Faulty Deployments: Persuading Women and Constructing Choice in Egypt

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The aim of this paper is to discuss how in the wider context of capital expansion and accumulation in the late twentieth century development initiatives in general, and family planning in particular, have helped to train and produce new bodies and selves.[1] Using the Egyptian case as an example, I argue that family planning programs do not just reduce the number of children and regulate reproduction; they also introduce or foster notions of individual choice and responsibility, risk aversion, and personal independence. In short, they help to construct a new kind of individuality which is guided by legal constructs of citizenship rather than by communitarian and familial control. Such a construction must be further situated within the global political economy that reorganizes markets and labor relations, and subsequently requires individuals to abstractly self-regulate themselves and respond to the pressures of want and self-interest (Scott 1995:211).

Within this context, recent global economic restructuring, as promulgated by the World Trade Organization (WTO), has further provided arguments for free trade and open foreign markets. The forced integration of national markets into the world system, the disappearance of national subsistence, and the new forms of division of labor present a different aspect to this reality (Jameson 1998:57). The poor in first- and third-world countries continue to face the effects of resource management and severe restrictions on social welfare as social subsidies and other state benefits are removed due to globalization's economic rationalization (Harvey 1996:143–44) of individual states. The crisis of the welfare

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state, therefore, can produce potential social dangers in the form of a restless populace. In such scenarios, modern states[2] become guarantors of progress; they function as referees that mediate individual obligations to moderate the burden of risk that a person imposes on society. However, before the globalizing and much heralded discourse on permanent re-training, self-management, and decentralized planning (Martin 1994; Donzelot 1991) becomes a reality in states such as Egypt, there is a need to construct a population that can be governed by self-regulatory mechanisms and through people's voluntarily compliance with the law. I argue that international development programs, like the family planning program in Egypt, are precisely meant to advance construction of modern subjectivities linked to the process of creating more socially controlling institutions like those already present in industrialized democracies.[3]

I submit that in Egypt the family planning program, through its pedagogical efforts, not only seeks to reduce population size, but also introduces notions of individual choice and self-regulation. In Egypt, as elsewhere, a primary target of the family planning program is the female body, although the male body is not ignored.[4] Egyptian women are invited to participate in family planning not through coercion but through their own conviction. They must be persuaded, which entails the production of desires that help women make the choice of contraception individually for themselves and, by extension, the good of the nation. Through this project, the family planning program introduces Egyptian women to new ideas and values about home, child welfare, and motherhood, and, consequently, imparts to them the meanings of family, community, and nation.

The notion of the self-regulating individual is paramount for these disciplinary techniques. Liberal thought, from this perspective, does not consider individuality as a foundational given that political institutions can regulate. Rather, it is a process of coming-to-be, a constructive agenda through which the individual is fashioned. A picture of liberalism that incorporates the ethical individual with collective rights and governmental restraint may be proper, but we need to also pay attention, as Uday Mehta (1992) reminds us, to liberalism's underlying fear of libertine excesses and human passions. People need to be taught to control their desires and learn to curb "natural" instincts in order to become self-disciplined and disciplining individuals.[5]

The family planning program in Egypt, in league with international agencies,[6] continues to emphasize this liberal notion of the individual through pedagogical discourses on self-denial, responsibility, and reason. Based on this individualized sense of self, development-oriented social science literature on Egypt highlights the possibility of women achieving high levels of personal autonomy through education, urban living, nuclearization of household, and employment outside the household. These attributes are positively related to preferences for lower family size and are statistically linked to an individual woman's increased ability to determine the size of her family (Nawar et al. 1995).

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However, in Egypt women's autonomy and its connection to work needs to be rethought in relation to the multiple roles women play in contributing toward their families' welfare.[7] In addition, I would assert that the category of the autonomous self needs to be placed within the perspective of women's own notions of self and constructions of the body rather than in abstract formulations. It should further be viewed within parameters of the economic and structural constraints that women face in their lives. For example, in recent years the social adjustment programs being instituted in Egypt have caused rising inflation and a deteriorating job market, and have left poor households economically more precarious in both urban and rural areas. These economic and social changes include the privatization of health, education, and social services, and have disproportionately negatively affected women's lives (Hatem 1994).[8] Clearly the issues are complex and varied and much research needs to be done, especially in the Middle East. For example, we must examine the larger social, economic, and cultural contexts in which women live, work, and reproduce. Thus rather than simply assuming that women's autonomy will be enhanced through the social processes of education, wage work, and modern living it is necessary to investigate their lived experiences and see how social practices determine their choices.

This paper will employ ethnographic examples to demonstrate some of the "persuasive" techniques employed by the Egyptian family planning program in counseling women to accept modern contraceptives. This is being carried out under the supervision of international donor agencies' (specifically USAID). I will also show how in the process of women reaching contraceptive decisions their bodies become situated between opposing forces. On one side is the state-sponsored family planning program which seeks to organize women's bodies by way of contraceptive devices. On the other side are social and cultural pressures on women, often including pressures to procreate.

The state, linked to international capital, seeks to change the behaviors and practices of its populace to produce self-regulating and modern desiring subjects. In attempting to do so it confronts a population that conceives and constitutes its selves, bodies, and communities in diverse ways. Partly, the task in what follows is to represent bodies and selves that continuously disrupt modern governmentality's desire to subjugate and to civilize, to examine lives that, from within the narrative of capital and coexisting with it, remind us of different ways of being human (Chakrabarty 2000:94). This investigative emphasis compels us to "take the vernacular voices of the popular and their modes of self fashioning seriously" (Scott 1999:215). Following David Scott (1999), I argue that to take people's practices seriously is to recognize their popular refusal to integrate into the middle-class identifications and associated moral truths that are provided by the postcolonial state and its international allies (Scott 1999:215).

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FIELDWORK

To study the Egyptian family planning program on multiple levels and at multiple sites, I conducted fifteen months of ethnographic fieldwork (1992–1994) in family planning clinics, in offices of international agencies, and in a delta village in the Governorate of Sharquaya. I also worked in a poor urban neighborhood of Behteem in Cairo.[9] The macro-, mid- and micro-level linkages that I draw from my fieldwork findings will be evident in what follows. I present examples of specific interventions through which the Egyptian family planning program seeks to create knowledge and consensus regarding its policies. I briefly evaluate the program and its emphasis on using the Information Education and Communication Program (IEC) to motivate contraceptive use within the Egyptian population. I further show how this process is linked to training doctors in individual counseling techniques. I then describe actual cases of counseling and service delivery in an urban family health clinic. Finally, I will briefly show how women from the communities I worked in conceived of their own bodies and made contraceptive choices.

