

ABORTION PILLS, TEST TUBE BABIES, AND SEX TOYS

**Emerging Sexual and
Reproductive Technologies
in the Middle East
and North Africa**

Edited by L. L. Wynn and Angel M. Foster

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stigma, raises concerns about the overuse of treatment. The results of this study also suggest that premature use of treatment and lack of information about the number of treatment cycles are shaping use. Improving counseling and information so patients are fully informed of risks, and establishing systems to better coordinate treatment are also priorities.

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Wanted Babies, Excess Fetuses

The Middle East's In Vitro Fertilization, High-Order Multiple Pregnancy, Fetal Reduction Nexus

Marcia C. Inhorn

Although rarely acknowledged by global health agencies, infertility is an important reproductive health problem, affecting between 50 million and 185 million people worldwide (Boivin et al. 2007; Mascarenhas et al. 2012; Rutstein and Shah 2004). Approximately 8 percent to 12 percent of reproductive-aged couples suffer from infertility in any given population, but in some regions of the world, particularly sub-Saharan Africa, South Asia, and the Middle East and North Africa (MENA), infertility rates are significantly higher, ranging from 10 percent to 30 percent (Mascarenhas et al. 2012; Nachtigall 2006; Ombelet, Cooke, et al. 2008; Ombelet, Devroey, et al. 2008). In the MENA region, an estimated 10 percent to 22 percent of all reproductive-aged couples suffer from infertility (Serour 2008b; Soraya Tremayne, personal communication 2014), with the condition taking three main forms: tubal infertility due to sterilizing reproductive tract infections; polycystic ovary syndrome, a form of ovulatory infertility related to the region's twin epidemics of obesity and diabetes; and male infertility, mostly genetic in nature, which contributes to at least 60 percent of all Middle Eastern infertility cases (Inhorn 2003b, 2012, 2015).

Given the region's significant infertility problems, assisted reproductive technologies, including in vitro fertilization (IVF), have spread rapidly across the region. Only two years after the 1978 birth of Louise Brown, the world's first IVF baby, a fatwa from Egypt's renowned Islamic university, Al Azhar, condoned the use of IVF to overcome marital infertility. By 1986, IVF centers had opened in Egypt, Jordan, and Saudi Arabia. By 1996, Egypt alone hosted more than 50 IVF clinics (Inhorn 2003b). Today, the MENA region boasts one of the largest, most robust IVF industries in the world. As shown in Table 7.1, the MENA region ranks second only to Asia (with its IVF-populous nations of China, India, and Japan) in total number of IVF clinics

(Jones et al. 2010). Furthermore, virtually every MENA nation, including those not represented in Table 7.1, hosts at least one IVF clinic—even impoverished nations such as Yemen and Palestine, and war-torn countries such as Iraq and Syria.

Yet, the presence of a strong regional IVF industry has led to new issues and concerns. One of the major emergent problems is the dramatic increase in the rate of multifetal pregnancies. Although multifetal pregnancies are often thrilling to Middle Eastern IVF patients who have waited for years to have a baby and desperately desire multiples in order to complete their families in a single IVF attempt, such pregnancies are the source of significant risks to both the prospective mother and her children. Maternal risks include gestational diabetes, hypertension and preeclampsia, pregnancy loss, and postpartum hemorrhage. Infants born as part of a multiple pregnancy are at a greater risk of prematurity, low birth weight, chronic lung disease, cerebral palsy, a range of cognitive delays, and higher rates of perinatal death (American College of Obstetricians and Gynecologists 2013). Furthermore, the medical costs associated with multiple births escalate with each additional fetus (Collins 2002). Health care expenditures “are quadrupled for twins and are 10 times higher for triplets” (American College of Obstetricians and Gynecologists 2013, 2).

Given the risks of multifetal pregnancies and their increasing incidence in the MENA region, a new problem has emerged—one that will be described in this chapter as the IVF-HOMP-MFPR nexus. This term captures the intersection of three medical realities: the transfer of too many IVF embryos into infertile women’s wombs in IVF clinics across the region; the resulting high-order multiple pregnancies (HOMPs), with triplets, quadruplets, and beyond; and the introduction of a medical procedure to reduce these high-risk HOMP pregnancies, which is called multifetal pregnancy reduction (MFPR). In short, across the MENA region, IVF cycles are producing “wanted babies” for infertile couples, but also many “excess fetuses,” which are being selectively aborted through MFPR. This unlikely juxtaposition of two opposing reproductive technologies—IVF and abortion—produces myriad problems for IVF patients, especially those living in MENA countries where access to abortion is severely restricted.

