CHAPTER 17 MASCULINITIES
The Male Reproductive Body

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Introduction

In many cultures, the male reproductive body has traditionally been seen as the seat of masculinity. Men must continually prove their manhood by performing acts that cement their social status "as men" in relation to both other men and women (Melhuus 1996). These often entail demonstrations of valorized forms of male reproductive and sexual embodiment, signposting a virility comprised of the conflated abilities to sexually penetrate and procreate (Dudgeon and Inhorn 2003).

This chapter focuses on manhood in Mexico and the Middle East, the sites of our ethnographic research. Our studies of masculinity in the context of sexual and reproductive health care demonstrate both that gender norms and ideals are diverse and changing, and that despite this fluidity, individuals may fear that their status as men is threatened by the physical inability to sexually penetrate or reproduce. For example, a 68-year-old Mexican man facing the amputation of his cancerous penis became depressed and suicidal, saying that affairs with a variety of women had been a definitive aspect of his life, and so "without my penis, I feel that now I'm not a man." Although he was married and had fathered many children, he feared that his future inability to engage in penetrative sex would mark him as unmanly. Along similar lines, many Egyptian men suffering from infertility reported they would feel that, "I am not a man" if this problem became publically known (Inhorn 2003).

These fears reveal "manhood" to be a fragile status achieved partly through public demonstrations of related forms of sexual/reproductive embodiment: having a penis, being able to sexually penetrate, and producing offspring. Thus, men's sexual and reproductive embodiment reproduces much more than the next generation of humans;

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it reproduces specific ways of being a man. The ways that men embody sexuality and procreation powerfully shape not only whether they are seen by others "as men," but also what kind of men they are thought to be. In cultural contexts where the definition of a "good" man is hotly contested, these forms of embodiment are a key way of living out forms of gendered personhood that have significant social consequences. Sexual and reproductive embodiment is profoundly relational, since sexual penetration and procreation require partners, and may literally create new family members and subsequent relationships. These forms of embodiment not only demonstrate specific kinds of manliness to the world at large, but mediate interpersonal relationships with wives, lovers and children.

Despite negative local stereotypes that sex for men is an instrumental act, meant to show dominance or produce offspring, most of our informants experienced sex and reproduction as embodiments of affective bonds. Relationships mediated by sex, reproduction, and love were thus crucial in shaping individuals' masculine selfhoods. In cases where life or bodily circumstances made sex and reproduction difficult, many men also experienced sexual and reproductive embodiment as a site for struggling against often intertwined structural and biological limitations.

Here, we will examine the ways Mexican and Middle Eastern men used medical technologies in the hopes of producing specific forms of reproductive and sexual embodiment. Using the cases of erectile dysfunction (ED) treatment in Mexico and assisted reproductive technologies (ARTs) in the Middle East, we will show how individuals finding it difficult to have penetrative sex or father children consciously use medical interventions to accomplish a range of ends. These include embodying particular forms of manhood, encouraging particular kinds of social relations, and attempting to overcome the obstacles presented by bodies and structural settings that hamper erectile function or fertility. While these technologies can be used to facilitate the performance of "traditional" masculinities based on patriarchal valorization of penetration and procreation, we found that men more frequently use these interventions to embody masculinities defined by the webs of affective relationships in which sex and reproduction occur.

Our research involved clinic-based ethnographic interviews with hundreds of men experiencing sexual and reproductive health issues. It included over 300 reproductive-aged men, generally ages 25–50, from across the Middle East. They were recruited and interviewed mostly at assisted reproduction clinics in Beirut, Lebanon and in the United Arab Emirates (Inhorn 2004a, b). In Mexico, it included over 250 older men, most aged 50–70, recruited and interviewed in the urology department of a government-run hospital in the city of Cuernavaca (Wentzell 2009).

