

9 'Assisted' motherhood in global Dubai: reproductive tourists and their helpers

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Introduction: the new phenomenon of reproductive tourism

What motivates the global movements of infertile people searching for assisted reproductive technologies (ARTs)? And who are the individuals who assist the infertile in their global quests to become parents? These are questions to be addressed in this chapter, which focuses on the newly described phenomenon of 'reproductive tourism' – defined as

the travelling by candidate service recipients from one institution, jurisdiction or country where treatment is not available to another institution, jurisdiction or country where they can obtain the kind of medically assisted reproduction they desire. As such, it is part of the more general 'medical tourism'.

(Pennings 2002: 337)

Little is known about the motivations of reproductive tourists in any part of the world. A front-page story in the *New York Times*, entitled 'Fertility Tourists Go Great Lengths to Conceive', claimed that infertile Americans were seeking services abroad, 'in places like South Africa, Israel, Italy, Germany, and Canada, where the costs can be much lower' (Lee 2005: A1). However, economic factors may not be the sole consideration. Scholars who are beginning to theorize the relationship between nation states, reproductive tourism, and global reproductive rights suggest that the causes of such transnational tourism may be manifold. Seven discrete, but often interrelated, factors promoting reproductive tourism have been cited in the existing literature:

- (1) individual countries may prohibit a specific service for religious or ethical reasons;
- (2) a specific service may be unavailable because of lack of expertise, equipment or donor gametes (eggs, sperm or embryos);
- (3) a service may be unavailable because it is not considered sufficiently safe or its risks are unknown;
- (4) certain categories of individuals may not receive a service, especially at public expense, on the basis of age, marital status, or sexual orientation;

- (5) a service may not be available due to shortages and waiting lists;
- (6) a service may be cheaper in another country; and
- (7) privacy concerns may lead ART consumers to cross national and international borders (Blyth and Farrand 2005; Deech 2003; Matorras 2005; Pennings 2002; Pennings *et al.* 2008).

Not surprisingly, given these disparate factors, a policy debate is growing over the desirability of national and international legislation to restrict reproductive tourism. As Pennings notes in the *Journal of Medical Ethics*, '[t]he more widespread this phenomenon, the louder the call for international measures to stop these movements' (Pennings 2002: 337).

As of now, the purported 'causes' of reproductive tourism are still speculative, and little empirical research has yet to be undertaken. Most of the extant literature on reproductive tourism focuses on the West, particularly upon border crossing between European Union nations (Deech 2003; Storrow 2005). Little is known about reproductive tourism outside Europe and America, or about the forces that motivate infertile persons to undertake international travel in their 'quests for conception' (Inhorn 1994). Only through in-depth, ethnographic analysis of the actual stories, desires, and migratory pathways of reproductive tourists themselves may we begin to shed light on the complex calculus of factors governing this global movement of reproductive actors.

This chapter examines the theoretical interplay between forces of globalization and reproductive tourism in the Middle East. It begins with an overview of Arjun Appadurai's (1996) theory of global 'scapes', which is highly relevant in thinking about the global landscape in which ARTs are being rapidly deployed. However, Appadurai's theory of global scapes can also be expanded and 'engendered' to include the complex 'reproscape' in which the multiple 'flows' of reproductive tourism occur. In the global reproscape, issues of bodily commodification are paramount, given that reproductive tourism may be undertaken explicitly to procure human gametes, both sperm and eggs, which are disassociated from men's and women's bodies and increasingly sold on the open market. Furthermore, various 'assistants' – ranging from sperm and egg donors to gestational surrogates to childcare workers and servants – are implicated in the processes of global reproductive tourism in ways that have rarely been examined.

The second half of this chapter focuses on an empirical study of reproductive tourism, which I have carried out in the Muslim Middle East over the past 10 years, and particularly since 2003. Based on this Middle Eastern research, I will put forward four major arguments. First, reproductive tourism in the Middle East is highly inflected by local moral attitudes toward science, technology, and medicine. This includes local attitudes toward the religious practices of physicians themselves as well as varying Islamic bioethical approaches regarding the donation of human gametes and abortion (cf. Inhorn 2006a, 2006b, 2006c). Second, Middle Eastern reproductive tourists are 'assisted' by a variety of individuals, from Muslim and non-Muslim IVF physicians and embryologists, to anonymous and non-anonymous donors, to visible and invisible childcare workers and other

sorts of domestic servants. Throughout the Middle East, such 'assistants' come from a variety of nations and 'races', depending upon their roles in the processes of biological and social reproduction. Indeed, IVF baby-making and baby-caring in the Middle East are truly global phenomena, a kind of 'globalized motherhood' that has yet to be conceptualized and described. Third, because those who assist may not share a Middle Eastern background with the contracting infertile couple, hierarchies of race and nation are deeply implicated in these global processes of reproduction. Reproductive tourism in the Middle East becomes an example *par excellence* of 'stratified reproduction', in which some reproductive futures are valued at the expense of others (and some aspects of reproductivity are valued while others, like gestation, are minimized). Indeed, 'white' women from Europe and America are generally recruited as egg donors to facilitate 'biological motherhood', while poor women from Africa, South Asia and Southeast Asia are generally recruited to assist in the parenting of IVF babies. As such, reproductive tourism in the Middle East provides a key site for analysis of the gendered inequalities inherent in global reproductive flows.

Finally, nowhere in the Middle East are these forms of 'globalized motherhood' more apparent than in the United Arab Emirates, and specifically Dubai, the most 'global' of all Middle Eastern cities. Until the recent economic crisis, Dubai served as the major Middle Eastern hub for global flows of tourists and foreign workers. Known for its high tech sector in the areas of information technology and health care, Dubai has become *the* global site in the Middle East for wide-ranging reproductive tourism, despite local restrictions on both gamete donation and abortion.

To illustrate these arguments, three case studies will be presented. They speak to the multiplicity of global sites, assistants, and complexities (legal, religious, economic, ethnic, racial and sexual) evoked by reproductive tourism. Indeed, in each of these cases, motherhood is a prominent discourse of reproductive tourists' narratives. The women in these stories ardently desire children and hope to give birth to IVF babies – hopes and dreams that are shared by their husbands. However, in order to conceive, birth and parent these children, they rely heavily on various 'assistants', mostly women from other countries whose body parts and services are commodified and contracted. In short, 'globalized motherhood' in the new era of ARTs and concomitant reproductive tourism involves the globalization of people and their gametes; the fragmentation of motherhood among ova donors, gestational mothers and childcare workers; and the stratification of these mother figures according to a highly racialized national hierarchy and moral value system.

Globalization and reproductive tourism: from reproscapes to reproflows

Globalization can be understood, in a most basic sense, 'as the ever faster and ever denser streams of people, images, consumer goods, money markets, and communication networks around the world' (Schaebler and Stenberg 2004: xv–xv).

