

MASCULINITY, REPRODUCTION, AND MALE INFERTILITY SURGERY IN THE MIDDLE EAST

MARCIA C. INHORN



ABSTRACT

In the Middle East, many men who experience reproductive difficulties within marriage end up undergoing a risky form of male genital surgery called "varicocelelectomy." Promoted by urological surgeons as a way to enhance fertility, varicocelelectomy is a form of men's embodied suffering and a little-appreciated aspect of Middle Eastern men's reproductive lives. This article examines men's experiences of varicocelelectomy, particularly in Lebanon, where the surgery is commonly carried out on both infertile and fertile men's bodies, despite significant controversy and critique. Reasons for this surgery are examined, including physician avarice, masculinity expectations within homosocially competitive fertility regimes, and husbands' desires to share the burden of reproductive suffering with beloved wives. It is argued that within the Middle East, men as well as women are heavily implicated in the trials and tribulations of infertility treatment—a form of reproductive intervention that has been inaccurately "naturalized" by Western feminist scholars as an exclusively female domain and burden. Varicocelelectomy is not only an important issue in male reproductive health, but an understudied and unappreciated dimension of the lived experience of manhood in the region.

INVESTIGATING VARICOCELECTOMY

In the Middle East, many men who experience reproductive difficulties within marriage end up undergoing painful male genital surgeries to enhance their fertility. Specifically, a little-known surgery called "varicocelectomy" is promoted by Middle Eastern urological surgeons as a way to maximize fertility in subfertile men as well as in men whose wives are infertile. Varicocelectomies, which are an invasive and sometimes iatrogenic form of genital surgery, are a quite common and little-appreciated aspect of men's lives in the Middle East. Although infertile Middle Eastern women are often subject to highly invasive and sometimes iatrogenic infertility treatments in their "quests for conception" (Inhorn 1994; 2003), Middle Eastern men, too, suffer through surgeries that may complicate their own reproductive futures. Thus, varicocelectomy deserves scrutiny as a form of men's embodied suffering (Inhorn 2003).

But what is a varicocelectomy? A varicocelectomy is a testicular operation undertaken to remove a "varicocele," or a varicose-type dilation of the scrotal veins that drain the testes. In the largest varicocele prevalence study to date, undertaken among 9,034 male partners of couples consulting for infertility, the World Health Organization (1992) determined that 25 percent of the men with sperm defects had varicoceles, as opposed to only 12 percent of the men with normal sperm analyses. Although there is a substantial body of evidence suggesting that varicoceles can cause progressive testicular damage, considerable controversy exists in the Western biomedical community over whether the correction of a varicocele through varicocelectomy actually improves fertility and pregnancy outcomes. According to the World Health Organization in its major report on *Current Practices and Controversies in Assisted Reproduction* (Vayena, Rowe, and Griffin 2001), varicocelectomies are no longer warranted in treatment of male infertility. Specifically, a meta-analysis of randomized controlled studies has failed to show "any benefit of this approach" in the 23 percent of infertile men presenting with a varicocele (Tournaye 2001). In fact, "less than 20 percent of men with reproductive failure have potentially treatable conditions for which a rational or proven effective treatment is available" (Tournaye 2001).

Despite the lack of evidence that varicocelectomies actually improve sperm quality or quantity (Kamischke and Nieschlag 1998), urologists

throughout the Middle East continue to undertake varicocelectomies on thousands of subfertile men. In addition, some urologists convince *fertile* Middle Eastern men that they, too, should undergo varicocelectomy in order to prevent the *possibility* that a small, subclinical varicocele will lead to future male infertility outcomes. As will be shown in this article, men in the Middle East who are otherwise unlikely candidates for genital surgery end up agreeing with urologists to put their testicles "on the line" (in this case, the operating table) in order to stave off future reproductive problems and to share in their wives' quests for conception (Inhorn 1994). Although varicocelectomies are part of an often-futile quest for enhanced reproductive fitness, the eagerness of some Middle Eastern urologists to perform these surgeries, as well as the willingness of many men to undergo them, bespeaks the importance of fertility as a major component of Middle Eastern masculinity and marriage.

