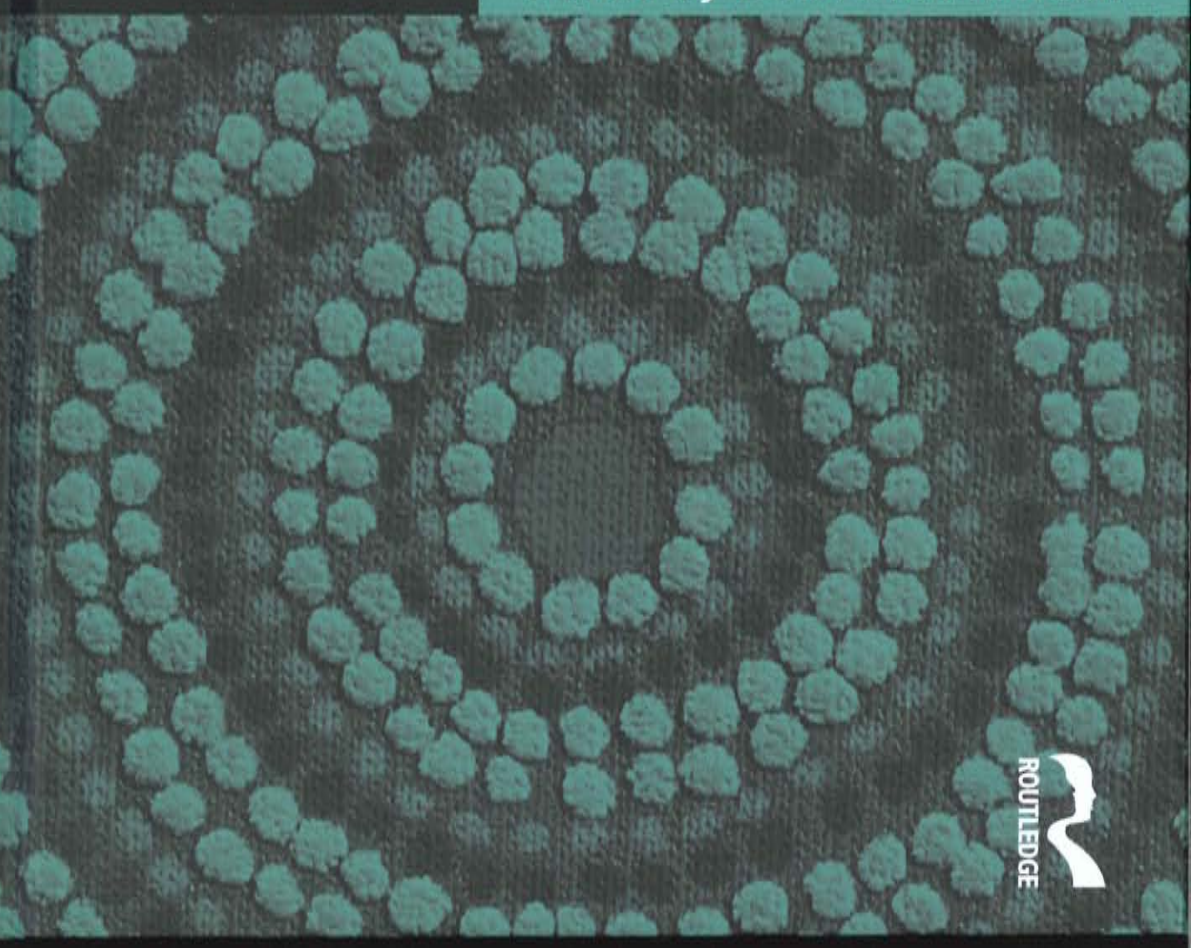
SEXUALITY, CULTURE AND HEALTH

TECHNOLOGIES OF SEXUALITY, IDENTITY AND SEXUAL HEALTH

Edited by Lenore Manderson



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Chapter 7

Diasporic sexuality

From condom ambivalence to ICSI quests in Lebanon

Marcia C. Inhorn

While conducting a medical anthropological study of male infertility in a busy in vitro fertilisation (IVF) clinic in Beirut, Lebanon, I met Mohsen, a Southern Lebanese Shia Muslim man who had fled to the West African country of Cote d'Ivoire in 1977 to escape the ravages of civil war in his home community. Mohsen agreed to participate in my study, with assurances that his ethnographic interview would be private and confidential. Literally hanging and hiding his head in shame, Mohsen described to me how he and 11 other young Lebanese Shia Muslim refugee men had had serial, group intercourse with a West African prostitute. Following this episode, he contracted a sexually transmitted infection (STI), which was quickly resolved with an antibiotic. Nonetheless, both Mohsen and his close hometown friend, Nabil, who had also participated in the group sex, had gone on to suffer from long-term infertility in their subsequent marriages, of 15- and 20-year durations, respectively. In Mohsen's view, it was this *zina,* or illicit sex act, that had caused his infertility. He lamented: 'Only God knows if this is the reason, but I think so. I feel guilty. But all of us were like this back in Abidjan [the capital of Cote d'Ivoire], because there were so many prostitutes.'

Little did Mohsen realise that his story is not unusual: a chain of events linking the youthful diasporic sexuality of young Muslim men like Mohsen to their later uses of male infertility technology 'back home' in Lebanon, and Lebanese IVF clinics are filled with such infertile Lebanese diasporic returnees, who lament similar sexual histories of indiscretion and infection. To overcome their male infertility, they must resort to intracytoplasmic sperm injection (ICSI), a variant of in vitro fertilisation (IVF) invented in Belgium in 1992 and designed specifically to overcome male infertility. Over the past two decades, nearly a half a million ICSI babies have purportedly been born around the world, including in the Middle East, where the technology has outstripped IVF as the single most common assisted reproductive technology (ART) (Inhorn 2012).

In this chapter, I explore six interrelated dimensions of sexuality, reproductive technology and globalisation in the Middle East. First, I argue that the now global phenomenon of 'forced migration' (Mowafi 2011), accompanied

by the eventual resettlement of youthful populations in diasporic communities in the global North and South, has led to a phenomenon that I call here *diasporic sexuality*. Diasporic sexuality is characterised by a loosening of the social mores and an absence of intergenerational control over marriage, sexuality and fertility normally found in home countries. Without such home-country social constraints, young men who flee to disparate diasporic settings around the world may be initiated into sex at earlier ages, with multiple partners, and outside of wedlock. As a result, their diasporic sexuality – premarital, marital and extramarital – may be quite different from what it would have been without a move to a foreign land. For Middle Easterners, I would argue that the extent of such unrestrained diasporic sexuality among men is quite profound, because of the very magnitude of forced migration from this region. As we shall see in the first section of this chapter, there is no other region of the world with higher proportions of external migration or internal displacement, mostly the result of war and other forms of political violence (Mowafi 2011).

The second aspect of sexuality, reproductive technology and globalisation to be explored in this chapter revolves around what I would call *condom ambivalence* in the Middle East. Condom use in the Middle East is poorly understood or studied. Nonetheless, available evidence from a number of different Middle Eastern countries shows that condoms are not easily accessible, and that many men are unwilling to use condoms for either contraception or disease prevention. This Middle Eastern condom ambivalence is partly a reflection of attitudes toward contraception as 'women's responsibility'. But it also signals the lack of sex education across the region and a number of cultural perceptions and misperceptions about condoms as a 'low-tech' reproductive technology. Such condom ambivalence may be ultimately deleterious to men's reproductive health and well-being. In addition to preventing the transmission of HIV, condoms are the best available prophylactic against two of the most common bacterial STIs, gonorrhoea and chlamydia, which can both lead to infectious, obstructive sterility in men and women.

The third issue to be taken up in this chapter involves *global disparities in assisted reproductive technology (ART) access*. Since the 1978 introduction of IVF in England, IVF and other related ARTs have spread quickly around the globe, including the 22 nations of the Muslim Middle East (Inhorn 2003, 2012; Inhorn and van Balen 2002). However, such ART globalisation has been very uneven (Nachtigall 2006). The global disparities in ART access are most glaring in Africa. Despite the World Health Organisation's recognition of an infection-induced 'infertility belt' stretching across the African subcontinent (Inhorn and van Balen 2002; Leonard 2002), only a small number of African nations offer ART services (e.g., Nigeria, South Africa, Kenya). ARTs are entirely absent in most of the resource-poor, war-ridden West African nations where Lebanese diasporic communities have tended to settle (e.g., Cote d'Ivoire, Liberia, Sierra Leone).

