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Regional reproductive quests:

Cross-border reproductive travel among infertile Indonesian couples

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Abstract:

Infertility is a significant reproductive health problem effecting at least 15% of heterosexual Indonesian couples during their reproductive lives. This article explores the preferences and decision making processes of 15 married infertile Indonesian couples, of high socioeconomic status, regarding intra-regional reproductive travel in Southeast Asia. We consider the reproductive destinations of Singapore, Malaysia and Thailand, revealing their distinct attractions for different couples. We identify a variety of push and pull factors influencing the choice to leave Indonesia to pursue assisted reproduction technologies (ART), as well as the factors shaping the choice of travel destination. One intractable push factor motivating couples to leave Indonesia is the strict regulation of ART, which designates gamete donation and surrogacy as illegal. The paramount concern of our informants was to maximise their chances of reproductive success, and perceptions of higher success rates for conception via ART elsewhere in Asia informed their travel choices. Emotional and psychological concerns were also crucial in determining travel destinations and included: a strong desire for privacy; the desire for emotional support whilst attempting conception via ART; the desire for emotional intimacy with one's partner; and the wish for religious compatibility with fertility providers and treatment protocols.

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Introduction

The social suffering stemming from infertility and childlessness in Indonesia is profound, and tends to impact women in more pervasive ways than men (Bennett, 2012). Motherhood is culturally constructed as universally desirable for Indonesian women, and it is extremely difficult for women to feel satisfied with their lives, or complete within their social identities, if they remain childless. Indonesian understandings of family also depend on the presence of at least one child to constitute a family. Couples who are married but have not produced children are viewed as families in waiting, and are described as *sudah menikah, tetapi belum keluarga* – literally meaning married but not yet a family. Despite the centrality of children to family formation, the Indonesian Association of In Vitro Fertilization (IA-IVF) estimates that only 10% of all Indonesian couples who experience infertility currently present to Indonesian fertility clinics in the hope of conceiving via assisted reproductive technologies (ART). This low presentation is partially due to the cost of ART, which is still prohibitive for most Indonesians, leaving access to these technologies largely the preserve of elites.

Previously we have investigated multiple barriers to accessing fertility care within Indonesia, identifying a range of inhibiting factors salient for infertile Indonesians of different backgrounds

and from different geographical locations. These barriers to access include: low confidence in infertility treatment; the number and location of fertility clinics; the lack of a well-established referral system; the cost of treatment; anxiety over receiving a diagnosis of sterility; fear over and reluctance to undergo vaginal examinations; and low levels of reproductive health literacy coupled with inadequate attention to patient education (Bennett and Wiweko et al., 2012, 2015). In this article we invert and widen our lens of enquiry to explore the decision making processes and preferences of infertile Indonesian couples who seek to access fertility care outside of their own country. This provides further insight into the array of reproductive strategies deployed by infertile Indonesians, and reveals how Indonesian couples' reproductive quests are not necessarily bounded by national borders, especially for those who do not face financial impediments. Our focus here is on intra-regional reproductive travel among Indonesians who undertake travel for the explicit purposes of attempting to conceive via ARTs elsewhere in Southeast Asia. Specifically, we discuss Singapore, Malaysia and Thailand as destinations for reproductive travel.

Infertile Indonesian couples who seek out ART beyond their national borders typically share the desire for a *bayi tabung* (test-tube baby). Regardless of the range of fertility treatments on offer abroad, the hopes of Indonesian couples we have worked with are universally centred on achieving assisted conception via in vitro fertilization (IVF) or intracytoplasmic sperm injection (ICSI). In this paper we follow the lay conceptualization of our informants by adopting 'IVF' as an umbrella term incorporating several procedures, which include: IVF, the extracorporeal

fertilisation of an embryoⁱ; ICSI, which is conducted in conjunction with IVF to overcome male infertility; and embryo transfer, which involves the placement of embryos into a woman's uterus or fallopian tube.

In this article we take the observations of Inhorn and Patrizio (2009), who outlined seven discrete factors promoting cross-border reproductive travel, as a starting point for our analysis of factors influencing intra-regional reproductive travel. We discuss the salience of several of the factors identified by Inhorn and Patrizio for our informants, including the prohibition of required fertility services or practices within the home country, the exclusion of particular categories of individuals from access to ART based on their social status, and the wish of individuals and couples to preserve their privacy (Inhorn and Patrizio, 2009). We also consider the salience of economic factors and the significance of our informants' perceptions of differing IVF success rates in different locations. Our analysis highlights the unique ways in which multiple push and pull factors intersect to influence couples' decisions regarding where to seek out ART. The definition of push factors that we apply refers to factors that influence Indonesians to access fertility care beyond their own borders. Conversely, we define pull factors as those factors which attract people to a particular foreign destination for reproductive travel. We also note how these motivating factors for reproductive travel are specific to a particular class context, which includes middle-class and elite Indonesians who can afford the costs associated with intra-regional reproductive travel.

