a particularly gendered form of prudence that we label, ‘gendered bio-responsibilization’ – the gendered nature of the emphasis on (individual) responsabilization of biological citizens. Such gendered burden of responsibilities displaces responsibility away from the state and medical professionals to (female) agency managers and the TEPs themselves.

Global egg provision via South Africa

Political, social and economic racial segregation, as well as intentional underdevelopment of Black South Africans, were the central tenets of South African policy long before official apartheid. Following centuries of development for the settler colonial communities and such intentional underdevelopment of the majority of the population, South Africa arguably constitutes both an ‘advanced liberal society’ and its corollary. By coopting the South African Government’s own brand name ‘middling nation’, we do not wish to replicate the notion that there exist ‘European’ enclaves in ‘Africa’, but to highlight that in the South African urban environment, multiple valences of neoliberalism, modernity and inequities interact. As Achille Mbembe describes the city of Johannesburg, ‘It is structurally shaped by the intertwined realities of bare life (mass poverty), the global logic of commodities, and the formation of a consumer public’ (Mbembe, 2004: 374). Communities of ART and egg provision in South Africa could confirm Rose’s description, as they are marked by increasing privatization of the (reproductive) healthcare market, individual responsibility in regard to health optimization, and the growth of a consumer public for healthcare goods. However, the market is riddled by debilitating inequities based on race and class (Coovadia et al., 2009) – a legacy of the colonial

state’s ‘enclave’ policy of catering exclusively to the health of ‘European soldiers, civil servants, and settlers’, reaffirmed by the apartheid state’s racist ideology which guided all health action between 1973 and 1994 (Digby, 2006; WHO, 1983). These structural inequalities shape the political economy of health care, reproductive health care and gamete provision in South Africa.

The history of egg provision in South Africa, both national and cross-border, starts as early as the 1980s. As was global practice during that time, egg provision often occurred through known providers, typically members of the clients’ families, or through a handful of anonymous providers sourced through the clinics. In 2004, an American woman in South Africa established an agency to partner South African egg providers with clients, mostly people coming from around the world for more affordable treatment, or to provide eggs in South African fertility clinics. The creation of an egg provision agency was part of a larger business in ‘medical tourism’ to South Africa. The first egg provision agency soon evolved into a much larger global organization that operated mostly in a ‘laissez faire’ manner, as does much of the fertility market in the USA.⁷ The agency, much like many other contemporary egg provision agencies, acted as an intermediary between clinics, egg providers and the recipient patients; they recruited, conducted basic screening of egg providers, and coordinated the well-timed egg extractions while maintaining anonymity between parties. The agency, however, was quickly embroiled in a scandal of providing ‘Bargain Babies in the Mother City’ (Peters, 2005),⁸ as one headline described. Fertility specialists, under the professional society known as the South African Society for Reproductive Medicine and Gynecological Endoscopy (SASREG), challenged the amount of compensation paid to egg providers – ZAR 10,000 (or approximately USD 1600 at the time)⁹ – which they considered excessive payment and undue inducement, and furthermore, an amount too expensive for local patients. As an immediate reaction, SASREG tried to clamp down on the agency as well as trying to regulate the industry through published guidelines that, in 2008, set the limit for compensation at ZAR 5000 (approximately USD 575). SASREG has since expanded these initial incursions into regulating the gamete provision market locally, and especially in limiting the travelling egg market and agencies involved in sending providers overseas.

⁷ Outright payment for eggs is usually prohibited by national legislation; providers are only to be reimbursed for work time lost, inconvenience and expenses. However, in countries with a more commercial approach to ART, like the USA, clinics routinely flout this requirement and it is understood that payment is, in essence, for a provider’s eggs; women may also be paid differently according to whether they have more desirable traits or have had previous successful cycles.

⁸ This was also shortly after a larger scandal involving organ trafficking, with medical tourists coming to South Africa, and particularly KwaZulu Natal, for organs such as kidneys (Kockott, 2005; Liebenberg, 2003; Templeton, 2003).

⁹ Throughout the article, we have given the amounts in South African Rand (ZAR) and US Dollars (USD). We have also attempted to provide the exchange rates as reflective of what they were at the time, if mentioned, as the ZAR/USD exchange has fluctuated considerably in the last 15 years.

