

## Rethinking reproductive “tourism” as reproductive “exile”

Whereas reproductive “tourism” implies leisure travel, reproductive “exile” bespeaks the numerous difficulties and constraints faced by infertile patients who are “forced” to travel globally for assisted reproduction. Given this reality, it is time to rethink the language of “reproductive tourism,” replacing it with more accurate and patient-centered terms. (*Fertil Steril*® 2009;92:904–6. ©2009 by American Society for Reproductive Medicine.)

Since the beginning of the new millennium, a growing global phenomenon of “medical tourism” has been identified. Within this realm, “reproductive tourism” (also known as “fertility tourism” or “procreative tourism”) has been defined as “the traveling by candidate service recipients from one institution, jurisdiction or country where treatment is not available to another institution, jurisdiction or country where they can obtain the kind of medically assisted reproduction they desire” (1). “Reproductive tourists” are thus usually defined as infertile individuals and couples who travel across national and international borders with the intention of receiving medical advice, assisted reproductive technology (ART) treatments, and, in some cases, donor gametes, embryos, or surrogacy services.

A front-page story in *The New York Times* entitled “Fertility Tourists Go Great Lengths to Conceive,” claimed that infertile Americans were seeking services abroad, “in places like South Africa, Israel, Italy, Germany, and Canada, where the costs can be much lower” (2). However, economic factors may not be the sole consideration. Scholars who are beginning to theorize the relationship between reproductive tourism and reproductive rights suggest that the causes of such tourism may be manifold. Seven discrete, but often interrelated, factors promoting reproductive tourism have been cited in the existing literature: [1] individual countries may prohibit a specific service for religious or ethical reasons; [2] a specific service may be unavailable because of lack of expertise, equipment, or donor technologies; [3] a service may be unavailable because it is not considered sufficiently safe or its risks are unknown; [4] certain categories of individuals may not receive a service, especially at public expense,

on the basis of age, marital status, or sexual orientation; [5] services may be unavailable because demand outstrips supply, leading to shortages and waiting lists; [6] services may be cheaper in other countries; and [7] finally, individuals may have personal wishes to preserve their privacy (1, 3–5).

In reality, the causes of reproductive tourism are still speculative, as robust empirical research has yet to be undertaken. However, a point that deserves immediate attention is the language of reproductive tourism. As noted by legal theorist Richard Storrow, tourism is a type of traveling that involves leisure, pleasure, and free time; thus, “clinics that cater to fertility tourists appear to welcome the development of new markets and have undertaken to market their services so as to create a fantasy of conceiving a child during a romantic holiday” (6). Indeed, infertile Americans who cannot afford their treatment in the United States (where a single egg donor cycle may cost up to \$30,000) may take real vacations in places like Thailand and India. There, they are placed in luxury resorts while receiving ART treatment. Morning clinic visits are followed by afternoon beach-resort pampering, replete with massages, food, sun, and fun. Even with the international travel, the costs are much lower, and the ART success rates are not so different from those found in the United States.

However, this image of a reproductive holiday may misrepresent the empirical realities of fertility travel for most couples. Storrow, for one, questions the language of tourism as an appropriate gloss: “Fertility tourism occurs when infertile individuals or couples travel abroad for the purposes of obtaining medical treatment for their infertility. Fertility tourism may also occur in the reverse, when the infertile import the third parties necessary for their fertility treatment. These definitions of fertility tourism are, on the one hand, difficult to harmonize with the idea of tourism as pleasure travel, particularly given that some infertile individuals describe their condition as devastatingly painful and their effort to relieve it as requiring enormous physical and emotional exertion” (6).

Received November 7, 2008; revised December 23, 2008; accepted January 2, 2009; published online February 26, 2009.

M.C.I. has nothing to disclose. P.P. has nothing to disclose.

Reprint requests: Marcia C. Inhorn, Department of Anthropology, 10 Sachem Street, Room 202, P.O. Box 208277, New Haven, CT 06520-8277 (FAX: 203-432-3669 E-mail: [marcia.inhorn@yale.edu](mailto:marcia.inhorn@yale.edu)).

