

- Struggle for Control*, ed. Vibeke Steffen, Richard Jenkins, and Hanne Jesen. Copenhagen: Museum Tusculanum Press.
- Turner, Victor. 1967. *The Forest of Symbols*. Ithaca: Cornell University Press.
- Weston, Kath. 1991. *Families We Choose: Lesbians, Gays, Kinship*. New York: Columbia University Press.
- . 1995. "Forever Is a Long Time: Romancing the Real in Gay Kinship Ideologies." In *Naturalizing Power: Essays in Feminist Cultural Analysis*, ed. Sylvia Yanagisako and Carol Delaney. London: Routledge.
- . 1997. "The Virtual Anthropologist." In *Anthropological Locations: Boundaries and Grounds of a Field Science*, ed. Akhil Gupta and James Ferguson. Berkeley: University of California Press.
- Wirtberg, Ingegerd. 1992. *His and Hers Childlessness*. Stockholm: Department of Psychiatry and Psychology, Karolinska Institutet.
- Yanagisako, Sylvia, and Carol Delaney. 1995. "Naturalizing Power." In *Naturalizing Power: Essays in Feminist Cultural Analysis*, ed. Sylvia Yanagisako and Carol Delaney. London: Routledge.
- , eds. 1995. *Naturalizing Power: Essays in Feminist Cultural Analysis*. London: Routledge.

## Chapter 10

# MALE GENITAL CUTTING: MASCULINITY, REPRODUCTION, AND MALE INFERTILITY SURGERIES IN EGYPT AND LEBANON

Marcia C. Inhorn

For nearly two decades, female genital cutting (aka female circumcision, female genital mutilation, female genital surgery) has been a topic of global reproductive health and human rights activism. It began with a Western feminist campaign to eradicate this practice and evolved into a more culturally nuanced, indigenous activism seen in many African and Middle Eastern countries where the procedure continues to be practiced. The controversies surrounding the Western-spearheaded campaign to eliminate female genital cutting from the globe have evoked, on the one hand, images of child abuse and torture and neocolonial visions of culturally disrespectful Eurocentric paternalism (or maternalism, as the case may be) on the other hand. Perhaps no other female reproductive health topic has elicited such global outrage, as shown by American medical anthropologist Ellen Gruenbaum in *The Female Circumcision Controversy: An Anthropological Perspective* (2001), which offers a deeply sensitive and highly nuanced account of both sides of the debate from the author's standpoint as a long-term ethnographer of Sudan.

What is missing in the global outcry over genital cutting is an acknowledgment that males around the world are also having their

genitals cut, beginning in infancy and ending in late adulthood. Worldwide, male circumcision rates are estimated to be between 25 and 40 percent (Circlist 2004). In the Muslim world, Israel, and the United States, circumcision rates are much higher (between 75 and 100 percent), with males routinely circumcised shortly after birth or in early childhood, either because of religious mandates (in the Jewish and Islamic worlds) or because of hygienic and accompanying aesthetic preferences and rationales. The American Academy of Pediatrics considers male circumcision to be an elective surgery, with no compelling medical benefits that warrant it as a routine procedure for newborns. Nevertheless, the majority of parents still circumcise their sons at birth or in the first week of life, with an estimated 1.2 million newborn males circumcised in the United States annually at a cost of between \$150 and \$270 million (American Academy of Pediatrics 1999). Although male circumcision is clearly accompanied by pain and discomfort, especially in the absence of effective local anesthesia, and is usually practiced on children who have no say in the matter or power to prevent the surgery from taking place, male circumcision has not evoked a similar global response. Presumably, this is because male circumcision has different sexual implications than female circumcision. To wit, one of the reasons female circumcision has evoked such a visceral response among Western feminists is that it challenges Eurocentric notions of female orgasm and women's ability to achieve sexual pleasure (Lane and Rubinstein 1996, Parker 1995). The same is not true for male circumcision; though it, too, may affect sexual pleasure, it is usually not linked to the inhibition of male orgasm, hence the lack of comparable prioritization as a global health issue. In other words, when it comes to cutting young genitals, there is a striking lack of comparability in global reactions to male versus female versions of the procedure.

Furthermore, males continue to undergo genital cutting well into adulthood, for purposes very much related to their reproductive futures. Globally, many men undergo vasectomy, or surgical sterilization, as a permanent form of birth control. Vasectomy rates in China and the United States are 10 and 14 percent, respectively, but even in semirural, conservative regions of Oaxaca, Mexico, some men are choosing vasectomy as a way to share the contraceptive burden and reproductive "suffering" of their wives, as shown by anthropologist Matthew Gutmann (2007). In addition, vasectomy in Oaxaca is viewed by some men in Gutmann's study as a way to enhance pregnancy-free extramarital affairs. Either way, the use of vasectomy in Oaxaca serves as a form of male participation in contraception, one of the goals being promoted after the International Conference on

Population and Development (ICPD), hosted in Cairo, Egypt, more than a decade ago (Dudgeon and Inhorn this volume).

