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Surveillance in Medically Assisted Reproductive Care in France

Alexandra Desy, AFIN Research Group and Outreach Center, Department of Social and Cultural Anthropology, Universitat Autònoma de Barcelona, Barcelona, Spain

Diana Marre, AFIN Research Group and Outreach Center, Department of Social and Cultural Anthropology, Universitat Autònoma de Barcelona, Barcelona, Spain

ABSTRACT

Beyond the laws, different institutions watch over – or *veille sur* – the access to and practice of medically assisted reproductive care in France. Although a shift in the moral regimes underlying French reproductive governance can be observed, ART practices are monitored through surveillance mechanisms, the economic and medical nature of which conceals their normalizing function. Woman and couples who do not correspond to these norms are prevented from forming a family through the French ART system. In this article we show how, faced with this reproductive exclusion, French women and couples choose to undertake cross-border reproductive care.

KEYWORDS: France; cross-border reproductive travel; infertility; medically assisted reproduction; reproductive exclusion; surveillance

Media teaser: We argue that reproductive care in France is shaped by medical and economic surveillance, restricting access and prompting many to seek ART treatments abroad.

CONTACT: Alexandra Desy, PhD candidate, alexandra.desy@uab.cat, AFIN Research Group and Outreach Center, Universitat Autònoma de Barcelona, c/Vila i Puig s/n, 08193 Cerdanyola del Vallès, Barcelona, Spain.

Introduction

Until the end of 2021, France had some of the most restrictive legislation on access and practice of reproductive medicine in Europe (Desy and Marre 2022; Desy and Marre 2024; Merchant 2019; Pennings 2019): it was authorized only for heterosexual couples in which the woman were under 43 years of age, and who were infertile because of a disease or the treatment of a disease prior to their reproductive project (Brunet 2019; Vialle 2017) (Law n°2021-1017). These limitations meant that French women and couples were the largest group of people undertaking cross-border reproductive care in Europe (Desy and Marre 2022; Rozée and de La Rochebrochard 2021; Shenfield et al. 2010; Wyns et al. 2022). As a consequence of its more liberal legal framework and proximity, Spain was the leading destination for French women and couples seeking reproductive services (Marre 2018; Marre, San Román and Guerra 2018). In 2021, revision of the legislation in France allowed the opening of access to treatment to single women and same-sex female couples, marking a radical shift in French reproductive governance. However, in a system that was already suffering from long waiting lists due to insufficient medical facilities and a lack of donated gametes (de La Rochebrochard 2018; Pérez Hernández 2021), access to treatment has not become easier and many people remain excluded and forced to travel to access reproductive treatments (Rozée and de La Rochebrochard 2021).

The progress of reproductive medicine, both in terms of medical expertise and of the diversity of treatments now available, has contributed to important social transformations over the past forty years. The Foucauldian concept of biopower, encapsulated in the formula “to make live and to let die” (Foucault 2003:239), provides a lens for understanding the regulatory and normalizing functions of medically assisted reproduction. Biopower operates through the governance of populations, using

institutional frameworks to manage life, particularly through bodies and their reproductive capacities. In the context of assisted reproductive technologies, this extends to the mechanisms by which state institutions shape reproductive practices, balancing care and control. In the 1990s, pioneering anthropologists Faye Ginsburg and Rayna Rapp laid the foundations of the anthropology of reproduction, arguing that reproduction was not a private matter but inherently political and indissociable from the context in which it takes place (Ginsburg and Rapp 1991; Ginsburg and Rapp 1995). Through the concept of reproductive politics, they showed that reproductive practices are intersected and shaped by a set of power relations – including, beyond State power, those of Western medicine – and have political implications. In 2012, anthropologists Lynn Morgan and Elizabeth Roberts built on this concept to develop that of reproductive governance, which allows for the study of the mechanisms through which powerful institutions in societies “use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control the reproductive behaviors and population practices” (Morgan and Roberts 2012:243). Thus, they illustrated how the family and the bodies that constitute it continue to be one of the main devices through which the State monitors and regulates the population (Fonseca, Marre and Rifiotis 2021; Morgan 2019; Morgan and Roberts 2012). Morgan and Roberts linked governance to the expression of society’s moral regimes – drawing on the Foucauldian concept of regimes of truth – defining them as the privileged norms of morality used to “govern people’s intimate behaviors, ethical judgements and their public manifestations” (Morgan and Roberts 2012:242). These norms are expressed in everyday private relationships, but also through institutions, including those of medicine, through different mechanisms and practices that assess their conformity (Fassin 2010). Surveillance, often considered the main organizing mechanisms of