THE FAMILY PLANNING PROGRAM

Until the early 1980s, the Egyptian state had been sensitive to a developmentalist argument that emphasized socioeconomic development rather than the mere providing of family planning services. Yet dependency on international funding and support increasingly forced a shift in focus. International donor agencies, primarily USAID, criticized as ineffective the integrated development-oriented approach, under which population policy was subsumed. To effect change with regard to this policy, in the late 1970s and the early 1980s USAID exerted considerable pressure on the Egyptian government to change its focus toward a more directed fertility-control program. Bilateral U.S. Assistance to Egypt's population program through USAID commenced in 1977. It far exceeded any other source of international funding, providing about 75 percent of all donor assistance (USAID Status Report 1992).[10] The Egyptian population program has also been supported by UNFPA, The World Bank, and other European aid agencies.

In 1985 USAID recommended the establishment of the National Population Council, through which these donors introduced a new National Population Plan that focused on family planning with an emphasis on service delivery. The Plan emphasized the "free choice" of citizens to control their family size and the right of people to migrate internally or externally (Ibrahim 1995).

Following this, in 1988, The National Population Council (NPC) coordinated a drive to decrease the rate of annual population growth from 2.8 percent to 2.1 percent by the year 2001. The NPC estimated that 51 percent of couples would have to use contraceptives, as opposed to the 35.4 percent then using

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modern methods (USAID 1994). Demographic surveys by the mid-1990s had started to show that the contraceptive prevalence rate was 47 percent among married women,[11] and the Total Fertility Rate (TFR)[12] had declined from 6.6 percent in the late 1960s to 3.9 percent (DHS 1996). The population donor agencies, however, continued to expand their efforts in the public and private sectors. Their hypothetical population projections indicated that the TFR was still too high. They claimed that the rate of increase would raise unemployment rates, accelerate the loss of agricultural land, speed up urbanization, and reduce per capita investment in education. In short, all the indices of development and the standard of living would be adversely affected (Cochrane and Massiah 1995).

Based on survey data,[13] international analysts further argued that although the contraceptive prevalence rate had increased, there was still an "unmet need" for contraceptives. Simply put, unmet need referred to those women who said that they wanted no more children or wanted to space their pregnancies, but were not using contraception (Cochrane and Massiah 1995). Analysts estimated that 15 to 20 percent of married fecund/fertile women in Egypt fell into this category of unmet need. The situation, they contended, could be improved with family planning services that gave women more contraceptive choice (Cochrane and Massiah 1995:15–16).

In 1994 the International Conference on Population and Development (ICPD) in Cairo pressured international family planning programs to be more sensitive to the issue of reproductive rights based on ideas of gender equality, equity, and the empowerment of women. The move paralleled a shift from a model of service delivery, based primarily on targets and incentives strategy, to one that integrated information, education, and communication. The latter was the IEC approach (Hartman 1995:155).

The Egyptian family planning program has followed these trends. In addition to investing in a rhetoric on women's equality and reproductive health, policy advocates have expanded family planning delivery in conjunction with the IEC programs.[14] Within this strategy the internationally supported reproductive rights agenda played a complimentary role to the family planning program by helping it to be more "sensitive" to the needs of clients (Population Council Issue Paper 1994). It sought to streamline the program and address its weaknesses through an agenda of cultural sensitivity, counseling, and persuasion.

These pedagogical techniques have been significant in light of changes in the contraceptive options that became available to poor Egyptian women. Until the mid-1980s the pill was the most widely used contraceptive among Egyptian women. Studies of oral contraceptive use in Egypt (SPACC/FHI 1990; DHS 1992), however, convinced policy makers that Egyptian women were not "responsible" enough to use them properly. They therefore devised ways to bypass oral contraceptives altogether. By the late 1980s, government health clinics had expanded IUD availability and aggressively introduced the highly subsidized

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IUD CuT380,[15] a long-acting contraceptive. The effectiveness of this method depended much less on women's behaviors and ideas.

As a high percentage of women discontinued to use both the pill and the IUD, policy planners had introduced injectables and Norplant into the public and private sectors by the early 1990s. Both these methods were heavily subsidized by USAID and targeted toward rural and urban poor women. Despite an uproar in the U.S. media on the use of Norplant among poor, indigent, and minority women, USAID in Egypt made Norplant widely available under the rhetoric of expanded choice.[16] It must be stressed that these new "choices" were invariably provider-dependent and took decision making away from Egyptian women. Under the argument of "unmet need" there was an effort by international providers to expand control. Long-term IUDs, injectables, and Norplant guaranteed that Egyptian women, not trusted to regularly take the pill, could now be regulated for an extended period.

The availability of different contraceptives was linked to informational campaigns that sought to persuade women to make the right choices for themselves. The IEC project in Egypt has been successful in making population one of the major issues that people think about when considering the country's future development. Data collection through bi-annual contraceptive prevalence surveys, attitudinal surveys, anthropological research, and focus groups are concomitantly used to evaluate and technically strengthen the program. While early twentieth-century censuses in Egypt made general correlations between land and population growth, demographic surveys conducted in recent years have been targeted at understanding the structural, familial, individual, and cultural patterns of why people use or do not use contraceptives. The information gathered guides the production of directed-media messages intended to dispel rumors and provide focussed communication regarding the benefits of family planning (Gillespie et al. 1989). Advertising and communication campaigns also project an image of family life in which smaller numbers of children are linked to a modern life style, disposable income, items of mass consumption, and an overall better future.

One example of this media campaign is a promotional video on proper counseling which is shown in Egyptian family planning clinics. It tells the story of Fatima who lives in a working class neighborhood in a large city. She is shown to be frustrated by her daily chores and by the burden of caring for her children alone while her husband is away at work. One day a neighbor explains to her the benefits of family planning. The neighbor then accompanies Fatima to the clinic where she is received with extreme courtesy and is counseled on the pros and cons of a range of contraceptive choices. The neighbor, although the facilitator of this process, makes it clear that her personal experience with contraceptives does not make her eligible to give Fatima advice. It is only the trained staff of the clinic that can help Fatima with clear and precise instructions, because every individual is different and each body has particular needs. Adver-

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tisements like these make evident two major themes: First, women should not listen to anyone but the family planning program specialists for proper contraceptive instructions. Second, queries about contraceptives should be made in the personal context of the session, and each woman has to be counseled individually. Indeed, the overall approach toward family planning service delivery in Egypt is being reoriented towards "client satisfaction." The emphasis is on the quality of care and treating the client with respect.

