African Masculinities

Men in Africa from the Late Nineteenth Century to the Present

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17. Sexuality, Masculinity, and Infertility in Egypt: Potent Troubles in Marital and Medical Encounters

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Africa is a continent with high rates of infertility, including a so-called infertility belt around its center (Ericksen and Brunette 1996; Larsen 1994). Although much of this infertility has been attributed to infectious scarring of female reproductive tracts (World Health Organization 1987), "male factors" remain an under-appreciated but a significant cause of infertility in Africa and elsewhere (Irvine 1998), contributing to more than half of all cases of infertility globally. Among the male factors leading to infertility is sexual dysfunction, including problems of impotence, ejaculation, and intromission (vaginal penetration), whereby sperm are unable to enter the female reproductive tract. Indeed, problems of sexual potency and male infertility are conventionally conflated in the popular discourses of many societies, as both are associated with losses of "virility" and "manhood" (Webb and Daniluk 1999).

Although most cases of male infertility have nothing to do with sexual dysfunction, some do. In Egypt, the focus of this article, male sexual dysfunction is one of the "hidden" and thus grossly under-appreciated causes of infertility, a finding also reported from South Africa (Van Zyl 1987a, b). That high levels of male sexual dysfunction may occur in African countries such as Egypt is not surprising: on the one hand, male sexual dysfunction may be due to organic causes such as diabetes mellitus and nutritional deficiencies (particularly of zinc), which are major problems in Egypt (Amin 2001). In addition, Egyptian males may be at greater risk for sexual dysfunction because of "lifestyle factors" (e.g., heavy

smoking) that result in disrupted vascular flow to the sexual organs. Other cases of sexual dysfunction may be due to psychosocial factors, such as lack of heterosexual desire on the part of homosexual men forced into marriage in one of the "most-married" societies in the world (Inhorn 1996).

No matter the cause, male sexual dysfunction is profoundly threatening to notions of hegemonic masculinity (Connell 1996) in a society where masculinity is homosocially competitive and the same Arabic term is often employed for both sexual "virility" and "manhood." Furthermore, infertility, in Egypt as elsewhere, is *the* medical condition that most clearly casts doubt upon a man's ability to impregnate a woman through "normal," heterosexual, penetrative sex. Infertility is a "sexual" condition, one that challenges normative male sexuality, masculinity, and paternity in places like Egypt, where "to be a man" means to be a virile patriarch who begets children, particularly sons (Ali 1996; Ouzgane 1997).

This chapter examines the marital and medical troubles of mostly poor urban Egyptian couples, childless because of male sexual dysfunction. The findings and arguments in this chapter are based on two periods of field research (1988–1989 in Alexandria and 1996 in Cairo), in which my focus of investigation was the problem of infertility, including its causes and consequences.[1] Nearly half of the infertility cases in the first study were attributable to a "male factor," and 13 percent were due to sexual dysfunctions, which were reported to me by wives but never reported to, nor charted by, a physician. Similarly, in the second study, several women reported that their husbands were "infertile" because of sexual dysfunction or were experiencing sexual performance problems as a consequence of infertility treatment. Thus, in most of these cases, the sexual dysfunction was the primary cause of the infertility, preventing the husband from successfully penetrating and ejaculating into the wife's vagina.

This chapter explores the gendered dimensions and consequences of male sexual dysfunction in this patriarchal cultural setting, where this impairment of male bodies—glossed as "weakness" of the male sexual organ—is a profoundly emasculating, embarrassing, and thus "invisible" subject. Furthermore, it is a problem with tremendous impact on women's lives, not only in terms of their sexual fulfillment, but in terms of their gendered identity, given that women, and not men, are "blamed" for reproductive failings and expected to seek treatment for them. That women deemed "infertile" as a result of their husbands' sexual dysfunction are put in a tremendous bind should become clear in the following case study, which illustrates many of the themes of this chapter.

