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Exploitation, structural injustice, and the cross-border trade in human ova

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ABSTRACT

Global demand for human ova in *in vitro* fertilization has led to its expansion in countries with falling average incomes and rising female unemployment. Paid egg donation in the context of national, regional, and global inequalities has the potential to exploit women who are socioeconomically vulnerable, and indeed there is ample evidence that it does. Structural injustices that render women in middle-income countries – and even some high-income countries – economically vulnerable contribute to a context of ‘omissive coercion’ (Wilkinson 2003) that is morally troubling. When egg brokers or fertility clinics take advantage of these background structural injustices and prospective ova providers’ vulnerability in order to pay them less than they need to meet their livelihood needs, they engage in exploitation. Analyzing paid egg donation as a form of reproductive labor, however, can direct our attention to reforms that would reduce exploitative instances of this practice. In contrast to those who see egg provision as inescapably commodifying and harmful, I argue that compensated egg provision can be made less exploitative. I defend my approach against commodification-driven analyses of egg donation and concerns about undue inducement, and conclude by discussing some of the ways in which policy-makers and medical practitioners might reduce the harms that may result from this global practice.

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Introduction

Exploitation concerns have recently overtaken commodification worries in discussions about the ethics of commercial gestational surrogacy (Ballantyne 2014; Deonandan, Green, and van Beinum 2012; Kirby 2014; Panitch 2013a). This shift reflects the globalization of the practice and the fact that countries with considerable poverty, like India, have become prime locations for surrogacy. By contrast, much moral analysis of commercial egg provision¹ for *in vitro fertilization* (IVF) remains focused on issues associated with this practice in rich countries, such as undue inducement and informed consent (Gurmanian 2001; Kenney and McGowan 2014; Levine 2010; Steinbock 2004). Analyses of another key concern, that of the risks of bodily and tissue commodification in egg provision for IVF and stem cell research, do increasingly address its global character (Dickenson 2002, 2007; Gupta 2012; Waldby 2008; Widdows 2009, 2013). Yet commodification-driven critiques of

ova provision tend to see the commercialization of women's tissues or cells as leading inexorably to their exploitation – or indeed, as constitutive of their exploitation (Gupta and Richters 2008; Pfeffer 2011). The movement of eggs, money, and people (both would-be parents and paid donors) across different socioeconomic and geopolitical contexts, however, arguably warrants a more fine-grained analysis of the problem of economic exploitation in ova provision – one informed by the growing body of empirical data on donors' socioeconomic circumstances and their motivations for, and experiences of, giving (or selling) their eggs. Not only do commercial surrogacy arrangements in the global South routinely use third party eggs, but would-be parents commonly travel from high-income countries (HICs) to middle-income countries (MICs) in Central and Eastern Europe, or to other HICs countries with turbulent economies (e.g. Spain and Greece) to access ova for donor egg IVF (Shenfield et al. 2010).

Just as the developing world setting of commercial surrogacy is not well grasped from within traditional Western theoretical debates about surrogacy (Bailey 2011; Khader 2013), so too does the global context of paid egg provision require that ethicists expand their theoretical toolkit. In what follows, I ask whether women who provide ova for payment in a globalized assisted reproductive technology (ART) industry are wrongfully exploited. The answer to this question will depend on the account of exploitation used and what one thinks paid egg provision consists in: egg vending, selling one's labor, or feminized care work? While it is tempting to see paid egg provision as a form of 'mutually advantageous and consensual exploitation' (Wertheimer 1996, 20), this view's focus on unfair price leads us to overlook more fundamental reasons why some paid egg donation arrangements are exploitative. I argue that background structural injustices (Young 2011) make many prospective egg providers in MICs and some HICs² vulnerable to offers to sell their eggs for a sum that will not suffice to meet their needs at a level that would allow them to easily refuse such offers in future and so exit this particular form of livelihood; such background injustices also make would-be egg donors, especially in MICs, susceptible to receiving substandard medical care. It is the very socioeconomic vulnerability – and, at times, precarious political status (in the case of migrant women) – of these women that makes it possible for those transacting with them to offer terms that fail to meet their livelihood needs (Sample 2003) – in other words, to exploit them.

While I conclude that the globalized commercial egg trade is very often wrongfully exploitative, I argue that it is not inevitably or inherently so. As others have argued in the case of global gestational surrogacy, reducing the background vulnerability of those who engage in egg provision and simultaneously improving the terms (compensation and medical care) could dramatically reduce its exploitative character (Ballantyne 2014; Kirby 2014; Panitch 2013b; Wilkinson 2003). Reducing the harm of paid egg provision – including the harm of exploitation – is preferable to attempts to implement a global ban on the practice: not only would a ban be unlikely to protect or improve the lives of women who currently participate in it, but it might worsen the situation of those who continue to do so despite a ban. While I do not make specific social policy proposals for reducing the structural injustices faced by women in MICs and HICs, I do suggest several reforms that could reduce the exploitation in paid oocyte provision. In the final part of the paper, I raise and respond to two objections to my argument that paid egg donation is not intrinsically exploitative and so is best regulated and reformed, not banned: the concern that improving the terms of ova provision will provide undue, unethical

inducement to do it; and the belief that payment for ova commodifies and degrades women, regardless of the terms.

The contours of transnational egg provision

Donor egg IVF now accounts for over 25 K IVF cycles annually in Europe, and 20 K cycles a year in the US (Kupka et al. 2014; Centers for Disease Control and Prevention 2015).³ Cross-border demand drives this demand nearly a quarter of the estimated 11–14 K patients who cross European borders annually to receive ART treatment do so to access donor eggs (Shenfield et al. 2010). Unevenness of access and cost has fueled the growth of private ART clinics in countries with fewer regulations in this sector (Spar 2005). Would-be egg recipients include women with low ovarian reserve or poor egg quality, as well as the ‘socially infertile’, such as gay male couples who wish to have children using their own sperm and donor eggs. Patients or clients typically hail from HICs that prohibit commercial egg provision, such as Sweden, France, Canada, Japan, and UK, or else ban donor egg IVF altogether, such as Germany, Austria, Italy, Switzerland, and Norway (IFFS 2013). Further ‘push’ factors include the age and civil (marriage) status eligibility requirements and conditions attached to accessing ART treatment nationally. Legal restrictions on specific treatments and ineligibility were cited as key reasons for seeking ART abroad by patients from 49 countries in 6 European states; some would-be parents also travel to access anonymous gametes (Shenfield et al. 2010). Long wait lists for oocytes at home – attributed to low compensation levels and/or lack of anonymity for donors – and lower cost abroad are the final factors driving fertility travel (Shenfield et al. 2010).

