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Embodying emergent masculinities:

Men engaging with reproductive and sexual health technologies in the Middle East and Mexico

ABSTRACT

We employ Raymond Williams's concept of "emergence" to capture new forms of embodied masculinities in the Middle East and Mexico, two sites marked by powerful local stereotypes of manliness. Men there are enacting "emergent masculinities"—living out new ways of being men in attempts to counter forms of manhood that they see as harmfully hegemonic. They do this partly through engagements with emergent health technologies, including assisted reproductive technologies for male infertility and pharmaceutical technologies for erectile dysfunction that today are reshaping sociopolitical and intimate realities. We argue that masculinities research within anthropology must account for these ongoing, embodied changes in men's enactments of masculinities over time on both individual and societal levels. Furthermore, we heed R. W. Connell's advice that reformulations of hegemonic masculinity theory must consider new comparative geographies, forms of masculine embodiment, and social dynamics of masculinity around the globe. [*men, masculinity, emergent masculinities, male infertility, erectile dysfunction, assisted reproductive technology, Viagra, Middle East, Mexico*]

Anthropologists and gender theorists have long argued that gender is not a natural essence but is relationally performed in response to an individual's particular cultural and structural situation (Butler 1990; de Beauvoir 1975; Mead 2001; Ortner and Whitehead 1981). These claims grew out of attempts to understand women's subordinate status worldwide, and it is because of this interest that ethnographic investigations of gender have historically focused on women (Reiter 1975; Rosaldo and Lamphere 1974). In comparison, relatively few studies address the social construction of maleness and masculinity. For example, a 2006 review of the 157 existing ethnographies of gender and reproduction found that only one of these works, *Birthing Fathers* (Reed 2005), focused on men (Inhorn 2006). This is a problematic state of affairs, because excluding men from the study of gender suggests that their bodies, attitudes, and actions are both "natural" and "essential" (Gutmann 2007).

To combat this imbalance, a growing body of anthropological work has focused a social constructionist lens on manhood, generating new understandings of local masculinities. Much of the seminal work in this area has come from Latin America and the Mediterranean region (Brandes 1981; Gilmore 1991, 2001; Gutmann 1996, 2003; Herzfeld 1988; Padilla et al. 2007) and focuses on masculinity in relation to the emergence of the HIV/AIDS epidemic (Carillo 2002; González-López 2005; Gutmann 2007; Hirsch 2003; Lancaster 1992; Padilla 2007; Parker 1991, 1998; Parker and Cáceres 1999). Comparatively less work on masculinity has emerged from other parts of the world, including Africa and the Middle East, and relatively little of this work is ethnographically informed (Ali 1996, 2000; Cornwall and Lindisfarne 1994; Ghoussoub and Sinclair-Lewis 2000; Jacob 2011; Kanaaneh 2005, 2008; Massad 2007; Ouzgane 2006; Ouzgane and Morrell 2005).

Existing anthropological research on masculinities reveals that men's understandings of their own actions are powerfully mediated by stereotypes of local masculinity (Gutmann 1996). Generally speaking, such research focuses on men's attempts to either embody or reject locally

hegemonic forms of manhood. For example, Diane King and Linda Stone (2010) argue that patrilineal societies stretching from North Africa through Europe and Asia are characterized by “lineal masculinity,” in which men’s hegemonic goals are to produce sons, found their own lineages, and ultimately be remembered as strong leaders of clans and tribes. In another recent example, Mark Padilla (2007) shows how heterosexually identified, often married, male sex workers in the Dominican Republic’s booming tourism industry embody the hegemonically masculine ideal of *tigueraje*, a form of masculinity based on tricksterism, to mediate their same-sex work encounters. Josué Ramirez (2009), meanwhile, details younger men’s efforts to act “against machismo” in Mexico City, and emerging ethnography from Japan shows how young middle-class men are rejecting the corporate, heavy-drinking “salaryman model” of masculinity, attempting instead to forge new forms of domestic partnership with wives or girlfriends (Taga 2004).

Here, we build on these recent ethnographic examples of men’s negotiations of hegemonic and alternative masculinities. To this end, we propose the concept of “emergent masculinities” to account for ongoing, context-specific, embodied changes within men’s enactments of masculinity, particularly as they encounter emerging health technologies. To do so, we draw on the foundational work of Marxist scholars R. W. Connell and Raymond Williams, combining their insights on “hegemonic masculinity” and “emergence,” respectively. Following an explication of our concept of “emergent masculinities,” we apply this analytic to our ethnographic findings from two sites marked by powerful stereotypes of local manliness—the Arab Middle East and Mexico—showing how men in these areas use their experiences of changing reproductive and sexual health to live out manliness in new ways that diverge from pernicious stereotypes. In the Middle East, men are employing assisted reproductive technologies (ARTs) to overcome male infertility and to create families within companionate marriages. In Mexico, older men are rejecting erectile dysfunction (ED) pharmaceuticals such as Viagra, thereby moving away from performances of masculinity that they consider “macho” and inappropriate to dignified older age. Through these examples, we seek to show how men’s encounters with emerging reproductive and sexual health technologies shed light on the relational, embodied, and ever-changing nature of lived masculinities over the male life course and across generational time.

Emergent masculinities

Our notion of “emergent masculinities” is inspired by Connell’s theory of “hegemonic masculinity,” the first and most widely used social constructionist analytic developed specifically for studying masculinities (Carrigan et al. 1985; Connell 1995). Drawing explicitly from feminist theory and

Marxist sociology, Connell sought to reconcile the lived reality of inequality among men with the fact of men’s group dominance over women. This new theory sought to examine hierarchical inequality among men, relate analysis of masculinity to feminist insights on the social construction of gender, and resist the structure-versus-individual dichotomy plaguing contemporary studies of gender and class (Carrigan et al. 1985). To achieve these goals, Connell used Antonio Gramsci’s (1971) concept of “hegemony,” a social mechanism through which various groups develop the “will to conform” with a leading group’s way of being, thereby facilitating class-based domination. Connell argued that by using hegemony to understand masculinity, scholars could reveal the hierarchical production of various masculinities, the way power functions to mediate this production, and the dialectical relationships between hierarchical structures and practiced masculinities (Carrigan et al. 1985).

Connell (1995) defined hegemonic masculinity as the strategy for being a man that legitimizes patriarchy and enables gendered social dominance in a given cultural context; it is shaped by, though not necessarily identical to, cultural ideals of manliness. Although hegemonic masculinities vary across cultures, they often share traits that enable social dominance, including command of wealth and resources, attractiveness, virility, physical strength, heterosexuality, and emotional detachment. Many men may aspire to live out hegemonic masculinity, but only those with access to the necessary social and structural resources may do so; this state of affairs creates inequality among men, in which excluded men may actually become complicit (Carrigan et al. 1985). Connell (1993) also argues that men inhabiting nonhegemonic (variously called “subordinated,” “subaltern,” or “alternative”) masculinities may do so in a variety of ways, ranging from uncomfortable resignation to deliberate protest.

