

INTRODUCTION

Reconceiving Middle Eastern Manhood

This book is a tribute to Middle Eastern men such as Hamza, my driver in Lebanon, whose stories never make it to the front pages of the *New York Times*, to flashing news bulletins on CNN, or to Academy Award-winning movies such as *The Hurt Locker*. Hamza is an ordinary man, living through a millennial moment of political violence within the Middle East and between the Middle East and the West. That Hamza was willing to drive me, an American female anthropologist, through a post-9/11 world marked by increasing tension and bloodshed—much of it perpetrated by my own country in the region—seems to me now quite extraordinary. With courage and conviction, Hamza shared his life story, his inner thoughts, his deep sorrows, and his eventual profound happiness with me. Although I came to know Hamza best, he is but one of the hundreds of Middle Eastern men who told me their stories. *The New Arab Man* is my testament to their suffering, their resilience, and their humanity.

Hamza's story reveals many of the themes to be taken up in the chapters that follow. First and foremost, Hamza is infertile; infertility impedes reproduction among a disproportionate percentage of Middle Eastern men. This epidemic of male infertility—which many men attribute to their unrelenting life stresses, including war—has led to a recalibration of manhood in ways to be described at length in this volume. As I argue, reproduction, fatherhood, and manhood are in a state of flux—or what I shall call “emergence”—in the Middle Eastern region as a whole. “Emergent masculinities” bespeak not only the new treatment options available for male infertility but also men's changing desires for a happy life. As seen in Hamza's story, becoming a father was but one of several life goals. Most important to him was the achievement of a loving and understanding relationship with his wife, Janna, his younger cousin. Consanguineous or cousin marriage is widespread across the Middle Eastern region and may be tied to the high rates of male infertility there. However, cousin marriage may also be companionate, marked by romantic love, deep affection, and abiding commitments.

I argue that Hamza and Janna's loving marriage was facilitated by being childless. This finding is counterintuitive, for infertility is widely considered

within the Middle Eastern region to be an inevitable source of marital duress and eventual divorce. Many men's and women's stories suggest otherwise, and male infertility is no longer the major crisis of masculinity that it was once perceived to be. The notions of a "childless couple" or "child-free living" have yet to enter the cultural lexicon. Nonetheless, Hamza and Janna lived happily for more than a decade as a childless Middle Eastern couple. As dual-income migrants, Hamza and Janna were able to enjoy life together, experiencing the attractions of the booming Arab Gulf economy and saving enough money to realize another major dream when they built a rather palatial, marble-tiled, single-family home back in Lebanon.

Such diasporic dreams are profoundly different from a generation ago. Migration and remittances, nuclear residence, dual careers, companionate marriage, romantic love, being a happily married couple, and a childless couple at that—all of these are new patterns that are definitely emerging across the region but have barely been noticed by scholars and media commentators. In part I of this book, "Emergent Masculinities," this phenomenon of happily married but childless Middle Eastern couples is explored at some length from Middle Eastern men's own perspectives. Many men do not want to be perceived as domineering patriarchs; they do not view fatherhood as the be-all and end-all of masculinity; they value conjugal intimacy and privacy, sometimes at the expense of larger familial commitments; and they often adore their wives as friends and lovers, having learned sexuality together in the context of dual premarital virginity. Hamza's story represents these emerging forms of masculinity and conjugality.

Hamza's story also highlights the emergence of changing moral commitments over the course of a man's lifetime. We see in Hamza's tale the moral quest to be a good Muslim man in a religiously complex, even fractured, environment. Men's religious commitments are the subject of part II, "Islamic Masculinities." We still know too little about Middle Eastern men *as practicing Muslims*, or how Islam shapes men's identities.¹ Although Islam is the dominant regional religion, the Middle East is home to many faiths, with eighteen registered religious sects in the country of Lebanon alone. Hamza was born into the minority Shia branch of Islam, which is the single largest religious group in southern Lebanon, in the southern suburbs of Beirut, and perhaps in the country as a whole. But among the Shia, there are major divergences in levels of religiosity, clerical authority, political affiliation, and attitudes toward modernity, including the use of high-tech reproductive medicine. Hamza considered himself to be a pious Shia Muslim. However, he interacted continuously with foreigners and, like most other Lebanese, did not make his religiosity publicly manifest in a country where sectarian rivalries have been the source of tragic violence. Had I not pursued an anthropological line of questioning with Hamza, I might never have known of his religious allegiances.

Hamza's religious and political convictions also changed over the years and were influenced by the tragedy of his father's wartime death. Hamza eventually sided with Hizbullah, during the local power struggle between two rival Shia political factions. However, Hamza's own piety and comportment could only be described as moderate. Although sympathetic to Hizbullah, Hamza worked vociferously to distance himself from the terrorist label. Despite his patriotic rhetoric, Hamza decidedly did *not* take up arms with Hizbullah against Israel in the 2006 war, instead seeking protection for his young family with the Druze, another minority religious sect.

Like many other Middle Eastern men whose lives are explored in the pages that follow, Hamza did not always agree with religious authorities. For example, Hamza did not view sperm donation as a solution to his male infertility, even though he followed the teachings of Iran's Ayatollah Khamene'i, who had issued a *fatwa*, or religious decree, allowing donor technologies. As shown in part II of this volume, religion has shaped the very contours of the assisted reproductive technology industry in the Middle East, with attitudes toward in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), gamete donation, embryo disposition and storage, multifetal pregnancy reduction (a form of abortion), and the possibility of adoption heavily infused with local moral sensibilities. Most Muslim men are keen to follow authoritative Islamic *fatwas* and bioethical statements, all of which have allowed IVF and ICSI as solutions to infertility. However, Sunni Islamic authorities continue to ban both gamete donation and surrogacy.² This Sunni ban on third-party reproductive assistance carries great moral authority, for reasons to be explored in part II. Nonetheless, Ayatollah Khamene'i's unprecedented permission of third-party donation, including sperm donation, egg donation, embryo donation, and surrogacy, has created new possibilities in Shia-dominant Lebanon and Iran. How Middle Eastern men accommodate or resist these novel interventions—and the moral justifications they draw on to do so—are also the subject of part II.

Throughout this volume, we follow Middle Eastern men on their quests for ICSI, the reproductive technology that allowed Hamza to become a father. We examine the trials and tribulations of what men call *tifl unhub* (literally, "baby of the tube," or test-tube baby) or, simply, "the operation." Increasingly, the quest for ICSI involves "reproductive tourism," whereby infertile men travel between IVF centers and between countries in search of ICSI success. Such reproductive travel, I argue, is better understood as "reproductive exile,"³ for many infertile couples feel forced to leave home in order to access reliable assisted reproductive health services. Such movements are all too familiar for most Middle Eastern men. Men such as Hamza are a population in motion, with a high percentage of men moving across borders in the course of their lifetimes for reasons having to do

with politics, economics, and, in some cases, reproductive disruptions that require cross-border reproductive care (CBRC).

DISRUPTING OUR SCHOLARSHIP AND ASSUMPTIONS

This is a book about disruptions, with the term “disruption” taking on two important meanings. First, the term “reproductive disruption”—which I have used in my earlier writing⁴—captures the sense of disjuncture, asynchrony, loss, injustice, and stigma that many infertile people feel when they discover that they are unable to conceive a child. Male infertility, like female infertility, definitely constitutes a reproductive disruption, and one that comes as a surprise to most men, who have no idea that they are infertile until diagnosed through semen analysis, usually after marriage.

Second, I intend for this book to disrupt many taken-for-granted assumptions about men’s lives, and particularly Middle Eastern men’s lives. Preconceived notions about the malevolence of Middle Eastern men certainly come to us through the media, both cinematic and informational. As one of my colleagues summed it up, after attending a research seminar on my work: “You just can’t buy a positive picture of a Middle Eastern man these days.” This vilification of Middle Eastern-qua-Muslim men through both popular and scholarly discourses is the subject of the next chapter, “Hegemonic Masculinity.” Suffice it to say here that one of the main goals of this book is to disrupt stereotypes, or what we think we know about Middle Eastern men as patriarchs, polygynists, protestors, religious fanatics, and terrorists—men who represent the very epitome of brutality, rage, and misogyny. This book purports to be an antidote to that kind of thinking, my attempt to humanize men who have been categorically condemned by the media and many politicians as “guilty” after 9/11.⁵

Part of the failure to humanize Middle Eastern men lies in the hands of scholars. In the new millennium, there is a dire need to retool our scholarship on Middle Eastern men’s lives. In this regard, two contemporary anthropological theorists have urged scholars to engage in such scholarly disruptions and thereby unseat facile essentializations. One of our most esteemed Middle Eastern anthropologists is Lila Abu-Lughod of Columbia University, the author of the award-winning *Veiled Sentiments: Honor and Piety in a Bedouin Society*.⁶ In her 1991 seminal essay, “Writing Against Culture,” Abu-Lughod took issue with the way in which anthropologists were using the “culture” concept; by representing cultures as seemingly coherent, timeless, and discrete, they ignored history and engaged in a project of profound “othering.”⁷ She urged anthropologists to write against culture by focusing instead on discourse and practice, global connections, or ethnographies of the particular. Turning her critical gaze on

the anthropology of the Arab world, she also challenged the discipline's obsession with particular ethnographic "prestige zones" (e.g., Morocco under the influence of interpretive anthropologist Clifford Geertz) and with particular "zones of theory" that were taking on a talismanic quality within Middle Eastern anthropology at the time.⁸ These zones of theory included tribalism and segmentary lineage theory; harem theory, or the presumed "private" space relegated to Middle Eastern women; and Islam, which she called the "theoretical metonym" for the Arab world. She lamented the relative poverty of anthropological theory on political economy and class, or the anthropology of emotions. In both of her provocative works, she beseeched the anthropological discipline to "reform" itself through attention to history and power.