THE CASE OF NARIMAN, HER IMPOTENT HUSBAND, HER EGYPTIAN DOCTOR, AND HER AMERICAN "*DUKTURA*"

When I first met Nariman[2] in the halls of the University of Alexandria's infertility clinic, this Ruebenesque local beauty—who wore a long dress and head covering that accentuated her brilliant aquamarine eyes—was 33 years old, married to a diabetic husband more than 20 years her senior, and, with the exception of three early miscarriages, had been unable to become pregnant with her husband, Naguib, over 16 years of marriage. Naguib had been Nariman's "choice" when she was only 17. The eldest daughter of a "severe" father who remarried twice after Nariman's mother died (when Nariman was only 11), Nariman could not wait to escape her unfortunate circumstances in a small Upper Egyptian village. She saw Naguib, her semi-educated, older, first cousin,[3] as a way out of the confines of her abusive father's home in a sleepy southern Egyptian town.

Upon marriage, Naguib took Nariman to his family's apartment in a working-class neighborhood of Alexandria, where he was employed as a semiskilled wool analyst in a textile factory. Naguib, his father, and his brother, who shared the small, two-bedroom apartment, were kind to Nariman, and her primary role was to serve the needs of her male in-laws.

However, over the years, Nariman has become increasingly dissatisfied with the quality of her marriage, and has come to the conclusion that marrying an older man—versus the many young suitors who once wanted her and asked for her hand—was a big mistake. Indeed, with her twinkling blue–green eyes, wide revealing smile, and voluptuous body of very generous proportions—considered the ultimate in sensual beauty by most lower-class Egyptian men—Nariman claims that there are, even now, many men who still "want" her if her husband dies or divorces her. Such an outcome, furthermore, is not considered unlikely in Nariman's poor urban neighborhood, given Naguib's advanced age and the fact that Nariman has never produced any children for him, thereby increasing the possibility that he might leave her.

However, despite her stoic public acceptance of her purported infertility, Nariman knows that the primary cause of her long-term childlessness can be due to one cause only: her husband's impotence and his low libido, which she deems her "biggest problem in life." Even though three semen analyses have revealed that Naguib is not infertile, his impotence has rendered their marriage childless, a situation that Nariman must endure. As Nariman explained in one of six lengthy interviews I conducted with her in

the hospital where she had come seeking treatment:

> My husband doesn't want sex often, maybe one time a week. I want it more than that, because I want a baby. Sometimes, my body also wants it. We have fights about this all the time. But sometimes his "thing" [i.e., penis] is not standing. Actually, most of the time, 90 percent of the time. Of course, it makes me upset . . . But he is shy to go to a doctor for this problem [i.e., impotence], because it's a shame for a man. So I went one day to a doctor for men [i.e., andrologist] instead of him. This doctor gave me some medicine—cream to put on his thing—but it didn't work. Sometimes when it stands, it is very weak. And when he is able to have sex, only half of the time he "brings" [i.e., "comes," ejaculates]. But the biggest problem is his "weakness." And it *is* a problem. My feelings have changed toward him; they've gotten worse. Not having children is not a problem for him; he's very happy. But I'm not. Although I don't like him, I still take care of all his needs. I do everything for him.

One of the things that Nariman does "for" Naguib is seek treatment, because he refuses to consult a physician about his sexual problems, probably linked to his poorly controlled diabetes. In fact, Naguib believes that his problems may not be "medical" at all but rather due to an *ʿamal*, or an act of sorcery by a jealous male rival, which has rendered him *marbut*, or "tied" in his genital region. Naguib himself visited a *munaggim*, or traditional spiritist healer, who read the Qur'an over Naguib and wrote a *higab*, or amulet, which he was supposed to wear until the *rabt* disappeared. However, as a disbelieving Nariman pointed out, "This *shaikh* just wanted money. He took lots of money just to tell him lies. I myself don't believe *at all* in things like that."

Although Nariman herself has also visited many traditional healers, she has spent most of her efforts in the world of Egyptian gynecology, where she has consulted numerous male physicians about her childlessness. Remarkably, after more than a decade of "searching for children" in the world of biomedicine, Nariman has never been asked by a single physician about her sex life and its possible relationship to her ongoing childlessness. In fact, the most recent physician she consulted at the University of Alexandria Hospital prescribed ovulation-inducing medications and timed intercourse, telling her on which days she must "go home and have sexual relations with your husband." Because Nariman, a lower-class, uneducated woman, was thoroughly intimidated by this purportedly brilliant, but extremely busy and frankly supercilious academic physician, she found herself totally unable to tell him about her problematic sexual history, her husband's inability to perform "on demand," and her own reluctance

to ask her husband for sex, which was against "Egyptian traditions and customs."