In our own National Science Foundation-funded study of so-called reproductive tourism, we are examining infertile couples' actual experiences of reproductive travel. At present, we have interviewed more than 125 couples from nearly 50 countries, including couples from the United States, Europe, the Middle East, South Asia, Southeast Asia, Africa, and Australia. To our knowledge, this is the first large-scale qualitative study of global reproductive travel. As part of this study, we are examining the numerous "arenas of constraint"—or the economic, cultural, social, legal, and practical obstacles and apprehensions—that motivate some couples to travel abroad for the purposes of assisted reproduction, while others are prohibited from doing so (7, 8).

One of our most important findings to date has to do with the language of reproductive tourism. Most reproductive travelers in our study vociferously critique this term. Their own travel, they explain, is undertaken out of the desperate need for a child and is highly stressful and costly. Because reproductive tourism implies fun, leisure, and holidays under the sun, it is a term that is cavalier and insensitive. As one Australian patient put it, "Reproductive tourism' sounds like a 'gimmick', which makes a mockery of infertile people's suffering." In virtually every case, infertile couples describe their preferences *not* to travel if only legal, trustworthy, and economical services were made available closer to home.

Reproductive travelers' own critique of the term reproductive tourism suggests the need for some scholarly revision. To perpetuate the concept of reproductive tourism may be to misrepresent the subjective world of reproductive travelers, very few of whom experience their travel in truly touristic terms. Instead, the notion of "reproductive exile" may be closer to most patients' subjective experience of reproductive travel. The term exile has two meanings: either forced removal from one's native country or a voluntary absence. Both meanings are accurate to describe reproductive travel. Namely, in our qualitative study, reproductive travelers describe how they feel "forced" to leave their home countries to access safe, effective, affordable, and legal infertility care. Their choice to use ARTs to produce a child is voluntary, but their travel abroad is not.

Legal barriers in particular bespeak the politics of exile, and such politically motivated reproductive exile may be increasing. For example, in recent years, several Western European nations, including Italy, Norway, Germany, and Great Britain, have enacted strict legislation prohibiting some or all forms of gamete donation, especially anonymous gamete donation, as well as gestational surrogacy (5). In Italy, for example, the law dictates the exact number of oocytes to be fertilized (maximum 3), and prohibits embryo cryopreservation and all forms of gamete donation. In France, meanwhile, lesbian and single women do not have access to ART. Such restrictions have triggered European

reproductive travel on a massive scale, either to less restrictive Western European countries such as Spain (9), or to the "white" post-Soviet bloc of Eastern Europe (e.g., countries such as Russia, Czech Republic, and Romania). There, clinics can "employ the Internet to attract fertility tourists with promises of cut-rate in vitro fertilization, high success rates, liberal reproductive policies and little administrative oversight" (7).

Furthermore, young women in these countries may comprise a vulnerable population of egg donors, who are compelled out of economic necessity to sell their ova in the local reproductive marketplace. Given the newly recognized category of the "traveling foreign egg donor" who seeks economic mobility through the sale of her body parts (10), unregulated fertility tourism has been compared with sex tourism, as young women in the economically deteriorated post-socialist societies discover that prostitution and egg donation offer economic rewards. As Storrow argues, "egg donation, like prostitution, will be especially attractive in regions of the world where large numbers of women with few choices want to improve their economic circumstances by any means available" (6).

Given the growth of the global reproductive tourism industry, it is time to assess this phenomenon and the very language that we use to describe it. Indeed, Guido Pennings, one of the leading ethicists of reproductive travel, urges scholars, journalists, and commentators to "clean up our language" and to replace the term reproductive tourism with the term cross-border reproductive care (11). The advantage of this term is that it avoids the negative connotations of tourism; it is objective and descriptive; and it links with the more general term cross-border health care. The term is also similar to cross-border ART, which was recently discussed and advocated by some patient groups at the 2008 meeting of the European Society for Human Reproduction and Embryology (ESHRE). As they noted, the need to travel from one country to another to receive ART is very concerning to patients themselves—and should be to the clinical community. In response to their concerns, ESHRE has formed a task force on cross-border reproductive care (5). In North America, the Canadian Fertility and Andrology Society (CFAS) has launched an on-line survey, endorsed by SART/ASRM, to poll North American fertility clinics about their cross-border care practices, including estimates of the numbers of patients coming from other countries. Compiling such data is extremely timely, especially given "the call for international measures to stop these movements" (1). Furthermore, the neutral language of cross-border ART care (aka cross-border reproductive care) being used by ESHRE, CFAS, and SART/ASRM avoids the problematic language of tourism and its accompanying connotations of leisure travel.

