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Frank van Balen, Trudie Gerrits and Marcia Inhorn

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Philip Kohnstamm Fonds
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Egyptian mothers of testtubes babies: Gender, Islam and the globalisation of new reproductive technologies

Marcia C. Inhorn,

Department of Anthropology, Emory University, Georgia, USA

I'd like to begin by mentioning two births: one of Louise Brown, the world's first 'testtube baby,' conceived and born in England in 1978, and the other of Heba Mohammed, Egypt's first testtube baby, born less than a decade later in 1987. The lives of these two girls, one Western and one Middle Eastern, are connected by a modern technology, in vitro fertilization (IVF), that allowed their parents to overcome otherwise intractable infertility. It is their global connection and the ways in which Western-generated technologies such as IVF are received in places like Egypt that provides the major focus of my presentation today. Despite the relative lack of Western concern and commentary on the problems of infertility in the non-western world, our very coming together at this conference proves that significant infertility problems exist around the globe. Thus, it should come as no surprise that 'high-tech' reproductive technologies are being marketed to and consumed by those in the so-called "developing world" on a massive scale. For example, limited reports indicate that these technologies have spread to several parts of Latin America, Asia, and Africa. But perhaps nowhere is this globalisation process more evident than in the nearly twenty nations of the Muslim Middle East, where new reproductive technologies have reached such small, petro-rich countries as Bahrain and Qatar to larger but less prosperous nations such as Morocco and Egypt.

Egypt provides a particularly fascinating locus for investigation of this global transfer of new reproductive technologies because of its ironic position as one of the poor, purportedly 'overpopulated' Arab nations. Egypt was the first Middle Eastern Muslim country to establish a national population reduction program through family planning in the 1960s. As in the vast majority of the world's societies, infertility was not included in this program as either a population problem, a more general public health concern, or an issue of human suffering for Egyptian citizens, especially women. Nonetheless, a recent World Health

Organization-sponsored study placed the total infertility prevalence rate among married Egyptian couples at 12 per cent (Egyptian Fertility Care Society, 1995). Given the size of this population and the strong culturally embedded desire for two or more children expressed by virtually all Egyptian men and women, it is not surprising that Egypt provides a ready market for the new reproductive technologies. Indeed, with its long history of colonially inspired Western medicine (Inhorn, 1994), Egypt has been on the forefront of IVF development in the Middle East, now hosting more than 35 IVF centers in full operation or development, more than any other Muslim or non-Muslim country in the region, including Israel. In other words, less than ten years after the birth of Louise Brown in England, IVF had already spread to Egypt, and in the decade following Heba Mohammed's IVF conception and birth, the new reproductive technologies have come to flourish in the country. However, these technologies are not transferred into cultural voids when they reach places like Egypt. Local considerations, be they cultural, social, economic, or political, shape and sometimes curtail the way in which these Western-generated technologies are both offered to and received by non-western subjects. Examining the structural and cultural constraints facing IVF consumers wherever these technologies spread serves to deconstruct the myth that the new reproductive technologies are some sort of 'panacea' for infertility wherever it occurs. Instead, it is useful to ask how third world recipients of global technologies resist their application, or at least reconfigure the ways they are to be adopted in local cultural contexts (Freeman, 1999). In other words, globalisation is not enacted in a uniform manner around the world, nor is it simply homogenizing necessarily "Westernising" or even "Americanising" in its effects (Appadurai, 1996; Hannerz, 1996). The global is always imbued with local meaning, and local actors mould the very form that global processes take, doing so in ways that highlight the dialectics of gender and class, production and consumption, local and global cultures (Freeman, 1999). Anthropology, with its tools of ethnography, its central concept of culture, and its attention to history, represents a unique realm for examining these tensions, and the ways in which local actors in specific cultural contexts confront, experience, and give shape to the forms of globalisation (Freeman, 1999).

