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Diasporic dreaming: return reproductive tourism to the Middle East

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Marcia C Inhorn, PhD, MPH, is the William K Lanman Jr Professor of Anthropology and International Affairs at Yale University, as I no longer serve as Chair of the Council on Middle East Studies. A specialist on Middle Eastern gender 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 20 years. In 2010, she was the first Diane Middlebrook and Carl Djerassi Visiting Professor at the Centre for Gender Studies, University of Cambridge.

Abstract This article attempts to capture the dynamics of return reproductive tourism to the Middle East, based on ethnographic research undertaken at four different Middle Eastern locales (Egypt, Lebanon, United Arab Emirates and Arab America). Across the Middle Eastern diaspora, which is now vast, due to the disruptions of war and political violence, infertile couples often dream of making a test-tube baby 'back home' for a variety of cultural, moral and psychological reasons. These reasons – including medical expatriotism, the language of medicine, co-religion and moral trustworthiness, donor phenotype, the comforts of home and discrimination – are rarely highlighted in the scholarly literature on cross-border reproductive care. Thus, further empirical investigation is needed in order to assess additional reasons for reproductive travel beyond Euro-America. Of particular concern are the needs of 'stranded' refugee populations, who are constrained from seeking assisted reproduction technology 'back home', but who may face economic constraints and cultural discrimination in host communities. 

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Introduction

As described in the Introduction to this symposium issue, the term 'reproductive tourism' is gradually being supplanted by the more neutral term 'cross-border reproductive care' (CBRC). However, this paper retains the term 'tourism' for a specific reason, namely to draw attention to a little-known variant of reproductive travel, 'return

reproductive tourism'. Return reproductive tourism has three distinctive features: (i) a return to a 'home' country of origin to undertake assisted reproduction technology; (ii) a 'holiday' visit to family in the home country; (iii) motivation by a set of factors that are different than those usually cited in the scholarly literature on CBRC. Return reproductive tourism is undertaken by expatriate populations or those living outside their countries of birth. These

expatriates may include, inter alia, immigrants, guest workers, political exiles and refugees, all of them living in what have come to be known as 'diasporas' (Dufoix, 2008). Such diasporic populations number in the millions around the world and are heavily represented in the Western countries of the European Union, North America and Australia. Such diasporic communities may confront their own infertility problems and may face the need for assisted reproduction technology. But, instead of relying on the assisted reproduction resources and services of the host country, members of these communities dream of making a test-tube baby 'back home' for a multitude of reasons.

Such diasporic dreaming about seeking assisted reproduction 'back home' in the Middle East is the topic of this paper. With only a few exceptions (Gürtin-Broadbent, 2009; Inhorn, 2003), such return reproductive tourism among infertile diasporic populations has been little explored in the existing literature. This paper focuses on return reproductive tourism to the Middle East, among both Middle Easterners living outside the region, as well as among the region's own internal migrant populations. In focusing on Middle Eastern diasporic communities and their quests for assisted reproduction technology, three major arguments are forwarded. The first argument is historical: even before the term 'reproductive tourism' was invented at the turn of the new millennium, many infertile Middle Eastern diasporic couples were already returning to the Middle East with the arrival of assisted reproduction technology in the region in the late 1980s (Inhorn, 2003): this pattern of return reproductive tourism continues unabated in the 21st century. Second, this desire for assisted reproduction technology 'back home' is linked to a constellation of features that are cultural and psychosocial in nature, so far rarely mentioned in the literature as factors underlying reproductive tourism. Finally, for some diasporic infertile couples, the term 'reproductive exile' is a more accurate descriptor of their assisted reproduction-seeking experiences (Inhorn and Patrizio, 2009; Matorras, 2005): many Middle Eastern infertile couples are political exiles and refugees. Having left their home countries because of war and political violence (Inhorn, 2008; Inhorn and Fakh, 2005), some of these couples remain 'stranded' – unable to return home because of ongoing political violence, fear of death, lack of return visas and lack of assisted reproduction services in the war-torn home country. However, most of these refugees and political exiles lack sufficient economic resources to undertake assisted reproduction in the host country. They are a particularly tragic group of reproductive/political exiles who deserve scholarly and activist attention.

Middle Eastern diasporas

Originally, the term 'diaspora' referred to geographically scattered religious groups living as minorities among people of other faiths. However, between the 1970s and 1990s, the term diaspora was greatly expanded to encompass most contemporary forms of out-migration. As noted by French scholar Stephane Dufoix in his book *Diasporas*, "'diaspora'" has become a term that refers to any

phenomenon of dispersion from a place; the organization of an ethnic, national, or religious community in one or more countries; a population spread over more than one territory; the places of dispersion; any nonterritorial space where exchanges take place, and so on' (Dufoix, 2008, p. 2).

For centuries, the Middle East has been a site of both diasporic concentration and dispersion. For example, Armenians fleeing the Ottoman Turks settled in ethnic enclave communities in Lebanon, Syria and Egypt. Similarly, the Druze, a persecuted Shi'a Muslim minority subgroup, fled to the high mountains of Lebanon, Syria and what would become the state of Israel in 1948. In more recent years, the region has been home to significant internal and external migration, because of three historical processes: (i) mid-20th century decolonization movements across the Middle East and North Africa, some of it associated with bloody violence (e.g. Algeria); (ii) uneven regional political economies, related largely to the varying regional dispersion of oil wealth; and (iii) political violence and outright war occurring in many Middle Eastern nations over the past 60 years (Gelvin, 2005). This includes 10 military interventions by the USA alone, including its two current wars in Iraq and Afghanistan (Inhorn, 2008). In 2011, most of the revolutionary uprisings across the Middle Eastern region have involved violence and the flight of refugees, especially from Libya and Syria.

