

## Chapter 15

# SEARCHING FOR LOVE AND TEST-TUBE BABIES

## IRAQI REFUGEE MEN IN REPRODUCTIVE EXILE ON THE MARGINS OF DETROIT

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### Introduction

In the United States, there are nearly 200,000 Iraqi refugees. They began arriving in 1992 in the wake of the First Gulf War and were later joined by refugees of the Second Gulf War, who started gaining admission to the United States in 2008. Some of these refugees came as families, while others did not. This was especially true for young Iraqi men, many of whom fled alone from their war-ravaged country. Some of these men were part of the military forces that fought against Saddam Hussein and his brutal regime. Others assisted U.S. forces as translators, drivers, and guides (Campbell 2016). Still others were civilian noncombatants, caught up in the violence. Many were lucky to make it out of Iraq alive.

Thousands of Iraqi refugee men were eventually resettled in Michigan, the Midwestern state with the largest number of both first- and second-wave Iraqi refugees. Some of these refugees came directly to Michigan from the Middle East, assigned there by the U.S. Refugee Admissions Program. However, others took circuitous routes, finding a permanent home in Michigan only after initial

placements in other states. In most cases, these Iraqi refugees ended up on the outskirts of Michigan's largest city, forming part of an ethnic enclave community that scholars dubbed "Arab Detroit" at the start of the new millennium (Abraham and Shryock 2000).

This chapter focuses on Iraqi refugee life in Arab Detroit. Iraqi refugees there have been described as a "forgotten population" (Human Rights Institute 2009), one that faces high rates of unemployment, life below the U.S. federal poverty line, a lack of medical insurance, and an inability to access America's fee-for-service, privatized healthcare system. For those with chronic health conditions, accessing medical care can be a major struggle (Taylor et al., 2014). This is true for Iraqi refugee couples who face serious reproductive health problems, including infertility, or the inability to conceive a child. Unable to access expensive assisted reproductive technologies (ARTs) in the U.S. healthcare system but unable to return to their "home" country to seek medical care, infertile Iraqi refugees exist in a liminal state, one that will be characterized in this chapter as "reproductive exile." For Iraqi refugee men in particular, who face high rates of male infertility for reasons to be explained in this chapter, their attempts to seek treatment demonstrate their reproductive agency, despite many obstacles to reproductive success.

This chapter explores Iraqi refugee men's search for love and test-tube babies in America. As we will see in men's stories, children are the markers of full adult personhood, the route to happiness and commitment within marriage, the key to social acceptance in the community, and the path to future immortality. Children are cherished and beloved by their Arab mothers but also by their Arab fathers. Arab fathers generally extoll the virtues of their children as the absolute joys of their life, their reasons for living (Inhorn 2012). Thus, infertility, or the inability to conceive a child, represents a major reproductive disruption, a source of great anguish and existential pain.

To reveal the suffering of infertility within the Arab refugee community, I begin with an ethnographic foray into Arab Detroit, the so-called capital of Arab America. I turn to my study of infertility there, focusing primarily on the infertility problems of Arab refugee men. These men are structurally vulnerable in the U.S. healthcare system (Quesada, Hart, and Bourgois 2011), where problems of access are accentuated by poverty, lack of insurance coverage, and nonexistent safety nets. Such problems are revealed in the stories of three Iraqi refugee men, whom I call Ali, Ibrahim, and Sadiq. Their stories embody agency and hope but also highlight disappointment and despair.

### The Ethnographic Setting: Arab Detroit

On the outskirts of Detroit, past the polluting smokestacks of the massive Ford Rouge automobile factory, lies a nondescript, two-story, red brick, medical office building, located on the same treeless, cement-gray, commercial boulevard as the Ford factory. The street itself is utterly cheerless—drab buildings, gray skies, plenty of snow, some of it blackened by car exhaust and ambient pollution. However, once inside the office building's front door, any visitor is transported into another world—the Arab world. Within the building's small circular front lobby, elderly Arab men with white skullcaps pass by with their sun-creased faces and backs stooped from lives of hard manual labor. As they wait in line at the Lebanese-run pharmacy, Iraqi women dressed in black abayas (traditional long cloaks) and Yemeni women wearing black niqabs (facial veils) cross the foyer, pushing their sick children in strollers into the first-floor pediatric clinic. Young Arab couples without any children take the flight of circular stairs to the second floor, hoping to pass by unnoticed as they enter the second-floor infertility clinic.

This medical center is located in Arab Detroit, Michigan, an upper Midwestern, wintry, rust belt state that might seem like an unlikely home for immigrant Arabs. With its cold, snowy climate, flagging auto industry, and widespread poverty—on graphic display with the 2016 lead-drinking water crisis in Flint, Michigan, and the teacher sick-outs protesting dangerously deteriorating public schools in Detroit—this mostly working-class state has relatively little to offer to incoming Arab migrants and refugees. Yet, over the past fifty years, the greater Detroit metropolitan area has been one of North America's largest Arab receiving grounds. Beginning in the 1950s, exiled Palestinians started resettling in the Detroit suburbs, a pattern that continued among Palestinians over the ensuing decades.

By the 1970s, Palestinians were joined by Lebanese, whose numbers swelled with each passing decade of the Lebanese Civil War. By the 1990s, Lebanese and Palestinians were joined by Iraqis, tens of thousands who came as refugees in the aftermath of the First Gulf War. Thus, over half a century, metropolitan Detroit absorbed three major populations of fleeing Arabs—Palestinians, then Lebanese, then Iraqis. By 2005, the U.S. Census Bureau showed that both the Iraqi and Lebanese populations in Arab Detroit had grown significantly but that Iraqis now outnumbered the Lebanese, at 39 percent versus 31 percent of the overall population (Schopmeyer 2011).