In the case of Egypt in particular, infertile women and men willing to consider the use of new reproductive technologies are confronted with eight major "arenas of constraint" or various structural, ideological, social relational, and practical obstacles and apprehensions surrounding the use of these technologies. Some of these, such as the physical risks and low success rates associated with IVF, are

similar to those faced by Western users of IVF. However, as will be argued here, many of the dilemmas experienced by Egyptian IVF consumers are deeply embedded in local cultural understandings and practices. As will be highlighted today, these arenas of constraint range from significant class-based barriers to access, to gender dynamics within marriage, to local versions of Islam, which legislate upon the appropriate use of these technologies and thus restrict how so-called 'babies of the tube' are to be made. Such culturally specific considerations speak to the need for greater historical and local ethnographic grounding of bioethical, feminist, and technological debates surrounding the various impacts of reproductive technologies. For, as the ethnographic research presented in this paper suggests, the use of new reproductive technologies in Egypt involves not only a unique history, but different understandings of the role of medicine, marriage, and morality, all of which profoundly influence Egyptian women's and men's decisions about whether or not to utilize these technologies.

The Ethnographic Setting and the Ethnographic Subjects

The research upon which this paper is based encompasses two distinct time frames. Specifying this timing and the circumstances of my research is, I believe, quite important in understanding the historicity of the NRT globalisation process. The first period is the late 1980s, or what may be called the 'early IVF period' in Egypt. The first Egyptian IVF center had just opened in an elite suburb of Cairo in 1986, and hence the new reproductive technologies were neither widely available nor widely understood in the country. In these early days, I conducted fifteen months of anthropological fieldwork on the problem of infertility in Egypt, basing my research in Alexandria, Egypt's second largest city. Working through the University of Alexandria's large, public, ob/gyn hospital, popularly known as 'Shatby,' I conducted in-depth, semi-structured interviews with one hundred infertile women and a comparison group of ninety fertile ones, the vast majority of whom were poor, uneducated, illiterate, and unemployed in wage labour. Many of the infertile women participating in my study were seeking treatment at Shatby Hospital not only because the infertility services there were free, but specifically because of the hospital's widely publicized claims to a supposedly 'free,' government-sponsored IVF program.

Moving ahead, the second period of research is the mid-1990s, or what may be characterized as the 'IVF boom period' in Egypt. To wit, Egypt is now in the midst of massive reproductive technology transfer, with new urban IVF centers cropping up in private hospitals and clinics on a regular basis. In the midst of this

IVF explosion, I spent the summer of 1996 in Cairo conducting participant observation and in-depth, semi-structured interviewing with sixty-six middle- to upper class, highly educated, professionally employed women and about half of their husbands. Most of whom were undergoing IVF or related procedures at two of the major IVF centers in this city of nearly 20 million inhabitants. Thus, my work on this subject incorporates both a longitudinal perspective and a class-based comparison of infertile women seeking treatment in the two largest cities of Egypt. It reveals how the treatment experiences of poor and elite infertile women differ dramatically by virtue of education, economic resources, and power within their marriages, and how a time span of less than a decade has dramatically altered the infertility treatment landscape in Egypt.

Class

First, with respect to social class, would-be Egyptian IVF consumers share one of the major constraints also faced by Western consumers of these technologies: Namely, these technologies are absolutely unaffordable for most poor and even middle-class Egyptian patients, even though they are often aware and highly desirous of such treatments.

With only one exception, all Egyptian IVF centers today are private concerns, charging comparatively high prices for the procedures and drugs that patients pay for out-of-pocket since health insurance in Egypt is new and not widespread. The one exception to this rule is the University of Alexandria's Shatby Hospital, where I conducted my initial research on infertility in the late 1980s. Shortly after I left Egypt, Shatby Hospital did open its own IVF center, and the first Alexandrine 'baby of the tubes' was born and heralded in the Egyptian media in early 1992. However, since those early publicity-driven days of 'free,' government-sponsored IVF, fewer and fewer testtube babies have been born to poor Egyptian women. As Egypt's one and only public IVF program, the Shatby Hospital IVF clinic continues to run, but on such a low volume that very few patients receive treatment and success rates are compromised. For the most part, the physicians charged with running this public clinic put their energies into their private IVF practices which, as is typical for Egyptian physicians working in the public sector, they run 'on the side.' Indeed, the Egyptian doctors who own and operate private IVF clinics comprise a small, elite corps of highly educated and biomedically sophisticated reproductive medicine specialists. Most of them have utilized their own economic resources to seek training in IVF in either Europe or the U.S. And, although many of these physicians have some sympathy for less

