



Medical Anthropology

Cross-Cultural Studies in Health and Illness

ISSN: 0145-9740 (Print) 1545-5882 (Online) Journal homepage: <http://www.tandfonline.com/loi/gmea20>

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To cite this article: Marcia C. Inhorn (2018) Searching for Love and Test-Tube Babies: Iraqi Refugee Men in Reproductive Exile on the Margins of Detroit, *Medical Anthropology*, 37:2, 145-157, DOI: [10.1080/01459740.2016.1276904](https://doi.org/10.1080/01459740.2016.1276904)

To link to this article: <https://doi.org/10.1080/01459740.2016.1276904>



Accepted author version posted online: 06 Jan 2017.
Published online: 13 Feb 2017.



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Searching for Love and Test-Tube Babies: Iraqi Refugee Men in Reproductive Exile on the Margins of Detroit

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ABSTRACT

In this article, I explore the reproductive health problems faced by Iraqi refugees, one of America's most rapidly growing immigrant populations. Based on anthropological research in "Arab Detroit," the "capital" of Arab America, I explore the experiences of Iraqi refugee men seeking medical help for their infertility. Most required intracytoplasmic sperm injection (ICSI), a variant of in vitro fertilization (IVF). However, in America's privatized medical system—where a single cycle can cost more than \$12,000—few could possibly afford this assisted reproductive technology (ART). Although Iraqi refugees had diasporic dreams of making a test-tube baby, they were stuck in a situation of "reproductive exile"—forced out of their home country by war, but unable to access costly ARTs in the country that led to their displacement. I elaborate on the concept of reproductive exile, attempting to translate Iraqi refugee men's reproductive agency and desires, but also their profound disappointments.

KEYWORDS

Detroit; Iraqi refugees; assisted reproductive technologies; male infertility; reproductive exile; structural vulnerability

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 came as families. Others, especially young Iraqi men, did not; many 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 US forces as translators, drivers, and guides (Campbell 2016). Still others were civilian noncombatants, who were 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 US Refugee Admissions Program. Others took circuitous routes, finding a permanent home in Michigan only after an initial placement in another state. In most cases, they 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).

In this article, I focus on Iraqi refugee life in Arab Detroit. Iraqi refugees there have been described as a "forgotten" population (Human Rights Institute 2009:1), one that faces high rates of unemployment, life below the US federal poverty line, lack of medical insurance, and inability to access America's fee-for-service, privatized health care 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 US health care system, but unable to return to their "home" country to seek medical care, infertile Iraqi refugees exist in a liminal state, one that I characterized as "reproductive exile." Iraqi

refugee men in particular, who, as I will explain, face high rates of male infertility, in their attempts to seek treatment, demonstrate their reproductive agency, despite many obstacles to reproductive success.

In this article, I explore 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, 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 US health care 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 are replete with agency and hope, but also highlight their disappointments 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, 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 children take the flight of circular stairs to the second floor, hoping to pass by unnoticed as they enter the 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" to protest the 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 50 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 five 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 US 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 versus 31 percent of the overall population (Schopmeyer 2011).

These Lebanese and Iraqi refugees settled primarily in Dearborn, a Detroit suburb 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. However, 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, including clothing stores, restaurants, and bakeries, and a multitude of services for Arabic-language speakers, including immigration and legal aid, medical facilities, a refugee assistance program, and a number of Islamic schools and mosques, including the Islamic Center of America, the largest mosque in North America.

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, leaving 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 US-led war in Iraq. Indeed, despite the initial US government reluctance to take in any more fleeing Iraqi refugees, by 2008 and 2009, fully one-quarter of all refugees entering the United States were Iraqis, with Arab Detroit taking its full share, nearly as many as the cities of New York, Chicago, and Los Angeles combined (Schopmeyer 2011). Although Arab populations can be found across all 50 US states, the largest concentrations live in California, Illinois, Michigan, New York, and Texas. Most Iraqi refugees have been resettled in California, Michigan, and Texas, although they, too, are spread across 50 states (Svab 2013).

Most of these Shia Muslim Arab refugees have eventually applied for US citizenship, a process that can take place after a five-year mandatory legal residency period. Rates of US 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 US citizenship gains, these families live in poverty. Whereas the median household income in the United States is \$53,657, and the US 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 households 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), and by March 2011, the 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 the major US 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 is in stark contrast to the predominantly white suburbs of Detroit, where just 5 percent of residents live in poverty.