In short, the media-based social awareness campaign toward family planning is consolidated by family planning counselors interacting with individual women. Techniques of incorporating the patient's perspective are thought to be efficient ways of increasing "user rates" and they are one strategy for dealing with on-going problem of non-compliance. Family planning counseling procedures in Egypt, as elsewhere, tend to develop particular forms of self-awareness among women through a language of rights. They seek to develop a contractual relationship between women and providers within which women have a right to information and a choice of different contraceptive methods. The language of informed consent is used to show the non-hierarchical nature of the encounter. Women are given options to "choose" from, out of their own "free will."[17] It is important to bear in mind that the donor-assisted family planning program seeks not only to enhance the range of choices available to individual women but also to create conditions in which only certain choices may be made. They foreclose discussion of any other viewpoint or practice and, within the discursive terrain set up by the program, they leave no space to maneuver except within the program's own tightly constricted arena. When clients come to the clinic, they are assumed to be reasonably aware of family planning methods, either from information provided by friends or by the mass media. The counselor's task is to enhance the likelihood that the women will leave the clinic having selected one of the contraceptives available there.[18] However liberatory the language of individual choice may appear to be, it precludes choosing no contraception at all.

Keeping the above in mind, programs concentrate not only on fundamentally changing patient behavior but also that of the physicians themselves. Donors agencies, like USAID, also seek to actively change what they consider to be the non-enthusiastic and hierarchical behavior of the health professionals themselves. The task of training physicians links itself to the task of producing family planning workers as agents whose views are consistent with those of the international donor agencies.

TRAINING OF TRAINERS

At the time of my fieldwork (1992–1994), there were several programs in Egypt that trained family planning workers in counseling techniques. One of these was located at the Regional Center for Training at the Ain Shams University in Cairo. This program was funded by USAID under its technical assistance pro-

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gram to the Egyptian Ministry of Health (MOH) and was administered by Johns Hopkins University. The Center conducted a number of short and long courses for doctors, nurses, and other family planning service providers. I myself attended a week-long course for doctors, concentrating primarily on sessions that dealt with counseling techniques within the larger Training of Trainers (TOT) program.[19]

The sessions I attended brought together twenty male and female physicians from different parts of the country. The group was given an overview of female reproductive physiology, and training on the risks and advantages of different contraceptive devices, after which counseling lectures were scheduled.

After a preliminary introduction to the topic the instructor, who had been trained at Johns Hopkins, lectured on how best to interact with the clients. Some doctors were interested in how to best approach initial interviews of clients. The instructor responded that doctors should cultivate a good tone of voice, be friendly, and avoid medical terminology. This behavior would relax most women and generate a level of trust in the client provider relationship. The group was also told to refrain from using leading questions in all situations since they might not benefit the encounter and the client might feel apprehensive about answering them. The client needed to feel comfortable and be able to provide information with minimal coercion. She was to be encouraged to ask questions, to which providers were to listen carefully. Her questions would reveal not only her degree of knowledge, level of motivation, and attitudes toward family planning, but also things about which she had been misinformed or was ignorant or apprehensive.

The session went on to address how counseling could combat rumors about family planning. Some doctors raised the point that many Egyptian women believe that an IUD can rise to the heart. A general discussion followed among the participants on how best to counter this rumor in a clinical setting. One suggestion was to explain carefully that there was no connection between the uterus, where the IUD is placed, and the heart. "Tell them that IUD is in a closed box" said one participant. Another person remarked that the woman should reassure herself by continuously feeling the thread of the IUD. Then the instructor showed us a model of the uterus. She said that such models should be present in every clinic to help explain to women how the IUD is inserted and retained within the uterus. She said that this rumor had been countered in other countries with by providing client's with scientific information in lay terms.

One of the participants raised the issue of side-effects generated by different methods, and there was a discussion about when *not* to prescribe certain methods according to the client's history. Yet there was also a consensus that some side-effects should be treated as normal. For example, everyone agreed that women should be told that not having or having a menstrual cycle while on Depo-Provera (injectable) was normal. Similarly, headaches or swelling of breasts were normal when on the pill. It was deemed preferable to tell a woman be-

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forehand about these side effects so that she would not discontinue taking the oral contraceptives when she experienced them.

The training sessions were based on a literature that has been developed in health-communication studies addressing problems of non-compliance. This literature emphasizes that an authoritative doctor can have a negative impact on long-term drug compliance by patients; that restoring the patient's trust in her physician necessitates a relationship-centered medicine that takes the patient's perspective into account (Roter 1995); and that, while mass media campaigns, subsidized prices, and social marketing are important, face-to-face personal communication is crucial for effectively delivering the family planning message (Population Reports 1987).

In line with this view, the training sessions in Cairo emphasized that doctors should appear more caring in order to encourage women to use contraceptives. Improved communication by counseling staff too was thought to lead to enhanced understandings of the health risks associated with various contraceptive methods. Public health literature on compliance has emphasized the importance of continuing treatment even when the patient feels free of symptoms (Lewenthal and Cameron 1987). Similarly, women were to be told to continue taking the pill even if their husbands were away, and regardless of side-effects such as headaches, breast tenderness or spotting blood.

The training sessions were conduits through which models of patient compliance were being imported into the Egyptian family planning context by international donor agencies. These models are intrinsically connected to evolving health practices in the West. They are built on the notion of a speaking patient who gives the doctor a history of subjective complaints. Patient histories are treated as those aspects of their lives that are invisible to doctors. The physicians need to listen not only to obtain information but also to understand the person. Through this process, it is maintained, the patient and doctor become bound together in a relationship of mutual assistance, one situated within the realm of the medical paradigm (Armstrong 1984).

Indeed, in counseling techniques embedded in models of "listening to the patient," what has remained unsaid in previous patient-doctor encounters should now be brought forward. This is advised under the rubric of helping women help themselves via the rhetoric of facilitating the individual decision making process. In actuality, however, the choice and autonomy that these counseling techniques are said to facilitate remain illusionary. The terms of the contract are not freely chosen by all. Rather, they are predetermined by the clinical staff and the family planning program. These encounters constantly emphasize the individual risks related to multiple childbirth and the social risks of having too many children. Such assertions make many women feel responsible for the social and economic problems facing the entire nation. In the name of individual choice they are guided into accepting contraception as part of their becoming

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responsible individuals who may have to suffer "minor" health problems for the larger social good.

