

## Assisted Reproductive Technologies and Fertility “Tourism”: Examples from Global Dubai and the Ivy League

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What motivates the global movements of infertile people searching for assisted reproductive technologies (ARTs)? In this article, we attempt to answer this question by exploring infertile patients' practices of so-called “fertility tourism.” Based on ethnographic research carried out with nearly 300 infertile travelers in two major ART centers—one in the global hub of the United Arab Emirates and the other at a major East Coast Ivy League university—we examine a diverse set of reasons for reproductive travel. We argue that reproductive “tourism” should be reconceptualized as reproductive “exile” in that infertile couples feel barred from accessing ARTs in their home countries. Listening to reproductive travel stories is key to understanding infertile couples' transnational “quests for conception.” Stories of two couples, one from Lebanon and one from Italy, demonstrate the poignancy of these quests and begin to shed light on the complex calculus of factors governing this global movement of reproductive actors.

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What motivates the global movements of infertile people searching for assisted reproductive technologies (ARTs)? In this article, we attempt to answer this question by exploring infertile patients' practices of so-called "fertility tourism" (also known as reproductive tourism, procreative tourism, and cross-border reproductive care [CBRC]). Fertility tourism has been defined as "the traveling 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).

In a front-page story in the *New York Times* (January 25, 2005) titled, "Fertility Tourists Go Great Lengths to Conceive," it was 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. Eight discrete but often interrelated factors promoting fertility tourism have been cited repeatedly in the existing literature: (1) individual countries may prohibit a specific service for religious, ethical, or legal reasons; (2) a specific service may be unavailable because of lack of expertise and equipment; (3) a specific service may be unavailable because of affordability and supply, especially regarding donor gametes and surrogates, leading to shortages and waiting lists; (4) a service may be unavailable because it is not considered sufficiently safe or its risks are unknown, so that countries exercising safety precautions may prohibit procedures that are available elsewhere; (5) certain categories of individuals may not receive a service, especially at public expense, on the basis of age, marital status, or sexual orientation; (6) individuals may fear lack of medical privacy and confidentiality and thus seek services elsewhere; (7) individuals may fear poor quality medical care and low ART success rates and thus seek services elsewhere; and finally, (8) services may simply be cheaper in other countries (Blyth and Farrand 2005; Deech 2003; Pennings 2002, 2004; Pennings et al. 2008).

Of these eight factors, two of them—law evasion and cost—have been repeatedly cited as the major reasons underlying fertility tourism. Legal scholars, bioethicists, and clinicians point to concerns over reproductive rights, freedom, and autonomy; legal regulation and harmonization on a global scale; and global health care equity, including lack of access to ART in resource-poor nations (Blyth and Farrand 2005; Cohen 2006; Collins and Cook 2010; Inhorn 2009; Ikemoto 2009; Jones and Keith 2006; Merlet 2009; Pennings 2008; Smith et al. 2010; Spar 2005; Stephenson 2009; Storrow 2005a, 2005b). These scholars have also begun to explore infertile patients' reasons for traveling, using primarily anonymous, self-administered research tools such as survey questionnaires distributed through clinics, the Internet, or patient support groups (Blyth 2010; Nygren et al. 2010; Shenfield et al. 2010; Thorn and Dill 2010).

So far, most of these studies focus on Euro-America and Australia, with particular attention given to issues of patient border-crossing between European Union nations (Blyth 2010; Deech 2003; Pennings 2004; Pennings et al. 2008; McKelvey et al. 2009; Shenfield et al. 2010). One clinical study has focused on Latin America (Smith et al. 2010), and several scholars have expressed concern about reproductive "outsourcing" to India, especially regarding gestational surrogacy (Jones and Keith 2006; Smerdon 2008/2009; Stephenson 2009). The fact that fertility

tourism is a growing global phenomenon outside of Euro-America has been acknowledged by the Task Force on Ethics and Law of the European Society for Human Reproduction and Embryology (ESHRE), which has just developed a ESHRE Code of Practice for CBRC (Pennings et al. 2008; Shenfield 2011). Other organizations concerned with CBRC include the International Committee Monitoring Assisted Reproductive Technologies (Nygren et al. 2010); the International Forum on Cross-Border Reproductive Care (CBRC) (Collins and Cook 2010); the Society of Cross-Border Reproductive Care (SCRC), which held its first board meeting in Vienna, Austria, March 26–27, 2010; and the International Federation of Social Workers (IFSW), which has drafted a policy paper on cross-border reproductive services (Blyth and Auffrey 2008).

