

EastBordNet

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**Working Paper**

**Bodies Bridging Borders**

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## Abstract

*What is legal may not necessarily be considered moral (and vice versa). I would like to pick up the theme of borders as both bridges and boundaries by looking at the movement of bodies and 'body bits' across them. This paper begins a review of the literature on the trajectories of biological bodies and bodily substances in biomedical procedures. It will focus on how boundaries between countries facilitate access to advanced biotechnologies such as IVF (in vitro fertilisation), with or without the use donated gametes or embryos. It places the specific examples of what has been called 'reproductive tourism' within a broader field of medical migrations. What is disallowed (not permitted) in one country may not only be allowed but actively encouraged (in the form of 'medical tourism') in another. In this sense, borders act as bridges across which people requiring various biomedical interventions travel. I draw on the ethnographic example of Lebanon where no national legislation allows many women, who would otherwise find IVF prohibited through religious injunctions, access to fertility services.*

## Medical Migrations

Recent research on 'medical migrations' and what has been dubbed 'medical tourism' has highlighted the movement not only of persons but also of body parts and body substances across the borders of nation states. North Americans are travelling to Costa Rica for inexpensive (compared to the United States), state-of-the-art cosmetic surgery and dentistry (Ackerman f/c); while Japanese travellers look to Bangkok or Malaysia for the same. The British, it is reported, are 'flocking' to Hungary, Poland and Turkey for dental treatment and combining cosmetic surgery with a safari in South Africa or sightseeing with a 'tummy tuck'

in India. The large and consistent increase year by year in British people seeking medical and dental treatment abroad prompted the first medical tourism fair in London in 2008. An obvious success, the show has become a yearly event. As I write, however, it is announced that the 'Health and Medical Tourism Show', due to be held at the Olympia Conference Centre, April 17-18 2010, has been postponed because the majority of exhibitors cannot get there. Advertising, before the 'ash cloud' grounded flights into and out of Europe, promised:

Medical and health service providers from around the world will be at the show, representing Europe, Scandinavia, the Middle East, China and South East Asia, Australia, South America and Canada, ChirurgiePro from North Africa, Medical Malta, Nicosia Dental Policlinic and more.<sup>1</sup>

A number of urban centres are vying to become 'the centre' of medical tourism. Bangkok, for example, is marketing itself as the 'hub of medical tourism' by cultivating an advantage over other urban contenders such as Mumbai and Singapore through an emphasis on its 'Western style' facilities and Western trained staff (Wilson 2010; Wilson f/c). Indeed private hospitals in Bangkok have close collaborative relations with Thai immigration services which allow not only extended visas for surgery but for extensions to be granted in the hospitals by visiting immigration officers (Thompson 2008). Of note, here, is the interdigitation of 'the state' and 'the market': an assemblage which includes both state bureaucracy and biomedical interventions, as well as the hopes, desires and imaginaries of global biological citizens.

Of course, it is not only bodies that are crossing borders, but also body parts: organs, tissues, cells, fluids and more. Anthropologist Nancy Scheper Hughes has been following

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<sup>11</sup> [http://www.lth-hotels.com/london\\_events/health-tourism-show.htm](http://www.lth-hotels.com/london_events/health-tourism-show.htm) (accessed 20.04.10) re cancellation <http://www.eco.co.uk/event/destination-health--the-health--medical-tourism-show/220> (accessed 20.04.10).

solid organs, their ‘donors’ and recipients for more than a decade (Scheper-Hughes 2007; Scheper-Hughes 2008). She has been vociferous in her criticism of the procurement of organs and their movement from less wealthy ‘donors’ to more wealthy recipients. As Director of Organs Watch, her investigations have exposed (and I use that word deliberately) the international trafficking in body parts and revealed illegal ‘transplant rings’ operating in, for example, Moldova, Turkey and Israel. She traces networks of donors, brokers and recipients of organs that connect countries such as Brazil and Moldova (organ ‘donors’) the United States, the Gulf States and Israel (organ recipients) and South Africa and Cuba (sites of surgery).

This paper will not focus directly on the movement of body parts across the world, legal or otherwise, nor will it address head on the inequalities between ‘donors’ and ‘recipients’ and between the global north and south. The traffic in human organs clearly raises important questions that fall under the remit of EastbordNet and it would be interesting to think further about whether the traffic in organs follows the same routes as the traffic in women, for example: or, to put it another way, whether ‘transplant tourism’ and ‘sex tourism’ flow in similar directions and congeal in the same sites. Instead, this paper focuses on a sub—field of medical migrations: on what has been called ‘reproductive tourism’ (also ‘fertility tourism’ or ‘procreative tourism’ - I shall return to the problem of language below and in WS3). While analogies have been made between ‘reproductive tourism’ and ‘sex tourism’, I am not going to address the connections here, although we may feel compelled to return to them in WS3.<sup>2</sup> Here I want to focus on the legitimate and legal movement of people and body parts and the

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<sup>2</sup> Legal scholar Richard Storrow writes that egg donation (we could add surrogacy) like prostitution will be ‘especially attractive in regions of the world where large numbers of women with few choices want to improve their economic circumstances’ (Storrow 2005: 326).

porousness of boundaries when it comes to fertility services. I am interested in the ways in which (some) women (and sometimes their partners) travel from one country to another to gain access to assisted reproductive technologies (ART). I juxtapose examples from northern and southern 'European' borders and start by looking at the vexed question of language.

