


# TRANSFORMING



# Ethnographic Knowledge

Edited by Rebecca Hardin and Kamari Maxine Clarke



---

# Transforming Ethnographic Knowledge

Edited by

REBECCA HARDIN

and

KAMARI MAXINE CLARKE

The University of Wisconsin Press

recollection of the past. This debate is a form of "dialogue," but so are the moments when worshippers from diverse locales choose to highlight the sameness of similarly named gods, their shared autonomy from Christian authority, and "Yoruba" religion's unique worthiness of respect among black Atlantic religious traditions.

Applied to this case, the "creolization" metaphor aptly captures the historical importance of diverse subordinate groups' mutually transformative interaction in the context of Euro-American dominance. However, with its assumption that African American cultures are essentially local phenomena requiring local explanation, the "creolization" metaphor entirely overlooks that translocal context of local identity-making, collective self-legitimization, and the struggle for authority. Far more than "survival," "roots," "collective memory," "creolization," "ships," and "rhizomes," the "dialogue" metaphor renders the ironic completely comprehensible. Sometimes, the whitest among us—like Antonio Castañeda Márquez and the Italian *candomblecistas* of São Paulo—become the most African. Such is the power of metaphor in self-fashioning, and such is the power of "dialogue" over mere "roots," "survivals," and "collective memories."

## Diasporic Dreaming

*"Return Reproductive Tourism"*  
to the Middle East

MARCIA C. INHORN

### The Ethnography of an Emerging Global Technology

In 1978, Louise Brown, the world's first in vitro fertilization (IVF) baby, was born in England. In 1980, the first Islamic *fatwa* on medically assisted reproduction was written, allowing IVF to be undertaken by infertile married Muslim couples. In 1986, the first IVF clinics opened in three Middle Eastern Muslim countries, Egypt, Jordan, and Saudi Arabia. In 1988, while still a medical anthropology graduate student, I arrived in Egypt in an attempt to understand the infertility experiences of poor urban women seeking biomedical treatment in a public maternity hospital in Alexandria. This particular hospital aspired to offer IVF to Egypt's poor; thus, women were clamoring to the clinic from all over the country. Indeed, by 1991, the hospital's first IVF baby was born (Inhorn 1994). In that same year, intracytoplasmic sperm injection (ICSI), a variant of IVF designed to overcome male infertility, was introduced in Belgium. And by 1994, IVF physicians in Cairo had brought ICSI to Egypt, creating massive demand for this new assisted reproductive technology (ART). In 1996, I returned to Egypt to study the experiences of mostly elite infertile Egyptian couples who were seeking access to both IVF and ICSI (Inhorn 2003). Many of these Egyptian couples were transnational labor migrants to the petro-rich Arab Gulf who were returning on "IVF holidays" to Egypt. Although the term *reproductive tourism* had yet to be coined by the media, it was clear that Egyptian couples were crossing international borders in their "quests for conception" (Inhorn 1994).



By 1999, what had been a majority Sunni Islamic ban on third-party reproductive assistance—that is, no sperm donation, egg donation, embryo donation, or surrogacy—was effectively broken when Iran's leading Shia Muslim ayatollah issued a *fatwa* allowing donor technologies to be used as a “marriage savior.” By 2000, clinics in Shia-dominant Iran and Lebanon had begun to offer third-party reproductive assistance to their infertile patients. In 2003, I relocated my study to Lebanon, where I found burgeoning demand for donor technologies, especially egg donation, among infertile Muslim couples (Inhorn 2012). Not all of these couples were Shia Muslims or Lebanese. Indeed, numerous Syrians, Palestinians, and couples from other Middle Eastern Muslim countries were arriving in Beirut on secret “IVF holidays” to use IVF or ICSI with donor eggs. In addition, infertile Lebanese couples were flocking back to Beirut from the diaspora. Having fled the country during the fifteen-year (1975–90) Lebanese civil war, they were “coming home” to make their “test-tube babies” in a place of cultural comfort.

