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Whose autonomy, whose interests? A donor-focused analysis of surrogacy and egg donation from the global South

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Abstract

This article provides a donor-focused analysis of how transnational reproductive donation intersects with issues central to bodily autonomy of surrogates and egg donors from the global South. Little is known about the autonomy of surrogates and egg donors, especially among those from the global South. This article addresses this gap by examining two key issues on surrogacy and egg donation—conflict of interest and recruitment market. With these issues, this paper presents contexts of the reproductive body as a space of contestation for autonomy. Analysis reveals that bodily autonomy is not an absolute entitlement available for surrogates and egg donors from the global South. Having bodily autonomy is a privileged disposition rather than a universal liberty for reproductive donors. The discussions in this work encourage further examination to understand the multi-layered experiences of reproductive donors from the global South, towards deeper interrogation of the processes of reproductive industry.

KEYWORDS

bioethics, body as space, reproductive bodies, reproductive donation, reproductive donors

1 | INTRODUCTION

Autonomy as a question of "who has the right to your body?" is deeply entrenched within the discussions on reproductive donation. This paper examines women's bodily autonomy in surrogacy and egg donation from a donor-focused lens. For the purposes of discussion, "autonomy" refers to donors making their own decisions over their bodies,[1] able to participate in reproductive activities without discrimination, social sanctions, or statutory regulation.[2,3]

Autonomy is central to women donors' decisions because it provides assurance that choices are made based on their own independent bodily discretion.[4] However, little is known about the autonomy of surrogates and egg donors, especially among those *from* the global South. The term global South in this article is loosely used to describe the "Majority World" or countries where the majority of the global population lives including low- and middle-income countries in Africa, Asia, and Latin America.[5] The global South is a fertile ground for analysing the body as space as these bodies host an "integration of paid body labour in the capitalist economy and the recognition of bodies, emotions, and sexualities as

[1]Orobitg, G., & Salazar, C. (2005). The Gift of Motherhood: Egg Donation in a Barcelona Infertility Clinic. *Ethnos*. 70(1): 31–52; Oshana, M. (2006). *Personal Autonomy in Society*. Hampshire, UK: Ashgate.

[2]Blyth, E., & Farrand, A. (2005). Reproductive Tourism - A Price Worth Paying for Reproductive Autonomy? *Critical Social Policy*. *25*(1), 91–114.

[3]Mackenzie, C., & Stoljar, N. (2000). *Relational Autonomy: Feminist Perspective on Autonomy, Agency and the Social Self*. New York: Oxford University Press.

[4]Farrell, A.-M., Devereux, J., Karpin, I., & Weller, P. (2017). *Health law: frameworks and context*. Port Melbourne, VIC: Cambridge University Press.

[5]Alam, S. (2008). Majority world: Challenging the West's rhetoric of democracy. *Amerasia Journal*. 34(1), 89–98.

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sites of commodification".[6] However, note that the terms "global North" and "global South" are not just physical locations, but reflect social, historical, and political relationships,[7] which implies that the difference between North and South is rather fluid[8] as defined by a complex interplay of power dynamics that determine the distribution of autonomy to reproductive donors and recipients. Yet for the sake of discussion, and as explained in greater detail in the methodology, the majority of literature on reproductive donors in the global South pertains to donors from South Asia, South East Asia, Latin America, and the Middle East.

A donor-oriented examination of bodily autonomy in reproductive donation scholarship receives far less attention compared to fertility patients and recipients in legal, economic, and medical literature. While there is clear interest to protect all parties in reproductive donation—donors, recipients, donor-conceived children and practitioners—donors from the global South remain at the margins of discussions. Given the scarcity of discussions on donor-oriented bodily autonomy, this article turns the gaze toward surrogates and egg donors and investigates issues of reproductive autonomy in the context of the global South by examining women donors' bodies as the focus of analysis.

This paper aims to advance current bioethical discussions by (1) examining the body-related issues donors face within surrogacy and egg donation, and by (2) discussing the implications of donor-focused issues to the concept of bodily autonomy. This article's contributions to the literature on bioethics and reproductive donation lies in offering a discussion of bodily autonomy from a donor-oriented perspective. This paper has five parts. Firstly, this work provides a theoretical framework that discusses bodily autonomy. Secondly, this work outlines the context of women's bodily autonomy within transnational, reproductive donation, with a focus on donors from the global South. Thirdly, this article examines the issues on conflict of interest and recruitment market in surrogacy and egg donation. Fourthly, the discussion section outlines the implications of surrogacy and egg donation issues to the concept of bodily autonomy. Finally, the conclusion sums up the article by inviting further research concerning equitable distribution of body autonomy in reproductive donation.

This paper, like many others, has certain limitations. The discussions in this work could only represent certain issues of conflict of interest and recruitment, and consequently only give a partial picture of the bodily autonomy issues faced by surrogates and egg donors from the global South. Also, caution is to be practised in reading this work given the heterogeneous nature of reproductive donation; only the most salient and common issues experienced by donors were chosen for discussion. Finally, note that while this article could have included women that donate embryos, the act of donating to a recipient is not *per se* the primary goal of most embryo donors, who happen to have excess embryos. Donating surplus embryos for stem-cell research, for instance, comes secondary after a successful IVF.[9] Nevertheless, this work's analysis offers a different perspective in understanding reproductive donors from the global South through a concerted literature examination of issues faced by reproductive donors. This work is not meant to be an exhaustive examination of issues faced by reproductive donors from the global South, but rather hopes to serve as an alternative lens that underpin the wider social positions of reproductive donors.

2 | METHODOLOGY

This article examines academic literature on reproductive donors in the global South in the 21st century (between 2000 and 2021), a period with remarkable developments in reproductive donation, such as the emergence of selective reproductive technologies (SRTs) for infertility[10] and the growth of surrogacy.[11] The literature analysed are mainly written in English including books, journal articles, conference proceedings, and book chapters, with contents related to reproductive donors from the global South. The search included the databases Google Scholar and university subscription of academic databases such as EBSCOHost, Sage, Scopus, Taylor and Francis, Web of Science, and Wiley. Results yielded hundreds of documents but only 60 publications were considered to contain enough information about the reproductive donors from the global South. Let it be clear that this study does not incorporate primary data from reproductive donors but the literature analysed included first-hand data from surrogates and egg donors.

