Male infertility, Chronicity, and the Plight of Palestinian Men in Israel and Lebanon

Marcia C. Inhorn and Daphna Birenbaum-Carmeli

Male infertility is a neglected reproductive health problem, yet it contributes to at least half of all cases of subfertility worldwide (P. Chan 2007; Kim 2001). Male infertility is often idiopathic, or of unknown cause; hence, it is recalcitrant to prevention and is among the most difficult forms of infertility to treat (Carr et al. 2005; Devroey et al. 1998; Irvine 1998; Kamischke and Nieschlag 1998).

Male factors in infertility include low sperm count (oligospermia),azoospermia, sperm motility (asthenospermia), defects of sperm morphology (teratozoospermia), and total absence of sperm in the ejaculate (azoospermia), the latter sometimes due to infection-induced obstructions of the epididymis.

Male infertility is a health and social problem that remains deeply hidden, even in the West. Studies have shown it to be among the most stigmatizing of all male health conditions (Becker 2000, 2002; Cannon et al. 2004; Greil 1991; Inhorn 2004b; Lloyd 1996; Upton 2002). Such stigmatization is clearly related to issues of sexuality. Male infertility is popularly, although usually mistakenly, associated with impotency, as both disrupt a man's ability to impregnate a woman and prove one's virility, paternity, and manhood (Inhorn 2002, 2003a, 2003b, 2004b; Upton 2002; Webb and Daniuk 1999). Although little is known about the experience of male infertility worldwide, scattered reports show that male infertility, like female infertility, has profound effects on personhood, marriage, and family relations, particularly in pronatalist settings where all adults are expected to marry and produce offspring (Carmeli and Birenbaum-Carmeli 1999, 2000; Inhorn 2002, 2003b, 2004a; Upton 2002). Thus, male infertility is a cause of profound human suffering, particularly in high-fertility societies where all men are expected to father offspring. For this reason alone, it is a reproductive health problem of considerable significance.

In the Middle East region, all adults are expected to marry and produce offspring, raising and nurturing children, especially sons, is a key component of male patriarchal authority; and men who do not become family "patriarchs"
may be deemed weak and ineffective (Birembaum-Carmeli et al. 1995; Gour and Birembaum-Carmeli 1994, 2000; Ghoussoub and Sinclair-Webb forthcoming; Inhorn 2002, 2003b, 2004a; Lindisfarne 1994). In such a social climate, climate-unresolved male infertility has far-reaching implications for the construction of masculinity, marital life, kinship, and community relations.

In Euro-America, there is little difference in men’s and women’s rates of infertility: male infertility contributes to about 40 to 50 percent of all infertility cases. In the Middle East region, in contrast, male infertility appears considerably higher, with rates of 60 to 70 percent in infertility clinics (Inhorn 2004a). This is partly an artifact of the lower rates of infertility in women compared to other settings, due to relatively low rates of sexually transmitted infections (STIs). But male infertility is also influenced by cultural factors in the region. Pesticides, lead, and other heavy metals are pervasive and toxic; thus, ambient air pollution may contribute to male infertility (Aboud et al., forthcoming-a; Hopkins et al. 2001). Heavy consumption of coffee and tobacco by Middle Eastern men may also exert negative effects on male fertility (Curtis et al. 1997; Inhorn 1994; Kobji et al., forthcoming). Rare spermatid sperm defects also appear to be responsible for many—perhaps most—male infertility cases, due to microdeletions on the Y chromosome. Such microdeletions are magnified through the consanguineous (cousin) marriage practices preferred among Muslim populations across the Middle Eastern region (Baccetti et al. 2001; Inhorn and Birembaum-Carmeli, forthcoming; Inhorn forthcoming-a, forthcoming-b, forthcoming-c; Latini et al. 2004). These forms of male infertility tend to be very severe, to cluster in families, and to be untreatable (Baccetti et al. 2001), presenting as a chronic condition over the course of a man’s entire life.

A variant of in vitro fertilization (IVF) known as intracytoplasmic sperm injection (ICSI) may assist severely infertile men to reproduce. Spermatozoa are injected directly into oocytes, effectively forcing fertilization to occur. And as a result, this allows a viable spermatozoon to be retrieved from an infertile man’s body, sometimes through painful testicular aspirations and biopsies—ICSI can enable infertile men to father biogenetically related offspring. ICSI provides infertile Muslim men with their “only hope” to overcome their infertility, given the widespread Muslim prohibition on donor insemination and legal adoption (Cohn 2008; Inhorn 1996, 2003a; Meilrow and Schenker 1997; Seour 1996; Sonbol and Tremayne, forthcoming). However, ICSI is expensive and subsidized by only a few Middle Eastern Muslim states. Infertile Muslim couples must pay between $2,000 and $5,000 for one ICSI cycle, effectively restricting the technology to middle and upper classes (Inhorn 2003a).

