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2 A review of Islamic Middle Eastern migrants: traditional and religious cultural beliefs about procreation in the context of infertility treatment*

In many societies cultural beliefs about procreation exist that differ from the Western biomedical model. In the Middle East monogenetic patriarchal preformation models and mixtures of these models with the biomedical model exist, alongside the Western biomedical model. This review gives an overview of these non-biomedical beliefs in the Middle East and their connection with the biomedical model. The likelihood that non-biomedical procreation beliefs exist among a number of Middle Eastern migrants is demonstrated and it is shown how these beliefs might influence the experience of infertility and their attitudes towards infertility treatment. Several suggestions for improving health care are made.

2.1 Introduction

The growing numbers of non-Western migrants in Western Europe have significant consequences at all levels of society. With respect to healthcare, the increasing ethnic and cultural heterogeneity is reflected in the growing diversity of illness experiences, healthcare needs, healthcare-seeking behavior, morbidity and mortality (Baarnhielm & Ekblad, 2000; Kleinman, 1980, 1988; Richters, 2000; Van der Veen, Schrijvers, & Redout, 2003). This diversity cannot be attributed solely to the consequences of the low socio-economic status often held by migrants (Richters, 2000). It is also

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influenced by the migrants' cultural background (Kleinman, 1980, 1988; Richters, 2000; Shadid, 1993; Tseng & Strettzer, 1997). The cultural background of a people – defined as their norms, values and ideas – influences the way they experience a problem or disease, present complaints or problems, and behave, as well as the possibilities they discern to overcome their problems (Kleinman, 1980, 1988; Tseng & Strettzer, 1997). Migrants have a special cultural position because they are confronted with at least two cultural frameworks: their culture of origin and the dominant culture of the country of immigration. Their own cultural framework is defined by their acculturation processes (e.g., Kamperman, Komproe, & De Jong, 2003a). Knowledge of migrants' cultural frameworks is important to optimize the healthcare they are given (Richters, 2000; Shadid, 1993).

The current paper focuses on the way in which cultural and religious factors relating to Turkish and Arabian Islamic migrants (hereafter called Middle Eastern migrants), who are living in Western countries, might have an impact on treatment issues concerned with infertility. With respect to fertility problems, Van Balen and Inhorn (Van Balen & Inhorn) noted that cultural background influences the way people experience their fertility problems, the consequences of fertility problems and their healthcare-seeking behavior. In this respect, two cultural aspects that influence each other in a variety of ways are frequently mentioned, namely traditional and religious cultural beliefs about procreation (Inhorn, 1996a, 1996b, 2003a, 2003b; Inhorn & Buss, 1994; Meirow & Schenker, 1997; Schenker, 2000; Serour, El Ghar, & Mansour, 1990; Serour, 1998, 2001) and the cultural position of women, men and children (Daar & Merali, 2001; Inhorn & Van Balen, 2002; Kagitcibasi, 1982; Kagitcibasi & Sunar, 1997; Yuksel, 1995; Yuksel, Siemann, & Kentenich, 1996a).

Anthropological and ethical studies in the Middle East have shown that there are tradition- and religion- based implicit and explicit assumptions on procreation that differ from the Western biomedical model (Beller-Hann, 1999; Delaney, 1991; Gailly, 1993; Inhorn, 1996b, 2003c; Loizos & Heady, 1999) or do not allow all the optional treatments offered by Western biomedical systems (e.g., Inhorn, 1996a, 2003b; Meirow & Schenker, 1997; Schenker, 2000; Serour, 1998, 2001; Serour et al., 1990) The patriarchal nature of Middle Eastern societies plays an important role in

these beliefs about procreation and in how infertility problems are experienced (Delaney, 1991; Inhorn, 1996b).