There are several limitations to the method outlined above. First, academic literature on reproductive donors from the global South is often written by researchers from more developed countries, which may reflect their perspectives and biases, rather than those of donors from the global South. Second, the literature is often focused on the medical and ethical dimensions of reproductive donation, rather than on the lived experiences of donors. Third, this work recognises that the academic literature selected for analysis may not be accessible to researchers in the global South, alluding to the issue of the underrepresentation of researchers in and from the global South in academic literature.

Due to the heterogeneity of the literature reviewed, the findings may only represent certain experiences of reproductive donors and

[6]Jana, M., & Hammer, A. (2021). Reproductive Work in the Global South: Lived Experiences and Social Relations of Commercial Surrogacy in India. *Work, Employment and Society*. 095001702199737, p. 5.

[7]Burman, E. (1995). The Abnormal distribution of development: policies for Southern women and children. *Gender, Place and Culture: A Journal of Feminist Geography*. 2(1), 21–36.

[8]Sud, N., & Sánchez-Ancochea, D. (2022). Southern Discomfort: Interrogating the Category of the Global South. *Development and Change*. 53(6), 1123–1150.

[9]Samorinha, C., Pereira, M., Machado, H., Figueiredo, B., & Silva, S. (2014). Factors Associated with the Donation and Non-donation of Embryos for Research: A Systematic Review. *Human Reproduction Update*. 20, 641–655.

[10]Wahlberg, A., & Gammeltoft, T. M. (2017). *Selective Reproduction in the 21st Century*. Cham: Springer International Publishing AG.

[11]Winddance Twine, F. (2015). *Outsourcing the Womb: Race, Class and Gestational Surrogacy in a Global Market*. London: Taylor & Francis Group.

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cannot encompass all perspectives. However, the examined materials still provide insights into the issues faced by reproductive donors, and these limitations open opportunities as key areas for future research and points of reflection in further discussions on reproductive donation.

3 | THEORETICAL FRAMEWORK

Bodily autonomy can easily allude to Foucault's concept of governmentality. Foucault's concept of governmentality easily comes to mind in unpacking autonomy of reproductive donors from the global South. Governmentality pertains to practices and technologies of power to regulate and manage populations. In the context of reproductive donation, governmentality manifests through how the reproductive capacities of donors are controlled and exploited by actors within the global reproductive industry. Yet arguably the idea of complete bodily autonomy cannot be fully achieved as human choices are influenced by a multitude of external factors that are intricately woven into various power dynamics, which remain beyond one's control. Consequently, it is not just the global South donors, who lack autonomy as no one holds complete control over their autonomy, although some individuals may possess greater control over the factors affecting their decision-making.

Nonetheless, there is another form of autonomy that can be exercised, which focuses on the ability to participate in the decision-making process rather than relying on autonomous decisions. Nancy Fraser's[12] discussion of autonomy acknowledges the constraints and limitations within which all decisions are made, and prioritises parity of participation over the individual's absolute control. I suggest that, by thinking of autonomy through the lens of participation, we may develop a rather more nuanced account of reproductive donation and donor's autonomy. This form of autonomy can be exercised through considering the level of donor involvement in decision-making processes. Yet Fraser contends that neoliberalism undermines the conditions of possibility for real autonomy by depriving individuals of the resources and opportunities they need to pursue their own interests.[13] In this sense, the reproductive donation industry diminishes the ability of donors to participate in making decisions about their own bodies, leaving the discretion to the so-called authorities.

An important discussion in decision-making over one's body is what Adriana Petryna calls "ethical variability",[14] or the differences in ethical standards in human research, which cannot simply be reduced to cultural relativism, but is rather driven by the exploitation of vulnerabilities such as poverty, limited healthcare access, and inadequate ethical review processes. Since clinical trials aim at "cost-effective variability in ethical standards in human research",[15] it holds the potential to compromise ethical standards of pharmaceutical, biotechnology, and medical research, altering ethical standards with ambiguity in order to facilitate the conduct of clinical trials. Petryna also highlights "the tensions of promoting equal standards for all research and in altering those standards to fit certain values and needs".[16]

The issue of parity of participation on reproductive donation can be seen through how the reproductive donation industry manoeuvres ethical standards and regulations to facilitate the conduct of clinical trials in cost-effective ways, taking away decision-making abilities from donors. A strategy, for example, is when industries exploit donors' financial needs through the rhetoric of sacrifice rather than seeing reproductive donation as a bodily choice.[17] It is also smarter to conduct surrogacy or egg donation in cultures with little or no legal consequences or more permissive laws than in those that view reproductive donation as a form of exploitation and may have strict laws prohibiting it.[18,19] In these examples, ethical variability highlights the limitations on individual autonomy and the ways in which power dynamics shape decision-making.

Ethical variability in reproductive donation with donors from the global South highlights the tensions between the need for ethical standards in clinical trials and the practical considerations that influence their implementation. Yet the autonomy of reproductive donors from the global South is often restricted, but these restrictions can be challenged and negotiated. Thus, while the autonomy of reproductive donors is often limited, it can also be regained and contested through participation. This is particularly relevant for donors from the global South, who may be subject to a variety of cultural, social, and economic pressures that make them more vulnerable to exploitation and manipulation.[20] However, there needs to be caution in relying too heavily on broad-brush analyses that depict the transnational reproductive donation as a straightforward North-South dynamic in which the global North exploits the global South.[21] The point is not to accuse all transnational reproductive donations as exploitative or that all donors from the global South are passive victims. Rather, the point is to highlight the complex dynamics at play in reproductive donation practices.

[12]Fraser N. (1986). Toward a discourse ethic of solidarity. *Praxis International*. 5(4), 425–429.
[13]Fraser N. (1997) *Justice Interruptus: Critical Reflections on the 'Postsocialist' Condition*. New York: Routledge.
[14]Petryna, A. (2005). Ethical variability: Drug development and globalizing clinical trials. *American Ethnologist*. *32*(2), 183–197.
[15]Petryna, op. cit. note 14, p. 184.
[16]Petryna, A. (2009). *When Experiments Travel: Clinical Trials and the Global Search for Human Subjects*. Princeton: Princeton University Press, p. 33.
[17]Unnithan, M. (2010). Infertility and Assisted Reproductive Technologies (ARTs) in a Globalising India: Ethics, Medicalisation and Agency. *Asian Bioethics Review*. 2, 3–18.
[18]Rothman, B. (1989). *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*. New York: Norton.
[19]Nordqvist, P. (2018). Un/familiar Connections: On the Relevance of a Sociology of Personal Life for Exploring Egg and Sperm Donation. *Sociology of Health & Illness*. 41(3), 601–615.
[20]Jana & Hammer, op. cit. note 6.
[21]Schurr, C. (2018). The baby business booms: Economic geographies of assisted reproduction. *Geography Compass*. 12(8), e12395–n/a.