This chapter on the IVF-HOMP-MFPR nexus is based on anthropological field research I carried out in six IVF clinics in three MENA countries: Egypt (1988–1989, 1996), Lebanon (2003), and the United Arab Emirates (UAE; 2007). In particular, I undertook ethnographic interviews with and gathered reproductive life histories from IVF-seeking infertile individuals and couples in each of the three countries, totaling more than four hundred patient-couples. The chapter focuses primarily on infertile women’s experiences

Table 7.1. Non-Western IVF: A Selective Regional Comparison of Number of Clinics by Region

MENA		Latin America	
Algeria	7	Argentina	22–25
Egypt	52–55	Brazil	150
Iran	40	Chile	8–9
Israel	24–30	Colombia	19–21
Jordan	19	Cuba	1
Kuwait	12	Dominican Republic	4
Lebanon	20	Ecuador	6–8
Libya	9–10	El Salvador	1–4
Morocco	18	Mexico	Uncertain
Saudi Arabia	24–40	Panama	7
Tunisia	8	Paraguay	1–3
Turkey	112–16	Peru	5–7
United Arab Emirates	10	Trinidad and Tobago	1–2
		Uruguay	4
		Venezuela	17–18
Asia		Sub-Saharan Africa	
Bangladesh	10	Burkina Faso	1
China	102–300	Cameroon	2
Hong Kong	7	Democratic Republic of Congo	1
India	500	Ethiopia	1
Indonesia	12	Ghana	7
Japan	606–18	Ivory Coast	3
Malaysia	26	Kenya	4
Nepal	3	Mali	1
Pakistan	10	Nigeria	16–20
Philippines	4	Senegal	2
Singapore	9	South Africa	12–15
Sri Lanka	5	Sudan	4
Taiwan	72–78	Togo	1
Thailand	35	Uganda	1
Vietnam	11–12	Zimbabwe	1

Adapted from Jones et al. (2011)

of the IVF-HOMP-MFPR nexus, and the ways in which local abortion laws complicate their reproductive decision making. The first half of the chapter examines the IVF-HOMP-MFPR nexus from a medical standpoint, highlighting recent policy attempts to reduce the IVF-HOMP problem worldwide. The IVF-HOMP-MFPR nexus in the MENA region is then reviewed, given emerging evidence from the Middle East IVF registry (Serour 2008b). The second half of this chapter focuses specifically on the UAE, where a serious IVF-HOMP problem exists despite enactment of one of the world's most stringent assisted reproduction laws. Moreover, the UAE's very restrictive abortion law precludes the practice of MFPR. Thus, women who require MFPR must travel outside of the country to evade the abortion law. In the final section the stories of two multiply pregnant "reproductive outlaws" are highlighted.

The IVF-HOMP-MFPR Nexus

IVF involves four basic steps: hormonal stimulation of a woman's ovaries so they will produce excess eggs; removal of the eggs directly from the ovaries, usually via ultrasound-guided, transvaginal needle aspiration, but sometimes via laparoscopic surgery; laboratory-based in vitro fertilization of the eggs, using spermatozoa that have been retrieved via masturbation-ejaculation or testicular aspiration; and transfer of one or more fertilized embryos back into the woman's uterus. The number of embryos to be transferred depends upon a variety of factors, including embryo quality, a woman's age, physician recommendations, and patient preference (Dixon et al. 2008). Although laws, policies, and ethical guidelines may determine the practice of embryo transfer in some jurisdictions, overall there is neither international law nor medical consensus regarding the best number of embryos to be transferred in a given cycle (Jones et al. 2010). Many IVF clinics practice multiple embryo transfer (MET), where more than two embryos are transferred into a woman's uterus in the hope that at least one will implant and lead to a successful IVF pregnancy. The practice of MET is fueled by clinics' desire to boost their IVF success rates, as well as patients' desire to achieve positive pregnancy results.