Using more neutral and descriptive language, such as reproductive travel or cross-border reproductive care, is

commendable on the part of these major ART organizations. However, we would like to suggest, as has Roberto Matorras, president of the Spanish Society of Fertility (9), that the term reproductive exile has a place in these discussions. We would argue, based on our current qualitative study, that feelings of exile are a more accurate descriptor of the patient experience. For most reproductive travelers, traveling for reproductive care is far from a neutral experience. Instead, it may be challenging, time-consuming, frustrating, impoverishing, frightening, and even life-threatening. For most, it is a kind of forced travel from home, which may feel like a major yet undeserved punishment. Such reproductive exile may add considerably to the despair and stigmatization of infertility, especially for couples coming from societies where physical reproduction is socially mandatory.

In summary, the time has come to rethink the language of reproductive tourism and to replace it with a new vocabulary. This vocabulary must not only describe the movements of reproductive travelers, but also capture the considerable travails encountered in the global quest for conception (12). Reproductive exile provoked by restrictive reproductive laws and other arenas of constraint compounds the human tragedy of infertility. It is hoped that future empirical research with individuals and couples subjected to such temporary but painful exiles will spur policy-makers to address this important issue. The ethics of such exile suggest that both justice and compassion are necessary to assure individual autonomy and respect in the maintenance of reproductive rights.

Marcia C. Inhorn, Ph.D., M.P.H.<sup>a</sup>

Pasquale Patrizio, M.D., M.B.E., H.C.L.D.<sup>b</sup>

<sup>a</sup> *Department of Anthropology, and* <sup>b</sup> *Yale Fertility Center, Department of Obstetrics, Gynecology & Reproductive Sciences, Yale University, New Haven, Connecticut*

## REFERENCES

1. Pennings G. Reproductive tourism as moral pluralism in motion. *J Med Ethics* 2002;28:337–41.
2. Lee FR. Fertility tourists go great lengths to conceive. *The New York Times*, January 25, 2005:A1.
3. Blyth E, Farrand A. Reproductive tourism—a price worth paying for reproductive autonomy? *Critical Soc Policy* 2005;25:91–114.
4. Deech R. Reproductive tourism in Europe: infertility and human rights. *Global Governance* 2003;9:425–32.
5. Pennings G, de Wert G, Shenfield F, Cohen J, Tarlatzis B, Devroey P. ESHRE Task Force on Ethics and Law 15: Cross-border reproductive care. *Hum Reprod* 2008;23:2182–4.
6. Storrow RF. Quests for conception: fertility tourists, globalization, and feminist legal theory. *Hastings Law J* 2005;57:295–330.
7. Inhorn MC. *Local babies, global science: gender, religion, and in vitro fertilization in Egypt*. New York: Routledge, 2003.
8. Inhorn MC, Fakhri MH. Arab Americans, African Americans, and infertility: barriers to reproduction and medical care. *Fertil Steril* 2006;85:844–52.
9. Matorras R. Reproductive exile versus reproductive tourism. *Hum Reprod* 2005;20:3571.
10. Heng BC. Regulatory safeguards needed for the travelling foreign egg donor. *Hum Reprod* 2007;22:2350–2.
11. Pennings G. Reply: reproductive exile versus reproductive tourism. *Hum Reprod* 2005;3571–2.
12. Inhorn MC. *Quest for conception: gender, infertility, and Egyptian medical traditions*. Philadelphia: University of Pennsylvania, 1994. Press.