Geographies of assisted reproduction: The Spanish egg donation economy as a global/intimate contact zone

Laura Perler
Carolin Schurr
University of Bern
laura.perler@giub.unibe.ch
carolin.schurr@giub.unibe.ch

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Abstract

This article starts from the idea that a fertility clinic is a "contact zone" where differently positioned subjects meet. Broader power relations become tangible in this specific geography of assisted reproduction. This article examines different scales, such as the fertility clinic itself, the national context of reproductive politics in Spain, and the transnational connections of contemporary clinic consortia. By doing so, we reveal the interrelationships that shape this contact zone from the intimate to the global. This interscalar analysis leads to a critique of a transnational fertility industry that is heavily inflicted with logics of productivity and capital accumulation and in which the lives of egg receivers are valued over the lives of egg donors.

Keywords: egg donation; global/intimate; reproductive geographies; contact zone; assisted reproductive technologies

Resum. *Geografies de reproducció assistida: l'economia espanyola de la donació d'òvuls com a zona de contacte global/íntima*

Aquest article parteix de la idea que la clínica de fertilitat és una «zona de contacte» on es troben subjectes en diferents posicions i es tornen tangibles relacions de poder més àmplies. L'article examina diferents escales, com la mateixa clínica de fertilitat, el context nacional de la política reproductiva a Espanya i les connexions transnacionals dels consorcis clínics contemporanis. En fer-ho, revelem les interrelacions que donen forma a aquesta zona de contacte des del que és íntim fins al que és global. Aquesta anàlisi interescalar ens porta a la crítica d'una indústria transnacional de la fertilitat que està fortament imbuïda de lògiques de productivitat i acumulació de capital i en què la vida de les receptores d'òvuls es valora més que la de les donants d'òvuls.

Paraules clau: donació d'òvuls; global/íntima; geografies reproductives; zona de contacte; tecnologies de reproducció assistida

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Resumen. *Geografías de la reproducción asistida: la economía española de la donación de óvulos como zona de contacto global/íntima*

Este artículo parte de la idea de que la clínica de fertilidad es una «zona de contacto» en la que se encuentran sujetos en diferentes posiciones y se vuelven tangibles relaciones de poder más amplias. El artículo examina diferentes escalas, como la propia clínica de fertilidad, el contexto nacional de la política reproductiva en España y las conexiones transnacionales de los consorcios clínicos contemporáneos. Al hacerlo revelamos las interrelaciones que dan forma a esta zona de contacto desde lo íntimo hasta lo global. Este análisis interescalar nos lleva a la crítica de una industria transnacional de la fertilidad que está fuertemente imbuida de lógicas de productividad y acumulación de capital y en la que la vida de las receptoras de óvulos se valora más que la de las donantes de óvulos.

Palabras clave: donación de óvulos; global/íntima; geografías reproductivas; zona de contacto; tecnologías de reproducción asistida

Résumé. *Géographies de la reproduction assistée : L'économie espagnole du don d'ovules comme zone de contact global/intime*

Cet article part de l'idée que la clinique de fertilité est une « zone de contact » dans laquelle se retrouvent des sujets dans des positions différentes et des relations de pouvoir plus larges deviennent tangibles. Cet article examine différentes échelles, telles que celle de la clinique de fertilité elle-même, le contexte national de la politique de reproduction en Espagne et les connexions transnationales des consortiums cliniques contemporains. Ce faisant, nous révélons les interrelations qui façonnent cette zone de contact de l'intime au global. Cette analyse interscalaire conduit à une critique d'une industrie transnationale de la fécondité fortement imprégnée de logiques de productivité et d'accumulation de capital et dans laquelle la vie des receveuses d'ovules est plus valorisée que celle des donneuses d'ovules.

Mots-clés : don d'ovules ; global/intime ; géographies reproductives ; zone de contact ; technologies de procréation assistée

Summary

1. Introduction

> It was in April 2013 when Marina and Pedro began to think seriously about their future. The economic crisis, they told me, triggered many questions: "How should we go on? Are our pensions still safe? What will our future look like?" Marina and Pedro suddenly realized that times were changing: even if you had a good job, there was suddenly a strong chance of ending up unemployed. And at the age of 50, one would probably stay unemployed. So they began to think about self-employment. One evening, they were at a friend's house. There they met the director of a fertility clinic. It was a life-changing evening for the couple. The conversation turned – as usual – to the crisis. Their new acquaintance's words set the course for Marina and Pedro's future. She said: "Today everyone is talking about urban gardens and self-sufficiency. But I say, stop planting your tomatoes and bring me blonde women with blue eyes." It was at this moment that the idea first occurred to them to create an agency that refers egg donors to clinics. (Diary note, Barcelona, 10.4.2017)