Stereotypes and Realities of Mexican and Middle Eastern Masculinities

This research revealed the influences of both local and international discourses about the pitfalls of "traditional" masculinities. Our informants reported deep awareness of the global stereotypes about their cultures' masculinity, including aggressive, patriarchal styles of manliness marked by violence and domineering gender relations. In the case of Mexico, men are thought to be *macho*; to exhibit the desire to dominate

and sexually penetrate all available women (and potentially, lower-status men), to drink, carouse, and fight, and to remain emotionally closed and callous (Amuchástegui and Szasz 2007; Gutmann 1996; McKee Irwin 2003). In the post 9–11 world, the dominant stereotype associated with Middle Eastern men is that of the terrorist – radically religious, violently militaristic, hypermasculine, and exhibiting profound patriarchal control over women (Inhorn and Fakih 2006; Ouzgane 2006). As with the *macho,* the terrorist stereotype is associated with emotional callousness, but this is linked to hyper-religiosity in which Muslim men view nonMuslims as less than human and thus subject to violent attack. Aside from the extreme aspects of each stereotype – sexual in the case of the Mexican macho and violently religious in the case of the Muslim Middle Eastern terrorist – "traditional" masculinities in both sites are associated with forms of male dominance over women. In these notions of dominance, men exert patriarchal control over wives and other females, lack tenderness toward their wives but seek to have children by them, view children, and particularly sons, as a status symbol, and are generally distant yet domineering in the family setting.

The men we spoke with reported wrestling with "traditional" local masculinities. Some decried them as damning stereotypes, while conversely others believed that they were culturally endemic or biologically inescapable. Many understood them as negative tendencies to which they were susceptible, but which they must fight in order to be "good" men and have positive relationships with their wives and family. For example, Middle Eastern participants sometimes spoke of "the Eastern man" or the "Eastern mentality." The "Eastern man" is purportedly polygynous, patriarchal and patrilineal, desiring sons to perpetuate his genealogy and patrimony into the future. Yet, most of these men's lives were far different from these local stereotypes. For instance, when asked if this was their first marriage, most exclaimed, "The first and the last!" some going on to point out that "I love my wife. She is a good person."

Similarly, men in the Mexican study continually referred to *machismo* when asked about their own ways of being men, but then cast it as a damaging discourse about Mexican masculinity, rather than as a valid way to be a man in modern society. They felt that Mexican society was marked by macho instances of bad male behavior, often in terms of their own drinking, infidelity, and emotional closure as youths, which they were now maturing out of. Most participants argued that being macho was an undesirable and unacceptable way to be a man, since times were changing and their nation was modernizing. In today's Mexico, they said, women have the same rights as men, and men should enjoy close, emotional relationships with their wives and children.

In summary, even within an overall social context of ongoing if contested patriarchy, Middle Eastern and Mexican marriages and sexual liaisons are often loving sites that are crucial to defining men's gendered selfhoods. Most Middle Eastern men reported wanting to be married to a woman with whom they could experience ongoing romantic love (Inhorn 2007a). Far from being uncaring, unfeeling, polygynous patriarchs, Middle Eastern men, once married, tend to be deeply invested "family men," demonstrating love, both verbally and physically, to their wives and children. Similarly, although marital fidelity was not a common practice especially among older men, most Mexican study participants felt that their wives and families were crucial to both their success in life and to their very selfhood. Participants commonly stated, "Without my wife, I would be nothing!" and spoke respectfully of their wives' accomplishments and work ethic, particularly in terms of raising their families. Many older

men also reported a shift toward – and younger men a wholesale adoption of – the idea that marriage should be companionate and based on romantic love. Thus, our study participants' sexual and reproductive practices functioned as ways of embodying the sorts of manhood they wished to enact, in the relational setting of close relationships and families.

