



Marcia C. Inhorn is the William K. Lanman, Jr., Professor of Anthropology and International Affairs at Yale University. A specialist on Middle Eastern gender, religion, and health issues, Inhorn has conducted research on the social impact of infertility and assisted reproductive technologies in Egypt, Lebanon, the United Arab Emirates, and Arab America over the past twenty-five years. She is editor of eight volumes and author of four books on the subject, including most recently *The New Arab Man: Emergent Masculinities, Technologies, and Islam in the Middle East* (2012). Inhorn is the founding editor of the *Journal of Middle East Women's Studies* (*JMEWS*) and coeditor of Berghahn's *Fertility, Reproduction, and Sexuality* series. Inhorn has directed Yale's Council on Middle East Studies and the Center for Middle Eastern and North African Studies at the University of Michigan. Currently, she serves on the Board of Directors of the Middle East Studies Association and was president of the Society for Medical Anthropology of the American Anthropological Association. In fall 2010, Inhorn was the first Diane Middlebrook and Carl Djerassi Visiting Professor at the Centre for Gender Studies, University of Cambridge.

REPRODUCTIVE EXILE in GLOBAL DUBAI: SOUTH ASIAN STORIES

MARCIA C. INHORN

ABSTRACT As India becomes the center for global commercial surrogacy, infertile Indians themselves may be forced to seek assisted reproductive technology (ART) services elsewhere. The inability of Indian couples to access affordable, high-quality services in their home country may force them to become reproductive tourists—a phenomenon defined in this article as “reproductive exile.” Reproductive exile bespeaks the “forced” nature of fertility travel, when infertile couples must leave their home country in order to access safe, effective, affordable, and legal infertility care. Their choice to use ARTs to produce a child is voluntary, but their travel abroad is not. Furthermore, the term *exile* takes on additional meanings in the South Asian context. South Asian laborers, both poor and middle-class, may feel forced to leave home in order to secure a living wage, send home remittances, save for their futures, and accrue enough money to access ART services. For many South Asians, Dubai is now the global hub for both labor migration and reproductive exile, owing to the long history of

South Asian–Arab Gulf transnationalism, as well as Dubai’s reputation for specializing in all manner of “high-tech” services. In this article, reproductive exile to global Dubai will be explored, along with three South Asian stories highlighting infertile couples’ dreams of making a test-tube baby.

KEYWORDS: assisted reproductive technologies, fertility tourism, reproductive exile, South Asia, Dubai



As early as 1991, a new term, *procreative tourism*, was adopted by legal scholars in an attempt to describe the increasing transnational movements of people searching for in vitro fertilization (IVF) and other forms of assisted reproductive technology (ART) (Knoppers and LeBris 1991). By the beginning of the new millennium, journalists had begun to report on this new social phenomenon, calling it variously “reproductive tourism,” “fertility tourism,” or “procreative tourism.” According to reports in the *New York Times* (Lee 2005) and *Wall Street Journal* (Tesoriero 2008) and by *BBC News* (Briggs 2006), infertile Western couples seeking to produce a child through ARTs were traveling across national and international borders to access IVF and its variants. Although little was known about this type of “tourism,” ethicists and legal scholars began to examine these media reports and attempt to define this type of travel. One of the earliest analysts, a Belgian ethicist named Guido Pennings, defined reproductive tourism as “the travelling by candidate service recipients from one institution, jurisdiction or country where treatment is not available to another institution, jurisdiction or country where they can obtain the kind of medically assisted reproduction they desire. As such, it is part of the more general ‘medical tourism’” (Pennings 2002: 337). Indeed, the language of reproductive “tourism” placed the search for a “test-tube baby” within the same class as orthopedic, cardiac, and plastic surgeries, the other most common types of medical care sought abroad. According to some scholars, such medical care counted as “tourism,” because “engaging in tourist activities, such as recovering in resorts in destination countries, is a common part of the medical tourism experience” (Crooks et al. 2011: 726).

In the flurry of scholarly commentaries that followed, eight standard reasons for reproductive “tourism” were repeatedly cited: (1) individual countries may prohibit a specific service for religious, ethical, or legal reasons; (2) a specific service may be unavailable because of lack of expertise and equipment; (3) a specific service may be unavailable because of supply problems, leading to shortages and waiting lists; (4) a service may be unavailable because it is not considered sufficiently safe or its risks are unknown, so that countries exercising safety precautions may prohibit procedures

that are available elsewhere; (5) certain categories of individuals may not receive a service, especially at public expense, on the basis of age, marital status, or sexual orientation; (6) individuals may fear lack of medical privacy and confidentiality and thus seek services elsewhere; (7) individuals may fear poor-quality medical care and lower ART success rates and thus seek services elsewhere; and, finally, (8) services may simply be cheaper in other countries (Blyth and Farrand 2005; Deech 2003; Pennings 2002, 2004; Pennings et al. 2008).

Particular concern revolved around the legal, ethical, and social justice issues surrounding border crossing within the European Union (EU) nations (Blyth 2010; Deech 2003; Pennings 2004; Pennings et al. 2008; McKelvey et al. 2009; Shenfield et al. 2010). Namely, by the beginning of the new millennium, it had become abundantly clear that many infertile Europeans were traveling from country to country within the EU as a means of “law evasion” (Storrow 2010), in an effort to bypass legal restrictions on ARTs at home. The possibility of “legal harmonization” across Europe was raised and then quickly dismissed by the European Society of Human Reproduction and Embryology (ESHRE), the major EU-based ART organization (Pennings 2004). However, Euro-American legal scholars and bioethicists continued to worry about what the phenomenon of reproductive tourism meant for reproductive rights, as well as to bioethical concerns of freedom, liberty, and patient autonomy (Blyth and Farrand 2005; Cohen 2006; Collins and Cook 2010; Ikemoto 2009; Jones and Keith 2006; Merlet 2009; Pennings 2008; Smith et al. 2009; Spar 2006; Stephenson 2009; Storrow 2005a, 2005b). Because of this focus on Europe, it came to be recognized that two European sites, Spain and Denmark, were serving as global “hubs” for egg and sperm donation, respectively (Bergmann 2011). Namely, because of relaxed regulatory environments—as well as the notable willingness of young Spanish women and Danish men to “donate” their eggs and sperm, with or without a fee—reproductive tourists from many other European nations, as well as the United States, were clamoring to these two global “hubs” in search of third-party reproductive assistance.

