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The reproductive journeys of French women over 40 seeking assisted reproductive technology treatments in Spain

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ABSTRACT

Fertility decline is a complex phenomenon resulting from converging social and cultural changes that are governed through politics. As it has been discussed in many studies, the European's low fertility rate goes hand in hand with the trend of maternity postponement. Although in many European countries over the last decades reproduction is envisaged as an individual choice that can be made at older ages, having a child after a certain age can be impossible -either "naturally" or using assisted reproductive technology-depending on the medical and legislative possibilities and limits of the country in which people live. In the extremely diverse European reproscape, reproductive legislations have forced but also allowed many people to seek reproductive treatments outside their home countries.

Spain is a leading destination in Europe for cross border reproductive travel and, of the foreigners it receives, the French are the largest group. Despite having a history of strong pro-natalist policies, France has been one of the strictest European countries regarding access to medically assisted procreation. Until 2022, only heterosexual couples in which women were under 43 years of age could access treatments. Despite the recent opening of access to "all women", including single women and same-sex female couples, women over 43 years of age were once again excluded from the new legal framework and therefore remain condemned to travel abroad to access reproductive treatments. In this article, we analyze the experience of French women over 40 who cross the Spanish border to access reproductive treatments in order to fulfill their desire to have children. Through ethnographic data emerging from six years of participant observation and in-depth interviews with 15 women, we explore why they remain excluded from the French system of reproductive governance and the obstacles they face during their reproductive journey.

1. Introduction

In May 2021, France's High Commissioner for the France 2030 Investment Plan called for a National Pact for Demography. He stated, "[…]The balance of society and, in the long term, the maintenance of our social contract depends on demographic vitality," sounding the alarm that the fertility rate was too low. This proposal occurred in the wake of a long history of natalist reproductive policies (Desy and Marre, 2022; Robcis, 2016). A few months later, on September 28, 2021, after more than a year of negotiations and parliamentary debates, but also heated debates in civil society, France completed its fourth revision of its Bioethics Law, extending access to medically assisted reproduction to "all women." Despite the COVID-19 pandemic, France's total fertility rate in 2020 was 1.83 children per woman (Papon, 2024). With these figures, France continues to be one of the most fertile countries in Europe, whose average is 1.50 children per woman (Eurostat. Fertility Indicators, 2022). Some European countries, such as Spain, are well below this average. Indeed, the Spanish fertility rate is around 1.19 (Eurostat. Fertility Indicators, 2022), making Spain one of the least fertile countries on the European continent—and in the world—with a rate that places it in the category of "lowest-low fertility rate" countries (Alvarez and Marre, 2021). This can be explained by a political history which, unlike France, has not favored family policies and has made reproduction a private matter, the sole responsibility of individuals (Alvarez, 2018; Alvarez and Marre, 2021; Marre et al., 2018).

Within Europe, France and Spain, although they share a border, are at the opposite poles of the scale in terms of fertility, but also in their reproductive policies. regarding access to medically assisted

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reproductive technologies and treatments. Indeed, since the first law passed in 1988, Spain has allowed treatment for "women who have reached the age of majority and are psychophysically healthy, if they have freely and consciously requested and accepted them, and if they have been previously and duly informed" (Law 35/1988). Not very precise, this law has provided a particularly flexible and inclusive framework by allowing access to treatment for all women, regardless of their sexual orientation and marital status. Moreover, with the last revision of the law, in 2006, the age limit for access to treatment was removed. On the other hand, until the last revision of its Bioethics Law, France only authorized access to medically assisted reproduction to heterosexual couples in which the woman was under 43 years old, making this country one of the most exclusive in Europe in terms of reproductive policies, with a strong commitment to the preservation of the traditional family. Despite the recent opening of access to treatment to "all women," the age limit, has not been questioned, leaving women over 43 excluded from the new legal framework. This condemns them either to give up their reproductive plans or to travel abroad, as many already do, to access a more inclusive legal framework, a phenomenon for which a certain "democratization" has been observed (Rozée Gomez and de La Rochebrochard, 2013), without forgetting the reproductive stratification that it may entail, with some people who will not be able to make these journeys, and a very differential impact depending on the economic situation of those who will undertake them (Desy and Marre, 2022).