In the last decade, numerous such agencies have emerged which provide a database of potential egg providers for recipients resident in South Africa and also for those abroad. For recruitment, screening and coordination, they charge an agency fee, in addition to the provider's fees [now regulated at ZAR 7000 (USD 515) per cycle at the time of writing] and medical costs. To understand the purchasing power of this compensation, one must also consider the stark racial and class disparities in South Africa. South Africa is one of the most unequal countries in the world, and after centuries of colonialism and 50 years of apartheid policies, class is deeply imbricated in race. For instance, Statistics South Africa, the government census agency, estimated the average yearly income of white South Africans as almost five times that of black South Africans (ZAR 444,446 compared with ZAR 138,168) in 2014/2015 (eNCA, 2017). Thus, ZAR 7000 takes on a different meaning depending on the recipient. At the same time, the egg provision industry, when recruiting providers for clients within South Africa or providers willing to travel abroad, takes clear and stated steps to screen out poor women from their rosters.¹⁰

Many medical professionals in the South African fertility industry view egg agencies as a 'necessary evil', as one of the interviewed physicians referred to them. Agencies are able to recruit egg providers, a set of skills and time commitment that many clinics lack, yet they are criticized for charging patients an additional 'matching fee' for their services and thus driving up the cost of IVF with egg provision for local patients.¹¹ However, local fertility specialists reserve their full ire for those agencies that take egg providers to clinics abroad. A recent regulation implemented by SASREG prohibits any local egg agencies from taking egg providers overseas. Although local agencies had, for several years, organized overseas trips to Canada and India, the travelling egg provision phenomenon came into the spotlight because of another scandal. In 2009, a group of South African egg providers travelling overseas to an Indian fertility clinic in Mumbai returned and one provider suffered from ovarian hyper-stimulation syndrome, a medical condition occurring in 1–5% of IVF cycles (Steward et al., 2014). She was treated in South Africa and recovered; however, the medical establishment subsequently implemented an effective ban on local agencies coordinating such overseas donations trips.

As a response to the SASREG ban on local agencies coordinating such trips overseas, a handful of exclusively international agencies have emerged that have a presence in South Africa but do not work with local clinics and thus do not come under SASREG regulations. These exclusively 'global' agencies systematically take South African providers to countries such as the USA, Australia, Cambodia, Cyprus,

Ukraine, Malaysia and Mexico, and, until recently, Thailand, India and Nepal. The agencies' recruitment process and advertisements emphasize the tourist appeal of the destination, such as elephant rides in Thailand or the beautiful hotels and pools. The majority of advertisements and recruiting efforts also emphasize altruism. For example, 'A candle loses nothing by lighting another candle' was one slogan.

Most agencies network and establish relationships with clinics in destination countries. Once they receive details about prospective clients, the agencies provide a short-list of potential egg providers based on the clients' requests, such as race and ethnicity, educational attainments, interests, age, hobbies, etc. The agencies recruit egg providers through multiple avenues, such as Facebook, targeted Google advertisements, student newspapers, student radio and posters on campus. Egg providers either search independently for agencies or come via word-of-mouth recommendations. Many are repeat egg providers. Once contact is made between the young woman and the agency, she must fill out an application, which becomes the basis for screening as well as the profile that is used to match egg providers with recipient clients. Providers are screened for medical history and psychological or mental health history, and profiles include information on personality, hobbies, educational attainments, appearance and sometimes photographs (or in an attempt to maintain some anonymity, baby photographs of the provider). However, much like the rest of the industry, there are few regulations and TEPs regularly talk of meeting the recipients either virtually (via Facebook and Skype) or even in person in the destination country.