As a result of these global disparities in ART access, infertile Middle Eastern men such as Mohsen, living in the African diaspora, must contemplate the fourth phenomenon to be discussed in this chapter: namely, the *return reproductive tourism* of Lebanese men seeking ART services in their home country (Inhorn 2011). As I have defined it elsewhere (Inhorn 2011), return reproductive tourism has three distinctive features: (1) it is undertaken by expatriate populations, or those living outside their countries of birth; (2) it involves return to a home country of origin to undertake ARTs, and (3) it can be considered tourism because it involves a holiday visit to family in the home country.

Much of this return reproductive tourism to Lebanon is undertaken to overcome *male infertility*, the fifth issue to be taken up in this chapter. Of the more than 15 per cent of reproductive-aged couples worldwide who suffer from infertility, male infertility contributes to *more than half* of all cases (Vayena *et al.* 2002). Male infertility is especially common in the Middle East, where it is estimated to affect between 60 and 90 per cent of all ART clinic cases (Inhorn 2004a). This high prevalence of male infertility in the Middle East and elsewhere is not popularly known. Male infertility has been called a neglected reproductive health problem, one that remains deeply hidden (Inhorn 2012; Mundigo 1998). Studies have shown male infertility to be among the most stigmatising of all male health conditions (Becker 2000; Lloyd 1996; Upton 2002). The depth of this stigmatisation may be even deeper in non-Western settings such as the Middle East, casting a permanent shadow on a man's community standing. Such stigmatisation is clearly related to issues of sexuality. Male infertility is popularly, although usually mistakenly, conflated with *impotency* (i.e., erectile dysfunction), as both disrupt a man's ability to impregnate a woman and to prove one's virility, paternity and manhood. This 'fertility–virility linkage' (Lloyd 1996) means that men who are infertile are assumed to be impotent, even though most are not.

Male infertility involves four major categories of sperm defects, including low sperm count (*oligozoospermia*), poor sperm motility (*asthenozoospermia*), defects of sperm morphology (*teratozoospermia*) and total absence of sperm in the ejaculate (*azoospermia*). Azoospermia may be due to lack of sperm production (*non-obstructive azoospermia*) or blockages in sperm transport (*obstructive azoospermia*), often caused by prior STI-induced damage to the epididymis, the major sperm-carrying vessel. Moreover, non-obstructive azoospermia is highly prevalent in the Middle East, as are cases of severe oligoasthenozoospermia (i.e., very low sperm count and poor motility) (Inhorn 2012). Most cases of these cases of *male infertility* cannot be effectively treated; male infertility is a condition that is generally chronic and incurable (Inhorn 2012, Maduro and Lamb 2002).

Nonetheless, the high-tech variant of IVF known as ICSI (pronounced 'ik-see') has proven to be a singularly effective solution to male infertility. Indeed, the introduction of ICSI in Belgium in 1992 was a watershed event.

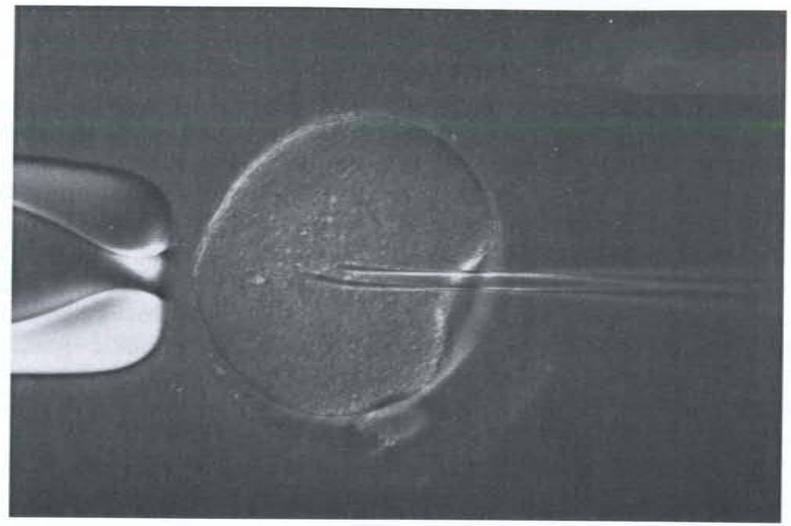

Figure 7.1 Intracytoplasmic sperm injection (ICSI). Courtesy of Getty Images

A variant of IVF, ICSI solves the problem of male infertility in a way that IVF cannot. With standard IVF, spermatozoa are removed from a man's body through masturbation, and oocytes are surgically removed from a woman's ovaries following hormonal stimulation. Once these male and female gametes are retrieved, they are introduced to each other in a petri dish in an IVF laboratory, in the hopes of fertilisation. However, 'weak' sperm (i.e., low numbers, poor movement, misshapen) are poor fertilisers. Through micromanipulation of otherwise infertile sperm under a high-powered microscope, they can be injected directly into human oocytes, effectively aiding fertilisation to occur (see Figure 7.1). As long as one viable spermatozoon can be extracted from an infertile man's body, it can be ICSI-injected into an oocyte, leading to the potential creation of a human embryo. With ICSI, then, otherwise sterile men can father biogenetic offspring. This includes azoospermic men, who produce no sperm in their ejaculate and must therefore have their testicles painfully aspirated or biopsied in the search for sperm. In short, ICSI gives infertile men a greater chance of producing a 'take-home baby'.

The coming of ICSI to the Middle East in 1994, where it was introduced in an IVF clinic in Cairo (Inhorn 2003), has led to a virtual 'coming out' of male infertility across the region, as men acknowledge their infertility and seek the ICSI solution. The coming of this new 'hope technology' (Franklin 1997) has repaired diminished masculinity in men who were once silently suffering from their infertility. Furthermore, ICSI is being used in the Middle East and elsewhere as the assisted reproductive technology of choice, effectively replacing

its predecessor IVF. Whereas IVF leaves fertilisation up to chance, ICSI does not. Thus, ICSI provides a more guaranteed way of creating 'the elusive embryo' (Becker 2000).

This rapid globalisation of ICSI from the west to the Middle East has led millions of Middle Eastern men on *ICSI quests,* which are the final issue to be taken up in this chapter. These ICSI quests may be in country, as Middle Eastern men from the hinterlands travel to the major urban centres were ICSI is generally offered in private IVF clinics (Inhorn 2004b). Or these ICSI quests may involve return reproductive tourism of Middle Eastern men such as Mohsen, who are living their lives in the diaspora. Infertile men's enthusiasm for this expensive and high-tech solution provides a stark contrast to their condom ambivalence. Whereas condoms bespeak *zina,* or illicit sexuality, ICSI is viewed as a helpful reproductive technology designed to overcome a medical problem, thereby facilitating men's ability to become biological fathers.

This ICSI solution is not a panacea, however. As we shall see through two case studies, such ICSI quests are fraught with challenges, including for the women who must embody this technology, even if they themselves are healthy and fertile. The stories of Ali and Fadia, travelling to Lebanon from Côte d'Ivoire *on their second ICSI quest,* and Karim and Mona, returning to their diasporic community in Nigeria after their fifth failed ICSI quest in Lebanon, bespeak the difficulties of accessing and then conceiving with ICSI. As I will argue, it is a *dashed-hope technology* for the majority of Middle Eastern infertile men. Through their stories of hope and then despair, the complex relationship between men's youthful diasporic sexuality, condom ambivalence and later unsuccessful ICSI quests to Lebanon should become abundantly clear.

Ethnographic setting and research methods

I base this chapter on an ethnographic study entitled Middle Eastern Masculinities in the Age of New Reproductive Technologies, which I carried out from January to August 2003 in Beirut, Lebanon. Exactly 220 Middle Eastern men from a variety of social classes and religious backgrounds participated in the study. The men hailed from three nations, mainly Lebanon, but also Syria and Palestine. The majority were Muslim (70 per cent), about half Shia (35 per cent), half Sunni (30 per cent), and a small number of Druze (4 per cent) and Alawi (1 per cent). The remaining men in the study, nearly one-third (30 per cent), were Christians from a variety of denominations, including Maronite Catholic (14 per cent), Greek Orthodox (8 per cent), Armenian Orthodox (2 per cent) and Roman Catholic (2 per cent).