More than two decades later, Middle Eastern anthropology has yet to break out completely from its theoretical and ethnographic shackles. Of the approximately 420 ethnographies written by anthropologists over the past sixty years—exactly half of which have been published in the new millennium—most focus on only six of the twenty-two Middle Eastern nations, including in order, Israel/Palestine, Egypt, Morocco, Iran, Turkey, and Yemen. Afghanistan, Algeria, Jordan, Lebanon, Sudan, Syria, and Saudi Arabia constitute a second tier of ethnographic attention, with at least ten books on each country, many of them quite old and outdated. Geopolitically crucial countries such as Syria and Iraq, the countries of origin of many of the men in my study, have been difficult to access and, hence, much less studied. The small, petro-rich kingdoms of the Arab Gulf, where many of the men in my study, including Hamza, have migrated, have received the least ethnographic attention.

Works on the original "zones of theory"—namely, tribalism, gender (qua veiled women), and Islam—continue to form a kind of holy triumvirate, composing one-quarter of the entire anthropological corpus. These are followed by numerous ethnographies of place—namely, villages, towns, urban quarters, minority ethnic enclaves, and migrant neighborhoods—which are heavily overrepresented among the remainder. Thankfully, many newer themes have emerged over the past decade and are being celebrated at the 2011 Middle East Studies Association Annual Meeting under the title "Anthropology of the Middle East: A New Millennium."⁹ Some of these newer themes include studies of mass mediation and popular culture, Middle Eastern youth and education, law and human rights, language and literature, colonial politics and modern violence, memory and subjectivity, fine arts and architecture, diaspora and transnationalism, forced migration, and tourism. There is now even one ethnography on sexuality and sexual practice from contemporary Iran.¹⁰ However, ethnographies of science, technology, and medicine—the theme of my own work in the Middle East over the past twenty-five years¹¹—are relatively few and

far between.¹² Middle Eastern anthropology is decidedly out of touch with the up-and-coming discipline of science and technology studies, which has produced a decade's worth of award-winning anthropological ethnographies.¹³

Furthermore, ethnographies of masculinity—or “men as men,” to use Matthew Gutmann's well-turned phrase¹⁴—are, to my knowledge, nonexistent for the Middle Eastern region as a whole. This glaring lacuna is indexical of problems in the wider discipline of anthropology. Gutmann, a professor at Brown University, has lamented the erasure of men from contemporary gender scholarship in anthropology. Ethnographic accounts of masculinity are rare and tend to focus on the “manly” subjects, such as physical training, sport, education, wage earning, and militarism.¹⁵ Although the literature on masculinity is beginning to grow in anthropology, the majority of it hails from Euro-America and Latin America, and much of this Americanist scholarship centers on masculinity construction among men who have sex with men, given the grim specter of the HIV/AIDS epidemic.¹⁶

Within such studies, Gutmann notes that masculinity is often described imprecisely. Four distinct notions of masculinity can be found in anthropological discourse: masculinity as anything men *think* and *do*; masculinity as anything men think and do to *be* men; masculinity as reflected by some men being inherently *more manly* than others; and masculinity as anything that woman are *not*, emphasizing the central importance of male-female relations.¹⁷ In his award-winning ethnography, *Fixing Men: Sex, Birth Control, and AIDS in Mexico*, Gutmann unpacks ten common misconceptions about men's reproductive lives and sexuality, including, for example, that men do not—and will not—take responsibility for birth control.¹⁸ His research from Oaxaca shows that some men are embracing vasectomy as a permanent form of male contraception. Their reasons for doing so are varied but include conjugal empathy and sacrifice, themes that are also prominent in Middle Eastern men's narratives.

Like Abu-Lughod's and Gutmann's, my own work on gender and reproduction in the Middle East has caused me to reflect on such silences and misconceptions. In what follows, I examine scholarly erasures and policy assumptions regarding men, before describing my own ethnographic foray into the world of Middle Eastern men's reproductive lives.

REEMBEDDING MEN IN REPRODUCTION

According to a widely held but largely untested assumption in feminist social science, population policy, and lay circles, men are disinterested and disengaged in matters of human reproduction. Because men do not

give birth, their power and attention lies elsewhere in social life, with the responsibility for pregnancy, parturition, breastfeeding, and childcare remaining solely in the hands of women. Drawing upon the title of Simon de Beauvoir's great feminist treatise,¹⁹ my colleagues and I have argued that men are relegated to be "the second sex" in the scholarship of reproduction, including in anthropology.²⁰

Case in point: When I surveyed the state of the art in the year 2006, I found that more than 150 ethnographic volumes on reproduction and women's health had been written in the past twenty-five years, with nearly two-thirds of those volumes published since the new millennium.²¹ Only four ethnographies on men—two on men's experiences of childbirth and fathering in the United States,²² one on soldiers' reproductive and sexual troubles after the first Gulf War,²³ and Gutmann's book on men's reproduction and sexuality in Mexico²⁴—have ever been published, to my knowledge. To date, there are no ethnographic monographs devoted to male infertility or men's use of assisted reproductive technologies, including donor sperm;²⁵ erectile dysfunction or other sexual health problems;²⁶ sexually transmitted infections (STIs) other than HIV/AIDS; men's usage of the vast repertoire of contraceptives; older men's experiences with prostate cancer and reproductive aging; men's attitudes toward prenatal genetic testing and fetal demise; men's feelings about partners' abortions; men's experiences of pregnancy loss and child death; and men's reproductive health in general. Certainly, other vital topics could be added to this list if it were widened to include smoking, cardiac disease, diabetes, and the like. Although several new journals are devoted to men's health (e.g., *International Journal of Men's Health*, *Journal of Men's Health and Gender*), the empirical literature is still scant compared to that devoted to women and reproduction. Although men influence women's reproductive lives and health in a variety of ways, how women influence men's reproductive lives is rarely explored. Instead, when men are included in reproductive health studies, the focus is generally on the consequences of their actions for women's reproductive lives and well-being.

But are men truly so disassociated from reproduction? This book challenges that assumption, bringing men back into the reproductive imaginary as reproductive progenitors, partners, decision makers, lovers, nurturers, and fathers. Men not only contribute their gametes to human procreation but are often heavily involved and invested in most aspects of the reproductive process, from coupling to impregnation to parenting. Furthermore, men have their own reproductive issues and concerns, which may be connected to but also separate from women's reproductive health and well-being. Thus, men need to be reconceived as reproductive in their own right, and men's reproductive rights need to be acknowledged along with women's.

This insight—that men have reproductive issues and rights—was first suggested on a policy level at a major 1994 conference in Cairo, Egypt. Called the International Conference on Population and Development (ICPD), a broad new approach to population policy, called the Reproductive Health Initiative, was conceived.²⁷ Men were included in the new rubric of “reproductive health for all,” and infertility was recognized as an impediment to “family planning” in the truest sense of that term. The Reproductive Health Initiative promised to move population policy beyond the narrow focus on fertility control. ICPD was hailed by many, including Third World feminist organizations, as a great historical achievement.

Despite the broad definition of reproductive health put forward at the ICPD conference, the Reproductive Health Initiative still remains heavily focused on population reduction through family planning. Some critics argue that the term “reproductive health” has simply replaced the term “family planning” in population and international health discourses, with little substantive change at the level of actual programs.²⁸ Moreover, the questions can be asked: Has the ICPD Reproductive Health Initiative actually improved the reproductive lives of men? And are men and women suffering from infertility actually better off than they were in 1994? The answers to these questions remain unclear.

Treatment of infertility in order to conceive a desired child is now being conceptualized as a fundamental reproductive right. However, reproductive rights discourse continues to be based on Eurocentric, neoliberal bourgeois notions of reproductive “choice” that may not apply to or be operationalized in many non-Euro-American societies, or among poor minority communities within Euro-American settings, where reproductive rights may be severely constrained.²⁹ Reproductive health discourses are still predicated on Western-generated notions of the right to choose (be it contraception, abortion, infertility treatments, or parenthood itself). These discourses assume, at some rudimentary level, a body of autonomous individuals who are free to make choices and who can come together in a concerted way to vocalize their resistance as political agents.³⁰ Yet, in many non-Euro-American societies such as the Middle East, individual agency is often subsumed within larger collectivities such as the extended family; hence, there may be limited opportunities for individual action and expression. Moreover, strategies of everyday resistance and group mobilization (e.g., infertility support and lobbying groups) may be severely constrained by the political contexts within which individuals live their lives.

Globalization, the concomitant spread of biomedicine, and neoliberal values of reproductive “choice” and “freedom” in a now privatized reproductive “marketplace” suggest that individuals bear responsibility for their health and illness, with every person expected to care for himself or herself

in the name of striving for a better quality of life.³¹ Within this perspective, a person with a condition such as infertility should actively seek treatment or find other strategies to overcome the childlessness. With regard to male infertility in particular, seeking a solution becomes a challenge and test of a man's capacity to fend for himself, his wife, his marriage, and the future of his family. For those men who fail in this regard, they may be blamed for not availing themselves of their choices in the reproductive marketplace. Yet men's reproductive choices may be severely constrained by both biology (a lack of sperm) or access (a lack of ICSI)—constraints that the ICPD initiative has done little to overcome.³²

In short, the neoliberal reproductive rights discourse first promulgated at the utopian Cairo ICPD conference has yet to materialize for many people around the world, including many infertile Middle Eastern men. The discourse is oriented toward women, is still focused on population control and the provision of birth control, and fails to account for the many ways in which people lack true reproductive agency.

