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AFFILIATION, DISCRIMINATION, AND WELL-BEING IN MODERN EGYPT: CULTURAL AND SOCIAL DIMENSIONS

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Abstract

This thesis contributes to knowledge in the field of medical anthropology, particularly in Egypt and the Middle East, in two specific ways. First, the thesis demonstrates how a limited focus on kinship and micro social relations precludes a full understanding of the life experiences of people, especially at times of illness. The thesis shows that these conceptual limitations stem from a romanticized view of Egyptian culture--a view that poorly corresponds to the contemporary Egyptian situation. The thesis proposes that social networks and the ground between micro and macro social associations need to be incorporated into future studies of medical anthropology in general, and in Egypt and the Middle East in particular. Second, the thesis demonstrates how cultural values linked to the diversity of social classes and unequal access to social and financial capital shape illness experience. It is argued that access to biomedical services is a social manifestation of culturally constructed subcultures where kinship, social networks, and social hierarchy produce the current inequalities in well-being among inhabitants of modern Egypt. A cultural and social analysis grounded in the history of Egyptian modernity is pursued here to better understand current inequality in social and physical well-being. Space, aesthetics, religion, network affiliation, and other factors constitute essential elements of this analysis. The thesis proposes integrating a study of the cultural manifestations of the production of social inequality into all future studies of illness in Egypt and the Middle East. It is concluded that a culture of social distinctions and discrimination prevails, and that such a culture shapes social relations and illness experience. Unless this culture is understood and addressed, there is little hope for an equal distribution of resources for well-being among Egyptians.

(Key words: Egypt - Kinship - Social Networks - Class - Space - Social Distinctions)

Résumé

Cette thèse se veut une contribution à l'anthropologie de la médecine en Egypte et de l'anthropologie au Moyen-Orient, et ce dans deux domaines particuliers. Dans un premier temps, cette thèse démontre comment une concentration limitée sur la famille et les micro-relations sociales, ne permet pas une pleine compréhension de l'expérience des personnes, particulièrement face à la maladie. Cette limitation théorique découle d'une perception romantique de la culture égyptienne, perception qui ne correspond pas à la situation actuelle en Egypte. Cette thèse propose que les réseaux sociaux et le champ qui s'étend entre les micro-relations et macro-sociales devraient être incorporés dans l'anthropologie de la médecine en Egypte et au Moyen-Orient. En deuxième temps, la thèse montre la façon dont l'expérience de la maladie est mise en forme par les valeurs culturelles associées à la hiérarchie sociale et par un accès inéquitable ou capital matériel et social. On propose ici que l'accessibilité aux services biomédicaux représente la manifestation sociale de sous-culture, dans lesquelles la famille, le réseau social ainsi que la hiérarchie sociale concourent à produire une iniquité en terme de bien-être au sein du peuple dans l'Egypte moderne. Une analyse socioculturelle ancrée dans l'histoire de l'Egypte moderne est poursuivie ici dans le but de mieux comprendre les iniquités contemporaines en matière de bien-être au sein du peuple Egyptien. L'espace, l'esthétique, la religion, les affiliations et d'autres facteurs constituent les éléments essentiels de cette analyse. Cette thèse propose que des études portant sur l'iniquité sociale et ses manifestations culturelles fait partie intégrante des études futures sur la maladie en Egypte et au Moyen-Orient. En conclusion, une culture de distinction sociale et de discrimination prévaut ici un modèle des relations sociales et des expériences de la maladie. C'est à nous de comprendre cette culture de distinction et de s'en occuper. Il n'y a peu d'espoir de parvenir à une distribution équitable du bien-être entre les Egyptiens.

(Mots-clés: Egypte, parenté, réseau social, hiérarchie sociale, l'espace, distinction sociale).

For my mother,
whose
unequivocal
love and care
carried me
through all
times bad and
good.

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I would also like to thank my Professors, Margaret Lock, Allan Young, and Ellen Corin who, for years, have shown their continuing enthusiastic support. Mr. Roger Hardister, the Middle East Regional Director of the Near East Foundation has been very generous with his intellectual and moral support throughout this project, and indeed my whole career. Here, I would like to thank him for his unique spirit and relentless drive to support others to reach their full potential. The responsibility for views expressed here is entirely mine.

A Note on Pronunciation and Transliteration

The use of the Arabic language here is greatly simplified so as to make it accessible to both Arabic and non-Arabic readers. Colloquial Arabic is the one mostly used to highlight important expressions in Egyptian culture. The letter *ayn* (the eighteenth in the alphabet) in Arabic is indicated as "`" and the letter *hamza* is indicated as "'". The fifth letter of the alphabet *jeem* is indicated by the letter "g" to denote how it is pronounced in colloquial Egyptian Arabic, while in more formal terms and in references it will be indicated by the letter "j" which is more in accordance with classical Arabic rules. The pronunciation of the letter that is similar to the letters "ch" in the German language is indicated as "kh." The letter "gh", the nineteenth in the alphabet, indicates a sound closer to the pronunciation of the letter "r" in French (as in *merci*, which would be pronounced as *me(gh)ci)*. This linguistic simplification may have shortcomings, but it is hoped that it makes reading easier since the language itself is not the focus of this thesis. Arab names in the thesis and references are written as closely as possible to the way they would be pronounced in colloquial Arabic.

CHAPTER ONE:
THE THIN AND THE THICK:
THEORY, CULTURE, AND ILLNESS IN MODERN EGYPT

> The move away from the singularities of 'class' or 'gender' as primary conceptual and organizational categories has resulted in an awareness of the subject positions--of race, gender, generation, institutional location, geopolitical locale, sexual orientation--that inhabit any claim to identity in the modern world. What is theoretically innovative, and politically crucial is the need to think beyond narratives of originary and initial subjectivities and to focus on those moments or processes that are produced in the articulation of cultural differences.
>
> (Bhabha1994:1)

Introduction: How Different!?

While shopping with some visiting friends from the U.S.A. in the tent-makers street in Old Cairo, I became acutely aware of two things: first, of my *mustawa igtima'i* (social level) in Egypt, and, second, the urge in Egyptian culture rapidly to situate others in recognizable *mustawayaat igtima'eyah* (social levels) or *fi'aat igtimaeyah* (categories). Since we were in one of the few remaining fairly intact specialized craft streets, past history seemed to converge with present realities of contemporary social differentiation. In Egypt, these terms are commonly referred to as *mustawayaat* and *fi'aat* as a short hand. Both these terms carry elements of prevailing social structure and cultural values in Egypt.

It seemed that whatever I did or did not do, the shopkeepers had an urge to situate me culturally, socially and economically. Was I a tour guide, an Egyptian living in America coming to shop with my rich

Western friends? Did I originally come from a well- to-do family, or did I have new money from the West?[1] Saying only a few words or getting involved in a lengthy exchange; accepting the offered soda or not; drinking the whole bottle or not; putting on my sunglasses or not; squinting against the blown dust or sun rays peeking through the ancient cracking roof or not--all these things seemed only to serve as clues to my economic, social, and cultural identity.

Distinguishing Otherness:

This incident was a culmination of numerous other similar observations and incidents throughout my life in Egypt. The whole picture became clearer during my recent fieldwork in Cairo. Continuing to categorize and demarcate people one from the other, compelling people to know their place on the social ladder (high or low)--these activities apparently contribute to survival clues within the existing social order in contemporary Egypt. A culture that distinguishes people according to their social level reaffirms the cultural construction of Egyptianness. The preoccupation of Egyptians with situating others with appropriate *mustawayaat* and *fi'aat* is rarely captured in contemporary medical anthropology, but has important consequences, I believe, for behaviors relating to health and illness.

This thesis addresses local manifestations of social differentiation and other issues with two audiences in mind: international scholars and Egyptian scholars. For these two audiences, many areas of common interest exist. However, their interests are not always identical. Most

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[1] For Egyptians, the West mainly refers to Western Europe and North America.

Egyptian scholars and intellectuals study their own culture mainly to reveal its uniformity and harmony. Conventionally, their interest is in preserving a particular representation of Egyptian culture and society. This representation is contrasted with a picture of Western societies which are considered to be more individualistic and unequal. My attempt to examine the similar and different areas of interest of both these audiences is inherently problematic; and the final result will not be completely satisfactory to either of these audiences. However, I realize that this is the price of doing research at the end of the 20th century where pluralism in cultural interpretations and representation of everyday life prevails.

In this thesis, *mustawyaat* and *fi'aat* will be used interchangeably to refer to local cultural categories encompassing attitudes and behaviors that manifest a constant engagement by social actors in social differentiation. Material and non-material possessions are potential assets or liabilities in the practice of social differentiation. The outward manifestations of social standing, displayed on the body, in manners, comportment, acquisitions, and life-style are very popular sites for Egyptians (of all classes) to draw on to reproduce *mustawayaat il igtima'eyah*.

This preoccupation with *mustawayaat* reveals the articulation of social position and disposition in Egyptian society.[2] Specifically, thinking and acting based on an internalized recognition of *mustawayaat*

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[2] See Swartz 1997: 150-153) on the contributions of Bourdieu and Weber in this regard.

implies allocating values and social positions to self and others. Like other areas of social life, well-being and illnesses are grounded in the historically continuous and culturally constructed logic of *mustawayaat* present in modern Egypt. The *mustawayaat* and *fi'aat* can be considered as local idioms revealing the interconnectedness between social categories and cultural values. In other words, *mustawayaat* and *fi'aat* will be used in this thesis to highlight the local interpretations and manifestations of structural as well as cultural diversity.

Mustawayaat and *fi'aat* are closely linked to concepts of social class and social hierarchy. However, they differ in that they are local idioms Egyptians use in everyday life to denote an interpretation of social differentiation that is both economic and cultural. In chapters Five and Six the overlap between the concept of class and *mustawayaat* and *fi'aat* will become clearer. The idea of Egyptian social classes has been present for a century or more in Egypt, but the cultural manifestations of social class have yet to be fully explored, especially as they relate to health and illness. A culturally informed approach to an understanding of social classes in Egypt is proposed in chapters Five and Six.

I concede that it is possible to claim that the nature of the interaction mentioned above between myself and the shopkeepers is either limited to my own perception or is a manoeuver by them to maximize material gains. However, this episode highlights the point that the practices which stem from a local knowledge of these *mustawayaat* in

urban Egypt are a matter of the highest social significance.[3]

It is proposed here that this concept of *mustawayaat* is useful in a medical anthropology inquiry because health and illness are construed in an environment where social *mustawayaat* are an unexamined part of everyday life. Choosing to seek health care or not, being healthy, having a certain type of illness, or being on a certain type of medication, seeking a particular medical system or a health care system--all these attitudes represent ways that modern Egyptians live out their assigned social position and that of others.

As we will see, the art of distinguishing the social position of others is linked to local concepts that assert perceptions of appropriate attitudes and behaviors of different social categories. For example, shame is often felt by and brought upon many women who seek gynecological services, particularly after menopause. A menopausal woman or a woman with an absent husband is judged as a person who ought to be asexual and therefore should not need the services of a gynecologist. Overt breaking of this moral constraint by women brings about

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[3] Local knowledge of *mustawayaat* may be comparable to Bourdieu's (1984) concept of social distinction. However, Bourdieu was interested in the social relational basis of distinction in aesthetics in the West at the age of modernity. This thesis is more interested in differentiation in social relations in modern Egypt and the historical continuities of these relations. The focus here relates to how decisions about social and health issues are linked to perceptions and practices of different *mustawyaat igtima'eyah*.

cultural, social, and at times, economic repercussions.[4] Life without an identifiable *mustawayaat* and its associated attitudes and behaviors is unimaginable in Egypt. Further, well-being and illness are arenas for both the enhancement of solidarity and the contestation of social differentiation.

Section One: Approaches to the Study of People in Medical Anthropology:

A complete interpretation of how a conception of *mustawayaat* is articulated in Egypt may enable reconciliation of the polarity in medical anthropology between interpretive versus political and economic approaches. It is, after all, through personal interpretations of the social location of self and others that a modern Egyptian comes to realize his or her identity and character, a process that is essentially political.

A meaning-centered/interpretive approach focuses on the value of elucidation of an individual's subjective world and experiences (Good et al. 1985). However, as Geertz notes:

> The selves that bump and jostle each other...get their definition from associative relations they are imputed to have with the society that surrounds them. They are contextualized persons.
>
> (Geertz 1983:66)

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[4] This might explain evidence of the delayed help-seeking behavior of Egyptian women in gynecological conditions. However, at times, women muster the necessary social support from other women or relatives to meet their need for medical attention in the absence of a husband.

It is evident from the present research that a meaning-centered approach must locate meanings generated by individuals and their ideas about identity within social relations of differentiation. In this thesis, therefore, a modest attempt is made to re-frame medical anthropological approaches so that they can be applied to a study of personal lives in modern Egypt. History, environment, space, social class, social interaction, decision making, and interaction with institutions of the state are all areas which will be explored. One purpose is to link diversity in experience of illness with diversity in social location.

A Tale of Two Approaches:

The meaning-centered approach in medical anthropology emphasizes that exploring people's interpretive models about health and illness is necessary to understand the subjective experience of illness. This subjective experience does not stand in a one to one relationship with disease (Good and Good 1981; Kleinman 1980, 1988a, 1988b; Lewis 1981; Nichter 1989). Furthermore, there is a recognition of society's impact in shaping personal identity, subjective experience, and explanatory models (Good and Good 1981, Kleinman 1980, Kleinman et al. 1987). Good et al. (1985) proposed the meaning-centered approach as an epistemological and methodological means of exploring the experiences as lived and explained by people.

This thesis builds on this work by exploring how, when views about health and illness are translated into behaviors, these behaviors exhibit basic structural and cultural aspects of society. It is evident from the present research that the subjective experience of illness in Egypt is part of the overall subjective

experience of living in a particular where *mustawayaat* is considered a matter of common sense. These experiences are effectively naturalized by the relational milieu through which perceptions of identity and the body are produced (see also Scheper Hughes and Lock 1987, Lock 1988a, 1988b).

Interpretive medical anthropology's choice to focus on the illness and distress and the meanings attributed to them by individuals (Kleinman 1980,1988a; see Herzlich and Pierret 1986; Cobb and Hamera 1986; Kleinman and Good 1985b) reveals an inherent weakness. This approach routinely misses the political nuances of social relations and the structural conditions which produce disparities among belief systems. Moreover, this approach also often fails to account for structural foundations in the discrepancies in knowledge and power between lay people and professionals, and, as related in the following chapters, the structural and interpretive foundations of diversity within in-between groups.[5]

In contrast to the interpretive approach, Critical Medical Anthropology is informed by work on the political economy of health and colonialism (Morsy 1990a; e.g. Onoge 1975, Fanon 1978, Brown 1978, see Singer 1990a). Morsy (1979) identified the political economy of health as the missing link in Medical Anthropology. Singer writes that Critical Medical Anthropology addresses the

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[5] A positive note comes from Lock (1988a:4) who states that interpretive medical anthropology realizes that "interpretation itself is a product of particular historical and cultural determinants."

> ...shortcomings of conventional medical anthropology [including] microlevel circumscription, neglect of social relations, medicalization, and ecological reductionism.
> (Singer 1989:1193; see also Singer 1990a, 1990b; Baer et al. 1986)

Critical Medical Anthropology stemmed in part from a concern with international health issues concerning the relationship between the international economy, imperialism, local power relations, and people's health (e.g. Morsy 1979,1990a; Elling 1981; Baer 1986; Baer et al. 1986; Press 1990; Stebbins 1986; Singer 1986, 1989, 1990b).[6] These anthropologists strove to uncover the structural nature of inequalities in health. However, they met limited success in capturing the nuances of actual behavior within social categories.

Critical medical anthropologists also paid particular attention to social relations in the clinic (e.g. Baer 1989; Baer et al. 1986; Press 1990; Singer 1986, 1989, 1990a, 1992b; Lazarus and Pappas 1986). In chapter Six, the case will be made that during times of illness existing social relations in a society become exaggerated as they are manifested in differential access to biomedical resources (see for example Singer 1987, 1989; Pascall 1986; Morgan et al. 1985; Roberts 1981; Khattab and Kamal 1991; Turner 1987; Navarro 1986; Scully 1980; Rapp 1988; Singer et al. 1988; Hartmann 1987; Romito and Hovelaque 1987).

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[6] Seminal work in this area include Taussig's (1978) in Colombia, Aidoo's (1982) in Ghana, Laurell (1989), Laurell et al.'s (1977) in Mexico, Morsy's (1978a, 1978b, 1981) in Egypt, Turshen's (1977) in Tanzania, and Frankenberg's (1980). Writers in this area, however, are not strictly self-designated critical medical anthropologists.

Critical Medical Anthropology has been criticized for introducing to anthropology notions of world economy which are no longer current, failing to account for diversity among and within specific contexts, and not acknowledging the value of different theoretical approaches (Morgan 1987; see response by Baer 1990; reconciliation attempts by Singer 1990a, 1992a; and Singer et al. 1992). In chapter Four, some of these problems will be addressed by proposing at least three levels of contemporary analysis of social relations and their implications for well-being in Egypt.

Medical Anthropology of Egypt:

At the heart of the reorientation of Medical Anthropology has been a critical look at forms of societal stratification that control the pace, content, and outcome of social, cultural, economic and political change. Morsy has led the anthropological studies of Egypt and the Middle East in this direction. She has demonstrated how a change in social and health conditions is always a result of a struggle over culturally recognized sources of power and prestige (Morsy 1978b, 1993b). As modernity has come to prevail in Egypt, economic systems have changed, along with forms of social organization, identities, and cultural values that have themselves gone through a slow process of transformation (see Latouche 1989, Bhabha 1994 for similar arguments). Moreover, studying the influence of modernization in Egypt calls for an evaluation of change in relations of production and relations of social and cultural reproduction. However, few have succeeded in combining the interpretive and political and economic dimensions of *mustawayaat* and *fi'aat* and the interaction between local and global factors in naturalizing social differentiation in illness situations.

In this research, an historical approach has been undertaken following the invitation by Morsy (1993a, 1993b) and Gallagher (1990). The latter advocates interpreting the past "in terms of social relationships of power and domination" (Gallagher 1982:101). This research starts from their insistence on situating the politics of affinity within the locally shaped dynamics of modernity in relation to illness management.

However, as will become evident from this study, life strategies and experiences are also largely guided by internalized notions of social and physical identity, which are, in turn, linked to the larger social and cultural milieu. In agreement with Early (1993a), social categories are explored here not only as culturally shaped entities but also as sociopolitical entities. It will also be shown that, directly or indirectly, cultural values guide the stratified nature of decision-making about illness while adhering to the parameters of *mustawayaat*.

The inseparability of physical location, financial resources, social stratification, and well-being will be presented throughout this thesis. The neighborhood of Sayeda Zeinab, one of the oldest in Cairo, was the location where most of the subject matter of the thesis was investigated. It is also a location where many similarities with other locations in the Middle East exist. As in Yemen, for example, so in Sayeda Zeinab, increasingly, there is a widespread belief that:

> ...the greater the expense of the service or medication, the more efficacious it must be. Urban specialists who charge the highest consultation fees are known by name and their care is preferred.

> Health has become a commodity that one purchases rather than the result of a moderate lifestyle. (Myntti 1988:518)

Clearly, for patients and doctors of all social classes, notions of health, illness, and illness management dynamically connect perceptual and practical processes to social ideology. These notions are also specific to class and physical location. Aziza, a 28-year-old recently married female medical doctor from Sayeda Zeinab expressed her well-being in terms of mastery over life events. She said: "At my age, as a doctor and a future mother, *hayati lazim tikun mahsoubah sah,*" meaning "my life has to be rightly calculated." This is in contrast to Gamilah who is of the same age, but an uneducated housewife residing in Sayeda Zeinab, who said: "*Ana mish talbah hagah leyah wi li 'eialy gheir el satr,*" meaning "I ask for nothing for myself and my children except a shield or protection." The concept of *el satr* (shield)is a complex one with religious and non-religious connotations.

Gamilah was suggesting that what she is looking for is the protection provided by God against the evil eyes of people, including neighbors who live very close by. This should provide her with the means to eat, live and shelter away from the evils of other people. For her and many others, the world outside is more significant than the world inside her. This is in contrast with Aziza, the doctor, whose well-being is largely her personal responsibility, and who considers the physical world of Sayeda Zeinab too constraining for her to develop to her full capacity.

In other words, any study of illness and decision-making in Egypt must examine the pervasiveness of the stratified nature of cultural values linked to *mustawayaat*. To explore this complexity, there are two requirements: The first one is to expand the usual unit of analysis by which affiliation is studied beyond kinship (see chapters Three and Four). The second one is to factor into the equation the local and global economic and cultural variables which shapes decision-making about life in general and illness in particular (see chapters five and six).

Thus, culture, politics, individual and group decision-making in connection with illness are the focus of this research. The thesis involves the relational aspects of the politics of decision-making in illness. Decision-making and help-seeking behavior are the privileged areas of this research because they make two important revelations about society. First, these two areas reveal the dynamics of the relationship among individuals, groups, and institutional structures in society. Second, they have the potential to defuse the myth that health and illness related decisions are <u>either</u> a cultural process <u>or</u> a structural process. In addition, decision-making and health-seeking behavior are in themselves important because they have implications for the health status of people.

My interest here is to convey how the perceptions and behaviors of my informants reveal cultural values and internalized notions of social structures. Hence, this thesis is not about macro-politics, nor is it about micro- or infra-politics in Egypt; it is about how social relations and perceptions shape the nature of personal and group decisions in illness. It is about how every

life or illness management decision is not only a meaning-centered decision but also a political decision based on an intellectual and subjective internalization by individuals of a naturalized social hierarchy.

Decision-making and help-seeking behavior are explored specifically in relation to biomedicine. Early on in this research, it became clear that more than in other medical systems in modern Egypt, biomedicine has become a primary context for manifesting the *mustawayaat* in help-seeking behavior. Biomedical practice is the context which highlights the link between decision-making and the fundamental values of *mustawayaat* in society. Privileging biomedicine rather than concentrating on the many other types of medical systems in contemporary Egypt may also enhance our comprehension of the links between cultural values and institutions of modernity in everyday life in modern Egypt.

Section Two: Made-in-Egypt Modernity:

In Egyptian modernity (see below for my interpretation of this term), which started almost two centuries ago, benefits were always unequally distributed. Modernity, as a time of social uncertainty, revealed the need to emphasize social categorization (see Bourdieu 1984). Preexisting and emerging social distinctions made such differentiation possible and easier.[7] Two matters are certain: change is happening and the cost and benefits of Egyptian modernity are not randomly distributed. This also reflects the importance of a study of historical

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[7] According to recent studies, this is a situation not unique to Egypt or developing countries (Wilkinson 1996).

continuities and the cultural values underlying social organization as determinants of well-being. In other words, a mere cross-section of time, structure, and values is not sufficient.[8]

A contemporary study of Egyptian culture must then include a study of the historical-structural continuities between the past and present in social processes, including modernization. Egyptian modernity, as with other modernities, is a local version of modernity with the past and the present being engaged in an interactive process (see Armbrust 1996:7, see Jean and John Comaroff 1991). For these connections to be studied, this thesis builds on the work of many contemporary anthropologists who recognize the need for a theory to explain the interactive and dynamic nature of personal and groups' experiences in their historicized, structured and interpretive entirety (Lock 1993b, Young 1993, Comaroff 1988, Jean and John Comaroff 1991, 1993). Hence, modernity as a social condition contains interpretive and political aspects that display inter- and intra-social-category variations which are not fully captured in the current Medical Anthropology of the Middle East.

Concern with modernity in this thesis is logical and unavoidable. First, as an Egyptian, over the past thirty-five years I have previously been exposed to different variations on the theme of modernity. A socialist version turned into a liberal economics version; a collective vision turned into an individualized mission, with myself

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[8] Refer to Moghadam (1993:19-27) for an overview of the nature, diversity and implications of social change in Middle Eastern societies.

and others in all cases as the recipients of a political agenda. Second, modernity is a master trope in Egyptian politics, economics, social sciences, literature, and culture. It largely defines the goals of Egypt and Egyptians and is what defines our position on the global scale of well-being. Egyptian life is predicated upon a delicate tension and balance between being true to tradition and modernity.