Europeans are the largest group traveling abroad for donor egg IVF (Payne 2015; Shenfield et al. 2010), but North Americans (Downie and Baylis 2013; Hughes and DeJean 2010; Speir 2011), Australians (Rodino, Goedeke, and Nowoweiski 2014), Middle Eastern (Carney 2010b; Inhorn, Shrivastav, and Patrizio 2012), and Asian nationals (Whittaker 2011) also readily cross borders to access this treatment. Some travel to clinics in other HICs with fewer regulations around assisted reproduction: 80% of fertility patients from Canada who travel to the US do so for donor egg IVF (Hughes and DeJean 2010). But the largest number travel to ART clinics in HICs with rising unemployment and falling real wages, such as Spain, Russia, Czech Republic, Hungary, Cyprus, Greece, Kazakhstan, Poland, Bulgaria, and Ukraine (Carney 2010a, 2010b; IFFS 2013; Shenfield et al. 2010). Fertility clinics in economically hard-hit Spain perform over half of all donor egg IVF cycles in Europe (Kupka et al. 2014), drawing patients mainly from the EU, especially Italy and the UK (Shenfield et al. 2010). India and Thailand are the main Asian hubs for ART treatment (IFFS 2013), offering extensive donor egg IVF and private egg bank services; both countries have high rates of poverty, making both paid gestational surrogacy and/or egg donation an attractive option for many would-be surrogates or donors. Finally, the MICs of Brazil, Columbia, Ecuador, and Mexico are donor egg IVF travel destinations, as are Venezuela and Argentina (recently re-classified as HICs); all of these countries report high levels of inequality and considerable poverty.

In addition to would-be parents traveling abroad for oocytes, donors and ova are sometimes shipped across borders. ‘Egg brokers’ recruit and arrange the transport of donors to clinics in countries with liberal laws on egg donation and/or surrogacy,⁴ where treatment is usually offered at a lower cost (Carney 2010b, 2011c; Drane and Bloedorn 2013). Egg

banks and brokers also find it profitable to ship frozen eggs and embryos worldwide,⁵ including from places where women provide eggs for little compensation to countries where paying for ova is illegal, such as Canada and Israel (Downie and Baylis 2013; Nahman 2011, 2013; Somfalvi 2013).

Prima facie case of exploitation?

While demographic data suggest that many cross-border donor egg IVF recipients are of middle, and occasionally, lower, income and occupational levels (Bergmann 2011; Gomez and de La Rochebrochard 2013; Speir 2011), they are nonetheless better off than most donors. And indeed, the financial motivation for egg donation is most pronounced among women with a less stable source of income. In a 2011–2012 study of 1423 donors in 11 European (some non-EU) countries by the European Society for Human Reproduction and Embryology's (ESHRE) Task Force on Cross-border Reproductive Care (CBRC) and the European IVF Monitoring Consortium, younger and less educated women were the most likely to cite strictly financial incentive for providing eggs. Notably, women from countries experiencing economic turbulence were most likely to report financial motivation: 40% of donors in Greece and 52% of donors in Russia cited it as their sole motivation; a combination of financial and altruistic motives was reported by 57% of donors in Spain and 59% of donors in Ukraine (Pennings et al. 2014). Unemployed women were considerably less likely to cite purely altruistic motivations for donating eggs, as were part-time workers and students. Similar findings were reported in a US study, in which 94% of egg donors who identified as students said 'financial compensation was a significant factor in their decision to donate eggs' (Kenney and McGowan 2010, 464), versus 56.8% of nonstudents. Some studies report that repeat donors are much more likely to be motivated by financial incentives; significantly, repeated (compensated or paid) donation is common in countries with high rates of female under- and unemployment (Pennings et al. 2014; Zuber 2013). And because many of the leading countries for donor egg IVF, such as Spain and Cyprus, have no national donor registries, repeat donations above the recommended maximum number of cycles are common.

Those with presumed financial need thus make up a sizable proportion of egg providers: in Europe, the US, and elsewhere, oocyte providers are often students and/or under- or unemployed: 24% of donors in Spain and 22% in Ukraine are unemployed (Pennings et al. 2014). It should not surprise us that few women are willing to undergo ova donation without compensation or payment: the process is physically taxing and moderately time-consuming, consisting of blood screening tests, 10–14 days of (usually self-administered) hormonal shots for to stimulate egg follicles, and a minor surgical procedure to extract mature oocytes. Donors receive no therapeutic benefits and often experience unpleasant side effects; they also face a small chance of serious health risks, as well as possible but unknown long-term consequences. While outright payment is often prohibited by national legislation and/or medical association guidelines, compensation for expenses and lost income – liberally interpreted – is common. In the EU, compensation usually falls between €500 and €1400 (adjusted for purchasing power) for one cycle (Pennings et al. 2014). In Cyprus, where fertility clinics typically recruit Eastern European migrants who cannot legally work, compensation is often as low as \$500 USD (Carney 2010c). Payment is much higher in the US, typically ranging from \$4000\$ to \$8000 USD,

and some US clinics ignore the American Society of Reproductive Medicine's (ASRM) recommendation that remuneration not exceed \$10,000 per donor cycle (ASRM Ethics Committee 2007). Payment is freely permitted in India, where women receive on average \$450–650 USD per successful cycle, or occasionally up to \$1500 USD (Chatterjee and Janwalkar 2014; Jha 2014).

Structural injustice and vulnerability

Whether or not medical donation – compensated or not – is conducted with the informed and valid consent of the participants is critical to determining whether a procedure is ethical and non-exploitative. Bioethicists have argued that in the case of clinical trials among poor populations, ensuring valid consent is not simply a matter of whether volunteers have been fully informed of the risks and side effects. Rather, it also requires that their compliance not be compelled by desperate economic circumstances (Emanuel 2004; Emanuel and Hawkins 2008). The possibility that valid consent to a risky trial or medical donation may be undermined by acute poverty is partly about whether the promise of payment interferes with a donor's or medical volunteer's ability to accurately weigh the risks of his or her participation. Less narrowly, however, it is about whether or not an agent has the requisite capacities and opportunities required to make their choices genuine, uncoerced ones (O'Neill 2000). While a lack of adequate alternative options does not, in itself, invalidate consent or make a transaction exploitative (Wertheimer 1996), it arguably makes a decision to engage in a risky or physically painful activity in return for payment morally suspect. Specifically, my claim here is that while a woman in dire circumstances who agrees to undergo egg harvesting is not coerced in the strict sense, she is vulnerable to exploitative contractual terms and treatment.