Over the past five years, medical anthropologists have increasingly undertaken ethnographic research on fertility tourism, employing both participant observation and person-centered, ethnographic interviewing methods with infertile patients and other individuals who participate in cross-border reproductive care. Their global scope is impressive. For example, a special issue of *Reproductive BioMedicine Online* on Cross-Border Reproductive Care (November 2011) highlights medical anthropological work on reproductive travel from Turkey to Cyprus (Gurtin-Broadbent 2011); Australia to Thailand (Whittaker 2011); Germany to Spain and the Czech Republic (Bergmann 2011); the United States to the Czech Republic (Speier 2011); the United Kingdom to Spain (Hudson and Culley 2011); Italy to various European Union countries (Zanini 2011); Israel to Romania (Nahman 2011); and the United States and Europe to India for gestational surrogacy (Pande 2011). Similarly, a forthcoming volume on *Islam and Assisted Reproductive Technologies: Sunni and Shia Perspectives* (Inhorn and Tremayne 2012) includes studies of fertility tourism to and within the Muslim Middle East.

This interest in the experiential worlds of fertility tourists—as well as egg donors, gestational surrogates, and the clinical staff who deal with them—is part of the new millennial interest within medical anthropology in medical tourism. Since 2010, four special issues on medical tourism, guest-edited by medical anthropologists, have appeared in *Global Social Policy* (10, 3); *Signs: Journal of Women in Culture and Society* (36, 2); *Anthropology and Medicine* (17, 3); as well as in this journal, *Medical Anthropology* (29, 4). In 2011, a call for papers on medical and reproductive tourism was made by *Gender, Place and Culture*.

In short, medical anthropology has increasingly claimed this topic as its own. Through in-depth analyses of the stories, desires, travel trajectories, and experiences of medical travelers, medical anthropologists are beginning to shed light on the complex calculus of factors governing these global movements, including of fertility tourists embarking on their “quests for conception” (Inhorn 1994).

In this article, based on multisited ethnographic research conducted in the Middle East and the United States, we forward five key propositions. First, most infertile couples engage in the transnational appropriation of ARTs because of “reproductive exile” from home countries. We define reproductive exile as “forced” travel, when most or all other routes to local ART appropriation are barred. Second, underlying this reproductive exile are numerous “arenas of constraint,” which we define as the structural, ideological, and practical obstacles and apprehensions preventing local access to safe, effective, and affordable ARTs (Inhorn 2003a, 2003b). Third, those who embark on transnational quests for conception often have many anxieties and concerns, which revolve around the risks both of ARTs and of travel. Fertility tourism is deemed potentially risky for reproductive bodies, the health of potential offspring, and travelers’

own future health and well-being. Fourth, considering these risks, fertility tourists make calculated decisions about ART destinations, often choosing cosmopolitan, global "hub" cities considered to offer superior, "high-tech," high-quality health care (e.g., Brussels, Barcelona, Los Angeles, Sydney, Singapore, and Dubai). Among fertility tourists who are seeking donor eggs and sperm, sites may be chosen on the basis of medical "trustworthiness" as well as "superior-quality" gametes (e.g., Denmark, the Ivy League). Finally, those traveling for ARTs and gametes are not always affluent. Indeed, the case studies presented in this article belie the media-produced image of wealthy Euro-Americans traveling to tropical vacation spots to make an IVF baby "on holiday." Instead, infertile patients' own critique of the term "tourism" suggests the urgent need for scholarly rethinking of which term(s) should be used for medical travel.

## RESEARCH BACKGROUND AND METHODS

Here, we examine fertility tourism from the perspective of men and women who have crossed international borders in search of solutions for childlessness. Our article is based on a three-year study (2007–2009) of fertility tourists to the Middle East and the United States.

To our knowledge, this study represents the first large-scale, comparative, ethnographic investigation of fertility tourism from the point of view of patients themselves.