Materials and methods

This article emerges from two independent ethnographic projects conducted by the authors on the global market in reproductive services and the South African fertility industry. The authors conducted detailed open-ended, semi-structured interviews with 10 medical professionals connected with the global fertility industry; this included four fertility specialists, one psychologist, three clinic owners and two embryologists. The authors interviewed five current or former international egg agency owners and managers and 11 women who had travelled abroad to provide eggs. The authors recruited these 11 providers in three ways: through direct contact during fieldwork at clinics, snowball sampling via previously interviewed providers, or via the participating agencies. One of the agency owners reported negative press coverage of their work, and thus requested that the interviews with egg providers be conducted in their presence. Two of the interviews were conducted in the presence of agency staff, which could potentially result in overly positive responses from the egg providers. However, we found that the responses did not differ substantively. All participants were given pseudonyms to protect their anonymity. The authors obscured details of the place of work of medical professionals to further protect their anonymity.

Given the racial composition of the South African population, the fact that almost all medical professionals and agency owners were white demonstrated the persistent and ingrained structural inequalities based on race. The

¹⁰ A full explanation is beyond the purview of this paper, but for instance, all agencies and clinics require a certificate of high school completion, and education is deeply classed. One agency, for example, stated outright that they do not have any 'disadvantaged donors'.

¹¹ An IVF cycle with one's own egg may cost, on average, between ZAR 40,000 and ZAR 60,000 (USD 3000 to 4400). IVF with egg provision may increase this by ZAR 30,000 (USD 2200) depending on the agency fee, any additional travel costs for the egg provider, and the clinic's stimulation protocol.

medical professionals (except the psychologist) were all men and the owners of egg agencies were all women. All of the egg providers we spoke with were white women. While providers come from all areas of South Africa, most were from urban centres of Johannesburg, Cape Town and Durban. Agency managers were reluctant to specify the racial demographics of egg providers, but there were many indications that mostly white women are recruited. For instance, all advertisements and online photos of current egg providers featured exclusively white women. One agency stated that they did not have any 'disadvantaged donors', a code to racial and class distinctions in South Africa as mentioned previously. Among the egg providers interviewed, all except two had a university education. The ages ranged from 21 to 29 years, although the youngest said she first travelled for egg provision at 18 years of age. Interviews were transcribed, and the transcriptions and field notes were coded thematically. Additional data include media reports (television, in print or online), and social media debates and advertisements. These were also coded and subject to analysis along the themes that emerged in participant observation and interview narratives. We emphasize the media representations as the research was conducted during a time of increased public attention to the travelling egg provision industry in South Africa. Our interviews with agencies and TEPs took place shortly after the media reportage and public scandal described above, and the narratives and counter-narratives described below have to be analysed as interactional.

Media and medical professionals: paternal protectionism and 'saving the girls'

Several weeks before the broadcast aired in April 2016, the team of four from *Carte Blanche* squeezed their way into the tight hallways of the fertility clinic. They were visiting to interview two key figures in the industry – a fertility physician and a psychologist – who were outspoken in their opposition to travelling egg provision. The team of journalists had already interviewed two TEPs who described their experience as 'exploitative' and 'traumatic'. The journalists and experts debated numerous frames for anchoring the story. The potential frames discussed were the rising costs of university education driving students to desperate forms of work; the correlation between the demand for third party reproduction and the challenges in adopting children in the Global North; and the many motivations of egg providers to 'donate' their eggs anonymously. However, these suggestions were quickly abandoned in favour of a clear narrative summarized by the *Carte Blanche* team: 'We want to scare people medically. We want to scare these girls from going overseas.' The emphasis was to be on 'unscrupulous' agencies that took advantage of these well-meaning young women, as evidenced in what became the introduction to the piece:

Carte Blanche exposes the ugly truth behind global egg donation agencies robbing women of their chances of ever having their own babies.

The verb 'robbing' clearly established the victim/perpetrator relation in this narrative. The egg providers were victims and the agencies were pure villains in an 'illegal

international network, where human tissue is traded for cold hard cash on the black market'. The egg providers, framed as 'unsuspecting' young girls, just wanted to do good and 'donate' for a family in need, and instead found themselves being pumped excessively with hormones, having their eggs extracted in unhygienic conditions in dirty surgical theatres, that resulted in possible long-term consequences for their own ability to have children one day. 'I walked in here as a hero,' said the TEP chosen by the public broadcast, 'and left a victim. They literally harvested me for everything I had.'