Anthropologists have contributed significantly to theorizing the nature of these global flows – and to providing numerous ethnographic examples of the 'global' or the reception of things 'global' at various 'local' levels (Appadurai 1996; Basch, Glick Schiller and Blanc 1994; Freeman 1999; Friedman 1994; Hannerz 1996; Inhorn 2003; Lewellen 2002; Mazzarella 2003; Mintz 1985; Nelson and Rouse 2000; Ong and Collier 2005; Ritzer 1993, 1998, 2002; Wallerstein 1974, 1984; Watson 1997).

One of the major anthropological theorists of globalization, Arjun Appadurai, has delineated a 'global cultural economy' in which global movements operate through five pathways, which he famously calls 'scapes' (1990, 1996). According to Appadurai, globalization is characterized by the movement of people (ethnoscapes), technology (technoscapes), money (financescapes), images (mediascapes), and ideas (ideoscapes), which now follow increasingly complex trajectories, moving at different speeds across the globe. Using Appadurai's language of 'scapes', I argue that reproductive tourism might be thought of productively as a much more complex 'reproscape', combining numerous dimensions of globalization and global flows. To wit, reproductive tourism occurs in a new world order characterized not only by circulating reproductive technologies (technoscapes), but also by circulating reproductive actors (ethnoscapes) and their body parts (bioscapes), leading to a large-scale global industry (financescapes), in which images (mediascapes) and ideas (ideoscapes) about making lovely babies while on holiday come into play.

Indeed, using the newer language of 'global assemblages' being forwarded by Aihwa Ong and Stephen Collier (2005) in their edited collection of the same name, this phenomenon might be thought of as a 'global reproductive assemblage'. Yet, I find this trope less attractive than the older notion of 'scapes' – or those transnational distributions of correlated elements whose display can be represented as landscapes (Appadurai 1996: 33). For I envision the world in which I am working as a Middle Eastern landscape, entailing a distinct geography traversed by global flows of reproductive actors, technologies and body parts. Furthermore, this reproscape is highly gendered – with technologies enacted on men's and women's bodies in highly differentiated ways. Gender was never the focus of Appadurai's original work on globalization, nor was the human body and the commodification and movement of its parts (a.k.a. bioscapes, in the language of medical anthropology). Indeed, it might be more useful to replace Appadurai's non-gendered language of 'scapes' with a more gendered notion of 'flows' – or what I will call 'reproflows'. Reproflows bespeak the flow of semen, ova, sperm, embryos, and menstrual blood; the flow of semen through genital vessels to ejaculatory emissions; the flow of oocytes and embryos down fallopian tubes; the flow of menstrual blood when conception is not achieved; and the flow of impregnating spermatozoa on the path to oocytes, or what Emily Martin (1991) has so famously called 'the romance of egg and sperm'.

Reproflows also bespeak larger, extracorporeal, global movements – of reproductive technologies invented in one country, which then 'flow' to others through a variety of commercial means; of embryos 'flowing' from one country to another

through the work of embryo 'couriers' carrying their cryopreservation tanks of men and women 'flowing' across transnational borders in search of reproductive 'assistance'; and of reproductive 'assistors' who 'flow' and are 'flown' to other countries in transnational reproductive networks. However, as I argue, reproductive 'assistance' takes other forms as well. In glittering Dubai – the Arab 'city of gold', which is currently the Middle Eastern hub of intense global flows – reproductive assistance takes many forms, involving multidirectional flows of human workers and their body parts. Dubai in particular has encouraged the importation of foreign labourers – particularly unskilled foreign female domestics and male construction workers, but also white-collar professionals from around the globe – at least prior to the 2008–2009 global economic crisis. As a result, Dubai has become home to a truly 'global' work force, who are implicated in unexpected ways in the world of reproductive tourism.

Studying reproductive tourism

Before describing this Middle Eastern-qua-global site of reproductive tourism, it is important to locate my research in space and time. I ventured to Dubai in January 2007 to explore how reproductive tourism might unfold in the most 'global' of Middle Eastern cities. The UAE hosts more than a dozen IVF centres, all private except for two government clinics. The largest private clinic in the UAE is called 'Conceive', and is located strategically on the border between the neighbouring emirates of Dubai and Sharjah. It is directed by Dr. Pankaj Shrivastav, an Indian Hindu physician widely regarded as the 'father' of IVF in the UAE. 'Conceive' serves three patient populations: 1) Emirati 'locals', as they are called; 2) a large foreign expatriate community known as 'expats'; and 3) reproductive tourists coming from abroad, including many other parts of the Middle East, South Asia, Africa, Europe and America. During a six-month period, I interviewed nearly 240 individuals representing 125 patient-couples, hailing from exactly 50 countries. The majority were Indians, followed in rank order by Lebanese, Emiratis, British, Pakistanis, Sudanese, Filipinos and Palestinians. I followed the IVF treatment and travel trajectories of many of these couples over the course of six months. During this time, I collected rich life-histories, migration narratives, and marital stories from many individuals and couples, who were recruited into my study based on their experiences of reproductive travel.

It is important to note that I was literally 'led' to the UAE by the results of my earlier research on male infertility undertaken in Beirut, Lebanon. There, I spent the first eight months of 2003 interviewing 220 Middle Eastern men, mostly Lebanese, but also Syrians and Palestinians, about their experiences of infertility and uses of ARTs (Inhorn 2004, 2006a, 2006b). Many of these men were themselves 'reproductive tourists', who had returned to Lebanon from other countries in order to attempt a cycle of ART with their wives. Some had lived, or were currently living, in the United Arab Emirates, and especially the emirate of Dubai, which they considered to be the most 'progressive' Arab country outside of Lebanon (and also free from Lebanon's ongoing political and economic

problems). In my interviews, the 'lure of Dubai' featured prominently, and many Lebanese men, including my infertile driver, urged me to base my next study there. I heeded their advice, heading to the UAE in 2007. This chapter is based largely on the latter period of research. However, the interesting links between my two Middle Eastern study locations will become clear in the case studies that follow.

Three patterns of reproductive tourism

During the course of my research in the UAE, I identified three major patterns of reproductive travel – or what I came to think of as 'reproflows' to and from the UAE. Although there are many different factors underlying these reproflows, I want to highlight several of the most salient themes. I will then illustrate these themes through the stories of four Middle Eastern reproductive 'tourists' – namely, a Lebanese husband and his Syrian wife, an Israeli woman, and a Palestinian man. Their stories speak to processes of globalization and the ways in which various women from around the world – including Russian and American egg donors, Indian and Sudanese physicians, South and Southeast Asian childcare workers, servants, and 'mistresses' – are implicated in globalized forms of motherhood.