### Tourists, migrants and pawns

It is clearly inaccurate, in many cases, to suggest that travelling across borders to get access to biomedical treatment is a form of tourism. Tourism implies pleasure and leisure, and we would be hard pressed to imagine many of the endeavours I describe below as pleasurable. Nevertheless, the marketing of some procedures in certain localities rests on the potential for visitors to combine medical treatment with 'a holiday'. It is also fair to say that many of the countries and clinics vying to become 'hubs' of medical tourism are advertising their wares in idioms resonant of the tourist industry. I think, however, that is important to disaggregate the numerous procedures that fall under the rubric of medical tourism and look at what gets screened out when they get lumped together under this idiom. The medical procedures that British 'clients' seek abroad, for example, tend to be those that are not provided by the National Health Service (NHS), or are rationed or scarce. The British, then, are finding less expensive alternatives to private medicine or more timely alternatives to the NHS. In the case of ART, treatment on the NHS is limited and patchy and has up to recently depended on the policies of the local Health Authority. If available on the NHS, IVF is limited (e.g. three attempts on the NHS), age restrictions apply and donor gametes are in 'short supply'. In Britain, as in many other European countries, ART is both facilitated and hindered by legislation. European women travel abroad in order to bypass the legislation in their countries of residence. For example, egg donation is prohibited in Norway; there is a ban on all 'third party intervention' (gamete donations and surrogacy) in Germany; and in Italy not only third

party intervention is prohibited but also the cryopreservation of embryos and gametes.

Furthermore, in Italy, for example, fertility treatment is also restricted to married, heterosexual couples.<sup>3</sup>

Charis Thompson provides a useful taxonomy for medical migrations. She reserves the idiom ‘medical tourism’ for ‘empowered biosocial citizens’ who traverse economic, political and regulatory regimes to get access to desired treatment which in turn brings revenue and creates a new labour market in host countries (Thompson 2008). She uses ‘medical migration’ to refer to movements across regional and national boundaries that allows for health care (without persecution) and is related to immigration or migrant status. ‘Medical trafficking’ maps onto the cleavages between the global south and the poor of the global north who act as biological resource for the wealthy. The examples I draw on below have features of all three and, as in most taxonomies that attempt to tidy up social flows and impose order on biosocial assemblages, the reality is more messy.<sup>4</sup>

### The Vikings are coming

In 2005, a change in legislation in the UK lifted the clause guaranteeing anonymity for gamete donors. Although the change in legislation affected both egg and sperm donation, it was sperm donation that drew the most attention. Predictably, perhaps, the number of men offering their semen dropped. Danish clinics, with the most advanced sperm banks in Europe,

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<sup>3</sup> I want to ask, although this may not be the place, whether the desire of lesbians, single or older women for IVF with donated gametes is analogous to the desire of the same ‘categories’ of women for blepharoplasty or liposuction? All, it could be argued, are elective, and all are biomedical ‘solutions’ to non life-threatening, and some would say social, ‘disorders’.

<sup>4</sup> And see Clarke 2008 for a useful literature review of reproductive technologies in East Asia ((Clarke 2008))

stepped in. This movement of bodily substance across national boundaries prompted dramatic (and amusing) headlines in both ‘gutter’ and ‘quality’ press alike to the tune of the ‘New Viking Invasion’:

The Vikings are coming. As sperm donations in Britain slow to a trickle, Denmark has become the sperm powerhouse of Europe (Times Nov 2006).

Less well reported was the fact that one of the Danish clinics offering its surplus semen to Britain (at a price), cited the European Union’s ideal of the internal free market and its commitment to the free movement of goods and services, and threatened legal proceedings if the HEFA did not permit the import of its goods (Deech 2003).<sup>5</sup> At the same time that cryopreserved sperm is exported from Denmark to Britain (and indeed to many other countries), Denmark is also attracting ‘clients’ from neighbouring countries such as Sweden (where full disclosure of the identity of gamete donors is encouraged) and from Norway (where egg donation is prohibited). At the same time as providing anonymized gametes, Danish clinics also offer fertility services to single women and do not impose the same age restrictions as other European countries.<sup>6</sup> One Danish clinic reports a 40% rise in British women attending the clinic since 2005, while another has opened franchises in India and the United States (Bionews Jan 11th 2010).<sup>7</sup>

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<sup>5</sup> The HEFA is the Human Embryology and Fertilisation Authority which is the body that regulates ART and fertility clinics in Britain,

<sup>6</sup> Finland passed legislation in 2006 allowing for gamete donation, to heterosexual couples, lesbian couples and single women, with no age restrictions on either men or women, but with the insistence that gamete donors are registered and identifiable.

<sup>7</sup> [http://www.bionews.org.uk/page\\_52667.asp](http://www.bionews.org.uk/page_52667.asp)

A further factor in the ‘Viking invasion’ and the availability of ‘spare’ Danish semen is the comparatively high limit set on how many children can be conceived from one sperm donor. Currently it is twenty five in Denmark compared to five in France. British clinics count by families: while there is no limit to the number of children that can be conceived from one sperm donor it can only be within ten families.

