

6 Infertility and the Quest for Conception in Egypt

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Infertility: A Woman's Problem

In Egypt, infertility, or the inability to conceive, is a devastating problem for women, who are typically blamed for the reproductive failing and must bear the burden of overcoming it through a reproductive quest that is sometimes traumatic and often unfruitful. This quest for conception—or the “search for children”, as Egyptian women themselves call it—involves remedies of quite disparate origins and natures and is a near-universal phenomenon for infertile Egyptian women of all social backgrounds.¹ So powerful is their desire to have children and the force of social pressure that comes to bear upon them that many infertile women may risk all that they have, including their lives, in their quest for conception.

Underlying this sometimes desperate, often relentless quest is a patriarchal fertility mandate requiring all Egyptian women to be mothers. Women who are unable to achieve entrance into the “cult of motherhood” (Bouhdiba, 1985) are seen as being less than other women, as depriving their husbands and husbands’ families of offspring, and as endangering other people’s children through their uncontrollable envy (Inhorn, 1996). Infertile women’s greatest immediate threat comes from husbands, who have the right under Islamic law to replace an infertile wife through outright divorce or polygynous remarriage. Such replacement is usually urged by husbands’ extended family members, who may view a wife who thwarts her husband’s virile procreativity as, at best, “useless” and, at worst, a threat to the social reproduction of the patrilineage at large.

Furthermore, for most Egyptian women, their stigmatization is exacerbated by their inability to achieve motherhood through other institutionalized means, including adoption. Islamic law disallows adoption, although it specifies in great detail how orphans are to be treated (Esposito, 1982, 1991). The permanent, legal fostering of

abandoned infants—which, for all intents and purposes, is tantamount to adoption as it is known in the West—is available in Egypt, but is unacceptable to most Egyptians for a host of cultural reasons (Inhorn, 1996). Thus, biological parenthood—having a child of one’s own—is the only tenable option.

To summarize, then, in Egypt, poor infertile women tend to face tremendous social pressures, ranging from duress within the marriage, to stigmatization within the extended family network, to outright ostracism within the larger community of fertile women. Indeed, of all the types of persons that one could be, there are very few less desirable social identities than that of the infertile woman, or *umm il-ghayyib*, “Mother of the Missing One”, as Egyptians are apt to call her, giving this particular identity all of the classic features of a stigma. Goffman (1963, p. 3) defined a stigma as

an attribute that makes [her] different from others in the category of persons available for [her] to be, and of a less desirable kind—in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. [She] is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive.

Egyptian Ethnogynecologies

Given the stigmatizing and threatening nature of infertility, it is not surprising that most infertile Egyptian women are medical “pilgrims,” seeking diagnosis and treatment options from a variety of sources, often simultaneously. In Egypt, gynecologists are not the sole caretakers of infertile women, nor are they necessarily the first line of resort. Rather than there being only one hegemonic form of gynecology, we may speak of multiple Egyptian “gynecologies,” or multiple philosophies regarding the appropriate diagnosis and treatment of women’s reproductive bodies. For heuristic purposes, it is easiest to divide these gynecologies into two major categories, *ethnogynecology*, or nonbiomedical, “traditional” forms of gynecologic care, and *biogynecology*, or modern Western, biomedically-based gynecology. However, such a dualistic and seemingly dialectically opposed representation of the Egyptian

gynecological realm is too simplistic. Instead, numerous healing philosophies are still present in Egypt, leading to a multifaceted array of etiological, diagnostic, and therapeutic beliefs and practices regarding the nature and treatment of infertility.

These multiple healing philosophies are the result of the dynamic syncretism of four major literate medical traditions in Egypt, the most recent of which is European colonially-produced Egyptian biomedicine. Prior to the introduction of Western biomedicine in the mid-1800's, Egypt was home to:

(1) the 5,000-year-old system of *pharaonic medicine*, known to us through a variety of medical papyri (Leake, 1952) and involving the extensive use of an herbal pharmacopoeia by pharaonic medical practitioners (Mannich, 1989);