Whilst teasing out the key considerations shaping couple's preferences regarding reproductive travel we also map out what Bondi, Davidson and Smith coined the 'emotional geographies' of our informants by illuminating how particular geographic locations are invested with specific social, emotional and psychological meanings (Bondi and Davidson et al., 2005). In doing so we engage with the intimacies of reproductive travel and respond to the call by Whittaker (2010) for an increased consideration of the decision making and social meanings embedded in people's experiences of medical travel in the Asian region. We focus on the most common emotional and psychological concerns expressed among the couples we interviewed, which include: the desire to maximise the chances of treatment success; a strong wish for privacy; a desire for emotional support while abroad; alternatively the desire for emotional distance and privacy from families and communities at home; the wish for religious compatibility with their reproductive health providers; and finally the aspiration to achieve greater emotional and sexual intimacy within a marriage.

Methodology

Deciphering patterns of intra-regional reproductive travel among Indonesians currently relies heavily on qualitative and anecdotal data, and grey literature produced by professional medical bodies. Our understanding of regional patterns of reproductive travel has also been facilitated by

the networks of Indonesian fertility consultants (referred to locally as K-FER), who are in regular contact with their peers in Southeast Asia, and some of whom work as IVF consultants in Singapore and Malaysia.

The perspectives we elucidate in this article are enriched by their location within a larger ethnography conducted by the first author, focused on the multiple ways in which married infertile Indonesian couples negotiate their quests for reproduction. Reproductive travel emerged from this larger study as one of multiple pathways that couples consider in their efforts to form families. Between 2010 and 2014 the first author conducted field research into compromised fertility in Jakarta, Surabaya, Yogyakarta, Denpasar and West Lombok. This larger ethnography is comprised of 47 case studies of Indonesian couples who have experienced compromised fertility. The second author was able to offer long-term perspectives on the interpersonal aspects and emotional geographies of reproductive travel for infertile Indonesians, based on his professional practice in the Indonesian fertility field over the past 15 years. Other informants who contributed to our understanding of intra-regional reproductive travel include 15 Indonesian K-FER interviewed between 2010 and 2014.

We also refer to the findings of a survey developed by both authors, with a sample of 220 women infertility patients recruited through fertility clinics in Jakarta, Surabaya and Denpasar. This survey investigated women's health seeking histories, including their travel to access fertility

treatment. Findings of this survey clarified that socioeconomic class is a key determinant of the geographical distance that Indonesian couples are able to travel in pursuit of reproductive success (Bennett and Wiwkeo et al., 2012). Consequently, as noted above, cross-border reproductive travel for Indonesians is in most instances the preserve of the middle-class and elite, and the perspectives represented in this paper should be read in their class-specific context.

Ethnographic narratives provide rich insight into what is important to women and couples when considering different destinations for reproductive travel. Among the 47 women with whom case studies were constructed, 15 discussed their plans for/or experiences of intra-regional reproductive travel, and five case studies also incorporated interviews with husbands. Thus, the total number of people who discussed their plans for/or experiences of reproductive travel was 20, comprised of 15 women and five men. The couples in this sub-sample were Muslim, Christian and Hindu, although the majority were Muslim (9 out of 15 couples), there were no couples of mixed religion or mixed ethnicity. The ethnic groups of informants were self-described and included Javanese (9 couples), Batak (1 couple), Balinese (1 couple), Chinese (2 couples) and Indonesian (2 couples). All of our informants were at least tri-lingual speaking their mother tongues (according to their ethnic group), Indonesian and conversational English, which is indicative of their high levels of education and elevated socioeconomic status. Interviews were typically conducted in Indonesian, or a combination of Indonesian and English, following the linguistic preferences of informants.

Levels of formal education among our informants were high, with all having completed senior high school and most having undertaken tertiary study. Only three out of the 15 women informants had not continued on to tertiary education and all of the men had obtained a tertiary degree. We determined that socioeconomic status of these 15 couples was at least middle class or higher. We based this on the criteria that all owned homes and private means of transport, and all households generated a regular monthly income of over US\$500 (three couples indicated a regular monthly income of over US\$2000). All of these 15 couples were childless and seeking to have a first child, and none expressed any preference for a child of a particular sex.

Access to and regulation of ART in Indonesia - the limitations of home

Because such a large proportion of people suffering infertility do not seek biomedical care accurate rates of infertility in Indonesia are difficult to establish. None the less, the accepted wisdom is that between 15 and 22 per cent of Indonesian women experience infertility during their reproductive years, which is based on data collected only from women in Indonesia's Demographic Health Surveys (Bennett and Wiweko et al., 2012). Fertility treatment is not included within state family planning or safe motherhood programs, regardless of its centrality to creating families and to maternal health. Additionally, subsidisation of ART is absent in Indonesia's national public health insurance scheme. There is no established referral system for fertility treatment in the primary health system and no coverage of fertility treatment by private

health insurance policies. Consequently, all Indonesian IVF patients will be full-fee paying, regardless of whether they seek care within or outside of their national borders.

ART capability was established early in Indonesia in 1988, yet initially the industry developed slowly and only recently begun to expand with relative speed. Since 2010 Indonesia has made huge strides in terms of increasing its annual number of IVF cycles, which doubled in five years to reach 4,000 cycles in 2014 (IA-IVF, 2014). In 2010 there were only 15 registered fertility clinics, by 2015 that figure almost doubled to 28. Notwithstanding the increasing number of clinics, they have remained heavily clustered in large cities, particularly in Java and Bali, and are located in only four of Indonesia's nine hundred plus inhabited islands (see Map 1.).