Our informants thus tended to see sex and procreation as parts of their lives where they could choose between reproducing "traditional" ways of being men, or enacting alternatives. When their health or social settings made it difficult to attain erection or to procreate, they often used medical assistance for erection or fertilization quite thoughtfully, understanding it as a way to put their bodies in line with the embodied masculinities they desired, which in turn would facilitate particular kinds of romantic and family relationships. Thus, their search for medical help was not intended as a simple biomedical fix for broken biology. Instead, it was often a quest for particular forms of embodiment that facilitated affective relationships that would reciprocally define their individual manhood. In the following sections, we discuss the availability and use of ED treatments in Mexico and ARTs in the Middle East, and present ways that men use these medical interventions to be particular kinds of men, by embodying specific forms of sexuality and reproduction.

Erectile Dysfunction Treatment in Mexico

Since the 1998 introduction of Viagra, Mexico and other world sites have seen a "medicalization of impotence," in which the proliferation of medical fixes for non-normative erections has led to societal re-imaginings of impotence as the biomedical pathology "erectile dysfunction" (ED) (Tiefer 1994). Defined medically as "the persistent inability to achieve or maintain an erection sufficient for satisfactory sexual performance" (Lizza and Rosen 1999), ED treatments have both captured the popular imagination, and been critiqued as an over-medicalization of a complexly bio-social experience. Critics argue that ED treatments promote particular social norms of health, sexuality and masculinity as biological facts, casting "satisfactory" sex as a cross-cultural universal requiring a hard penis, and a "naturally" never-ending desire to sexually penetrate (Loe 2004; Potts et al. 2004).

The idea that less-than-ideal erections can be understood as ED has taken hold in both Mexican medicine and popular culture. A generic version of Viagra is on the list of drugs that government hospitals are required to provide at no cost to eligible patients, and has recently been dispensed free of charge to older men in Mexico City in a government attempt to raise morale among the aged (CNN 2008). Viagra competitors Cialis and Levitra are also readily available without a prescription. These drugs, as well as herbal copycats like "Powersex" and "Himcaps," are advertised on brightly colored signs posted on pharmacy walls, and "M-force," the most heavily marketed ED supplement, advertises frequently on Mexican network television. The label "Viagra" is frequently attached to food items thought to have reinvigorating properties, like the ostensibly aphrodisiac sea urchin broth now known locally as "Viagra soup." Finally, ED and Viagra jokes are common fare in television comedies and joking relationships among friends, often in contexts that lampoon the "macho" nature of Mexican men and their supposed obsession with frequent, indiscriminate

penetrative sex. Thus, Mexican men who experience decreasing erectile function do so in a context where the possibility of seeking medical mediation for this change is ever-present and easily accessible.

However, while references to ED and its treatments are ubiquitous in Mexico, this does not mean that men have adopted this understanding of erectile difficulty wholesale in their thinking and sexual practice. In fact, men's responses to decreasing erectile function in the context of Viagra often echo the concerns posed by social scientist critics of ED drugs. Many informants argued that medically mediated, "youthful" practices of sexuality are inappropriate for older bodies, relationships, and place as elders in their social worlds. Thus, interviews with older men showed that they tended to consciously reject medical ED treatment when faced with decreasing erectile function. While these men understood themselves in part through the lens of Mexican machismo – often saying that they were machos in their youths – relationships with female partners and family members, acknowledgment of their own aging bodies, and alternative ideas about masculinity had become more important to their emerging ways of being men. They often embodied "ex-machista" status by explicitly rejecting drugs like Viagra, instead seeking to gracefully inhabit their changing bodies by accepting decreases in erectile function as prompts to become faithful and to focus on developing affective bonds with wives and family members, rather than chasing women in the street.

Those study participants who did seek ED treatment often did so because they felt they were not old enough, or "ready," to make this life-course change. Instead, they feared that erectile difficulty would jeopardize existing, or foreclose the possibility of new, affective sexual relationships. They saw ED drugs as treating the physical symptom of a much more complex problem of masculinity. Men using treatments like Viagra often reported that they did not "feel like men" because they were failing in their relationships with women or in other social markers of manliness like work or finance. Many believed that their bodies were overtaxed by hard work, illness and emotional distress, and hoped that ED treatment would help them to embody one aspect of successful manliness and thus set them on the course to recuperating other aspect of their masculinity.

