A Reader in Medical Anthropology
Theoretical Trajectories, Emergent Realities
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Sakina’s Story

On a rainy day in late November 1988, Sakina sat weeping on a bench in a corridor of the Sharty Hospital. Just told that both of her fallopian tubes were blocked and that the only way for her to achieve pregnancy was through in vitro fertilization (IVF), Sakina was insensible. Her worries were many. First, she feared the reaction of her husband, Hanif, who was tired of spending his hard-earned money on her infertility therapies and who had told her three times over the past year that he planned to divorce her and remarried "for children" if she did not become pregnant soon. Second, she was worried about the cost of IVF, given that her first instruction was to purchase two packets of medicine costing £E 350 ($140) each. Having only £E 100 ($40) left after selling her last gold bracelet for £E 300 ($120), Sakina knew that she was definitely unable to afford IVF on her own and that Hanif, with his small salary as a laborer in a textile factory, was probably unwilling and unable to finance this expensive therapy. Third, she was worried about the effect of IVF on her body. Although as the daughter of a dawas, or traditional healer, she had already tried many painful ethnogynaecological and biogynecological therapies, Sakina heard from other women in the hospital that the IVF doctors "took things from the tubes and put them back" and, frankly, she had no idea what "tubes" they were talking about or whether these tubes were the same ones that the doctor had said were "blocked" in her body. Fourth, as a Muslim woman, Sakina was uncertain about the acceptability of IVF in her religion. Although she suspected that IVF was not forbidden as long as "it’s from the husband," she was uninform about the reactions of religious experts in this subject and feared Hanif’s interpretation of the religious permissible of the procedure. Finally, Sakina was extremely concerned about the reception of her family and neighbors to her bringing home a "tubes baby" — a baby that might face perpetual ostracism if the nature of its creation was made known to the community. Thus, she realized that if she were to undertake IVF, she would have to keep this fact secret from everyone — except, of course, from her sympathetic mother.

However, of all of these concerns, Sakina's financial worries were the most immediate and were the issues that had made her burst into tears in the doctor's office. When the doctor told her to purchase the two packets of expensive medicine, she told him that she could not afford even one packet and would therefore be unable to undertake IVF therapy. He offered to provide one packet of the drug for free if she would agree to participate as a subject in his clinical study of IVF patients. Furthermore, he told her of a government pharmacy in midtown Alexandria where the drug could be purchased for only £2.20 (approximately $3.50). However, with only £100 ($40) to her name, Sakina was still £20 ($40) short.

A week after her desperate episode in the hospital, Sakina returned to Shady, smiling, with a packet of the expensive IVF medication in hand. During the ensuing week, she had received zakāt, or alms, from some upper-class Egyptians to whom she had told her sad story and who, taking pity on her, gave her the remaining £20 as a charitable donation. However, this did not solve all of Sakina's problems. For one, she had no refrigerator in which to store the sensitive drugs, and when she told the doctor that she had kept the packet of drugs at room temperature for several days, he admonished her for failing to follow his instructions. Second, she was told that the drug she purchased would be good for only one "trial" of IVF and that subsequent attempts to make a "tubes baby" would require additional medication.

Sakina's most serious problem, however, involved delays. Although she and other women whose tubes were blocked had been told that the IVF procedure would begin at the hospital immediately, a month of waiting turned into two months, and then into three, and, eventually, a year. During this interval, Sakina and other women like her were advised by their physicians to resell their expensive medications, lest the drugs lose their therapeutic efficacy and the women lose their money. Thus, more than a year after that fateful day in November 1988 when Sakina was told about her need for IVF, her dreams for a tif l-landhib, or a "baby of the tubes," were still unfulfilled.

egyptian women like her — a test-tube baby was, in fact, not in the making by the end of the 1980s.