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4 | CONTEXT OF BODILY AUTONOMY OF WOMEN DONORS FROM THE GLOBAL SOUTH

Context is essential for understanding reproductive autonomy.[22] In this regard, the global South is of particular interest to donorship and transnational reproductive donation because of the region's narrative of hyper-fertility,[23] in which donors' bodies serve a role of making reproductive ends meet for an entire global industry. Within the context of medical travel and reproductive tourism[24] as a major new source of economic development among developing countries,[25] it is important to recognise that donors from the global South are not just "individual operators"[26] who are making autonomous decisions about their bodies. Instead, these donors may be at risk for physical health problems, psychological harm, and lack of legal protection due to the complex power dynamics at play in the market. An example of this is the transnational reproductive donation that involves purchasing an egg cell from a donor in South Africa, then implanting it in a surrogate in India, and finally bringing the offspring to the recipients in the USA.[27] The issues concerning reproductive donation stem from cases of gamete donors from the global South, who are subjects of exploitation and deprived of support, care, and autonomy from the reproductive donation industry not only in legal terms but also in their bodily autonomy.

This article centres on two key issues on surrogacy and egg donation—conflict of interest and recruitment market. Conflict of interest and recruitment market issues highlight the experiences of reproductive donors and bring attention to the ways in which these practices may undermine actual autonomy. For instance, a classic issue on conflict of interest is whether a surrogate mother can breach the surrogacy arrangement and terminate pregnancy.[28] Likewise, this resonates with the question on whose interest is being favoured when egg donors do not wish to continue donating.[29] In terms of recruitment, the question for surrogacy and egg donation is how much of their decision to use their body as a reproductive space is an autonomous genuine decision.[30] The issues on conflict of interest and recruitment of human subjects from the global South are not exclusive to reproductive donation. Such bioethical concerns exist for controlled trials,[31] disease studies,[32] and international multi-site clinical trials.[33] Nevertheless, the current state of literature reflects the need for a deeper examination of women donor's bodily autonomy in reproductive donation.

5 | BODILY AUTONOMY AND CONFLICT OF INTEREST

One of the long-standing autonomy-related issues faced by reproductive donors from the global South is the question of whose bodily interest is protected in reproductive donation. In particular, reproductive donation continues to receive critical attention for raising issues of potential conflicts of interest (COI) or "set of circumstances that creates a risk that professional judgement or actions regarding a primary interest will be unduly influenced by a secondary interest",[34] specifically concerning recipient, physicians, and Assisted Reproductive Technology clinics, and donors.[35] Moreover, regulations on fair transnational surrogacy are underdeveloped in countries where most surrogates come from. For instance, since Thai laws put restrictions on surrogacy, Thai surrogates who get impregnated in Laos go back to Thailand to carry the pregnancy and birth there.[36] Ensuring that going abroad is an independent decision by Thai donors remains unclear. These donors receive no particular protection and access to any COI information as there is a lack of surrogacy policies, laws, or regulations in Laos,[37] which could have aid donors to make informed decisions and demand their preferences about the donation. This is pertinent to cases wherein there might be legal repercussions and risks for the donors. For example, Indian surrogates who relocated to Nepal to carry out pregnancy and give birth were left stranded after a massive earthquake hit Nepal in 2015.[38] In another example, Cambodian surrogates have experienced imprisonment and charged with human trafficking.[39]

[22]Johnston, J., & Zacharias, R. L. (2017). The Future of Reproductive Autonomy. *The Hastings Center Report*. 47(S3), S6–S11, p. S10.

[23]Schurr, C. (2017). From Biopolitics to Bioeconomies: The ART of (Re-)producing White Futures in Mexico's Surrogacy Market. *Environment and Planning D: Society and Space*. 35(2), 241–262.

[24]Blyth & Farrand, op. cit. note 2.

[25]Whittaker, A. (2010). Challenges of Medical Travel to Global Regulation: A Case Study of Reproductive Travel in Asia. *Global Social Policy. 10*(3), 396–415.

[26]Nordqvist, P. (2018). Un/familiar Connections: on the Relevance of a Sociology of Personal Life for Exploring Egg and Sperm Donation. *Sociology of Health & Illness*. 41(3), 601–615, p. 602.

[27]Deomampo, D. (2013). Gendered Geographies of Reproductive Tourism. *Gender & Society*. 27(4), 514–537, p. 173.

[28]Stuhmcke, A. (2021). Reflections on Autonomy in Travel for Cross Border Reproductive Care. *Monash Bioethics Review*. 39(1), 1–27; See also Whittaker, A., & Speier, A. (2010). "Cycling Overseas": Care, Commodification, and Stratification in Cross-Border Reproductive Travel. *Medical Anthropology*. 29, 363-383.

[29]Waldby, C. (2019). *The Oocyte Economy*. Durham, N.C: Duke University Press.

[30]Wicks, E. (2016). *The State and the Body Legal Regulation of Bodily Autonomy*. Oxford, Portland, Oregon: Hart Publishing.

[31]Newton., & Appiah-Poku, J. (2007). Opinions of researchers based in the UK on recruiting subjects from developing countries into randomized controlled trials. *Developing World Bioethics*. 7(3), 149–156.

[32]Princewill, C. W., Jegede, A. S., Nordström, K., Lanre-Abass, B., & Elger, B. S. (2017). Factors Affecting Women's Autonomous Decision Making In Research Participation Amongst Yoruba Women Of Western Nigeria. *Developing World Bioethics*. *17*(1), 40–49.

[33]Nakada, H., Hasthorpe, S., IJsselmuiden, C., Kombe, F., Ba, M., Matei, M., et al. (2019). Recommendations for promoting international multi-site clinical trials—from a viewpoint of ethics review. *Developing World Bioethics*. *19*(4), 192–195.

[34]National Research Council. (2009). Principles for Identifying and Assessing Conflicts of Interest. In B. Lo & M. J. Field (Eds.), *Conflict of Interest in Medical Research, Education, and Practice* (pp. 44–61). Washington, D.C.: The National Academies Press, p. 46.

[35]Werner-Felmayer, G. (2018). Globalisation and Market Orientation: A Challenge Within Reproductive Medicine. In S. Mitra, S. Schicktanz, & T. Patel. (Eds.), *Cross-Cultural Comparisons on Surrogacy and Egg Donation: Interdisciplinary Perspectives from India, Germany and Israel*. (pp. 13–34). Cham: Palgrave Macmillan.