In my own work on Middle Eastern infertility, I have been struck by the failure of reproductive rights discourse to resonate with most audiences. Namely, is the right to bear children a human right? Many individuals would answer no to that question, especially in the context of poverty or overpopulation (e.g., Gaza, or Cairo with its 20 million inhabitants). The suffering of the infertile in places such as the Middle East evokes little sympathy. Instead, most Westerners, and even some Middle Eastern elites, argue that Middle Eastern fertility levels should be dramatically curtailed, and individuals' reproductive rights to bear a child questioned and constrained. That I have argued vociferously for the right to IVF, ICSI, and other reproductive technologies in resource-poor settings such as Egypt seems incredibly naïve—even *ill-conceived*—to many.³³ A recent conversation, which occurred “behind my back,” is just one of hundreds of examples I could recount over the ensuing years since I began my research. A member of my own extended family, a high school teacher in Ohio, recently asked my parents what kind of research I *really* do, and why Yale University would want to hire me for it. When my then eighty-three-year-old mother attempted to explain the importance of overcoming infertility in the Middle East, my cousin retorted, quite aggressively: “Why would she want to help terrorists have babies? They'll just bring future terrorists into the world!”³⁴

Although Middle Eastern men are conceived of as particularly ominous reproductive actors, the *negative* contributions of men in general have emerged from ICPD reproductive health discourses. Men either impregnate women (sometimes against their will) or cause women's poor reproductive health outcomes, through HIV/AIDS, other STI exposure, sexual

violence, or physical abuse. In addition, they have been regarded as formidable barriers to women's decision making about fertility, contraceptive use, and health care utilization in general.³⁵

Two recent attempts to reframe men's contributions more positively are noteworthy. In the first, both men and women are seen as having reproductive rights, but men are also seen as having "responsibilities" toward their families.³⁶ "Responsible men" share in family planning; remain faithful to their partners; seek health care for their partners during pregnancy, birth, and postpartum; and participate as fathers in family life and child care. To wit, "real men" are "responsible men," whose role is to protect and ensure the reproductive rights and well-being of others.

But what are the problems of this framework? First, responsible men rhetoric is blatantly patriarchal, if men are primarily conceived of as paternalistic protectors of women and children. Second, in this framework, women's and men's contributions to reproductive health are seen as inherently unequal, and their experiences of reproductive health as fundamentally different. Interventions following from this framework remain focused on the reproductive health problems *caused* by men, along with approaches designed to *empower* women. Third, the fact that the reproductive rights of men and women coexist in relationship to each other is fundamentally ignored; if men, too, have reproductive rights, then women should also have "responsibilities" in protecting men's reproductive rights and health. Fourth, if men are conceived of as primarily responsible for others, then their own reproductive health problems are ignored; this is particularly problematic for integrating men into reproductive health interventions and programs. Finally, a framework that invests men with responsibilities suggests that men are fundamentally "irresponsible." This assumption is profoundly problematic, even denigrating. Many men are already responsible when it comes to reproduction and have been acting so for centuries, according to historical research on reproduction and contraception.³⁷

The second framework for including men in reproductive health heralds them as "partners" to women.³⁸ Men as partners is a "client-based" approach, which seeks to provide sustainable reproductive health care for men without compromising (and hopefully improving) services for women. Such a perspective recognizes men's important contributions to reproductive health, as well as men's own reproductive health care needs. It attempts to reconcile conflicting reproductive goals within the context of reproductive "partnerships," primarily among married couples. Such an approach focuses on men as husbands and members of a family, with a significant locus of responsibility for reproduction.

What are the problematic assumptions of this framework? First, given the explicit focus on the cooperation of men and women in reproductive

decision making, this framework downplays the different reproductive and sexual strategies and goals that men and women may pursue separately, including outside of the marital union.³⁹ A related problem is the ideological assumption of heterosexual monogamy and fidelity within marriage, which has become a programmatic goal of the men-as-partners approach. Third, this perspective has been difficult to implement, as the definition of “partner” has been difficult to operationalize, even within the context of marriage. Does marriage make a man a partner, or does “partnership” bespeak more nuanced notions of love, companionship, friendship, and the like? Fourth, on a programmatic level, this approach does not clearly answer whether services for men should be integrated or separate from those for women; this is a contentious issue that depends heavily on existing services as well as the kinds of services provided. Finally, the partner perspective also makes several implicit assumptions about men and reproductive health—namely, that educating men about men’s and women’s reproductive health needs will make men more sensitive and responsive to these needs and that incorporating men into reproductive health programs will improve both men’s and women’s reproductive health outcomes. Such assumptions may not hold in all contexts.

Men in the Middle East may feel greatly responsible for reproduction and may strive to be the best possible partners to their wives. This is true even though few Middle Eastern men have been “targeted” in the kinds of programs just described. Their sense of responsibility and partnership comes from other sources, including conjugal love, which, as I argue, has been virtually overlooked in population and reproductive health discourses (as well as in Middle East anthropology). That men—even Middle Eastern men—actually *love* their wives and will do what they can to meet their wives’ reproductive desires and needs seems to have been lost in the popular imagination and by the population studies establishment. Middle Eastern men as responsible reproductive partners, in love with wives whom they wish to please, is, perhaps, the abiding theme of this volume.

UNSEATING PATRIARCHY

Implicit in much of the ICPD discourse is that the reproductive and sexual needs of women are culturally subordinate to those of men. In many locales around the world, this may be true: namely, men may have implicit rights *over* women’s reproduction and sexuality. Thus, the achievement of equity in reproductive health requires unseating patriarchy wherever it is detected. The concept of patriarchy, or men’s systematic domination of key structural and ideological resources and positions, does not fully explain poor reproductive health outcomes for women. Yet a strong ar-

gument can be made that patriarchy affects women's reproductive health on both macrostructural and microstructural levels.⁴⁰ On the macrostructural level, women's reproductive health is affected by male policy makers, male health care administrators, and male service providers, who may perpetuate a dominant "male definition" of what is important and what is not without taking heed of women's perceptions and felt needs. On the microstructural level, research shows that men are more likely to have more sexual partners over their lives; to have multiple partners simultaneously; to pursue commercial sex; to have extramarital sexual relations; and to commit an act of violence against women, adolescents and children, and other men.⁴¹ Men have the option to be absent at childbirth; tend to commit smaller percentages of their income to children and childcare; and contribute less time to direct childcare.⁴² In short, men's relative superior power and privilege in most societies may have dire consequences on women's lives and reproductive well-being.

Men's relative power and privilege over women has been the dominant trope in the Middle Eastern gender studies literature—much of it written by Middle Eastern-born scholars—where the concept of "patriarchy" has served as a theoretical metonym. Scholars have unearthed the patriarchy in Islamic scriptural representations of women and in Islamic personal status laws.⁴³ They have analyzed childhood socialization practices that produce patriarchy in Middle Eastern family life.⁴⁴ They have critiqued a variety of Middle Eastern patriarchal practices ranging from veiling to female genital cutting to honor killing.⁴⁵ They have analyzed women's resistance to men's violence, including through women's storytelling, poetics, and memoirs of war.⁴⁶ And they have hailed the emergence of Middle Eastern feminist movements, both historically and amid growing male-dominated Islamism.⁴⁷

Furthermore, nearly one hundred ethnographies have been written by anthropologists about Middle Eastern women. Very few of these ethnographies have examined women's and men's actual relationships within the context of marriage. This lacuna reflects the highly gender-divided world of Middle Eastern anthropology: namely, women study women, and men study men. Ethnographers and ethnographies of what might be called "gender interaction" or "marital ethnography" are largely absent, not only for the Middle East but within the discipline of anthropology as a whole.⁴⁸

As a result of this lopsided view of gender through the eyes of women subjects and scholars, very little has been written about Middle Eastern men as men. A growing interest in Middle Eastern homoeroticism can be detected,⁴⁹ as well as the study of what might be called "military masculinity."⁵⁰ Four recent volumes examine primarily discursive traditions, including writings on Arab men's (and women's) sexuality since the early

nineteenth century,⁵¹ Arab men's portrayals in fiction since 1967,⁵² and Arab men's representations in Hollywood post-9/11.⁵³ The fourth volume, which is a compendium, is appropriately titled *Imagined Masculinities*, to signal how little is known about the realities of men's lives in the Middle Eastern region.⁵⁴ Calling the Middle East "one of the seats of patriarchy," the editors nonetheless challenge women's studies scholars to focus on masculinity as a "complementary endeavour" to their various "feminist projects."⁵⁵ The editors argue that Middle Eastern patriarchy "is both more complex . . . more implicated in the structure of social relations than has sometimes been admitted, and at the same time not as monolithic as has been suggested."⁵⁶ For example, in her chapter on representations of maleness in the Arab popular media, Ghousseub argues for "men's tortured conception of their own 'masculinity': its meanings, demands and projections." She poses the rhetorical question, "Who said it was easy to be a man?"⁵⁷ Through chapters on male circumcision, military service, and men's images in the Middle Eastern media, movies, and memoirs, the underlying purpose of the volume is to recalibrate understandings of Middle Eastern men's lives, including their oppression by other men. The editors and authors strive to show that men's lives may not be easy, particularly in a region that is highly militarized and where young men are often conscripted. However, the theme of patriarchy prevails throughout the volume. The editors remind us that men are "positioned at the thresholds and have often attempted to police the mobility and conduct of their sisters, daughters, companions, wives, and comrades, sometimes—quite often in fact—with the complicity of their mothers and other senior women."⁵⁸