contemporary biopolitics, has been extensively studied across various disciplines. Kevin Haggerty and Richard Ericson defined it in 2006 as “the collection and analysis of information about populations in order to govern their activities” (Haggerty and Ericson 2006:3), and it is used through different regulatory technologies (Haggerty 2009; Haggerty and Ericson 2006; Lyon 2007). Surveillance, the technologies of which can be seen as “the implantation and realization of biopower” (Puumeister 2014:1), becomes a means to both facilitate and restrict access to assisted reproductive technologies. The choice to frame this analysis through the concept of surveillance reflects a deliberate *etic* perspective, aimed at understanding the intersection of care and control in French reproductive governance. While the interviewees did not explicitly refer to surveillance, their interviews showed experiences of vigilance, regulation, and judgment that align with the Foucauldian notion. This concept is used as an analytical tool to understand how mechanisms of governance operate to facilitate but also impose normative boundaries on who can or cannot access reproductive treatments.

In this article, we will focus on surveillance in the field of medically assisted reproductive care by analyzing the case of France. We aim at showing how biopolitical surveillance and care intersect, taking a wider look at the social logics that structure and regulate French medically assisted reproductive care practices by means of different surveillance mechanisms, from the law to the intimacy of the medical consultation, through the requirement to produce discourses that will be evaluated by the medical institution. We also explore what forms surveillance takes in a context where it is common – though by no means simple – to seek in another country what is not available, or even allowed, in one’s home country. Lastly, we will analyze how different types of interpersonal surveillance are involved in these journeys, in order to examine how they too can contribute to (or obstruct) the care process.

The data on which we draw in this article is based on over seven years of fieldwork in Barcelona's fertility clinics. The research included in-depth interviews with 36 French women and couples who crossed the Spanish border to fulfil their reproductive desire. Recruitment strategies included calls for participation through fertility clinics and on social media platforms. Ethical considerations included informed consent, anonymity, and the potential sensitivities of discussing deeply personal and often stigmatized reproductive journeys. The research took place during the very last years prior to the revision of the Bioethics Law, as well as during the transitional latency period before it came into force. This temporal scope allowed for an analysis of the evolving legal and moral frameworks shaping access to assisted reproductive technologies and the responses of French women and couples navigating the changes.

French governance of medically assisted reproductive care

Amandine, the first French “test-tube baby”, was born on February 24, 1982, four years after Louise Brown, in England, the first child in the world born thanks to the in vitro fertilization technique. The conception of these first babies, for whom fertilization took place outside the woman's body, sparked an unprecedented debate in the different spheres of French society, as well as in the rest of the world. Undoubtedly, from the very beginning, this new technology had a direct and definitive impact on the foundations of the French society. Received as a scientific and social revolution, reproductive medicine with the In Vitro Fertilization (IVF) technique gave rise to an important political and social debate, as it shook the norms of kinship and filiation but also the conception of medicine (Mehl 1999; Mehl 2011; Memmi 2003; Théry 2012). As life could now be “created” and not just cared for, what were the prospects for

humankind? What was the place of the State within this new major possibility and, above all, how could the power that these scientific advances gave to society be controlled and its excesses be prevented? To answer these questions, the *Comité Consultatif National d'Éthique* [the National Ethical Advisory Committee] was created in 1983 with the aim to provide expertise and help legislate on ethical and social issues raised by advances in the scientific field. Two years later, in 1985, experts from many disciplines – including scientists, politicians, anthropologists, lawyers, psychiatrists, and philosophers – were brought together to decide on the foundations of what in 1994 would become, after long discussions on the implications of this new technology, the *Loi Bioéthique* [Bioethics Law], the French legislative framework for the practice of and access to medically assisted reproduction.