However, within the past five years or so, a South Asian country has also joined the ranks of “global hub.” As noted in several articles in this special section, India is now the leader in commercial gestational surrogacy—currently a \$445 million business, with the Indian Council for Medical Research projecting profits to reach nearly \$6 billion in the next few years (Pande 2011; Rudrappa 2010). With more than 250 IVF clinics and several centers dedicated to commercial surrogacy, India is now catering to infertile reproductive tourists from the West, who may be seeking cheaper services and evading various ART and surrogacy restrictions at home. Indeed, two documentary films—*Google Baby* and *Made in India*—highlight the journeys of American couples, one gay and one straight, who head to

India to hire gestational surrogates. In October 2007, *The Oprah Winfrey Show* also featured American couples who were traveling to India for this purpose.

This development of India as a global surrogacy hub has attracted criticism from legal and feminist scholars (Dolnick 2007; Jones and Keith 2006; Rudrappa 2010; Smerdon 2008–9; Stephenson 2009). According to critics, India has become the “go-to” site for surrogacy tourism only because of the willingness of poor Indian women to “rent their wombs” to affluent Western couples. Describing commercial surrogacy as the “reproductive outsourcing” of Western pregnancy (Jones and Keith 2006; Rudrappa 2010; Stephenson 2009), some feminist groups, including the Delhi-based Sama: Resource Group for Women and Health, are pushing for increasing regulation and legal protections, given the potential for exploitation and abuse of poor Indian women’s bodies (Sama 2010). Commercial surrogacy in India is an example par excellence of what anthropologist Lawrence Cohen (2005) has called “bioavailability.” Bioavailability signals the selective disaggregation of persons’ cells or tissues for reincorporation into another body, as in gamete donation or kidney transplantation, or the use of another person’s body to further the biological needs of others, as in the gestation of another couple’s fetus. The bioavailability of poor Indian surrogates to wealthy Western “contracting couples” highlights the inherent unevenness of globalization and the ways in which some parties may be disadvantaged, wronged, or even physically harmed in transnational processes (Appadurai 1996, 2001; Ginsburg and Rapp 1995; Inhorn 2003; Tsing 2005). Speaking specifically of sub-Saharan Africa, James Ferguson (2006) has coined the term *global shadows* to focus attention on resource-poor places and spaces where such disadvantage and harm may be inflicted. In a somewhat different vein, Aihwa Ong and Stephen J. Collier (2005) examine the broad structural transformations and new configurations of society and culture accompanying globalization. Calling these “global assemblages,” Ong and Collier (2005: 4) point more specifically to “technoscience, circuits of licit and illicit exchange, systems of administration or governance, and regimes of ethics or values.” Based on this definition, reproductive tourism, including commercial surrogacy, could certainly be thought of as a “global assemblage,” involving the global spread of ARTs, international circuits of traveling people and body parts, systems of clinical and tourism administration, increasing regulatory governance, and growing concern about ethics and values. Conceiving of reproductive tourism in this way ties this phenomenon to larger political and economic structures, legacies of socialism and postsocialism, the underdevelopment of medical systems in some parts of the world, consumerism in health care, and how travel trajectories may be tied up with ongoing postcolonial relations between certain countries (e.g., the United Kingdom and India).

A RELATED BUT DIFFERENT INDIAN STORY

The interest in India as a new global hub in transnational circuits of postcolonial reproductive tourism and bioavailability is an important scholarly development. However, this article attempts to illuminate a related but different Indian story. To wit, Indian couples themselves may be infertile and may be in need of ART services. However, with India's increasing focus on a Western reproductive "tourist" market, infertile Indians themselves may be "forced out" of their home country. In comparison with their infertile Western counterparts, local Indian couples may receive less individualized and privatized medical attention and poorer-quality care, leading to lower success rates, at costs that are made higher by the influx of more affluent Western ART "consumers." The inability of Indian couples to access affordable, high-quality services in their own country may "force" them to become reproductive "tourists" as well. This story of infertile couples from an ART "global hub" who are being forced to look elsewhere for ART services is a story that has yet to be told and is the main one to be illuminated in this article.

Furthermore, I argue that the subjective sense of being "forced out" of a country's ART sector should be called "reproductive exile" rather than "reproductive tourism." Following Roberto Matorras (2005), who first used the term *reproductive exile*, I and my colleague Pasquale Patrizio (Inhorn and Patrizio 2009) have elaborated on the term by citing the numerous difficulties and constraints faced by infertile patients who are "forced" to travel globally for assisted reproduction. As we note, the term *exile* has two meanings: either forced removal from one's native country or a voluntary absence. We argue that both meanings are accurate descriptors of reproductive travel. Infertile reproductive travelers often feel "forced" to leave their home country to access safe, effective, affordable, and legal infertility care. Their choice to use ARTs to produce a child is voluntary, but their travel abroad is not.