In this paper we examine - on the basis of a literature review - these cultural and religious beliefs concerning procreation and discuss the possible influence of these beliefs on treatment issues relating to infertile Middle Eastern migrants in Western Europe. In describing these beliefs we build mainly on the work of Delaney (1986, 1987, 1991), who studied procreative folk theories in a rural Anatolian Turkish village in the 1980s, and of Inhorn (e.g., 1996a, 1996b, 2003a, 2003b), who conducted extensive ethnographic studies on infertile men and women and medical physicians in Egypt during the 1980s and 1990s. To place these non-biomedical Middle Eastern beliefs in the proper context, this paper begins with a short history of the development of the Western biomedical model.

2.2 The development of the Western biomedical model

Written theories on procreation date from the fourth century BC. These theories on procreation were based on reasoning and on observations made without special tools. Aristotle (384-322 BC) and Hippocrates (460-370 BC) can be seen as the founders of monogenetic and bigenetic procreation theories. Aristotle based his theory on embryological research. In *De Generatio Animalium* he described the male contribution to procreation as providing the seed that turns the menstrual blood into a new person (Darmon, 1977; Riddle, 1997; Stonehouse, 1999; Van der Waals, 1987). Hippocrates, however, stated that both the woman and the man contributed in a generative way to the development of the embryo (Darmon, 1977; Riddle, 1997). A paradigm shift was brought about by the work of William Harvey (1578-1657) who stated that all life starts from an egg. He was convinced that after being fertilized by male seed the egg would become a fetus. He named this process of gradual fetal development 'epigenesis' (Riddle, 1997).

Malpighi (1628-1694) objected to Harvey's idea of epigenesis. He stated that animalcules exist prior to fertilization (Riddle, 1997). This theory is also called the preformation doctrine (Stonehouse, 1999; Van der Waals, 1987). Although some

preformation theorists thought that the egg contained the animalcules - preformed miniscule embryos - other scientists stated that the semen contained the animalcules (Stonehouse, 1999). This last view was strengthened in 1677 when Antonie van Leeuwenhoek (1632-1723) believed he saw animalcules in sperm through the microscope he had invented. The importance of semen was confirmed by Spallanzani (1729-1799). Spallanzani proved that spermatozoa were necessary to procreate (Van der Waals, 1987). New discoveries in the 19th century – such as the discovery of the mammalian ovum in 1827 by Von Baer – confirmed the epigenesis doctrine. Although these discoveries demonstrated that the maternal contribution to procreation amounts to more than merely carrying and nurturing a child, Stonehouse (1999) stated that some scientists (e.g., Brooks, 1883) found it difficult to accept the maternal generative contribution and were not willing to propagate this new knowledge. Today, the equal maternal and paternal generative contribution to procreation is regarded in the West and by biomedical institutions all over the world to be the only true model.

2.3 Traditional beliefs about procreation in the Middle East

During the Middle Ages, we see that there were adherents to both the Aristotelian idea of the one-seed doctrine and the Hippocratic two–seeds doctrine, not only in Europe, but also in the Middle East (Elgood, 1970; Weisser, 1983). Although not much is known about the further development of these procreation beliefs, studies on the history of medicine show that during the Ottoman Empire, medicine was influenced by a variety of different traditions (Aksel, 1944; Murphey, 1992). These included Central Asian and Shamanistic folk traditions, Seljukids and Byzantines traditions, Hellenistic medicine, Romanized Galenic medicine and the scientific traditions of Middle Eastern and Arab Islamic medicine (Murphey, 1992). At the end of the 17th century, Ottoman medicine gradually turned towards the West, leading to exchanges of doctors and to the translation of Western books. The increasing contacts with Western Europe during the 19th century resulted in the establishment of European biomedicine when the West was still discussing how procreation occurred

