

# Sexuality, Masculinity, and Infertility in Egypt: Potent Troubles in the Marital and Medical Encounters

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In Africa, high rates of infertility are due to infection and many other factors. This article explores male sexual dysfunction as both a cause and consequence of infertility in Egypt. Because sexual dysfunction is profoundly emasculating in a country where hegemonic masculinities are competitive, sexually troubled men in childless marriages do not routinely seek treatment from male physicians, leaving their wives to seek treatment for purported "infertility." However, the medical encounter between elite male physicians and poor women patients is characterized by a "don't ask, don't tell" policy, rendering sexual problems invisible. Furthermore, women are culturally prohibited from initiating sex, but infertility therapies often require them to do so. Marital difficulties in both the performance of sex and gender are the result. The article concludes with speculations on the future of male sexual dysfunction in the era of expanding sex education, sex therapy, Viagra, and new reproductive technologies.

**Key Words:** sexuality, masculinity, infertility, impotence, marriage, biomedicine, doctor-patient relations, new reproductive technologies, sex education, Islam, anthropology, Egypt

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Africa is a continent with high rates of infertility, including a so-called "infertility belt" wrapped around its center (Cates, 1985; Ericksen & 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 significant cause of infertility in Africa and else-

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where (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” (Inhorn, 1994; Webb & 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, 1987b). 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 repressed homosexuals 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 Egyptian notions of hegemonic masculinity (Connell, 1996, 2001) in a society where masculinity is homosocially competitive and the same Arabic term is often employed for both sexual “virility” and “manhood” (L. Ouzgane, personal communication, May 17, 2000). 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 implicates and deeply 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, 1992, 2000; Ouzgane, 1997). Thus, male sexual dysfunction, and its implications for both masculinity and infertility in African countries such as Egypt, is a topic worthy of further investigation.

To that end, this article examines the marital and medical troubles of mostly poor urban Egyptian couples who are childless as a result of male sexual dysfunction. Following a description of the study itself, I turn to the story of one Egyptian couple, whose “case” exemplifies many of the themes explored in this paper. This will be followed by a description of the male sexual problems causing childlessness among other couples in this study, and what couples did (or did not do) to resolve these problems. In particular, I will focus on what happens when wives in sexually troubled marriages seek treatment for their purported “infertility” from male Egyptian gynecologists—who often compound the problems through sexually insensitive biomedical infertility investigations and treatments. In the final section, I explore how rapidly globalizing new treatments for male sexual dysfunction, as well as increased sex education and psychological counseling, may begin to create “openings” for the transformation of sexuality, masculinity, and infertility in a changing Egyptian cultural landscape.

## METHODOLOGY

The findings and arguments in this article are based on two periods of field research in Egypt, in which my primary focus of investigation was the problem of infertility, including its causes and consequences. The first period took place in Alexandria, Egypt's second largest city, over fifteen months in 1988-89. The 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 infertile patients from the northwestern Nile Delta region. There, I conducted in-depth, semi-structured interviews in the Egyptian dialect of Arabic with 190 women, 100 of whom were infertile and 90 of whom were fertile "controls." These interviews took place privately in a small room in the hospital, and one section of the semi-structured questionnaire asked specifically about sexual practices and histories. Although most of the women in this study were poor, uneducated, illiterate or semi-literate housewives, who had never gone beyond grade school nor been employed in wage labor outside their homes, they nonetheless proved to be excellent and articulate informants, who seemed to enjoy the chance to "tell their stories" to an engaged listener, who would, to use their terms, "take their secrets far away." Following these interviews, I was invited by many women to their homes, usually in poor neighborhoods in Alexandria and its outskirts, where I was then introduced to their husbands. Nearly half of the 100 husbands of women in the study suffered from a "male factor": 40 percent had a medically diagnosed male infertility problem, as reported during interviews and confirmed through medical chart reviews, and 13 percent suffered from sexual dysfunctions reported to me by their wives but never reported to, nor charted by, a physician. 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.

Returning to Egypt during the summer of 1996, I spent three months from mid-May to mid-August conducting participant observation and in-depth semi-structured interviews in two private hospital-based in vitro fertilization (IVF) clinics located in exclusive suburbs of Cairo. In this second study, involving 66 cases of infertility, most of my informants were educated, middle- to upper-class Egyptians who, unlike my Alexandrian informants, often presented to these IVF clinics as couples. Thus, unlike my initial fieldwork, where women served as my primary informants, the more recent study involved both male and female informants in nearly 40 percent of cases. Of the male partners among these 66 couples, 70 percent suffered from a diagnosed male infertility problem. Although I did not take sexual histories as I had in my first study, several women reported to me that their husbands were "infertile" because of sexual dysfunction or were experiencing sexual performance problems as a consequence of infertility treatment.