Although Connell is most concerned with understanding relationships between forms of masculinity in all of their dynamic complexity, the focus on “hegemonic masculinity” in relation to “subordinate” masculinity has led to static dualisms in scholarly applications of this theory. In a 20th-anniversary reassessment of hegemonic masculinity theory, Connell and James Messerschmidt (2005) lament other scholars’ frequent portrayal of hegemonic masculinity as an “assemblage of toxic traits” rather than as a context-dependent subject position. For example, they argue that equation of hegemonic masculinity with machismo in Mexico or with Middle Eastern terrorism reinforces the most negative images of masculinity and is simply not true to most men’s lives. Instead, men in these sites may relate to these hegemonic stereotypes in complex, conflicted, and transformative ways. To counteract this problematic reductionism, Connell and Messerschmidt call for attention to four underdeveloped aspects of hegemonic masculinity theory:

the nature of gender hierarchy, including the relationships between masculinities and femininities; the geography of masculine configurations, or the interaction of local, regional, and global factors in masculinity construction; the process of social embodiment; and the dynamics of masculinities on both individual and social levels.

Heeding this call for theoretical reformulation, we focus on three of these underdeveloped domains—new comparative geographies of masculinity, new forms of male embodiment, and new rapidly changing dynamics of masculinities—to explore contemporary aspects of manhood in our diverse field settings. In so doing, we explicitly move away from a primary focus on gender hierarchy¹—as well as the hierarchically evocative term *hegemonic masculinity* itself—to focus on all that is new and changing in conceptions and practices of masculinity. We draw from Williams's work on "emergence" to propose the term *emergent masculinities*, which is intended to evoke novelty and transformation.

Although not a masculinity scholar per se, Williams, like Connell, is interested in cultural processes of hegemony. In his seminal essay, "Dominant, Residual, and Emergent," Williams (1977) asks how a dominant group maintains a cultural system, and how this system might change over time. He argues, "No dominant social order and therefore no dominant culture ever in reality includes or exhausts all human practice, human energy, and human intention" (Williams 1977:125). Instead, "new meanings and values, new practices, new relationships and kinds of relationship are continually being created" (Williams 1977:123). Williams calls this process "emergence" to signify that which is novel rather than strictly alternative or oppositional to the dominant culture. These emergent elements may eventually be incorporated into the dominant culture, causing the social order itself to change over time.

We believe that Williams's focus on the emergent can be fruitfully applied to the study of what we call "emergent masculinities." To wit, manly selfhood is not a thing or a constant; rather, it is an act that is ever in progress. Men must act as men in different ways from moment to moment and in different contexts. For instance, an individual man acts out masculinity differently in a talk with his wife, in his workplace, over drinks with his friends, or while playing a game with his children. Individual masculinities also change in response to larger life changes, such as job change, marriage, or fatherhood. Importantly, men live out all these changes in bodies that are also ever changing; these changes include aging, becoming ill or well, and being altered through medical treatment, exercise, or neglect. All of this occurs in local social worlds that are rapidly changing as a result of globalization and a wide variety of political, economic, technological, and cultural transformations. In one recent example, young "secular" men have taken to the streets of the Middle East in 2011 to champion democracy

and decry social injustice. As seen through their protest, a veritable "revolution" in men's (and women's) social worlds is occurring across the Middle Eastern region today and requires scholarly attention (Joseph 2011). The concept of "emergent masculinities," we argue, speaks to these processes of social change, as men navigate—and ultimately transform—their social worlds.

In our view, then, the term *emergent masculinities*—intentionally plural—embraces social history, globalizing geographies, masculine embodiment, new masculine dynamics, and social movements in a way that *hegemonic masculinity* cannot. Whereas *hegemony* emphasizes the dominant and hierarchical, *emergence* highlights the novel and transformative. When applied to manhood, *emergence* encapsulates change over the male life course as men age, change over the generations as male youth grow to adulthood, and changes in social history that involve men in transformative social processes. Finally, *emergent masculinities* highlights new forms of everyday masculine practice that accompany these social trends. These include, for example, men's desire to "date" their partners before marriage, men's acceptance of condoms and vasectomy as forms of male birth control, men's desires to live in nuclear family residences with their wives and children, men's encouragement of daughters' education, and men's use of social media technologies in homes and workplaces. All of these masculine practices are, in fact, emerging in the Middle East, Mexico, and elsewhere but cannot be fully theorized if understood only in relationship to gender hierarchies.

Furthermore, emergent masculinities must be understood in relation to the concept of "embodiment," as used within medical anthropology (Csordas 1990; Mauss 1973; Scheper-Hughes and Lock 1987). Embodiment in relation to masculinity is locally and historically situated. For example, "six-pack abs" have supplanted the handlebar mustache as a marker of vigorous masculinity in the contemporary West, and a potbelly may signal poor fitness in one society but masculine prosperity in another. Similarly, individual men's physical changes over time require reformulations of their own ways of being men, for example, as they grow older or become sick. Thus, emergent masculinities codevelop with changes in the ideals of and possibilities for men's physical embodiment across the life course and at different times and places.

In addition, emergent masculinities highlight the ways that new medical technologies enable new forms of embodied masculine practice. These medical technologies include a wide range of interventions, such as vitamins, testosterone, performance-enhancing drugs, antidepressants, insulin, antihypertensives, antiretrovirals, ED treatments, and many other forms of life-prolonging or enhancing medication (Biehl 2009; Marshall and Katz 2002; Petryna et al. 2006). However, men's engagement with medical

technology spans other dimensions as well. For example, men may accept genital surgery as a form of birth control (Gutmann 2007) or fertility enhancement (Inhorn 2007b). Focusing on men's use of new technologies to embody new forms of manhood is a logical extension of anthropology's long-standing attention to the relationship between bodily and cultural experience in the context of emerging social and institutional forms (Foucault 1975; Rabinow and Rose 2006).

Here, we demonstrate the utility of an embodied emergent masculinities approach when applied to two non-Euro-American ethnographic contexts. We analyze men's experiences of ARTs in the Middle East and of ED drugs in Mexico, sites where men are finding new ways to position themselves in relation to tenacious, globally diffused stereotypes. After describing our fieldwork, we examine the stereotypic ideas of masculinity that influence local understandings of manliness in the Middle East and Mexico. We then present comparative ethnographic cases of emergent masculinities, as Middle Eastern men face infertility and ARTs and Mexican men face decreasing erectile function and pharmacological treatments. Our goal in presenting these two cases is to show that an emergent masculinities approach can serve ethnographers well in realizing Connell's call for greater understanding of the dynamics of manhood and men's social and physical embodiment in a variety of geographic settings around the world.

