

Missing Motherhood

*Infertility,
Technology,
and Poverty
in Egyptian
Women's Lives*

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In Egypt, infertility, or the inability to conceive, is a devastating problem for women. They face a triple burden: blame for the failure to conceive; negative evaluation and social ostracism as dangerous, un(re)productive members of society; and responsibility for overcoming the infertility through a reproductive quest that is often traumatic and unfruitful (Inhorn 1994a, 1996). 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. So powerful is their desire to have children and so mighty is 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 (Inhorn 1994a).

Underlying this sometimes desperate, often relentless quest is a patriarchal fertility mandate requiring all Egyptian women to be mothers (Inhorn 1996). 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.

As members of a predominantly Muslim society, infertile women's greatest social threat comes from husbands, who have the right under Islamic law to replace an infertile wife through outright divorce or polygynous remarriage. Although husbands of infertile women are often reluctant or totally unwilling to claim such rights, replacement of this sort is usually urged by husbands' extended family members, who 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 (Inhorn 1996). Thus, in Egypt, infertile women of all backgrounds tend to face tremendous social pressures, ranging from duress within the marriage to stigmatization within the extended family network and 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 sometimes call her, giving this particular identity all of the classic features of a stigma. Goffman (1963: 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."

Given the grave social onus of infertility, it is not surprising that infertile Egyptian women—who are seen as "missing motherhood"—are quite willing to subject their bodies to a variety of treatment modalities. These range from five-thousand-year-old pharaonic prescriptions to the latest in new reproductive technologies. In this essay, I will explore both ends of the therapeutic spectrum, from the most "traditional" to the most "modern" treatments being offered to infertile women in Egypt today. I will begin by exploring what might best be described as "old" medicine in Egypt—not only traditional ethnomedical practices grounded in centuries-old medical traditions, but also outdated biomedical practices that are still commonly

used in infertility treatment in contemporary Egypt. Then I will fast-forward to more recent developments in Egypt—in terms of both my own ethnographic research and the advent of high-tech reproductive technologies that have taken the country by storm and revolutionized the practice of infertility medicine.

Problematizing Infertility

In this essay, my goal as a medical anthropologist and feminist scholar concerned with women's health and well-being is to highlight the various considerations and constraints infertile Egyptian women face when assessing treatment options, including those associated with the relatively recent introduction in Egypt of in vitro fertilization, known as *afāl lanābib*, or literally "babies of the tubes." As part of this discussion, I will put forward three major arguments. First, the experience of infertility treatment in Egypt is extremely gender-biased: women tend to be blamed for infertility problems in their marriages, are therefore expected to seek treatment services with sometimes minimal support from their husbands, and are subjected to highly invasive, often agonizing therapies, even in the face of documented male infertility problems. Second, the experience of infertility treatment in Egypt has become inextricably linked to one's class position in this markedly class-based society: the poor continue to receive "older" infertility therapies, be they ethnomedical or biomedical, for most cannot begin to afford the newer, more efficacious treatment modalities available primarily to the educated elite of this society. And, finally, the experience of infertility treatment in Egypt cannot be understood without reference to religion, specifically Islam, and its particular patriarchal ideologies and dogmas about the nature of gender, kinship, family life, motherhood, and the role of God in the control of science and medicine.

As a prelude to this discussion, I intend to explore the "local moral world" (Kleinman and Kleinman 1991) of one poor urban Egyptian woman, Fadia, who found herself caught in a struggle to achieve motherhood with the current reproductive technologies and treatments available to her.¹ Fadia's story clearly illustrates the plight of poor infertile Egyptian women

who, in their culturally mandatory attempts to become mothers, must also avoid financial ruin, moral opprobrium, bodily harm, marital collapse, and psychic despair. I would argue that understanding the desperate quest for motherhood that women such as Fadia face is important for three major reasons.

First, from the widest global perspective, infertility is a significant although seriously underrecognized public health problem. Because international population efforts have been directed almost entirely to fertility reduction through family planning, few population programs consider infertility to be a population issue, and thus the mission of most family planning programs rarely involves helping infertile couples to build families. Yet such neglect of infertility as a global population problem seems misguided. In many societies, high infertility rates can be shown to coexist with high fertility rates, especially in the wake of epidemics of sexually transmitted diseases (STDs) that produce sterility. Perhaps nowhere is this more evident than in the AIDS-stricken "infertility belt" of Central Africa, where as many as 30 to 50 percent of all couples in some populations are unable to conceive, leading to further depopulation (Collet et al. 1988; World Health Organization 1987).

Given its location slightly to the north of this African infertility belt, Egypt has a much less prevalent infertility problem. Yet infertility still occurs in a significant proportion of Egyptian couples, making Egypt more similar, demographically speaking, to many Western nations. A recent World Health Organization-sponsored study conducted in seven diverse locations around Egypt placed the total infertility prevalence rate among married couples at 12 percent (Egyptian Fertility Care Society 1995). This included the 4.3 percent of couples experiencing so-called primary infertility, or the inability to conceive after one year of trying with no history of previous pregnancy in the woman, as well as the 7.7 percent of couples with so-called secondary infertility, or the inability to conceive after one year of trying in light of at least one previous pregnancy in the woman. Unfortunately, Egypt, like the vast majority of the world's societies, has made no provision in its long-standing population efforts to address the issue of infertility as

either a population problem, a more general public health concern, or an issue of human suffering for its citizens, especially women. In other words, little effort is made in Egypt to address the concerns of the infertile subpopulation, given the historically exclusive focus on hyperfertility and overpopulation as matters of national importance.