Despite the introduction in the 1990s of new, improved reproductive technologies to overcome male infertility,¹ varicocelectomy continues to be practiced widely in the Middle East, in part because of patient demand. But why do Middle Eastern men want varicocelectomy? And what do they have to say about their experiences? This paper examines the discourse among men who have undergone the surgery, as well as among IVF practitioners who are critical of the practice. Although most men who undergo varicocelectomy seem to experience postoperative "buyer's remorse," their motivations for undergoing varicocelectomy are powerful. On the one hand, they can demonstrate their commitment to marriage—in a region of the world where marriage is highly valued—by sharing somatically in their wives' treatment quests (Inhorn 1994). The very marks of varicocelectomy left on a man's body symbolize this shared suffering. Additionally, varicocelectomy holds the promise of increased fertility in a region of the world where fertility and manhood are closely related. In fact, varicocelectomy cannot be understood without examining Middle Eastern masculinity. Masculinity, in turn, requires contextualization within the wider sphere of Middle Eastern gender studies, the topic to which I now turn.

MIDDLE EASTERN MASCULINITIES

Middle Eastern varicocelectomy practices cannot be understood without reference to Middle Eastern masculinity as it is being theorized in

Middle East studies today. Namely, a repeating theme in the small but growing literature on Middle Eastern masculinities is one of homosocial competition between men in the realms of virility and fertility, which are typically conflated (Ali 1996; 2000; Lindisfarne 1994; Ouzgane 1997). According to Ouzgane, a scholar of contemporary Arabic literature, virility emerges as "the essence of Arab masculinity" (3) in the novels of some of the region's most eminent writers, with men in these stories both distinguishing themselves, and being distinguished from other men, through the fathering of children and especially sons. Men living in pronatalist Middle Eastern communities are expected to have children, as reflected in the relatively high marriage and fertility rates across the region (Population Reference Bureau 2004). Furthermore, on a social structural level, Middle Eastern men achieve social power in the classic patriarchal, patrilineal, patrilocal, endogamous extended family (Eickelman 1998; Joseph 1993; 1994; 2000; Kandiyoti 1988; Moghadam 1993) through the birth of children, especially sons, who will perpetuate patrilineal structures into the future (Delaney 1991; Inhorn 1996; Obermeyer 1999; Ouzgane 1997). Thus, in this region of the world, which "with some truth, is still regarded as one of the seats of patriarchy" (Ghousoub and Sinclair-Webb 2000, 8), men who do not become family "patriarchs" through physical and social reproduction may be deemed "weak" and ineffective (Lindisfarne 1994), and may be encouraged to take additional wives in order to contribute to the patrilineage and to "prove" their masculine virility and fertility (Inhorn 1996).

If this is, in fact, the case, as much of the theoretical, empirical, and contemporary popular literature from this region suggests, then the experience of infertility or subfertility for a Middle Eastern man can only be imagined as an extremely threatening and emasculating condition (Inhorn 2004a), one that needs to be overcome by any means, including varicocectomy. The widespread acceptance of varicocectomy as a fertility-enhancing surgery in the Middle East bespeaks a world in which the performance of masculinity is homosocially competitive and men work hard to sustain their public images as powerful, virile patriarchs. Men living within such an environment will likely "do what they can"—even if it means resorting to a varicocectomy—in order to impregnate their childless wives. With impregnation, they prove their manhood and perpetuate the patrilineage through the production of off-

spring. Thus, in Foucauldian terms (1977), varicocelectomies are one of the ways male reproductive bodies are disciplined to meet Middle Eastern societal demands of virility, fertility, and patriarchal continuity.

Furthermore, men must achieve these patriarchal goals within the confines of marriage, since in the Muslim world, marriage is considered a moral and legal mandate and adultery a major sin (Inhorn 2003; Seirour 1996). Marriage is a highly valued and normatively upheld institution throughout the Middle East. Islam extols the virtues of marriage, regarding it as *Sunna*, or the way of the Prophet Muhammad. Among Middle Eastern Christian populations, marriage is similarly condoned, and divorce is either difficult or impossible to obtain. Thus, Middle Easterners are among the "most married" people in the world (Omran and Roudi 1993), with well over 90 percent of adults marrying at least once in a lifetime. This is a region of the world where long-term marital commitments accompanied by love are highly valued, despite Western stereotypes of widespread marital polygyny and divorce.²

Indeed, despite widespread expectations *within* the Middle East that infertile marriages are bound to fail—with men necessarily blaming women for the infertility and divorcing them if they do not produce children, especially sons—such expectations may represent indigenous stereotypes. As I would argue, the success of so many infertile marriages in the Middle East bespeaks the strengthening of "conjugal connectivity" at the expense of patriarchy (Inhorn 1996), which, as confirmed by other Middle Eastern feminist theorists (Joseph 1993, 1994; Moghadam 2004), is being undermined.