Fieldwork

This article is based on ethnographic research undertaken by both authors since 2003. From January through August 2003, Inhorn undertook a field-based study entitled "Middle Eastern Masculinities in the Age of New Reproductive Technologies" in Beirut, Lebanon, involving in-depth interviews with 220 men, mostly Lebanese but also Syrian and Palestinian. This was followed by five years (2003–08) of research with 55 Arab men living in the ethnic enclave community of Dearborn, Michigan; most were recently arrived political and economic refugees from Iraq, Lebanon, and Yemen and were primarily Arabic speaking. From January through June 2007, six months of additional fieldwork on so-called reproductive tourism were undertaken in the United Arab Emirates, with 240 individuals from 50 countries. In this "global hub," Arab men hailed from many parts of the Middle East, including the Levant, North Africa, the Arab Gulf, Iraq, and Iran. Furthermore, men in the three studies represented a variety of social classes, ranging from poor to wealthy.

Throughout the course of these three studies, Inhorn interviewed more than 330 Middle Eastern men, mostly alone in a private room, but sometimes with their wives, as they attempted to overcome their infertility in *in vitro* fertilization (IVF) clinic settings. Fieldwork focused on

reproductive-aged men, generally ages 25–50, who were seeking ARTs to overcome either male or female infertility (or, in some cases, both). More than half of the interviews were conducted in Arabic (57 percent) and about one-third in English (35 percent), with the remainder involving both languages (8 percent). Many of the men in these studies had lived outside the Middle East and spoke excellent English (along with other languages in many cases). In the Beirut and Dearborn studies, most men also completed eight-page reproductive-history questionnaires, which were administered verbally to each man as part of the interview.

In addition, Inhorn conducted many hours of participant-observation in the waiting areas, laboratories, ultrasound rooms, and operating theaters of four major IVF clinics in three countries. In a few cases, men asked to meet outside the clinic settings, including in their homes. Hundreds of pages of field notes were recorded and entered into a laptop computer for the purposes of later data analysis. Formal tape-recorded interviews were also conducted with nearly 20 IVF physicians, embryologists, nurses, and pharmaceutical representatives, and, in Lebanon, with three Muslim clerics.

Wentzell undertook similar clinic-based, in-depth interviews in an ethnographic study of men's experiences of aging, illness, and changing sexual function in the central Mexican city of Cuernavaca in 2007–08. This research was based in the urology department of a government-funded hospital that is part of the Instituto Mexicano del Seguro Social (IMSS) system. The IMSS offers health care to all privately employed workers and their dependents in the nation, or about half of the Mexican population. However, because waiting times for appointments are long and resources sometimes scarce, IMSS-eligible people with enough money often opt for private care. Thus, most of the men interviewed were working class.

Wentzell conducted Spanish-language interviews with 250 male IMSS urology patients; about fifty of these men were interviewed with their wives. Interviews took place in a private room and were digitally recorded. Men of all ages, ranging from the late teens to the early nineties, were interviewed. However, because most participants were seeking treatment for age-related prostate problems or chronic illnesses such as diabetes (which cause urological problems), most study participants were in their fifties and sixties. Wentzell also observed the daily life of the urology department and conducted formal interviews with the department's doctors and staff as well as with private physicians, pharmacists, and drug sales representatives.

Even though both authors are women, male informants reported feeling comfortable being interviewed by them, once they realized through the informed consent process that the interviews were confidential and were for the purposes of anthropological research rather than tabloid journalism. As educated *dukturas*—*doctoras*, both authors were

assumed to understand reproductive and sexual health problems, so most informants were candid about their situations. Participants sometimes said that they felt comfortable telling a woman things they would feel too ashamed to tell another man. That both authors are from the United States may also have facilitated this research. The reported assumption that U.S. women are sexually knowledgeable led participants to explain sexual histories that they feared would shock a Mexican or Middle Eastern Muslim woman. Although the authors' identities appeared to generate certain blind spots,² study participants seemed to speak relatively freely about potentially "taboo" topics like masturbation, infidelity, paying for sex, committing domestic violence, and engaging in acts that "go against the religion" (either Islam or Catholicism). Many men reported experiencing their interviews as cathartic, saying that they felt unburdened after discussing health and sexual issues that some had never broached with anyone before.

What follows are findings from these ethnographic studies of masculinity in relation to sexual and reproductive health in two different regions of the world. We begin by examining men's own changing views of masculinity, especially in relationship to locally identifiable forms of self-stereotyping. We then turn to our two specific cases, beginning with an examination of male infertility in the Middle East and its solution through the emerging technology of intracytoplasmic sperm injection (ICSI). Thereafter, we focus on Mexico, where aging men consider the meanings of decreased erectile function and the use of emerging pharmaceutical technologies to overcome it. Through two case studies of individual men, we highlight the interaction of emergent masculinities with these emergent reproductive and sexual health technologies. Although these men are drawn from small, specialized, and nonrandom populations—and thus may not be representative of Middle Eastern or Mexican men as a whole—our research nonetheless suggests that masculinity is changing quite broadly and rapidly across these regions, requiring a much more dynamic and complex analysis of masculinity in the 21st century.

Masculinity in the Middle East and Mexico: Moving beyond the stereotypes

Many cultures have well-defined stereotypes of local manhood—including indigenous forms of "self-stereotyping" (Rogozen-Soltar 2009)—to which men in these settings self-consciously relate. For example, both the Middle East and Latin America are known for aggressive, patriarchal styles of manliness marked by violence and domineering gender relations. In the post-9/11 world, the dominant stereotype associated with Middle Eastern men is that of the terrorist—radically religious, violently militaristic, and hypermasculine (Inhorn and Fakih 2006; Massad 2007; Myntti

et al. 2002; Ouzgane 2006; Shaheen 2008). In general, Middle Eastern men are said to exert patriarchal control over wives and other females; lack tenderness toward their wives but seek to have children by them; view children, and particularly sons, as a status symbol; and be aggressively, even violently, domineering in the family setting. These characteristics of Middle Eastern masculinity are propagated not only by the Western media but by Western scholars as well (Inhorn in press; Massad 2007).