This common practice of MET has led to one of the most significant challenges in assisted reproduction: the high incidence of multifetal pregnancies. According to a team of international experts, the number of embryos transferred is "the principal contributor to the multiple pregnancy rate" (Jones et al. 2010, 24). Indeed, recent studies show that IVF accounts for 31 percent of multiple births in the United States, 22 percent in Europe, and 10 percent in Australia (Connolly et al. 2010). Overall, it is estimated that MET has led to

a twenty-fold increase in the incidence of twinning and a four-hundred-fold increase in the number of higher-order multiple pregnancies (Scotland et al. 2007). In Europe, attempts have been made to reduce these rates through a European Union-wide policy of double embryo transfer (DET) (Scotland et al. 2006). Although DET has reduced the number of triplet pregnancies significantly, the twin pregnancy rate remains "unacceptably high" (Scotland et al. 2007). In the United States, no DET policies have been set. As a result, America's twin rate has increased 76 percent since 1980, while the triplet and higher-order multiple rate has increased by more than 400 percent (American College of Obstetricians and Gynecologists 2013).

Given these troubling statistics, more people are calling for single embryo transfer (SET), and some European and North American IVF clinics have already adopted this strategy on a voluntary basis (Scotland et al. 2007). However, SET is not widespread around the world. Most IVF clinics continue with MET on the basis of a combination of four factors: the particular case of infertility; the woman's age (more embryos are implanted in older women because their success rates are lower); the value placed on a live birth; and the relative importance placed on adverse outcomes (Dixon et al. 2008). Many infertile women care more about IVF success (having a "take-home baby") than about future health risks for their offspring. As the authors of one recent UK study concluded, "Some women waiting for IVF treatment view severe child disability outcomes associated with double embryo transfer as being more desirable than having no child at all" (Scotland et al. 2007, 977).

Given the substantial risks to infants born from HOMP, current medical guidelines recommend eliminating one or more of the fetuses in a multifetal pregnancy through MFPR. Often called "fetal reduction," MFPR is a form of selective abortion in which potassium chloride is injected transabdominally under ultrasound guidance into one or more of the fetal hearts, causing selective fetal demise and reabsorption of the fetal material by the woman's body. Fetal reduction usually takes place in the first trimester or early second trimester, and is generally used to reduce quadruplet and triplet pregnancies down to twins (American College of Obstetricians and Gynecologists 2013).

Without fetal reduction, a HOMP is by definition a very high-risk pregnancy. Thus, from a medical standpoint, fetal reduction is a way to diminish that risk by reducing a HOMP to a more manageable twin or singleton pregnancy. In the United States, the Committee on Ethics of the American College of Obstetricians and Gynecologists (ACOG) has recently issued a report advising MFPR for all HOMP, with nondirective counseling to women facing these pregnancies and full informed consent. However, the ACOG ethics committee was unable to conclude whether HOMP should

be reduced to twins or singletons, or whether twin pregnancies should be subject to MFPR at all. In other words, best practices regarding multifetal pregnancies remain controversial even in the West. The ACOG committee's most important recommendation was to prevent multifetal pregnancies from occurring in the first place through more judicious practices of IVF embryo transfer and infertility care.

In the MENA region, ethical debate on HOMP and MFPR practices has yet to take place, meaning that the IVF-HOMP-MFPR nexus continues unabated. Multifetal pregnancies are estimated to occur in at least one-quarter to one-third of all MENA IVF conceptions (Serour 2008b). According to Gamal I. Serour, the leading IVF scholar-activist of the region and past president of the International Federation of Gynecology and Obstetrics, "too many embryos" are being routinely transferred in IVF clinics across the Middle East. "The financial difficulties often drive couples and the treating physicians as well to be inclined to request and apply the policy which leads to the highest pregnancy rate irrespective of the outcome of the pregnancy" (Serour 2008b, 37). For example, a study using Middle East IVF registry data, conducted among thirteen IVF clinics in nine different MENA countries, found high rates of embryo transfer: 25.9 percent of women undergoing IVF received at least four embryos; 42 percent received three; and only 32.1 percent received one or two embryos. As a result, twin and higher-order IVF pregnancy rates were quite high—ranging from 28 percent to 32.6 percent (Serour 2008b).