Infertile refugees: An Arab Detroit study

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 above. 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 this 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 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, although most cases are genetically based, involving microscopic deletions on the Y chromosome. In the Middle East, such genetic mutations are linked to high rates of consanguineous

(i.e., cousin) marriage, which increases the risk for genetic defects overall. As a result, male infertility often clusters in families and 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 medication or surgery. Instead, the only way to overcome most serious cases is through an assisted reproductive technology (ART) called intracytoplasmic sperm injection (ICSI), a variant of IVF designed specifically for male infertility problems.

With ICSI, women undergo hormonal stimulation to produce excess oocytes (eggs). Through a transvaginal operation requiring general anesthesia, these eggs are 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 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 95 Arab patients—55 men and 40 women, most of whom came to the clinic as couples and I interviewed together, but some of whom came alone, including 18 infertile men and 4 infertile women whom I interviewed separately. Of all the men in my study, 42 (76 percent) were facing infertility problems, a statistic speaking to the high prevalence of male infertility among this Arab population.

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). I also interviewed a small number of Palestinians (6 percent), and 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, exacerbated by the 2003 US invasion of Iraq. At the same time, the Michigan economy was beginning to deteriorate, as Detroit's auto industry spiraled downward. In 2013, US President Barack Obama helped 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—the largest municipal bankruptcy in US history, in terms of both the size of the city and the size of its debt, which was estimated at \$18–\$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 Shyrock 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). My own interlocutors in Arab Detroit faced a great deal of hardship: most were precariously employed, and often desperately poor. Moreover, I heard many stories of sadness and despair, resulting in part from their refugee status. Most Iraqi refugees, and many of the Lebanese in my study, had come to America within the past 10 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 the many struggles that they were facing. However, 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 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, assisted reproductive technologies that are extremely expensive in the United States—at an average of cost of \$12,513 per cycle, the most expensive in the world (Connolly et al. 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. At this time, the Lebanese doctor would drive down from IVF Michigan’s main headquarters in an affluent northern Detroit suburb to see his poor Arab patients. At the Dearborn office, he or the clinic administrator (a Lebanese Shia Muslim woman) would introduce me to patients who were willing to be part of 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 population, whose overall medical knowledge and scientific literacy remained low. Many of my interlocutors wanted to know more about the medical causes of infertility, as well as whether any forms of health insurance coverage were available for infertility treatment.

Most 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 and 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 socio-demographics and sexual and reproductive health. By the end of the third year, I dispensed with the semi-structured 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.¹

What was most striking about this study was the amount of suffering revealed in the interviews, especially among infertile men. Reproductive-aged men, most 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, *il 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 United States as official refugees.

Overall, this 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 US health care 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 person's health at risk. Structural vulnerabilities lead to "health disparities" (Braveman 2006), which are defined as differences in health status, health environment, and health care 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 had attended school in the United States, and few had gone beyond high school in their home countries. Without 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 lives below the poverty line. With accelerating problems in the auto industry from the early 2000s, 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. Most men and women did not have private health insurance to cover the costs of their medical care. Most did not own credit cards, and 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 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," given that they were 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 participants 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": forced to leave their home countries because of war and political violence, and on arrival in the United States, 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 US health care 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, where 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 comes closest to representing my infertile Arab interlocutors' own subjectivities, even though this is my term, not theirs. The cruel political paradoxes of this reproductive exile were manifold. The US "host" country had destroyed Iraq's infrastructure, including its health care system, and 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 the US military intervention, including in the nascent Iraqi IVF sector.²

Male reproductive agency: Searching for love and test-tube babies

Having nowhere to (re)turn, the men in my study were nonetheless active seekers of reproductive health care, often coming alone to the IVF Michigan clinic to consult with the male Lebanese IVF physician. Once there, they were willing to subject their bodies to a variety of reproductive diagnoses and treatment, often undergoing repeated rounds of semen analysis, genetic analysis, hormonal therapies, and painful testicular biopsies and aspirations. In short, they 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 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, their 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 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, hoping 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 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: Shaykh 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, 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. 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.