Several authors have analyzed the experiences of patients in cross-border reproductive travels (Inhorn, 2015, 2020; Whittaker et al., 2019; Bergmann, 2011a; Blyth, 2010) and a few scholars have addressed the reproductive journeys of French single women, same-sex female couples and heterosexual couples who are unable to access to an assisted reproductive treatment in France (Desy and Marre, 2022; Merchant, 2019; Pennings, 2019; Madero et al., 2017; Rozée Gomez and de La Rochebrochard, 2013). However, there is a lack of research on ART in the context of late motherhood, both in France and internationally (Majumdar, 2021a, 2021b; Cardin, 2019; Hamideh et al., 2012; Cooke et al., 2010). The women in our study are part of the global phenomenon of motherhood postponement (Kohler et al., 2002). Indeed, the age of women at the time of their first birth has increased substantially, as the requirements of "intensive" motherhood (O'Reilly, 2012; Hays, 1996) have prompted women to meet several conditions in order to achieve "readiness" (Sodha, 2022; Vialle, 2020; Cooke et al., 2012). In this article, our aim is to encapsulate the reproductive exclusion paths of these "late" mothers, the reasons that led them there, and the stigmatizing discourses they face during their cross-border fertility journey.

2. Methods

We analyze this subject through ethnographic data emerging from six years of participant observation and in-depth interviews with French women seeking ART treatments in Barcelona. A call for participation was communicated through several clinics to their patients via email, through the clinics' computer system. To prevent any feelings of coercion, it was agreed that no mention of the research project would be made by the healthcare or administrative staff at the clinics. The call included the principal author's email address, to which individuals could write if they wished to participate. Participants were not incentivized, and the call explicitly stated that responding to the email was not necessary and that participation was voluntary and anonymous. The same call for participation was also disseminated through social media.

We conducted 15 semi-structured interviews with French women over 40. The interviews were conducted in French. All interviews were done individually, recorded, and transcribed. The data analysis process started with a comprehensive review of each interview transcript, followed by a thematic analysis of their content (Strauss and Corbin, 1990) to extract specific and recurring themes. This process was done independently by both authors and then compared to select the more evident themes, that were then transformed into codes and applied by the first author to all interviews, with the supervision of the second author.

As this study was carried out through fieldwork in several private Spanish fertility clinics that receive foreign patients, all the participants were carrying out or had carried out their reproductive plan through a cross-border reproductive journey. All of them had in common that the 43-year limit imposed by the French social security system meant that they were unable to receive treatment in their country of origin, France, either directly, for those who were over 43 when they started their reproductive project, or indirectly, when the waiting time to be treated would have made them exceed this age limit. In addition, in order to provide more details on their socioeconomic data, it should be noted that the participants all reported a median income -around 2000 euros per month (INSEE, 2024)- with the exception of two who placed themselves in an "affluent social class", without specifying their exact income. Although there is very little official data in France on the link between family income and birth rate, a report by the Institut National de la Statistique et des Études Économiques in 2022 revealed that both the lowest and highest income women tend to have more children -with the lowest 10% and highest 10% of income earners having on average 2.3 and 2.0 children respectively- and that women from middle-income families often had fewer or only one child (Institut National de la Statistique et des Études Économiques, 2024).

3. Assisted reproductive technologies and cross-border reproductive travel

Considering that many European countries have "lowest" fertility rates (UN, 2020) and that international adoption has decreased significantly worldwide since 2007 (Selman, 2012), assisted reproductive treatments have become a standard medical practice. To respond to the unfulfilled desire for parenthood, different forms of "assisted procreation" have been developed, including adoption and medical assisted reproductive treatments, practices on which technological, scientific and communication changes have had a direct impact, creating a unique space for the global circulation of medical services and technologies.

Reproductive medicine involves the set of techniques, technologies and medical treatments aimed at achieving pregnancy in case of medical or social infertility. The main treatments are artificial insemination, in vitro fertilization with or without gamete donation, and embryo donation. The effectiveness of these techniques has increased exponentially since the early years. The 20-s and most recent ESHRE report (Wyns et al., 2022) with data on assisted reproductive treatments performed in 2018 in Europe shows a continued increase in the number of treatment cycles. Europe is the continent where most assisted reproductive treatments are performed in the world and it is also one of the continents on which cross-border reproductive travels have developed the most, enhanced by an area of free movement and a great variability of reproductive legislation and policies (Mouzon et al., 2020).