Thus, rather than simply using ED drugs to unthinkingly pursue penetrative sex, many men sought the bodily ability to perform sex acts that they saw as both appropriate to their particular phase of life, and believed would cement their desired, affective social relations with women. For instance, Pepe, a 68-year-old barber and self-styled ladies' man, used Viagra to have penetrative sex that reproduced a set of social relations that made him feel not only virile, but like a responsible provider. Pepe suffered from a narrowing of his urethra caused by the improper removal of a catheter over a decade ago, after which "my capacity lessened… My potency lessened." He is married and reports feeling great affection for his wife, saying that they love each other and "get along well." However, he says that they only have sex "sporadically, because it doesn't appeal to her" since she is diabetic and at an age, 61, where he believes many women lose interest in sex. However, her embodiment of chronic illness and lack of sexual interest does not match his desire to appear vigorous and have frequent sex. "I'm active," he explains.

Thus, Pepe maintains sexual relationships with other women in order to incorporate a "youthful" type of sexuality into his masculinity. He does not see this as a

betrayal of his wife, but a simple consequence of her lack of sexual interest. Because his wife does not want sex, he explains, "You have to find a little friend… out of necessity." Pepe is aware that this "necessity" has been abandoned by many men his age, and he eventually expects to make a lifestyle shift to fidelity. He says, "The moment must arrive when with age, my capacity will lessen. I will dedicate myself to my wife, and to my family." However, he does not feel that this time has arrived, so he uses Viagra in order to mitigate the decreases that have already occurred in his sexual function, combining the embodied practice of taking Viagra with the intersubjective practice of sex with younger women to act out a youthful and healthy sexuality.

Not only the fact that he has sex with younger women, but the affective components of, and manly responsibilities linked to, their relationships are crucial to his masculine selfhood. He meets weekly with young single mothers who he says do not demand, but do appreciate, "little presents, some little help." He says that he likes to go out with women who he knows are needy and who he can help. "I give, but voluntarily. A help… I help her, she helps me with my problem… It's beautiful." It is also important to him to satisfy his "little friends" sexually, and he has incorporated his Viagra use into his embodiment of being a skilled lover. He says that sex with Viagra, "is different – my partner is more satisfied," and "that way the experience is more complete, mutual." Thus, the Viagra-fueled embodiment of frequent penetrative sex enables Pepe to construct social relationships in which he can live out a specific kind of responsible, patriarchal, but tender and considerate, and sexually vigorous masculinity. While this form of manhood is "traditional" in that it is based on penetrative sex, it also incorporates elements of an alternative masculinity based on the provision of not only material, but emotional, support to the women in his life.

ARTs in the Middle East

While male infertility was previously seen as a stigmatized condition in the Middle East, fieldwork in the new millennium has revealed that men are now challenging the conspiracy of silence around this experience (Inhorn 2004a). This seems largely due to a normalization process occurring over time as a result of the "medicalization" of male infertility. Men acknowledge that there is increasing openness about male infertility these days, particularly in light of the modern infertility treatment services being provided and advertised widely across the Middle Eastern region (Inhorn 2003). Furthermore, once inside treatment centers, men seem to begin understanding male infertility as a problem, "like any other medical condition." Thus, they typically stated in interviews that male infertility "has nothing to do with manhood."

For many men who have accepted this new "medical model" of infertility, male infertility is *not* the major "crisis of masculinity" that it is supposed to be for "traditional" forms of Middle Eastern manhood. For example, George, a Lebanese Christian oil executive, explained that there are now two views of male infertility – an "insider's" and an "outsider's" perspective:

> In Lebanon, yes, male infertility does affect manhood. Men don't want to admit they can't have children. They're not men any more. But this is not the view of people inside treatment. People who are "in" know it *is* a medical problem. So we don't feel this

> problem of manhood or womanhood. In our company, four to five people have IVF babies. One guy was married for 15 years, and he went to Singapore [for IVF]. Then another one went there. So, in my company, people talk about it. I tell everybody about it. I don't mind. Because it's easier to tell everyone what you're doing. Even at work, it's easier to tell them, so that they just stop asking. My boss said, "You've been married for more than two years and you didn't get your wife pregnant yet?" I said, "I'm trying, but I couldn't get my wife pregnant yet." Two days ago, I told him I'm coming for IVF. But this is *very* uncharacteristic of Lebanese people. People think like, "Manhood. He can't have children." So a lot of people blame the woman, even when it's male infertility. This is because people are secretive. They don't know the problem is male infertility, and so they say [it's from] the woman.