Test-Tube Babies on TV

By the end of 1988, when Sakina ventured to Shady Hospital to meet her need for IVF, the subject of IVF was familiar to many urban Egyptians, who recognized this assisted reproductive technology by the name tif l-landhib, literally, "baby of the tubes." Following an announcement in Al-Ahram newspaper in July 1987 of the first Egyptian "test-tube baby," the Egyptian media began to capitalize on Egypt's newest reproductive technology, in the form of factual discussions of the technique, debates over the religious permissibility of the procedure, and melodramatic television dramas about infertility women undergoing IVF. In fact, in a popular televised tamaalīy, a dramatic, fictional soap opera that aired in 1989, the story was told of a woman who spent thousands of Egyptian pounds undergoing IVF following years of hopeless infertility. Unfortunately, the protagonist was forced to remain in bed throughout her pregnancy — a false representation — and, at four months, she miscarried her "baby of the tubes" in a dramatic twist of fate. This television show served as the primary means by which the Egyptian public learned about IVF, although the information conveyed about this new reproductive technology was flawed and viewers' understandings were thus extremely incomplete. Suddenly, women who had never before heard of "test-tube babies" were instant experts on the subject, having watched the soap opera and drawn realistic inferences from it. As one woman described it, "They take the mufa from him, his back, and another from her, and they put it in a jar. And they put chemicals in to revive the dead womb, and the wombs start to grow in a jar, and it becomes a child — not a jar filled with pickles, but like an aquarium where the child grows for seven to nine months, and then it put in a nursery. The woman has to stay on her back all the time." Thus, following the airing of the tamaalīy, "tif l-landhib" became a household word in

egypt, although, as apparent in this woman's description, few Egyptians understood much about how "babies of the tubes" were actually created or how many had been born in Egypt. The misleading rumor that many test-tube babies had in fact been born in the country was perpetuated by publicity surrounding the eventual birth in Cairo of IVF quadruplets to a woman who had been infertile for seventeen years.

Although most of the national publicity about IVF in Egypt emanated from Cairo, where the first private IVF center was established in 1986 (Serdou, El Ghair, and Maansour 1990), Alexandria, too, became the site of major IVF activity, with the emergence of both a private IVF clinic and a public program at the government's military hospital. However, both of these IVF pilot programs failed to produce any "babies of the tubes" and were discontinued almost immediately.

Nevertheless, having begun a successful ABI (artificial insemination by husband) program, administrators at Shady Hospital decided to continue with plans to expand their assisted reproductive technology program to include IVF. Laboratory supplies necessary for IVF were ordered from abroad; extra laboratory personnel were hired; research projects involving IVF were designed; and IVF candidates such as Sakina were selected from the patient population and enlisted in the IVF program. Furthermore, as noted previously, a widely read national newspaper magazine called October — equivalent to Time or Newsweek in the United States — announced in a lengthy article that Shady Hospital had begun its own "baby of the tubes" program. This article alone brought hundreds of women to the hospital hoping to undergo IVF. Some were women who had undergone unsuccessful IVF trials in Cairo or Alexandria; some were women who had discovered that they could not afford the costs associated with IVF in a private center; and some were infertile women who thought that a "baby of the tubes" might provide the long-awaited solution to their infertility problems.

Of the hundreds of infertile women who came to Shady seeking IVF, only a small number (including 13 percent of the infertile women in this study), actually entered the IVF program as candidates. Most of these women were those with confirmed bilateral tubal obstruction, for whom AIH was not possible and IVF was their only real hope for achieving pregnancy.

Women's Concerns

Yet, for these women, most of whom were poor, their eagerness to undergo IVF was tempered by numerous practical and moral concerns, similar to those described for AIH, but of a slightly different order. Their questions about IVF, as we shall see, revolved not only around its expense and religious permeability, but around the complicated "mechanics" of a new reproductive technology in which the technological imperative of biomedicine is perhaps quintessentially embodied.

What kind of "tube"?

Many Egyptians, both men and women alike, were troubled by IVF because of the difficult question of "tubes." As we have seen, many Egyptian women had heard about women's "tubes" (that is, fallopian tubes) and realized that their blockage constituted a major infertility problem. Yet, the structure and function of these tubes and their location in relation to other female reproductive organs were subjects only partially understood by most women, who viewed the uterus and ovaries as the major female reproductive parts. As IVF became popularized in Egypt, however, many women came to realize that "babies of the tubes" were for infertile women with blocked tubes. But were these "tubes" of the same kind?

After seeing the soap opera, many Egyptians came to surmise that the term "baby of the tubes" actually referred to babies conceived and even inserted in glass tubes during the course of gestation. Naturally, the thought of babies "artificially produced" in glass test tubes was one most disturbing to Egyptian men and women, whose convictions about the necessity of natural, God-given conception, childbirth, and parent-child ties were extremely strong. As a result, many Egyptians suspected that IVF was most certainly harmful, or forbidden,
as reflected in women’s discourse on the subject. As women explained:

They’ve just invented test tubes and everything two years ago. I consider a child brought this way not to be my own child. It’s not the same as when you carry a child in your body. These artificial ways don’t feel the same — the tenderness and love.