That patriarchy is shifting in favor of conjugal connectivity and more egalitarian gender dynamics is also suggested by recent research on men and reproduction in Lebanon. In their article "Challenging the Stereotypes," American medical anthropologist Cynthia Myntti and a team of Lebanese researchers (2002) explore the use of withdrawal (aka coitus interruptus) as a form of male-controlled contraception. Instead of the stereotype of the "dominant Mediterranean male" who controls reproductive decision making, Myntti and her colleagues found that men and women were mutually negotiating and agreeing to withdrawal as a form of contraception, in recognition of the need to limit childbearing and to spare the wife's health and future fertility. In other words, Lebanese men were taking responsibility for contraception out of con-

cern for their wives, in what could be described as a *shared* commitment toward mutually agreed upon reproductive goals and sexual pleasure.

As I would argue based on my own research in Lebanon and Egypt, the same sort of dynamics are operative within the framework of infertile marriages. Despite a Middle Eastern social complex of classic patriarchy, competitive masculinity, and high fertility rates, men who find themselves having reproductive difficulties within marriage are often willing to contribute in the ways they can to facilitate mutually agreed upon reproductive goals. Men desire children *with the wives they love*. Thus, when reproduction is delayed, men within the Middle East are often willing to participate in the embodied aspects of infertility treatment—ranging from semen collection to surgery—whether or not they actually have a male infertility problem. For men who *are* infertile, varicocelelectomy is but one of the therapeutic strategies they are willing to undertake in order to enhance their reproductive potential (Inhorn 2003; 2004a). Yet, even among men who are *fertile*, undertaking a varicocelelectomy—to purportedly increase sperm count and prevent any future demise in sperm parameters—is one way men can share their wives' suffering and participate in the treatment quest. Indeed, varicocelelectomy can be thought of as a measure that a "good" husband takes to prove his loving connectivity to his infertile wife. Ultimately, Middle Eastern men's willingness to undertake varicocelelectomies, even when medically unnecessary, bespeaks the deep feelings of love, loyalty, and commitment that many fertile men feel toward their long-suffering infertile wives.

SITUATING MALE INFERTILITY SURGERIES

The importance of varicocelelectomy in the Middle East became apparent to me in the first weeks of my doctoral research in Alexandria, Egypt, in the fall of 1988. An Egyptian physician who agreed to review a semi-structured reproductive history interview guide that I had constructed laughed out loud when he read my naïve questions about vasectomy. I had assumed that some Egyptian men might choose vasectomy as a form of contraception, and that some might become secondarily infertile as a result of a previous vasectomy. But this physician informed me that I was wrong. According to him, "No Egyptian man agrees to a vasectomy." On the contrary, he told me, men in Egypt have surger-

ies to *promote* their fertility, a fact that I would be told by physicians from other Middle Eastern countries later on. Indeed, in the study that I conducted in Alexandria with 190 married Egyptian women (Inhorn 1994), 100 of whom were infertile and 90 of whom were fertile controls, vasectomy had never been used by any of the husbands as a form of permanent contraception, because, as their wives told me, Egyptian men's ongoing ability to produce offspring is perceived by them to be crucial to their masculinity.

When I returned to Cairo in 1996, to conduct a study of in vitro fertilization (IVF) among infertile Egyptian couples, I discovered that fertility-enhancing surgeries were indeed being conducted on infertile Egyptian men. Among the 66 middle- to upper-class couples I interviewed in two Cairo-based IVF clinics, 70 percent were presenting for IVF primarily because of male infertility problems, and 17 percent of the men in the study had undergone a varicocelelectomy to supposedly overcome their infertility problems (Inhorn 2003). Some had undergone this surgery twice, due to failure of a previous repair or a recurrence of the varicocele. In at least one case, the surgery itself caused the iatrogenic outcome of obstructive azoospermia, or lack of any sperm in the ejaculate due to a blockage of the epididymis caused by the surgery.