Beyond presenting the history of its legislative construction, our aim is to highlight here how, from the very first debates until today, questions relating to bioethics in France have not been left in the hands of experts, scientists and politicians, but have been thought of as social and public issues that must be regulated by law (Robcis 2016). From the beginning, France opted for strict legislation that did not – or should not – leave any individual freedom to practitioners and patients (Mehl 2011; Memmi 2003), and the legislation was written to leave as little as possible to interpretation. The law stated that access to medically assisted reproduction was restricted to married heterosexual couples who had been living together for at least two years and who had been diagnosed with medical infertility, linked to a pathology, and in which the woman was of “reproductive age” – that is, no older than 43 years of age. Legislators also decided that only what was enshrined in the law could be practiced, hence also limiting research and innovation as every act involving the manipulation of “human material” had to be previously inspected and authorized by a commission. It is

therefore in these terms, those corresponding to “a medical response to a medical problem”, that medically assisted reproduction was conceived, according to a model that could be described as “therapeutic” (Brunet, 2019). Thus, French reproductive medicine was framed as a form of closely monitored – or *surveillé* in French– medical care, intended for those whose medical condition prevented them from reproducing. The Bioethics Law has only been revised three times since its entry into force: in 2004, 2011, and most recently, in 2021. Until the last revision of the law, no major changes were implemented concerning access to medically assisted reproduction¹. In 2021, after long and often heated debates involving experts, politicians, and society in general, access to reproductive treatments was opened to single women and same-sex female couples, and gamete preservation for social reasons was allowed. Moreover, it was also confirmed that treatments for single women and same-sex female couples would also be fully reimbursed by the public health insurance system, within the same maximum number of attempts mentioned above.

This leads us to the heart of French health care system and its public and universal health insurance, the *Sécurité Sociale* [Social Security], designed to provide universal and egalitarian health coverage to anyone residing in France. Founded on the principle of “national solidarity” (Code de la Sécurité Sociale, Article L111-1), the *Sécurité Sociale* allows access to and reimbursement of care², structured by the mechanism of the French welfare state. Since the first Bioethics Law, the French State decided to cover 100 percent of the cost of medically assisted procreation, albeit limited to six artificial inseminations and four IVF cycles. This was decided even though the full coverage was otherwise mainly limited to serious and/or chronic illnesses and expensive treatments and care.

Having the highest fertility rate in Europe (Eurostat, 2021) and a history of natalist policies, procreation of France citizens is thought of as a public issue that the State must take care of, intervening through medical and financial means. However, until 2021, French governance did not “take care” of the reproduction of all families, but rather a specific family model: the traditional family according to the heteronormative model, composed of a father and a mother of reproductive age, and ideally with several children (Desy and Marre 2022; Robcis 2016), within a fundamentally “familyist”³ moral regime. Through the indispensable surveillance of the medical establishment in assisted procreation and the biological justification, the French State provided a biopolitical care intended to preserve the social norm of the traditional family and, until 2021, excluded those families that did not correspond to this model.

The last revision of the law marked a turning point for French society and its way of conceiving not only medicine, but also reproduction and family. Indeed, by enshrining in the law the right to access to reproductive treatments for single women and same-sex couples – future single-parent families by choice and homosexual parent families – the State indirectly, but explicitly, recognized their legitimacy to constitute a family (Mehl 2021). It is therefore the evolution of the French family, thought of as the nucleus of its society (Robcis 2016), which the State seems to recognize the legitimacy of with the latest revision of the Bioethics Law (Mehl 2021). Beyond the legislative change, it is a sign that a modification in the “moral regimes” (Morgan and Roberts 2012) of French society is occurring.

The pathway to medically assisted reproductive care under surveillance

If the legislative framework has changed and avenues opened for those previously excluded, the mechanisms through which the French State oversees, or *surveille*, the

practice of reproductive medicine have not. One rule prevails and is key to understanding one of the main mechanisms of French surveillance: it is mandatory to go before a medical doctor in order to access treatments, regardless of whether it is a question of medical or social infertility, defined here as the absence of male reproductive gametes. Indeed, the gynecologist must evaluate the patient's request before authorizing the women or the couple to proceed with the treatment. This evaluation takes the form of an interview which takes place during the first medical consultation⁴. Although the law is not precise about the composition of this evaluation, it states that the physician must "verify the motivation of both members of the couple or of the unmarried woman" (Article L2141-10). For this evaluation, which may by several, the only compulsory presence stipulated by the law is that of the physician⁵.