The lack of alternative income-generating options is an important aspect of the socio-economic vulnerability of many of the women who provide eggs for commercial ART clinics geared to a global clientele, such as clinics in India, Spain, Czech Republic, Greece, Cyprus, Ukraine, and Russia. Before I make the case for this, and for the role that vulnerability plays in making possible the exploitation of some ova providers, it is worth looking at Iris Young's (2011) analysis of structural injustices. According to Young, certain background features of a society's social structure can contribute to the socio-economic vulnerability of some social groups (such as women), even in HICs. Young discusses the case of Sandy, a single mother who is structurally vulnerable to the condition of homelessness due to a range of factors beyond her control, including a housing market that favors dual income families; a sex-segregated labor market that does not offer non-college-educated women like Sandy a living wage; "the spatial mismatch" that locates [low-wage] jobs far from most affordable housing; and a poor public transportation system (2011, 45). The wrong of structural injustice that Sandy faces is, Young emphasizes, separable from harms attributable to 'individual interaction' or even 'specific actions and policies of states or other powerful institutions' (2011, 45). It is, rather, the wrong of multiple underlying social-structural processes that shape her housing, education, and employment opportunities.

Vulnerability to structural injustices can illuminate what is morally wrong (not just unlucky) about the social and economic vulnerability of many women who opt to become ova donors for payment. Analogous to Young's analysis of Sandy's vulnerability

to homelessness, we can observe that women who are under- or unemployed, students, or migrants, are vulnerable to poverty and have very limited options for earning income. This lack of alternatives is part and parcel of what it is to be vulnerable to a condition like poverty or homelessness against the background of structural injustices. This is not to say that egg vendors are coerced; they may opt instead to engage in other undesirable work, like transactional sex, or simply fall deeper into poverty. Just as becoming homeless will depend on a number of factors, including the actions of the vulnerable individual, so whether a woman agrees to undergo ova extraction for cash depends in part upon her own choices in the face of limited options. But though an offer to pay a vulnerable woman for her eggs does not coerce in the sense of making 'any preexisting options less eligible ... it may well compromise the voluntariness of [a woman's] choice' (Wertheimer 1996, 110) insofar as the lure of payment makes her disregard or downplay risks to herself.

What structural features can explain the vulnerability to low income or poverty of some categories of women (students, migrants, and young mothers) in countries where egg harvesting is big business? Many of these states have a segregated labor market in which women experience high rates of under- and unemployment and low pay; in such a context, students, single mothers, or migrants are especially susceptible to poverty. Notably, several countries in Europe with significant commercial fertility industries – Greece, Czech Republic, Spain, Hungary, and Cyprus – have large gender gaps in pay.⁶ In these countries, moreover, having a child at home dramatically increases a young woman's transition time to a first job, but not that of men (European Commission 2014); this scenario also correlates strongly with part-time work. Young, frequently single, mothers appear to be the biggest source of egg donors in some European states (EU and non-EU): 67% of donors in Czech Republic, 53% in Greece, 99% in Ukraine, and 100% in Russia are mothers, according to the largest study of egg donors in this region (Pennings et al. 2014, 1080). In India, the sources of egg donors' vulnerability are many. The gender pay gap in the formal sector in India is even more dramatic (Varkkey and Korde 2013), and female unemployment is high (especially among widows and single mothers). Interviews with Indian donors suggest that many have primary responsibility for the care and support of their children (Chatterjee and Janwalkar 2014). Nor is it only working-class women in India who are at risk of exploitation: 'educated, upper-middle-class Indian women have found a new occupation as egg donors in order to supplement family income due to the recent financial meltdown' (Gupta 2012, 31).

We can see more clearly how a backdrop of pervasive structural inequalities contributes to the economic vulnerability of many prospective egg donors and predisposes them to exploitative egg harvesting arrangements by considering the situation of migrants who become donors. Migrant women (and in some European countries, foreign students) typically have even fewer avenues for earning income than do citizens or permanent residents, as many have a precarious (illegal) political status. The high percentage of migrant women from former Soviet bloc countries (and to a lesser extent, Latin America) providing eggs for payment in clinics in Greece, Cyprus, Portugal, and Spain (Bergmann 2011; Carney 2010a, 2010b, 2010c; Pennings et al., 2014) is thus worrying, because these women generally have dramatically reduced opportunities and bargaining power. Migrant women from Central and Eastern Europe are preferred egg donors in many clinics in ART hubs in Southern Europe as well as Israel because of their perceived

phenotypical similarity to clients (Carney 2010a, 2010b, 2010c; Nahman 2011, 2013). Donors in Cyprus, which has quickly become a major hub for donor egg IVF for women from Europe and further afield, are typically economic migrants from Russia, Ukraine, Moldova, and Romania, with tenuous immigration status (Carney 2010a, 2010b, 2010c).

Migrant women from Latin America and Eastern Europe whose precarious economic and political status leaves them with few options for earning an income, and under- or unemployed women in Russia, Ukraine, and India who cannot find other ways to meet their livelihood needs, may feel tremendous pressure to accept an offer from an egg broker or fertility clinic that they would strongly prefer not to accept. Amrita Pande quotes Salma, an Indian surrogate, as saying 'Who would choose to do this? This is not work, this is *majboori* [a compulsion]. It's just something we have to do to survive' (2010, 988). We can acknowledge a desperate woman's *apparent* consent to undertake exploitative reproductive labor without thereby concluding that it is an ethical transaction (Donchin 2010, 325). As Wilkinson (2003) notes in his discussion of gestational surrogacy, moreover, 'mere voluntariness' is not the same as *fully* valid consent. Useful here is Wilkinson's notion 'omissive coercion': insofar as an agent is threatened with denial of what she needs by a given duty-bearer – who may be the exploiter, or the state – unless she undertakes to do 'y' (Wilkinson 2003, 177), we can say that she is omissively coerced.⁷ Where an egg provider's socioeconomic vulnerability is acute, she is threatened with not getting that which she needs unless she undertakes this (or similarly unappealing and possibly risky) work. Whether we view the state as the duty-bearer that is failing the reproductive worker (Gupta 2012; Panitch 2013a), or see it as the fault of the fertility clinic's owners, or even the commissioning parents, makes little difference at this juncture; the point is that a prospective egg provider who decides to undergo this uncomfortable medical donation procedure in order to meet her livelihood needs faces a desperate choice, and is vulnerable to exploitation.