Not surprisingly, these three major factors – decolonization, uneven political economies and political violence – have led to massive population movements within the Middle East and beyond. The Middle East and North Africa have the largest percentage of migrants in the world and the world's highest proportion of internally displaced persons (Mowafi, 2011). It is probably fair to say that no other region of the world has been more affected by the population disruptions and diasporic dispersions associated with political violence. Over the past two decades in particular, 15 of the 22 Middle Eastern nation-states (roughly 85% of the region's total population) have suffered in protracted conflict situations (Mowafi, 2011). However, this figure does not include the new situations of political violence emerging since the 2011 'Arab spring'.

Among the most significant patterns of violence-related internal migration within the Middle East are: (i) the expulsion of Palestinians from Israel in 1948, with movements into Jordan, Lebanon, Syria and Palestinian enclaves in the Arab Gulf; (ii) the exodus of Lebanese to a variety of Middle Eastern countries during the Lebanese civil war (1975–1990), subsequent Israeli occupation of southern Lebanon (1990–2000) and the 2006 Israel–Lebanese 'summer war'; (iii) massive Egyptian labour out-migration, first to Iraq during the 1980s Iran–Iraq War (followed by their expulsion at the time of the First Gulf War), and then to most countries of the Arab Gulf over the past two decades; (iv) political exile of nearly half a million Sudanese to Egypt and the Arab Gulf because of Sudan's civil war; (v) two waves of Iraqi refugees, first to Saudi Arabia (with subsequent resettlement in the USA) after the First Gulf War (1990–1991) and then more than 4.8 million Iraqi internally displaced persons and refugees moving to Syria, Jordan and Lebanon in the aftermath of the 2003 US-led invasion of Iraq; (vi) 6 million Afghan refugees fleeing to

Pakistan and Iran in the aftermath of the Soviet invasion of Afghanistan (1979) and since the 2001 US-led war in that country; and (vii) on a more mundane level, movement of hundreds of thousands of educated professionals from resource-poor Middle Eastern countries to the booming Arab Gulf economies.

What is perhaps less realized is the extent to which Middle Eastern diasporic populations have simply fled the region altogether. The figures below have been compiled from a variety of United Nations and web-based sources. Of the estimated 15 million Lebanese worldwide, only 3.5 million live in Lebanon today. Nearly 7 million Lebanese are estimated to live in Brazil alone and nearly half a million in the USA, where they make up the single largest group of Arab Americans. Lebanese ethnic enclaves can also be found throughout the world, including in most parts of Latin America and the Caribbean, in French-speaking West Africa (particularly Cote d'Ivoire, Sierra Leone and Senegal), Europe, Australia and Canada. Of the estimated 11 million Palestinians worldwide, 6.6 million are refugees and nearly half a million are internally displaced persons. Nearly 1 million Palestinians live outside the region, mostly in Chile, but also in a variety of Latin American and Western countries. Following the 1979 Islamic revolution, 4–5 million Iranians left the country, primarily to North America (both the USA and Canada), Europe and Australia. Since the 1979 Soviet invasion and 2001 US-led war in Afghanistan, Afghans now constitute the world's largest refugee population, with more than 3 million Afghans fleeing to other countries, including 200,000 who have received asylum in the West. Sadly, the number of Iraqis who have received political asylum and resettlement in the West since 2003 is estimated at only 60,000, according to the United Nations High Commission for Refugees and the US Citizenship and Immigration Services.

In addition to these 'violence-created' diasporas, millions of Middle Easterners have also fled economic poverty in resource-poor countries. Nearly 18 million Syrians are estimated to live outside the Middle East, primarily in North America, Europe, South America (particularly Brazil, Chile, Venezuela and Colombia), Australia and Africa. Between 7 and 9 million Turks now live in Europe as 'guest workers', including nearly half in Germany alone. Approximately 4.5 million Moroccans live abroad, with two-thirds of these in Europe. As the former colonial power, France is home to 1.6 million Moroccans, but large populations of Moroccans also live in Spain (767,000), Italy (500,000), the Netherlands (350,000), Germany (200,000) and the USA (200,000). Because of France's history of colonialism in North Africa, millions of Algerians and Tunisians have also migrated there, especially during the 1992–2002 decade of Islamist political violence in Algeria. Nearly half a million Egyptians, both poor labourers and educated professionals, have migrated to the USA, Canada and Italy. Finally, hailing from one of the world's poorest nations, nearly 600,000 Yemenis live outside their country, mostly in India and parts of south-east Asia (e.g. Singapore), but also in the UK (80,000) and the USA (12,000). Inside the country, 7 million Yemenis live in hunger, yet Yemen has granted refugee status to 164,000 Somalis since the Somali civil war, which began in 1988 (Mowafi, 2011). Unofficial estimates of Somalis in Yemen put the figures at 1 million, further exacerbating poverty, unemployment, malnutrition and now political violence in the country.

The ethnographic studies

Given the massive scope of this Middle Eastern diaspora, it is important to understand how Middle Eastern expatriate communities deal with their infertility problems and attempts to access assisted reproduction services, including return to their home countries. This paper examines the phenomenon of return reproductive tourism to the Middle East based on anthropological studies of infertility and assisted reproduction technology in four different Middle Eastern locations (Table 1).