The same could be said for Latin America. For example, in Mexico, popular media representations and "culture of poverty" scholarship (Lewis 1971, 2011) deem all Mexican men to be macho—to exhibit the desire to dominate and sexually penetrate all available women (and, potentially, lower-status men); to drink, carouse, and be licentious; to back up sexual aggression with violence; and to remain emotionally closed and callous (Amuchástegui and Szasz 2007; Brandes 2003; Gutmann 1996; Irwin 2003). Aside from their extreme aspects—sexual in the case of the Mexican macho and murderous in the case of the Muslim Middle Eastern terrorist—both stereotypes are associated with male violence, linked to hyperreligiosity in the case of Muslim men and alcohol in the case of Mexicans.

Our comparative ethnographic research suggests a different reality. In both of our field sites, our male informants were keenly aware of the aforementioned stereotypes, and their personal ways of being men were shaped by their complex relations to these powerful and negative ideas of masculinity. For example, Middle Eastern participants often challenged the notion of "the Eastern man" or the "Oriental mentality." The Eastern man purportedly upholds the "four Ps": polygyny (marrying up to four wives, according to Islamic law), patrilineality (needing offspring, and especially sons, to perpetuate his genealogy and patrimony into the future), patriarchy (control over the women and junior men in his family), and patrilocality (staying in his parents' home upon marriage). Yet most men's real lives were far different from these local stereotypes. For instance, when asked if their current marriage was their first, many men exclaimed, "The first and the last!" with most men going on to express their fondness for their wives and their deep feelings of conjugal love (Arabic, *hubb*) and affection.

These professions of love speak to Middle Eastern men's "conjugal connectivity" (Inhorn 1996, in press), a term deriving from Suad Joseph's (1993, 1994, 1999) important insights about "patriarchal connectivity" and "intimate selving" within Arab families. Middle Eastern men are socialized to be deeply enmeshed in family structures, which Joseph calls "patriarchal connectivity." Such connectivity emerges through childhood socialization practices but also manifests itself later in life when men marry (Inhorn 1996, in press). The word for "love," *hubb*, is truly one of the most important words in the Arabic lexicon (Inhorn 2007a, in press; Soueif 2000). Given the love stories that abound in

contemporary Middle Eastern literature and the love songs that fill the airwaves, it is not surprising that companionate marriage accompanied by “romantic” love is a contemporary ideal in the Middle Eastern region, as it has been for centuries (with ample support from the Islamic scriptures; Baron 1991; Musallam 2009; Tappan in press). Indeed, Islam extols the virtues of marriage—so much so that more than 95 percent of Middle Eastern men marry at some point in their lives. Although polygyny is allowed in Islam, the rates of polygyny in Middle Eastern countries are extremely low (from 1 to 4 percent), and both Morocco and Tunisia formally outlaw this practice (Omran and Roudi 1993).

In summary, even within an overall social context of ongoing patriarchy, Middle Eastern marriages are often loving, committed, and connected. The significant expense of marriage—particularly on the part of bridegrooms and their families—adds a heavy economic incentive to conjugal connectivity, for the price of disharmony and divorce is high (Singerman and Ibrahim 2001). In the new millennium, then, most Middle Eastern men want to be married to a woman with whom they can experience ongoing romantic love. Far from being uncaring, unfeeling, polygynous patriarchs, Middle Eastern men, once married, tend to be deeply invested family men, demonstrating love, both verbally and physically, to their wives and children. They do not want to be viewed—nor do they view themselves—according to either local notions of “the Eastern man” or global stereotypes of the “violent terrorist.” That many Middle Eastern men want to be known as gentle and loving husbands and fathers is a reality that has eluded the popular imagination, especially in the post-9/11 frenzy of vitriol, in which all Arabs, and Arab men in particular, are deemed “guilty” (Shaheen 2008).

Similarly, men in the Mexican study continually referred to machismo when asked about their own ways of being men but then cast it as a damaging discourse about Mexican masculinity rather than as a valid way to be a man in modern society. They felt that Mexican society was marked by machismo, a social pressure that led some men to behave badly, especially in terms of drinking, being unfaithful, and being emotionally closed when they were young. Most participants argued that being macho was an undesirable and unacceptable way to be a man, because times were changing and their nation was modernizing. In today’s Mexico, they said, women have the same rights as men, and men should enjoy close, emotional relationships with their wives and children. In ways that recall the “conjugal connectivity” visible in the Middle Eastern setting, most men felt their wives and families were crucial both to their success in life and to their very selfhood. Participants commonly stated, “Without my wife, I would be nothing!” and spoke respectfully of their wives’ accomplishments and work ethics, particularly in terms of raising their families. Many older men also reported a shift toward, and younger

men a wholesale adoption of, the idea that marriage should be companionate and based on romantic love (Carillo 2002; González-López 2005; Hirsch 2003).

Importantly, many older men who extolled the virtues of egalitarian relationships said that they themselves had been quite macho in their youths. They saw embodiment of machismo as an immature phase to be enjoyed but grown out of. They had proudly become, in the words of one participant, “ex-machistas,” maturing and focusing on emotional relationships with family, especially as age and illness made it both difficult and unbecoming to carouse and seek extramarital sex. For many men of this generation, decreasing erectile function emerged in concert with increasing social valorization of companionate marriage and gender equity. This intersection of social context and embodied experience generated the emergence of new, “ex-machista” masculinities for older men and the emergence of new ideals for masculinity on the societal level. Both older and younger men in the study said that Mexican men as a group would have to become less macho as their nation “modernized.” Older men frequently called for younger men to behave differently than they had in the past, and middle-aged participants often consciously strove to be different kinds of husbands and men than their sometimes distant, unfaithful, or abusive fathers (Wentzell in press).

In both of our studies, men’s reproductive and sexual health was the key site for shifts in individual enactments of masculinity. Both stereotypes of local masculinity involve strong dimensions of virility and fertility. Middle Eastern and Mexican men who experience bodily change or difficulty in these areas may explore treatment options that “rehabilitate” their virile, fertile manhood. Yet, as the following ethnographic cases show, relationships with these technologies are not straightforward. Rather, depending on the type of medical technology and social context, men act out and embody emergent masculinities that they view as appropriate to their changing bodies, social situations, and cultural contexts.

Emergent masculinities and ICSI in the Middle East

Male infertility accounts for more than half of all cases of infertility worldwide (Vayena et al. 2002), but it is even more prevalent in the Middle East, where it accounts for 60 to 90 percent of all IVF clinic cases (Inhorn 2004, in press). Accordingly, Middle Eastern men who are infertile may suffer over their infertility for a number of important reasons. First, problems of male fertility, which are generally based on defects of sperm,³ are popularly, although mistakenly, conflated with problems of virility, which involve sexual dysfunction. Although male infertility and ED are two different conditions, this distinction is not widely understood in the Middle East or elsewhere. Because of this

“fertility–virility linkage” (Lloyd 1996), men who are infertile are mistakenly assumed to be impotent. In the Middle Eastern context, they may also be assumed to be homosexual (Inhorn 2005, in press). This conflation of virility and fertility is problematic, because Middle Eastern men are expected to compete with one another in these realms (Ali 2000; Lindisfarne 1994; Ouzgane 1997). Indeed, sexual virility emerges as the “essence of Arab masculinity” 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, especially sons (Ouzgane 1997).