At the time of the study in 2003, there were approximately 15 to 20 emerging IVF clinics in Lebanon – one of the highest numbers per capita in the world (Inhorn 2012). The study was based in two of the earliest, busiest and most successful IVF clinics in Lebanon, both located in central Beirut.

One clinic was part of a large, private university-based teaching hospital and catered to a religiously mixed patient population of both Sunni and Shia Muslims, Christians of a variety of sects, Druze and various immigrant and refugee populations. All of the IVF doctors were male, Maronite Catholics, who had received their IVF training in both the USA and Japan. All of the embryologists and nursing staff were Muslim women, only one of whom had trained outside the country in Belgium.

The other research setting was a private, stand-alone IVF clinic catering primarily to southern Lebanese Shia Muslim patients, but with occasional Christian and Sunni Muslim patients from both Lebanon and neighbouring Syria. In this clinic, all of the IVF doctors were Muslim, half Sunni and half Shia, with the only practicing female IVF doctor (a Sunni Muslim) in the city. The male IVF physician who owned and directed this clinic had trained at Yale University and had opened one of the largest and most successful private IVF clinics in the Midwestern USA. At the time of the study, he was also in the process of opening an IVF clinic in Dubai, United Arab Emirates, and thus he flew regularly between Detroit–Beirut–Dubai to see patients and undertake IVF and ICSI cycles.

Between these two clinics, 220 men were recruited, 120 of whom were infertile, and 100 of whom were fertile men married to infertile women. Men's fertility status was determined by semen analyses, which were carried out in the IVF clinics' laboratories, and which were based on the guidelines set out by the World Health Organization (2010). Infertile men in this study generally knew that they suffered from this condition, based on multiple semen analyses, sometimes carried out over many years. All of the men were recruited into the study while in the midst of seeking or undertaking an IVF or ICSI cycle. In 44 of these cases, men's wives also participated in interviews.

Importantly, nearly half of the men in the study (exactly 100) had spent extended periods of their lives abroad, in 50 different countries of residence (see Table 7.1). At the time of the study, 32 of the Lebanese men were living abroad: 11 in sub-Saharan Africa (Côte d'Ivoire, Sierra Leone, Senegal, Nigeria, Gabo, Ethiopia); ten in other parts of the Middle East (Saudi Arabia, UAE, Kuwait, Yemen, Egypt, Tunisia); five in North America (the USA or Canada); three in South America (Brazil, Panama); two in Europe (the Netherlands, Switzerland); and one in Asia (Taiwan). In total, 57 of the 220 men (25 per cent) were undertaking reproductive tourism at the time of the study. Of these, 37 men were engaging in return reproductive tourism to Lebanon, primarily to undertake ICSI for male infertility, but also for wives' infertility problems (Inhorn 2012).

In-depth ethnographic interviews were undertaken with all of the men in the study. More than half of the interviews were conducted in Arabic (57 per cent) and about one-third in English (35 per cent), with the remainder involving both languages (8 per cent). Because so many of the men in the

Table 7.1 Middle Eastern men in the diaspora: 50 countries of stated residence

North America	*South America*	*Europe*	*Middle East*	*Africa*	*Asia*	*Australia-Pacific*
United States (19)	Brazil (4)	United Kingdom (10)	Lebanon (17)	Cote d'Ivoire (7)	Kazakhstan (1)	Australia (2)
Canada (6)	Panama (2)	France (9)	Saudi Arabia (11)	Sierra Leone (3)	Taiwan (1)	
	Venezuela (2)	Russia (7)	United Arab Emirates (10)	West Africa Unidentified (3)		
		Switzerland (6)	Kuwait (7)	Liberia (2)		
		Netherlands (4)	Syria (6)	Nigeria (2)		
		West/East Germany (4)	Egypt (3)	Gambia (1)		
		Belgium (4)	Iraq (2)	Senegal (1)		
		Sweden (3)	Iran (2)	Gabon (1)		
		Greece (3)	Jordan (2)	Mauritania (1)		
		Cyprus (2)	Libya (2)	Zaire (1)		
		Armenia (1)	Yemen (2)	Zambia (1)		
		Ukraine (1)	Oman (1)	Ethiopia (1)		
		Romania (1)	Tunisia (1)			
		Luxemborg (1)	Turkey (1)			
		Unidentified (1)	Gulf Unidentified (1)			
N = 2	N = 3	N = 15	N = 15	N = 12	N = 2	N = 1

study had lived outside the Middle East, they spoke excellent English (along with other languages in many cases). Interviews sometimes lasted two to three hours, because, as we will see, many of the men in the study shared information that was often deeply personal and poignant.

Middle Eastern diasporas

In order to understand these men's lives, it is important to begin with the landscape of diaspora in the Middle East. Originally, the term diaspora referred to geographically scattered religious groups living as minorities among people of other faiths. However, between the 1970s and 1990s, the term diaspora was greatly expanded to encompass most contemporary forms of out-migration. As noted by French scholar Stephane Dufoix in his book *Diasporas*, '"diaspora" has become a term that refers to any phenomenon of dispersion from a place; the organisation of an ethnic, national, or religious community in one or more countries; a population spread over more than one territory; the places of dispersion; any nonterritorial space where exchanges take place, and so on' (Dufoix 2008: 2).

For centuries, the Middle East has been a site of both diasporic concentration and dispersion. For example, Armenians fleeing the Ottoman Turks settled in ethnic enclave communities in Lebanon, Syria and Egypt. Similarly, the Druze, a persecuted minority group that emerged from Shia Islam in the eleventh century, fled in 1948 to the high mountains of Lebanon, Syria and what would become the state of Israel. In more recent years, the region has become the site of significant internal and external migration, because of three historical processes: (1) mid twentieth-century decolonisation movements across the Middle East and North Africa, some of it associated with bloody violence (e.g., Algeria); (2) uneven regional political economies, related largely to the varying regional dispersion of oil wealth; and (3) political violence and outright war occurring in many Middle Eastern nations over the past 60 years (Gelvin 2005). This includes ten military interventions by the USA alone, including two current wars in Iraq and Afghanistan (Inhorn 2008). In 2011, most of the revolutionary uprisings across the Middle Eastern region have involved violence and the flight of refugees, especially from Libya and Syria.

These three major factors – decolonisation, uneven political economies and political violence – have led to massive population movements within the Middle East and beyond. The Middle East and North Africa have the largest percentage of migrants in the world, and the world's highest proportion of internally displaced persons (IDPs) (Mowafi 2011). No region of the world has been more affected by the population disruptions and diasporic dispersions associated with political violence. Over the past two decades in particular, 15 of the 22 Middle Eastern nation-states (roughly 85 per cent of the region's total population) have suffered in protracted conflict situations

Table 7.2 Lebanon: a civil war timeline

1970:	PLO arrives in Lebanon following 'Black September' massacre of Palestinians in Jordan
1975:	War officially begins in April between Christian Phalangists and PLO
1976:	Arab League approves 40,000 Syrian troops as peacekeepers in Lebanon
1978:	Israel invades Lebanon and occupies South with aid of Southern Lebanese Army
1982:	Israeli forces invade Beirut and support massacres by Phalangists in Sabra and Shatila Palestinian refugee camps
1983:	Attacks on U.S. and French military garrisons, leading to deaths of 241 U.S. marines and 58 French soldiers
1984:	Assassination of American University of Beirut President Malcolm Kerr by unknown assailants
1985–1989:	Period of intense fighting between shifting Muslim, Christian, and Druze factions
1989:	Taif Agreement signed in Saudi Arabia to end war
1990:	War officially ends, although violence continues in early 1990s
1990–2000:	Ongoing Israeli occupation of Southern Lebanon
2000:	Withdrawal of Israeli troops in May, with liberation of military prisons
2003:	U.S. and British invasion of Iraq prompts anti-Western violence in Lebanon
2005:	Assassination of Lebanese Prime Minister Rafik Hariri in February draws international scrutiny and leads Syria to withdraw its troops from Lebanon in April under international pressure
2005-2006:	Continuous assassinations of leading political leaders and journalists
2006:	The six-week 'summer war' between Hisbullah and Israel

(Mowafi 2011). However, this figure does not include the new situations of political violence emerging since the 2011 'Arab spring'.