In Israel, in contrast, the state funds IVF and ICSI services more comprehensively than any other country in the world, and Israel’s consumption rates per capita are therefore highest. This is partly because of the perceived centrality of reproduction for national survival and regeneration (Kahn 2000). IVF services are provided in twenty-four IVF centers throughout the country at a rate of up to five free cycles or until the live birth of two children (Kahn 2000). These services are extended to women of all marital statuses until they are forty-five years of age, or, if using donor oocytes, age fifty-one (Birembaum-Carmeli and Inhorn forthcoming). Although patients must make a small financial investment to complete an ART cycle (e.g., minimal supplementary patient contributions, travel expenses, and days off work), universal state funding makes Israeli ART services more socioeconomically diverse than in most other countries.

Although state funding is directed primarily toward the state’s Jewish population, treatment is also offered to and widely consumed by non-Jewish women. Palestinian citizens living within Israel are therefore in a privileged position as the only Middle Eastern Muslim population with free access to IVF services. This is especially important, given that Israel’s minority populations are among the most highly pronatalist (partly as a reaction to Israel’s nationalist campaigns to limit Muslim birthrates) (Kanaaneh 2002). Childbearing is of paramount importance to Israel’s religious minorities, who, despite widespread access to fertility services, have relatively high average numbers of children per family in Muslim families, 2.6 in Druze families, and 2.14 in Christian families (Birembaum-Carmeli and Carmeli, forthcoming; Kanaaneh 2002). However, the overall Palestinian population also suffers from high rates of male infertility—up to 70 percent of all couples seeking infertility treatment (director of the Hadassah IVF center, personal communication, December 2007).

**Palestinian Men and the Middle Eastern State**

**Palestinian Citizens of Israel**

Despite infertile Palestinian men within Israel enjoying generous ART benefits, infertile men in Israel, as elsewhere in the Middle East, are deprived of many other human rights. Israel’s Palestinians constitute a sizable minority population of Israel’s total population of seven million, 80 percent is Jewish and 17 percent is Palestinian Muslim (an additional 2 percent are Christian and 1 percent Druze). Officially, the non-Jewish minorities are equal Israeli citizens. In practice, minority populations are subject to various sorts of formal and informal discrimination and restrictions on multiple levels.1

In Israel, more than 260,000 Palestinians live within Israel as “internally displaced persons” (IDPs)—removed from their original homes and sometimes expelled from nearby “unregistered” villages that receive no government services (Synowsky 1998). In the sphere of education, Israeli Palestinians have a higher student-to-teacher ratio, less equipped schools, insufficient vocational education, and lower achievement levels (Al-Haj 1995; Ellikovits 1997; Sinooha 1989), and are underrepresented in higher education (Guri-Rosenblit 1996, 1999). In the labor market, technological professions are semiofficially blocked to Palestinians on grounds of state security. About two-thirds of Israeli Palestinians are
unskilled workers (Adva Center 2003); unemployment among Israeli Palestinians continues to soar (Mesch and Stier 1997); and income levels are significantly lower when compared to Jewish counterparts (Adva Center 2004).

Another crucial point of difference is in the political realm. With the exception of Druze men, Israel’s other religious minorities are exempted from military service. Consequently, Israeli Palestinians are less exposed to the experiences of military service than those faced by Israeli Jewish men. But this does not mean that Palestinians bypass the devastation of regional wars. For example, the 2006 summer war between Israel and Lebanon’s Hezbollah significantly affected the Palestinian population living in the northern regions of Israel, including Haifa. In neighboring Lebanon, Palestinians living in refugee camps throughout the southern half of the country faced considerable death and destruction, but were unable to flee to safer havens to escape the fighting.

**Palestinian Refugees in Lebanon**

In the year 2003, the number of Palestinian refugees was estimated at 850,000 in total. Most of them live within one hundred miles of the borders of Jordan, more than one-third in the West Bank and Gaza Strip, and about 15 percent equally distributed between Syria and Lebanon. Of these refugees, 3.8 million are registered with the United Nations Relief and Works Agency (UNRWA), which administers fifty-nine refugee camps throughout the West Bank, Gaza Strip, Jordan, Syria, and Lebanon. Since UNRWA refugees are outside the jurisdiction of the UN High Commission for Refugees (UNHCR), they enjoy fewer protections than refugees elsewhere in the world.

According to UNRWA, nearly four hundred thousand people are registered in Lebanon, where they now constitute approximately 10 percent of the total Lebanese population of 4.3 million. Yet, Lebanon is the host country where the “least hospitable” to Palestinian refugees, and they have faced unique problems of reception since their arrival in 1948. For example, the “unruly” presence of the Palestinians—including the existence of the Palestine Liberation Organization (PLO) in Lebanese refugee camps—has been widely blamed by the Lebanese government and its citizens for the descent into fifteen years of civil war (1975-1990) (Inhorn and Koebeissi 2006; Said and Hitchens 2001). Palestinian refugees are still considered “foreigners” in Lebanon, even after living there for generations (exact sixty years, from 1948 to 2008). Palestinians are prohibited legally from working in more than seventy trades and professions, and also experience high rates of unemployment, limited access to educational facilities and lack of access to government social services; social services are provided to almost entirely by UNRWA. Although some educated Palestinian families settled in Lebanon in 1948 have been able to maintain middle-class professionals status, the vast majority remain poor and stateless, granted travel documents but not citizenship (Peters 2005). Sons and daughters of middle-class Palestinian families in Lebanon often migrate to the Arab Gulf in search of employment.