To illustrate this point, we take the following example. This tension came to a head-on collision early in 1997 as the Egyptian authorities were forced by the media to intervene in what has become known as the "Devil Worshiping Case" (see e.g. Rashwan 1997:3). Whilst this could be the focus of another interesting thesis, I choose here to offer the following quote from a newspaper article:

> "Don't you know that you are violating God's ordinances by disfiguring His creation in this way [by a tatoo]?"
>
> The young man, who could have pointed out to his inquisitor that there are those, in this country and outside it, who would consider her make-up and dress a much more serious violation of what God has ordained, did not do so, however. While obviously baffled by the charge of "devil worshiping"...he was more than willing to concede having sinned on this and practically every other count.
>
> Self-styled arbiters of God's laws as interpreted by Egyptian officialdom, and more specifically Egyptian state television, the two inquisitors were thrown into total confusion, however, when the young prisoner insisted that not just "heavy metal"--which the Egyptian media and security bodies have uncovered as a fiendish plot to corrupt our youth and send them "head-banging" into the arms of Satan--but *all* music was sinful.
>
> In fact, the youth said, anything that diverts a person from invoking the name of God is sinful. "Who told you this?" the two TV

> authorities barked in unison. "The sheikhs." answered the young man after some hesitation. Torn between their initial response of firmly denying "such nonsense"--after all the mega-organisation has been damned in countless Friday sermons,during the past twenty years, as a principal source of sinfulness, licentiousness and immorality--and I suspect, the dawning recognition that 'the sheikhs' in question may have been the very same sheikhs whom the Interior Ministry had brought in to lecture the kids in prison, [this] to the two presenters this presented a comic sight.
>
> (Shukrallah 1997:9)

This rather lengthy quote is presented here, first to illustrate the multiplicity of institutions, social and political involved in the conflict between what is perceived as authenticity and modernity. Second, these conflicts not only occur at the social level but also at the personal level where contradictory social values are at once embodied and enacted, revealing the complex nature of modern Egypt. Third, this quote reveals the schism between many intellectuals and the state's institutions. But, probably most importantly, it reveals the struggle in Egypt to reach a made-in-Egypt formula of modernity--an endeavor that the Comaroffs say is possible and indeed inevitable in all geographical locations (see Jean and John Comaroff 1991).

Therefore, in this thesis modernity means an historical process of modernization that aligned and aligns Egypt with the European and wider Western way of life in economics, social organization, and the norms of rationalization and secularization. It is an historical process with contemporary continuities. It is also an historical process whose terms may have largely been set outside Egypt, but its current manifestation is as

Egyptian as can be. Egyptian modernity is a local experience, one of "many modernities" (Jean and John Comaroff 1993:xi). Like other modernities, it is a local adaptation of the West's "vehicles of moral economy" (Jean and John Comaroff 1991:9).

This thesis is informed by the stance that modernity is an interactive process between local and global forces, abd that it produces local versions of modernities (Jean and John Comaroff 1991, 1993; John and Jean Comaroff 1992, 1997; Appadurai 1996). The actual dynamics of interaction are postponed for a future project, while attention is focused on how social interaction and specific events reveal locality-specific versions of modernity (John and Jean Comaroff 1992). It is in the everyday practices that modernity is revealed (Jean and John Comaroff 1993:xvi). As will be shown in chapters Five and Six, in modern Egypt, even though change is steered by class relations and global interconnectedness, it is manifested in strategies employed by social groups to perceive and handle ill health in a particular way.[9]

Egyptians as Nationals:

Historically, the entwining of modernity and nationalism has come to shape institutional structures--formal,

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[9] The historical continuities of social organization and cultural beliefs infuse perception and practice of health and illness management. For example, Lock demonstrates how in Japan bodily experiences of both genders, of all ages, particularly those of women, are highly regulated--and medicalized--partly to realize national goals and a national identity (Lock 1985,1987b,1991,1992; see also Kaufert 1988). Social categorization between colonizer/colonized, high *mustawayaat*/low *mustawayaat*, bureaucrats/subjects, etc. create the moral standards of body normalcy and abnormalcy, and will be shown here to manifest themselves in local indigenous practices (see also Comaroff 1988).

informal, government, non-government, private--and personal decisions in illness. During the course of this research, it became evident that in Egypt the relationship between the state and the bodies of individual Egyptians has, especially in the past two centuries, been largely shaped by a national agenda of modernity (see Armbrust 1996). Even where non-governmental organizations are trying to make some inroads, they may actually block alternatives to the existing social order through the services they offer in place of or in tacit agreement with the government (see Salamon 1994:119, Morsy 1988a).

Modernity is what nations and individuals and groups in these nations make it out to be (Bhabha 1994). Citizenship and national affiliation in many locations in the Middle East are "experienced through communities" which shape the very nature of social and gender relations in society (Joseph 1993:24). Thus, a *mustawayaat* conception in Egypt derives its legitimacy partly from a national ethos of modernity. Rationalization of everyday life, illness, and ensuing decisions are often framed within the ethos of modernity. This ethos, however, translates in Egypt into an implicit and explicit class bias woven into the threads of social institutions such as health services and education (Richards and Waterbury 1990). Class differences and social categorization into *mustawayaat* are intimately related, as we will see later on.

This research will demonstrate that illness experience (or what will be termed later "illness practice") is indeed a cultural construction influenced by social class and cultural beliefs (J. Young 1980; Nichter 1981; Finkler 1986). As such it reproduces the social order

(see Foucault 1978, Bourdieu 1984). In the Egyptian case, modernity becomes the ideological frame for social practice.

Findings from this study are reminiscent of other work showing how human perceptions and actions embody the cultural values of the time and place where they exist; these, in turn, embody a larger ecological context. Lock observed that social and national ideology is encoded into the body and is revealed through human action (Lock 1985, 1987b, 1991, 1992). Latouche points out that modernity has produced the conditions for globalization through producing systems of economic and cultural uniformity (Latouche 1989). This is shown in more detail in chapters Five and Six, where it can be seen how institutions apparently work according to a national project which operates through infiltrating cultural values already present (Bhabha 1994).

In this thesis, I attempt to capture how the body has become the main focus of a political art of social differences whose basic tenets are not challenged by alternative forms of social relations. These relations are based on a social stratification of access to assets of control and social benefits. In this, I am informed by Scheper-Hughes and Lock (1987), who postulate the presence of three bodies: "phenomenally experienced individual body-self...a social body...and...as a body politic, an artifact of social and political control" (p6). In the present study, this view will be extended to demonstrate that management of ill-health is trapped within the confines of a modern stratified social and cultural order.

Section Three: Culture, Affiliation and Discrimination:

A deliberate choice has been made in this thesis to consider health and illness from a relational perspective. Conditions of life, health and illness are more than just corporeal states. Health is the articulation between an individual's biology and identity, collective authority, and the policy of the state--it is therefore a cultural construction constituted by perceived and subjectively experienced existing social realities (Eisenberg 1977, Young 1982, Frankenberg 1980, Morsy 1993b). Concepts of health, illness and disease are produced through sociocultural filters which control the allocation of these conditions and their labels in a given society. Hence, giving legitimacy to biological conditions as illness is a political process mediated through social relations. When investigated, these social relations will reveal the complex nature of social relations and cultural values that shape well-being and ill-being in any given society. The dynamics of decision-making become the outward manifestation of social affiliations and social interaction.

It will be argued that social affiliation in Egypt is more sophisticated and complex than Medical Anthropology has been able to reveal, with implications for the health and well-being of individuals. Hence, I will rely on more than just standard medical anthropological approaches in attempting to reveal aspects of the local *mustawayaat* formulation which influences the health conditions and illness management among of Egyptians.

Distinguished Social Interaction:

History did not produce cultural uniformity in Egypt. It is a truism that "increasingly, 'national' cultures are being produced from the perspective of disenfranchised minorities" (Bhabha 1994:5-6; see also Joseph 1993:24). In Egypt, the outcome of modernity is only as good as a person's capacity to distinguish and act in accordance with the parameters of *il mustawayaat* or *il fi'aat il igtima'eyah*.

To enact one's *mustawa* (social level or standard, *sing.*) resources are required. Whether material or relational, these resources are obtained through an historical negotiation articulating local knowledge embodying cultural values and social systems. Modernity has changed the nature of these resources in the West so that they have become more materialistic and tangible (Bourdieu 1984). In Egypt, these resources are the material resources promoted by modernity and the non-material and relational resources retained from the past that are reworked into the present. Historically, in Egypt, all resources are not equally accessible to all (Morsy 1993a, 1993b; Adams 1986; Sonbol 1991), and, themselves, fuel social differentiation. As a 32-year-old man from the Sayeda Zeinab district told me: "*lazim yib'aa 'andi haja 'alashan adafii' 'an nafsi wi 'an 'eyali*," ("I have to have something to defend myself and my children"). Egyptians recognize this simple rational formula: to become something you must already have something. This formula is fueled by both a preoccupation with *hadatha* (modernity) and *mustawayaat* in Egypt.

Traditional Egyptian capitalism which is kin-based is a form of dependency capitalism that also permeated other aspects of life, especially consumption patterns (Imam

1991:43). Subsequently, social and health care systems were based on a prevailing culture of social differentiation. Biomedicine became a convenient complement to social categorization. It is not too surprising that this is reflected in policies and services:

> The performance of basic health services is low as a result of the nature of health policies in Egypt. In the 1960s and 1970s, high priority was given to large-scale projects and the expansion of free health services for all, especially in rural areas. The policy neglected the provisions of low-cost access to small neighborhood health services for many people, particularly in rural areas. In addition, the Egyptian health system is largely curative and physician-oriented, despite the [nature] of the major health problems in the country. [Consequently,] For those who can afford it, the health service provided by the private sector is an alternative. But for the poor, low-quality public facilities are the only resort, especially given the increase in the costs of private health services. (INP 1995:53)

Yet, as Scott (1990), Browner (1989), and Altorki (1986) noted, the weak have their tools to challenge the status quo. The weak and the poor in Egypt consistently link wealth with emotional and ethical degradation "*nass bidun akhlaak aw qiyam aw muthul*" translating into: "people with no morals, values, or ideals." Inequality in access to material resources challenge a basic belief in the necessity of harmony between emotions and values. The only way to prove that material resources are not degrading to the person and society is to share them as widely as possible, fulfilling relational obligations that go beyond kin to include different levels of obligations to other groups of society. The *mustawayaat* determine not only access to resources but levels of obligations and their extent. As one of my informants said: "*Il mal yigib inhitaat akhlaki, illa iza il wahid*

'adah il wagib il igtima'i illi 'aleeh itigah il-akhareen," meaning "money brings ethical failure/degradation unless one performs his social duties towards others."

A Place for Capital Culture:

Medical Anthropology has not been attentive enough to place and space as a form of capital that shapes the health conditions of a people; there is, however, some acknowledgment of the relation between locality and disease occurrences, hierarchy of resort, perceptions, and medical resources in anthropological and epidemiological studies (e.g. Lane and Meleis 1991, Lane and Millar 1987; Lane et al. 1993; Inhorn and Brown 1990; Inhorn and Buss 1993; Armstrong 1988). In this literature, "place" is a concept whose meaning lies in its direct role in shaping health status. In this thesis, space, it will be shown, works in much more nuanced ways. It is the primary site of the "'scopic regimes' of modernity" requiring "spatialisation of critical enquiry" (Gregory et al. 1994:8). In other words, space is explored as the embodiment of sometimes competing and sometimes complementary value systems that inform the strategies of survival or oppression experienced by different actors.

Based on this conception, space is considered a social commodity that is not equally accessible in size or quality to different social groups in Egyptian society. Like other commodities, it is not universally accessible, but its inherent value is based on existing shared values. As a form of capital, place shapes availability and access to other resources that influence well-being in general, not only health and illness conditions (see chapter Six). Yet, with interest in both meaning and

critical enquiry, it is surprising that "there has apparently been very little corresponding curiosity about what aspects of the social, cultural, or economic environment might contribute to area variations in health" (Macintyre et al. 1993:217). Space, then, is a social milieu where relations have implications for health and illness occurrence and practice.

The concept of area is also closely linked to the concept of "place", which is "one of the most multi-layered and multi-purpose words in our language" (Harvey 1993:4). Its physical and metaphorical connotations are only made more complex by its link to personal and communal identities which, despite heterogeneity, "can nevertheless be forged through a 'sense of place'" (Asthana 1996:10). Place is at once physical, social, and cognitive.

Chapters Five and Six deal with some of these nuances of social systems, cultural values, area, capital, and resources, well-being, health and illness. The connection among these elements is clearly present in Egypt, even if not fully explored, as reported by Morsy:

> ...it is evident that for the people of FatiHa, the proper functioning of the body is not independent of its surroundings. Illness causation, which is given primary emphasis in diagnosis, is defined in terms of body-environment interactions. The body is perceived as a complex, mysterious reservoir which apprehends and experiences the effects of the natural, supernatural, and social environments of an individual. (Morsy 1980:93)

The present thesis builds on Morsy's conclusions by showing that situationally determined treatment and management of illness conditions reveal personal perceptions about the body and the location of the person in the social context (see chapter Five). More

specifically, the focus here is on the dynamic factors which influence the relationship between the person and the social environment, and its implications on his/her choices of illness management. Area relationships, like other forms of capital, provide the pretext, the 'site' where ideology meets perception and interpretation. Health and illness, whether considered from an interpretive or a political economy perspective, may not be completely understood without grasping these relationships.

But, where does one start to study modernization in health, culture, economics, and politics in Egypt? In order to accomplish this with any success, one must deal first with two fundamental social and cultural institutions: religion and medical care in Egypt.

Religious Directions:

In Egyptian modernity there is a tension about the extent to which Egyptians should embrace the principles of religion--Islam or Christianity--in everyday life. Since this question is unlikely to be resolved in the near future, I have chosen a different approach to this topic that is more relevant for the purposes of this research.

Religion provides a basic framework for cultural values which Egyptians know about and to a varying degree, live by. Because these values have become so integrated into everyday Egyptian life, I argue that it is impossible to separate religion and culture. For example, in Egypt, the concepts of *kheir* (good), *sharr* (evil), *yamin* (right), *yassar* (left), *el satr* (shield or protection), institutions such as *usrah* (family), *ummah* (nation), and figures such as *qa'id* (leader) all have religious and secular connotations which people fuse together. This

fusion, in itself, is predicated on relevant social categories. The example of the concept *el satr* mentioned earlier is a case in point. For the two women of the two social classes, the word for shelter and shielding has a different meaning. For the lower-class woman it has more of a religious connotation where her conditions and good deeds, even if not enough, should grant her thanks to Allah, a shelter from want and exploitive people. For the upper class woman, it is her own plans which, when pursued faithfully, will result in her being rewarded by the better social position to which she aspires. In both cases the religious connotations have become entwined with traditional and ideological connotations.

Second, I choose not to follow the over-simplified argument that oppression of weaker members of Middle Eastern societies is rooted in the paternalistic and patriarchal nature of Islam. As Moghadam notes: "Islam is neither more or less patriarchal than the other major religions. Moreover, Islam is experienced, practiced, and interpreted quite differently over time and space" (1993:8). There is plenty of literature to attest to the unfair portrayal of Islam and that these views are Western constructs (e.g. Said 1978, Moghadam 1993, Hassan 1997). I choose to argue that social relations are lived and produced by a combination of a moral and political-economic ideology of which religion is one element, not *the* element. As Fahim notes, for example:

> This process of Islamization [or displaced Nubians], then, appears to be closely interrelated with modernization...[religion] is being promoted to promote the notion of integration among the three Nubian ethnic groups...and to promote the necessity for their assimilation to the neighboring non-Nubian groups.
>
> (Fahim 1985:465)

In other words, social relations are not dependent on religion outside its effective interaction with social ideologies.

Third, the focus of this research is on how biomedical care is linked to and asserts the cultural value of *mustawayaat*. It has been pointed out that in Egypt even the new "Islamization of medicine" is a vehicle for sharing the power of the state, rather than an alternative medical system (Morsy 1988a). It is a case of "cultural elaboration of global hegemonic biomedicine and a culturally appropriate mode of preserving health care as a component of the state-controlled welfare package" (Morsy 1988a:366). The concern here is with this articulation of medicine, state systems, and ideology, which both subsumes and is informed by theological and cultural values.

In other words, focusing on social relations as predetermined by religion *per se* blocks the study of other relations produced by social and national ideologies and perpetuates orientalism (see Said 1978). It also becomes an impediment to study the embeddedness of cultural-ideological structures, political-legal structures, and economic systems within social institutions in the modern Middle East and Egypt (Moghadam 1993).

Rather, the emphasis should be on the interaction between cultural values of affiliation--which have a vast domain in both Islam and Christianity in Egypt--and the ideology of civilizational social change (see Wilkinson 1996:211-232; also Ibrahim et al. 1996: 34-35). Accordingly, the focus shifts from questioning whether people are religious or not, or how much their actions manifest

their religiosity, to a question of: given the moral and political economy of Egypt, how is life experienced and illness managed?

Civilization, Mustawayaat and Illness:

Tahadur (civilizing), *hadatha* (modernity), *hadaari* (civilized), and *hadith* (modern) have all become terms of value judgment in Egypt. As is true elsewhere, these terms have come to mark categories of a hierarchized social distinction (see Pinell 1996, Jean and John Comaroff 1991:15). When the city of Cairo puts up a sign in one of the largest central squares reading "*Mashru' Dawraat Myah Hadaareyeh,*" meaning "The Project of Civilized Water Closets," this should not be mistaken as anything less than a civilizing process of modernization which creates the social standards and cultural values for all of Egypt and Egyptians.

The same applies to government hospitals and non-governmental organizations' medical facilities. For example, it is a very common occurrence to read in the newspaper information such as the following: The Minister of Health promises: "40 million Egyptian pounds to make a 'civilizational leap' in hospitals of mental health" (M. Zayed 1997:9). Clearly, the W.C.s are one element of an internalized value of modernity which asserts the nature of a symbolic and instrumental relationship between the state and the people; between individual people and groups; and between the state, the people and the outside world, as will be explained in chapter Six. As Latouche observes, the project of civilization *is* the project of modernization *is* a global project (Latouche 1989).

The link between science, state ideology, and people's health is well documented (e.g. Foucault 1973, 1978; Lock 1988a, 1991; Fox 1990; Pinell 1996). This link is internalized to varying degrees among the *fi'aat il igtima'eyah* in Egypt through explicit and implicit policies which contribute to shaping cultural values. When the government promotes or turns a blind eye to the mushrooming of the private/non-governmental sector in health care in Egypt, it admits to the failure of its modernization project of the 1950s and the 1960s. The government is, in fact, clearly promoting a different kind of modernity, in which care of the self is left to individuals and social groups who, as it was pointed out earlier, lack the political means to challenge the fundamental social causes of illness. In a government hospital, one informant said:

> ...they asked me to bring from the needle to the rocket [meaning everything]...I have to give the nurse LE 2 everyday [US$ 0.60] in order to change my sheet and to bring me my food.

Another woman lamented:

> After three hours of waiting in the emergency room when we started asking if someone will ever come to examine our patient, the doctor came screaming at us saying 'You must thank God that we even allowed you here.'

Finally, another young man said:

> I am here [in the public hospital] awaiting my operation...I do errands all day for the other patients, otherwise no one cares for them. I buy their medication and other supplies ordered by the doctor or the nurse. I do some shopping for food and fruits for them. I follow up on the time of their medication...I do not know who will do all of that for them and for me after I have my operation.

Biomedicine qua modernity is nothing less than a new context for the practice of social discrimination among different *fi'aat*. The mechanisms and institutions of modernity have contributed to linking illness and illness management with the social location of individuals. This practice has become so accepted that it is taken as a cultural destiny by patients and their families. Healing, then, does not "derive straightforwardly from medical beliefs, without regard to the dynamics of health care" (Morsy 1981:160).

Consequently, it is clear in "modern, civilized" Egypt that "the 'patient of today'... must be a medical auxiliary trained to take part in his own medical care" (Pinell 1996:14). However, in Egypt patients are and continually become part of social networks. Patients do not have to be active only in their own health care, but in the care of others, even if only temporarily. In Egypt, a patient, according to her/his *mustawa* has to be a diagnostician, healer, carer, financier, and negotiator, as can be seen in chapters Three and Four. in In a climate of restrained channels of official affiliation these networks reaffirm a group's social and cultural inferiority, while simultaneously reaffirming that modernity in Egypt is in accordance with *mustawayaat*. Inequality then is not only a social process, it is also a political and a psychosocial process:

> ...the psychosocial processes around inequality, social cohesion and its effect on health are overwhelmingly important. They are not important only from the point of view of those low down the social scale who suffer them most, but also because the deterioration of public life, the loss of a sense of community...are fundamentally important. (Wilkinson 1996:215)

The following chapters will expound the historical and economic perspectives necessary to situate the forms and meaning of social interaction in connection with health care in context. The interface of culture and modernity in its symbolic and economic forms is an underlying theme throughout this research. But, for now, I will turn to a brief overview of the Egyptian medical system.

Section Four: Egypt's Bitter Pills:

Egypt's population exceeds 60 million with about 44% urban residents (MOH 1994a). In 1991, life expectancy at birth for males was 62.9 years and for females 66.4 years (MOH 1994a). The leading cause of morbidity among males is accidents, violence, and poisoning (28.2%), followed by diseases of the digestive system (20.6%. With females, the leading causes of morbidity are pregnancy, labor, and postnatal complications (35.1%), followed by diseases of the digestive system (14.2%) (MOH 1994a). The total fertility rate (TFR) declined from 5.3 children in 1980 to 3.6 children as a national average and 3.01 children in urban areas in 1995 (NPC 1995). On average, married women of 15-49 years who are current users of family planning in Egypt have increased from 56% in 1988 to 58.1% in 1995; but in Cairo use has decreased from 58.9% to 56.9% in the same period (NPC 1995).

In 1994, it was estimated that the Ministry of Health provided 59.2% of the total number of hospital beds (MOH 1994a). Hospital beds are 2.3/1000 population in urban areas compared to 1.2/1000 as a national average and 0.3/1000 in rural areas. On the national level, for every 10,000 population, there is an average of 19.6 doctors and 19.6 nurses, nursing assistants, and midwives. On the level of the Ministry of Health there exist 9.1

doctors/10,000 population, compared to 10.2/10,000 nurses and assistants (MOH 1994a).

Despite a wide discrepancy in access and utilization of health care services, for most Egyptians illness practice comprises a diversity of services and systems used synchronically and diachronically (e.g. Morsy 1981, 1993b; Gran 1979; Jagailloux 1986; Early 1982, 1988; Inhorn 1994). Herbal medicine, popular techniques, and chemical concoctions are used simultaneously. However, over the past two decades, the use of herbal medicine, as with modern medications, has been infused with cultural values directly relating to the ill person, his/her environment, his/her status, and the status of the practitioners. In other words, the practice of healing has taken on the cultural patterns of social distinction.

For example, people from different *mustawayaat* may drink cumin for their stomach discomfort or tie a band with a knot with a lime around their forehead for headaches. They may seek or receive advice from their social network about lay or biomedical treatments. People may give advice about treatment based on popular lay (folk or biomedical) knowledge without realizing that they are jumping between medical systems or combining different spheres of knowledge (see also Leslie 1980).

However, this unity is somewhat misleading. For example, now with the establishment of several herbal manufacturing companies that present their products directly to the public and medical professionals, the practice of natural herbal healing has taken on the coloration of social discrimination. It is no longer a case of healing by integrating sociomoral bonds with medical knowledge (see Gran 1979). As in the case of

Japan, as "traditional medicine has entered the world of big business" (Lock 1987a:7), the higher *mustawayaat* in Egypt are more readily using traditional medicine by buying modern packaged products. The higher *mustawayaat* people buy prepackaged products more than unprocessed products from herbalists because they believe these products to be more hygienic and "natural." This behavior is contrasted with that of the lower *mustawayaat* who willingly accept easily obtainable unrefined medications because these medications are all they can afford financially, and because they are not treated disrespectfully. The poor can only afford to buy herbs from the herbalist, not from the pharmacy or the grocery store where the *fi'aat il qadirah* (financially able social categories) are increasingly buying them.[10] This should not come as a complete surprise:

> ...class structure...generates different cultures of which medical philosophies are a part. Periphery capitalism in the Arab world can simultaneously support, in changing historical relationships, allopathic medicine for a ruling group, holistic medicine for the middle classes, and homeopathic medicine for the lower classes.
>
> (Gran 1979:346)

The historical social differentiation in medical care is further reflected in the current shape of biomedical practice in Egypt where the location a person goes indicates his/her status and that of his/her social network (see chapters Five and Six). This is partly a

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[10] Terms such as "the poor" are used here to refer to the groups of socially and economically disadvantaged in Egyptian society. It is not used to denote any homogeneity or uniformity in life conditions or interests or choices among this group. The term is used as a shorthand to refer to a complex social and cultural collectivity.

result of the presence of at least three health care systems in Egypt (see below), in addition to the sphere of lay or folk medicine. To start with, Egyptians do not perceive a value hierarchy in folk medicine. In other words, being treated by a Koranic healer, or herbalist or folk techniques, all carry more or less the same cultural value. Folk medicine, then, like folk illnesses and culture-bound syndromes such as spirit possession, create a form of common identification, particularly in stressful situations (Boddy 1989, Constantinides 1982, Press 1978, Hahn 1985, Uzzell 1974, Lock 1990, Rubel et al. 1985, Rubel 1977). On the other hand, as we will see, biomedical treatment is another story.