This snapshot from Marina and Pedro's lives illustrates the relationship between Spain's major economic crisis and its vibrant fertility sector. It also suggests the fertility clinic as a possible nexus, a link, between a couple's unstable working conditions and the promise of a billion-euro industry. The fertility clinic is an example of what Mary-Louise Pratt has described as a "contact zone", a "space in which peoples geographically and historically separated come into contact with each other and establish ongoing relations, usually involving conditions of coercion, radical inequality, and intractable conflict" (2008: 8). The fertility clinic is the place where Spanish egg and sperm donors "donate"[1] their sex cells, which prospective parents from other European countries purchase in the hope of creating a family. However, it is also a place where a wide variety of practitioners from different backgrounds come together to deal with the patients: doctors, psychologists, geneticists, and embryologists. However, despite their specific situatedness, these actors are all part of a single transnational bioeconomy. Ultimately, the clinic is the spatial node where a specific present is produced by intimate desires to create a family, individual labor practices, national regulations and market mechanisms, and global flows of finance, knowledge, pharmaceuticals, and other socio-material goods (Perler and Schurr, 2019; Schurr, 2018). *Clinic* is actually the wrong term because it suggests something singular. But the clinic is more than that; it involves a multiplicity of actors, ranging from patients and oocyte donors to cleaners, nurses, technicians, physicians, genetic counselors, and investors. Vora describes surrogacy as a contact zone in which "participants negotiate the

1. The term "egg donor" is by now widely criticized by feminist scholars. Alternatives include "TRC - Transfers of Reproductive Capacity" (Lafuente-Funes, 2020), "egg seller" (Nahman, 2008), and "egg provider" (Lundin, 2012). In this paper, while we recognize its problematic nature, we feel that the use of a euphemistic term such as egg donor is extremely important to the highly commercialized setting we describe and therefore should not be expunged.

meaning of surrogacy arrangements through experimental modes of sociality" (Vora, 2014: 63). For us, the fertility clinic functions as a contact zone where people and processes otherwise separated by large distances and operating on different scales come into contact. Here, we pay particular attention to how these different scales are intertwined in Spain's oocyte economy when making babies goes transnational.

Geographers have only recently begun to engage with the spatialities of reproduction. The edited collection *Reproductive geographies: bodies, places and politics* (England et al., 2018) is the first attempt to systematically discuss issues of biological reproduction from a geographical perspective. Chapters of this book, as well as a few other publications in the field of geography, focus on the role that space and place play in the way bodies experience conception, pregnancy and birth in such diverse locations as fertility clinics (Collard, 2018; England, 2018), hospitals (Fannin, 2003), birth centers (Hazen, 2018), and homes during homebirth (Whitson, 2018). Most of geography's engagement with reproductive technologies focuses on reproductive mobilities when analyzing people's efforts to access reproductive technologies abroad when they have restricted or no access to them in their own territories (Parry et al., 2016). At the center of this small body of literature are border crossings in search of technologies for abortion (Calkin, 2019; Freeman, 2017), assisted reproductive technologies (Payne, 2015; Schurr, 2018), and surrogacy (Lewis, 2021; Schurr and Militz, 2018; Schurr, 2019). These publications have started to engage with the role that space, place, and mobility play in people's experiences of reproduction, but scale has yet to be addressed in depth despite its potential for understanding uneven geographies of access to reproductive technologies (for an exception, see McKinnon, 2016).

Taking scale and the concept of the global/intimate (Pratt and Rosner, 2012) as central categories of analysis, this article departs from the (inter) national scale to look at the particular contexts of the fertility industry in Spain. We do so by first tracing the history and legal situation of the fertility industry at the national level. We then zoom out to show how the Spanish fertility industry has become a transnational marketplace in recent decades. We then focus on the local spaces of one specific fertility clinic (CREAVIVA). We reveal how this clinic functions as a contact zone where differently positioned subjects, such as egg recipients and donors and different practitioners, all meet. In the conclusions, we focus on the entanglements of scales from the intimate to the global that shape the contact zone in a fertility clinic, to present a critique of a global fertility industry that is heavily influenced by logics of productivity and capital accumulation.

The article is based on Laura Perler's (the principal researcher of this study) extensive ethnographic fieldwork in Valencia, Barcelona, and Alicante from 2018 to 2019[2], which consisted of ten months of participant observation in a

2. The research for this study was conducted between 2016 and 2020 as part of Laura's PhD thesis, and was funded by the Swiss National Science Foundation.

clinic and semi-structured interviews with ten egg donors, four egg recipients, and 38 in-vitro fertilization (IVF) doctors, clinical staff, and geneticists. The Egg donors and recipients we interviewed were not recruited through clinics and we interviewed them outside the clinical context. As this research field is highly sensitive, ethical considerations were integral to our research design (Perler, 2021). Laura obtained the participants' consent both by building transparent, trusting relationships and by getting them to sign Informed Consent forms. While all names are anonymized, including that of the main clinic in which Laura did the fieldwork, the clinics that are presented in the historical and contemporary review of the Spanish fertility market are not. This is because information on those clinics is indeed publicly available and thus does not need to be anonymized. We coded the material in the Maxqda qualitative analysis program and analyzed it inductively using Strauss and Corbin's (1990) grounded theory.