Given this significant IVF-HOMP correlation, MFPR is "widely practiced in many countries of the ME," according to Serour (2008b, 37). In countries in the MENA region where abortion is legally restricted, MFPR is often justified as a life-saving, or at least health-preserving, form of abortion, which follows the Islamic principle that "necessity permits the prohibited and the choice of lesser harm" (Serour 2008a, 36). In these contexts, "Multi-fetal pregnancy reduction . . . is performed with the intention not to induce abortion, but to preserve the life of remaining fetuses and minimize complications to the mother" (Serour 2008a, 36). In other words, MFPR is accorded a kind of exceptional status as a legitimate form of therapeutic abortion in many countries of the Middle East. As such, it is both offered to women and performed on a regular basis in many Middle Eastern IVF clinics.

In my research in both Egypt and Lebanon, I interviewed IVF physicians who performed MFPR for cases of HOMP, as well as those who did not because of their moral stance against abortion. I also encountered Egyptian and Lebanese women who had reluctantly undergone MFPR in order to reduce their HOMP pregnancies to twins. In most of these cases, the decision was morally and emotionally fraught. For example, Hala, a young Egyptian

woman with an infertile husband, described how she had undergone MFPR to bring her total number of fetuses from five down to two. She went through the harrowing procedure without her husband's knowledge, for she feared that he would tell his family, setting off circulation of a "big story" with rumors and gossip. Despite the emotionally torturous decision about whether to go through with the reduction, Hala had told only her twin sister about what she had done. Relieved by the confidentiality of our conversation in the back room of a Cairo IVF clinic, Hala unburdened herself to me about her painful decision, including her feeling that she had somehow lied to her husband. Yet, Hala's infertile husband was thrilled to be "fathering" twins. Because Hala herself was a twin, the IVF pregnancy could also be passed off as a natural conception. For her part, Hala simply hoped that the remaining fetuses were viable and that the twins would be born healthy.

The Case of the United Arab Emirates

In some senses, Hala was lucky to be living in Egypt, where MFPR is medically available as a form of therapeutic abortion. In thirteen MENA countries abortion laws have been described as "very restrictive" (Hessini 2007), in that abortion is allowed only when a pregnant woman's life is in jeopardy. Such is the case in the UAE, where the abortion law was adopted on December 20, 1987, as part of the country's penal code. The UAE law allows abortion only when necessary to save a woman's life. No other exceptions are granted, including abortion for the purposes of physical or mental health, after rape or incest, for fetal impairment, or for economic or social reasons. A person who induces an abortion is subject to five years' imprisonment, or up to seven years if the abortion is performed without the woman's consent. Indeed, the UAE's approach to abortion has been characterized as "punitive" by some reproductive health experts (Hessini 2007), who have pointed to government sting operations designed to entrap both abortion-seeking women and their physician-providers.

Given this strict Emirati abortion law, MFPR is technically illegal in the UAE unless the woman's life is in danger. This poses problems for the UAE IVF industry, which continues to produce high numbers of multifetal pregnancies as a result of MET practices. Indeed, despite the 2010 passage of a comprehensive assisted reproduction law, known as Federal Law No. 11, IVF clinics in the UAE are still allowed to practice MET, as shown in Table 7.2. Whereas current international standards advise the transfer of only one or two embryos for women under the age of thirty-five (Jones et al. 2010), UAE Federal Law No. 11 permits the transfer of three to four embryos into a

woman's uterus, depending upon her age (three if she is thirty-five or under, four if she is over thirty-five).

Federal Law No. 11 produces the very conditions that lead to MFPR by allowing Emirati IVF clinics to transfer multiple embryos. Women with IVF-induced HOMP pregnancies in the UAE are thus faced with difficult decisions about what to do. Some chose to continue their high-risk, HOMP pregnancies, facing potentially significant medical complications for both themselves and their babies. Those who follow physicians' advice to undergo MFPR must do so outside the country, thus evading the law. This is because Federal Law No. 11 collides with the UAE abortion law, which does not allow MFPR except to save a woman's life.

In the Emirates, I met several women who were forced to become law evaders of this kind. They had received MET as part of IVF and had become pregnant with multiple fetuses, usually triplets. Those women who chose fetal reduction were generally guided by their physicians to either London or Mumbai, where they could receive the MFPR procedure both legally and safely. I also met a few Middle Eastern expatriates who decided to return to their MENA home countries, where therapeutic abortions were still legally allowed.