Sharing the reproductive suffering of wives through male genital cutting may manifest itself differently in different parts of the world, including Cairo. In the Middle East, many men are willing to undergo painful male genital cutting to *enhance*, rather than inhibit, male 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 men whose wives are infertile. Varicoceles are varicose-type dilations of the scrotal veins that drain the testes that occur in about 15 percent of all men. Supposedly, if left untreated, they lead to a progressive decline in semen quality, which may be related to male infertility. Thus, urological surgeons have promoted varicocelectomies as a way to improve semen quality, even in the absence of well-designed studies to prove their efficacy in helping to achieve pregnancy (Kamischke and Nieschlag 1998).

Furthermore, in the Middle Eastern region, some urologists convince fertile men that they, too, should undergo varicocelectomy in order to prevent the possibility that a small, subclinical varicocele will lead to future male infertility problems. 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 entrepreneurial 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.

This chapter explores the relationship of varicocelectomy and other related forms of genital cutting to social norms of masculinity in the Middle East. The chapter begins by examining the considerable controversy over varicocelectomy that has emerged within the Western biomedical community. Despite a vociferous debate over the efficacy of this surgery and the introduction of new, improved techniques to overcome male infertility, varicocelectomy continues to be practiced widely in the Middle East, in part because of patient demand. But why do men want varicocelectomy? And what do they have to say about their experiences? The chapter's focus shifts from biomedical discourse on varicocelectomy to patient discourse among men who have undergone the surgery. Although most men

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 (Inhorn 1994). The very marks of varicocelectomy left on a man's body symbolize this shared suffering. On the other hand, varicocelectomy holds the promise of increased fertility in a region of the world where fertility and manhood are closely related. Indeed, varicocelectomy cannot be understood without examining Middle Eastern masculinity, which in turn, requires contextualization within the wider sphere of Middle Eastern gender studies, the final topic of this chapter. The ultimate goal of this chapter is to reveal why a little-known but biomedically controversial urological surgery is so popular in the Middle East. To answer this question, I begin with my 1988 journey to the region.

### Situating Male Genital Cutting: Research Settings, Methods, and Prevalence Rates

The importance of male genital cutting 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 semistructured reproductive history interview guide I had constructed laughed when he read my naive 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 due to a previous vasectomy. But according to this physician, "No Egyptian man agrees to a vasectomy." On the contrary, he told me, men in Egypt have surgeries to *promote* their fertility. Over time this statement was repeated to me by other Middle Eastern physicians and women I interviewed. The study that I conducted in Alexandria included 190 married Egyptian women (Inhorn 1994), 100 of whom were infertile and 90 of whom were fertile. None of their husbands used vasectomy 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 sixty-six 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 varicocelectomy 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.

The high prevalence of both male infertility and varicocelectomy 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 new reproductive technologies in 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). 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). 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.

I collected a large amount of data during the eight-month study period in Beirut. This included 220 complete eight-page reproductive history/epidemiological questionnaires, which I administered verbally 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 toxic metal analysis.

This chapter is based primarily on reproductive history and ethnographic data from a 2003 Lebanese study. As I was to discover,

55 of the 121 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 showed 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 form of male genital cutting in which sperm are drawn out directly from the testicles. In total, 64 of the 120 infertile controls in the study—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, eighteen 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, it 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.

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. However, the efficacy of varicocelectomy as a therapeutic and preventive surgery remains seriously in doubt. In the next section, I briefly review the Western biomedical debate surrounding varicocelectomy, contrasting it with the other forms of male genital cutting performed on infertile men as part of assisted reproduction. Special attention is paid to Lebanese IVF physicians'

and embryologists' critical discourse on varicocelectomy and their explanations for why the surgery continues to be practiced in such great numbers in Lebanon.

## Biomedical Discourses of Male Genital Cutting

### *The Varicocelectomy Controversy*

Varicoceles are varicose veins in the scrotum, which can make the scrotum feel like it contains a “bag of worms.” Varicoceles may be large or small, with the small ones detectable only by an advanced technology such as ultrasound. About 15 percent of all men have varicoceles; however, 21 to 41 percent of men with deterioration of the spermogram (i.e., infertile men) present with a varicocele (Takahara, Sakatoku, and Cockett 1991). In the largest varicocele prevalence study to date, undertaken among 9,034 male partners of couples consulting for infertility, the World Health Organization (WHO) (1992) determined that 25 percent of the men with sperm defects had varicoceles, as opposed to only 12 percent of the men with normal spermograms. Thus, the WHO study concluded that varicoceles are clearly associated with a deterioration of testicular function and subfertility, although not in all males. Furthermore, the causal pathophysiology, or why varicocelectomies lead to subfertility, remains unclear. Four causal mechanisms—disorders of thermoregulation, endocrine anomalies, biochemical anomalies, and hemodynamic anomalies—have been proposed (Audebert 2004), with the most commonly cited reason being elevated intrascrotal temperature, which is damaging to sperm production (Irvine 1998).

Although there is a substantial body of evidence suggesting that varicoceles cause progressive testicular damage, considerable controversy exists in the biomedical community over whether the correction of a varicocele through varicocelectomy actually improves fertility and pregnancy outcomes. Many urological surgeons, including in the Western countries (Goldstein 1995; Laven et al. 1992; Madgar et al. 1995), support varicocelectomy as a means of tying off damaged veins and restoring sperm production. In the United States, varicocelectomies remain popular and are advertised on clinic websites.