(2) the most historically influential system of *Yunani (Greek) medicine*, which was the basis of Arab medicine throughout the Middle East for many centuries. *Yunani* medicine was based on the teachings of Hippocrates and his student Claudius Galen, who studied at the then-famous medical school in ancient Alexandria, Egypt. Hippocrates and Galen were the major proponents of "humoral pathology," in which the physiological functions of the body were seen to be regulated by four basic humors, blood, phlegm, yellow bile, and black bile, which required equilibration through various hot and cold, wet and dry therapies to ensure bodily well-being; and

(3) the system of medicine known as *prophetic medicine*, which emerged following the rise of Islam in the seventh century A.D. and is based on the Prophet Muhammad's teachings about health and hygiene in the Islamic scriptures. Prophetic medicine was particularly popular with the masses, for it incorporated traditional concepts and practices from Arab folk medicine, such as the writing of religious sayings in curative amulets, methods to ward off the evil eye, and the practice of cupping, or the placement of a glass jar over a lit object on the skin, all of which are widely practiced in Egypt today.

In fact, although none of these ancient medical traditions continue today as recognizable systems of medical practice, their influence is definitely felt in the realm of contemporary Egyptian ethnogynecology, where healers of various types treat the infertile (especially lesser educated women of the lower classes) with the *materia medica* and the power of beliefs derived from these earlier traditions. The primary

ethnogynecologists in Egypt today are *dayat*, or traditional midwives, who usually treat the ailments of the infertile, as well as delivering the majority of Egypt's babies (Assaad and El Katsha, 1981; El Malatawy, 1985). However, *dayat* are not the only ethnogynecologists. In urban Egypt today, infertile women may seek the help of one or more *sittat kabira*, or elderly laywomen healers known for treating the most common bodily complaints of women; *attarin*, or herbalists, who deal in the herbs and minerals necessary for various healing appurtenances; *munaggimin*, or spiritist healers, who tend to specialize in sorcery nullification and spirit invocation and appeasement; and, finally, *shuyukh bil-baraka*, or blessed shaiks, living and dead, who provide divine intercession for infertile women on their healing pilgrimages to saints' tombs and other "shrines of conception" (Betteridge, 1992).

Although some infertile women eschew the services of such healers—placing their entire faith in "God and doctors"—the majority continue to rely on these popular, indigenous practitioners. For it is these healers, and not doctors, who recognize, diagnose, and treat the many ethnogynecological causes of infertility. These include, among other things:

(1) *Kabsa* (also known as *mushahara*), which is considered by most lower-class urban and rural women to be the primary cause of infertility. *Kabsa* involves the entrance of a polluted individual or substance into the room of a new bride or newly delivered mother, rendering their reproductive bodies "bound" by the pollutant. Although the *kabsa* concept is extremely complex (Inhorn, 1994a, 1994b), suffice it to say that a woman who has been affected by *kabsa* must undergo one or more depolluting rituals of consubstantiality, in which she is "unbound" through re-exposure to the putative pollutant (either blood, urine, sexual excreta, the discharges of death, or gold, which is thought to pollute the poor).

(2) Many women experience *rutuba*, or utero-ovarian humidity contracted through exposure of the genitals to cold drafts or cold water. *Rutuba* is thought to be remedied through either cupping or vaginal suppositories called *suwaf*, which are thought to drain the moisture from an affected woman's reproductive organs, but may, in fact, be the cause of ascending, sterilizing infections in some women.

(3) Another common cause of infertility is *dahr maftuh*, or an open back, caused by overexertion and requiring cupping, traditional

cauterization, or an externally-worn belt padlock to “close” the back which cannot properly “carry” a pregnancy.

(4) *Khadda*, or severe shock or fright, is thought to render many women infertile and must be remedied through either countershocking or edible substances placed in a special pan called the *tast it-tarba*, or “pan of shock”.

(5) *Amal*, or sorcery, is thought to render both men and women infertile and requires divination and nullification by mostly male spiritist healers.

(6) Finally, there is the *ukht taht il-ard*, or spirit-sister under the ground, a mostly benevolent subterranean spirit-counterpart who, when angered by her earthly sister, can render the latter infertile until she is properly appeased through small animal sacrifices or the provision of mostly edible gifts.