My own intellectual genealogy as a Middle Eastern studies scholar and the founding editor of the *Journal of Middle East Women's Studies* (JMEWS) is tied up in this feminist project. For more than two decades, I have focused on Egypt, writing a series of three books that one scholar has dubbed my "Egyptian trilogy."⁵⁹ The second volume, *Infertility and Patriarchy: The Cultural Politics of Gender and Family Life in Egypt*, represents my most extended contribution to this feminist genre. In the book, I localize patriarchy within the Egyptian context, offering the following formulation:

Patriarchy is characterized by relations of power and authority of males over females, which are (1) learned through gender socialization within the family, where males wield power through the socially defined institution of fatherhood; (2) manifested in both inter- and intragender interactions within the family and in other interpersonal milieus; (3) legitimized through deeply engrained, pervasive ideologies of inherent male superiority; and (4) institutionalized on many societal levels (legal, political, economic, educational, religious, and so on).⁶⁰

The remainder of the book examines the ways in which patriarchy is “lived” by poor urban infertile Egyptian women in their relationships with husbands, in-laws, and community members. I argue that the severe stigmatization, threats of marital dissolution, and social ostracism faced by infertile women are rationalized and perpetuated by the dominant procreative ideology in Egypt, which attributes life-giving powers to men through spermatogenesis of fetuses and blames women for thwarting men’s procreative powers. The book concludes with an analysis of the social and cultural factors perpetuating emphatic pronatalism in Egypt and the resultant “cult of motherhood” that is increasing in importance with the rise of Islamism in the country.

In later publications, including contributions to edited volumes on *Islamic Masculinities*⁶¹ and *African Masculinities*,⁶² I describe the ways in which fertile Egyptian women are scapegoated for their husbands’ infertility and impotence. In “The Worms Are Weak’: Male Infertility and Patriarchal Paradoxes in Egypt,” I demonstrate four ways in which Egyptian women carry the social and physical onus of male infertility.⁶³ First, they are blamed for the reproductive failure and expected to bear their husbands’ secret in silence. Second, lacking the signs of pregnancy, their gendered identities are diminished, while their husbands’ masculine identities remain relatively intact. Third, they are expected to endure a childless marriage, while their husbands may become increasingly frustrated, demoralized, and divorce prone. And, finally, they are expected to seek treatment for their husbands’ infertility, a form of asymmetrical, gendered embodiment that leaves men physically unscathed. As I conclude, infertile Egyptian men experience various forms of privilege in their marriages, social relations, and treatment experiences, often to the detriment of the wives who love and support them.

Similarly, in “Sexuality, Masculinity, and Infertility in Egypt: Potent Troubles in the Marital and Medical Encounters,” I show how hegemonic constructions of masculinity prohibit frank marital and medical discussions of male sexual dysfunction, producing acute dilemmas for women who are labeled infertile by virtue of their childlessness.⁶⁴ In a culture that rewards and locates masculinity in a man’s ability to father children, male sexual dysfunction is rendered invisible—particularly within a “don’t ask, don’t tell” regime upheld by impotent husbands and the male gynecologists who proceed to treat these men’s wives. Although male sexual dysfunction represents a “crisis moment” for hegemonic Egyptian masculinity, this masculine crisis is lived most acutely by women, who must absorb both the sexual shame and the reproductive blame in public.

These publications were based on research conducted entirely with poor Egyptian women. As I wrote in the introduction to *Infertility and Patriarchy*, “I came to know much more about Egyptian *husbands*, as seen

through the eyes of Egyptian wives, than about Egyptian *men* in either a general sense or individually.”⁶⁵ However, my portrayal of poor Egyptian husbands was not entirely unsympathetic, one-sided, and unfair. The most important chapter of my book, “Conjugal Connectivity,” described the ways in which many poor Egyptian men support and protect their infertile wives within an otherwise hostile social milieu. These men’s desires for “companionate” marriages—characterized by loving connectivity even in the face of female infertility—was perhaps the major insight of the study. Relatively few of the infertile women that I encountered were living lives of brutal oppression by domineering patriarchs. Rather, many of them described their good fortune in having adoring spouses and satisfying sex lives—contrary, they admitted, to what was expected for a childless marriage within their social environment.

Since then, I have gone on to reconsider the ways in which I once systematically excluded men from my earlier studies. I returned to Egypt in the late 1990s to study elite women’s utilization of in vitro fertilization and was literally overwhelmed by husbands’ response to my study, with nearly half of them coming forward to speak with me, usually about their own infertility problems. The majority of these couples (70%) were seeking assisted reproduction because of male infertility in a society where infertility affects more than 15 percent of all married couples, and at least 60–70 percent of the infertility problems hail from men’s own reproductive tracts. It was then that I realized the toll on men’s bodies and lives entailed by male infertility, and I attempted to portray this embodied suffering and emasculation in my third book, *Local Babies, Global Science: Gender, Religion, and In Vitro Fertilization in Egypt*.⁶⁶

The New Arab Man is my own act of scholarly contrition—my frankly apologetic attempt to render visible the lives of Middle Eastern men whom I once regarded as imponderable and forbidden research subjects. In this book, I challenge many of my earlier claims and assumptions about Middle Eastern patriarchy and men’s lives. I argue that Middle Eastern patriarchy today is being unseated by Middle Eastern men themselves, who are questioning traditional notions of manhood. This does not mean that patriarchy is nonexistent in the Middle East; certainly, it does persist in a variety of forms. However, we need to rethink whether patriarchy should remain the dominant theoretical trope. Better empiricism—actually studying men’s lives and their relationships with women—might help to undo patriarchal assumptions in Middle Eastern gender studies. In short, as Middle Eastern feminist scholars, we could do a much better job of nuancing our patriarchal polemics, if we only took ethnographic realities into account.

In my own long-term, feminist research project, I had argued to myself and others that Middle Eastern men were off limits to me, as a female anthropologist studying the intimacies of reproduction, sexuality, and infer-

tility. However, the Egyptian men who volunteered for my study in the late 1990s proved that I might need to rethink many of my methodological assumptions. One Middle Eastern–born colleague, Lahoucine Ouzgane, was also especially helpful in this regard. When I discussed with him my reluctance to move forward with a post-9/11 project on Middle Eastern male infertility, he surmised that I might possess superior access to this sensitive research subject by virtue of my positionality. First, if Middle Eastern men regard fertility as an important and somewhat competitive attribute of manhood, then it might be very difficult for them to discuss infertility with another man, he surmised. As a woman, I might be better positioned to enter this secret world of reproductive shame, providing at least some men the only opportunity for frank discussion. Second, a Western woman is assumed to be knowledgeable in the ways of sex and conception, so that sexually troubled Middle Eastern men might be able to discuss their problems and questions more freely. Third, as an educated *duktura* and professor of medical anthropology and public health, I might be considered a potentially knowledgeable and empathic confidante, sworn to secrecy by virtue of research ethics. Fourth, as a middle-aged woman “past my prime,” I could represent a quasi-maternal and comforting presence, especially to younger men. Finally, as a temporary visitor to these men’s social worlds, I might be seen as taking “men’s secrets” far away, providing a fleeting moment in their tortured lives for honesty, candor, and catharsis.

NARRATING MEN’S REPRODUCTIVE LIFE HISTORIES

The New Arab Man is the outcome of my own ethnographic attempt to render men’s lives visible. I have made the collection of Middle Eastern men’s stories my major research project in the post-9/11, wars-in-Iraq-and-Afghanistan world in which we live. Hundreds of Middle Eastern men have come forward to tell me their “reproductive life histories.” What is a reproductive life history? This is a term I have coined to merge the methodological genres of cultural anthropology and epidemiology, the two disciplines in which I have received advanced training.⁶⁷ The “reproductive history,” as used in epidemiology, explores the important reproductive events in individuals’ lives through a process of structured interviewing. Questions revolve around premarital and marital sexuality, contraception, conjugality, infertility, pregnancy, pregnancy loss, childbirth, and maternal and neonatal mortality. Reproductive epidemiology also focuses on so-called risk factors (e.g., smoking, sexually transmitted infections) that may lead to so-called disease outcomes (e.g., infertility, stillbirth). Carefully rendered reproductive histories can provide an incredible wealth of

information on both epidemiological and demographic variables. Through systematic and detailed reproductive histories, reproductive disruptions of all kinds may emerge.