A second general problem impeding our current understanding of infertility involves the scholarly lacuna associated with women's cross-cultural experiences of, and desires for, motherhood. Relatively little is known beyond the most superficial, survey-based level about why women worldwide want and/or need to have children. (Equally important and even less clearly understood is why men need to prove their fertility and may desire both children and the experiences of fatherhood.) This is perhaps especially important in high-fertility societies such as Egypt, where women unable to achieve culturally valorized motherhood roles suffer significantly over their infertility. Because feminist analyses of motherhood and, more recently, analyses of the new reproductive technologies tend to decry the patriarchal motherhood mandate, they often (although not always) fail to acknowledge the issues of women's agency and desire—namely, that women in places such as Egypt are genuinely enthusiastic about having children, will go to great lengths to bear and nurture their offspring, and consider themselves fulfilled rather than oppressed by their motherhood roles. Thus, infertility is a particularly cruel misfortune in such pronatalist, matrifocal settings.

A third, related issue is the Western bias in reproductive technology discussions. The vast majority of the social scientific, feminist, and ethical discussions surrounding motherhood, infertility, and the new reproductive technologies focus on Western women, particularly those in the United States, Western Europe (especially Britain), and Australia, which is largely (although not exclusively) where these technologies have been developed. In general, these discussions tend to be highly polemical in nature and textually based, rather than ethnographically enriched by the experiences of real women. In such discussions, furthermore, the issues surrounding the transfer of new reproductive technology to the so-called developing world

are rarely acknowledged, perhaps because of unexamined, Eurocentric, even neo-Malthusian prejudices surrounding the "hyperfertility" of non-Western women and their inherent unworthiness as candidates for these technologies.

Nonetheless, given that significant infertility problems exist in the developing world, it should come as no surprise that the transfer of high-tech reproductive technology to the developing countries is occurring on a massive scale. Perhaps nowhere is this technological globalization process more evident than in the nearly twenty nations of the Muslim Middle East, where IVF centers are present in countries as minuscule as Bahrain and Qatar to those as large as Saudi Arabia and Egypt, which alone boasts thirty-six IVF centers. Most important, when new reproductive technologies reach places like Egypt, they do not enter cultural voids. Rather, local considerations, be they cultural, social, economic, or political, shape the way these Western-generated technologies are both offered to and received by non-Western subjects. In other words, the assumption on the part of global producer nations that technologies are "immune to culture" and can thus be "appropriately" transferred and implemented anywhere and everywhere is subject to challenge once local formulations, perceptions, and consumption of these technologies are taken into consideration. In the case of the regionally underprivileged nation of Egypt, infertile women and men willing to consider the use of new reproductive technologies face a series of culturally specific constraints. As will be highlighted in this paper, these range from the particular culturally infused dynamics of gender relations to class-based barriers to access, and local versions of Islam, that legislate upon the "appropriate" use of these technologies and thus restrict who can benefit from them.

Such culturally specific considerations speak to the need for greater historical and local grounding of ethical, feminist, and technoscience debates surrounding the various impacts of reproductive technologies. Currently, moral, scientific, and gendered discussions of these technologies tend to be situated in Western histories, discourses, and understandings. But, as we shall see in this essay, the use of reproductive technology in Egypt involves

not only a unique history but different understandings of the body, medicine, and morality, all of which profoundly influence women's decisions about whether or not to utilize these technologies.

Research Setting and Methodology

The research upon which this paper is based encompasses two distinct time frames. The first period is the late 1980s, or what may be called the early IVF period in Egypt. In 1988–89, when I conducted fifteen months of anthropological fieldwork on the problem of infertility in Alexandria, Egypt, IVF was neither widely available nor widely understood in the country. During this initial period of research, I based my inquiry in the University of Alexandria's large public ob/gyn hospital catering to the infertile. At this hospital, popularly known as Shatby, I conducted in-depth, semistructured interviews with one hundred infertile women and a comparison group of ninety fertile ones. With few exceptions, these women were poor, uneducated, and illiterate or only semiliterate, and most had never been employed in wage labor outside their homes.² Furthermore, many of these women came from first- or second-generation rural migrant families who had moved to Alexandria, Egypt's second largest city, in search of an improved quality of life. It is important to note here that my research among these women began in the hospital but eventually took me to the homes and home communities of these women, where I conducted additional unstructured interviews and participant observation. Furthermore, it was through my research in women's homes and communities that I met a variety of traditional healers, who also participated as willing informants in my study. It is also extremely critical to note here, given the later focus of this essay on IVF in Egypt, that many of the infertile women participating in my study were seeking treatment at Shatby Hospital specifically because of the hospital's widely publicized claims of a free, government-sponsored IVF program. Yet by the end of my fifteen-month tenure in Egypt, it had become apparent to all my poor IVF-desiring informants that an IVF program at this public hospital had yet to arrive. Furthermore, it appeared that

IVF was not going to be the promised government freebie for poor infertile women with infection-blocked fallopian tubes.

Moving ahead, the second period of research is the late 1990s, or what may be called the IVF boom period in Egypt. Egypt is now in the midst of massive reproductive technology transfer, with new urban IVF centers cropping up 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, semistructured interviews with sixty-six middle- to upper-class women and their husbands undergoing IVF (or a small variety of closely related new reproductive technologies) at two of the major IVF centers in this city of nearly twenty million inhabitants. Both of these IVF centers were situated in private hospitals in Heliopolis and Maadi, elite neighborhoods on the outskirts of Cairo. The patients presenting to these IVF clinics were generally well-educated, professional, comparatively affluent women, who were often accompanied by their husbands. Indeed, in 40 percent of the interviews conducted in these clinics, husbands were present and participated, often enthusiastically, in discussions. Moreover, whereas interviews in the first study were conducted entirely in colloquial Egyptian Arabic, many of the women and men who participated in the second study spoke fluent, even flawless English, and chose to conduct the interview in their second language.

Thus, this essay offers both a diachronic and class-based comparison of infertile women seeking treatment in the two largest cities of Egypt. The essay reveals how the treatment experiences of poor and elite women differ by virtue of economic resources, and how a time span of less than ten years has dramatically altered the infertility treatment landscape in Egypt. However, the essay places primary emphasis on the plight of poor Egyptian women, who continue to be excluded from the high-tech revolution in infertility treatment in Egypt today. The case of Fadia, to whose story we now turn, illustrates the special problems that infertile women who are members of the Egyptian underclass face, and how their treatment decisions are affected by their gender, class, and religious identities as poor Muslim women.