Infertility is one of the many reasons why large numbers of people undertake cross-border travel to access medical treatments. Although there are no clear statistics, the number of those who traveled to access medical treatment abroad was estimated to be around five million in 2016 (Horsfall and Lunt, 2016). When it comes to cross-border reproductive travel, data opacity is even more evident. There are no figures that provide a precise quantitative picture of the phenomenon, even though quantitative (Rozée Gomez and de La Rochebrochard, 2013; Blyth, 2010; Pennings, 2010; Shenfield et al., 2010) and qualitative studies (Inhorn and Patrizio, 2018; Nahman, 2016; Bergmann, 2011a; Inhorn and Gürtin, 2011) show that more and more people are traveling each year to access ART outside of their country of origin. Academic literature has long shown that restrictions or openings of cultural, technological, economic and/or religious freedoms regarding assisted reproductive medicine and services have been important factors in the development of hubs for reproductive travel in Europe and worldwide (Whittaker et al., 2019; Nahman, 2016; Inhorn and Gürtin, 2011;

Pennings, 2010; Culley and Hudson, 2009). It is the case for Spain, which has become the most important destination in the European reproscape (Desy and Marre, 2022; Alkorta, 2021; Hudson, 2017; Inhorn, 2015; Bergmann, 2011b). Statistics from Spain show that it is the second country in Europe, behind Russia, in terms of assisted reproduction cycles. According to the latest ESHRE report, in 2018, 1.007.598 treatment cycles were reported (67.095 more than in 2017, +7.1%) to have been performed in 39 countries, of which 140.498 were performed in Spain (155.949 in Russia). More specifically, regarding treatments with oocyte donation, Spain ranks first with a total of 37.618 cycles performed (9.804 in Russia). The same report states that the reasons why people travel to access treatment abroad are: access to higher quality treatment (42.3%), because the treatment was illegal (21.1%) or too expensive (25%) in the country where they live, or because of the waiting list (11.5%) (Wyns et al., 2022).

Indeed, it is the prestige of Spanish reproductive medicine, its particularly inclusive law, as well as the large availability of oocytes, that have made Spain one of the preferred destinations for cross-border reproductive travel (Desy and Marre, 2022; Wyns et al., 2022; Marre et al., 2018). Since its first legislation concerning assisted reproduction in 1988 (Law 35/1988), Spain stood out from the European reproscape by being among the most inclusive: any woman over 18 years of age, regardless of her sexual orientation and marital status, could access assisted reproduction treatments, including gamete donation. The law on assisted reproduction, which was -and remains-not very precise, left a great deal of freedom to the clinics from the very beginning. Following the general movement that had started since the democratic transition after Franco's dictatorship, with the idea that the state had to gradually divest itself of its attributions, decentralize and outsource tasks: the Spanish state outsourced the suitability of adoption and also outsourced and privatized the management of reproductive medicine (Marre, 2018). Additionally, professional associations -such as the Spanish Fertility Society (SEF)- became key players in the Spanish reproductive medicine field, advocating for the maintenance of its liberal policies (Perler and Schurr, 2022; Lafuente-Funes, 2020). The last revision of the law in 2006 (Law 14/2006) amended it to remove the age limit for women to start assisted reproductive treatment, thus making the law even more inclusive. Each clinic can decide autonomously what age limit is imposed. Another important feature of assisted reproduction in Spain is related to the provision of gametes by third parties, and more particularly that of oocytes. Spain is the country in Europe that provides the most eggs, internally and externally, which results in a waiting list of only three to five months for private clinics which dominate the oocyte donation market (Perler and Schurr, 2022; Lafuente-Funes, 2020). Many authors attribute the Spanish leadership in assisted reproductive cycles to the high availability of oocytes in Spain (Shenfield et al., 2010). While this has been linked to the Spanish altruistic culture regarding blood and organ donation (Matesanz et al., 2017; Rodríguez-Arias et al., 2010), other authors refer to the way the Spanish reproductive bioeconomy (Waldby, 2019; Cooper and Waldby, 2014) regarding oocyte provision has been regulated and organized (Perler and Schurr, 2022; Molas Closas, 2021; Lafuente-Funes, 2017). According to the law, oocyte provision in Spain must be anonymous, which results in the providers' invisibility that has been reinforced by the fact that the national providers registry has only been implemented in 2022 -although it has been required since the first law in 1988- after four years of being piloted (Alkorta, 2021; Álvarez Plaza, 2015). Furthermore, the high availability of oocyte in Spain has been considered to be based on the unpaid reproductive work (Marre, 2018; Marre et al., 2018), clinical labor (Cooper and Waldby, 2014) or the transference of the reproductive capacity by providers (Lafuente-Funes, 2020). Although the law states that donation must be altruistic, oocyte providers receive a 900–1.200 euros compensation to "cover their costs" which appears to be the main reason to "donate" (Molas Closas, 2021; Orobitg et al., 2013; Cambrón Infante, 2008; Orobitg and Salazar, 2005). It is also important to note that the inclusiveness of the Spanish approach to ART is limited by socioeconomic status as ART in the public health system is much more restricted. Spanish social security only covers four cycles of insemination with a woman's male partner -six with donor sperm- and three IVF cycles, only for those who have not had a child before and if the woman is under 40 (Law 35/1988). The long waiting times coupled with these limitations are therefore also pushing national patients towards the private sector.