The first study, undertaken in 1996, in two major, private hospital-based IVF clinics in Cairo, Egypt, involved 66 assisted reproduction-seeking Egyptian women and 27 of their husbands, many of whom were currently living outside the country, mostly as middle-class professionals in the Arab Gulf. Of the 66 women patients interviewed, 18 were living abroad with their husbands in the Gulf. The primary host country was Saudi Arabia (10 of 18), but a number of Egyptian couples were also living in the smaller Gulf countries of Oman, United Arab Emirates (UAE) and Qatar. This initial study was intended to examine the introduction of assisted reproduction technology in Egypt and it included couples suffering from female infertility, male infertility or both (Inhorn, 2003).

The second study, undertaken in 2003, was based in two major IVF clinics in Beirut, Lebanon, one in a private university hospital and the other in a private stand-alone clinic. As an ethnographic case-control study of male infertility and assisted reproduction seeking, 120 infertile men (cases) and 100 fertile men (controls) were interviewed, as were 44 of their wives. Most of the men were Lebanese, but 20 were Syrian and 11 were Palestinians either living in Lebanon or in the Palestinian diaspora. Importantly, nearly half of the men in the study (exactly 100) had spent extended periods of their lives abroad, in exactly 50 different countries of residence. At the time of the study 32 of the Lebanese men were living abroad, including 11 in sub-Saharan Africa (Cote d'Ivoire, Sierra Leone, Senegal, Nigeria, Gabon, Ethiopia), 10 in other parts of the Middle East (Saudi Arabia, UAE, Kuwait, Yemen, Egypt, Tunisia), five in North America, three in South America (Brazil, Panama), two in Europe (Netherlands, Switzerland) and one in Asia (Taiwan). In addition, all 20 of the Syrian men in the study had travelled with their wives to Beirut to seek cross-border services, as had five of the Palestinian men living in the Arab Gulf (Abu Dhabi and Dubai) and Central Asia (Kazakhstan). In total, 57 of the 220 men (25%) were undertaking CBRC at the time of the study. Of these, 37 men (17% of total) were engaging in return reproductive tourism to Lebanon, primarily to undertake intracytoplasmic sperm injection (ICSI) for male infertility, but also for wives' infertility problems (Inhorn, 2012).

Following the Lebanese study, a 5-year research project (2003–2008) on infertility and assisted reproduction seeking was conducted among the Middle Eastern diasporic population in metropolitan Detroit, Michigan, the largest ethnic enclave of Middle Easterners in North America. According to the 2000 census, more than 400,000 Arab Americans live in so-called 'Arab Detroit' (Abraham and Shryock, 2000), which represents nearly 30% of the entire US Arab American population. Most of these Arab Americans live in Dearborn,

Table 1 Middle Eastern study populations.

Year of study	Country of study	No. of participants (gender)	Countries of origin ('home')	Countries of current residence ('host')	No. of return reproductive tourists	Primary type of diasporic population studied
1996	Egypt	93 (66 women, 27 men)	Egypt	Arab Gulf countries	18 (to Egypt)	Egyptian labour migrants, mostly middle-class professionals
2003	Lebanon	264 (44 women, 220 men)	Lebanon, Syria, Palestine	Sub-Saharan Africa; other Middle Eastern countries; North America; South America; Europe; Asia	37 (to Lebanon); also 20 Syrian reproductive tourists to Lebanon	Lebanese war refugees, who permanently resettled in host countries
2003–2008	'Arab Detroit', USA	95 (40 women, 55 men)	Lebanon, Syria, Palestine, Yemen, Iraq	USA	3 couples (2 to Lebanon, 1 Iraqi refugee couple to Bahrain)	Lebanese, Palestinian, and Iraqi war refugees; Syrian and Yemeni labour migrants; mostly recent resettlement in the USA
2007	United Arab Emirates (UEA)	219 (121 women, 98 men)	50 countries in: South Asia, Middle East, Europe, sub-Saharan Africa, Australia, USA	All 7 Emirates of UAE, plus 17 countries	219 reproductive travellers	Temporary reproductive tourists to UAE, as well as labour migrants to UAE, mostly middle-class professionals

a south-western suburb of Detroit, Michigan, which has been dubbed the 'capital of Arab America' and which is home to a major Ford automobile manufacturing plant. Arab Americans living in Dearborn are mostly Lebanese, Syrian, Palestinian and Yemeni migrants and refugees. But, since the First Gulf War in 1991, 80,000 Iraqi refugees also settled in this ethnic enclave community, with thousands of new Iraqi refugees arriving since 2003. Within this community, the study was based in an Arab-serving IVF satellite clinic in Dearborn, where 95 Arab Americans – 55 men and 40 women, including 31 couples together – were interviewed. Most of the Arab Americans in the study were from Lebanon, Iraq and Yemen (in that order), but several Palestinians, Syrians and one Moroccan immigrant were also included (Inhorn and Fakh, 2005). As in Lebanon, the initial focus of this study (2003–2005) was on male infertility and ICSI, but later included couples with female infertility problems.