Thus, confidential interviews (with guarantees of anonymity) in a variety of Egyptian infertility treatment settings afforded me the opportunity to explore the impact of male sexual dysfunction on the lives of infertile Egyptian couples of all social classes. This paper represents a first attempt to understand 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 who are 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 to which this article will return in later sections.

### THE CASE OF NARIMAN,<sup>1</sup> HER IMPOTENT HUSBAND, HER EGYPTIAN DOCTOR, AND HER AMERICAN “DUKTURA”

When I first met Nariman 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 long years of marriage. Naguib had been Nariman’s “choice” when she was only 17 years old. 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,<sup>2</sup> 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 semi-skilled wool analyst in an Egyptian textile factory. Naguib, his elderly father, and his brother, who shared the small, two-bedroom apartment, were kind to Nariman, and her primary role in the household 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.

She continued,

My feelings have changed toward him; they've gotten worse. But then I try to console myself and try to be nice again. Most of the time now, I'm not "accepting" him [i.e., she's repulsed by him], even though he's nice with me. It's because of the difference in age and during sexual relations, he's not that good. And he's not the happy type; he's somber. He doesn't understand me, and that's because of the difference in age. At the beginning, I was young and didn't know [any better]. But now I really feel it. It's better to choose someone close to your age. Frankly, I wish I had a different husband, especially now that I don't have any children. I feel very lonely at home; I feel empty. If I had children with him, my feelings toward him won't change, but at least I will fill this emptiness in my life. 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, which are 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 *amal*, or an act of sorcery by a jealous male rival, which has rendered him *marbūt*, or "tied" in his genital region. Naguib himself visited a *munaggīm*, or traditional spiritist healer, who read the Qur'an over Naguib and wrote a *higāb*, or amulet, which he was supposed to wear until the *rabṭ* 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 [i.e., that sorcery can cause impotence]."

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. Although Nariman suffers from a blocked fallopian tube, probably as a result of a post-miscarriage infection, she has nothing else preventing her from becoming pregnant. Thus, it is rather

remarkable that, over 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 “*duktūra*” 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, who became a close friend during my 15 months in the field, that we go together to speak to the physician. She consented, and, although the exchange with the doctor was somewhat awkward and tense, he immediately changed his treatment protocol, eliminating the “timed intercourse” component and scheduling Nariman for future artificial insemination using her husband’s sperm.<sup>3</sup> 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 quite varied. Some men, such as Naguib, suffered from low libido and impotence. Sometimes, the impotence was total, as in the case of a man with a war-related spinal cord injury; 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, as well as 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, lamented:

My husband doesn’t like to have sex a lot. His penis is not very stiff before entering, and when he enters, it becomes weak before ejaculating. And when he ejaculates, everything is “out” [i.e., outside the vagina]. Since the first day of marriage, even the wedding night, he couldn’t do it with his penis and had to use his finger. Over a period of two years, only four times he’s entered and it’s not complete, because in the morning, the sheets are all wet [i.e., where he’s ejaculated]. So this is a problem for me, but I can’t say something like this to my husband. And now [the infertility doctors] tell me to have sex and I can’t because he’s impotent. When he enters, it’s very weak and it becomes small and comes out. Of course, it’s not a normal sex life. Sometimes, I just feel it’s a joke or a game of children. But it depends on my mood and how I take it. I think it’s because he’s very nervous and always his nerves are tired. This is the reason he’s this way.... I never asked him anything so that he doesn’t get embarrassed. 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 [there is something wrong] in the picture: 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. Quite 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 dys-

function falls into this category. On the one hand, women view it as a “problem of nerves,” but it is their husbands’ “nervousness” that keeps many women from initiating frank discussions about how this “nervous” condition might be treated.

Unfortunately, few Egyptians—men or women, rich or poor—are willing to go to psychologists or psychiatrists for help. To do so is to admit true mental illness, which is profoundly stigmatizing. Thus, clinical psychology and psychiatry are marginalized professions in Egypt, reserved for the “worst” possible cases. And a “bad case of nerves”—even if it may cause sexual dysfunction—simply does not fall into this category.