Spanish clinics have adapted to users from other countries, including offering remote communication and services in their native languages (Desy and Marre, 2022). According to the Spanish Fertility Society, in 2021, 19.534 IVF cycles were performed for people from foreign countries. Among them, French clients represented the largest group, for whom 40.6% (8.928) of the cycles were conducted. In the same report, of the 12.1% of people who indicated the reason why they had come to Spain for treatment, almost 26.17% stated that it was because the "technique was illegal in their country of origin" or "the patient does not comply with the legal conditions in their country". The majority of IVF cycles performed for foreigners (50.8%) involved egg donation (SEF, 2021). This type of treatment, which requires the use of a third party's gamete, is recommended in cases in which the reproductive cells of the person who wishes to have a child are of insufficient quality or non-existent. This may be due to a disease when it occurs early in reproductive life, but the main reason is usually age, as from the age of 25 the quantity and quality of the ovarian reserve gradually decreases, a process that accelerates significantly from the age of 35. Although fertility decline is neither a new nor a Western phenomenon, women and men have never before become mothers and fathers so late in life (Marre, 2018; Mills et al., 2011). The strong trend of postponing motherhood has made age the leading cause of infertility worldwide (UN, 2020).

4. More and more French women are having children after turning 40

While France has for many years been one of the countries with the highest birth rate in Europe, the fertility rate of women aged between 40 and 50 has been rising steadily since the mid-1980s. Whereas in 2000, 100 women would have had an average of 5.6 children, in 2019 they would have had an average of 10.1 children (Papon, 2022). Cultural paradigm shifts in the last decades of the 20th century changed the conception of motherhood. Among them, the widespread availability of contraceptives, the decriminalization of abortion and women's access to education and the labor market led, in part, to an understanding of reproduction and motherhood as products of desire and/or rational, individual reproductive choice (Alvarez and Marre, 2021; Marre, 2018; Krause and De Zordo, 2012; Inhorn and Van Balen, 2002). Although in many European countries in recent decades reproduction is seen as an individual choice that can be made at older ages, having a child after a certain age may be impossible—either "naturally" or through ART without donation—depending on the possibilities and the medical and legislative limits of the country in which people live (Desy and Marre, 2022).

The use of medically assisted procreation in France has increased almost continuously since the 1980s. In 2019, 3.7% of French children were conceived by medically assisted reproduction, including 2.9% by IVF and 0.8% by artificial insemination. In other words, on average, one out of every 27 children born in 2020 was conceived through ART (de La Rochebrochard, 2022). French law on medically assisted reproduction is framed by the French Civil Code (1804), which contains principles such as the "respect for human dignity" (art. 16-1 c. civ.) or the "integrity and non-ownership of the human body" and the "non-commercial removal or transfer of any part of the body" (art. 16-5 and 16-6 c.civ.), and the Bioethics Law (Loi Bioéthique, 1994) which has been revised three times: in 2004, 2011, and most recently in 2021–2022. Donation is free and, together with the weight of the ethical principles mentioned above, this largely explains the shortage of oocytes and sperm in France. The

waiting list for egg donation can range from three to five years depending on the medical center, which leads to women as young as 38 being denied access to treatment (de La Rochebrochard, 2018). The exclusion is made without exception and regardless of the woman's medical and reproductive history, as illustrated by the case of one of the women interviewed, Eleonore, who was 42 at the time of the interview. With a plan to have a child, which she started with her partner at 36, after unsuccessful attempts without ART, IVF was recommended. However, at the time of her check-up mammogram, she was diagnosed with breast cancer. Before starting chemotherapy, she underwent fertility preservation in order to be able to continue her maternity plans after the cancer treatment. Three years later, she made four unsuccessful attempts at IVF. She explains: "I had just turned 40 and at the hospital our team said: 'You can't wait, the waiting times are too long, so the only solution for you is Spain'."