Despite the rhetoric of the training sessions, in the actual counseling sessions that I attended doctors routinely went beyond telling women of the health risks involved in multiple pregnancies. "Why do you want to have so many children, are you going to feed them grass?" a counselor admonished a mother in one clinic I visited. A staff member at a Cairo-based NGO working in the area of population told me that in their information campaign they emphasize that women who have many children should understand the social impact of large families. Women are told that if the population does not decrease people will have to start living in the desert.[20] Similarly, while attending another family planning training session for doctors and nurses, the trainer told us, "You should tell women, that if they can endure pregnancy for nine months, is it not better to use the pill or IUDs and just endure discomfort for three months."[21] It is evident that the aspirations of policy makers do not always translate into corresponding practices by the health care providers. In the next section I explore this argument through a brief description of counseling in a family planning clinic in one Cairo neighborhood.

A FAMILY PLANNING CLINIC

I regularly visited a clinic located in a public hospital in Shuhbra, a lower-middle-class neighborhood of Cairo. I was introduced to the clinic staff by a senior female doctor who worked for a family planning development project at the Ministry of Health. Over the course of a year, I went to the clinic once a week, and had the opportunity to observe the treatment and counseling of women away from the policy assertions of higher-level bureaucrats.

The clinic was a small room in a large hospital and was open from nine in the morning until about two in the afternoon. The clinic furniture consisted of a large desk with a number of chairs behind it for the doctors. The patient's area included a couple of chairs in front of the desk and a bench in the passage outside. The room was divided by a movable curtain partition into the "consultation" section with the desk and the chairs, and the "examination" section, with an examination table. I would attend the clinic with three female doctors who were occasionally joined by a male doctor who was also the clinic manager. Present also was a senior nurse and some younger trainee nurses who assisted the doctors with injections and IUD insertions. In their conversations with me the doctors often stated that life was economically very difficult for the area's people and that most men worked two or three jobs. According to these doctors, family planning gave people some hope of reducing their household expenditure. IUDs were the most popular method and the doctors maintained that women preferred them to injections or the pill.[22]

The clientele at the clinic was quite varied in terms of their needs. General-

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ly women who came to this clinic belonged to the lower-middle classes. Some were in their forties and came for regular Depo-Provera injections. Others came to initiate contraceptive use since their husbands were returning from abroad. Most women were accompanied by a female relative or friend, although at times they would come with their children and, occasionally, on their own.

On one occasion a woman with an IUD, inserted a few months before, came to the clinic complaining of heavy bleeding during her menstruation (menorrhagia). She was in her late twenties and had three children. A doctor removed her IUD but tried to persuade her to accept monthly injections as an alternative. The woman refused and left without accepting any other form of contraceptive. After she left, the doctors discussed whether the proposal to give her injections had been wise. One doctor who was somewhat older than the others argued that injections should not be given to younger women or those who desired more children. A much younger doctor, who had advised the use of injections and had recently completed a three-week family planning training course much like the one described above, argued that in the literature there were no contraindications based on age. The older doctor insisted that it was not simply a matter of age, and argued that "[since] "the injections also cause cancer and we do not know their long-term effect on the uterus, giving it to younger clients may put their future fertility at risk."

This discussion suggested that regardless of guidelines concerning available contraceptives in family planning manuals, and the strong emphasis on the noncarcinogenic nature of injections in these guidelines, doctors still created their own reasons for prescribing different contraceptives. Doctors did not just differ in their understandings of medical literature; their personal life histories and political beliefs also variously shaped their attitudes toward family planning. The older doctor who had opposed the injection suggestion was more religious than the others in her general outlook on life. She argued that the recommendations on contraceptive use ignored the cultural and social conditions of poor Egyptian women. She believed that injections were always harmful for younger women and should not be prescribed to women who had not completed their family. She similarly opposed the use of Norplant and thought that women should not be exposed to long-term pill use. She saw her role as that of a judicious mediator between the harmful effects of some contraceptives and her unknowing female patients.

By and large, however, the doctors would agree among themselves while prescribing contraceptive methods. The counseling techniques mentioned in the previous section were seldom used to persuade women. Although the doctors were polite in their demeanor, they were aware of their social power and prestige in the eyes of their poor urban clients. They would suggest a contraceptive and sometimes firmly order the women to act accordingly. When this failed, the nurse, who was closer to the patients in social class, would join the conversa-

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tion and admonish the women for not thinking about their health and their family's future. This pressure invariably would have an effect on those women who were initially reluctant to continue with IUDs or were thinking of postponing taking oral contraceptives.

Many women came with problems of bleeding and infections while on IUDs. This population may not be a sufficient basis from which to generalize about the prevalence of IUD-related problems in the entire community, but almost every fourth client at the clinic came to have her IUD removed for a specific complication.

These women would tell the doctors how they had been living with foul discharges due to IUD use but did not have the time or resources to come and be examined by a doctor. The high cost of medical examinations kept many women from coming to the clinic until their health had already deteriorated. Contraceptive prices are subsidized in Egypt, but the expense of even a few extra Egyptian Pounds can make a significant dent in household budgets—a family's total monthly income is sometimes less than one hundred Egyptian pounds. Additional expenses of transportation, the clinic fee, and in case of infections the price of medicines, often discouraged women from visiting the clinic.

This problem was echoed by the doctors themselves. When I asked the clinic head about the level of care offered women by the Ministry of Health, he replied: "The MOH treats us like step-children. Look at our pay, why should we care?" He went on to state that since the government does not pay them enough they are more interested in their private practices than in providing services to the public clinic's clientele. "Anyway," he continued "these are poor [women] who come here. When we see infections it is mostly with those patients who have not come for their follow-up due to financial reasons. The issue is poverty . . . not our skills."

I have so far shown how the Egyptian family planning program emphasizes individual decision-making by women, the localized action of IUDs, and the somewhat "benign" health risks of oral contraceptives. Like most of its international counterparts, it also propagates the construction of a modern and medically normalized body. Moreover, there is an emphasis on seeking help from only medically trained doctors. How women conceive of their own bodies, seek other healers, or go to local midwives for childbirth, are perceived as challenges to the medical model of the body.