Thus, when Nariman befriended me, the American female "*duktura*" with the demonstrated ability to speak frankly in a foreign language to male Egyptian gynecologists, she pleaded with me to write the problem of her husband's impotence in English on a piece of paper, which she could then hand to the famous doctor and "run." Instead, I suggested to Nariman that we go together to speak to the physician. She consented, and, although the exchange with the doctor was tense, he immediately changed his treatment protocol, eliminating the "timed intercourse" component and scheduling Nariman for future artificial insemination using her husband's sperm.[4] Privately, he revealed to me his aggravation that Nariman had never told him about her husband's impotence after many visits to his infertility clinic. This had resulted, he said, in valuable time being "wasted." Yet, this physician never took sexual histories from his infertile patients, thereby maintaining the sexual silences that had resulted in misguided treatment attempts.

SEXUAL TROUBLES IN THE MARITAL ENCOUNTER

Among some Egyptian couples, such as Nariman and Naguib, infertility may be a proxy for "troubled sex" in ways that Egyptian infertility specialists fail to recognize. Clearly, for this couple and many others like them, having "relations"—as sexual intercourse is politely referred to in the Egyptian dialect of Arabic—is a source of great anxiety and marital duress. In both of my studies in Egypt, I encountered couples for whom husbands' inability to perform sexually had been an enduring feature of their marriages and had resulted in a failure of procreation for which wives were typically blamed. The problems, furthermore, were varied. Some men, such as Naguib, suffered from low libido and impotence. Sometimes, the impotence was total; in other cases, initial erections were quickly lost upon vaginal penetration. A few men were able to achieve an erection and ejaculate "on their own" (through masturbation or night-time "wet dreams"), but were unable to achieve erection for the purposes of marital intercourse. In one case, a man who had frequented prostitutes before marriage was able to achieve and maintain an erection only between his wife's legs (the method he had learned with prostitutes), but lost his erection as soon he attempted to penetrate his wife's vagina (so-called failure of intromission). In two cases, husbands' impotence had led to unconsummated marriage

over several months, and very infrequent intercourse during the ensuing years. Furthermore, some husbands who were able to achieve an erection suffered from problems of ejaculation, including premature ejaculation occurring outside the vagina, and retarded ejaculation whereby sperm could not be released into the vagina.

These problems were typically reported as "upsetting" to both husband and wife, causing marital friction in many cases. Men were often humiliated by their inability to "perform," but were either indignant or depressed and distant when their wives mentioned the problem to them or suggested that they seek medical attention. Most men were too "embarrassed" to do anything proactive about their "problem"; but their passivity meant that their wives suffered the social scrutiny and blame for the ongoing childlessness, including among husbands' relatives. Wives, in turn, were profoundly demoralized—by the sexual dysfunctions themselves, by husbands' refusals to discuss the problem or seek help, by the resulting lack of pregnancy, and by the burden of blame for the infertility that rested on their shoulders. A 30-year-old woman, married for two years to an impotent man, lamented: "When he enters [penetrates], it's very weak, and it becomes small and comes out. I think it's because he's very nervous and always his nerves are tired. You can't sit and talk with him, and I can't open this subject with him because I don't know what his reaction will be. He will get more nervous, and this will cause more trouble for him. But *I'm* the one getting treated. *I'm* supposed to be the reason [for the childlessness]. So *I* am in the bad position. Maybe that's my share in life. I have to accept it and live with it."

As apparent in this excerpt, Egyptian women seek to understand why their husbands are unable to have normal sex with them, and they tend to attribute their husbands' sexual dysfunctions to psychological problems. Often, women resort to the language of "nerves," a common Egyptian illness idiom, to explain their husbands' sexual dysfunctions. In fact, many Egyptian women—even those without impotent husbands—consider their husbands "nervous" and irritable types, with whom they proceed cautiously when discussing sensitive subjects. Sexual dysfunction falls into this category, and is viewed by women as a "problem of nerves," but it is their husbands' "nervousness" that keeps women from initiating frank discussions about how this "nervous" condition might be treated.