Until the last revision of the law, the use of ART treatments and techniques was strictly limited to heterosexual couples diagnosed with pathological infertility, following a therapeutic ART model (Desy and Marre, 2022; Brunet, 2019), and the woman had to be under 43 years old. This "therapeutic" model corresponded to a purely medical definition of infertility, not a social one -such as age or the absence of a reproductively compatible partner-, in which assisted reproductive treatments were understood as medical care that could only be accessed for medical purposes, that is, as a "medical response to a medical problem" (Desy and Marre, 2022; Brunet, 2019; Lafuente-Funes, 2017), and fertility preservation was only authorized for medical purposes. Moreover, access to assisted reproductive treatments cannot be understood without mentioning the French health system, the Social Security, which provides health coverage that aims to be universal and egalitarian and allows access to care and reimbursement of such care, health services and medicines to anyone residing in France. Thus, even today, those who access treatment benefit from full financial coverage, albeit limited to six artificial inseminations and four IVF attempts. On the other hand, there is no private system with private clinics as in Spain. Some semi-private clinics can make consultations and carry out medical follow-ups, but they cannot perform assisted reproduction treatments with oocytes donation, so it is inevitable to go through the public system. The age limit of 43 years is not written into the law, but it is imposed by the Social Security for any medical act involving the collection of gametes (integral to IVF), which therefore makes it inflexible. As for oocyte preservation for social reasons -a technique that could be thought of as a possible answer to the need for eggs in the context of advanced maternal age-, it has only been allowed in France since the revision of the law in 2022, between ages 29 and 37.

According to French sociologist Manon Vialle, "[…] French society perpetuates a moral vision reinforced by biological/social, nature/culture, and female/male binaries, which precludes access to ART, justified by this distinction between 'normal' and 'pathological' infertility" (Vialle, 2020). The revision of the Bioethics Law which led to the opening of access to medically assisted reproduction to "all women" modified the conception of the French therapeutic model of ART, by including the management of social infertility. Yet the boundary between the biological and the social has not been brought into question with regard to the age limit of 43 for access to treatment. The French Biomedicine Agency justifies this limit as corresponding to the reproductive age for women and highlights the medical risks of pregnancy at older ages. Thus, the criteria put forward is biological and is based on ovarian capacity to define reproductive age. Furthermore, only ovarian capacity is taken into account, without considering the difference between it and gestational capacity: the uterus is capable of carrying a child, with the help of medicine to start the pregnancy, long after the ovaries have stopped producing egg. Medical advances make it possible to provide increasingly better support for late pregnancies, when they occur without medical help, and specific support protocols have been created -more check-ups, close monitoring of certain risks associated with age, etc. However, these same risks -and presumably the cost of the associated care measures-seem, for the medical system, to outweigh the benefits to these women in the context of medically assisted reproduction. With regard to men, meanwhile, the criterion is set at "approximately 59 years" and is justified by the interests of the child. This difference in criteria for what is deemed to be "appropriate" reproductive age, physiological for women and social for men, leads to a difference in access to medically assisted procreation. If menopause marks the end of the possibilities of a reproductive journey with medical help, andropause finds a medical response, such as the increasingly frequently used technique of intracytoplasmic injection (ICSI) (Vialle, 2020; Friese et al., 2006). Moreover, the physiological limit is imposed on all women, regardless of the variability of their bodies and the fact that, if some women reach the limit of their ovarian capacity at the age of 40, others will do so after 50 years old. Alice, 47, one of the women who took part in the study while she was waiting for an egg donation, explains that she and her partner started their reproductive plans when she was 45 and he was 42: "I went to see my gynecologist who told me that my ovarian reserve still gave me the possibility of trying naturally. We tried for a few months without results. So, I went to the hospital next door and was told at the reception desk, in front of the whole waiting room, 'Well, we don't do [treatments] at your age, you should have listened to the clock and thought about it earlier.' I was laughed at." After this experience, Alice and her partner arranged their cross-border reproductive travel. By this point, her fertility had come to an end, forcing her to resort to third-party gamete donation.