When US troops invaded Iraq at the end of 1990, the US 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 post-war 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. 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 release, he fled to neighboring Syria, then 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 resettled 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 marriage: he 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, 22 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 Ali had undergone a corrective testicular surgery (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

married 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, Nadia was becoming desperate to have her own 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, becoming 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 the \$200 monthly remittances to his elderly, disabled parents in Iraq. Ever since he fled Iraq, Shaykh Ali had not worked either as an engineer or as a Muslim cleric, the two professions for which he was highly trained.

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 an American. Indeed, during our conversation, Shaykh Ali asked me if I was married (“Yes”), and then if I could help him 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, the sperm were being released “naturally,” through nighttime emissions, once or twice each week.

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 Khamene’i 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 Shaykh Ali 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.

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, spending four months in a Basra hospital following surgery to remove the bullet fragments. However, 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, back in Iraq, 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 30 years old, Ibrahim had experienced sexual intercourse only twice in his life, both times in Basra before the First Gulf War. On arrival in America, Ibrahim discovered the “open” sexual environment of the United States. With his good looks and decent English skills—acquired as an engineering student in Iraq—he was considered attractive by American women, and as he confessed sheepishly, he began having numerous sexual liaisons. “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 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 and killing her in the passenger seat, causing Ibrahim significant stress and feelings that he was now responsible for the loss of two loved ones. Ibrahim spent a year in the hospital with multiple fractures. 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 willing to move to America to be with Ibrahim.

After his release from the hospital, Ibrahim moved to Arizona, then to Dearborn. 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. Several months later, Amira joined Ibrahim in Dearborn as his wife. However, 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 infertility was a medical condition and not God’s punishment for his past, it was telling that he was seeking medical therapy when I met him, hoping to “activate” his sperm production by taking medication. Although the Lebanese doctor could not offer a miracle cure, Ibrahim was attempting to achieve reproductive success. His most ardent desire, he told me, was to become the father of one or more test-tube babies. To that end, he was trying to make some money at a local Arab-owned computer firm, while also finishing his computer science degree at a local community college. However, he made only \$1500 a month—not enough to cover his household expenses, as well as the remittances his large Iraqi family expected him to send back home. Furthermore, his employer offered no health insurance, so he had been 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 \$5000,” 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

preteen years in a Saudi refugee camp, they 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 '90s, 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, he was nonetheless 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 30. 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 was well on her way to obtaining a bachelor's degree in information technology (IT) management. In addition, she had obtained a coveted government position at the state's unemployment agency, and being fully bilingual, she 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, they also had some measure of marital privacy. Like most Arab newlyweds, they started trying to make a family from the first day of marriage.

However, 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, 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 quite 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. To add insult to injury, 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 itself seemed to be going well. Because Fatima was still young, in her late twenties, she produced 26 healthy eggs, a considerable number, which were retrieved from her ovaries in an

outpatient procedure 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 most 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 responded, 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, that 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. 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, 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

My goal in this article has been to render visible the overwhelming problems faced by many Arab refugees who have come to the United States in their darkest hour of need. I have attempted 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 agentive, 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 have characterized in this article 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. 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.

Notes

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 profound 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.

Acknowledgments

I am grateful to the Iraqi refugees who shared their often painful stories with me at IVF Michigan. This study was made possible by the IVF Michigan staff, especially Dr. Michael Hassan Fakih and Hanaa Hijazi. Thanks also go to Linda Rae Bennett and Bregje de Kok for including me in this special issue and for their thoughtful editorial comments and advice. I also appreciate the editorial guidance of *Medical Anthropology*'s Editor Lenore Manderson and Editorial Assistant Victoria Team.

Funding

This research was funded by two generous grants from the Cultural Anthropology program of the US National Science Foundation.