Thinking again of attempts in Bangkok to market the city as the hub of medical tourism in Asia, it is tempting to see Denmark as the ‘fertility hub’ of Europe: while it is clearly not as simple or sensationalist as that, Denmark’s marketing success alerts us to the relationship between current neoliberal ideologies of choice and free market and expansive national policies. Bucking the trend is Italy. After a period of appearing as if it were the ‘reproductive tourist centre’ of Europe with high profile clinicians such as Professor Severino Antinori, who held out the promise of cloned embryos, and high profile cases such as those of elderly and post-menopausal women achieving pregnancies through donated and ‘young’ ova, Italy enacted one the more restrictive legislative regimes in Europe: prohibiting gamete donation and embryo storage and confining fertility treatment to heterosexual married couples. Post-menopausal women are more likely now to travel to Eastern Europe for donated ova. Last year, Elizabeth Adeney, for example, gave birth in Cambridge, UK to her first child. She was sixty six years old at the time and her son was conceived through IVF, using donor sperm and ova, in a clinic in the Ukraine. The year before, a sixty year old woman travelled from the UK to Russia and was successful in achieving a pregnancy using IVF with a donor egg. Hungary, Romania and the Czech Republic are today touted as good destinations for Europeans (and North Americans) seeking fertility services.<sup>8</sup> All have ova to offer as well as

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<sup>8</sup> The Guardian newspaper ran a story in 2009 with the headline ‘British women head for Czech republic and Spain as fertility tourism thrives in Europe’ (The Guardian, 30 June 2009). Amy Speier (n.d) has carried out ethnographic research with couples from the US who

shorter waiting lists and no age restrictions. The ‘shortage’ of ova in Britain is blamed on the lack of anonymity and existing restrictions on payment.<sup>9</sup> Britain, unlike Spain and the US, is squeamish about payment for body parts (Titmuss 1970; Steiner 2003). Tied partly to the welfare state and social medicine, it is deemed inappropriate to pay for body substances - including blood and gametes. There is also fairly rigorous regulation of ART in the UK overseen by the HEFA who also license and inspect clinics. It is the HEFA who attract the ire of individuals who perceive their choice to be thwarted and of the media who report its decisions as removed from reality. Recall the case of Diana Blood (Simpson 2001).

Mrs Blood applied to the HEFA to use the sperm of her deceased husband which she had asked to be extracted while he was in a coma after contracting meningitis. The authority refused on the grounds that, except for medical purposes, it is unlawful to remove the gametes from an unconscious person and without consent. Mrs Blood launched a media campaign and sought to have the law overturned arguing that she and her husband had planned to have a child before his sudden and untimely death and that they had talked about posthumous birth. The Court of Appeal decreed that the HEFA should take its decision again as it had not taken sufficiently into account the European principle of freedom to seek medical services. For the HEFA, the Court had not taken sufficiently into account the manner in which the sperm was procured - leaving the question of whether it should be legal to remove gametes from the ‘thousands of young people who die unexpectedly every year’ (Deech 2003). Mrs Blood took her deceased husband’s sperm to Belgium where she was successfully inseminated (twice).

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travel to the Czech Republic for fertility treatment. They cite lower costs and more compassionate treatment as the reason they travel to the Czech Republic.

<sup>9</sup> In Britain only ‘expenses’ can be reimbursed. I was always struck on my visits to the University of Barcelona by the posters displayed prominently in the corridors and women’s toilets urging students to donate their eggs for a fee (then, in 2006, 900 Euros).

Belgium has no laws on ART and offers fertility services to residents of all its neighbouring countries: Germany, for example, where (like Italy) neither gamete donation nor embryo storage is permitted.

There is a substantial body of research highlighting the diverse political, social and economic regimes that govern and give meaning to biotechnology in different parts of the world. Numerous scholars have turned their attention to the ways in which biotechnology is appropriated, adapted, rejected, shaped etc. in its travels (Kleinman, Das and Lock 1997). For some commentators reproductive tourism is a pragmatic solution to contested moral regimes, as such it presupposes legal and moral diversity: it presupposes, in other words, borders. Guido Pennings argues that it goes some way to resolving conflict between the moral majority and individual rights (Pennings 2002; Pennings 2005) and furthermore:

Contrary to the allegations, reproductive tourism may actually reduce social injustice and unfairness by allowing poorer patients from rich countries to obtain the treatment they cannot afford in their home country (Pennings 2005: 122).

Others question whether the risks entailed in 'reproductive tourism' are a 'price worth paying for freedom of choice' (Deech 2003). Reproductive tourism, then, is thriving in Europe. People are travelling abroad to get access to scarce commodities such as gametes, to bypass legislation or restrictions according to age, sexuality or marital status 'at home', or to reduce the cost of treatment. The media (in Britain at least) has had a field day reporting the dramatic, and for those concerned, often fraught, stories of older women in search of younger ova; posthumous conception as in the case of Diana Blood; or the attempts by gay men to have a child of 'their own' as in the case of Mancunian couple Tony and Barry Drewitt-Barlow who secured both egg donor and surrogate mother in the United States.

An information and knowledge economy is developing apace with the ‘business’ of fertility enhancement. Global IVF dot com, for example, is a resource to advise, promote and share information about getting access to fertility services across the world. With a blog, a guest speaker/expert, a news page, interactive map and collection of articles, it promotes and warns of the pitfalls of reproductive tourism. In the words of its promotional blurb:

#### WHAT IS GLOBAL IVF?

In a world with ever shrinking borders, more and more people who need help having a family are traveling abroad for assistance. The reasons are varied: greatly reduced costs, greater availability of resources, no age or gender restrictions, shorter wait time, and more lenient laws. Whatever your reason, Global IVF.com is designed to make your journey less stressful and more successful.