Lebanon represents one of the Middle Eastern countries most affected by ongoing political violence. The civil war in Lebanon, which lasted for 15 years (1975–90), could be described as 'intersectarian', in that it involved major fighting between multiple ethnic-religious groups. Nonetheless, a variety of external actors were involved in the civil war, including the USA, Israel, the Palestine Liberation Organisation (PLO), Syria, Iran and Russia (see Table 7.2). The war had severe impacts on the socio-demographic, economic and health conditions in the country. At the socio-demographic level, the war resulted in the death of 7 per cent of the Lebanese population, the serious injuries of 10 per cent, the internal displacement of 25 per cent and the emigration of nearly 30 per cent of the population (Jabbra 2004; Joseph 1994; Saxena *et al.* 2004). At the economic level, the war resulted in severe deterioration of Lebanon's physical infrastructure, environmental sanitation, social services, health care and schools (Inhorn and Kobeissi 2006).

Given the breakdown of social services and the chaos created by war and destruction, many Lebanese attempted to flee the country during the war period. Only 3.5 million Lebanese are estimated to remain in Lebanon today, whereas nearly 15 million are thought to live outside the home country. Nearly seven million of these diasporic Lebanese refugees are estimated to live

in Brazil, and nearly a half a million in the USA, where they make up the single largest group of Arab Americans. Lebanese ethnic enclaves can also be found throughout the world, including in most parts of Latin America and the Caribbean, in French-speaking West Africa (particularly Côte d'Ivoire, Sierra Leone and Senegal), and Western Europe, Australia and Canada.

Of those Lebanese who fled during the war years, a disproportionate number were young men, whose parents feared they would be conscripted into militias or otherwise be targeted for killing. In some senses, these young men were the lucky ones, in that their sisters often remained in Lebanon throughout the war years, eventually aging into spinsters because of disrupted male-to-female sex ratios (Inhorn and Kobeissi 2006). Yet, young men's lives, too, were disrupted by war. Periods of residence outside of the country affected Lebanese men's abilities to marry in a timely fashion and also led some of them to contract STIs, as in the case of Mohsen. In fact, for many young Lebanese men, exile outside of the home country led to patterns of condomless diasporic sex, sometimes with prostitutes, which many of them later blamed for 'ruining their reproductive organs'.

Diasporic sexuality and condom ambivalence

In my ethnographic research in Lebanon, I asked all 220 men a series of questions about their sex lives, which were part of detailed reproductive histories. These reproductive histories included questions about age of sexual initiation, numbers of sexual partners (past and present), practices of contraception including condom use, histories of STIs, and current sexual relationships and problems. Assuming a high level of candour during the confidential interviewing process, nearly one-third of these 220 men stated that they had never had another sexual partner other than their current wife. A few men seemed slightly embarrassed to admit their premarital virginity. As one man put it: 'Maybe you won't believe this, but it [sex] was when I got married. She was the first.' Others were proud of their lifetime monogamy, fidelity and morality. For example, one man stated emphatically: 'No girlfriends! No sexual relations!', while another man answered my question, 'When did you first have sex?' by saying: "On my wedding night. Never before, and with no one else after!'

Eight per cent of men in my study had had only two sexual partners, either because they had divorced and remarried, or because they had one serious girlfriend before marriage. Two-thirds of the men reported sex with less than ten lifetime partners, and usually with less than five. These were mostly men who had lived their entire lives in the Middle East, where premarital sexuality does occur, but in a limited fashion. As one Lebanese man explained: 'It is very rare in Lebanon to have multiple partners, or sex before marriage.' Another put it more whimsically: 'In Lebanon, because of religion, you have to take sex like a thief! Lebanon is not sexually open like America, which is why all Lebanese men want to go there!'

Virtually all of the men who reported more than ten lifetime sexual partners had spent their youths outside the Middle East, either in West Africa, Latin America, Europe, the USA or Canada. This was particularly true of the 30 men (17 per cent) who claimed to have had more than 100 sexual partners, or 'so many' that the numbers were 'uncountable'. Not all of these men were proud of their sexual pasts, sometimes openly regretting the dissipation of their reproductive potential. Indeed, Table 7.3 reveals a great deal about diasporic sexuality and accompanying shame. As illustrated, some men attributed their current male infertility problems to excessive premarital sex, encounters with prostitutes and the contraction of STIs. Furthermore, those men who admitted to having extramarital sexual partners, past or present, often felt guilty about adultery, although they may have tried to justify it as a result of sexual problems within marriage.

Interestingly, few of these men had ever used condoms. Only 27 of the 220 men (12 per cent) in the study reported that they had ever used condoms. Of these 27 condom users, half had used condoms within marriage, generally for a brief honeymoon period or as a temporary form of birth spacing. Condoms were never reported as a primary form of contraception within marriage. The other half (13 of the total 220 men, or 6 per cent) had used condoms as a prophylactic technology either before marriage or with extramarital lovers. Without exception, these men had lived in diasporic communities in North America (Canada, the USA), South America (Venezuela), Europe (France, Germany, Greece, Sweden, United Kingdom), West Africa (Côte d'Ivoire, Sierra Leone) and the Arab Gulf (Saudi Arabia, United Arab Emirates). Even though these men had used condoms, often at a partner's request, only one man claimed consistent use – or as he put it, '*always* with my sex partners'. The rest admitted using condoms only sporadically, and a few men described getting girlfriends pregnant, followed by abortions.

These very low levels of condom use in the study population meant that most men's diasporic sexuality was condom-less. Of the 79 diasporic Lebanese men who reported having multiple sexual partners, 66 of these men (84 per cent) had never used condoms. When I asked men about their condom use, most simply said 'no' or 'never', with some adding that condoms are 'not common', 'not popular', or used 'very little' by Lebanese men. This study finding – that Lebanese men do not use condoms and view them as uncommon and unpopular – is supported by a recent, large-scale study by Andrzej Kulczycki (2004) on condom use among Shia Muslims from Southern Lebanon. Based on 25 qualitative focus groups with both men and women, as well as a survey of 589 women of childbearing age, the study found low overall levels of condom use in the study population, accompanied by high levels of negative commentary among male focus-group participants.

According to Kulczycki, most men held many 'encumbering beliefs' about condoms. These included concerns about condoms' perceived fragility and ineffectiveness (i.e., condoms break and tear); both male and female sensory

Table 7.3 Lebanese men's reported diasporic sexuality and guilt

Country	*Fertility Status*	*Reported Problems*
Lebanese, formerly living in U.S.	Infertile	Too much premarital sex with approximately10 partners. "I thought probably that I exhausted myself before marriage. I let myself go. I let everything out before the right moment, and now I'm being punished."
Lebanese, living in Panama	Fertile, but with erectile dysfunction	Considering himself "like a Panamanian with too many" sexual partners, he currently has one primary mistress and two to three other extramarital relations. He is impotent about half the time he tries to make love to his wife, so he uses Viagra. "The problem here is marriage. It's something psychological. I have a problem, and I have to talk about this problem. But the culture makes it difficult to talk about personal things. I don't like this. I'm not a medical person, but if someone explains this problem [of impotence], then we can learn about this." [Speaking to the anthropologist], "Maybe you will write a book, and I can read it and learn."
Lebanese, formerly living in Cote d'Ivoire	Infertile	Covering his face in shame, he admitted to having "weakness" in sex and problems producing a semen sample. He attributes this to diabetes. He believes his infertility is due to participation in group sex with an African prostitute, which led to an STI.
Lebanese, formerly living in Russia	Infertile	Premarital sex with more than 25 partners in Russia, where he contracted two STIs. Blames his infertility on the STIs. "One friend, a doctor in Russia, told me to get married back then, because maybe these infections will cause long-term problems. I'm happy with my wife and my life, but sometimes I think, 'Why didn't I get married in Russia, so that I could have a child?' If I had gotten married in Russia, I'm sure I would have a child now."
Lebanese, living in Sierra Leone	Infertile	Married to his second cousin. Had premarital gonorrhea from an "uncountable" number of sexual partners. His virginal Russian girlfriend became pregnant and had an abortion. He believes his infertility is the "price he paid" for his sexual history. "Sexually, during the old days, I was enjoying life a lot when living in Africa. My girlfriend got pregnant and she had an abortion. After that, when I got married, these little things caused weakness. I enjoyed [sex] a lot, but I already spent my reproduction." [Do you feel guilty?] "Not guilty exactly, but too much of it [sex] brought some weakness. In my opinion, the problem is that any young guy living in Africa needs to receive the advice, 'Take good care of yourself'." Currently, he lives apart from his wife in Lebanon, so has problems of quick ejaculation when he has sex with her after long periods of abstinence.
Lebanese	Infertile	Believes his infertility is due to a history of 4 to 5 STIs with more than 50 sexual partners. Now suffers from impotence and loss of sexual desire.