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References

- Abbey-Lambertz, K.
 2014 Most Detroit families can't afford their basic needs: Report. The Huffington Post, September 15.
- Abraham, N., S. Howell, and A. Shryock, eds.
 2011 Arab Detroit 9/11: Life in the Terror Decade. Detroit, MI: Wayne State University Press.
- Abraham, N. and A. Shryock, eds.
 2000 Arab Detroit: From Margin to Mainstream. Detroit, MI: Wayne State University Press.
- Bouffard, K.
 2015 Census bureau: Detroit is poorest big city in US. The Detroit News, September 17.
- Bourgois, P. and L. K. Hart.
 2011 Commentary on Genberg *et al.* (2011): The structural vulnerability imposed by hypersegregated US inner-

- city neighborhoods—A theoretical and practical challenge for substance abuse research. *Addiction* 106:1975–1977.
- Braveman, P.
2006 Health disparities and health equity: Concepts and measurement. *Annual Review of Public Health* 27:167–194.
- Buchmueller, T. C., Z. M. Levinson, H. G. Levy, and B. L. Wolfe
2016 Effects of the Affordable Care Act on racial and ethnic disparities in health insurance coverage. *American Journal of Public Health* 106:1416–1421.
- Campbell, M. O.
2016 *Interpreters of Occupation: Gender and the Politics of Belonging in an Iraqi Refugee Network*. Syracuse, NY: Syracuse University Press.
- Connolly, M. P., Hoorens, S., and G. M. Chambers
2010 The costs and consequences of assisted reproductive technology: An economic perspective. *Human Reproduction* 16:603–613.
- Davey, M.
2014 Detroit is out of bankruptcy, but not out of the woods. *New York Times*, December 10.
- Detroit Arab American Study Team
2009 *Citizenship and Crisis: Arab Detroit after 9/11*. New York: Russell Sage.
- Franklin, S.
1997 *Embodied Progress: A Cultural Account of Assisted Conception*. London: Routledge.
- Gutmann, M.
2007 *Fixing Men: Sex, Birth Control, and AIDS in Mexico*. Berkeley, CA: University of California Press.
- Human Rights Institute, Georgetown University Law Center
2009 *Refugee Crisis in America: Iraqis and Their Resettlement Experience*. Washington DC: Georgetown Law Library.
- Inhorn, M. C.
1996 *Infertility and Patriarchy: The Cultural Politics of Gender and Patriarchy in Egypt*. Philadelphia, PA: University of Pennsylvania Press.
- _____.
2003 *Local Babies, Global Science: Gender, Religion, and In Vitro Fertilization in Egypt*. New York: Routledge.
- _____.
2012 *The New Arab Man: Emergent Masculinities, Technologies, and Islam in the Middle East*. Princeton, NJ: Princeton University Press.
- _____.
2015 *Cosmopolitan Conceptions: IVF Sojourns in Global Dubai*. Durham, NC: Duke University Press.
- _____.
2016 Medical cosmopolitanism in global Dubai: A twenty-first-century transnational intracytoplasmic sperm injection (ICSI) depot. *Medical Anthropology Quarterly*. doi:10.1111/maq.12275
- Maraniss, D.
2015 *Once in a Great City: A Detroit Story*. New York: Simon & Schuster.
- Myntti, C., A. Ballan, O. Dewachi, F. El-Kak, and M. E. Deeb
2000 Challenging the stereotypes: Men, withdrawal, and reproductive health in Lebanon. *Contraception* 65:165–170.
- Quesada, J., L. K. Hart, and P. Bourgois
2011 Structural vulnerability and health: Latino migrant laborers in the United States. *Medical Anthropology* 30 (4):339–362.
- Sadik, S., S. Abdulrahman, M. Bradley, and R. Jenkins
2011 Integrating mental health into primary health care in Iraq. *Mental Health in Family Medicine* 8:39–49.
- Schopmeyer, K.
2011 Arab Detroit after 9/11: A changing demographic portrait. In *Arab Detroit 9/11: Life in the Terror Decade*. N. Abraham, S. Howell, and A. Shryock, eds. Pp. 29–63. Detroit, MI: Wayne State University Press.
- Sheppard, C.
2011 Hard time for Iraqi refugees in weak US job market. March 3. www.reuters.com.
- Svab, P.
2013 110,000 Iraqi refugees in US, where are they? *The Epoch Times*, January 31.
- Taylor, E. M., E. A. Yanni, C. Pezzi, M. Guterbock, E. Rothney, E. Harton, J. Montour, C. Elias, and H. Burke
2014 Physical and mental health status of Iraqi refugees resettled in the United States. *Journal of Immigrant and Minority Health* 16:1130–1137.