The final study was undertaken in 2007 in the then-booming Arab Gulf country, the UAE. This study was focused specifically on the phenomenon of reproductive tourism. It was based in the UAE's largest private IVF clinic, located on the border of the neighbouring emirates of Dubai and Sharjah. There, in-depth ethnographic interviews were conducted with 219 reproductive travellers, representing 125 infertile couples hailing from exactly 50 countries. The majority were Indian, followed by, in rank order, Lebanese, Emiratis, British, Pakistanis, Sudanese, Filipinos and Palestinians. The treatment and travel trajectories of these couples were explored, including, in some cases, return reproductive tourism to a variety of Middle Eastern countries (Inhorn and Shrivastav, 2010).

In all of these studies, interviews were conducted in either Arabic or English, depending upon the preference of the interviewee. Generally speaking, the interviews were unstructured and followed a basic interview guide constructed by the author. In all of the interviews undertaken in Lebanon and in about half of those in Arab Detroit, a semi-structured reproductive life history interview was also administered to all of the men in the study, in order to understand their experiences of male infertility and assisted reproduction seeking. In general, interviews lasted about 1 h, although they ranged in length from 0.5 to 3 h. All interviews were conducted in private rooms, usually within the clinics themselves and occasionally in research subjects' homes. In the initial stages of research in both Egypt and Lebanon, a local research assistant was present. However, most interviews were conducted by the author alone. All research subjects were asked to read and sign an informed consent form in either Arabic or English. Consent for the research was received from the Institutional Review Boards at the author's home institutions (Emory University for the 1996 study, University of Michigan for the 2003–2008 studies. In July 2008, the author moved to Yale University).

Return reproductive tourism to the Middle East

As noted earlier, the phenomenon of return reproductive tourism began long before the term 'reproductive tourism' was ever coined. In the 1996 Egyptian study, a pattern of return reproductive tourism was noted among mostly middle- and upper-middle-class Egyptian labour migrant cou-

ples, who were returning from the Arab Gulf during their annual summer leaves. Because the Arab Gulf states are unbearably warm during the summer months, many migrant couples return to Egypt during July, August or September. During this 1-month holiday back home, infertile Egyptian migrant couples may attempt a single assisted reproduction cycle in an Egyptian IVF clinic. As a result, IVF clinics in Cairo are packed with return reproductive tourists during the summer months (Inhorn, 2003).

According to Egyptian migrant couples in this study, three major factors underlay their transnational treatment quests: (i) the greater affordability of assisted reproduction services in Egypt versus the Gulf countries; (ii) greater trust in Egyptian medicine over medicine in the Gulf; and (iii) the perceived ease and comfort of undertaking assisted reproduction in a familiar environment, including staying temporarily in one's natal home with supportive parents. Thus, these visits to Egypt were, in some sense, 'IVF holidays' in that they combined dimensions of treatment-seeking with pleasure and relaxation. On the other hand, virtually all of the Egyptian couples in the study emphasized that undertaking IVF 'back home' often ruined their annual vacations. These visits to Egypt included the stresses of hormonal injections, daily trips to IVF clinics for follicular monitoring, costly and time-consuming surgical egg retrievals and embryo transfers, and, in many cases, the perceived need to hide the IVF cycle from most, if not all, family members. Because ICSI to overcome male infertility had just been introduced to Egypt at the time of the study, it was especially shrouded in secrecy (Inhorn, 2003). Thus, couples with an infertile husband were often attempting to maintain complete medical privacy while, at the same time, achieve holiday-like merriment with family members. Balancing levity with medical embodiment of assisted reproduction technology – all during a single summer month in Egypt – was often profoundly difficult to achieve. It is also important to note that, in some cases, labour migration in the Gulf had preceded the discovery of the couple's infertility. However, in other cases, couples had chosen to migrate to the Gulf precisely because they needed the higher incomes necessary to generate cash for assisted reproduction seeking back in Egypt.

In the second study in Lebanon, which focused on male infertility, a similar pattern of return reproductive tourism for ICSI was discovered. As in the Egyptian study, some Lebanese men were working as temporary expatriates in the Arab Gulf. However, most were permanent residents of other countries, having fled during *al harb* (the war), which lasted from 1975–1990. During the civil war period, almost one-third of the Lebanese population fled the country, especially young men, whose families wanted them to avoid conscription or militia involvement. Many Lebanese youth were sent to the Arab Gulf to work. Others were sent to live with family members or friends already residing outside of the Middle East, particularly in West Africa.

Of the 32 Lebanese return reproductive tourists interviewed in Beirut IVF clinics in 2003, their reasons for returning to Lebanon were quite similar to those offered by Egyptians. In general, they cited: (i) increased affordability of assisted reproduction technology in Lebanon, especially for those living in North America; (ii) increased trust in Lebanese medicine over medicine in the host country, espe-

cially for those living in other Middle Eastern countries; and (iii) desire to experience an assisted reproduction cycle in the midst of a supportive family environment. However, for Lebanese living in West Africa, they were essentially 'forced' to return to Lebanon, because of a lack of assisted reproduction services in their host countries. Sub-Saharan Africa is a major region of the world where assisted reproduction services are relatively absent (Inhorn, 2009). Of the 191 WHO member states, only 48 had medical facilities offering assisted reproduction technology as of 2006 (Nachtigall, 2006). Assisted reproduction facilities are absent in the majority of the 34 sub-Saharan African nations, which are struggling with life-threatening diseases such as HIV/AIDS, neonatal and maternal mortality, malaria and tuberculosis (Okonofua, 1996). Although Lebanese diasporic communities in West Africa are often comparatively affluent, assisted reproduction technology is simply not available in host countries. For example, with 100,000 Lebanese living in Abidjan, the capital of Cote d'Ivoire, the city hosts a Lebanese hospital with Lebanese physicians. However, there is no IVF clinic in that hospital or in the country as a whole. It is also important to point out that, as of 2011, political violence in Cote d'Ivoire does not bode well for the diasporic Lebanese community in that country.