Reproflows to the UAE

Why were infertile couples flowing into the UAE? Partly because of the lure of Dubai as a 'high tech' tourist destination: reproductive travellers are attracted to Dubai as a 'global city', including its recent marketing as a high-tech medical care setting (e.g. Dubai's own 'Health Care City'). Because Dubai is positioning itself in the world of global tourism, including medical tourism, it now provides easy access to three-month 'visitors' visas, which allow enough time for reproductive travellers to complete an entire IVF cycle in the country. This is especially attractive for reproductive travellers coming from parts of sub-Saharan Africa, where IVF clinics may literally not be available, and where accessing visas to foreign countries may also be quite difficult. Dubai has made it easy for elite Africans to travel there in search of reproductive health services.

Similarly, many reproductive tourists from Great Britain came to Dubai, lamenting what they described as years of ineffective, low-quality infertility care in the publicly funded National Health Service (NHS). State-subsidized IVF services in the United Kingdom involve both lotteries and waiting lists. Thus, those who can afford to flee from the NHS either end up in expensive private clinics in London, or travel overseas, generally within the former British colonies. For some infertile British couples, especially those with immigrant backgrounds, it is literally less expensive to travel abroad to the UAE than to access services in the UK; in addition, travelling to the UAE can be coupled with visiting family members and friends working in the nearby Gulf countries, India, or Pakistan.

Generally speaking, for those reproductive tourists flowing into the UAE, the theme of disenchantment is paramount. Many of these couples have gone through multiple cycles of IVF in other countries, eventually becoming dissatisfied with

the quality or efficacy of their medical care. In my UAE study, I met scores of once hopeful, but now wary couples coming from Europe, South Asia, and other countries in the Middle East. They spoke of multiple ART attempts at home, and the disappointments and complications that had ensued. In many cases, in-country ART services were less costly than those in the UAE (at approximately \$5,000 per cycle). But these couples had become distrustful of the 'cheap' ART services 'back home' (e.g. in India). Instead, they perceived themselves as being 'forced' from their home countries because of poor-quality medical services, waiting lists, and various legal restrictions. Furthermore, few of these travellers saw themselves as reproductive 'tourists', loudly critiquing this term as 'gimmicky', cavalier and insensitive to their profound suffering. In virtually every case, infertile couples described their preferences *not* to travel if only legal, trustworthy and economical services were made available closer to home. Their feelings of being 'pushed out' of their home countries made these travellers consider themselves 'reproductive exiles': if their 'choice' is to voluntarily use ARTs to produce a child, then they perceived their travel abroad to be involuntary (Inhorn and Patrizio 2009).

There were many such disenchanting, reproductive exiles in my study. However, I will focus on one Middle Eastern, Sunni Muslim couple, who finally came to Dubai after five previous attempts to produce a 'take-home' IVF baby had failed in Lebanon. Having met this couple during my earlier study in Lebanon, I became reacquainted with them, by surprise, in the UAE IVF clinic, where I heard their follow-up story.

The disenchanting Levantine couple

Walking down the hallway of Conceive Clinic in February 2007, I saw a couple who looked very familiar to me. As it turned out, I had already met them in Lebanon, where the husband, Abdullah,¹ had participated in my 2003 Beirut-based study. I interviewed the couple again in the UAE, both together and separately. Abdullah was particularly forthcoming, telling me about the couple's experiences and frustrations, just as he had during my earlier interview in Beirut. Between Beirut and Dubai, I spent many hours with this couple, who had struggled mightily to produce a child.

Abdullah's wife, Muna, was Syrian. She had attended pharmacy school in Lebanon, where she married Abdullah, and assumed a pharmacy position in Beirut. Shortly after their wedding, Abdullah migrated by himself to the UAE because he was struggling financially in Lebanon, despite his American business-school degree and his certification as a financial analyst. Living apart for nearly seven years, Abdullah returned to Beirut regularly to see Muna and to try to make an IVF baby with her there.

When I first met Abdullah in Beirut in 2003, he and Muna were undertaking their third IVF cycle. Their first IVF procedure had resulted in a twin pregnancy. But the twins, a boy and a girl, were stillborn at 21 weeks of gestation. The second IVF with the same Lebanese doctor was unsuccessful. At the time of my interview, Abdullah and Muna had switched to another Lebanese IVF clinic.

Unfortunately, neither a third, fourth, nor fifth IVF cycle in Lebanon produced a pregnancy. Repeated hope then failure had left Abdullah and Muna frustrated, exhausted and worried. Abdullah was clear that he did not place any blame for the infertility on Muna, who suffered from blocked fallopian tubes (which they understood as having resulted from an earlier ovarian cyst surgery in Damascus, Syria). Rather, he believed in Muna's inherent right to motherhood through IVF. As a 'fair' and 'understanding' husband, he should support his wife in reaching her goal. He explained:

She was pregnant on the first try with twins, male and female. But she lost them in the fifth month. I felt unhappy, but I was trying not to show it; I was trying to help her. Especially in the Middle East, the mentality is that if your wife doesn't have babies, you must have a second wife. A lot of families indirectly or directly push their sons [to remarry]. But I try to reassure her that if she hasn't any babies, our marriage is all about her and not about babies only. I think that if the [infertility] problem was [from] me, I would need the same help. I wouldn't need someone to destroy me! Plus, she's educated, a pharmacist, and very clever. So I don't want to put her down. In Arabic culture, in Middle Eastern culture, they tell you, 'Go marry! Go get yourself another wife'. But I will not, because I believe maybe God sent me to help my wife, to be there for her. And maybe because we have been patient with each other, our life is always happy. We accept each other. She accepts me when I've been having financial problems. And I accept her with this problem. It's all about sharing and accepting each other. No one is perfect; everyone has something wrong.

Although Abdullah clearly loved Muna and did not blame her for their childlessness, he was extremely critical of some of the Lebanese IVF physicians who had treated her. He explained:

Actually, we were looking for the right doctor. But [doctors in Lebanon] have made us upset, because they lack honesty and we are seeking trust. 'Don't lie to us! Tell me exactly what's going on'. These people [certain doctors] were not the right people, because they were not being honest. We needed to get away from these people, because we were wasting our time and money. All of my 'perks' [bonuses] were going, but not improving my life. I'm running and the dollars are running ahead of me!

Muna, however, was determined to carry out IVF in Lebanon. She explained, 'I don't have confidence in just *any* doctor. For example, for my teeth, I prefer to be in Lebanon. I think there's more education, and they give more care in Lebanon. There are some doctors [in Lebanon] who are very good'.