2. The national context: Spain as an El Dorado for reproductive medicine

According to the most recent figures, for the year 2015, about 15% of Europe's 850,000 assisted reproductive treatment (ART) cycles were performed in Spain (De Geyter et al., 2020: 2). Spain is thus the European leader in assisted reproduction in general, and egg donation and reprogenetics in particular (de Mouzon et al., 2010; De Geyter et al., 2020; Pavone and Arias, 2012). In 2017, a total of 140,000 in vitro cycles were performed in more than 250 Spanish clinics. Of these cycles, 42,063 were performed with donated oocytes, representing more than a quarter of all cycles (Sociedad Española de Fertilidad (SEF), 2017: 35). The European Society for Reproductive Medicine estimates that 50% of European egg donations occur in Spain (ESHRE, 2017). Spain is also the European leader in reprogenetics (Pavone and Arias, 2012: 237). This has resulted in a thriving fertility industry with annual growth of around 5% in 2016 – a significant figure in a country suffering prolonged economic recession (DBK Informa, 2017). To understand Spain's leading position in Europe's fertility economy, we must look back to the origins of its fertility business.

2.1. A nation with a long history of reproductive medicine

As clinic staff repeatedly emphasized to us, the development of reproductive medicine advanced in gigantic steps. In 1984, Victoria Anna was the first child conceived through in vitro fertilization (IVF) in a private clinic in Barcelona, the Instituto Dexeus (Coroleu Lletget, 2011: 80). Four years later, the same clinic recorded the first birth of twins conceived with the help of oocyte donation. This was followed in the 1990s by the successful use of intracytoplasmic sperm injection (ICSI), a technology whereby the sperm is injected directly into the cytoplasm of the oocyte via microinjection. Twenty-five years later, almost 90% of all in vitro fertilizations are performed as ICSI procedures (Sociedad Española de Fertilidad (SEF), 2017: 5).

In 2007, the introduction of another new technology marked the beginning of an era for egg donation: cryopreservation. The Instituto Valenciano de Infertilidad (IVI) was the first to transfer vitrified oocytes (Coroleu Lletget, 2011: 81ff). Thanks to this innovation, oocytes no longer needed to be transferred directly but could instead be stored in oocyte banks. The capacity for freezing oocytes accelerated their marketization (Parry, 2008, 2012). In addition, lower hormonal stimulation in IVF patients also resulted in fewer surplus eggs. Due to this demedicalization of IVF patients, and in the context of a major economic crisis with high rates of youth unemployment, a new industry emerged: harvesting oocytes from younger donors. The possibility not only to extract germ cells from the body and fertilize them in vitro but also to store them by cryopreservation and transport them over long distances meant a further "capitalization of vitality" (Rose, 2006: 38). Indeed, society thus had increasing abilities "to control, manage, engineer, reshape, and modulate the very vital capacity of human beings as living creatures" (ebd., 3).

A suitable legal basis was important in order for this lively bioeconomy to flourish. In 1988, Spain was one of the first countries in the world to introduce legislation on assisted reproduction. Since then the law has been succinctly liberalized, as we show later. However, Spanish law was already quite liberal in 1988, because it allowed access to reproductive technologies for all persons without any restrictions in terms of marital status or sexual orientation (Abellán, 2011: 85ff.). This liberal stance, which is exceptional in the European context, can also be explained by the time when the first law was created – in Spain's young democracy under the government of Felipe González, of the Spanish Socialist Workers' Party (PSOE). This period immediately following the long dictatorship of Francisco Franco (1936-1975) brought a wave of modernization (Alkorta Idiakez, 2006: 355). The political transition was accompanied by what is commonly referred to in Spain as *la movida*, the social and cultural countermovement to fascism, a shift toward liberal societal models and a rejection of traditional family values and Catholicism (Fouce, 2009: 144). In this respect, the law on assisted reproduction was a child of its time and provided a Springboard for an industry that would undergo massive growth in the following decades.

These liberal policies were also promoted by professional associations such as the Sociedad Española para el Estudio de la Esterilidad (SEEE), which was founded as early as 1953. Renamed the Sociedad Española de Fertilidad (SEF) in the 1970s, this is an association of professional groups that deal with questions of reproduction: andrology, embryology, psychology, gynaecology, and nursing. As such, it maintains scientific exchange at various levels and is the organizer of diverse working groups and conferences (Coroleu Lletget, 2011: 72 ff.). The SEF also collects and coordinates data from individual clinics, publishes the latest statistics on reproductive medicine, and coordinates the statements of Spanish clinics on topics such as the anonymity of germ cell donors and the use of genetic carrier tests (See e.g., Muñoz et al., 2019; Sociedad Española de Fertilidad (SEF), 2017; Castilla et al., 2019).