Paradoxically, reproductive exile to create a "test-tube baby" shares much in common with what is called "abortion tourism," or the quest to abort an unwanted fetus in another country owing to home-country abortion restrictions. For example, because abortion is outlawed in Ireland, many Irish Catholic women seek abortion in England and other EU countries where abortion is legal (Sterling 1997). Such "abortion tourism" is also increasing in the United States, where abortion services are being abolished in some states because of popular protests and political pressure. Reproductive travel for ARTs and abortion services are both examples par excellence of reproductive exile, despite their very different goals and motivations.¹

Furthermore, the term *exile* takes on additional meanings in the South Asian context. For Indians, as well as for many Pakistani, Bangladeshi, and Sri Lankan workers, lucrative and stable employment may be hard to find in their home countries. Thus South Asian labor-

ers, both poor and middle-class, may feel “forced” to leave home in order to secure a living wage and be able to send home remittances, to save for the future. Such labor migration, whether temporary or permanent, represents a form of “economic exile” in many cases, given that it symbolizes the dire lack of economic opportunities in one’s home country and subjective experiences of being “forced” to migrate out of economic necessity. In the case of many South Asian infertile couples, reproductive and economic exile go hand in hand. Namely, the costs of accessing ARTs may be so high that infertile couples cannot afford treatment without the extra funds accrued through dual-income labor migration abroad. In my earlier 1996 study of Egyptian ART seekers, labor migration to the Arab Gulf countries was often sought as the only way to afford IVF back in Egypt (Inhorn 2003). In my 2007 study of reproductive travelers to Dubai, the majority were South Asian couples, both Indian and Pakistani, who had migrated to the Arab Gulf for economic reasons, including the need to save money for IVF and other ART services (Inhorn 2011b; Inhorn and Shrivastav 2010). For many infertile South Asian couples, Dubai is now their “global hub” for ARTs. Despite India’s postcolonial connections to the United Kingdom, very few infertile South Asian couples are heading to London for ART services. If anything, South Asian couples living in Britain feel “forced out” of the costly and exclusionary ART sector in that country. Instead, infertile Indian, Pakistani, and other South Asian couples now look to Dubai as a global ART hub for two reasons, to be explored in this article. First, South Asia and the Arab Gulf share a lengthy history of “inter-Asian connection.” Second, Dubai, as the glittering “City of Gold” (Krane 2009), is seen by many South Asians as specializing in all manner of “high-tech” services, including information technology and health care (e.g., Dubai’s “Health Care City”). In my study of reproductive travel to Dubai (Inhorn 2010), the large numbers of infertile Indian and Pakistani couples presenting there reflected not only the long history of South Asian–Arab Gulf transnationalism but also South Asian dreams of conception in high-tech Dubai. In this article, three case studies highlight these dreams of making a test-tube baby in global Dubai.

THE ETHNOGRAPHIC STUDY

This article explores the reproductive travel of infertile South Asian couples from India and Pakistan to Dubai, one of seven emirates of the United Arab Emirates (UAE), located to the east of Saudi Arabia. In 2009 alone, the Dubai International Airport handled 38 million travelers (Aw 2010), a tribute to Dubai’s importance in global circuitries of international travel.

As the Middle East’s most “global” and “cosmopolitan” city, Dubai proved to be a fascinating site in which to study reproductive travel. In 2007 the UAE as a whole hosted eleven IVF clinics, all private concerns except for two government facilities (one in Dubai

and one in Al Ain, Abu Dhabi). My study was based in the largest private clinic in the UAE, called Conceive, the Gynaecology and Fertility Centre, which was strategically located on the border between the neighboring emirates of Dubai and Sharjah. Conceive is owned by a local UAE business sponsor and is directed by Dr. Pankaj Shrivastav, one of the original founders of IVF in the UAE in the early 1990s.² Indian-born and British-educated, Dr. Shrivastav directs a truly multinational and multisectarian clinical staff, hailing from several Middle Eastern and South Asian countries (India, Iraq, Pakistan, Palestine, the Philippines, and Sudan), as well as several major religions (Islam, Christianity, and Hinduism). Furthermore, Conceive serves three distinct patient populations: (1) local infertile Emirati couples, (2) a large expatriate community living in the UAE, and (3) many reproductive “tourists” coming from abroad, including other parts of the Middle East, South Asia, Africa, and Europe.

My study at Conceive took place from January 1 to June 30, 2007. There, I conducted in-depth, ethnographic interviews, lasting one-half to three hours, with a total of 219 individuals, representing 125 patient-couples, hailing from exactly fifty countries. The majority were Indian, followed in rank order by Lebanese, Emiratis, British, Pakistanis, Sudanese, Filipinos, and Palestinians. The IVF treatment and travel trajectories of many of these couples were followed over the course of six months. In addition, more than twenty staff members, including physicians, embryologists, nurses, and clinic managers were formally and informally interviewed during the study period. Clinic observation and photography were also conducted throughout the study, particularly in the waiting areas. Patients were generally recruited from waiting areas, where a study ad in both English and Arabic had been placed. Because English is the lingua franca of the UAE, it was the primary language used in most of the interviews.

Infertile South Asian couples made up the main patient population of Conceive and were the single largest cohort of participants in my study. I interviewed seventy-eight South Asians, representing forty-three patient-couples. The majority were Indian (thirty-three couples), followed by Pakistanis (eight couples). One couple hailed from Sri Lanka, and another self-identified as Kashmiri, although they were citizens of India. Interestingly, this was a religiously mixed population: twenty-seven of the Indian couples were Hindu, all of the Pakistani couples were Muslim, six of the Indian couples were Muslim (including the Kashmiri couple), and three of the Indian couples were Christian. The only Sri Lankan couple in this study was Muslim, because their ancestors were Muslims from Malaysia. Most of these couples had taken up residence in one of the seven UAE emirates, some having relocated there for the explicit purposes of conception.³ Many of the UAE-based couples had traveled across the various emirates seeking treatment at Conceive. Furthermore, some couples had traveled directly from India and Pakistan, while a

few had come from as far as the United Kingdom, the United States, and China.

INTER-ASIAN CONNECTIONS AND ECONOMIC EXILE

When I began my research in Dubai, I had no idea that I would encounter so many Indian and Pakistani reproductive travelers. But their stories shed light on the South Asian reproductive experience, as well as the deep ties, or “inter-Asian connections,” between South Asia and the Arab Gulf (Davidson 2005, 2008). Indeed, the UAE cannot be understood in isolation from South Asia. In many respects, the UAE is less “Arab” than “South Asian”—even though such a statement would be viewed as sacrilegious by most Emiratis. Nonetheless, in total population terms, as well as in local cultural values, the South Asian countries of India and Pakistan have had a major influence in shaping a nation that—despite its meteoric rise—is only forty years old.