Map 1. Distribution of registered fertility clinics in Indonesia 2015.

Source: IA-IVF Annual Report 2015.

The concentrated geographical distribution of fertility clinics has significant equity implications for Indonesians in regional areas and outer islands. In our 2011 survey of 220 women fertility patients only 46% reported that they were able to access specialist fertility care within their own city or district (Bennett and Wiweko et al., 2012). The remaining 64% had to travel significant distances to access care and 4% reported that they had previously travelled abroad for fertility care (ibid.). The concentration of clinics in major Indonesian cities, and particularly on the islands of Java and Bali, means that travel in order to access ART is understood as normative. We believe that the expectation that travel within Indonesia is necessary for many couples to access the fertility care they require may lessen psychological barriers to travelling abroad to access reproductive technologies.

Based on interviews with K-FER who have been privy to the reproductive histories of their patients, we assert that the proportion of couples travelling elsewhere in Asia to access ART has escalated over the past decade, despite the increasing capacity of fertility clinics within Indonesia. This loss of potential patients to other fertility clinics in the region was a major concern for the clinic managers and K-FER we interviewed, who were acutely aware that many of their clinics were operating below full capacity. When we quizzed K-FER on their opinions about why some

Indonesians prefer to seek out ART abroad, they asserted that many infertile couples had 'low confidence in Indonesian fertility clinics' and held the perception that 'overseas clinics had higher IVF success rates'. The K-FER we spoke with also strongly asserted that the common perception that IVF success rates were higher abroad was not supported by objective measures.

Ethnographic and survey data indicated that patterns of mobility involved in accessing fertility clinics within Indonesia were not determined by proximity alone. Some couples chose distant clinics based on the superior reputations of particular doctors, indicating the importance of reputation in determining treatment destinations. Others did so based on the availability of relatives or friends to support them. This echoes the findings of Ormond and Sulianti (2014) regarding the importance of social support networks in facilitating medical travel by Indonesians to Malaysia. Other couples were motivated by prior disappointments closer to home and extended their travel in the hope of reproductive success.

Another key push factor motivating Indonesians to leave home and seek ART abroad is Indonesia's narrow regulatory framework pertaining to assisted reproduction. This framework is constituted through the convergence of legal, professional, religious and social institutions, and is policed by both formal mechanisms and societal surveillance. In terms of state-based regulation, there are surprisingly few documents referring to ART, with the most recent being published in 1999.ⁱⁱ The lack of more recent legislation reflects the narrowness of the original stipulations

concerning who is eligible to access ART and under what circumstances those technologies may be deployed. We suggest that there has been little incentive for the Indonesian Government to update relevant legislation due to the absence of political agitation for the expansion of citizen's rights to access ART.

Indonesia's existing legislation dictates that ART is only legally available to married heterosexual couples, and that gameteⁱⁱⁱ donation and gestational surrogacy are both illegal under any circumstances (ROI, 1992). Moreover, the transfer of embryos to a wife's uterus is legally limited to three embryos when she is under the age of 35, and limited to four embryos if the wife is over the age of 35 (ibid.). Thus in order to qualify for ART in Indonesia one must be in a heterosexual marriage, be able to provide their own viable female and male gametes, and the wife must be able to carry a child to full term. Indonesians who require donor gametes or surrogacy for assisted reproduction to be successful must travel abroad. Thus, the first promoting factor for cross-border reproductive travel identified by Inhorn and Patrizio (2009), which is the prohibition of required fertility services or practices for religious or ethical reasons, is highly applicable in the Indonesian context where gamete donation and surrogacy are illegal.

Inhorn and Patrizio (ibid.) also identified the exclusion of particular categories of individuals from legal access to ART based on their social status, as a promoting factor for reproductive travel. The social control of reproduction through the strict regulation of access to ART services in Indonesia

represents an enormous barrier to accessing ART for those Indonesians who are designated as socially infertile.^{iv} Same-sex couples and single people must look beyond Indonesia to take advantage of ART, not because of biological limitations, but rather because their social status does not comply with the heteronormative assumptions about how families should be constituted in Indonesia (Wieringa, 2015). While this paper is focused on the reproductive experiences of married heterosexual couples, the impact of Indonesia's narrow and discriminatory ART legislation upon unmarried and same-sex couples is a critical issue warranting future research.

Preferences and perceptions of key destinations for intra-regional reproductive travel

Three Southeast Asian countries emerged as preferred destinations for reproductive travel among the couples in this study. In order of popularity they are Singapore, Malaysia and Thailand. Ease of cross-border medical travel to all three of these countries is facilitated by regional immigration agreements that allow entry without a visa for Indonesians for stays of up to 30 days. Based on estimates provided through the professional networks of Indonesian fertility consultants, we estimate a minimum of 500 Indonesian couples undergo IVF procedures elsewhere in Southeast Asia annually, and that the total number may be as high as 1,000 couples (Pers. Com. IA-IVF, 2015).