The study was conducted in two distinct locales: a large ART clinic on the border of Dubai, one of the seven United Arab Emirates (UAE), and a university-based ART clinic in New Haven, Connecticut. Nearly 300 infertile men and women, traveling egg donors and surrogates, embryo couriers, and ART clinic staff were interviewed over three years. Fertility tourists hailed from more than 50 nations and six continents (North America, South America, Europe, Australia, Asia, and Africa). The majority of interviews were conducted in private rooms in ART clinic settings, although some interviews in the United States were conducted over the telephone or in patients' homes. All interviews proceeded following written informed consent, and the research was approved by the Human Subjects Committee, Yale University. The interviews were ethnographic and open-ended, involving an unstructured interview guide, and were conducted by the first author, a medical anthropologist with long-term research experience on infertility and ARTs in both settings. Interviews were conducted in either English or Arabic, depending on research subjects' preferences, and lasted from one-half to three hours. In addition, the authors undertook extensive research on the various legal and religious precedents affecting ART practice in these settings (Inhorn and Patrizio 2009; Inhorn, Patrizio, and Serour 2010; Inhorn and Shrivastav 2010).

## ART IN GLOBAL DUBAI

The study began in an ART clinic located on the border of Dubai, UAE. There, in-depth ethnographic interviews were conducted with nearly 220 individuals: 125 patient-couples from 50 countries including India especially, followed in rank order by Lebanon, the Emirates, Britain, Pakistan, Sudan, the Philippines, and Palestine. Both male and female infertility were implicated, but male infertility was often the reason for "secret" travel (Inhorn 2011). Women experiencing female infertility, especially from the Middle East, South Asia, and Africa, were often under

incredible social and marital pressure. In these cases, supportive husbands were often "escaping" with their wives to Dubai to seek solutions to the childlessness.

In Dubai, participants described a number of reasons why they had traveled in search of ARTs. First, the emirate of Dubai is luring travelers as a "global city," including as a high-tech medical care setting (e.g., Dubai Health Care City). Reproductive travelers are attracted to Dubai because of this marketing, but in addition, through word-of-mouth referrals from regional networks of physicians and from patient websites and chat rooms where other ART seekers can state their preferences about specific clinics. Moreover, compared to many other countries, the emirate of Dubai makes it easy for most reproductive travelers to enter on a multimonth "visitor's visa," which allows them to complete an entire ART cycle (minimally four to six weeks) with only one trip to the country.

As a result, Dubai is a regional hub for infertile couples from other parts of the Middle East (e.g., Oman, Yemen) and East Africa (e.g., Djibouti, Sudan, Mauritius)—countries where ART clinics are either completely absent or minimally present. For these patients, Dubai represents the closest and easiest country of ART access. But Dubai is not only a regional hub. It has become a global hub, with 38 million travelers passing through Dubai alone in the year 2009 (Aw 2010). They include European reproductive travelers who come to Dubai to bypass restrictions in Europe, where ARTs may be readily available but where many countries have enacted multiple restrictions, including age limits and strict embryo transfer guidelines (Shenfield et al. 2010).

This is especially true of reproductive travelers from Great Britain, seeking refuge in Dubai after spending years on National Health Service waiting lists. Although publicly funded ARTs are available, they operate on a postal code lottery system and are often deemed by patients to be low-quality and ineffective (Hudson and Culley 2011). Thus, British residents—especially those of South Asian and Middle Eastern background—travel to Dubai to access services unavailable to them in the United Kingdom but close to their countries of origin.

Just as infertile couples are flowing into Dubai for ART services, many also flow out of the country for a variety of reasons. First, reproductive travelers who have attempted to access low-cost ART services in government clinics in the UAE have faced long delays and waiting lists, prompting them to leave the country (or the emirate). This is especially true of expatriate workers, who have lower priority and lower rates of subsidization than the local Emirati population. Even though Emiratis have guaranteed access to these state-subsidized ART centers, some of them chose to leave the country (or travel to a different emirate) in search of privacy/secretcy in a milieu where both infertility and ART are still highly stigmatizing.

As is the case with other Sunni-majority Middle Eastern countries, the UAE does not permit any form of third-party reproductive assistance (i.e., sperm and egg donation, embryo donation, or surrogacy), and is one of the few Middle Eastern countries, along with Turkey, to enact a legal ban on this practice (Gurtin 2011, 2012; Inhorn 2003, 2006, 2010a, 2010b; Inhorn and Shrivastav 2010; Inhorn and Tremayne 2012; Serour 2008). Reproductive travelers who require third-party donation or surrogacy to overcome their infertility must travel outside the Sunni Muslim Middle East. The UAE also prohibits multifetal pregnancy reduction (i.e., a form of selective abortion when too many embryos implant in the uterus) and cryopreservation (freezing of excess embryos and gametes). As of January 2010, these services are all legally banned under Islamic *shari'a* law in the UAE, including for non-Muslim expatriate residents of the country.