Biomedicine, Ideology, and Order:

There is great pluralism in biomedical health care services in Egypt. And yet, managing illness is not simply a matter of autonomy and choice (Browner 1993), it is also a matter of access to and quality of health services available in a given location. First, in Egypt there is the sphere of private medicine in the form of private clinics and private hospitals, which are mostly centered in Cairo and to some extent in Alexandria. There is also the public health system which is nominally free, but in reality is of very dubious efficiency, and is in fact not free. Additionally, there is the non-governmental organizations' (NGO) sector consisting largely of a very large number of small hospitals or outpatient clinics. In the NGO sector, people expect to pay less than at private facilities but get a better quality of treatment than at government hospitals. Finally, there is the health insurance sector which up to now benefits government civil servants, factory workers, and school children, and some segments of the private sector. In addition to the reasons mentioned earlier, the

focus of current research on biomedical health care is, on the one hand, due to its widescale availability and popularity in Egypt. On the other hand, this can be attributed to the frequency and quality of biomedical encounters and care which are more dependent on financial affordability than traditional medicine (Nichter 1989). Furthermore, the use of both traditional and biomedical services in combination is widespread in Egypt.

In Egypt, public health care is theoretically available to all at no cost through the facilities of the Ministry of Health or the Ministry of Education, which provide primary, secondary and tertiary care. People are free to seek care at any facility on any level. In reality, such freedom is compromised by constricted access to good quality services and affordability. In Egypt, the quality of public health care has been deteriorating steadily for at least the past two decades (Al-Arishi 1992:7). It has become an institution lacking in care and concern about the dignity of patients where one loses both time and money (see Morsy 1993b).

Most Egyptians during the late nineteenth century became familiar with modern medicine (Gallagher 1990). The advance of biomedicine in Egypt at that time and in the early part of the Twentieth Century was intertwined with the agenda of nationalism and sentiments opposed to the British occupation (Gallagher 1990).[11] In the 1930s,

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[11] After the declaration of Egypt as a kingdom independent of Turkey and Britain by King Fouad in 1922, a movement in civil society flourished. The results included the establishment and enlargement of the medical facilities of multiple hospitals, initially by an Egyptian Christian Coptic association, then later by other civil associations (see Gallagher 1990). These associations demonstrated the need and

(continued...)

apart from a few small government hospitals, the Kasr El Aini Hospital in Cairo was the only major public biomedical center in Egypt (see chapter Six). Early in the Twentieth Century, improvements in public health facilities by the Department of Public Health were instituted. However, "most of the better hospitals were...privately owned" (Gallagher 1990:10). Thus, not only has private health care been available alongside the four decades old public health care system (Dalton et al. 1982, Richmond and Norris 1988), it has also in reality been available for much longer.

In most cases, social status, status within the household, affordability, accessibility and quality of care determine which sector is contacted during times of illness (see Morsy 1993b). The dynamics of these determinants take a different shape under different economic environments, but in all cases the underlying value system remains the same: "current attempts to 'upgrade' health services in Egypt have been influenced by the so-called 'developed country model'" (Morsy 1988:364). In other words, the value of modernity, which underlined the introduction of biomedicine into Egypt, is now also expressed in a linear development discourse. Thus, cultural values are reproduced which further assert overt and covert modes of social discrimination.

For example, the private sector is heavily subsidized indirectly by the government in terms of public medical schooling, subsidized medications, and the employment of all physicians by the government (Dalton et al. 1982).

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[11](...continued)
usefulness of their role in public health during times of epidemics (see Gallagher 1990).

This represents a considerable conflict of interest (Richmond and Norris 1988), further entrenching and naturalizing systems of social discrimination. Furthermore, the private sector, relied on heavily by many people (Richmond and Norris 1988), is no longer in the financial reach of the majority:

> Private hospitals, and particularly those established within the framework of investment legislation, remain off limits to people living on fixed incomes and unable to raise their income in proportion to the soaring inflation rate.
>
> (Morsy 1988a:361)

In the estimation of the Egyptian Ministry of Health, in current prices the per capita expenditure on health has increased from LE 1.83 in 1975 to LE 9.47 in 1987-1988 (MOH 1987). Personal expenditure on health in Egypt represents 55% of the total national expenditure on health, 90% of which is expended in private clinics and health centers, where two thirds of this amount is spent on medications (Berman et al. forthcoming). Simply put, those who can afford private care or what has become known as *'ilag iktissadi* (economical treatment) in public biomedical facilities have to use funds from other budget items, and those who cannot do so have to forgo medical treatment, or accept the low quality of public health services. In government hospitals, the *'ilag il-iktissadi* schemes have been introduced visibly since the late 1980s. This means treatment at a cost according to degrees of services (First, Economical, and Regular). Accordingly, the Egyptian biomedical services have become more commodified according to market economy principles in all types of health care services (Zaki 1995:12). These medical services have become a playground for "the typically non-moral interaction between cosmopolitan

practitioner and patient in a market economy" (Nichter 1989:227).

In an advertisement of a private hospital, not only the treatment is costly, it is also stratified, and placed in value terms Egyptians understand and live by:

> The Mother's Hospital is privileged to provide the lowest prices for the best services:
> *Excellent First Class Natural [Delivery] LE 450 [US$ 132]
> *Excellent First Class Caesarian [Delivery] LE 950 [US$ 279]
> *First Class Natural [Delivery] LE 400 [US$ 118]
> *First Class Caesarian [Delivery] LE 850 [US$ 250]
> *Shared First Class Natural [Delivery] LE 280 [US$ 82]
> *Shared First Class Caesarian [Delivery] LE 590 [US$ 174]
> *Economical Degree Natural [Delivery] LE 350 [US$ 103]
> *Economical Degree Caesarian [Delivery] LE 750 [US$ 221]...
> (*Al Wafd* 1996b:1, my translation)

Health care follows a logic of *mustawayaat*. Biomedicine in modern Egypt has not stopped at medicalization. It continuously reasserts itself and is reasserted by its intertwining with social categorization. The practice of medicine, then, is a "reflection of the organization and values of society at large" (Lock 1987a:7). Riad, a 34-year-old man from Sayeda Zeinab said:

> When my sister had her accident, they took her to [a public hospital], but we went and got her out of there. This was no place for us, but you know when we took her to another private hospital, they wanted a down payment of LE 1500 [US$ 441], in addition to LE 120 [US $ 35] for every day at the hospital. We could not afford this, both my father and my mother together make about LE 350 a month [US$ 103]. So we took her to a smaller hospital attached to the mosque. My mother had to sell all her gold and take off from work for six months till my sister was able to move...In Egypt if you do not have money, do not get sick; and if you get sick, go somewhere that fits your means *('ala 'ad haalak)*.

The inability of the government to adequately finance the rising health care needs of the population and the existing systems of social discrimination have permitted the development of inequalities in health care services in Egypt. Ultimately, the locus of the public/private health care debate in Egypt should be about how their co-existence naturalizes the forms and systems of discrimination and distinction already present in society.

With severe illness conditions, people would do their best to raise enough funds to shift to a higher (cost) level of health care. But, in general, using any of these services carries with it a cultural value judged according to its level of modernity and potential to contribute to perceptions of social status. A 22-year-old university student told me:

> When I had my hernia operation I could have gone to the Student's Hospital and had it for free; but, you know, we [the family] agreed that I go to that small hospital attached to the mosque on the main street. The Student's Hospital is for the *ghalaabah* [poor, defeated].

As it is elsewhere, income and sociocultural (as well as economic) resource mobilization is a crucial factor in the utilization of health services (see Haddad and Fournier 1995). It is a market model which one doctor sums up by saying: "No physician is unaware of his market value. You will get the treatment you pay for" (quoted in Hassanin 1991:14).

Pharmaceuticalization:

Egypt is no exception to a worldwide trend of "pharmaceuticalization" (Nichter 1989:238; see Myntti 1988, Nichter and Vuckovic 1994), that has become a tool in reaffirming social categorization. "Illness

identities" (Nichter and Vuckovic 1994:293), have become linked with long lists of medications, or as Egyptians say "*rushitah wish wi dahr,*" meaning "a prescription sheet full front and back," including expensive ones, even if these medications are unaffordable.

During this research, it became evident that medication serves to reaffirm social discrimination: the quantity and quality of what one takes reveals the relationship with modern and traditional values--how "'modern' and 'traditional' values may be embodied and communicated" (Nichter and Vuckovic 1994:288). As Amaal recounted angrily to me what she had told her husband's family about their interference in her marital life:

> These *mutakhaliffin* [not modern, backward individuals], they do not understand. I have to take four medicines, some capsules and some tablets, just to be able to open my eyes and go to my work to support this family. They live in their huts in the village and think food falls from the sky.

Medication came to contribute to the authenticity of her identity and claim to privacy. For medication to function as a moral agent, there is no need in many cases even to go to the doctor, or to complete the whole course of medication, or to worry whether the medications are working on the cause or on the symptoms. The source of legitimacy is not only the doctor. Legitimacy comes through the use of the tools of biomedicine in the person's social context. Probably of more importance, self-medication points to the symbiotic relation between social ideology and illness practice.[12] While the

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[12] Self medication, as elsewhere, is not without physical danger, even if it helps heal cognitive and social dissonance (see van der Geest and Hardon 1990).

practice of professional and self-'pharmaceuticalization' is not examined in the following chapters, it is raised here to point out the potential for research into the implications of social discrimination through the influence and use of biomedical tools and services.

Section Five: An Egyptian Researcher:

At times during fieldwork I was grateful that my life bore so many similarities to that of the people I came to know. I often wondered if, as an Egyptian, I should do more than 'study' my fellow Egyptians. It was remarkable to imagine that I could step back out of their lives into mine. These feelings were never resolved; and I suspect they never will be. But these feelings were simplified when later I found out that in fact I could not step out of the life of these people. With many of them, I had developed an emotional bond that made it impossible to dissociate myself socially or intellectually from their world. The world of my informants had become mine just as mine had become theirs. They wanted me to know all about them as they wanted to know all about me.

However, one thing became clear, when I was with those who had accepted me, I was subjected to many questions which would help determine important matters in Egyptian daily life. Of crucial importance in this regard were my social standing and my ethical stances in relation to concerns about matters of everyday life including matters of health and illness.

It did not matter how hard I downplayed my social background and profession as a medical doctor--these attributes haunted me throughout the process. All aspects of my identity were continuously asserted in spite of my

continuing attempts to be one of 'them', with my informants. This allowed the people to expect from me something normally unobtainable. Being a doctor meant that I had to always be in a position to give. It took a long time for people to accept that I was not there to give them something every time I saw them. Being a doctor meant that I had what they did not have in knowledge or money. It was a case of expecting extra reciprocity or, at times, even one-sided giving.

The interaction became a case of "I do not experience your experience [but] paradoxically, your experience is *made* mine; I experience my experience of you" (Kapferer 1986:189). Even though I was a native, my informants did not want me to get too native: they liked having me from the outside, as a link or a spy or an ambassador to the outside world. Even though I was a social researcher, my informants liked my medical credentials more. They related their medical problems much more easily than their social problems. More specifically, they found it easier to relate to the certainty that a drug or a doctor's diagnosis would bring them than to relate to a diagnosis of their social ailments. In other words, my informants brought me back to square one. I was where I had left off when I turned my back on clinical medicine. I was back to making diagnoses of biological conditions for which my informants' desire was to receive a label and medication. Many times I was forced into the mold, in spite of my best intentions and my ten years of studying and working on the social aspects of health and illness.

Arab Women in the Field and related studies comprise a welcome contribution in the study of how indigenousness is operative through the culturally salient values of gender, class, education (Altorki and El-Solh 1988), age

and kinship (Altorki 1985, 1988; L. Abu-Lughod 1988), motherhood (Morsy 1988b), ethnicity (Shami 1988), and religious affiliation (L. Abu-Lughod 1988). Hence, indigenousness works in combination with the "situational context" (El-Solh 1988). In the field, relations are a form of "intersubjective construction of liminal modes of communication" (Rabinow 1977:155). In my case, indigenousness helped my informants to relate to me with trust, once past the occasional initial suspicion. It helped me to build more self-confidence in my questioning and interpretations. The more I related my indigenous self to their experiences, the more all of our lives made sense. Matters such as playing sports in the street or a private club, being beaten up by a teacher in a public school or not, drinking dirty tap water or not were all relational experiences; their/our indigenous experiences forced us to look closer at "our" Egyptianness.

The interest of my informants in confirming my social standing was also a prerequisite to asserting my moral stance towards their problems. If I was one of them, I could not be of much help. But if I was sympathetic to them, and of a distinct social standing, then perhaps I could become beneficial to them. This is somewhat similar to what Good notes:

> When carrying out our research in Iran in the 1970s, we could only enter religious discourse as potential converts, participate in political discourse by assuming some position in relation to the Shah's struggle for legitimacy as well as the religious and secular resistance to his rule, or engage in medical discourse as potential actors. (Good 1994:23)

This 'positioning' is intertwined with the belief system of my informants. It is natural for them to try to position me socially and emotionally as part of their

everyday practice of social distinction. I belonged somewhere else, but this did not mean that I was useless or not sympathetic.

As human beings and as anthropologists, each of us has a personal, professional and relational history which, wittingly or unwittingly, informs us what we do in the field or in academia. When I was with a 60-year-old woman whose children abandoned her "because of their wives," I could not help but sense the bitterness of growing old and being lonely in Cairo, compared to the ageing of others who are more securely in the emotional and/or financial care of their offspring. I could not help but think of the cruelty of the offspring and the potential for their punishment in the other life. Closer to home, I could not help but think of my own mother and my aunts, in their late sixties and seventies, whose loved offspring are very much part of their lives. For them, and for myself, abandonment is an ultimate sin which brings shame, physical deterioration, and demoralization to everyone involved.

These might or might not differ from the impressions of other Egyptian anthropologists. But it is probably different from what a Western anthropologist would experience. For myself, the old woman touched me personally. She embodied my internalized values and inner feelings. For myself to abandon my mother, or for any mother to be abandoned, is unthinkable, even for a happy marriage.

Ideally, these incidents should tell us as much about ourselves as about other people, about us not as natural rational arbitrators, but as culturally irrational products of a particular social setting:

> ...reflexivity demands not only an adequate critical understanding of oneself through all phases of research, but ultimately such an understanding of one's own society as well.
>
> (Marcus and Fischer 1986:109-110)

Reflexive anthropology is of interest only if it reveals more of the social context of knowledge production or the cultural categories of the researched people. In the present research, it became clear that the analysis of the role of the researcher needs to be and can be more sophisticated than is currently the case. It became necessary and possible to add to the conventional categories of gender, class, age, and education by studying their interaction and meaning in the everyday life of the researcher and that of the researched.

Due to my social and background and training as a physician, my thinking had developed to comprehend the world in a particular linear manner. Life was a linear process where what happens tomorrow is the result of today's actions. The responsibility was mine and time is linear. This contrasted with the conception of many of my informants for whom life is a perpetual cycle of experiences and events which are outside their control. The certainty I was taught at my medical school was not entirely erased by my education in the social sciences. Many times I found myself engaged in conversations which revealed the oddity of my linear thinking and personal volition. In these and other instances I learned that as a native, my world as a doctor and my *mustawa* were only tangentially similar to the world of most of my informants.

I am hesitant to endorse the claim that only women can study sex-segregated societies (Altorki and El-Solh 1988;

Altorki 1985,1988; see Adams 1986). First, the degree of sex-segregation in the Arab world is extremely varied (Altorki and El-Solh 1988; Mernissi 1987[1975]). Second, the 'status' of women ethnographers *may* allow easier access by them to the world of men (Morsy 1988, El-Solh 1988, L. Abu-Lughod 1988, cf. Wikan 1980). Both these positions are incompatible with the shortage of anthropological studies of Arab men or of both genders (exceptions: N. El Messiri 1977, S. El Messiri 1978a). A shift has occurred from the past's man-made ethnography (see Morsy 1988b), which has come along with the "indigenization of scholarship" (L. Abu Lughod 1989:293).

However, probably this shift needs to be supplemented by more sophisticated ways of looking at social relations during fieldwork. For example, while most Egyptian men are not versed in the arts of cooking and housekeeping, my years of living and studying away from my kin's house meant that I had to acquire some such experiences. Food shopping, cooking, housekeeping tips were frequently the topic of conversation with women, with the men being more interested in the sense of independence that comes with such skills. In some ways, I had crossed my gender parameter as an Egyptian man. This has challenged some of my informants' deeply held social assumptions, and in turn challenged my own assumptions about gender and fieldwork in anthropology. This also challenged my own gender and social status. In fieldwork, inadvertently, we cross many social and gender boundaries. This means that there needs to be a deeper analysis of the subcategories constituting the identity of the researcher and the researched which go beyond indigenousness, gender, or class.

An example of this is the difference in taste and aesthetics in everyday living, and how it affects the context and outcome of interaction in the research process. This is probably made even more interesting when the researcher is from the same place as the researched. In this research, for example, even though I had a great interest in social interaction and social relations, I found it very difficult to overcome my discomfort and claustrophobia in overcrowded places, which would be one ideal site for studying social interaction. Hence, there is not much information in this thesis on interactions among large groups of people, for example the birthday celebrations of holy persons (*moulids*), which are sites of intensive social interaction. Mingling with thousands of people was not what I considered an option for me.

Where does this leave the anthropologist in terms of making moral judgments, acting on them, and constructing his or her knowledge based on them? In some circumstances I was aware of some of the harm as well as of the cultural basis for making moral judgments. I found myself several times in the middle of a "typical" story in Egypt: husband beats wife, wife takes money from husband's pocket and/or hides information from him or manipulates the children to dislike their father. Each disputant tells me their story and tries to bring me over to his/her side. Each is trying to win points at the other's expense through me when I disapprove of the behavior of their partner. Before jumping onto high moral ground, I had to situate these people in their context, and myself in my context. They are a family, one which has been going through disputes for a decade since they were married. They have children; neither of them is able to support the family without the help of the other; both are probably victims of a culture of defeat. Is it not a

problem to try to do something that will keep them together for the sake of the family and the children? Is it morally right to side with one and not the other? Are you siding with one in order not to offend him or her because he or she is one of your principal informants? Is it not problematic to be in the middle of this situation as an anthropologist from that same culture? However, this is not the worst scenario that a single eligible anthropologist can meet, especially in his or her own culture. Attempts of match-making abound, as do, to a lesser extent, flirtations.

As anthropologists, our presence inevitably alters the map of power wherever we are in the field. This could be due to our access to knowledge, contacts, being outsiders, having a certain hair color, the objects we possess, or any of these put together. Communities and cultures have in their fabric power structures always in need of reemphasizing or challenging. Our presence provides a stimulus and a tool for this to happen, either on the micro level of the family, or the meso level of small communities, or the macro level of national politics or international relations. If we sit back and romanticize our presence in local communities, we are severely mistaken. Being modest and low-key, going native, keeping neutral, and so on are all different ways of maintaining our illusion that we are flies on the wall.

It is my contention that understanding a society is made more difficult when the researched society is one's own. This was manifested in my level of discomfort in probing people to tell stories about their lives. I suspect this is because Egypt is a society where questioning is discouraged. Gossip is an accepted social behavior, but

questioning is an antisocial behavior that Egyptian children are raised to avoid. It is somewhat shameful to be curious. It is disrespectful to try to inquire about the nature or dynamics of social relationships, and it is a problem if one does not take sides. All this is even more true when it comes to questioning figures whose social authority comes from their age, class, or professional position.

How in such an atmosphere could anyone come up with questions and answers and further questions? Naturally, many manage to overcome this hurdle and achieve marvels. However, Egyptian society, as verbal and as vocal as it is, appreciates timidity and shyness among both men and women. Being raised in a middle-class culture where one is commended for timidity and reservation (see Dwyer 1978), it seems to me that the most important step in this research is to overcome my internalized identity and characteristics.

For months, even though originally a medical doctor, I wondered if I dared to ask women about their life stories, not to mention their health and economic conditions. However, true to Egyptian cultural ideals, weaknesses and vulnerability could be turned into an asset. Timidity, quietness and listening rather than being a good interrogator usually paid off.

Critics of postmodernity say there is so much self-reflexivity today that it stands in the way of scientific progress. One could equally say, however, that the problem is that there is not enough of it. The first step towards understanding the moral order of other cultures and people is understanding our own moral world and our role in reconstructing cultures of a different moral

world. Reconstructions which we turn around in order to share them with others who come from yet different moral worlds. Is it even imaginable to think this relationship can be anything but unequal?

Indigenous ethnographers are not absolved of the blame for framing their research questions within the domain of the dominant culture of EuroAmerica and for writing only or mainly with a Western audience in mind (Morsy 1991, e.g. Abdel Baki 1977). For Morsy (1988, cf. Fahim 1985, cf. Fahim in Altorki and El-Solh 1988) indigenous research does not always result in indigenous theiry.[13]

Finally, reflexivity is a problem because anthropologists have a tendency to remain mysterious and their assumptions to remain unexamined. For an Arab anthropologist, to be publicly self-reflexive flies in the face of Islamic and Middle Eastern culture which above all emphasizes modesty. Talking and writing about oneself is not only intellectually challenging, but also emotionally challenging. It is as if one has to deny one's roots to assert a new identity as a Western-educated anthropologist. Certain merits of self-reflexivity are undeniable, but the merits of modesty are also hard to deny. To be a middle-class doctor, educated in the social sciences in Western universities makes self-reflexivity all the more culturally challenging. As an Egyptian, I grew up accustomed to the cultural value that modesty must increase as one's status becomes higher. This cultural value is challenged by intellectual

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[13] However, indigenous inquiry can take at times the form of an intellectual iron curtain allowing only the sympathetic and the native. This is especially because Western ethnographers are granted various privileges (Inhorn and Buss 1993).

debates about self-reflexivity within which one's cultural values seem to be forgotten because, for myself, I cannot help but associate much of what passes for self-reflexivity as immodesty.

Section Six: Overview of the Layout:

The chapters of this thesis comprise four parts. Part One consists of chapters One and Two. The above chapter One is the introduction to the theoretical issues which have informed this research. Chapter Two is an overview of the cultural, social, economic, and political conditions in Sayeda Zeinab, the neighborhood where the research took place. Part Two consists of chapters Three and Four. Both deal with the importance of the theoretical and practical aspects of rethinking the units of analysis in the study of Egypt and the Middle East. This part is an invitation to give reciprocity and social networks their due place in cultural and social studies of Egypt.

Part Three consists of chapters Five and Six. Both chapters show historical continuities and heterogeneity in the management of illness in modern Egyptian culture. It is proposed in these chapters that inadequate attention to structural and historical influences in the management of ill-health obscures the diversity in national and personal experiences of illness management in Egypt today. The invitation is for more sophisticated studies of the relationships among historical, structural, national, and personal factors in illness management. In the last part, the conclusions, a few propositions will be made for further research and policy.

In this thesis, somewhat lengthy narrative accounts will be relied on to convey fieldwork data. This strategy has its pros and cons. I hope it conveys some of the complex texture of everyday Egyptian life. It is designed to bring out the sense of continuity between the theoretical and conceptual issues raised in this thesis. Moreover, this strategy aims at revealing a possible match between a multi-layered conceptual interpretation and the multi-layered social complexity of an informant's life. However, this may at times be at the cost of diversity and quantity of ethnographic data. To the extent possible, it is attempted here to benefit from the pros and minimize the cons of this presentation strategy. It is hoped that readers, particularly anthropologists, will bear with this strategy.

Conclusion:

Both an interpretive approach and Critical Medical Anthropology fail to capture the pluralistic nature of social interaction and social relations shaping the conditions of health and illness in society. What is needed is a critical interpretive Medical Anthropology (Lock and Scheper-Hughes 1990) that pays special attention to social relations. It is an anthropology of social relations which would capture the shifting grounds of vertical and horizontal relational milieux in every culture. It would be an anthropology which goes beyond just an anthropology of class relations or of gender and gender relations (see Moore 1988). In other words, it would be an anthropology of social relations as the site of enactment of culture and social systems.

CHAPTER TWO:
SAYEDA ZEINAB: PLACE, TIES AND TRACES OF MODERNITY

I. if I complain of a quarter of what I have to bear to iron, it would melt

The first is my estrangement and the second is my written destiny

And the third, I was the winner but I became defeated

How, Time, do you inflict change on hearts?!
(An Old Egyptian Folk Song)

Introduction:

The capitals of Islamic Egypt were *Al Fustat* established in 642, *Al 'Askar* established in 750, and *Al Qata'i'* established in 868. They were the precursors of *Al Qahira*, established in 969, the fourth capital of Islamic Egypt (Raymond 1994, Al Razzaz 1995a, J. Abu-Lughod 1971). The foundation of *Al Qahira*, which later came to be known as Cairo, was laid in the year 969, almost 1030 years ago. As the Prophet Mohammed preferred no water to be between Him and His Moslem military, the idea of Alexandria as the capital was dropped, due to its unsuitable geographic location, and *Al Fustat* was established (H. Ramadan 1994:240). Around *Al Fustat* emerged the three subsequent Islamic capitals of Egypt now encompassed by Cairo. It was not until the establishment of Saladin's citadel in 1176 that it became the currently defined Cairo encompassing its four predecessors (Raymond 1994, Al Razzaz 1995b). Thus, it was confirmed tnat "Islam was above all an urban civilization" (Polk 1969:xviii; see Costello 1977).

