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Gender, Religion, and In Vitro Fertilization

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Egypt

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Since the birth of Louise Brown, the world's first 'test-tube baby' in 1978, the new reproductive technologies (NRTs) have spread around the globe, reaching countries far from the technology-producing nations of the West. Perhaps nowhere is this globalization process more evident than in the nearly twenty nations of the Muslim Middle East, where in vitro fertilization (IVF) centres have opened in nations ranging from small, oil-rich Bahrain and Qatar to larger but less prosperous Morocco and Egypt. Egypt provides a particularly fascinating locus for investigation of this global transfer of NRTs because of its ironic position as one of the poor, 'overpopulated' Arab nations.

Egypt was the first Middle Eastern Muslim country to establish a national population reduction programme through family planning in the 1960s. However, as in the vast majority of the world's societies, infertility was not included in this programme as either a population problem, a more general public health concern, or an issue of human suffering for Egyptian citizens, especially women. Nonetheless, a recent World Health Organization-sponsored study placed the total infertility prevalence rate among married Egyptian couples at 12 per cent (Egyptian Fertility Care Society 1995). Given the size of this infertile population and the strong desire for two or more children expressed by virtually all Egyptian men and women, it is not surprising that Egypt provides a ready market for the NRTs. Indeed, Egypt has been at the forefront of NRT development in the region, now hosting nearly 40 IVF centres, more than neighbouring Israel (Kahn 2000).

NRTs and culture

New reproductive technologies are not transferred into cultural voids when they reach places like Egypt. Local considerations, be they cultural, social, economic, or political, shape and sometimes curtail the way 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 reproductive 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. Instead, it is useful to ask how third world recipients of global technologies resist their application, or at least reconfigure the ways they are to be adopted in local cultural contexts. In other words, globalization is not enacted in a uniform manner around the world, nor is it simply homogenizing in its effects. The global is always imbued with local meaning, and local actors mould the very form that global processes take, doing so in ways that highlight the dialectics of gender and class, production and consumption, and local and global cultures (Freeman 1999).

In the case of Egypt in particular, infertile women and men willing to consider the use of NRTs are confronted with eight major 'arenas of constraint', or various structural, ideological, social-relational, and practical obstacles and apprehensions. Some of these constraints – such as class-based barriers to IVF access, the physical risks, and low success rates associated with IVF – are similar to those faced by Western consumers of these technologies. However, many of the dilemmas experienced by Egyptian IVF patients are deeply embedded in local cultural understandings and practices. These constraints range from gender dynamics within marriage to local versions of Islam, which legislate upon the appropriate use of these technologies and thus restrict how test-tube babies are to be made.

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Indeed, given the daunting series of obstacles confronted by Egyptian IVF patients, it is remarkable that Egyptian *atfal l-anabib*, or literally 'babies of the tubes', are being born on an almost daily basis in some of the major IVF centres in the country.

Egyptian IVF landscape

In 1996, I conducted medical anthropological fieldwork in two of the major IVF centres in Cairo. In-depth, semi-structured interviews were conducted with 66 middle- to upper-class, highly educated, professional women and their husbands, the vast majority of whom were seeking IVF services. This Egyptian IVF research followed an earlier project on infertility undertaken with poor infertile Egyptian women in 1988–1989 (Inhorn 1994). In that study, in-depth, semi-structured interviews were conducted with 100 infertile women and a comparison group of 90 fertile ones, the vast majority of whom were poor, uneducated, illiterate housewives (Inhorn 1996). These poor women were seeking treatment at the University of Alexandria's public ob/gyn teaching hospital, which had widely publicized its opening of a supposedly 'free' government-sponsored IVF programme.

Thus, my work on this subject incorporates both a longitudinal perspective and a class-based comparison of infertile women seeking IVF treatment in the two largest cities of Egypt. It reveals how the treatment experiences of poor and elite infertile women differ dramatically by virtue of education, economic resources, and subsequent access to IVF, and how a time-span of a decade has dramatically altered the IVF treatment landscape in the country.