In this chapter, we explore Palestinian men’s lives on both sides of the conflict-ridden political border. We argue that, in many ways, infertile Palestinian men live lives of “quiet desperation,” especially when they face the stigma of infertility. Among Palestinians, infertility presents as a threat to the normative childbearing. For men, male infertility leads to various forms of embodied suffering and social marginalization within their patriarchal social context. The situation is made much worse for Palestinian men in Lebanon by the complete lack of state rights and subsequent difficulties of accessing ARTs. While Israel subsidizes ARTs for all Palestinian citizens, Lebanon does not, leaving many Palestinian men in a very difficult position. Moreover, many of these men attribute their infertility to the chronic hardships of their lives, including exposure to multiple wars, injuries, refugeism and exile, impoverishment, and toxic labor, and depression. Palestinian men seeking treatment in Lebanon speak openly of their lack of basic human rights, not only in Lebanon, but also for migrants in other countries. For them, infertility is symptomatic—what the very manifestation—of their chronic condition of statelessness, violence, and suffering. Chronicity, therefore, has multiple meanings—as a lived experience of infertility and its treatment and as a biographical, socio-cultural, and political process of sudden psychological trauma and discord to the larger political reality of chronic statelessness, oppression, lack of basic rights, and lives spent in exile.

**Male Infertility as Symptomatic of Palestinian Suffering**

In this chapter, we explore male infertility as an understudied chronic condition, which (a) manifests in early adulthood, (b) is usually identified through diagnostic procedures occurring after marriage, (c) is generally incurable because of biogenic etiology, (d) must be solved through high-tech medical interventions that may or may not be accessible, and (e) when unresolved by these interventions, may manifest as a lifelong experience of reproductive impairment. Although male infertility is rarely classified as a chronic disease or even a disease (Van Balen and Inhorn 2002), chronicity is a hallmark feature of male infertility. Among Palestinian men who have suffered throughout their lives, male infertility comes as yet another devastating blow to selfhood, social reproduction, and escape from misery. We draw on data from interviews with Palestinian men in five countries: Israel, Lebanon, the United Arab Emirates, and the United States. Together, more than thirty Palestinian men were interviewed in the four settings; here we focus on the thirteen men interviewed in Israel and the eleven men interviewed “across the border” in Lebanon. In Lebanon, interviews were conducted by Marcia C. Inhorn over eight months in 2003 (notably, during the Occupation of Iraq), in two of the busiest and most successful IVF clinics in central Beirut. One was located in a large, private, university-based teaching
hospital and catered to a religiously mixed patient population of Christians and Shia Muslims, Christians of various sects, Druze, and various Jewish populations. The other was a private, stand-alone IVF clinic catering specifically to southern Lebanese Shia patients, but also Christian and Sunni patients from Lebanon, Syria, and the Palestinian refugee camps in Lebanon. Between these two clinics, 220 Lebanese, Syrian, and Palestinian men were recruited into the study. One hundred twenty were infertile, and one hundred were fertile “controls” who were accompanying their partners to the clinics. Of the eleven Palestinian men who were interviewed, five were infertile themselves, and four were married to infertile women.

The major theme of the interviews in Lebanon—althoughLesser 2005—was the multiplicity of suffering that the men had endured, whether they had lived through or were currently living in a state of perpetual suffering. All eleven men interviewed in Lebanon had suffered multiple, changing events, including political violence tied to the Lebanon war, the First Gulf War in Kuwait. In all cases but one, these men were refugees following the flight of their parents to refugee camps throughout the case of some middle-class families. In all cases but one, they had lived through—or to flee from—the fifteen-year Lebanese civil war, which had cost the country and led to the blaming and victimization of Palestinian, especially Syrian Palestinian men (Maldini 1999; Said and Hitchens 2001; Testa 1988).

All of the men who stayed in Lebanon during the civil war were injured and hospitalized, hadfamily members who were injured or abducted, were injured in bomb shelters through periods of heavy bombardment, or were hit by their homes at various periods throughout the war. Two of them lived in Ein el-Hilweh refugee camp in southern Lebanon when the war started (where they remain today). Neither was able to exit the camp or the country during the civil war, so they stayed and were caught up in the fighting. In both cases for Fatah, the military wing of the PLO. Both were severely injured and remaining in an UNWRA hospital for six months. His home was also in an Israeli bombing campaign. The parents of seven of the men sent them out of the country, or fled together as families to safe “host” countries. One man living in Kuwait with his two brothers was beaten (including in the genitals) by a gang of angry Kuwaitis, who were the Palestinians during the First Gulf War (when the PLO sided with Hussein against the U.S.-led coalition). In another case, a young man by his middle-class family to the United States to pursue an engineering course was brutally beaten by a gang of Italian youths who discovered his Palestinian origin and kicked him so hard in the genital region that he has since impotence problems ever since.