Vulnerability to exploitation

Socioeconomically vulnerable women who agree to become egg providers in order to meet their basic needs experience social-structural injustices that are both national and global in nature. Egg brokers, fertility clinics, and doctors who take advantage of prospective donors' vulnerability to offer them terms for their reproductive services that cannot meet egg providers' needs are engaged in exploitation. It is this taking advantage of an agent's vulnerability in order to derive profit that I argue, along with Ruth Sample, is at the heart of disadvantaged egg providers' exploitation: 'vulnerability is typically (if not always) at the root of exploitation. When we exploit others, we make use of their genuine need for the sake of advantage in ways that fail to respect them' (Sample 2003, 75). Egg vendors who experience deep structural injustices and very limited opportunities cannot readily refuse an offer of fast cash, even one that will not significantly improve their situation (as is usually the case). Following Sample, we can say that an exploitative offer is one that ignores a vulnerable person's livelihood needs while giving the exploiter most of the benefits: 'Interacting with others for profit and allowing them a meager existence while personally prospering displays a lack of respect for their humanity and dignity' (2003, 89).

This view contrasts with the claim that (non-harmful) exploitation reduces to unfair price, or unfair distribution of profit. Wertheimer believes that unfair price lies at the heart of what he calls ‘mutually advantageous exploitation’, which occurs when an agent ‘takes unfair advantage’ of another (1996, 207). In this form of exploitation, an exploitee enters voluntarily into a transaction and derives some benefit from it, but less than she should: ‘A gains *unfairly* or *excessively* [“in relation to some appropriate baseline”] by an action or transaction that is *beneficial* to B’ (Wertheimer 1996, 207, emphasis in original). He suggests that surrogacy and similarly undesirable work might best be understood as mutually advantageous exploitation. While this may well characterize paid egg provision in contexts in which donors do not experience significant socioeconomic vulnerability yet receive an unfair distribution of the benefits, I argue that it does not capture what is morally troubling about paid ova procurement in the commercial ART sector in MICs (and some HICs). Arguably, the notion of mutually advantageous exploitation elides the difference between voluntariness and valid consent; in so doing, it also fails to consider the possibility of omissive coercion caused by structural injustices. In the case of contract surrogacy, Wertheimer claims, ‘the intended parent’s proposal is an offer, and offers do not coerce’ (1996, 111). Yet consider an Ecuadorian migrant to Spain who badly needs money to cover the living costs of herself and her child, but who has very few income-generating options due to her liminal immigration status, the national context of high unemployment (as high as 27% in recent years), and her inability to access social support services (as a non-EU national). In Wertheimer’s view, she participates in mutually beneficial exploitation insofar as she agrees to undergo ova extraction at an *unfair* rate of compensation – say, a low rate paid to non-EU nationals. But ‘fair’ compensation, relative to the market rate paid to Spanish donors (€1000) profit made by the doctor and/or clinic, would effectively nullify her exploitation.

This dubious (or at least, hasty) conclusion downplays the force of the national and global structural injustices that the migrant egg donor faces. Surely we can and should *doubt* whether her consent is robust or fully valid; the donor’s lack of alternative options and sheer desperation, for one thing, may lead her to play down or even discount the possible risks to her health, and perhaps to donate multiple times. While there are good reasons to reserve an automatic judgment of invalid consent for situations in which deception or overt coercion is used to pressure an agent into an arrangement (Ballantyne 2014; Wertheimer 1996), I argue that the notion of mutually advantageous exploitation simply fails to grasp the moral seriousness of impairments to the autonomy and consent of vulnerable women who undertake risky, unpleasant work.

Wertheimer’s emphasis on unfair price and excessive gain by one person in a (mutually advantageous) exploitative transaction also seems a poor fit for a discussion about the ethics of paid ova provision given the huge range that exists in compensation paid to egg donors globally. At the present time, it is not possible to determine, as a baseline, a fair ‘market’ price for the services of egg donors. As Ballantyne notes (2014, 89), not only are human eggs ‘not broadly accepted as market services/goods’ in the countries with commercial fertility industries, but ‘a market analysis will not tell us how much sellers should be paid’ – even if it can ‘allow us to predict how much the sellers are likely to be paid’. Taking advantage of a prospective egg donor’s socioeconomic vulnerability to pay her a wage that is simply too low to meet her basic needs – and profiting

from this arrangement – is, I argue, exploitative for reasons that do not depend on unfair market price.

A conception of exploitation that focuses on whether a contractor profits from offering a vulnerable person terms that will not meet their livelihood needs seems better to capture what is morally problematic about some commercial egg donation arrangements. The payment of \$500 USD that a Russian migrant in Cyprus receives for egg provision can in no way reduce her vulnerability to poverty; whether it is an unfair price relative to the profits reaped by the clinic or doctor is not insignificant, but neither is it morally exculpatory. The egg donation arrangement she enters into is exploitative because it consists in both ‘a particular kind of disrespect toward a person in pursuit of ... [one’s own] advantage’ and a failure ‘to improve the situation of ... interactors sufficiently’ (Sample 2003, 70). A vulnerable egg donor who receives a fair distribution of profits, and/or a fair/market rate for her services, may still be wrongfully exploited, on my view, if an egg broker or fertility clinic takes advantage of her vulnerability to pay her less than what she needs to meet her livelihood needs (and profits from doing so). Indeed, as Snyder has argued, this kind of exploitative transaction may also contribute to vulnerable persons making demeaning choices: by encouraging a person to agree to an exploitative transaction that fails to meet her basic needs, the exploiter encourages the exploitee to make a ‘demeaning choice’ that wrongs them ‘by making them participants in their own degradation’ (2013, 350, 352).

Some who consider unfair price as constitutive of reproductive workers’ exploitation see it as reflective of – or even a proxy for – a more serious moral worry: lack of bargaining power and susceptibility to omissive coercion (Panitch 2013a). Here what is important is

not whether the offer threatens to make her worse off, but whether she is able to negotiate for a fair share of the benefits. The extent to which an Indian surrogate is forced to accept the terms as presented to her depends on the quality of her bargaining power. ... A surrogate’s bargaining power can be assessed on the basis of her fungibility, her lack of alternative options, and the urgency of her own and her family’s needs. (Panitch 2013a, 334)

The lack of bargaining power experienced by a socioeconomically vulnerable prospective egg donor is due in large part to the (national and global) structural injustices that she faces. And this lack of power is indeed to be morally condemned. But an important question here is whether we should still consider her to be exploited (despite her relative lack of power) if she were very well paid. We may want to say that a highly paid donor is still omissively coerced, if her background vulnerability and lack of options warrant this judgment. But if a fertility clinic was required by law to pay her a high fee for an egg donation cycle – sufficient to meet her livelihood needs – and the highest standard of medical care and informed consent were met, it is not clear why we should *necessarily* still see her as exploited in virtue of her lack of bargaining power.