When George speaks of IVF in his interview, he is referring to the newer variant of IVF called intracytoplasmic sperm injection (ICSI). First developed in Belgium in the early 1990s, ICSI has allowed thousands of severely infertile men to father children with their own sperm. As long as even one viable spermatozoon can be retrieved from an infertile man's body – including through painful testicular aspirations and biopsies – this spermatozoon can be injected directly into the oocyte with the aid of a "micromanipulator" on a high-powered microscope, effectively forcing fertilization to occur. Over the past two decades, ICSI has become widely available in assisted reproduction centers in the West, and it has been available since 1994 in the Middle East. First introduced in Egypt, it then quickly spread to IVF centers in other Middle Eastern countries, and is now the most commonly performed ART in the region.

Indeed, the arrival of ICSI in the Middle East has led to a "coming out" of male infertility and a boom in the local IVF industry. Hundreds of thousands of infertile Middle Eastern men are now undergoing ICSI each year, with clinics opening up in order to meet local demand. Large countries such as Egypt, Iran, and Saudi Arabia each boast more than 50 IVF clinics where ICSI is performed. Even the small and lesser-developed countries of the Middle East, such as Yemen and Oman, now host urban IVF centers where ICSI can be obtained. The very success of this regional IVF industry – fueled by the significant demand for ICSI – bespeaks the medicalization of male infertility, men's willingness to try this medical technology, and the growing regional acceptance of male infertility as a medical issue rather than stigmatized defect (Inhorn 2004a). As George's story shows, many men are self-consciously using ARTs not to embody "traditional" masculinities, but to embody roles of fatherhood set into affective marital ties.

Thus, in both Mexico and the Middle East, men's sexual and reproductive embodiments ground individual enactments of masculinity that, especially when they require medical assistance, are often quite self-conscious. Since stereotypes of local masculinity involve strong dimensions of virility and fertility in these sites, men who experience bodily change or difficulty in these areas may explore treatment options that "rehabilitate" their virile, fertile manhood. Yet, as the following ethnographic cases show, men's relationships with these technologies are not straightforward. Rather, depending upon the type of medical technology and social context, men perform new types of embodied masculinities that they view as appropriate to their changing bodies, social situations, and cultural contexts. The following case studies show how men in each site sought to reshape their sexual/reproductive embodiment in order to live out a masculinity centered on affective bonds with lovers, wives and family.

Mexico: José's Story

José, a divorced, 40-year-old construction worker, was one of the few men who came to the hospital urology department specifically for ED treatment. Though soft-spoken, he was open about his sexual and other problems, and hungry for treatment information. He saw his erectile difficulties to be caused not only by physical problems, but also by the emotional consequences of his failed marriage and subsequent dating experiences, as well as his troubles at work. José understood his erectile problems to result from a failure to perform successful masculinity in these arenas, resulting in an unmanly embodiment marked by a lack of sexual desire. José hoped that ED treatment would restore this desire, in turn helping him to more successfully interact with women both sexually and romantically, and thus restore his status as a "normal" man.

José reported that he sought treatment, "because I have an erection problem, I need stimulation, appetite to have sex with a partner. I've had this problem since 2003, I've lost the sexual appetite, I need to have – to be well." He reported that his "lack of desire" was linked to a series of problematic interactions with women. His sexual difficulties began in the same year that he split up with his wife; he said that, "There was a problem, we were splitting up, my sexual appetite was diminishing."