Eventually, Abdullah's tolerance of IVF in Lebanon wore thin. 'At the end, I started getting sick and tired of this thing. Perhaps I didn't mention this to her, but I was thinking, "My God! How long do I have to put up with this?"'

After the fifth failed IVF cycle, Abdullah finally convinced Muna to try IVF abroad. Although they were preparing to immigrate to Canada, Abdullah had heard about a 'famous' Indian IVF doctor in Dubai, who had started his own UAE-based clinic called Conceive. He convinced Muna to travel to the UAE, in order to 'give one last chance here before we pack and go'. Because they had spent six years undertaking five unsuccessful cycles of IVF in Lebanon, it was difficult to 'begin again' in another Middle Eastern country. Furthermore, Muna had serious doubts about undertaking 'reproductive tourism' at Conceive clinic in the UAE.

Abdullah was candid about Muna's misgivings:

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].² Second, he's non-Muslim. She mentioned it one time, and I changed the way she was thinking, and then she didn't mention it anymore. It was a kind of anxiety; she was not feeling comfortable because he is not Muslim. But that's stupid, I believe, and wrong. I do believe that people, whatever their religion, if they behave to you properly, and you behave properly, then people will behave right with you. But my wife is scared. If the hospital is Christian, she's afraid that they will not treat her the right way. But that's wrong. We are not all the same. In a Christian or Jewish Hospital, in a medical center, people are supposed to treat you right, no matter what religion you are.

According to Abdullah, Muna's 'traditional' Syrian family only served to fuel her fears. 'I'm lucky because my wife is not around her family', he said. 'Her family [members] are religious, and they practice the religion, and they are sharing her decision about the need for a Muslim doctor. So I'm lucky that they are not involved.'

Once Muna started coming to the UAE to consult with Dr. Pankaj, she felt good about her decision to 'give up on Lebanon'. She explained:

I am a Sunni Muslim and so is my husband. But in this country [the UAE], it's regular to see Indians because they live in this country, and almost all of the doctors are Indian. The most important thing is to search for a good doctor. Indian doctors *are* good. They respect you; they treat you better sometimes than Arabs.

Abdullah himself had nothing but praise for Dr. Pankaj:

My wife had this religious problem, 'Oh, he's not Muslim, Dr. Pankaj'. But I told her, 'You never look at this person's religion. You look at the *result*, not whether he's Christian or Hindu or Muslim'. I told her, 'Don't worry. He's okay'. Then she started treatment and she was *amazed* at the way Dr. Pankaj was treating her. Everything he does, he mentions God's name. When inside the operating room, the Qur'an was being read [on tape] and he's not even

Muslim! She said, 'I can't believe this doctor is not Muslim. Look at how much he respects his people!'

Abdullah continued

He was very smart, intelligent, polite, respectful. He's not just treating the causes; he's also psychologically treating us, because he's being *positive*, and making us feel that the baby is next door, not far away. But we have to do what we have to do. If something is wrong [an infertility problem], we have to know it. So this is a point. I did feel that he is also updated on medical research. One time, he checked something on a website; he always has his [medical] sources. So this is very, very good.

Indeed, on their first IVF cycle at Dr. Pankaj's clinic in the UAE – but their sixth cycle overall – Muna became pregnant, eventually giving birth to a healthy baby daughter named Sarah. When I met Muna and Abdullah at Dr. Pankaj's clinic – exactly four years after our initial meeting in Lebanon – I was delighted to see their cherubic, year old toddler, dressed in a red jumper, white turtleneck and tights, with little gold earrings. She was being pushed in a fashionable stroller by a petite Filipina childcare worker.

Over the spring of 2007, I saw Muna, Sarah, and the Filipina 'maid-quananny' many times. Muna was attempting her seventh IVF cycle in order to produce a sibling for Sarah. The maid-nanny – wearing a dull maid's uniform, with her hair tied back modestly in a kerchief – was always a silent presence, pushing Sarah's stroller down the halls of the clinic. She was never introduced to me by either Muna or Abdullah, nor was she ever mentioned in any of their lengthy conversations with me. I came to think of this Filipina maid-nanny as 'the invisible woman' – the person who was neither a clinic staff member, nor an infertile patient, nor an egg donor. She received absolutely no attention from anyone, even though her role was to care for and nurture a precious 'miracle baby' (as most IVF babies are called by their doctors and parents). Indeed, Sarah – one of the few IVF babies to appear regularly in the clinic – received lavish attention from the clinic staff, as well as some patients. But Sarah's Filipina maid-nanny – who pushed her stroller, changed her diaper, fed her her bottle, and hummed her to sleep while her parents were in the operating and recovery rooms – was never acknowledged by anyone.

This total lack of acknowledgment was especially striking to me for two reasons: first, Muna, but especially Abdullah, were loquacious interlocutors, who spent hours telling me their story. Yet, they never mentioned their hiring of the Filipina maid-nanny, nor her importance in their lives as the caretaker of their precious IVF baby. Second, this Filipina domestic worker was clearly not a Muslim, as apparent by her dress and demeanour (and the fact that most Filipinas are Catholic). Given that Muna was *so* concerned about the religion of her IVF doctor – the one who helped her to *conceive* Sarah – she seemed not to care at all about the religion or ethnicity of her childcare worker – the one who helped to

raise Sarah. As we will see in the interviews that follow, domestic servants from South and Southeast Asia are typically employed by middle- and upper-class Arab families living in the Gulf, as well as by elite families in less affluent parts of the Middle East, including Lebanon. Mostly non-Muslim domestic workers play major 'behind-the-scenes' roles in raising Muslim Middle Eastern children. Yet their reproductive labour is rarely recognized, and is sometimes exploited, as we shall see in the next case study to be presented.

Reproflows from the UAE

Just as infertile couples like Muna and Abdullah are flowing *into* the UAE, many couples are flowing *out* of the country for various reasons. Among the local Emirati population, desires for privacy are paramount. For most Emiratis, infertility is still deemed stigmatizing, and undertaking IVF has significant Islamic moral implications (Inhorn 2003, 2006a, 2006b, 2006c). 'Locals', as they are referred to in the UAE, fear running into other locals at IVF clinics in their country. Emirati families are large, tribal and intermarried, but the total Emirati population is relatively small – an estimated 10 to 20 per cent of the total UAE population of approximately 4 million. Infertile Emirati couples living in a small country fear that they may inadvertently run into other Emirati couples while seeking ART services, and consequently, that their 'secret' will get out within Emirati social networks. As a result, infertile Emirati couples – men in their flowing white robes and women in their flowing black ones – may take great pains to locate a 'remote' clinic, either in another Emirate or outside of the country altogether.