When combined with anthropological ethnography, reproductive histories take on additional meanings, transforming into full-fledged reproductive life histories. In anthropology, the "life history" is one of the most important ways in which ethnographers elicit chronological accounts of persons' lives, through processes of gentle questioning and probing.⁶⁸ Life histories are, in my view, the *sine qua non* of ethnography—that which takes our field to a different level of subjective inquiry. In medical anthropology, some of the most compelling and award-winning ethnographies adopt the life history genre.⁶⁹ Psychological anthropologists, too, have argued for the importance of "person-centered ethnography," which attempts to develop "experience-near ways of describing and analyzing human behavior, subjective experience, and psychological processes."⁷⁰

Here, I have attempted to conjoin the two disparate genres—epidemiological reproductive history with anthropological life history—to elicit nuanced reproductive life histories from Middle Eastern men. The resulting person-centered, reproductive accounts take us to places well beyond reproduction, providing rich entrée into experiential worlds, local moralities, and embodied subjectivities. The exploration of Middle Eastern men's subjectivity is at the heart of this endeavor. I am inspired in this regard by my medical anthropologist colleagues at Harvard and Princeton, who have challenged us to "rethink subjectivity" in the modern era:

In the many settings in which anthropologists now work, the vagaries of modern life are undoing and remaking people's lives in new and ominous ways. The subjects of our study struggle with the possibilities and dangers of economic globalization, the threat of endless violence and insecurity, and the new infrastructures and forms of political domination and resistance that lie in the shadows of grand claims of democratization and reform. Once the door to the study of subjectivity is open, anthropology and its practitioners must find new ways to engage particularities of affect, cognition, moral responsibility, and action.⁷¹

My own ethnography is a foray into these multiple domains: of politics, war, globalization, economic stresses, emotions, identities, religious subjectivities, and moral and practical responses to technological innovation. My research is based on reproductive life history interviews carried out with more than 330 Middle Eastern men in Egypt (1996), Lebanon (2003), United Arab Emirates (2007), and so-called "Arab Detroit," Michigan (2003–8), the capital of Arab America.⁷² In these four places, I have interviewed

men from fourteen different Middle Eastern countries. These include the Levantine countries of Lebanon, Syria, Palestine, and Jordan; the Arab Gulf countries of UAE, Bahrain, Oman, and Yemen; the North African countries of Egypt, Sudan, and Morocco; the war-torn country of Iraq; and the non-Arab Middle Eastern countries of Iran and Turkey. In addition, during my 2007 research project on "Globalization and Reproductive Tourism in the Arab World," I interviewed Muslim men from many different parts of South and Southeast Asia (e.g., India, Pakistan, Sri Lanka, Malaysia, Indonesia), as well as East Africa (e.g., Somalia, Djibouti, Tanzania), who were coming to the UAE to access ICSI.

As a result of this research over more than a decade, I have come to know, *inter alia*, Lebanese taxi drivers, Syrian university professors, refugees in Palestinian camps, wealthy Egyptian businessmen, Iraqi Shia clerics, Hizbullah police officers, Yemeni American auto workers, Lebanese Christian house painters, Emirati engineers, Armenian Lebanese jewelers, Syrian Bedouin shepherds, Druze *shaykhs*, Sudanese doctors, Syrian construction workers, Bahraini oil men, wealthy Lebanese in the African diaspora, and many poor and middle-class men, mostly from Lebanon, Syria, Palestine, and Iraq. The list goes on, but it is united by one fact: all of these men have shared their reproductive life histories with me.

In this book, I focus primarily on the Lebanese, Syrian, and Palestinian men who participated in my three-year study called "Middle Eastern Masculinities in the Age of New Reproductive Technologies," which began in Beirut, Lebanon, in January 2003. There, I met Hamza, as well as 220 mostly childless men who were visiting Lebanese IVF clinics. Throughout this book, I present basic statistical information about these 220 men—120 of them infertile, and 100 of them fertile—all of whom hailed from the Levant (Lebanon, Syria, Palestine). Usually, I present this information in the form of simple percentages, with many accompanying tables of information derived from their reproductive life stories. I also believe it is important to say a few words about these men, as well as the ways I "studied" them. I firmly believe that anthropologists should share their methodological tool kit with readers, with students, and with each other. Too often such details are submerged in footnotes or erased altogether from ethnographies. This, in my opinion, is an unfortunate omission, which reduces the credibility of anthropology to the wider world.

Who were these 220 men? Most were Lebanese citizens, born and raised in the country and survivors of the civil war. Seventy-five percent were currently residing in the country, and 16 percent were expatriates, who either were born outside the country or had fled to other countries during the war years. These expatriate Lebanese lived all over the world, but primarily in South America, West Africa, North America, Europe, and the Arab Gulf. Additionally, 6 percent of the men in the study were Syrians,

both Muslim and Christian, who were traveling to Beirut with their wives (and sometimes an accompanying Syrian doctor) as reproductive tourists. They hoped to access assisted reproductive technologies in Lebanon, a country that they viewed as technologically superior and more open to the West than their politically and economically isolated home country. The remaining men in the study were Palestinians, almost all Sunni Muslims. Most were living in the country as refugees, their families having fled there in 1948 after the founding of the nation of Israel. Two of these men were living in refugee camps; a few had achieved middle-class status as professionals; and a handful of these men were living more successful but also more complicated lives in the Arab Gulf Palestinian diaspora.

The men in this study came from all social classes and religious backgrounds, but they were generally united by their experiences of the Lebanese civil war, many attributing their current infertility problems to this collective trauma. Like Hamza, the majority of the men in this study were Muslim (70%), about half Shia (35%), half Sunni (30%), and a small number of Druze (4%) and Alawi (1%), both minority Shia Muslim subsects. Interestingly, only two of these men were of mixed Muslim parentage, and nine men, all Muslim, refused to define a religious sect or declared themselves atheists or nonpracticing. (Issues of religious affiliation and dissent are taken up in chapter 8.) The remaining men in the study, nearly one-third (30%), were Christians from a variety of denominations, including Maronite Catholic (14%), Greek Orthodox (8%), Armenian Orthodox (2%), and Roman Catholic (2%). One man was a Lebanese Jew, and he was living outside the country.

As in my earlier Egyptian study, which was based in two of Cairo's major IVF clinics, I was fortunate to gain ethnographic access to two of the 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 and Maronite Catholics; all of the embryologists and nursing staff were Muslim women.

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 neighboring 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. In Lebanon and in the Muslim Middle East more generally, the gender and religious affiliation of physicians can matter to patients, especially in the morally contentious world of assisted reproduction. For example, Sunni Muslim patients may prefer Sunni Muslim physicians who



FIGURE 1. The anthropologist with Lebanese IVF clinic staff

are similarly opposed to gamete donation. Furthermore, the most pious Muslim couples are generally uncomfortable if male physicians conduct gynecological exams; thus, they may seek out a female infertility physician, as was the case in this clinic.

Between these two clinics, I conducted formal tape-recorded interviews with six IVF physicians, two embryologists, and one IVF clinic head nurse (figure 1). With the help of some of these clinic staff members, I was able to recruit 220 Lebanese, Syrian, and Palestinian men into my study. Because of my interest in merging ethnographic and epidemiological analysis, I designed the study in a classic “case-control” fashion, with 120 infertile cases and 100 fertile controls. I was able to assess men’s fertility status not only on the basis of their interviews but also on the results of their semen analyses, which were provided to both me and the men in the study by the on-site IVF clinic laboratories, and which were based on the guidelines set out by the World Health Organization.⁷³ Infertile men in this study generally knew that they suffered from this condition, as a result of multiple semen analyses, sometimes carried out over many years. In a few cases, however, infertile men in this study had assumed that they were fertile and first learned about their infertility condition upon visits to the IVF clinics where I was conducting my research.

The fertile men in this study were all husbands of infertile women seeking IVF. Although some of these men “misclassified” themselves as infer-

tile, their semen analyses carried out on the day of the interview proved to be normal. The inclusion of fertile men in this epidemiological case-control study served important ethnographic purposes; it allowed me to understand the experiences and perspectives of infertile men, as well as men who were not infertile but who were experiencing childless marriages. Their stories—usually of love and support for their infertile wives—were often deeply moving and are included in this volume. I met many of the wives of both fertile and infertile men in Lebanon, and in 20 percent of the interviews, wives were present, sometimes actively participating in the interview responses and discussions.⁷⁴

As in my Egyptian study, more than half of my interviews were conducted in Arabic (57%) and about one-third in English (35%), with the remainder involving both languages (8%). Many of the men in the study had lived outside the Middle East and spoke excellent English (along with other languages in many cases). I conducted about half of the interviews alone, and half with a research assistant, especially in the initial stages of research when I was familiarizing myself with a distinct colloquial dialect of Arabic (Levantine versus Egyptian).

All of the men were recruited into my study, usually by a physician, nurse, or other clinic staff member, while in the midst of seeking or undertaking an IVF or ICSI cycle. I interviewed most men alone, in a private room secured for the purposes of interviewing. Because virtually all of the men in my study were literate, they read the informed consent form (required by both my home and Lebanese host universities)⁷⁵ with great intensity and interest, signing their names in Arabic and/or English. On the consent form, I asked for a separate signature allowing tape-recording of the interview, an option to which few men agreed.⁷⁶ Once men had signed and been given a study number, I gave each man a copy of the consent form, as well as my business card, to keep in their personal records. After being convinced of the confidential, anonymous nature of our conversations, many of the men in the study opened up with rich interviews that were often deeply personal and poignant. Interviews sometimes lasted two to three hours, with a friendly exchange of phone numbers or email addresses at the end.