These Lebanese and Iraqi refugees settled primarily in Dearborn, a Detroit suburb located on the southwestern border of the city. Prior to Arab resettlement, Dearborn's claim to fame was the aforementioned Ford Rouge factory, the largest in the state of Michigan. But, by the year 2000, Dearborn had also become famous as a kind of "little Arabia." Beneath the billowing smokestacks of the Ford factory, the streets of Dearborn had become lined with scores of Arab-run businesses. Clothing stores, restaurants, and bakeries are intermingled with immigration and legal aid services, medical facilities, a refugee assistance program, and a number of Islamic schools and mosques serving the Arab community.

Although Dearborn is often called the "capital of Arab America," it could be more accurately described as the "capital of Muslim America," or, more precisely, the "capital of Shia Muslim America." Dearborn is home to nearly 80 percent of Arab Detroit's Muslim population, 56 percent of whom are Shias from Lebanon and Iraq (Detroit Arab American Study Team 2009). Seventy-five percent of them were born outside the United States; they left their home countries in the wake of sectarian-inflected violence. As minorities in the Middle East, Shia Muslims are now the majority in Dearborn, a population that has continued to grow because of the 2003 U.S.-led war in Iraq.

Indeed, despite initial U.S. government reluctance to take in any more fleeing Iraqi refugees, by 2008 and 2009, fully one-quarter of all refugees entering the U.S. were Iraqis, with Arab Detroit taking in as many as the cities of New York, Chicago, and Los Angeles combined (Schopmeyer 2011). Iraqi populations can be found across all fifty U.S. states, but most have been resettled in California, Michigan, and Texas, with Michigan taking more than its fair share (Svab 2013).

Interestingly, most Iraqi refugees have eventually applied for U.S. citizenship, a process of naturalization that can take place after a five-year mandatory legal residency period. Rates of U.S. citizenship are high in Arab Detroit, at 80 percent overall, including 80 percent of all Iraqis, who have been eager to become naturalized citizens (Detroit Arab American Study Team 2009).

Yet, despite their U.S. citizenship gains, Iraqi refugee families in Arab Detroit live in poverty. Whereas the median household income in the United States is \$53,657 and the U.S. federal poverty line is \$24,300 for a family of four, nearly half, or 42 percent, of Iraqi refugees live on abysmally low household incomes of less than \$10,000 per year. Although at least one-quarter of all Arab Detroit house-

holds earn incomes below \$30,000 a year, Iraqi refugees are by far the poorest group, with 82 percent of all Iraqi Muslim families living on household incomes of less than \$30,000 per year (Schopmeyer 2011). Not surprisingly, by March 2011, reported unemployment rates for Iraqi refugee men in Michigan were more than 25 percent, or nearly three times, the national average of 9 percent (Sheppard 2011).

This sociodemographic poverty profile is shared by the city of Detroit, which is predominantly African American. Among major U.S. cities with populations above 200,000, Detroit ranked first in the percentage of its population living below the poverty line, at 39.3 percent (Bouffard 2015). Furthermore, 67 percent of Detroit families, or more than two-thirds, were either in poverty or in a state of ALICE—asset limited, income constrained, (although) employed (Abbey-Lambertz 2014). This stands in stark contrast to the predominantly White suburbs of Detroit, where just 5 percent of residents live in poverty.

To summarize then, an overarching sociodemographic profile of Arab Detroit reveals a poor, struggling community of mostly Shia Muslim war refugees from Iraq and Lebanon, all of them existing, literally and figuratively, on the margins of Detroit, a poor, deteriorating rust belt city. A map of metropolitan Detroit would thus show three sectors: first, a poor, virtually Black inner city, connected on its southwestern margin to a mostly poor Arab ethnic enclave community, and surrounded on all sides by a ring of suburban White affluence.

### **Infertile Refugees: An Arab Detroit Study**

Here, in this Arab Shia Muslim ethnic enclave made up of mostly war refugees from Iraq and Lebanon, lies the red brick medical office building described in the introduction to this chapter. On the second floor of that Dearborn medical office building is the satellite clinic of IVF Michigan, the largest infertility and in vitro fertilization (IVF) treatment center in southeastern Michigan and northwestern Ohio. In IVF Michigan's Dearborn clinic, a Lebanese American Shia Muslim IVF physician—"famous" for his medical skills and his tender mercies—attempts to treat the reproductive health problems faced by this poor Arab Muslim population.

Although infertility is often assumed to be a female reproductive health problem, more than half of all cases of childlessness involve a so-called male factor (Inhorn 2012). Male infertility has multiple

etiologies; however, most cases are genetically based, sometimes involving microscopic deletions on the Y chromosome. In the Middle East, such genetic mutations are clearly linked to high rates of consanguineous (i.e., cousin) marriage, which increases the risk for genetic defects. As a result, male infertility often clusters in families in the Middle East and often involves very severe cases (Inhorn 2012). Of the four different types of male infertility—oligozoospermia (low sperm count), asthenozoospermia (poor sperm motility, or movement), teratozoospermia (poor sperm morphology, or shape), and azoospermia (total lack of sperm in the ejaculate)—azoospermia is the most serious form. Often genetically based and incurable, male infertility is usually unresponsive to any form of medication or surgery. Instead, the only way to overcome most serious cases is through an assisted reproductive technology called intracytoplasmic sperm injection (ICSI), a variant of IVF designed specifically to overcome male infertility problems.