Violence was therefore a part of virtually every narrative among Palestinian men interviewed in Lebanon. In most cases, men linked the violence to their male infertility. The most commonly cited reason for male infertility was the physical and emotional pain inflicted on Palestinian men by the Israeli occupation of southern Lebanon and the suffering of thousands of Palestinian and Syrian men. It is likely resumed during the 2006 Israel– Lebanon summer war, which occurred after the interview was conducted.) At the time of this study in 2003, four men interviewed outside Lebanon, but had returned to Beirut for ART services. They had returned to Lebanon permanently following war-related exile. Many fears regarding their lives back in Lebanon, but remained there because of lies and lack of other life options.

All of these men were heavy smokers (one-half to three packs per day) and tied their smoking to their infertility problems. Rather, they found smoking to be their major form of relief from chronic stress, tension, and psychological states. Expressions of depression were frequent in the cases of these men who described their life as “taking a camel on my back.” Another complained, “wearing dirty, threadbare clothing to the clinic and living in Lebanon throughout his life—said that he drank a bottle of whisky a week, though alcohol is prohibited by his religion, “just when I’m in a bad mood, I realized that his “bad mood” occurred frequently, with “stress every day, unemployment, poverty, and fifteen years of childlessness. He was happy in this life. Personally, I’ve never been relieved in my life, for I didn’t think it was the stress, the exposure to gases in the type of work I do, the exposure to the sun. I think maybe the work is more important; the work is stressful. But also it’s from too much work.” The politics, the situation. I think too much about the stability, the economic situation, the lack of stability and having to move from one country to another.

Male Infertility, Masculinity, and Biographical Disruption

Palestinian men in Lebanon were more likely to tie their infertility to the hardships of being Palestinian in a hostile world, most men in both
Israel and Lebanon viewed male infertility itself as a major life disruption, as their view, being infertile had created a situation of significant divergence from what was considered a "normal" life trajectory. Generally, these men had expected to marry and have children in their twenties. Delayed marriage and childbearing and male infertility were not valorized, even for men pursuing professional careers. Male infertility resulted in a sense of asynchronicity, of life "off schedule" out of time. Being "off schedule" served to materialize their reproductive engagements, setting them apart from peers, and demonstrating the gap between ruptured biographies and the normal (Palestinian) life course. In this case, a thirty-year-old Palestinian man in Israel, who had been in treatment for infertility for more than five years:

I'm not young; I'm thirty. When my son is twenty, I'll be fifty at least. When will I build his house? We don't rent a house the way we buy. We purchase land and build. It takes a lot of time, a lot of money and nobody knows what's in store for him. You only live once. You start with a little child, and when you grow up, you marry and want to have children. You prepare for this all your life, but now I'm not young anymore.

An even stronger sense of asynchronicity imbued the narrative of a Palestinian man, age forty-four, who was living in a midsize village in Israel's Muslim Galilee region. Having divorced and remarried in order to have children, he reflected on his previous marriage and childless life:

I am forty-four today. Some of my schoolmates are already grandfathers. You know, we marry early, at nineteen, twenty-so. If someone has a daughter of twenty-four, who has married at eighteen, nineteen, today he's a grandfather. Some [children] go to the university. And I was the first one to marry among my friends. I was twenty. So sometimes I have these thoughts, about those two kids, the two miscarriages we had in our first marriage. They should have been twenty, twenty-one today. And in a great, it's fun, you know, a man of forty-four who has children of twenty-one. It's a joy.

Local context is of great significance. Palestinians in Israel and Lebanon marry much earlier than Palestinians in Lebanon, who have faced demographic shifts and delayed childbearing as a result of the long conflict (Kobeissi et al., forthcoming). One man in Lebanon, who had spent time in the war years in Kuwait and had then traveled to Europe to study, had some somewhat different views about marriage and family life as a result of living outside Lebanon. He did not marry until age forty, and instead of taking a much younger, highly fertile wife (the common course), he decided to marry an otherwise unmarriageable relative, who was living in Lebanon. For that at age thirty-nine, with a mentally retarded sister, she would have other suitors. Although he married her out of compassion rather than love, he explained:

From the beginning of marriage, I made it clear to my wife—before marriage, we could adopt a child, because we married at an older age, that shouldn't affect our marriage or our life. I think in the long run, the woman will ultimately be affected if we don't find a solution, because, of course, the wife is much more emotional than the husband. I mean, she is identifying her personhood [sic]. She feels inferiority, that something's wrong and she feels down, depressed. Despite the fact that I told her that adopting our own children doesn't matter, I'm sure, ultimately, that that will affect her. Two times, when the operation [IVF] failed, she felt neglected and cried. I tried to ease her pain and tell her that it doesn't make sense from the first operation. We're both old, and because of our ages, our chances are less. So now, we're both trying to sort it out [their male infertility problems].