The high prevalence of both male infertility and varicocelelectomy in Egypt piqued my curiosity; thus, I resolved to undertake a study of male infertility and its treatment in the Middle East, in the midst of the massive globalization of assisted reproductive technologies to this part of the world (Inhorn 2003). In January 2003, I embarked on an eight-month study of Middle Eastern masculinities in the age of new reproductive technologies in Beirut, Lebanon (Inhorn 2004a). As in my Egyptian study, I was fortunate to gain ethnographic access to two of the busiest and most successful IVF clinics in central Beirut (Inhorn 2004b). Between these two clinics, I was able to recruit 220 Lebanese, Syrian, and Lebanese-Palestinian men into my study; 120 of them were infertile cases (i.e., based on spermogram results and World Health Organization definitions of male infertility), and 100 were fertile controls (i.e., the husbands of infertile women whose spermogram results showed them to have normal sperm parameters).³ This epidemiological case-control design also served important ethnographic purposes; it allowed me to understand the experiences and perspectives of infertile

men, as well as men who were *not* infertile but who were experiencing childless marriages.

A large amount of data was collected during the eight-month study period in Beirut. This included: 220 complete eight-page reproductive history/epidemiological questionnaires, which I administered verbally in either Arabic or English or both to each man in the study; 1,200 pages of qualitative interview transcripts, generated from open-ended interviews with all of the men in the study and some of their wives; more than 200 pages of interview transcripts generated from open-ended interviews with six IVF physicians, two embryologists, and one IVF unit head nurse; 550 pages of field notes, based on participant observation and informal interviews and conversations with staff and patients at the two IVF clinics; and more than 200 blood samples, which were frozen in the Beirut IVF laboratories and then hand-carried by me via airplane to the United States for purposes of later toxic metal analysis.

This article is based primarily on reproductive history and ethnographic data from the more recent Lebanese study, which focused primarily on men and their reproductive health. As I was to discover, 55 of the 120 infertile men in the Lebanese study—exactly 45 percent—had undergone varicocelectomies. Four of these men had undergone the operation twice, and one man a staggering three times! Twenty-two of these men (18 percent) had had both testicles manipulated in the surgery; sometimes, they stood to show me the incision scars in both their right and left inguinal areas. Five men suffered from serious complications, including formation of a hydrocele (i.e., “bag of water” forming around the testis), which required second surgeries. The vast majority of the infertile men who had undergone varicocelectomy noted, with defeat and anger, that the varicocelectomy was not successful, leading to no improvement in their low sperm counts. Furthermore, three of the infertile men in the study had had varicocelectomy surgeries to supposedly overcome azoospermia—a complete absence of sperm in the ejaculate that is clearly *not* caused by a varicocele. Ultimately, all of the azoospermic men in the study (12 out of 120, or 10 percent) ended up undergoing testicular aspirations or biopsies, another invasive genital operation in which sperm are drawn out directly from the testicles. Thus, in total, 64 of the 120 infertile controls in the study—or 53 percent—had

undergone one or more genital surgeries as part of the male infertility treatment quest.

These high figures among infertile men may seem less surprising than the data from *fertile* men in Lebanon. Stunningly, 18 of the 100 fertile controls (18 percent) in the study had also undergone varicocelectomy, in six cases before marriage. According to these men, physicians had convinced them that small varicoceles detected on routine exams could lead to future male fertility impairments; thus, they became convinced of the need for surgery. Among the rest of the fertile men who had undergone a varicocelectomy following marriage, varicocelectomy constituted the male contribution to the infertility treatment quest. Ultimately, three of the fertile men suffered complications from varicocelectomies, including hydroceles necessitating additional surgery. However, these men were fortunate in that repeat genital surgeries did not impair their fertility.