With ICSI, women undergo hormonal stimulation to produce excess oocytes (eggs). Through a transvaginal operation requiring general anesthesia, these eggs are then removed from a woman's ovaries, engendering some degree of risk and discomfort for the woman herself. Extracted eggs are then microscopically injected with an infertile husband's "weak" sperm, effectively forcing fertilization to occur. Through ICSI, otherwise sterile men can become fathers of biogenetic offspring—even those who must have their testicles painfully biopsied or aspirated in the search for sperm. ICSI, then, is a "masculine hope technology" (Inhorn 2016), often the only hope for infertile Muslim men, who are generally religiously prohibited from seeking alternative forms of fatherhood either through sperm donation or child adoption (Inhorn 2012).

Given the scope of the male infertility problem among Arab men, my study in Dearborn ended up focusing heavily on this condition. Within the IVF Michigan Dearborn clinic, I met ninety-five Arab patients—fifty-five men and forty women, most of whom came to the clinic as couples and I interviewed together, but some of whom came alone, including eighteen infertile men and four infertile women, who I interviewed separately. Of all the men in my study, forty-two of them, or fully three-quarters (76 percent), were facing infertility problems, a statistic speaking to the high prevalence of male infertility among this Arab population.

In terms of country of origin, almost half of my interlocutors were from Lebanon (45 percent), with the other half split almost evenly between Iraqis (23 percent), and Yemenis (21 percent). However,

I also interviewed a small number of Palestinians (6 percent), as well as one Syrian man. My study took place over a five-year period, from the fall of 2003 through the summer of 2008. At the time, post-9/11 Islamophobia in the United States was running high and was further exacerbated by the 2003 U.S. invasion of Iraq. At the same time, the Michigan economy was beginning to deteriorate, as Detroit's auto industry spiraled downward. In 2013, President Barack Obama helped to facilitate an auto industry bailout to prevent Ford, General Motors, and the other large Michigan automakers from closing their plants. But by then, Detroit's economy was so decimated that the city was forced to declare Chapter 9 bankruptcy. This was the largest municipal bankruptcy in U.S. history, both in terms of the size of the city and the size of its debt, which was estimated at \$18 to \$20 billion (Davey 2014).

In short, the timing of my Arab Detroit study happened in the midst of the post-9/11 "Terror Decade" (Abraham, Howell, and Shryock 2011) as well as during the buildup to the "Great Recession," in which the downturn in the Michigan auto economy played a leading role (Maraniss 2015). Not surprisingly then, my interlocutors in Arab Detroit faced a great deal of hardship. Most of them were precariously employed and often desperately poor. Moreover, I heard many stories of sadness and despair, resulting in part from their refugee status. Most of the Iraqi refugees, and many of the Lebanese in my study, had come to America within the past ten years. Thus, my interlocutors spoke to me of war traumas and deaths in the family, reproductive health impairments and physical disabilities, divorces and loneliness, poverty and chronic stress. Infertility, or the inability to have a child, was just one of many struggles that most of my interlocutors were facing. But it was through this lens of infertility that I came to know about their other hardships. In an Arab cultural setting in which marriage and parenthood are considered mandatory aspects of adult personhood, the inability to become pregnant was a major heartache for most of the Arab Muslim men and women in my study. Furthermore, poverty and lack of health insurance had prevented most of them from accessing affordable infertility treatment, especially IVF and ICSI, ARTs that are extremely expensive in the United States; at an average cost of \$12,513 per cycle, they are the most expensive in the world (Connolly, Hoorens, and Chambers 2010). However, IVF and ICSI are rarely covered by American health insurance companies, as these technologies are deemed elective, including under the Affordable Care Act (Buchmueller et al. 2016).

I listened to these stories of hardship over hundreds of hours spent in the IVF Michigan clinic, usually on Friday afternoons after the main Muslim communal prayer had been held at local mosques around the city. This was also the time when the Lebanese doctor would drive down from IVF Michigan's main headquarters in an affluent northern Detroit suburb to see his poor Arab patients in the Dearborn office. There, he or the clinic administrator (also a Lebanese Shia Muslim woman) would introduce me to patients willing to participate in my research project. I had just returned from an eight-month study of male infertility in Lebanon, where, as a non-Muslim but Arabic-speaking American woman, I had been able to successfully interview hundreds of mostly Shia Muslim Arab men (Inhorn 2012). This fact, along with my many years of research on, and cultural sensitivity toward, infertility in the Middle East, probably served to increase my perceived trustworthiness. Most people agreed to speak with me, and I often spent hours serving as both an ethnographer and health educator for this infertile Arab refugee population, whose overall medical knowledge and scientific literacy remained low. Indeed, many of my interlocutors wanted to know more about the medical causes of infertility as well as whether there were any forms of health insurance coverage for infertility treatment.

It is important to note, however, that most of the individuals who participated in my study were literate in Arabic, and sometimes English. Thus, they were asked to read and sign informed consent forms in either one of those languages. I made it clear that participation in my study was entirely voluntary, as well as confidential. We always met in a back office space, where we would sit together around a small round table. The ethnographic interviews usually lasted about an hour, but would sometimes take all afternoon, usually when a man, a woman, or couple had much that they wanted to convey to me. I conducted about half of the interviews in English and half in Arabic, sometimes switching back and forth between the two languages, as was common practice in the clinic.