Indonesians who settle on destinations with more permissive regulatory regimes are highly unlikely to publically disclose their intentions of undertaking ART in contexts that contravene the regulations of their society. However, in the confidential context of this research our informants openly discussed their preferences, plans and experiences in relation to reproductive travel. Three couples disclosed that their key motivation for travelling abroad was to access donor gametes in Singapore. Another couple discussed the possibility of gamete donation and surrogacy which they had hoped to pursue in Thailand. Thus, four couples out of 15 revealed that their reproductive travel was in part motivated by their understandings of the expanded legal and biological possibilities abroad.

None of the couples interviewed expressed any interest in pre-implantation genetic diagnosis either for the detection of chromosomal abnormalities or for the purposes of sex-selection. Several women expressed a strong belief that any form of pre-implantation screening was *haram* (prohibited for Muslims) and stated that if such an option was offered they would refuse it, despite there being no specific legislation forbidding these procedures in Indonesia. Attitudes toward surrogacy were mixed, with some couples believing it was acceptable provided that it was a non-commercial arrangement and that the surrogate was a female relative. Other couples considered surrogacy *haram*, and noted the Islamic injunction on a man having sexual relations with women who are sisters, thus conflating sexual relations with artificial insemination.

The cost of IVF in Singapore, Malaysia and Thailand is unregulated and typically calculated on a sliding scale according to the procedures required and the financial means of patients. The full costs associated with IVF are rarely advertised in clinic brochures or on websites, and are negotiated following initial consultations. While exact information regarding the cost of ART is very difficult for Indonesians to ascertain prior to travelling abroad, regional differences in the perceived costs of ART were relevant to their decision making processes. Couples considering IVF abroad sought out information regarding the associated costs through informal channels, learning from the experiences of others in their trusted social networks. This same mechanism for information gathering among medical travellers was noted by Ormond and Sulianti (2014) in their study of Indonesians seeking cross-border health care in Malaysia. However, several couples clarified that their main concern over determining the cost of procedures was to ensure that they had sufficient funds available at the time of their travel, rather than to choose the cheapest option.

Despite wide variation in the cost of IVF both within and between different countries, there is a regional hierarchy in terms of the lowest fees available in different countries. In Indonesia, the minimum rate for a single IVF cycle is quoted as between US\$3,000 to US\$4,500 (IA-IVF, 2014). This is roughly parallel to what is quoted in Thailand, from US\$3,000 to US\$5,000 (IVF-MB, 2015), while Malaysian fees generally start at US\$5,000 per cycle (CFC, 2015; FA, 2015). Singapore is by far the most expensive location for ART in the region, with base rates for IVF being advertised from US\$8,000 to US\$11,000 (Tan, 2011).

Singapore is viewed by many Indonesians as a highly 'modern' country with an excellent health system and as providing a very high quality of medical care. Despite the relatively inflated cost of IVF in Singapore, eight out of fifteen women informants cited Singapore as their first choice for a location in which to attempt IVF. This perception is perhaps underpinned by Singapore's established reputation in other areas of medicine that attracts medical travellers such as cosmetic surgery and prosthetics. A number of Singaporean fertility clinics and private hospitals have dedicated agents in Jakarta (Indonesia's capital) promoting their services, which further facilitates the uptake of Indonesian patients. Singapore has no citizenship requirements for patients to undergo assisted reproduction, but does restrict treatment to legally married heterosexual couples (Heng, 2008). Singaporean regulations do not allow surrogacy, but unlike Indonesia do allow the donation of gametes for married couples (ibid.). Thus, for married Indonesian couples who are unable to produce their own biological ovum or sperm, Singapore offers the possibility of biological donors, which is not a legal option at home. This clearly represented a pull factor towards Singapore for couples in our study.

We found that couples most likely to travel to Singapore were those who were financially affluent, had family or friends in Singapore, and were in need of biological donors. There was a preference among ethnic Chinese Indonesians for seeking out ARTs in Singapore, due to the high number of families who have relatives and close friends residing there. Our Chinese Indonesian informants

also articulated a sense of comfort or safety (*nyaman*) in seeking medical care in Singapore because of its Chinese ethnic majority, which ameliorated the vulnerability they often felt belonging to an ethnic minority in Indonesia.

Lisa and Geri a middle-class Christian couple of Batak ethnicity. Both originally from North Sumatra, they met in Yogyakarta during their tertiary studies and had married completing their business degrees. After six years of marriage they had not conceived and had saved the funds necessary for financing up to two rounds of IVF. Despite the availability of fertility clinics in Yogyakarta, where they had settled, this couple was intent on travelling to Singapore for treatment. The couple were devout Catholics and pointed out that none of the clinics offering ART in Yogyakarta were Catholic clinics or were located within Catholic hospitals. Lisa and Geri explained that they would feel more *nyaman* with a fertility doctor of the same religion (which they assumed would be the case in Singapore due to its large Chinese Christian community).