The borders between countries mark out different fertility regimes: different possibilities for biomedical intervention in involuntary childlessness. Borders mark the interface between distinctive ‘local moral worlds’ (Kleinman 1992) which appropriate and insinuate biotechnology into their cultural and religious interstices. At the same time, however, while national legislation does not fully restrict or circumscribe what is available to citizens of that nation in terms of ART, mobility and thus access to fertility services is, of course, unevenly distributed. Traveling to Denmark to undergo IVF with donated ova, possibly and usually on more than one occasion, is beyond the reach of many Europeans. Then again, it is often thus ‘at home’. While Global IVF dot com points to a world with ‘shrinking’ borders, by which I take them to mean less dense, more porous borders, I want to argue that the borders themselves both facilitate and curtail access to fertility treatments and to do so I turn to the ‘southern’ borders of Europe. While not strictly Europe, I focus on Lebanon partly again because I have carried out some research in Lebanon albeit preliminary and also because it

figures as bridge between ‘east’ and ‘west’. Lebanon raises interesting questions about the borders of Europe, as well as internal borders between different religions.

Before turning Lebanon, it might be worth mentioning for present purposes that Turkey is emerging as a ‘popular’ destination for fertility treatment. The website <http://www.ivfinturkey.co.uk/> suggests that a good rate of success, much cheaper treatment than in the UK or the US, and no waiting lists make Turkey ‘one one of the leading fertility tourism destinations among Europeans and Americans’. I should also mention Israel which has the most comprehensive, state-sponsored fertility services in the world. Israeli women (both single and married) have access to a wide range of assisted reproductive technologies including surrogacy paid for by the State until two live births are achieved. Israel also promotes itself as a centre for reproductive tourism with clinics advertising IVF at ‘a fraction of the cost’ of North America and Europe. And finally, Jennifer Rimm writes that ‘India is currently a top destination for fertility tourism. High quality health care, Western-trained doctors and low medical costs make India attractive to would-be Western parents’ and not only Western parents (Rimm 2009). It turns out that India is top of the list for surrogacy arrangements.

A word of caution needs to be uttered amidst the hype of freedom and choice and the positive idioms of touristic adventures. The shadow figure in the cheaper hence more accessible egg donation programmes in the Czech Republic is the poorly remunerated egg donor (Speier n.d.). And the surrogate mothers in India say that they have no choice in the decision and that they sacrifice their own body and dignity for the well being of the rest of family: that the payment they receive for gestating the baby of a wealthier foreigner contributes to the welfare of their own children (Unnithan n.d.).

### Bodies crossing borders

On my fourth morning in Beirut, the Syrian caretaker of the building in which I was living told me, over the phone, that today was a holiday. He said he had just heard it on the radio. The news belied the noise coming from the construction site next to my apartment which had, that morning, as on the previous three mornings, served as my alarm clock. I looked out my tenth floor window, the workers were directly facing me - no hard hats, some no shoes - Iraqi mostly, I had been told. The workers slept in the shell of the building at night acting as night guards as well as labourers.<sup>10</sup> I assumed they were working that day because whatever holiday it was it did not extend to casual or undocumented labour. I phoned a colleague and friend at the university, she was not there. I asked the secretary why today was a holiday. She was indignant, tetchy even: 'It is not a holiday', she told me emphatically and in a way that provoked guilt in me as if I had been caught in an intention to skive off. As the day unfolded, I came to realise that her indignation was not directed at me, but at those who thought they had the right to call a holiday when they did not. However, I did not know this yet.

I flagged a service taxi to take me downtown to my appointment (my first 'proper' interview) with the Head of the Evangelical Church in Lebanon. The passenger in the front seat helped explain to the driver where I was going and then told me in a mixture of English, French and Arabic that there would be demonstrations later; that downtown would be full of people; that it would be very busy. It was only then that I noticed how quiet it actually was: how few cars there were on the road and how the cacophony of vehicles vying for limited space, that had shocked me on my arrival in Beirut, was muted. 'Why', I asked, limited to English and poor French. 'The bodies', he said. 'Which bodies?', I managed. He explained,

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<sup>10</sup> See John Chalcraft's account of Syrian labour in Lebanon and its ebbs and flows since the 1950s (CBRL Newsletter 2005). Syrians, he writes 'are often strongly conscious of low pay, long hours, hard and unprotected work, insecurity, employer profiteering, lack of benefits, and Lebanese hostility' (Chalcraft 2005: 26-32).

but my linguistic shortcomings blocked further understanding and understandably he gave up. After a short lull, while I mulled over the possibilities of demonstrations and bodies, I managed to ask him if there would be trouble. He looked genuinely surprised at what he evidently considered a surprising question. I read, ‘of course not!’ or ‘as if!’ in his expressive shrug of the shoulders and loud ‘tut!’

I discovered later that ‘the bodies’ to which he referred were the five, live Hizballah combatants that had been held in Israeli prisons who were being swapped for the bodies of the two dead Israeli soldiers whose kidnapping had sparked the Israeli bombing of Lebanon in August 2006. Unconnected as it may seem, it is the secretary’s response that I think pertinent to these preliminary thoughts on Lebanon and reproductive tourism. The secretary’s implicit question, posed in different ways from many Lebanese perspectives, was why should one religious view prevail over another?

The multi-religious fabric of Lebanon and a commitment to preserving it came up in many conversations I had with Lebanese professionals and budding professionals (predominantly theologians, medical practitioners and lawyers as well as students of medicine and public health) about assisted reproductive technologies in Lebanon.<sup>11</sup> Freedom of thought and freedom of religion, I was frequently told, are characteristic of Lebanese society and are what differentiates Lebanon from other countries in the region. Alongside freedom of religion, runs the idea that Lebanon is and always has been hybrid - in betwixt and between

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<sup>11</sup> Indeed freedom of conscience is enshrined in the Lebanese constitution of 1926 (Clarke 2009).

the west and the east - an amalgamation of Arab civilisation and Western influences: shaped and moulded by both, and unique.<sup>12</sup> In the words of one young Lebanese woman:

I think Lebanon carries the Eastern traditions, or the Eastern culture, but at the same time it's more open than any other Arab country ... it might get some influences from abroad, from the West, but still, it has its own touch in it.