It took almost a hundred years after the Arab conquest of Egypt (641) and the building of *Al Fustat* for Moslems to abandon military life and start other occupations such as farming (H. Ramadan 1994:23). The way was paved for eventual trade routes and networks with Arabia and Asia. By the tenth and eleventh centuries, a hierarchy of wealth became increasingly acceptable for the first time, and the cultural manifestations of this hierarchy became a normal way of everyday life. Thus, it was acceptable to express material wealth in spatial and aesthetic spheres as can still be witnessed today in the older parts of Cairo where elaborate *biyout* (houses, palaces, pl.) of the 13th and 14th century still stand. Distance, space and privacy increasingly came to be the differentiating criteria of *il fi'aat il igtima'eyah* before the development of notions of modernity.

The link between Egypt's new social hierarchy and external entities was confirmed during the Mamluk years (1250-1517) and the Ottoman period (1517-1798) (Raymond 1994), with continuities up to the present time (Zaalouk 1989, Mitchel 1991). Urban and social spaces were defined according to global trends in economic and cultural imperialism. Thus, in Cairo, during the Ottoman period, the stage was set for the future. The most important rule for the organization of human life was the division of urban space and social space:

> ...the geographical repartition of the residential districts reflected not only the differences which separated the...[classes]...but also the economical and social cleavages which divided the population in various strata [producing] the projection, on the map, of the global political, economic, social, and national structure of contemporary urban society. (Raymond 1982:110)

In Cairo, space became increasingly dependent on the intensification of links within European culture and economies. This was manifested in the establishment of artificial lakes and mansions surrounding the park of *Ezbekeyeh* in the modern part of Cairo during the first part of this century. This park was designed to imitate the famous parks and lifestyle of European cities. Another example is the deterioration of the space which was previously occupied by different guilds and their masters and craftsmen. This was directly related to the increased industrialization of society, and the increased centralization of the state, which was considered a sign of modernity.[1]

In Cairo, the organization of classes on the cityscape has always followed a gradient scheme. The upper class districts were mostly separated from the lower class districts by a middle class district of mid-level bureaucrats and mid-size entrepreneurs (Himdan 1996). Where exceptions occurred, water of the river Nile served as a partition instead of a middle class district (Himdan 1996). However, it is important to realize that separation or even isolation of *mustawayaat* in Egypt never meant segregation (Himdan 1996).[2]

1

Historically, the growth of Cairo happened mostly towards the North, West and North-East of the city (Ibrahim 1992, Raymond 1994, Himdan 1996), as opposed to the current East-West growth axis (United Nations 1990:10). The city expanded from 5 square kilometers during the early 19th century to 15 square kilometers by the end of the century (United Nation 1990:6).

2

Spatially and architecturally, due to urban mobility, natural disasters, epidemics, and neglect, certain pockets of urban Cairo were always allowed to decay to rubble. The growth of Cairo in and out of these deteriorated spaces was always a

(continued...)

While the social space of the elites puts them behind the driving wheel for manipulation of urban space, the 'others' are seen and treated as a homogeneous group with uniform needs (Vigier and Serageldin 1982). The morphology of urban space and the symbolic value of its elements are ammunition in the preservation of the division between the *mustawayaat*. In the present thesis, studying a traditional populous area of Cairo revealed how cultural and social aspects of everyday living manifest the modernized echelons of power.

Section One: Sayeda Zeinab: A Socio-cultural Profile:

Continuities and Mustawayaat in Sayeda Zeinab:

The district of Sayeda Zeinab is one of the areas of Cairo which have weathered the test of time until recently. In contrast to earlier times, the centuries-old district of Sayeda Zeinab emerged ingloriously defeated after many bleak patches of material and social deprivation. For example, *El Kahlig el Misri* (The Egyptian Gulf) and *Birket el Fil* (The Elephant's Pond), two known locations in the district, were two of the prime urban locations for living and for recreation in Cairo for centuries until the beginning of the 19th century (Ibrahim 1992; Raymond 1982, 1994). Now the former is a main thoroughfare with shops and street

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[2](...continued)
result of external social and economic factors (Ibrahim 1992, Raymond 1994). Then after a lapse of many years, sometimes even centuries (Ibrahim 1992), the demands of population size and limited habitable space recreated interest in these unoccupied abandoned spaces (Himdan 1996). People living in decaying urban spaces had one of two choices. If they had enough material capital, they packed up and went elsewhere. If not, they remained to witness their own spatial and social withering. With their social withering came their biological deterioration through disease and illness (Raymond 1994).

vendors on both sides. The latter constitutes one of the poorest subdistricts in Cairo.

The district was among those subjected to the first wave of modernization and city expansion in the 19th century (Raymond 1994). Since the time of Mohamed Ali, considered the father of modern Egypt, and the emergence of the modern state in Egypt, Sayeda Zeinab and its immediate environs were prime spots for bureaucrats' and officials' residences (Raymond 1994, J. Abu-Lughod 1971), which reinvigorated the space with material and social capital, but which now remain only in a rudimentary form.

In Sayeda Zeinab, some of the oldest Islamic monuments in Cairo exist alongside with the newest neon-lit and metal or marble facade shops. Sayeda Zeinab is also the location where houses have fallen down like sand castles and eventually turned into garbage dumps next to fifteen storey buildings. These mixed signals concerning the economic and urban landscape of Sayeda Zeinab make it a unique area of Cairo. For example, among the 15 subdistricts of Sayeda Zeinab, there exist areas which are amongst the poorest in Cairo (*Tolon*, ranking number 236 among 314 subdistricts of Greater Cairo), and subdistricts that are among the highest in socio-economic standards in Cairo (*Insha* and *Mounira*, ranking number 24 among all 314 subdistricts of Greater Cairo) (CAPMAS 1990; see Tables I and II).

Socio-economic Rank	Sub-district	% Population	Greater Cairo Socio-economic Rank
1	Insha and Mounira	7	24
2	Khairat	5	39
3	El Sabbaeen	4	56
4	Darb El Gamameze	8	59
5	Sonkor	5	85
6	El Atrees	5	86
7	El Aini	6	94
8	El Darb El Gided	3	98
9	El Hanafi	9	103
10	El Baghalah	9	105
11	El Sayeda	8	112
12	Hadayek Zainhom	6	139
13	El Kabsh	7	148
14	Zainhom	11	211
15	Tolon (Lowest)	8	236
Greater Cairo Mean		100%	

Table I. Socio-economic Ranking of the Subdistricts of Sayeda Zeinab. (Source: CAPMAS 1990)

Socio-economic Rank	Sub-district	% Literacy	% University Education	% High Level Occupation
1	Insha and Mounira	85	20	40
2	Khairat	85	18	29
3	El Sabaeen	82	13	31
4	Darb El Gamamez	81	12	29
5	Sonkor	75	9	23
6	El Atrees	78	9	25
7	El Aini	68	10	24
8	El Darb El Gided	77	8	20
9	El Hanafi	70	8	22
10	El Baghalah	77	9	19
11	El Sayeda	71	6	20
12	Hadayek Zainhom	68	5	15
13	El Kabsh	65	6	17
14	Zainhom	59	3	10
15	Tolon (Lowest)	56	2	8
Greater Cairo Mean		68	8	20

Table II. General Characteristics of the Population of Sayeda Zeinab. (Source: CAPMAS 1990)

Local Meanings of Tradition and Modernity:

Besides its historical roots, certain areas of Sayeda Zeinab are an outstanding witness to the mixture of modernity and traditional values which is peculiar to Egypt and its urban areas (Khashaba 1995:9). In the early part of the century, modernity was passed along to Cairo from Europe, to occupy the hearts of the colonized people, albeit in an unequal way, for the modern urban districts adopted a local interpretation of the imported modernity. For example, new districts such as:

> ...Garden City [were] flourishing with one or two more areas, [while] the Sayeda [Zeinab] district was dissolving with its similar districts...[which were] being transformed and moved from dissolving medieval areas into the declining nineteenth [and twentieth] century areas.
>
> (Khashaba 1995:9, my translation)

Economic and physical modernization was assumed to have transformed the people. It was presumed that changes in structure inevitably lead to ideological changes.

> ...modernizers thought that for the society to be 'modern' or 'modernized' all they needed was to borrow the laws and rules of modernity, leaving its own old mind and identity the same.
>
> (Khashaba 1995:9, my translation)

This legacy produced an environment specific to urban Egypt and to Sayeda Zeinab in particular. Rather unusual for Cairo, Sayeda Zeinab has residents which comes from different *fi'aat* and *mustawayaat*. Their discourse on social life copies the stratification of the discourse on modernity. As in the results reported by Zayed (1992), people from different *mustawayaat* in the area embody and transmit different cultural values of modernity. The upper classes express it in terms of personal and social objectives (see A. Zayed 1992:176), for which some

compromises are required: as a prominent and wealthy political figure in the area noted: "*ihna binhid alashan nibni*" (we destroy in order to build,) adding that "if we do not help ourselves no one will help us." As noted by A. Zayed (1992) this should come as no surprise to anyone from the classes that are integrated into the machinery of modernization.

On the other hand, the discourse of the middle class on modernity is one of hope and aspiration (see A. Zayed 1992:177). It is their ambition to catch up with what they believe is missing. Education is a main avenue of fulfilling their aspirations, and they are themselves the main vehicle for the propagation and assertion of modernization. Nevertheless, they "embody all the contradictions accompanying this culture [of modernity]" (A. Zayed 1992:177). As a female teacher in Sayeda Zeinab noted:

> Of course I wanted to live alone with my husband when we were first married. I wanted to be free to manage my house away from my mother-in-law. I went with my husband to visit her every other Friday, but once I closed my door, I was in my house and I did what I want.

This embodiment of a self-worth and diversification of social relations is a manifestation of a certain interpretation of modernity that is not available to what Egyptians call *il mustawayaat ili taht* (lower social levels) for whom modernity is a burden (see A. Zayed 1992:180). People in this *mustawa* (level/standard) can cannot afford the social norms, the cultural values, or the modern lifestyle surrounding them or seen on television. Modernity remains for them largely an ethos of consumption, which they translate into acquisitions whenever they have a chance to purchase something.

Additionally, for these lower *mustawayaat,* it also means an emotional burden. The lower the *mustawa* the more people worry about the incompatibility of their lack of modernization and the rapidly modernizing world around them. As a mother of an available bride said:

> I wish my daughter could marry someone like you, but I know it is not possible; she is beautiful and a good housekeeper, but we had her stay home after preparatory school to help me in the house...The school and private lessons were becoming too expensive...

The *mustawayaat illi fouk* (higher social levels) in Sayeda Zeinab seem keen on the personal and corporeal dimensions of modernization, whether in terms of pleasure or restraint; the *mustawayaat il wustah* (mid-levels) seem to be keen on education and knowledge; and the *mustawayaat illi taht* (low-levels) are preoccupied with the basics of eating, drinking and survival (see A. Zayed 1992). Modernization in Sayeda Zeinab and Egypt, then, created the standards of a modern economy; but modernization also creates the diverse cultural and social values of everyday life in modern Egypt.

Up, Down, and Sideways:

In Egypt, people are distrustful of the state which sets the modernization agenda. This may be due to the historical actions of a centralized state which repeatedly harmed the voiceless poor and benefitted the powerful. For many Egyptians, this distrust translates into isolation of one's self and one's immediate group from organization as a form of cultural adaptation (Shukri et al. 1995:134). The economic differentiation of the past eventually came to be linked to political differentiation, separating authority and responsibility. As the "government in Egypt was always imposed from

above--sometimes for the people but never of or by the people" (Polk 1969:xviii), it is not surprising that

> ...the average Egyptian, even the well-to-do and well-educated classes, had little feeling of responsibility for, or experience in managing any affairs outside his front door...inexperience in public responsibility on the local level, and exclusion by Europeans from control over the most obvious and immediate "national" tasks...have had profound consequences in more recent history.
>
> (Polk 1969:xix)

Hence, in an environment where social differentiation is a cherished cultural heritage, and where the state has created a system to perpetuate it and to block paths to altering social *fi'aat*, it is not surprising that individuals and groups only think in terms of their narrowest unit of affiliation. But what kind of life can a person have in a city which is complex enough to require its own Board of Trustees (Abdel Akher 1995:13)?

In the case of most residents of Sayeda Zeinab, especially in the poorer districts, they are less interested in public politics than in private politics. People from the various *mustawayaat* prefer to depend on horizontal arrangements amongst themselves in order to meet their social and health needs. The commonly observed exclusion of the majority of people in the district from active contribution to politics occurs even though people are not insulated from formal institutions. It may be, following Foucault, that this sociopolitical segregation occurs precisely because the people are **not** isolated from formal institutions (Foucault 1977, 1973). These institutions, such as hospitals, schools, and bureaucracies are infused with an ethos of patronage and discrimination. Accordingly, people from all *fi'aat* have

internalized a specific wisdom matching the prevailing naturalized social order.

The naturalized social order is one of stratified affiliation. Hence, Egyptians are socialized to continuously enhance their horizontal relationships within an atmosphere of social differentiation. This serves at least two purposes. First, this ensures the supply of much valued emotional and practical resources and assets for members sharing horizontal relations. Second, horizontal social relations provide the foundation on which vertical social relations can be manipulated for maximum benefit. Consequently, obtaining a job, escaping military recruitment, getting a bank loan, being admitted into a hospital or a school, or accessing other social services and institutions becomes a matter of moving the right player in the social hierarchy. Naturally, power and resources for each horizontal social network are not randomly distributed in society. An uncle or a neighbor or a family friend may play a key role in getting a job for an individual. A job almost always translates--especially for men, regardless of their age bracket--into a *mustawa igtima'y* (social level/standard) for the individual and his/her family. This also means that access to vertical relations is dependent on the quantity and quality of horizontal social relations in society.

To take a cursory look at some of the relational concerns of people in Sayeda Zeinab, I recorded the most frequent topics of conversation among both men and women of two different socio-economic groups. This took place during the period of February/March 1996. All were recorded at ten social events which included five people or more of the same gender and a comparable socio-economic level:

Men of income level of 100-300/month Livres Egyptiennes (LE) (app. 30-90 US$)

1. Government corruption
2. News from the newspaper or television
3. Personal, family, or work related problems
4. Seeking advice for solving a problem

Men of a income level below LE 100:

1. Work or lack thereof
2. Rich people
3. Government related harassment or problems
4. Seeking advice for solving a problem

Women of the income level of LE 100-300

1. Children and schooling
2. Food and cooking
3. Health related problems for family members
4. Health related problems for self

Women of the income level of less than LE 100

1. Food and cooking
2. Rich people
3. Children
4. Seeking advice for solving a problem.

Naturally, this list changes with time and even by season of the year. This little exercise reveals a relational tendency. But this rather crude method also showed at least two important issues of interest in terms of social discrimination. The poorer segment are more keen on filling their stomachs than on caring for their bodies or communities. Second, women who are better off are relatively more integrated into the culture of care of the self and family during times of illness. There are many more questions than answers that this brief exercise presents. However, the point is that the *mustawayaat* are probably the best predictors of peoples' list of topics requiring individual or family or social network

reciprocity. In other words, in modern Egypt, a *mustawayaat* conceptualization reveals not only the living conditions, but the preconditions for everyday life and illness, as we shall see later in this chapter and in the following chapters.

Gender and Social Association:

A principal mechanism of developing and accessing the emotional and instrumental world of a social network is gossip (see Epstein 1969b). While men pretend that women do it more often, men also get involved in extensive communications about the details of their lives and the lives of their friends and foes. The boundary between the communicable and the non-communicable seems to be very thin and dependent mainly on how much information a person has to communicate and who is around to share it with. While this indicates the value of verbal communication in Egyptian culture, it also implies that those (men or women) who are verbally and socially active are in a better position to access and make accessible to others emotional and instrumental support (see chapter Four). Nadi, a 55-year-old civil servant, said:

> My wife knows, I have to sit at the '*ahwah* [coffee shop] four-five times a week. I like my *shilla* [group of friends or acquaintances] there...we sit to talk about politics, about work, about family, about everything...we give advice to each other all the time, and use our *ma'arif* [acquaintances] to solve problems we may have... For example, this is how I got my son a room in the university dormitory in Minia [300 km south of Cairo] and how I got my friend Abdel Aal a lower estimate for his operation from the doctor in the hospital who turned out to be the husband of my boss at work.

At first glance women may seem to be less active and less socially interactive . However, a study of Sayeda Zeinab shows this is not an entirely accurate statement. Beneath

the surface, women in Sayeda Zeinab are very active in their own way. There are fewer public interactions for most of them (other than shopping). But their interaction with their neighbors, relatives, and friends is quite intense; it is anything but docile. Perhaps men have more diversity in their social networks, but the impression one gets from women is that their interaction is more intimate and on a regular basis (see Early 1993a). They also rely heavily on reciprocity networks for loans, arranging marriages, or for arranging business deals for themselves or their family members. This is not to say that the economic or social location of women is the same as for men. Rather, reciprocity is used effectively for the benefit of both men and women by both sexes in Sayeda Zeinab.

Social activities in Sayeda Zeinab are quite conventional and limited. For older women and younger girls, apart from sitting on the doorstep before sunset, and watching television, there is little chance to be part of any social activities. Gatherings of more than three or four women are rare except for funerals or weddings.

For men in Sayeda Zeinab choices are not drastically different. Apart from the *'ahwa baladi* (coffee Shop), the occasional football matches for young men in the street, and participation in some of the very limited activities of non-governmental organizations, there is not much else to do. This in part reflects that:

> ...the informal networks of the extended family, neighborhood, and other small community groups, that has at one time provided a substantial measure of help against adversity, were gradually weakened during the 1950s and 1960s as a result of increased urbanization and industrialization. The weakening of these informal

> supports, while regrettable, was the unavoidable outcome of modernization. (Ibrahim et al. 1996:35)

One of the consequences of the lack of any organized social interaction in the district is that the chances are non-existent for developing shared interests for different ages, genders and classes. Social interaction skills and the ability to deal with personal or community problems are rarely cultivated through collective organization.[3]

Emotions and Affiliation:

Many Sayeda Zeinab residents consider themselves neglected and *ghalaabah* (poor, defeated). This view is eroding their dignity. This erosion is increasing as social and economic expectations in these 'modern' times rise. Consequently, dignity becomes unattainable by all. Even Sayeda Zeinab, people say, has become a place where "those who have are worthy and those who do not are not worthy," or as it is said in Arabic: "*illi 'anduh yissawi, wi illi ma'andoush ma yisaweesh.*"

In this milieu, even concern about emotions and dignity steadily are replaced by concern for the material aspects of everyday life. Kawthar, a young woman, said in response to her mother's attempts to get her to accept a specific groom:

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[3] This lack of organized affiliation is linked to many implicit and explicit state policies which affect different social groups differently. For example, in Cairo, out of 25 government-run palaces and houses where cultural activities are organized (called *kusur il thaqafah* or Cultural Palaces), 18 exist in wealthy neighborhoods where 58.8% of all shows are presented, and only eight exist in poor neighborhoods (El Bahrawi 1997:31).

> My mother thinks that because the daughter of the neighbor married someone who owns an apartment that this means that Rabab [the neighbor] is better than me... I told her that Rabab is a fat girl whose sneaky ways got her that husband...I am not like that and I never want to get a husband this way...but my mother is ignorant, she thinks that everyone now looks at me expecting me to marry the same kind of man...they are all ignorant.

Kawthar's situation reveals her life in a culture where it does not matter what you are or what you have, what really matters is how these compare to what others are or what others have. In other words, status in a culture is relational and requires strategies to maintain and enhance it. In the face of challenges to dignity and emotions among genders and generations of different *fi'aat*, many people become engaged in upgrading their self-presentation and downgrading others, even if only using verbal strategies such as gossips, insults, and accusations. In this environment, the social parameters of each *mustawa* is confirmed and loyalties are created within each *mustawa*.

Education:

Another crushed dream in Sayeda Zeinab is that of education. Most families see education for their children as their most important means to improve their *mustawa*. In the blistering wind of reality, many of those committed to education have to choose between sending girls to faraway schools (within the district but still requiring sometimes a 20-30 minute walk), as in the subdistrict of *Qal'et el Kabsh*, or forcing them to stay home for fear of insecurity, harassment in the streets or even worse. Or, these families have to choose to send boys to school or to pay for necessities. For the lower

classes, the choices are more basic: it is either to find employment or to educate children.

Under difficult economic circumstances, education tends to be relegated to a secondary status. Money for private tutoring and books and stationery items is scarce. The most severe measure is usually to stop the education of one or more of the children completely in order to allow him/her to work to increase the family income.[4] It is remarkable how values are malleable in face of economic hardships.[5]

The most difficult role for young people and their families is that they have to choose between improving their social standing through higher education or improving their economic standing through low skilled labor. In Sayeda Zeinab as elsewhere in Egypt, social capital and economic capital are increasingly separated from each other. Area residents also have to pay for the failure of the government to create an educational environment which would not have to be supplemented from the parents' income with private tutoring. The latter is the

> ...*prima facie* evidence that the nominally 'free' public education system in Egypt is lacking in quality...such practices inevitably mean that the education system is biased against the poor who cannot afford these lessons. (INP 1995:57)

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[4] Apparently, earlier trends are being reversed. More girls than boys stay longer in school, especially among the lower socio-economic groups, because sons are pulled out to work to supplement family income (Hoodfar 1990).

[5] This complexity is reflected in the illiteracy rate in the area, which for females above the age of 10 constitutes 36% compared to 20% for males (CAPMAS 1990).

This means that:

> Unfortunately, those same groups who have the most to benefit from more education are also the same groups who participate in the least, and whose parents are also disadvantaged.
>
> (INP 1995:56; also Fergani 1994a, 1994b)

The most fortunate ones in the area, and those who are more educated continue to keep their children in school. For the majority of them, while future employment seems increasingly unattainable, they know of no other way to at least guarantee a social standing in society. As in many developing countries, the middle class view education as their last resort to hold onto their social standing. But to what degree is education or training useful for the livelihood of most Sayeda Zeinab residents?

Section Two: Sayeda Zeinab: An Economic Profile:

Economics:

Based on the present research, it can be confirmed that Sayeda Zeinab follows the patterns of unemployment in Egypt where:

> In urban Egypt, the unemployment rates between males (8.2 percent) and females (27.8 percent) are higher than the national rates, as well as higher than in rural areas (6.6 and 18 percent respectively). This indicates that accessibility to work is relatively more difficult in urban areas than in rural ones for both males and females, but that this difficulty affects females more than males.
>
> (INP 1995:62)

Sayeda Zeinab is neither the industrial Cairo subcity of the 1950s and 1960s nor an affluent modern district. It stands somewhere between dependency on industries of the

modern economy and conventional sources of income. Sources of income can be divided into two main categories: government related and non-government related. Non-government related can be further divided into production related, commerce and trade related, and service related.

A very large number of residents rely on government related income, either from employment, assistance from the Ministry of Social Affairs, the President Sadat Pension fund, or their own pension. In most cases this income is not sufficient to meet daily requirements and social obligations.

Women and Work:

The number of women from Sayeda Zeinab employed by the government seems to be quite restricted. This is supported by data confirming that:

> ...most Egyptian females capable of working are either not available for work or not looking for it, and this trend is more noticeable in urban than in rural areas of Egypt. (INP 1995:62)

Probably due to their modest level of education and traditional views on the role of women, women, along with most men, do not know much about finding or creating employment opportunities. Compared to 4% of the women in the area who are self-employed, 16% of the men are self-employed. This reflects the low rate of self-employment in the area as a whole (CAPMAS 1991). In Sayeda Zeinab, it is mainly in clothing shops and sweets shops/corner stores that women are represented in the service sector. Women are absent from all coffee shops, hotels, and the like. However, this sector still represents a good area for the absorption of the local unemployed.

Many families of different economic classes have been left behind by heads of families going to work in the Gulf countries. The range of work varies from construction workers to doctors. Women are often left to lead their families, sometimes at their peril. In many instances families of these labor migrants have had to struggle for a long period of time before they started getting any money transfers.

The high unemployment of women in Sayeda Zeinab is of particular significance when one notes that it is estimated that close to 16% of homes in Cairo are headed by females as the sole income providers (Nawar 1995:3). These women rely in 26% of cases mainly on external support from kin and non-kin, of which 64% is from the state (Nawar 1995:9). In many other cases these women are the sole and main contributor to the income of the family. Thus, their lack of representation in the labor force affects the well-being of the whole family. This is crucial also for their identity as these women start feeling as being unemployed rather than housewives.