In Arab America, on the other hand, the situation was reversed. Assisted reproduction services are readily available. However, the average price of one assisted reproduction cycle in the USA is more than US\$12,000 (Spar, 2006). There are very few American 'mandate states', which provide either full or partial assisted reproduction subsidization to state residents. Furthermore, very few US insurance companies cover the complete costs of an assisted reproduction cycle. Thus, most Americans pay for assisted reproduction services entirely out-of-pocket, which is why less than 1% of infertile Americans ultimately conceive through IVF and related technology (Spar, 2006).

This was certainly true of the infertile Arab American couples in the Dearborn study. With few exceptions, most of those interviewed were either war refugees or political exiles from Lebanon and Iraq or economic refugees from poor rural communities in Yemen. The vast majority of these infertile Arab Americans were impoverished, working in unskilled positions without medical benefits. Many of them could barely pay for office visits (at US\$150), let alone the cost of a single assisted reproduction cycle (Inhorn and Fakh, 2005). Among the total group of nearly 100 interviewees, only 19 ICSI cycles had ever been undertaken – but six of these had been tried by one upper-middle-class Lebanese couple, twice in the USA and four times through return reproductive tourism to Lebanon. Among the remaining 13 ICSI cycles, two had involved return reproductive tourism to the Middle East (Lebanon, Bahrain). The rest had been performed in the USA under great financial duress. Couples in the study had taken out bank loans or loans from friends and family, had sold the wife's bridal gold or family land in the home country, or put the entire cost of the ICSI cycle onto a credit card, going deep into debt in the process.

Indeed, financial duress was a major theme of these Arab American interviews, as was the deep demoralization of ICSI failures. Of the 19 total ICSI cycles, only two children – both

ICSI sons of Iraqi refugees – had been born, one as a result of travel to an IVF clinic in Bahrain, a small Arab Gulf island nation near Iraq. It is important to note that, at the time of this writing, there were no functioning IVF clinics in most of Iraq, including the capital city of Baghdad. Iraqi couples who require assisted reproduction technology must travel to Mosul, a Kurdish-dominated city in the northern territory of Iraq, where Kurdish is spoken as the first language. Those Iraqis who can afford to do so may travel to the neighbouring countries of Syria, Jordan and Iran, each with its own active assisted reproduction sector (Abbasi-Shavazi et al., 2008). Although once renowned for its medical infrastructure and high level of medical expertise, Iraq has experienced the decimation of its medical system during the current war, including the targeted killing of medical personnel by militia groups and the subsequent flight of most qualified physicians from the country (Inhorn, 2008; Inhorn and Kobeissi, 2006). Many of these physicians have settled in neighbouring Middle Eastern countries, such as Syria, Jordan, Lebanon and Egypt, and a few have been given political asylum in Western countries, including the USA.

Diasporic dreaming: return reproductive tourism 'back home'

Why do diasporic Middle Eastern infertile couples dream of making a test-tube baby back home? Over the series of studies described above, five major factors pulling infertile diasporic couples 'back home' have become apparent. A sixth factor – perceived cultural discrimination – serves as a push factor for some couples, who believe that they are either treated unfairly or neglected in a host country's medical system. Interestingly, none of these factors are the ones repeatedly cited in the CBRC literature (i.e. laws, religion and ethics, costs, lack of services, shortages and waiting lists, safety, category exclusion, privacy, quality of care, success rates). This list of standard factors emphasizes the 'push' toward travel: couples feel forced out of their home countries by various restrictions, constraints and pragmatic reasons such as comparative costs. Alternatively, with return reproductive tourism, on the other hand, the desire to travel is fuelled by a number of cultural, moral and psychosocial 'pull' factors, described below with accompanying ethnographic vignettes.

Medical expatriatism

Middle Eastern expatriates living in diasporic communities abroad often maintain both patriotic and nostalgic attachments to home, even if they have never lived in the home country. Such patriotism may be manifest in feelings about the relative superiority of home-country medical services versus those in the host country. Such medical expatriatism (Inhorn, 2003) is clearly found among both Egyptian and Lebanese expatriates, who are often convinced of the superior medical professionalism and experience to be found in home-country assisted reproduction clinics. Among Egyptians, this medical expatriatism is rooted in the fact that Egypt was one of the first three countries to initiate assisted reproduction technology in the region, as well as Egypt's

long history of medicine and large number of medical schools. As a result, many Egyptian expatriates declared Egyptian assisted reproduction services to be more 'professional', 'advanced' and 'experienced' than those of host countries, including the Arab Gulf.