The SEF's publications show that it primarily defends the positions of private clinics. For example, in response to the Spanish National Ethics Committee's opposition to donor anonymity, it advocated in favour of it (Muñoz et al., 2019). The SEF argues that individuals do not have the right to know their own ancestry and that donors have a right to preserve their privacy. Further, they contend:

> It is undeniable that the removal of anonymity would reduce not only the number of donors but of effective donations more generally, which would directly affect private assisted reproduction centers, which would result in an economic disaster. (Muñoz et al., 2019: 20)[3]

Here, the maintenance of anonymity is directly linked to the private centers, which are viewed as guarantors of economic stability. The SEF, as an association of professional groups, is not obliged to adopt an independent position. However, its clear stance in favor of private clinics underlines the importance of private players in the field of reproductive medicine in Spain.

Another important actor in this field is the Comisión Nacional de Reproducción Humana Asistida (CNRHA), established in 1997 under Royal Decree 415/1997, which is the central body responsible for monitoring everything related to germ cell donors and for implementing the national donor registry. In 2019, however, the Commission mandated the SEF to implement the registry (SIRHA)[4]. The various postures of the CNRHA suggest that it is also aligned very closely with private clinics and is more of a liberal expert body than an independent commission (for more information on this topic, see Pavone and Arias, 2012: 243ff.; Pavone, 2010: 115).

In summary, Spain has a very long history in reproductive medicine. This thriving economy has received key support from liberal legislations, driven the early establishment of numerous private fertility clinics, and fostered the presence of professional associations that are able to defend their positions.

2.2. National legislation of assisted reproduction: Liberal and loyal to private clinics

As outlined above, Spain was one of the first countries in the world to pass laws permitting assisted reproduction. It holds a very unique position in the European landscape. While there is only a complete ban on egg donation in Switzerland, Norway and Germany, the other countries are nevertheless much more restrictive. For example, in the United Kingdom, egg donation is

3. All Spanish quotations were translated into English by the authors.
4. This register, which has been required by law since 1988, is not yet in regular use. A first national register (SIRHA) was made compulsory for all clinics in January 2020. This could lead to major changes in the future, especially with regard to multiple donors. However, as of today (August 2022), we have received informal confirmation that the registry is still not in regular operation.

legal but non-anonymous and the long waiting list leads people to go abroad for treatment. In Italy, donation is only accessible to heterosexual couples who are sterile because of medical conditions and requires a medical indication (Speichert, 2021; Pennings et al., 2008). Compared to other European countries, Spain was therefore not only early in establishing a law, but also very liberal (for more information on the resulting market dynamics of those diverse national legislations see Hudson et al., 2020).

In 1988, the first law was adopted on reproductive medicine, legalizing egg donation (Act 35/1988). This law was amended in 2003 to Act 45/2003 and was finally replaced in 2006 by Act 14/2006, which is still in force today. The 2003 amendment was intended to clarify the status of leftover embryos, thus creating the possibility of using embryos for research purposes under restricted conditions. This law also defined a maximum number of oocytes that could be generated per cycle. The 2006 law abolished this maximum number and also promoted liberalization in other respects. New provisions were enacted regarding the further approval and use of novel and experimental technologies in reproduction. Instead of the limited number of technologies listed in the previous law, the 2006 amendment now allowed the health authority to endorse new ones through regulations. This is a direct legal response to the rapid developments in reproductive medicine. Today, the Spanish reproductive market is primarily regulated by Act 14/2006.

Much of Act 14/2006 concerns egg donation. For example, Art. 5, para. 3 defines it as an altruistic act:

> [T]he donation must never be of a lucrative or commercial nature. Any financial compensation must only strictly compensate for the physical inconvenience and travel and work expenses that may be incurred as a result of the donation and must not provide a financial incentive for the donation.

When the main researcher of this study conducted her research in 2019–20, this compensation was between 900 and 1,300 euros per donation. As it is not classified as earnings, it is not taxable. In comparison, the average monthly income for a full-time job in Spain in 2020 was 1,050 euros per month (Eurostat, 2020). The average age of donors in Spain is 25 years old (Lucía and Núñez, 2015). This age group suffers low wages and disproportionately high un- and underemployment, which means that the compensation of around 1,000 euros is a clear financial incentive, contrary to the altruistic requirement laid down by law (Lafuente-Funes, 2020). Clinical staff often commented on the paradox between the national legislation of oocyte donation as an act of altruism and the donors' most important motivation being financial:

> So, it's clear that they also donate for economic motives. Very few tell you that they're making the donation for purely altruistic reasons. But one does not exclude the other, of course. Many have diverse motives, and the most common of these is to help other women. Many who are mothers, for example, think that having children is something important and therefore want to

> help childless couples. Others know people who can't have children … These are probably the most common motives, along with the economic. (Elena, psychologist, Valencia, 12.7.2018)

Egg donation being nationally legislated as altruistic but at the same time being financially remunerated is described by many authors as a central feature of Spanish practice (Lafuente-Funes, 2020; Rivas et al., 2019; Molas and Bestard, 2017; Degli Esposti and Pavone, 2019). Another paragraph of this article of Act 14/2006 also prohibits any commercial advertising that could motivate egg donation. This prohibition is controversial, in particular because the advertising techniques on social media platforms address donors as altruistic, sympathetic women and encourage them to donate, so even if advertisement is officially illegal, egg donation is advertised in practice (Molas and Whittaker, 2021).