As I concentrate on women's experiences and responses in the following sections it shall become clear that their relationship to contraception is determined by a range of social variables. Some women in Egypt perceive their bodies and selves in relational terms and might, therefore, undermine the construction of the autonomous subject model. Others may use contraceptives informed by their own understanding of their bodily functions, or by their social circumstances.

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WOMEN'S BODIES

Childbirth remains a cherished goal for most Egyptian families. It is the fulfillment of the idealized feminine role and establishes women as guarantors of lineage continuity. Threats of infertility and delayed pregnancy of new brides are major sources of social anxiety in most Egyptian households. Women talk about how children tie their husbands down. They reason that husbands of wives who give them the gift of children, especially of boys, are less likely to seek divorce or another wife. The desire for children, women say, forces men to remarry. Here, they acknowledge that both men and women very much need children.

Mothers, fearing negative reactions, urge their newlywed daughters to get pregnant soon after their weddings. Similarly, mothers-in-law drop subtle and not so subtle hints to their daughters-in-law about getting pregnant. Women in both urban and rural areas complain of being stigmatized as infertile if they do not conceive early in their marriages. It became clear that most rural and urban families do want children, and thus the family planning program's insistence on birth control may be at odds with the preoccupations of women themselves, for whom childbirth is a blessing and infertility a social stigma (Inhorn 1994).

This stigma linked to infertility became evident to me when once I visited a male friend in a working class district of Cairo. His mother, Umm Tayab, asked me why I did not have any children as my wife and I had been married for several years. My explanation of how both of us had decided to pursue professional careers and had postponed having children left her unconvinced. Umm Tayab quietly left the room and came back with a smooth stone. She said that she had received it from her mother. "If your wife is *makbusa* then I can help her and this stone is the key to the cure" she told me. Being *makbusa* implied that my wife, in this case, had been ritually afflicted and suffered from *kabsa* (being bound, squeezed, pressed). There were several ways in which a woman could become *makbusa*. Umm Tayab continued:

> When a young bride sees a woman who is breastfeeding, or one who has just given birth then the bride may not be able to get pregnant. The answer is to do something so that the *makbusa* becomes better. I give these women this stone, they pass it through their dress seven times and then they bathe with its water on the last days of the Arabic month. This is not *sehr* [magic] or the *ain* [the eye] but it is the effect that the breastfeeding women have on the new bride.

Umm Tayab was a healer in her own right and she helped in the diagnosis and treatment of women in the community whom she thought were suffering from *kabsa*. I was not sure how to proceed with her advice. With my own understanding of the situation I did not feel that our not having children was because my wife had *kabsa*. Yet she had introduced me to an important aspect of women's ideas about inflicted infertility and its healing.[23]

For example, for many women I spoke to, infertility was considered a state

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of abnormality that needed attention and correction. An "open" body is thought to be more vulnerable to affliction and ill health. New mothers are considered open since they have just given birth and discarded impurities. So are newlywed women open due to the sexual act, as are women who are menstruating or girls who have been recently circumcised. Similarly, my informants considered fresh burial sites to be open and liminal. This notion of liminality places the "temporary" and the "open" in contrast to the "normal" and "closed." These open bodies and spaces, in turn, are thought to dampen the re-generative potentials of other bodies.[24]

Following this construction of the reproductive female body, we can see why moments of celebrated openness, such as birthing or the first sexual act, also signify periods of vulnerability. If a woman who has recently had an abortion or delivered a child enters a room of another woman who has also recently delivered, this may cause the second woman's breast milk to dry up. For another example, if someone attends a cemetery burial or sees a funeral and then visits a new bride, she would become *makbusa*. Being *makbusa* implies being ritually afflicted, and suffering from *kabsa* means becoming infertile (also see Inhorn 1994).

The diagnosis for this affliction takes place when the afflicted woman does not conceive in the following year. The series of events is resurrected and a cure is found as an antidote for the causal event. The ambiguity present in these acts must be reversed and re-ordered through inversion and restatement (Boddy 1989:106). Women asserted to me that blood plays a central role in causing *kabsa*, and the solution takes many forms. Women are sometimes asked to place menstrual blood in a bucket of water and then bathe with it.[25] In other rituals women who are related in this schema step together into a bowl of water seven times and then bath with it.

It is important to understand this discussion of *kabsa* in light of the autonomous-self model propagated by the family planning program. This argument becomes clearer when we also consider how international advocates of reproductive rights respond to the diversity of views and practices found globally among women. Women belonging to different cultures and religious beliefs, with distinct bodily experiences and sexual practices, may challenge the language of equality, personhood, or bodily integrity that is put forward by international feminist groups. The argument is echoed by some reproductive-rights activists who stress that women should reclaim their bodies as a political site (Petchesky 1995).[26] Within this context, reproductive rights literature contends that local beliefs and practices, even those enacted by women, can never take precedence over the social responsibility of governments and intergovernmental groups to ensure the propagation of human rights, promote women's development, and respect women's self-determination (Correa and Petchesky 1994:118). In these perspectives we find a liberal desire to understand women's own perspectives, but women's actual practices are viewed as secondary to the

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goal of international standards of health and hygiene. This universalizing narrative privileges an assumed solidarity among women by abstracting out specific histories and local experiences.[27] International unity is achieved through an excision of the "cultural" and the subsuming of difference in the name of unifying and universalistic principles (Butler 1998). This seemingly progressive political agenda, therefore, remains embedded within the construction of an individualized sense of self whose rights are to be protected, and a bounded body whose integrity is to be maintained. In contrast, ideas about *kabsa* show us how female bodies in Egypt are sometimes more broadly conceived in relation to the social aspects of life. Beliefs about infertility, the drying of breast milk, and the effects other people may have on one's bodily functions, display the interconnectedness people posit between ill health and social relations. Boundary transgressions may be committed by the very people who are in vulnerable states—the relationship can be one between bodies of people who unknowingly afflict, and the bodies of those afflicted. These perspectives contrasts with the emphases within medical and reproductive rights discourse. They help us to think of bodies and selves not only in individuated forms but also in relational ways, linking different bodies and spaces , each being essential to the normal health of the other.[28]

WOMEN'S CHOICES[29]

Several women evoked body imageries of menstruation as a time when bodily impurities are washed out. They did so in explaining their ideas of how modern contraceptive methods work. For example, they said that injection treatments need to be discussed in relation to their effect on menstruation. One side-effect of injectables like Depo-Provera is the cessation of menstruation, and so such treatments were not very popular, especially among younger women nervous that they might retain impurities. Also, like anywhere, a missed period in Egypt is normally seen as an indicator of a possible pregnancy, and the amenorrhea related to Depo-Provera disrupts the normal meaning of a missed period. Women use the contraception to avoid pregnancy, but experience little or no bleeding, a sign of potential pregnancy. However troublesome a monthly cycle may seem, it is a visceral sign of socially valued fertility. This confusion needs to be understood in light of the profound belief of these women that, although contraceptives may help prevent pregnancy, the final decision is God's.