For these women, the need to engage in abortion-related law evasion clearly led to the fragmentation of their IVF pregnancy care. Once the fetal reduction was completed, they traveled back to the UAE for follow-up care with the reduced-but-still-risky twin pregnancy, which was usually monitored by a different set of high-risk ob-gyn physicians. This concatenation of law evasion, forced reproductive travel, and fragmented pregnancy care was usually experienced much more vividly by wives than by their husbands. Although husbands were often sympathetic with and supportive of their multiply pregnant wives, it was the women who ultimately underwent the embodied disruptions of reproductive travel during high-risk pregnancy, as well as the moral angst engendered by the selection of some of their cherished fetuses over others.

I met several of these women after they became law-evading fetal reducers. In most cases they described the fetal reduction as a form of trauma accompanied by significant emotional anguish. Reem, a half-Lebanese, half-Egyptian woman who had been living and working in Dubai as a sales manager for many years, was in the midst of a complicated, unstable high-order multiple pregnancy when I first met her. She was pregnant with four fetuses and was thus advised to undergo a fetal reduction to twins. When she asked whether the MFPR could be performed in the UAE, she was told that "they don't do it here. It's considered abortion and not right." She lamented to me:

So I have to travel three and a half hours to Lebanon. In Lebanon, they *do* do it. But they don't advertise it. It's not on the Internet. They never declare it, because it's illegal. But that's the Lebanese way. In Lebanon it's a very complicated issue because of the different religions. The Muslims will say one thing, and the Christians will say something else. But in Islam, abortion is okay *if* for the sake of the mother's health, and so the Muslim doctors will do it.

Extremely sick with an IVF complication called ovarian hyperstimulation syndrome (OHSS), Reem was nonetheless forced to become a law evader. She flew to Beirut, where she underwent a fetal reduction that she could only describe as "awful." She was wide awake during the entire procedure and thus watched the ultrasound screen as potassium chloride was injected into two out of four of the fetal hearts. She returned to Dubai, still sick with OHSS. The rest of the pregnancy went well, and Reem ended up delivering healthy twins five months later.

Similarly, Adiva, a thirty-year-old Indian IT specialist who was a member of Dubai's large South Asian community, had undergone fetal reduction in Mumbai two weeks before I met her. Adiva was clearly shaken as she poured out her story:

Adiva: We did three IUIs [intrauterine inseminations], and they were unsuccessful. Then we did an IVF, and it was unsuccessful. Finally, we had some frozen embryos, so one month after the IVF, we used them, and it worked. I got pregnant with triplets. But then I had to have an embryo reduction, which was very, very traumatic.¹ They reduced to twins. I had identical twins, and in the same sac. They did the embryo reduction with one twin, but we lost both of them. So the reduction was on one, but we lost both. So now, it's a singleton, rather than twins.

Author: That must have been very difficult.

Adiva: Well, it was [the doctor's] advice, and also the radiologist we visited in Bombay [Mumbai], and the gynecologist, plus my family doctor. They were also suggesting the same thing. They said there could be complications with twins in the same sac. We definitely couldn't keep triplets; that was too much of a risk. And we didn't want to gamble with the whole pregnancy. So lots of people were saying the same thing. "It's best that you do this, and not get all emotional." But it is traumatic! I would have kept

Table 7.2. The UAE's assisted reproduction law: Permissions and prohibitions

Procedure	Permitted (Halal)	Prohibited (Haram)	Comments
Anonymous third-party reproductive assistance		✓	
Cryopreservation (freezing) of embryos		✓	Only the "required number of eggs" are to be fertilized, and any excess embryos must be left to expire "in a natural manner"; this law is being challenged by physicians and patients as "anti-woman," and thus is being applied differently across the emirates
Cryopreservation of gametes (sperm and egg freezing)	✓		With annual written consent of both husband and wife for a maximum of five years
Donation of embryos		✓	
Donation of gametes		✓	Both egg and sperm donation
Embryo banks		✓	In keeping with the prohibition on cryopreservation of embryos, but being applied differently across the emirates
Embryo couriers		✓	No delivery of frozen embryos into or out of the country
Experimentation on the embryo		✓	