Although most sexually dysfunctional Egyptian men refuse to seek psychological help, some do take their sexual problems to specialists. On the one hand, there are men’s physicians in Egypt known as “andrologists,” who, in urban areas such as Cairo and Alexandria, treat men 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.

On the other hand, 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 *marbūt*, 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 who is 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, a *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 *munaggimīn*, 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*,” or relatively large sums of money, to counteract the sorcery through a variety of methods. However, as seen in the case of Naguib, *munaggimīn* often “fail to deliver,”<sup>4</sup> 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 *munaggimīn*—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, often involving a single question about sexual frequency on the part of the consulting physician. In these tense moments in the medical encounter, wives typically remain silent, allowing husbands to provide a self-report of sexual frequency. 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 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 beyond basic high school reproductive biology, sex education is not taught in Egyptian schools, including in the fourteen Egyptian medical schools, which are overcrowded and have been criticized for their inability to adequately train the thousands of students who graduate each year (the largest number in the Middle Eastern region) (El-Mehairy, 1984; Inhorn, 1994). However, even if Egyptian physicians were to receive comprehensive education in human sexuality, it is likely that sexual denial and discomfort in the clinical encounter will persist, for reasons having to do with class- and gender-based power differentials, as well as increasing religious conservatism. In other words, the problem of physician-patient "missed communication" about sex in the management of infertility is linked to larger cultural forces involving medical professionalism, the persistence of patriarchal structures, and the rising tide of Islamism in the country.

With regard to medical professionalism, the lack of discussion about sexuality in the Egyptian clinical setting is part and parcel of the pervasive problem of poor communication engendered by medical elitism in Egypt. The patronizing attitudes and lack of cultural sensitivity of many Egyptian physicians toward their patients—especially poor, uneducated ones presenting at public medical facilities—has been noted by a number of scholars, who have described the untoward effects of medical paternalism on doctor-patient interaction (El-Mehairy, 1984; Inhorn, 1994; Sonbol, 1991). Indeed, 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 their social distancing of the lower and even middle-class patients who present to their clinics. Such distancing 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.

For their part, Egyptian physicians tend to rationalize their general lack of communication with patients by pointing to their lack of time to provide adequate patient education and counseling; their belief that patients actually fear explicit questioning and exchange of information and will seek treatment elsewhere if a physician is too communicative; and their belief in the inherent ignorance of uneducated, illiterate patients, who cannot begin to fathom frank medical discussions. Yet, it is equally plausible that Egyptian physicians do not foster open dialogue with patients in an attempt to maintain their privileges of elite professional status, including exclusive rights to esoteric information, authority to label and legitimate sickness, and the

acquisition of social prestige and economic reward for the monopolization of authoritative knowledge (Ehrenreich, 1978). Indeed, one candid Egyptian IVF physician lamented the fact that most Egyptian doctors want to be treated “like movie stars,” or god-like figures who stand high above their patients and expect reverence from them.

Furthermore, in the domain of infertility, such problems of professional status are compounded by the persistence of medical patriarchy. Although an analysis of Egyptian patriarchy is beyond the scope of this discussion and can be found elsewhere (Inhorn, 1996), suffice it to say that patriarchy, if defined broadly as relations of relative power and authority of men over women, maintained through mechanisms of male domination and control, is certainly operative in Egyptian biomedicine. For example, Egyptian gynecology, one of the “prestigious” specialties, is a remarkably male-dominated profession. Thus, even if an infertile woman wished to see a female specialist, she would be hard-pressed to find one in Egypt.<sup>5</sup> Yet, 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. The resultant inability of many infertile women to find a “sympathetic” male physician contributes to the common pattern of “doctor-shopping” in the country (Inhorn, 1994).

Moreover, as suggested by the physician’s comments above, rather 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.

Furthermore, 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. As in other religiously conservative countries of the Middle East and Africa, more and more Egyptians prefer true gender segregation in the medical realm—with female patients being treated by female physicians and male patients being treated by male physicians. 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 frus-

trated 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 Egyptian “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 tube or cup, often in a private room of an otherwise public space (such as a hospital). 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 really 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.'" Really, these doctors are savage—against humanity.