In all likelihood, few of these traditional remedies are demonstrably efficacious in overcoming infertility, and some of them certainly involve painful, repulsive, or harmful practices involving, for example, the exchange of blood and other bodily fluids (Inhorn, 1994a, 1994b). However, when compared to biogynecological treatment practices for infertility in Egypt, ethnogynecological remedies tend to be much *less* invasive—and may be ultimately less deleterious as well.

Egyptian Biogynecology

In the biomedical management of infertility in Egypt, women’s bodies (and rarely men’s) tend to be subjected to invasive, agonizing methods of diagnosis, treatment, and “control” (e.g., of sexual relations). In fact, Foucault’s (1977) notion of “biopower”—in which human bodies become the site of ideological control and are disciplined, punished, and in other ways manipulated through “technologies of the body”—seems quite germane to this discussion. For Egyptian biomedicine, a historically recent British colonial import which remains the institutionalized source of biopower in this setting, has created through subtle hegemonic coercion and consent (Gramsci, 1971) a class of docile, subordinated infertile women, who are ready to subject themselves to almost any form of biogynecological bodily invasion because of their belief in the inherent superiority of high-tech biomedical “fixes”. That mostly male

biogynecologists willingly invade women’s bodies—surgically and vaginally—in the pursuit of blatantly capitalist ends is the source of the “untherapeutic therapeutics” rampant in the Egyptian biogynecological setting.

Namely, Egyptian women who seek biomedical treatment for their infertility—and this includes middle- and upper-class women, as well as most poor women, who may sell virtually everything they own in order to finance their expensive biomedical quests—are typically subjected to an array of outdated, inefficacious, and even iatrogenic, or disease-producing, therapies that are widely practiced by Egyptian biogynecologists. In addition to frequent biogynecological abuse of fertility drugs—which are overprescribed and can lead to serious, unmonitored side effects, including further infertility problems, in many patients—infertile Egyptian women typically undergo multiple invasive procedures. The three most common include:

(1) tubal insufflation, or *nafq*, an antiquated diagnostic procedure in which carbon dioxide is pumped or insufflated into the uterine cavity to purportedly “blow open” blocked fallopian tubes. This procedure, which was introduced in the U.S. literally decades ago as a method of diagnosis, continues to be a routine treatment in Egypt, although it was never intended to be used therapeutically and can only be found in the annals of gynecological history in the West (Speert, 1958, 1973, 1980). Furthermore, tubal insufflation actually produces further tubal infertility problems in some women, by forcing pathogenic bacteria from the lower into the upper genital tract, where these bacteria lead to sterilizing infection (Inhorn and Buss, 1993).

(2) dilation and curettage (D&C), or *tausi wi kaht*, involving the purported “cleaning” of the uterine cavity through the removal of the endometrial lining by scraping it off with a sharp curette. Although D&C is indicated for post miscarriage bleeding, it has been obsolete for decades in the treatment of infertility in the West (Bates and Wiser, 1984; Winkel, 1993).

(3) cervical electrocautery, or *kayy*, another irrational and obsolete procedure, in which the purportedly “eroded” cervix is thermocauterized by a heated instrument, leading to potential destruction of the glands providing cervical mucus necessary for the transport of sperm into the upper genital tract (Haas and Galle, 1984).

In addition to this most popular “triad” of biogynecological infertility treatments, many infertile Egyptian women undergo an array of other nonsensical and potentially deleterious invasive procedures, including the injection of antibiotic “cocktails” into the uterus, surgical removal of “wedges” of the ovaries, and the various tubal surgeries, where the delicate fallopian tubes are cut and resutured without the aid of a surgical microscope, leading to their shortening and permanent scarring.²

Although a detailed cultural critique of Egyptian biogynecological practice is beyond the scope of this chapter and is presented elsewhere (Inhorn, 1994a), suffice it to say here that an indigenous critique is beginning to emerge from within the Egyptian biogynecological community itself. It involves the subversive discourse of primarily younger, often university-based physicians, who rail against the irrational, inefficacious and harmful practices of many of their community-based colleagues. According to this small physician elite, most Egyptian biogynecologists continue to perform these procedures for two reasons: (1) first, because of their outdated medical knowledge, which derives from an antiquated system of medical education in Egypt (El-Mehairy, 1984, Sonbol, 1991); and (2) second, because of their frank greed for money in a climate of stiff competition for paying clientele.