What is a varicocelectomy? First, it does not constitute a direct form of testicular cutting, although the testicles are physically handled in the operation. Namely, a small incision is made in the lower abdomen on the side of the affected testicle. The affected testicle is “delivered” (much like a baby is delivered through cesarean

section) through the incision so that the surgeon can examine the testicle and its circulatory system. Offending veins are "ligated" (tied off, as in tubal ligation), and the testicle is returned to the scrotum. With the advent of microsurgical techniques (using a surgical magnifying microscope), the surgeon can find and preserve the tiny testicular artery that brings blood to the testes, and also identify and preserve the lymphatic system, eliminating the risk of hydrocele. Thus, microsurgery helps to avoid the three most common complications of varicocele—hydrocele, testicular artery injury, and varicocele recurrence. Furthermore, these newer microsurgical techniques have allowed the surgery to be done on an outpatient basis. In the United States, for example, about 30,000 men undergo varicocele surgery annually, the vast majority of them sent home on the same day with pain medication (Virginia Mason Medical Center 2004).

Although urological surgeons are eager to promote varicocele surgery as a safe, simple, outpatient procedure that reestablishes proper testicular blood flow, hence improving male fertility through enhanced sperm production, the reproductive medicine community is less sanguine about the procedure. As pointed out in a review of male infertility diagnosis and treatment methods called "Do We Treat the Male or His Gamete?" Belgian reproductive medical specialist Devroey and colleagues (1998) argue that no peer-reviewed data based on well-designed clinical studies are available to demonstrate the benefit of varicocele surgery in overcoming male infertility. Thus, they conclude that "conventional therapies," including varicocele surgery, are "empirical and ineffective" in the treatment of male infertility (183). In the same issue of *Human Reproduction*, German reproductive medical specialists Kamischke and Nieschlag published a review of "Conventional Treatments of Male Infertility in the Age of Evidence-Based Andrology" (1998). As they pointed out, evidence-based medicine demands "high-quality, properly designed, truly randomized, placebo-controlled" studies, which have "pregnancy as the main outcome measure" (67). With varicocele surgery, "the purported improvement of male fertility has hardly been assessed by controlled clinical trials aiming to appraise pregnancy rates" (68). In a properly randomized, controlled, prospective trial, which compared a varicocele surgery treatment group with a control group that received clinical infertility counseling over a twelve-month period, no significant differences in the cumulative pregnancy rate of the two groups were found (Nieschlag, Hertile, Fischedick, and Behre, 1995). Thus, Kamischke and Nieschlag concluded that "intervention

can no longer be recommended," because "it remains questionable whether interventional treatment is superior to no treatment or to counseling in terms of fertility" (1998:69).

In the years since the first major critiques of varicocele surgery were published, the evidence against it has mounted. According to a WHO-sponsored report (Vayena, Rowe, and Griffin 2001), varicocele surgeries 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). Indeed, "less than twenty percent of men with reproductive failure have potentially treatable conditions for which a rational or proven effective treatment is available" (Tournaye 2001:83).

### The Introduction of ICSI

Instead of surgical treatment on the male genital tract to overcome male infertility, most evidence points to treatments that manipulate the male gamete—namely, the spermatozoon. In Belgium in 1992, intracytoplasmic sperm injection (ICSI) was introduced for this purpose. A variant of IVF, ICSI requires only a single viable spermatozoon, which is injected directly into an oocyte by means of a micromanipulator on a high-powered microscope. ICSI essentially "forces" fertilization to occur, even with very low sperm counts and poor sperm motility. It has proven "highly efficient in cases of severe male infertility that would otherwise be untreatable" (Tournaye 2001:84).

Even in cases of azoospermia, where no spermatozoa are found in the ejaculate, sperm can be removed directly from the testicles for use in the ICSI procedure (Devroey et al. 1998). Testicular sperm can be retrieved by different techniques, including testicular sperm extraction, which refers to an open excisional testicular biopsy; testicular sperm aspiration, which refers to methods by which testicular sperm are aspirated from the testicles; and fine-needle aspiration, in which thin-gauge needles are used to aspirate sperm from the testicles. These techniques are performed under either general or local anesthesia. As a form of testicular "needlework," they are usually accompanied by significant pain and discomfort.<sup>1</sup> However, for azoospermic men, ICSI with testicular extraction of sperm represents the only hope for producing biological offspring. In other words, ICSI has brought with it a new form of male genital cutting, but one that has proven remarkably effective

in the production of offspring among azoospermic men who would otherwise be permanently sterile.

Since the early 1990s ICSI, with and without testicular cutting, has been used extensively around the world to produce offspring for infertile males. A cumulative live birth rate of 60 percent has been reported after five cycles of ICSI in patients under thirty-eight using it as their first line of treatment (Osmanagaoglu et al. 1999). Moreover, fertilization failures are rare (2.8 percent) in men who produce sperm in their ejaculate (Tournaye 2001). Thus, ICSI is now the preferred method for overcoming male infertility in assisted reproduction centers around the world, including in the Middle East.