Art. 5, para. 5 then establishes the relative anonymity of the donation, defining it as anonymous but granting the children resulting from the donation "the right to receive, either themselves or through their legal representatives, general information about the donors that does not reveal their identity." However, practice in individual centers regarding release of donor data to donor-derived children is often much more restrictive than that required by law. It tends toward full anonymity, which is not lifted even when the child reaches the age of majority (Rivas et al., 2019: 631).

Rivas et al. (2019) argue that the two main legal foundations of Spanish egg donation, its anonymity and non-commercial nature, are paradoxically also the fundamental characteristics of the appropriation of donors' reproductive labor by allowing egg recipients and donors to be alienated from each other and economic mechanisms and thus be obscured by the notion of donation (2019: 639). In this regard, Degli Esposti and Pavone also speak of a quasi-social market that benefits from the fact that the disposal of oocytes can be conceptualized as altruism and donation (2019: 7). These Spanish analyses thus share the finding that Waldby and Cooper (2008: 67) have already made for the transnational market of oocytes, whereby gifting, altruism, and solidarity in a capitalist bioeconomy instead provide opportunities to expropriate donors of their body parts, which are then transformed into commodities.

Art. 5, para. 7 then specifies that a maximum of six children may be born per donation. This regulation, which was created primarily to prevent possible incest between genetic relatives resulting from anonymous donations, is especially problematic, particularly given the transnational dimension of donation. If oocytes are sent to different countries, more oocytes can be generated per donor: six live births per country. In addition, the lack of a national donor registry leads certain donors to visit several clinics in order to donate regularly. This was often described as "*hecha la ley, hecha la trampa*"[5] by donors:

5. "Every law has its loophole".

> In that clinic there, I made six donations, actually you can only do six. But well, "hecha la ley, hecha la trampa" (Every law has its loopholes). Because the clinics don't know about each other, I just took advantage of that a little bit, because … I have to do the shopping, pay for the Internet, pay for tobacco, all the vices we have are paid for by me. Then on top of that, I have to pay the insurance and all that. In the end … my salary … is gone, just like that. (Jenny, egg donor, Valencia, 25.6.2018)

In sum, it can be said that Spanish legislation as a whole is very liberally formulated. The consequence of this is that private clinics and professional associations are free to tailor the laws to their own needs.

3. Going transnational: Private equity firms and reproductive tourism

Although the Spanish public health system offers free treatment and medication, its long waiting lists encourage many Spanish women to turn to the private sector (Marre, San Román and Guerra, 2018: 7) In addition, limited resources in the public health system lead to more limited services. For example, certain technologies, such as preimplantation genetic diagnosis and egg donation, can only be offered conditionally or not at all (Pérez Milán, 2011; Pavone, 2010: 114). The egg donation market in Spain is hence clearly dominated by private providers (Lafuente-Funes, 2020; Pavone and Arias, 2012): 80% of assisted reproductive treatments in Spain take place in private clinics. In 2016, Spanish clinics produced a total turnover of 530 million euros, of which 410 million euros were handled by private clinics (DBK Informa, 2017; Rivas et al., 2019: 624). This proportion can be explained primarily by the importance of reproductive mobility: many people travel to Spain from abroad for reproductive medicine treatment, and clinics increasingly export their oocytes to other countries.

The reasons for reproductive mobility are manifold: very high barriers to adoption, legal restrictions such as bans on egg donation in the country of origin, difficult or impossible access for groups such as lesbian couples, long waiting lists in the public system, and significantly higher costs in the countries of origin (Pennings et al., 2008; Shenfield et al., 2010; Martin, 2014). Spain's liberal legislation, general tourism infrastructure, and the reputation of Spanish reproductive medicine for its professionalism and multilingualism have made the country a "reproductive paradise" for an international clientele (López and Moreno, 2015: 249). Consequently, the Mediterranean region, traditionally dominated by tourism, hosts the largest proportion of private clinics (Alkorta Idiakez, 2006; Pavone and Arias, 2012; Sociedad Española de Fertilidad (SEF), 2017).

Thus far, it should be clear that the mobility-oriented private sector has contributed to a flourishing and crisis-resistant fertility industry. As the anthropologist Sunder Rajan has impressively shown in his book *Biocapital*, biotechnologies can only be understood "by simultaneously analyzing the market frameworks within which they emerge" (2006: 33). As we now demonstrate,

increasing transnationalization and organizational restructuring are paradigmatic of the Spanish fertility market.