Participant of this study report very different experiences regarding the content of this evaluation. "At our first appointment, I appreciated the fact that a specialist listened to me and talked to me for an hour, while showing empathy," said Célia, about her first interview in a private center in France. This private center⁶ was the second one she visited after having undergone three IVF cycles in another private center before, which she was not satisfied with. About the last pre-IVF appointment in the previous center, she said: "During this last 10-minute appointment at 100 euros, in front of me and my partner, he told us that endometriosis was not important [...]. He added that last time we were almost there, and that this time should be the one." The experience of these interviews varied greatly between those who took part in the interviews conducted for this study. For Aurore, who went through two public ART centers as she moved in the meantime, these interviews are repetitive: "It's always the same questions: when was your last period, how long have you been trying to have a child, have you ever become pregnant, and so on." Some interviewees reported lengthy interviews, such as

Clara who explained: “It was the same doctor who diagnosed my [ovarian] insufficiency and allowed me to freeze my eggs. He asked me a lot of questions: how I was doing and how things were going in my relationship, whether we felt ready to move on to the donation stage, because ‘it was going to be a long time’. He explained everything in detail to make sure I knew what I was getting into. But I had been thinking about it for a long time and had already investigated Spain, but it made me feel bad to tell him.”. Others refer to rather short interviews focused on medical issues, such as Séverine: “She [the medical doctor] didn’t ask me many questions, she just commented on my tests. She asked me if I wanted to do this alone, I said yes, and then that was that.” Asked if she expected it to be different, she replied, “I had read on forums that some centers ask some women to come with someone, and that worried me because I hadn’t told anyone at the time, I wanted to wait and see how it went.” Although not officially confirmed by the medical centers, this practice that seems to be reserved for women who are planning to become solo mothers has been reported on social networks. Another interviewee with a plan for solo motherhood at the age of 33, Léa, also recounted that the gynecologist at the ART center told her that at her age it was “rushed” and that she should not “lose hope of meeting someone”. These practices have been the subject of several press releases from various French associations that consider them to be abusive and not in line with the law, which provides for non-discriminatory treatment of the requests (Hussonnois-Alaya 2022).

What people who have undergone during a physician’s evaluation of their reproductive project report does not appear to be consistent. The length of these interviews and the topics – medical, social, psychological – on which the questions are based, and even the tone of the exchange – simple conversation or questioning – vary greatly from one physician to another. However, regardless of its content, the interview

during which these people will have to elaborate a discourse exposing motivations that the expert will have to evaluate as il/legitimate can be considered in itself as a regulatory mechanism of a surveillance nature, in that it is based on the recollection of biographical data from these women and couples (Memmi 2003). As the French sociologist Dominique Memmi pointed out, this can be analyzed as a “government by word” in which people have to produce an autobiographical narrative that will be evaluated by an expert whose function is care (Memmi 2003; Memmi 2006). Thus, even if there is no medical reason for the request, the physician, as the embodiment of the medical institution in which the State places the responsibility for the compliance with the law, remains the gatekeeper to the reproductive treatment’s pathway (Memmi 2003).

On the official website of the French administration, it is stated that the authorization must be based on “the probability of success of the reproductive treatment and the meeting of conditions favorable to the reception of a child under good conditions” (Service Public 2022); although the law does not clearly specify what these conditions are. Appearing here in an almost “naturalized” form, given that it emanates from the medical institution, the surveillance of what is “right” or “bad”, “legitimate” or “illegitimate”, as regards to the appropriate conditions for welcoming a child, is in line with the familialism of French public policy, which in recent years has focused on the interests of children (Messu 2020). Through the compulsory evaluation that will authorize these families to procreate or not, the State’s power of surveillance is delegated to its agents, the physicians, who will have to decide whether they meet the expected conditions to have a child, according to a moral value system that comes from the social norm that the French society (re)produces (Fassin 2009; Fassin 2010). The requirement to justify reproductive intentions before medical professionals illustrates how care is conditional upon conformity to societal norms. This dual nature of

surveillance, as both a tool of inclusion and exclusion, reveals its Janus-faced character.

While framed as a means to ensure ethical medical practices, it simultaneously functions as a gatekeeping mechanism, reinforcing normative ideals of family and reproduction.

On the other hand, the French public social security system corresponds to another surveillance mechanism, this one economic. “Biopolitics today in terms of managing the reproduction of life would reside in a surveillance ensured through the exercise of the economic provision or withdrawal, of the to-and-fro of what is known as the welfare state or the social state” (Memmi 2003:84). Through the system of the *Sécurité Sociale*, a regulation is operated through financial incentives or disincentives. While the French State ensures the reproduction of the families – of which the definition has been broadened – by reimbursing the full (high) cost of medically assisted procreation, it does so only until the woman’s 43rd birthday, whereas the law authorizes treatment until the woman’s 45th birthday. In French society where “late” motherhood still suffers from a great stigma, the absence of economic assistance appears as a form of delegitimization of this type of maternity (Desy and Marre 2024; Vialle 2020).

Cross-border reproductive travel as a way to ‘escape’ surveillance?