(Aksel, 1944; Inhorn, 2003b). Nowadays, the Western biomedical model concerning procreation is common ground within the medical world around the Mediterranean. However, various other explanations about procreation are still prevalent among the Middle Eastern population (Beller-Hann, 1999; Delaney, 1991; Gailly, 1993). Along with the biomedical model, several models, quite similar to previous Western beliefs, exist that do not acknowledge the equal male and female generative contribution to procreation. They emphasize, to various degrees, the greater importance of the male contribution compared to that of the female (Inhorn, 1996b; Inhorn, 2003b). The existing unequal male and female generative procreation theories in the Middle East can be divided into monogenetic patriarchal preformation models, and mixtures of these models and the Western biomedical model. Monogenetic patriarchal preformation models are also known as seed and soil theories, according to which the male places the seed into the 'soil' of the female. The male seed contains preformed minuscule embryos, or 'animalcules'. The soil of the mother is her nurturing uterus, whereby she influences the physical development of the fetus but does not contribute to the generative aspects of the fetus (Gailly, 1993).

There are several examples of mixtures of the biomedical model and patriarchal monogenetic preformation models. Delaney (1991) mentioned an example where the biomedical knowledge that men, too, can be sterile had been translated into the fact that sometimes the seed is alive and sometimes it is dead. Inhorn (Inhorn, 1996b) mentioned a model that contains limited female generative contribution. The mother produces eggs, which mix with the male sperm during conception. However, the eggs have less power than the sperm as regards the development of the fetus. Both types of non-biomedical procreation models are found in rural populations in Turkey and in lower class rural and urban populations in Egypt (Inhorn, 2003b).

Several factors may have contributed to the continuing existence of non-biomedical procreation models (monogenetic patriarchal preformation models and 'mixed' models) in the Middle East. Four factors will be discussed here, namely the cultural organization of kinship; Islam; Turkish and Middle-Eastern educational systems; and media access in the Middle East.

The cultural organization of kinship is one of the factors both Delaney (1986, 1991) and Inhorn (Inhorn, 1996b, 2003b) linked to the seed and soil doctrine. With

respect to kinship, Delaney – and other anthropologists – argued that procreation beliefs implicitly contain beliefs about how people are related to each other. The seed and soil doctrine implies a strong emphasis on patrilineal relatedness and thereby influences kinship structure within a society and thus gender roles (Delaney, 1991). Indeed, a strong patrilineal and patrilocal organization of kinship has been confirmed by several studies in the Middle East (Duben, 1982; Schiffauer, 1987). The patrilineal and patrilocal organization of kinship is a strong aspect of Middle Eastern cultures and might therefore enforce the continuation of patriarchal procreation theories.

The notion of patrilineal lineage is also typical of Islam, the second link Delaney (1991) made. She linked the seed and soil doctrine to the foundation of Islam, and suggested that monotheism implies a monogenetic rather than a polygenetic view on the creation of mankind: ”God created the first man and created in men the means of transmitting life” (Delaney, 1991). However, not all scientists agree with the suggestion that Islam propounds and encourages a monogenetic procreation doctrine (e.g., Hussain, 1999; Sholkamy, 1999). According to their interpretation, Islam postulates equal paternal and maternal generative contribution to procreation. Whichever interpretation is right, monogenetic interpretations of the Koran and the patriarchal nature of Islam may contribute to the continuity of the seed and soil doctrine.

In addition to the possibly reciprocal influence of patrilineal kinship, Islam and the seed and soil doctrine, other aspects that could influence the maintenance of the seed and soil doctrine are the educational systems and the access to media in the Middle East. With respect to reproductive knowledge, it seems that educational systems in the Middle East, to a greater or lesser degree, fall short on two aspects: the provision of reproductive and/or sexual education and the inclusion of all people in their educational settings (Inhorn, 2003b; Yuksel, 1995; Our bodies ourselves, 2003). It is likely that having no reproductive or sexual education means that not all children learn about reproduction and reproductive organs according to the biomedical model. Illiterate people have no access at all to written information. Additionally, in some rural areas in the Middle East access to health information through the media is poor (e.g., television, newspapers). With no information available about the biomedical model through education or media, it is no wonder that other models persist.