And this man and his wife were working as teachers in UNWRA schools in Jordan and were exposed on a daily basis to many Palestinian refugee children, including orphans. Unusual among the men in this study, this man had contemplated adopting an orphaned child:

Adoptation, yes, why not? I thought about this. So even though you are a kid who is not originally yours, with time, he'll get used to you, he will be like your kid. But she's not supporting the idea. She prefers her own kid. But I think, in the long run, if we do adopt, eventually we would get used to it and we would treat the other as our own. She would feel the motherly affection, and I think it's a good idea, a humanitarian act. A human being is a human being. And the children—any child. I can, I think, feel pleasure to have any child. Sometimes I feel myself a father of any child. I can play with him, talk with him, and most of the children love me.

Although earlier, however, legal adoption is not an option for most Muslim men who follow the religious guidelines prohibiting this practice (Bargach 2008; Inhorn 2006a; Sonbol 1995), and so was not a viable solution for infertile Palestinian men in this study. To repair an infertile marriage and to achieve full adult personhood, a Palestinian man must achieve biological fatherhood through the impregnation of his wife.

The inability to impregnate one's wife created threats to masculinity for men in this study, on both a personal and community level. A Palestinian man living in Lebanon remarked:

Sometimes I do, I do ask this question, "Why me?" "Why am I not like other men?" But I'm a believer in God. And I'm trying. I tried so many
medications, so many treatments. And it's depressing, yes. But even when I started to see doctors, this is a long time. I feel guilty, because my wife. She wants to have a baby. Before, I didn't, I wasn't as much. I wasn't wanting a child so much. But now I'm starting to think about. I love kids, yes. I love them. And, for the future, they will take care of my wife and me, later in life.

This man's comments are telling. First, his infertility has cast doubt upon his masculinity, although he is reluctant to admit it, because it is to question God's wisdom. Second, his infertility has been challenging, thrusting him into a decade of unsuccessful treatment-seeking. During this time, his wife has desperately wanted a child, suffering her own “cortical” life disruption, for which he feels very guilty. Although initially denying fatherhood feelings in the early part of his marriage, he has developed a need for children. He also worries about the future life course in terms of few social safety nets. In short, childlessness has caused chronic biographical disruptions for both this man and his wife.

Male Infertility and the Burden of Secrecy

When a Middle Eastern man is infertile, his wife is usually expected to accept the situation, and even assume the blame for the reproductive failure in public (Inhorn 2003a, 2003b, 2004a). A Palestinian man living in a country who had traveled back to Beirut for treatment, had a great deal of emotional distress about this injustice:

When I was married, I went to a doctor, and he was all secrecy around him. "Why must it be secret? I'm not shy about it. It's a sickness, men looking for treatment." I wouldn't do like other men [do]. They have a problem with their wives. I wouldn't do this. I say it's from men, they go to get treatment. But in the Middle East, for a man to go to hospital [for infertility], they feel like he's not a man anymore, and they blame the woman. My wife, she would tell other people, "No, it's from me," so that I don't feel hurt. But then she knew there's nothing wrong with her, so why should she do this? Men are much less [invasive] than women's, so men should pursue it. In Jordanian, they think it affects their manhood. So the wife are the same. A man is like a woman, there's no difference. If you get sick, and I can get sick. It's just a disease. So I tell people it's mine. But, on the contrary, other men will say [to me], "I'm a man because I have children. If you don't have a child, you're not a man."

As is clear from this man's statement, male infertility is considered emasculating and stigmatizing—a real threat to manhood. As a result, men may refuse to reveal their condition in public (Inhorn and Birenbaum-Curlett forthcoming). Male infertility is shrouded in secrecy, leading to problems of disclosure. Yet, this secrecy is not invariant, and as the field becomes "medicalized," there seems to be a normalization occurring, particularly in the decades since ICSI was introduced in the 1980s. In the Lebanese study, men acknowledged increasing openness about infertility these days, particularly in light of the modern infertility services being provided and advertised widely in the country. Furthermore, in private treatment centers, men were beginning to accept that male infertility can be a medical problem, "like any other medical condition." Thus, male infertility is not necessarily the major crisis of masculinity that it used to be.

In this study, the men in this study in both Lebanon and Israel exhibited a range of communication patterns, ranging from full disclosure and close attention to treatment details to complete concealment and secrecy. A significant percentage of men in both countries had consulted relatives and friends to obtain advice and the names of good infertility specialists. In some families, the husband took an even more active role by escorting the couple to the hospital, buying them tickets, or caring for the wife after an ICSI cycle. Other men preferred to avoid intimate sharing of their cases, whether with their communication with family, etc., members; they explained that they were receiving treatment, but would not divulge the timeline or technical details.