Despite the lack of clear statistics, scholars have shown that cross-border reproductive travel is a phenomenon that has been steadily growing and has been studied by qualitative and quantitative research in various parts of the world (Bergmann 2011a; Blyth 2010; Inhorn and Gurtin 2011; Salama et al. 2018; Pennings 2010; Nahman 2016; Shenfield et al. 2010; Whittaker, Inhorn and Shenfield 2019). In an increasingly globalized landscape where people and information circulate rapidly, cross-border reproductive care reflects broader transnational dynamics in health governance.

Countries with restrictive assisted reproductive technologies policies, such as France, often drive individuals or couples toward countries with more liberal frameworks, such as Spain, Belgium, or Greece, to access treatments that are prohibited or difficult to access in their home country or region, with better care and outcomes, with less waiting time, or with more discretion. These transnational reproductive journeys highlight disparities in access and regulation across borders, raising questions about how national policies intersect with global trends.

In the diverse European reproscape (Inhorn 2011), in terms of legislation concerning access to and the practice of medically assisted procreation, Spain is the polar opposite of France. Its private health system for reproductive medicine, that to which foreigners have access, is more developed than the public system and it is a thriving industry that accounts for a significant proportion of Spanish gross domestic product (Alkorta 2021). For its geographical accessibility from France, its high success rates, a very high availability of donated gametes⁷ (Lafuente-Funes 2020; Molas Closas 2021; Molas Closas and Whittaker 2022; Perler and Schurr 2022), and the fact that anyone can access treatment regardless of marital status and, since 2006, without age limit, Spain is the preferred destination for French women and couples (Bergmann 2011b; Desy and Marre 2022; Alkorta 2021). Moreover, they are welcomed in a system that has been able to adapt to foreign patients, in which, as an example, medical services are provided in the patients' mother tongue (Riverola 2018). The Spanish medical system, unlike the French one, is highly liberalised (Alkorta 2021).

In 2019, according to the last report published by the Spanish Fertility Society before the covid-19 pandemic, 37 percent of the foreign patients who had undergone treatment that year were French, making them the largest group of international patients, with 6,930 of the total 18,847 IVF cycles performed for foreigners (SEF 2020).

Although the French national Biomedicine Agency reports that 110,174 IVF cycles were carried out in France in 2019, there is no data on IVF cycles carried out by the French abroad (Agence de la Biomédecine 2020). In this biopolitics where surveillance is prevalent, the fact that these data are not collected raises questions, in that this could be analyzed as an implicit legitimization of these practices, a decompression valve for a medical system overloaded with demands, or the prevalence for the interest of demographic growth. In any case, the number of IVF cycles carried out in Spain are the equivalent of 6 percent of those carried out in France, bearing in mind that Spain is not the only destination for cross-border reproductive travel by the French in Europe. This is also the case for Belgium (Pennings 2019), Greece, or the Czech Republic, often chosen because of their economic accessibility in comparison to Spain (Rozée Gomez and de La Rochebrochard 2013).

Cross-border reproductive travel is therefore not an uncommon alternative for French people unable to access medically assisted reproductive treatments through their national system and is known to reproductive health professionals in France. “The psychologist asked me to come back with my partner, if the IVF did not work, in order to talk about egg donation, and I told her that we were going to Spain [...]. She said that it would be good to see the doctor. I told her that the check-up and complementary tests had already been done [...]. I was aware before this interview that my speech could be prejudicial to me, that my egg donation file could be refused, or end up at the end of the pile, because I would have criticized a professional system too much. I fully assumed this risk, because I knew I was going to Spain”, recounted Camille in her interview, about the last appointment she had at her French ART center. At first glance, therefore, cross-border reproductive travel may seem like a way to circumvent French surveillance.

However, for what seems to be most of the people we interviewed, crossing borders to access reproductive treatments did not mean that all stages of the treatment took place in the country where the treatment was carried out. Rather, the person undertaking the treatment receives instructions from the Spanish clinic that they must carry out remotely from France (Desy and Marre 2022). Only the final stage of the treatment process – that is, oocyte puncture, insemination, embryo transfer, or deposit of the sperm sample – is done at the Spanish clinic. Even more so since the COVID-19 pandemic, which has accelerated the digitalization of medical services, almost all the communication is done electronically, including the first consultation with the foreign clinic. This requires that all analyses and medical examinations, or the acquisition of medication, must be prescribed by a French medical physician. In other words, those who undergo treatment abroad must find a physician who agrees to “translate” the prescriptions from the Spanish clinic, and this is often not done without obstacles (Desy and Marre 2022).