2.4 Middle Eastern migrants, procreation and infertility

We have no clear evidence for the existence of non-biomedical models about procreation among Middle Eastern migrants with fertility problems. Some migrants adopt the host countries beliefs and second generation migrants are influenced by the host countries educational systems. However, many migrants from Middle Eastern countries do not show a rapid adaptation to Western beliefs and attitudes regarding procreation, sexuality, and family roles. There are several indications that non-biomedical models exist among a number of Middle Eastern migrants. The first indication is that several studies (David, Borde, & Kentenich, 2000) have suggested that many migrants know little about bodily functions according to the biomedical model. A further indication is the fact that women are blamed for infertility (Yuksel, 1995; Yuksel et al., 1996a; Yuksel, Siemann, & Kentenich, 1996b). Several studies on infertility in the Middle East showed that women are blamed for not conceiving (Delaney, 1991; Guz et al., 2003; Inhorn, 2003b). Both Delaney (1991) and Inhorn (2003b) emphasized that although seed and soil doctrines and mixed models confer more importance to the male contribution and might even hold the men responsible for creating the child, not conceiving is thought to be the woman's fault. Men are seen as fertile as long as they are able to ejaculate. The production of an ejaculate is seen as proof of the existence of animalcules and of men's ability to give life. Virility is seen as fertility. This assumed direct link between fertility and the ejaculate implies that when a man is able to ejaculate but the woman does not conceive, the problems derive from the nurturing and carrying ability of the woman. The female body rejects the seed. This might be because of remaining impurities in the womb (temporary), not having enough clean blood to feed the fetus (temporary or long term) or because the woman is barren (which means there is something wrong with her insides) (long-term) (Delaney, 1991). Yuksel et al. (1996a, 1996b) found that even if infertile Turkish migrant men are told about their infertility almost half of them deny or do not accept this.

A third indication of the existence of non-biomedical beliefs concerning procreation derives from the continuing influx of new Middle Eastern migrants coming to live in the West. These new migrants bring their own beliefs and knowledge with

them, and it is likely that some of them have cultural beliefs concerning procreation that differ from the biomedical one. A confrontation with biomedical knowledge in healthcare settings in Western countries might not directly replace original beliefs. Delaney (1991) suggested that biomedical knowledge about conception is "filtered through the net of their own beliefs" (Delaney, 1991, p.53). Other possible influences are the continuing existence of patrilineal and patrilocal structures of kinship in migration situations (Nauck & Kohlmann, 1999) and the maintenance of Islam as the major religion.

Both the continuing existence of patrilineal and patrilocal structures and the enduring importance of Islam also influence the importance of having children. Islam strongly supports having children (Beller-Hann, 1999; Husain, 2000). According to Beller-Hann (1999) getting married and having children is even seen as the "only accepted course of life" (Beller-Hann, 1999, p.118). Also, increasing social and economic wealth affects the reasons of having children. While the economic and material importance of children becomes less important, and therefore the number of children decreases, psychologically or individually motivated reasons for having children increase (Kagitcibasi, 1997). However, social reasons and a general pronatalist society, which do not accept childlessness as a lifestyle or a choice, remain important reasons for having children among Middle Eastern migrants (Yuksel, 1995; Yuksel et al., 1996a, 1996b). Because of the continuing importance of social reasons and pronatalist social norms, couples who voluntarily or involuntarily remain childless are subject to much social pressure to have children from both inside and outside the family.