His divorce was directly related to health problems that had limited his capacity to work and earn money. When asked why he and his wife split up, he explained: "It's a historical problem. We were good, but when I got a pacemaker in 2003 – when I was born, there wasn't money, my parents didn't take me to a doctor and they say my heart is very slow – my wife saw that I wasn't going to achieve anything because I was sick." [Interviewer: "Achieve what?"] "Something in life, having something."

At the time he received the pacemaker, José was working in construction and his wife was a housewife. He took a less physically taxing job, doing maintenance in a condominium community, but his wife complained that he did not earn enough and worked too many hours. As a result of these quarrels, he says, "Bad moods arose, we got angry over anything. We split." His wife stayed in their home with their three children, and he "went to the street."

José said that a final, emotionally problematic, interaction with a woman cemented his sexual difficulties. He says that his sexual problems were caused by the trauma of his divorce, as well as by this subsequent experience: "It was also due to… after that [the divorce], I met a girl, we tried to have sex, I saw the problem. She had an infection, she told me before." [Interviewer: "Which?"] "Herpes. That, when it got in here [pointing to his head], it really made me think, 'I shouldn't do this, how foul.' I didn't want to have sex."

However, he felt obligated to sleep with her, in order to comply with manly duties that he understood to entail both sexual penetration, and consideration for his partner's feelings. Nevertheless, he found it "difficult to achieve erection," and told her he could not do it again; "she left sad." José says that, "After that, now I can't do it. If I see a pretty girl, I don't grow, I don't feel arousal, it doesn't appeal to me. I need to feel arousal, appetite. I don't feel anything. I don't think about it anymore – if I think about it, I get nervous."

Thus, health problems related to childhood poverty caused difficulties in José's work life, which in turn hampered his ability to provide for his family and maintain a positive

emotional relationship with his wife. José believed that the emotional pain caused by his divorce curtailed his "sexual appetite," which was further damaged by a troubling sexual experience that combined a lack of desire with the fear of sex causing bodily harm. In this case, an interlinked web of structural, social, and emotional problems had come together to be embodied as a lack of desire that José would come to define as ED.

Through medical treatment for this lack of desire, José both asserted that failings in multiple areas of life that were significant for his manhood, and also altered his embodied sexuality. Using ED treatment thus broke one link in the chain of events that together formed a faltering masculinity. Although even thinking about sex had become a source of emotional pain for José, he continues to seek medical treatment that he hopes will restore his sexual desire and erectile function. When asked why, he replied, "I want to return to having that, because it's normal, the normal life of a man. I think, I'm sick, I have a problem, I'm not living normally." He says that he wants to have a partner again, although he cannot meet one now because, "I'm afraid that I won't function. Before when I saw a pretty girl, lots of erection, arousal. Now even if I see a pretty girl – when I see someone I like, I get nervous, weak."

It is clear that José hopes to return to what he considers a "normal" masculine state, in both mind and body, by overcoming the lack of desire caused by problems in multiple areas of his life. Yet, the medical treatment he has received has not helped with his sexual problems. Over the course of his treatment-seeking, José was prescribed multiple ED drugs, but he felt wary of them and usually decided against using them. He said that he once tried sex with an ED drug and was unsatisfied with the experience. He used it with a friend from his hometown, with whom he discussed his heart problems. He said, "I achieved erection, but very little… Successful, but only a little. I was very tense, nervous. I had penetration, but was not that firm."

José thus fantasizes that the use of a medication can cause him to physically embody manly sexuality in a way that will bring his emotions and social relations in line, but simultaneously believes that the emotional toll of his interrelated loss of sexual confidence and desire is a complexly social problem that cannot simply be medicated away. His embodied lack of desire is intimately related to nervousness, unhappiness, a history of failed relationships with women and embodied ill-health. Unlike Pepe's use of Viagra to have sexually and emotionally fulfilling liaisons that enable him to act out the sort of masculinity he desires, José has been unsuccessful in using technology to foster the sorts of interaction that would make him feel like a "good" man. This difference seems to be partly due to José's difficulties in the other areas of life, like work, that would make him feel successfully manly.