Although most sexually dysfunctional Egyptian men refuse to seek psychological help (deeming it profoundly stigmatizing), some do take their sexual problems to specialists. Egyptian "andrologists" treat men in urban areas for problems ranging from male infertility to sexually transmitted diseases. However, as seen in the various scenarios above, many men

are reluctant to take sexual problems to physicians, in part because they do not view sexual dysfunction as a medical problem and in part because they find the very act of sharing their sexual inadequacies with a male physician humiliating. Time and time again, women told me that their husbands were "shy" or "embarrassed" to seek medical attention, because of the great "shame" of sexual dysfunction in terms of diminished manhood.

Some Egyptian men, especially those of the lower class such as Naguib, are more inclined to visit a specialist if they can attribute their sexual dysfunction to a *rabt*—or sorcery act undertaken by an envious rival. Being "*marbut*," or "tied" in the genital region, is not an endogenous problem having to do with one's own mental state or physical condition. Rather, it is a very "social" disease—linked to jealousy and competition and thought to be caused by one less virile (Ali 1996). Thus, being impotent by virtue of a *rabt* is significantly less threatening to a man's gender identity and masculinity, for it implies that a man is a person *to be envied* by other men, who might be driven by their jealousy to an act of vengeful sorcery. That Naguib had been successful in attracting a young, beautiful wife—whom he was able to "keep" despite the childlessness and the fact that others wanted her—was a sure sign to him that he had been "done in" by an *'amal*, or act of sorcery that had caused him to be impotent. Indeed, among the rural and urban Egyptian masses, *rabt* is considered "*the* male disease" (el Sendiony 1974)—an ultimate form of masculine competition whereby men cause the demise of each other's sexual organs.

As a very "culturally specific" condition, *rabt* can be resolved only through what el Sendiony (1974) has described as "traditional Egyptian psychotherapy." Traditional healers, primarily the *munaggimin*, or spiritist healers who specialize in both the making and undoing of sorcery, are often visited by lower-class men such as Naguib, who pay these "*shaikhs*" relatively large sums of money to counteract the sorcery through a variety of methods. However, as seen in the case of Naguib, *munaggimin* often "fail to deliver,"[5] suggesting that sexual dysfunction may have other causes beyond the psychologically disruptive effects of presumed sorcery.

As a result, wives such as Nariman—whose husbands refuse to go to andrologists and who fail to be cured by *munaggimin*—are faced with two thorny choices: to remain "quiet" and maintain the marital/sexual status quo, or to seek treatment for "their problem," which is the resulting childlessness. Given that Islam is a medically "activist" religion, encouraging believers to seek solutions to their suffering (Inhorn 1994), it is not surprising that many Egyptian women are willing to resort to infertility treatment if it offers them a way to become pregnant without an erect phallus. Indeed, high-tech infertility treatments, as they are now practiced in parts of urban Egypt, have

bypassed sexual reproduction. But, as we shall see in the following section, seeking infertility treatment is, in and of itself, sexually disruptive in ways that many Egyptian women, such as Nariman, never anticipated.

SEXUAL TROUBLES IN THE MEDICAL ENCOUNTER

As seen in Nariman's story, Egyptian infertility physicians, most of whom are male, rarely ask their women patients about sexual practices or problems that may be hindering fertility outcomes. This is as true in public hospital-based infertility clinics as it is in private infertility clinics. For example, in interviews I conducted with 17 Egyptian gynecologists—about half of them from a public teaching hospital-based infertility clinic and the other half from private infertility clinics—all but three indicated that they did not routinely ask their women patients about sexual issues, feeling that it was incumbent upon their patients to report sexual problems to them. Furthermore, even in high-tech Egyptian in vitro fertilization (IVF) clinics, where husbands and wives are expected to seek treatment together, I was told by physicians that sexual history-taking (if present at all) is brief and superficial. Presumably, some men, particularly those ashamed about their sexual inadequacy, do not answer honestly and are never challenged by their wives or their attending physicians.

In the Egyptian medical encounter between physicians and infertile patients, an unofficial "don't ask, don't tell" policy is clearly in place—one that maintains sexual silences and virtual erasures of male sexual dysfunctions. As one woman with an impotent husband complained, "I never told [the doctor] about my husband's problems. He never asked me these questions; he just asked for the sperm. I'm not embarrassed to tell him, but he didn't ask me. I *would* tell him if he asked me, but he just talks quickly and I don't understand him well, and I am shy to tell him anything."