This discussion shows why our judgments about exploitation in cases concerning reproductive workers should not pivot on the matter of fair market price, or relatedly, on a fair distribution of the profits. Similarly, while the ‘fair-trade’ approach that some have defended as applicable to global surrogacy (Humbyrd 2009) might be more likely than non-fair-trade approaches to ensure that egg donors receive compensation adequate to meet their livelihood needs, the fairness requirement is essentially a proxy for what is important: that donors be paid enough to meet their needs and so remove the coercive

character of the transaction. Where donor egg IVF is priced relatively low (as it is in Cyprus and India, for example), a fair market price paid to egg providers may not suffice to reduce a vulnerable donor's poverty; yet we would surely want to ascribe exploitation to a situation in which clinics profit from offering cut-rate donor egg IVF to a global clientele by using a reserve pool of unemployed or poor women. Conversely, it seems wrong to say that a very well-compensated and well-treated (vulnerable) donor is necessarily exploited if she receives too low a *percentage* of the profit (though we may still have other moral objections here). Remedying this problem of inadequate compensation may well coincide with giving the egg provider a larger proportion of the profits, or in Wertheimer's terms, a *fairer* distribution of the benefits – but not necessarily. It is possible that the fee paid by the egg *recipient* – or her insurance carrier, or potentially the state – could be raised, and the payment to the egg provider increased, without changing the proportion of the profit she receives. If the compensation she receives suffices to lift the donor out of poverty for the next, say, four months, and both her medical care and the process for ensuring informed consent are of a high standard, we have reason to consider it non-exploitative.

My analysis suggests that vulnerability caused by socio-structural injustices is best understood as a necessary, but not sufficient, condition for wrongful exploitation. For exploitation to be present, it must also be the case that an agent takes advantage of these structural injustices to pay a vulnerable worker a sum that is too low to meet her livelihood needs, or to treat them badly in some other way (e.g. fail to provide them with adequate medical care). A person who suffers from socioeconomic vulnerability may have no offers at all, or may decline the offer of an exploitative transaction in lieu of other options (e.g. panhandling, or joining a religious order). Equally, it is possible that a woman who is economically vulnerable could be made an offer that would significantly improve her financial circumstances without jeopardizing her health or otherwise harming or deceiving her. In such an instance, she is not exploited, but may nonetheless experience vulnerability and the associated diminished options for remedying it. The pressure that she experiences in light of her economic desperation is morally serious, but need not lead invariably to exploitative arrangements. ART regulatory regimes at the state level could do much to enforce an industry-wide standard payment to egg donors that would ensure that they are compensated at a rate that reduces their economic vulnerability.

It is relatively straightforward to determine what would constitute non-exploitative medical care of a donor: it requires that the safest hormonal protocols be used so as to minimize the risk of ovarian hyperstimulation syndrome (OHSS); a willingness to cancel a cycle if OHSS or other serious conditions develop; and follow-up medical care for egg donors to the standard that fertility patients receive. But the question of what level of compensation would make an arrangement with a socioeconomically vulnerable egg donor non-exploitative is more difficult. Given the diverse circumstances of donors, how can we determine what payment for their reproductive services or labor would reduce their vulnerability to low income or poverty? This calculation is further complicated by the claim, implicit in the structural injustice critique, that states should increase social welfare supports so that women should not be vulnerable to exploitative offers. But absent dramatic change on the social welfare front, the fee paid to donors in MICs and economically turbulent HICs for a single egg cycle should suffice to ensure that they are not susceptible to poverty in the near future; this fee, for example, should allow her to

meet her needs (for housing, food, transport, etc.) for the average amount of time it takes to secure employment, or to start receiving social benefits, following a job loss. It is nonetheless important to acknowledge that egg donation is not something one can undertake indefinitely – six cycles is the usual upper limit – and that income from this activity is unlikely to be a woman's sole source of support.

In tandem with better standards of medical care and consent, a higher rate of pay would contribute significantly to meeting a donor's livelihood-related needs and so not constitute a degrading offer (Sample 2003) or force a demeaning choice (Snyder 2013). This would likely raise the overall cost of donor egg IVF, but this is morally justifiable so long as a commercial fertility industry exists, provided that it reduces the exploitation of ova providers.⁸ One important consequence of mandating a higher fee to be paid to donors and perhaps making it a standard amount (set nationally) is that it might put oocyte brokers – who are more likely to impose exploitative terms – out of business. Brokers profit financially from donors' reproductive labor and have an incentive to downplay the side effects and risks of egg harvesting in order to recruit more women; similar problems have been noted by ethicists in connection with surrogacy brokers (Satz 2010). The ESHRE's Task Force on CBRC warns that 'using brokers increases the risks of disproportionate enticement, which in some cases can go as far as completely disregarding women's rights and interests by submitting them to superovulation without explanation of either the process or the outcomes' (Shenfield 2011, 661). Restricting brokers is also necessary to improve the process of securing explicit, informed consent, by clearing the way to appoint an egg provider's public advocate to represent the interests of donors (Kirby 2014). Requiring that both egg providers and recipients have legal representation by different parties and requiring psychological counseling for prospective egg providers are additional policy changes that could help to decrease exploitation in paid egg provision arrangements. A nationally standardized donor fee would not only make the egg broker business less viable; it would also discourage clinics from charging different fees according to the perceived desirability of different women's oocytes, which reinforces the idea that eggs are to be bought and sold (Levine 2010), rather than compensating women for their reproductive labor.⁹

Under- or unemployed young women in MICs and HICs who become egg donors as a way of making ends meet will remain susceptible to omissive coercion in light of the structural injustices and entrenched disadvantages that they face. The undesirable and possibly risky work that they agree to undertake will depend on many factors, including their own (constrained) choices. But insofar as paid egg donation is concerned, compensation that suffices to meet their livelihood needs, in tandem with better medical care and standards for informed consent, can render these arrangements *less* exploitative – and possibly non-exploitative. Indeed, my claim is that absent vulnerability to socio-structural injustices, and with higher pay and higher standards of care and informed consent, paid egg provision – even in lower MICs – is not exploitative.