A large amount of data was collected during the eight-month study period in Beirut. This included 220 completed eight-page reproductive history questionnaires, which I administered verbally to each man in the study; 1,200 pages of qualitative interview transcripts, generated from open-ended interviews with all of the men in the study and some of their wives or other family members; 550 pages of field notes, based on participant observation and informal interviews and conversations with clinic staff and patients in clinic waiting areas, as well as two pharmaceutical company

representatives, several American egg donors and sperm recipients, and three Shia Muslim clerics; and more than 200 blood samples, which were frozen in the Beirut IVF laboratories and then hand-carried by me via airplane to the United States for the purposes of later toxic metal analysis.⁷⁷

In addition, I gave four major presentations on my research while in Lebanon: one grand rounds in the Department of Obstetrics and Gynecology at the American University of Beirut hospital; one lecture in the AUB Faculty of Health Sciences (i.e., the public health school); one seminar at the Middle East Reproductive Health Working Group annual conference; and one keynote presentation at the European Society for Human Reproduction and Embryology, which took place that year in Madrid.

A few crucial points also bear mentioning here. First, the problem with formal methodological description is that it cannot capture the “feeling” of fieldwork—or, for me, what it was like to spend hundreds of hours in Middle Eastern IVF clinics, to meet strangers who became interlocutors and friends, and to become the privileged confidante of men’s deepest secrets and sorrows. I have tried to describe my experiences as an ethnographer in the private spaces of Middle Eastern IVF clinics elsewhere,⁷⁸ and some of those ethnographic vignettes emerge in the pages that follow.

Second, there were many men who were asked to participate in my study but refused—sometimes directly to my face and quite coldly. This problem of outright refusal—or, in gentler terms, “nonresponse”⁷⁹—is taken up in chapter 2, as it is a problem that has plagued male infertility research around the world. Having said that, many men were quite willing to talk with me, some of them volunteering after reading my study ad placed in clinic waiting areas. Why did men volunteer to talk? I believe that there are many reasons, some more important than others.

First, most of these men were seeking answers; they wanted to understand *why* they were infertile and were willing to talk with me about their etiological beliefs and suspicions. Second, there is inordinate down time for men in IVF clinics, where they must sit patiently in waiting areas while their wives undergo the gynecological procedures that are part of any IVF or ICSI cycle. Sometimes, I sat in the waiting areas with them, striking up individual and group conversations on a variety of topics. My presence in the waiting areas could sometimes lighten the tense and somber mood as men waited for hours—sometimes rubbing prayer beads or staring at their cell phones—for their wives to finish the operation. During these long waiting periods, many men agreed to participate formally in my study.

In addition, fluent English speakers often enjoyed the opportunity to use their English with me or, as one friendly Hizbullah member joked, “to have a dialogue with an American.” Many of the fluent English speakers had spent time in the States, and reminded me, in their demeanor and

remarks, of their “quasi Americanness.” In fact, many of the Lebanese men in this study had relatives in Michigan, and were delighted to know that I was a professor (at that time) at the University of Michigan. As one man quipped, “Are you from Michigan? (Yes.) All my family is in Michigan! All of Lebanon is in Michigan!”

For most men, the opportunity to tell their full reproductive story—often for the first time to anyone—was therapeutic, cathartic, even confessional. Once in a private interview room, men’s stories often came tumbling out, with seemingly taciturn men warming up, even becoming garrulous. Conversations with these mostly war-scarred men could become quite emotionally intense. Some men became teary-eyed while recounting the war dead and their own harrowing wartime experiences. In other cases, men who had lost precious ICSI babies through neonatal mortality or stillbirth described the beauty of their children, their names, their burials, and showed me, if they had them, their babies’ photographs. As the mother of stillborn twin daughters, I shared my own deep sense of loss and expressed my condolences to these very sad, childless men.

Although the mood of this research was heavy—far from the lighthearted and sometimes bawdy humor that characterized my earlier Egyptian research with women—suffice it to say that there were many sweet and funny moments, as men gushed to me about their beautiful wives, or conveyed the exciting news of an ICSI pregnancy, or showed me their ultrasound pictures of growing fetuses. Some men who had completed interviews subsequently convinced other men in the waiting areas to talk to the “nice American *duktura*,” even though “she comes from the land of George Bush!” A few men invited me to their homes (although this has always been rare in the secretive world of IVF and ICSI).⁸⁰ Many men thanked me profusely, expressed appreciation for research that was “helping our people and our country,” and promised to stay in touch with me. Some of them did, emailing me to ask follow-up questions or sharing the joyous news of ICSI births.

After eight months in Lebanon, I returned to Michigan in August 2003 to begin the next phase of my male infertility research in Dearborn, home of North America’s largest Arab American population. Working through an Arab-serving IVF clinic in the heart of the Dearborn ethnic enclave, I met fifty-five Arab immigrant men, most of them still lacking American citizenship rights. The majority were refugees, having sought political asylum from the Palestinian conflict, the Lebanese civil war, or the First Gulf War in Iraq. In addition, I met several Yemeni men who had come to the United States to escape grinding rural poverty but whose lives in impoverished Yemeni American enclaves remained difficult. I met forty of the wives of these men, most of them veiled, including with black facial veils if they

were Yemeni. Nine of these women were interviewed alone, and thirty-one with their husbands.

In general, these Detroit Arab men and their wives were unassimilated and spoke Arabic as their primary language. As a group, they were poorly educated and marginally employed in the low-wage service and industrial sectors. Their existence on the margins of mainstream American society has been exacerbated in recent years by the slow death of Michigan's industrial economy and the rise of U.S. homeland security surveillance. Despite the support of a variety of mosque communities and Islamic social services, these men's economic and political situations in America continued to worsen with each passing year of my research, which began in 2003 and ended in 2008 with my move to Yale University.⁸¹

I must juxtapose this despair of postindustrial Detroit to the "glitter" of global Dubai, where millions of men like Hamza have gone to seek their fortunes. There, I spent the first half of 2007, conducting a study of globalization and reproductive tourism in a large, multinational IVF clinic on the border of Sharjah and Dubai.⁸² I met Middle Eastern men from across the region, including Lebanon, Syria, Palestine, Morocco, Tunisia, Sudan, Iran, and Turkey. For the first time, I interviewed men from the Arab Gulf, mostly Emiratis dressed in their long white robes and headscarves, but also men from neighboring Bahrain and Oman. Taken altogether, more than 330 men in four field sites—Egypt, Lebanon, Arab Detroit, and UAE—have provided me with what might be the largest single "masculinities data set" of any scholar, past or present, working in the Middle East.

Finally, as noted in the prologue, I also traveled to Iran in March 2006 to deliver a keynote address at a University of Tehran-sponsored conference on "Embryo and Gamete Donation." Although I am a non-Muslim, American female anthropologist, I was invited by the Iranian Shia Muslim male conference organizers to represent the Sunni Muslim view on assisted conception, given my extensive research on this topic in Egypt. Iran is an especially important country in this high-tech world of assisted reproduction, hosting more than seventy clinics, one of which I visited. Muslim men's and women's attitudes toward the newest technological variants are being shaped by male Shia clerics, particularly in Iran, who are using *ijtihad*, or religious reasoning, to interpret and make sense of these new technologies.⁸³ Their *fatwas*, or religious decrees, outlining rules for assisted reproduction, third-party gamete donation, and adoption, have had an enormous impact on infertile Muslims' lives, shaping the contours of acceptable reproduction. For Muslim men in particular, these rulings on technologically assisted fatherhood have had significant effects on masculinities in ways that could never have been imagined when the technologies were introduced to the Muslim world nearly twenty-five years ago.

EMERGING TECHNOLOGIES AND MASCULINITIES

As seen in the aforementioned description, my engagement with Middle Eastern infertility and assisted reproductive technologies—or ARTs, as they are now called by clinicians and scholars—has been one of long duration. I have been studying this same topic, in its various manifestations, since the introduction of IVF to Egypt in 1986. By following infertility and assisted reproduction in the Middle East over the past twenty-five years, I have been able to witness the introduction of new biotechnologies, the new social and cultural accommodations and innovations accompanying these technologies, and the important moral discourses and transformations resulting from this technological emergence. These various forms of emergence—of biotechnologies themselves, of accompanying social and cultural phenomena, and of moral deliberations—are at the very heart of this ethnography.

The world of assisted reproduction is characterized by constant discovery and innovation. Biomedical understandings of and solutions for infertility have emerged almost continuously since the birth on July 25, 1978, of England's Louise Brown, the world's first test-tube baby. Louise Brown is now thirty-three and the married mother of a young son, Cameron, who was conceived naturally and born on December 20, 2006. In 2010, Robert G. Edwards, a retired professor of physiology at the University of Cambridge, received the Nobel Prize in Physiology or Medicine for the invention of in vitro fertilization, which he developed in consort with British obstetrician Patrick Steptoe.

Since this British invention of IVF more than thirty years ago, the world has seen the rapid expansion of a host of assisted reproductive technologies, including: *in vitro fertilization* to overcome female infertility, especially blocked fallopian tubes; *intracytoplasmic sperm injection* to overcome male infertility; *third-party reproductive assistance* (with donor oocytes, sperm, embryos, and uteruses, as in *surrogacy*) to overcome absolute sterility; *multifetal pregnancy reduction* to selectively abort multiple-gestation IVF pregnancies; *ooplasm transfer* (OT), of cytoplasm from a younger to an older woman's oocytes, to improve egg quality in perimenopausal women; *cryopreservation* (freezing) and storage of unused sperm, embryos, oocytes, and now ovaries; *preimplantation genetic diagnosis* (PGD) to select "against" embryos with genetic defects and to select "for" embryos with specific and/or desired traits, including sex; *human embryonic stem cell* (hESC) research on unused embryos for the purposes of therapeutic intervention; and *human cloning*, or the possibility for asexual, autonomous reproduction, which has already occurred in other mammals (e.g., Dolly the sheep).⁸⁴ Most of these technologies are discussed throughout the course

of this book and are more fully defined in the Glossary of Medical Terms, which contains a complete list of medical vocabulary found in this volume.