In addition, ART services in the UAE—at approximately US \$5000 per cycle—are relatively expensive compared to neighboring countries (e.g., Egypt, Syria, India). Reproductive travelers

are often keenly aware of the comparative costs of ART in different countries and may travel to a cheaper locale. This is especially true of expatriates, who may be able to access state-subsidized services based on ongoing citizenship rights in their own countries. (The UAE does not grant citizenship to non-Emiratis, including expatriate families who have lived in the UAE for decades.) More affluent expatriate residents of the UAE are often actively engaged in Internet searches of ART clinics abroad, and are attracted by fertility "tourist packages" offered in countries such as India, Singapore, and Thailand. They may not regard these locales as "holiday sites" but rather as trustworthy countries in which to obtain the services they need.

Many expatriates also demonstrate what we call "medical (ex)patriotism": namely, a belief that the "home country" offers higher-quality medical services than the "host country" (Inhorn 2003, 2010b). This patriotic attachment propels many infertile couples back to their natal countries during month-long annual leaves. These travels are often justified by reproductive travelers who have faced poor-quality medical care in the UAE. Some travelers recite medical "horror stories" in which they or a loved one experienced serious complications and near-death experiences at the hands of local medical personnel. In addition, expatriates often prefer to try ART "back home" because they will be hosted and cared for by their families. This kind of family support, especially by parents, is considered critical by some couples (Inhorn 2011, 2012). Finally, some reproductive travelers leave Dubai in the third trimester of their ART pregnancies to deliver their offspring in "the West" (e.g., Canada, United Kingdom, United States). Their desire is to produce an "anchor baby" who will eventually confer citizenship rights to the whole family.

We found that many infertile patients were traveling "to and fro"—in and out of Dubai during a single ART cycle. For example, those needing donor eggs would travel to Lebanon and Cyprus, those needing multifetal pregnancy reduction would travel to London or India, and those with financial constraints would undertake diagnostic laparoscopy in India to save on costs. Infertile couples who had frozen embryos in storage abroad would retrieve them transnationally, either by traveling abroad or hiring the services of an embryo courier. As of 2010, both cryopreservation and embryo couriers were outlawed in the UAE, suggesting that in the future more couples will be forced to travel outside the UAE for embryo cryopreservation services.

Because of their difficulty in accessing the full range of ART services in the UAE, infertile couples in this setting often ended up receiving very fragmented care. Sometimes, this could be life-threatening; in our study, several travelers recounted serious reproductive emergencies when travelling, including ovarian hyperstimulation syndrome, ectopic pregnancies, and severe reproductive tract infections.

To illustrate some of these issues, we turn to the story of a couple, who we will call Abdullah and Muna, following them on their ART quest from Lebanon to Dubai. As we illustrate, poor-quality care and lack of ART success in Lebanon eventually caused them to travel. However, other arenas of constraint—including a Muslim woman's religious apprehensions about seeking care from a male, non-Muslim physician—were barriers to travel that had to be first overcome. In the Muslim Middle East, such religiously inspired moral concerns are significant factors in both motivating and dissuading couples from reproductive travel (Inhorn 2003a). Reproductive travelers' own subjective moral concerns must also be recognized in addition to the official religious bans and laws on ARTs that are most often cited as important in the CBRC literature (Pennings 2002, 2004; Pennings et al. 2008; Shenfield et al. 2010).

### Abdullah and Muna: From Beirut to Dubai

Abdullah is Lebanese and Muna is Syrian. They met while Muna was attending pharmacy school in Lebanon, and married in Beirut. Shortly after their wedding, Abdullah migrated alone to Dubai; 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, who was working as a pharmacist. Their attempts to conceive were unsuccessful, so they eventually turned to ARTs.

The first IVF procedure in Beirut resulted in a twin pregnancy. But the twins, a boy and a girl, were stillborn at 21 weeks' gestation due to a uterine infection. The second IVF with the same Lebanese doctor was unsuccessful, so Abdullah and Muna switched to another Lebanese IVF clinic. Unfortunately, neither a third, fourth, nor fifth IVF cycle in Lebanon produced a pregnancy. Repeated hope then failure 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 (the result of an earlier botched ovarian cyst surgery in 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 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 clinic. Abdullah convinced Muna to travel to Dubai 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 fertility tourism in Dubai. 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]. 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, 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:

My wife had this religious problem, "Oh, he's not Muslim, [the doctor]." 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 [the doctor] 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!"... 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 in Dubai—but their sixth cycle overall—Muna became pregnant, eventually giving birth to a healthy baby daughter named Sarah. The cherubic toddler, with her little gold earrings, became a happy fixture at the UAE clinic, as Abdulla and Muna began their seventh IVF cycle in an attempt to give Sarah a sibling.