Egyptian gynecologists offered many rationales for their lack of sexual history-taking, ranging from lack of time, to cultural prohibitions against inter-gender sexual discourse, to concerns over loss of (offended) clientele, to beliefs (on the part of many) that sexual problems will eventually "come out," either through the admissions of frustrated wives or through diagnostic tests and treatments that reveal the absence of sperm. In some cases, physicians were slightly apologetic about their clinical lacuna, typically justifying it by pointing to their own lack of sex education and self-perceived inability to advise their patients on sexual matters. As one physician admitted:

> I think we are ignorant about sexual relations between partners. And usually doctors didn't ask precisely or specifically about this point. Most doctors themselves are ashamed to talk about this, so it is not well diagnosed. And if I ask about this, the patient, especially the infertile male, may leave and go to another doctor. Even when female doctors talk to female patients, this happens. But with infertility, they can't hide this easily, and women should tell us. But there's no teaching of doctors about *how* to ask, so it is not well examined.

In doctors' defense, it is true that Egyptian physicians do not receive comprehensive education in human sexuality. But it is also likely that sexual denial and discomfort in the clinical encounter persist, for three major reasons having to do with larger cultural forces. First, physicians as a professional group—consisting of individuals drawn mainly from the middle to upper classes—seem to maintain the privileges of elite status through the paternalistic social distancing of the lower and even middle-class patients who present to their clinics. Such medical paternalism is achieved through lack of disclosure of medical information, with physicians controlling what can be asked by patients and revealed to them; brief and often brusque communication styles; and use of English (including on patients' medical records and prescriptions) to obscure patients' understandings of their own medical conditions (Inhorn 1994).

Second, problems of medical paternalism are compounded by the persistence of patriarchal structures surrounding male doctor/female patient relations. Egyptian gynecology, one of the "prestigious" specialties, is a remarkably male-dominated profession. Because male physicians in this patriarchal setting view it as their socially sanctioned right to completely control the clinical encounter with female patients, frank intimidation of women patients, particularly those from lower social classes, is the unfortunate norm. Furthermore, marked cultural restrictions on what is considered appropriate male–female discourse are operative in gynecological encounters. Whereas frank "sex talk" is allowed between married women and between men, it is generally "tabooed" in mixed-sex settings, including the medical encounter between male physicians and their female clients.

These gendered patterns of sexual communication seem to be crystallizing even further as a result of heightened Islamic religiosity in the country over the past two decades (Inhorn 2003). As in other religiously conservative countries of the Middle East and Africa, more and more Egyptians are preferring true gender segregation in the medical realm—with female patients being treated by female physicians and male patients being treated by male physicians.[6] Particularly among Egyptian Islamists, who consider themselves to be particularly devout Muslims and who dress in enveloping garb (including facial veils for women) to preserve their gendered modesty,

examination or treatment by a physician of the opposite sex is considered immodest and even sinful. Thus, many Islamist husbands will not allow their wives to discuss "sensitive" topics with—let alone be treated by—a male physician. Clearly, many Egyptian male gynecologists living in an increasingly gender-segregated, religiously conservative environment are aware of these cultural forces and are reluctant to lose "religious" patients by exploring the gender-sensitive, even "sinful" topic of sex. Ultimately, increasing Islamist influence in Egyptian medicine (including control over the Egyptian Physicians' Syndicate) has the potential to put male gynecologists out of business if female patients refuse to visit them. Thus, few male gynecologists are willing to jeopardize their livelihoods by offending female patients (and their husbands) in these ways.

These social and cultural forces have affected the practice of Egyptian medicine in ways that are detrimental for women like Nariman, who remain sexually frustrated by their husbands, silenced by their physicians, and expected to cope with their unrequited motherhood on their own. Clearly, among couples for whom sexual dysfunction has led to infertility, greater openness in the medical encounter would be welcome. Yet, as it now stands, most Egyptian physicians use their power to give and to withhold information, to ask questions and answer them as they see fit. Unfortunately, in the area of infertility management, it is the exceptional physician who probes the lives of patients with sexual problems, many of whom are often desperate to discuss these problems but too intimidated to begin the process.