Second, on the social structural level, 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 (Inhorn 2003a). Within the purportedly patriarchal, patrilineal, patrilocal family structure, men achieve social power through the birth of children, especially sons, who will perpetuate patrilineal structures into the future (Inhorn 1996; King and Stone 2010; Obermeyer 1999). Thus, men who do not become family patriarchs through physical and social reproduction may be deemed weak and ineffective and may be encouraged to take additional wives (through divorce or polygyny) to “prove” their fertility (Lindisfarne 1994). In short, the experience of male infertility for Middle Eastern men can only be imagined as extremely threatening and emasculating; thus, men work hard to sustain their public images as “powerful, virile” patriarchs (Ouzgane 1997:4).

The question, of course, is whether this is true: Does male infertility emasculate Middle Eastern men? During earlier ethnographic fieldwork carried out by Inhorn in Egypt during the decade from 1985 to 1996, few men were willing to tell anyone, including their closest family members, that they suffered from infertility. Male infertility was described variously as an “embarrassing,” “sensitive,” and “private” subject for the Egyptian male, who would necessarily feel *ana mish raagil*—“I am not a man”—if others were to know that he was the cause of a couple’s inability to conceive. Because of the association between male infertility and manhood, men’s wives were generally expected to participate in a two-person cult of silence about the problem, which usually meant that women shouldered the blame for the infertility in public. When women were questioned (as is often the case in Egypt) about the source of their childlessness, most responded that there was “nothing wrong” with either partner or that the matter was “up to God.” Sometimes, women suggested to their acquaintances that they themselves were seeking treatment for the infertility. Women often explained that they “covered” for their husbands out of love and loyalty. However, some women also said that they feared the potential familial and marital consequences of exposing their husbands’ secret (Inhorn 2003b, 2005).

However, in the more recent research on masculinities conducted since 2003 in a variety of Middle Eastern field sites, this conspiracy of silence has not been as readily apparent. Why? As noted above, gender and marital relations are changing in the region, with parents educating their children in different ways than previous generations did and married couples negotiating new forms of conjugality. Distancing himself from what he referred to as the “Oriental mentality,” a Lebanese man explained,

Most of them [infertile men], they don’t talk at all [about it]. They don’t even go to have tests to see [if they are infertile]. So, if they don’t have children, it’s the wife who can’t have [them]. I think even the educated—no, maybe less with educated people—but they equate having children with being a man. So, when they go to have tests and see that it’s male infertility, of course, they will feel affected. But I have an understanding wife. All of my masculinity is here, within the couple. If a couple has good relations, this will not affect them. It’s a medical problem. Even in the family, we were not raised in this Oriental way. It’s not like, “He’s a boy, he’s the boss. She’s a girl, she has to obey.” We were all raised the same in my family.

In addition, a normalization process seems to have been occurring over time as a result of the “medicalization” of male infertility. Men acknowledge that there is increasing openness about male infertility these days, particularly in light of the modern infertility treatment services being provided and advertised widely across the Middle Eastern region (Inhorn 2003a, 2004). Furthermore, once inside treatment centers, men seem to begin accepting that male infertility is a medical problem, “like any other medical condition.” Thus, they typically stated in interviews that male infertility “has nothing to do with manhood.” For many men who have accepted the new “medical model” of infertility, male infertility is not the major “crisis of masculinity” that it is supposed to be.

George,⁴ a Lebanese Christian oil executive, explained that there are now two views of male infertility—an “insider’s” and an “outsider’s” perspective:

In Lebanon, yes, male infertility does affect manhood. Men don’t want to admit they can’t have children. They’re not men any more. But this is not the view of people inside treatment. People who are “in” know it is a medical problem. So we don’t feel this problem of manhood or womanhood. In our company, four to five people have IVF babies. One guy was married for 15 years, and he went to Singapore [for IVF]. Then another one went there. So, in my company, people talk about it. I tell everybody about it. I don’t mind. Because it’s easier to tell everyone what you’re doing. Even at work, it’s easier to tell them, so that they just stop asking. My boss said, “You’ve been married for more than

two years and you didn't get your wife pregnant yet?" I said, "I'm trying, but I couldn't get my wife pregnant yet." Two days ago, I told him I'm coming for IVF. But this is *very* uncharacteristic of Lebanese people. People think like, "Manhood. He can't have children." So a lot of people blame the woman, even when it's male infertility. This is because people are secretive. They don't know the problem is male infertility, and so they say [it's from] the woman.

When George speaks of IVF in his interview, he is referring to the newer variant of IVF known as ICSI (pronounced "ik-see"). First developed in Belgium in the early 1990s, ICSI allows severely infertile men to father children with their own sperm. As long as even one viable spermatozoon can be retrieved from an infertile man's body—including through painful testicular aspirations and biopsies—this spermatozoon can be injected directly into the oocyte (egg) with the aid of a "micromanipulator" on a high-powered microscope, thereby aiding fertilization. Over the past two decades, ICSI has become widely available in IVF clinics in the West, where it has now helped an estimated 400,000 severely infertile men to father their own biological children. Since 1994, ICSI has also been available in the Middle East—where it was first introduced in Egypt (Inhorn 2003a) then quickly spread to IVF centers in other countries. ICSI is now the most commonly performed ART across the region (Inhorn in press). As such, it is replacing older, but less efficacious treatments for male infertility, including varicoelectomy, a form of genital surgery that is no longer recommended by the WHO to overcome male infertility (Inhorn 2007b).

The arrival of ICSI in the Middle East has led to a "coming out" of male infertility and a "boom" in the local IVF industry. Hundreds of thousands of Middle Eastern infertile men are now undergoing ICSI each year, with more and more clinics opening up to meet local demand. Large countries such as Egypt, Iran, Saudi Arabia, and Turkey each boast more than 50 IVF clinics where ICSI is performed. Even the smaller and less-developed countries of the Middle East, such as Yemen and Oman, now host urban IVF centers where ICSI can be obtained. The very success of this regional IVF industry—fueled by the significant demand for ICSI—bespeaks the medicalization of male infertility, men's willingness to try this medical technology, and the growing regional acceptance of male infertility as a medical issue rather than a "stigma" of manhood (Inhorn 2004, in press).