Even though there is no law preventing French physicians from following up people who have treatment abroad⁸, many refuse to do so, even after the law was revised. In her interview, Estelle, with a plan to become a solo mother, explained that she had to visit several physicians before having to find a professional in the capital, even though she lives in a provincial town in a different region: “Another [gynecologist] told me: ‘I can’t tell you anything.’ So, it was a bit hard; I thought I was not going to make it. [...] The gynecologists in town, they didn’t want to answer me. So, finally, I managed to find a gynecologist in Paris who was willing to follow me, and, above all, who answered my questions.” These refusals to follow up can multiply, forcing women and couples to consult different centers and health professionals for analyses, ultrasounds, prescriptions for medicines, and even their purchase in certain pharmacies

that refused, at least before the law was modified, to sell medicines for ovarian stimulation to a woman who was not reimbursed by the Social Security. In such cases this was because pharmacies suspected – or even asked directly – that she was carrying out a solo procedure abroad (see, e.g., the case of Anne in Desy and Marre 2022). Moreover, this was not limited to women who planned for solo motherhood. This rejection, for example, was also experienced by Louise and her partner, who were just starting their journey in Spain at the time of the interview and were in what they described as the “anxious” process of finding a gynecologist to follow them in France: “She [the gynecologist who had been following them in their previous ART process] told us bluntly that it would be done without her and that she couldn’t help us. She said she could do some examinations, but she wouldn’t prescribe anything.” Such difficulties are not, however, the case for all, as some doctors do agree to undertake these follow-ups, recommend themselves to continue the project abroad, and even communicate with the Spanish doctor to facilitate the patients’ care, as was the case for Monica and her partner: “We were lucky, it was the same professor who recommended Dr X [a physician from their Spanish fertility clinic] who always followed us, and they were emailing each other.” Therefore, in this case too, the doctor remains in the position of gatekeeper. Thus, surveillance does not stop when women and couples cross the border and continues to be deployed through the French healthcare system. Even abroad, French citizens remain subject to these mechanisms, which highlights the reach of surveillance in reproductive governance.

In addition, neither does the economic surveillance of the Sécurité Sociale and its system of incentives and disincentives (Memmi 2003) disappear for reproductive journeys abroad: there is a financial aid, which existed only for heterosexual couples until 2021 and has since also been opened up for single women and same-sex female

couples, which can be applied for up to the age of 43 for the woman, according to the same rules as for treatments in France. Here, too, it is necessary to go through an evaluation process which consists of the constitution of a file that includes a letter explaining the reasons for the request, which will have to be studied by a commission. However, there is an important difference: the economic coverage is far from 100 percent of the cost of treatment. Monica and Lucas explained: “We were covered for 1500 euros of what we have to pay. In our case, this left us to pay 9000 euros in total, roughly.” Through this system of economic assistance, which can be refused, and which if accepted will in any case be less than the aid for treatments carried out in France, the Sécurité Sociale operates a form of hierarchization of the legitimacy of these reproductive projects (Mehl 2021).

While such regulations are justified as safeguards for public health and resource allocation, they also have exclusionary effects. The age limit of 43 for full financial coverage by the Sécurité Sociale, despite the legal age for treatment being 45, disadvantages women over 43. Similarly, the delegation of medical but also moral evaluations to medical professionals can result in access restrictions for women with a solo reproductive project, same-sex couples, or women with a “late” reproductive project. This demonstrates how surveillance mechanisms operate as a normalizing tool for French reproductive governance, perpetuating exclusion for those who do not fit the heteronormative family model.

Interpersonal surveillance as a possible network of care

This final section aims at showing another aspect of surveillance, counterbalancing the relationship between surveillance and care presented above. Indeed, surveillance can

also be interpersonal as it appears in everyday private relationships. Families, as well as communities, are watched, but they also watch themselves, and familial and social interactions can shape the journeys of women and couples navigating medically assisted reproduction.

In her interview, Monica explained: “My parents, especially my mother because she’s a biologist, help us a lot. She’s called a lot of colleagues to ask them questions or ask for contacts, and when I do research on the internet, I show her so she can explain certain things to me or give me her opinion. And sometimes she shows me things she found, too.” Several participants named certain family members as a fundamental source of support and care in their journey. Such care can be emotional and material: “We asked my parents for help. They know what we’re doing, in broad terms, and they support us like that. We wouldn’t have been able to pay otherwise. Besides, they really want to be grandparents. [...] I have three brothers and they have children, but I’m the only girl, so it’s different”, said Barbara. Here surveillance appears to be more palatable, as the family takes care of the woman or the couple through different means. By being a source of support, families also make sure that the woman or couple can carry on with their reproductive project, securing their well-being and their material needs, including when the parental project does not correspond to the social norm.