Economics and Unemployment:

Sayeda Zeinab is known for many production-related activities. A few medium size factories exist. However, the majority consist of small workshops producing items such as chandeliers, lamps, food processing, and so forth.[6] There is also a high percentage of employment in the service sector such as restaurants and coffee shops

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[6] In general, small-scale economic activities predominate in Sayeda Zeinab, with 57% of economic establishments involving only one worker (CAPMAS 1991). Commercial and trade activities constitute about 44% of economic activities in Sayeda Zeinab (CAPMAS 1991), employing about 35% of the workers.

in the area, up to 38% (CAPMAS 1991). This high rate is characteristic of traditional areas such as Sayeda Zeinab. These are seen as safe investments.

In Sayeda Zeinab, as in other similar areas, unemployment is high. There are no accurate figures, but in 1986, 13% of the workforce in Sayeda Zeinab were thought to be unemployed (CAPMAS 1991). Given the overall trend in the economy, this can be expected to be much higher, especially when compared to the 12.2% in Cairo and 10.7% nationally revealed in 1994 (INP 1994). In Sayeda Zeinab all categories of unemployment exist.

Unemployed Professionals and University Graduates: These are usually the most disenchanted. They feel that they have a dream that will never come true. They have skills which are not in high demand by current labor market standards. Many of them are reluctant to change their lines of profession to suit the labor market. Others are interested but are unaware as to how to do it. Both groups resent being categorized with those they consider not to have invested their time and energy in education. They usually refer to these people as the lower classes. Most unemployed professionals and university graduates believe that their problems should be addressed separately from other lower *mustawayaat*. In most cases when an educated person or a professional enters the job market, it is for life.[7]

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[7] However, this brings up the issue of masked unemployment, especially in the government, because many of these people are employed by the government, but work less than their full capacity or not at all.

Mid-Level Education Graduates: For many years, young people and their parents thought that mid-level education was the second best alternative to university education. Now they are disenchanted because neither do they have what they perceive as the benefit of university education nor have they received the benefit of a more versatile job market. This group is less vocal than university graduates because they have, to a certain degree, internalized a sense of inferiority, feeling that the state and society consider them inferior to professionals and university graduates. With the lack of government jobs in Sayeda Zeinab, these individuals are likely to be employed in the service and trade sectors where workers are vulnerable to the whims of their employers. In most cases they are laid off for no apparent reason. They receive minimal, if any, training on the tasks they are expected to perform. Because of the large percentage of unemployment in this group, these individuals submit to many unfair conditions and practices by owners, such as declaring smaller amounts in contracts (for tax and social security fraud), working longer hours, and being released with no pay during pregnancy. However, it seems that this group usually has better luck reentering the job market than their more highly educated counterparts. Probably the reason for this is that they have fewer inhibitions about the nature of the work they are willing to do.

Vocational Workers: These seem to be the least vocal or maybe the least heard. They are frustrated because they escape the notice of most statistics, government programs, and even external assistance. Vocational workers are either graduates of vocational schools or are trained through apprenticeship--both of which are quite popular in Sayeda Zeinab. The popularity of these

programs is because they take a shorter time and their graduates are able to earn a reasonable income.[8] The existence in the district of many workshops whose owners live nearby also encourages residents to have their children pursue apprenticeships in these workshops. This group includes carpenters with no workshops, wall painters, and construction workers whose work depends on the cycle of capital in the entire country, as well as in Sayeda Zeinab particularly. Their hope depends on others. They derive their income from their physical labor and skills. With the lack of jobs and social security, they become more irritable knowing that their physical strength, which is their main asset, is ebbing away with every day they sit in the coffee shop waiting for a contractor to come by. After a long period of absence, some of them fail to successfully reenter the labor market for several years. The declining condition of their health, their lack of resourcefulness, and the new trends in vocations like carpentry, iron work, or car repair, for example, make many of these people permanently unemployable.

Youth Unemployment: Given the somewhat commercial nature of the area, unlike the upper middle class areas of Cairo and the upper middle class subdistricts of Sayeda Zeinab, it is acceptable that young people engage in some activities to increase their income or that of their families. Because child labor and apprenticeship systems exist in Sayeda Zeinab, it is viewed as natural that

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[8] This local wisdom is confirmed by reports that compared to the 14% of the labor force that has a high education, 44% of the labor force has a medium level educational certificate or less, while 42% of the labor force is illiterate in Egypt (INP 1995:59).

young people of il *mustawayaat ili taht* with free time should seek some form of employment. However, this is not matched by opportunity. Most of these young prefer to work in the area of Sayeda Zeinab, but this is often untenable because of the very limited number of employment opportunities. And this is further complicated when one notes that some families rely mainly on the income of their young offspring for survival. This is especially prevalent in cases where the father is absent due to death or desertion, when children contribute at least equally to their mother or even wholly to the subsistence of their families.

The summer is usually the time for both seasonal employment and seasonal unemployment. It is the season when most people are returning from Arab countries during the holidays with some money to build houses, improve existing ones, start new businesses, or get married. It is also the high season of unemployment because there are fewer people now than before returning to Sayeda Zeinab with 'petro-money' due to the shrinkage of the labor market in the Arab Gulf countries. Those who return with money are becoming more careful with their expenditures when they return to Egypt.[9] Furthermore, in many cases, those returning want the strongest workers and those who know the latest trends, neither of which can be attained by somebody who has not had an opportunity to work for a long time.

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[9] Migrant laborers sense their job situation is ever more tenuous because of constant changes in the labor market and its regulations in Arab Gulf countries, which are moving more towards indigenization of their labor force.

As Egypt enters the "second generation" of Structural Adjustment Policies (SAPs) and economic reform (*Al Ahram* 1993, Parfitt 1993), little is known about the dynamics through which economic deprivation and this new structural transformation affect the different *mustawayaat* in Egypt, particularly their health and illness management. The challenge may be in the difficulty of pinpointing the direct impact of such policies on the health of the population. Most studies (see Kanji et al. 1991:990) are mainly concerned with socio-economic determinants of health in general and not with the *dynamics* through which specific economic reforms affect health status and health-seeking behavior. These reforms affect Egypt's support for these services, whose access to and utilization by the population are already prone to social differentiation with its underlying cultural values (see chapters one, Five and Six).

An analysis of the national statistics shows that within five years (1990/1991-1995/1996) the cost of living index rose by 160% in urban areas, matched by a decrease of real income of urban families by 14%, and that the income per person for those who are employed has declined by 19% in urban areas, meaning that more family members have to work to stay in the same socio-economic position (Fergani 1997:66). As Sami, a 40-year-old general manager in the government, said: "*il nass assbahit diliwa'ti kulaha ghalaabah, illi biyishtaghal wi illi ma biyishtaghalsh,*" meaning, "All people have become defeated/poor, those who work and those who do not work."

Coping in Sayeda Zeinab:

Om Abdou is an illiterate 40-year-old woman who has lived in the neighborhood since her marriage twenty-two years ago. The mother of three daughters and two sons, a wife for 25 years, she lives with her family in a two-bedroom apartment on the third floor of a crumbling four-storey building. Om Abdou works as a housemaid, for which she gets about LE 100 (app. US$29/month). Shaaker, her husband, was diagnosed with T.B. three years ago, hospitalized for one year, then released to stay at home. He had been working in a public sector textile factory in a Cairo suburb; his current income has been reduced to about LE 100 (app. US$ 29) since all incentives and bonuses are cut because he is unable to work.

The older son has been awaiting a job with the government since he ended his training at the telecommunications institute. The 19-year-old daughter, after finishing her commercial secondary education, is employed as a trainee for LE 50/month (app. US$ 15). The other children are at different stages in their education.

Life for Om Abdou and her husband is a series of emotional, social, and economic negotiations. Om Abdou, during one of many crying spells, said: "I am tired, I feel like all the problems of the world are on my shoulders and crashing on my head. I need to rest, I have rheumatism, cannot see well anymore, and do not sleep at night from my back [ache]." She adds with more tears in her eyes, "*Ana ghalbaanah,*" literally meaning "I am defeated, poor and helpless." Moreover, she wastes no opportunity to emphasize that her whole family is *ghalaabah.*

Her social position is such that having an income only grants her minimal security, since earning money does not always improve the status of women in the family (Naguib and Lloyd 1994, Hijab 1988, Gerner 1984, Marshall 1984). Om Abdou concedes that she is not free to do exactly as she pleases with the family money, but her situation also indicates that gender relations within the family are not only shaped by tradition but also by economic imperatives.

The pool of money is hardly enough for the expenses of the whole family. Teachers for each of the two younger children have to be paid LE 35/month (app. US$10) for private tutoring. No pay means running the risk of being banned by the teacher from entering the classroom, not to mention the humiliation in front of classmates. Om Abdou said:

> I cannot let them leave the school...next year I will let Ali only [the youngest son] go *yeta'lim san'ah* [to learn a vocation].

As for the girls, she later clarified:

> No, I will let them continue in school...you see their sister, she gives me the LE 50 a month, not like her older brother...these days the girls need to be educated to have a *'aris mohtaram* (a respectable groom).

Like Om Abdou, other people are surviving somehow. Their coping at times seems to be haphazard and ineffectual, but in most cases it takes a strategic form. Home seems to be the sphere where most experiments to meet the demands of everyday life take place. People first try to reduce costs. A starting point is to cut down on leisure and entertainment. The second measure is obtaining goods of lesser quality at a cheaper price. The third is cutting down on essential items. To accompany these

reductions, there can always be a cutting back on reciprocity. These measures also include a reallocation of resources in the family and social network and/or active income pooling or supplementation measures and/or selling personal/family belongings or heirlooms, or for women to start or to enter a savings club (*gamei'ah*). These steps are often interspersed with borrowing money from a family member or a neighbor. Neighbors are preferred, as one 40-year-old housewife told me:

> ...because they know and see your situation better than your own sister or brother...also one does not feel humiliated because you know they will need you someday to borrow money or for another favor...you will always find a way to return their dues (*tirud lihom il gamil*).

More importantly, these measures include sacrifices in cultural values:

> I was receiving LE 50 from my son before he got married; now his wife made sure he would not come to see us, and only every now and then does he come along with some fruit and LE 20 [app. US$ 6] or something like that.

Another said:

> When my friends from my *shilla* [group of friends] got married some years ago, I was single and had a good business, I gave them money, lent them money, and gave them nice gifts for their houses... Now I have had to leave some of my things with the friend of one of my neighbors in order for me to be lent some money.

To cope, many area residents get involved in commercial activities. The number of commercial activities in Sayeda Zeinab has changed over the decade from 1976 to 1986 from 1,042 to 8,818 (CAPMAS 1991). Area residents have been socialized in an atmosphere of entrepreneurship that makes it natural to think of commercial activity for income supplementation. Uneducated women of lower

mustawayaat are at the lower end of the income scale, doing petty trading and food processing. Men and some government employees seem to be able to draw on their educational skills or jobs to bring a supplement to their income.[10]

One of the most common coping strategies is for another family member to be of help, or completely take over the income earning tasks for the entire family. In many such instances, the person who has to step in is the wife/mother who may be lacking in skills or physical strength, but still has to go to work outside the home or work doubly hard at home to make time available for another family member to earn an income. This kind of situation takes its toll on women and their relationships with their husbands and other family members. Income is so low and skills are so poor that there is little hope of improving either their social or economic status. In many cases some of them express this contradiction by saying that they are "*ghalaabah, aghlab min il-gholb,*" meaning "poor and defeated, more than defeat itself."

Coping in Sayeda Zeinab can be seen as similar to other districts in Egypt and elsewhere as well, where:

> The general assertion that rampant city poverty per se breeds upheaval...is untenable. In nonwelfare states, the typical response of urbanites to poverty has not been to revolt, but to work harder: to assume multiple jobs, work longer hours, spend more time seeking formal and informal employment, and increase household participation (particularly of women and youth) in the labor force.
>
> (Brockerhoff and Brennan 1997:35)

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[10] This fuels a public debate on the role of familial and communal affiliation in securing advanced structural privileges through control over social institutions (e.g. see Aboul Ela 1996 on medical education).

There are no simple coping formulae. For every decision, cultural values interact with social and economic conditions to influence both the dynamics and the results of decision-making. In all cases, some kind of gender, generational, or other forms of discrimination is at the heart of a family survival.

To cope, many families can be likened to the state, unwittingly grading their offspring or siblings or friends in terms of their credit-worthiness, while taking cultural and social factors into account. Fatma, a mother of four sons aged 20-36 said:

> I would give Yasser (the third son) all the money he asks for because I know he is responsible and always returns it before I even ask him for it... Magdi (the oldest son), if it is left to me, I would not give him anything, he never returns anything...but I do anyway...he has two children, he knows this is why I help him as much as I can... I give him money which I know I will never see again.

Families 'tighten their belt'(*rabt il-hizam*), 'reschedule payments'(*i'adet gadwalah*), and talk of consumption (*istihlak*) and contingency (*ihtiyatti*). These families worry and calculate about what comes in and what goes out, "*illi dakhil wi illi kharig.*" This comes as no surprise to anyone: first, because of the role of the state over the past two centuries in propagating the discourse of modernization and economics; and, second, because even if people were slow to absorb the discourse before, now its speed is increasing and its implications are widespread.

People are more sophisticated; they also link economic disparity to "sick" social relations: Naguibah, a 32-

year-old housewife who finished high school, said: "Here in Egypt, your fingers are not alike, there is the rich one and there is the '*ghalbaan zai halnah*' (defeated like us)." For her, inequality between *fi'aat* is the norm. To be Egyptian means that some *mustawayaat* have to suffer while other *mustawayaat* don't.

Economic hardship, then, poses a serious challenge to people's status at home, in the community, and in society. From people's perspective, coping/managing or *tasaruf* is different among different *mustawayaat* because after all "*kul wahid wi bi'toh*" (everyone has a different [social, cultural and economic] environment). Coping, therefore, is a renegotiation of social positions in society.

Section Three: Living in Modernity, In Health and Illness:

In the less-than-optimal physical and social environment of Sayeda Zeinab, it is no wonder that infectious and allergic diseases are very common. Many of the area residents and biomedical and traditional medical personnel refer to them as *amrad il ghalaabah* (diseases of the poor/defeated). With the poor quality and crowded housing, residents of the area have a high level of morbidity. This has seasonal variations such as colds and chest diseases in the winter, and gastrointestinal diseases in the summer. Children are more susceptible to these diseases. Skin diseases seem to be very common among both children and adults.

Adults suffer not just from communicable diseases. There is a high level of chronic diseases among adults. The most common are arthritis and rheumatism, especially

among women. There is also a perception among area residents that there is an increase in the number of cases of cancer, which, according to meetings with doctors from the area, is almost always discovered only when it is too late.

Modernity, Disease and Illness:

Each epoch in Egypt has employed monuments to propagate state ideology. The reverence of death was manifested in the burial pyramids. This later gave way to Mohamed Ali's reverence for the West, which was manifested in large development projects, including medical education and public health systems (Gallagher 1990, see chapter Six). This led later to the post-1952 revolution ambivalence about social equality (see Dessouki 1982), which was manifested in the proliferation of the institutions of the welfare state, including institutions of public health care, but with a clear urban bias. This, in turn, also led to the current ambivalence of market capitalism which is manifested in the proliferation of private health care in Egypt, while fee-for-service (actual or *de facto*) schemes in public hospitals are promoted.

The public health concerns of the Sayeda Zeinab residents seem to have historical continuities. In the past, the public health conditions in Cairo and the health of its general population were worsened by the spatial organization of the city itself. Sandy, unpaved roads are still the source of many eye, chest, gastrointestinal and skin diseases in the summer from flying dust, and in the winter when the dust turns to mud. Diseases could be attributed to narrowness and dirt in the streets in *Al*

Qahira and later Cairo (Raymond 1994).[11] Similar conditions still exist in many of the subdistricts of Sayeda Zeinab. For most people, the environment of the area is an amalgamation of audio and visual pollution, air and water pollution, and garbage accumulation everywhere.

Clinical space, exemplified in the newly established hospitals of the nineteenth and twentieth centuries, is where diseases of the working class have traditionally been treated, with no parallel establishments for the prevention of these diseases.[12] In general, in the current health services, there is a focus on treating diseases rather than preventing them.[13]

Where the largest teaching hospital in Egypt (the *Kasr El Ayni* Hospital) stands, on the border of Sayeda Zeinab, an adjacent forest of biomedical and allied services were established (see Ibrahim 1992, Jagailloux 1986). Nursing, midwifery, and pharmaceutical education were the first to be set up nearby shortly after the establishment of Kasr El Ainy as a medical school. It is only logical within this cult of centralization that urban spaces should be

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[11] Cairo still has "one of the lowest provisions of road space per capita" (United Nations 1990:1).

[12] Tabibzadeh, Rossi-Espagnet and Maxwell (1989) note that the medical professionals in hospitals in urban centers are not likely to understand the need for Primary Health Care and are likely even to develop antagonistic attitudes towards it.

[13] Vaccination and Oral Rehydration Therapy (ORT) are the only preventive measures which are popularly known and practiced. This is because of the medical campaign on these topics.

organized according to the interests of the powerful classes; thus what is already centralized is further reinforced by institutions which reinforce its central status. Thus, urban space and clinical space embody key cultural concepts within their imported ideals. Institutions in the urban space are not separate from the dynamics of urbanization itself (Chaichian 1988:40). The layout of urban and clinical space was imported from the West. Models of streets, parks, transportation, housing, hospital buildings, medical specialization, and medical treatment were imported in form, function, and symbol. This facilitated internalizing notions about urban space, health and illness that remain current.

It is, therfore, not surprising that people often refer to themselves, their neighborhood, and their city in terms of illness:

> Cairo has become a chronic patient. Through time, diseases have infiltrated it from crowdedness, shanty towns, pressure on services and pollution. It is time for the patient to start the first steps toward treatment.... (Ibrahim et al. 1993:3, my translation)

This situation has bred in Sayeda Zeinab an atmosphere where illness, not health, is a mental preoccupation because of environmental and economic conditions. It also arises in a modern environment where preoccupation with the body and its functions and the ability of biomedicine to treat it have become part and parcel of the civilizing process of modernization in Egypt and elsewhere (see Pinell 1996; John and Jean Comaroff 1997; see chapter Six below). Medicalization, and pharmaceuticalization have become an integral part of everyday life.

Facilities of Modernity:

Public and private health services are scattered throughout Sayeda Zeinab. There are major hospitals such as *Aboul Reesh* for children, *El Talabah* for students (Western part of Sayeda Zeinab), *El Houd Marsoud* and *El Mounira* (Eastern part of Sayeda Zeinab) for general health services. There are a few Maternal and Child Health (MCH) centers, as in *Hadayek Zeinhom* (South-Eastern part of Sayeda Zeinab). Additionally, a few small private outpatient clinics and hospitals in *Berkit El Fil* (North-Eastern part of Sayeda Zeinab) and *Qal'et El Kabsh* (Eastern part of Sayeda Zeinab). Pharmacies also play an important role in the provision of health care services.

Poverty and fierce competition in health care are important elements in the utilization of health care services (Haddad and Fournier 1995. Both exist in Sayeda Zeinab, where the populous area is a fertile ground for all medical systems and services to operate. It allows for those with a good business sense to create businesses where the customers are. However, in terms of quality, which is beyond the scope of this chapter, suffice it to say that in Egypt, ironically, there is a history of poor quality of client services, especially once the individual is perceived to have become a client.[14] As for public hospital care, the majority in Sayeda Zeinab consider it to be "*hagah tiqriff*" meaning "something disgusting" suggesting a very bad hygienic condition of public hospitals, quality of care and interaction. This is made more complex because

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[14] Refer to chapter four in A. Ramadan (1995) for "true stories" and a journalistic analysis of the crisis of medical education and medical care in Egypt, as regards issues of ethics, cost, service and the state.

> ...theory and evidence point to a rich mixture of public and private activity in health care that is at odds with the polar ideological debate over the public versus private issue. (Griffin 1989:1)

The Political Economy of Illness Practices:

In dealing with health problems, residents of Sayeda Zeinab are very eclectic. They choose one form of service one time and switch to another at another time. Many family members go to the doctor and then skip the next few appointments. They take one family member at a time and another at another time. Perceptions about and dynamics of health care will be discussed in later chapters. A short overview is presented here as pertinent to Sayeda Zeinab.

Public hospitals have a bad reputation in Sayeda Zeinab. There are very few people who actually have a positive attitude toward them. In most ***mustawayaat,*** the poor treatment of patients by staff in these hospitals, their lack of cleanliness, the long waiting time, the lack of privacy, and the lack of medication are cited as the main reasons why these hospitals are not the first choice. As Salma, a 42-year-old woman who went into a government hospital for a hysterectomy two years ago, quoted as saying:

> I was so worried, as if I was lost...I had to worry about my husband and the children...but you will not believe, I had to bring my own sheet and blanket. They [staff] gave me a sheet but they never washed it, and they did not give me a blanket... One day my brother and his friend had a big fight with the nurse, their voices were up to the sky... They discovered that she had not been giving me my piece of chicken for lunch that the doctor ordered and not bringing me anything to eat for dinner after the operation because she was waiting for a daily tip of LE 3 [US$ 0.80].

The *mustawayaat* that actually go to public hospitals in Sayeda Zeinab do so for several reasons: first, because they cannot afford a better quality service; second, perhaps because they suffer from a serious disease and think that educational hospitals have a much highly qualified staff. However, it is not uncommon for private and non-governmental services to be the main service providers for an increasing majority of Egyptians. This matches reports which indicate that:

> By the late 1980s, under pressure of rising costs the state began to gradually withdraw from the area of providing free health services to the needy. This led Islamic PVOs [private voluntary organizations] to assume a much greater role in this area--giving rise to what may be called 'social Islam', paralleling 'political Islam'. (Ibrahim et al. 1996:81)

This unequal distribution of the benefits of modernity is locally operationalized in Egypt:

> For those who can afford it, the health service provided by the private sector is an alternative. But for the poor, low-quality public facilities are the only resort, especially given the increase in the costs of private health services. Over the 1981/2-1990/1 period, the increase in costs of health services for the poorest 30 percent in urban areas has been higher (710 percent) than the percentage increase in the costs of health services for the better-off categories over the same period (a 666.7 percent increase for the middle-income category, and 233.8 percent increase for the top 20 percent). (INP 1995:53)

This indicates an increase in people's reliance on non-government and/or privately owned medical facilities, which provide relatively better service, but, more importantly, delay the need for any structural social or health care reform (see Morsy 1988a). People are adapting gradually, almost without reflection, to the reformed project of modernization. Modernization has brought to

Egypt, in its local application, long lines of patients whose problems may be physical, but more importantly, are structural. Salma, the hysterectomy patient, added later: "*il massareef qassamit wistinah,*" meaning "expenses broke our backs." Not because of the operation itself which was nominally free, but because the LE 200/month [app. US$ 59] salary of her husband could not keep up with the tips and medical supplies, which included imported medication, catheters, syringes, bandages, food, intravenous solutions, and many other items which are readily available from the pharmacies lining up the road to the hospital.

There are no big private hospitals in Sayeda Zeinab. Most of the private hospitals are affiliated with mosques and comprise an outpatient clinic. Occasionally, there are facilities for minor surgeries, including removal of kidney stones, as in *Qal'et El Kabsh* (Eastern part of Sayeda Zeinab). In most cases these centers are chosen by patients because of the way people are treated. Patients are generally not entitled to free medication at these institutions, although the examination fee is paid; but they still attend because those who cannot afford better care feel they are getting better treatment and attention than at public health care facilities. Sometimes, these patients can even be exonerated from paying the fees because they are poor.

Many of these private facilities are partly financed by the institutions they are affiliated with, such as a mosque, a church, or a non-governmental organization. However, many of them are also directly funded by donations from wealthy community or non-community members who are in contact with the managers of the facilities. In these places, those not-always-anonymous donors are

designated by the label *fa'il kheir* [good doer, sing.]. This label transcends the mechanistic nature of donating money or equipment. It is rooted in the cultural values of affiliation and *takaful* [co-sponsorship] which have strong religious and traditional connotations. A manager of one of the private hospitals once said: "If it was not for these *fa'ileen el kheir* [pl.] we would have closed a long time ago, but God sends."

In many cases, the people, particularly mothers with children, perceive these services to be better primarily because they are familiar with the staff. However, most private and non-governmental facilities focus on curative services, with minimal attention to preventive services, and there are no health awareness services whatsoever.