IEWS OF VARICOCELECTOMY FROM IVF CLINICIANS

The high percentage of varicocelectomy surgeries among *both* infertile and fertile men in Lebanon might make sense if varicocelectomies could *truly* improve low sperm counts or prevent low sperm counts from developing. This is a question I posed in interviews with six Lebanese IVF physicians, as well as two embryologists and an IVF nurse. Their responses to the varicocelectomy question were telling. They all described varicocelectomies as unwarranted, although they stressed that the majority of infertile Lebanese men and many fertile men with small varicoceles still undergo them. They criticized urologists in Lebanon for performing varicocelectomies with great abandon. They said urologists *need* to perform varicocelectomies if they are to attract infertile patients and to make money off this large patient population. They also stressed that it is easy to convince a vulnerable infertile man that a varicocelectomy will be the solution to his infertility problem. Infertile men are, in effect, an "easy sell," as most of them would do anything to overcome this difficult and emasculating condition. Finally, because infertility is a threat to masculinity, even *fertile* men may be convinced by urologists to undergo a varicocelectomy, believing that their future fertility is at stake.

These issues were emphasized one day in an informal conversation I had with three embryologists, all at the same IVF clinic. They explained to me that each of them had a brother who had undergone a varicocelelectomy. In one case, the brother had an excellent sperm count—140 million before and after the surgery—so the varicocelelectomy was clearly unwarranted. But a urologist had convinced him that this might help his wife to become pregnant. It did not; after two years of marriage, his wife was still not pregnant. In another case, the brother had a “borderline” sperm count of 35 million—still well above the WHO definition of 20 million as a low sperm count. A urologist convinced him to undergo a varicocelelectomy, which did nothing to change the sperm count, nor to overcome pain with sexual intercourse (which was likely due to a poorly performed childhood circumcision). In the third case, the embryologist had argued with his brother *not* to have the varicocelelectomy, telling him that it was a useless operation. But his brother was convinced by the urologist’s advice and went ahead with the varicocelelectomy anyway—again, for naught. When I asked the embryologists why all three of their educated brothers had undertaken unnecessary varicocelelectomies, they attributed it to physician avarice in an increasingly privatized and competitive medical environment. Varicocelelectomies are money-making ventures for urologists, who can charge USD 1,000 for their services (in an economy where the average physician has a mean monthly salary of only USD 2,000), plus generate substantial income for a hospital and business for its operating room.⁴ Varicocelelectomies in Lebanon are performed in the hospital (but not necessarily with an advanced surgical microscope), with additional hospital charges and operating room fees accruing to the patient. Given that monthly household incomes in Lebanon are well below USD 1,000, a varicocelelectomy costing USD 1,000, in addition to hospital and operating room charges, is a significant sacrifice for Lebanese men to make.

One of the three embryologists described the varicocelelectomy situation in Lebanon as a kind of urological “abuse” of men, especially infertile ones who are under significant social pressure to impregnate their wives.

I think [the men in this clinic] were kind of abused by the urologist.... I think any man, [he] goes to be checked. They tell him, “You know, you

could have a varicocele," or something. I think they [urologists] abuse it just for doing operations on patients. Because mostly before and after the operation, the sperm doesn't change quality. In some cases, it might be effective, but not in all of them. I know a lot of people who had the operation and the sperm stayed the same. [And] that's not counting sometimes that it gets worse.

When I asked this embryologist whether Lebanese urologists might consider shifting from doing varicocelectomies to vasectomies in order to offer useful surgical skills, he remarked,

There is a difference in the population in the thinking between the Eastern countries and the Western countries. Here, it's very important for men to have children. It's very important—this is like the goal of their life almost. In England, they can live without children, without any problem. But here, there is social stress and family stress that keeps on pressuring people to have children. Men just have to have kids in order to continue to be a real man. This is the popular thinking.

In short, varicocelectomies offer men the hope of improved fertility and the easy production of offspring, which, according to this embryologist, is "like the goal of their life." Thus, it could be argued that Lebanese urologists are simply offering a lucrative service that men want in order to fulfill their social and ego needs. But the question remains, what *do* men want? Why do men agree to undergo varicocelectomy, and what do they have to say about their experiences? These are the questions to be explored in the following section.