As having children within Middle Eastern migrant communities is both much expected and also linked with a higher status, both men and women experience a psychological burden when pregnancy does not occur: their desire to have a child remains unfulfilled; they do not meet the socially desired expectation of a couple with children and they do not obtain the higher status given to parents. Importantly, there are gender specific consequences. These consequences are related to the assumed causes of fertility problems. Blaming the woman for not being able to conceive strongly intensifies the psychological burden of these women (Guz et al., 2003). For men the additional burden derives from the fact that having children is also a public

expression of their sexual virility, which leads to social recognition of their masculinity and thereby legitimizes their sense of honor. Not having children therefore affects their feeling of honor (Delaney, 1991; Gilmore, 1987a, 1987b; Rodriquez Mosquera, Manstead, & Fischer, 2002). The men's psychological burden is also influenced by the fact that they are not able to continue the patrilineal family line.

2.5 Middle Eastern migrants and biomedical infertility treatment

Beliefs about procreation may not only influence the causes people accept and the psychological burden infertile couples experience, but may also affect attitudes towards infertility treatment. No studies have so far focused on attitudes of Middle Eastern migrants towards, and underlying reasons for, Artificial Reproductive Technologies (ARTs). Therefore we can only speculate about attitudes towards ARTs.

In general men who experience infertility as a situation caused by women might be less involved in infertility examinations and treatments as they do not consider themselves as a possible cause. With respect to male examinations, they may also not understand the necessity of physical and semen investigations. Therefore their attitudes towards these examinations can be negative and they may not be willingly to cooperate. Furthermore, they may feel offended as fertility is linked with virility. A proposed examination may be interpreted as casting doubt on their virility and their true masculinity. Women who hold monogenetic patriarchal beliefs might not understand the necessity of examinations, except those dealing with the uterus, as they might not have any knowledge of eggs, ovary, ovarian tubes or ovulation.

With respect to artificial reproductive technologies (ARTs), seed-and-soil doctrines restrict the number of acceptable and comprehensible ARTs. Treatment options for male fertility problems (e.g., MESA, TESA or sperm donation) may not be considered as an option as nothing can be wrong with the seed. Treatments focused on eggs, ovary and/or ovarian tubes (e.g., IVF, tubal operations, hormones to stimulate the ovarian cycle, donor egg) will not be understood. The only remaining remedies within the boundaries of the patriarchal monogenetic procreation doctrine are treatments related to the uterus (e.g., IUI, treatment of endometriosis).

While non-biomedical procreation beliefs may limit the use of ARTs because of the lack of biomedical knowledge, Islamic beliefs concerning procreation may also restrict ARTs use because of ideological beliefs. In the Muslim world qualified scholars of religious law, assisted by technical experts, discuss bioethics and the use of ARTs according to the Islamic law, or Shariah, which is based on primary (Quran, Sunna, Hadith, Igmaah, Kias) and secondary sources. As ARTs are recent developments, they are not mentioned in the primary sources of the Shariah (Daar & Al Khitamy, 2001; Inhorn, 2003a; Schenker, 2000; Serour, 1996, 1998). However, the primary sources do mention the importance of marriage, and procreation and emphasize the lines of genealogy, whose purity is of prime importance in Islam (Serour, 1998; Meirow & Schenker, 1997; Daar & Al Khitamy, 2001). Based on these values the most important regulation, or fatwa, within the Sunni branch of Islam, is that ARTs involving a third party, whether he or she provides sperm, an egg, an embryo or an uterus, are not acceptable (Serour, 1996, 1998). Although some fatwas within the Shi'a branch of Islam contradict the Sunni stance, the majority of the fatwas agree with the prohibition on third party donation (Inhorn, 2003a; Jafarzadeh, 2000). Islamic religious beliefs concerning procreation therefore could have a strong impact on ARTs use.

In a large study on Turkish migrants with fertility problems in Berlin, 80% of Turkish migrants with fertility problems were indeed unwilling to undergo insemination with donor seed (AID) (David, Yuksel, & Kentenich, 1998; Kentenich, Gacinski, & Yuksel, 2001; Yuksel, 1995; Yuksel et al., 1996a, 1996b). In this respect no differences were found regarding Germans with fertility problems. However, the last group might have had different reasons for their negative attitudes towards AID. Western infertility studies have shown that infertile couples are reluctant to use AID, because of the absence of a genetic link between father and child and the possible social emotional problems for both the fathers and the children (Brewaeys & Van Balen, 1997). As the Berlin study had not studied the motivations, the question remains unanswered whether indeed cultural and religious beliefs play a role in the negative attitude of Middle Eastern migrants towards AID.