### Structural Vulnerability and Reproductive Exile

For the first three years of my study, I focused primarily on male infertility, asking the men in my study to answer a series of semi-structured research questions covering sociodemographics and sexual and reproductive health. By the end of third year, I dispensed

with the semistructured portion of my study to focus more generally on Arab couples' infertility treatment quests, including any attempts they had made to access IVF or ICSI. Many perceived barriers to medical care were discussed during these interviews, along with other problematic aspects of being infertile in a pronatalist cultural milieu where prolonged childlessness was profoundly stigmatizing, the source of gossip, pity, derision, and even outright social ostracism.<sup>1</sup>

Most striking about my ethnographic study in Dearborn was the amount of suffering revealed in the interviews, especially among infertile men. Reproductive-aged men, most of them in their twenties, thirties, and early forties, had endured many hardships as political refugees, including the trials and tribulations of war, torture, and persecution in their home countries. As in my earlier study in Lebanon, *al harb*, "the war," figured prominently in men's reproductive narratives (Inhorn 2012). Iraqis, in particular, feared that their infertility was somehow due to war-related exposures and traumas. In fact, most of the men and women in my study had emigrated to the United States under conditions of economic or political duress in their home countries, including all of the Iraqis, who had come to the country as official refugees.

Overall, this Arab Muslim refugee population was *structurally vulnerable*—a term forwarded by medical anthropologist Philippe Bourgois and his colleagues to highlight the positionality of marginalized populations within class-based systems of economic exploitation and discrimination (Bourgois and Hart 2011; Quesada, Hart, and Bourgois 2011). Focusing primarily on interactions within the U.S. healthcare system, Bourgois and his colleagues describe structural vulnerability as an individual's social location within society's multiple, overlapping, and mutually reinforcing power hierarchies (e.g., socioeconomic, racial, and cultural) and institutional and policy-level statuses (e.g., immigration status, labor force participation, access to health insurance), which put a patient's health at risk. Thus, structural vulnerabilities lead to "health disparities" (Braveman 2006), which are defined as differences in health status, health environment, and healthcare access, leading structurally vulnerable patient populations to have significantly poorer health outcomes than others.

In my study, numerous structural vulnerabilities and health disparities were clearly at play. Most of my interlocutors were poorly educated, as few of them had attended school in the United States, and few had gone beyond high school in their home countries. With-

out good English skills or advanced educations, most of the Arab men in my study were employed in low-wage, blue-collar, or service-sector occupations, mainly as gas station attendants, dishwashers and busboys in Middle Eastern restaurants, truck drivers, construction workers, auto mechanics, used car salesmen, or factory workers. Salaries were generally low, with many men and their wives living in small apartments in Dearborn and generally eking out subsistence livings below the poverty line. With accelerating problems in the Detroit-based auto industry beginning in the early 2000s, unemployment rates in this community began to skyrocket by 2005. Several of the Arab men in my study had lost their jobs and were living off a combination of unemployment and Social Security benefits and, in a few cases, welfare and food stamps.

Without regular employment, most of the Arab men and women in my study did not have private health insurance to cover the costs of their medical care. Most did not own credit cards. As a result, virtually all of their financial transactions, including visits to medical clinics, were handled in cash. In cases of medical emergency, financial and social safety nets were generally missing, forcing some participants in my study to rely on local Islamic charities for relief.

In general, the Arab Muslim men and women in my study described their lives as "hard" and "stressful." Traumatic conditions had forced them to flee their home countries in the Middle East, but once they arrived in the United States, they found themselves mired in multiple, overlapping forms of structural vulnerability—un- and underemployment, economic deprivation, educational deficits, linguistic and cultural barriers, social discrimination and exclusion, and lack of adequate social support.

Furthermore, all of the participants in my study could be considered "reproductively vulnerable," because they were facing persistent, often intractable, infertility problems in an unforgiving social environment in which parenthood was culturally expected and long-term childlessness socially stigmatized. Virtually all of my interlocutors required IVF or ICSI to overcome their difficult infertility problems. Yet, they were living in the most expensive country in the world in which to make a test-tube baby.

I came to think of these poor, struggling, infertile refugees as "reproductive exiles." On the one hand, they were forced to leave their home countries because of war and political violence. But once they arrived in the United States, they found themselves stranded—unable to return to their home country because of the ongoing violence but unable to access infertility services due to their structural

vulnerability within the U.S. healthcare system. Exile, thus, had two meanings for this population: first, the forced removal from one's home country, with little hope of return; and second, the feeling of being forced out of an inaccessible health care system, in which the "hope technology" of IVF (Franklin 1997) and the "masculine hope technology" of ICSI (Inhorn 2016) remained distant and fleeting mirages. This sense of reproductive exile—of being unable to access IVF or ICSI in the United States, but being unable to return home to embattled countries with shattered healthcare systems—comes closest to representing my infertile Arab interlocutors' own subjectivities, even though this is my term, not theirs. Furthermore, the cruel political paradoxes of this reproductive exile were manifold. To wit, it was the U.S. host country that had destroyed Iraq's infrastructure, including its healthcare system. The U.S. invasion of Iraq led to the destruction of an estimated 12 percent of Iraq's hospitals and primary care centers (Sadik et al. 2011). Furthermore, although Iraq was once considered a regional leader in medicine, much of this capacity was destroyed by war, including in the nascent Iraqi IVF sector.<sup>2</sup>

### **Male Reproductive Agency: Searching for Love and Test-Tube Babies**

Having nowhere to return to, the infertile Arab refugee men in my study were active seekers of reproductive health care, often coming alone to the IVF Michigan clinic to consult with the male Lebanese IVF physician. Once there, these men were willing to subject their bodies to a variety of reproductive diagnoses and treatment, often undergoing repeated rounds of semen analysis, genetic analysis, and hormonal therapies and painful testicular biopsies and aspirations. In short, these Arab refugee men were willing to put their reproductive bodies on the line. Such "male reproductive agency" is rarely portrayed in studies of Arab men or in anthropological studies of reproduction more generally (Gutmann 2007; Myntti et al. 2000). However, Arab Muslim men are often caring and concerned reproductive agents (Inhorn 2012). Such male reproductive agency entails love and sacrifice, embodied interventions and agony, and care and concern for the well-being of both wives and children. In some cases, Arab men's reproductive agency also involves heartbreaking compromises and sacrifices, including "freeing" wives from childless marriages when male infertility is deemed hopeless.