There are eighteen registered religions in Lebanon each theoretically with the right to adjudicate on matters of personal status: inheritance, divorce and the custody of children. Separate religious courts serve Sunni, Shia, Druze, and Maronites - other Christian courts include Greek Orthodox, Greek Catholic, Armenian Catholic, Armenian Orthodox, Latin, Syriac Catholic and Syriac Orthodox. Abortion, medical assistance of reproduction, contraception, embryo research and organ transplantation also come under the umbrella of 'personal status law'.<sup>13</sup> A Unesco sponsored report on bioethical regimes in sixteen Arab states reports that, in Lebanon, the religious denominations are on 'equal footing and none has the character or nature of civil law' and that The Lebanese Constitution renders the State responsible for respecting the autonomy of all confessions.<sup>14</sup>

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<sup>12</sup> Suad Joseph (2000) argues that both sectarian pluralism and extended kinship are 'hegemonic civic myths' which act together to deter citizenship equality for Lebanese women.

<sup>13</sup> 'Final report of Mapping Bioethics Regulations in 16 Arab Member States in the UNESCO', by Prof. Fouad N. Boustany, Sec. General Lebanese National Consultative Committee of Bioethics.

<sup>14</sup> I am not qualified to discuss the finer details and historical precedents of the confessional system in Lebanon (Makdissi 2008). Suffice to say that a minimal millet system initiated

While I take seriously the point made by a number of scholars that broad categories such as Shia, Sunni and Maronite should not be taken as given and that the long tradition of secular liberalism in Lebanon should not be ignored (Deeb 2008; Clarke 2009), in an investigation of reproductive tourism in Lebanon it is necessary, I think, to start with the broad categories, not least because, in practice, it is the boundaries between them that prevent legislation and thus facilitate access to fertility treatment not only for many Lebanese but also for women from further afield.<sup>15</sup>

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during the Ottoman empire which grouped citizens into four 'loosely defined religious categories' - Muslim, Christian Orthodox, Armenian and Jewish (Joseph 2000) grew and expanded with European intervention and colonisation, and was then firmed up under the French Mandate after World War 1 (Joseph 2000; Clarke 2009). The legacy is a political system which divides up parliament and political office by confession and an agreement that the president should be Maronite, the prime minister Sunni, and the speaker of the house Shia. The Taif agreement signed in 1989, which formally ended the Lebanese civil wars, reapportioned seats in parliament from 60:40 in favour of Christians, to 50% Christian and 50% Muslim. The political stalemates since the Syrian withdrawal from Lebanon in 2005, and exacerbated by the war with Israel 2006, are fuelled by perceptions of a changed demographic and a call for increased Shia representation in government (Deeb 2008). Many of my conversations about ART in Lebanon turned at some point to the fact that there has been no census since 1932 - a census, it is thought, that would reveal a Christian minority and would force changes to old political settlements.

<sup>15</sup> See Morgan Clarke for an excellent and detailed account of the problems (and folly) of trying to ascertain the 'Islamic position on such and such': it is 'not only diverse and a matter of opinion, but may vary according to circumstance' (2009: 68).

In the context of ART, the Maronite official position is aligned with the Roman Catholic church.<sup>16</sup> This means that fertility treatment, as in contraception and abortion, is forbidden. The dominant Sunni position permits AI and IVF only for married couples and with no ‘third party’ intrusion - ie no sperm, egg or embryo donation or surrogacy arrangements (and see (Inhorn 2006); Clarke 2009). The Greek Orthodox patriarch has been persuaded of the same: to allow Artificial Insemination (AI) and IVF using only the gametes of the married couple. Shia guidelines differ according to whether one follows the religious teaching of Ayatollahs Fadlallah in Lebanon, Sistani in Iraq, or Khamene’i in Iran. But broadly speaking, IVF and AI with the gametes of the married couple are allowed, and some Shi’ite authorities also permit egg and embryo donation as well as surrogacy.<sup>17</sup>

The different religious views have prevented national legislation. One clinician put it this way:

I think it will be very difficult to make legislation [about ART] inside the Lebanese government because the Church [Catholic] and Islam disagree on this subject. The Church is against IVF, and Islam is with IVF and egg donation and sperm donation.

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<sup>16</sup> I was told that it cannot afford not to tow the line - ie that the Maronite church in Lebanon needs the support of the Vatican. This is tied to a general anxiety about demographic shifts which suggest that more Lebanese Christians than Lebanese Muslims have emigrated, that fertility rates are higher in Muslim families than Christian and that despite political system of representation which privileges Christians they now make up only 25-30% of the population (Abukhalil 2008)

<sup>17</sup> See Clarke (2009) for a detailed and scholarly account of the different Shiite ‘schools’ of thought and for the relationship between Islamic law, independent reasoning, and religious leaders.

This clinician is convinced that it will be very difficult for the government to override any one official religious position on the subject: the main sticking point, as he sees it is the relatively restrictive Maronite view. For others it is the relatively liberal Shiite view. A draft law on bioethics has been shelved and when I was last in Lebanon in 2009 there was no prospect of it being ratified.