The discussions between the fertility experts and the media resonated with what we heard individually from fertility experts – the medical experts were keen to protect young women from exploitation and possible harm, but they also wanted to maintain control over the local pool of 'sought after' (white) eggs. The challenge for the media was to make clear to viewers and the public that while egg provision abroad was risky and exploitative, egg provision within South Africa was unquestionably a 'good' act, and one that should be continued and celebrated. To effectively make this claim, the frame needed to create this clear-cut villain/victim binary, the villains were the doctors and clinics outside of South Africa, and the agency managers who misled and lured the 'gullible girls' away from an altruistic act at home. Dr. Peter, one of the leading fertility experts in South Africa, explains the crisis of TEPs as follows:

So what is happening now, we've got these agencies that are an uncontrolled bunch of people that have created an industry on the backs of gullible girls, profiting big from their sought after eggs...They [the agencies] advertise by all means, you know in the public domain. They say come and have a holiday in India or in Thailand.. ...So what do they do? You can go and look at all these adverts. Just Google it. So what do they do, they put up a little advert, they get these gullible young girls, they go out to Thailand, spend two weeks there, overstimulated, and then they come back. They get 20, 30 eggs per patient. They sell for, you don't even know what kind of money those people on the other side. Now I've got, I think I've got a legitimate problem with that. To me that is not acceptable.... It's a sick industry! It's a 'vrot' [Afrikaans for rotten] industry.

Dr. Richard, another fertility expert and founding member of SASREG, adds to this description of 'vrot' industry:

The donors, they started arriving back [from India and Thailand] here with hyperstimulation syndrome, so they would just walk into the clinic here and collapse and everything and then we rush them to ICU and they are sick as anything and having all kinds of serious problems. You know so for that reason, we have to be able to stop these agencies from doing it ...And these donors I don't think they know what they are in for. I think they just get told 'it's a lovely holiday in India it's all fun and you get paid a lot of money', they don't really understand what they really doing so they come back very shocked, traumatized...

The doctors' narratives are clear: the 'vrot' industry and the exploitative global agency owners that take the girls abroad must be stopped. Local agencies, however, could escape the label of 'villains' as long as they work with only South African doctors and fertility clinics, and keep the girls

and the white eggs within the country. Dr. Peter reiterates this when he says:

I haven't got a problem with an agency. But let the agency just work with us.Keep the girls at home. Our system here [of egg provision] works perfectly. It is not about money. If they donate here, these girls can really do good, and not get hurt! ...We need them here.

Egg providers, within this 'vrot' industry, are naïve and gullible 'girls' who need protection and should be kept home, where the local medical establishment can offer the proper care. Through media depictions, public interviews and as the prevailing medical establishment, these experts sought a specific narrative through which to engender responsibilities to egg providers. In infantilizing TEPs as 'girls', and especially naïve ones, the narrative delegitimizes their participation as full citizens. Their participation – and thus 'risky' behaviour – is blamed fully on the global agencies that 'duped' them into participation. In the doctors' narrative, the 'girls' could be redirected to local clinics, allowing for their moral rejuvenation, properly protecting them from risks abroad and the commercial interests of unscrupulous agencies, and conveniently returning the clients, the egg providers (and their 'sought after eggs'), to South African clinics.

The egg agencies and trip coordinators provide a counter-narrative that, although seemingly countering the medical professional framing of the issue, reaffirms the individual and gendered responsabilization of the risks associated with this industry.

Agency managers and responsible maternalism

Although the term 'reproductive tourism' has been debated and criticized for its misplaced focus on 'pleasure' in a form of travel that is mostly out of desperation (Inhorn and Patrizio, 2009; Pennings, 2005), several scholars have simultaneously emphasized that the label 'tourism' may well resonate with some aspects of this form of travel (Bergmann, 2011; Deomampo, 2013; Speier, 2016; Whittaker and Speier, 2010). For instance, in her ethnography of North Americans' pursuit of IVF in the Czech Republic, anthropologist Amy Speier describes how her respondents conceptualize their travel as both treatment and vacation. In our interviews and fieldwork, notions of 'tourism' and 'holidays' pervaded much of the discussion around and among TEPs. Agencies advertise that accommodation would be at luxurious 'five-star' hotels in 'exotic' locales with the potential of adventures during their stays. One agency coordinator argues that what attracts women to their company is their ability to arrange everything:

Girls that want to come to our company, come to us because we do everything for them. They think of nothing. We book all the appointments. They don't have to run around much. They go lie on the beach and have a bit of a vacation and take their medication once a day and then retrieve.