Here, I have chosen to present three stories of Iraqi men, all of whom fled to the United States in the aftermath of the First Gulf War. Two of these men were severely infertile; they had come to the clinic alone, where I met them. In the third case, I met with the husband and wife together. The first story is about a religious cleric still searching for love, passion, and fatherhood. The second story is about a former Shia resistance fighter, who blames himself for his infertility and hopes ICSI will assuage his guilt. The final story is about an Iraqi refugee couple, who threw caution to the wind to make a test-tube baby. All of these Iraqi refugees had painful stories to tell, but, as we will see, none of them had given up hope of making families and new lives in America.

#### ***The First Story: Shayk Ali and His Search for Love***

Spring was just around the corner in Michigan when I ventured to Dearborn on an overcast day in May. Upon my arrival, the clinic staff told me that someone had come to the clinic especially to meet me, after he had read my study ad posted in the clinic's waiting area. This volunteer was Ali, and as I was soon to discover, he was a religiously trained Iraqi Shia Muslim shaykh (cleric). This tall, substantial man—standing well over six feet tall—in his black suit and white dress shirt and with a closely trimmed beard was an imposing figure. Yet, as we sat together in a private space in the clinic, it became clear that Shaykh Ali was a broken man, with a life story that was quite tragic.

Shaykh Ali had been born in southern Iraq to a large family of six sons and six daughters. In the early years of Iraq's Baathist political regime, even poor Shia families were able to educate their children, sons and daughters, under the social welfare system. So Ali and all of his brothers were sent to the University of Baghdad, where they earned master's degrees in engineering. However, before they attended college, Ali and his brothers had studied in a Shia madrasa in the holy city of Najaf, where Ali had learned to read and interpret the Qur'an. He graduated as a Shia cleric in 1985, six years before the First Gulf War, an event that would change his life forever.

When U.S. troops invaded Iraq at the end of 1990, the U.S. government armed both the Shia Muslims in southern Iraq and the Kurds in northern Iraq, encouraging them to rise up against the regime of Saddam Hussein. Shaykh Ali's religiously trained family members did not fight but were caught in the postwar dragnet. Targeted by Saddam's regime for being religious Shia Muslims, Shaykh Ali and two of his brothers were sent to prison. The two brothers—

both shaykhs, both engineers, and both young fathers of two children—were killed, news that made their elderly father go blind instantly. Shaykh Ali survived his three years of imprisonment, but he was brutally beaten and tortured in a small, dark “dungeon,” where he lived from 1991 to 1994. Upon his unexpected release, he fled to neighboring Syria and then to Lebanon, where the large Shia Muslim community took him in on a temporary basis. Soon thereafter, he was granted political asylum in the United States and was resettled as a refugee in Arizona.

In Arizona, Shaykh Ali met his future wife, Nadia, also a resettled Iraqi refugee. Shaykh Ali and Nadia loved each other and were physically passionate, sometimes making love two to three times a day. This was partly intended to conceive a child, which both of them ardently desired. However, Shaykh Ali’s undisclosed medical past caught up with him early on in the marriage. Shaykh Ali had been born with undescended testicles, a medical condition that should have been surgically corrected when he was still an infant (to bring the undescended testes down into his scrotum). By the time he entered college, Ali realized that something was wrong, so he sought a doctor’s advice and was told to undergo semen analysis. “That was in 1983, twenty-two years ago, when I did my first test in Iraq and they found no sperm,” he said. “That day was very sad, very sad. The doctor explained, ‘No, nothing!’ and I cried.” Although Shaykh Ali had undergone a corrective testicular surgery, called orchiopexy, when he arrived as a refugee in Lebanon, he also underwent a testicular biopsy, in which small samples of his testicles were removed in an attempt to find any existing sperm. Again, no sperm were found.

Shaykh Ali went on to marry Nadia, hoping that some future scientific discovery would “cure” him. For example, he had read about a football player in California who had injured his testicle but who had undergone a supposed testicular transplant from his brother. Shaykh Ali wondered if this was a common operation (it is not), for which he would eventually become eligible.

Meanwhile, Shaykh Ali’s wife Nadia was becoming desperate to have children, given the scrutiny of her childlessness in the growing Iraqi refugee community in Arizona. Although she loved her husband, she loved children even more, telling him, “I need a baby.” Eventually, she exercised her right to divorce within the American judicial system, leaving Shaykh Ali after three years of marriage. She remarried quickly and became the mother of two children. Out of love and compassion for her first husband, she continued to call

Shaykh Ali, letting her young children speak to their “uncle” on the telephone.

To mend his broken heart, Shaykh Ali moved to the much larger Iraqi refugee community in Arab Detroit. There, he knew no one, but he found easy employment as a clerk in a Lebanese-owned gas station. In his job, he earned \$500/week, barely enough to cover his rent (\$700/month), his food (\$300/month), his car payments and gasoline (\$300/month), and remittances to his elderly, disabled parents in Iraq (\$200/month). Ever since he fled Iraq, Shaykh Ali had not worked as either an engineer or a Muslim cleric, the two professions for which he was highly trained.