[36]Hibino, Y. (2020). Non-commercial Surrogacy in Thailand: Ethical, Legal, and Social Implications in Local and Global Contexts. *Asian Bioethics Review*. 12(2), 135–147.

[37]Attawet, J. (2021). Mapping Transnational Commercial Surrogacy Arrangements in South and Southeast Asia. *Medico-Legal Journal*. 89(2), 128–132.

[38]Duttagupta, I. (2015, May 5). Why Surrogacy Issue Emerges After Nepal Earthquake. *The Economic Times*. Retrieved November 7, 2021, from: https://economictimes.indiatimes.com/blogs/globalindian/why-surrogacy-issue-emerges-after-nepal-earthquake/

[39]Handley, E. (2018, June 23). Cambodia: 33 Pregnant Women Found in Raid on Child Surrogacy Ring. *The Guardian*. Retrieved November 12, 2021, from: https://www.theguardian.com/world/2018/jun/23/cambodia-33-pregnant-women-found-in-raid-on-child-surrogacy-ring

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Moreover, donors' bodily autonomy is compromised in terms of the lack of scrutiny of informed consent within policymaking. For example, clinics are not necessarily strictly mandated to report or document donor treatments performed or medical complications that result from donation.[40] This compromises the autonomy of donors as they are not made aware of the entire procedures related to their bodies, which could affect how they decide on their bodies. In egg donation, for instance, there is lack of mandatory legislation that requires a strict follow-up with donors after the eggs are removed from Iranian donors.[41] The absence of effective regulations in reproductive donation raises concerns about conflict of interest, as laws, medical organisations, or individual practitioners may prioritise the interests of the intended parents over the donor. For example, India's colonial history left surrogates reliant on doctors as authority figures. When doctors represent both surrogates and commissioning parents, conflicts of interest may arise, with the interests of the commissioning parents, as the paying party, being privileged over those of the surrogate mothers. This dynamic has the potential to perpetuate exploitation and perpetuate unequal treatment in the realm of commercial surrogacy.[42] This can result in the donor's health and informed decision-making being overlooked, creating unequal distribution of commitment, which disadvantages the donor. Conflict of interest can also occur when donors' consent is not properly secured such as the lack of mandate for clinics to report all treatments and complications related to donation,[43] creating a conflict of interest that favours clinics over that of donors.[44]

Issues in bodily autonomy also manifest in the dearth of clear mandates for clinics to have post-donation physical and psychological examinations with donors after the procedures. However, whilst donor counselling is provided in the global North,[45] such service is only a recommendation in most countries in the global South, being offered as only an option or “suitable opportunity”.[46] There is an imbalance in reproduction-related counselling received by recipients and donors, especially from the global South. Where any reference is made to donor counselling, these include comprehensive counselling that include recipients, donors, and donor-conceived children.[47] The case of surrogacy is a useful example to unpack this autonomy issue. While it is recommended that surrogates receive professional counselling prior to, during, and after pregnancy, most studies show that surrogates are not provided enough psychological counselling and legal advice sessions.[48] For instance, the surrogate counselling system in Iran does not provide the exhaustive legal information for potential surrogates.[49] In India, a counsellor's role does not necessarily entail providing psychological aid but serves as a guard to “provid[e] surveillance of the surrogates, to ‘make sure that the clients don't get fooled’”.[50] On another matter is that surrogates do not always seek and utilise counselling and follow-up procedures even if these services are made available.[51]

In terms of egg donation, there is no assurance of counselling for oocyte donors from the global South, who are usually economically disadvantaged, young women.[52] Also, there is very little available data, if any, on cross-border migration of donors and whether counselling is provided to them in such cases.[53] Moreover, counselling's focus on extracting information from donors such as personal/biographical data, as well as evaluating the donor's appropriateness favours recipients over meeting the discretionary needs of donors. The examples above raise autonomy-related issues especially for cross-country donorship because counselling is not always available in a language that foreign donors understand[54] and may infringe with other ethical rights of the donors.[55]

In the discussion above, the body or body parts of donors travel from the global South to another location, attesting to the advanced reproductive technology. Consequently, the donor's identity—as a human *from the South*—is reduced into its reproductive function, making external controls dominate the donor's body within a rather formalistic and bureaucratic ethical framework which does not necessarily safeguard their interests. The medical industry is inclined toward client service, whereby donors may face systemic inequalities, financial pressures, and lack of informed consent, thus violating their bodily autonomy.

6 | BODILY AUTONOMY VS MARKET

The “baby business”[56] has gained attention in the international market, and has eventually shed light on global stratification and inequalities in reproductive rights.[57,58] Many donors from the global

[40]Cahn, N., & Collins, J. (2014). Fully Informed Consent for Prospective Egg Donors. *Virtual Mentor*. 16(1), 49–56.

[41]Nosrati, S. F., Amirian, M., & Irani, M. (2019). Legal and Religious Counselling Aspects of Gamete Donation in Iran: Review study. *Iranian Journal of Obstetrics, Gynecology and Infertility*. 22(6), 85–96.

[42]Deonandan, R., Green, S., & van Beinum, A. (2012). Ethical concerns for maternal surrogacy and reproductive tourism. *Journal of Medical Ethics*. 38(12), 742–745.

[43]Cahn., & Collins, op. cit. note 40.

[44]Vera, D. (2016). R-Egg-Ulation: A Call for Greater Regulation of the Big Business of Human Egg Harvesting. Michigan *Journal of Law and Gender*. 23(2), 391–424.

[45]Mihailov, E., Wangmo, T., Federiuc, V., & Elger, B. (Eds.). (2018). *Contemporary Debates in Bioethics: European Perspectives*. Warsaw: De Gruyter Open Poland.

[46]Blyth, E., Thorn, P., & Wischmann, T. (2011). CBRC and Psychosocial Counselling: Assessing Needs and Developing an Ethical Framework for Practice. *Reproductive BioMedicine Online*. 23, 642– 651, p. 643.

[47]Goedeke, S., Daniels, K., & Thorpe, M. (2016). Embryo Donation and Counselling for the Welfare of Donors, Recipients, their Families and Children. *Human Reproduction*. 31(2), 412–418.