According to this coordinator, part of the appeal of travelling egg provision is that it is carefree travel, organized and paid for by the agency coordinators. This is

set up to contrast to local egg agencies, where egg providers must take on much of the responsibility and decision-making themselves.

The team – typically a group of egg providers and women agency coordinators – travel together to the destination countries, where the agency coordinates hotel accommodation and transport to and from clinics for further testing, screening, monitoring of the process by local doctors and eventual egg retrieval. Egg providers spend approximately 2 weeks in the destination country, during which they have daily hormone injections and several ovarian scans. During this time, spanning at least 10 days, they often tour the area, go shopping and socialize with other egg providers.

This assembling of young women, often in a foreign country for the first time, with extra spending money on hand, all undergoing the same treatment with hormones, elicits a sort of sisterly bonding, a camp atmosphere with maternalistic oversight from the agency and coordinators. Agencies we spoke with emphasized that they placed strict rules on the egg providers, such as no drinking or smoking, and eating three nutritious meals a day. Egg providers were instructed to always tour in pairs and have a working mobile phone on them. As such, agencies act not only as coordinators for a highly technical, capital-intensive and time-sensitive medical arrangement, but as a travel agent, tour guide, and – extending the analogy – camp leader.

As many of the destination countries are in the Global South, much of this discourse around being 'carefree' takes on a tone of protectionism against the seeming dangers of 'Third World' travel – food that can cause illness, prohibitions and warnings against drugs and alcohol, paired travel to avoid muggings, and warning tales of sex trafficking. Agency coordinators act as maternal figures for the comfort, care and surveillance of their 'girls'. While several scholars have described the narratives of altruism and gifting between providers and the recipients involved in third party reproductions (e.g. Konrad, 2005; Pande, 2011; Shaw, 2007), coordinators and TEPs we interacted with frequently emphasized another aspect of the responsabilization – the bonds of care and affection between them. Elizabeth, an agency owner and trip coordinator, constantly emphasized her role as a 'camp leader' or a 'den mother':

So the girls, even if they have a problem, they feel and they're comfortable enough to come in. I'll leave my hotel door unlatched, so my door doesn't ever close. I remember the one day that I got back from shopping, and I was sharing a room with another coordinator, and I turned the light on. There's five of them sleeping in the bed. Her and four donors, and they're having an afternoon nap together!

Much like Elizabeth talks of the maternal care and bonding between coordinator and the TEPs, Candice, a former TEP and currently a coordinator, laughs and says that even while she snorkels in Cambodia with her 'girls' she keeps her cellphone handy, just in case there is an emergency.

While softened with stories of sisterly bonding, these narratives often emphasized the burden of responsibility and care on the agency coordinators, and the reasons for the strict surveillance of TEPs. Coordinators described TEPs as impetuous, naïve and hormonal girls, legitimizing the need for maternal care and surveillance. Mandy, coordinator of

one of the largest 'global' agencies, describes the daily rituals as high drama involving much 'girly' and hormone-induced tantrums:

[Egg] retrieval is where the drama comes in... So in the beginning they go on a high. They go on trips. They go visit everywhere. But once it's retrieval time, it gets serious. They get locked down in a hotel, and this is when they get ratty, hormonal, fighting and crying. This is when I have to get strict with them and keep a close watch... I must say it's very hard work to manage the seven, eight or even 12 girls full of hormones. It's very difficult, and you have to be very strict, but I think they know my rules. I am very clear on the rules. I enjoy the trip, I enjoy the young people, I enjoy the clinics and everything, but at the end you are tired, ya, you get tired of constantly minding them.