The Advent of IVF

With the recent introduction of the “advanced reproductive technologies” (ARTs) into Egypt—including intrauterine insemination (IUI), *in vitro* fertilization (IVF) and, most recently, intracytoplasmic sperm injection (ICSI) for cases of serious male-factor infertility—the potential for further misuse and abuse of infertility technologies seems even more acute. For, with these technologies, the products of conception are actually removed from men’s and women’s bodies, manipulated in various ways, and then replaced in women’s bodies by doctors, a delicate process requiring technical expertise (and moral scrupulousness) on the part of physicians and economic resources on the part of patients, both of which may be lacking.

Interestingly, despite its regionally underprivileged position as one of the few poor, overpopulated Arab nations, Egypt was home to the first IVF center, which opened in Cairo in 1986 (Serour et al., 1990, 1991).

Today, Cairo and Alexandria (the second largest Egyptian city) together boast ten such centers, with several more likely to open by the year 2000. Although the annual per capita GNP in Egypt is approximately \$790 (Population Reference Bureau, 1997), infertile Egyptians (as well as wealthy Arabs from other countries) are clamoring to these IVF clinics, where a single trial of IVF can cost most than \$3,000. Indeed, in some of the most successful centers in Cairo, *atfal l-anabib*—or, literally, “babies of the tubes”—are born on an almost daily basis.

However, such advanced reproductive technologies are certainly *not* available to every infertile Egyptian. In actuality, the “average” infertile Egyptian couple faces myriad obstacles in obtaining these services, even if they are willing to try them and accepting of their uncertain outcome. These obstacles to utilization are best conceptualized as “arenas of constraint”, and revolve around the following issues:

(1) *Knowledge*: Less educated Egyptians, who constitute the bulk of the urban and rural population, may lack specific infertility knowledge, including an understanding of the nature of the ARTs and the risks posed by them. Although the Egyptian media have played a major role over the past decade in familiarizing the general public with, and even advocating the use of these ARTs, there continues to be a considerable knowledge gap that may prevent some infertile Egyptians from seeking ART services.

(2) *Class*: Because of the privatization of ART services and the general dearth of health insurance in Egypt, ARTs are prohibitively expensive for many, if not most, Egyptians in this rigidly class-stratified society. Those coming to IVF clinics in Egypt today are generally upper-middle to upper class gainfully employed women and men, many of whom have worked as transmigrants in the petro-rich Gulf countries in order to finance their infertility therapies. This restriction of ART services to an elite group of Egyptian patients is unlikely to change in the near future.

(3) *Marital Relations*: As noted at the outset of this paper, conjugal relations are often highly problematic in the face of infertility. Assuming the “blame” for infertility and the responsibility of overcoming it through medical help-seeking at IVF centers may be difficult for one or both partners in an infertile marriage. Furthermore, infertility-related marital stress may be exacerbated by expensive, high-tech infertility treatment. This is particularly true with the recent advent of ICSI, a procedure that

allows men with very poor sperm quality to procreate. Namely, some infertile Egyptian men in long-term marriages with “accepting” wives are choosing to cast off these perimenopausal women in order to impregnate younger, potentially more fecund spouses.

(4) *Religion*: The official Islamic position on the ARTs, one that has been upheld by the minority Coptic Christian leadership in Egypt, is that donation of ova, sperm, or embryo, as well as surrogacy is strictly forbidden (Aboulghar et al., 1990; El Hak, 1981). The major reason has to do with the privileging of “natural,” biological ties between parents and their offspring. Thus, religion itself could be viewed as a major constraining factor in terms of who may benefit from the ARTs and, indeed, how “families” are to be formed. Yet, few Egyptians see it this way. Instead, infertile Egyptians remain concerned about upholding the moral codes imposed by their religions and about ensuring the maternity/paternity of fetuses through ARTs. Given this concern, many infertile Egyptians who are considering undergoing ART services agonize over the possibility of “accidental donation” (i.e., seminal, ova, and embryo “mixups” in the IVF laboratory), which, in some cases of extreme uncertainty and skepticism, may prevent couples from undertaking ART procedures.