Since its independence from Great Britain in 1971, the UAE, once known as the Trucial States, has been heavily dependent on South Asian foreign labor to build its new national infrastructure (Ali 2010; Davidson 2005, 2008, 2009). India in particular has been the main source of labor migration. For centuries, India was a major Arab Gulf trading partner, bringing goods from the eastern Silk Road to the Emirates via the Arabian Sea, through the Strait of Hormuz, into the Persian Gulf.

With the founding of the new Emirati state, the movement of goods from India was expanded to include the importation of male laborers (Ali 2010). By the mid- to late 1970s, Indian men, sometimes accompanied by their families, began emigrating to the UAE as workers, not only in their traditional role as merchants but also as construction contractors and laborers. For example, Indians brought with them both the equipment and know-how to dredge the Dubai canal, which soon became Dubai’s fashionable center, known for its high-rise office buildings and international hotels. The “old” Dubai Indian families who were involved in these early brick-and-mortar projects sometimes became quite affluent, setting up their own residential Indian communities, schools, and markets (Krane 2009).

Following this early wave of Indian emigration, a second and this time much more massive wave of South Asian emigrants came to the UAE in the 1990s. The emirates of Dubai and Abu Dhabi were in the midst of a financial and construction boom. Waves of male workers were imported not only from India but also from Pakistan, where the ruler of Dubai had received his early military training. Most of these South Asian laborers were employed in the construction sector, sometimes as engineers and contractors but mostly as hard-hat laborers, who lived in temporary labor camps situated throughout the country (Ali 2010). Through the work of these South Asian builders, the UAE was becoming known around the world for its uniquely iconic architecture, including the sailboat-shaped Burj Al Arab; the

Dubai Golf Club, which replicates the Sydney Opera House in miniature; the Emirates (Twin) Towers, designed by award-winning Iraqi female architect Zaha Hadid; and, most recently, the Burj Khalifa, the world's tallest building and a dazzling, upside-down icicle when illuminated at night. The UAE was also becoming a virtual mecca of global shopping. By the new millennium, the UAE was home to the largest number of major shopping malls per capita (fifty as of this writing), many of them equipped with indoor ice-skating rinks, or, in the case of the Mall of the Emirates, a mind-boggling indoor ski slope.

In 2007 the UAE Ministry of Labor published its first reliable report on the scope of the country's imported foreign labor (DeParle 2007a). While Emiratis themselves numbered only eight hundred thousand, the country hosted 4.5 million foreigners, or 85 percent of the total population of slightly more than 5 million, and 99 percent of the private workforce (Ali 2010; Aw 2010; DeParle 2007a). A full two-thirds of these foreigners were from South Asia, including more than 1 million Indians, nearly as many Pakistanis, and many workers from Sri Lanka. Before the 2008 economic crisis, which brought the Dubai construction sector to a screeching halt, nearly one-quarter of the total foreign population was employed as construction workers, the vast majority of them South Asian (Ali 2010; DeParle 2007a).

Not all of these South Asian labor migrants were male construction workers. Indeed, a significant part of the South Asian labor force in the UAE comprised women, many of them uneducated domestics who were employed in Emirati and expatriate homes as maids and nannies (Inhorn 2010). Furthermore, it is important to point out that not all South Asian migrants to the UAE were uneducated men and women. The UAE's professional classes—including health-care workers, information technology and computer specialists, engineers, bankers and financial analysts, teachers, and other educated professionals—were largely South Asian in origin (DeParle 2007b). To take but one example, Conceive was the beneficiary of this educated South Asian professional class. Not only the clinic's director but half of its physicians, embryologists, and anesthetists were from India.

Despite the existence of these strong inter-Asian connections between the UAE and South Asia, the UAE was never a true paradise for most Indian and Pakistani workers and their families (Ali 2010). The connections between the UAE and South Asia might best be described as "frayed ties," or what anthropologist Pardis Mahdavi (2011) has called "gridlock." To wit, the UAE has never extended citizenship rights to its non-Emirati foreign labor force, including its majority South Asian population. All South Asian expatriate workers, who are referred to in the Emirates as "subcontinentals" or "nonresident Indians" (NRIs), lack Emirati citizenship papers. This is true even of the oldest Indian families in Dubai, some having lived in the emirate for five generations. They do not hold Emirati passports, do not have voting rights, can be deported at will, and are generally

considered to be second-class “noncitizens.” In the national hierarchy of relative privilege, Indians (many of whom are Hindu) rank at the bottom after Pakistanis (most of whom are Muslim). Indeed, most Indians in the UAE lament their positioning in a ranked list of nationalities, with Emiratis at the top, followed by other Arab Gulf “nationals,” and then, in descending order of importance, Americans, other Middle Eastern Arabs, Europeans, Iranians, Pakistanis, Indonesians and Malaysians, and then Indians and Filipinos.

Furthermore, many South Asians in the UAE experience their lives in terms of what I am calling here “economic exile” or what another scholar of Dubai has called a “gilded cage” (Ali 2010). Lacking well-remunerated jobs back home, they migrate to the UAE simply to make money. In the “flush” period of the 1990s and early 2000s, salaries in the UAE were often two to five times higher than salaries for equivalent work in India or Pakistan. “Excess” money made in the UAE could be sent back to South Asia as remittances. Nonetheless, South Asian foreign workers, including middle-class professional couples, generally did not view the UAE as a desirable location for permanent residence. Rather, they were undertaking voluntary exile in order to provide a better life for their parents and children back home. Such economic exile was bittersweet in many cases, involving long periods of separation from family, including one’s own children, who were often left in the care of other family members. The loneliness of solo South Asian labor migration—especially for mothers and fathers—is a sad story unto itself, but one that has yet to be fully told (Inhorn 2010; Khalaf and Alkobaisi 1999).