5. The exclusive criterion of the "biological clock"

The idea of a "biological clock" is widely present in the French collective imagination. This metaphor corresponds to the idea that women -as it is almost never used for men-have a physiological clock that manifests itself according to a precise and universal calendar to indicate that they could -or should-conceive a child. Coralie was 43 years old at the time of the interview and two years into a solo maternity journey that she undertook in Spain before the revision of the law. She stated, "I would have preferred to conceive a family in a much more traditional way. But between men who do not consider having a child […] and others who are fantastic but not free or with a double life, we deal with it. Accept and move forward while making choices. The biological clock is binding for us women." The idea of women's biological clock, thought of as a neutral and objective description of the woman's body, is the social expression of a biologizing view of women and motherhood, which reduces a woman's identity to her ability to bear children and understands motherhood as natural and therefore innate (Yopo Díaz, 2021; Friese et al., 2006). The idea of the biological clock articulates with a discourse that blames women for prioritizing their careers over their reproductive plans (Sodha, 2022; Yopo Díaz, 2021; Vialle, 2020). Yet the experience of women who carry out reproductive plans after the age of 40 is tremendously more diverse than the single experience reflected in this guilt-ridden social discourse, and it is often the result of various factors that lead them to delay motherhood. Above all, the narratives of these women show that the onset of the desire for motherhood is explained as the result of a combination of social and not biological reasons. Marion, who was 40 years old at the time of the interview, explained, "For me, even though I always knew I wanted to be a mother one day, the biological clock did not ring [she laughs]. I saw all my friends getting married, having children, but I wasn't thinking about that. The urge came not so long ago. I was 39, fresh out of a relationship with a man who didn't want children and I started asking about sperm donation." In her interview, Marion explained that the waiting times she was offered following the opening of access to treatment for single women would have jeopardized her possibilities: "I couldn't wait because the waiting time was over two years. Not only was I going to be less fertile, but if it didn't work, I was going to be close to my 43rd birthday, and I had seen that it was no longer possible after that. I realized that in France it wasn't going to be possible, so I looked at

Denmark or Spain."

For Marion and most of the women interviewed, the motherhood journey began long after they first thought about becoming mothers, and in certain cases even long after they had developed a maternity desire. This is the case for Nathalie, 45, who "[…] never imagined [herself] without children." In her interview, she listed the romantic relationships she had experienced and for some partners, she added in connection with motherhood: "With [X] too, I thought about it." Nathalie was in a solo motherhood journey, but she explained that it was not her first choice: "For me, the order of things was: first marriage and then baby." In their narratives, many of the women who participated in this study linked the delay of motherhood to their attempt to achieve the conditions considered ideal for the arrival of a child. As for Marion and Coralie, solo motherhood did not often appear as a first choice, but rather came after a history in which the women had several relationships that did not lead to parenthood. As the years passed, they arrived at the age they had when they started their motherhood journey through ART. In a society in which it is socially accepted for a woman to have several relationships in the course of her life, two of the main criteria for deciding to have a child were having a "stable relationship" and, in the case of partnered people, having a partner who also desired a child. Laure, 42 and pregnant with her second child at the time of the interview, discovered that she was going through premature ovarian failure at 36 and went through a three-year ART course in France. After that failed, she was redirected to egg donation in Spain because of the waiting time for donation in France, which would have put her over the 43-year limit. On the subject of planning her motherhood journey, she explained that she was waiting for her desire to match that of her partner: "I had a crazy desire, I felt life, I was full of joy, and I wanted to have a child. Except that [my partner] was not at all in this state of mind and that for a year, a year and a half or two years, for him, having a child was not at all a current plan." In her interview, 47-year-old Catherine, pregnant at the time of the study after three IVF attempts with egg donation, linked the relationship issue to her own feeling of readiness for motherhood: "I think that desire is linked, at least for me, to my relationship. In the relationship I was in, because I wasn't mature enough to move forward in my relationship, that's my feeling, I wasn't mature enough to have a child. Maybe if I had been with another partner, my desire would have come sooner."