The Middle East boasts a booming private industry in assisted reproduction (Inhorn 2003). Egypt, for example, hosts fifty IVF centers for a population of seventy million and tiny Lebanon, with its three to five million inhabitants (depending on which estimate is used), boasts approximately fifteen IVF centers, one of the highest per capita rates in the world. In both Egypt and Lebanon, ICSI is routinely used in cases of male infertility, following its introduction in Egypt in 1994. Thus, ICSI has enabled thousands of infertile Arab men to become biological fathers (Inhorn 2003).

### Views of Varicocelectomy from IVF Clinicians

Given the success of ICSI in the region, the question remains as to why so many varicocelectomies continue to be performed on Middle Eastern men. 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. The doctor with perhaps the most to say about varicocelectomy explained it this way:

You know, varicocelectomy, it's probably one of the most common surgeries done here. I don't know why. Basically, there is a big difference in the concept of the effect of varicocele on the semen parameters between urologists and infertility specialists. It's very common, whenever a urologist is checking a man and finding a small varicocele without even sometimes checking his semen analysis, [that] he will do a varicocelectomy. And you know, sometimes the effect is worse on the sperm later on. So, definitely, there should be strict indications to do these varicocelectomies.

I know at least in the army here, they do a checkup for everybody. Everyone who wants to join the army, they do check up for this varicocele in the genital exam. And everyone who has a varicocele

is subject to varicocelectomy. So, imagine—it is said in the literature [that] fifteen percent of men have an anatomic varicocele. So if everybody has varicocelectomy, all the patients that have been coming from the army or are related to the military, they have a high incidence of varicocelectomy. And most of them ended up having oligospermia [low sperm count]. To start with, it was a little bit low, [but] it ended up very severe oligo.

Another IVF physician explained that Lebanese urologists need to believe in the efficacy of varicocelectomy in order to claim competence and expertise in the world of infertility:

I think many urologists still feel that varicocele remains a major problem. And some even believe that if the semen parameters are normal and you allow it [varicocele] to remain, it may actually affect the semen parameters. But actually, the trend has changed, [as of] some fifteen years ago, ten years ago. I would say more in Europe than in the US. There was a urology conference [in a Beirut suburb] some four years ago, and some European urologists were brought in here to stress the fact that varicocelectomy should not be done indiscriminately. And then, after a whole day of conference, they had an interactive button on each table so that everyone could share his or her view. So then they asked several questions to see if there has been a change in the views of the people present. When they reached the question of varicocelectomy, they gave a case and they said, "Do you think a varicocelectomy should be done?" And 90 percent responded "yes."

When I asked this physician if Lebanese urologists want to do varicocelectomies as a lucrative form of surgery, he replied, "The main reason is money." He added, "Some still hold it to be the only contribution urologists can have toward the fertility problem." Another Lebanese IVF physician, who had given a presentation at the Beirut conference, said,

It's really difficult to convince urologists of the evidence that [varicocelectomy] has no role in improving the pregnancy rate. Actually, I gave a talk in a urology meeting four years ago here in Beirut. It was a regional meeting, and so I gave a talk about varicoceles, and I think that everybody hated me in that room.

When I asked whether it was because they perceived him to be taking away their income, he remarked,

I think most of them, they do it for the money. It's really very easy to convince somebody with a mild defect of the spermogram or oligospermia [i.e., low sperm count] that he has an indication [for varicocelectomy].

These themes were repeated in virtually every interview with Lebanese physicians and embryologists. First, they described varicocelectomies as unwarranted but stressed that the majority of infertile Lebanese men and many fertile men with small varicoceles still undergo them. Second, 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 make money off this large patient population. Third, they 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 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 varicocelectomy. In one case, the brother had an excellent sperm count—140 million before and after the surgery—so the varicocelectomy 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 varicocelectomy, which did nothing to change the sperm count or to overcome pain with sexual intercourse, which was likely due to his childhood circumcision. In the third case, the embryologist had argued with his brother *not* to have the varicocelectomy, telling him that it was a useless operation. But his brother was convinced by the urologist's advice and went ahead with the varicocelectomy anyway—again, for naught. When I asked the embryologists why all three of their educated brothers had undertaken unnecessary varicocelectomies, they attributed it to physician avarice. Varicocelectomies are money-making ventures for urologists, who can charge US\$1,000 for their services (in an economy where the average physician has a monthly salary of US\$2,000) plus generate substantial income for a hospital and business for its operating room.<sup>2</sup> Unlike in the United States, varicocelectomies 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 US\$1,000, the surgery is a significant sacrifice for Lebanese families to make.

One of the three embryologists described the varicocelectomy 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. You know, 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. Some of them [urologists], they abuse this kind of operation. You know, there are several grades in the varicocele. Sometimes it's Grade I or Grade II; these don't need to be operated. If it's a Grade III or Grade IV, these need an operation. So the urologists, they start doing the operations at Grade I. Anything they see, they just want to make the operation.

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

Well, 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, vasectomies cannot become a popular surgery in Lebanon, because they eliminate fertility potential. On the contrary, varicocelectomies offer men the hope of improved fertility and the easy production of offspring, which, according to this embryologist, are "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 questions are explored in the next section.