With the advent of these various technologies, men's lives and bodies have become increasingly medicalized. Male infertility provides a case in point. Once regarded as a source of male shame, imperfect manhood, or God's will—with most men told by their doctors that the source of the problem was "idiopathic," or unknown—male infertility has been reclassified as a biomedical disease category, with recognized causes, precise diagnostic techniques, and new technological fixes. In a twenty-first century marked by DNA microscopy, genetic karyotyping, four-dimensional ultrasonography, gamete micromanipulation, and preimplantation genetic diagnosis, male infertility has entered an era of profound biomedicalization—or the regulation of bodily processes themselves⁸⁵—with men submitting their genitals to needles, knives, scopes, ultrasounds, and operating theaters in the hopes of conception.

Throughout this book, we examine Middle Eastern men's entrée into this high-tech world of biomedicine, where diagnoses of infertility are proffered and solutions recommended. Beginning with masturbation and ending at ICSI, we follow this arduous, embodied process and men's quests for conception. Part of the questing process involves the search for understanding. "Why did this happen to me?" Men have ample time to contemplate this question, sharing their insights with a curious anthropologist. In men's indigenous theories of causality, "weak" sperm are often tied to conditions beyond men's control, from God's will to family inheritance to relentless war and associated stress.

It is important to point out here that this medicalization of male infertility is relatively new. In the Middle East, the advent of laboratory-based semen analysis did not become widespread until the 1970s,⁸⁶ nor did it become fully reliable according to World Health Organization standards until much later.⁸⁷ Furthermore, until the early 1990s in the West, the only known solution to male infertility was donor insemination, the oldest of the reproductive technologies, but one still shrouded in secrecy and stigma.⁸⁸ The introduction of ICSI—pronounced "ick-see"—in Belgium in 1992 was a watershed event. 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 fertilization. However, weak sperm (i.e., low numbers, poor movement, misshapen) are poor fertilizers. Through "micromanipulation" of otherwise infertile sperm under a high-powered microscope, they can be injected directly into human oocytes, effectively aiding fertilization to occur



FIGURE 2. Intracytoplasmic sperm injection. Spike Walker/Stone/Getty Images

(figure 2). 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."⁸⁹

The coming of ICSI to the Middle East in 1994, where it was introduced in an IVF clinic in Cairo,⁹⁰ 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" 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. Why? Basically, IVF leaves fertilization up to chance, whereas ICSI does not. Thus, ICSI provides a more guaranteed way of creating "the elusive embryo."⁹¹ When patients' success rates increase, so do clinics' reputations. Thus, the world is beginning to witness the replacement of IVF by ICSI.⁹² With ICSI, human fertilization is increasingly aided and abetted by human embryologists working in IVF laboratories around the world.

ICSI may be a breakthrough technology, but it is by no means a panacea. For one, the precisely timed collection of semen—what Lisa Jean Moore has called "man's most precious fluid"⁹³—can produce deep anxiety

TABLE 1. Middle Eastern men in the diaspora: Fifty countries of stated residence

<i>North America</i>	<i>South America</i>	<i>Europe</i>	<i>Middle East</i>	<i>Africa</i>	<i>Asia</i>	<i>Australia-Pacific</i>
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 unspecified (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)			
		Luxembourg (1)	Turkey (1)			
		Unidentified (1)	Gulf Unidentified (1)			

Note: Total number of countries in each region: North America, 2; South America, 3; Europe, 15; Middle East, 15; Africa, 12; Asia, 2; Australia-Pacific, 1.

and even impotence, but it is imperative for all ICSI procedures. Second, ICSI has not supplanted sperm donation entirely, because some men produce no spermatozoa whatsoever. Third, ICSI sometimes does not succeed, leading to endless rounds of fruitless repetition among some couples. Fourth, when it does succeed, ICSI may be perpetuating genetic defects into future generations. Male infertility seems to have a strong genetic ba-

TABLE 2. Men's stated reasons for periods spent abroad

<i>Reason</i>	<i>Number of Men</i>
Political exile/refugee	44
Education	31
Employment	27
Medical/reproductive tourism	55
Family unification	3
Father's work	3

sis, through mutations of the Y chromosome and other inherited disorders that may be passed by ICSI to male offspring. The ethics of passing genetic mutations to children has been a cause for concern.⁹⁴ Fifth, ICSI involves a grueling surgical procedure for women. And it is also highly dependent upon the complicated stimulation and extraction of healthy oocytes from women's bodies. Whereas the fecundity of older men can often be enhanced through ICSI, women's fertility is highly age sensitive, with oocyte quality declining at later stages of the reproductive life cycle.⁹⁵ In short, older women may "age out" of ICSI, causing highly gendered, life-course disruptions surrounding women's "biological clocks."⁹⁶ Finally, men may arrive at ICSI after years of other failed treatment options. ICSI is expensive, usually costing thousands of dollars, and is often deemed a last resort, especially for men without adequate financial resources.

Throughout this volume, we follow men's stories of heartbreak as well as their ICSI successes. Male users of these technologies are often well aware of the social messages encoded in their ICSI quests, and this knowledge shapes what might be called men's "medically assisted ways of being men."⁹⁷ In the end, individual men may wholeheartedly adopt, experimentally adapt, or altogether reject these technologies in their attempts to embody idealized norms of masculinity.

Furthermore, these technologies would not have reached the region were it not for Middle Eastern IVF doctors—schooled in places such as London, Sydney, Tokyo, and Los Angeles, and at institutions such as Harvard and Yale⁹⁸—who have brought their learning back home, taking pride in the development of new Middle Eastern IVF clinics and practices. Through these entrepreneurial physicians, these technologies have arrived, one by one, in the Middle East, eventually spreading (although unevenly) across the entire region. Although rarely portrayed as a high-tech location, the Middle East is, in fact, awash in assisted reproductive technologies, with some Middle Eastern countries—especially Egypt, Saudi Arabia, Turkey, and Iran—claiming well over fifty IVF clinics each. Urban centers in

these countries have become major hubs for medical innovation and tourism. Iran, for example, leads the way in gamete donation and surrogacy, as well as organ transplantation, sexual reassignment surgery, vasectomy, and a therapeutic stem cell industry.⁹⁹ In IVF clinics in Tehran, Arabic translators are employed to facilitate communication between Arab reproductive tourists and the Farsi-speaking physicians and clinical staff. These therapeutic border-crossings—what I have called “quests for conception” in my early work¹⁰⁰—are part and parcel of regional transnationalism and mobility.

In fact, the Middle East is a region in constant motion. Middle Easterners are circulating from country to country for the purposes of medical treatment, education, employment, trade, and pilgrimage, as well as leaving the region, both temporarily and permanently, for purposes of resettlement. The degree of Middle Eastern mobility cannot be understated. In my study of 220 Middle Eastern men, exactly 100, or nearly half, had lived outside their countries for extended periods (table 1), either to escape the war, to pursue education or employment opportunities, or to be united with family elsewhere (table 2). One-quarter of these men—37 Lebanese living outside the country and 18 Syrians—had traveled to Beirut as reproductive tourists, attempting to access IVF and ICSI.

EMERGENT MASCULINITIES

In part I of this book, I argue that Middle Eastern men’s own conceptions of masculinity are changing, not only as a result of these transnational experiences and global influences but also in response to emerging health technologies that are entering the region. Change is also coming from *within* Middle Eastern societies, as men reconceptualize their own lives, contrasting them to their fathers’ generation. Men are quite cognizant of traditional stereotypes; they can articulate these and can explain how their own lives differ. In short, manhood is not static; new masculinities are emerging in the Middle East and require our consideration.

In this book, I examine Middle Eastern men’s lives in relation to what I call “the four M’s”: masculinity, marriage, morality, and medical treatment seeking. I argue that Middle Eastern masculinity is in a state of flux, with shifting praxis in the realms of reproduction, sexuality, marriage, and family life. I examine the ways in which Middle Eastern men are rethinking what it means to be a man, especially in the context of infertile marriages.

The focus of this volume is on “emergence”: that which is “new” is highlighted. As Raymond Williams reminds us in his seminal essay, “Dominant, Residual, and Emergent”: “New meanings and values, new practices, new

relationships and kinds of relationship are continually being created."¹⁰¹ Drawing upon Williams's notion of the emergent, I argue that an "emergent masculinities" approach is needed to understand Middle Eastern manhood. In other words, manly selfhood is not a thing or a constant; rather, it is an act that is ever in progress. Men enact manhood in different ways from moment to moment, as they move through the different social contexts that form their daily lives. Individual masculinities also change in response to larger life changes; these may include health problems such as infertility, 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, or being altered through medical treatment, exercise, or neglect. By calling for an emergent masculinities approach, I call for attention to this ongoing, relational, and embodied process of change in the ways men enact masculinity. In short, I argue that any theory used to understand the *practice* of masculinity must account for the *emergence* of change, physically and socially, over time.

