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Procreative tourism: debating the meaning of cross-border reproductive care in the 21st century

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“...from the moment of IVF discovery, reproductive travel was undertaken, some of it under conditions of secrecy.”

On 20 June 2012, the media announced the death of Lesley Brown, aged 64 years, the world's first 'test-tube baby mother'. During her reproductive years, Lesley suffered from blocked Fallopian tubes, the exact problem that IVF was designed to bypass. She and her husband had to travel across southern England (from Bristol to Cambridge) to meet Robert Edwards and his physician partner, Patrick Steptoe, who ultimately delivered baby Louise Brown in a distant third location in order to avoid both media scrutiny and moral condemnation (i.e., accusations that they were 'playing God' owing to Louise's test-tube conception). In short, from the moment of IVF discovery, reproductive travel was undertaken, some of it under conditions of secrecy.

By today's standards, Lesley Brown would be considered as a 'procreative tourist', for she met all of the criteria of the following definition: "The travelling 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]. If Lesley Brown could be considered as a procreative tourist, then procreative tourism (also known as reproductive tourism or fertility tourism) is as old as IVF itself – 35 years, to be exact.

The debate

Today, the term 'procreative tourism' is being hotly debated [2]. As several scholars

have argued, the term 'tourism' connotes pleasure travel, financial freedom and choice of destination, as well as the luxury of being on a 'holiday'. Thus, it may not reflect most patients' difficult experiences in seeking IVF across borders. Although some commentators insisted that 'tourism' reflects the broader economic infrastructures that underpin the global fertility market and its link to the tourism industry [3], most analysts have argued for a more 'neutral' term, decoupling this form of IVF travel from leisure. In one of the most compelling commentaries, legal scholar Richard Storrow questioned the trope of 'fertility tourism' as an appropriate descriptor for reproductive travel. "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." [4]

In an effort to find a better term, scholars have proposed three more neutral alternatives: 'transnational reproduction', 'reproductive travel' and 'cross-border

reproductive care' (CBRC). Interestingly, and for no compelling conceptual reason, CBRC has rapidly gained the widest acceptance in the scholarly literature, judging by the sheer number of citations from 2010 onwards [5]. However, CBRC, too, is a vexed term. 'Care' may be a questionable component of the cross-border reproductive experience, even if IVF services are, indeed, delivered [6]. As feminist scholars are quick to point out, the potential for trauma, abuse and exploitation is ever present in cross-border reproductive 'care', not only for infertility patients, but also for those individuals, such as egg donors and gestational surrogates, who 'assist' them. Thus, feminist scholars have forwarded a more politicized and gendered vocabulary of procreative 'traffic' (implying the 'trafficking' of women and their donor gametes), 'eggs-ploitation' and procreative 'outsourcing' to describe reproduction across borders [7–9].

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Whether reproductive travelers should be called 'patients' has also been fundamentally questioned, since many reproductive travelers are not, technically, infertile [10]. Single women and men wanting children, as well as gay couples hoping to become parents, are increasingly traveling abroad for assisted reproduction, often in search of gestational surrogates in poor countries where these services are more affordable. Within such a global market of 'gay procreative tourism' and 'single mothers (and fathers) by choice', those seeking assisted reproductive technology services may be conceptualized as procreative 'consumers, agents or opportunists' [11,12]. Thus, the very terminology used to describe this phenomenon and the people who participate in it remains very much open to debate.

Reproductive exile & law evasion

In our opinion, the notion of 'reproductive exile' comes closest to most patients' subjective experience of reproductive travel [13]. Exile can mean either a forced or a voluntary absence from one's home country. When applied to reproductive travel, the term 'exile' bespeaks most patients' feelings of being 'forced' to travel in order to receive legal, affordable, high-quality assisted reproduction services. In our experience, reproductive exile is not a term used by reproductive travelers themselves. Nonetheless, it clearly reflects the sense of betrayal and abandonment that most IVF patients feel as citizens of countries where their reproductive needs cannot or will not be met. Their choice to use IVF to overcome infertility is voluntary, but their travel abroad is not.

Once travel for IVF is set in motion, feelings of reproductive exile may become much more painful and acute. Reproductive travel is often logistically challenging, time-consuming, frustrating, impoverishing, frightening and even life-threatening. Travel abroad may feel like a major yet undeserved punishment. Such reproductive exile may also add considerably to the despair and stigmatization of infertility, especially for couples coming from

societies where physical reproduction is socially mandatory, but where reproductive travel abroad for IVF is cloaked in secrecy and shame.