Having observed these Middle Eastern “homecomings,” I decided to relocate my study of assisted reproduction to a “sending” community in the heart of Arab America. My field site was Dearborn, Michigan, an ethnic enclave community with the largest number of Arabs in North America (Abraham and Shryock 2000). There, I found numerous Middle Eastern infertile couples who were dreaming of making an IVF baby “back home” in the Middle East. Over five years (2003–8), I studied these couples’ longings for children, as well as their diasporic dreams of pursuing affordable ARTs in the Arab world. In 2007, I traveled to the Middle East’s only “global hub” city—namely, Dubai in the United Arab Emirates—to follow the return trips of Middle Eastern infertile couples from the diaspora. In Dubai, I found not only diasporic Middle Eastern returnees but also hundreds of infertile couples from around the globe, engaging in what scholars and media pundits were now calling “reproductive tourism,” “fertility tourism,” “procreative tourism,” or, more neutrally, “cross-border reproductive care” (CBRC) (Gürtin and Inhorn 2011).

In short, what began as a medical anthropological study of infertility among Egypt’s poor emerged over time into a multisited ethnographic investigation of an emerging global technology and its uses in the Muslim Middle East. In my ethnographic studies of ARTs, the term *emergence* has special resonance. As defined by Raymond Williams (1978, 125), emergence involves “new meanings and values, new practices, new relationships and kinds of relationship [that] are continually being created.” In the world of assisted reproduction, *emergence* is everywhere. First, the technologies themselves are emergent—for example, ICSI evolved as a subtle but revolutionary variant of IVF (Inhorn and Birenbaum-Carmeli 2008). Almost as soon as these new technological variants arrived, they globalized rapidly

(Inhorn 2003), creating new local markets and consumer demands (Spar 2006). Bioethical discourses surrounding these technologies—for example, whether donor technologies are permissible—are also emerging, in the Islamic world as elsewhere (Inhorn and Tremayne 2012). Furthermore, in the past decade, the global phenomenon of “reproductive tourism” has definitely emerged, with infertile couples criss-crossing the globe in pursuit of twenty-first-century, high-tech conception.

In the Middle East, a phenomenon of what I call “return reproductive tourism” is also emerging. Namely, diasporic Middle Eastern couples who are infertile often dream of making a test-tube baby “back home” for a variety of cultural, moral, and psychological reasons. In this chapter, I attempt to capture the motivations and dynamics underlying return reproductive tourism to the Middle East, based on ethnographic research undertaken in four different Middle Eastern “sending” and “receiving” communities. Only through such a multisited ethnographic research strategy would the dynamics of return reproductive tourism become clear to me.

George E. Marcus (1995) was the first to coin the term multisited ethnography to describe qualitative research that “moves from its conventional single-site location . . . to multiple sites of observation and participation that cross-cut dichotomies such as the ‘local’ and the ‘global,’ the ‘lifeworld’ and the ‘system’” (Marcus 1995, 95). According to Marcus, such multisited research is particularly useful when examining “the circulation of cultural meanings, objects, and identities in diffuse time-space” (96). Reproductive tourism lends itself especially well to multisited ethnographic approaches, including what Marcus calls “tracking” through space and time. In my own ethnographic research, tracking routes of ART circulation has included following the spread of ARTs from Euro-American sites of invention into “receiving” sites such as Cairo and Beirut, where Middle Eastern IVF physicians have opened their clinics, offered new services, and catered to reproductive travelers. My ethnographic research has also involved listening to the stories of hundreds of Middle Eastern ART seekers in diverse locales before, during, and after their reproductive travel.

Most Middle Eastern ART seekers are practicing Muslims, and thus they are very concerned about “following the religion” in the creation of human life (Inhorn 2003, 2012). Medical anthropologist Arthur Kleinman (1997, 45) has invoked the term *local moral worlds* to capture “what is at stake in everyday experience.” Local moral worlds are perhaps best exposed in the realm of medical decision making. When patients confront emerging health technologies such as ARTs, which in some way challenge their deeply embedded religious traditions, the “local moral” becomes abundantly apparent. The emergence of ARTs in the Middle East has



provided an example par excellence of local moral worlds “in motion.” To wit, infertile Middle Eastern Muslim couples living in diasporic communities must now make very difficult decisions about “what is at stake” in their quests for conception. In many cases, the stakes are high and the quests are transnational in nature. In this chapter, I illuminate the importance and character of this emerging phenomenon of return reproductive tourism within the burgeoning Middle Eastern diaspora of the new millennium.