These facilities are not always based on communal values of care and affinity. For many young doctors, it is a place for them to train and earn a living; for patients it is a place to get what they cannot obtain elsewhere, including a treatment with dignity; for others it is a place to make quick money. A doctor from the area once told me:

> As you see, I have my *moustawssaf* [polyclinic] in the basement of this building owned by my father; the inspector came every week to close it because the two examination rooms have no windows...that is until I found out that all he was after was some money...he had forced me to close it down until a month later I agreed to pay him LE 500 (US$ 147] to allow me to reopen again.

A large segment of Sayeda Zeinab residents are covered by health insurance, including those who work in the government or private sector and children at schools are covered by a school health insurance scheme. However, for most women and families who do not fall under these

categories, there is no access to health and medical insurance. Most have to pay directly for any contact with providers or for medication. Many mothers hear that their children can benefit from the school health insurance program, but have had no chance to learn how to access the system. Furthermore, many residents have expressed a lack of confidence in the facilities they are referred to by the health insurance doctor because they believe they are deprived of certain services and benefits by those operating the system. Most of them feel that this is just another way of diverting their income into channels over which they have no control.

In reality, pharmacists are probably the people's first choice for medical care in Sayeda Zeinab. Dissatisfaction with services and heavy reliance on pharmacists reflect a culture of 'pharmaceuticalization' (see chapter One). Somatic and psychosomatic ailments are pharmaceuticalized, even if not medicalized in the sense of receiving a diagnosis by a biomedical professional.

There are many pharmacies in the area which are accessible to most people. However, while the pharmacists themselves are accessible, people and pharmacists report that the price of medication is not always affordable. Being the first choice of many sick people, most pharmacists feel a greater obligation to help residents of the area. Some of them sometimes accept less money for the required medication. Others manage to collect partially used medications which are still valid and give them to poor patients who come to the pharmacy and who are known to them. Others keep only the bare minimum and basic medications because they know that many people cannot afford the price of costly medication. Pharmacists observe that doctors' prescriptions are getting longer

and that the patients are increasingly purchasing less of the prescribed medication. When asked, some pharmacists commented saying "*inta muntazir eeh!? Il-nass ma'andahash filus,*" meaning:"What do you expect?! People have no money."

A large number of women and men mentioned that they rarely go to a doctor when they feel ill, or that they have gone but have discontinued the medication and have not returned to the doctor. This becomes more burdensome when combined with the psychological stress created by a daily life which is generally seen to be difficult and consuming: "*el hayah el youmeen dul sa'b (life is hard these days).*" Clearly, access to health care in Egypt is intimately related to social differentiation.

Physical Ailments and Social Realignment:

People do not manage illness independently of other social realities which are more directly affected by economic hardship. In my several meetings with Om Abdou, the housemaid mother of five mentioned earlier, it became clear that matters of illness are matters of both physical and emotional survival. "But what about your rheumatism and eyes?" I once asked. She replied: "Nothing is free in this country anymore... I work like a donkey, and I cannot even go to have the *elag* [treatment]." So when Om Zakaria, Om Abdou's neighbor, gave her a few capsules from her own rheumatism medication, Om Abdou was happy and felt that her condition had improved. The capsules were a partial cure for the physical pain, the burden of her social position.

"But, how do you know it is rheumatism? It could be something else?" I asked. She replied:

You are talking like the doctor of the *moustawssaf* [clinic in the mosque]... I went to him two years ago and told him I have rheumatism, he asked me the same question. I said I know I have it and I want to have this medication, and I showed him the box of the medication Om Zakaria had given to me... You know what happened, I left with a big list of *elag* [medication, treatment]... I never went back, and never bought the medicine.

A very similar interaction was repeated in my presence when accompanying Om Abdou to a Cairo educational hospital along with Om Zakaria and her daughter. When they approached the resident and two interns, this is a segment of the conversation which took place:

Resident: *Kheir*?! [Good; here meaning what is wrong?]

Om Abdou: I've had rheumatism for a long time, it is eating my bones.

Resident: Where do you have it?

Om Abdou: In my knees, wrists and hands. [Holding and pressing those body parts with her hands.]

Resident: Have you taken medication for it before?

Om Zakaria: Yes, my son, I gave her some pills from the medicine the doctor in our neighborhood had prescribed for me. I don't know the name but they were orange-colored capsules in a yellow and white box, they cost LE 9 from the pharmacy.

Resident: You don't remember the name?

Om Zakaria: No, but she felt good with it, didn't you? Tell him.

Om Abdou: Yes, I did.

Resident: Did it make you feel comfortable?

Om Abdo: Yes.

Resident: I will write you the name but you have to go and get it from outside.

Om Abdou: In the name of the prophet write some vitamins for me, *da ana ghalbaanah wi ta'abanah* [I am defeated, poor and tired].

Resident: OK, here you go.
Om Zakaria: Are they available at the window [the hospital's pharmacy]?
Resident: Yes.
Om Zakaria and Om Abdou:
Thank you, God bless you my son.

Om Abdou was never examined, or asked for how long she used the medication, or if she was taking other medications. It is, however, particularly fascinating how she managed to get the exact prescription for the medication and the vitamins she wanted. She may have had no rheumatism, or had contraindications to this medication, even so, she was successful. In fact, contrary to conventional linear thinking about power relations, the doctor, Om Abdou, and her friend all received what they wanted out of the encounter (see Sachs 1989).

After ten days, Om Abdou could no longer afford to buy the medication. However, as the prescription paper was misplaced in Om Abdou's small apartment, it became like a ghost haunting the whole family. Whenever Om Abdou felt under excessive stress, she made it clear to the family, particularly her 'children', that she had sacrificed her health (and life) because of a lack of money.

Om Abdou's husband, Shaaker, who is in his mid-fifties, said at our first meeting: "What can you learn from me, *ana ghalbaan* [I am defeated]." Later, Shaaker and I had lengthy conversations on some mornings. He and his family have developed a self-perception as being *ghalaabah* (pl.), poor defeated people, which has shaped how they relate to the outside world. Their whole world has come

to be divided into a *ghalaabah wi aqweyah* dichotomy [the defeated and the powerful].

The *ghalbaan* (*ghalbaanah* for females, sing.) person is one who could be given such a label based on a myriad of criteria: diminished physical stature, poverty, gender, age, occupation, place of residence, illness, or many others. However, for these *ghalaabah*, the two most important reasons for being assigned such a label are poverty and illness. The *ghalaabah/aqweyah* dualism is a local idiom linked to social *mustawayaat*. This idiom is complex because while it connotes helplessness, it masks the way in which it can be mobilized to negotiate emotional and material reciprocity. For instance, Shaaker found no better ways of finding work for his daughter than approaching an acquaintance who had a friend working as an accountant in a factory:

> I told him, "Ask him, tell him *ihna ghalabah* [we are all defeated]...I need your help to find my daughter a job."

Whether or not a daughter gets a job, the family is nonetheless defeated; and, more importantly, they continued to have a self-perception of being on the losing side of the *ghalaabah/aqweyah* dichotomy. The helplessness aspect of this idiom is manifested in decision-making during illness. For many in Sayeda Zeinab there simply are no decisions to be made at times of ill health: they do not seek health care, they cannot afford the examination, the medication, or at times even the transport back and forth to a health facility. For another segment, each decision becomes a complex process of estimation and calculation depending on the nature of the disease; its frequency or severity; if someone else in the family already is in the same condition; the

disposition of neighbors or relatives; the month of the year and other expected expenditures during that month; which family member has the complaint; and how the family really feels about having a family member having a particular disease among them; plus a host of numerous other factors. In the end, the decision may still be that it is not affordable for some to contact a health professional.

While Om Abdou's family seems powerless and un-authoritative, they have developed a micro-political formula for asserting and obtaining at least some of their basic needs. They exercise their moral authority to achieve certain ends. Ironically, this formula meets their needs while, simultaneously, it naturalizes the cultural foundation of prevailing social discrimination. Furthermore, within the family, there are grades of moral authority that are often based on a moral economy of emotions. When Om Abdou sits rubbing her knees or asks her daughter to rub her aching shoulder, or tells her son in a very special tone of voice "I cannot raise my head, yet I go to work everyday," she is not only anxious for her son to get a job, she is making it known that she is doing her share in the maintenance of the family. Thus, the least she can obtain in return is some monopoly over the emotional domain of the family. Om Abdou is unable to go to the doctor because of financial constraints, but she makes sure it is known, not only to her family members, but also to me and to others in her social network. Such reminders are often disguised as other concepts such as *tadheyah* (sacrifice).

She, like others in Sayeda Zeinab, has to settle for compensating for her physical deterioration by demanding loyalty and exerting indirect control over the weaker

members of the family or the social network. Those who dare to oppose her suffer an emotional defeat.

Sharing is Healing:

For the majority of the population decisions about health care are syncretic. In Sayeda Zeinab, as in Egypt as a whole, biomedicine is widely used and is often preceded, supplemented, or followed by traditional remedies and healers (see Lane and Meleis 1991:1205). On another level, for many people, private sector and public sector doctors both treat a patient for the same condition without the knowledge of each other.

Usually in Sayeda Zeinab, the patient is taken to several locations to find out what she/he or her/his family think is the best treatment. Simultaneously, this can be and is often combined with a host of home remedies, traditional herbal medications or organized healing events and interventions. According to most people, no harm can be done from having too much of a good thing. If one thing works, why not try another? If none works, then there is no harm in trying yet another alternative. The people of Sayeda Zeinab say we do not worry about it too much, "*ihna dafii'n dafii'n,*" meaning "we are the ones who are paying in any case."

For everyone, the source of traditional and biomedical knowledge remains a mixture between personal experience and experimentation that are linked to informational reciprocity with members of the same and other social group. I have found that women in Sayeda Zeinab have different styles of conveying bodily ailments than do men. Many women from different *mustawayaat*, consider mild and even moderate headaches, joint aches, arthritis, sprains, skin discoloration and pigmentation, dry skin,

hair loss, urine discoloration, urine retention, diarrhea and constipation, secretions from genital organs and many other illnesses to be part of everyday life, and require no treatment by either traditional or biomedical remedies. This is similar to what has also been reported in rural Egypt by Lane and Meleis (1991).

In Sayeda Zeinab, women seemed more likely than men to communicate to on another and to their close social networks their minor and mild psychological and physical ailments or discomforts. This is congruent with the cultural emphasis on verbal exchange in repeated and tedious ways noted by other researchers (Early 1993, Wikan 1996). However for severe illnesses, behavioral responses are different. For the middle class women, the presentation of their ailments is not quite so dramatic, but has many of the elements which are more compatible with what was observed in Sayeda Zeinab among lower class women. Lane and Meleis (1991) observed in rural Egypt that:

> ...for non severe illnesses [the individual is] quite stoic. However, when the pain becomes severe enough, a woman cries, refuses to move, and acts like she is dying. The other women in her household begin to pace around her and say, 'Oh sister, oh, one thousand salama, Oh, sister.' Other kinswomen from nearby homes come and join in the chorus, begging God to spare their sister. Soon the men are alerted to the woman's problems and return home to find five or more women wailing like professional mourners around a woman who is rocking back and forth and crying through clinched teeth. They hasten to call on a relative or neighbor who owns a car to come and take the woman to a doctor.
>
> (Lane and Meleis 1991:1206)

Such presentations of illness signify differences in identities among different *fi'aat*. Women and men who create such elaborate performances are often referred to

by doctors and the upper classes as being *nass baladi*, or *nass mutakhaliffah*, in other words traditional people or backward people, not modern. The presentation of illness, then, becomes a medium to get some attention, but it also becomes a way to reconfirm status.[15]

Conclusions:

Everyday decisions in Sayeda Zeinab are partly constituted by manipulation of opposable cultural idioms such as the defeated and the powerful. Economic reform and "expenditure switching...transfer[s] costs from the paid to the unpaid economy with poor women often footing the bill" (Kanji et al. 1991:992). However, although being of lower *mustawayaat* may mean being the economic underdog, it does not mean being totally helpless. Idioms of "defeat" and "sacrifice" are related to local conceptions of *mustawayaat* and relative emotional and material wealth. However, these idioms, while they provide temporary emotional satisfaction, do not constitute a challenge of the naturalization of the cultural manifestation of social differentiation in modern Egypt.

Enhancing local/global economic links creates a local version of modernity where resources reproduce preexisting *mustawayaat* and are differentiated according to them. For most, survival of the individual has become more important than survival of the community and

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[15] Even with diversity in illness presentation, among the issues that remain unexplained: the delay in seeking health care, especially documented in the case of maternal mortality and other reproductive health issues (see Khattab 1992, MOH 1994b).

society. Families and social networks have been challenged through attempts to make economic and emotional improvements. More than ever, coping by individuals and families depends on significant changes in patterns of social affiliation. In light of this, scholars need to adopt a more sophisticated view of illness practices and the role of the family and social affiliations in everyday life. This is what we will study in the next chapter.

CHAPTER THREE:
VIRTUAL REALITY:
KINSHIP, SOCIAL NETWORKS, AND WELL-BEING IN EGYPT

> Your Children are not your children.
> They are the sons and daughters of Life's longing for itself.
> They come through you but not from you,
> And though they are with you yet they belong not to you.
>
> You may give them your love but not your thoughts,
> For they have their own thoughts,
> You may house their bodies but not their souls,
> For their souls dwell in the house of tomorrow, which you cannot visit, not even in your dreams.
> You may strive to be like them, but seek not to make them like you.
> For life goes not backward nor tarries with yesterday.
>
> You are the bows from which your children as living arrows are sent forth.
> The archer sees the mark upon the path of the infinite, and He bends you with His might that His arrows may go swift and far.
> Let your bending in the archer's hand be for gladness;
> For even as He loves the arrow that flies, so He loves also the bow that is stable. (Gibran 1972[1923]:17-18)

Introduction:

Life in Egypt is becoming increasingly shaped by the homogenizing forces of the global political economy. But the everyday life of Egyptians is neither completely adapted to the parameters of global economics nor entirely disengaged from them. Cultural mechanisms of living and survival as well as social and political institutions are perceived by most Egyptians to be in a constant state of tension between survival or demise, as they are challenged by the forces of modernity (see

Hegazi 1995). The tension between cultural practices and institutions on the one hand, and a political-economic ideology of modernity and its associated institutions on the other, fuels a lively public discourse in Egypt itself and also an international discourse on Egypt in the social sciences and politics.

In Egypt, a pro-modernity camp subscribes to the inevitability of progress from "tradition" to "modernity." On the other hand, a pro-tradition camp subscribes to an ethos of cultural exclusivity and *il hifaz 'ala il assaalah* (authentic identity preservation). This dichotomous debate has been current since the second half of the Nineteenth Century. In this relational context, one camp seems to believe that their world is:

> ...endangered by change and movement, in which equilibrium implies stagnation. Development is the betrayal of itself, a denial of its identity which is predicated on stasis and petrification. Identity, in this cultural age is built on the illusion of authenticity, in other words, on the reproduction of a model considered to be above and beyond the dimension of time, untouched by the tide of development and change. (El Mernissi 1988:40)

Both camps include ordinary Egyptians, social scientists, philosophers, and politicians. Both camps are concerned with an interpretation of modernity and culture, but they share a narrow representation of Egyptians as falling into one camp or the other. This tension forces insiders and outsiders to question the limitations of the debate, especially in terms of the nature of social relations.

> ...one must ask what the consequences, if not determinations, are of social theorizing that concentrates on the internal dynamics of cultures treated as ahistorical social wholes detached from their global contexts--theorizing that does not seriously question the global and historical conditions of its own presence.
>
> (L. Abu-Lughod 1989:275)

Among the followers of both camps, the implications of modernity for kinship and social relations is a matter of intense debate in Egypt. Both sides agree on the centrality of *il-usrah il-misreyah* (the Egyptian family) at this stage of social change in Egypt. Despite their explicit polar opposition, there is a commonality here. Families are considered central to the propagation of social norms and cultural values. Both camps agree that adjustment in families to new local and global realities will determine the shape of Egyptian society of the future.

Consequently, a simple and narrow representation of the social, cultural and political aspects of the everyday life of Egyptians is most often observed. This representation is evident in the overemphasis on discussions about the family in the social sciences and public discourse. This is a discourse which excludes other social ties and bonds from most existing frames of reference. This narrow representation becomes intensified when it comes to the health of the Egyptian people, where, somehow, the family is treated as the primary social institution influencing health and illness. As such, it is quite reminiscent of victim-blaming strategies used in many social and health policies in Egypt and around the world by medical professionals and policy-makers.[1]

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[1] Examples of victim-blaming strategies in Egypt and elsewhere in health education campaigns that target mothers as the agents responsible for their children to be free of diarrhea, acute respiratory infections, accidents, communicable diseases; urging mothers to breastfeed, educate and incorporate in their children a sense of belonging and loyalty to Egyptian society. All of this takes place within an

(continued...)

This chapter is about subverting a simplistic representation of social ties and their relation to health and illness in contemporary Egypt. I will argue that as well as family ties there are other ties which mediate the emotional and material aspects of everyday life in Egypt. These ties are also effectively linked to the local idiom of *mustawayaat*.

Section One of this chapter explores the representation of Egypt and the Middle East in the social science literature. Because this is a vast literature, the focus is mainly on the representation of the role of kinship in Egyptian life. In section Two, a case study of a woman from Cairo is presented. She finds herself in a web of social ties which defy any simple links between kinship and survival or illness management strategies. Chapter Four then offers a discussion and suggestions as to how the scientific representation of Egypt might be enriched by a more sophisticated approach to understanding social ties.

Section One: Representation of Kinship in Egypt and the Middle East:

The earliest theory of kinship in Egypt was proposed by Ibn Khaldoun; this theory later influenced the early Egyptian and British sociological and anthropological

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[1](...continued)
belonging and loyalty to Egyptian society. All of this takes place within an environment of limited resources in most families, inequalities in access to and control over resources, and exclusion from macro political spheres. In this context, *mas'uliyat il om* (the responsibility of the mother), as touted in the media and by doctors and government officials, turns to be a nationwide organized victim-blaming strategy.

tradition (Hamed 1982). Subsequently, Ibn Khaldoun's comprehensive theory of kinship was diluted to an extensive inquiry into the family to the exclusion of other domains of social interaction. More recent inquiry reveals that the notion of family in the Middle East is complex; it sustains several encompassing notions such as kin, house, household (see Eickelman 1981, Rugh 1984, Morsy 1990b, Tucker 1993), "blood" (L. Abu-Lughod 1986), and *nisba*-type categorization (Geertz 1983). The diversity in family organization reflects both traditional values and recent political-economic necessities, though the latter subject has not been fully explored as yet (see Shorter 1989, Adams 1986). Hind, for example, is a 52-year-old widow from Sayeda Zeinab whose work is to wrap candies in a candy factory. She is a mother of four offsprings aged between 18 and 30. She says:

> After my husband died, the oldest of my children was 12 and I was pregnant with the youngest. His family never liked me, they always thought he should have married someone richer and more beautiful. They did not care that I am a good mother and a good wife... When he died, they came for the first forty days [of mourning] then I rarely heard from them. My brother is a *'aamil tarahil* [mobile day laborer] and my sisters are at the end of *Sa'ed* [upper Egypt], they could never afford to come either for the mourning period or afterwards... My husband's family [who lives about 30 minutes on a city bus ride] never even came to give the *'ideyah* [bonus] for the feast for the children. They knew he [her husband] had no pension... I had to go and find a job. A wife of a friend of my husband worked in this candy factory. After the mourning period, I asked her to find me a job there, and she did... I raised my children alone; she [the husband's friend's wife] became my sister and some of my workmates became my real family.

Hind locates the value of her friends in the idiom of the family. While blood sisters remain sisters, other kind of sisters are created through friendship. This special

sisterhood is not the kinship usually explored in conventional anthropological and sociological literature on Egypt (cf. Early 1993a). Kinship, then is not a cultural static.

Reproduction of Kinship:

In the Middle East, as elsewhere, marriage is not only necessary but inevitable (Rugh 1984, Toubia 1988, Stamm and Tsui 1986). Matrimony is a public matter (Naguib and Lloyd 1994); a contract between two collectivities (Mustafa 1987; Altorki 1977,1985,1986; Marsot 1978). For marriage, power negotiations and vested interest alliances are struck among the lower as well as the upper classes (Rugh 1984). Because marriages are mostly arranged by the involved families, they are in themselves the domain of considerable political and social negotiations (Stamm and Tsui 1986; Watson 1992; Rugh 1984; Early 1993a). Women/mothers are the important agents who strike social and political alliances in a society which largely maintains itself through informal social institutions (Altorki 1985, 1986; Barakat 1985; Mernissi 1987[1975]; see Eickelman 1981).

The Arab family holds a complex network of affinity and symbolism (Altorki 1985, 1986; Moghadam 1993). This is to an extent that deep interdependence, sentimentality, commitment, and self-denial may verge on morbidity (Barakat 1985:30). This self-denial serves emotional and practical ends. Sameer, a 41-year-old father of three said:

> The only pleasure left in my life is smoking... Now I have to stop it to be able to afford the private tutoring for my children at school.

Among all *mustawayaat*, the value of self denial remains in cementing social ties through the creation of

emotional bonds where today's investments are expected to be redeemed in the future. But these investments in emotional and material exchanges are not random. Emotions and material resources are always seen by Egyptians to have *hudud* (limits); reciprocity with kin and others is often differentiated.

Social ties with the mother's kin are often stronger and structurally and functionally different from those of the father's kin.[2] Affective relations are often reserved for kin from the mother's side. It is not uncommon to find offspring with completely polarized emotional and material ties to kin on both parental sides. As a 22-year-old girl said:

> You know what they say, *il khalah om* [the maternal aunt is like a mother]... I used to go every summer to stay with *khalty* [my maternal aunt] in El Fayoum [A governorate 150 Km south of Cairo]...I had such fun with my cousins there... But, 'Amety [my paternal aunt] I only saw here a few times in my life. My mother did not get along with her in-laws so we grew up going only may be once or twice a year during the feast with my father... We [children] all stopped going [to paternal kin] a few years ago as soon as we started having our own friends...

Filial love (Dwyer 1978) is recognized as having stronger ties than conjugal bonds (Rugh 1984, Stamm and Tsui 1986, Altorki 1986). Women derive status and insurance from motherhood (Youssef 1978; Hatem 1985; Shami 1990; Barakat 1985; Dwyer 1978; Hussein 1968; Morsy 1990b; Wikan 1980). The mother-son relationship is particularly strong, to the point of mutual emotional dependence and eroticism (Hatem 1985, Altorki 1986, Rugh 1984, Wikan 1980, Dwyer

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[2] In the case of Japan, Yanagisako (1977) calls this a 'uterine bias.'

1978, Mernissi 1987[1975]).[3] However, it is not really clear why, in ethnography, more appears about the mother-son than about the mother-daughter relationship (see Dwyer 1978).[4] The relationship of male in-laws receives cursory, if any, mention (Salih 1987).

It is true that it is difficult to imagine an Arab without a family (Lesch and Sullivan 1986). However, ethnographers and sociologists hold dear a highly deterministic view of kinship and the household where practices are derived, almost exclusively, from the normative structures described above (Eickelman 1981, B. Ibrahim 1985b, Rassam 1982, Inhorn 1996). Al-Khatib and van Nieuwenhuijze (1982) and Hopkins (1991a) grant more individualism to household members. A position which is supported by Rugh's observation that "each person's position also carries with it a value in itself that gives it independent importance within the group" (Rugh 1984:150). This intra-familial diversity in values and functions is yet to be fully explored ethnographically (Hatem 1985).

Even when the family is a focus of study, intrafamilial relationships are limited to the conventional dyad of woman/mother-man/husband/son. Also, the role of other

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[3] This closeness is manifested in an intense competition for emotional and material ends between mothers and daughters-in-law (Hatem 1985; Morsy 1978a, 1978b, 1990b; Altorki 1986; Rassam 1982; Wikan 1980; Mernissi 1987[1975], Singerman 1995).

[4] The latter is also a very intense domain of identification in Egypt and the Middle East (Hatem 1985, Rugh 1984) and even in other societies such as Japan (Yanagisako 1977).

members of the social universe of any of these players seems to be obliterated in the literature on the family. This leads to a false conclusion that the reproduction of the family in Egypt and the Middle East is a private matter. Neither the emotional nor material worlds are, then, independent of social ideology and cultural values. For example, for the *Awlad Ali* bedouins, emotions and filiative discourse are embedded in the politics of collective identity and ideological exclusiveness (L. Abu-Lughod 1986). The case of the *Awlad Ali* illustrates how cultural expression of corporateness is stratified within the same society. It is therefore, a group and a context specific arrangement (see L. Abu-Lughod 1986:48, see also Fukuyama 1995). The interaction of ideology and affiliation takes a culture-specific form. This lack of conceptualization of the interaction within and between social institutions points to a fundamental problem of unraveling the family's "relations to other loci of consciousness formation" (Harvey 1989:236).