Table 7.3 (continued)

Country	*Fertility Status*	*Reported Problems*
Lebanese, living in Nigeria	Infertile	Had several hundred premarital sexual partners in Dubai and Europe. Contracted genital herpes, which recurs when he is under stress. He experiences impotence "when I have to give sperm."
Lebanese, formerly living in US, Europe, and Africa	Fertile	Had more than 100 sexual partners, especially in Africa, where he contracted five STIs. His wife suspects he is having affairs and asks him about this frequently. "She's very suffocating!"
Lebanese, traveling to Europe for work	Infertile	Has had more than 300 sexual partners, never liking to sleep with a woman more than once. He told a doctor, who prescribed an anti-anxiety medication and an anti-depressant. Since marriage, he has been overworked and has painful migraine headaches after sex, which has affected his desire. "When I have stress, I don't feel like it [sex]. And sex makes me feel tension, not relaxation. I have the drive, but no time, and I'm worried about a migraine after intercourse."
Lebanese	Infertile	Started masturbating and having sex at age 16, contracting two STIs and eventually developing a problem with ejaculation. "At first, it was a very strong ejaculation, then it weakened." He attributes his infertility to "an excess of sexual intercourse" with more than 100 partners.
Lebanese, formerly living in Switzerland	Infertile	Has extramarital sexual partners in Dubai and Europe when he travels for business. Blames his infertility on excessive youthful masturbation and early sexual activity. "I became sexually active at a very young age, 15 onwards. I think a man should be sexually active at age 30. [Do you feel guilty?] I don't feel guilty, but now there is no room any more for mistakes. If I make any mistake, this won't be acceptable because I'm a man." [Do you feel you are being punished by God for your past mistakes?] "Yes, sometimes, perhaps this could be it."
Lebanese, formerly living in Venezuela	Infertile	Blames his infertility on his premarital masturbation, when he did not have a constant sex partner. "A doctor said to me that infertility is the consequence of *not* having constant [sexual] relations. The interruption. This is the only problem [for his fertility]." Even so, in Venezuela he had "for sure" more than 1,000 sexual partners, "or five to seven women every month." He contracted an STI, and was circumcised at age 22 "for cleanliness."
Lebanese	Infertile	Blames his infertility on STIs. Lived with a Filipina maid/girlfriend for 11 years, and then with a woman from Mauritius. Both became pregnant and aborted. He contracted 2 STIs, including genital herpes. "I got sick with an STD from a woman, a bad woman, and I took injections. I had some herpes from the woman from Mauritius, the kind that comes on the mouth."

deprivation and pain, leading to sexual dissatisfaction; interference with marital intimacy due to unwanted delays in coitus; the 'unnaturalness' of condoms as a 'tent' or man-made covering over the penis; and a barrier or interference in God's fertility mandate. Furthermore, condoms were strongly stigmatised for their association with illicit sex; in the focus groups, condoms were associated with promiscuity, and men were reluctant to use them for fear of raising suspicions of infidelity or of having an STI. As Kulczycki (2004: 253) noted:

> The topics of extramarital affairs and sexually transmitted diseases (STDs) were awkward to bring up in focus-group discussions in light of strictly enforced sanctions against nonmarital sexual relations. No participants deemed STDs, let alone HIV, to be a problem in their own communities. Nevertheless, both men and women said that some HIV-infected individuals lived quietly in the village communities and had contracted the virus when working abroad in Africa … Several women mentioned that whereas migrant workers might use condoms with other women when overseas, they would never do so with their wives. Most women apparently believe that their marital relationships are monogamous and do not seem worried about the risk of acquiring an STD.

As Kulczycki explained, the low prevalence rates for condom use in Lebanon are not unique. Across the Middle East, contraceptive prevalence rates in general lag behind most other developing regions, and condom use is relatively rare, despite limited alternative contraceptive options and growing awareness of STIs, including HIV. In the few studies of condom use in other parts of the Middle East, including Egypt, Jordan, the Arab Gulf and among US Arab immigrants, condom use rates are uniformly low, while negative attitudes toward condoms are uniformly high (Al Mulla *et al.* 1996, Boutros and Skordis 2010; Ehsanzadeh-Cheemeh *et al.* 2009, Shaeer and Shaeer 2011). In all of these studies, researchers found high dissatisfaction rates with condoms among those who had ever used them; many negative attitudes about condoms, including the belief that they are to be purchased and used only by homosexuals (a highly stigmatised category of persons); and the notion that condoms should be reserved as a marital contraceptive. Because of the lack of sexual education across the region, understandings about the role of condoms in STI disease prevention was low. Even male and female sex workers at high risk of STIs knew little about condoms and rarely used them with their clients (Boutros and Skordis 2010).

According to the authors of one of these studies (Ehsanzadeh-Cheemeh *et al.* 2009: 230): 'Condom use is seen as a sign of embarrassment, immorality and corruption in Middle Eastern culture. Embarrassment with regard to condoms in particular is a barrier to condom use.' They also note that some Middle Eastern immigrants develop '"parallel lives" when they move out of

their home country. Being away from their families, friends and communities allows them a certain degree of freedom which, if taken advantage of, can lead to promiscuity.'

The ambivalence toward condoms found in all of these studies must be seen in light of the Islamic concept of *zina,* or illicit sex. In Islam, licit sex is defined as heterosexual intercourse within marriage. Thus, *zina,* or illicit sex, is defined as any form of sexuality outside the heterosexual marital union. Premarital, extramarital and homosexual sex are all considered *zina,* as is masturbation, which is generally looked upon unfavourably within the Islamic legal schools (Khuri 2001; Musallam 1983). In short, the only form of licit sex within Islam is marital sex, thus leaving open multiple possible forms of sexual transgression.

Condoms, it seems, connote *zina,* even though there is no particular mandate against condoms in Islam (Omran 1992). Indeed, *azl,* or coitus interruptus, has been promoted in the Islamic scriptures as a viable form of male-controlled contraception (Musallam 1983). Thus, the problem with condoms is neither a religious injunction against birth control, nor toward male involvement in contraception. Rather, Middle Eastern men's *condom ambivalence* rests with the association between condoms and *zina,* which clearly discourages men from purchasing and using condoms as a form of contraception and disease prevention.

Unfortunately, the problem with such condom ambivalence is that it does not prevent *zina,* or illicit sex, from happening. As seen in my own study, the majority of Lebanese men had had premarital sexual partners, and this was especially true of those men living in diasporic settings, where promiscuous, condom-less sex was, in fact, the norm. In general, these mostly Muslim men framed their diasporic sexual experiences within the religious framework of *zina.* They blamed themselves for their sexual exploits, and felt considerable remorse. Those who were infertile believed that they were 'paying the price' for their past sexual mistakes, or that God was directly 'punishing' them for their *zina.* Talking to men about their sexual histories often opened up a veritable floodgate of emotional angst. For example, one man lamented:

> I think the excess of sexual intercourse could have affected my fertility. Having several different women could have weakened my sperm. It's like eating too many different foods at once; it makes you feel nausea, vomiting. So how about having several partners? I think this is the main cause of my infertility. I had too much sex without condoms, and it weakened the sperm. Although I felt the desire to have intercourse at the time, I am feeling guilty now.