### Return Reproductive Tourism

To begin, I offer a concise definition of *return reproductive tourism*, which is characterized by three distinctive features: (1) it involves return to a “home” country of origin to undertake ARTs, (2) it involves a “holiday” visit to family in the home country, and (3) it is motivated by a set of factors that are different than those usually cited in the scholarly literature on reproductive tourism (i.e., restrictive laws, religion and ethics, costs, lack of services, shortages and waiting lists, safety concerns, category exclusion, lack of privacy, poor quality of care, poor success rates) (Gürtin and Inhorn 2011).

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. These diasporic communities may confront their own infertility problems, and may face the need for ARTs. But, instead of relying on “host” country ART resources and services, members of these communities undertake return reproductive tourism to countries of origin.

I focus on return reproductive tourism to the Middle East, among Middle Easterners living outside of the region and among the region’s own internal migrant populations. In focusing on Middle Eastern diasporic communities and their quests for ARTs, I forward three major arguments. The first argument is historical: Even before the term *reproductive tourism* was coined at the turn of the new millennium, many infertile Middle Eastern diasporic couples had been returning to the Middle East since the arrival of ARTs in the region in the late 1980s (Inhorn 2003). This pattern continues unabated in the twenty-first century. Second, this desire for ARTs “back home” is linked to cultural and psychosocial factors so far rarely mentioned in the literature. Finally, for some diasporic infertile couples, the term *reproductive exile* is a more accurate descriptor of their ART-seeking

experiences (Inhorn and Patrizio 2009). 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 Fakihi 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 ART services in the war-torn home country. However, most of these refugees and political exiles lack sufficient economic resources to undertake ARTs in the host country. They are a particularly tragic group of reproductive and political exiles who deserve our 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, 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 Shia 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: (1) mid-twentieth-century decolonization movements across the Middle East and North Africa, some of it associated with bloody violence (e.g., Algeria); (2) uneven regional political economies, related largely to the varying regional dispersion of oil wealth; and (3) political violence and outright war occurring in many Middle Eastern nations over the past sixty years (Gelvin 2005). This includes ten military interventions by the United States alone, including its two recent 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 (IDPs) (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, fifteen of the twenty-two Middle Eastern nation-states (roughly 85 percent 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: (1) the expulsion of Palestinians from Israel in 1948, with movements into Jordan, Lebanon, Syria, and Palestinian enclaves in the Arab Gulf; (2) the exodus of Lebanese to a variety of Middle Eastern countries during the Lebanese civil war (1975–90), subsequent Israeli occupation of southern Lebanon (1990–2000), and the 2006 Israel-Lebanese "summer war"; (3) massive Egyptian labor 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; (4) political exile of nearly half a million Sudanese to Egypt and the Arab Gulf because of Sudan's ongoing civil war; (5) two waves of Iraqi refugees, first to Saudi Arabia (with subsequent resettlement in the United States) after the first Gulf War (1990–91) and then more than 4.8 million Iraqi IDPs and refugees moving to Syria, Jordan, and Lebanon in the aftermath of the 2003 U.S.-led invasion of Iraq; (6) 6 million Afghan refugees fleeing to Pakistan and Iran in the aftermath of the Soviet invasion of Afghanistan (1979) and since the 2001 U.S.-led war in that country; and (7) 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.<sup>1</sup> 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 one-half million in the United States, 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 Côte d'Ivoire, Sierra Leone, and Senegal), and Europe, Australia, and Canada. Of the estimated 11 million Palestinians worldwide, 6.6 million are refugees and nearly one-half 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 to 5 million Iranians left the country, primarily going to North America (both the

United States and Canada), Europe, and Australia. Since the 1979 Soviet invasion and the 2001 U.S.-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 U.S. 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 of them 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 United States (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 one-half million Egyptians, both poor laborers and educated professionals, have migrated to the United States, 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 Southeast Asia (e.g., Singapore), but also in the United Kingdom (80,000) and the United States (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 Multisited 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 attempt to access ART services, including through return to home countries. As noted earlier, this chapter examines the phenomenon of return reproductive tourism to the Middle East based on ethnographic studies of infertility and ART-seeking in four different Middle Eastern locations, as summarized in table 1.