(5) *Providers*: Given these anxieties, a paramount concern for potential ART clients is the trustworthiness of physician providers. The importance of good doctor-patient relationships for those undergoing ART services cannot be underestimated, although not all physician providers seem to realize this. Those who do may develop “saint-like” reputations and attract large patient followings. Those who do not may be viewed as incompetent, uncaring, or morally lax, particularly if they also do not accentuate their Muslim religiosity. Thus, considerable “doctor-shopping” between IVF centers results from the inconstancy of physician-patient relations.

(6) *Embodiment*: For those Egyptians who manage to overcome all of the aforementioned hurdles and embark upon a trial of IVF, ICSI, or a related high-tech procedure, the physical and emotional consequences can be severe, especially for women. Powerful and expensive hormonal agents are difficult to obtain in this developing world setting and, when available, exact high physical tolls on patients. Women, furthermore, describe significant physical and emotional duress following embryo transfer, when most “take to bed” in often vain attempts to ensure

implantation and ultimate pregnancy. Furthermore, the emotional devastation following a failed trial is often experienced in relative isolation, as psychotherapy or support groups of any kind are lacking in Egypt.

(7) *Safety and Efficacy*: Given these physical and emotional ramifications, questions of safety and efficacy—such as “Will I succeed in becoming pregnant?” and “Will I and my testtube baby(s) be all right?”—are in the forefront of Egyptian couples’ minds. Patients routinely parley percentages of success, likening the process to “gambling”. Unfortunately, because of various technical obstacles and lack of training and technique on the part of some providers, local success rates may be comparatively diminished, but are rarely presented as such to patients. Instead, patients may be given inflated statistics in order to maintain hope and willingness to undergo ART procedures.

(8) *Stigma*: Finally, even when Egyptian women do succeed in bearing “babies of the tubes”, few are willing to admit to anyone, outside of their closest family members, that conception occurred in anything but an “ordinary” fashion. Despite widespread public knowledge that “babies of the tubes” are, in fact, being “made” in Egypt, the actual production of such children remains in the realm of the extraordinary and is a subject of wild speculation and moral uncertainty. Thus, the majority of patients undergoing ART procedures are extremely concerned about issues of confidentiality, because of the social stigma and ridicule that they anticipate may be directed toward them or their “testtube child” as it grows up. In other words, Egyptian IVF patients live in a society that has yet to come to terms with the myriad implications of the advanced reproductive technologies being so rapidly imported or, for that matter, to fully accept the human beings who are created and forever affected by these technologies.

Conclusion: Futures for the Infertile

Unfortunately, for many infertile Egyptian couples, including those who submit their bodies to advanced reproductive technologies, their efforts to be “cured” of their infertility are often fruitless. Given the difficulty and burden of this reproductive quest, as well as its unpredictable outcome, it becomes essential to ask: What can be done to prevent infertility in

Egypt in the first place and to ensure that Egyptian women (and men) who are infertile receive appropriate diagnostic and treatment services? Furthermore, this question has much broader geographical implications, considering the extent of the sizable "infertility belt" that runs through the heart of Central Africa from Sudan and Tanzania in the East to Gabon in the West (Cates et al., 1985; Collet et al., 1988; World Health Organization, 1987). Indeed, in some Central African populations, infertility problems may be present in one-third to one-half of all couples attempting to conceive, resulting primarily from sexually-transmitted-disease-induced scarring and occlusion of the fallopian tubes. Coupled with the epidemic of acquired immune deficiency syndrome throughout many parts of Central and Southern Africa, such high rates of infectious infertility pose a significant threat of depopulation. Yet, because of the incessant Western focus on population control and fertility reduction, infertility has been seriously trivialized as a major public health issue in Africa, the Middle East, and elsewhere and has been ignored as a source of profound human suffering for the millions of women around the globe who are unable to meet their dreams of building a family.

So, what can be done? For the Egyptian case, but perhaps for the rest of Africa and other parts of the globe as well, the following recommendations for reproductive health policy are intended as a step in the right direction.

Recommendation One: Incorporate Infertility as an Integral Part of Family Planning. Too few nations have viewed assisting wanted pregnancies as part of their family planning missions, despite the fact that the UN's Universal Declaration of Human Rights argues that men and women have "the right to marry and to found a family". If the term "family planning" is taken at face value, then it truly should include the management of infertility in addition to the provision of birth control to women, and it must include men as interested parties to the planning of their families, including as partners to their wives in infertility diagnosis and treatment.