While motherhood has become a choice, having a child appears to be thought of as the result of a plan, which must be carried out under the "right conditions". The period during which women establish the conditions they deem necessary, regardless of whether they desire motherhood, is characterized by what Vialle conceptualizes as the "feelings of unreadiness/unavailability for motherhood" (Vialle, 2020). Vialle differentiates this feeling of unreadiness according to four broad categories defined as follows: partner availability -the expectation of finding a suitable partner-, conjugal readiness -the expectation that the couple will be ready for a parenting journey-, affective readiness -the expectation of feeling emotionally ready, or "mature" enough, as Catherine described it-, material readiness -the expectation of having enough material resources available- (Vialle, 2020). The concern to meet the material conditions deemed sufficient appeared in the interview of Marie, 41 years old and awaiting embryo donation after the diagnosis of infertility in both her and her partner: "Life meant that, like everyone else, we had to study. Then my husband, as he was in the army, it was a bit more complicated, so we were waiting for him to come back, for a transfer, which he didn't get immediately. And the more we moved on … I think that's the case for a lot of people, we tried to stabilize the situation, to have our studies finished, to have a roof over our heads and to have the minimum, I mean, to give the child. Unfortunately, he didn't get his transfer and I got a job, in fact, at the age of 32, so that delayed a little bit, I mean, our desire to have a child, although it was very present. And then we started naturally at 36–37 years old and then … it's true that it didn't come naturally." As "women envisage a reproductive temporality that is based on physical, social, and relational factors" (Vialle, 2020), the criteria they wish to meet before becoming mothers correspond to the objective of being able to welcome a child in a stable environment, in order to be able to provide him/her with the conditions they consider necessary for his/her proper development: a loving and structured family (which often appears to be understood according to a traditional model of the family), time and emotional availability, and economic and material resources. The interest of the child, which is prioritized in the case of fathers considered to be too old in the French system, also appears as the criterion of choice in the narrative of these women. It is therefore in contradiction with the biological criterion of the French 43-year limit for women, which ends up excluding them from their national system even years before this limit. Cross-border reproductive travel then appears to be the last but also the only solution, even though it involves traveling well beyond the physical, insofar as it is also cultural and emotional, and requires the mobilization of numerous economic, psychological, and temporal resources in its logistical complexity which includes being a patient in two states (Desy and Marre, 2022).

6. The reproductive exclusion of French "late" mothers

To consider the exclusion of "late" motherhood only in its first stages, which led participants to seek reproductive medical treatments abroad, would, however, leave a great gap regarding the implications of this exclusion on their lives. While women can circumvent the law by receiving treatment abroad, the stigmatization of this type of motherhood is sufficiently rooted in French reproductive governance -a concept introduced by Morgan and Roberts (2012) to analyze the privileged standards of morality used to "govern people's intimate behaviours, ethical judgements and their public manifestations"- to have an impact on their experiences while they are realizing their desire to become mothers.

For these French women who make a cross-border reproductive journey, the stages carried out in Spain correspond to the first and last (by cycle, at least) of their journey. After the first visit to the Spanish clinic, these women follow the instructions of their medical team and carry out the examinations, analyses, and treatment (taking medication, injections) from their home country. Only in the last stage, the transfer, insemination, or egg collection, do they have to cross the Spanish border again (Desy and Marre, 2022). After the COVID-19 pandemic, which has favored the digitalization of medicine and the development of medical tele-consultations, many carry out the first consultation at a distance and only travel for the last stage of the process. Consequently, this situation implies the need for "double monitoring" both by the Spanish medical team and by health professionals in France, for medical examinations (e.g., monitoring ultrasounds, hysteroscopies, hysterosonographies, etc.), analyses, and for medical prescriptions. France's ban on health professionals from advising their patients to undergo treatments abroad that would be illegal in France—as well as monitoring them and prescribing them medication—was revoked in 2016. However, the experience of the women interviewed shows that many health professionals and centers still refuse to provide them with any medical attention related to their motherhood plans.

While for some of them the exclusion occurs before they start their treatment, as in the aforementioned case of Alice who was rejected at the hospital reception, for others it occurs during the course of treatment, when the follow-up from Spain is already in place and the demand is for medical care which should be theoretically available to everyone in France. This was the case for Clara, 49, and her 51-year-old partner, who had been trying to conceive for seven years and had a history of repeated miscarriages. Waiting for an egg donation at the time of the interview, she explained the difficulty of setting up the double follow-up that her gynecologist, who had cared for her during these miscarriages, decided not to provide care related to their treatment in Spain: "It is perhaps one of the things that hurt me the most, because we trusted him. He told us that he could no longer care for us and that he would refer us to one of