Whereas a decade ago IVF clinics were often run by local fertility doctors, a different picture is emerging today. International investors are entering the fertility business and are doing so at a fast pace (Muñoz, 2020). This is understandable from looking at the figures. In 2019, for example, market research firm Data Bridge estimated that the global reproductive market will grow by 9.25% annually, generating $41.4 billion in annual revenue by 2026 (Data Bridge, 2019). In the wake of this change, the market trend is toward transnational clinical consortia, whose association with strong financial partners provides the necessary capital to fund these high-cost developments (Hecking, 2019). Alternative investment companies in particular, which handle enormous amounts of financial capital from private investors as well as from pension funds, have grown rapidly since the economic crisis of 2008. As traditional investments are barely profitable anymore due to low interest rates, these firms focus on private equity, investing in unlisted companies with the aim of restructuring them profitably and then selling them at a high return.

The Catalan clinic Eugin provides an example of this. It was founded in 1999 by two physicians from Barcelona and very quickly became an important player in Spain's fast-growing reproductive tourism industry. Whereas patients initially traveled to Barcelona for treatment, over the years, the clinic has opened other branches in Europe and South America (Berengueras, 2015). ProA Capital, a Spanish private equity firm, bought the clinic in 2010. Just four years later, ProA Capital put the clinic consortium up for sale again (Agustín, 2014). Both Fosun, the largest Chinese financial conglomerate, and Nordic Capital, a Swedish private equity firm, expressed interest in buying the clinic, but it was eventually purchased for 143 million euros by NMC Health, a publicly traded healthcare company from the United Arab Emirates (Agustín, 2015).

Another prominent example of the trend toward transnationalization is Spain's largest hospital consortium, the Instituto Valenciano de Infertilidad (IVI), whose clinics can be found in several countries of Europe and in South and Central America. The clinic was founded in 1990 by Antonio Pellicer and José Remohí, two Spanish physicians. In 2000, Carlos Bertomeu, the president of the airline Air Nostrum, joined IVI as a shareholder. This marked the first shift toward a more business-oriented organization. In 2017, IVI merged with the US IVF giant RMANJ, and IVI-RMA Global became the world's largest IVF chain (Serra, 2018). In 2020, the conglomerates' clinics in the United Arab Emirates and Oman were sold to the investment firm Gulf Capital for 90 million euros (Muñoz, 2020).

Another international player that has entered the Spanish reproductive market in recent years is the German conglomerate NextClinics, which exemplifies yet another dimension of the Spanish market, namely its reprogenetization. NextClinics is the owner of several clinics, genetics laboratories, and germ cell banks in the Czech Republic, Germany, Spain, Estonia, Austria,

and Switzerland. It is financed by the US investment fund Oaktree Capital. Between 2017 and 2019, the company claims to have invested more than 225 million euros in clinics and laboratories in Europe, and it now employs 900 people (NextClinics, 2019). The development of this clinic consortium is part of what Sunder Rajan has described as a new phase of capitalism in which biotechnology is a central form of capital accumulation (2006: 3). The company's webpage states that it centers its business around three pillars: reproductive clinics (Nextclinics), laboratories (Nextlab), and digital technologies for individualized healthcare (Nextlife) (NextClinics Webpage). In this fusion between genetics and reproductive medicine, the anticipatory aspect is central:

> A genetic laboratory is one of the last areas of laboratory medicine that is developing dynamically. It plays a huge role in medicine as it can see a bit into the future, so it can suggest what will happen. All other medical results show what happened, but genetics tells you what will happen on the basis of the human genome: what you're susceptible to, how to live, etc. Assisted reproduction is an ideal gateway to this type of predictive medicine. (NextClinics, 2018)

NextClinics thus symbolizes a future-oriented age in which ever more opportunities arise to set the course for "the future that we might inhabit" (Rose, 2006: 5). Reproductive mobility is an integral part of NextClinics' strategy. Its presence in several European countries offers patients substantial freedom of choice as well as "incidentally enjoying the benefits of unique destinations" (NextClinics Webpage). As the CEO explains, the mobility of these patients, as well as their independence from national insurance systems, is a great advantage for NextClinics:

> Because we don't care for sick patients, they can travel and even fly to see us. Moreover, genetic samples from clients who pay their own way can travel around the world. If you extract a genetic sample in the Czech Republic paid for by an insurer, then it can only be analyzed in the Czech Republic. And when you have a throng of these private clients, you can buy the most expensive equipment and hire the best people. Therefore, genetics is a major project and we are prepared to invest significant funds and emotional capital into it. (NextClinics, 2018)

The Spanish reproductive medicine market is part of a capitalist economic logic. The liberal legislation, together with a dynamic market, provides an ideal Springboard for international investors to increase their capital by restructuring, optimizing, and relocating clinics. These macroeconomic forces that are turning the Spanish fertility economy into a transnational market meet in the local spaces of the clinic, which we now describe in more detail.