The Story of Fadia

"All my life was despair and torture and sorrow and sadness. Sometimes I would sit like this and cry, and I say, 'Even God, when I got married, he doesn't want to be generous with me, I mean [to] bring a child to stay. I mean, even if anything happened between me and Osman [her husband], disagreements or anything, this child of mine would make me stay [with Osman], would not make me go. Go where? If I went away, the same thing that happened to my mother would happen to me.' So, you find me crying and scared all the time. When I sit alone, I'm upset. I cry. I'm afraid. I'm thinking. And I say, 'Who knows what will happen tomorrow? Who knows what the years are hiding?'"

These are the words of Fadia, a poor urban Egyptian woman whose life has been marred by infertility and by the husbands and male family members who, in claiming their patriarchal authority, have oppressed and abused her. Like so many of the lower-class migrants to Egypt's northern cities, Fadia was born and raised in the south of Egypt, a land called Sa'idi by Egyptians, home of the major monuments of Egypt's pharaonic past and a place of renowned cultural conservatism and respect for tradition. Fadia's father, a local ne'er-do-well, fled Sa'idi for Alexandria, leaving behind a wife and four young daughters. As a child, Fadia was raised alternately by her impoverished and disempowered mother and by her paternal grandparents and uncles, who withdrew Fadia from school at the age of twelve, treating her as their servant.

Because of her mother's inability to control the events surrounding Fadia's life and her father's complete abnegation of his parental responsibilities, Fadia's marriage prospects, per Sa'idi custom, were under the control of her paternal uncles. Like her mother, the adolescent Fadia had become a real beauty, with flowing black hair, smooth olive skin, dark almond-shaped eyes, and a perfect smile and figure, neither too plump nor too thin. Although the local Arabic teacher was in love with Fadia and asked for her hand in marriage, Fadia's paternal uncles decided that she should marry her maternal first cousin Iid, a man who was physically and emotionally repugnant to her. Although her relatives told her, "Ma'lish [never

mind], you'll love him tomorrow," "tomorrow" never came for the eighteen-year-old Fadia. In her brief marriage to Iid, Fadia endured life-threatening physical violence (her husband beat her and once stabbed her in the back), marital rape, and continuous emotional abuse. Only through a desperate suicide attempt involving the ingestion of mercurochrome and iodine was Fadia able to convince her husband (and the various paternal and maternal relatives pitted against her) to give her a divorce.

However, as a divorcee in a small Sa'idi town with no real family or home to call her own, Fadia decided to flee to Alexandria to live with the degenerate father who had never treated her as his child. Before Fadia left, her mother pleaded with her not to go: "Your father is difficult. Your father will beat you. And your father will disgrace you in front of people. He's bad, not good. If he was good, we would have lived with him. We could have stayed. And nobody would have forced you into anything. You could have been educated. Your father is not good." But, believing that temporary escape from the suffocating environment of her Sa'idi relatives was her only alternative, Fadia decided to migrate to the north.

Everything Fadia's mother told her daughter turned out to be true. When Fadia arrived in Alexandria, she found her drug-addicted father living in a small room with neither furniture nor a wardrobe nor food to eat. Although he agreed to take Fadia in, he proceeded to abuse her viciously, just as Fadia's mother had predicted. This included chaining Fadia to the door, heating a knife over a gas flame, and then putting the knife on Fadia's body so as to burn and scar her for life.

Obviously Fadia needed a way out of yet another intolerable situation, and Osman, a divorced neighbor of Fadia's father, provided the vehicle of escape. One day, when Fadia was walking down the street to buy some milk, Osman spotted her and, admiring her beauty, came to inquire about her from some neighbors. Discovering that she was a divorcee, Osman proposed immediately. Although Fadia found the balding, chain-smoking Osman unattractive and too old (he was ten years her senior), she sensed that he might be kind to her, especially in comparison to her sadistic father. Furthermore, as a divorcee who had already lost her virginity—thus depriv-

ing a future husband of the "delight and deliciousness" of penetrating a woman who is still "blocked"—Fadia, feeling devalued and stigmatized, believed her chances of attracting a more desirable husband were slim. Thus, reluctantly and without ceremonial fanfare, Fadia married Osman, moving into the poor carpenter's ground-floor, one-room apartment in a lower-class Alexandria neighborhood.

As with Fadia, Osman's conjugal track record was not good. He had already wed four women, including one who turned out to be a true hermaphrodite, and he had executed the writing of a formal marriage contract with a fifth woman, whom he had divorced even before undertaking an official wedding ceremony. However, all of these serial marriages had ended quickly and inauspiciously, without children resulting from any of the unions. With the young, lovely Fadia, Osman hoped that his marital and procreative luck would improve.

Indeed, within the first two years of her marriage to Osman, Fadia became pregnant three times. But she miscarried each time in the first trimester. The third miscarriage was particularly traumatic, for Fadia bled profusely, was hospitalized for twenty-two days, and underwent two painful episodes of *tausi' wi kaht*, or dilatation and curettage (D&C) of her uterus. According to Fadia, the experience reminded her of the time, a decade earlier, when, following her circumcision by a traditional midwife, she had bled profusely and spent a month in a government hospital in order to convalesce from the hemorrhage.

Unfortunately for Fadia, her reproductive luck with Osman did not improve. Following the third miscarriage and a trip home to Sa'id to visit her poor mother, Fadia did not become pregnant again. Osman, vexed over Fadia's failure to bear his children, became increasingly short-tempered—smoking as many as four packs of cigarettes a day, suffering severe impotence problems, and insulting, threatening, and beating his wife from time to time out of sheer frustration over yet another ill-fated marriage.

Yet Fadia convinced Osman to let her seek treatment for her infertility, which Fadia helped to finance by joining neighborhood savings clubs and selling off all her bridal gold. Fadia tried many *wasfat baladi*, or traditional

remedies, including, among other things, stepping over the gravedigger's tools in a local cemetery, sitting on a freshly delivered placenta, wearing black glycerin-imbued vaginal suppositories, undergoing cupping to draw "a glass of air from her back," wearing a band of rubber with a padlock around her waist, placing Qur'anic amulets under her pillow, licking a rock at a shrine of conception until her tongue bled, and visiting spiritist healers who prescribed elaborate and expensive animal sacrifices to appease the angered spirit-sister under the ground.