his colleagues and when we asked him why, he simply said that he couldn't. We told him that he could, because we had checked, but he still refused. We didn't understand at all." While in Clara's case, the colleague to whom her gynecologist referred her agreed to follow her and she did not face any further difficulties, others face multiple rejections throughout their journey, which complicates the logistics of their care (see the case of Anne in Desy and Marre, 2022). It is possible that professionals and centers refuse to participate in ART care because they doubt the quality of the treatment the patients were receiving in Spain and preferred not to be involved. However, this is unlikely considering Spain's international reputation as being at the forefront of reproductive medicine. In addition, as a safeguard, Spanish clinics request several examinations from older patients, such as a cardiologist's certification of the woman's good cardiac health. Given that the law does not prohibit this care and that reproductive medicine and current medical knowledge on the possibility of a pregnancy after the age of 43 provide a solid medical framework for these women, the refusal of these health professionals appears to be linked to a moral issue that does not recognize the legitimacy of these women in their motherhood plans and therefore of their request for medical support to achieve their objective. Therefore, clinical staff contribute to the stigma of late motherhood by highlighting the risks associated with late pregnancies, including increased health risks for both the mother and child, and by suggesting that these women are prioritizing their desires over the welfare of their child (Adrian et al., 2021). Justine, 42, on a solo motherhood journey that started before the revision of the law, also reported in her interview the refusals she faced and the words of a gynecologist: "I went to several gynecologists in the city […] and there I had to face negative comments, but really radical. One of them said to me, 'No, but you don't know what it's like to raise a child.'"

Even though these women continued to pursue their plans despite the obstacles, for many of them, the fear of the opinion of close friends and family troubled them: "I am afraid of what my family and friends will think," said Clara, who was mentioned above. Valérie, 47, explained, "I don't know how to tell my parents. I'm afraid of what they'll think, that they will reject me, that they'll think I've made an irresponsible choice." Valérie was pregnant at the time of the interview after an embryo donation and had separated last year from her partner after starting their ART journey together during the first year of the covid-19 pandemic. In the same vein, but projecting a little further into motherhood, Sylvie, 44, had given birth to her first child three months before the interview. She expressed the following concern: "I'm afraid that when I go to pick him up from school, the other children and parents will think I'm his grandmother." Clara, mentioned earlier, expressed a similar worry, "I'm afraid of the other children at school … Because we know that children are cruel to each other. I'm afraid they'll make fun of him by telling him I'm his grandmother." Although in the narrative of these women, we find the idea that the "right conditions" to have a child had not been given until now, the common concerns expressed in the preceding examples show how reproductive governance is expressed not only in the high spheres of power but also in the sphere of intimate relationships, through moral regimes. These women who pursue motherhood after the age of 40 negotiate French moral regimes that reify a certain type of family, the traditional nuclear one, built according to a precise -especially for women-timeline (Desy and Marre, 2022; Vialle, 2020; Robcis, 2016).

7. Final comments

This study connects with the global phenomenon of motherhood postponement, which is at the root of the use of assisted reproductive technologies to fulfil the desire for a child at an age when fertility is in sharp decline (De Zordo et al., 2022). By focusing on French women's experiences of cross-border reproductive travel at the age of 40 or more, we contribute to an academic literature that addresses the reasons why people cross borders to access reproductive health treatments due to exclusive reasons. For the women who participated in this study, the exclusive criterion was their age. Despite France's evolving bioethics laws that have recently expanded access to medically assisted reproduction to "all women", women conceiving at older age still face reproductive exclusion in a context in which "late" motherhood is still highly stigmatized. Delving into the pervasive notion of the "biological clock" that primarily targets women, suggesting a finite window for reproductive capabilities that would only be defined by biological reasons, we highlighted how this binary view on fertility doesn't reflect that the decisions surrounding motherhood are often shaped by a complex interplay of personal, social, and cultural factors rather than a simple ticking clock.

Furthermore, reproductive exclusion is not only a one-time phenomenon in a women's lives. Rather, it begins when they first formulate their reproductive journey and continues during and beyond it. French legislation, fulfilling its role as a social tool, has been molded in the reified model of the traditional family (Desy and Marre, 2022; Robcis, 2016), which is heterosexual and nuclear and composed of a father and a mother of "reproductive age," according to a restricted calendar that excludes late motherhood. Within this framework, despite reproductive policies that are intended to favor demographic growth, not all families are invited to reproduce. Rather only those that correspond to a defined and normative model of family, and, above all, motherhood receive the sanction and support of the state. However, in the current context, the limits imposed by a country's reproductive governance do not seem to be sufficient to prevent women from achieving diverse motherhoods, when they have the resources to bypass them.

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CRediT authorship contribution statement

Alexandra Desy: Writing – review & editing, Writing – original draft, Resources, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Diana Marre:** Supervision, Resources, Methodology, Investigation, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Data availability

The data that has been used is confidential.

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