Such performance difficulties—as well as decreased sexual satisfaction on the part of many men undergoing treatment for infertility—have been widely reported from around the world (Boivin, Takefman, Brender, & Tulandi, 1992; Daniluk, 1988; Greil, Porter, & Leitko, 1990; Takefman, Brender, Boivin, & Tulandi, 1990), including in other parts of Africa (Hurwitz, 1989; Van Zyl, 1987a, 1987b). In particular, the Sims-Huhner or so-called "postcoital test" (PCT) has been described as a major source of "iatrogenically imposed impotence" (Rantala & Koskimies, 1988). Designed to evaluate the interaction of sperm and cervical mucus during the ovulatory phase of the menstrual cycle, the PCT requires couples to engage in intercourse on the approximate day of ovulation and then return to the physician's office within several hours of this sexual encounter for a vaginal sample of sperm and mucus to be collected. As noted by Boivin et al. (1992), "The reason why the PCT is associated with sexual difficulties is that couples are obliged to engage in sex regardless of their level of sexual desire and they must do so with the knowledge that their physician will grade (indirectly) the outcome of their sexual performance" (p. 510).

In Egypt, many infertility specialists rely on the results of the PCT as a kind of proxy indicator of sexual dysfunction—one specialist even describing the PCT as the "confessional chair." Yet, it is important to note that cultural scripts of "normative" sex in Egypt—which are different from ones in the West where the PCT was developed—complicate the very meaning of the PCT in ways that Egyptian physicians themselves may not realize. Namely, 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" (then return two hours later for a PCT) are typically disconcerted, deeming themselves entirely incapable of asking their husbands for sex—even for the purposes of this important test. Thus, negative results on the PCT may or may not be indicative of male sexual dysfunction. In some cases, a husband may be capable of "performing for the test," but 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 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 tests such as the PCT are threatening to both the performance of sex and gender in this cultural setting. Not surprisingly, Nariman and many other women like her who were told by their physicians to initiate sex with their husbands came to me in obvious distress, seeking advice on how they should handle this situation. Because many of them did not feel they could share their distress with their doctors, I was either asked to intervene on their behalf to find a culturally acceptable way of achieving the same diagnostic or treatment results, or expected to provide words of comfort and wisdom to women about how

they might best approach their husbands. In short, despite my own lack of professional training in this area, I served as an unofficial patient educator and counselor, providing services sorely missing in the Egyptian clinical encounter with male infertility physicians.

### FUTURES FOR THE SEXUALLY DYSFUNCTIONAL

What can be done in Egypt to alleviate the suffering of both sexually dysfunctional men and their long-suffering "infertile" wives? Although a lengthy set of policy recommendations is clearly beyond the scope of this discussion, let me conclude by noting a number of simple changes, some of which are already beginning to emerge, which could 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.

Egyptian physicians could do a much better job of relieving patients' anxieties related to sexuality by performing simple 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. Indeed, two of the gynecologists I interviewed in Alexandria, one male and one female, had incorporated aspects of sexual counseling into their thriving private practices. They described for me, 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 particularly 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 and has been highly recommended (e.g., Boivin et al., 1992; Rantala & 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, for all of the reasons described above. 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, p. 27). Like the physicians I interviewed in Alexandria who had incorporated sexual counseling into their practices, 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, p. 27).

Sex education is also slowly coming to Egypt—through satellite dishes and black-market pornographic videos which bring Western sexual ideas and practices directly to Egyptians of all social classes—as well as through indigenous attempts at sex education. Indeed, as of May 2000, Egyptian state television announced its launching of "Nefertiti TV," a new network named after the ancient Egyptian queen



in which topics previously thought to be “taboo” will be addressed through soap operas and chat shows and broadcast via satellite across the country. According to the female director of the new channel, “Sex education will be for everyone—mothers to help their daughters, young women and men. This television channel will leave no issue untouched and everything will be discussed bravely, honestly and with freedom” (Boulware, 2000). She added that the producers did not anticipate religious opposition “because Islam dictates that everything must be taught scientifically.”