[48]Ahmari Tehran, H., Tashi, S., Mehran, N., Eskandari, N., & Dadkhah Tehrani, T. (2014). Emotional Experiences in Surrogate Mothers: A Qualitative Study. *Iranian Journal of Reproductive Medicine*. 12(7), 471–480.

[49]Taebi, M., Alavi, N. M., & Ahmadi, S. M. (2020). The Experiences of Surrogate Mothers: A Qualitative Study. *Nursing and Midwifery Studies*. 9(1), 51–59.

[50]Pande, A. (2009). It May Be Her Eggs, But It's My Blood: Surrogates and Everyday Forms of Kinship in India. *Qualitative Sociology*. 32(4), 379–397.

[51]van den Akker, O. (2007). Psychosocial Aspects of Surrogate Motherhood. *Human Reproduction Update*. 13(1), 53–62.

[52]Pande, op. cit. note 50.

[53]Blyth, Thorn, & Wischmann, op. cit. note 46.

[54]Shenfield, F., Pennings, G., De Mouzon, J., Ferraretti, A. P., Goossens, V., & ESHRE Taskforce on Cross Border Reproductive Care. (2011). ESHRE's good practice guide for cross border reproductive care for centers and practitioners. *Human Reproduction*. 26: 1625–1627.

[55]Riggs, D. (2016). Narratives of Choice Amongst White Australians who Undertake Surrogacy Arrangements in India. *Journal of Medical Humanities*. 37, 313–325.

[56]Spar, D. (2006). *The Baby Business: How Money, Science, and Politics Drive the Commerce for Conception*. Cambridge: Harvard Business School Press.

[57]Kroløkke, C., Foss, K., & Pant, S. (2012). Fertility Travel: The Commodification of Human Reproduction. *Cultural Politics*. 8(2), 273–282.

[58]Nahman, M. (2011). Reverse Traffic: Intersecting Inequalities in Human Egg Donation. *Reproductive Biomedicine Online* 23, 626–633.

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South make “desperate choices”[59] and rely upon their bodies to feed their families. An enduring bodily autonomy issue here lies in the potential of monetary incentives to obscure genuine autonomous decisions over one's reproductive body parts. As Jackson reminds us, “those of us who experience no risk to our health in return for our wages are a relatively privileged minority”.[60] At the forefront of reproductive tourism issues is the debate on whether or not to legalise compensation for reproductive donation, which is tied to issues of exploitation.[61] [62] While altruistic donation is the most encouraged motivation for reproductive donation globally,[63] the shifts and specificity in donor recruitment cannot deny the increasing market-drivenness of gamete donation. Although countries in the global South are taking actions to further improve their systems to protect human dignity and to prevent exploitation and discrimination, the reproductive industry continues to foster unequal distribution of bodily autonomy as low-income individuals, especially women, have become the target providers of gametes in exchange for monetary compensation as they are likely to agree with the terms of donation.[64] For instance, most surrogates from South Asia, Southeast Asia, and the Middle East are women who have low educational levels and are living under poverty, with clear financial needs without emotional conflict.[65,66] Specifically, surrogates in Cambodia, India, Laos, Nepal, and Thailand are given the least agency in deciding about their terms and condition on surrogacy.[67,68] Meanwhile, in Mexico, egg/oocyte donors are aware of the presence of social, physical, and mental health risks[69] along with complications such as ovarian hyper-stimulation syndrome and pelvic infections and psychological burden,[70,71] but they are drawn to donate because it meets financial needs and provides an “exit strategy” from domestic violence.[72]

The entanglements of the reproductive market and donors' autonomy also manifests in terms of how the donor's body is valued. The value (or lack thereof) of the reproductive donor's body is positioned within the context of an uneven development of discussions regarding various ways to compensate donors. Autonomy also involves deciding how one's bodily services can be compensated beyond financial means as monetary incentives are not always welcome and even shameful for donors[73,74] depending on gender, ethnicity, race, geographic origins, religion and culture. Most common non-compliance is related to compensation practices and the appropriate age-range of women targeted as potential donors.[75] While there are differences in what can be remunerated in reproductive donation among national laws, countries in the global South lack clearly defined legal terms about what constitutes a “compensation”[76], especially from the perspective of donors. Furthermore, any profit from clients is usually framed within the discourse of alms-giving or beneficence instead of the recipient's obligation to the donor. For instance, while Indian surrogates can receive extra-financial benefits, such as further assistance and constant communication with the recipients, this arrangement is understood as an extension of generosity from the intended parent(s) to the surrogate and not necessarily as a sense of accountability.[77] In this context, the surrogate's autonomy to dictate how her body gets valued is by-passed in the name of the so-called kindness of intended parents.

Another issue on bodily autonomy in the market is the unevenness of who gets to decide on who benefits from the donors' body. While clients can choose their donors, little is known about the degree in which donors get to choose the intended parent(s). There is literature providing information that donors are given the decision to pursue donation when they meet potential clients[78] but this does not go deeper into how donors actually get to decide. Furthermore, clients and clinics impose strict filtering in reproductive donation, requiring donors to give private information but donors cannot demand the same level of information from the intended parents. Recruitment in reproductive donation is a matter of whose body counts as appropriate from the side of clients. In this regard, an appropriate body is not only a matter of physical health but also of the body owner's social location. For instance, the surrogacy industry targets donors from economically disadvantaged countries to search for egg donors. For egg donors, higher pay is given to White or East

[59]Widdows, H. (2013). Rejecting the Choice Paradigm: Rethinking the Ethical Framework in Prostitution and Egg Sale Debates. In S. Madhok, K. Wilson, A. Phillips, & C. Hemmings (Eds.), *Gender, Agency and Coercion*. (pp. 157–180). London: Palgrave Macmillan.

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[65]Blyth, Thorn., & Wischmann, op. cit. note 48.

[66]Adib Moghaddam, E., Kazemi, A., Kheirabadi, G., & Ahmadi, S. M. (2020). Self-image and Social-image of the Donors: Two Different Views from Oocyte Donors' Eyes. *Journal of Health Psychology*. 27(3).

[67]Attawet, op. cit. note 38.

[68]Saxena, P., Mishra, A., & Malik, S. (2012). Surrogacy: Ethical and Legal Issues. Indian Journal of Community Medicine. *Indian Association of Preventive & Social Medicine*. 37(4), 211–213.

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[72]Werner-Felmayer, op. cit. note 36.

[73]Egli, D., Chen, A., Saphier, G., Powers, D., Alper, M., Katz, K., Berger, B., Goland, R., Leibel, R., Melton, D., & Eggan K. (2011). Impracticality of Egg Donor Recruitment in the Absence of Compensation. *Cell Stem Cell*. 293–294.