Table 1. Middle Eastern study populations

Year of study	Country of study	Country of origin ("home")	Country of current residence ("host")	Number of "return reproductive tourists"	Primary type of diasporic population studied
1996	Egypt	Egypt	Arab Gulf countries	18 of 66 (to Egypt)	Egyptian labor migrants, mostly middle-class professionals
2003	Lebanon	Lebanon, Syria, Palestine	Sub-Saharan Africa; other Middle Eastern countries; North America; South America; Europe; Asia	37 of 189 (to Lebanon); also 20 Syrian reproductive tourists (to Lebanon)	Lebanese war refugees, who permanently resettled in host countries
2003-8	United States (Detroit, Michigan)	Lebanon, Syria, Palestine, Yemen, Iraq	United States	3 of 95 (2 to Lebanon, 1 Iraqi refugee couple to Bahrain)	Lebanese, Palestinian, and Iraqi war refugees; Syrian and Yemeni labor migrants; mostly recent resettlement in the U.S.
2007	United Arab Emirates	50 countries in South Asia, Middle East, Europe, sub-Saharan Africa, Australia, US	7 Emirates of UAE, plus 17 countries	219 "reproductive travelers" (to UAE)	Temporary reproductive "tourists" to UAE, as well as labor migrants to UAE, mostly middle-class professionals

The first study, undertaken in 1996 in two major, private hospital-based IVF clinics in Cairo, Egypt, involved 66 ART-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 ARTs in

Egypt and 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 ART-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 (Côte d'Ivoire, Sierra Leone, Senegal, Nigeria, Gabon, Ethiopia); 10 in other parts of the Middle East (Saudi Arabia, UAE, Kuwait, Yemen, Egypt, Tunisia); 5 in North America; 3 in South America (Brazil, Panama); 2 in Europe (Netherlands, Switzerland); and 1 in Asia (Taiwan). In addition, all 20 of the Syrian men in the study had traveled with their wives to Beirut to seek cross-border ART services, as had 5 of the Palestinian men living in the Arab Gulf (Abu Dhabi and Dubai) and Central Asia (Kazakhstan). In total, 57 of the 220 men—or exactly 25 percent—were undertaking cross-border reproductive care at the time of the study. Of these, 37 men—or 17 percent of the total study population—were engaging in return reproductive tourism to Lebanon, primarily to undertake ICSI for male infertility but also for their wives' infertility problems (Inhorn 2012).

Following the Lebanese study, a five-year research project (2003-8) on infertility and ART treatment seeking was conducted among the Middle Eastern diasporic population in southeastern 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 percent of the entire U.S. Arab American population. Most of these Arab Americans live in Dearborn, a southwestern suburb of Detroit, which has been dubbed the "capital of Arab America." 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 Fakih



2005). As in Lebanon, the initial focus of this study (2003–5) was on male infertility and ICSI but later included couples with female infertility problems.

The final study was undertaken in 2007 in the UAE, then a booming Arab Gulf country. 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 neighboring emirates of Dubai and Sharjah. There, in-depth ethnographic interviews were conducted with 219 reproductive travelers, representing 125 infertile couples hailing from exactly 50 countries. The majority were Indian, followed in rank order by Lebanese, Emiratis, British, Pakistanis, Sudanese, Filipinos, and Palestinians. The ART 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).<sup>2</sup>