The disagreement leaves the door open and allows not only Lebanese couples but also visitors to get access to fertility treatment. I was told that, by Western European or North American standards, IVF is relatively inexpensive and that I would be surprised at how many people, who are not particularly wealthy, can afford IVF in Lebanon

### Slippery slope

The goal posts shift. What is initially unacceptable becomes possible. The clinicians with whom I spoke in Lebanon all remarked that the desire to achieve a pregnancy overrides religious considerations and, as time goes by, if less intrusive treatments are unsuccessful, Lebanese people will consider what they wouldn't have considered before. People move from one clinic to another, or from one specialist to another, to get access to what they need.

Despite (or because of) religious injunctions, Sunni and Maronite women make their way to clinics which facilitate the donation of ova and embryos. Ova come from other IVF patients, paid foreign donors (I am told that one facility brings live egg donors from the United States and another from Eastern Europe), or from friends or family. Anthropologist Marcia Inhorn, who has worked extensively on ART in the Middle East, writes that donor eggs come from either Shi'a women who accept egg donation or from non-Muslim North American women (Inhorn 2006). She is struck by the irony of American women donating eggs to 'supporters of Hizballah' an organisation designated as 'terrorist' in the United States. She is also struck by

the movement of eggs from Shi'a to Sunni bodies. It is perhaps not as surprising from a Lebanese perspective as it might be from an American one.

For our purposes here, the points to underline thus far are:

- there is great demand for ART across the Middle East, linked to what I am calling 'an imperative to reproduce' (see below).
- ARTs, including donor technologies and surrogacy, are available privately in Lebanon and the industry is supported by a surplus of well-qualified medical personnel.<sup>18</sup>
- ARTs fall under the jurisdiction of personal status law and there is no national legislation or regulation.

### An imperative to reproduce

Both marriage and having children within marriage are of paramount importance across the Middle East. Stigma is attached to being unmarried and an even greater stigma to not having children after marriage. As in our very early work on ART in England in the early 1990s (Edwards 1993; Edwards 1999; Edwards 2000a; Edwards 2000b), many people with whom I spoke about ART in Beirut, were reminded of adoption. They readily made connections between adoption and ART and the practice of adoption was often raised as a marker of distinction between Christians and Muslims - predominantly by Christians who say that Muslims do not allow adoption. In fact, adoption is not a preferred option across Lebanon and

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<sup>18</sup> Scheper Hughes writes of how South Africa and Cuba are significant sites for surgery in the 'organ transplant industry' because both have a 'surplus' of highly qualified low paid surgeons.

while ‘transnational adoption’ may be another significant strand of ‘reproductive tourism in Europe’, this is not the case in Lebanon.<sup>19</sup>

Familiarity, similarity, resemblance, shared physical characteristics between parents and offspring are significant. As one woman put it:

There’s an important link between the parents and the child, and it is very important for people to have a biological child, and it is very important for a woman to have her own child, her blood, it came from her.

In Shia thinking adopted children can never be considered one’s own. However one should look after orphans, but while orphans should be cared for they cannot be appropriated. A child is considered an orphan if he does not have a father. Listen to this clinician who regularly seeks advice from the office of Ayatollah Fadlallah.

Fadlallah is not against adoption, but he says that we can take a baby who hasn’t any resources, we can give him money, we can consider him our baby, but really he is not our baby. But if we have a daughter and we get an orphan boy, they can marry each other. It is not our real baby. Religion is not against adoption, but we cannot consider this baby our real baby. And we must know that it is not our real baby. It is not

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<sup>19</sup> Transnational adoption merits more attention in any discussion on ‘bodies crossing borders’ and the bridges that adopted children make between donor and recipient countries is significant in the context of this meeting. For example, Norway ‘imports’ more babies per capita than any other European country (in the past from South America and East Asia and more recently from Russia and China) and Signe Howell writes of the efforts made by adoptive parents to bridge the distance between their children’s ‘two cultures’ (Howell 2006)

discouraged to take care of these babies, and the prophet Mohammed says that if we take care of an orphan, surely we will go to paradise. But the point is that it is not our real baby.

Several interviewees drew out a hierarchy of preference for me. If IVF were needed, then ideally the gametes should come from the couple. Failing that, egg donation would be possible because the mother would contribute to the child through pregnancy. Failing that adoption would be more preferable than sperm donation because then both parents are equal (i.e. equally unrelated). I was told that Fadlallah has also agreed to embryo donation but not sperm donation. With embryo donation both parents are similarly unrelated to the child. With egg donation the mother is still related via pregnancy but, without the contribution of sperm, the father is not physically related to the child at all.

### Walking on broken glass

Many of my interviewees, pointed out that other pressing concerns - lasting peace, economic stability, reconstruction after war, and so on - means that regulating ART is low on a list of priorities. Others identify the difficulty in making a law that is more in line with one religious view than another and many see no virtue in pushing through a law that is not based on consensus.

A finely tuned public politeness skirts overt disagreement between religions. This is partly to do with a sense of risk and an imperative for political co-existence - much is perceived to be at risk in overt contestation.<sup>20</sup> This caution is apparent in the way in which the

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<sup>20</sup> Criticism and scorn are reserved for the various external threats to Lebanon variously Israel, Syria, Iran , the US depending on who you talk to.