In both countries, men invested a great deal of energy in deciding whether and to what extent, to share information about their male infertility problem, and avoid discussing it within their social surroundings. One Israeli Palestinian man was burdened by the thought of telling his parents and in-laws about his infertility. Aged thirty-three and married for six years (five of those years without a child), this religious Muslim construction worker explained, "Wouldn't that be a thing to tell the family? When they ask, we say 'Allah akbar' [God is great]." Another man, a more highly educated computer technician, aged thirty-eight and married for just two years, described how he and his wife, a long time coming,” telling their parents that they were delaying childbearing in order to establish themselves professionally. This man added that his wife was concerned that the parents might accuse the other of the problem, so they preferred to conceal the infertility. Even a letter that was custom, which his mother had found, did not lead him to greater openness on the male infertility problem. "We decided to keep it all secret, and not anyone. Today, for instance, no one knows we're here at all. I would go quietly. 'Quiet water runs deep' is the saying, right? A third Israeli man rationalized the secrecy through his wish to spare his wife of the discomfort visits," which only result in "the [visitors'] children making a mess that she [his wife] then has to tidy up when she has no power."
Secrecy was even more important outside of the family, in relation to friends and colleagues. With the exception of one man who said he was "completely" honest with his friends, all other Israeli Palestinians described the treatment as "a very personal thing" and preferred to keep it a secret. Most of these men described how he proactively obstructed any "probing" by acquaintances:

Two days ago, we went out with friends. And there’s another couple that wants to go to treatment so they asked us. I explained, but not ‘from myself,’ I said: ‘According to what I read in the books, they recommend, and so…’ I talk as an educated man without revealing that I’m undergoing the process myself.

A thirty-three-year-old bus driver, married for four years, attributes concealment to the expectations of being hurt by commentary and gossip:

It’s difficult for her anyway, and then people around say to me, ‘You didn’t have a baby because you didn’t sleep enough, you were working too hard, you don’t really want children.’ And people gossip. It’s harder for her than for me.\footnote{Ibid: 69}

While all Israeli Palestinians in the study had confided in their spouses primarily in order to be granted days off for clinic visits, all had kept the infertility and treatment secret from their colleagues. Even when presented with a direct question—namely, "What did you talk about so privately with the other man in the study, a thirty-three-year-old bakery worker, carefully guarding his secret: "Of course, I invented something completely different. It’s about their business, the things I’m going through at home."

Male Infertility and the Travails of Treatment

One reason why Palestinian men may prefer not to disclose their infertility and its treatment is that treatment itself may be stigmatized. In the Middle East, IVF and ICSI retain a “technological stigma” as a morally dubious way to have a baby (Inhorn 2003a). Even though all branches of Islam consider IVF morally permissible forms of treatment—as long as they are performed with the husband’s sperm and a wife’s eggs—lingering suspicions continue about artificial mix-ups or immoral doctors intentionally mixing sperm. As a result, Middle Eastern Muslim men often worry about these eventualities and fret about what people might be thinking. As one Palestinian man living in Lebanon explained:

I won’t tell anyone, because the community here in Lebanon, they would let you go without asking something like this: “Isn’t it haram [forbidden]? What’s that!” And they will look at you differently. I mean, that here in [named] hospital, they do it perfectly. But we heard that not in other hospitals, there are so many problems like that [i.e., sperm mixing]. But here at [named] hospital, it’s perfect.

Despite these anxieties, all men in this study were attempting to overcome infertility via biomedical treatment, including through repeated trials of last-ditch schemes. The decision to pursue treatment was a central factor shaping the experience of infertility. Whereas in the past, male infertility was first and foremost a non-event—a vacuum in one’s life that could not be overcome with therapy—today in the era of ICSI, male infertility has become a dense terrain, filled with biomedical intervention. ICSI has traveled globally, transformed infertile men and their fertile wives into patients, regular visitors to the reproductive healthcare system. In short, at the dawn of the new millennium, ICSI has become a major factor shaping contemporary infertility experiences across the globe.

We asked that ICSI now plays in the very definition of male infertility and treatment. While male infertility is defined outside clinic walls as the perceived inability of a man to impregnate his wife, this definition quickly becomes once an infertile man steps into an IVF clinic, where a differentiation of male infertility comes into play. The concept of “degrees of male infertility” is immediately applied, in order to locate the patient along an impairment continuum. This graded perception of the severity of male infertility is directly clinic generated and treatment related. Through the microscope in the laboratory, experts examine sperm retrieved from semen—semen that is separated from semen through various spinning and washing techniques—then graded on the basis of numerous fertility-related factors, including motility, morphology, and shape. On the basis of this grading system, physicians then provide treatment recommendations, including whether or not ICSI will be helpful in a given case. Indeed, the grade of the impairment determines the treatment that will be proposed. Intratruterine insemination (IUI) using the man’s sperm is generally recommended for less severe cases of male infertility, when this fails, a couple will move on to ICSI. Failing ICSI may make severe impairment is construed as much grave than failing IUI at that point, the only alternative is donor insemination (DI), which is legally prohibited for Sunni Muslim men.