However, when none of these remedies worked to make her pregnant, Fadia stopped the folk remedies altogether and started going again to the doctors who had cared for her during her previous miscarriages. Several of them requested a semen analysis from Osman, which he grudgingly underwent three times. The semen analyses revealed a chronic prostate infection and poor sperm motility, for which Osman was prescribed expensive drug therapy. Fadia, meanwhile, underwent both drug therapy and invasive procedures, including the painful *kayy*, or cervical electrocautery, in which her cervix was thermocauterized by a heated instrument, as well as hydrotubation, or injections of antibiotic and anti-inflammatory drug "cocktails" into her uterus. Eventually laparoscopy, a diagnostic surgical procedure to examine the inner recesses of Fadia's pelvis, was performed at the University of Alexandria's public ob/gyn teaching hospital. There Fadia was diagnosed as having a large ovarian cyst, a severe pelvic infection, and blockage of both fallopian tubes. Following an operation to remove the cyst and to "clean out" the fallopian tubes, a young physician told Fadia that her chances of conceiving normally without the help of Egypt's newest treatment modality, in vitro fertilization (IVF), were nearly impossible. Fadia refused to believe the doctor and was incensed that he should predict such a hopeless future for her fertility.

Meanwhile, the religiously devout Osman was sometimes generous and compassionate toward Fadia, telling her that he would support her in her treatment efforts, while at other times he was tyrannical, blaming her for their continuing childlessness and yelling at her, "Get out! I don't

want you." When Fadia broached the subject of IVF with Osman, he was adamantly opposed—not only because of the extraordinary expense, which was well beyond their means, but also because a popular televised cleric had deemed IVF to be *harām*, or forbidden by Islam. According to Osman, the sinfulness of this procedure certainly derived from the fact that "another man's sperm" might be introduced during the IVF procedure. Thus, "a man would be raising someone other than his own child; a man should *never* allow his wife to do that [IVF]."

Unfortunately for Fadia, however, the young doctor was right about Fadia's need for IVF. Although Fadia herself was willing to try IVF, which she believed had been discovered in and imported from America, she realized her chances of undergoing this treatment were remote, given her ongoing poverty and her husband's moral opposition to the procedure. Thus, with few treatment options left open to her, Fadia hoped that Osman's own "weak worms" (sperm of suboptimal quality) and lack of children from his previous marriages would keep him "silent" on the subject of divorce. For if Osman divorced her, as was his right under Islamic personal status law, she would truly have nowhere else to go.

Persistently worried and depressed over this increasingly likely eventuality, the infertile Fadia lamented her fate. "My circumstances are bad. I don't find help. I don't find defense. I don't find somebody to stand by me. So I'd better take it from the start and live and it's finished. It's a life anyway. It has no love. It has no happiness, but it's not important. What's important is that I'm living, and that's it. If I was working, I would have been a free individual. No one would be able to stand in my way. But I don't work. I have no profession in my hand or a job or anything to have a *piaster* [i.e., a penny] out of it or to do something with it. No, I need someone to feed me, to provide me drink, and to support me. What can I do? I live. Yes, it's possible if I'm working, if I'm an employee, no one would be able to stand in my way. But I'm weak. Why? I'm helpless. I have no profession or a weapon in my hand or anything. It's my fate. Naturally, [if I had] children, to me, a child calms his mother. If she doesn't bear children, he [the husband] gets married [to

a second wife], and he has children, and he leaves her, he forgets her—even if they have constant love between them. He forgets her and goes back to his children. . . . Of course, to me, I want [children]. I want because if anything happened to him [Osman], no one can take the apartment away from me. No one can take the furnishings. No one can take anything from me. But if I don't have children—and send evil away!—if anything happened to him, they will take everything, his brothers. By God! And I go out like this—just like a servant.

"It's torment. I am in torture. [But] thank God. There is nothing in my hand that I can do [to have children]. If there were anything in my hand, I would have done it. But I have *nothing* in my hand. . . . This is my life story. I said it, and I talked. It's finished."

Little did the despairing Fadia realize that her story, told to me in its entirety in December 1989, had yet to "finish" and, in fact, was soon to take a turn for the better. In the fall of 1992, I received the following letter from Fadia:

"In the name of God, my friend and sister, Doctor Marcia, I send my greetings and eagerness to you and your husband and to the family, young and old. A thousand thousand salutations to your father and one thousand to your mother and brothers. I send my best wishes from the beautiful, generous Egypt. Congratulations on your recent marriage and may you have babies. I am very eager to see you, and I cannot forget you for a moment, and I am always speaking about you.

"I am fine, thanks be to God, and I have new information to tell you—that a misunderstanding happened between me and Osman and we separated from each other [divorced], and I left the apartment and everything [behind]. Then God gave me a prize: I married a young god, a beautiful and decent man, who works as a general bus driver. He loved me, and I loved him affectionately, and I gave him everything. We got married on November 11, 1991, after the divorce from Osman on August 28, 1991. My new husband's name is Mohammed. I wish you can visit Egypt and know him. He is very good and he loves me. . . . Thank you very, very much for you are still remembering me."

Procreative Ideologies and Women's Bodies

For most infertile Egyptian women such as Fadia, their stigmatization and their desperate attempts to be cured of their infertility are 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 it is unacceptable among Egyptians of all social classes for a host of cultural reasons (Inhorn 1996).³ Thus, biological parenthood—actually giving birth to a child—is the only tenable option for most Egyptian women.