Draft Law on ART has been shelved. The inability to ratify the law and the quiet frustration felt by various key players is symptom of a heightened politeness which is strategically and politically crucial and not only in the field of bioethics. This does not mean to say that criticism of religion is muted - not at all. The powerful mix of religion and politics is often and loudly identified as ‘the problem’ in Lebanon; as holding back peace and prosperity. But criticisms, while loud and articulate, are directed at the heady mix of politics and religion and generic ‘men in beards’ (ayatollahs, patriarchs and archbishops), not at different ontological standpoints. Political co-existence requires some kind of accommodation so it seems best not to disagree too publicly about ART. Best to avoid or tone down dogma: tenets of when life begins, what constitutes a proper person and legitimate kinship. One cleric told me with feeling: ‘This [fertility treatment] is not the place for dogma’.

The same sentiment was expressed by the former Health Minister who had undertaken the work of drafting the first Lebanese law on ART. For him, positions that do not allow any form of IVF or AI (the Maronite official view, for example) are unreasonable. In his view, those who pronounce on ART and who want a stronger bioethical regime need to learn to empathise more with those suffering from infertility. He is in favour of the draft law which allows IVF, ICSI<sup>21</sup> and AI but only with the gametes of the married couple: that is, with no third party involvement.

My role as an anthropologist in this field is suspect. On the one hand, I am warned not to lump Sunni and Shia approaches together and to be better attuned to the differences not only between them but also within them. On the other, that I should not separate them out

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<sup>21</sup> ICSI stands for intracytoplasmic sperm injection where one sperm is injected directly into the ova. It means that sperm from men with poor or low sperm counts can be used. Inhorn writes of how this has proven a boon to infertile couples in the Middle East allowing men to father ‘their own’ children.

and should avoid making much of what are after all minor differences between the two - to do so, I was warned, would be divisive in a politically sensitive climate.

I was also told that Christians cannot appear fragmented. Best, not only in light of the changing demographics within Lebanon, but also in relation to the politics of the Middle East and foreign intervention more broadly, for them to appear united and for the catholic sects not to go head to head with the Vatican whose support they need.

There are many truths in Lebanon and there is finely tuned choreography between what is hidden and what is revealed, when and to whom. The Draft Law on ART acts as an ethnographic window through which some of the fault lines in contemporary Lebanese society and the constant effort required to prevent them deepening can be discerned. It also reveals accommodations, the function of the unsaid and the implicit, and a virtue in opacity rather than 'the tyranny of transparency' we are becoming accustomed to in 'the West'. This raises, for me, thorny methodological questions about research on ART in Lebanon - what are the implications for revealing, that is making explicit, what is, on the ground, implicit: known, but strategically and temporarily hidden. Well known secrets allow not only Lebanese women but other women in the Middle East to get access to fertility treatment (commonplace elsewhere) that may be inaccessible otherwise. At the same time without legislation or guidelines (let alone their implementation) mechanisms for ensuring fair and safe treatment are, at best, patchy. Of interest (to me) is the way in which the ethnography of biotechnology in Lebanon reveals both more and less than the place of biotechnology in Lebanon. It acts as an ethnographic window through which aspects of the political texture of contemporary Lebanese society can be discerned. I am interested in the micro politics of secrets, lies and polite avoidance; how secrets are as enabling as they are debilitating and how they function in other arenas of social life.

### An enchantment with biotechnology

Cosmetic surgery is popular in Lebanon. Although, just as in getting access to IVF, I was told that women (particularly) sacrifice much, save and borrow to get the treatment they need. Banks earmark loans for both. According to many of my interviewees, the cost of cosmetic surgery in Lebanon is relatively low and the quality high.<sup>22</sup> Clients from other Arab countries, particularly the Gulf States, come to Lebanon for both the treatment of infertility and cosmetic surgery.<sup>23</sup> In the summer of 2008, large groups of wealthy Arab tourists, browsing the jewellery shops and designer labels in Beirut's up-market shopping mall, were a common sight. The women wore fine, black Burkhas, dark sunglasses and monogrammed and jewel-trimmed black hijabs. A number also sported a small, white plaster across the bridge of their nose. That summer also saw an advertisement for a pizza shop which featured three cartoon figures of tousle-headed youth who could 'come as they were' ie not dress up. One also had the small, white, tell-tale plaster across her nose. The same summer a national bank advertised fertility loans, and an exhibition of the work of a young Lebanese artist, Tagreed Darghouth, was shown in a gallery in the Hamra district of Beirut.

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<sup>22</sup> For example, I was told that an IVF cycle costs \$1,000 in Lebanon compared to \$3,000 in the US. I do not know how accurate these figures are, but competition between clinics and the relatively low pay of well-qualified doctors are said to keep costs low.

<sup>23</sup> Inhorn (2006) writes that Sunni Muslim 'patients' come from Egypt and Syria for medical treatment in Lebanon (and see Clarke 2009).



In the summer of 2008 hundreds of posters advertising fertility loans appeared overnight across Beirut and its suburbs.

Tagreed's exhibition was of a series of paintings portraying the bodily effects of cosmetic surgery. The paintings are of bruised and scarred larger than life faces and bodies of women in the process of healing after surgery. One wall exhibited a series of seven paintings each of the bandaged, swollen and bruised face of a woman who had had a 'nose job'.

Tagreed painted some from photographs friends had sent her and others from friends and acquaintances willing to sit. In her words:

... a friend of mine did plastic surgery. She is my age, about twenty nine, and she took a picture of herself after the operation while she was healing. I painted from her picture.