The ICSI revolution in the Middle East also bespeaks married couples' ardent desires for children and women's willingness to undergo invasive interventions to achieve parenthood. Indeed, women also "embody ICSI" quite profoundly. To become pregnant by ICSI, women are required to undergo a full cycle of IVF—complete with hormonal ovarian stimulation, surgical oocyte retrieval, and

transvaginal embryo transfer—an invasive process that takes its toll on a woman's body. Women's willingness to do this for their husbands out of love and desire and men's concerns about their wives' embodied sacrifice and suffering characterize most couples attending Middle Eastern IVF clinics. Such loving commitments are rarely highlighted in global discourses about gender relations in the region (Inhorn 2007b). However, the following case, involving an infertile Syrian man and his love for his wife, testifies to these new embodiments of emergent masculinity and conjugal connectivity in the Middle East.

The case of Hisham

Hisham hails from the relatively poor country of Syria, where he is the oldest of six children. Like so many other young Syrian men, Hisham and his two brothers all left the country to work, the brothers in the United States and Hisham in the Arab Gulf. Following an unpleasant stint in Saudi Arabia, Hisham moved to the United Arab Emirates. There, he accrued enough financial resources to marry, agreeing to an arranged marriage with a Syrian woman named Rana, who was ten years his junior.

In preparation for the wedding, Hisham decided to undergo premarital semen analysis to ascertain his fertility. Although the test was not required by law or by Rana's family, Hisham—like increasing numbers of Middle Eastern men—thought it sensible to have it done, given the growing recognition in the region that men too may be infertile. Although Hisham was not deemed infertile per se, his sperm count was considered "borderline." Consulting a urologist, a fellow Syrian, at an Emirati hospital, Hisham was convinced by the physician that he could "improve" his fertility by undergoing a varicoelectomy, an invasive genital surgery designed to remove varicose veins from the testicles. Eager to please his new young wife, Hisham underwent the procedure shortly after marriage. This is a decision that Hisham now deeply regrets. Not only was the surgery unsuccessful but it was also actually iatrogenic, causing irreparable bodily harm. Hisham's sperm count plummeted after the operation and has never returned to normal since then. As a result, his only hope of producing a child is through ICSI.

At the time of his 2007 interview in an Emirati IVF clinic, Hisham and Rana were trying their second cycle of ICSI, carried out in secrecy from both of their families. Hisham said that he was not at all "embarrassed" about his infertility problem. Rather, he explained that feelings of "empathy" would lead the relatives to worry and intervene with long-distance phone calls. It was simply less stressful for both him and Rana to tell their families about the ICSI once they had obtained a successful result.

As educated, middle-class professionals with a science background, Hisham and Rana realized that ICSI could not guarantee a successful pregnancy. Indeed, their first ICSI

attempt in Lebanon was “a very bad experience,” both interpersonally and physically. Hisham and Rana were far happier with the quality of care at this second clinic on the border of “high-tech” Dubai. But in Dubai, the cost of an ICSI cycle was much higher than elsewhere—nearly \$5,000, as opposed to only \$2,000 in Lebanon—which had required Hisham to use his credit card and take out a bank loan. “I’m now in a lot of debt trying to make a baby,” Hisham explained. “Plus, I’m afraid for her [Rana]. I don’t know if there are bad effects from the hormones. She started feeling dizzy and vomiting. She was feeling very weak, feeling always sleepy. I don’t want to see her suffer this way.”

Hisham is thinking of returning to Syria if the current cycle of ICSI is not successful. He says that ICSI is now widely available in the cities of Damascus, Aleppo, and Homs, for only one-third the cost of an ICSI cycle in the Emirates. Furthermore, in Syria, he can rely on his family and in-laws to take care of his beloved wife, Rana, who he feels has “suffered” for him. Hisham is full of love, respect, and empathy for his wife, which he expressed throughout his interview:

Insha’Allah [God willing], she’ll get a baby. She’s suffering, actually, and I’m feeling pretty awful about it. She is trained as a chemist, but she works long days as a secretary with a horrible commute to Dubai. I wish if she gets a baby, she can quit her job and maybe I can bring her mother, one or two months, then my mother, just to take care of her. Like they can help her so that she can just sit, because she’s very, very active, and I’m afraid for her.

According to Hisham, he often volunteers to cook and do housework, because he and Rana both work 12-hour days, six days a week. But his wife is adamant about carrying out what she perceives to be her domestic duties. “It’s really exhausting for her,” he said, “with lots of tension, pressure. And for nothing! We don’t have children, so it seems like all of this work is not worth it.”

Never once did Hisham mention his own masculinity throughout the course of a two-hour, wide-ranging interview. He does not consider male infertility to be a problem of manhood; rather, it is a problem of sperm counts, which can be overcome through the now widely accepted medical solution of ICSI. The only “blame” Hisham assigns is to the Syrian urologist who “tricked” him into undertaking a dangerous surgery.

Furthermore, Hisham is not the only infertile man in his social world. One of his close Syrian friends, Eyad, is also infertile, and they share their trials and tribulations openly. Eyad led Hisham to the Emirati IVF clinic, where he is also pursuing ICSI with his wife. If necessary, both Eyad and Hisham will take their wives back to Syria to undergo future ICSI cycles.

However, Hisham remains hopeful that he and Rana will achieve a successful ICSI pregnancy in the Emirates. No matter what happens, they remain committed to each other and to God’s plan for their lives. “Even if there is no success, this is God’s will,” Hisham concluded. “We did our best, and we’ll say *mash Allah* [what God wills].”

Emergent masculinities and Viagra in Mexico

Whereas infertile Middle Eastern men such as Hisham are embracing ARTs to demonstrate new forms of medicalized masculinity and conjugal connectivity, research in urban Mexico shows that men may also embody emergent masculinities through the rejection of medical interventions. Since the 1998 introduction of Viagra, Mexico and other world sites have seen a “medicalization of impotence,” in which the proliferation of medical fixes for nonnormative erections have cast men as having ED, a physiological problem with a biomedical solution (Tiefer 1994). The idea that less-than-ideal erections can be understood as ED has taken hold in both Mexican medicine and popular culture. A generic version of Viagra is on the list of drugs that government hospitals are required to provide at no cost to eligible patients, and it has recently been dispensed free of charge to older men in Mexico City in a government attempt to raise morale among the aged (CNN 2008). Viagra competitors Cialis and Levitra are also readily available without a prescription. These drugs, as well as herbal copycats like Powersex and Himcaps, are advertised on brightly colored signs posted on pharmacy walls, and M-force, the most heavily marketed ED supplement, advertises frequently on Mexican network television. The label “Viagra” is frequently attached to food items thought to have reinvigorating properties, like the ostensibly aphrodisiac sea urchin broth now known locally as “Viagra soup.” Finally, ED and Viagra jokes are common fare in television comedies and joking relationships among friends, often in contexts that lampoon the “macho” nature of Mexican men and their supposed obsession with frequent, indiscriminate penetrative sex. Thus, Mexican men who experience decreasing erectile function do so in a context in which the possibility of seeking medical mediation for this change is ever present and easily accessible.