4. The local space: Division of labor and (non)relations in the contact zone

In a fertility clinic, multiple actors move in a fragmented world. Gynecologists, nurses, administrative personnel, managers, egg donors and egg recipients

come together in the clinic. The one in which Laura conducted her ethnographic fieldwork, and which we call CREAVIVA here, provides an example of the division and conditions of labor that characterize the Spanish oocyte economy at large. We pay particular attention to the power relations between the medical staff, egg donors, and egg recipients and how these (non)relations are played out at the scale of the clinic.

The main task of a fertility clinic is to "assist" reproduction, and in the case of egg donation, prospective parents wishing for a child are "assisted" with the help of an oocyte donor. In the case of CREAVIVA, the medical staff had two primary tasks: the less frequent work with (national and international) IVF patients and the much more frequent work with egg (and less frequently sperm) donors[6]. The work with egg donors was often described by physicians and nurses as "boring, repetitive, it was the same procedures over and over again, nothing new" (Diary note, Valencia, 1.5.2018). In contrast, the work with the recipients was perceived as much more satisfying. As the clinic worked with two specific European countries, there were even two specialized service sections that could respond to the specific needs of international recipients travelling to Spain. With egg recipients, doctors had to find individual solutions to a wide variety of problems. This was not the case with egg donors, as illustrated in the following diary note:

> Today I'm accompanying Livia, a gynecologist who has been working at the clinic for a long time, in her daily routine. During a break, I ask her if she likes working here. She answers: "I like reproductive medicine, but the donors are a bit boring, as you can see now … In reproductive medicine, we want to help women to get pregnant, but here it's always just about looking for follicles and sucking them out." A few days earlier, I accompanied another doctor who told me something similar. Surprised, he even asked me why I would be interested in his work here, as it is totally boring and repetitive, always the same *girls*. (diary note, Valencia, 2.5.2018)

But who are these *girls*, these women who provide their oocytes? In a study of egg donors in Europe led by bioethicist Guido Pennings, the donor profile in Spain is described as a "young woman who is unlikely to work full time, single or divorced and childless, who donates more than once" (Pennings et al., 2014: 1084). He concludes that the Spanish donor typically donates for a combination of altruistic and financial reasons. Although his research design can be questioned – donors were contacted through clinics, and certain questions such as those about motivations for donation can hardly be asked through questionnaires – his results confirm the profile of donors that we found in our research. Most of the donors were under 25, many were in unstable jobs, and most of them were multiple donors. This was also confirmed by the survey that Laura conducted of 30 donors at CREAVIVA, where more than half of the

6. While CREAVIVA worked mainly with frozen sperm from a sperm bank, egg donors were recruited and oocytes extracted and frozen in the clinic.

respondents reported monthly earnings of less than 700 euros (own data). The clinic's staff confirmed that there are primarily two groups of donors. The first consists of female students who donate once or twice to bridge a temporary financial problem. The second and far more prevalent group is young women who are employed in the service or cleaning sector, often single mothers, who donate eggs routinely and for whom donation represents a substitute income.

The clinic is the place where this embodied labor mainly takes place and where both producers and consumers of human tissues come together. Vora has demonstrated how, in the case of surrogacy in India, clinics "endeavor to separate social relationships from reproductive bodies" (Vora, 2014: 64). In Spain, we can observe a similar attempt to prevent any contact between oocyte donors and recipients. Although egg donors and egg recipients go to the very same clinic, the anonymity of the donation requires that they remain spatially separated. The clinic is hence better described as a "noncontact zone". The specificity of this spatial division is highly indicative of the broader power relations that shape the fertility clinic. At CREAVIVA, the recipients waited in a room with TV and music while the donors were sat in a corridor and made invisible – the staff would use this corridor in a routine manner without taking any notice of who was sitting there (diary note, Valencia, 9.11.2018). The spatial division between donors and recipients is also evident in the following diary note from a field trip to Alicante:

> We are in Alicante to conduct interviews with fertility clinics. I came here before when I accompanied a couple from Switzerland to their embryo transfer. On arrival at the clinic, I show my colleague the palm-lined path to the door, which I had entered a year earlier. We enter and check in at the reception desk. I say that we have an appointment with Dr. Bartosz for an interview about egg donation. The woman in reception glares at us and says: "That's not here." I tell her that I have already made contact with the doctor and that I am sure that it is here. The woman in reception gets angry. She escorts us to the door and points to an inconspicuous path at the very edge of the clinic area. "That's the way through," she says and abruptly closes the door in our faces. We are both a bit puzzled and take the path that leads us behind the clinic into a building in a neighboring area. When we step through the door, we find ourselves in a waiting room. It is less luxurious than the other one; there is a water dispenser, and chairs are left leaning against the wall. We start to understand. I had said that we came for an *entrevista* (interview) about egg donation. The egg donor information session is also called an *entrevista*, and besides, we are both around 30, so we fit the profile of potential donors. The woman thought we were egg donors and sent us to the donor section. When we go back and explain the misunderstanding to the woman at the reception desk, her attitude changes. She asks us to please take a seat and offers us a cup of coffee or tea. (diary note, Alicante, 19.11.2018)