## Men's Experiences of Male Genital Cutting

### *Buyer's Remorse*

For the many men in this study, varicocelectomy stood out as their only experience of hospitalization and surgery. Most men were proud of their good health, and many commented that they rarely, if ever, visited a physician. Yet, nearly half of the infertile men 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 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. 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 by Lebanese infertility specialists also emerged in interviews with men, including those who had experienced complications from the operation; 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 physicians. The 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 benefited from the surgery. A few examples are 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.<sup>3</sup> 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 divorced him 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 ccs of water on the right, and on the left, two ccs 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 twenty-five 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.

This man was one of several in the study who had been imprisoned during the Lebanese civil war. In this man's case, his testicular problems stemmed from genital beatings he sustained while a prisoner in Southern Lebanon and a series of testicular operations he undertook after his release. For him, the varicocelectomy represented a final genital operation in a series of agonizing genital events, which he described in graphic detail.

Another man, also wrongfully imprisoned during the Israeli invasion of Southern Lebanon in 1982, described the complications of his varicocelectomy seventeen years later:

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 twenty-two to twenty-three million and the motility stayed seventy 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 six to seven percent chance of complications." I was among the six to seven 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 hope 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 this 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. 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.<sup>4</sup> He kept the marriage and the child secret from his wife, stating, "I'm very loyal. I've been married for seventeen 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 general anesthesia as part of an IVF or ICSI cycle.

It was clear to the men in this study that women suffer when undergoing infertility therapies. On the one hand, varicocelelectomies represent these men's good-faith efforts to share the physical risks and suffering of infertility experienced by their wives. On the other hand, they contribute to men's own masculine desires to produce highly valued offspring. In social terms, varicocelelectomies are undertaken for two main reasons: to bolster marriage through shared suffering and to bolster masculinity through fertility. Varicocelelectomy scars, 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.<sup>5</sup> Both socially and symbolically, varicocelelectomies reveal a great deal about gender and marital relations in Lebanon and elsewhere in the Middle East where these operations are widely performed. For this reason, they need to be theorized in gendered terms.

### **Theorizing Male Genital Cutting in Middle Eastern Gender Studies**

#### *Middle Eastern Masculinities*

I would argue that Middle Eastern varicocelelectomy practices, as well as other forms of male genital cutting described in this chapter, cannot be understood without reference to Middle Eastern masculinity and is being theorized in Middle Eastern studies. Namely, a repeating

theme in the small but growing literature on Middle Eastern masculinities is one of homosocial competition among 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" (1997:3) 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, patrilineal, 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 (Delaney 1991; Inhorn 1996; Obermeyer 1999; Ouzgane 1997). In this region of the world, which "with some truth, is still regarded as one of the seats of patriarchy" (Ghoussoub 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). Moreover, they 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 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 varicocelelectomy. The widespread acceptance of varicocelelectomy 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 varicocelelectomy—in order to impregnate their childless wives. With impregnation, they prove their manhood and perpetuate the patrilineage through the production of offspring. Thus, in Foucauldian terms (1977), varicocelelectomies 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, because in the Muslim world, marriage is considered a moral and legal mandate and adultery a major sin (Inhorn 2003; Serour 1996). Indeed, 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, including those living in Lebanon and Egypt, marriage is similarly revered, 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 polygamy and divorce.<sup>6</sup>

### *Conjugal Connectivity*

Marriages in the Middle East are definitely evolving toward a companionate ideal, or what I have termed in my own work as "conjugal connectivity" (Inhorn 1996). In *Infertility and Patriarchy: The Cultural Politics of Gender and Family Life in Egypt*, I draw upon Lebanese-American anthropologist Suad Joseph's (1993, 1994, 1999) provocative work on "patriarchal connectivity" in the Middle East—or the ways patriarchy operates through both male domination and deeply enmeshed, loving commitments between Arab patriarchs and their family members. As argued by Joseph (1993, 1994, 1999, 2004), "intimate selving" in Arab families involves expectations of patriarchal connectivity, whereby men assume patriarchal power in the family not only with advancing age and authority but through the explicit production of offspring, whom they love and nurture as well as dominate and control.

Moving beyond Joseph's focus on the Arab family to the Arab couple, I suggest that the loving commitments of patriarchal connectivity also operate in the marital sphere. In my earlier work on Egypt (Inhorn 1994, 1996, 2003), I have demonstrated that both men and women, including poor men and women, are negotiating new kinds of marital relationships based on loving connectivity, which is experienced and expected in families of origin but has heretofore been unexpected and unexamined in the conjugal unit. That conjugal connectivity is operative among couples experiencing infertility problems in both Egypt and Lebanon attests to shifting marital praxis and the importance of love, mutual respect, and the sharing of life's problems even in the absence of desired children.

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. I would argue that the success of so many infertile marriages in the Middle East bespeaks the strengthening of conjugal connectivity at the expense of patriarchy, which—as confirmed by other Middle Eastern feminist theorists (Moghadam 2004)—is being undermined.