It is the Islamic moral injunction against certain forms of ART that also drive the *non*-local, expatriate population outside of the country, although for different reasons. Namely, in all Sunni-dominant Middle Eastern Muslim countries including the UAE, third-party assisted conception – including ova donation, sperm donation, embryo donation and gestational surrogacy – are strictly banned. Only three Middle Eastern countries – Israel, which is a Jewish state, and Iran and Lebanon, which have Shia Muslim majorities – allow these forms of third-party reproductive 'assistance'. In the Shia case, permissive *fatwas* issued by revered local clerics have allowed various forms of third-party donation to be practised (Abbasi-Shavazi *et al.* 2007; Clarke 2009; Inhorn 2006a, 2006b; Tremayne 2009). The result has been a steady flow of infertile Middle Eastern Shia Muslims – and many Middle Eastern Sunni Muslims as well – to the Arab country of Lebanon and the Persian country of Iran in search of donor gametes (Clarke 2009; Garmaroudi 2008; Inhorn 2006a, 2006b).

The polygamous Palestinian exile

The search for donor gametes outside of the UAE is exemplified by the case of Eyad, a Sunni Muslim Palestinian man who had lived for years in the Arab Gulf as a worker in the petroleum industry. As a Palestinian refugee, Eyad's entire life had been extremely difficult and stressful. His parents fled their home in Haifa with

the formation of the state of Israel in 1948. They ended up in a Palestinian refugee camp in Saida, Lebanon, where they eventually bore ten children. Because of the harsh living conditions in the camp, and then the outbreak of the Lebanese civil war in 1975, nine of the ten children, including Eyad, fled the country (the remaining sibling died in the war). Eyad, exiled from Lebanon at the age of 15, left behind his childhood sweetheart, Lubna, who was also his *bint 'amma*, or first cousin.³ He had promised to marry her when the war ended, but the war raged on for a full 15 years, preventing Eyad from returning to Lebanon to retrieve her.

Instead, at age 30, he married a Palestinian woman from the West Bank of Jordan, who bore him two daughters and a son. As Palestinians without a country of their own, they chose to migrate to Kuwait, where Eyad could make a better living as a crane operator in the oilfields. Despite a decent standard of living and company benefits, Eyad's marriage and family life were unhappy. His feelings for his first love Lubna had never waned, and thus his marriage was fraught with problems and fighting. Furthermore, when Iraq invaded Kuwait in 1990, the Palestinian residents of Kuwait were caught in the middle (mostly because the PLO backed the regime of Saddam Hussein over the Kuwaiti monarchy). Without citizenship rights, Palestinian residents of Kuwait were ostracized and exiled by the Kuwaitis. Eyad and two brothers were kidnapped and beaten, before being turned over by their Kuwaiti captors to the American forces in Desert Storm. At this point, Eyad fled with his family to Damascus, Syria, where he found a safe haven for his family and good private schools for his children. But Eyad could not find work in Syria, a poor and isolated Middle Eastern country without major oilfields. Given few options, he returned by himself to the Arab Gulf, this time to Dubai, where he renewed his work in the petroleum industry. Living by himself for nearly 10 years (1992–2002) was difficult for Eyad, partly because of his sexual frustration. He explained, 'I can't sleep with my wife [in Syria], so I feel pain, pain in the testicles. Any man who sees some beautiful girl and can't have sex will feel this way'.

Given his ongoing marital problems, it made sense to Eyad to take a lover, his Filippina housemaid. 'I got one girlfriend [in the UAE] because I haven't a wife [to have sex with]', he said. 'She loves me *too* much, that girlfriend. She was a Filippino [sic]. She wanted to get one baby to look like me, but I said "no"'. In fact, Eyad had no intention of marrying or impregnating his Filippina maid-cum-mistress, although she lived in his apartment – first as a maid, then sharing his bed – for nearly a decade. Instead, Eyad began thinking about taking his 'first love', Lubna, as his second wife. Lubna had never married during the war years and thus remained a '40-year-old virgin', with few if any marital prospects. Eventually, Eyad proposed and Lubna agreed, although Eyad's first wife was furious.⁴ (Eyad never described the reaction of his Filippina maid-mistress, or whether he continued to have sexual relations with her).

Eyad married Lubna in the summer of 2000, although she continued to live in her mother's apartment in Lebanon and Eyad continued to work in the Gulf. Because Lubna lived in a United Nations-supported refugee camp, her rights to exit Lebanon as a refugee were severely restricted. Furthermore, the UAE does

not grant political asylum or citizenship rights to foreigners living in the country. In short, Lubna was not free to leave Lebanon, even as Eyad's lawful wife.

As newlyweds already in their forties, Eyad and Lubna faced infertility problems from the beginning of their marriage. Eyad's semen was tested at a laboratory in the UAE and determined to be fertile. Lubna, however, was told that she had entered peri-menopause, and that her chances of conceiving were less than 5 per cent even with IVF. If Eyad had been able to marry Lubna when she was still a teenager, they might have had children together quite easily. But now, at age 41, Lubna needed an egg donor, according to the IVF physicians she consulted in Beirut.

'She needs eggs', Eyad explained to me. 'The doctor told us to do this [IVF] with donor eggs. He didn't tell me I must do this, but he said that she *needs* this operation. If he sends us to any other hospital or doctor, they will say the same thing'.

Although Eyad would have preferred to undertake IVF in the UAE – given his bad experiences with war-related violence and ongoing discrimination against Palestinian refugees in Lebanon – he knew that accessing ARTs in the UAE would be virtually impossible for two reasons: First, Lubna would have great difficulty travelling to the UAE as a 'stateless' Palestinian refugee without an official passport. Second, he learned that gamete donation was not performed in the UAE according to the Sunni Islamic *fatwas* that had been issued against the practice. As a result, the only option for Eyad and Lubna was to attempt IVF in Lebanon, one of only two Shia Muslim majority countries (along with Iran) where gamete donation is practised.

Given that Eyad did not reside in Lebanon, he began his career as a 'reproductive traveller' by flying to Lebanon on several occasions to deposit his sperm in the IVF clinic. When I met Eyad and Lubna, they were in the midst of a donor-egg cycle. He explained his decision to use donor eggs in this way:

In Islam, donation is *haram*. I mean, in Islam you should try to get the eggs from the wife and [sperm] from the husband if you want to make IVF. The eggs from the wife and the *bizri* [seeds] from the man, not from outside. Since we're using an egg donor, if I get a baby, it's *my* son, because it's *my bizri*. But it's not *her* son, because the eggs came from another girl. The other girl – that's her mother.

But my wife, she *really* needs a child. It's more important to her to be a mother than following the religion. So I don't mind. I'm not too much a Muslim. I pray, but sometimes you should 'move' a little. For her psychology, she *needs* that baby. I could go to take a baby already born from outside and bring it to our house [i.e. adoption]. But when she puts it in here [he points to the belly], day by day, she's feeling it growing inside her. It's born *from* her. She's feeling that it's *really her* baby. But if I get [an orphan] from outside, she won't feel it's *her* baby. And my wife *should* be its mother. Because she will care for him in the future, and she feels the pains *from* today and *forever*!