However, Shaykh Ali’s biggest problem was his inability to remarry. “There are lots of women in Iraq,” he said, “but they all want children. There is no Iraqi woman who does not want to be a mother.” Shaykh Ali was not opposed to marrying a divorcee or a widow with children, even if American. Indeed, during our conversation, Shaykh Ali asked me if I was married (“yes”) and then if I could help him to find an American wife. “My health is very good,” he explained. “Every day, I wake up with an erection. I am *strong*. My sex drive is very good. But for the past six years in America, I’ve not used it. I *need* a wife. I need one *now*. Any wife, American or Iraqi, Muslim or not. It doesn’t matter to me. Can you help me?”

I told Shaykh Ali that I would contact a friend, a widowed Sunni Muslim woman with children, who also hoped to remarry. Meanwhile, I asked Shaykh Ali if he was allowed to masturbate to relieve his sexual tension. “No, this is haram [religiously forbidden],” he explained. “I cannot do this.” Instead, he told me, that semen was being released “naturally,” through nighttime emissions, which were occurring once or twice each week.

Furthermore, during the afternoon’s office visit, Shaykh Ali had been advised by one of the clinic staff to consider using sperm donation. “It’s difficult,” Shaykh Ali confided to me afterward:

In Iran, Ayatollah Khamenei says it’s halal [religiously permitted]. But it’s a problem. For example, if the [infertility] problem was from your husband, would you get donor sperm? It’s hard. I love science, but it is very difficult for me to accept this [donor sperm]. After [the doctor] suggested this, my self-feeling was very bad. My psychological state is now very bad.

I left Dearborn on that cold spring afternoon feeling very sorry for Shaykh Ali and his plight. As promised, I contacted my widowed friend to see whether she would be interested in meeting him as a

prospective husband. However, as a devout Sunni Muslim woman, she could not imagine herself being married to a devout Shia Muslim cleric. She declined my offer of an introduction to Shaykh Ali, a self-described *miskiin*, or "poor one," in every sense of that term.

### *The Second Story: Ibrahim and His Search for ICSI*

Whereas Shaykh Ali had suffered in Iraq because of his religious convictions, Ibrahim, a 37-year-old Iraqi refugee, had suffered as a freedom fighter. As a young man in Basra, Iraq, Ibrahim had joined the Shia resistance, participating in the *intifada* (uprising) to remove Saddam Hussein from power following the First Gulf War. Ibrahim was shot in the pelvis and spent four months in a Basra hospital following surgery to remove the bullet fragments. But shortly after Ibrahim's release, Saddam's forces crushed the Shia-led uprising. Ibrahim fled to Saudi Arabia with thousands of other Shia fighters. There, he lived in an isolated, desert refugee camp in appalling conditions. However, it was back in Iraq that Ibrahim's family faced Saddam's revenge. Ibrahim's older brother, the father of four young children, was taken from his home by soldiers. As Ibrahim lamented, "I lost my brother because of me. After I left, they took him. He has four children, and they never heard from him again."

Ibrahim could not go back to Iraq. So, after six years in Saudi confinement, he was admitted to the United States as a refugee. Already thirty years old, Ibrahim had experienced sexual intercourse only twice in his life, both times back in Basra before the First Gulf War. With his arrival in America, however, Ibrahim soon discovered the "open" sexual environment of the United States. With his good looks and decent English skills—acquired as an engineering student in Iraq—Ibrahim was considered attractive by American women. Thus, Ibrahim began having numerous sexual liaisons, a fact that he confessed sheepishly. "I am blaming myself. My libido is high, and maybe I 'spent' all of my sperm back before marriage, because I had an active sex life. I don't know, sometimes. I did what I did, but it wasn't right . . . maybe God wants to punish me."

Ibrahim then went on to describe how he had once loved a young woman from Missouri, the state where he was initially resettled. But the steering wheel on a U-Haul truck he was driving locked in place, causing the truck to crash, which killed his American girlfriend in the passenger seat. Ibrahim spent a year in the hospital with multiple fractures. But the death of his girlfriend caused Ibrahim significant stress; now he felt responsible for the loss of two loved ones.

During his recuperation, Ibrahim spoke to his father back in Iraq. "Why do you have such a tough life?" his father asked him. "You need to settle down." The family began looking for an Iraqi wife, one who would be willing to move to America to be with Ibrahim.

After his release from the hospital, Ibrahim eventually moved to Arizona and then to Dearborn to be part of a larger Iraqi refugee community. There, he began thinking about marriage, and he let his family intervene. This is how Ibrahim met Amira, his younger sister's friend and a high school chemistry teacher in Basra. Amira and Ibrahim courted for several months by long-distance telephone calls before he eventually traveled to Jordan to meet her and sign the marriage contract.

Although it took several months, Amira eventually joined Ibrahim in Dearborn as his wife. But after a year of living together, with sex almost every day, Amira was not getting pregnant. Haunted by his sexual past, Ibrahim suspected that he might be infertile. He came alone to the Dearborn IVF clinic, where he underwent a semen analysis.

I happened to meet Ibrahim soon after he had received the devastating news of his very low sperm count. Ibrahim lamented to me:

I was shocked. I cried, 'cause I want a baby. I feel upset. I feel like I'm not a normal person. She [Amira] is the strong one. She said, "I don't care, as long as I have you. We do our best, and that's it." But, especially among Arab people, I feel like I'm not a man. It's a bad feeling. I don't know where it comes from, but I feel this.