In my study, many Lebanese men who had lived abroad had contracted STIs through such unprotected, promiscuous, diasporic sexuality. Although STIs are not the leading cause of male infertility, some STIs, especially gonorrhea and chlamydia, may lead to irreversible changes in the male reproductive tract, leading to later obstructive infertility. In my study, many men lamented their youthful sexual transgressions and histories of STIs, claiming that they had 'used up their good sperm,' 'abused their reproductive organs', or 'already wasted their fertility'. Past sexual mistakes were deemed the source of current infertility problems, with some Muslim men claiming that they were being punished by God for their sexual transgressions. The story of Ali, who fled by himself to Abidjan, Côte d'Ivoire, at the tender age of 16, demonstrates how a young Lebanese man's diasporic sexuality and aversion to condom use may affect his later reproductive life and his need to return to Lebanon for ICSI.

The story of Ali's sex life without condoms

When we met in a Beirut IVF clinic, Ali was a 40-year-old childless man with a severe case of oligoasthenozoospermia (low sperm count and poor motility). With little prompting, Ali poured out the story of his solo flight from Lebanon to Africa, his entrée into the world of West African premarital sex, and his eventual marriage to a young Lebanese beauty. But, with marriage, Ali also discovered that he was infertile, leading him and his young wife back to Lebanon for ICSI.

Ali was born in the southern Lebanese Shia community of Nabatiye, known during the war years as a Hisbullah stronghold. By 1979, the war in Lebanon was raging, and Ali's parents feared that he would be conscripted into one of the Shia militias forming in the country. As the only son in a family with four daughters, Ali was considered a precious child. Thus, fearing for his safety, his parents found a way for Ali to leave Lebanon, even though, at the age of 16, he was only in his second year of high school.

Travelling for the first time and all alone, Ali was sent to Abidjan, where his father's sister had already emigrated. This move to Côte d'Ivoire changed Ali's life forever. As he explained:

> In Côte d'Ivoire, it's not like Lebanon. The French are there, and the young French men are used to having lots of women, some white, some black. You could take a woman for five minutes in a car. It was like that 20 years ago when I arrived. I was living alone in Côte d'Ivoire, although when I was 18 years old, one of my Lebanese friends came to live with me for two years. But I lived alone, going from school, to work, to home. And, from the ages of 16 to 37, I maybe had 10,000 different women. [Anthropologist: 'Really?'] Yes, it was a different life. From age 16 years old, I was having sex with a different woman every day, or maybe four times a week. If I saw someone on the beach, I would 'take one' [for sex]. If it was on the weekend, it was in a hotel, or otherwise in my house. I was a young guy, and I rented a studio and I had a car. I was

not living with anyone. My parents were back here in Lebanon, and they helped me to escape from the war.

With no parental oversight and no sex education of any kind, Ali pursued a path of reckless, condom-less sex, although he practiced coitus interruptus to prevent his girlfriends from getting pregnant. As he explained:

> I never got any of my girlfriends pregnant. I was scared to get an out-of-wedlock child. I once went out with a girl who loved me a lot and wanted kids, but I escaped. Although she tried to convince me, 'I will take the child and raise it by myself', I was *very* much concerned about establishing a family for a child. Sixty to seventy percent of Lebanese men there had children out of wedlock during the 1980s and 90s, and the children were of different nationalities. There was a lot of 'sexual openness', and it was very different. People of all nationalities were living together, and because of the heat and maybe the food they eat, it makes people sexual.

When Ali first heard about HIV/AIDS in 1989, he was in a faithful relationship with a Dutch girlfriend. But because he started hearing about cases of AIDS and because he never liked using condoms, he altered his behaviour by 'only having sex with married women I knew well'. However, prior to this point, he had never practiced any form of safe sex; thus, he had contracted six or seven STIs over a ten-year period. As he explained:

> All of the Lebanese and French men were like this, and we were definitely *not* using condoms, or *preservatoires* as they are called in French. All of the men in Côte d'Ivoire have this same problem of multiple infections, sometimes 50 of them. In my case, I had six or seven infections, with something white coming out. I took pills in most cases. But I did have one infection where something like coal came out of my penis. I was very afraid of injections when I was young, so I took pills only. But, after two months, it still wasn't normal, and so only then did I take injections.

In retrospect, Ali says he deeply regrets his decision to forego a medical checkup and delay the treatment of his STI, because he attributes his current infertility to 'this problem'. As he lamented:

> In my opinion, the problem is from the two months when I didn't take injections for this STD. I didn't see the doctor because I was afraid of the injections for the infection. I feared they would be very painful. But maybe this infection, this is the problem now. There is no other reason for my infertility.

Today, Ali describes himself as having a severe male infertility problem, or in local parlance, *da'if ktiir* (a lot of weakness): 'The number is three to four million, but the problem is the percentage living: only 30 percent after three hours. The first 30 minutes are okay, but after one-half hour, they [sperm] are dead.'

As is often the case, Ali did not discover that he was infertile until four months after marriage.

> I went to a doctor in Abidjan, the same Lebanese doctor who was following my wife at first. She had some infections after our first sexual intercourse, so they thought this was a female problem. But I myself suggested to the doctor, 'Why not test me? And they discovered my low sperm count.'

Ali continued:

> I was not affected, because it wasn't the end of the world. But I became much more affected when the doctor prescribed hormones to my wife when he shouldn't have. The problem is from me, not her. I automatically comforted my wife, 'I'm the source, not you, so stop taking those hormone injections.'

Ali described how he had made a conscious decision to marry a Lebanese woman of the same religious faith.

> I'm 40, and all the people my age already have children. I promised myself to marry only a Lebanese Shia woman like myself. A lot of Lebanese in Côte d'Ivoire were married to French, Europeans, and their marital lives were not successful. *Lots* of marital problems. So, because of my character, I can see living the same lifestyle as the Europeans, but not the same marital life.
>
> My cousins, three of them, one took a French wife, and she took her children and left her husband for France. Another cousin's wife couldn't adapt to Lebanon. She stayed for two years here and said, 'I want to go back to France. Divorce me.' The third one, his wife took him to France and he's living there with their children. But he's not concerned with Lebanon or his parents. So, with all of those problems, I took the decision to marry a Lebanese Shia woman. It doesn't mean I'm not 'modern,' but I've witnessed those things. Experience is one thing, and hearing is another thing, and they all have big problems in their lives.

With matchmaking help from his sisters in Lebanon, Ali chose to marry Fadia, a 20-year-old woman who had spent her entire life in Beirut. As Ali explained:

> My wife is very pretty and educated. She's very pretty, a real beauty. I love her very much. Although I used to love my girlfriends, I couldn't go out with only one. But since marriage, I've gotten stable, maybe because of her nature. I don't know if it's my nicest sexual relationship, but I do know that I love her a lot and I consider her not just a sex partner. Although she does what is expected during the sex act, it's different than going out with a 'professional', because professionals are different and know different things. But I have no desire to be with anyone else. Maybe because of my age and because I love my wife, I am faithful to her. In fact, sometimes for her sake, I have sex even when I don't want to, just to satisfy her desire.

Both Ali and Fadia are eager to have children, and so have moved quickly on their journey toward ICSI. Ali inquired about male infertility treatment at the Lebanese hospital in Abidjan, but the Lebanese physicians there could not offer him any solutions, telling him to 'wait' and hope for pregnancy to occur 'accidentally'. Dissatisfied with this response, Ali learned that 'the operation' (i.e., ICSI) was being performed at the university hospital in Beirut. Thus, he and his wife travelled to Beirut in their second year of marriage, 'so as not to waste time'.

In 2002, Ali and Fadia undertook their first cycle of ICSI in the Beirut IVF clinic. Happily, Fadia became pregnant with twins on the first attempt. But at five months gestation, the twin boys, Muhammad and Hussein, were stillborn. As Ali recounted:

> She was so upset at first, because they were already big boys. In Islam, if a fetus is four months old, they must be named and buried. So we named them and buried them here in Lebanon. My wife is feeling very fragile after this.