REPRODUCTIVE EXILE IN GLOBAL DUBAI

If self-imposed economic exile is the norm for many South Asians living in the UAE, then *involuntary reproductive exile* is the term that most closely captures the subjective experience of those who are childless and are forced to travel across borders for reproductive health care. In my study at Conceive, I met many South Asian couples who felt constrained in accessing ART services in the UAE and others who felt similarly constrained “back home” in India and Pakistan. All the couples in my study had traveled at some point to receive ART services. In many cases, infertile couples had embarked on costly reproductive travel “to and fro”—from India to Dubai to India to Dubai and back again.

Of all of the nationalities represented in my study, Indian couples in particular described the medical hardships and poor-quality care they had endured in packed IVF clinics in their home country. Their decisions to travel to Dubai for ART services were often a form of escape from what they perceived as untrustworthy medical care. This was also true of the Pakistani couples in my study. As of 2007, Pakistan had only five IVF clinics, all of them opened in recent years. Pakistani couples in my study generally did not trust these clinics. More important, they hoped to evade the “technological

stigma” still surrounding IVF in a Muslim country where ARTs are deemed to be *haram*, or “religiously forbidden” (Inhorn 2003). Many of the Pakistanis and Indians in my study were traveling to Conceive under the cover of total secrecy, usually under the guise of a “holiday in Dubai.”

Yet never in my study did any couple use the term *holiday* to describe their actual experiences of ART-seeking. Patients themselves were very critical of the term *tourism* as a gloss for their reproductive travel. According to reproductive travelers themselves, the term *tourism* is highly problematic. Reproductive travel, they explain, is undertaken out of the “desperate” need for a child and is highly stressful and costly. Because *reproductive tourism* implies fun, leisure, and holidays under the sun, it is a term that is cavalier and insensitive, making a mockery of infertile people’s suffering. As one male patient at Conceive simply put it, “‘Reproductive tourism’ sounds like a gimmick.”

In my study, infertile South Asian couples described their preferences *not* to travel if only legal, trustworthy, and affordable services were made available “at home.” First, home represents a “comfort zone.” Infertile patients are more familiar with the medical system, may have developed emotional attachments to particular clinics and physicians specializing in obstetrics and gynecology, and speak the same language and share cultural assumptions with the medical staff in the home country. Furthermore, patients may have well-developed social support networks at home, including family members and friends who can be counted on to demonstrate “tender loving care” during the lengthy and sometimes physically challenging ART treatment process. In addition, infertile patients consider the pragmatics of reproductive travel—including absorbing the economic costs, making travel arrangements, finding appropriate lodging, acquiring travel visas, transporting cold-chain-sensitive medications, communicating with foreign clinics, and being away for extended periods—to be arduous. Patients often complain that reproductive travel is emotionally exhausting, financially draining, and logistically impractical and should be avoided at all costs, if possible.

Most of the South Asian infertile couples in my study were solidly middle-class. They were educated professionals who could speak English and who could afford the expenses of reproductive travel and lodging. Nonetheless, most admitted that affording the travel *and* the costs of IVF—at US\$5,000 per cycle in Dubai—was an economic hardship. Among middle-class couples, both husbands’ and wives’ salaries were required to pay for the travel and treatments. For many of these couples, taking time off from work was a major problem. Men and women who work must schedule ART cycles within the parameters of their busy lives. Traveling often involves asking for permission from employers to use vacation time, medical disability leave, or unpaid leave. Furthermore, many ART-seeking couples have major careers, which may be disrupted by reproductive travel. In my

study, South Asian men often made noble attempts to fit travel within the demands of their professional lives. However, many South Asian career women had left their professions altogether, owing to the impossible demands of balancing work with reproductive travel for ART. Women were sometimes forced to travel alone between the UAE and India or Pakistan, because their husbands were unable to “escape” demanding jobs.

In short, for South Asian and other professional couples in my study, reproductive travel was seen as jeopardizing work, especially in a time of global economic uncertainty. Because reproductive travel requires time off, the depletion of vacation and sick days, or unpaid leave, permissions must often be sought, thereby revealing infertility problems to employers. As we shall see in the stories that follow, many infertile South Asian couples desire secrecy. They also want to stay together, literally and figuratively, during the entire ART treatment process, but reproductive travel may pull them apart.

The stories of the few lower-class South Asian couples in my study were particularly poignant. Some of these long-term childless couples had migrated in order to save the money for a single ART cycle, upon which they were pinning all of their hopes and dreams. I remember the heartbreak when a poor couple from Tamil Nadu—who had been covered in sacred marigold dust on the day the ultrasound proved she was pregnant—came on their next visit only to discover that the fetal heartbeat had stopped. The beautiful and diminutive wife, dressed in a colorful sari, was rendered speechless by the sad news. The infertile husband, who was a pipefitter, blamed himself for the infertility and miscarriage, believing that he was being punished for his premarital sexual relationship with an “elderly” (i.e., older) Indian woman.

The high costs of IVF and other ARTs were problematic for most of the South Asian couples in my study, but finding cheaper services was not the only reason for reproductive travel. Table 1 summarizes the stated reasons for reproductive travel among the forty-three South Asian couples in my study. The eight “standard” reasons for reproductive tourism that are cited in the existing literature are listed first. Although seven of these reasons were mentioned at least once by South Asian couples in my study, only three of these reasons—privacy, quality of medical services, and cost—were repeatedly mentioned, as highlighted in table 1. Furthermore, the table shows quite clearly that additional reasons, such as “family interference” and “desire for doctor of same nation, language, or religion,” are important factors for reproductive travel among South Asians; the same is true for Middle Eastern infertile couples (Inhorn 2011a). The brief stories of three South Asian “traveling” couples—one Indian Hindu, one Indian Muslim, and one Pakistani Muslim—will attempt to highlight the great variety of factors compelling couples’ reproductive travel. Although the focus of this article is on India, I include a Pakistani couple’s story for four reasons: (1) Pakistan is a neighbor-