That patriarchy is shifting in favor of conjugal connectivity and more egalitarian gender dynamics are also suggested by research on men and reproduction in Lebanon. In a 2002 article “Challenging the Stereotypes,” American medical anthropologist Cynthia Myntti and a team of Lebanese researchers explore the use of withdrawal (*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 concern for their wives, in what could be described as a shared commitment toward mutually agreed upon reproductive goals and sexual pleasure.

Based on my 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 infertile, undertaking a varicocelelectomy—to purportedly increase sperm count and prevent any future demise in sperm parameters—may mean way men can share their wives’ suffering and participate in the treatment quest. Indeed, varicocelelectomy can be thought of as a means 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 infertile men feel toward their long-suffering infertile wives.

### *Unseating Stereotypes about Men and Reproduction*

The willingness of Middle Eastern men to have their genital areas cut open for such reasons may come as a surprise, especially given Western stereotypes of Middle Eastern men as inherently violent, fanatical, and unloving. Clearly, “tropes of male terrorism” need to be unseated for the Middle East, much as *machismo* for Latin America (Gutmann 1996, 2003). Furthermore, a strong feminist argument that has been put forward regarding men and reproduction requires serious challenge. Namely, Western feminist scholars such as Judith Lorber (1989) and Irma van der Ploeg (1995) have claimed in their work 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” (1995:461).

As I have demonstrated in this chapter, this earlier feminist argument about the “unscathed” infertile male body is both untrue and inherently dated. In addition to varicocelelectomies, which have been performed on male bodies for decades, the newest reproductive technologies require, in some cases, painful genital penetration in the form of testicular biopsies and aspirations. Men who are azoospermic are routinely subjected to genital cutting on diagnostic and therapeutic levels.<sup>7</sup> For azoospermic men in the Middle East, testicular aspirations and/or biopsies may represent the third in a series of genital cutting procedures, beginning with male circumcision in childhood, proceeding to varicocelelectomy following marriage, and ending in testicular aspiration and/or biopsy as the “last resort” in infertility treatment. Thus, in the Middle East, many infertile men have 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.

Male genital cutting to enhance or restore fertility—even when noninvasive procedures are pointless and potentially damaging—is

an underappreciated aspect of male reproductive health that deserves further global scrutiny. Male genital cutting involves surgeries performed for many reasons, including physician avarice, masculinity expectations within patriarchal regimes, and husbands' desires to share the burdens of reproduction with beloved wives. Male genital cutting in all of its forms is a topic requiring serious and sustained attention, much as female genital cutting has been highlighted in global public health advocacy. The importance of male genital cutting is a timely topic for the twenty-first century, not only in the Middle East but in the rest of the world, including the United States, where male genital cutting practices continue unabated. If we care so much about women's genitals, then we must also care about men's genitals and begin to question the various reasons why male genital cutting is performed so widely around the globe.

### Acknowledgments

I want to express my gratitude to the numerous men in Egypt and Lebanon who spoke to me about their infertility and reproductive lives. The IVF physicians, nurses, and staff members who helped me recruit male patients into this study deserve great credit—Antoine Abu Musa, Johnny Awwad, Abbass Fakih, Michael H. Fakih, Walid Ghutmi, Najwa Hammoud, Antoine Hannoun, Azhar Ismail, Da'ad Lakkis, Zaher Nassar, Gamal Serour, Khaled Sakhel, Hanady Shrra, Mohamed Yehia, Salah Zaki, and Tony Zreik. I also want to thank my primary research assistants Mary Ghanem (in Lebanon) and Tayseer Salem (in Egypt), as well as Huda Zurayk and Rima Afifi, who cordially provided me with institutional affiliations in the American University of Beirut Faculty of Health Sciences. I am grateful to Beth Talbot and Nina Kohli-Laven for research assistance on this chapter, as well as to Matthew Gutmann for sharing his new work on vasectomy in Mexico. This research was generously supported by the National Science Foundation and the U.S. Department of Education Fulbright-Hays Program.

### Notes

1. The multiple testicular penetrations often required to extract sperm from the testicles are exquisitely painful; that is why the procedure is always performed under either local or general anesthesia. In one of the clinics in which I worked, testicular aspirations were routinely being performed under general anesthesia. In the other clinic, testicular

biopsies were performed under local anesthesia in a clinical consultation room off the main IVF clinic waiting area. Azoospermic men who were taken into these rooms for the purposes of testicular biopsy often emerged walking slowly with their legs spread. I once tried to interview one of these men, with his encouragement, following his testicular biopsy. But his pain and discomfort became overwhelming, and his urologist recommended that he return to the clinical consultation room to lie down. Occasionally, men were required to undergo these painful biopsies when "performance anxiety" prevented them from producing a necessary semen sample at the time of IVF ova retrieval.