In addition to public ventures in mass sex education, 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—otherwise known as Viagra—the new oral treatment for erectile dysfunction (ED) that has created a veritable “revolution” in the treatment of impotence in the West. Not surprisingly, its manufacturer, New York-based Pfizer Pharmaceuticals, is marketing Viagra globally with more than \$3 billion in annual sales. As of 1998, Egypt had become one of the global sites of Viagra distribution, with much media publicity and brisk sales (including a black marketing of Viagra as a “street” drug to prolong erection, in the same way that hashish is traditionally used by Middle Eastern men) (S. Idris, personal communication, March 20, 2001). Indeed, new pharmaceutically based cures for impotence—and Egyptian men’s desires to utilize 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)—known in Egypt as the “microscopic injection”—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—this spermatozoon can be injected directly into an ovum under a high-powered laboratory microscope, leading to subsequent fertilization and pregnancy in some cases. In other words, men with sexual dysfunction who are unable to produce semen samples through ejaculation are now candidates for this new procedure. Although the efficacy of ICSI remains relatively low (< 20 percent), some Egyptian IVF centers, which began offering these services in the mid-1990s, have achieved success rates comparable to or exceeding those of Western centers. Nonetheless, the price tag for ICSI remains high, effectively barring lower-class men such as Naguib from utilizing this new technology.

Still, it is fair to conclude that 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, where issues of equity and access are less pronounced. Taken together, emergent medical technologies, new forms of medical counseling and sex therapy, and media-generated attempts to bring sex education to Egyptians such as Nariman and Naguib may create openings for the transformation of sexuality, masculinity, and infertility in a changing Egypt as it enters the new millennium.

## NOTES

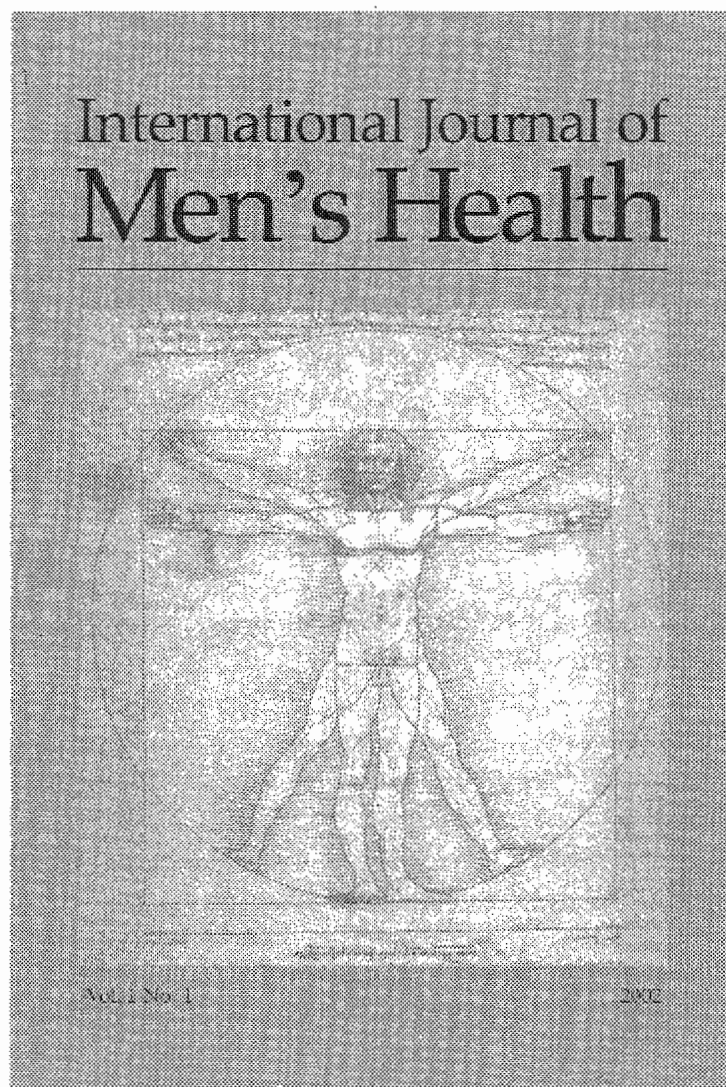
1. All names are pseudonyms.
2. Cousin marriage is a common practice in Egypt among all social classes, with patrilineal parallel cousin marriage being the preferred form.
3. Because donor insemination is religiously prohibited in all Muslim countries including Egypt (Meirow & Schenker, 1997), artificial insemination with the husband's sperm (AIH) is the only form of artificial insemination performed in the country. Although it still requires the production of a semen sample, it is not as sexually "demanding" as timed intercourse, given that semen for AIH can be donated at one's leisure and stored for future use.
4. See Inhorn (1994) for a lengthy discussion of the role of *munaggimīn* in Egyptian ethnomedicine. *Munaggimīn* generally have a poor reputation in Egypt as unscrupulous charlatans who deal in the sacrilegious business of sorcery. Not surprisingly, they are ardently opposed by Islamist groups in the country.
5. 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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