Recommendation Two: Expand the Scope of the Safe Motherhood Initiative to Include Fertility. As it now stands, the primary focus of the Safe Motherhood Initiative has been maternal mortality from unsafe delivery and abortion. However, many of the other pressing health needs of women, including the desires of infertile women to become mothers through a safe therapeutic quest, have been effectively ignored by this

initiative. Thus, an expanded Safe Motherhood Initiative would address a much broader range of reproductive health issues, and perhaps even challenge the patriarchal wisdom that women around the world *must* become mothers and must be "targeted" as such in international health campaigns.

Recommendation Three: Recognize and Integrate the Services of Traditional Healers. Although the World Health Organization has supported the integration of traditional healers, and particularly traditional birth attendants, into primary health care initiatives (World Health Organization, 1992), little real progress has been made in this direction. Moreover, although traditional birth attendant training programs are underway around the world, the role of TBAs as ethnogynecologists who treat the infertile has been entirely neglected by international health agencies. Yet, as we have seen, traditional healers are actively engaged with the infertile, often as the first line of therapeutic resort. In the Egyptian case at least, they are willing to learn about and incorporate biomedical techniques into their practice, as well as to cooperate on a referral basis with Egyptian physicians. Thus, Egyptian traditional healers would welcome official recognition as ancillary primary health care personnel and could be trained to perform simple differential diagnosis of infertility problems and to direct patients' husbands to laboratories for semen analysis.

Recommendation Four: Evaluate and Upgrade Biomedical Health Services. In Egypt, physicians need to be made more responsive to popular health culture, as well as to the perceived needs of their patients. In addition to the "resocialization" of physicians, medical education in Egypt needs to be "unfrozen" and "decolonized" (Blizard, 1991), for, as apparent from the foregoing description, antiquated, British-style medical education in Egypt is neither appropriate for nor responsive to existing national health-care needs. Beyond medical education, numerous structural changes in the Egyptian biomedical system are necessary, including, among other things, implementing continuing medical education programs for physicians to upgrade their clinical knowledge and skills, the formulation of bioethical standards for medical research and practice, the training of qualified paramedical personnel, and the improvement of the public health care infrastructure. In addition, Egyptian biomedicine would benefit from demasculinization, or the reversal of long-term male domination of the biomedical sector, including

the health specialties devoted to women. This will become increasingly important as the conservative Islamic climate in Egypt grows ever stronger.

Recommendation Five: Promote and Monitor the Use of Appropriate Health Technology. The promotion of the appropriate use of health technology in Egypt will require the development of a technology assessment profession in which women are involved. The major goals of such technology assessment would be to monitor the importation of technologies (including pharmaceuticals) into the country and to evaluate their safe use in clinical practice. In addition, physicians' attitudes toward the use of technologies as money-making ventures must be changed as part of the aforementioned reorientation of medical education. With the rapid expansion of advanced reproductive technologies being offered in urban Egyptian centers, the need for such reorientation of attitudes and monitoring of the technologies themselves is particularly urgent.³

Recommendation Six: Redress Political and Economic Problems Impinging on Fertility. This is the broadest recommendation and the most difficult to achieve. It will involve the implementation of new directions in reproductive health policy that attempt to eliminate the major underlying risk factors for infertility in Egypt, including sterilizing sexually-transmitted diseases and iatrogenic ethno- and biomedical practices. Tackling the "political epidemiology" of infertility in Egypt will require state intervention and political will, which are currently absent in the face of Egypt's other pressing political, economic, and health problems.

Given this daunting agenda, the future for the infertile women of Egypt remains unclear. Both collectively and individually, they face a "medical and emotional road of trials" (Sandelowski et al., 1992)—one whose end is rarely in sight. That they journey down this tortuous road with such fortitude, dignity, and conviction is a testament to their spirit as pilgrims, whose "search for children" holds in store the promise of a better life.