Older women who were approaching menopause and had completed their families accepted injections more regularly. They argued that not much blood would come out anyway and thus they had less fear of retention. Because their bodies were older and no longer fertile, they stressed, they did not produce menstrual blood as abundantly as younger, fertile bodies. These women felt that their bodies had changed and could absorb more harm.[30]

Given these connotations of menstrual blood, *dayas* (traditional midwives) to whom I spoke and women themselves maintained that if a woman shed lit-

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tle blood during childbirth then she may have clean lactation (*bitrad'a nadif*). The cleanliness in this respect referred to lactating without having menstrual cycles. Such women were considered protected from getting pregnant for an extended time period without need for contraceptives. It was maintained, however, that only those who had "clean lactation" were so protected, and those women who started to menstruate while breastfeeding did accept contraception to postpone their next pregnancy.

In contrast, the doctors I spoke to at family planning clinics discouraged these beliefs about "clean lactation" as merely an excuse women employed to delay using contraceptives after giving birth. Recent programs on child survival in Egypt, started under the auspices of UNICEF and USAID, monitor infant mortality rates and the effects of various diseases on children. Through the ministry of health clinics this program encourages breastfeeding as a precaution against early childhood diseases. The program gives women special training on breastfeeding, proper weaning techniques, and general childcare. However, as much as doctors recommend breastfeeding for children's well-being, the same clinicians discourage prolonged breastfeeding as a method of contraception (Ministry of Health, Egypt).

Most women hear about contraceptives through their friends, neighbors, or other women that are already using them. Media messages on the radio and television are also very important, and one important media message is the family planning program's emphasis on *tanzeem*—used in the sense of spacing—as opposed to *tahdeed* (root *hadd*: boundary, hence cutting off, complete cessation, or control). Women respond favorably to this spacing message since it gives them the option of postponing pregnancy while retaining their image of being fertile, intact. Women may thus use contraceptives to "rest" from periodic pregnancies. Women may incorporate contraceptives into their lives, as Bledsoe et al. (1998) show for rural Gambia, to slow down their reproductive potential and allow their bodies to heal and recuperate from the trauma of delivery and the demands of breastfeeding. Women's decisions to take "rest" is intrinsically connected to how they perceive their bodily functions.

To elaborate, women who do want to use oral contraceptives sometimes feel that it has deleterious effects on their health. So while on the one hand they use it to prevent pregnancies, on the other they may stop using contraceptives to take "rest" from the ill effects they have on their bodies. For example, Nafisa, an urban housewife and the mother of five, after having breast-fed her two-and-a-half-year-old child for two years, decided to start using contraceptive pills. She said "I only take pills during times of need. I stopped them two months ago because I was suffering from headaches, dizziness, and a complete loss of energy." She continued, "I am using the pill (*huboob*) now because I cannot raise any more children. I take them even though they make me *ta'baan* (tired, unwell)."

The word *ta'baan* here means to be tired, but in colloquial Arabic it is also

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used to convey a range of negative physical and emotional states. Women on contraceptive pills use the word to mean being unwell due to either weakness, headaches, or general listlessness. Women on oral contraceptives, like Nafisa, would sometimes talk about how they would tolerate the unhealthy effects of contraceptive pills for a period of months, and then take a few months of "rest" from it since their bodies would be *ta'baan* due to prolonged use.

One woman in the village argued: "We are farmers, we are not strong and we are not healthy, so we cannot take the pill every day and also work at home and in the fields." Village women stated that they gain weight while using contraceptive pills. Oral contraceptives, women argued, besides other symptoms, cause obesity and produce breakthrough bleeding. Being heavy/full is a part of local notions of beauty and bodily aesthetics, since it reflects good health and nutrition. But women told me that the weight increase associated with oral contraceptive use is due to the retention of fluids (bad blood) which are then stored under the skin. They say this produces swelling with no concomitant gain in strength, making them lethargic and weak.

Only a proper diet (primarily meat) can cure this feeling of fatigue. Poverty and lack of resources complicates these states since a healthy diet is out of reach for many. Further, breakthrough bleeding is also undesirable since, besides other problems relating to general weakness and complaints of dizzy spells, it hinders religious duties because Muslim women are not allowed to pray while menstruating. These women thus associate oral contraceptive use directly to their socio-economic circumstances, since a good diet would neutralize the harmful effects of the pills. Both rural and urban female informants explained to me how upper-class women could tolerate the pill better because they had appropriate diets to counter side-effects.

Women understand their bodies as internally connected and affected by flows that expel impurities, and this leads them at times to reject IUDs. They fear that besides producing breakthrough bleeding the IUD could travel up into their heart and cause serious problems. IUDs, women told me, could also travel upward and penetrate the head of the fetus if a pregnancy occurred despite contraceptive use (everyone knows that contraceptives cannot compete with the will of Allah).

However, in some cases women prefer to use IUDs, especially while they are breastfeeding. They also use them when oral contraceptives have caused them physical discomfort. Naeima, an urban woman with a history of nine pregnancies, decided to get an IUD inserted seven years ago after her last child was born. Her husband, according to her, had always opposed her using contraception, arguing that as long as he was alive she would have to go on bearing children. "Now," she said, "he cannot argue with me anymore; he sees how my health is deteriorating and knows that I cannot bear anymore children." She continued, "My daughter has a baby now and so it would be inappropriate for me to have more children at this stage."

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When she had her IUD inserted the doctor told her that she might suffer episodes of bleeding. She did complain of heavy bleeding during her menstrual periods and of intermittent bleeding during the month, accompanied by dizziness, backaches, and general malaise. "I am used to all this," she told us, "now that I have had them for six years." She acknowledged that she had been asked to see the doctor for regular check-ups, but responded angrily: "Look around you, what do you see? This is a harsh life; how can I afford to go to the doctor every now and then. I have young children to raise, there are other expenses."