“Reproductive exile is often provoked by restrictive laws, which impinge upon the rights of citizens to overcome their infertility.”

Reproductive exile is often provoked by restrictive laws, which impinge upon the rights of citizens to overcome their infertility. Such politically motivated law evasion appears to be the single most important factor fueling reproductive tourism, particularly in the EU [14]. As Belgian bioethicist Guido Pennings notes: “The most noticeable characteristic of the legal situation in Europe regarding medically assisted reproduction is the enormous variety of rules. It is hard to find two countries with the same rules regarding a topic like embryo research or donor insemination” [15]. As a result, neighboring European countries have different: restrictions regarding age limitations; restrictions regarding compulsory heterosexuality and marriage of commissioning couples; prohibitions on gamete donation and surrogacy; prohibitions on maximum embryo production and transfer guidelines; prohibitions on embryo freezing; and patients' freedom from diseases and disabilities. Given this variability, the IVF landscape in Europe is characterized by 'legal mosaicism' – or a patchwork of 'restrictive and permissive' countries [15]. In such a legal environment, procreative tourism is said to function as a 'safety valve', allowing IVF patients to 'evade' or 'circumvent' the law. Research from within the EU clearly shows that IVF patients are, indeed, traveling from more restrictive countries (e.g., Austria, France, Germany, the UK, Italy and Norway) to less restrictive ones (e.g., Belgium, Czech Republic, Denmark, Greece and Spain). In addition, many western Europeans are leaving the EU altogether, especially for post-Soviet, eastern European countries, which are comparatively unregulated (e.g., Romania, Russia and Ukraine) [16].

Legal harmonization & harm reduction

In an attempt to ameliorate this situation, calls have been made within the EU for legal harmonization of assisted reproduction across the continent. However, such harmonization is extremely unlikely, owing to the different religious and moral valences underlying individual countries' IVF laws. Pennings argues that the easiest way to eliminate a substantial portion of reproductive tourism within the EU would be to abolish all forms of restrictive and coercive legislation, and to adopt a 'soft law' approach, which mainly focuses on issues of safety and good clinical practice [15]. The latter approach, sometimes called 'harm reduction', appears to be gaining ground. For example, in 2010, an International Forum on Cross-Border Reproductive Care was held, emphasizing that quality and safety should be the key considerations among IVF physicians serving those who travel [17]. A year later, the European Society of Human Reproduction and Embryology Cross-Border Reproductive Care Taskforce issued a

'good practice code' for IVF clinicians, with recommendations on how to care for patients seeking IVF across borders [18].

Despite these efforts to 'soften' the law and increase safety, countries are still free to regulate or deregulate assisted reproduction as they see fit. For example, the USA has no national legislation regulating IVF clinics, making it a 'go-to' site for many European, Australian and Asian patients interested in both gamete donation and surrogacy. Turkey, on the other hand, has enacted the world's toughest IVF law, which bans reproductive tourism (especially to 'permissive' Cyprus) for its citizens [19]. Although largely symbolic and unenforceable, the 2010 Turkish law legally instantiates the religious ban on gamete donation, which is in force throughout the Sunni Islamic world, spanning from Morocco to Malaysia [20]. Turkey may be the first country to legally ban reproductive tourism, but other Muslim countries may eventually follow suit.

Outlawing reproductive tourism – a form of travel that is already shrouded in secrecy – may push this practice further underground. Partly because of patients' fears that they may be breaking the law – or at least doing something in a moral 'gray zone' – they may undertake their reproductive travel under conditions of strict confidentiality, sharing their secret with no one. As a result, very little is actually known about reproductive tourists themselves.

Media reports tend to focus on single individuals, often extreme cases. Such sensationalism sells papers, but it has also led in some cases to strong moral condemnation of reproductive tourists.

Conclusion

At the present moment, then, the most urgent need is for more empirical research, both quantitative and qualitative in nature. Who are these procreative tourists? How many of them are there? Why do they travel? Where are they from? Where do they go? What have they experienced? Was the travel difficult? Were they satisfied with the outcome? Did the journey end with a successful pregnancy – even a 'take-home baby'? How do their home countries treat them upon their return? These are all open questions in the new millennium.

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