It’s not the same as when you carry the child inside you and suffer with it. It’s as if you’re taking it from somewhere else. It grows outside the womb of the mother, so it looks like going and getting it “ready-made.”

They say they put a tube into the woman and after some months, she delivers normally. But what would the father feel? If the father does have a child, will he still love the one of the test tube? This is hard, of course, because God stopped your pregnancy, so you come and put in the test tube, not knowing if you’re saying, ‘I didn’t give you, so we’ll get her pregnant.’

A number of important themes emerge from these and other women’s statements. First, women were extremely concerned about the “artificial versus natural” creation of fetuses “outside versus inside” women’s bodies. In a Muslim country where adoption is prohibited by Islamic law, parenthood is synonymous with “natural” (that is, biological) parenthood, which, for most Muslims, is tantamount to the gestation inside a woman’s body of her own husband’s fetus. Fetuses that are viewed as being gestated outside the woman’s body — even if produced through the conception substance of husband and wife — are not only deemed unnatural, but, like orphans, would be viewed as strangers by a husband and wife, who will therefore lack appropriate parental sentiments. In addition, many women shared the unknown aspects of IVF, including the dubious origin of the products of conception used in the procedure (which, unlike AHI, could come from both male and female donors); the excessive experimentation on women’s bodies; and the tampering with natural processes best left to God. Indeed, women’s ultimate fears were of God himself, whose will would be violated if human beings were to attempt to “play God” through the production of man-made babies.

In addition, as reflected in women’s statements, considerable confusion existed over the mechanics of IVF, fueling women’s concern about the artificiality of the process, especially the perplexing aspect of prolonged extracorporeal gestation. Given the lack of disclosure on the part of physicians, even women who were being considered or prepared for the procedure could only speculate as to the technical aspects of IVF, based on what they could deduce from the news media, from the infamous soap operas, or from physicians’ volleyed comments. Because these sources provided only cursory explanations, most women’s understandings about the nature of IVF were superficial at best.

Women who were better informed about the mechanical aspects of IVF understood that the procedure involved the initial creation of the embryo outside the woman’s womb through a process that involved a woman’s reproductive component (although few were sure of what this was) and mixture of this component with the husband’s component (either “worms,” “fluid,” or “spermatic animals”) in a glass container, or tube. After some period of time, ranging in the minds from twenty-four hours to three months, the fetus, kept in a “machine” or “incubator” during this period, was returned to the woman’s uterus through a process of “injection,” as in AHI.

Yet, even women who understood the basic aspects of the procedure were often misinformed about important details. As one such woman explained, “The first thing, they get the sperm. They take one of the eggs out. They mix it in something that looks like a uterus, a glass or a tube. Then they ask her if she wants a boy or a girl. They choose the right womb, and they put it in the thing that looks like the uterus of the woman, and they leave it for nine months. After that, they do a very small operation with two stitches and put it back in her uterus. Then she is pregnant.”

Women who had some idea about the technical aspects of IVF were usually less likely to view the procedure as morally or religiously forbidden, as an act “going against God.” In fact, these women, most of whom were infertile, were more likely to laud IVF as the best
eXemplar of medical progress. At one such advocate of high-tech reproductive medicine explained, “New medicine is very advanced. In the old days, lots of people couldn’t have kids. But now we have ‘tubes babies.’” Another commented, “We see that infertility was there even since the Prophet’s time, only then they didn’t have test tubes and things that they have now. So now a woman can go and plant a child in a test tube and have her own baby, but she couldn’t do that long ago. This is because science has become very advanced.”

Accepted by Islam?

Because of their superior knowledge of the technical aspects of the IVF procedure — including the use of a husband’s sperm and wife’s ovum — infertile women were also more likely than others to accept IVF as religiously permitted. Although some religious or formal Islamic legal opinion on the permissibility of IVF was issued by the grand shahib of Al-Azhar Mosque, Shaihk Gud El Hek Al Gud El Hek, as early as March 23, 1980 (El Hek 1981), few Egyptians were aware of the shahib’s pronouncement even by the end of the decade. In his opinion, the shahib clearly specified that IVF was an acceptable line of treatment as long as it was carried out by expert scientists with sperm from a husband and eggs from a wife with “no mixing with other cells from other couples or other species, and the concept is implemented in the uterus of the same woman from whom the ovum were taken” (Aboulghar, Serour, and Mamouz 1990).