MEN'S EXPERIENCES OF VARICOCELECTOMY

Buyer's Remorse

For the many men in this study who had undergone a varicocelectomy, it stood out as their only experience of hospitalization and surgery. Most men were proud of their good health, even if they smoked, and many commented that they rarely, if ever, visited a physician. Yet nearly half of the infertile men in this study and nearly one-fifth of the fertile men had undergone a varicocelectomy operation, including several who had undergone the surgery before marriage or more than once.

Most had consented to the surgery because a doctor whom they trusted had recommended it as a way to improve their sperm count or, in the case of fertile men, to preserve their future fertility. Most were stoic about the surgery, saying it was not too painful and that they had recovered without complications. They could always indicate whether the operation had been performed on one or both testicles, based on recalling in which side(s) of the lower abdomen the incisions had been made. In the course of my interviews, some men stood to show me their incisions without embarrassment, much as they showed me their gunshot and shrapnel wounds from living through the Lebanese Civil War.

But stoicism gave way to anger and remorse among a significant number of men in the study. The critique of varicocelectomy being forwarded by Lebanese infertility specialists also emerged in interviews with men, including those who had experienced complications from the varicocelectomy; those who had experienced no improvement in their semen parameters or whose sperm counts had worsened following the operation; and those who believed they had been duped into a varicocelectomy by one physician, only to be told by another that the varicocelectomy was probably unnecessary. These angry and/or remorseful men, who saw themselves as having undertaken an unnecessary operation at the hands of an unscrupulous and greedy urologist, were the majority. Only a handful of men felt that they (or, more accurately, their sperm counts) had clearly benefited from the surgery. A few examples will be illustrative of the overwhelmingly critical discourse of men who had undergone a varicocelectomy, only to find themselves in a Lebanese IVF clinic facing ongoing infertility problems.

One Lebanese man, who resided permanently in West Africa, returned to Lebanon after his brief first marriage to a cousin broke up.⁵ Seeking a solution to his infertility, he underwent a varicocelectomy in 1997 with, in his words, "no improvement." In his view, "The doctors here are all liars. I didn't even have it [a varicocele], but I did it because the doctor told me to."

Another man, whose first wife initiated a divorce because of his infertility problems, described the varicocelectomies he undertook twice, once within each marriage:

In 1985, I did my first varicocelectomy, then two times, in the first

marriage and the second marriage. Maybe this operation was a mistake. They did something wrong in the second operation and my testicle became swollen on the right—very swollen for two months. I went to a doctor and he said that there were five cc's of water on the right, and on the left, two cc's of water in the testicle. He did another operation to drain the testicles. And in this last operation, they told me it killed the cells. There was an infection, and they had to drain it.

When I asked him why he had been willing to undergo two varicocelectomies, he said,

In Lebanon 25 years ago, anyone who has a problem having children, they directly tell him to do a varicocelectomy. The doctors here, they say you have to do it. But before the operation, my percentage [of sperm motility] was high, and after the operation, it decreased. It was futile.

Another man described a varicocelectomy he had undertaken before marriage:

I didn't have any serious varicocele problem, but I used to follow doctors' advice. I did it just so the doctor would be working. These doctors do the operation for materialistic purposes. Only one doctor told me to do it. I did a Doppler [ultrasound] at [a hospital in Southern Lebanon], and they said there is no varicocele. But this one doctor said, "Your testicle is small; you need this varicocelectomy." So I did it.

Another man described the complications of his varicocelectomy undertaken 17 years earlier:

The operation was a failure. It caused complications. I had water retention in the testicles, and they were swollen for two years, and the swelling was increasing. There was a "bag of water," and I did another surgery to remove the water. So the [sperm] count [before the operation] was 22 to 23 million and the motility stayed 70 percent. But after the surgery to remove the water [this was in 2002], there were no sperms. After the operation, it went to zero. I took a course of medications [which he names] after the operation. After the medicines, the count increased from 100,000 to 1 million.

When I asked him if the operation was a mistake, he responded,

Of course the varicocelelectomy was a mistake. A doctor was recommended to me [in a Southern Lebanese city]. He was a professor there—or at least they considered him a professor. Maybe he deceives the people. At first, this doctor told me, “Maybe this operation will succeed or maybe not. There’s a 6 to 7 percent chance of complications.” I was among the 6 to 7 percent. I was pushed to do this operation by the doctor, because he gave me some sort of hope. He said, “Fifty percent of men who do a varicocelelectomy have pregnant wives.” That’s why, in the end, I did the varicocelelectomy.