While the agency owners and coordinators challenged the medical and media framing of TEPs as naïve and duped into providing, their own framing of TEPs was far from consistent. TEPs were, on the one hand, framed as rational biocitizens looking to do some good but also lacking sufficient responsibility in their hunt for an opportunity to travel. Later in the conversation, Mandy adds that the 'hormonal girls' are well informed about their decision to become TEPs, and many are repeat donors hunting for another exotic destination:

Mandy: You must just remember all of these girls are repeat donors... They've donated in Nepal, Mexico, India, Cyprus... A lot of these donors wouldn't ordinarily get the opportunity to travel overseas so... We have to keep a check. Even in South Africa, they donate for local agencies six times and when they know they can't donate any further because they have reached an agency's stipulated limit, then go over to another local company and they donate. They lie, A, they lie. Every day we find a new donor who is lying...

A: Why would they lie, you think?

Mandy: Students, I have a lot of students. The young people of today don't really want to take responsibility now. They don't want a full-time job where they start eight o'clock in the morning and work till five and get a salary. And it's like they all have this free spirit [giggles] and it's better to sleep during the day and work at night and get a few Rands. This suits them perfectly!

Mandy labelled the TEPs as well-informed, impetuous, irresponsible girls looking to 'make a quick buck'. In fact, part of the recruitment process at a reputed international agency, like the one Mandy works at, is to make sure that such irresponsible girls are either discouraged from providing their eggs or adequately monitored:

We are two international agencies that work together in South Africa even though we are actually competition for one another. But it is important to see – because sometimes the donors get matched with me but they would rather want to go on a trip with another agency taking a trip to Cambodia... and then they will drop me and they will go with her. These agencies, these fly-by-night ones, they sign up with everyone, and they commit to different trips without any background check on the clinics the girls will be sent to! And then we, the real agencies, also get a bad name.

The problem with the ban imposed by SASREG, Mandy and other agency owners argue, is precisely that they do not

recognize this difference between responsible and irresponsible agencies. While the 'fly-by-night' category of agencies tap into the gullibility of 'impetuous girls', the 'good' agencies not only recruit more responsible providers but also ensure that the more impetuous ones are protected and disciplined, becoming an appropriately responsible citizen.

Our interviews with agency owners and managers reveal complex ways in which the dispersal of responsibility in this new biopolitical era interacts with older forms of hierarchies based on gender. While male professionals seek to protect the 'naïve' and 'easily duped' young female egg provider, agency owners reiterate their responsibility towards and the kin-like forms of labour in ensuring the safety of egg providers. At the same time, they reinforce the gendered reprobation of the egg providers, who are not responsible enough to make the right choices (yet responsible enough to make the choice to 'donate'), by depicting them as frivolous, impetuous or even deceitful in their search of a 'quick buck'. Unlike the 'fly-by-night' agencies, a good agency is one that is successfully able to discipline the impetuous nature of the girls into the required bio-responsibility.

Egg providers and responsible altruism

While the medical fraternity and the agency coordinators often framed the TEPs in contradictory ways, the TEPs themselves viewed their role in multiple ways – as moral and altruistic figures helping to build families, as sisters in the adventure of travelling and providing eggs, and as responsible rational actors.

The TEPs we spoke with agreed with the agencies that there are indeed 'unscrupulous' agencies and 'good' ones. When addressing the *Carte Blanche* broadcast, many expressed sympathy with the young women interviewed in the piece, but said that all egg providers need to do their full research to ensure their well-being. Such was the response of Julie, who we mentioned at the start of this article. Julie was among many, many egg providers who took to Facebook with the hashtag #IwasNOTEggspoited following the media broadcast:

With any procedure you run the risk of complications, like the ones mentioned on the *Carte Blanche* story. If the donor cycles are managed properly by coordinators who are trained to handle these situations, the severity of the outcomes could have been significantly reduced. This is why I urge all young girls interested in becoming egg donors to do their research not only on what the procedure entails but also to do extensive research on the agencies that they choose to go through.