## THE EAST COAST IVY LEAGUE

Whereas Dubai represents a global hub for both expatriate labor migration and reproductive tourism, the coastal cities of the United States have tended to draw European, Latin American, and East Asian reproductive tourists for specific ART services (Thompson 2005). In our study, conducted at the Yale University Fertility Center, reproductive travelers represented nine different nationalities and five different self-identified ethnicities. In most cases, these patients had traveled to the Center because of religious and legal restrictions and limitations on gamete donation and surrogacy in their home countries. However, there were other reasons for travel to Yale as well.

First, the Center is regarded as a "prestigious," university-based, ART program with "Ivy League" donors (both sperm and egg). Couples needing donor services are hopeful that they will receive the gametes of highly intelligent Yale students, even though the clinic makes no such promises. (In fact, most donors come from neighboring communities and colleges.) Beyond the lure of "superior Ivy League" gametes, some couples simply have greater trust in university-based clinics than in the private practice and largely unregulated world of ART (Spar 2005). The Yale IVF physicians, furthermore, are all foreign born and are part of the highly diverse and "global" reproductive medicine community. The physicians are Western trained, yet speak other languages, as advertised on the clinic's website. Thus, patients from those countries feel a cultural and linguistic affinity that is compelling, especially when arcane medical information must be communicated.

Reproductive travelers from other countries are generally fleeing religiously based legal restrictions in their home countries. This is especially true for Italian couples. In Italy, a 2004 law has prohibited most forms of ART, including gamete donation and surrogacy, making it the second most "restrictive" country in the world (other than Costa Rica, where ARTs are banned altogether; Inhorn, Patrizio, and Serour 2010). The United States, on the other hand, is known as the "Wild West" of infertility treatment, with no national ART laws (Spar 2005). Thus, most couples come to the United States to escape stricter legislation, especially that which disallows various forms of third-party reproductive assistance. Such "law evasion" (Storror 2010, 2011) is particularly true of middle-aged career couples who have delayed childbearing but are unable to access donor oocytes and surrogates in their home countries. The United States is viewed as one of the few "trustworthy" sites for accessing donor technologies and surrogacy, particularly compared to Spain or India, two of the major global hubs for these practices, respectively (Bergmann 2010, 2011; Pande 2011).

Connecticut is also one of the few US states that allows commercial surrogacy. Neighboring New York does not, thereby propelling many reproductive travelers to Connecticut (as opposed to New York City). Connecticut is also one of the only US "mandate states": namely, state law mandates economic coverage of IVF-related treatments, including partial coverage of some of the services of third-party gamete donation, for state residents. Thus, unlike most states, Connecticut subsidizes this form of fertility treatment for its citizens, creating equal access for all infertile couples regardless of economic means. Foreign reproductive travelers do not share these privileges of access and subsidization. However, some former residents of the state, including foreigners who have completed medical school or graduate training at Yale, retain their state residency in order to travel back for subsidized reproductive services.

To illustrate, we include the story of a couple who we will call Chiara and Alessandro, as they ventured from Italy to Spain and eventually to the United States in their quest for ARTs.

### Chiara and Alessandro: From Italy to Spain to the United States

Chiara and Alessandro are an Italian career couple, he an officer in the Italian police force and she a research geologist. They had been trying to make a baby throughout their 10 years of marriage, eventually turning to ARTs. In Rome, where all the IVF clinics are private and expensive, Chiara and Alessandro undertook two ART cycles without success. As a couple with so-called unexplained infertility, Chiara and Alessandro were frustrated by the absence of a diagnosis as well as the 16,000 Euros they had spent on two failed procedures.

Chiara and Alessandro also felt stymied by Italy's restrictive legislation. Through research on the Internet, they discovered that preimplantation genetic diagnosis (PGD) might uncover the cause of their infertility. However, PGD was officially prohibited under Italy's ART law. As Alessandro explained:

It is not permitted. When you ask the reason for your infertility problems, the doctor just says, "This is something unknown. There is not a medical reason at the moment. The science doesn't exist to find out the real reasons." But this is not true. We tried to do some research on the Internet, and we find that it is possible, by PGD, to find some of the factors behind this problem. In Italy, "unknown infertility" problems may have a reason.