Despite all men but one were Sunni Muslims, DI was not the question, because all were compelled to pursue ICSI once they learned of a severe sperm abnormality in the Lebanese study, five men were on their first cycle of ICSI at time of the interview, but four had undergone repeated cycles of IVF or ICSI—two in three cases and five times in one case. The “chronic” nature of infertility was striking. Even though the eleven men in this group had been trying on average of ten years—to cousins in five cases—they had yet to achieve...
pregnancies after years of relentless “searching” marked by “chronic” sperm sampling and hormonal treatment in some cases. Many had visited multiple doctors and undergone repeated semen analyses. But, because of lack of economic resources, poor medical advice, unsuccessful trials of IVF and ICSI, and the religious prohibition against artificial insemination (DI), they had failed to achieve viable pregnancies with their own sperm.

**Male Infertility, Reproductive Rights, and the Middle Eastern State**

There is significant dissatisfaction with the level of biomedical care for male infertility in Lebanon. Although Lebanese medicine is generally highly rated in comparison to medical care in other Middle Eastern countries (e.g., neighboring Syria), men complained that Lebanese doctors are “greedy” and “commercial” and will mislead patients in order to make money. Unsavory mercantilistic practices in medicine were a common refrain in the interviews, even among Palestinian citizens in the general male infertility study. Because Lebanon’s medical costs are highly privatized, Lebanese physicians are steeped in fierce competition for patients in a small, resource-poor country, where patients may have difficulty paying for their services.

Such is the case with infertility. Infertility medicine in Lebanon is an extremely private industry, with more than fifteen IVF clinics competing vigorously (Clarke 2008). The Lebanese state—which is weak and politically divided—has nothing to regulate or subsidize infertility treatment services, meaning patients must pay for diagnosis and treatment out of pocket. Without regulatory oversight, infertility services may be suboptimal, even in some cases. Men in particular are subject to negative competition. For these reasons, most infertile men begin their treatment with urologists, who commonly perform an unnecessary genitourinary surgery called “vasectomy.” When I interviewed Lebanese urologists, many claimed that vasectomy will necessarily lead to a man’s impaired fertility, this surgery is overused and does little to improve sperm profiles in most infertile men (Inhorn 2007a). Several of the Palestinian men had undergone vasectomies in Lebanon—sometimes twice—before experiencing any improvement in their fertility profiles.

Furthermore, in Lebanon, all of the men who had undergone ICSI for it—sometimes dearly—found the high cost of this procedure. According to a study, a single cycle of ICSI cost between US$2,000 and US$10,000, depending on medications. The average annual income of the Palestinian men was less than US$32,000 (excluding the one outlier who made US$84,000/year in an Asian medical equipment sales position). For the Palestinian men, one cycle represented one-sixth to one-third of their annual income. For those living in refugee camps and earning only US$2,340/year and US$2,100/year, respectively, ICSI represented a year’s worth of income which they could ill afford.

While most men complained about the high cost of treatment, none expected that the state would provide this service to them for free. Their experiences with the Lebanese state had been largely negative. They realized, if anything, that the way of tangible benefits, and many of them had considered the state’s basic opposition to the Palestinians as a result. Furthermore, these men longed to return to their families’ original home in Palestine, but as Palestinians living in Lebanon, they had no right to return. (Lebanese citizens also cannot travel to Israel.) One educated Palestinian summed up the situation quite poignantly:

“I have a problem in shape [of the sperm] and the activity and the number. He [the doctor] told me, ‘After six months, if there is no solution you will have to go to Beirut.’ He said the only solution is ICSI. I had the IUI two times already, but both times the result was negative. After that, my brother gave me the name of a new doctor in Syria, a very, very nice and good doctor. But he looked at all of our tests and he said, ‘I will have to go in vitro.’ But we have our jobs as teachers, and it is very, very hard to make [because of lack of money]. So we asked him to make IUI or IUI plus twice in Syria. The results were also negative. My friend in the UK also has a problem like this, so he told me, ‘In Beirut, they have a very good [IVF] center.’ But I was afraid to go to the center because of the price. He told me it would be $4,000 to $5,000, which is very hard for me. And, of course, there is nothing to help me—nothing at all [no state subsidies are available]. Then I heard that the price in Syria is less, approximately $2,000. But another problem is traveling to Syria, which is very hard for me. I had to sign different papers because I am Palestinian—entrance and exit visa. And we should enter [Syria from the Lebanese border] early in the morning. In the afternoon, we can’t go [across the border]. This is a big problem, a big problem. After fifty years [of Palestinian life in Lebanon], we still have problems. We have no human rights. I have the papers of my grandfather from our lands in Palestine. These were papers from the British Mandate. But where are the rights? We’re from northern Palestine. Since 1948, we have no hope to go back. But I have hope, not for me, but for the next generation ... [His green eyes welled up at this point, and he terminated the interview to another subject.]”