The specific spatial location of egg recipients and donors in the clinic mirror the uneven (non)relationship they each have in this anonymous and highly capitalized market in general. Whereas egg recipients enter this market

as clients, egg donors are laborers who assume the "speculative but visceral risks […] that define the unequal exchange of the contemporary biomedical economy" (Cooper and Waldby, 2014: 32). In this process, the clinic uses specific taming techniques to manage the donor and extract their body parts (Molas and Perler, 2020; Molas, 2021).

Egg donors are not only made invisible through the spatial arrangements of the clinic, but also discursively, as the following example from an observation protocol from a session with CREAVIVA's psychologist shows:

> Asked about her motivations for donating, the egg donor responds that her main motivation is to help other women. The psychologist replies: "Yes, this is an important aspect, because the eggs you donate go into a bank, and a lot of women get pregnant thanks to this bank". (diary note, Valencia, 6.3.2018)

In this discursive shift by the psychologist, it is no longer the donor who helps others to become pregnant but the clinic through its egg bank. The egg donor is alienated from her body and from her bodily labor. This alienation of the donors has been identified as an important element of the bioeconomy at large (Cooper and Waldby, 2014; Namberger, 2019; Théry, 2012). The general trend in Spain towards egg banks has created an additional spatial intermediary between donor and recipient. This specialization in clinics that treat egg recipients and egg banks that deal with egg donors further separates these two subjects from each other. On the egg recipients' side, this spatial distance can lead to further emotional detachment. One recipient from Switzerland, for example, said:

> There were definitely advantages to be had from doing it in Spain. For example, that there was a certain distance. I don't have to stand in the supermarket thinking, "oh, this checkout girl is so annoying, but gosh, what if she is the potential [donor]." It really is a completely different world there. And this is something I am glad about, in a way. That there is a distance". (Linda, egg recipient, Bern, 1.10. 2017)

The distance between egg donor and recipient helps Linda to accept the donation. However, that alienation is also a central feature of the broader inequality within the egg donation economy, which is actively managed by clinics through both spatial arrangements and discursive practices that marginalize egg donors and render their labor invisible.

In sum, it is on the local scale of the clinic that the (non)relationship between donors and recipients is managed, no matter whether this concerns the donation of oocytes for national or international customers. Although the clinic comes into being through national legislations and policies as well as transnational market forces, a close look at its spatial division between a glamorous "front stage" for the consumer and a shady "backstage" (Perler, 2015) for the reproductive laborers sheds light on how uneven power relations are reproduced on a local scale.

5. Conclusion

Viewing the clinic as a contact zone between people who are normally geographically separated and processes located at different scales helps us to understand how intimate desires for procreation and individual obligations to care (Perler and Schurr, 2020) are entangled with a stratified division of labor in local clinics, national laws that regulate and facilitate the consumption of assisted reproductive technologies, and global flows of finance, knowledge, oocyte donors, and reproductive consumers. The intimate experiences of producing oocytes and reproducing babies are embedded in and engendered by national legislation and politics as well as global fertility chains that often follow well-established routes of tourism, commerce, and colonial empires. Concurrently, these intimate desires to procreate push the boundaries of national legislation, established medical protocols, and financial investment to experiment with new reprogenetic technologies and increasingly transnational business models. Showing the entanglements of scales that characterize this global market, while also trying to disentangle how processes taking place on different scales and in distant places affect each other, this article has shown how the geographical concept of scale can help to understand the geographies of egg donation. Departing from viewing the fertility clinic as a "contact zone" in which different scales are intertwined, such a geography of assisted reproduction advances debates on the flattening and relational construction of scale (Brenner, 2001; Marston, 2000; Marston et al., 2005). Integrating not just the body, but also body parts such as sex cells into our analysis of scale and showing their interrelatedness with other scales such as the clinic, the nation and the transnational serves to expand the boundaries of geographical debates towards the finest scale.

Viewing the clinic as a contact zone also reveals the complex interplay of intimate desires, economic interests, clinical experimentation, and division of labor. It is by studying the intimate experiences of egg donors and recipients that we can grasp how the national intimate (Militz, 2020) and the global intimate (Pratt and Rosner, 2012, Perler and Schurr, 2020) are entangled and constitute each other. Our analysis shows not only how intimate desires for children have engendered a new transnational industry but also how global flows of capital and national economy and legislation both facilitate and regulate those who procreate and those who labor in this global market.

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