Hopes of Impregnation

This final remark is telling. Varicocelelectomies “give men hope” that they will be able to impregnate their wives in a society where marital fertility is very important. Men in Lebanon, as well as in other Middle Eastern societies, feel compelled by societal norms to father children. Thus, varicocelelectomy continues to be touted as the means to achieve this goal. Several men in the study said that they were convinced to do a varicocelelectomy based on the examples of other men whose inability to impregnate their wives had been overcome following the surgery.

Such was the case of a Lebanese man living in West Africa who returned to Lebanon in 1988 to undertake a varicocelelectomy after he was unable to impregnate his wife of three years. As he explained, “I didn’t want to do the operation, but I saw several possibilities. And I was really lost about what solution to take.” As in the other cases cited above, the varicocelelectomy did not help him to impregnate his wife. Eventually, pressured by his family members to “see his child,” he undertook a brief polygynous marriage to a second wife, who bore a daughter in 2001.⁶ He kept the marriage and the child secret from his wife, stating, “I’m very loyal. I’ve been married for 17 years, and I’ve had no other women except this one woman. This is because I love my wife.”

Another fertile man explained that he did a varicocelelectomy “for his wife” of nine years, given that she had already suffered through a miscarriage, two ectopic pregnancies, and the stillbirth of IVF twins.

They told me there is a varicocele, but it doesn’t affect [my fertility].

Yet I did the operation, about four to five years ago. My wife thought that maybe by doing the operation, maybe things would improve. She wanted me to do it, because she got scared that [the varicocele] might lead to further problems. Even though the doctor said it wasn't necessary, because I got my wife pregnant the first year of our marriage, I did it for her.

Many men in this study, both fertile and infertile, spoke lovingly of their wives and emphasized that they would never divorce them (or take a second wife). They viewed the quest for conception as a mutual endeavor, and they had come with their wives to IVF centers, often after several years of marriage, in order to try another way of conceiving a child. Both fertile and infertile men often felt sorry for the physical risks their wives had had to take as part of infertility treatment, particularly with repeated IVF or ICSI cycles. They expressed concern over the long-term risks of the powerful hormones women were required to take to stimulate their ovaries, and over the various "operations" (i.e., retrieval of ova and transfer of embryos) performed on women under partial or general anesthesia as part of an IVF or ICSI cycle.

It was clear to the men in this study, both fertile and infertile, that women suffer when undergoing infertility therapies. Varicocelectomies represent, on one level, these men's good faith efforts to share the physical risks and suffering of infertility experienced by their wives. At the same time, varicocelectomies contribute to men's own masculine desires to produce highly valued offspring. Thus, in social terms, varicocelectomies are undertaken for two main reasons: to bolster marriage through shared suffering, and to bolster masculinity through fertility. Indeed, the scars of varicocelectomy, which are proudly revealed by some men, represent a kind of bodily marking, symbolizing male responsibility for reproduction and men's investment in their marriages and commitment to fatherhood. Both socially and symbolically, varicocelectomies reveal a great deal about gender and marital relations in Lebanon and elsewhere in the Middle East where these operations are widely performed.

CONCLUSION

These findings on the high prevalence of varicocelectomy in the Middle Eastern region present a serious challenge to one of the strongest femi-

nist assertions in the world of infertility scholarship. Namely, Western feminist scholars such as Judith Lorber (1989) and Irma van der Ploeg (1995) have argued forcefully that men participate little in the unpleasant embodiment of infertility treatment, even when they are the infertile partner. Lorber uses the term "patriarchal bargain" (following Turkish feminist scholar Deniz Kandiyoti) to describe the ways in which women married to infertile men must consent to treatment on their own bodies in order to resolve the cultural pressure on women to become mothers. Van der Ploeg takes this argument one step further by suggesting that men's bodies, "by contrast, seem to remain relatively stable and untouched, even when... male pathologies are at issue" (461).

As shown in this article on varicolectomy, the Western feminist argument about the "unscathed" infertile male body requires considerable refinement. In the Middle East, many infertile men share painful "body histories" with their wives (Inhorn 2003), a fact that has been little discussed or recognized by feminist scholars, infertility scholars, or the public health experts concerned with men and reproductive health.