In addition to displaying a complicated preference for contraceptive use, Naeima's example contradicts the image of poor women presented in development-oriented literature, as silent sufferers (e.g. Khattab 1993). Her reluctance to seek therapy for her ailments, however, does sensitize us to the economic pressures on families, and how women continuously sacrifice their own needs for the family.

Women use contraceptives and make choices, negotiating their way through a range of opinions and options. In rural and urban Egypt, as nuclear families rely more on themselves rather than on their extended families, the burden of raising children falls increasingly on women's shoulders. With the concomitant burdens of domestic work and increasing pressures to find wage labor to sustain their household, women complain that multiple, periodic pregnancies are a drain on their health. Using contraception may give some of these women the respite they seek.

These case examples suggest that, despite the family planning program's persuasive efforts, women are having to make choices informed by the socio-economic hardships they face in a society undergoing economic rationalization under international pressure. These social processes are having a direct impact on the lives of both the rural and urban poor people with whom I spoke. At the same time, their conceptions of the interconnectedness of different parts of the body guide them in their use of contraceptives.

CONCLUSION

For the Egyptian family program the acceptance and use of contraceptives by women depends upon their systematic, regular, and responsible use. Their perspective assumes an autonomous self that can act as a "free agent," independent of other influences on decision-making. Through counseling, media advertisements, and adult education classes, the medical construction of their bodies is explained to Egyptian women. They are not required to completely comprehend how different contraceptives prevent pregnancy, so long as they accept that they are more effective than other methods of birth control, use them continuously according to the physician's instructions, and ignore other sources of information. They need to understand their own bodies as unique, private, and unrelated to others. The maintenance of their own health must take precedence over other concerns. Women are encouraged to subjugate their own interests to

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a greater social good advocated by state representatives. They are required to abandon familial and domestic concerns, and to enter as individuals the realm of the universal and the civil, the domain of impending citizenship.

I would argue that this intervention is embedded in the liberal narrative of managing populations with their consent, In the Egyptian case, this is not intended to produce a full-fledged right-bearing citizen. Rather, the motive is to construct an individualized sensibility that will diligently follow the advice of a benevolent state. This becomes evident especially when we observe that arguments on the autonomy of women, and choice in fertility control, are made as Egyptian welfare structures are being dismantled, leaving families, especially women and children, economically and socially vulnerable. The integration, albeit unevenly, of global markets and media forms has no doubt produced universalized forms of consumptive desires. Yet social and spatial polarization are preventing the majority of Egyptians from satisfying those needs, and producing conflict and tension. Free market capitalism in Egypt has proved unable to deliver the abstract cultural pleasures of freedom, democracy, and the ideal of citizenship. The state has, through public health campaigns, austerity measures, political violence, police aggression, and housing crises coerced people into becoming more compliant with their fate. The goal of constructing a modern atomized citizenry with allegiance to the state rather than to local communities and networks of power has remained elusive. The desired process of "homogenization is at best superficial" (Trouillot 2001:129). We can see the practice of family planning in Egypt as a case of faulty deployment of modern regimes of social control, regimes embedded in modern management and behavior modification techniques. Rather, socio-economic pressures have compelled many Egyptians to curtail their family size. Visions of modern living, linked to desires to educate children, have in most households, forced families to think differently about their resources and their future. I would also argue that poor Egyptian women still retain a certain level of independence, in part because of breaches in the pedagogical project, in part because they do not see themselves as the isolated individuals targeted by the programs.

In an insightful essay Mary Poovey (1992) persuasively suggests the person needs to be thought of not as an individualized unit but rather as inseparable from the social relations in which each person is inevitably bound. Poovey thus returns the construct "individual" to the fold of a heterogeneity placed within social relations (Poovey 1992: 251–53). Other feminist theorists have, like Poovey, long opposed traditional liberal accounts of the individualistic self, and have argued for a more relational sense of the self;[31] a self constructed and sustained in the social context. They have further shown the situated nature of the self, and the identification of this social self with the body.[32]

For the women I spoke to, being fertile was extremely important because it offered them social acceptance and respect. The option of contraceptive use was always selected after they had already proven their ability to become pregnant.

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Even if these women used contraceptives they would place them within a framework of an already constituted self that was linked and situated in a larger social environment. This has been pointed out in our previous discussion of *kabsa*. Ideas propagated by the family planning program may be pragmatically incorporated within patterns in which the self constructs itself. But it may not have an exclusive and unique space such as the program wants it to have.[33]

In describing people's attitudes toward the family planning program I have shown how women's own views and ideas on the body, the self, and the community interrogate the construction of the autonomous self and of contractual rights. Following Partha Chatterjee (1993), I maintain that it is crucial to investigate the narrative of the community that is unyielding in its constructions of the individual and the social to the disciplinary and hegemonic pressures of the modern state within a universalizing economy. To emphasize people's own experiences of their body, and popular practices, is to perhaps also insist on a different trajectory for political subjectivity and community; a future politics that cannot be fully encompassed within the narrative of the liberal state (Scott 1999:215).

NOTES

1. Development projects are primarily geared toward changing the traditional practices and habits of the people in the developing world, in order to help them make the transition to lifestyles of the globalizing model of the West. The "West" here is used as a historical term rather than a geographical construct. It is, as Akhil Gupta (1997:321) argues, a conjugation of place, power, and knowledge (Gupta 1997:321) that has historically imposed its rationalities onto other societies.

2. Modern states are characterized by growth in urbanization, changes in subjectivities, with increased individualizing tendencies, bureaucratic rationalisms, traditional/modern temporal grids linked to progress, mass media, mass production, and an emphasis on scientific thought (Ivy 1990:4–5).

3. Following Antonio Gramsci's major dictum, however, if pedagogy and developmental initiatives fail, or the rhetoric of equality and justice does not succeed, brute force and extreme forms of violence are employed to tame and discipline.

4. Elsewhere I have shown (Asdar Ali 2000; in press) how men are targeted by the family planning program in Egypt and how they respond to it.

5. Uday Mehta asserts that Locke's liberalism is primarily conservative. The pedagogical construction of the individual raises barriers against self-expression and eccentric and unpredictable behavior in order to impose a normality that is compatible with traditional norms and purposes (Mehta 1992:1–36). The free will of Lockean liberalism is a will that has been husbanded, regulated, and educated into one of social restraint and submission to law and higher authority. Individuality is thus constructed as normative, and contrasted to social and individual pathology (ibid:126–74).