However, the family can also act as a disincentive to the parental project, or even oppose it. Some participants explained that they have kept their reproductive project secret, in a clear attempt to escape their relatives’ surveillance: “I haven’t talked about it because I know I won’t be supported, I don’t want to become the favorite topic of conversation”, said Marie. Thus, if some women keep their planned maternity a secret, it is so that it does not come under the scrutiny of the family, who will remind them of their non-conformity with family norms. Natacha remembers an altercation of

this kind about her plans for solo motherhood: “[My aunt] said to me, ‘Are you crazy? What’s he going to do without a father? He’ll be traumatized, you’re completely selfish!’ Since then, I’ve cut ties, I was really disappointed.”

As these interview excerpts demonstrate, family is a key place for reinforcing or contesting normative reproductive and family values. Interactions with relatives extend beyond general moral judgment, as they can actively influence access to treatments, emotional and social well-being, or even the material feasibility of reproductive projects, as it was the case for Barbara. Indeed, relatives may provide financial or logistical help, or emotional encouragement, but they can also hinder the process through opposition or subtle forms of judgment. Therefore, interpersonal surveillance transforms what might otherwise be personal opinions into mechanisms of regulation that align with societal norms. Here, surveillance does not imply coercion, but implicit control exercised within the family.

In several of the interviews, there was also the idea of a need for care that was not being met by their relatives, leading the women or couple to seek it elsewhere. Asked if she could talk about her journey with those around her, Natacha replied: “So, mainly with my mother. With my father, he doesn’t understand anything, but he’s committed. I think it’s a matter of prudishness on his part. With my mother, we share everything. And with my friends... I don’t know. I don’t think they understand. Somehow, for those who have children, they don’t fully understand the determination that [her partner] and I have, in fact, to push ourselves to the end of our journey [...]” Anna, too, said: “These are things I can’t really discuss with my parents or my friends, because they’re following classic patterns [of family].” As for Fanny, she explained: “Unfortunately, I don’t have any friends in my situation, so I feel a bit alone, it’s true.” She added: “But there are the forums and it’s incredible, this community! In fact,

they're really friends. Virtual friends, but friends. And that's a huge help! If I've got a question, I can get an answer within the hour. We go through all the same things: miscarriages, everything, all the dramas, the joys, the babies that arrive, we follow the pregnancies. It's very special, but in the end, I think it's great."

For people undergoing medically assisted procreation, and even more so for those who have been excluded from their national care system, the internet and the possibility of accessing an online community of people in a similar position to their own has become a main source of care (Inhorn and Gurtin 2011; Gurtin 2011). Although offering the possibility of anonymous and chosen access, sharing on the forums mostly requires the formulation of an autobiographical narrative in order to participate. Indeed, most private groups on social networks such as Facebook require users to explain why they are requesting access and prompts them to explain their background beforehand. Although for the most part open access, many forums also feature users starting a discussion thread by explaining their background and the specific issue that brought them here. On users' profiles or in their signature, under their pseudonym, we can see a schematic summary – often using emoticons, for example – of the number of years spent on the infertility journey, IVF attempts, whether the result was positive or negative, whether a pregnancy is underway or whether it resulted in a birth, and also the number of gestational losses. As Fanny recalled in her interview, users check on the wellbeing of their peers: "How are you? How are you feeling? Do you have an update from the clinic? Any news?", and help and support each other through the doubts, questions and difficult times along the way. As a caring space where users can find a community with whom they share and sometimes discuss a non-traditional parenting norm (e.g. specific forums for solo mums), for some these forums have become part of their daily life and one of their principal sources of care (Bergmann 2011a).

Final comments

In this article we have demonstrated how institutions, beyond their legislative mandates, watch over – or *veille sur* in French– the access to and practice of medically assisted reproductive care in France. The French term “*veille sur*” has a subtle nuance that differs slightly from the English word “surveillance”. Whereas, in English, surveillance is often synonymous with control, or monitoring, “*veiller sur*” – here in the infinitive – has an additional dimension of attention, or vigilance. While remaining within a regulatory framework, it implies a form of protection and nurturing. This duality resonates with biopolitics, both care and control, reflecting the tension between care and surveillance as mechanism of enforcing norms.