However, the ubiquity of references to ED and its treatments in Mexico does not mean that men have adopted a medical understanding of erectile difficulty wholesale in their thinking and sexual practice. Older, working-class men seeking treatment for urological problems in the hospital field site tended to consciously reject medical ED treatment when faced with decreasing erectile function.⁵ Although this medical technology would have enabled them to continue “youthful” practices of frequent, penetrative sexuality, they saw declining erectile function as a way to embody a “mature” masculinity appropriate to their age

and declining health. Most interviewees accepted decreasing erectile function as a way to embody emergent masculinities centered on affective bonds with family rather than sexual conquest and did not wish to medicate away this new social possibility.

At the same time that these men understood themselves in part through the lens of “hegemonic” Mexican machismo—often saying that they were machos in their youth—relationships with female partners and family members, acknowledgment of their own aging bodies, and alternative ideas about masculinity had become more important to their emerging ways of being men. In general, study participants saw cessation of previously enjoyed and valorized practices like sex, drinking, smoking, and overwork (which they sometimes called “vices”) not as a sad consequence of aging but as a proactive step to be taken to mature responsibly. For many, embodying age-appropriate manliness was a point of masculine pride. In response to a question about whether he continued to engage in sex, a 68-year-old barber laughed and stated, “Here in Mexico, we have a saying: after old age, chicken pox . . . It means that some things become silly when one is older.” Similarly linking “hegemonic” ideas about the importance of sex to manliness to his youthful performances of masculinity, a 64-year-old retired university staff member remarked, “Now I don’t have sex. I don’t have the desire, I don’t feel that. I don’t even try. It gets erased. I don’t feel bad—sometimes when I was young, yes, if you couldn’t get it [up], you felt bad, but not now. A youth looks for it, now no.” Importantly, many men felt that their previous, more stereotypical attitudes toward sex now enabled them to be men in ways that did not focus on sexuality, because they had basically had their fill. A 64-year-old retired mechanic stated that his “sex life now doesn’t exist, doesn’t exist. But, I’m satisfied, from my youth. I don’t miss it. Thank God, I had a lot of fun before I got married.”

New and age-appropriate ways of relating, sexually and emotionally, to their wives were a key element of these men’s emergent “mature” masculinities. A 67-year-old bakery owner voiced the commonly held notion that cessation or decrease in penetrative sex would pave the way for a new, more companionate and affective relationship with one’s wife. He stated that marital sex “is like a plant that dries up over time, the force ceases. When you get old, you’re more tired—spending time together is more important. Spending time together happily.” Men in relationships that had been marked by gendered inequality often came to declare themselves “ex-machistas” and to understand their reconfigured marital relations in terms of women’s rights. For example, a 55-year-old retired laundry worker stated, “I was a womanizer. The truth is, now I don’t have the same capacity. I’m 55, I know what I am. I don’t want problems with my wife. Like I deserve respect from her, she deserves it from me as well.” Similarly, a 61-year-old construction worker reported that

he first experienced decreasing sexual function as a devastating threat to his masculine selfhood, and thus to the marriage in which he enacted virile manhood. However, he had come to see this shift as socially, mentally, and physically beneficial. He stated that when he became less able to achieve erections eight years ago, “I thought, I’ll be useless, my wife will cheat on me. But now, I’ve changed, I don’t want to wander the streets, I’m dedicated to the home.” He also noted that sex with his wife had undergone a “beautiful change”—they had sex on the less frequent schedule that she desired, and she “set the conditions.” He said that sex had become more pleasurable for them both, rather than an obligation for her, and that he no longer had the “sick mind” that once led him to desire sex constantly, which, he believed, had stressed his prostate and caused health problems. Thus, although men often reported being initially upset with changing erectile function and sometimes considered ED drug use, they ultimately incorporated new ways of embodying sexuality into emergent masculinities focused on more tender, egalitarian relationships with female partners.

Even participants who felt unable to salvage relationships with their wives after years of strife and infidelity came to accept decreasing erectile function as an appropriate form of embodiment of respectable aging. Many interviewees said that unreliable erections caused by aging and illness meant that they could no longer be unfaithful and that it would now be unseemly for them to try. A 68-year-old retired administrator, who stated that his wife had discovered a now-finished affair and remained angry with him, said that he was no longer unfaithful because his ability to attain erection had decreased. He responded to a question about why he had not tried an ED drug in this way:

That’s the most difficult question that’s ever been put to me. Why not? Because I love women . . . look. Because the only person I could use it with would be my wife—I can’t go back to my lover and ask forgiveness. And I’m certain my wife would reject me. She also can’t respond physically—there’s no lubrication—the last few times, it hurt her a little, the lack of lubrication. And it was more like an obligation, physical necessity but not psychological—she’s thinking of Tom Selleck! Possibly that’s why. At my age, I’d look ridiculous going out with young girls! I don’t want to gross anyone out; it hasn’t been important to find a cure for this situation.

In summary, study participants saw acting in a manner appropriate to one’s age as a crucial element of “good” masculinity, and most understood decreasing sexuality to be a key element of “normal,” socially appropriate aging. An 81-year-old retired factory worker explained that decreasing erectile function was “part of the process” and “something that I’ve lived. It’s nature, I’m diminishing, and I take that as something normal.” Many others saw lessening of

erectile function in men as akin to menopause in women, which they understood to entail reduction of sexual desire. They also generally saw a decrease in or cessation of penetrative sex as physically appropriate to aging or ill bodies, understanding the use of ED drugs to artificially prolong the sexually active phase of their lives as not only socially inappropriate but also physically dangerous.

Some participants said that the drugs' potential side effects made them risky. For example, a 64-year-old retired utility company worker, who had experienced decreasing erectile function following kidney disease, said that he had not tried an ED drug "principally because of my kidney—it could hurt my kidney. At our age, sex isn't so urgent—false satisfactions. Sexual satisfaction is great, but you shouldn't demand so much of the organism, you'll do damage." Others believed that the drugs' "unnatural" effect of prolonging youthful sexuality would put dangerous amounts of stress on older bodies. One participant warned that ED drugs will "accelerate you, to your death. Many friends have told me, they will accelerate you a lot, then you'll collapse, that stuff will kill you." Thus, the majority of participants understood diminished erectile function and sexual activity in older age as part of a healthy and socially appropriate life cycle. The emergence of new, "mature" forms of masculinity that led most older participants to see ED treatment as "silly" or "unnecessary" also shaped the emergence of new health concerns that reinforced this notion. Whereas social inappropriateness was participants' most commonly stated reason for rejecting ED treatments, many also feared that thwarting natural bodily changes through "unnatural" medical intervention might cause bodily harm or hasten death. Hugo's story illustrates how rejection of ED treatment serves as a way to embody an emerging form of "mature" masculinity.