Objection 1: undue inducement and informed consent

Might higher payments lead women, especially economically vulnerable women, to make risky choices, as some ethicists warn (Steinbock 2004, 262)? The ESHRE (2002, 1408) is concerned that 'an excessive payment would seriously challenge the very notion of informed

consent by the donor'. According to its Task Force on CBRC, 'such enticement may ... put pressure on vulnerable, low-income women' (Shenfield 2011, 659). The ASRM (2007, 306) worries that 'the higher the payment, the greater the possibility that women will discount risks'. The concern that high payment against the background of economic hardship would lure women who strongly prefer not to give their eggs seems valid. But it is not clear that paying a *lower* fee would dissuade the most desperate would-be donors from taking this work anyway, and perhaps even needing to donate many more times so as to increase their income.

The undue inducement objection covers cases in which the promise of high payment leads a person to ignore or downplay risks as well as instances where one decides to proceed regardless of risks. Both are reasonable concerns in the case of paid ova donation. But there is reason to think that at least in Europe, where standards for securing informed consent are already very good, ova donors are not made less aware of side effects and risks simply in virtue of higher payment. The large 2012 European study cited above showed no relationship between strong financial motives and being unaware of the procedure's risks (Pennings et al. 2014, 1087). Donors from countries in which large numbers of women said they were chiefly motivated by the promise of remuneration reported similarly high rates of medical risk counseling; indeed, some reported *higher* rates of comprehensive counseling than those in countries where altruism in donation prevails and payment is not allowed (Pennings et al. 2014, 1082). Unfortunately, there is no data that tells us whether, and what level of, *payment* per se affects egg providers' *assessment* of risks, which is of course not the same as being informed.

The possible harms associated with ova extraction are also relevant to the undue inducement concern. How significant it is to disregard risks in the case of egg donation, and therefore how much weight to give to the undue inducement concern, will also depend upon the side effects and risks of ovarian induction and extraction. The most serious short-term complication of ovarian induction is the risk of OHSS, which can cause symptoms ranging from bloating and nausea to abdominal pain, shortness of breath, and blood clots; its severe form, if untreated, is potentially fatal. Most studies put the risk of severe OHSS at around 1–2% (Maxwell, Cholst, and Rosenwaks 2008, 2169; Sauer 2001), but milder forms of OHSS are more common. Significantly, severe OHSS occurs less frequently in women who undergo ovarian induction/extraction *without IVF*, as in the case of donors, because the hormone released during subsequent implantation of the embryo – which triggers the most serious cases of OHSS – is absent (Ellison and Meliker 2011, 26; Maxwell, Cholst, and Rosenwaks 2008, 2169). Because they are screened, donors are also unlikely to have polycystic ovarian syndrome, which greatly increases the likelihood of OHSS. These risks can be further minimized by more aggressive policies of canceling donor cycles in which OHSS seems to be developing. There is also a recent trend toward shorter and safer hormonal protocols yielding fewer mature oocytes; in particular, some protocols now eliminate the use of human chorionic gonadotrophin (hCG) because of its close association with OHSS (Mertes and Pennings 2011).

The possible long-term effects of egg donation on later infertility (on which there is very little research) and uncertainty about heightened rates of certain cancers are ongoing concerns. Evidence regarding cancer risk is mixed: while some studies have shown that controlled ovarian hyperstimulation for the purpose of egg maturation and retrieval puts

women at higher risk of developing uterine cancer (Calderon-Margalit et al. 2008), others report that IVF patients are no more likely to develop either general cancers or hormonal-related cancers (Sergentanis 2014; Yli-Kuha et al. 2012). All agree that more studies are needed on the long-term effects of ovarian induction and extraction, especially on *donors* as opposed to IVF patients.

In its Good Practice Guide for CBRC, the ESHR Task Force on CBRC underscores the need for additional regulations and mechanisms to enforce these safer protocols (Shenfield 2011, 660). Better oversight of commercial fertility practices in particular is needed since there will no doubt continue to be pressure from clients to maximize egg yield, which in turn requires higher doses of hormones.¹⁰ To further reduce harms, strict limits on the number of donations a woman can undertake ought to be uniformly implemented, and better enforcement mechanisms (such as national egg donor registries) put into place.¹¹

Might higher compensation and better terms of work dramatically increase the number of women who agree to undergo egg retrieval in return for payment? Might it therefore promote a line of work for which, by all accounts, we have insufficient long-term health data? It seems unlikely. With the advent of ‘social egg freezing’, fewer women who delay child-bearing may seek out donor eggs. Egg-sharing schemes among women undergoing IVF, made easier by egg and embryo freezing, have also increased, reducing the need for paid donors in some places. And the advances made in recent years in vitrification techniques has made it less likely that a woman with ovarian failure will seek out more than one donation cycle, since the success rates of pregnancy from thawed frozen embryos are on par with those of fresh embryos (ASRM and SART 2013; Mertes and Penning 2011). Indeed, the rate of growth of donor egg IVF has begun to level off in the US, at least (Centers for Disease Control and Prevention 2013).

Objection 2: feminist concerns about exploitative commodification

For some feminist critics of commercial egg donation, minimizing the health risks associated with egg donation, meeting the criteria for fully informed consent, and improving the compensation of donors, would not make this practice ethical (Dickenson 2002, 2007, and 2013; Pfeffer 2011; Widdows 2009, 2013). On their view, paid egg provision, like contract surrogacy, is inherently harmful insofar as it wrongly commodifies the human body and violates people’s intrinsic worth. According to Widdows (2009, 19),

If human tissue cannot be turned into a commodity without harming people’s worth as persons, then any form of tissue sale, including but not exclusive to female tissue such as eggs, is in a sense exploitative, *whatever price is offered for it* (emphasis in original).

Widdows and Pfeffer join feminist reproductive health activists in drawing a parallel between the harms and risks of egg selling on the one hand and sex work/sex trafficking and organ selling on the other (see also Storrow 2005–2006). Both are exploitative, on their view, because the harms and risks they invariably present are not ones that women would choose, absent coercive circumstances (Widdows 2009). Commodification is thought to explain why better pay and work conditions will not ever make them less exploitative (Dickenson 2013; Gupta 2012). According Gupta (2012, 47) ‘even if it is given a human face by adopting legislation to soften

its sharp edges, industrialized commercial reproduction remains commodification'. This does not just impact individual women but is detrimental to women's social equality overall (Acero 2009).