My wife loves babies *so* much, because she cared for the children of her sister, and they love her too much. All the time, by telephone, they're calling and saying, 'Auntie. Where is she?' She loves them, because they are the

children of her sister. And she'll make a great mother, because she hasn't any children and she loves children.

She wants a baby. She needs a baby. So I'm doing this IVF for *her*, yes, for *her*. We're doing it very secretly, because maybe it's not a baby who looks like me or his mother, and people will ask, 'From where did you get that baby?' People will talk. In America, it's normal [to use a donor], and in Europe. But with us here, it's difficult to do – *very* difficult. If we are in America, or outside the Middle East, it would be normal. But in the Middle East, we'll have to tell people that we did this operation [IVF] from her eggs and my *bizri*, so people will believe this is our child.

Interestingly, despite Eyad's desire to convince the world of a biological conception with his dark-haired, olive-skinned wife, he had become fairly obsessed with a 'white' American egg donor, who he happened to spot in the Lebanese IVF clinic. In fact, this particular Beirut-based clinic employed both Lebanese and American egg donors; the latter were paid an additional \$1,000 to travel to the Middle East for egg harvesting. When Eyad spotted the voluptuous, fair-skinned, bleached blonde 'beauty' in her khaki shorts and tank top, he became immediately smitten:

Yesterday, I saw a very beautiful girl outside [in the hallway]. She's American, I'm sure. So I told the doctor, 'Take \$1,000 more! And give me the eggs from that girl!' She was fat a little bit, and really, really very beautiful. There was something 'quiet' about her, and something about her face. Directly, my eyes went to her. She was really beautiful and my heart opened to her.

I hope my wife gets some eggs from that girl, because my child, she'll be coming white – already American! – and not black like my wife'. He added, facetiously, 'My child, when he comes, he will take the American passport in the future!'

At that point in the interview, I asked Eyad how he had spied the donor, given that the egg donation was intended to be 'anonymous'. He explained:

Yesterday, at 1 pm, maybe 12:30, when I was about to give my 'seeds' [sperm], I went up and I see her going inside [the operating room]. I told my wife about it. 'I've seen a girl who is too much beautiful! I hope we get eggs from her'. I also told the doctor then, 'I'll give you \$1,000 more!'

I want a child who looks like an American. My father looked like an American. His face was white. My sisters, they are white, and their hair is very blonde, and me and two of my brothers. The others look like my mother [i.e. dark hair, olive skin]. My wife [Lubna] is too dark, and my first [wife] even more. I'm the only one who is white. So I hope that the baby will be coming white like me. [He laughed] If she gets a white baby, I'll give them \$1,000!

I asked Eyad what the doctors thought about his request, and if they were willing to grant his wish. 'No', he responded sadly. But he added:

I told them, 'Please, if you give me eggs, *not* from a Sri Lankan, *not* from an Indian, but white like me'. My sons and daughter are *asmar shwaya* [slightly brown], like their mother. I want a white baby to look like me. But [the doctor] just laughed. He said that none [of the egg donors] are Sri Lankan or Indian or from the Philippines. From *America* they're coming.

I then asked Eyad why he preferred an American donor. 'Why not?' he exclaimed. 'American girls are giving their eggs all over the world. In the future all people will look like they are Americans!'

When I asked Eyad whether people would believe that a very 'white' baby had been conceived with his darker-skinned wife's eggs, he replied:

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's Filipino slept with my wife! Or that's what people will say if my wife uses eggs from a Filipino.

At that point in the interview, I could not help but think of Eyad's Filipino maid, whose own reproductive desires had been entirely thwarted by Eyad. In Eyad's racial hierarchy, she was neither worthy of bearing his children directly nor of providing the 'white, American eggs' that he so desired. Her role in his life was to provide domestic and sexual services, with Eyad paying directly for the former and indirectly for the latter. The 'love' which she demonstrated toward Eyad – and about which he boasted openly in the interview – was apparently not reciprocated and meant little to him in the long run. Although she was Eyad's only other self-reported sexual partner outside of his polygamous marriage, she was classified as a 'girlfriend', not a 'wife'.

Lubna, on the other hand, was deemed a sympathetic second wife by Eyad. She was Palestinian, his first cousin, and an educated schoolteacher in a Lebanese refugee camp. Although she was neither 'white' nor 'beautiful' like the American egg donor, Eyad still loved her from his childhood and felt great sympathy toward her as a maritally and reproductively frustrated woman who had 'waited' for him for nearly 30 years. She had been emotionally hurt in the process, as Eyad had taken another wife and raised a family. But Lubna's patience had been rewarded. Eyad still loved her enough to marry her (against his first wife's objections) and to pursue costly IVF cycles with her. Already the father of three and in his late forties, Eyad did not desire more children. But he was willing to pursue IVF for Lubna, whose 'right' to motherhood he valorized.

Nonetheless, this valorization of motherhood took great moral courage, for in order for Lubna to become a mother, a 'forbidden' technology, namely egg

donation, was required. It meant that Eyad was forced to leave the Sunni-dominant UAE and to help underwrite the costly 'importation' of a white American egg donor. Eyad was clear that as long as he was engaged in the business of 'buying eggs' for his reproductively elderly wife, he might as well 'pay extra' for the highest-quality American ones, in order to 'lighten up' his own offspring.

Whether Eyad and Lubna went on to produce a donor child is unknown, as I never encountered them again at the clinic. I did discover, however, that the eggs of the 'beautiful' American donor were, indeed, used in Eyad's and Lubna's cycle. According to the clinic's embryologist, this fact was a coincidence based on the donor's egg quality, rather than acquiescence on the part of the clinic to Eyad's request or to his 'bribe' to pay more for her 'white' eggs.

The egg donor, for her part, was entirely unaware of Eyad's longings for her. She was a working-class, 24-year-old from the Upper Midwest, who waited tables and tended bar in a chain restaurant. She had been 'recruited' into egg donation by a friend, and she was hoping to eventually pay off all of her credit-card bills through repeated egg donation in Lebanon (for which she was paid \$3,000 per cycle). Additionally, as a Christian, she had no moral qualms about donating her eggs. She believed that she was performing an altruistic act, by allowing couples who desperately wanted a child to become parents. Indeed, as she passed by the clinic's bulletin board, which was loaded with photos of Lebanese IVF babies, she would point out, 'This one is mine', based on what she perceived to be the phenotypical similarities that Eyad had so admired, namely, her fair skin and large 'Caucasian' eyes.