Although a shift in the moral regimes underlying French reproductive governance can be observed, with the opening of access to single women and same-sex female couples, French biopolitics, while gradually erasing certain prohibitions, regulate ART practices through surveillance mechanisms of which the economic and medical nature conceals its normalizing function (Memmi 2002; Mehl 2021). Among those, the mandatory evaluation by a medical doctor to access reproductive treatments, regardless of whether infertility is medical or social, while ensuring medical oversight, positions physicians as gatekeepers who evaluate not only medical but also moral criteria. Woman and couples who do not correspond to this norm or those who do not produce the expected discourse before the physician are prevented from forming a family through medically assisted reproductive treatments in the framework of the French ART system. This situation raises significant questions about whether medical professionals should act as arbiters of reproductive legitimacy and whether alternative models of reproductive governance could ensure equitable access without reinforcing normative biases.

It is important to acknowledge that not all French bioethicists agree with the principle underpinning French reproductive governance. While some support the exclusive framework that emphasizes the protection of a heteronormative family structure – albeit less so since the opening of the law – others criticize its exclusionary nature and its failure to consider changes in family norms. Beyond academic circles and debates, these issues are deeply linked to social movements. Feminist and LGBTQ+ advocacy groups, for example, have mobilized to call for wider access to medically assisted reproductive technologies as a matter of reproductive justice.

Still, faced with this reproductive exclusion, thousands of French women and couples choose to undertake cross-border reproductive care, mostly in Spain (Desy and Marre 2022; Desy and Marre 2024; Madero et al. 2017; Merchant 2019; Pennings 2019; Rozée Gomez and de La Rochebrochard 2013). Moreover, another form of care, this one interpersonal, takes shape for the women and couples who embark on those journeys. Indeed, family, friends and online communities can also have a major impact on their journey, demonstrating how, whether biopolitical or interpersonal, surveillance appears to be inherent to care. By extending care across borders, through interpersonal networks, online communities, and clinics abroad, these reproductive journeys show us how care is multiple, embodied and affective. This dual perspective of surveillance and care therefore offers a layered understanding of reproductive governance.

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Notes on contributors: Alexandra Desy is PhD candidate in Social and Cultural Anthropology at the Universitat Autònoma de Barcelona. She is a member of the AFIN Research Group and Outreach Centre since 2019. Her research interests include assisted human reproduction, cross-border reproductive travel, and reproductive health. ORCID 0000-0003-3414-5606

Diana Marre is a Doctor in Social and Cultural Anthropology and a Professor of Anthropology of Gender at the Universitat Autònoma de Barcelona. She is the Director of the AFIN Research Group and Outreach Centre. Her areas of expertise include human reproduction, gender, anthropology of health, and grief. ORCID 0000-0003-2852-3762

Notes

¹ The only change in relation to assisted reproduction was the authorization in the 2011 revision of the technology of oocyte vitrification, which allows extremely rapid freezing.

² Its coverage is total or partial and it is calculated based on a rate of reimbursement which takes into account the degree of “incapacitation” given by the illness or the accident, the cost of treatment, and the personal situation of each individual.

³ Camille Robcis, French intellectual history scholar and author, has defined the notion of “familialism” in the French context as: “the French commitment to the heterosexual family norm” (Robcis 2016:24).

⁴ The waiting time is of six months for this first appointment in a public assisted reproductive technology -ART- center as against to one month in a private ART center.

⁵ This whole process must be repeated with each new IVF cycle -involving a new stimulation or an insemination.

⁶ In France, the public and private health sectors coexist but do not compete, in that the private sector is designed to complement the public sector, as health is socially and culturally understood as a public issue that should not be liberalised. The difference between the private and public sectors is that in the former, physicians are salaried, whereas in the latter they are self-employed. Medical exams, procedures and appointments in the private sector are subject to the same rules as in the public sector for the patients, also reimbursed in accordance with the Social Security system. In the private sector, physicians are allowed to set their own prices and may therefore charge “extra fees” over and above those set by the Social Security.

⁷ Private fertility clinics in Spain, which have the monopoly on gamete donation, offer waiting times ranging from a few days for sperm donation to 1 to 3 months for egg donation.

⁸ A statement from the Ministry of Health in 2013 banned physicians from following or advising people undergoing ART abroad, but it was revoked in 2016.

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