However, among Egypt's large urban underclass, the "biology" of parenthood can be seen to vary considerably from that which most Westerners assume to be universal. Instead of a child "belonging" equally to both parents—who, in the duogenetic theory of procreation found in the West, are seen as contributing equally to the hereditary substance of their offspring—children in Egypt are seen by most less-educated, lower-class men and women as being "created" primarily by their fathers. In other words, in the popular, monogenetic theory of procreation found throughout Egypt, as well as in other parts of the Middle East (Delaney 1991; Good 1980; Greenwood 1981), men are seen as creating preformed fetuses through spermatogenesis; these fetuses are then carried in men's sperm (or "worms," as sperm are referred to among the urban poor) to women's wombs through the act of sexual intercourse. In other words, if men's "worms carry the kids," as Egyptians are apt to put it, then women's wombs are seen as mere vessels, or receptacles, for men's most essential, substantive input.

Two alternative theories do grant women some procreative role, although the substances they contribute to fetal formation are deemed less important than those of men. In one version, women supply menstrual blood as an actual product of conception, which "mixes with the man's worms." However, because menstrual blood is deemed insalubrious and

polluting, many Egyptian women who hold this view are also troubled by what they perceive to be the contribution of a dangerous, defiling substance to the development of a healthy fetus. A much less commonly held view, but one that is beginning to gain credence with the spread of Western-style education to the poor, regards women as egg producers—eggs that must necessarily unite with sperm in order to produce a fetus. However, this seemingly duogenetic theory of procreation remains androcentric; women's eggs are deemed less important, contributing "less than half" or "little at all" to conception when compared to the major role afforded to men's sperm.

Moreover, women are blamed for endangering masculine procreativity by virtue of wombs that fail to facilitate conception and thus men's dominant role in this process. Given that men are widely believed to engender their own offspring, it is a truly ironic, patriarchal paradox that women, rather than men, are generally blamed for failures in the reproductive realm. As long as a man retains his ability to ejaculate his worm-borne fetuses into a woman's waiting womb, he is deemed both virile and fertile. The notion of male infertility has reached the masses in Egypt due to the widespread dissemination of semen analysis technology over the past two decades. Thus, men such as Fadia's husband Osman are known to suffer from "weak worms," as sperm pathologies are generally referred to by lower-class Egyptians. However, male infertility is rarely entertained as the absolute cause of any case of childlessness. This is because worms are thought capable of being invigorated, even enlivened, by a variety of "strengthening" medications. In other words, the actual clinical severity of many male infertility problems, which rarely respond well to drug treatment alone, remains unrecognized by the vast majority of Egyptians.

Rather, women are typically blamed for being infertile, because their reproductive bodies are seen as more complicated than those of men and, hence, more prone to mechanistic failures of the "reproductive equipment." Such "equipment" includes the uterus, fallopian tubes, and ovaries, which are viewed as unstable (even "wandering"), mechanically fragile, and thus subject to both injury and internal failure. Women are viewed as having "many things that can go wrong" with their reproductive bodies, a view

that is supported when women seek infertility treatment and are subjected to numerous painful and time-consuming diagnostic and therapeutic procedures. The degree to which Egyptian women view their own reproductive bodies as fragile, potentially malfunctioning, and difficult to treat is remarkable, as is their willingness to accept and then internalize patriarchal ideologies of reproductive blame. Indeed, women who are told by physicians that their husbands are suffering from serious male-factor infertility typically continue to seek treatment for themselves, under the assumption that something *must* be wrong with them, too. This well-internalized view of women's reproductive bodies as the site of numerous potential problems makes sense when considered in light of the five-thousand-year history of Egyptian gynecology.

Egyptian Ethnogynecologies

In Egypt, rather than there being only one hegemonic form of gynecology, it is more accurate to speak of multiple gynecologies, or multiple, historically based 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: biogynecology, or "modern," Western-derived, biologically based gynecology, and ethnogynecology, or nonbiomedical, "traditional" forms of gynecological care. However, such a dualistic and seemingly dialectically opposed representation of the Egyptian gynecological realm is nothing if not 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 colonially produced Egyptian biomedicine. Prior to the introduction of biomedicine in the mid-1800s, Egypt was home to (1) pharaonic medicine, a five-thousand-year-old medical system known to us through a variety of medical papyri (Leake 1952) and involving the extensive use of an herbal pharmacopoeia by pharaonic medical practitioners (Manniche

1989); (2) *yūnānī* medicine, the most historically influential, colonially produced system of Greek medicine, which was the basis of Arab medicine throughout the Middle East for many centuries. Hippocrates and Galen, the fathers of *yūnānī* medicine, were 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) prophetic medicine, which emerged following the rise of Islam in the seventh century A.D. Prophetic medicine was based on the Prophet Muhammad's teachings about health and hygiene in the Islamic scriptures and was particularly popular with the masses, for it incorporated traditional concepts and practices from Arab folk medicine (Millar and Lane 1988). These included methods to ward off the evil eye, the writing of religious sayings in curative amulets, 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 Egyptian infertility treatment today.

In fact, although none of these ancient medical traditions continues 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 with the materia medica and the power of beliefs derived from these earlier traditions. The primary ethnogynecologists in Egypt today are *dāyāt*, or traditional midwives, who treat the ailments of the infertile as well as deliver the majority of Egypt's babies. However, *dāyāt* are not the only ethnogynecologists. In urban Egypt today, poor infertile women may seek the help of one or more *sittāt kabira*, or elderly lay women healers known for treating the most common bodily complaints of women; *ʿaṭṭārīn*, or herbalists, who deal in the herbs and minerals necessary for various healing appurtenances; *munaggimīn*, or spiritist healers, who tend to specialize in sorcery nullification, and spirit invocation and appeasement; and, finally, *shuyūkh bil-baraka*, or blessed shaikhs, living and dead, who provide divine intercession for infertile women on

their healing pilgrimages to saints' tombs and other "shrines of conception" (Betteridge 1992).

Some poor infertile women eschew the services of such healers, placing their entire faith in "God and doctors." However, as seen in the case of Fadia and her pursuit of a variety of traditional remedies, the vast majority of lower-class women continue to rely on these popular, indigenous practitioners at least as a first line of resort; for it is these healers, and not doctors, who recognize, diagnose, and treat the many ethnogynecological causes of infertility.