At this point, I wanted to offer Ibrahim some kind of solace, so I told him, "But it's just a medical condition like any other condition." He then replied, "Well, this helps to calm me down. I *am* beginning to feel like that—like some people are born and don't have nice hair. It's just something I'm born with."

Whether Ibrahim truly believed that his male infertility was a medical condition and not God's punishment for his past, it was telling that when I met him he was seeking medical therapy, hoping to activate his sperm production by taking medication. Although the Lebanese doctor could offer him no such miracle cure, Ibrahim was attempting to achieve reproductive success. His most ardent desire, he told me, was to father one or more test-tube babies.

To that end, Ibrahim was trying to earn money at a local Arab-owned computer firm, while also finishing his computer science degree at a local community college. However, he made only \$1,500 a month—not enough to cover his household expenses and the re-



mittances his large Iraqi family expected him to send back to his home country. Furthermore, his employer offered no health insurance, leaving him uninsured for the past four years.

When Ibrahim was told that he would need a \$15,000 cycle of ICSI with accompanying medications, he was shocked. "I *could* do it if it costs \$5,000," he explained, "because I might be able to save the money or borrow the money from a friend. But \$15,000, no way." Indeed, unless and until Ibrahim's fortunes somehow changed, he and Amira were living in a state of reproductive exile, effectively banished from the world of test-tube baby making, with no way for Ibrahim to achieve fatherhood or a sense of atonement for his feelings of having sinned.

### *The Third Story: Sadiq and Fatima and Their Search for a Test-Tube Baby*

Like Ibrahim, both Sadiq and Fatima had grown up in Basra and had been forced to flee with their families during the failed Shia intifada against Saddam Hussein. Having spent their formative preteenage years in a Saudi refugee camp, Sadiq and Fatima eventually moved with their families to Lincoln, Nebraska, the city that granted them asylum. When I asked Sadiq and Fatima why they were resettled in America's heartland, Sadiq replied, "I don't know why. Why there? They just picked Lincoln, Nebraska, I guess." Fatima added, "Now Nebraska is supposed to be a good place for Iraqis. But when we were there, back in the early nineties, there were very little, not too many Arabs." For that reason, Fatima's family left Lincoln for Philadelphia within a year but decided to move permanently to Dearborn, with its growing Iraqi refugee population.

Sadiq's family stayed in Lincoln for several years, and Sadiq was somewhat nostalgic about his early days in Nebraska. Although he had not been able to go to high school or to learn English fluently, Sadiq was able to obtain meaningful employment in Lincoln's Kawasaki factory, which manufactured all-terrain vehicles. "I never looked for a job. The job looked for me!" Sadiq exclaimed. But then he added quietly, "Now I look for it, but I can't find it."

As I soon discovered, Sadiq was currently unemployed. When he had moved with his family to Dearborn seven years earlier, he had begun working as a baker in a Lebanese restaurant before landing a factory job in a company making plastic parts for the local automotive industry. As good factory jobs with accompanying benefits were hard to find in Michigan's depressed economy, Sadiq had been lucky to secure this kind of stable employment. He used his job to

save money for his marriage. He also took a second night job in a Lebanese-owned gas station.

Through connections in the local Iraqi community, Sadiq met Fatima and married her on a cold winter day in January, shortly before he turned thirty. Sadiq was attracted to Fatima not only for her beauty but because she was smart and was one of the few Iraqi refugee women attending the local branch of the University of Michigan. Fatima applied herself to her studies and was well on her way to obtaining a bachelor's degree in information technology management. In addition, Fatima had obtained a coveted government position at the state's unemployment agency. Being fully bilingual, Fatima was able to help local Arab refugees and immigrants fill out their unemployment forms. Fatima's position provided her with health insurance benefits and allowed her to pay her own way through college, as her father could not afford the tuition bills.

Sadiq and Fatima began their marriage with the highest of hopes. They both had good jobs with benefits. Fatima was on track to graduate from college. And in a depressed housing market with low interest rates, the couple was able to buy a small house on a tree-lined street in a mostly Lebanese Shia neighborhood. Living apart from their large families for the first time in their lives, Sadiq and Fatima also had some measure of marital privacy. Like most Arab newlyweds, they started trying to make a family from the first day of marriage.

But a year and a half later, the couple's plans had gone terribly awry. Metro Detroit was in an economic freefall. Sadiq's factory job, reliant on the local GM and Ford factories, swiftly disappeared due to downsizing. Furthermore, Sadiq was disturbed by the fact that he had not been able to impregnate Fatima, who was being scrutinized by women in the community for not becoming pregnant. Although Sadiq's wages as a gas station attendant were meager, he encouraged Fatima to make an appointment for both of them at the local infertility clinic.

Although the Lebanese IVF physician explained to Sadiq and Fatima that they might eventually become pregnant without the help of IVF or ICSI, they were anxious to start a family. Throwing caution to the wind, they decided to put all of their remaining savings—\$10,000, to be exact—into the purchase of a single IVF cycle, a procedure that was not covered by Fatima's health insurance plan. Furthermore, Fatima lost that plan when she decided to cut back to half-time employment. With the daily blood tests, ultrasounds scans, and hormone injections, fitting her medical appointments into a full-

time work schedule was too difficult. Moreover, Sadiq lost his gas station job soon after Fatima began the IVF cycle. But because they were already committed—and had paid fully for the IVF—they decided to press forward.