2. I questioned all of the men in my study about their monthly income levels. Most Lebanese men made US\$1,000 or less a month, resulting in annual incomes of less than US\$12,000. Physicians' salaries were usually higher. According to Lebanese public health professor Kassem Kassak and colleagues (n.d.), average physician incomes in Lebanon are approximately US\$2,000 a month.
3. 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 Côte d'Ivoire, where fortunes have been made in diamond mining and other forms of entrepreneurship. This outmigration was intensified during the fifteen-year Lebanese civil war (1975–1990). 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-patriotism" can be found among Egyptian medical migrants returning to Egypt from the Arab Gulf (Inhorn 2003).
4. This was a unique case of polygyny, which was rare in this study population. In this case, the man spoke by cell phone 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 the 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."
5. I am grateful to my coeditors for pointing out the potential symbolic associations of varicocelelectomy.
6. Divorce rates in the Middle East are estimated to be about 25 percent, half the rate recorded in the United States (Fluehr-Lobban 1990). Furthermore, across the region, polygyny rates are only 3 to 4 percent (Omran and Roudi 1993).
7. Azoospermia, probably due to microdeletions on the Y chromosome, is more frequent in the Middle East than in the West. IVF physicians speculate that it may be due to consanguineous marriage practices (i.e., family and village endogamy).

## References

- Ali, Kamran Asdar. 1996. "Notes on Rethinking Masculinities: An Egyptian Case." In *Learning about Sexuality: A Practical Beginning*, ed. S. Zeidenstein and Kirsten Moore. New York: Population Council.
- . 2000. "Making 'Responsible' Men: Planning the Family in Egypt." In *Fertility and the Male Life-Cycle in the Era of Fertility Decline*, ed. Caroline Bledsoe, Susanna Lerner, and Jane I. Guyer. Oxford: Oxford University Press.
- American Academy of Pediatrics. 1999. "Circumcision Policy Statement." *Pediatrics* 103:686–93.
- Audebert, Alain. 2004. "Varicocele and Male Hypofertility—Current Data." [www.gynweb.fr](http://www.gynweb.fr).
- Circlist. 2004. "Worldwide Male Circumcision Rates." [www.circlist.com/rites/rates.html](http://www.circlist.com/rites/rates.html).
- Delaney, Carol. 1991. *The Seed and the Soil: Gender and Cosmology in Turkish Village Society*. Berkeley: University of California Press.
- Devroey, P., M. Vandervorst, P. Nagy, and A. Van Steirteghem. 1998. "Do We Treat the Male or His Gamete?" *Human Reproduction* 13(Suppl. 1):178–85.
- Eickelman, Dale F. 1998. *The Middle East and Central Asia: An Anthropological Approach*, 3rd ed. Upper Saddle River, NJ: Prentice Hall.
- Fluehr-Lobban, Carolyn. 1990. *Modern Egypt and its Heritage*. Pittsburgh: Carnegie Museum of Natural History.
- Foucault, Michel. 1977. *Discipline & Punish: The Birth of the Prison*. Trans. Alan Sheridan. New York: Vintage Books.
- Ghousoub, Mai, and Emma Sinclair-Webb, eds. 2000. *Imagined Masculinities: Male Identity and Culture in the Modern Middle East*. London: Saqi Books.
- Goldstein, M. 1995. *Surgery of Male Infertility*. Philadelphia: W. B. Saunders.
- Gruenbaum, Ellen. 2001. *The Female Circumcision Controversy: An Anthropological Perspective*. Philadelphia: University of Pennsylvania Press.
- Gutmann, Matthew. 1996. *The Meanings of Macho: Being a Man in Mexico City*. Berkeley: University of California Press.
- . ed. 2003. *Changing Men and Masculinities in Latin America*. Durham: Duke University Press.
- . 2005. "Scoring Men: Vasectomies and the Totemic Illusion of Male Sexuality in Oaxaca." *Culture, Medicine, and Psychiatry* 29(1):79–101.
- . 2007. *Fixing Men: Sex, Birth Control, and AIDS in Mexico*. Berkeley: University of California Press.
- Inhorn, Marcia C. 1994. *Quest for Conception: Gender, Infertility, and Egyptian Medical Traditions*. Philadelphia: University of Pennsylvania Press.
- . 1996. *Infertility and Patriarchy: The Cultural Politics of Gender and Family Life in Egypt*. Philadelphia: University of Pennsylvania Press.
- . 2003. *Local Babies, Global Science: Gender, Religion, and In Vitro Fertilization in Egypt*. New York: Routledge.
- . 2004a. "Middle Eastern Masculinities in the Age of New Reproductive Technologies: Male Infertility and Stigma in Egypt and Lebanon." *Medical Anthropology Quarterly* 18:34–53.
- . 2004b. "Privacy, Privatization, and the Politics of Patronage: Ethnographic Challenges to Penetrating the Secret World of Middle Eastern, Hospital-based In Vitro Fertilization." *Social Science & Medicine* 59:2095–108.
- Irvine, D. S. 1998. "Epidemiology and Aetiology of Male Infertility." *Human Reproduction* 13 (Suppl. 1):33–44.
- Joseph, Suad. 1993. "Connectivity and Patriarchy among Urban Working-Class Arab Families in Lebanon." *Ethos* 21:452–84.
- . 1994. "Brother/Sister Relationships: Connectivity, Love, and Power in the Reproduction of Patriarchy in Lebanon." *American Ethnologist* 21:50–73.
- , ed. 1999. *Intimate Selving in Arab Families: Gender, Self, and Identity*. Syracuse, NY: Syracuse University Press.
- , ed. 2000. *Gender and Citizenship in the Middle East*. Syracuse, NY: Syracuse University Press.
- . 2004. "Conceiving Family Relationships in Post-War Lebanon." *Journal of Comparative Family Studies* 35:271–93.
- Kamischke, A., and E. Neischlag. 1998. "Conventional Treatments of Male Infertility in the Age of Evidence-based Andrology." *Human Reproduction* 13 (Suppl. 1):62–75.
- Kandiyoti, Deniz. 1988. "Bargaining with Patriarchy." *Gender and Society* 2:274–90.
- Kassak, K. M., H. Ghomrawi, A. M. A. Osseiran, and H. Kobeissi. n.d. "The Providers of Health Services in Lebanon: I. A Survey of Physicians." Unpublished manuscript.
- Lane, Sandra D., and Robert A. Rubinstein. 1996. "Judging the Other: Responding to Traditional Female Genital Surgeries." *Hastings Center Report* (May–June):31–40.
- Laven, J. S., L. C. Haans, W. P. Mali, et al. 1992. "Effects of Varicocele Treatment in Adolescents: A Randomized Study." *Fertility & Sterility* 58:756–62.
- Lindisfarne, Nancy. 1994. "Variant Masculinities, Variant Virginites: Rethinking 'Honour and Shame.'" In *Dislocating Masculinity: Comparative Ethnographies*, ed. Andrea Cornwall and Nancy Lindisfarne. London: Routledge.
- Lorber, Judith. 1989. "Choice, Gift, or Patriarchal Bargain? Women's Consent to In Vitro Fertilization in Male Infertility." *Hypatia* 4:23–36.
- Madgar, I., R. Weissenberg, B. Lunenfeld, et al. 1995. "Controlled Trial of High Spermatic Vein Ligation for Varicocele in Infertile Men." *Fertility & Sterility* 63:120–24.
- Moghadam, Valentine M. 1993. *Modernizing Women: Gender and Social Change in the Middle East*. Boulder: Lynne Rienner.
- . 2004. "Patriarchy in Transition: Women and the Changing Family in the Middle East." *Journal of Comparative Family Studies* 35:137–62.
- , Cynthia, Abir Ballan, Omar Dewachi, Faysal El-Kak, and Mary E. 2002. "Challenging the Stereotypes: Men, Withdrawal, and Reproductive Health in Lebanon." *Contraception* 65:165–70.
- , J. L. Hertile, A. Fishedick, and H. M. Behre. 1995. "Treatment of Varicocele: Counseling as Effective as Occlusion of the Vena Spermatica." *Human Reproduction* 10:347–53.