Geri and Lisa had already attended an Indonesian fertility clinic for diagnosis, and it appeared that there were both male and female factors involved in their infertility. When asked about why they did not proceed with treatment through the local clinic, they explained that they felt a lack of warmth and engagement from the clinic staff. They did not mention whether gamete donation was possible in Indonesia, but explained that the clinic they intended to visit in Singapore had advertised much higher success rates than those advertised by the local clinic. Lisa and Geri were

clear that their most important consideration in choosing a destination for ART was maximising their chances of reproductive success. For this couple, perceptions of the competence and success rates of over-seas clinics were central in their choice of destination. Geri asserted his opinion that Singapore was 'number 1' for ART in the region. When I enquired about why Singapore was "number 1" he shared his opinion that; 'success rates for IVF were the highest in Singapore, the technologies used were more up-to-date in Singapore, and that the quality of service offered to patients was better.' While Geri's reasoning was largely based on perception rather than any experience of seeking out fertility care in Singapore, this perception was what counted in their decision making.

Malaysia was cited as the preferred destination for undertaking IVF by four of our informants, and was clearly more popular among couples who would find it more difficult to cover the costs of seeking reproductive care abroad. Westcoast Malaysian IVF clinics have emerged as an alternative ART destination, most popular among Muslim couples who live in Sumatra or West Java and are in closer proximity to Malaysia. This is mirrored by the frequent travel of Indonesians living close to Malaysian borders for other forms of medical care, which are perceived by many as being of higher quality than those services available in remote regions of Indonesia (Ormond, 2013; Ormond and Sulianti, 2014). For married couples who are able to provide viable biological gametes, the strict regulatory guidelines in Malaysia do not present a problem. Additionally, there are no citizenship requirements to qualify for ART in Malaysia.

Several informants commented that Malaysia would be a less challenging destination to navigate due to the ease of communication with health personnel, as the Malay and Indonesian languages are so similar. Two devout Muslim women also expressed a preference for undergoing IVF in Malaysia as they sought a cultural and religious context compatible with their values, and one in which they felt confident that the procedures would be *halal*. Siti, a Javanese-Muslim woman of 35 years, had been childless for ten years and was planning reproductive travel to Malaysia. She explained her religious concerns in the following way:

If we travel outside our country to make a test tube baby, it should be to an Islamic country, somewhere that we can be sure our actions are *halal*. If the doctor is not Muslim, will they care if our child is conceived in the right way? Islamically that is. I don't think so. We will feel *nyaman* (at ease/safe) with a Muslim doctor.

Thailand was viewed as representing the greatest range of reproductive possibilities among our informants, and yet was only cited as a preferred destination by three couples. We suggest that in part this may have reflected the additional linguistic barriers couples perceived that they might encounter in Thailand, in comparison with Malaysia and Singapore where there is greater linguistic and cultural overlap with Indonesia. However, Thailand was viewed as an attractive destination for those couples who faced the situation where they could neither conceive nor carry a biological child of their own. The cost of living in Thailand, and of short term accommodation, is significantly lower than it is for Singapore and also compels some couples to choose Thailand. Thailand was also well known among our informants for medical travel in the areas of dentistry

and plastic surgery. One couple in our study who planned to seek out ART in Thailand were highly concerned about the possibility of achieving privacy, which they saw as more plausible in Thailand, and we elaborate on their concerns in the next section.

Another couple explicitly discussed their hope of conceiving via IVF in Thailand, which would have required both a donor ovum and a surrogate. This couple believed that gamete donation and surrogacy were legal in Thailand at the time of their interview in August 2013. The perception that Thailand offered a more permissive environment for foreign couples seeking solutions to complicated reproductive dilemmas, was no doubt driven by the reality that assisted reproduction was loosely regulated in Thailand prior to 2010 when the draft 'Pregnancy by Medically Assisted Reproductive Technology Act' was introduced to parliament (Whittaker, 2015). Whittaker (2016) provides a detailed account of the significant shifts Thailand has undergone with respect to ART regulation. These changes have sought to better protect children born of IVF, and Thai women previously open to exploitation as commercial gamete donors and gestational surrogates (ibid.). The current legal framework in Thailand now prohibits commercial surrogacy and ova donation, and limits surrogacy to heterosexual couples with at least one Thai partner (ibid.). While more considered and detailed regulation of ART in Thailand clearly affords greater protection to Thai women and babies born of IVF, an unintended consequence may be that infertile couples elsewhere in the region will need to travel further afar to gain access to the option of legal surrogacy.

Our findings revealed that a complex matrix of concerns influenced different couples in choosing to pursue assisted reproduction away from home, but still within their region. Key concerns expressed by different couples included: their perceived chances of reproductive success abroad; the legal possibilities for ART abroad; religious and linguistic compatibility; and the cost of ART procedures and related travel. The availability of cheaper ART in other countries was noted by Inhorn and Patrizio (2009) as a potential promoting factor for reproductive travel. In this study we found that all couples considered the costs of ART, associated travel and accommodation when budgeting for their reproductive travel. However, none of the couples interviewed described the high cost of IVF in Indonesia as the key motivating factor in their decision to seek fertility care abroad. Over half of the couples we spoke with in fact chose Singapore, the most expensive ART destination visited, as their preferred destination. We believe this willingness to pay higher fees for IVF services abroad partly reflects the high socioeconomic status of our informants, most of whom had reliable access to the financial capital required. It appeared that, the relative degree of financial security among our informants meant that they were not forced to place financial considerations at the centre of their decision making processes. Instead, an overwhelming concern for maximising the chances of reproductive success was the first priority expressed by all of our informants.