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Notes

- 1 This paper is based on two periods of field research in Egypt. In 1988-89, the author spent fifteen months in Alexandria, Egypt, basing her study of infertility in the University of Alexandria's public teaching hospital. This hospital (popularly referred to as "Shatby Hospital") serves mainly a poor population of urban and periurban women. One hundred ninety of these women, including 100 infertile cases and 90 fertile controls, participated in this study, which involved in-depth, semistructured interviews conducted in the hospital in the local dialect of Arabic. In addition, the author conducted informal interviewing and participant observation in the homes and home communities of some of these women, where traditional healers were met, interviewed, and observed as they worked. Seventeen physicians, mostly from Shatby Hospital but some from the surrounding community, were also interviewed. An expanded presentation of the findings of this study can be found in two books, *Quest for Conception: Gender, Infertility, and Egyptian Medical Traditions* (University of Pennsylvania Press, 1994) and *Infertility and Patriarchy: The Cultural Politics of Gender and Family Life in Egypt* (University of Pennsylvania Press, 1996). In 1996, the author returned to Egypt to conduct a three-month study of middle- to upper-class infertile couples attending two *in vitro* fertilization clinics in Cairo. Sixty-six women and nearly 40 percent of their husbands participated in in-depth, semistructured interviews in either English or the local dialect of Arabic. The preliminary findings of this study are presented in this chapter. An expanded presentation is forthcoming in a book entitled *Egyptian Mothers of Testtube Babies: Gender, Islam, and the Globalization of Advanced Reproductive Technologies* (Rutgers University Press, forthcoming).
- 2 The only recognized gynecological microsurgery and laparoscopic surgery center in Egypt is in Cairo's Al-Azhar University Medical Center (Serour, et al., 1988; 1989).
- 3 Mohamed Yehia, a professor of obstetrics and gynecology at Ain Shams University and the director of an IVF center in Cairo's El Nuzha Hospital, has been publicly calling for a national monitoring system for Egyptian IVF centers. So far, there has been no consensus on how such a "watchdog" system would be organized or who should run it.