Table 1 Reasons for Reproductive Travel among South Asian Infertile Couples

Reason	Indian Couples N = 35	Pakistani Couples N = 8	Total N = 43
Legal, religious, or ethical prohibitions (donors, surrogates, fetal reduction)	5	0	5
Lack of expertise or equipment	1	2	3
Supply problems, with shortages and waiting lists	5	0	5
Safety risks	0	0	0
Prohibitions based on age, marital status, or sexual orientation	1	0	1
Medical privacy and confidentiality	14	8	22
Poor-quality medical care and low success rates	17	3	20
Cost factors, including cheaper services elsewhere	8	2	10
Family interference	4	1	5
Desire for doctor of same nation, language, or religion	6	0	6
Anchor baby with citizenship rights in Western country	0	2	2
Family support/referral	2	0	2
Lack of medical malpractice	1	0	1
Lack of clinic psychological support	0	1	1
Matching donor phenotype	1	0	1

ing South Asian country which, like India, has historical ties to the Arab Gulf; (2) like India, Pakistan has large numbers of both “economic” and “reproductive exiles” in Dubai; (3) unlike India, Pakistan is not a global epicenter of reproductive “tourism”; and (4) hence the situation for infertile Pakistani Muslim couples is a bit different from that of Indian couples, whose access to ARTs “back home” is much better. As will be seen in the three stories that follow, the reasons for and experiences of reproductive travel between “home” and “host” countries are diverse. Yet the stories share themes of economic hardship, constrained ART access, religious prohibitions and anxieties, and desires for privacy, which have “forced” these couples to Dubai in their “quests for conception” (Inhorn 1994).

SOUTH ASIAN STORIES

Beena and Atul

Originally from Hyderabad, Beena and Atul are middle-class professionals, who eventually moved to Dubai to access jobs that could underwrite the costs of ARTs back in India. However, the difficult and time-consuming logistics of reproductive travel to India have forced Beena to give up her teaching position. Furthermore, Beena describes her ART experiences “back home” in India as a “mental

trauma.” Beena told me that they had chosen to travel to Mumbai at the urging of two gynecologist friends, who claimed that India was now the global epicenter of IVF, and was especially equipped to perform intracytoplasmic sperm injection (ICSI), which was required to overcome Atul’s male infertility. Beena described the experience as “difficult and expensive”:

We were staying in Mumbai, where we have no family. We were going “up and down” the city, travelling by taxi, taking all our time just getting to the clinic. We stayed in a hotel for a month and it was *not* nearby, but we received no help from the clinic. Every time, it was coming and going, and “tourism” is *not* the right word; it doesn’t sound right at all to describe what we went through. Although we were going for our own needs, on our own, it was not for tourism. We wanted something to happen in our world. We *had* to do it, to go somewhere, to start somewhere, out of necessity. We had always planned on... we all want children at some point. And we are really wanting [children] a lot. In our culture, you’re expected to have children. And I love kids. I wanted to do it, to go to India, and him, too. I went to India because it’s my own country, and I thought it was better to do it there. But, really, now, it is not what I expected. All the expenses, moving up and down the country. It wasn’t an actual holiday, because it wasn’t comfortable at all.

Like many other diasporic Indian couples who had undertaken “return reproductive tourism” to India (Inhorn 2011a), Beena described the conditions in the overcrowded clinic, where no appointments were given and where couples were seen on a “first come, first served” basis. She and Atul often waited for four hours to have a two-to three-minute appointment with a doctor, never the same one as on the previous visit. The “rushing” team of doctors, lack of physician-patient communication, and lack of privacy among throngs of desperate patients gave Beena and Atul the sense that they were being “experimented on,” on a kind of “trial and error” basis. Indeed, the physicians in Mumbai failed to diagnose Beena’s own problem of polycystic ovary syndrome (PCOS), an ovulatory condition that is common among South Asian women. Only upon her visit to Conceive in Dubai was Beena’s PCOS correctly diagnosed.

Atul and Beena ended up spending \$14,000 on their first failed trial of ICSI, given the accompanying expenses of travel, lodging, and meals. “My husband is a businessman, so it didn’t ‘pinch’ us so much in the pocket,” Beena said. “But it *is* expensive if you’re an NRI. I have a residence permit that I renew every three years, and my husband, too. We’re expats in this country. ‘Locals’ [i.e., Emiratis] don’t face all this.”

Because Atul has a serious male infertility problem, five ICSI attempts in Dubai have yielded only one pregnancy, which ended in an early miscarriage. Beena and Atul realize that they may have to

consider sperm donation, which is not legally allowed in the Sunni-Muslim UAE (Inhorn 2011b; Inhorn and Shrivastav 2010). As Beena explained:

They do donation in India, and I think it's a very good idea. It is a good chance for people who don't have healthy sperm or healthy eggs. It helps couples get into parenthood, so it is a good idea. But I see it as a last option for us. Once ICSI is done and if we don't get results, then we will probably go to donation. But we'd have to go back [to India]. Everything is done back in India. For Hindus it's not an issue. In Islam, it is. So they don't have it here. It's very restricted! If we need egg donation or sperm donation, then we might have to go back. Otherwise, I'm quite happy doing it here. I have no other reason to go back.

Fatima and Mahmoud

Fatima and Mahmoud are an Indian Muslim couple from Kerala, who have been living in the UAE emirate of Abu Dhabi for the past six years. Fatima suffers from a painful condition of endometriosis, which has blocked her fallopian tubes. Needing a laparoscopic surgery to remove the endometrial tissue and ease the unremitting pain, Fatima and Mahmoud traveled home to Kerala, where they were charged one-fifth of what it would have cost them in the UAE. However, the surgery could not repair Fatima's tubal blockage, and she was referred by her gynecologist to the government IVF clinic in Al Ain, Abu Dhabi. They were told that the IVF cycle would be subsidized by the UAE government but that they would have to wait one to two years for their turn. They waited for two years, at which point they were told that the UAE government no longer subsidized IVF for non-Emiratis. "You know," Mahmoud complained, "we waited for two years like that—*two whole years*—before they started calling us for the initial checkups. But now, they tell us, you have to pay the full cost if you're an expat."