Yet, there is something paradoxical about this "don't ask, don't tell" policy: at the same time that physicians ask little or nothing about their infertile patients' sex lives, they place extraordinary sexual demands on infertile couples—extending matter-of-fact directives to women about when they should ask their husbands (or bring them in) for semen samples and when they should go home "to have relations with your husband." Indeed, many diagnostic and therapeutic procedures in infertility management are sexually demanding, requiring physician-directed, scheduled intercourse, as well as frequent (even urgent) semen samples produced through masturbatory ejaculation into a plastic cup. Such "sex on demand" is problematic in Egypt for two reasons.

First, Egyptian gender norms, at least among the lower to lower-middle class, prohibit women from initiating sex, as sexual initiation is deemed a solely masculine act and prerogative. Thus, women "ordered" by their infertility physicians to "go home and have relations with your husband" or to "tell your husband to produce a semen sample" are typically disconcerted,

deeming themselves entirely incapable of asking their husbands for sex or semen. In some cases, a wife may be so unnerved by being perceived as "needing" sex—or, alternatively, she may be so concerned about a husband's unpredictable reaction if she asks for it—that she may lose the nerve altogether to follow through with the physician's instructions. Clearly, for women such as Nariman, the distress of asking a husband for sex is intensified when male sexual performance is implicated as the very reason for the infertility. Thus, the "good women don't ask for it" policy characterizing Egyptian marital relations, at least among the lower class, means that infertility diagnosis and treatment is threatening to both the performance of sex and gender in this cultural setting.

Second, infertility diagnosis and treatment often leads to male sexual performance difficulties, as well as decreased male sexual satisfaction, a finding that has been widely reported from around the world (Daniluk 1988; Greil et al. 1990; Hurwitz 1989; Takefman et al. 1990). For Egyptian men, the task of producing a semen sample may be experienced as deeply emasculating: typically, they show up under duress at a hospital-based or otherwise crowded infertility clinic, only to be given a plastic container and asked to produce a specimen (on their own) in a unisex clinic bathroom, while others wait outside. Even for men without obvious sexual dysfunctions, the performance anxiety and sense of public humiliation may be profound. One highly educated IVF patient described her husband's failure to produce a crucial semen sample—and her resultant anger at the cavalier response of the treating physician—as follows: "Unfortunately, I told [the IVF doctor] that my husband has difficulty in making a sample in the clinic, and I asked can we do it at home. He said, 'No, it's better at the center and come on Friday [i.e., the Egyptian weekend]; you'll find no one there, and he'll feel free and feel so good.' So, the doctor told us at the last minute, 'Come on Friday, and he will do it [masturbation] easily.' When he went there, he found many, many, many people. It was crowded even on a Friday. It was in September, so the weather was very hot. And it was a small, small bathroom right beside the nurse's office. And he started sweating and couldn't do it. After that, he was very upset and said, 'I hate marriage.' "

She continued, "My ovaries had started to work, and I took all the expensive medicine, and then there was no use, because he couldn't provide a semen sample. [The doctor] said, 'Oh well, you can try next time.' I was angry, and I told him, 'You are not a doctor. You are not honest. You're wasting the time and money of people. We are not people from a village to be told 'Come here. Do this. Do that.' These doctors are savage—against humanity."

THE FUTURE FOR THE SEXUALLY DYSFUNCTIONAL

What can be done in Egypt to alleviate the suffering of sexually dysfunctional men and their long-suffering "infertile" wives? A number of emergent changes may go a long way toward bringing the problem of sexual dysfunction into the open and helping those men (and their wives) who suffer from this problem.

First, some Egyptian physicians are beginning to perform sexual counseling services. Despite the protestations of many physicians, sexual counseling is *not* impossible in Egypt—and may, in fact, make a physician popular and successful. For example, two gynecologists I interviewed, one male and one female, had incorporated aspects of sexual counseling into their thriving private practices. They described, in frank but graphic terms, how they dealt with sexual problems ranging from unconsummated marriages, to lack of orgasm, to premature ejaculation and erectile dysfunction. Both were proud of their "successes," and were pleased with the babies subsequently born from some of these sexually troubled unions. This aspect of physician counseling—even in the absence of more direct psychotherapeutic intervention—has been shown to have therapeutic effects in other settings (Rantala and Koskimies 1988).