In the world of Egyptian IVF, considerable attention must be paid to issues of religion and gender. In Egypt, the official Islamic position on NRTs – manifested through a series of *fatwas* issued from al-Azhar University since 1980 and subsequently upheld by the minority Coptic Christian patriarchate in the country – has supported IVF and related technologies as means to overcome marital infertility. However, in Sunni (as opposed to Shi'a) Islam,* all forms of so-called 'third party donation' – of sperm, eggs, embryos, or wombs (as in surrogacy) – are strictly forbidden, for reasons having to do with the privileging of marriage, 'pure lineage', and the 'natural' biological ties between parents and their offspring. Viewing the al-Azhar *fatwa* as authoritative, Egyptian IVF patients explain that sperm, egg, or embryo donation leads to a 'mixture of relations'. Such mixing severs blood ties between parents and their offspring; confuses issues of paternity, descent, and inheritance; and leads to potentially incestuous marriages of the children of unknown egg or sperm donors. Thus, for Egyptian women with infertile husbands, the thought of using donor sperm from a 'bank' is simply reprehensible and is tantamount in their minds to committing *zina*, or adultery. Egyptian IVF patients, as well as their IVF doctors, attempt to scrupulously uphold these religious injunctions forbidding third-party donation practices, thereby revealing a level of conjunction between moral discourse and medical practice that is



PHOTO: NOZHA INTERNATIONAL HOSPITAL, CAIRO, EGYPT

not found in most other regions of the world (e.g. Kahn 2000; Nicholson and Nicholson 1994).

However, from a gender perspective, this religiously condoned privileging of biological parenthood has not necessarily been advantageous for Egyptian women, who are unable to solve their childlessness through either Western-style adoption, which is expressly prohibited in the Islamic scriptures (Sonbol 1995), surrogacy, or donor-egg technologies. Indeed, the saddest new twist in marital politics in Egypt has occurred as a result of the relatively recent advent in Egypt of intracytoplasmic sperm injection (ICSI) – a variant of IVF that allows men with very poor sperm quality to procreate. As long as a single viable spermatozoon can be retrieved from a man's body, including through painful testicular biopsies, this spermatozoon can be injected directly into the ovum, thereby 'forcing' fertilization to take place. Thus, ICSI heralds a revolution in overcoming male infertility, and its arrival in Egypt in 1994 has led to the flooding of IVF clinics with couples whose marriages have been affected by long-term male infertility.

Unfortunately, many of the wives of these Egyptian men, who have 'stood by' their infertile husbands for years, even decades in some cases, have grown too old to produce viable ova for the ICSI procedure. Because the al-Azhar *fatwa* forbids the use of ova donation or surrogacy, couples with a 'reproductively elderly' wife face four difficult options: (1) to remain together permanently without children; (2) to legally foster an orphan child, which is rarely viewed as an acceptable option, particularly among elites who want heirs to their fortunes; (3) to remain together in a polygynous marriage, which is rarely viewed as a tenable option by women themselves; or (4) to divorce so that the husband can marry a younger, more fertile woman. Unfortunately, more and more highly educated, upper-class Egyptian men are choosing the final option of divorce – believing that their own reproductive destinies may lie with younger, 'replacement' wives, who are allowed to them under Islam's personal status laws.

Thus, the use of IVF, ICSI, and other NRTs has myriad local implications in Egypt and in other parts of the Muslim world. As suggested

by this study, these local cultural implications must be studied by Middle Eastern scholars, in order to document both the benefits and pitfalls of the new reproductive technologies that are spreading so rapidly around the globe.

Note

* The supreme jurisprudent of Shi'ite Islam in Iran has allowed the use of donor egg technology. Donor sperm technology is also allowed, although the offspring are not allowed to inherit from the social father.

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