Lebanon: Hussein's Story

Hussein is a 42-year-old police officer from Southern Lebanon who is infertile and still childless after nine years of marriage. Hussein's first words to the anthropologist were, "I have suffered a lot in my life." He next told the harrowing tale of his capture by the Israelis and two-year detention in the notorious Khiam Prison during the Lebanese civil war. He was put in solitary confinement – "where you could not see day from night in some of the cells, and there were no toilets" – and forced to eat the same food, without any meat, for the length of his imprisonment. He was also tortured with

electricity to his genitals on three separate interrogations, "and there were many interrogations." As he explained, "I wasn't married then, and I didn't do a sperm test before marriage because I was young then. This was almost 23 years ago. But *maybe* this [the torture] is the cause of my sperm problems." In addition, upon his release from Khiam in a prisoner swap with the Israelis, Hussein was involved in a major car accident, breaking 24 bones, suffering internal bleeding, and experiencing two months of unconsciousness as a result of a severe head injury that required brain surgery. He reiterated, "The war was very bad. We lived our life in the war, and I suffered a lot."

Today, Hussein suffers from variable oligospermia, sperm counts that fluctuate below normal. "I've had *many* semen tests," he explained. "The number goes up and goes down. It is not fixed. But there is 'weakness,' the doctors said." Although he has impregnated his 35-year-old wife four times, she has gone on to miscarry early in each pregnancy.

In an attempt to try to overcome his infertility, Hussein underwent varicoceletomy, a major urological operation to strip varicose veins from the testicles. However, varicoceletomy is a controversial and generally inefficacious surgery (Inhorn 2007b; Inhorn 2009), and Hussein now believes that this pointless operation only helped the Lebanese physician with his "commerce." In addition, Hussein has taken many hormonal medications, Humegon, Pregnyl, and Clomid, all in unsuccessful attempts to increase his sperm production.

Finally, upon learning that his infertile male cousin had visited an IVF clinic and had produced triplets with his wife, Hussein decided to follow suit. As he explained, "We had hoped to get pregnant and make a baby without doing IVF, since she's been pregnant four times. But she's 35 years old now. We've tried, but now I'm 42 and she's 35, and we're afraid we'll get too old." Hussein continued,

> In our society, when a woman is the cause [of the infertility], the man will leave her and divorce her. So society will not have mercy on a women who doesn't have a baby. But I'm only afraid that she'll reach an age when she can't have children, and then our society won't have mercy on her. I don't want her to experience this. I won't allow this social pressure. It usually happens, but I don't allow it. In general, I don't allow other people to interfere in my life.

According to Hussein, his wife has been his only sexual partner, because "I'm committed to my religion, to the *shari'a* [Islamic law]. I respect and protect the woman, and I don't just follow my [sexual] desires." Indeed, as a pious Shia Muslim and member of the Hizbullah "resistance," Hussein explained why he could not shake the female anthropologist's hand – or any woman's hand – "not because I hate women, but because of my religion" [and its prohibition on "touch or gaze" across genders] (see also Deeb 2006).

Hussein also explained that he and his wife were committed to each other and deeply in love, despite their unfulfilled desire for a family. He described this lack as the only major problem in their relationship:

> We *love* children. In my family, we are seven brothers, and some of them have sons who are almost my age. In my family, we do care about having children. I have many nieces and nephews, and I like to treat my nieces and nephews kindly, which makes her jealous. Her psychology is *very, very* affected! We don't have any other problems except this problem of not having children.

However, he said that despite the psychological consequences of childlessness, their marriage remained strong. He stated, "But she accepts this situation, because if she didn't, she would have asked me for a divorce. She loves me *a lot*! And I would have changed [replaced] her if I didn't love her. It's very easy to divorce. But the husband and wife are one body, one soul."