For Julie, the main task of a responsible egg provider is to find the right agency. Egg providers admit that the process can be risky, but instead of being critical of the unforeseen risks involved in their egg provision, they emphasize that the responsible and rational response is proper homework and a considered choice. Responsible egg providers find the right agency – one with a good reputation and one that cares appropriately for 'their girls'. This framing both reproduces the dichotomy of 'good' and 'bad' agencies, and displaces the moral dilemma away from the critical question of implicit risks of egg provision. The 'risk' and hence the

responsibility is placed instead on the choice of agency. Many egg providers emphasized the time and energy that they spent hunting for the right agency, but also to ensure that provision was appropriate for them. Elizabeth, a 26-year-old who has provided her eggs eight times, talks of her intensive research and 'right aptitude' to commit to egg provision:

...And most of the girls have done their own research before. They're not like, 'Oh Thailand, that looks like fun. Vacation!' Anyways, for me, I heard about it... and did some research on it. It took me a year to decide this was something I wanted to do and I felt that I had the right aptitude to be able to, you know, be ok with the life term commitment. Not commitment per se, just knowing that it's a forever decision, not something that you can go back and change.

Researching egg provision is not simply an assessment of the risks of the procedures, but a responsible evaluation of the agency, and their own commitment and aptitude for the process. Crystal, a 21-year-old who has provided her eggs six times, emphasized her extensive research before taking the decision to share her fertility:

So one of my friends used to donate for [international agency] and she said it was ok, you know, but I didn't just believe her... I did a lot of research about it, I spoke to people who donated and then I found out how it is and what it really does. And I was like, well if I, if I'm fertile enough I will help with the greatest of pleasure.

Egg providers emphasize the dire need to take responsibility to find the agency that will care for them properly, offering them sufficient maternal and medical surveillance. These narratives complicate traditional frames of TEPs as either entrepreneurial agents or as gullible, exploited victims. TEPs we spoke with sought to fashion themselves as responsible researchers, taking charge of their bodies as egg providers, and yet seeking out and emphasizing the maternal care and medical surveillance they need from 'above'. Crystal describes the rules the agency sets out and that she and other TEPs conformed to during their travels in Thailand:

The [international egg donor agency] is very like, particular. 'You need to have a SIM card, so we can get a hold of you if you go out, and you need to tell us and you need to make sure you're with someone.' It's just mainly for protection because, especially if you've not travelled abroad and you don't know where you're going, it can be quite dangerous. You see, so they really look after you. It's probably the best way for a young person that is interested in donating and wants to travel. Because they get to see places through a protective way.

For Crystal, the rules demonstrate a maternal caring by the agency. Rules, imposed by the agencies and followed by TEPs, demonstrate the personal responsibility that 'good' biocitizens must incorporate. The risks, however, do not come from the procedure they are engaged in – one that they have researched and chosen – but incorporates tropes of the 'dangers' of the 'Third World' and the need for agencies to 'protect girls'.

Sophia, a 25-year-old egg provider, talks of her experience during one of her international travels, when the coordinator failed to play this expected maternal role. After two provisions in South Africa, Sophia travelled to Thailand with

a group of other egg providers where she realized the risks of travelling to a foreign country with the wrong agency:

I mean, we're basically meant to keep our bodies as healthy as possible. We go for this... We went for this quite dangerous – I thought it was quite dangerous trip on these elephants, in the middle of night... And we got bitten by mosquitos. And it was in a malaria area. And I was just like, this isn't, this doesn't feel like we should be doing this. And even when we were out, we went to one of these, I don't know kind of Thai [erotic] show things, whatever. And she [egg provision coordinator] wanted to get drugs. And I'm like you are the person who should be guiding us ... I do not want to do this. I even walked away from her and told her to just get away from me. We're in a foreign country, you are exposing us to all these [dangers] when you're meant to be the person completely managing our group.

Sophia believes her previous encounter was terrible because her coordinator did not meet up to the expectations of responsible and maternal caring. To find the perfect company that cares appropriately for them and to weigh up their aptitude for egg provision, TEPs emphasize the amount of research and time they spent in finding the 'right' agency and to ultimately make the decision to provide eggs. However, the 'risks' are made 'worth it' if the egg provision allows the provider to work towards the 'ultimate reward' in altruism, and in shaping an altruistic and moral subjectivity. Crystal, like many other TEPs, adopted the discourse of 'giving the gift of life' in framing her identity as a TEP:

I've never been able to give back to people or anything in life, and this is my way of giving back because it doesn't harm me. It doesn't hurt me. I mean, I'm fine. You get a bit swollen, but it's like a period – you get swollen. It doesn't harm me. So, if I can help someone in the process of doing it, then that is amazing. And when I met my IP [intended parent] she was so, she was like, 'Thank you so much,' and she started crying. She was like, 'Can I hug you?' and I'm like, 'Of course you can.' So happy, you know they're so grateful, and it just makes it so much better.