Although Western commentators tend to recommend psychological counseling services for sexually dysfunctional infertile couples (Daniluk 1988), psychological therapy per se will probably never become widely popular in Egypt. Even highly educated patients in Egyptian IVF centers refuse initial psychological consultations, which have been tried but then discontinued by some clinics. Nonetheless, this too may be slowly changing. Egyptian psychologists trained in the West are beginning to set up sex therapy practices in urban Egypt, where they cater to high-paying elites as well as occasional charity cases. One such "sexual healer," who preferred to be called by a pseudonym, talked to a Western reporter about her Cairo-based practice, in which she uses references to religion and "the man's duty to attend to his wife's sexual needs" as a therapeutic vehicle (Thompson 2000: 27). This therapist argued that education is a "key component of her treatment, particularly for unconsummated marriage, which trails homosexuality as her most common case" (Thompson 2000: 27).

Furthermore, new technologies are changing the nature of sex and sex education in Egypt. Satellite dishes and black-market videos are bringing Western sexual ideas and practices (including pornographic ones) directly to Egyptians of all social classes. In addition, Egypt is now the site of a number of new medical technologies designed to overcome the effects of male sexual dysfunction. One of these is sildenafil citrate—or Viagra—the new oral treatment for erectile dysfunction (ED) that has created a veritable "revolution" in the treatment of impotence in the West. Despite import restrictions, Viagra is sold as a popular "street" drug in Egypt, with considerable media attention and brisk sales. Indeed, new pharmaceutically based cures for impotence—and Egyptian men's desires to use them—may serve as one of the most effective vehicles for eventual normalization of this otherwise hidden and emasculating problem.

Finally, new reproductive technologies which literally bypass sexual reproduction have reached Egypt over the past decade and provide a means of overcoming male infertility as well as infertility due to male sexual dysfunction. In particular, the "newest" new reproductive technology, intracytoplasmic sperm injection (ICSI), a variant of IVF, has created a revolution in the treatment of multiple forms of male infertility. With ICSI, as long as one viable spermatozoon can be retrieved from a man's body—including through testicular biopsy or aspiration—this spermatozoon can be injected directly into an ovum under a high-powered laboratory microscope, leading to subsequent fertilization and pregnancy. The introduction of ICSI in urban Egypt constitutes an encouraging development in overcoming infertility due to sexual dysfunction, and may well presage other future developments in the realm of medical technology.

In conclusion, emergent medical technologies, new forms of medical counseling and sex therapy, and new forms of global media may create openings for the transformation of sexuality, masculinity, and infertility in Egypt as it enters the new millennium.

NOTES

A longer version of this essay appeared in *The Journal of Men's Studies* 10, 3 (2002): 343–359.

1. The first study was based in the University of Alexandria's Shatby Hospital, the major public ob/gyn teaching hospital, which catered to a large population of mostly poor infertile patients from the northwestern Nile Delta region. There, I conducted in-depth, semi-structured interviews, involving both reproductive and sexual histories, in the Egyptian dialect of Arabic with 190 women, 100 of whom were infertile and 90 of whom were fertile "controls." Returning to Egypt during the summer of 1996, I spent three summer months conducting in-depth, semi-structured interviews with 66 mostly affluent Egyptian couples in two private hospital-based in vitro fertilization (IVF) clinics located in exclusive suburbs of Cairo. Seventy percent of the husbands suffered from a male infertility problem, including, in some cases, sexual dysfunction.
2. All names are pseudonyms.
3. Cousin marriage is a common practice in Egypt among all social classes.

4. Because donor insemination is religiously prohibited in all Sunni Muslim countries including Egypt (Meirow and Schenker 1997), artificial insemination with husband's sperm (AIH) is the only form of artificial insemination performed in the country. It is not as sexually "demanding" as timed intercourse, given that semen can be donated at one's leisure and stored for future use.
5. *Munaggimin* generally have a poor reputation in Egypt as unscrupulous charlatans who deal in the sacrilegious business of sorcery (Inhorn 1994).
6. At the time of the 1996 study, only one female physician was involved in offering IVF services in Cairo. As the director of an IVF laboratory, her role did not normally include clinical consultation with patients.

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