When asked about whether his infertility affected his sense of manhood, Hussein said:

> I accept the fact that I'm infertile, but I always seek treatment and medicine to improve my situation. A person doesn't just sit and say, "This is from God." Of course, in the Qur'an… [Hussein stops momentarily to explain that in quoting a passage in Arabic from the Qur'an, one must truly understand what the Qur'an is saying, and then he or she will understand "everything."] There's a saying in the Qur'an that scientists are the people most afraid of God, because they get to that point of knowledge to really understand God's wishes.

He explained that ARTs are permitted by Islam, as long as procreation remains within the marital context:

> IVF is *halal* [permitted], if the sperm is from the man and the egg is from his wife, then there's no problem. But if the sperm is from outside [i.e., a donor], then it is *haram* [forbidden], and the same thing for the eggs, haram. But, if the egg is from my wife and the sperm is from me, then it is halal for the married couple. But in all Islam, in all religions, donation [of sperm and eggs] is wrong, according to my knowledge. The baby *has* to be from a married couple.

Hussein ended his interview by expressing his desire to have a child with his wife, the one and only woman in his life. Until this happens, they will continue to support the expenses of a child in a Hizbullah orphanage, as care for orphans is one of the major forms of charity to be performed by pious Muslims.

Indeed, Hussein's story defies the stereotypical masculinity that might be assigned to a member of Hizbullah. Hussein knows that Western outsiders view Hizbullah as a "terrorist" organization, but he explained that, "we're known as terrorists because we don't want our country to be occupied [by Israel]!" Hussein, in fact, prides himself on being a very law-abiding citizen and drug-enforcement officer in the police department, married to a teacher who he loves and respects. Furthermore, he attempts to "protect" her from the stigma of childlessness, which he "accepts" as a problem of his own reproductive body. Indeed, at several points in the interview, Hussein reiterated that his wife "doesn't have any problems."

A key way that Hussein is striving to embody this type of masculinity is through infertility treatment. He has undergone numerous semen analyses, taken multiple medications, and even undergone a useless genital surgery. His current motivation to try ICSI at an IVF clinic is influenced by his male relative, whose wife bore triplets. Although Hussein loves children and would very much like to become a father, his primary reason for trying ICSI is his concern for his wife, who he fears will be mocked by their "traditional" community if she reaches menopause without a child of her own. Indeed, it is his love for his wife – his feeling of being "one body, one soul" with her – as well as his Islamic piety, which has kept Hussein on the "straight path" toward ICSI.

Conclusion

This chapter has focused on Mexican and Middle Eastern men who seek medical assistance to have sex and father children, thereby striving to alter their physical bodies in ways that will facilitate loving relationships, happy families, and, in Hussein's case, religious piety. These men acknowledge that multiple ways of being men can make sense in their cultural contexts, and they seek to act in ways that defy what they see as negative and stereotypical notions of Mexican and Middle Eastern masculinities.

The new forms of embodiment enabled by treatments for erectile dysfunction and male infertility can support a range of ways of being men. The ethnographic cases presented here show that men often use medically mediated embodiments to enact the kinds of social relationships that enable them to be the kinds of men they desire to be – caring husbands, lovers, and fathers. Even men like Pepe, who used medical help to perform more "traditionally" manly acts like infidelity, seek to use their resulting embodiments to engage in meaningful relationships that are key to their self-making practices. These sexual and reproductive health interventions are also a site from which men struggle against frequently intertwined structural and biological limitations, like José's health-related work problems that undermined his sexual confidence, or the torture and imprisonment that may have lowered Hussein's sperm count.

In summary, the Middle Eastern and Mexican men's experiences recounted here show that men use medical treatments to reproduce particular forms of masculinity. The forms of manhood that they strive to embody often differ dramatically and powerfully from the stereotypical discourses of manhood that circulate, both locally and globally. Thus studying masculine embodiment in the new millennium is both a means of unseating sometimes pernicious stereotypes, and for understanding emergent forms of masculinity now appearing around the globe.

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