References

- Aboulghar, M. S., Serour, G. I. and Mansour, R. (1990), "Some Ethical and Legal Aspects of Medically Assisted Reproduction in Egypt," *International Journal of Bioethics*, vol. 1, pp. 265-68.
- Assaad, M., and El Katsha, S. (1981), "Formal and Informal Health Care in an Egyptian Delta Village," *Contact*, vol. 65, pp. 1-13.
- Bates, G. W. and Wiser, W. L. (1984), "Uterine Function and Abnormalities Causing Infertility," in J. Aiman (ed), *Infertility: Diagnosis and Management*, New York: Springer-Verlag, pp. 143-60.
- Betteridge, A. H. (1992), "Specialists in Miraculous Action: Some Shrines in Shiraz," in A. Morinis (ed), *Sacred Journeys: The Anthropology of Pilgrimage*, Westport, CT: Greenwood Press, pp. 189-210.
- Blizard, P. J. (1991), "International Standards in Medical Education or National Standards/Primary Health Care – Which Direction?" *Social Science and Medicine*, vol. 33, pp. 1163-70.
- Bouhdiba, A. (1985), *Sexuality in Islam*, London: Routledge & Kegan Paul.
- Cates, W., Farley, T. M. M. and Rowe, P. J. (1985), "Worldwide Patterns of Infertility: Is Africa Different?" *Lancet* (Sept. 14), pp. 596-98.
- Collet, M., Reniers, J., Frost, E., Gass, R., Yvert, F., Leclerc, A., Roth-Meyer, C., Ivanoff, B. and Meheus, A. (1988), "Infertility in Central Africa: Infection is the Cause," *International Journal of Gynecology and Obstetrics*, vol. 26, pp. 423-28.
- El Hak, G. and El Hak, A. G. (1981), *Medically Assisted Reproduction: Fatwa*, Cairo: Al-Azhar University.
- El Malatawy, A. (1985), *Daya Training Programme in Egypt*, Cairo: UNICEF.
- El-Mehairy, T. (1984), *Medical Doctors: A Study of Role Concept and Job Satisfaction. The Egyptian Case*, Leiden: E. J. Brill.
- Esposito, J. L. (1982), *Women in Muslim Family Law*, Syracuse, NY: Syracuse University Press.
- Esposito, J. L. (1991), *Islam: The Straight Path*, New York: Oxford University Press.
- Foucault, M. (1977), *Discipline & Punish: The Birth of the Prison*, trans. A. Sheridan, New York: Vintage.
- Goffman, E. (1963), *Stigma: Notes on the Management of Spoiled Identity*, Englewood Cliffs, NJ: Prentice-Hall.
- Gramsci, A. (1971), *Selections from the Prison Notebooks*, London: Lawrence and Wishart.
- Haas, G. G. and Galle, P. C. (1984), "The Cervix in Reproduction," in J. Aiman (ed), *Infertility: Diagnosis and Management*, New York: Springer-Verlag, pp. 123-41.
- Inhorn, M. C. (1994a), *Quest for Conception: Gender, Infertility, and Egyptian Medical Traditions*. Philadelphia: University of Pennsylvania Press.
- Inhorn, M. C. (1994b), "Kabsa (a.k.a. *Mushahara*) and Threatened Fertility in Egypt," *Social Science and Medicine*, vol. 39, pp. 487-505.
- Inhorn, M. C. (1996), *Infertility and Patriarchy: The Cultural Politics of Gender and Family Life in Egypt*, Philadelphia: University of Pennsylvania Press.
- Inhorn, M. C. and Buss, K. A. (1993), "Infertility, Infection, and Iatrogenesis in Egypt: The Epidemiology of Blocked Tubes," *Medical Anthropology*, vol. 15, pp. 1-28.
- Leake, C. D. (1952), *The Old Egyptian Medical Papyri*, Lawrence: University of Kansas Press.
- Manniche, L. (1989), *An Ancient Egyptian Herbal*, Austin: University of Texas Press.
- Population Reference Bureau (1997), *World Population Data Sheet of the Population Reference Bureau, Inc.: Demographic Data and Estimates for Countries and Regions of the World*, Washington, DC: Population Reference Bureau.
- Sandelowski, M. and Harris, B. G. (1992), "Relinquishing Infertility: The Work of Pregnancy for Infertile Couples," *Qualitative Health Research*, vol. 2, pp. 282-301.
- Serour, G. I., Hamed, A. F., Al-Agazi, H., Sultan, M. and Hegab, M. (1988), "Al-Azhar Experience with Microsurgery," *Journal of the Egyptian Society of Obstetrics and Gynecology*, vol. 14, pp. 9-16.
- Serour, G. I., Badraoui, M. H., El Agizi, H. M., Hamed, A. F. and Abdel-Aziz, F. (1989), "Laparoscopic Adhesiolysis for Infertile Patients with Pelvic Adhesive Disease," *International Journal of Gynecology and Obstetrics*, vol. 30, pp. 249-52.
- Serour, G. I., El Ghar, M. and Mansour, R. T. (1990), "In Vitro Fertilization and Embryo Transfer, Ethical Aspects in Techniques in the Muslim World," *Population Sciences*, vol. 9, pp. 45-54.
- Serour, G. I. (1991), "Infertility: A Health Problem in Muslim World," *Population Sciences*, vol. 10, pp. 41-58.
- Songol, A. E. (1991), *The Creation of a Medical Profession in Egypt, 1990-1992*, Syracuse, NY: Syracuse University Press.
- Speert, H. (1958), *Obstetric and Gynecologic Milestones: Essays in Eponymy*, New York: MacMillan.
- Speert, H. (1973), *Iconographia Gyniatrica: A Pictorial History of Gynecology and Obstetrics*, Philadelphia: F. A. Davis.
- Speert, H. (1980), *Obstetrics and Gynecology in America: A History*, Chicago: The American College of Obstetricians and Gynecologists.
- Winkel, C. A. (1993), "Diagnosis and Treatment of Uterine Pathology," in B. R. Carr and R. E. Blackwell (eds), *Textbook of Reproductive Medicine*, Norwalk, CT: Appleton & Lange, pp. 481-505.
- World Health Organization (1987), "Infections, Pregnancies, and Infertility: Perspectives on Prevention," *Fertility and Sterility*, vol. 47, pp. 964-68.
- World Health Organization (1992), *Traditional Birth Attendants: A Joint WHO/UNFPA/UNICEF Statement*, Geneva: World Health Organization.

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