Interestingly, these were the same three adjectives used by Lebanese expatriates to describe Lebanese assisted reproduction centres and physicians. Even though Lebanon was a relative latecomer to assisted reproduction technology – opening its first centres nearly a decade later than Egypt because of delays caused by the civil war (Inhorn et al., 2010) – pre-war Lebanon was often touted as the 'Switzerland of the Middle East', and Beirut was compared with Paris. Pre-war Lebanon was known for its excellent medical education and services, with a highly functioning medical system and many Western-trained specialists. According to most Lebanese expatriates, Lebanon's spirit of entrepreneurialism and resilience could never be thwarted. Thus, they trusted the post-war medical system in Lebanon, including its fairly new assisted reproduction clinics (begun in the mid-1990s), more than they trusted assisted reproduction services in their host countries. Interestingly, this was true even among Lebanese expatriates living in Europe and North America. Many of them touted the better 'experience' of Lebanese IVF physicians over American, Canadian or European counterparts. As one Lebanese living in Dearborn told me, 'Don't forget! In Lebanon, they've got experience for this one [assisted reproduction technology] better than here. For this one [assisted reproduction technology], Lebanon probably has better experience than the US.' A Lebanese woman living in Dearborn explained, 'Medicine in Lebanon is, what do you say? It is like "progressive", and I trust them.' Another Lebanese expatriate put it even more strongly, 'Honestly, Lebanese medicine is number one in the world! We're confident one hundred per cent.'

Such patriotic pride in one's country and its medical system is a compelling reason for many Middle Eastern infertile couples to return home. Even Iraqi refugees spoke with pride about Iraq's pre-war medical field. One young Iraqi refugee couple reminisced about their country in this way. According to the husband, 'We both left Iraq when we were young, and so we really don't know how the medical field is now. But they were very good, sincerely good, and [there were] a lot of very good Iraqi doctors, very smart doctors.' His wife added, poignantly, 'I would like to go and visit, but maybe not now. Not until the war is over. I would love to go back home to Iraq. But if you want to go back home and you see your country and feel bad all the time, you will just go there and get depressed.'

Language of medicine

A second major factor compelling return reproductive tourism is a linguistic one: undertaking a cycle of assisted reproduction technology involves a complex 'ontological choreography' (Thompson, 2005), accompanied by an arcane medical language. Learning this medical language is difficult enough for many infertile couples who are natives in the country of treatment seeking. However, for Middle Eastern diasporic couples who speak Arabic as their first –

and perhaps only – language, the thought of going through the complexities of an assisted reproduction cycle in an unfamiliar linguistic register is incredibly daunting. Thus, many of these couples prefer to return home in order to speak the same language as the assisted reproduction staff and, hence, understand the medical terminology, instructions and explanations delivered to them. In the Arabic-speaking world, the vocabulary and language of assisted reproduction medicine is delivered to patients in Arabic. Indeed, Arabic assisted reproduction discourse is rich with ‘seeds’, ‘planting’, ‘spermatic animals’, ‘microscopic injections’, ‘babies of the tubes’ and the like (Inhorn, 2003).

The importance of familiar medical language in one’s native tongue cannot be underestimated. This is especially true for monolingual Arabic speakers. In the Dearborn study, for example, exactly 40% of those interviewed spoke no English whatsoever or managed to get by in barely functional ‘broken English’. This was especially true of Yemeni migrants, especially Yemeni wives, many of whom were illiterate in both Arabic and English. For Iraqi refugees, especially those entering the USA in the aftermath of the 2003 invasion, most infertile couples in the study were still struggling with English. Even some Lebanese, the most ‘acculturated’ group of expatriates in Arab Detroit, were not proficient in English, especially if they had fled Lebanon in the aftermath of the 2006 Israeli–Hizbullah summer war.

As many of these monolingual Arabic speakers explained, they had come to the particular study clinic because of its Arabic-speaking physician and clinic receptionist. Several couples in the study had actually travelled great distances across state borders to access the particular Arabic-speaking clinician. For example, following an 8-h drive, an Iraqi refugee couple explained, ‘We came here from Nashville because the doctor is Arab. When we ask him about our case, he understands us. But the doctors in Nashville don’t.’ The husband added, ‘We tried too much in Nashville, with three different American doctors. We met a nice American woman doctor who tried to help us. But I’m coming here now because at least we can speak Arabic, and it takes someone who can do that to really understand our problem.’ Similarly, a young Lebanese woman who had flown to Michigan from Mississippi commented, ‘I live with my husband in another state, but I came here just to see the doctor, because I need an Arab doctor. It doesn’t matter if he’s Lebanese or not, but I just need to understand everything in Arabic. I can talk English, and I can understand, but the questions about these medical things are going to be easier for me in Arabic.’

Co-religion and moral trustworthiness

In addition to linguistic similarity, many Middle Eastern couples want to receive assisted reproduction technology from a physician of a similar religious background. For most Middle Easterners, this means seeking out an assisted reproduction practitioner who is a Muslim. The reasons have less to do with a sense of Muslim moral superiority than with the belief that a Muslim co-religionist will understand the particular Islamic bioethical considerations surrounding assisted reproduction technology. These Islamic guidelines

are rich and complex (Clarke, 2009; Inhorn, 2003; Inhorn and Tremayne, in press; Serour, 2008). Suffice to say that the dominant Sunni branch of Islam – constituting nearly 90% of the world’s Muslims – disallows any form of third-party reproductive assistance, including egg donation, sperm donation, embryo donation or surrogacy. For Shia Muslims, on the other hand, third-party reproductive assistance has been allowed by Ayatollah Ali Hussein al-Khamene’i, the Supreme Leader of the Islamic Republic of Iran. Hence, donor technology and surrogacy are now widely practised in Iran and also in Lebanon, which has followed the Iranian lead (Abbasi-Shavazi et al., 2008; Clarke, 2009; Clarke and Inhorn, 2011; Inhorn, 2006; ; Inhorn, 2011; Inhorn and Tremayne, in press).