Seeking out comfort and safety – negotiating *nyaman* whilst away from home

Infertility and attempts to overcome it invariably involve high degrees of emotional, psychological and social vulnerability, which are gendered (Inhorn, 1996; Bennett, 2012; Whittaker, 2015).

Assisted reproduction is also a risky process embodying unavoidable physiological discomfort and highly uncertain success rates that decline significantly with age. Leaving home to travel beyond one's national borders adds additional layers of ambiguity and risk to the reproductive quests of Indonesians. Unsurprisingly, infertile Indonesian couples considering reproductive travel commonly spoke about seeking out safe or comfortable contexts in which to negotiate IVF attempts abroad. They most often referred to this as a desire to cultivate a feeling or state of *nyaman* (a feeling of comfort, ease, convenience and safety) that could support their engagement with ART. The concept of *nyaman* embedded in the narratives of infertile couples referred to achieving an optimal state that would enable them to feel as at ease as possible in their negotiations of foreign places and new technologies. Their pursuit of *nyaman* required balancing intimate and social relations, to create circumstances that allowed couples to feel emotionally and socially safe and supported. Thus, this state of *nyaman* was constituted differently for each couple considering or undertaking reproductive travel. While the word *nyaman* is literally translated in English as comfortable or convenient, the concept has a deeper significance emotionally; it encompasses familiarity and ease, security and emotional warmth, as well as comfort.^v

The complex emotions that couples must negotiate when navigating both travel and fertility care involve their own intimate relationships, their family relationships and relationships with the

communities in which they are embedded in or relocate to. This emotional complexity is illustrated by the preferences of Mi Mi an ethnic Chinese-Indonesian woman born and raised in Java, whose emotional considerations in relation to attempting IVF were highly engaged with the female members of her family. She was aged 30 at the time of our interview, and had undergone two unsuccessful cycles of IVF, one in Jakarta and one in Singapore. She reflected on her desire to pursue IVF again in Singapore:

Mi Mi: It's very hard, I feel very low each time it [an IVF cycle] fails. So low, but I still have hope. To continue this process I need to be close to my younger sister who lives in Singapore. She really supports me. I don't want to be with my mother who is here [in Jakarta]. My mother worries too much, she asks too many questions. If I fail I will disappoint her too much, my failure becomes her burden. There is too much pressure here [in Jakarta]. It's better to be in Singapore. I have my sister who is very patient. She will take me out and take my mind off it, not always focusing on the problem.

Linda: So do you stay with your sister in Singapore?

Mi Mi: Oh of course I stay with my sister, it's a small apartment and she has two children, but it's like home, its *nyaman* [comfortable]. Hotels do not feel so warm [emotionally warm] and of course hotels are expensive. This treatment is very expensive, so if we can save money [on accommodation] we are happy.

Mi Mi's account illuminates the convergence of multiple emotional needs and the ways in which those needs are weighed against the economic cost of reproductive travel. Mi Mi is clear that she values and depends on emotional support from her sister in Singapore in the form of companionship and patience. At the same time she wishes to shield herself, and her mother, from the potential shared disappointment embedded in each attempt at IVF. For Mi Mi the pressure and burden of suffering associated with another possible failure to conceive are collective experiences,

impacting on her mother and herself. Thus, *nyaman* in this context required the management of collective hope and disappointment, and a spatial shift away from home (Jakarta) better enabled Mi Mi to achieve this. For Mi Mi Singapore offered the security of a temporary home in her sister's household, a home that was free from the social surveillance of the community she was raised in, and a home that could also shield her mother to some degree from potential gossip regarding Mi Mi's reproductive struggles. Establishing *nyaman* for Mi Mi involved a conscious choice to both disconnect with her immediate home environment and reconnect with another emotional anchor, her sister, in Singapore. The support her sister was able to offer represented an important pull factor for MiMi and her husband, just as the pressure or burden of her mother's heightened concern over her fertility acted as a push factor for seeking fertility treatment outside of Jakarta.

Middle-class Javanese-Muslim couple, Awing and Wiwik, had been unsuccessfully trying to conceive for five years when they were interviewed. For this couple ensuring privacy was a central motivation behind their plans to undergo IVF in Thailand. The couple were planning to disguise their reproductive travel as an extended holiday, and were hoping to save enough money to spend at least two months abroad. They had previously visited an infertility clinic in Java, where Awing (the husband) was diagnosed as having a very low sperm count, and Wiwik had been informed that there was no indication of female-factor infertility. This diagnosis of male-factor infertility had been very difficult for Awing to accept and he was extremely anxious that knowledge of his low fertility might become public if they were to attempt IVF at home. For Awing

maintaining privacy was central to feeling *nyaman*, and was a prerequisite to pursuing the couple's reproductive desires.

Not long after Awing's diagnosis he experienced what he described as a traumatic verbal 'attack on his honour and the honour of his wife'. A male colleague, knowing that Awing had been to a fertility clinic, loudly and publically offered to 'impregnate Wiwik' ...for him, as it was... 'obvious that he could not do it himself'. Awing reacted by striking the offending colleague, and both men received disciplinary action. However, Awing noted that he had received overwhelming support from his work peers and managers, who agreed that the insult had been both unacceptable and unprovoked. According to Wiwik, Awing had become withdrawn and increasingly unwilling to discuss their infertility issues following this incident.

