Getting Around Infertility

By Khalil E. Rajab*

Median projections of the Bahraini population in 1985 indicate that there were 82,000 couples between the ages of 20 and 45 years. By using the generally accepted incidence of infertility worldwide, and taking into account the regional variations, approximately 8,000 to 16,000 couples will have a fertility problem. If we consider also, that one fifth of infertility problems are due to tubal factors, around 1,500 to 3,000 couples may potentially benefit from in vitro fertilisation (IVF) and embryo transfer (ET) techniques.

Should we expand the list of IVF and ET indications to include endometriosis, male factors, the use of surrogate mothers and cases where the infertility can be attributed to immunological or unexplained factors, the target population for IVF would appreciably increase.

Some couples are childless because of later marriages, others have 'coital factors': infrequent or poorly timed intercourse, dyspareunia, premature ejaculation or the use of lubricants and douches. Such problems are, for the most part, readily diagnosed and solved but there are still hundreds of couples unable to have children because of more subtle and complex problems.

Some infertile couples may be diagnosed and given a relatively simple drug therapy, and become expectant parents in a matter of months. Others may wind through the maze of tests and attempted solutions, reaching the last resort of IVF and ET after many years.

Now where do we stand in Bahrain in relation to the management of infertility and what would be the future advances in this area ? As a matter of fact, over the past decade we have made some major strides in the advancement and refinement of the diagnosis and treatment of infertility, and we are still continuing to do so. In 1976 laparoscopic techniques, which include patency tests of the tubes, were introduced in the Salmaniya Medical Centre (SMC). In 1986 ultrasonic services were introduced in the radiology department, SMC. Facilities for scanning the ovaries and observing the follicular growth are all available on a day to day basis. Hysterosalpingography has been made safer : the use of non-ionic contrast media is now routine, and a much lower dosage of radiation is given to the gonads during this procedure.

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In 1981, and after training of staff in France, a radioimmunoassay facility became available in SMC. Also in 1981 the Obstetrics and Gynaecology department acquired the skills and equipment necessary to carry out tubal microsurgery in Bahrain, after a slow beginning the practice has now become routine.

Another important landmark was the availability of gonadotrophin preparations, which are produced by the two main companies in this field : Serona and Organon. In 1982 luteinizing hormone releasing hormone (LHRH) became available.

Two years later the College of Medicine and Medical Sciences opened and immediately a score of medical scientists became engaged in the teaching programme. A variety of scientific and research tools and equipment also became available, including most of the basic and non-clinical facilities which can be utilised for setting up an in vitro fertilisation and embryo transfer service.

Some may indeed question whether we are ready for IVF and ET, or if it is justifiable given the present climate of economic recession ? Could the expenses involved not potentially affect other more pressing medical needs ? Is the technique acceptable to our culture and religion [1,2] , and most importantly the people it is advanced for ? There is in fact no easy answer. Admittedly the target population for this treatment is a minority but why should a minority suffer the tragedy of being childless simply because they are a minority ! Is it not true that having children is one of the most basic human rights.

One cannot predict the future but it may well happen that the rapidly increasing knowledge, occurring as a result of IVF, will benefit the entire community in terms of more efficient reproduction and family planning. In addition, increasing knowledge of cellular growths and function may help in the prevention and treatment of congenital abnormalities, aging and cancer.

Sperm banks and artificial insemination by donor (AID) have always been controversial in Islam, and all Islamic sections share a forbidding of AID. The freezing of semen is looked at with some reservation, and the keeping of the husband's sperm or the wife's egg after their death is not allowed. The general contribution of Islamic jurists to their debate on IVF, reflects to a large extent their division on related issues such as contraception, sterilisation and abortion. Indeed Islamic jurists represent a diverse body of opinions on these issues and it is doubtful if any unified decision will ever be given on IVF.

In as far as the finance is concerned, the setting up and running of an IVF programme in Bahrain will not cost more than a fraction of the annual health budget. It could also be subsidised through private trusts.

It is now ten years since the delivery of the first IVF baby [3] , a success which attracted a great deal of medical and public attention. This momentous event signalled to all of us in the medical profession, the potential of solving problems of many forms of female infertility. It also opened the doors for a new line of research and made the methods of dealing with inherited defects nearer to being within our grasp.

Ever since Louise Brown was born on the 25th July 1978, more than 1,000 babies have been born by using this technique. IVF – ET clinics have mushroomed in many countries despite financial constraints and the scarcity of scientific support. In the Arabian Gulf a few babies have already been born after IVF treatment abroad. Regionally a number of IVF programmes are in progress. In Saudi Arabia both the private and public medical sectors have their own clinics. In Jordan there are also government and private clinics. In Egypt many clinics have opened in the past four years, and in Kuwait a clinic will soon be opened.

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