The case of Hugo

A long-distance truck driver who had acted out more "traditional" Mexican masculinity in the past, Hugo now seeks a tender and companionate relationship with his wife in the face of aging and prostate troubles. Hugo says that because he and his wife married young—he was 16, she 15—"we didn't have much experience." As a driver, he traveled constantly, which he says enabled him to make marital "mistakes": "I've made mistakes, been outside the married couple—it's because I'm a truck driver . . . strange beds, strange women, strange places, one suffers a lot." Hugo characterizes these infidelities and the time spent away from his family as "suffering." He describes himself and his wife early on in their marriage as childlike and "inexpert." He would cheat, and they would fight, "even reaching blows."

With the help of his wife, he later decided that a good life would involve a closer focus on his family. He recalls

a moment of epiphany when he was driving a bus after drinking: "My God, what am I doing? My children are growing!" He says that he took stock of his life, stopped drinking and smoking, and switched to a local truck route so that he could come home every night and "make more of the family."

Now, Hugo says that he and his wife do not fight, because they do not want to jeopardize their valued relationship. Looking back, he says, "I did think of leaving her, to be with someone else. Thank God I didn't! She put up with me. Thanks to her, we're together . . . Now it's not like before, inexperienced, and we continue growing, trying to understand each other better. That continues."

Although Hugo characterizes past acts as "mistakes," he sees that past as a necessary precondition for his current self. He says, "Now, the past is the past, now is now. I'm different." In this present, Hugo believes that tender and communicative relations with his wife are a key practice through which he acts out a mature masculinity. He links his changing sexual embodiment with his new way of being a man. He says that the support of his wife has been key to the emergence of his new style of masculinity: "Alone, one can't change. We have to walk together, have communication, support each other."

At the time of his interview, Hugo had just been told that he needed to have an operation on his enlarged prostate, which might decrease or even end his ability to have erections. When asked if he might use ED medication, he said that he would, instead, deal with this change like he had dealt with others—by talking with his wife, with whom, "there is communication, there is trust." Hugo says that he is unbothered by the prospect of decreased erectile function, especially because he believes that his prostate trouble was likely caused by too much sexual contact with other women earlier in his life. He plans to have the surgery and then to focus his remaining sexual capacity on a tender sex life that will satisfy his wife's needs. "The most important thing is to have sexual contact with her. Not punish her. Do my part . . . I understand my wife as a woman." Hugo is opposed to using medical ED treatment to accomplish this sexual contact. He likens ED drugs to the stimulants that he says other truck drivers take to stay alert. "My work is hard, long hours, many take drugs to get through—not me. If I did, now I'd be like a grandfather! I don't force my organism to continue. So, I feel very healthy."

Conclusion

As seen in these ethnographic vignettes, Middle Eastern and Mexican men are self-consciously acting out new masculinities in relationship to their changing bodies and new medical technologies that may mediate these changes. Our study populations faced specific sexual and reproductive health challenges and changes over time, which led them to

reflect quite consciously on their embodiments of masculinity in attempts to further particular social ends. Prior ethnographic research has shown that men who use health technologies are often well aware of the social messages encoded in their treatments and that this knowledge as well as the physical effects of the treatment and individuals' particular social contexts shape their medically assisted ways of being men (Potts et al. 2006; Rosenfeld and Faircloth 2006; Wentzell and Salmerón 2009). Thus, individual men may adopt, experiment with, or reject these medical technologies for embodying idealized norms of manhood, a process from which, individually or historically, new forms of masculinity may emerge. Whether they are using ARTs to physically perform companionate marriage or rejecting the medical opportunity to continue engaging in penetration-oriented sexuality, these men act as men in new ways by relating their changing bodies to their changing social worlds.

Around the world, men's bodies change over time in ways that require reformulations of masculine practice and identity. Although this process is especially apparent in our case studies, all men must continually forge emergent ways of being men as they relate to their changing bodies in the context of emerging reformulations of local norms of manhood. We argue that masculinities theory and research must become dynamic enough to account for these constant, embodied, interrelated changes in masculine identities and practices. Previous work on hegemonic masculinity has established the nature of masculinity as hierarchical, relational, and located in specific cultural contexts. The next step, as noted by Connell and demonstrated here, is to develop theoretical approaches that, when applied to ethnographic cases of real men's lives, account for the dynamism, embodiment, and geographically specific nuances of men's changing bodies and social worlds.

An emergent masculinities approach that takes new forms of masculine embodiment seriously as an object of empirical investigation helps to challenge pernicious stereotypes of masculinity that still persist in many regions of the world. An emergent masculinities approach requires ethnographic documentation of gender in practice—of men acting as men, in relation to women and other men—in diverse research settings. The Middle East and Mexico are excellent sites for rethinking masculinity, as men themselves recast their own lives in relation to globally diffused and locally debated “toxic” stereotypes. In short, Middle Eastern and Mexican men themselves are ready for an emergent masculinities approach to be applied.

In conclusion, we argue that the time has come for new thinking about manhood around the world. As anthropologists, we are committed to ethnography as the best way to explore men's changing social worlds, their evolving understandings of manhood, and their embodied experiences. We urge others to engage in similar studies of lived masculinities on the local level. By doing so, we can establish the

empirical base upon which to further develop an emergent masculinities approach and to bring masculinity theory up to date in the new millennium.

Notes

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1. However, gender hierarchies are clearly important, and one of us has written extensively about the nature of gender hierarchies, patriarchy, and hegemonic masculinity in Egypt (Inhorn 1994, 1996, 2003a, 2003b, 2004, 2005, 2006).

2. For example, in these mostly heterosexual, “married” settings, no men ever volunteered their experiences of same-sex sexuality nor did we usually ask.

3. Male infertility is of four types: oligozoospermia (poor sperm count), asthenozoospermia (poor sperm motility), teratozoospermia (poor sperm morphology), and azoospermia (absence of sperm in the ejaculate).

4. All names are pseudonyms.

5. In this study, 70 percent of 250 men reported decreased erectile function, but only 9 percent had ever used a medical ED treatment. Of those who had tried once, few continued. See Wentzell and Salmeron 2009.

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