In the next chapter, I examine R. W. Connell's theory of "hegemonic masculinity,"¹⁰² which has been widely adopted by most gender scholars and which I have used in my own work to understand societies' dominant forms of manhood.¹⁰³ I explore what "hegemonic masculinity, Middle Eastern style" might look like, on the basis of a reading of the existing literature. However, I argue that many, if not all, Middle Eastern men are striving for a much different notion of masculinity. By searching for evidence of hegemonic masculinity in the patriarchal Middle East, it is too easy to promote sterile reifications and facile judgments about men's lives, reinforcing harmful caricatures. Such caricatures have fed into notions of Middle Eastern "exceptionalism": namely, that the Middle East is exceptionally prone to violence, because the men there are exceptionally brutal, irrational, even psychopathic, and their predispositions are fueled by a hyperzealous, extremist religion.

I hope to challenge such stereotypes by telling stories of ordinary Middle Eastern men from a range of nations and backgrounds. Not all of the stories are happy ones: far from it. Nonetheless, they should serve to humanize the discourses of hegemonic masculinity, Middle Eastern style, which are constantly fed to us through the Western media. In this regard, I could not agree more with my medical anthropologist colleagues in Lebanon, who assert in their article, "Challenging the Stereotypes: Men, Withdrawal, and Reproductive Health in Lebanon":

We think it is vital for more nuanced research on sexual relationships, particularly in areas of the world where powerful stereotypes—traditional families, women's low status, oppressive religion, early marriage, high fertility, male dominance, vulnerability to divorce,

need to produce sons—influence the questions we ask and the interpretations of what we see and hear. While acknowledging the complexity of people’s sexual lives, our modest research suggests that it might be useful to credit women with some measure of agency, and men some measure of altruism and humanity.¹⁰⁴

In this same spirit, part I, “Emergent Masculinities” calls for a theoretical and ethnographic reframing of the relationship between hegemony, patriarchy, masculinity, marriage, and reproduction. The variability, hybridity, and transformation of masculinity that I detect in the Middle East today defy easy categorization. Middle Eastern men are appropriating diverse styles of masculinity, drawing from both indigenous and global forms. In so doing, they are reconceiving manhood in ways that have yet to be properly described but deserve our empirical attention.

ISLAMIC MASCULINITIES

In part II, “Islamic Masculinities,” I examine what it means to be a moral man in the context of emerging, and sometimes ethically controversial, reproductive technologies. I ask what is at stake for ordinary Muslim men as they attempt to make health-related decisions in a way that is morally satisfying and consistent with local religious norms. What do Muslim ICSI seekers think about making a test-tube baby? When faced with the need for donor eggs or sperm to overcome infertility, what do ordinary Muslim men (and women) actually do? Is the search for human gametes one of the major motivating factors for reproductive tourism in the Middle East?

Given the ongoing emergence of reproductive biotechnologies in the region, these are all open questions. It is imperative to examine what Harvard medical anthropologist Arthur Kleinman has called “local moral worlds” or “the moral accounts, [which] are the commitments of social participants in a local world about what is at stake in everyday experience.”¹⁰⁵ Through an “ethnography of experience,” Kleinman urges medical anthropologists to pay close attention to moral issues of spiritual pain and social suffering, which may accompany the arrival of new biotechnologies, such as ICSI, around the globe. Local moralities are perhaps best exposed when new health technologies confront deeply embedded religious and ethical traditions.¹⁰⁶ Such traditions may embrace new biotechnologies (e.g., life-saving health technologies) but prohibit aspects of those technologies that do not meet with religious moralities (e.g., sperm donation). For individuals confronting the moral stances and ambiguities of their local religious traditions, they must attempt to make sense of such religious responses,

while at the same time invoking their own moral subjectivities to find acceptable solutions to their often dire health needs and concerns.

Middle Eastern men, most of whom are practicing Muslims, must now make sense of a dizzying array of reproductive possibilities to overcome their childlessness. Quite importantly, Islamic institutions and individual clerics have provided considerable guidance in this regard, usually in the form of written *fatwas*, or authoritative religious decrees. But how do individual Muslim men of varying degrees of piety respond to these discursive fields of authority? As Talal Asad has argued in "The Idea of an Anthropology of Islam," "A practice is Islamic because it is authorized by the discursive traditions of Islam, and is so taught to Muslims." However, as Asad reminds us, "the resistances they encounter (from Muslims and non-Muslims) are equally the concern of an anthropology of Islam."¹⁰⁷

Religious resistances are incredibly important to any discussion of masculinity and assisted reproduction. On the one hand, three potential solutions to childlessness—third-party gamete donation, gestational surrogacy, and child adoption—are widely resisted, both religiously and socially, in Middle Eastern Muslim communities. On the other hand, not all Muslim men react similarly to these religious bans. There is emerging evidence of discordance and dissent across the region. Minority religious responses, on the part of both Shia Muslims and Christians, have been an important part of this equation.

In short, if we are to speak of an emerging "Islamic bioethics,"¹⁰⁸ then it is important to bear in mind that Muslims do not agree on some set of common global norms or "best practices." The assisted reproductive technologies and Muslims' attitudes toward them provide a compelling nexus for the study of what might be called "Islamic technoscience in practice," a topic about which very little is currently understood.

As noted by anthropologist Mazyar Lotfalian in his unique volume, *Islam, Technoscientific Identities, and the Culture of Curiosity*, there is a glaring lacuna in the study of science and technology in the Islamic world.¹⁰⁹ According to Lotfalian, there are "really only two strains of relevant work"—on the Islamic medieval sciences and on philosophical arguments for civilizational differences between Islamic and Western science and technology (i.e., Samuel P. Huntington's "clash of civilizations" thesis).¹¹⁰ This dearth of relevant scholarship clearly applies to the cross-cultural study of reproductive technologies. For example, in the seminal volume on *Third Party Assisted Conception across Cultures: Social, Legal and Ethical Perspectives*, not a single Muslim society is represented among the thirteen country case studies.¹¹¹

Yet, as these assisted reproductive technologies become further entrenched in the Muslim world, and as additional forms of biotechnology,

including stem cells and perhaps cloning, become available, it will be crucial to interrogate new local moralities, as well as new manifestations of masculinity and conjugality that are likely to arise in response to these technological innovations. Thus, as anthropologist of science and technology David Hess rightly observes, "Anthropology brings to these discussions a reminder that the cultural construction of science is a global phenomenon, and that the ongoing dialogue of technoculture often takes its most interesting turns in areas of the world outside the developed West."¹¹²

Clearly, the time has come to examine the globalization of assisted reproductive technologies to diverse Islamic contexts, particularly given the rapid technological development and globalization of these biotechnologies. Currently, there are about a dozen researchers who are engaging in empirical studies of assisted reproduction in the Islamic world, including in such countries as Iran, Turkey, and Malaysia.¹¹³ Their studies point to interesting variations in both the Islamic jurisprudence *and* the cultural responses to assisted reproduction, particularly between the two major branches of Islam, but even among co-sectarians from different countries (among Shia Muslims in Iran versus Lebanon).

In short, Islam, as a global religion, is not monolithic, timeless, and unchanging. As noted by Gelvin in his recent compelling history of *The Modern Middle East*,

The doctrines and institutions associated with Islam or any other religion are not frozen in time. They exist within history, not outside history. And while there are continuities of religious doctrines and institutions, the meaning those doctrines and institutions hold for society, and the function they play in society, evolve through time.¹¹⁴

Furthermore, Lahoucine Ouzgane has importuned scholars to render "Muslim men visible as gendered subjects."¹¹⁵ He has adopted the term "Islamic masculinities" as a way of thinking about Muslim men *as men* from a social constructionist perspective. The term "Islamic masculinities," according to Ouzgane,

is premised on the belief that men are not born; they are made; they construct their masculinities within particular social and historical contexts. Thus, masculinities in Islamic contexts emerge as a set of distinctive practices defined by men's positionings within a variety of religious and social structures.¹¹⁶

Although the literature on Muslim women's lives has truly flourished over the past thirty years, this literature has treated "Muslim men as an unmarked category," according to Ouzgane.¹¹⁷ He reminds us that Muslim men's lives are enacted in relationship to women; that the Muslim world is diverse and ever changing as a result of religious and political agendas,

Western imperialism, and the marked effects of globalization; and that, unfortunately, Muslim men's lives are now steeped in Eurocentric, anti-Arab, anti-Islamic bigotry. Thus, he calls for scholars to exercise caution, to provide accounts that militate against such essentialisms, and to make the consideration of local realities a priority. Only when masculinity studies are "grounded in historical, cultural, and geographical context" will the diversity of masculinities in the Muslim world become apparent.¹¹⁸

In short, not all Muslims, including Muslim men, are alike. Some are pious, while others are not. Some are scripturally oriented, while others value independent reasoning. Some follow particular clerics, while others consider their primary relationship to be with God. Some know that they are "rule breaking" but hope for God's mercy and forgiveness. Others simply do not care, having left the religion, or having identified themselves with secular humanism, communism, atheism, or science. This great diversity within the world's Muslims cannot be emphasized enough. As will be shown in the chapters that follow, Muslim men do not follow a single path. Their responses are mediated by a wide variety of ever-changing values and social forces, including the emergence of ICSI and other assisted reproductive technologies across the Middle East and many other parts of the Muslim world.

Indeed, the transformative effects of technology in Muslim men's lives cannot be overstated. The 2011 revolutions across the Middle East are a testament to the power of technology in reshaping the political landscape of an entire region. However, Facebook and Twitter are not the only transformative technologies in the Middle East today. Through their embrace of assisted reproductive technologies, Middle Eastern Muslim men are demonstrating their emerging masculinities, marital commitments, and moral subjectivities—and, in doing so, questioning many taken-for-granted assumptions about men *as men* in this critical region.