In Italy, the physicians also told Alessandro that his sperm count was low and that the solution for him would be intracytoplasmic sperm injection (ICSI), the variant of IVF to overcome male infertility. After two failed ICSI trials, Alessandro and Chiara turned to Spain, the European hub of reproductive tourism. Despite a one-year wait, the couple managed to get an appointment at an IVF clinic in Barcelona, where an Italian female IVF physician had married a Spanish IVF doctor. In Barcelona, they underwent one more ICSI cycle, again without success, but at a total price tag of 12,000 Euros.

"When we went home from Spain, she told me that maybe she did not want to do any more [embryo] transfers," Alessandro explained. "And I tried to convince her—to say that maybe the next time, if we search, we will find the main reason for the infertility. So I tried to make some research on the Internet, and that's where we tried to find [IVF clinic] sites in New York and at the famous research centers, like Yale, Harvard, and Berkeley universities."

Delighted to find an Italian IVF doctor at Yale, Alessandro sent an email, which was answered directly and immediately. Alessandro and Chiara made an appointment, after being assured that PGD could be used in the United States to make a potential diagnosis of their infertility problem. "It's not so easy to come here [to the US], to speak another language, especially about medical symptoms," Alessandro explained. "And this [Italian] doctor suggested that we don't try to do more ICSI [cycles] without a firm diagnosis. He told us that it is maybe possible that [Chiara] could have a problem with her oocytes, but that we would have to try PGD to confirm this hypothesis."

To save money, Chiara and Alessandro were instructed to undertake the preliminary hormonal stimulation in Rome before traveling to America. Their physician in Italy emailed the

Yale Fertility Center so that the timing of the oocyte harvesting would be precise upon the couple's arrival in the United States.

Settling into a hotel next door to the clinic, Chiara and Alessandro waited patiently for the results of their PGD diagnosis. As the doctor had surmised, Chiara suffered from poor oocyte quality. Although only 32 years of age, she had the "old oocytes" of a menopausal woman:

[The doctor] suggested that we don't try to do any more ICSI cycles without donor eggs. . . . Because without a donor, we were just basically wasting our money. So, for the first time, we learned that we needed to do ICSI with donor egg. So, we've been going along, at all of these different places, and we've actually been given the wrong information! This is very frustrating! If we'd had PGD in Italy, we could have discovered this a long time ago.

Chiara was particularly angry with the Italian IVF physician who told her—after her PGD diagnosis in the United States—that she should still use her own oocytes in another ICSI cycle. "After the PGD discovered my problem, in Italy, they continued to say to me, 'But you can try with your own oocytes!' Why would they say this to me? I do not know. This was very risky, because my oocytes, they have this genetic problem."

Angered by their treatment in Italy, the couple contemplated their options. They could try again in Spain, this time with donor eggs. That would have been the cheapest destination, given that clinics in Spain "import" poor women from all over South and Central America to donate their oocytes for very low fees. However, Chiara was uncomfortable with this choice. She explained,

In Spain, they give more human support [than in Italy], but the technical level is better in Italy. However, the laws are not as strict in Spain as they are in Italy, so I could do donor and PGD in Spain. The problem is, Spain is a big center for Europe. All the Europeans are coming to Spain, and especially to Barcelona, to receive donor eggs. The problem in Barcelona is that they put you on a waiting list, and maybe you may stay for one or two years before being called, even though you have to take the medicines in the meantime, just in case. Generally, they don't work with fresh oocytes, only cryopreserved ones. And, even if there are eggs, for the most part, the donors are coming from South America. And me, I am blonde and white, so someone from Central America is going to look a little bit different from me. For a girl like me, to get a matching donor, there is going to be a long line. And, we don't know about the health of this donor. Having a healthy and sane donor is the most important thing.

Discouraged, Chiara checked into adoption. But this, too, seemed extremely difficult. "The worst problem in Italy is wanting to adopt," Chiara said. "There are not any Italian children to adopt, so the cost to adopt a child in Italy is very, very high. And if you want to adopt from overseas, the international procedures are very strict and it requires a very long time. They say adoption is easier than it is."