For Sunni Muslim assisted reproduction patients, then, the major moral concern is avoiding any kind of third-party donation, either intentional or accidental (i.e. through medical negligence). Sunni Muslim assisted reproduction patients are often concerned about finding a Sunni Muslim physician who runs a clinic where donor technology is never employed. Issues of moral trustworthiness are clearly at stake. A Sunni Muslim physician, it is argued, will understand patients’ fears about ‘mixing’ (of gametes and embryos). A Sunni Muslim assisted reproduction practitioner will be particularly morally trustworthy in this regard, paying special attention to the labelling of specimens, the laboratory handling of gametes and the transfer of embryos, in order to avoid the ‘three Ms’ – mixtures, mix ups and mistakes – at all costs. Furthermore, because of moral injunctions against ‘touch and gaze’ across genders, some pious Sunni Muslims prefer an assisted reproduction practitioner to be female, so as to avoid the ‘male gaze’ in the intimacy of a gynaecological setting.

A Lebanese labour migrant explained his wife’s reluctance to attempt IVF with a well-known Indian Hindu physician practising in the UAE. ‘My wife still had the feeling, “How am I going to start treatment with a non-Muslim?” First of all, he’s a man, but she prefers a lady [physician]. Second, he’s non-Muslim. She mentioned it one time ... and then she didn’t mention it anymore. It was a kind of anxiety; she was not feeling comfortable because he is not Muslim.’ He added, ‘Her family [members] are religious, and they practise the religion, and they are sharing her decision about the need for a Muslim doctor.’ Because of his Syrian wife’s desire for a co-religionist, this Lebanese migrant, who was living in Dubai, flew to Lebanon five times over a period of 6 years to undertake ICSI, never achieving a single pregnancy. In desperation, his wife finally agreed to try ICSI with the Indian doctor in the UAE. Fortunately, they succeeded on their first attempt, bearing a healthy ICSI daughter.

Donor phenotype

Shia Muslims, too, often want a co-religionist and ideally a female Muslim assisted reproduction physician, particularly if they are religiously pious. However, for those Shia Muslims who accept the idea of third-party donation, they are often concerned about achieving phenotypic similarity with the donor, which, they argue, can be better achieved by returning to the home country. A donor of similar phenotype

is desired mostly for the sake of the donor child; a child who looks 'Arab' or 'Middle Eastern' will be believed to be the biological offspring of the infertile couple. This, in turn, will prevent future uncertainty, curiosity, scepticism or ridicule, especially given that donor technology is a relatively recent innovation in the Middle East (ca. 1999) and not widely accepted by the Muslim majority.

Having said this, both Iran and Lebanon, the only two Muslim-majority countries in the world where donor technology and surrogacy are practised, are becoming the sites of donor-driven return reproductive tourism, as well as more general cross-border reproductive travel among Middle Eastern couples of all religious backgrounds who are seeking donor gametes and surrogacy. In general, egg donation is much more widely accepted than sperm donation, and sperm donation is more common than surrogacy (Inhorn, 2012). In Iran, embryo donation is also widely practised, although less so (if at all) in Lebanon. Nonetheless, both Iran and Lebanon are becoming known in Middle Eastern circles as sites of third-party reproductive assistance. Increasingly, infertile Middle Eastern couples of all religious backgrounds – Sunni, Shia, Druze, Catholic, Orthodox and Protestant – are travelling to these two countries to access donor gametes, particularly donor eggs.

For example, during the 2003 Lebanese study, 11 couples were utilizing donor gametes, including six couples who had travelled to Lebanon for this purpose. Three were Syrian reproductive tourists, one was Palestinian living in Dubai, but two were Lebanese return reproductive tourists living in Kuwait and the USA. These 11 couples were religiously diverse: three Shia, four Sunni, one Druze, one Maronite Catholic, one Greek Orthodox and one Armenian Orthodox. In 10 of the 11 cases, donor eggs were being sought. Only one infertile man in the study – a Shia Muslim who followed the clerical directives of Ayatollah Khamene'i in Iran – had actually accepted donor spermatozoa, in this case, from a Lebanese medical student.

In short, the Shia Muslim permission of donor technology emanating from Iran has served to weaken the Sunni Muslim ban on this practice, thereby initiating a new form of reproductive tourism back to the Middle East, which is driven by donor phenotype. A Lebanese–Palestinian couple attempted to explain their desire for an egg donor who resembled either the light-skinned 'white' husband or the olive-skinned 'brown' wife. According to the husband, 'People here will say it's okay. Nothing's wrong, because I am white. Also, if my wife does not get a white child, it's okay. I'm white, but she's brown, so if the baby is brown, it's no problem. But if the baby is coming Filipino, then that's a problem, and I will refuse it! That means that one man who is Filipino slept with my wife! Or that's what people will say if my wife uses eggs [sic] from a Filipino.' Clearly, in this couple's local moral world, not only the baby's future, but the wife's moral reputation is also at stake, which is why achieving donor phenotypic similarity is deemed crucial.

Comforts of home

In addition, many husbands are concerned that their wives should experience assisted conceptions under optimal cir-

cumstances, surrounded by the tender loving care of family members, especially the wives' mothers. In the Middle East, mothers and daughters are often extremely close, deeming each other to be 'best friends' in life (Inhorn, 1996). Thus, if there is a single family member who knows about a couple's assisted reproduction seeking, it is generally the wife's mother, and often the husband's mother as well. Not surprisingly, Middle Eastern IVF clinic waiting areas are often crammed with elderly women, who are there to support their daughters and sons through the trials and tribulations of the 'operation' (as egg retrievals and embryo transfers are called).