For Tagreed, the popularity of cosmetic surgery stems from the influence of Western media and Lebanese celebrities. Two of the most popular young, female singers in the summer of 2008 had highly sculpted faces and bodies: their images were plastered around the city. They were similar in the shape of nose, height of cheekbone and fullness of lip: the effect of

expensive and extensive surgery and a 'look' that many young Lebanese women were attempting to emulate.<sup>24</sup> In the words of Tagreed :

Here, if you have noticed, lots of women do their noses? ... We have here our own natural shape that belongs to this area, and they want to get rid of it. I think it's a sign that we are no longer attached to our real identity. We want to imitate western beauty in some way. I think that is the severe effect of the media on women here, and all over the world, but in Lebanon especially.

Why Lebanon specially?

I think we are in some way closer to western countries than to our area. We have always been in some way, because there is a certain mix in Lebanon. We have been under the authority of France. We don't feel that we are Arabs in a way and we don't feel that we are Western in a way. We are trapped in the middle.

For Tagreed the image of beauty promoted in Lebanon is Western it has neither the face nor the look of the Middle East. Tagreed takes this further, fixing one's appearance, she suggests, improves the odds of marrying well. She describes one of her paintings thus:

The third painting, she's only eighteen years old. She's the daughter of a friend of mine, and her mom gave her a birthday present. Her nose job was a birthday present. I felt that the idea was very harsh, even though the mother thinks that it is normal - her daughter does not like her nose and she wants to help her.

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<sup>24</sup> For example, Nancy Ajram and Haifa Wehbe

Parents buy their daughter a ‘nose job’ (Blum 2003): a gift fraught, for Tagreed, with attempts at de-Arabicisation. Plastic surgery is held out, on the one hand, as an example of the freedom of Lebanese people to do as they choose (a comparison with other Arab countries is implicit in the message) and, on the other, is evoked as an example of a slavish adherence to the ideals and values of the West.

One of the young medical students I interviewed blames the latter on the number and type of images that Lebanese people are ‘bombarded’ with daily.

We much more easily capture ideas from the West because we’re bombarded everyday. ... you look at our city (Beirut) and it’s so Americanized, wherever you go. Like we have to take this highway to go the university in the north every week. When I first came back from Canada, I felt it was very aggressive how you have a series of billboards along the whole highway. Most of them are [pictures of] watches and jewellery and women. And what kind of women? The tall, blonde, perfect face. A very western woman who is not ours. You don’t see this in Syria or in Palestine, you see it in Amman, but not like in Beirut.

The last point I want to make in this tentative connection between cosmetic surgery and fertility treatment, reveals limits to the analogy. Infertility, as we have seen, is kept quiet. The fact of it and its treatment are stigmatised, but not so cosmetic surgery. I ask Tagreed whether women hide or disguise the fact that they have had a ‘nose job’.

No not at all, they go out with the bandages on. My friend went to her work directly after the operation, she stayed only two days at her house, and then went out with all the bandages. No there is no shame, because they don't feel that they are doing something wrong, they don't feel they are damaging themselves, they feel they are doing what they want to do.

Does this apparent lack of stigma rest on the fact that it is optional: that it is a visible example of one's ability to choose and to afford the enhancement on offer? By comparison, infertility treatment is no choice at all - the imperative to reproduce is keenly felt. Why does cosmetic surgery not reflect back, like fertility treatment, on 'shortcomings'? Partly because it does not compromise men and masculinity in the same way that infertility does. I was told that Lebanese women often take 'the blame' for infertility - shielding their husbands from the gaze of family. They also take responsibility for its treatment, attending the clinic, where they can, without their husband.

A different example of faith in biotechnological intervention, perhaps more pertinent here than cosmetic surgery, is the collection and storage of cord blood. Several clinicians told me that they are now regularly sending samples taken at birth to banks in the UK, Canada or the United States. Again, it is not clear to what extent parents are requesting this service or are taking up the offer of it, but there is a sense that the promise of biotechnology is taken seriously. In this case, as insurance for the future. When I expressed some reservation about how useful cord blood would be for the child as it grew up, one clinician firmly corrected me. In countries like Japan, Canada and the US, he told me, the technology is advanced and a person's cord blood cells can be used to treat their cancer or leukaemia in the future; he has no doubt that he will store the cord blood of his own babies.

The trouble with adoption and surrogacy, I was told, is that the mother is not seen to be pregnant. Such practices are harder to hide - more difficult to keep secret. The Lebanese, I was told over again, will not consider transnational adoption - they want their baby to look like them: to pass as 'their own'. Patients want reassurance that if they use donated gametes the resulting child will look like them. There is no compunction to reveal the methods of conception to distant family, or neighbours, or the child itself; and there seems to be widespread agreement that such knowledge is neither helpful nor necessary.

Talk, gossip and social visibility: Lebanese people know themselves to be seen. Infertility clinics are hidden away, disguised. People do not want to be seen entering them.

...the fact of going and taking a rendez-vous at the clinic and maybe going with your partner - it is a bit weird. We don't want people to see us.

The band-aid on the nose, however, makes visible efforts undertaken to improve one's appearance. It references moral rectitude and is an explicit marker of the ethically responsible person. Cosmetic surgery is an extension of the various non-surgical technologies for enhancing the body and needs to be seen in the light (and context) of prior and prevalent aesthetics of beauty. It is here that we might return to the links between cosmetic surgery and fertility treatment in Lebanon. Both enhance and augment bodies that are anyway continually being shaped. The question is whether this speaks to interesting comparisons between Middle Eastern and EuroAmerican deployments of nature. There is something deeply dodgy in 'interfering with nature' from many EuroAmerican perspectives. Is it the case that there is something deeply dodgy about not interfering with nature from some Middle Eastern perspectives?

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