Exchange and Reproduction of Kinship:

According to Altorki the family is not merely an institution of emotional socialization. The family "constitutes a person's reservoir of economic security, political influence, social support, and psychological succor" (Altorki 1977:279). Barakat points out that the family is the socio-economic unit of ideological and economic production in the Arab world (Barakat 1985:28, Rassam 1982:136). In this context, exchange is broadly defined to include all aspects that reproduce the family including information as an important currency of exchange (Altorki 1977,1986; Inhorn 1996). It is not a coincidence that at times of a family crisis, information exchange is intensified for the purpose of re-establishing the fundamental defining parameters of

social ties. Rabab recounts how she came to know her future husband:

> My mother told my two brothers that if they know what is good for them, they had better start thinking of one of their university colleagues who would be a suitable husband for me... She would ask them every day, I was embarrassed at first, it was as if I am not pretty or would not make a good housewife... Later I questioned my brothers on my own. I got to know of some of their friends, a few of them sounded nice... I wanted first and foremost a decent husband, with an apartment outside Sayeda Zeinab so I would not have to put up with people's gossip and the way they look into your life... I finally got to meet two of their colleagues whom I became a good friend with... I am not sure what they told them but they came to the house and we got to see each other... The one I liked was a friend of my older brother, in his last year in the university, and his father has a chicken farm...we finally got married after one year of engagement... I later got my brother married with my own hands (*'ala yaddi*).

Rabab's story is one of social ties and social obligations. It is a story of what counts: marriage and space. It is a story about the moral economy of social affiliation. In this process, information is an asset or capital whose exchange works to affirm current notions of social relations. But this moral economy requires more than dealing in abstract information. Material assets and commodities are also operative in this social exchange.

Morsy (1978b, 1982, 1990b) sees a bride's wealth (*mahr*) as a transference of woman's productive and reproductive capacities to her husband's kin group. In reality, though, most married women maintain strong financial and emotional ties to the men and women of their own kin (Moghadam 1993, Altorki 1986, Wickering 1991). In another interpretation, a bride's wealth is a gift to the bride or a contribution to the establishment of a common dwelling (Altorki 1986, Marsot 1978, see Eickelman 1981,

see Barakat 1985:40). Both views are in agreement on the symbolic value of a bride's wealth to signify matrimony and appropriation by men. The new roles of women and the changing political-economic situation have yet to be integrated into the analysis of the symbolism and function of a bride's wealth. A bride's wealth is portrayed as an exclusive domain for the family. In reality, however, a bride's wealth is not only a family matter, but also a social matter. An important function of a bride's wealth is to spread the knowledge about the value of the bride and her family in their social circles and their society. Two weeks before a 24-year-old Soha got married, her mother told me:

> I had to add another LE 1000 to the money he [the bridegroom] gave us to buy a bigger *shabkah* (gold wedding gift)...I also had to add another LE 2000 to his *mahr* (bride's wealth) to buy good furniture... I did not tell even her father... I did this in order that she can have a more comfortable life with her husband [he would appreciate her more since her family would have made a large financial contribution, a reason for more respect and deference]... I also did it so that my family, neighbors, her friends, and everyone else in the neighborhood knew that she was a special bride and that her bridegroom values her more than any money in the world.

Most conventional analysis, then, strips a bride's wealth of this kind of extra-familial context.

Morality, Sexuality, and Kinship:

Marriage is often portrayed to be full of animosity and contention, dominated by a leadership/obedience polarity between males and females (Mernissi 1987[1975], 1988; Hatem 1985; Barakat 1985). This polarity also leads to a heightening of the sexual dimension in any male-female encounter (Youssef 1978; Hatem 1988; Barakat 1985; Dorsky 1986; Jabbra and Jabbra 1992; Makhlouf 1979; Altorki 1986, 1988; Rassam 1982; see Eickelman 1981; Nelson 1974;

Hijab 1988; Mernissi 1987[1975]; Maher 1974; Wickering 1991; e.g. Early 1993a:68). This polarity also creates invisible barriers which segregate men and women (Altorki 1986:4). In most of the literature, women's sexuality is seen as the subject and object of social control (Dwyer 1978, Rassam 1982, El Saadawi 1990, Sabbah 1984). But, women's sexuality defines their proper place in society (Rassam 1982; El Saadawi 1979, 1980, 1983, 1984, 1990; Accad 1990; Malti-Douglas 1991). Yet, the discussion in one extreme is narrowed down to the sphere of the family regarding socialization and control over sexuality. The median area between the family and the society at large is often unexplored, leaving a large gap in terms of our understanding of the dynamics and/or the implication of social ties and social networks in mediating male and female sexuality in society.

This point was hammered home upon meeting the brother of a potential research assistant. The research assistant was a 27-year-old social worker, whose lawyer brother had asked to meet me to discuss the matter of her part-time job. She comes from what in Egypt is considered as *usrah mutadayenah* (a family that exhibits religiosity and adherence to Moslem rituals and behaviors, in brief, a religious family). She was wearing what has become known in Egypt in the past decade or so as "Islamic dress" at the time of our meeting: a loose seamless dress that completely covers the arms and the body right to the ankles. This is also worn with a loose headdress that covers the head and neck and falls in one piece down to the waist. Only the face and hands can be seen when wearing this outfit. This is an excerpt of my conversation with the 36-year-old lawyer, the brother of my potential research assistant:

Brother: I told my sister when she told me about you not to walk with you in the street.

Myself: Perhaps people who see us together in the streets do not know or wonder about the nature of our relation!

Brother: No, not really, I do not worry about people so much; if you are not doing something wrong you should never worry about people. The matter is that I do not want my sister to get used to walking alone with men in the streets. She might get used to it, like it, and think it is right.

Sister: Why do you say this?! I am not like that and I am not going to get used to that in this way!

Brother: I spoke my mind and I think you should respect it.

Sister: But...

This encounter was laden with undertones of the local meaning of dignity, association but more important, *sharaf*. *Sharaf* (Honor) is a concept usually dealt with as a domain of problematic relations between men and women (Youssef 1978, Dwyer 1978). It is considered dishonorable for an Egyptian or an Arab woman to lose her virginity except with her husband on their wedding night. Otherwise, she is considered to have jeopardized the honor of the whole kin by not following the moral and sexual code. The concept of honor often takes on religious tones. It also expands beyond sexual acts to encompass talking with strange men, opening the door to them in the absence of the husband, showing more of the body than necessary, and other numerous restrictions. However, these are *fi'aat*-dependent applications. Dress code, code of conduct, and the parameters of social relations with men are all shaped by class. In some of the streets in Sayeda Zeinab one can find street signs stating "veil or hell," which have been posted for a decade or so. This is not to be found in areas of *il mustawayaat ili qadirah* (financially able social levels)

in Cairo, or even the subdistricts where *il mustawayaat il woustah* (middle levels) live in Sayeda Zeinab.

Conventional scholarship proposes that honor is applied within a dualistic social moral standard along gender lines (Altorki 1986; El Saadawi 1983,1984,1990; Accad 1993 on El Saadawi). Conversely, it can be seen as an illustration of a continuum of morality between the sexes and indeed sexuality itself (Dwyer 1978). The concern with honor stems from a low valuation of women's minds and from the strength of religiosity in the society (Morsy 1982,1990b; Hatem 1985; Mernissi 1987; Dwyer 1978; Sabbah 1984). Men are supposed to be guardians of their women who, in turn, uphold a substantial component of the *sharaf* of their male. It is not uncommon for men to be considered victims of women who fail to protect either their own *sharaf* or that of their social network. Those men who are involved in this *'aar* (shame/ dishonor) and *fedihah* (scandal) are considered victims of the seducer of loose women. Hence, *sharaf* indicates the most powerful underlying tool of social differentiation in the region: morality (see Altorki 1986; Mernissi 1987[1975]; Rassam 1982; L. Abu-Lughod 1986,1988,1993; see Stauth 1989; see Wikan 1980 on morality as a social asset).

However, the literature is routinely concerned with the familial manifestation of this morality. The existence of an extra-familial context is largely muted. The family, which sometimes is represented as the mediator of culture and social institutions, is reduced to the domain *par excellence* of dealing with cultural tensions and moral conflicts.

Kinship and Social Stratification:

Hierarchical and non-kin social relations yield to the family as the most popular focus of institutional study by both native and non-native social scientists (e.g. Altorki 1985, 1986; Hatem 1985; Salih 1987; Barakat 1985; Salih and Salih 1987; Kamal et al. 1990; Lesch and Sullivan 1986; Tucker 1993; Rugh 1984). Kinship is mostly studied from a structural-functional perspective (e.g. Rugh 1984, Morsy 1982, Shami 1990). Kinship is seen to structure the identity of Egyptian and Middle Eastern individuals, society, and bureaucracy (Salih 1987, Eickelman 1981, Khalaf 1985, Tucker 1993, Al-Khatib and van Nieuwenhuijze 1982:98, see Adams 1986, L. Abu-Lughod 1986:32, Barakat 1985:28). Family affiliations are also a social manifestation of corporateness: "to belong inextricably to a caring group" (Rugh 1984:xi). Accordingly, individuality is interpreted as dysfunctional to a group survival (Hatem 1985, Rugh 1984). Being in a family which performs socially expected roles is the basis for social recognition for both men and women in Egypt (Naguib and Lloyd 1994).

Marsot (1978) and Cole (1981) note that contrary to Western conventional wisdom, it is the rich and upper class women who were more oppressed in Egypt. While this situation is currently reversed, the lesson remains: neither kinship nor class structure is the only relevant variable in gender analysis (Moghadam 1992). Critical historians interpret and present social institutions in the light of a dynamic articulation between continuously developing value systems (Tucker 1985, Kuhnke 1990, Gallagher 1990). In this light, work, health, and gender relations are expressions, not only of microlevel forces, but of nothing less than national politics (see Morsy 1993b). Ethnography, on the other hand, remains largely

chained to a static representation of value systems almost exclusively reproduced through kinship in Egypt and the Middle East.

Whether through control of sexuality (Wuthnow et al. 1984:173; Foucault 1978, 1988, see Sarup 1988), knowledge (Foucault 1978; Sarup 1988; Wuthnow et al. 1984), or habitus (Bourdieu 1977, 984), a person's location in the power schemata of society is based on gender, class and other culturally salient values (Morsy 1993b, Wikan 1980). Thus, attitudes and behaviors emerging as products of social interaction, are revelations concerning systematic discrimination and categorica differentiations in society (Morsy 1993b, Moghadam 1993, Wikan 1980, Early 1993a, Rugh 1984). Social distinction is revealed in the practice of everyday life, whether in daily discourse (A. Zayed 1992) or at times of illness.

The implications of a focus on the family extends to obscuring other forms of association, thus ignoring local conceptions of *mustawayaat*. The family is not divorced from the social-structural organization of the society as a whole. The very notion of a 'couple' or a 'husband and wife' differs among social classes (Inhorn 1996:98, Altorki 1986).

> The family can also substitute for community as a primary agent for the reproduction of differentiated labor power and hence of basic relations.... Family ambition helps shape social space at the same time as it can be an agent of transformation of class and employment structures. (Harvey 1989:237)

Hence, the emotional and material bonds of the family must always be situated within the context of broader social relations and their local interpretations. Mohsen (1985) demonstrates that for women social classes are not

created by tenable jobs, but that jobs are created according to tenable social class. Nesmah, a 26-year-old unmarried female said:

> When I graduated from the university [Faculty of Commerce], I realized that I had to have a connection to get a job. If you do not have a connection to get a job in the private sector, you are either going to stay home forever or get a low paying job and abuse from the owners of the private sector... If you are from a rich family, you have your connections, and you get a job right away in one of these foreign companies making LE 1000/month [US$290].

Moghadam (1991,1992,1993) and Fergani (1994b, 1994c) show how class can shape Middle Eastern women's choices and practices in production and reproduction. However, Altorki (1986) points out that it is the man whose work, education, and descent determine the social class of the family.

In Egypt and other Arab societies, being born into an upper-class family not only guarantees ascription into a high *mustawa*, it guarantees employment, income and educational opportunities, with the result that lower class families also reproduce their destinies through the biased social structure (Fergani 1994a, Altorki 1986).[5] Studies of kinship in Egypt and the Arab world are unsuccessful in linking social, political and cultural crises to other social structures.[6] There is a notable

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[5] Lane and Millar (1988) explore the impact of class differentials on the hierarchy of help-seeking behavior.

[6] This, however, is further complicated by the complex nature of social classes in the Middle East. Eickelman (1981:288) proposes that anthropology in cities could be a window to explain class transformations. Hatem (1988) suggests Islam provides the main link between the modern middle class and the working class. Moghadam (continued...)

absence of any recognition that the family can only be understood "through its relation to a dominant mode of production as well as to forms of state power" (Harvey 1989:236; see Pascall 1986:34-69, Rassam 1982). The study of this topic would inevitably lead to an expansion toward the study of cultural forms of affiliation in the society beyond the family context.

A common assumption in most of the studies on the subject of the family is a simplistic functionalist view of class/modernity/individualism where individualism is associated with higher classes and collectivism with lower ones (see Sennett and Cobb 1972). This view, while reproducing shallow conceptions of everyday life of Egyptians, diverts our attention from the local interpretations of social ideologies and cultural realities. Zohra, the widow, whose husband's family neglected her and her children said:

> After he died, I always prayed to have enough money and food for my children. But with the LE 75 [US$ 24] from my job I have to do other things to make this family live. I am not educated but I know that without the *jam'iyaat* [savings clubs] and my workmates I would have never been able to come this far. I still have a long

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[6](...continued)
(1993) proposes fine-tuning of the all-inclusive middle class category. Early (1993b) proposes that an intra-gender social location is a result of indigenous conceptual stratification rather than social stratification. Rugh (1984) notes that it is the relation of classes with formal institutions which determines their social position in society, rather then economic worth *per se*. On class formation and conflict, Hopkins (1985, 1991b) is interested in refining the conceptual parameters of the Egyptian working class, studying them within the urban context and under 'agrarian transition'. However, the limited number of studies that exist do not sufficiently decipher the complexity of the interaction between social structure and kinship nor are these relationships well theorized. See chapters Five and Six for more details on social classes in Egypt.

> road ahead, but thank God, there are always *fa'ileen kheir* [people who like to do good deeds, pl.]... I do not need my husband's family now, even the children know they [the husband's family] are not good people.

Examples such as this show how a narrow focus on the family fails to demonstrate important knowledge regarding the dynamic interaction between the family and social networks. In times of rapid social change, uncertainty becomes pervasive. But,

> although this uncertainty is an inherent part of both the natural and the social world, its impact is stronger on women than on men, on the poor than on the rich, and on rural people than on the urban people... Indeed, the social groups at the lowest levels of the social hierarchy are most confronted with risk and uncertainty.
>
> (Bourquia 1995:138)

The One and One Half: Men and Women:

Inevitably, inquiry into the family often shifts to an exclusive inquiry into women's (subordinated) status. In this type of inquiry, women become the exclusive subjects of extensive scholarship. Examples include *Women in the Muslim World* (Beck and Keddie eds. 1978), *Women and The Family in The Middle East* (Fernea ed. 1985), *Muslim Women* (Hussain ed. 1984), *Women of the Arab World* (Toubia ed. 1988), and *Arab Women* (Tucker ed. 1993).

Clearly, in a patriarchal society, women's situation may be disadvantageous (see Kandiyoti 1992). However, the focus on "women's marital status and living arrangements provide an insufficient frame for studying their vulnerability, and often projects a false picture of either economic security or poverty" (Bruce and Lloyd 1992:28). Zohra, the widow from Sayeda Zeinab, is a case in point. Her LE 75/month (app. US$ 22) income does not include the following partial list of items which also

contribute to her material survival (and which I have gathered from my repeated interviews with her):

* An average of approximately LE 200/annum (app.US$ 58) in ongoing loans from her workmates.
* Seasonal clothing donations she and her children get from the employer of the husband's friend whose wife helped her to get her job.
* Food donations on feasts and religious holidays from this same family and from the owner of the factory where she works.
* Lump sum of money from multiple simultaneous or consecutive savings clubs.

However, most important, her salary and her hardship do not reflect the emotional value of reciprocal affiliation her social network has added to her life, in addition to material assistance, nor does it reveal the emotional losses caused by her husband's death, and the absence of her own poor family.

The literature on Middle Eastern women passed through stages of:

> (1)...total exclusion of women...to (2) [their study] only as members of particular categories...to (3) cultural relativist studies of women...to (4) studies of the oppression of women...to (5) studies of the ways in which women are changing the face of the society. (Hale 1989:249)

However, "the anthropology of Middle Eastern women is theoretically underdeveloped relative to anthropology as a whole" (L. Abu-Lughod 1989:289).[7] Ethnography and other social sciences here identified adult women primarily in terms of familial, domestic, and maternal functions

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[7] The studies of women as active social actors are just coming of age (L. Abu-Lughod 1989; e.g. Sullivan 1987; Moghadam 1993).

(Morsy 1978a, 1978b; Hatem 1985; Dwyer 1978; hale 1989; cf. Sullivan 1987; cf. Kanawati 1991; cf. B. Ibrahim 1985a; cf. Early 1993b; cf. Morsy 1991). This overemphasis on women's intra-household relational roles has led to a failure to identify and expound other relational aspects of being a woman.[8] Focusing on "women-centered kin networks" inevitably means reducing their significant roles to that of motherhood, bypassing other significant social roles they play and precluding the study of any extra-household active roles women may indeed play (Yanagisako 1977).[9]

With economic threats to the role of the male-provider, more authors are interested in the implications for the role of women and their autonomy (Youssef 1978, Hatem 1985, Altorki 1986, Dwyer 1978, Rassam 1982, Mernissi 1987[1975], Nawar et al. 1995, Naguib and Lloyd 1994, Hoodfar 1997). Naguib and Lloyd (1994) point out that

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[8] When attempted, such studies fall within the chains of historicism or Western feminism (see Marsot 1978, Abdel Kader 1992b, Mikhail 1979, Hijab 1988, Mernissi 1988, Said 1985, Rugh 1984:xv, Tucker 1993, Hatem 1993, Badran 1993, cf. Sullivan 1987).

[9] Women in Egypt, as elsewhere, are socialized in the "ethic of caring" for others (Henderson 1991, Hall and Nelson 1996). It is no surprise, then, that children are situated within the very domain of women (Barakat 1985, Dwyer 1978, Altorki 1986, Morsy 1990b). Incidentally, children's health is usually discussed within the analytical framework of the family as a cultural broker between social systems and cultural ideals (see Shami 1990, Tekce 1989, Barakat 1985, Hoodfar 1986). Ethnographies point to the changing value of children and the connection with perpetual systematic reconfiguration in the region (Stamm and Tsui 1986, Youssef 1978, see volume edited by E. Fernea 1996, Altorki 1986). But also, children's value lies in their potential to produce social bonds and emotional ties where none have existed before (Inhorn 1996). Perhaps this is why they are socialized from infancy into "dependence and escapism" (Barakat 1985:36).

even the role of the family of the migrant husband has been eroded by the hardship created by current economic conditions. Youssef (1978), Hatem (1985), Altorki (1986) and Rassam (1982) see this as the end of female economic dependence on men. Others are less optimistic, seeing any role changes as temporary, conditional, and even impossible in a still highly patriarchal society, whose powers are based on economic means and doctrinal principles and social organizations (see Wikan 1980, Naguib and Lloyd 1994, Singerman and Hoodfar 1996). Yet, this literature is mostly concerned with changes in the role of women in the family, with minimal attention to change in their actual role in the society at large. Additionally, this concern inappropriately borrows the concepts and terms which do not explain the full depth of a local culture which "supports gender equality in the form of interaction and negotiation rather than women's autonomy" (Govindasamy and Malhotra 1996:328).

Practically no ethnography exists for men (an exception is S. El Messiri 1978a). This results in a problematic representation of the family, household, and social context, with a particular blind spot toward underlying social stratification. The direction of anthropology of the Muslim world will largely depend on "how Western anthropologists begin to position themselves in relation to Muslim Arabs" (L. Abu Lughod 1989:298).

Women and men are aligned in an asymmetrical yet complementary relationship within Egypt and the Arab world (Naguib and Lloyd 1994, Rassam 1982).[10] Hence, the

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[10] Mernissi (1987[1975]:xi) proposes that this asymmetry is also grounded in class (continued...)

family works to prepare gendered individuals for broader social interactions, affiliation, and differentiation that remain understudied.[11]

Variations on the concept of sex roles have been refuted and modified by a number of studies (Morsy 1978a, 1978b; Altorki 1986; Rassam 1982; see Eickelman 1981; Abdel Kader 1992a; Mohsen 1985; Hussain 1984; Sukkary-Stolba 1985; Sullivan 1987). These studies have demonstrated how society's differential socialization of children according to sex reproduces its moral code and acts as a determinant of identity (N. El Messiri 1977, S. El Messiri 1978b), status (Rassam 1982), work (Saunders and Mehenna 1986, Sukkary-Stolba 1985), and health of its members (Morsy 1978b, 1982; Tekce 1989). Yet, these roles seem to be primarily of concern as they are enacted only within the family milieu in the literature. The dynamics of extra-familial social relations remains obscure. The roles of the members of a society are not only granted but also negotiated (Ozbay 1992, Nelson 1974, Altorki 1986), with inequality in roles being the rule (Rugh 1984).

> Extended families can mean different things at different periods of history. While they allow a sharing, a mutuality, a kind of protection often unknown to persons in nuclear families, they also make possible a kind of restrictiveness, a feeling that others are always involved in one's personal affairs. What appears as

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[10](...continued)
conflicts which get expressed in "acute sex-focused dissent."

[11] The family is the context where polarized gender identities are created through its inherent structure, sex-differentiated conceptualizations, social stratification, symbolic representations, and practices (see Morsy 1993b, Bourquia 1995, Tucker 1985; Stamm and Tsui 1986; Youssef 1978; Morsy 1978b,1982,1990b; Barakat 1985; Rugh 1984; Adams 1986).

> sustaining bonds at one time may appear as oppressive chains at another...the interdependent relations of extended families [can even be] a source of personal humiliation rather than of collective strength. (Sennett and Cobb 1972:107)

Clearly, relations sometimes complement and sometimes conflict with each other.[12] Zohra, our Sayeda Zeinab widow, said:

> Of course I can never go and tell my husband's family they are wrong. After all they are the family of my children. They might need them someday. Maybe if I was rich I would have confronted them and told them they are people with no blood [i.e. shameless], but what can I say, if I was rich I would not have even cared to look at their faces.

Thus, analysis should include the dynamic interaction within and between social institutions. Women have at their disposal, within the family itself and the society, certain culturally sanctioned tools of power negotiation (Edger and Glezer 1994, Barakat 1985, Morsy 1993b). Conversely, not all the young, poor and uneducated men have the social tools for exercising their presumed manly power. The family milieu, then, is not the exclusive arena of exercising machismo, as portrayed in most of the literature. Rather, it is an arena of an ongoing and not-yet-concluded struggle where the parties employ the tools of effective negotiation (Edgar and Glezer 1994).

Intimacy in the Extra-familial Context:

Our repertoire of Egyptian and Arab social ties and affects is extremely narrow. For example, friendship is

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12 The study of culture is possible through studying conflicts in health events (Morsy 1982), sexuality (Rassam 1982), sacred texts (Sabbah 1984), and systems of symbols (Geertz 1983).

often relegated to secondary status, if not completely neglected in favor of studying the family milieu (cf. Wikan 1980). This is far from the complex intertwining of kinship, affinity, affects and behaviors.

> The old forms of intimacy appear oppressive, and you feel you have to be free. Yet when you do make the break, your loyalties and social bonds often remain with the same people as before. While you appear more in control of your own life, you feel threatened by the loss of a sense of fraternity with people you value.
>
> (Sennett and Cobb 1972:110)

It is reasonable to say that horizontal expressions of emotions such as love and affection, rather than hierarchical emotional expressions of hate, submission, and control, are absent from most of our ethnographic representations (see Edgar and Glezer 1994, see El Saadawi in Accad 1993 on "true love", see Kanawati 1973 on friendship and collegiality). One result is narrow ontological categories focusing on roles rather than social relations between partners in the family milieu (Edgar and Glezer 1994). Another result is a skewed representation of social interaction and social bonds devoid of much of what makes Egyptian culture rich and mediates social life. This skewed presentation blocks our view of the many cultural forms of affiliation which are sometimes lateral and sometimes hierarchical.

Abdel Salaam, a 42-year-old man, a secretary at a lawyer's office, like many other Egyptians, distinguishes between *sadiq* (friend), *sadiq qadeem* (old friend), *sahib* (somewhere between friend and acquaintance, or friend [colloq.]), *ma'rifah* (acquaintance), and *usrah* (family). These categories sometimes overlap. But they also conflate temporal, spatial, moral, and economic categories. Longevity in time, proximity in space,

emotional expression of closeness, and material support when needed are the basis of judging and rejuvenating non-hierarchical relations. Abdel Salaam said: "I know many people, but when it comes to opening my heart, I only do it with old friends."