For Crystal, egg provision is a way to be selfless without causing too much harm to one's own body. Given the commonplace criticism from medical establishments, and often from friends and family members, many TEPs rely on similar tropes of egg provisions as ultimately an altruistic act. While Crystal describes a specific recipient in her story, the majority rely on abstract affective images to corral a sense of moral correctness in their decisions to provide eggs.

TEPs, like Crystal and Sophia, demonstrate 'prudent' biocitizenship by taking on the responsibility to measure and weigh certain risks. However, the risks they measure are not the medical risks emphasized by the medical establishment. The risks instead come from 'bad' agencies, improper aptitude for egg provision, and from the dangerous 'Third World'. Such a discursive placement of risks displaces any discussion as to whether egg provision is right through to whether the women themselves are right for egg provision.

Conclusion

Biological citizenship, [Charles \(2013\)](#) argues, engenders responsibility and obligation within a field of risks. This is in

contrast to its more popular framing as novel forms of political and social engagement within an economy of hope (Rose and Novas, 2005). Despite the latter authors' focus on 'bottom up' engagements with governance, Charles and others (Nadesan, 2008; Plows and Boddington, 2006; Raman and Tutton, 2010; Wehling, 2010) have emphasized the interaction of such new forms of biopolitics with more 'traditional' forms of governance such as expert knowledge and state-led health promotion policies that frame 'acceptable' forms of choice. In this study of TEPs – young women travelling from South Africa to provide eggs – we find a similar 'messy' reality and state/citizen/health expert interactions (Colvin et al., 2010).

While male medical experts and the media seek to protect the 'naïve' young female egg providers from the greed of global agencies and dangers of the Third World, the predominantly female agency owners and travel coordinators reiterate their responsibility towards ensuring the safety of TEPs. At the same time, they reinforce the gendered reprobation of the egg providers, who are not responsible enough to make the right choices, by depicting them as frivolous or even deceitful in their search of a 'quick buck'. In contrast to such framing of their actions as naïve, impetuous, risky and deceitful, TEPs couch their egg provision as a responsible, rational and altruistic choice. At the same time, as young women travelling the world in search of an adventure, they surrender themselves to the care and surveillance of agencies, to the assumed risks of using new technologies, and to travelling the 'Third World'. By analysing these multiple discourses, we have highlighted the gendered valences of these responsibilities and obligations. Travelling egg provision is embedded within complicated and contradictory webs of values – with gendered undertones – of celebrating altruism and embracing kin-like relations with agency workers and fellow egg providers, plus the twinned desire to 'do good' while also earning money and exploring the world. Finally, in emphasizing their own roles and responsibilities, TEPs reaffirm the underlining logic of biocitizenship – choice-enhancing possibilities that emphasize individual consumption.

Here, we also highlighted the shifting location of 'risks' in these various discourses. For the medical experts, the risk of travelling egg provision is located in 'Third World' clinics and immoral agencies; for agencies, the risk lies in 'Third World' dangers and irresponsible egg providers; and finally, egg providers view the risks in 'Third World' dangers of disease and criminality, as well as in making an ill-informed choice of agency. In essence, such framings erase the critical need for further dialogue around the roles and responsibilities of the state and scientific community in bolstering the scrutiny of the egg provision industry, arguably one with many long-term unknown variables, and unarguably one that is based exclusively on the bodies of women (Deveaux, 2016). This framing of risks and responsibilities, in essence, assists the global circulation and normalization of new biomedical advances, especially the booming market for assisted fertility – markets that can potentially bring unlimited hope and yet impose unprecedented obligations on certain biocitizens.

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