Using the last of their life savings with "a little help" from Chiara's parents, the couple made the difficult decision to undergo the US \$30,000 ICSI-donor egg cycle in the United States. Despite the costs and although Alessandro had to ask for a special leave permit from his supervisor at work, the couple felt "forced" to pursue third-party reproductive assistance outside their home country. Alessandro explained:

Maybe if we can do this kind of treatment in Italy, it would be more comfortable for us. . . . But because this is not permitted in Italy at all, we had to find another solution. We were *forced* to find a solution. So it is like forced travel. The Italian constitution says that Italy is a *nonreligious state*. But in fact, this is not true. Italian citizens must follow the Italian law, and the Italian law is affected by the association of Italian bishops, who said, "We must respect life." I'm a practicing Catholic, but I wish the Italian Church had a different position so that we could obtain this kind of thing. The official position is always "no." But if you speak face-to-face with some Italian priests, they view this [ART] as "helping nature."

During their fourth and final ICSI cycle in the United States, Chiara and Alessandro remained hopeful. With donor oocytes, the Yale doctor predicted that their chance of pregnancy could be as high as 60 percent. As Chiara concluded, "It has been a lot of effort, but we're full of hope."

But upon their return to Italy, Chiara and Alessandro's dreams of having a test-tube baby came to a sudden and tragic end. Alessandro resumed his high-intensity job as a police officer, but was killed in the line of duty. Alessandro was 40 years old, leaving behind the 32-year-old love of his life, but no children.

### RETHINKING FERTILITY "TOURISM"

As these two cases suggest, the language of fertility tourism is rarely appropriate for describing reproductive travel. The term "medical tourism"—and the more specific variants of "reproductive tourism," "fertility tourism," or "procreative tourism"—have been routinely applied by both scholars and the Western media to describe the phenomenon of cross-border medical care. Nonetheless, most reproductive travelers in our study vociferously critiqued the term tourism. Their travel, they explained, was undertaken out of the "desperate" need for a child and was highly stressful and costly. Because tourism implies fun, leisure, and holidays under the sun, it is a term that is cavalier and insensitive. As one Australian patient put it, "'Reproductive tourism' sounds like a 'gimmick,'" which makes a mockery of infertile people's suffering. In virtually every case, infertile couples described their preferences *not* to travel if only legal, trustworthy, and economical services were available closer to home.

Reproductive travelers' own critique of the term fertility tourism suggests the need for some scholarly revision. To perpetuate the concept of tourism may be to misrepresent the subjective world of reproductive travelers, very few of whom experience their travel in truly touristic terms. Instead, the notion of "reproductive exile" may be closer to most patients' subjective experience of reproductive travel (Inhorn and Patrizio 2009; Matorras 2005; Pennings 2005). The term exile has two meanings: either forced removal from one's native country or a voluntary absence. Both meanings are accurate to describe reproductive travel. In our study, reproductive travelers described how they felt "forced" to leave their home countries to access safe, effective, affordable, and legal infertility care. Their choice to use ARTs to produce a child was voluntary, but their travel abroad was not.

Legal barriers in particular bespeak the politics of exile, and such politically motivated reproductive exile may be increasing. For example, in recent years, several Western European nations, including Norway, Germany, and Great Britain, have enacted strict legislation prohibiting some or all forms of gamete donation, especially anonymous gamete donation, as well as gestational surrogacy (Jones and Cohen 2007; Pennings 2004, 2008; Pennings et al. 2008; Shenfield et al.

2010). In Southern Europe, Spain prohibits surrogacy, Italy prohibits both surrogacy and gamete donation, and France prohibits lesbian and single women from accessing ART (Matorras 2005; Inhorn, Patrizio, and Serour 2010). Such restrictions have triggered European reproductive travel on a massive scale, especially to the post-Soviet bloc of Eastern Europe (e.g., to Russia, Czech Republic, and Romania) (Bergmann 2011; Nahman 2011; Speier 2011). There, clinics can "employ the Internet to attract fertility tourists with promises of cut-rate in vitro fertilization, high success rates, liberal reproductive policies and little administrative oversight" (Storror 2005a:307).

However, legal restrictions are not the only reasons why infertile couples feel forced to travel. Various cultural and psychosocial factors, which are rarely cited in the clinical and bioethical literature on CBRC, also come into play. These include, *inter alia*, feelings of medical (ex)patriotism; the desire for physicians who are co-religionists; the desire for family support and "tender loving care"; the lure of particular global hubs and their open visa processes; the attraction of "prestige zones" where "superior" gametes can be sought; and couples' hopes of delivering an ART "anchor baby" to obtain citizenship rights in another country. For many couples, these are compelling factors in their "diasporic dreams" of making a test-tube baby abroad (Inhorn 2010b, 2011).