Kabsa, also known as *mushāhara*, is considered by most poor, uneducated 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 *kabsa* is extremely complex and is described in great detail elsewhere (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 reexposure to the putative pollutant (blood, urine, sexual excreta, the discharges of death, or gold, which is thought to pollute the poor).

Second, many women experience *ruṭūba*, or utero-ovarian humidity contracted through exposure of the genitals to cold drafts or cold water. *Ruṭūba* is thought to be remedied through either cupping or vaginal suppositories called *ṣuwaf*, which are thought to drain the moisture from an affected woman's reproductive organs, but which, in fact, may be ethnoiatrogenic, causing ascending, sterilizing infections in some women (Inhorn 1994a).

Third, *dahr maftuh*, or an open back, is another common cause of infertility, believed to be caused by overexertion. This condition requires cupping, traditional cauterization, or an externally worn belt and padlock to "close" the back, which cannot properly "carry" a pregnancy.

Fourth, *khadda*, or a severe shock or fright, is thought to render both men and women infertile and must be remedied either by countershocking

or by placing edible substances in a special pan called the *last it-tar'ba*, or "pan of shock."

Similarly, *'amal*, or sorcery, is believed to be a cause of both male and female infertility and requires divination and nullification by mostly male spiritist healers, who are often viewed with skepticism as being unscrupulous and immoral.

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 gifts, usually food.

Although poor women vary in the degree and extent to which they accept these ethnologies and act upon them in their treatment quests, suffice it to say that ethnogynecological beliefs, treatments, and practitioners are alive and well in Egypt among the urban underclass, providing an alternative therapeutic realm for poor infertile women that is rich and varied in its content.

On one hand, these ethnogynecological therapies tend to be much more accessible, affordable, and, on some levels, culturally acceptable than foreign-based biogynecological treatment modalities. Furthermore, although their efficacy is both unknown and questionable, these ethnogynecological therapies tend to be much less invasive and potentially less iatrogenic than biogynecological "cures."¹ On the other hand, ethnogynecological therapies are not entirely unproblematic for poor infertile Egyptian women. Some procedures, such as cupping, are extremely painful, while others, especially the practices revolving around *kabsa* (which involve, among other things, exposure to miscarried fetuses, the bloody by-products of birth, cemeteries, morgues, and skeletons) are reported by many women to be repulsive and traumatizing. Furthermore, in the era of AIDS and other blood-borne infections, the exchange of blood and bodily fluids required in many of these ethnogynecological practices can only be seen as ultimately health-demoting. Finally, for many poor Egyptian women who are sensitive to the ever-increasing Islamist discourse in the country, these ethnogynecological practices may produce great moral ambiguity and anxiety,

ety, because at least some of these practices, especially those associated with sorcery, have been directly condemned as pre-Islamic superstitions that go "against the religion."

Indeed, although most poor infertile women consider and attempt to counter one or more of these possible ethnogynecological causes of their infertility, they acknowledge and agree with the Islamist discourse stating that infertility and its solution are ultimately up to Allah, God the Almighty, who decides who will be infertile and who will not, as well as who will overcome her infertility with his help. Because God created medicine so that believers might seek the solution to their own suffering, poor infertile Egyptian women take very seriously their quests for conception, attempting to demonstrate to God their belief in his healing power. Thus, today, most infertile Egyptian women are peripatetic pilgrims, embarking on relentless healing quests. For many women, these quests take them from healers to holy sites and, not inconsequentially, to numerous physicians.

Egyptian Biogynecology

For many poor women, ethnogynecology remains an especially appealing avenue for therapy, because of the considerable constraints to proper infertility care posed by Egyptian biomedicine. In the biomedical management of infertility in Egypt, it is women's bodies—not men's—that tend to be subjected to expensive, invasive, agonizing, and often iatrogenic methods of surveillance and control. 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" designed to create, ultimately, politically docile subjects—seems quite germane to this discussion. Egyptian biomedicine, a historically recent British colonial import that 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; these women are too readily subjected to, and accommodating of, various forms of biogynecological bodily invasion, touted by many physicians as being high-tech biomedical "fixes" for infertility. That mostly male

biogynecologists with little if any training in infertility management willingly invade infertile women's bodies—both vaginally and abdominally—in the pursuit of blatantly patriarchal and capitalist ends is the source of what might best be called the “untherapeutic therapeutics” rampant in the Egyptian biogynecological setting (Inhorn 1994a).

In Egypt today, those women who cannot afford IVF and the other new reproductive technologies are typically subjected to an array of outdated, inefficacious, and even iatrogenic therapies that are widely practiced by Egyptian biogynecologists. In many cases, the subjects of these iatrogenic practices are poor, minimally educated women, who, having been convinced of the superiority of biomedicine or simply desperate to be cured, may sell virtually everything they own in order to finance their biomedical quests to doctors who can only be described as second-rate. Typically, these physicians engage in the blatant abuse of fertility drugs—overprescribing them to patients and failing to monitor sometimes serious side effects, which may lead to additional infertility problems. Furthermore, infertile Egyptian women typically undergo multiple invasive procedures.

One of these invasive procedures is tubal insufflation, or *nafq* in Arabic, an antiquated diagnostic procedure in which carbon dioxide is pumped into the uterine cavity to purportedly “blow open” blocked fallopian tubes. This procedure, which was introduced in the United States 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 now is found only in the annals of gynecological history in the West (Speert 1980). Furthermore, tubal insufflation actually produces further infertility problems in some women, by forcing pathogenic bacteria from the lower part of the genital tract into the upper part, where these bacteria lead to sterilizing infection (Inhorn and Buss 1993).

Second, many infertile women are subjected to dilatation and curettage (D&C), or *tausi' wi kaht* in Arabic, involving the purported “cleaning” of the uterine cavity through scraping off the endometrial lining by a sharp curette. Although D&C is indicated for postmiscarriage bleeding, it has been obsolete for decades in the treatment of infertility in the West, and

this is no longer included in contemporary texts in reproductive medicine (Carr and Blackwell 1993).