Not only is such maternal support deemed psychologically comforting, but many diasporic infertile Middle Eastern couples maintain an ardent belief that they will become pregnant if they can somehow manage to try assisted reproduction technology in the home country. Return reproductive tourism back home is deemed more 'relaxed', more 'familiar' and more 'comforting' – in short, much less stressful than attempting to access assisted reproduction technology in an unfamiliar host-country clinical setting. This belief in the psychosocial benefits of simply being 'at home' while pursuing assisted reproduction technology is an important factor and a repeating theme among reproductive tourists of all kinds. Indeed, in the study of reproductive travel undertaken in the UAE, most travellers were adamant about the 'comforts of home' and the importance of being in the home environment, if possible, when undergoing an assisted reproduction cycle (Inhorn and Shrivastav, 2010).

A young Lebanese couple, married for 6 years, had been unable to become pregnant since arriving as immigrants to Dearborn. They were frustrated by their diagnosis of unexplained infertility and were seriously considering returning to Lebanon to undergo IVF. As the husband explained, 'Actually, I was thinking of going back to Lebanon, because she believes that better doctors are over there, and also that she can get pregnant "by her family"'. Her mother is over there. Her father passed away, but her mom is there and she went to a few doctors to ask about my wife's case. If [my wife] went back there, it's better for her. Her mom, she also thinks that if [my wife] goes there, she can get pregnant.' He added, 'It's not an issue of money. IVF is cheaper there, but it is more about what she believes. She's never been back to Lebanon since she got here in 2003. Psychologically, this could be a good reason to go back.'

Discrimination

One of the reasons why Middle Eastern infertile couples may want to return home is that they do not feel comfortable in host-country assisted reproduction clinics. Subtle and not-so-subtle forms of cultural discrimination may be at work, especially for Arabs and Muslims in a post-9/11 world (Inhorn and Fakih, 2005; Inhorn and Serour, 2011; Shaheen, 2008). During the studies in Lebanon and Dearborn, several cases of outright medical discrimination were reported during interviews with infertile couples. For example, a Shi'a Muslim man living in Lebanon had been seriously injured in a car accident. He sought emergency medical care in Lebanon, but was referred for rehabilitation to the USA. Unfor-

tunately, he was denied an exit visa by the US Embassy in Beirut, because he lived in the Hezbollah stronghold of Baalbek. His lack of full recovery left him partially paralyzed and impotent, thus requiring ICSI with testicular aspiration in order to conceive.

In a somewhat different case, a Lebanese refugee living in the Netherlands was denied referral for ICSI by his Dutch primary care physician following a diagnosis of azoospermia. The Dutch physician, who was not an infertility specialist, deemed azoospermia to be 'hopeless' and repeatedly refused to refer his Lebanese patient for further fully subsidized medical evaluation within the Netherlands. Eventually, this Lebanese man accrued enough money to return to Lebanon, where ICSI with testicular aspiration (costing US\$5000) led to the birth of a healthy son. At the time of his interview, this new father was justifiably angry at 'those Dutch doctors'. He described his plan to petition the Dutch government for reimbursement of all his treatment and travel expenses and was collecting the necessary documents from the Lebanese assisted reproduction clinic.

Other examples of discrimination – or at least profound lack of cultural sensitivity – abound. For example, a young Yemeni couple, married for 11 years, described their dream of seeking assisted reproduction technology back in Yemen, if they could only afford it. The wife lamented the discrimination they had faced at the hands of American physicians. 'Some doctors in Yemen are so-so, but some are good and specialized. I wish I can go to Yemen [for assisted reproduction technology], because it is not the same as here.' She continued, 'If the doctors here were Arab, we can trust them more than Americans. When we went to the doctor [from a town in Michigan], he was an American male. We told him that we want a child, and he told us, "Why are you coming?!" "We want pregnancy." "You're young! You are babies!" "No, I want." "What we think about you – we think you're babies." "No, I'm not a baby.'" In this dialogue, the physician's blatant misrecognition of a young Yemeni couple's justifiable desire to have a child after 11 years of marriage is all the more egregious because of the perceived name-calling – i.e. telling an adult couple that they are 'babies', too young to be parents. The Yemeni wife in this story is remarkable for defending herself – in English – to the offensive American male physician. In so doing, she claims her right to be perceived as an adult and a potential mother of an American child.

Conclusion

This article has attempted to capture the dynamics of return reproductive tourism to the Middle East. Across the Middle Eastern diaspora, infertile couples often dream of making a test-tube baby 'back home' for a variety of cultural, moral and psychological reasons. These reasons are not the standard ones already highlighted in the scholarly literature on CBRC. Thus, further empirical investigation of different forms of reproductive travel – and in different regions of the world beyond Euro-America – must continue into the future.

As shown in this paper, three issues haunt the Middle Eastern diaspora at the time of this writing: (i) ongoing forms of political violence, which have forced so many

Middle Easterners into refugeeism and exile in host countries; (ii) the many constraints, economic and political, that prevent them from returning to their home countries to seek assisted reproduction technology; and (iii) the levels of discrimination faced by Middle Easterners in post-9/11 Euro-America, including in medical facilities. As a result, diasporic dreams of Middle Eastern test-tube babies are unrealistic for many infertile but 'stranded' refugee couples. How to best address the infertility of refugee populations – those who have been forced to travel to save their own lives – is a troubling question for reproductive health professionals in the new millennium.

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