Reflows to and from the UAE

A final important, high-stakes moral issue in the sagas of couples flowing into and out of the UAE has to do with abortion. Abortion is criminalized in most Middle Eastern countries, including the UAE. In the UAE, even so-called 'therapeutic abortion' (e.g. in cases of fetal abnormalities or demise) is extremely difficult, if not impossible, to obtain. The lack of local abortion services poses problems for the local UAE IVF industry. When more than one embryo is implanted in a woman's uterus in the course of IVF, the woman is usually advised to 'reduce' the number of fetuses because multiple pregnancies are less likely to survive, more likely to be born preterm, and more likely to have significant impairments. 'Fetal reduction' is a form of 'selective' abortion in which potassium sulfide is injected into the heart, causing fetal demise. Because of the current UAE abortion law, however, all women who require a fetal reduction in the midst of a 'high-order' multiple embryo IVF pregnancy must leave the country, often during very difficult moments in their reproductive lives.

As a result of these abortion restrictions, reproductive travellers flow into and out of the UAE, and then often back again, as they attempt to access abortion services following a successful IVF cycle. Indeed, I met reproductive travellers who had entered and exited the UAE several times, while attempting, for example, to start their IVF cycle in the UAE, then access donor eggs in Beirut or Bombay,

returning to the UAE for pregnancy monitoring. Women who were discovered, upon ultrasound, to be carrying three, four, or more fetuses – sometimes as the result of a donor cycle – were then told to ‘reduce’ the pregnancy abroad. South and Southeast Asian couples tended to head eastward, usually to India, while Middle Eastern and European patients tended to head westward, often to London, where they could obtain a safe abortion.

The final case study, a woman who I shall call Elaine, bespeaks some of the trials and tribulations of a reproductive traveller who is forced to move to and from the UAE multiple times during the course of a single IVF cycle. In Elaine’s case, she is prevented from accessing *both* egg donation and abortion in the UAE, and faces similar difficulties in her home country of Israel. Elaine’s case is also interesting for what it tells us about the ‘helper women’ who are now expected to assist global elites in their transnational quests for motherhood.

The Israeli ‘Julie Andrews’

During my second month in the UAE, Dr. Pankaj introduced me to Elaine, an Ashkenazi Jewish woman, born in the United States, raised in France, and a citizen of Israel for the past 18 years. She and her husband had recently moved their family to Dubai for her husband’s work – using their American passports rather than their Israeli ones (as Israelis are not allowed official travel to many Arab countries, including the UAE). Elaine had seven-year-old IVF twins, a blondish boy and girl, whose school pictures she showed me. She herself was a thin, blonde, light-skinned woman, similar to the thousands of such blonde, light-skinned Europeans and Americans who, generally speaking, ‘live the high life’ in glitzy Dubai as well-paid professionals.

Over a series of long and interesting in-depth interviews with Elaine, I learned her ‘confidential’ story – namely, that she had left the UAE on two previous occasions to receive donor eggs in Cyprus, a site that is now relatively famous in both Israeli and American Jewish reproductive tourism circles. There, a Cypriot clinic, closely affiliated with an IVF clinic in the US, recruits non-Jewish Russian women as egg donors, offering the donors expenses-paid family vacations in return. Generally speaking, the recipients are middle-aged Israeli or American Jewish women such as Elaine, who have not been successful with IVF in Israel and who require donor eggs. In Elaine’s case, she felt that her reproductive path was being ‘blocked’ in Israel, because of her advanced maternal age and her repeated IVF failures. This was her perception. Indeed, Elaine had undergone nine IVF cycles in Israel, producing large numbers of eggs, but generally of poor quality. Although she had conceived and born IVF twins, none of her other IVF cycles were successful, and she regretted not going ‘the donor route’ several years earlier. Indeed, Elaine was already 47, although her appearance was relatively youthful.

Once Elaine moved to the UAE, she found the Conceive clinic, where she formed a therapeutic alliance with the clinic director, Dr. Pankaj. As a non-Muslim, Hindu Indian physician, educated in the UK, he supported Elaine’s decision to use a donor, although he did not orchestrate the reproductive travel for her. Elaine

did her own investigation, largely through the internet, and was pleased that the clinic in Cyprus specialized not only in IVF, but also in pre-implantation genetic diagnosis (PGD), a procedure to detect genetic anomalies in the eight-cell IVF embryo. Given the clinic’s primary clientele of older Ashkenazi Jewish women, PGD was being used on a regular basis among women concerned about the so-called ‘Jewish genetic diseases’. Further, of great importance to Elaine was donor phenotype. Namely, Elaine wanted a ‘pale’-skinned woman to look like her, and she was convinced by the staff at the Cypriot clinic that they carefully ‘matched’ their light-skinned, Russian donors to their European and American Jewish clientele. Convinced of the desirability of reproductive tourism to Cyprus, Elaine made the trip two times, concluding her second donor cycle just weeks before I met her at the UAE clinic.

There, Elaine described for me at length her desire for more children, and how she had always imagined herself like Julie Andrews in *The Sound of Music*. Living for 20 years in the Middle East had increased her pro-natalism and her beliefs in the importance of motherhood as a Jewish woman’s primary role in life. Yet, Elaine, who had just found out that she was pregnant as we began our first interview, did not consider motherhood to be feasible without extra ‘assistance’. Like so many other elite women who I encountered in Dubai (as well as in my previous work in Egypt and Lebanon), Elaine relied heavily on nannies and maids, women who were ‘imported’ into Dubai from foreign countries, mostly in South and Southeast Asia. Elaine justified her need for motherhood ‘assistance’ based on the fact that (a) her husband worked most of the time and she did not expect him to actively co-parent with her, (b) she had IVF twins, who required extra care and attention, and (c) she believed that she was now carrying another set of multiples. Indeed, Elaine complained bitterly about the possibility of having another set of twins. Although she desperately wanted more children, she believed that the birth of twins would negatively affect her own and her children’s lives. In particular, she would have to bring another part-time nanny and an extra maid into her home, which would necessitate the purchase of an even larger villa. At the time of our first interview, Elaine spent a significant amount of time fretting about the possibility of twins, telling me:

I’m already feeling physically terrible. My breasts, also—I feel I’m bursting with milk! I’m very nervous. I don’t know what’s going on in there. But we’ll know in 10 days and take it from there, one step at a time. But it’s keeping me up at night. I’m really worried. We’ll have to get a bigger place, and hire a live-in maid, plus a part-time nanny. So that she can get my kids from school and I can breastfeed.