2.6 Conclusion and Discussion

Through a literature study, we have given an overview of existing beliefs about procreation in the Middle East and shown that these beliefs are almost similar to biomedical beliefs in Western Europe more than a century ago. We have discussed the possibility that these beliefs are maintained in migration settings. Although no studies exist on the cultural beliefs of Middle Eastern migrants concerning procreation, indirect evidence supports the existence of these beliefs among Middle Eastern migrants in Western Europe. We focused on the possible impact of these non-biomedical beliefs about procreation on how infertility problems and infertility treatment issues are experienced, in order to alert health care providers to potential problems that these migrants may face when seeking infertility treatment. However, as no studies exist on the procreational beliefs of Middle Eastern migrants, and few studies exist on their infertility problems, our account of the impact of these beliefs is limited. We are not able to understand several issues, such as how Middle Eastern migrants with non-biomedical procreation theories receive and adapt biomedical knowledge. Further research is needed to provide the missing answers.

Nevertheless, we would like to make some recommendations to clinicians working with infertile Middle Eastern migrant patients. Although some clinicians are aware of the cultural background of migrants and adapt their care giving to these patients, several studies have shown that a lack of knowledge about migrants' cultural frameworks still exists among healthcare providers (e.g., Olthuis & Van Heteren, 2003; Yebei, 2000).

To optimize the healthcare given to infertile Middle Eastern migrant couples, clinicians should be aware of the possible impact of non-biomedical beliefs concerning procreation, both on treatment issues and on the specific psycho-cultural stress associated with childlessness. Furthermore, they may need to adapt the content of their interaction with the patient. Taking into account the possibility that their patients hold non-biomedical procreation beliefs, we recommend healthcare providers should verify whether their patients know how conception takes place according to the biomedical model. If not, clinicians could spend time on explaining how conception takes place, paying special attention to the male and female contributions, and to fetal de-

velopment. It might be necessary to come back to this during the different stages of infertility treatment. Explaining the biomedical procreation model may enhance male participation in examinations as well as faith in therapy, as the importance and meaning of several types of examination and treatment would be better understood. A fuller understanding of procreation might also help to invalidate the direct link between fertility and virility and might also reduce the unjustified blaming and stigmatization of women. However, stigmatization of women and linking virility with fertility is not merely an issue between the patients, it might also be necessary to inform the broader community by, for instance, offering leaflets, education through community workers or through the media.

Islamic religious beliefs about the use of ARTs may influence the attitudes towards ARTs and restrict the number of treatment options. We think it is important that physicians should be aware of these fatwas, and their consequences, for a better understanding of their patients. However, we want to stress that physicians still have to offer and discuss all the available treatments: all patients have the right to make their own decisions. Some patients may follow the Islamic regulations, while others may decide to use these treatments for reasons they consider more important.

The main focus of this paper was non-biomedical procreation beliefs of infertile Middle Eastern migrants in Western European societies, and in particular the effects of these beliefs on treatment issues. However, in several non-Western cultures beliefs exist that are comparable to those held by some Middle Eastern migrants, or at least beliefs that fundamentally differ from the modern Western biomedical model (Gerrits, 1997; Inhorn & Van Balen, 2002; Sundby, 1997). In many Western European countries, rapidly growing numbers of third-world ethnic groups are establishing themselves and founding new migrant cultures, in which beliefs about procreation and conception that are originally quite different to those of the host culture have to be attuned in some way to modern Western medicine. It is important that healthcare providers are knowledgeable about these different cultural beliefs regarding procreation and treatment and that they handle these beliefs with respect.