The IVF cycle seemed to be going well. Because Fatima was still young, in her late twenties, she produced twenty-six healthy eggs, a considerable number, which were retrieved from her ovaries in an outpatient procedure that was performed under general anesthesia. However, two days later, when Fatima was scheduled for the transfer of the embryos back into her uterus, she began to feel unwell. Her abdomen became extremely bloated, and she found herself gasping for breath. In addition, severe pain and cramping in her lower abdomen and legs meant that she could not walk, or even stand, on her own.

Realizing that something was terribly wrong, Sadiq rushed Fatima to the emergency room of the local Dearborn hospital, where she was admitted for ovarian hyperstimulation syndrome (OHSS). OHSS is a rare but potentially fatal complication resulting from some forms of fertility medication, and Fatima's case was severe. She experienced marked abdominal bloating above the waist and shortness of breath due to pleural effusion, or the buildup of excess fluid in her lungs. Fatima described the medical emergency—and the unpaid hospital bill totaling thousands—to me in this way:

This is the worst time *ever* in both of our lives. I *never* got that much sick before. This was the toughest time I've ever had. And I had spent a lot of time coming for ultrasounds and bloodwork. It was costly, painful, and also time-consuming. Every other day, I was doing treatment. But no one knew, not even the family. It was too personal, and I wanted to keep this to ourselves. Also, I had been working full time for the state. But because we wanted to start a family, I cut to part time and lost my state benefits. We started treatment from our own pockets. But when we left the hospital, the hospital bill was still unpaid. We're going to have to ask a charity to help pay for our hospital bills. It's a charity in the hospital. They will pay for the stay, but you have to prove that you're low income or not working. I wasn't expecting that I'm going to get sick when I saved just enough money for the *in vitro*. The IVF was maybe \$10,000, all totaled with the medicine. At least that is paid for. But now we're so broke that I can't go back to school in the fall. . . . I was planning to graduate on time, but this is never going to happen.

Because Fatima had revealed their financial woes to me, I asked the couple if their families could help provide them with any form of

financial support. Sadiq was the first to respond, explaining how the Michigan economy was sinking:

Businesses around here keep laying people off. So there are not that many people who can help us in our families. If we have no choice, then I've got to go to my family. But first, I must try my best. We just bought a house, but now she's sick, and I never thought this would happen.

Moreover, Sadiq and Fatima had just received totally unexpected news that very afternoon—namely, Fatima was pregnant, even though none of her IVF embryos had been transferred to her womb in the midst of her life-threatening OHSS emergency.

Although I was happy for this young Arab refugee couple—who had faced a perilous journey and so many subsequent difficulties—I was confused about Fatima's "mystery" pregnancy. Fatima explained to me that the doctor had told them to refrain from sex during the IVF cycle. But, once again, they had thrown caution to the wind. One episode of unprotected sex had resulted in an unplanned pregnancy—a "natural" pregnancy that had withstood the rigors of IVF hormonal stimulation and a severe case of OHSS.

As the clinic was about to shut its doors for the weekend, I asked Fatima how she was feeling about the pregnancy. "I didn't know I was pregnant," she explained. "It was a surprise, an unexpected surprise!" Sadiq added, "Oh yeah, it was the lucky nine, the lucky shot!"

Fatima was still feeling sick and distended from the OHSS. Sadiq was still unemployed with no idea where he would find another job. The couple's mortgage and hospital bills were unpaid, and they were now facing the real risk of bankruptcy and housing foreclosure. In fact, they were stuck—pregnant and sick, unemployed and broke.

Still, on that summer afternoon, I couldn't help but notice that Fatima and Sadiq were beaming. They had each other. They had a miraculous pregnancy. And they now had hopes and dreams of a future baby—to be born safe but poor on the margins of Detroit.

## Conclusion

The goal of this chapter is to render visible the overwhelming problems faced by many Arab refugees who come to the United States in their darkest hour of need. I attempt to link issues of refugee resettlement, structural vulnerability, and reproductive exile through

a focus on the plight of infertile refugees—and particularly the travails of Iraqi refugee men—who were attending the Arab-serving IVF clinic where I conducted my study in Arab Detroit.

Despite their many hardships, most of these Iraqi refugee men were reproductively agentic, doing the best they could to overcome their infertility problems. Yet, for most, the solution to their infertility, IVF or ICSI, was out of reach. Thus, the men and women in my study were caught in a state of reproductive exile—unable to return to war-torn countries, yet unable to gain access to the promises of American reproductive medicine. Unable to go “back home” but unable to feel entirely “at home” in America as impoverished, childless refugees, my interlocutors existed in a kind of liminal state, which I characterize in this chapter as reproductive exile.

For Iraqi refugee men who have suffered so much—including war, torture, and flight—their search for love and test-tube babies is an existential quest, an attempt to make meaning and new life in the aftermath of all that has been lost. Thus, for them, reproductive exile is a tragic condition of liminality—of being “stuck” betwixt and between two countries, in an unwanted, untreatable state of barrenness, in a cultural and social world where children mean so much.

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## Notes

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1. I have written a great deal about the profound desire for children among Arab populations in a variety of Middle Eastern countries, including Egypt, Lebanon, and the United Arab Emirates (Inhorn 1996, 2012, 2015). In Arab Detroit, I found the same ardent “child desire” among infertile couples who were often desperate to conceive. Those who did not often faced social scrutiny within the community.
2. The Middle East as a whole hosts a flourishing IVF industry (Inhorn 2003, 2012, 2015). However, the Iraqi IVF sector was destroyed by war, leaving only one functioning clinic in Iraqi Kurdistan.

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