[74]Taragin-Zeller, L. (2019). “Conceiving God's Children”: Toward a Flexible Model of Reproductive Decision-Making. *Medical Anthropology*. 38, 370–383.

[75]Alberta, H., Berry, R., & Levine, A. (2014). Risk Disclosure and the Recruitment of Oocyte Donors: Are Advertisers Telling the Full Story? *Journal of Law, Medicine & Ethics*. 42(2), 232–243.

[76]Daar, J., Benward, J., Collins, L., Davis, J., Francis, L., Gates, E., et al. (2016). Financial Compensation of Oocyte Donors: An Ethics Committee Opinion. *Fertility and Sterility*. *106*(7), e15–e19.

[77]Pande, A. (2016). Global Reproductive Inequalities, Neo-eugenics and Commercial Surrogacy in India. *Current Sociology*. 64(2), 244–258.

[78]Baía, I., de Freitas, C., & Silva, S. (2019). Changing Criteria of Access to Gamete Donation: The Views of Donors and Recipients. *European Journal of Public Health*. *29*(Supplement 4).

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Asian, educated, and middle-class women.[79] Such preferences resonate with "post-colonial discursive imaginaries of white desirability".[80] Only in intra-Asian donation are non-white donors preferable, with bodily specificity include phenotypic markers of "being Asian" such as dark brown or black hair, skin, and eye.[81] Moreover, Arab egg donors might find it difficult to find clients because of the stigma surrounding Arab states.[82]

The previous examples are what Cohen refers to as "bioavailability"[83] or the notion that "some bodies [are] more bioavailable than others based on similarity (especially in terms of immunology and phenotypic resemblance) and marginality (in terms of class, gender, caste, race, etc.)".[84] Bioavailability may force a donor's willingness to travel to other countries for financial compensation, which is common for donors from the global South. For instance, Indian donors are inclined to work with rich clients in Dubai.[85] While it is now possible to have "reverse traffic" or"extract[ing] ova from women in developing countries without making them travel [….] by transporting a canister of eggs",[86] many transnational reproductive donors still need to travel abroad. However, the bioavailability of donors may not always be compatible with their bodily interests. For instance, screening of reproductive donors usually includes interviews about their sexual lives and practices. In cultures where conversations about reproduction and sex are taboo, the process of donation can induce donor anxiety.[87]

Regulation of compensation also provides a lens on how the donors' bodily autonomy is dismissed in reproductive donation. This begs the question of whether laws and regulations should limit the reasons for donating reproductive materials, and to what extent can reproductive donation be considered as a form of bodily autonomy in the presence of compensation. While intensive discussions on regulating donor compensation are already on-going, there is still a lack of direction and enforceable laws concerning fair compensation to donors as part of the longstanding debates about the acceptability of compensation for gamete donors. On the one hand, setting detailed compensation policies can prevent undue exploitation[88] but on the other hand, monetary incentives can be considered as just another form of bribery that diminishes the value of the human body.[89,90] But the question is the extent to which donors are involved in these discussions. In practical terms, the lack of transparent and legal regulation has provoked reproductive health advocates to demand further regulation because reproductive donation is prone to exploiting donors, especially women who have limited options to earn a living.[91] Such critical decisions need donor inputs and participation, especially from those who are prone to exploitation. An example of this issue is the lack of equity in policy making and legislation on the rights and duties between surrogate mothers and intended parents in surrogacy agreements.[92] The lack of legal mandate to ensure the surrogate mother's compensation makes exploitation occur given that a considerable number of surrogates are poor, illiterate and rural women who did not receive psychological screening or legal counselling.[93] As surrogacy requires intensive care before, during and after delivery, surrogates may be rather placed under exploitative conditions.

7 | DISCUSSION: IMPLICATIONS ON WOMEN'S REPRODUCTIVE AUTONOMY—TOWARDS AN EQUITABLE DISTRIBUTION OF AUTONOMY

The examples discussed above suggest that autonomy over one's body is an entitlement, reflecting participatory privileges in reproductive donation or the lack thereof. While an individual might argue that it is his/her individual decision to make his/hers reproductive capacity available for commercial activities (buying, renting, etc), lack of adequate participation in the decision-making process clearly undermines such personal freedom. The lack of decision-making in the donation process diminishes the autonomy of the donor, as they may not have full control or agency over their own reproductive materials. The flow of reproductive services across national borders creates a global market in which people can seek and access reproductive services. However, this market can also force individuals to donate due to their needs, not their autonomy, leading to ethical dilemmas and inequalities. Specifically, prospective donor individuals in the global South are more susceptible to exploitation than those in other parts of the world.[94] The ethical dilemmas and inequalities arising from global reproductive donation are shaped by the regulation and governance of reproductive services and technologies by various actors. These regulations can change over time, leading to further ethical variability.

This brings to the fore bioethical questions on the unequal distribution of autonomy amongst the donors from the global South.

[79]Pollock, A. (2003). Complicating Power in High-Tech Reproduction: Narratives of Anonymous Paid Egg Donors. *Journal of Medical Humanities*. 24, 241–263.
[80]Schurr, op. cit. note 23, p. 244.
[81]Hudson, N., & Culley, L. (2014). Infertility, Gamete Donation and Relatedness in British South Asian Communities. In T. Freeman, S. Graham, F. Ebtehaj, & M. Richards (Eds.), *Relatedness in Assisted Reproduction: Families, Origins and Identities*. (pp. 232-250). Cambridge: Cambridge University Press.
[82]Nahman, op. cit. note 60.
[83]Cohen, L. (2005). Operability, Bioavailability and Exception. In: A. Ong, & S. Collier (Eds.), *Global Assemblages: Technology, Politics and Ethics as Anthropological Problems*. (pp. 79–90). Malden: Blackwell.
[84]Perler, L., & Schurr, C. (2021). Intimate Lives in the Global Bioeconomy: Reproductive Biographies of Mexican Egg Donors. *Body & Society*. 27(3), 3–27, p. 7.
[85]Inhorn, M. C. (2012). Reproductive Exile in Global Dubai: South Asian Stories. *Cultural Politics*. 8, 283–306.
[86]Nahman, op. cit. note 60.
[87]Adib Moghaddam, Kazemi, Kheirabadi, & Ahmadi, op. cit. note 68.
[88]Fox, D. (2008). Paying for Particulars in People-To-Be: Commercialisation, Commodification and Commensurability in Human Reproduction. *Journal of Medical Ethics*. 34(3), 162–166.
[89]Raphael-Leff, J. (2010). The gift of gametes–unconscious motivation, commodification and problematics of genealogy. *Feminist Review*. 94(1), 117–137.
[90]Lenk, C., & Beier, K. (2012). Is the Commercialisation of Human Tissue and Body Material Forbidden in the Countries of the European Union? *Journal of Medical Ethics*. 38(6), 342–346.
[91]Adib Moghaddam, Kazemi, Kheirabadi, & Ahmadi, op. cit. note 68.
[92]Pande, A. (2016). Global Reproductive Inequalities, Neo-eugenics and Commercial Surrogacy in India. *Current Sociology*. 64(2), 244–258.
[93]Saxena, Mishra, & Malik, op. cit. note 70.
[94]Jana & Hammer, op. cit. note 6.