Gender (sex) selection	✓		Purportedly only for sex-linked genetic disorders
Intracytoplasmic sperm injection (ICSI)	✓		Only using a married couple's gametes (egg and sperm)
Intrauterine insemination (IUI)	✓		Only using a married couple's gametes (egg and sperm)
In vitro fertilization (IVF)	✓		Only using a married couple's gametes (egg and sperm)
Multifetal pregnancy reduction (MFPR)		✓	A form of selective fetal abortion not explicitly mentioned in the ART law, but not being practiced in most emirates of the UAE, where abortion is illegal
Polygynous gestational surrogacy		✓	With a wife in a polygynous marriage serving as a surrogate for her co-wife
Posthumous insemination		✓	
Preimplantation genetic diagnosis (PGD)	✓		For genetic screening and "family balancing"
Reproductive cloning		✓	Part of a universal ban on this procedure
Same-sex couples using ART		✓	Marriage of a heterosexual couple is required, with three forms of identification (passport or ID, marriage license, photos of both spouses)
Single women using ART		✓	Marriage of a heterosexual couple is required, with three forms of identification (passport or ID, marriage license, photos of both spouses)
Surrogacy via IVF		✓	
Therapeutic (stem cell) cloning		✓	

all three! That would have been totally fine. And my husband was the same as me. We were both very emotional about it. But, in the end, however, it was obviously our decision. After all this treatment, this baby, it's precious. I feel blessed to be having this one.

Author: Might I ask, were there any religious issues with doing this reduction?

Adiva: We're Hindu, so it doesn't matter. In India, it's fine to do this. I think here in the Middle East, they don't consider it good to reduce. I think there is a law that you can't. . . . At any rate, they don't do it here, which is why we went to India.

Author: And where exactly did you go?

Adiva: We're from Delhi, but we did the reduction in Bombay. We have lots of family there, but we didn't tell them anything. I decided to keep it quiet. They didn't even know about the pregnancy, because I don't think I would have been in the mood to make any small talk after this! "What did you do?" The inertia, the trauma! I wouldn't want to explain. So we decided to do it very quietly. Only my family knows and his family knows. Our nuclear families, but not the aunts and uncles. There's no need for it. Because if I tell them, then they'll all know.

Author: So you've been through quite a lot recently.

Adiva: I've had so many things done! I don't even remember. But it's a small price to pay for something so precious.

In these brief accounts, Adiva and Reem describe the many issues at the heart of the IVF-HOMP-MFPR nexus. These include the conflicting desires and clinical risks accompanying a HOMP pregnancy; the weight of a woman's decision making amid medical pressure for fetal reduction; the emotional trauma of undertaking this ultrasound-guided procedure; the illegality of abortion in the UAE, making reproductive travel for MFPR a necessity; and the desire to keep the fetal reduction secret, even from family members and friends. Given these many dilemmas, fetal reduction was a most challenging form of law evasion. Women who were multiply pregnant and often quite nauseated were forced to travel abroad in order to eliminate one or more of their cherished IVF fetuses. Not always sure that they had done the right thing, these women returned to the UAE, praying that the remaining fetus or fetuses would "hold" inside their wombs, lest they be faced with an unbearable pregnancy loss.

Conclusion

The emergence of IVF to overcome the MENA region's significant infertility problems can be viewed as a tremendous success story. The MENA IVF industry is almost thirty years old and has developed into one of the largest, most medically sophisticated IVF industries in the world. Yet the success of MENA IVF has coproduced new anxieties. One of these is multifetal pregnancy, which is a burgeoning problem in the Middle East due to the IVF practice of MET. The dramatic increase in IVF HOMP has generated, in turn, the need for MFPR to reduce the excess IVF fetuses. When MFPR is illegal, as it is in the UAE, pregnant women must travel abroad in order to seek their fetal reductions elsewhere. Put another way, otherwise law-abiding women become reproductive outlaws of a sort—literally navigating outside of the law in order to procure a needed but prohibited reproductive technology.

At the end of the day—as they are fond of saying in the UAE—the emergence of IVF in the MENA region has coproduced great joys and great sorrows. On the one hand, IVF has helped to create legions of precious "take-home" babies for thousands of infertile Middle Eastern couples. Yet, IVF has also produced many negative consequences, including a plethora of high-risk multifetal pregnancies, fetal reductions of otherwise wanted babies, and the creation of a new class of traumatized, pregnant reproductive outlaws. In short, the IVF-HOMP-MFPR nexus—and the law evasion surrounding it—is one of the more troubling aspects of assisted reproduction as it is taking place in the MENA region today.

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NOTE

1. It is interesting to note that Adiva uses the term *embryo reduction* rather than *fetal reduction*. Imagining the removal of early embryos may be easier for her than conceiving of the selective abortion of actual fetuses.