Believing that they were priced out of private-clinic IVF in the Emirates, Mahmoud and Fatima traveled back to India, checking on a "well-known" hospital in Karnataka. There they were told that IVF was still in the "planning stages" and that they would have to wait another one to two years. Fatima, meanwhile, was diagnosed with an ovarian cyst, which was removed by a second laparoscopic surgery. They left the hospital with a request to return in a year once an IVF clinic had been established. Upon their return to Abu Dhabi, Fatima became pregnant, but with an emergency ectopic (tubal) pregnancy, which was removed by medication. This exact same cycle—returning to India, being told to wait for IVF, undergoing laparoscopic cyst removal, then becoming pregnant with an emergency ectopic—happened a second time as well, although this time in their home state of Kerala. "After that, I was so depressed, you know," Mahmoud commented.

Eventually, Mahmoud and Fatima learned of Conceive, with its Indian physician director. When I met Mahmoud and Fatima in the clinic, they had just undertaken their first cycle of IVF, and they laughed while telling me that it had taken them a full five years to finally access this reproductive technology. Lucky for them, Fatima became pregnant on the first cycle, which they attributed to the “great job” being done by the doctor and the clinic staff as a whole. Nonetheless, as Muslims, they did not plan on telling *anyone* about the IVF. As Mahmoud explained, “IVF is not accepted. Actually, some people believe that what we’re doing is against God’s wishes. We don’t believe this, but some people do. They don’t agree with IVF.”

Although Mahmoud stressed the need for absolute secrecy to prevent “family interference,” as well as the negative judgment of others in their Indian Muslim community, he had nonetheless been forced to borrow money from his relatives. He told them simply that his wife was “receiving treatment.” “For six years, I’ve been spending all my money on this. I don’t have anything left. I’ve spent *a lot* of money over five to six years. So I took a loan from my father and his relatives. They’re helping, but I’ll pay them back. It is my wish to pay for this from my own pocket.” According to Mahmoud, his working-class, monthly salary of AED 3,000 (about US\$850) was not enough to cover the \$5,000 IVF cycle in Dubai. “It is *very* difficult to save for this,” Mahmoud explained. “But I brought her here only for this—to have a baby—nothing else. And a loan was necessary for that. And I’ve traveled a lot for this—two countries, two emirates!” But Fatima, having returned from her pregnancy scan, added the final word on our interview: “We were coming here from Abu Dhabi *very* tense. But we reached here, and we became *very* happy!”

Omar and Aneela

Omar and Aneela are another long-term infertile couple, devoted to each other despite a completely arranged marriage back in Pakistan thirteen years earlier. I spoke to Omar, who wore a long religious beard, as he sat quietly next to Aneela’s bedside. Despite a decade of residence in the UAE, this was their first IVF attempt. Omar explained their long journey to IVF in this way:

Our culture is very different. Frankly, if children are not coming, religious persons advise you. The ulama, the professors of religion, are giving advice to women. The ulama have no objection to going to doctors. But we are in the stage of fertilization [IVF] now, and some of our senior guys—the ulama—don’t feel it’s good. They don’t accept it, IVF. One doctor, Rashid Latif, made the first test-tube baby in Pakistan, in Lahore. And the popular opinion was against him. The ulama and the people, they don’t like it.

Because of this religious opposition, Omar said he spent thirteen years on “useless” medical travel to and from Pakistan, where his

wife visited many physicians for her uterine fibroids. Finally, an honest Pakistani physician told the couple that IVF was their only hope. Omar and Aneela visited a new IVF hospital in Lahore, where a cycle of IVF cost about AED 24,000 (US\$6,860). Given the high expense, the clinic was filled with wealthy Pakistani expatriates from Britain and the United States. As Omar explained:

They were Pakistanis working overseas and at top jobs, on the minister's level. It is only "high-generating" people who go to these private hospitals, Western-level people, businessmen. Regular, normal people like us, there is no way they can go to these private hospitals in Pakistan. And even the ulama and some religious types of people, it's the same thing—no. So they visit homeopathic doctors, because they can't afford private care. Governmental hospitals, most don't have IVF treatments. This is because in Pakistan, the people are not mentally prepared to get IVF treatment, so the government also is not interested to get the instruments and maintain the expenses. The private-sector doctors make IVF in their private clinics, and there are only maybe four or five in the whole country, even though the population is around maybe 200 million.

Omar then joked, "People still are bringing twelve children! We, the infertile, are saving the population! For the last thirteen years, comically, I am helping the population problem!"

Fortunately for Omar and Aneela, a kind-hearted Pakistani IVF physician told them that they should not give up on their treatment quest, even though the couple could not afford IVF in Pakistan. He directed them to the government IVF clinic in Dubai, which was state-subsidized and thus affordable for lower-middle-class couples. Yet Omar and Aneela waited three months to secure an initial appointment. "Three months is waiting *too* much," Omar exclaimed. "We should be able to come and get an appointment right away. In three months, lots can happen. Even the first appointment, the first patient visit should be immediate, so that we can move forward. But three months, mentally, this was a long time."

Put off by this long waiting time, Omar learned about "an Indian doctor" who had opened a private IVF clinic on the border of Dubai. They faced no waiting time in scheduling their first appointment at Conceive, where I met them. I asked Omar if they had any qualms about pursuing IVF with an Indian Hindu physician. Despite his religious beard and prayer-calloused forehead, Omar replied adamantly:

No, no, no! We don't have any feeling like that. Our culture is different, our religion is different, but all humans are born in God. I love all people. The media is stating we're Muslim people who like terrorism and jihad and nothing else. But we love others. We are not agreeing with jihad. We're also very loving.

Maybe you do not watch Asian movies, but they are mostly loving stories. Just see the Taj Mahal! Not all people can make the Taj Mahal! One stone is very difficult [to make]! It would be a challenge for most lovers!