At the time of Ali's interview, he and Fadia were beginning to embark on their second cycle of ICSI. As Ali told me:

> I don't have a problem, but the problem is in the family. In Lebanon, they, the family, want children. But I say it's from God, whatever God wants. I and my wife don't really need to do ICSI, but my wife wants a child. The Shia Muslim women in Lebanon feel that if they don't get a child from the husband, and then the husband dies, then they won't get anything, no security. But if they have a child, the child takes everything [i.e., the inheritance] and will support his mother. All of Lebanon is like this. This is a problem in Lebanon, Syria, all of the Muslim countries, generally. If there are no children, he will take a second wife or if he dies, she'll get nothing. A lot of people in Lebanon are like this, and this *is* a problem. So, for this reason, the woman wants children. It is a *social* problem – the misery of the woman.

Ali vows that his own marriage will be different: 'I love my wife, and I will do everything in front of my wife so that we will live comfortably together. Life is too short to hide things from each other.'

Although both Ali and Fadia want three children, they are 'believers', and will accept whatever God grants, even if that means living a life without children because of Ali's infertility.

Return reproductive tourism and ICSI quests

Ali and Fadia are among the many Lebanese returnees who I met in Beirut IVF clinics. Hailing from the West African Lebanese diaspora, these couples were essentially 'forced' to return to Lebanon, because of a lack of ICSI services in their host countries. Sub-Saharan Africa is a major region of the world where ARTs, including both IVF and ICSI, are relatively absent. Of the 191 WHO member states, only 48 have medical facilities offering ART services (Nachtigall 2006). IVF clinics are largely absent in Africa, which is struggling with life-threatening diseases such as HIV/AIDS, neonatal and maternal mortality, malaria, and tuberculosis (Okonofua 1996). For example, as of 2007, only nine of the 34 sub-Saharan African nations – including Cameroon, Ghana, Kenya, Nigeria, Senegal, South Africa, Togo, Uganda and Zimbabwe – were home to IVF clinics (Giwa-Osagie 2007). Côte d'Ivoire was not one of these countries. Thus, like Ali, the 100,000 Lebanese living mostly in Côte d'Ivoire's capital city of Abidjan are forced to seek such services elsewhere.

Compared to sub-Saharan Africa, the Middle East is a mecca of ART services. ARTs were introduced to the Middle East in 1986 in Egypt, Jordan and Saudi Arabia (Inhorn 2003). By 1987, the first IVF baby was born in Cairo. ICSI was introduced in 1994, only two years after its invention in Belgium. By 1996, Egypt hosted nearly ten IVF centres, but by 2003, there were more than 50. Today, IVF clinics are found in nearly all of the 22 Middle Eastern nations, including the petro-rich Gulf countries, such as Bahrain, Kuwait and United Arab Emirates, as well as the larger, but less prosperous countries of North Africa, including Egypt, Morocco and Sudan. The non-Arab Middle Eastern countries of Turkey and Iran are currently leading the regional industry, with more than 110 IVF clinics in Turkey (Gurtin 2012), and more than 70 in Iran (Tappan 2012). Iran is also the only Middle Eastern nation with both third-party assisted reproduction and stem cell industries (Abbasi-Shavazi *et al.* 2008, Inhorn and Tremayne 2012, Saniei 2012).

Although Lebanon was a relative latecomer to the Middle Eastern IVF scene, the end of the Lebanese civil war in 1990 hailed the rebirth of a thriving medical sector, including the introduction of IVF clinics in the early to mid 1990s. By the new millennium, a mini-boom in ART services was occurring, with the development of nearly 20 IVF centres in Beirut and the coastal cities of Saida and Tripoli (Clarke 2009; Clarke and Inhorn 2011). By

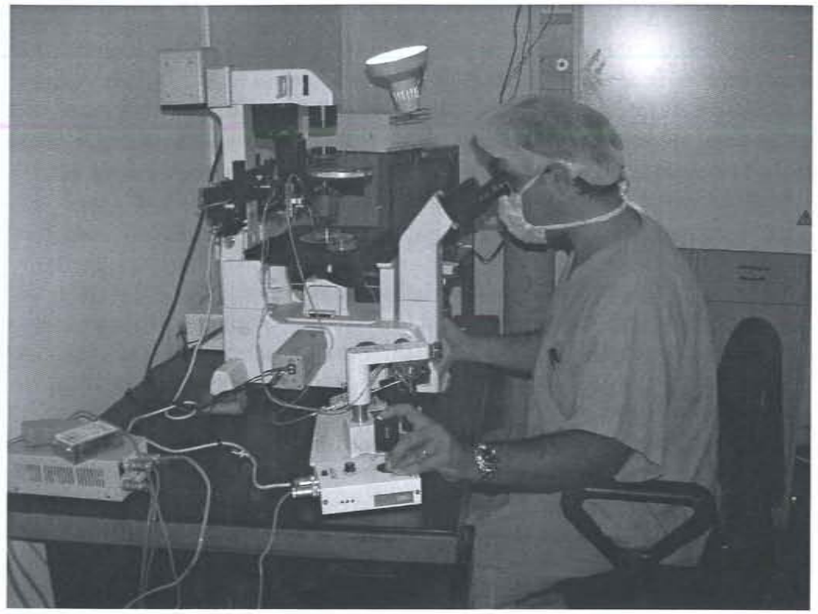

Figure 7.2 ICSI being performed in a Beirut IVF laboratory. Photograph by the author

the time I entered Lebanon as a researcher in 2003, ICSI was by far the most common ART procedure being performed in Lebanese IVF clinics (Inhorn 2012). Because ICSI increases fertilisation rates, it also enhances clinic success rates in a competitive market. As a result, in Lebanon, the demand for ICSI embryos is high. Lebanese IVF clinics today are filled with ICSI seekers, including diasporic 'return reproductive tourists' such as Mohsen and Ali. Baby photos prominently displayed on clinic walls, including in the operating theatres where ICSI is performed, 'keep hope alive' for these men (see Figure 7.2). As one man explained: 'I will try again and again and again. I will never lose hope.' Or, as another man put it: 'I will try until I die.'

The story of Karim, Mona and their failed ICSI

However much hope ICSI generates, it is nonetheless an imperfect solution to male infertility problems. As will be seen in the story of Karim and Mona, ICSI cannot guarantee either pregnancy or the elusive 'take-home baby', even with multiple, costly cycles. Karim and Mona were an attractive, self-ascribed 'career couple' who, like many successful Lebanese migrant-entrepreneurs, owned a business (a graphic design company) in Nigeria. Mona's family had migrated there during the Lebanese civil war, following an explosion that cost Mona the three middle fingers of her right hand. Karim's family, concerned

for his safety in a country where most young men were being recruited into warring militias, sent Karim to the United Arab Emirates to wait out the war years. There, Karim was very sexually active, and entered two brief and unsuccessful marriages with European women. As an educated, secular Shia Muslim, Karim says he feels no particular guilt about his early sexual exploits and heavy drinking, although he does worry that too much sex with several hundred women affected his sperm count. Karim has severe oligozoospermia, or a very low sperm count, which makes it quite unlikely that he can impregnate Mona, who has been proven fertile through a variety of diagnostic tests.

As Karim explained: 'Actually, we have in our tradition, if we don't have kids, they always look to the woman. They blame the woman. So the first thing I did, when I got the news, was to tell my mom. "We may have kids, we may not. But it's *me*—*my* problem". As always, she prayed to see my kids, but she died last August.' Tearing up, he added: 'For me, it's very sad, because we were *very* close.'

On his part, Karim ardently desires children, saying he has wanted a family most of his life. 'I adore kids,' he stated. 'I really love kids. Even when I was a young boy, I always took care of kids. I always liked to play with them.'

As for Mona, she says that she is 'not caring' whether she and Karim have children. 'If it happens, it happens,' she explained. 'Really, we work, and we're very busy. *Maybe* if I'm sitting at home doing nothing, I'd feel differently. But to be frank, if it doesn't happen, it doesn't happen. Even when I have my period, I am never crying or getting depressed. I'm not going to kill myself. We've been married for six years, and we love each other, and we have a good life. That's enough for me.'

At this point, Mona left the room to meet with their IVF physician, who had already seen them through two unsuccessful cycles of ICSI. Altogether, Mona and Karim have undertaken four cycles of ICSI, including two that succeeded but were followed by miscarriages. Karim continued the interview, stating: 'Honestly, I told [the doctor] if this time it didn't happen, I wouldn't be capable of doing it again. It's not a matter of money. When we travel, we come [to Lebanon] on a holiday. But we spend the month here between doctors and injections. We became tired and exhausted, really. So, from my end, I would say, yes, I would stop with this one. But I don't know what Mona thinks. I know she wants kids, but she's not trying to let it even bother her. But deep inside, I'm sure she's thinking about having a baby.'