Finally, many infertile women undergo the painful procedure called cervical electrocautery, or *kayy* in Arabic, 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 the cervical mucus necessary for the transport of sperm into the upper genital tract.

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

Although a detailed cultural critique of Egyptian biogynecological practices is beyond the scope of this essay 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: first, because of their outdated medical knowledge, which derives from an antiquated, colonially produced system of medical education in Egypt (El-Mehairy 1984; Sonbol 1991) and which is accompanied by a blatant lack of physician accountability through any form of systematic continuing medical education or malpractice; and second, because of physicians' frank greed for money in a climate of economic uncertainty and stiff competition for paying clientele. Poor infertile women, who are uneducated and often too easily impressed by male physicians' authority, constitute easy prey for unscrupulous physicians, who may justify their largely inefficacious treatments as a harmless form of hope for

their desperate female patients. As physicians practicing in a developing country, they realize all too well that it is such poor patients who will never be able to afford IVF and the other new reproductive technologies introduced to Egypt during the last decade. Thus, older reproductive technologies, which are applied in a cavalier and harmful fashion, are even justified as a form of "mercy" treatment by physicians who are incapable of offering the newer reproductive technologies to their poor patients.

The Advent of IVF

Thus, as it now stands, with few exceptions, poor Egyptian patients such as Fadia are simply unable to obtain IVF and the other new reproductive technologies, even if they are aware and highly desirous of such treatments. Among the poor, and even among most of the middle class, IVF is absolutely unaffordable—and probably will continue to be so indefinitely, given the personal expenditures required for such therapy in privately held IVF clinics.

It has now been more than ten years since the first IVF center in the Muslim Middle East opened in Cairo as a private concern, and the first Egyptian "baby of the tubes"—a little girl named Heba Mohammed—was born in 1987. By the early 1990s, the University of Alexandria's Shatby Hospital, where I conducted my original research, opened its own public IVF center, and the first Alexandrian "baby of the tubes" was born in early 1992. But since those early publicity-driven days of free, government-sponsored IVF, fewer and fewer test-tube babies have been born to poor Egyptian women. As Egypt's one and only public IVF program, the Shatby Hospital IVF clinic continues to operate, 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 clinic put their energies into their private IVF concerns—which, as is typical for most Egyptian physicians working in the public sector, they run on the side.

With only this one, rather suboptimal exception, the rest of the thirty-six IVF centers in Egypt today are private concerns, charging comparatively high prices for the procedures that patients pay out of pocket (since health

insurance in Egypt is new and not widespread). The doctors who run these centers, many of whom are university professors and are Western-trained, comprise a small, elite corps of highly educated and biomedically sophisticated reproductive medicine specialists in Egypt. Not surprisingly, their patients are also drawn from a relatively small group of educated, elite Egyptians, who are sophisticated about their medical options and can afford to pay for high-tech therapies. For the most part, these women are highly educated professionals who often speak English or French and are employed as doctors, lawyers, architects, engineers, accountants, bankers, professors, businesswomen, and even movie stars. Furthermore, many of these women and their husbands are members of the Egyptian "brain drain" generation—they increase their wealth by working in the petro-rich Arab Gulf countries, returning home annually on month-long vacations in order to undertake a trial of IVF.⁵

In other words, over a relatively short time span, 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 upper-class patients. This does not mean that elite doctors and patients are without sympathy for the poor and even middle-class women who cannot afford IVF therapy. For example, one IVF doctor in Cairo described his futile, ten-year campaign to introduce IVF at Cairo's largest public university teaching hospital, bemoaning the lack of political will that had frustrated his efforts. Furthermore, affluent women themselves lamented the high cost of IVF therapy and the need to repeat the therapy if it did not succeed, typically at a cost equivalent to nearly \$3,000 per trial. They 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 referring to poor women such as Fadia, 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 Eurocentric prejudice that, as noted earlier, seems to underlie much Western discourse on infertility and the new reproductive technologies and which is certainly rife in the Western-generated population discourse on Egypt. In this discourse, the new reproductive technologies to combat infertility *should not* be “for everyone,” because, the equation goes, those who cannot afford these technologies certainly cannot afford to have children. In this model, poor women do not deserve to be mothers, and any reproductive technology directed at them should inhibit—not facilitate—their fertility.

Religion and New Reproductive Technologies

Even if some affluent Egyptians think this way, rarely do they express this self-serving, neoeugenic argument openly, for it militates against the teachings of Islam, which state that every child is born with its own *rizq*, or source of sustenance. Egypt is a decidedly Muslim country, with more than 90 percent of its citizens Sunni Muslims and with public expressions of religiosity increasing under a two-decade-long wave of Islamic fervor. Although Egyptian Muslims are certainly heterogeneous in terms of religiosity and degree of religious expression and practice, it is also true that Islam provides a source of guidance for many Egyptian Muslims in a variety of arenas of human activity, be they spiritual, economic, educational, medical, or political. Instruction that informs or regulates the everyday activities of Muslims can be found in a number of theological documents, including the Qu’ran and the *hadith* (the traditions and sayings of the Prophet Muhammad), which are the primary Islamic scriptures. Together, these sources make up the body of Islamic jurisprudence called the *shari’a*. Those issues, such as the new reproductive technologies, which are not discussed in the centuries-old *shari’a*, are regularly legislated upon by the most venerable Islamic jurists in the form of written religious proclamations called *fatwās* (Lane and Rubinstein 1991).

Even before IVF emerged on the scene in Egypt, the grand shaikh of Egypt’s world-renowned Al-Azhar University issued a *fatwā* on the religious permissibility of IVF. 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 is implanted in the uterus of the same wife from whom the ova were taken” (Aboulghar, Serour, and Mansour 1990). In other words, in Egypt and in the rest of the Middle Eastern Muslim world, Islamic jurists have clearly spelled 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. Sperm, ova, and embryo donation are prohibited, as is surrogacy.