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For all its possible angles and nuance, the donor can be seen, at least, as dispossessing parity of participation. The compromise of bodily autonomy of the Southern reproductive body is a vibrant theme in the experiences of surrogates and egg donors. Such a limited autonomy is found within the broader discussions on racial and/or classist post-colonial biopolitics, healthcare market inequalities, and patriarchal and gendered reproductive expectations.[95] The bodies of the donors from the global South are embedded in geographical biopolitics and have become a space of hierarchical reproduction. These donors participate in the global market through negotiating their bodies and their reproductive labour as part of the transnational networks of the reproductive industry. This has implications on the narratives and construction of what a donor-from-the-global-South is. Reproductive donation does not only use parts of the body, but it also creates identities, albeit temporary, which reflect the malleable boundaries in protecting the donor's body.

7.1 | Body autonomy invaded by external control

The issues faced by surrogates and egg donors reflect a culture that sees a donor's body from the global South as a "normal" and more abundant space compared to the recipient's body. While the interests of donors have gained visibility in recent years, they remain largely disregarded in the regulatory and organisational contexts of reproductive donation in the global North, where the bodies of surrogates and egg donors from the global South are subjected to disciplining practices such as monitoring, control, and normalisation,[96] which curtails autonomous decisions by these donors over their bodies. For instance, the disproportionately low counselling access for donors from the global South are suggestive of an instrumentalised body, dismissing the need of donors to be heard concerning their sensibilities, actions, and opinions over their bodies. While donor eligibility is assessed in terms of rigid measures of mental stability, personality traits, and motivation, they are rarely given the upper hand to choose and demand post-treatment and counselling services from the recipients and/or fertility clinics. Moreover, while there are developments in legal measures that protect reproductive donors, it does not necessarily mean that donors from the global South are part of the discussions in reproductive donation. There is still a disproportionate effort in terms of legislative regulations to be more inclusive and donor-sensitive. While there are mandates in providing donor services such as counselling, this effort is unevenly distributed across the world and it is rare to see legislation that requires these services be made mandatory.[97,98]

[95]Perler & Schurr, op.cit. note 86.

[96]de Boer, M. L., Archetti, C., & Solbraekke, K. N. (2019). In/fertile Monsters: The Emancipatory Significance of Representations of Women on Infertility Reality TV. *Journal of Medical Humanities*. 43, 11–26.

[97]Sarojini, N., Marwah, V., & Shenoi, A. (2011). Globalisation of birth markets: A case study of assisted reproductive technologies in India. *Globalization and Health*. 7(1), 27–27.

[98]Widge, A., & Cleland, J. (2011). Negotiating boundaries: Accessing donor gametes in India. *Facts, Views & Vision in ObGyn*. 3(1), 53–60.

7.2 | Body autonomy bribed by compensation

The donor's body becomes a site of contesting bioethical dilemmas on one's bodily autonomy as the donors' need for compensation invites exploitation. As surrogates and egg donors from the global South are often coerced by their circumstance to use their bodies, they are denied their bodily autonomy and lose control over their own bodies and fertility to for monetary gains from the reproductive industry.[99] The extensive requirements of reproductive donors concerning their bodies spark discussions on the extent human beings can practise their reproductive autonomies *via* donation. This begs the question of whether law and regulation should intervene in a donor's motives and allow only specific motives to donate; or whether reproductive donation is an act of exercising bodily autonomy at all when there is compensation involved—is donating reproductive parts considered a tacit social agreement for general welfare such that the state can regulate it? As seen in the literature, issues of legal measures and recruitment of surrogates and egg donors seem to focus on not only policing the bodies of donors from the global South but also alluring them to donate in exchange of compensation. Low-income women undergo a series of examinations and reviews of their medical history, whereby medical institutions determine whether they "fit" as donors. A certain amount of compensation informally authorises strict checking whether donors are telling the truth about their sexual practices, lifestyle, and health habits regardless of whether the donor feels comfortable. The autonomy of donors from the global South is thus superseded by some form of bribery as they might preclude their bodily control over privacy lest they lose opportunity for income generation.

Yet, the same bodies are also disposable after certain procedures or transfers were achieved. The disposability of the bodies from the global South is a matter of class as the Southern body generally accentuates a lower-class identity found in the monetary-seeking subjects who are aware of the reproductive value of their body. This demonstrates an embodied reworking of what it is to live in relation to human reproduction, for example, by embracing the use of one's body as a site of technological practises. After having a critical embodied contribution to someone else's (lack of) fertility, donors are still left with questions concerning post-donation risks and side-effects that they might face.[100]

7.3 | Body autonomy neglected in the medical industry

A donor's body is sought after for a particular reason: reproduction. As technology progresses, resorting to ARTs is becoming commonplace for medically-diagnosed cases of infertility. In such a context, the donor's body becomes a mobile entity from the South to somewhere else; it also serves as a site of temporariness and

[99]Pande, A. (2014). *Wombs in Labor: Transnational Commercial Surrogacy in India*. New York: Columbia University Press.

[100]Blyth, Thorn, & Wischmann, op. cit. note 48.