Ultimately, in Palestinian men whose families did not leave in 1948 and who continued spending their lives in northern Israel, their Israeli citizenship denied them the right to state-subsidized medical treatment, including infertility. Israel is the only Middle Eastern nation-state that provides comprehensive, state-funded infertility treatment. Its state subsidization of IVF, ARTs is the most generous in the world (Birenbaum-Carmeli and Maimon 2004). Like all Jewish Israelis, Palestinian citizens of Israel are entitled to funding for fertility treatments, which are guaranteed as part of their
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In the states, they give everything, and in Europe, in Sweden, they give the medications, even the bus to the clinic they pay. In Sweden, something different.

We may choose to compare the services of those provided in neighboring countries, and criticize the Arab states as being ungenerous in their reproductive healthcare provision of all kinds, including to the Palestinians, if a woman wants to have a child she needs money. She should work.

In some neighboring countries, then our service is good. But, if we don't give, I don't think they do... It depends where you go.

If, in other countries it's probably worse. If they don't look after their own, who will take care for the babies? They really suffer in comparison.

I think that in Europe, welfare states, as they are called, more, because here, they take all their ideas from there. Sometimes an MP wants to criticize a decision they say, 'as they do in Europe, but the standard of living is higher there, so I guess governance.

I'm exposed to European countries, and in Sweden, for instance, the state funds up to four children. I also read in Sweden, you pay a flat rate, but they promise you sixty embryos, but they produce them in several aspirations, but they promise thirty. But most European countries pay up to four children, if we do and others don't.

Conclusion

We have examined male infertility as a chronic condition and the response to the chronic dilemmas of Palestinian life in the twenty-first century. As we have argued, male infertility is a significant cause of physical and social suffering, which is tied, in the Palestinian case, to the material and political constraints that have affected this population over the past sixty years. The Palestinian experience—the Middle Eastern state that has been least aligned with the Palestinian population in its midst—the experience of male infertility, its impact on war, injury, exile, and stress that are common themes of male infertility care, to which they feel entitled as taxpaying
citizens. Although some have suggested that Israel’s attention is focused on making sure that Palestinians do not reproduce (Kanaaneh 2002), research suggests a more cautiously optimistic finding: Fertility treatment for the Palestinian population may, in fact, serve as a conciliatory element in the otherwise convoluted regional reality. Because of their entitlement to infertility, Israeli Palestinian men generally had more positive feelings about overcoming their infertility, compared to the embittered, heart-wrenching, and often depressing accounts of the war-scarred, infertile Palestinian men in Lebanon. For the latter group, access to infertility services will likely never become imaginable.

Indeed, globalization and the concomitant spread of biomedicalization also brought along neoliberal values of reproductive “rights,” “choices,” and “freedom.” Such values invest the individual (and the so-called couple) with responsibility for their health and illness, with every person expected to pool himself in the name of striving for a better quality of life. Within this perspective, a person with a chronic condition such as male infertility should seek treatment, or find other strategies to overcome his childdlessness. Infertility is thus no longer mere destiny; it also becomes a challenge and a man’s capacity to fend for himself, his wife, his marriage, and the future of family. For those men who fail in this regard, they may be blamed for not following themselves in their choices in the reproductive marketplace (Spin 2000).

However, as argued elsewhere (Inhorn and Bharadwa 2007), the notion of reproductive “choice,” promulgated at the 1994 International Conference on Population and Development in Cairo and sustained to the present, has materialized for many people around the world. The discourse is oriented to women, is still focused on provision of birth control, and fails to accommodate many ways—social, economic, and political—in which people lack reproductive agency. For marginalized populations living as minorities, refugees, and exiles, including most infertile Palestinian men, reproductive choice and reproductive rights remain a utopian rhetoric.

In summary, male infertility is experienced by Palestinian men as a troubling, chronic condition that affects their subjectivities as men and members of their communities. For reasons that are still poorly understood, Palestinian men are at high risk of male infertility, a condition that is typically seen in relatively young men, but that is eventually experienced by many in a chronic, intractable condition. Male infertility can lead to years of repeated futile medicalization, a biomedical realm, given the generally incurable nature of this affliction, to infertility, as a biological reality that is graded by its severity, and often major biographical disruption and a chronic fact of life for men who fall into treatment modalities now available, including ICSI. Men live with the reality of male infertility on a daily basis, as they experience the disruptive and assumed coherence between one’s body and reproductive life cycle. Consequences of male infertility are especially grave because the norm of paternity...
Chronic Conditions, Fluid States
Chronicity and the Anthropology of Illness

EDITED BY
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Studies in Medical Anthropology
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