- Obermeyer, Carla Makhlof. 1999. "Fairness and Fertility: The Meaning of Son Preference in Morocco." In *Dynamics of Values in Fertility Change*, ed. Richard Leete. Oxford: Oxford University Press.
- Omran, Abdel Rahim, and Farzaneh Roudi. 1993. "The Middle East Population Puzzle." *Population Bulletin* 48:1-40.
- Osmanagaoglu, K., et al. 1999. "Cumulative Delivery Rates after 1051 Five-Year Follow-up of 498 Patients." *Human Reproduction* 14:261-263.
- Ouzgane, Lahoucine. 1997. "Masculinity as Virility in Tahar Ben Jelloun's Fiction." *Journal of Violence, Mimesis, and Culture* 4:1-13.
- Parker, Melissa. 1995. "Rethinking Female Circumcision." *Africa* 65:19-23.
- Population Reference Bureau. 2004. *World Population Data Sheet: Demographic Data and Estimates for the Countries and Regions of the World*. Washington, DC: Population Reference Bureau.
- Serour, Gamal I. 1996. "Bioethics in Reproductive Health: A Muslim Perspective." *Middle East Fertility Society Journal* 1:30-35.
- Takahara, H., J. Sakatoku, and A. T. K. Cockett. 1991. "The Pathophysiology of Varicocele in Male Infertility." *Fertility & Sterility* 55:861-68.
- Tournaye, Herman. 2001. "Gamete Source and Manipulation." In *Current Practices and Controversies in Assisted Reproduction*, ed. Effy Vayena, Patrick J. Rowe, and P. David Griffin. Geneva: World Health Organization.
- Van der Ploeg, Irma. 1995. "Hermaphrodite Patients: In Vitro Fertilization and the Transformation of Male Infertility." *Science, Technology, & Human Values* 20:460-81.
- Vayena, Effy, Patrick J. Rowe, and P. David Griffin, eds. 2001. *Current Practices and Controversies in Assisted Reproduction*. Geneva: World Health Organization.
- Virginia Mason Medical Center. 2004. "Varicocele Repair of Varicocele Surgery." [www.vmmc.org/dbFertility/sec1596.htm](http://www.vmmc.org/dbFertility/sec1596.htm).
- World Health Organization. 1992. "The Influence of Varicocele on Parameters of Fertility in a Large Group of Men Presenting to Infertility Clinics." *Fertility & Sterility* 57:1289-93.

## Part IV.

## CHILDBIRTH AND FATHERHOOD

## Fertility, Reproduction and Sexuality

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**Berghahn Books**  
New York • Oxford