Varicolectomies undertaken to enhance or restore fertility—even when these invasive procedures are pointless and potentially damaging—are an underappreciated aspect of male reproductive health that deserves further global scrutiny. As shown in this article, varicolectomies are performed for many reasons, including physician avarice, masculinity expectations within homosocially competitive fertility regimes, and husbands' desires to share the burdens of reproduction with beloved wives. In their desire to support their wives and to fulfill their own desires for fertile manhood, Middle Eastern men are, in fact, placing themselves at risk of unnecessary and harmful fertility interventions, replete with iatrogenic complications, significant financial sacrifice, and physical pain and suffering. Given these hardships, it is clear that men, too, are heavily implicated in the trials and tribulations of infertility treatment—a form of reproductive intervention that has been heavily "naturalized" by Western feminist scholars as an exclusively female domain and burden.

As we enter the new millennium, the time has come to incorporate men, including Middle Eastern men, into reproductive histories and narratives. Varicolectomy is an unfortunately common form of male

infertility surgery in the Middle East and, as shown in this article, is replete with its own complications and risks. As such, it is a topic requiring serious and sustained attention, not only as an important issue in male reproductive health, but as an understudied and unappreciated dimension of the lived experience of manhood in the Middle Eastern region.

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NOTES

1. The most successful solution to male infertility is a variant of in vitro fertilization called "intracytoplasmic sperm injection" (ICSI). As long as a single viable spermatozoon can be retrieved from an infertile man's body, including through painful testicular biopsies and aspirations, this spermatozoon can be injected directly into an oocyte under a high-powered microscope. Such "forced" fertilization often leads to the development of a normal embryo. Since the introduction of ICSI in Belgium in the early 1990s, millions of ICSI pregnancies have been achieved, with the birth of generally healthy ICSI offspring. In the Middle East, ICSI was first introduced in Egypt in 1994, and since then, it has been widely practiced in the hundreds of IVF centers across the region. For example, Egypt (population > 70 million) has nearly 60 IVF clinics, and Lebanon (population approximately 4

million) has nearly 15 IVF clinics, most of them offering ICSI services.

2. Divorce rates in the Middle East are estimated to be about 25 percent, or half the rate in the U.S. (Fluehr-Lobban 1990). Furthermore, across the region, polygyny rates are only 3 to 4 percent (Omran and Roudi 1993).

3. Most men knew their in/fertility status, based on semen analyses, including analyses conducted at the time of the study in the clinic sites.

4. I questioned all of the men in my study about their monthly income levels. Most Lebanese men made USD 1,000 or less each month, resulting in annual incomes of less than USD 12,000. Physician salaries were usually higher. As shown by Lebanese public health professor Kassem Kassak and colleagues (n.d.), average physician incomes in Lebanon are approximately USD 2,000 per month.

5. For more than a century, the Lebanese have migrated abroad from their small country, seeking new homes and fortunes in Africa, Latin America and the Caribbean, and the Western countries. A significant number of Southern Lebanese Shi'a have migrated to the countries of West Africa, including Senegal, Sierra Leone, and Cote d'Ivoire, where fortunes have been made in diamond mining and other forms of entrepreneurship. This outmigration was intensified during the 17-year Lebanese Civil War. Today, many of these West African Lebanese return to Lebanon for vacations, or to find marital partners. In addition, "medical migration" to Lebanon is very common, given migrants' greater confidence in Lebanese medical institutions than in West African ones. Similar "ex-patriatism" can be found among Egyptian medical migrants returning to Egypt from the Arab Gulf countries (Inhorn 2003).

6. This was a unique case of polygyny, which was rare in this study population. In this case, the man still spoke by cellphone with his young daughter every day, but did not see her or her mother in order to protect his wife's feelings. Nonetheless, he was hoping to find a way to bring this daughter into his marital home, the chances of which he believed were better if his wife could have a child of her own. Although this man did not question the paternity of his daughter and assumed that he was fertile, his semen analysis revealed an extremely low sperm count and poor motility, or what in medical terms is known as "severe oligoasthenospermia."

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