affluent patients, occasionally taking on IVF charity cases, they generally feel justified in charging high prices for their services and subsequently purchasing the lifestyles including, in some cases, chauffeur-driven BMWs and Mercedes-Benzes that the profit from these services brings to them. Not surprisingly, their patients also tend to be educated elites, who are sophisticated about their medical options and can afford to pay for high-tech therapies. In a society where the majority of women remain illiterate and do not work in the formal sector, the women patients who present to IVF clinics today tend to be highly educated professionals, who are employed as doctors, lawyers, architects, engineers, accountants, bankers, professors, tourism officials, and even movie stars. Furthermore, many of these women and their husbands are members of the Egyptian 'brain drain' generation; namely, they increase their wealth by working in the petro-rich Arab Gulf countries, returning home annually on month long summer vacations in order to undertake a trial of IVF. Some are true globe hopping migrants, moving temporarily to Western countries in order to try IVF, often before they become convinced to seek IVF at home. In other words, over a relatively short time span of a decade, the IVF scene in Egypt once touted as being open to even the poorest public-hospital patients has become extremely class-based and exclusionary, the arena of a handful of elite doctors and their high-class patients. This does not mean that elites both doctors and patients are without feeling for the poor and even middle-class women who cannot afford IVF therapy. For example, one IVF physician described his futile, ten-year campaign to introduce IVF at Cairo's largest public, ob/gyn teaching hospital, bemoaning the lack of political will that had frustrated his efforts.

Furthermore, affluent women themselves agreed that such therapy is exceedingly expensive, especially in light of what they view as a poor salary structure in Egypt and a generally low standard of living in this developing country. Yet, most of these patients also admitted that they and their husbands could afford repeated trials of IVF. And many stated bluntly during interviews that these therapies are 'not for everyone' the 'everyone' in this case tacitly meaning poor women, who are often known to wealthy women only in their capacity as domestic servants. Indeed, echoed in this exclusionary discourse is the same kind of prejudice which seems to underlie much Western discourse on the new reproductive technologies and which is certainly rife in the Western-generated population discourse on Egypt. Namely, the new reproductive technologies to combat infertility should not be 'for everyone,' because, as the equation goes, those who cannot afford these technologies certainly cannot 'afford children.' To wit, poor women do not

deserve to be mothers and especially not 'testtube mothers.' And any reproductive technology directed at them should be to inhibit--not facilitate--their fertility.

Gender

However, even Egyptian elites may find themselves limited in their avenues to IVF family formation for reasons having little to do with social class and subsequent access to new reproductive technologies. In addition to class-based constraints, gender relations and conjugal dynamics come into play when Egyptian wives and husbands, together or alone, seek IVF services.

Indeed, gender politics can be an arena of great contestation, for infertility is highly threatening to both men and women and is often destabilizing of otherwise comfortable, companionate marriages. Generally speaking, however, women experience the threat of infertility more keenly. To wit, women who are unable to achieve entrance into the 'cult of motherhood' (Bouhdiba 1985) in Egypt are seen as being less than other women, as depriving their husbands and husbands' families of offspring, and as even endangering other people's children through their uncontrollably envy. Typically, they are also blamed for the infertility, and they are expected to seek treatment. Thus, in Egypt, infertile women of all backgrounds tend to face tremendous social pressures, ranging from marital duress and dissolution, to stigmatisation within the extended family network, to outright ostracism within the larger community of fertile women