Infertile women who were being considered for IVF tended to be best informed about this theological opinion, having sought advice from religious clerics in some cases. Yet, many women, both infertile and fertile, continued to doubt that Islam would permit such a “strange and unnatural” act as the creation by physicians of a “ready-made child” from “outside the womb.” As with AHI, women’s husbands tended to be more even doubtful, creating problems for women who were thus thrust into the position of convincing their husbands of IVF’s religious permissibility.

However, many Egyptians’ anxieties about the religious permissibility of IVF were relieved when the popular televised Muslim cleric, Shaihk Muhammad Miswil al-Sharawi, cons and wives’ ovum as a last resort for infertile couples. Yet, many Egyptians — and especially the fertile, who were less attuned to such matters — were not aware of Sharawi’s statements, as reflected in the high percentages of those who believed IVF to be haram or were unsure of its religious permissibility.

How successful is IVF?

In addition to these moral-religious concerns, another major question in the minds of infertile women was whether or not IVF was successful in most cases. For poor women, such information, crucially, was given, the expense of the procedure. As with AHI, women were usually shocked to learn that IVF was not free, even in a public hospital, and that the major expense revolves around purchasing ovulation-inducing agents that cost anywhere from five hundred to one thousand Egyptian pounds (two hundred to four hundred dollars) per treatment cycle. This problem of expense was coupled with the problem of availability; “new-age” ovulation-inducing agents necessary for IVF were often obtained from abroad and were not widely available in most Egyptian pharmacies.

When women being prepared for IVF learned that one thousand pounds might purchase only one trial of IVF — and that up to six trials might be necessary without any guarantee of reproductive success — their enthusiasm for the procedure naturally waned. For this reason, success rates were rarely discussed among physicians, although women were obviously curious to know whether amounts exceeding one thousand pounds would buy “success” for a baby. Women often noted that they would spend all the money they could muster on IVF if only it would guarantee them a pregnancy outcome. What they were rarely told, however, was that pregnancy rates in the world’s best IVF centers were often less than 30 percent even in the short-term outcomes, and that success rates in start-up programs, such as the one at this hospital, could be expected to be much less. In essence, then, Egyptian women being prepared
for IVF had minimal guarantees of success, although most of them did not realize this.

How soon, if ever?

Given that many women with bilateral fallopian tubal blockage came to view IVF as their last resort—"their only hope" in their quest for conception—the realization that the highly touted IVF program had yet to become a reality at the hospital more than a year after its promised inception was also a source of frustration and fear for many women, especially those like Sakina who had promptly purchased expensive IVF drugs in preparation for the procedure. When women who had purchased these drugs were told to "sell them back" to pharmacies before their expiration dates, IVF candidates began to panic, criticizing the hospital for false advertising in their programs. Questions that had once been framed by IVF candidates as "how soon?" came to be posed as "will there ever be?" Unfortunately, by the end of the 1980s, IVF had yet to become a reality at Shatby Hospital, because of numerous political, economic, and logistical problems beyond the control of those who had hoped to make the IVF program a success.

Epilogue

After many delays, the long-awaited inception of the IVF program in Shatby Hospital occurred in the early months of 1991, almost two and a half years after the announcement of the program in October magazine. The equipment necessary to run an IVF laboratory was slow in coming to Alexandria, but by early 1991, it had arrived, and soon thereafter, the IVF laboratory and an accompanying andrology laboratory for high-tech semen analysis were in place. A team of young physicians, several of whom were trained in IVF in the United States and Great Britain, was assembled to run the assisted reproduction program (both AIM and IVF) in the hospital.

The first delivery of an Alexandrian "baby of the tubes" occurred in early 1992, only ten months after the IVF program's inception. The baby was delivered by caesarean by the gynecology professor who had referred the case, and members of the Egyptian media, including those from the television and radio stations, were present during the delivery. The head of the IVF program, who was also the chairman of the University of Alexandria's Department of Obstetrics and Gynecology, was present at the delivery, and many members of the local medical community were present as well.