Since Omar had raised the question of love, I asked him how he felt about his wife Aneela, who was still sleeping peacefully after her embryo transfer. This is what he told me:

At marriage, we had never seen each other! The first time I saw her was at marriage! But it became a love marriage. In Pakistan and among the Arab people, we *can* get a second wife. Also, in Pakistan, some families prefer to get a second wife. Actually, this is one problem for us in Pakistan. All the people feel that if a baby is not coming, it's the wife's problem. They blame the wife. But right now, the thinking, the opinions are different. It's changing. People are staying married. On the frontiers of Pakistan, no; they're getting a second or third wife normally. But the first is enough, I think! Only one is enough. Divorce is coming only for misunderstandings, and not this problem [of infertility]. Sometimes, if there is no child, there is pressure. But I love her.

Omar's love for his infertile wife had eventually led him to IVF in Dubai, where he managed to put together just enough money from the savings in his small shop to pay for the \$5,000 IVF cycle. As he said to me at the very end of our interview: "This is, in our minds, the final stage of treatment for us. *Insha'Allah* [God willing], *insha'Allah*. *Insha'Allah*, we're hopeful that after this treatment, we'll get a baby. We'll get a baby by God. But we don't need definitely positive results. We accept what our God gives us, and we're also happy if he doesn't give us a baby."

CONCLUSION

In the new millennium, Western scholars, journalists, and filmmakers have all become fascinated by the new phenomenon of medical tourism, including reproductive tourism as one of its most important variants. Particular attention has been paid to surrogacy tourism to the global hub of India, where poor women "rent their wombs" to infertile Western couples, making India the "mother destination," to use Sharmila Rudrappa's (2010) well-turned phrase. As a result of this attention, a dominant narrative of reproductive tourism has unfolded as follows:

1. Only affluent people, usually from the West, undertake medical travel.
2. Reproductive tourism is a selfish pursuit of affluent Euro-Americans who want to make a baby while "on holiday."

3. India is a global hub of Euro-American reproductive tourism trajectories, since Indian women's wombs are readily available "for hire."
4. India is already overpopulated and so does not concern itself with local infertility problems, if they exist.
5. Infertile Indians are so poor that they have little access to ARTs, let alone reproductive travel.
6. Indian men, and South Asian men more generally, would never spend the money on ARTs if their wives are infertile.
7. South Asian Muslim men are more likely to divorce or take a second wife than stay with an infertile woman.

The stories shared in this article refute many of these untested assumptions. That Indian and other South Asian infertile couples are traveling back and forth across the Arabian Sea and Persian Gulf in search of ARTs in global Dubai is an image that has been totally obscured within the dominant discourse. Thus my goal in this article has been to shed light on the stories of Indian and Pakistani reproductive sojourners, who have traveled to Dubai in their quests for conception. These quests are not "holidays"; far from it. Traveling for conception is generally difficult, even arduous; stressful, even frightening; expensive, even impoverishing. It is not done simply to satisfy a whim or a selfish desire; rather, it is done to fulfill a *need* for children, especially among men and women living within South Asian cultural settings of pronounced pronatalism.

In my view, then, reproductive exile comes closest to representing the lifeworlds of infertile South Asian reproductive "tourists," most of whom feel forced to travel in their search for conception. The need to achieve medical privacy in an unforgiving social environment, the fears of poor-quality health care and low ART success rates, and the difficulties of paying for expensive ARTs within private health-care settings are the major themes of South Asian couples' narratives. Yet these men and women also express additional concerns rarely presented in the scholarly literature. In particular, seeking the "comfort" of a familiar cultural environment within an ART treatment setting emerges as an abiding theme. For the South Asian couples in my study, Conceive felt "like home" for this reason and received extensive praise throughout the six months of my research project.

"At the end of the day"—a phrase popular among my South Asian interlocutors—reproductive travel is now part and parcel of the infertility experience among South Asian couples from India, Pakistan, and beyond. The UAE, with its majority South Asian population, has become a crucial destination in transnational circuits of reproductive mobility. Dubai in particular is the new "global hub" of South Asian reproductive travel. In some lucky cases, test-tube babies—"made in Dubai"—are the triumphant outcome of South Asian quests for conception.

ACKNOWLEDGMENTS

I want to thank Charlotte Kroløkke for inviting me to contribute to this special section. I also want to thank Biao Xiang and Mika Toyota for inviting me to participate in the National University of Singapore workshop “Reproduction Migration in Asia,” in which this essay was first presented. I also thank Holly Danzeisen and the Social Science Research Council for conference funding and logistical support. This essay was written in fall 2010 while I was the first Diane Middlebrook and Carl Djerassi Visiting Professor in the University of Cambridge Centre for Gender Studies, Department of Geography, and Downing College. I am particularly grateful to Jude Browne, Lesley Dixon, and Zeynep Gurtin, who welcomed me to the Cambridge gender studies community. In the United Arab Emirates, Dr. Pankaj Shrivastav and the Conceive staff facilitated all aspects of my research, for which am I eternally indebted. Without generous financial support from the National Science Foundation’s Cultural Anthropology Program and the US Department of Education Fulbright-Hays Faculty Abroad Program, this research in the UAE would not have been possible. Finally, I extend my most heartfelt thanks to the many infertile couples, from South Asia and beyond, who helped me understand their lifeworlds of reproductive travel, pain, and desire.

NOTES

1. I thank one of the anonymous reviewers for suggesting the reproductive tourism/abortion tourism comparison.
2. I was directed to Dr. Shrivastav by a Lebanese IVF physician, Michael H. Fakh, who had supported my earlier 2003 study of male infertility in Lebanon (Inhorn 2012). After I met with Dr. Shrivastav and explained my study to him, he welcomed me as a researcher throughout the first half of 2007. At that time, Conceive was the largest and busiest IVF clinic in the UAE, serving hundreds of infertile couples each month from many nations.
3. The seven emirates of the UAE are ‘Ajman, Umm al Qaywayn, Ra’s al Khaymah, Al Fujayrah, Sharjah, Dubai, and Abu Dhabi. Abu Dhabi is the capital and helped to “bail out” Dubai during the recent financial crisis.

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