### Return Reproductive Tourism to the Middle East

As noted earlier, the phenomenon of return reproductive tourism began long before the term was ever coined. In the 1996 Egyptian study, a pattern of return reproductive tourism was noted among mostly middle-class and upper-middle-class Egyptian labor migrant couples, 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 one-month holiday back home, infertile Egyptian migrant couples may attempt a single ART 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: (1) the greater affordability of ART services in Egypt versus the Gulf countries, (2) the greater trust in Egyptian medicine over medicine in the Gulf, and (3) the perceived ease and comfort of undertaking ARTs 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 simultaneously attempting to maintain complete medical privacy and achieve "holiday-like" merriment with family members. Balancing levity with medical embodiment of ARTs—all during a single summer month in Egypt—was often profoundly difficult to achieve. It is also important to note that, in some cases, labor 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 ART 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 to 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 (1) increased affordability of ARTs in Lebanon, especially for those living in North America; (2) increased trust in Lebanese medicine over medicine in the host country, especially for those living in other Middle Eastern countries; and (3) desire to experience an ART 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 ART services in their host countries. Sub-Saharan Africa is a major region of the world where ART services are relatively absent. Of the 191 WHO member states, only 48 had medical facilities offering ARTs as of 2006 (Nachtigall 2006). ART 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, ARTs are simply not available in host countries. For example, with 100,000 Lebanese living in Abidjan, the capital of Côte 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 Côte 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. ART services are readily available. However, the average price of one ART cycle in the United States is greater than \$12,000 (Spar 2006). There are very few American "mandate states," which provide either full or partial ART subsidization to state residents. Furthermore, very few U.S. insurance companies cover the complete costs of an ART cycle. Thus, most Americans pay for ART services entirely out of pocket, which is why less than 1 percent of infertile Americans ultimately conceive through IVF and related technologies (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 \$150), let alone the cost of a single ART cycle (Inhorn and Fakhri 2005). Among the total group of nearly 100 interviewees, only 19 ICSI cycles had ever been undertaken—but 6 of these had been tried by one upper-middle-class Lebanese couple, twice in the United States and four times through return reproductive tourism to Lebanon. Among the remaining 13 ICSI cycles, two had involved reproductive tourism to the Middle East (Lebanon, Bahrain). The rest had been performed in the United States under great financial duress. Couples in the study had taken out bank loans or loans from friends and family, had sold wives' bridal gold or family land back 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. From the 19 total ICSI cycles, only two children—both 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 in the capital city of Baghdad. Iraqi couples who require ARTs 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 neighboring countries of Syria, Jordan, and Iran, each with its own active ART 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

period, 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 neighboring Middle Eastern countries, such as Syria, Jordan, Lebanon, and Egypt, and a few have been given political asylum in Western countries, including the United States.

### **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 cross-border reproductive care 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: namely, couples feel forced out of their home countries by various restrictions, constraints, and pragmatic reasons such as comparative costs. With return reproductive tourism, on the other hand, the desire to travel is fueled by a number of pull factors, which are described below with accompanying ethnographic vignettes.

#### MEDICAL "EX-PATRIOTISM"

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 "ex-patriotism" (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 ART clinics. Among Egyptians, this medical ex-patriotism is rooted in the fact that Egypt was one of the first three countries to initiate ARTs 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 ART services to be more "professional," "advanced," and "experienced" than in host countries, including the Arab Gulf.



Interestingly, these were the same three adjectives used by Lebanese expatriates to describe Lebanese ART centers and physicians. Even though Lebanon was a relative latecomer to ARTs—opening its first centers nearly a decade later than Egypt because of delays caused by the civil war (Inhorn, Patrizio, and Serour 2010)—prewar Lebanon was often touted as the “Switzerland of the Middle East,” and Beirut was compared to Paris. Prewar 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 postwar medical system in Lebanon, including its fairly new ART clinics (begun in the mid-1990s), more than they trusted ART 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 man living in Dearborn told me: “Don’t forget! In Lebanon, they’ve got experience for this one [ARTs] better than here. For this one [ARTs], Lebanon probably has better experience than the U.S.” 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 percent.”

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 prewar 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: namely, undertaking a cycle of ARTs 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 ART 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 ART staff and, hence, understand the medical terminology, instructions, and explanations delivered to them. In the Arabic-speaking world, the vocabulary and language of ART medicine is delivered to patients in Arabic that 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 percent 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 United States 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 Detroit’s Arab community, 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 traveled great distances across state borders to access the particular Arabic-speaking clinician. For example, following an eight-hour drive, an Iraqi refugee couple explained: “We came here from Nashville because the doctor is Arabic. 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 Arabic 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 ARTs from a physician of a similar religious background. For most Middle Easterners, this means seeking out an ART practitioner who is a Muslim. The reasons



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 from a Filipino." Clearly, in this couple's local moral world, both the baby's future and the wife's moral reputation are at stake, which is why achieving donor phenotypic similarity is deemed crucial.