In addition, at the time of this writing, there are five or six ongoing IVF pregnancies at Shatby Hospital, other than those that have ended in spontaneous abortion. However, there have been some problems in following the IVF pregnancies, because many of the infertile women in the program consider it shameful to have become pregnant through IVF and therefore do not return to the hospital when they discover that they are pregnant with a "baby of the tubes."

It is important to point out in closing, that even as IVF has succeeded in conceiving several and and many disquieting questions about the implementation and future of IVF in Egypt—similar to those raised by concerned feminists in the West—remain. For example, will the focus on IVF divert attention away from the primary prevention of infertility in Egypt, especially among the poor, who are at greatest risk for infertility but who can least afford the new reproductive technologies? Will the commercialization of IVF in Egypt lead to the proliferation of for-profit clinics run by unscrupulous physicians, as in many other countries? Will IVF lead to the exploitation of patients and to a decrease in fertility rates? Will women who have been sterilized and may either accept or reject IVF treatment services as they become available (Serour, el-Ghar and Mansour 1991)? Thus, the experiences of poor infertile Egyptian women such as Sakina, as they attempt to grapple with the complex practical and moral dilemmas posed by IVF, may well serve as a guide for the therapeutic journeys of other infertile women, whose voices and stories have yet to be heard.

NOTE

1 The standard IVF protocol involves nine steps, occurring over four weeks (Harkness 1992), as follows: (1) a woman's current menstrual cycle is halted with gonadotropin-releasing hormone (GnRH) agonists (2) oocyte maturation induction is then induced through the administration of follicle-stimulating hormone (FSH) and drugs for eight to twelve days (3) ultrasound and blood tests are performed to monitor the development of ova follicles and embryos over a six- to twelve-day period, (4) serum progesterone levels are measured to assess the growth of the endometrial lining (5) mature ova (usually at least four) are retrieved from the woman vaginally through ultrasound-guided aspiration of the follicles(6) ova and sperm (obtained through the male partner's masturbation) are prepared in the laboratory and then combined for fertilization and cell division over a period of about forty-eight hours; (7) embryos emerging through the fertilization process are transferred (injected by a catheter) into the woman's uterus through the cervix within two days of egg retrieval; (8) the woman receives hormonal support, usually progesterone, for the first eight to nine weeks of pregnancy or until menstruation occurs; and (9) a pregnancy test is usually performed ten to twelve days after an IVF transfer.

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AIDS in 2006
Moving toward One World, One Hope?
Jim Yong Kim and Paul Farmer

For the past two decades, AIDS experts—clinicians, epidemiologists, policymakers, activists, and scientists—have gathered every two years to confer about what is now the world’s leading infectious cause of death among young adults. This year, the International AIDS Society is hosting the meeting in Toronto from August 13 through 18. The last time the conference was held in Canada, in 1996, its theme was “One World, One Hope.” But it was evident to conferees from the poorer reaches of the world that the price tag of the era’s great hope—combination antiretroviral therapy—rendered it out of their reach. Indeed, some African participants that year made a banner reading “One World, No Hope.”

Today, the global picture is quite different. The claims that have been made for the efficacy of antiretroviral therapy have proved to be well founded: in the United States, such therapy has prolonged life by an estimated 13 years—a success rate that would compare favorably with that of almost any treatment for cancer or complications of coronary artery disease. In addition, a number of lessons, with implications for policy and action, have emerged from efforts that are well under way in the developing world. During the past decade, we have gleaned these lessons from our work in setting global AIDS policies at the World Health Organization in Geneva and in implementing integrated programs for AIDS prevention and care in places such as rural Haiti and Rwanda. As vastly different as these places may be, they are part of one world, and we believe that ambitious policy goals, adequate funding, and knowledge about implementation can move us toward the elusive goal of shared hope.

The first lesson is that charging for AIDS prevention and care will pose insurmountable problems for people living in poverty, since there will always be those unable to pay even modest amounts for services or medications, whether generic or branded. Like efforts to battle airborne tuberculosis, such services should be seen as a public good for public health. Policymakers and public health officials, especially in heavily burdened regions, should adopt universal-access plans and waive fees for HIV care. Initially, this approach will require sustained donor contributions, but many African countries have recently set...