It is interesting to note that although this *fatwa* on IVF was issued as early as 1980, uncertainty about the Islamic position on IVF reigned throughout the pre-IVF period in Egypt, as evident in Fadia’s husband’s belief that IVF was religiously prohibited. By the mid-1990s, however, much of this moral uncertainty had given way to a kind of moral clarity abundantly apparent in the discourse of Egyptian women undergoing IVF. Stating that the religious aspect of IVF is its “most important” element, Egyptian IVF patients interviewed in the 1996 study were 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 the Egyptian women undergoing IVF in this study, the thought of using donor sperm from a sperm bank was simply reprehensible and was tantamount in their minds to committing *zina*, or adultery. Surrogacy, in addition, tampers with the “natural maternal bond,” which is meant to be an exclusive link between one mother and her biological child.

Furthermore, much of this righteous discourse was constructed in relation to discourses about the corrupt 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 IVF doctors who impregnate hundreds of women with their own sperm, only to be sent to prison; or IVF mothers who bear twins, one black

and one white, by two fathers because of careless sperm admixtures in western IVF laboratories. Proclaiming that this would never happen in Egypt—where women assume that their IVF doctors are good, religious Muslims—women in Egyptian IVF centers described in incredulous terms the immoral horror of Western IVF practices. They concluded smugly but apologetically to the American anthropologist researcher that “each society has its own traditions and customs.”

But, as an American anthropologist interested in understanding such “traditions and customs,” I also perceive what most infertile Egyptian Muslim women are unwilling to contemplate—namely, the paradoxical downside of Islam’s patriarchal moral code. On one hand, Islam glorifies motherhood and all its entails, insisting that women are endowed with a “natural maternal instinct” (Schleifer 1986). Yet, because of Islam, infertile women who attempt to realize their maternal instinct by resorting to reproductive technologies are particularly limited in their technological options. Moreover, these constraints are even greater when one considers that Islam prohibits adoption, again for reasons having to do with lack of a natural “maternal bond” between an adoptive mother and her child and, more important, the lack of “blood ties” between adoptive fathers and their offspring, leading to nagging questions of paternity, descent, and inheritance.

Finally, a particularly cruel irony that is occurring with increasing frequency in Egyptian IVF centers today has to do with male infertility. A brand-new reproductive technology called intracytoplasmic sperm injection (ICSI)—pronounced “iksee”—is allowing men with severe male-factor infertility to have “biological” children using their own sperm. Those Egyptian wives who have “stood by” their infertile husbands for many years but who are now too old to produce their own ova for the ICSI procedure are increasingly being “replaced” through divorce or polygynous remarriage. Because egg donation, sperm donation, and surrogacy are all strictly forbidden by Islam, infertile Egyptian husbands see their own reproductive futures as lying with younger “replacement” wives, who are allowed to men under Islam’s personal status laws.⁶ These laws, coupled with the Islamic position

on the need for biological paternity in the practice of IVF, place infertile Muslim women in a true reproductive bind.

Conclusion

It would seem appropriate to quote from Cris Shore’s recent essay on anthropology and the new reproductive technologies:

Attitudes toward conception communicate key structural principles about the nature of society: in this case, a patriarchal society still rooted in an ideology that stresses the importance of blood ties, the primacy of the nuclear family, and the superiority of paternity. . . . The lesson from anthropology is that every society has a vested interest in controlling reproduction, and in each, we tend to find dominant institutions—the church, the state, the medical profession, or whatever—competing to monopolize the discourses through which legitimate reproduction is conceptualized. (1992: 30)

Through my own anthropological inquiries into infertility in Egypt, I hope to have shed some light on the ways in which the reproductive destinies of infertile Egyptian women are being controlled, for better or for worse, by the male-dominated medical profession, the state-sponsored religion, and the overarching political economy of a society divided into a few haves and many have-nots. Unfortunately, for many of these infertile Egyptian women, rich and poor, their efforts to be cured of their infertility are often fruitless and thus their future remains unclear. Both collectively and individually, they face a “medical and emotional road of trials” (Sandelowski, Harris, and Black 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.

Notes

1. The name Fadia is a pseudonym.
2. For additional detail on the study population and research methodology, see Inhorn 1994a.
3. Not only is adoption culturally unacceptable among the urban poor, but it is also unacceptable among the wealthy, as apparent in my more recent research, carried out in 1996. Of the sixty-six couples participating in my study of IVF, only one couple was legally fostering a child. Most other couples had rejected this option out of hand, claiming it was "against the religion."
4. Neither I nor any other contemporary researcher has attempted to assess whether the ethnogynecological treatments for infertility used in Egypt are, in fact, efficacious. Some of the herbal substances used in various ethnopharmacologically based infertility remedies (e.g., suppositories) have been shown to have medicinal properties (Bedevian 1936). From a strictly biomedical standpoint, however, it is unlikely that any of the traditional remedies are substantially efficacious, and some are potentially iatrogenic in terms of exposing women to further genital tract infection.
5. Although a few women in this study had also traveled to Europe or the United States in order to try IVF, traveling outside the Middle Eastern Muslim world was generally not condoned by study participants as a wise or feasible option. In addition to the logistical difficulties of securing access to medical personnel, facilities, and housing, many women were concerned about the moral standards of non-Muslim Western IVF practitioners. They felt that the possibility of sperm and ova "mixups" was much higher in the West, either through careless laboratory practices or through intentional efforts on the part of physicians to increase their success rates. Most women were convinced that such "involuntary donation" of sperm and ova would never take place in Egypt or another Muslim country. Thus, most women chose to remain as patients within the Middle Eastern region.
6. Although I do not intend to suggest that Islam is more or less patriarchal than any other world religion, many feminist scholars (e.g., Badran 1993; Coulson and Hinchcliffe 1978; Hatem 1986; Smock and Youssef 1977; White 1978) have argued that Islam's personal status laws governing divorce and polygyny provide a glaring example of the nexus between patriarchal ideology and practice in the Middle East.

**Ideologies
and
Technologies
of
Motherhood**

Race

Class

Sexuality

Nationalism

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