The commodification critique of egg donation echoes Elizabeth Anderson's influential work on contract surrogacy; according to Anderson, this practice

represents an invasion of the market into a new sphere of conduct, that of specifically women's labor – that is, the labor of carrying children to term in pregnancy. When women's labor is treated as a commodity, the women who perform it are degraded. (1990, 75)

Anderson's claim is that women's unique reproductive labor is wrongly (and harmfully) treated as a commodity in commercial surrogacy, in part because it requires that the surrogate alienate her feelings of love for the child she is carrying, thereby substituting 'market norms for some of the norms of parental love'. This reflects a failure to value this good 'in an appropriate way' (Anderson 1990, 76, 72). The surrogate's rights are, moreover, disrespected insofar as her parental rights are wrongly treated 'as a kind of property right' (Anderson 1990, 76). It is unclear whether Anderson's view of contract surrogacy would necessarily imply that paid egg provision commodifies *women* (as opposed to babies) in harmful ways; in particular, a key aspect of what Anderson cites as 'treating women's labor as a commodity – the surrogate mother's alienation from loved ones' (1990, 87) does not seem applicable in the case of ova provision.

Yet treating a woman's ova as a commodity, and assessing her eligibility as a paid donor in light of certain features (hair color, eyes, height, and IQ), does seem to entail a certain commodifying treatment of her. Crossing borders to gain access to anonymous donor eggs from a woman almost certainly less well off than oneself may also make it easier to see her as a contractor selling a product, as opposed to a paid medical volunteer. Lisa Ikemoto, writing on global contract surrogacy, argues that surrogate carriers of a different race and social class are more easily commodified by affluent, white couples from abroad because of a process of 'racial distancing' (2009, 308). Although, it is more unusual for egg recipients to seek donors of a different race than them or their partners (Storow 2005–2006, 315), this does not mean that race is not a salient factor – as when the ova of Romanian and Ukrainian women are sent to Israeli and Irish clinics, or when unemployed eastern European migrants are recruited as egg providers by Spanish ART clinics, or when non-resident Indians seeking IVF treatment in India specify that they require a light skinned or Brahmin egg donor.

Commercial, cross-border donor egg IVF may encourage the commodification of oocyte providers in some contexts, because it encourages many of those involved (recipient, brokers, fertility agency staff, and medical personnel) to consider the donor's body in a highly strategic way, without concern for her overall well-being. But arguably this commodification is arguably chiefly harmful insofar as it contributes to the exploitation of ova provider, in the sense of too-low payment and/or substandard medical care. For example, if a donor is considered mainly in light of the quality and number of oocytes she is likely to produce – with profit riding on this calculation – it is more likely that she will be given higher and riskier doses of follicle-stimulating hormones (especially if, as sometimes happens, two clients are splitting the egg 'yield'). Moreover, she is likely to be paid less than the full promised amount if her cycle is canceled at the last minute due to poor response.

There are several possible reforms that could help to counter or even eliminate these commodifying practices, however. A system that treats ova providers as valued medical volunteers whose health is of paramount importance, and which mandates a high flat fee for her time and discomfort (irrespective of the number of mature oocytes retrieved), treats her with greater respect. Leaving the matching of donors and egg recipients up to doctors – as is the practice in many countries, including Spain – would further reduce the tendency to commodify providers. It is also possible that moving to a non-anonymous system of egg provision and/or one in which donors choose the recipients (both of which exist in a few jurisdictions) would better emphasize the humanity and equal value of the donor. Finally, implementing a nationally standardized fee for egg donation would not only help to ensure that donors are well compensated, but would signal that they are being paid for their reproductive labor (and time and discomfort)—not for their genetic attributes or their eggs.

Merely providing tissue, or engaging in labor?

Insofar as the commodification critique leads us to downplay the extent to which these new reproductive practices involve the real *labor* of women, feminist ethicists arguably have reason to move away from it. The commodification lens focuses on the wrongful sale of body tissues (or the ‘rental’ of body parts, like the vagina and uterus) in morally noxious markets. The idea that ova providers, like surrogates, are engaged in reproductive labor is of course compatible with the claim that they are also being commodified: Elizabeth Anderson writes, for example, of the problem of ‘treating women’s labor as a commodity’ (1990, 87), and Dickenson (2007, 77) describes women’s labor in creating ova for third party use as fundamentally alienated (because commodified). But if we consider the reproductive labor of egg provision as a kind of paid medical volunteer work involving a transfer of bodily cells, and situate this work in a context in which several of the above-mentioned reforms have been implemented, it is not clear why it should be seen as inescapably commodifying women. The claim that paid ova provision inherently commodifies reinforces the problematic idea that egg providers are merely selling their cells (Dickenson 2013; Widdows 2009), rather than participating in a (complex) medical undertaking that requires time and effort.

Against the commodification view that ova providers are merely vending eggs, we might instead see their work (in both monetized and altruistic systems) as a kind of biomedical labor, as Waldby and Cooper argue (2008, 59):

Women’s participation in the sale of eggs involves a very literal form of bodily, reproductive labour – a kind of labour that has been traditionally available to women but which has only recently been medicalised, technologised and standardized to an extent where it can be organised on a global scale ... This [biomedical] labour is not recognised generally as such, because it does not consist primarily in the performance of codified tasks but rather in subjects giving clinics access to the productivity of their *in vivo* biology ... It does, however, involve second-order tasks; compliance with often-complex medical regimes of dosing, testing, appointments and self-monitoring.

Similarly, in her ethnographic work on Indian gestational surrogacy, Pande argues that Indian surrogates are engaged in a new form of reproductive labor (2010, 972) – or what we might call ‘sexualized care work’ (142). The disciplining and training that makes Indian gestational surrogates into particular kinds of workers is problematic on

numerous levels, but Pande views this characterization of surrogacy as labor, as a more accurate description of what it is surrogates are actually doing. Her observation that seeing surrogacy as reproductive labor rather than mere womb rental/selling makes possible a more fine-grained analysis of surrogates' exploitation – as well as of their resistance – seems equally applicable to paid egg donation.