When I asked Karim about adoption, he responded readily: 'Adoption, that's one solution. We did actually think about it. We said if we don't succeed [with ICSI], we should go for adoption, here most probably [in Lebanon]. I mean, we know it is not really something they would advise or agree on in our religion. You should not give the kid your name, and at a certain age, you should inform the child [about the adoption]. But it's a possibility for us if this time [ICSI] fails.'

Two weeks after the interview, I saw Karim and Mona at the IVF clinic, where a post-ICSI pregnancy test revealed a negative result. Calm and collected, they were about to return to Africa, where the future of their loving marriage seemed certain, despite their ongoing childlessness.

ICSI: a 'dashed-hope technology'?

As I have argued elsewhere (Inhorn 2003, 2012), ICSI is perceived by infertile men, and by the IVF industry as a whole, as a 'hope technology', creating the only hope for infertile men with severe cases of male infertility. Unfortunately, as seen in Karim and Mona's story, ICSI cannot guarantee conception. As with IVF, overall ICSI success rates are usually less than 40 per cent, even in the world's best centres (Osmanagaoglu *et al.* 1999). Depending upon other factors, such as age-related egg quality and the severity of the male infertility, ICSI success rates can be significantly less. With failure rates of more than 60 per cent, ICSI could rightfully be reconceived as a *dashed-hope technology* for the majority of the world's ICSI seekers.

For example, of the 220 men in my Lebanese study, 177 of them had already undertaken ICSI. Among these 177 men, there was a grand total of 434 ICSI attempts – 274 among the infertile men, and 160 among the fertile men with infertile wives. Yet, there were only 18 ICSI children born to these men, including 13 ICSI sons and five ICSI daughters (including one set of female twins). Thus, the so-called 'take-home baby rate' was astonishingly low – only 4 per cent. This low rate of ICSI success increased considerably if all conceptions were considered, including current pregnancies (7), ectopic pregnancies (9), miscarriages and stillbirths (29) and neonatal deaths (4). In this case, 66 conceptions took place after 434 ICSI attempts, for a pregnancy rate (as opposed to a 'take-home' baby rate) of 29 per cent. This makes the overall success of ICSI in this Middle Eastern population seem closer to global standards. Nonetheless, most of these ICSI conceptions ended in heartbreak and suffering, including life-threatening ectopic pregnancies among men's wives, the stillbirth of seven sets of twins as in Ali and Fadia's story, and the deaths of three ICSI sons (including one with Downs' Syndrome) and one ICSI daughter (due to a congenital heart defect). Recounting their losses, men often wiped tears from their eyes.

Furthermore, some men – especially the 'repeaters' such as Karim and Mona – had spent small fortunes on their ICSI attempts. The average number of ICSIs was 2.5, but a few men in my study had undertaken ICSI more than ten times. When I asked men to estimate how much they had spent on their ICSI quests, those who were able to calculate averaged US$17,000, with total costs ranging from US$1,500 to US$100,000. These costs are exceedingly high for the Middle East, if it is considered that most men in my study made well under US$12,000 per year. In the USA, by comparison, the average cost of one ICSI cycle is more than US$12,000, and the cost of making one 'take-home baby' reaches nearly US$70,000 (Chambers *et al.* 2009; Collins 2002; Spar 2006).

Because of the costs of repetition, ICSI is an incredibly expensive technology, which many of the men in my study could ill afford. Some of them had used up their life savings; some had borrowed against their future retirement benefits; others had taken out bank loans; some had sold land; some of their wives had sold bridal gold; and in many cases, men relied on their families for financial aid, particularly from wealthier relatives in the diaspora. Some men had literally impoverished themselves in their ICSI quests. Others had waited years to save the requisite money for a single ICSI cycle. In a few cases, men told me matter-of-factly that they could only afford one ICSI. Thus, they were praying to God that their single attempt would succeed.

Conclusion

In this chapter, I have attempted to link sexuality to both low-tech and high-tech reproductive technologies through the stories of infertile diasporic Lebanese men. In the case of Lebanon, the story begins in 1975 with the outbreak of the Lebanese civil war. To escape the violence and conscription into various militias, many Lebanese families sent their teenage sons out of the country. Among Lebanese Shia Muslim youth, many were sent to Francophone West African countries, where a Lebanese Shia diaspora had previously settled. In West Africa, but also in other diasporic settings in Europe, South America and North America, young Lebanese men were initiated into diasporic sexuality, sometimes with prostitutes, oftentimes with hundreds of partners, and rarely with protective condoms. In many cases, men's condom ambivalence and non-use led to repeated STIs, which were sometimes inappropriately treated.

Most of these men eventually settled by marrying Lebanese women, who had often remained back home during the war years. However, problems with impregnation led to eventual diagnoses of male infertility, some of it attributable to sterilising STIs such as Gonorrhoea and Chlamydia. Without effective infertility diagnostic and treatment services in their host countries, these men and their wives began their journeys as return reproductive tourists, embarking on ICSI quests to Lebanese IVF clinics. Although ICSI is the only medical solution for most cases of male infertility, especially those that are severe, it cannot guarantee conception. As shown in the stories of Ali and Fadia and Karim and Mona, ICSI quests to Lebanon are often fraught with great challenges, including the heartbreaking losses of ICSI pregnancies, or the failure to conceive 'elusive embryos'. More often than naught, ICSI is a dashed-hope technology for infertile men in the Middle East and beyond.

Men's experiences of male infertility, pregnancy loss, ICSI, reproductive tourism, sexuality, condom use, STIs, religion, diaspora, war and violence are all understudied and hence poorly understood. This chapter has attempted to

link these various topics, showing that they are, indeed, intimately connected in Lebanese men's lives. As already documented for the Lebanese population, war has been extremely damaging to population health and the medical infrastructure (Inhorn 2008; Inhorn and Kobeissi 2006). However, that damage extends to reproductive health as well, particularly male reproductive health. This story of war, sex and male infertility has yet to be told, but deserves our recognition, especially for a region that continues to be embroiled in political violence.

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Chapter 8

Gender disappointment and cross-border high-tech sex selection

A new global sex trade

Andrea Whittaker

The starting point for this chapter is the moral and emotional investment people have in sex and gender, and how this is shaped by science, technology and social life. It involves the most fundamental of questions, that of the sex of a baby and the ways in which the biology and genetics of sex have become a commodity in global bioeconomies. The desire to influence and select the sex of a future child are ancient, yet now new reproductive technologies allow us to accurately manipulate human potentiality to ensure an embryo of the desired sex is implanted in a woman's womb. Recent developments of in vitro fertilisation (IVF), pre-implantation genetic diagnosis (PGD) and MicroSorting sperm present the ability to sex select as a biomedical technique. This apparently objective scientific procedure conceals implicit moral assumptions that are refiguring how genetic sex traits and families are imagined and reproduced. This chapter is about the intersection of these possibilities within a global bioeconomic market in which technologies and people travel across the globe. The advent of cross-border reproductive travel within the context of global capitalism raises a range of possibilities as people travel to circumvent restrictions of medical procedures in their home countries. A range of clinics – from Thailand to North Cyprus to California – offer sex selection services for non-medical purposes. Sex genes have become one of a myriad of commodities in this trade. Taussig, Rapp and Heath (2005: 201) note that within 'a marketplace of biomedical free choice' such as the medical travel trade provides, genes and their technology become alienable 'objects of desire' allowing people to remodel and reimagine the self, and their children, in new ways. In this chapter I explore some of these new imaginings and the political economy supporting their fulfilment. In describing this trade as a 'new global sex trade', I use deliberately provocative terminology designed to reflect the commodification of biological sex traits, and the foundations of this trade in gendered social constructions and expectations.

This chapter is informed by work completed for a broader anthropological study of the use of ARTs in Thailand. It draws on seven months' fieldwork in 2007–8 in three private clinics and two public infertility clinics (Whittaker and Speier 2010), and builds upon a larger body of work across the last 16 years