Indeed, infertile women of all social classes live in fear that their marriages will 'collapse,' for Islamic personal status laws consider a wife's barrenness to be a major grounds for divorce. Although Islam also allows women to divorce if male infertility can be proven, a woman's initiation of a divorce continues to be so stigmatising in Egypt that women rarely choose this option unless their marriages are truly unbearable (Inhorn 1996). Although most husbands of infertile Egyptian women do not divorce their wives, thereby resisting tremendous family pressure, divorces over childlessness do occur, including, sadly, that of my infertile research assistant in the summer of 1996. Indeed, even among the presumably 'enlightened' upper classes, some men would rather divorce their infertile wives than undergo the trials, tribulations, moral uncertainties, and expenses surrounding IVF.

Furthermore, during the IVF treatment process, marriages sometimes come unglued under the intense physical and psychological pressure that this therapy typically exacts on couples.

But perhaps the saddest new twist in marital politics in Egypt has occurred as a result of the recent introduction of intracytoplasmic sperm injection, or ICSI, the 'newest' new reproductive technology. Namely, with ICSI, cases of seemingly intractable male infertility can now be overcome. Thus, ICSI heralds a revolution in the treatment of male infertility, and its arrival in Egypt has led to the flooding of IVF clinics with male-infertility cases for example, 70 per cent of those couples I interviewed in the summer of '96.

But, unfortunately, many of the wives of these Egyptian men, who have 'stood by' their infertile husbands for years, even decades in some cases, have grown too old to produce viable ova for the ICSI procedure. Because Islamic law forbids any kind of ova donation or surrogacy, couples with a 'reproductively elderly' wife face four difficult options: first, to remain together permanently without children; second, to legally foster an orphan, which is rarely viewed as an acceptable option, particularly among elites; third, to remain together in a polygynous marriage, which is rarely viewed as a tenable option by women themselves; or, finally, to divorce so that the husband can remarry a younger, potentially more fecund woman. Unfortunately, more and more highly educated, upper-class Egyptian men are choosing the final option of divorce believing that their own reproductive destinies may lie with younger 'replacement' wives, who are allowed to men under Islam's personal status laws. Certainly, these laws coupled with the Islamic position on the need for biological parenthood in the practice of IVF and ICSI place infertile Egyptian women and the 'old' wives of infertile Egyptian men in an extremely precarious position vis à vis their reproductive and marital futures.

Religion

Indeed, Islam, in some senses, poses the most serious constraint on the practice of IVF in Egypt, both in terms of its restrictive legislation and in the anxieties over religious matters that it creates. Egypt is a decidedly Muslim country, with more than 90 per cent of its citizens Sunni Muslims and with public expressions of religiosity increasing under a two-decade long wave of Islamic revivalism. Although Egyptian Muslims are certainly heterogeneous in terms of religiosity and degree of religious expression, it is also true that Islam provides a source of guidance for many if not most Egyptian Muslims in a variety of arenas of human activity, including beliefs and practices regarding health and medicine. Instruction which informs or regulates the everyday activities of Muslims can be found in a number of theological documents which make up the body of Islamic

jurisprudence. Those issues, such as the introduction of new reproductive technologies, which are not discussed in the legal texts are regularly legislated upon by the most venerable Islamic legal authorities in the form of written religious proclamations called fatwas (Lane and Rubinstein 1991).

Even before IVF emerged on the scene in Egypt, the Grand Sheikh of Egypt's world-renowned Al-Azhar University issued a fatwa on the religious permissibility of IVF. Namely, he declared that IVF and similar therapies were an acceptable line of treatment as long as they were carried out by expert scientists with sperm from a husband and ova from a wife with 'no mixing with other cells from other couples or other species, and that the conceptus [the embryo] is implanted in the uterus of the same wife from whom the ova were taken' (Aboulghar et al. 1990). In other words, this fatwa, which is widely viewed as authoritative by physicians and patients in Egyptian (and other Middle Eastern) IVF centers today, clearly spells out which individuals undergoing reproductive therapies have the right to claim the status of 'mother' and 'father' namely, only the biological mother and father, who thereby maintain 'blood ties' to their IVF offspring. Donation of any kind either of sperm, ova, and embryos through IVF or donor insemination or of women's "wombs" through surrogacy arrangements are strictly prohibited.