6. I refer here to national agencies like the United States Agency for International Development (USAID) and to multilateral agencies like The World Bank, the International Monetary Fund (IMF), and the affiliated development agencies of the United Nations.

7. Autonomy as a concept in liberal thought is embedded in the discourse of a self-understanding and self-regulating individual who acts rationally and is partial to self-

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interest. Similarly, the liberal notion of agency is modeled on the idea of an autonomous subject "who possesses a will distinct from the will of others" (Asad 1995:15). Yet this construction overlooks the relations within which subjects are "formed, situated and sustained" (Asad 1995:15).

8. International agencies such as USAID, The World Bank, and the IMF, have since the mid-1980s compelled the Egyptian state to rationalize its economy, privatize it assets, and remove social subsidies. These same donor agencies provide the largest subsidies for population control. They believe that a reduction of state support would increase the cost of supporting many children and persuade families to adopt planning as a "voluntary and non-coercive" choice. The IMF-sponsored structural-adjustment policy was supposed to cut excesses in the economy. The family planning program was presumably supposed to guarantee a corresponding lean family. Playing on the imagery of surplus and waste, the structural-adjustment program and the population program in Egypt should be seen together as methods to streamline the social and economic corpus of Egypt.

9. Being a non-Egyptian, yet a Muslim male with a medical degree, I was unsure how women in the communities where I worked would react to my questions on personal relations, birthing, menstruation, and sexual practices. In one locality I was helped by a female field assistant. However, after a few weeks women in both areas, especially in the homes of my male friends, spoke directly to me about their ailments and their problems with contraception.

10. This coincided with the U.S. government's push toward the Camp David peace accord between Egypt and Israel.

11. This indicates the proportion of married women who were using some form of contraception at the time of the survey.

12. TFR is interpreted as the number of children a woman would have by the end of her childbearing years if she went through those years bearing children at currently observed rates. It is calculated by adding the age-specific fertility rates.

13. Biennial Contraceptive Prevalence Surveys and the Demographic and Health Surveys were both conducted by Macro International, based in Maryland in the United States.

14. The SIS (State Information Service) in Egypt is responsible for media announcements on family planning, and is primarily funded by USAID. Johns Hopkins University's Center for Communication Program works as a sub-contractor for the USAID, providing the major technical assistance for most advertising, and for the development of innovative advertising techniques such as television serials.

15. The CuT380 was developed by the Population Council and is the longest acting IUD on the market. The scientific literature claims that this long-term IUD can be used for eight years (Population Council 1992). The shorter-acting CuT200, with a life of under three years, was never introduced in Egypt.

16. Depo-Provera and Norplant both have Progesterone as the active ingredient. Depo-Provera is an injectable which, theoretically, protects for a three-month period, after which the injection is repeated. Norplant consists of slow-releasing needles placed under the skin for a duration of five years. Norplant is removed through a minor surgical procedure, but the drug causes weight gain which can produce fatty tissue around the needles, making removal difficult (see Morsy 1993 for a detailed article on Norplant trials in Egypt).

17. Consent, in the Lockean framework of liberal theory, is given to the government for it to exercise legitimate authority. Thus we consent to follow rules that may limit our own freedom through the our own free will (Hirschmann 1992). The act of consent binds citizens in a contract with the state; consent enmeshes actors in obligations.

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18. In a different context, Rayna Rapp (1988) suggests that the genetic counselors continuously tailor the highly technical nature of genetic information to the needs of the pregnant women being counseled. Since women do not have other models and experiences through which to understand this abstract scientific knowledge, the counselors act as gatekeepers between science and social experience (p. 154). Also see Taussig (1980) for a similar argument.

19. The training session was conducted in English mixed with Arabic during discussions and role plays. English was used more when technical and medical information was discussed, and the written material was also in English.

20. This imagery of the desert, opposed to the fertile land on the banks of the Nile, has played a major role in representations of Egypt's population problem (see Mitchell 1995).

21. The social nature of childbirth and familial relations are constantly undermined in this process by focusing on the individual health of the mother. Moreover, notwithstanding the rhetoric of female choice and autonomy, women are charged with complete personal responsibility for their own health, and attention is thus diverted from the state's failure to provide for its people (Morsy 1995:172).

22. The high frequency of IUD use may also be attributed to the monetary incentives available to the clinic staff from the Ministry of Health.

23. Marcia Inhorn (1994) presents an excellent analysis of *kabsa* among lower class urban women in Egypt.

24. Inhorn (1994) analyzes *kabsa* as ritual pollution, whereas Janice Boddy (1989) links it to spirit possession. My understanding of the process is closer to and influenced by Inhorn's rich analysis. However, at no time did my informants think of *kabsa* as an occurrence of pollution. I would restrict my own analysis by calling it an affliction.

25. In my discussions with women, *kabsa* was never understood as magic, a curse, possession by spirits, or the act of evil eye—the *ain*. The idea of an evil eye is linked to an expressed desire to harm another person, whereas *kabsa* is mostly an unknowing violation of boundaries.

26. Rosalind Petchesky's (1995) argument partially accepts the construction of the individual as historically developed in Western thought. However, it does seek to co-opt the collectivist politics of sharing and communal living in opposition to a narrower definition of the individual, linked as it is to the notion of property and market forces.

27. This argument is partly influenced by Judith Butler's (1998) critique of those Leftist/progressive intellectual positions that downplay identity politics as "merely" cultural (ibid:33), and which portrays these positions as unsympathetic to materialist issues. Butler argues that certain Marxist arguments construe cultural politics as factionalizing and particularistic and blame it for having lost a politics that unifies around a common goal, a common language, and an universal mode of rationality (ibid:34).

28. Elsewhere (Asdar Ali in press; also see Inhorn 1994) I discuss *khadda* (fright) and spirit possession as other ways in which women construct a social sense of self.

29. This portion of the paper was researched with the help of my female research assistant, Dahlia A. My use of the personal plural seeks to incorporate Dahlia's contribution to the study. I remain responsible, however, for the analysis.

30. See Bledsoe et al. 1994 for similar processes in Gambia.

31. Regarding this trajectory see the recent edited volume by Diana Tietjens Meyers (1997) among others.

32. In another context, the notion of embodiment is eloquently presented in Marilyn Strathern's work (1988) on dividual selves in Melanesia, where bodies and selves exist intrinsically enmeshed in social relations (ibid:302). Also see Emily Martin (1987).

33. I am indebted to Hanan Sabea for this insight.

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