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corporeal display of technology's advancement on reproduction, in which the identity of being "from the South" is constituted as an urgent body. The donor's body serves a space that contains specific resources such as gametes or uterus at the donor's disposal. "Matching" of donors and recipients is about the eligibility of the donor based on the results of screening and testing as defined in state regulations. The terms "donor selection" and "donor eligibility" suggest that donors are constructed as fulfilling a need, that is, the need for recipients and fertility clinics for high quality and marketable body parts to sell to recipients worldwide.[101]

While there is a sense of obligation that donors must fulfil within the broader ethical discussion, their autonomy suffers from neglect in favour of the strict requirements of the medical industry. This underscores the contentions regarding exceptional situations in which bodily autonomy would be required to establish limits. It raises the question of whether the state should intervene even if the donor refuses. It is important to consider that while bodily autonomy may generally encompass the freedom to use one's body for reproductive purposes, there may be exceptional situations where limits need to be established, such as when health concerns arise in relation to donation for commercial purposes. For instance, for the sake of health of the prospective offspring, surrogate and egg donors are required to undergo certain medical tests and provide their personal information, such as physical characteristics, family medical history, religion, personal achievements, and personality traits.[102] To an extent, this reflects a rather bigger sense of obligation not only to the recipients, but a duty to the ethics of the medical industry. Therefore, it is important to ask to what extent a donor's bodily autonomy should be respected in cases where health consequences might outweigh their autonomy, and whether the state can intervene even if the donor refuses. Such concerns suggest the unrecognised appropriation of donors' bodies within a perpetuating uneven distribution of reproductive autonomy in the medical industry. While the process of reproductive donation can be argued to have improvements in honouring individuals' bodily autonomy, such autonomy can be very limited. This is an important discussion for surrogates and egg donors from the global South as they usually have restricted decisions over their bodies in the process of donation. As Nelson[103] puts it, neglecting the autonomy of those involved in reproductive donation implies "the denial of meaningful reproductive choices for those who are economically and socially disadvantaged". As such, autonomy is to be extended to decisions of donors regarding their bodies, including selling their gametes if they so choose, with the demands they wish to make.

Furthermore, the previous discussions on conflict of interest and global market suggest the medical industry's neglect of donors, infringing some rights related to bodily autonomy. For example, in terms of health rights, access to adequate healthcare is frequently limited, and donors may not receive appropriate medical treatment before, during, and after the donation process. Additionally, there is a concern over the ownership and control of biological material, as donors may lack control over the use and disposition of their donated material and may not have access to information about any offspring that result from the donation. Mobility rights are also impacted, as donors may be required to travel to a specific location for the procedure, which can present challenges for individuals with limited mobility and amplify the stigma and discrimination associated with reproductive donation. Finally, the issue of economic rights pertains to the provision of fair and equitable compensation for the labour of donors. Exploitation often occurs when donors from low-income countries receive lower compensation compared to their counterparts in developed countries.

What, then, is the future of bodily autonomy of surrogates and egg donors from the global South? This question brings to the fore the need to widen the choices donors deserve and the autonomy they are entitled from their reproductive labour. For many donors from the global South, reproductive donation is a means to survive, at least temporarily, given the financial constraints and slow social mobility in the global South. As such, the reproductive industry needs to ensure autonomy within reproductive labour. Aside from equitable remuneration in reproductive labour, reproductive donors from the global South need to be protected from alienation of the commercialisation of their donation through a just and fair negotiation between the donor and recipients/clinics, including coverage of regular counselling and psychological services, post-donation check-ups and treatments, and rights to demand conditions. Yet aside from such measures, it is important to address the issues of global poverty that lead donors to risking their bodies because "regulating them [donors] will never suffice to stop people from readily endangering themselves in order to address their basic needs and aspirations or those of their family, and therefore be willing to subject themselves to exploitation".[104]

8 | CONCLUSION

The objective of this article has been to examine issues of bodily autonomy of surrogates and egg donors from the global South. The findings emphasise that conflict of interest and the global market in reproductive donation can undermine donors' bodily autonomy, thereby threatening the fundamental principles of reproductive rights and equity. The process of compensation, external controls by

[101]Note that there is a paradoxical nature in regards to the bodies of donors involved in assisted reproductive donation. On the one hand, the donor's bodies are deemed as "high quality" due to their ability to supply the necessary reproductive materials. On the other hand, the individual who embodies this body is frequently perceived as being of diminished value. This analogy is similar to the commodification of a pearl within an oyster, where the pearl is prized while the oyster itself is disregarded. This disparity highlights the need for a nuanced and critical examination of the ethical implications of reproductive donation, including the rights and agency of donors and the broader societal attitudes towards their bodies and wellbeing.

[102]D'Entrèves, M.P., & Vogel, U. (Eds.). (2000). *Public and Private: Legal, Political and Philosophical Perspectives* (1st ed.). London: Routledge, p. 10.

[103]Nelson, E. (2013). *Law, Policy and Reproductive Autonomy*. Portland: Hart Publishing.

[104]Nahavandi, op. cit. note 28, p. 4–5.

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medical authorities and recipients, and neglect by the medical industry further exacerbate the lack of participation of donors and perpetuate the unequal distribution of resources and opportunities in reproductive donation. Donors are their bodies, whereby the experiences of reproductive donors reflect the uneven distribution of bodily autonomy within reproductive donation. Body as space makes visible the ways in which socio-cultural, economic, and medical forces impinge on the lives of reproductive donors. Additionally, the lack of bodily autonomy of donors from the global South shows the penetrative medical structures within the context of rapid technological change in the medical field. In this context, the donor's body becomes more than a biological entity and extends as a form that resembles a space imbued with a social dimension that links the corporal and the spatial subjects.

A focus on the plight of reproductive donors from the global South gear towards moving beyond donors as mere participants in reproductive labour. Rather, they carry embodied reproductive identities with curtailed autonomy within the structural constraints of the transnational reproductive industry. In terms of practice, seeing donors' bodies as space reveals that acknowledging reproductive rights is one thing, but actually upholding donors' bodily autonomy in implementing reproductive rights is another[105]. The discussions in this work encourage further examination to understand the multi-layered experiences of reproductive donors from the global South, together with the wider social, cultural, geographical, and political relations towards deeper interrogation of the processes of reproductive industry. While the donor-focused issues presented in this paper cannot be entirely generalised, these issues are indicative of crucial cultural and societal affairs in reproductive donation, suggesting the importance of seeing the donor's body as a site to further understand reproductive donation concerns. As reproductive donors are situated within disproportionate opportunities, and social relations with different capacities, responding to the needs of reproductive donors cannot be established just by making pro-donor legislation available such as mandating counselling or ensuring fair compensation; rather, ensuring that the donor's body is rightful for autonomy.

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CONFLICT OF INTEREST STATEMENT

None to declare.

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[105]Morgan, L. (2015). Reproductive Rights or Reproductive Justice? Lessons from Argentina. *Health and Human Rights*. 17, 136–147.

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