Wiwik agreed that privacy was important when seeking out fertility treatment, but also asserted that by leaving behind their everyday lives for a while, the couple would have more time to focus on each other. Wiwik felt that travelling abroad would '*memaksa*' (force) Awing to face their fertility problem, as she felt he had been avoiding the issue. She noted that if they travelled elsewhere in Indonesia for IVF, there was always a chance someone who knew their family would see them. In this instance, both husband and wife felt that confidentiality was virtually impossible to guarantee in Indonesia, thus home could not provide the feeling of *nyaman* they sought.^{vi} Being away and adopting a temporary camouflage identity as anonymous tourists in Thailand

represented the safest option for this couple. Hence the impossibility of confidentiality was a key push factor for Wiwik and Awing, just as the perceived possibility of anonymity in Thailand acted as a pull factor for them.

Wiwik also hoped that the shared isolation would foster greater intimacy between them. Wiwik confided in a one-on-one interview that her husband's libido had declined following his diagnosis, and she feared he was experiencing a sense of shame that had impacted on his self-esteem. Wiwik joked that they needed a 'second honeymoon' to improve the intimacy and regularity of sex in their marriage. Her concerns were not only for their reproductive future, but also reflected a strong desire to attend to the emotional and psychological wellbeing of her husband and to improve her marriage. In this instance reproductive travel was a multifaceted strategy imbued with hopes of reproductive success, the possibility of privacy, and a deep concern for protecting the welfare of one's partner and marriage.

For Indonesians with compromised fertility maintaining privacy is understood as pivotal to avoiding or limiting social comment on their ability to reproduce or on the success of their attempts at IVF. At age 37, Made, a wealthy Balinese-Hindu woman had been married for twelve years without conceiving, and had suffered greatly due to constant gossip about her childlessness, her multiple attempts to conceive via IVF, and her marriage. Made described how her failure to reproduce had become a key signifier of her social status within her community. She noted that

her women neighbours would sometimes refer to her as '*mandul*' – meaning sterile, both to her face and behind her back. She also shared stories of how she was excluded from neighbourhood activities and social gatherings that were organised around mothering. Made was however, most maddened by constant gossip that her husband was sexually unfaithful, supposedly due to his disappointment with her infertility. She was quick to point out that she was confident that her husband was faithful to her, and that she believed it was he who had 'the problem' (ie. the fertility problem).

Made was entirely fed up with being the subject of community gossip and asserted her right to privacy as follows:

This is my life, it's not for people to watch. It's not a *sinetron* [television soap opera]. I don't want anyone knowing what I'm doing, it's just between me and my husband. Better to go to Singapore [for IVF]. People can gossip about my shopping trip, they can say I am throwing away money [on shopping], please let them. But not about my problems [fertility problems], no not that.

For women such as Made, whose social suffering has been enhanced by a lack of discretion and empathy within their own community, the desire for privacy becomes a powerful driver behind the decision to seek ART abroad. In such situations leaving home to pursue treatment elsewhere offers a form of protection from unwanted social comment and surveillance of one's reproductive life.^{vii} The wish of our participants to preserve their personal privacy in relation to their reproductive lives, confirms the salience of privacy as driving factor for pursuing reproductive travel as noted by Inhorn and Patrizio (2009).

Interestingly, anxiety over the physical safety (*keselamatan fisik or keamanan*) of undergoing assisted reproduction abroad was not a focus of discussion among our informants. Rather it was assumed that procedures such as hormone injections, egg harvesting, internal ultrasounds and sperm extractions would be unpleasant and painful, but necessarily so. While we encountered a recurring perception that the success rates and quality of services may be superior in Southeast Asian countries other than Indonesia, none of our informants described their experiences of Indonesian fertility treatment as unsafe. Nor did physical safety come up as a reason for choosing to seek out ARTs abroad. Thus in the context of this research, we did not find concerns over safety or unknown risks associated with reproductive procedures, to be a promoting factor for reproductive travel.

Overall, discussions of *nyaman* were centred very much on maximising the comfort and safety of the non-material conditions in which couples would travel abroad to undertake IVF, whether this be in relation to social, emotional or religious dimensions. Siti's words in the previous section of the article demonstrate that religious adherence was a crucial concern in her choice of destination. Siti asserts that she and her husband would 'feel at ease' with a Muslim doctor, highlighting the salience and complexity of couples' understandings of comfort and safety. This was similar to the preferences expressed by Lisa and Geri, who has a clear preference for a Christian fertility consultant and a Catholic hospital if possible.

Somewhat ironically, some couples felt they were only able to achieve a state of *nyaman* by travelling abroad because the circumstances of their immediate family lives, or the communities they were embedded in, failed to provide the privacy, emotional autonomy or support they required. We observed that the ways in which *nyaman* was constituted for different couples was at times in contradiction with the normative expectations of their families and communities. For some infertile couples the pursuit of *nyaman* in the context of reproductive travel involved a shift in subjectivity away from their identities as members of extended families or communities, and towards a narrower form of relational subjectivity that privileged them as a couple.