Although this fatwa on IVF was issued as early as 1980, uncertainty about the Islamic position on IVF reigned throughout the rest of the decade in Egypt. By the mid-1990s, however, much of this moral uncertainty had given away to a kind of moral clarity abundantly apparent in the discourse of Egyptian women and men undergoing IVF and ICSI. Stating that the religious aspect of IVF is its 'most important' element, Egyptian IVF patients interviewed in my 1996 study were relative experts on the religious dimensions of IVF. As they explained, sperm, egg, or embryo donation leads to a 'mixture of relations.' Such mixing severs blood ties between parents and their offspring; confuses issues of paternity, descent, and inheritance; and leads to potentially incestuous marriages of the children of unknown egg or sperm donors. Thus, for Egyptian women with infertile husbands, the thought of using donor sperm from a 'bank' was simply reprehensible and was tantamount in their minds to committing zina, or adultery. Surrogacy, in addition, was believed to tamper with the 'natural maternal bond,' which is meant to be an exclusive link between one mother and her biological children.

Furthermore, much of this righteous discourse is now constructed in relation to discourses about the moral corruption occurring in the Christian West. In Egypt,

news stories and television movies imported from America and Europe show women who 'rent their wombs,' only to struggle over custody of the children they bear; or infertility doctors who impregnate hundreds of women with their own sperm, only to be sent to prison; or IVF mothers, such as the one in the Netherlands, who bore black and white twins by two fathers because of a careless sperm admixture in an IVF laboratory. Proclaiming that this would never happen in Egypt where women can trust that their IVF doctors are good, vigilant Muslims women in Egyptian IVF centers described these stories, all of which happen to be true, with a kind of righteous incredulity. But such claims of moral superiority belie the fact that many Egyptians who are either contemplating or actually undertaking IVF in Egyptian IVF centers spend long hours worrying about 'accidental donation' namely, unintentional laboratory 'mix-ups' of semen, ova, or embryos. In some cases, these fears and suspicions may prevent couples from undertaking IVF altogether, for once the products of conception leave one's body, it is virtually impossible to know for sure whether these products will be returned untainted.

Thus, despite claims of moral superiority, there may be a paradoxical 'down side' to Islam's restrictive moral code and the various anxieties it creates over the "in vitro," or extra corporeal, handling of biogenetic substances. On the one hand, Islam glorifies motherhood and all it entails (Schleifer 1986), insisting that women are endowed with a 'natural maternal instinct' and that children are the 'decorations of worldly life.' Yet, because of Islam, infertile women who attempt to achieve glorious motherhood through resort to reproductive technologies are narrowly limited in their technological options. Moreover, these constraints seem even greater when one considers that Islam also prohibits adoption for the same reasons it disallows IVF donation practices thereby further restricting how families are to be formed and motherhood realized.

Conclusion

Through my anthropological work in Egypt, I hope to have shed some light on the ways in which the reproductive destinies of infertile Egyptian women are being constrained, if not always directly controlled, by deeply entrenched class divisions, gender hierarchies, and the state religion, which, in the case of the new reproductive technologies, directly informs the practices of the medical profession. Clearly, much is at stake here, 'not only traditional definitions of family, parenting, kin connection, and inheritance, but the conventional understandings of nature, life, humanity, morality, and the future' (Franklin and

Ragone 1998). For most infertile Egyptian women, their futures remain uncertain and their chances of becoming Egyptian mothers of testtube babies remain slim, given the myriad obstacles that face them. But for the lucky few, they are only too happy to be living in a society in which the global has become the local, and the fruits of globalisation are literally the testtube children they bear.

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