Having said this, it is important to reiterate that most couples in our study lamented the lack of necessary ART services in their own residential locales, and wished that they could remain "at home" for a variety of reasons. First, home represents a "comfort zone" for most infertile patients. They are familiar with the medical system, may have developed emotional attachments to particular clinics and ob/gyn physicians, speak the same language, and share cultural assumptions with the medical staff in the home country. Furthermore, patients may have well-developed social support networks at home, including family members and friends who can be counted on for emotional, financial, and logistical support during the lengthy and sometimes physically arduous ART treatment process.

In addition, infertile patients must consider the pragmatics of reproductive travel—including absorbing the economic costs, making travel arrangements, finding appropriate lodging, acquiring travel visas, transporting cold-chain-sensitive medications, communicating with foreign clinics, and being away for extended periods—to be arduous. Participants in our study often complained that reproductive travel was emotionally exhausting, financially draining, and logistically impractical, to be avoided at all costs, if possible.

For many people in our study, taking time off from work was also a major problem. Men and women must schedule ART cycles within the parameters of their busy lives. Traveling often involves asking for permission from employers to use vacation time, medical disability leave, or unpaid leave. Furthermore, many ART-seeking couples have careers that may be disrupted by reproductive travel. Men such as Abdullah and Alessandro often made noble attempts to fit travel within the demands of their professions. Many career women left their professions altogether due to the impossible demands of balancing work with reproductive travel for ART. Women were sometimes forced to travel alone because their husbands were unable to "escape" demanding jobs. Indeed, reproductive travel was seen as jeopardizing work because it required time off, the depletion of vacation and sick days, or unpaid leave. Permissions must be sought, thereby revealing infertility problems to employers. With the global economic downturn, jobs are less secure than before, making time off especially threatening. Further, many ART patients in our study were devoted couples who wanted to stay together, literally and figuratively, during the entire ART treatment process. Reproductive travel sometimes pulled them apart.

## CONCLUSION

In the new millennium, scholars, ART professionals, and the global media now recognize that fertility tourism is a growing global phenomenon. As infertile patients pursue ever more diverse treatment options around the globe, policymakers ponder whether limits should be set on the technologies themselves and on the fertility tourism surrounding them (Deech 2003). As one scholar of fertility tourism, Guido Pennings, noted in *The Journal of Medical Ethics*, "The more widespread this phenomenon, the louder the call for international measures to stop these movements" (2002:337). A great deal of speculation—including open condemnation by highly regarded public policymakers in internationally esteemed journals—suggests that fertility tourism has created an internationally "lopsided market in baby making," which requires careful ethical and legal regulation on a global level (Spar 2005:531). As Debora Spar, an ART economist and now president of Barnard College, argued, "As science continues to expand our menu of reproductive options, it will be increasingly important to engage in some kind of political debate and to ensure that some consideration stretches beyond the desires of individual parents" (2005:533).

We have illustrated the multiple desires, intentions, frustrations, and apprehensions of infertile couples as they travel to and from ART sites in two disparate parts of the world. Infertile couples seeking ARTs abroad generally do not want to be known as fertility "tourists," suggesting that the term "tourism" itself is an inappropriate gloss (Whittaker and Speier 2010; Whittaker, Manderson, and Cartwright 2010). In our view, the term reproductive "exile" comes much closer to infertile travelers' own subjectivities as they embark on their transnational quests for conception (Inhorn and Patrizio 2009). Medical anthropology has a major role to play in the study of these global movements. Together, medical anthropologists can provide important ethnographic insights of great relevance to future social policy and clinical practice. The motivating factors, experiences, and concerns of reproductive travelers themselves cannot be known a priori. Instead, through ethnography, medical anthropologists can shed light on a world of global fertility tourism that is burgeoning and that deserves our attention.

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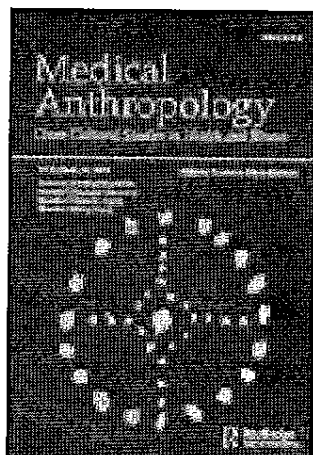
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### Assisted Reproductive Technologies and Fertility "Tourism": Examples from Global Dubai and the Ivy League

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