Conclusion

In this article we have identified a matrix of factors that influence infertile Indonesian couples' decisions in relation to intra-regional reproductive travel. We have discussed how these factors align with and diverge from those identified by Inhorn and Patrizio (2009), revealing unique patterns of decision making about both the choice to undertake reproductive travel, and the choice of destinations for intra-regional reproductive travel. We have established that the conservative regulatory framework which circumscribes the possibilities for ART for Indonesian citizens acts as a push factor for couples who are unable to supply their own biological gametes or require a surrogate to reproduce. Additionally, we have highlighted the discriminatory nature of Indonesia's ART regulations, which exclude anyone who is not in a heterosexual marriage. Our

findings confirm that the expanded legal possibilities for ART in other Southeast Asian countries represent a pull factor influencing some couples' choice of preferred destinations for reproductive travel.

Among our relatively affluent informants, we have observed that while economic considerations were always taken into account when determining a destination, economics did not prove to be the paramount concern of the couples we interviewed. Maximising the chances of reproductive success was the highest priority expressed by all of our informants, which reflects the extraordinary social suffering they experienced and the importance of achieving reproduction for these couples. However, the varied perceptions of different success rates for clinics in different destination countries were not supported by any objective evidence presented to us by our informants.

Another key concern motivating intra-regional reproductive travel was the wish for privacy. Many of the couples interviewed had no confidence that privacy in relation to their reproductive lives and fertility treatment could be achieved in Indonesia. We have highlighted not only the importance of the desire for privacy as a factor in promoting intra-regional reproductive travel, but also the complexity involved in interpreting and achieving privacy for different couples. While shifting cultural norms regarding personal privacy may indeed be a very long-term process, Indonesian fertility clinics could make tangible improvements in privacy by altering their intake

procedures, changing the layout of waiting and consultation rooms, and by requiring and enforcing confidentiality clauses among staff.

The notion of *nyaman* was a concept used by 12 out of 15 infertile couples to describe the various ingredients of an ideal social and emotional environment in which to negotiate assisted reproduction abroad. We have argued that the ability to negotiate *nyaman* in a particular location can be viewed as a type of pull factor influencing couples' choice of reproductive destination. By exploring the salience of *nyaman* for infertile couples we have illuminated the complexity of social, emotional and psychological concerns embedded in the emotional geographies of reproductive travel for our informants. The varied emotional and psychological aspects that constituted *nyaman* intersected in different ways for different couples, and included: the desire for privacy; the desire for emotional support while undergoing IVF; the desire for emotional intimacy with one's partner; and the importance of religious compatibility with fertility providers and treatment protocols.

The foregoing discussion has highlighted how being located at home in Indonesia does not automatically denote comfort or safety for couples seeking to overcome infertility. Conversely, travelling abroad for reproductive purposes does not necessary negate the desire to, or possibility of, feeling at ease or *nyaman* for Indonesians. Foreign locations within Southeast Asia are not automatically defined or experienced as alien or uncomfortable. Other locations in the region can

be negotiated and experienced in a manner that allows strategic and pragmatic attempts to create safe and comfortable contexts from which to attempt assisted reproduction. In the pursuit of intra-regional reproductive travel Indonesian couples, who have the financial means, can create optimal conditions that mediate the intrinsic vulnerabilities associated with both infertility and assisted reproduction in order to pursue their hopes of parenthood. At the same time, an expansion in the accessibility of Indonesian fertility clinics is needed to improve equity of access to ART for those Indonesians who experience infertility but lack the financial resources required to pursue ART either abroad or within their own country.

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Endnotes

ⁱ An embryo is an egg that has been fertilised by a sperm and has undergone one or more cell divisions.

ⁱⁱ Currently three government documents specifically refer to ART in Indonesia, these are: *Health Law No. 23, 1992* (Article 16) (ROI, 1992); special *Ministerial Directive No.72. On The Application of ART* issued by the Ministry of Health (MOH, 1999); and a publication titled *Guidelines for Test Tube Baby Services in Hospitals* that was issued by the Directorate of Special and Private Hospitals within the Ministry of Health in 1993 (MOH, 1993). A detailed analysis of these laws and guidelines and their implications for the social control of reproduction in Indonesian society is the focus of a forthcoming paper by the first author.

ⁱⁱⁱ A gamete is the term used to refer to a reproductive cell, either an egg or a sperm.

^{iv} Social infertility refers to people who are for social reasons considered ineligible to become parents or to access ART.

^v The concept of 'suitable medicine' among infertile Vietnamese couples has been elaborated on by Pashigian (2012). This notion of suitable medicines provides an insightful analysis of how decisions over which therapy or medicine to use are determined by complex and mutable sets of considerations. The dynamism and complexity of this process as described by Pashigian has resonance with the processes of infertile couples in this study, yet the notion of *nyaman* remains distinct and culturally specific, and refers specifically to shaping the 'context' in which couples pursue reproductive technologies rather than the 'kind' of therapies they choose.

^{vi} See Butt (2015) for a discussion of the numerous cultural and systemic barriers to protecting patient confidentiality in the context of HIV care in Eastern Indonesia.

^{vii} Privacy has also been noted by Inhorn and Shrivastav (2010) as an important factor motivating Muslim couples for the United Arab Emirates to seek out assisted reproduction abroad.

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