It’s really important to me that the children’s life—that they don’t get less because of another child ... You have to try to provide the child with attention and care. Look, if you can’t afford it, that’s one thing. But I want to bring nice people so that my children get more attention. I wouldn’t want someone else to raise my child. But I do want maximum assistance [emphasis mine]. If I can’t be there, then if I get a nice nanny, and the kids like her. I’m not just

shoving them on her ... That's why I need a live-in for the house and a part-time nanny. A maid can clean and cook and also watch the kids. But a nanny has to be a 'proper' person, an educated, trained nanny, not just someone who I throw a few dollars at every month.

Indeed, Elaine had spent a great deal of time contemplating the kinds of women who would offer her various forms of motherhood 'assistance': The ideal egg donor should be a white Russian schoolteacher or nurse; the children's nanny should be a Western-educated single woman, perhaps from India; and the live-in maid should be a low-cost and unobtrusive presence in the household, meaning that she would probably come from one of the poor South or Southeast Asian countries, such as the Philippines or Sri Lanka.

Much of Elaine's first interview with me revolved about her worry at having a multiple gestation, and her fear of a possible fetal reduction in her future. Indeed, as we closed our first interview, Elaine told me frankly that she was 'freaking out' about the possibility of having to undergo a selective abortion.

Unfortunately, Elaine's worries were justified. Ten days later, she phoned me to tell me she needed to travel in order to obtain a selective reduction. She had called her doctor in Israel, only to discover that there are many restrictions on selective reduction there. There would be at least two weeks of waiting, with many committees reviewing and then deciding upon her case. She was already eight weeks pregnant, and she did not want to wait that long. She was clear that she did not want to go through a triplet or even twin pregnancy. She did not mention medical advice or whether she had been informed of the risks.

The next time I saw Elaine in the clinic, she was truly morose. She was feeling desperately ill with the triplet pregnancy, but she was now faced with a decision to head for either Bombay or London for a selective reduction. Angry with the Israeli abortion restrictions, Elaine rejected India in favour of London, where she was given the name of a good fetal reductionist.

I did not see Elaine after that point, so I do not know the actual details of her reproductive travel. She was forced to leave the Middle East because of abortion restrictions in both the Arab Muslim and Israeli Jewish parts of the region. Furthermore, toward the end of my stay in the UAE, I heard one of the Muslim clinical staff pronounce a harsh judgement upon Elaine: She described her to me as 'the woman who had tried so many times to get pregnant by IVF, and when she finally got her wish, chose to eliminate not one, but two of her fetuses!'. In the clinician's view, Elaine had done something highly sinful, doubly *haram*, taking the lives of two potential children. This Muslim clinician no longer welcomed her as a patient.

Conclusion: a new form of stratified reproduction?

The stories of Abdullah and Muna, Eyad and Lubna, and Elaine demonstrate a number of important issues, including the complexities of global reproflows, the local moral worlds that shape reproductive travellers' trajectories; the imprecision

of glossing such reproductive travel as 'tourism'; and the disparities in gender, race, class, nation and age that place some women's reproductive desires and futures over others'. Indeed, the stories of reproductive 'tourism' described in this chapter provide powerful exemplars of 'stratified reproduction', a term coined by Shelley Colen in the seminal volume *Conceiving the New World Order: The Global Politics of Reproduction* (Ginsburg and Rapp 1995). In her chapter entitled 'Like a Mother to Them': Stratified Reproduction and West Indian Childcare Workers and Employers in New York', Colen defined the term as follows:

By *stratified reproduction* I mean that physical and social reproductive tasks are accomplished differentially according to inequalities that are based on hierarchies of class, race, ethnicity, gender, place in a global economy, and migration status and that are structured by social, economic, and political forces. The reproductive labour—physical, mental, and emotional—of bearing, raising, and socializing children ... is differentially experienced, valued, and rewarded according to inequalities of access to material and social resources in particular historical and cultural contexts. *Stratified reproduction, particularly with the increasing commodification of reproductive labour, itself reproduces stratification by reflecting, reinforcing, and intensifying the inequalities upon which it is based.*

(Colen 1995: 78)

The notion of stratified reproduction evokes the transnational inequalities whereby global elites, including the Middle Eastern elites described in this chapter, are able to achieve their reproductive desires through the 'assistance' of less fortunate women from other parts of the world. In Dubai, and in the Middle East more generally, these women generally come from South and Southeast Asia and sometimes Central Asia, Eastern Europe, or Africa. They are 'imported' as domestics, sometimes on legitimate work permits, but too often through illegal trafficking operations that land the unlucky ones in brothels as indentured prostitutes (Shelley 2008).

Over my years spent in the Middle East – and particularly since working with middle- to upper-class 'elite' couples in IVF clinics there – I have been struck by the now taken-for-granted assumption that proper motherhood in elite households necessitates the labour of multiple parties, primarily live-in maids, who are almost always poor women from Southeast Asia, Africa or the subcontinent. These women are generally poorly paid, live in tiny closet-like rooms, and work from sunrise to sunset. In many cases, they do the bulk of the childcare, as elite women pursue their careers or participate in networks of sociability. These maids and nannies – or motherhood 'assistors' – may be given a one-month vacation per year, which allows them to visit their *own* children back in the Philippines, Malaysia, Sri Lanka, Bangladesh, Ethiopia, Somalia, Sudan, or other faraway places.

That women seeking motherhood through IVF have come to expect this sort of 'assistance' strikes me as doubly perplexing. On the one hand, many of these women have waited years to bear a precious child. Yet, when these children are

born, they are in some cases turned over to the care of non-elite nannies, many of whom are uneducated, do not speak the same native language, or share the same religion. In addition, having experienced the pain of infertility and 'missing motherhood' (Inhorn 1996), it is hard to see how infertile elites can miss the point that the female maids they employ are also mothers – who are separated from their own children for years at a time. This fact rarely evokes much sympathy.

In short, the global 'reproscape' in which motherhood is 'assisted' through various means is a highly uneven terrain. Numerous inequalities and oppressive intersections based on nation, class, gender, race and religion surface on this global landscape, begging the questions: Who employs IVF in global reproscapes? Who benefits from reproductive 'assistance'? Who does the 'assisting'? Who does the 'labour'? Who is a 'mother'? Who is the 'other' in global mothering? As scholars of reproduction, we must continue to interrogate these global inequalities as we follow global reproflows into the future.

Notes

- 1 All patient names are pseudonyms, although the name of the physician cited in this chapter is not.
- 2 Some religiously devout Muslims also believe that a male physician should not even touch a woman's body.
- 3 Consanguinity, or cousin marriage, is commonly practised in the Middle East (Inhorn *et al.* 2009).
- 4 Polygamous marriage is rare in the Middle East overall (<5 per cent of all marriages). In some countries of North Africa (e.g. Tunisia, Morocco) it has been made illegal, even though it is allowed in Islam.

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