## COMFORTS OF HOME

In addition, many husbands are concerned that their wives experience ART conceptions under optimal circumstances, surrounded by the tender loving care of family members, especially 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 ART 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 ARTs back 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 ARTs in an unfamiliar host country clinical setting. This belief in the psychosocial benefits of simply being "at home" while pursuing ARTs 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 travelers were adamant about the "comforts of home" and the importance of being in the home environment, if possible, when undergoing an ART cycle (Inhorn and Shrivastav 2010).

A young Lebanese couple, married for six years, had been unable to become pregnant since arriving as immigrants to Dearborn, Michigan. 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 ART clinics. Subtle and not-so-subtle forms of cultural discrimination may be at work, especially for Arabs and Muslims in a post-September 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 Shia 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 United States. Unfortunately, he was denied an exit visa by the U.S. Embassy in Beirut, because he lived in the Hizbullah stronghold of Baalbek. His lack of full recovery had 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 he 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 \$5,000) 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 ART clinic.

Other examples of discrimination—or at least profound lack of cultural sensitivity—abounded. For example, a young Yemeni couple, married for eleven years, described their dream of seeking ARTs 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 ARTs], 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 eleven years of marriage is all the more egregious because of the perceived name-calling—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 chapter has attempted to capture ethnographically the emergence of a new phenomenon, 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—including medical ex-patriotism, 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 ethnographic investigation is definitely needed, in order to assess the dynamics of return reproductive tourism to other regions of the world beyond Euro-America.

Of particular concern in my own research are the needs of "stranded" Middle Eastern refugee populations, who are constrained from seeking ARTs back home but who may face economic constraints and cultural discrimination in host communities. Indeed, three issues continue to haunt the Middle Eastern diaspora at the time of this writing: (1) ongoing forms of political violence, which have forced so many Middle Easterners into refugeeism and exile in host countries; (2) the many constraints, economic and political, that prevent them from returning to their home countries to seek ARTs; and (3) the levels of discrimination faced by Middle Easterners in post-9/11 Euro-America, including in medical facilities

(Inhorn and Serour 2011). 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 health and welfare of refugee populations—those who have been forced to travel to save their own lives—will be a major challenge for future ethnographers of the Middle East, particularly in the aftermath of America's War on Terror in Iraq and the "dark autumn" that seems to have emerged from the Arab spring.

## NOTES

This chapter is an expanded version of my article "Diasporic Dreaming: Return Reproductive Tourism to the Middle East," reprinted with permission of Elsevier from *Reproductive Bio-Medicine Online* 23 (2011): 582–91. I wish to thank the journal editor, Martin Johnson, as well as Zeynep Gürtin, both of the University of Cambridge, for facilitating publication of the special issue on cross-border reproductive care, in which this article first appeared. I also extend my thanks to Kamari Clarke and Rebecca Hardin for inviting me to contribute to this edited volume. Profound thanks go to the hundreds of Middle Eastern men and women who have shared the details of their reproductive lives and travel with me, thereby making my multisited ethnographic research possible. Similar thanks go to the ART practitioners in Egypt, Lebanon, UAE, and Arab America who have welcomed me into their clinics. This research has been generously supported over the years by the National Science Foundation's Cultural Anthropology Program, and the U.S. Department of Education Fulbright-Hays Faculty Research Abroad Program. I am very grateful to these programs and am extremely sorry that the Fulbright-Hays program is no longer in existence as of this writing.

1. These figures have been compiled from a variety of United Nations and Web-based sources.

2. In each study, interviews were conducted in either Arabic or English, depending upon the preference of the interviewee. The interviews were generally unstructured and followed a basic interview guide constructed by me. In all of the interviews undertaken in Lebanon and in about half of those in 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 ART seeking. In general, interviews lasted about one hour, although they ranged in length from one-half hour to three hours. All interviews were conducted in private rooms, usually within the clinics 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 me alone. All research subjects were asked to read and sign an informed consent form in either Arabic or English. Consent for human subjects' research was received from institutional review boards (IRBs) at my home institutions (Emory University for the 1996 study, University of Michigan for the 2003–8 studies).