Understanding compensated egg provision within a reproductive labor framework directs our attention to reforms that would reduce the exploitative character of some ova donation arrangements (as well as certain commodifying tendencies). By contrast, the commodification critique tends to reject such reforms as pointless – why reform something that is invariably harmful to women? – and does not readily allow us to see some reproductive labor arrangements as morally better or worse than others (Panitch 2013b). This points to a further troubling feature of the commodification lens that Khader's (2013) intersectional feminist analysis of surrogacy brings to light: while a commodification lens can illuminate the ways that race, sex, and class may interact to make a woman multiply vulnerable or disadvantaged, it readily overlooks the intersecting effects that can actually *mitigate* gendered harms. This is due to the commodification critique's close alignment with what Khader calls the 'intensification thesis', which insists that 'the main way race and class subordination impacts gender oppression is by producing the same effects it produces on privileged women – albeit in an aggravated form' (2013, 76). The commodification analysis, in other words, tends to treat transactional sex work, ova provision and surrogacy as having a uniformly bad (i.e. because commodifying) effect on women, merely intensified in the case of women of color and of the global South. In the case of gestational surrogacy, it thus leads us to overlook the different experiences, circumstances, and relative benefits that, as Khader notes, lead Indian and American surrogates to have importantly diverging interests (2013, 77–78). Similarly, I argue that insofar as commercial ova provision is seen as irreducibly commodifying of women, it becomes impossible to distinguish morally between contexts that are exploitative and disempowering and those that are non-harmful and even beneficial for paid donors.

Conclusion: exploitation, but no ban?

When we view exploitation as taking unfair advantage of another's vulnerability in a way that fails to respect their livelihood-related needs, much of the global trade in donor eggs for IVF looks exploitative. Indeed, the cross-border aspect of this practice has increased the likelihood of exploitation by fueling its rapid commercial expansion without appropriate safeguards and regulations. Social-structural injustices that cause many women to be economically vulnerable may lead them to opt for risky work, and we cannot say in such cases that their consent is fully or robustly valid. The socio-economic vulnerability of prospective egg donors in MICs and economically turbulent HICs is what enables some fertility clinics and egg brokers to offer payment that will not meet donors' needs or significantly reduce their susceptibility to poverty. Commercial IVF clinics or egg banks also sometimes fail to provide donors with high-quality medical care throughout the process and for a time afterwards, for reasons of profit or just because they can; in doing so, they are guilty of devaluing and disrespecting donors in ways that contribute to their exploitation. Added to this, egg providers – paid and unpaid – do not always receive complete information about the short and

long-term health consequences of the donation procedure, thereby comprising their valid, informed consent (Gurmankian 2001; Kenney and McGowan 2010). These problems are especially acute in countries that lack an adequate regulatory environment: neither India nor Thailand, which encourage ART tourism, have ratified or implemented their draft national legislation governing medical practices around these technologies, and industry (voluntary) guidelines are weak.

I have argued that commercial cross-border egg provision exploits vulnerable women who have few alternative options due to social-structural injustices. But unless one thinks that payment for bodily tissues or substances is *always* morally wrong and/or harmful, or else new, dispositive information about the concrete individual or social harms of paid egg donation emerges, we have good reason to try to make it less exploitative and safer for women. A more tightly regulated system of paid egg donation, perhaps coordinated globally by a transnational body such as the International Federation of Fertility Societies, could require that ova donors be well paid and that the highest standards of care and informed consent are met. This could do much to reduce, or eliminate, the exploitative character of paid egg donation. A reformed system of egg provision seems a better solution than prohibition given that the latter would likely give rise to a black market in which women would be exploited in still worse ways (Resnik 2001). Nor does the prohibition approach address the likelihood that in the face of a ban, egg donors would simply turn to other equally (or more) exploitative work (Wilkinson 2003).

Ultimately, de-commercializing egg donation and putting assisted reproductive care under the purview of national health care systems (where these exist) would more readily help to ensure that donors in those countries are not exploited or commodified; it would, moreover, make it possible to provide more equal access to donor-facilitated ART treatment. But this is an unlikely scenario given that most governments are unwilling, for a variety of reasons, to cover or defray the costs of third-party assisted reproduction. Whether or not it is possible to push back against the commercialization of ova provision in the future is unclear; however, we need, in the present, to prioritize socioeconomic reforms that could reduce the structural injustices that make many women vulnerable to exploitative offers in reproductive as well as other currently exploitative forms of work (Baltantyne 2014; Kirby 2014; Panitch 2013a, 2013b; Wilkinson 2003). And where options for earning income are few, it is even more critical to introduce national and transnational legislation to prevent abuses, and to improve domestic and global oversight of donor-assisted reproductive technologies more generally.

Notes

1. I use the terms 'egg provision' and 'paid egg donation' (and their noun correlates) interchangeably in this article. The terms egg (or oocyte) donation, egg donor, and donor egg IVF are still commonly used in reproductive medicine, even when donors are paid or compensated.
2. While some egg donors in the US and other rich states face socioeconomic vulnerability caused by structural injustices, I have chose to focus here on egg donors in MICs as well as those HICs with high female unemployment.
3. The European figures are an underestimate, as some countries known to offer commercial donor egg IVF did not report in 2010 (e.g. Croatia, Cyprus, Latvia, and Estonia) and several reporting countries with commercial donor egg IVF (e.g. Greece) had low clinic participation rates (Kupka et al. 2014).

4. See also <http://weareeggdonors.com/category/egg-donor-stories/>, where donors recount being flown to Canada, Australia, South Africa, and Thailand for oocyte extraction.
5. Companies like (Australia-based) The World Egg Bank (<http://www.theworldeggbank.com>) arrange for donor eggs to be shipped frozen abroad, either from the clinic where the extraction occurs or from their own egg bank.
6. http://ec.europa.eu/justice/gender-equality/gender-pay-gap/situation-europe/index_en.htm.
7. This way of connecting consent and coercion 'tracks an "intuitive" distinction between exploitative and non-exploitative cases of underpayment' (Wilkinson 2003, 178), because voluntary underpayment, absent conditions of socioeconomic vulnerability, is usually not exploitative.
8. This does raise the serious question of distributive justice in access to donor egg IVF, but there are other means to consider, such as 'national altruistic self-sufficiency in human eggs' (Baylis and Downie 2014) and publically funded health insurance for fertility treatment (Panitch 2015).
9. Resnik (2001, 23) rejects the flat-fee approach that compensates women for their services, on the grounds that 'women would need to be paid much less than the market price for their eggs'; but it is not clear why the flat fee could not be set fairly high.
10. Russia and Spain, with commercialized ART, report the highest numbers of OHSS in Europe (401 and 180, respectively). *IFFS Surveillance* (2013).
11. The maximum number of donation cycles permitted in Spain, and recommended by the ASRM, is 6. Some countries also stipulate a maximum number of offspring from donor egg cycles (and/or sperm donation) – for example, 3 in Latvia and 6 in Spain. *IFFS Surveillance* (2013).

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