The Household:

Some of the literature on Egypt and the Arab world has attempted to expand the narrow parameters of inquiry into the family to include the household. However, the results share most of the shortcomings of the focus on the family. Concern with the household seems to focus on social organizations rather than on individuals and their diversity within a particular organization. At times, a coincident unity of interest between members of a household and a family has been presumed (Friedman 1984).

Generally, the concept of a household has also been employed to the detriment of the study of culture as an element of any significance. Moreover, the focus on the household allowed for the further entrenching of the study of economics as the main determinant in household relations (e.g. Friedman 1984). In the case of Zohra mentioned above, cultural values were embedded in household economics through reciprocity from her social network. Members of this network are effectively part of the equation of resource-allocation and decision-making in the family. A member of the network who allocates his/her contribution to a specific purpose such as schooling for the boy or girl, or new clothing, or other items, is effectively sharing the decision-making power in that family. But also, members of a network formed the emotional backbone of Zohra's family. However, in the literature, non-monetary and non-material social exchange is relegated to a secondary status in the formation,

definition, and continuation of a household (e.g. Singerman and Hoodfar 1996:xxxiii). Even then, most conventional definitions fail to explore the attributes of the household as

> ...one of the main institutional spheres of the world-economy...households are sets of relationships the boundaries of which are relatively elastic in relations to (a) long-term secular changes of labor and productive processes, (b) medium-term cycles of economic growth and stagnation, and (c) variations between and within zones of the world-economy in which they are located.
>
> (Friedman 1984:47)

Another serious deficiency is the ignorance of the simple fact that "the average number of people living in the same household has steadily decreased" (Van der Poel 1993:10), and that "while households are more confined to nuclear family members, the nuclear family itself is also showing signs of erosion" (Van der Poel 1993:11). Additionally, the household is often treated in a vacuum of social relations, where social interaction would take place only within the household, precluding understanding of the dynamic relation outside of it. A narrow view of the household makes it impossible to respond to an inquiry into the possibility for an individual to be a member of multiple households (Friedman 1984:51). Egypt might be the fertile ground to find an answer to this question:

> ...people identify themselves as victims of the systems and complain about their marginalization, they also become actors and develop parallel networks of exchange, information, and assistance which bring together relatives, neighbors, colleagues from work, and people from one's village.
>
> (Singerman and Hoodfar 1996:xxvii)

Pick and Obermeyer (1996) have found out that in the face of economic and cultural imperatives, alternative

household arrangements were created by women in South Africa where a new form of "alliance household formation" now exists. A characteristic of this alternative household is the unconventional and extended nature of social relations which include "nondescript combinations of people [who] provide support for women from remote rural areas" (Pick and Obermeyer 1996:1431).

This points to a gap in the literature on the household in the Middle East, which has done little to expand the study of social relations beyond the physical boundaries of family units, by-passing all other social relations in their structural, functional, and symbolic roots. Singerman and Hoodfar (1996) have attempted to go beyond the physical boundaries of the family to grasp a better understanding of the household. They point out that economic and collective interests of the family are served by "informal networks based in the household yet extending through all aspects of the community and beyond it" (Singerman and Hoodfar 1996:xxix). Notwithstanding the not-so-valid generalization about the household as the center of informal networks for all genders, ages, and classes, the volume they have edited, after admitting the importance of informal networks, ironically chooses to focus on the household (see Singerman and Hoodfar 1996).

In the bid for a broader frame, these authors fall short of effective conceptual integration of other social relations. The implicit assumption is that the household is where things happen. Where formal institutions of support are absent or dysfunctional, the household becomes the domain of distributional powers. Relationships within it become infused with ideological imperatives as well as cultural norms, which, by

definition, extend beyond the family and household sphere.

Kinship and New Realities:

New social and economic realities are simultaneously emphasizing and challenging the conventional role of kinship in the transfer of cultural values, material wealth, and social ideology. Consequently, the basis for *mustawayaat* and affiliation intertwine to produce a local version of kinship and social ties that is a hybrid of social ideology and cultural values. Sotia, a 33-year-old salesperson, mother of a son, aged 14, and a daughter, aged 10, put it this way:

> During the boy's [son] first year at school my husband and I had many fights. We could not cover the expenses of his school. My family and my husband's family know this. At one time I left the house to stay with my mother for one whole month. We finally reached the agreement that his family will pay for all the school expenses for the boy [son] and my family will pay all the school expenses for the girl [daughter].

The family is not the only relational context where dealing with social changes take place. Nor does the family escape social changes in itself. Moghadam notes: "One important dimension of social change in the region has been the weakening of the patriarchal family and traditional kinship systems" (Moghadam 1993:24). Conventionally, the family is the conceptual and methodological unit for investigating the determinants of health of Egyptian women and men (see Morsy 1978b, 1982; Early 1982, 1993; Inhorn 1994, 1996). However, the ethnography of Egypt still largely denies "the complexity and richness of family dynamics, especially in periods of rapid social change" (B. Ibrahim 1985a:257), not to mention the dynamics of non-kin social interaction.

Another antidote to the myth of familism which was observed during my fieldwork and also reported by A. Ramadan, consists of the internal cleavages within the family due to the labor migration of a member of the Arab Gulf countries. This has resulted in

> ...dividing the family, which was once poor, into a rich segment with an enormous capacity for consumption, and another segment that remained poor and looked enviously to the rich segment, while staying in Egypt to seek wealth in any way and at any moral cost.
> (A. Ramadan 1994:170, my translation)

Like changes in the economic basis of the Egyptian economy (see Zaalouk 1989), family relationships are changing. Increasingly, in modern Egypt, social relations are constituted through networks of inclusion, or what may be called the "practice of philia" (Rabinow 1996:13). Families remain the ultimate dream of cultural and religious accomplishment. However, significant reciprocity in emotional and material resources occurs outside the family milieu.

The family is also the mediator between the private world of the individual and the public sphere of the state (Moghadam 1993, see Bourquia 1995), or the *Umma*, the theological notion of statehood (Mernissi 1987[1975]). Here is where social ideologies of power, control of sexuality, and sexual divisions of labor are revealed (Tucker 1993; Mernissi 1987[1975], Tucker 1985, 1993; Hopkins 1991b; Adams 1986; Stauth 1989; Morsy 1990b).

> ...the boundaries between [the] state, civil society, and kinship or private domain are highly fluid. People's commitments remain grounded in kin and community. (Joseph 1993:25)

As early as Ibn Khaldoun, urbanization and modernity were portrayed as inimical to family continuity and family

relations (Hamed 1982, Salem 1996, see Mernissi 1987[1975], CSSES 1985, Bourquia 1995). While this view is still valid, its contemporary manifestations should be considered.

Urbanity and Affiliation:

In Sayeda Zeinab's 15 subdistricts, the socio-economic variation is very high, as can be seen in Tables I and II. This is quite evident when it comes to housing. Choices are not whether to live in one area or another, or in one apartment or another; but rather, for many, choices have been reduced to whether one can afford to pay the rent and utilities monthly or not, to live in a crumbling house or in a shanty town, or to be moved to another suburb of Cairo altogether, as in the case of the residents of the shanty town in the subdistrict of *Hadayek Zainhom* at the South-East side of Sayeda Zeinab.

Limited by a severe lack of choices, most people are cramped into the equivalence of two- or three-bedroom apartments. This, however, is better than many residents have in the subdistricts of *Qal'et El Kabsh* and *El 'Atrees* in the eastern part of Sayeda Zeinab, where more than one family share an apartment with one room per family and share cooking and toilet facilities. Many Sayeda Zeinab residents are living the tension that exists between urban living conditions and social affiliation.

Modernity is probably inimical to collective *dwelling* in the Middle East but not necessarily to collective *identification*. Because couples prefer "in contemporary Egypt..., to live apart from other family members" (Nawar et al. 1995:151), there seems to be a shift towards *the family in the mind* from *the family as a residential unit*.

Familial ties "often transcend the geographical boundaries of the household" (Bruce and Lloyd 1992:16).[13]

This state of affairs is further complicated by the fact that as far as possible Egyptians prefer their neolocal residences to be within the geographical vicinity of the family. As elsewhere, this challenges the presumed simplistic connection between modernity and the nuclearization of family structure (see Amin 1997). More importantly, it shows we need to focus more on actual functional ties rather than on structural channels of kinship. A similar challenge faces anthropologists elsewhere in Africa:

> The significant operational family unit is not...the physical household, but rather a wider residential system, in which several differently located parties act together as a network. [This] is not a destruction of the family unit but the fulfilment of one of its inherent potentials: dissemination of the member of the family in a number of places throughout the city, augmentation of its capacities for mutual support, and promotion of its members, thereby reinforcing its cohesion and power. (Houseman 1995:78)

As modernity increases, extended families seem to be recurring in Sayeda Zeinab.[14] Contrary to Latouche's

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[13] Keefe (1979) concludes, based on her research on three generations of Mexican Americans, that a local extended family structure is retained, albeit in a modified form. Her conclusion goes against conventional wisdom that urbanization and westernization lead to loss of family structure and value. She concludes that retaining the family structure is also related to social classes, with the middle and upper classes able to afford the responsibilities it takes to maintain a large family structure. However, in her research the reasons why Mexican Americans prefer to relate to kin are not sufficiently explored.

[14] This is evident in the historical continuity of forms of extension of kinship in many areas of social life. For example, the economic and moral welfare of children is

(continued...)

(1989) view that the failure of Westernization and modernization is evident in the desire to reconstruct social ties and in the rise of the informal economic sector, it is evident from the present research that this view is not universally applicable. People are trying to cope with rather than antagonize the modernization agenda of the state. What is clear in Sayeda Zeinab is that social ties and an informal economy constitute a strategic mode of survival that hinges on cultural values of affiliation and social differentiation.

A recurrence of living in extended families in urban Egypt and Sayeda Zeinab does not emanate from a revival of the culture of familial affiliation, rather it is mainly economic in nature. The lack of proper housing and income to support newly emerging families lead to the sharing of housing and household facilities with the younger generation. Because this trend employs social relations in the service of modern economics (a far cry from the romanticized nature of kinship in anthropology and sociology), social tension is the order of the day in most of these families. It is a case of intensification of social interaction and co-dependence where the political economy shapes social realities.

The combination of these emotionally and economcially stressful factors leads to serious ruptures in cultural values and social norms of affiliation, especially within the family. This becomes more complicated when one notes that embryonic families living in the family nest are not only unable to afford independent housing, but also

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[14](...continued)
rarely an exclusive affair of the nuclear family (see Shami 1990, Hoodfar 1988, Tekce 1989, Bruce and Lloyd 1992).

cannot afford an independent livelihood. These embryonic families are dependent on the larger family for their subsistence. The problem comes to the forefront when it is observed that in Sayeda Zeinab most families rely on fixed income with no hope of a future change. Hence, most families are barely surviving, and will barely survive. But how can the system of employment serve the social relational obligations if education itself is shaped to augment social discrimination and inequality?

From this research it became evident that reciprocity constitutes an antidote to the social and economic limitations in the life of the residents of Sayeda Zeinab. Those who are more socially active have greater access to emotional and material resources. They are also socially involved in regular activities, whether at home or in public places such as coffee shops, the few existing clubs or mosques. In almost every social network, reciprocity seemed to depend on a distinction between a core and a periphery, or what Hammer (1983) calls a 'core' and 'extended' group. Evidently, these positions are fluid and dynamic. Khaled, a 30-year-old area resident, a mini-bus driver, told me:

> Best friend!? What best friend? I do not see my best friends any more except on Friday night. The rest of the week I have my other *ma'arif* [acquaintances] or my family...

Khaled distinguishes between a periphery and a core, or a *ma'arif*, *ashab* [acquaintances, friends] and family [*usrah* or *'a'ilah*]. A core group is one in which social cohesion and *rabitah 'atifeyah* (emotional bond) are of paramount importance. Core or periphery is judged based on both emotional and instrumental values. The sources of emotional and material resources is more diverse and dynamic in an urban milieu.

An analysis of recent statistics indicates that the percentage of divorce in 1995 was one third of the total number of marriages in Cairo (Abu Kib 1996:20). This unexpectedly high percentage of severing the most prominent of social relations in Egypt is poignant. It means that, in a culture where affiliation is so significant, there must be other people who constitute the significant others for a high percentage of Cairenes, rather than spouses or nuclear families. It could also mean that knowing there is a likely chance of being in a social network which would make it possible to remarry and/or find emotional and material support encourages such breakups. It might further mean that people in busy Cairo are not worried too much about face-to-face interaction with the other partner after such breakups. This could also mean that consanguinity, which remains popular in social studies of Egypt, is either happening less, or is not an impediment to breakup in urban areas or both. The significance of these possibilities is in drawing our attention to the diverse and complex nature of affiliation in urban Egypt, which necessitates going beyond kinship or even the household as a unit of social analysis.

The challenge is to develop a framework to understand the everyday life strategies of combining social and material resources through social interaction. Abdel Salaam, quoted earlier on friendship said:

> When we were young we thought that education opens doors, now that we are older we realize that unless you have your family and friends to open doors for you, you are always going to stay at the bottom of the stairs... Once you start at the bottom, you always end up at the bottom, and your children end up there too... Perhaps my wife is right, you should always marry and befriend someone who is higher than you... How else would you live these days?!

In the extra-familial sphere, material goods are the "trump card in the game for social recognition" (Wikan 1980:135). Where social identification is incomplete without establishing social stratification, and where social interaction is a culturally salient priority, material goods are the means of ascertaining the social place of the person and/or kin within the local, national and international spheres. Social recognition in itself is a confirmation of social differentiation. For this process, emotions and material resources are the currency of exchange with both kin and non-kin to maintain one's *mustawa*.

In the next section the concept of social networks will be used to expand the sphere of inquiry beyond the narrow parameters of the family. It will be shown how the family and the household, while essential, should not be our exclusive lens for focusing on the well-being of Egyptians.

Section Two: Social Networks and Life Strategies in Egypt:

In the literature on Egypt and the Middle East, a focus on health means a focus on the family, which in turn, means a focus on women. The health of women and their role as brokers of family health are well represented in the literature. However, this comes at the expense of other determinants such as: the role of non-family members in health; the implications of social stratification on the health status and decision-making strategies of women, families, and communities; the hidden and actual social and financial costs versus the

perceived costs of health care, just to name a few. This section will concentrate mainly on illustrating how the illness practices (see chapter Five) of women themselves is misrepresented by an overemphasis on the role of the family as a mediator of health care. To start with, the health status of women in the literature on Egypt and the Middle East will be explored.

Women, Health, and Society:

Health, reproduction, and sexuality of Egyptian and Middle Eastern women are well studied in anthropology and other social sciences (e.g. Morsy 1978a, 1978b; Inhorn 1994; Inhorn and Buss 1993; Khattab and Kamal 1991; Gruenbaum 1990; Early 1982, 1993a; Dwyer 1978; S. El Messiri 1993; Toubia 1988; Haddad 1988, 1989; El Saadawi 1990; Khalaf 1985). Women are often portrayed as reproducers of offspring and of culture (Morsy 1990a, Boddy 1989). Hence, "a woman with fertility problems is a woman with social problems" (Early 1993a:180). However, a few scholars also try to link health to systematic determinants of disease and illness (e.g. Morsy 1978a, 1978b; Gruenbaum 1990; see volume by Nelson [ed.] 1983), Inhorn and Buss 1993, Zurayk et al. 1993).

Morsy (1978a, 1978b) and Zurayk et al. (1993) suggest that women's reproductive and general health is constrained by the decline of their economic independence, which itself is a manifestation of a more systematic discrimination against women in society. However, responses to these findings have produced highly deterministic theoretical frames of women's general and reproductive health. Accordingly, *every* woman would be bound to fall ill because of social and economic determinants. She would also be bound to be mistreated. Yet, this is not the case in reality. Application of

these promising broader theoretical frames seems unable to handle either the diversity among Egyptian women or the complexity of their lives. Since the findings by Morsy (1978a, 1978b) and others (Nelson [ed.] 1983) on the health implications of the family and public health care of women, there has been little progress in widening the sphere of inquiry or developing more sophisticated methodological tools for this purpose. There are only very few attempts to extend the inquiry beyond the family circle and how it interacts with other circles of illness practices, be they formal or informal.

Health is a demonstrative area of popular eclecticism where social networks mediate symbolic and material capital (Early 1993a:199, 1993b). Well-being is a product of the cleverness with which each of the actors processes the assets and resources made available through a network of social actors (Early 1993a). Social networks mediate health-seeking behavior and, therefore, situate an individual's health in a multilevel relational context. In the next few pages the story of a woman's embeddedness in roles and reciprocity within social networks will be explained through the case of Om Ali.

Agency and Experience:

Selective glimpses into the life of one person will be presented as illustrative material throughout this chapter and the next chapter. The name of the person is Om Ali (Mother of a son named Ali). I was introduced to Om Ali by the son of one of her woman friends whom I happened to know through a common friend. We quickly became acquainted at a time when health became the most important preoccupation for her and her social network. I frequently met her at her home and escorted her to clinics and hospitals. The following excerpts are

summaries of these encounters. In order to understand how Om Ali deals with her health problems we will delve in some detail into the 'boundaries' of her life.

> Om Ali is a 36-year-old woman. She was born in a village about 25 kilometers from *Zagazig, Sharkia* Governorate, in lower Egypt. She was married to her first cousin who is a carpenter. They were married in their village about 21 years ago. She was fifteen years old at that time. Om Ali received no formal education beyond grade three at school. She has three older sisters and one younger brother. Two of her sisters are married in the village. The other sister and the brother are married and live with their families in *Zagazig*. Om Ali moved to Cairo two years after her marriage, about nineteen years ago, when she was seventeen, and has been living in Sayeda Zeinab with her family since then. Om Ali said she and her husband moved to Cairo because her husband always had a fascination for the city. According to her, he was lured (*majzoub*) by lights, crowds, and life in Cairo. When they moved to Cairo they only knew of a cousin of her husband who lived there. The cousin helped her husband to find a job in Sayeda Zeinab where both worked with a workshop owner (*mea'lim)* of a business for making wooden doors and windows. Five years ago, the *mea'lim* told his workers, including the husband and the cousin, that the workshop had to be closed down. The owner had become very old and could no longer run the business and trusted no one else to do it for him. Shortly thereafter, the cousin and the husband managed to get themselves to Libya where they have been working for the past five years. They have not been to Cairo for three years because they are afraid if they leave Libya they may lose their jobs, and they may lose the money owed to them by their Libyan employer. Om Ali's husband managed to get her an invitation to visit him two and a half years ago when she stayed with him for two months. He managed to do the same last year; she went to spend two months in the summer with him. The children were out of school and went to stay at the house of their father's parents in *Sharkia*.

Personal contacts in Om Ali's milieu infused her life with cultural as well as material resources. Her life reveals the interactive nature of a life-world:

> ...both men and women have the potential to manipulate and to revise as well as to subordinate the structures and relationships around them...culture has a space for individuals to choose many different ways to express and live by their own ways.
>
> (Shorter and Anglin 1996:35-36)

In Om Ali's reality, social interaction extended beyond the family to other circles. These circles and their rules of reciprocity were shaped by material wealth, age, gender, religion, education, and other factors. In other words, Om Ali's interaction within her social circle is linked not only to her kin affiliation, but also to the material and non-material aspects of her social *mustawa*.

Everyday life of Om Ali is defined, formed, and maintained as a result of her social interactions with others. Om Ali's life has been formed both by the moral and political-economic order of the day, and the past. Zohra, the Sayeda Zeinab widow, said:

> I found that in order to survive, I have to swallow... I had to swallow the neglect from my husband's family, the yelling from my inspector at work, the pushing of the people in the bus, the demand of the schools of the children... I thought to myself, what is better, to fight all the world or live and let my children live. When I went to the insurance doctor and he tells me to rest at home for my backache, I tell him if your heart aches as much as mine aches for my children, you would not tell me that, we are *ghalaabah* [poor, defeated] who live next to the wall [*janb il-hayt*, i.e. on guard and in worry].

Om Ali and Zohra entered negotiations of their lives with limited emotional and material resources. The source of these resources is not the family alone, and its exchange does not occur with kin alone. Reciprocity then becomes focused on the exchange of values and valuables that are locally produced and internalized according to prevailing social ideology and cultural values. It was clear that Om

Ali is versed in the cultural dynamics of reciprocity in terms of augmentation and conversion, in ways which place her in a more favorable position. For example, she used her emotional coercion tactics with her husband in Libya to have him buy a gold ring she wanted, then used her material capital (the ring) to show her family, her neighbors and other acquaintances of her social network that her husband loves her and still wants her *('ayizha)* after all these years abroad. She had indeed managed not only to get and keep her material gain but also to exchange it and add to it emotional values that are both private and public. Therefore, she was boosting her social position in the network with both kin and non-kin.

In a similar fashion, Zohra hopes the education of her children will help them obtain love and respect from their future husband's family and to gain money and prestige in the society in general:

> I cannot wait to be called the mother of a doctor or an accountant or a teacher. Of course I will stop my job once any of them graduate from a university; they cannot be important people and have their mother work in the kind of work I do.

Through early and adult socialization with friends and neighbors in the village and Sayeda Zeinab, it had become quite ingrained in Om Ali, Zohra, and others, that social disadvantages could be successfully ameliorated by emotional exchange, particularly in the form of emotional superiority and coercion discourse ("I sacrifice therefore I am"). This is similar to Wikan's informant who is quoted as saying: "when I threaten to go, they come running after me and cry... But I reply, 'you don't love me for what *I* am, but only for what I can do for you'" (Wikan 1996:61).

This exchange is mediated through social interaction and situated within social networks. Om Ali, Zohra and others have learned how to accommodate, permeate, and resist limitations by a number of processes much like those used in research. By observation, questioning, hypothesizing, testing, deduction, and induction, they managed to know what can be done, and what cannot be done. Om Ali once said: "I would never let my husband stay out too late while in Cairo; this is how Amal, the woman in my *gam'iyeh* (savings club) lost her husband." They learned what they could have and how to get it. Also what they could not have and why. Their interaction with kin and social network granted them an environment in which they acquired and exercised strategies for everyday life.

The Weaving of a Life:

To return to the story of Om Ali.

> When she first moved to Cairo, Om Ali knew no one and was very young. She said she was the youngest married woman in the street where they lived when they first arrived. When she arrived with her husband they had ten Egyptian pounds with them. They had to stay with her husband's cousin and his family for two months. After her husband secured a job they decided to move, a decision which was discussed with the cousin and his wife. Both the cousin and the wife were--separately--instrumental in convincing the newly-arrived couple to settle in Sayeda Zeinab near them and near the workshop where the two husbands used to work.
>
> After all the years Om Ali has lived in Sayeda Zeinab, she has learned how to manage her life and the life of her children *(ashoof hali wi hal e'ially)*. She has integrated herself in the already existing networks of her husband's sister-in-law. The latter introduced Om Ali to the best places where to go buy vegetables, clothes, and objects for the house and kitchen. A friend of her husband's cousin's wife introduced her to the art of saving money behind the husband's back, of investing in gold, and of making some money on the side from baking or other odd jobs. Gradually Om Ali was

> apprenticed in the arts and skills of city dwelling. She learned how to take public transport, something she never had to worry about in her little village, where she either walked or never went anywhere far enough to require transport. She was also introduced to the best times and days for shopping. She even learned how to walk and talk like Cairenes (*zai il masarowa*). This, she thinks, was important for several reasons (e.g. not being cheated at shops). One of the most important skills she learned from her female network was how to handle or avoid the interest of male passers-by in the street. This included taking a whole range of manners, a dress code, dealing with language, help-seeking behavior, and so on. Also she learned an impressive array of skills and tactics about how to deal with her husband while he is in Cairo, and when he is in Libya.

The story of Om Ali demands in-depth analysis and detailed description (Geertz 1973). This is the only way to discern the multiplicity and hierarchy of the ends for which the social networks were employed. Social networks and reciprocity were used *inter alia* for obtaining jobs, learning social skills, learning attitudes and behaviors, strengthening status in the marital relationship, and saving and investing money. Hence, it is pivotal to

> ...recognize the high value Egyptians place on group membership and support, and [to] acknowledge that people abstractly perceive themselves most of the time as members of groups rather than as independent entities, it then becomes significant to look at what kinds of groups form and on the basis of what criteria.
>
> (Rugh 1984:38)

Rawia, is an uneducated 48-year-old woman. She is the wife of a train conductor with whom she moved to Sayeda Zeinab after her marriage thirty years ago. She said:

> When I moved here, I was so lonely...I used to sit for days and days waiting for my husband to come back from his travel, I was alone at home like a dog... I started shopping, made some friends with women in the market, with some neighbors...there are people with white hearts and there are people with black hearts. You have to *ti'ashirhom* [live and mingle with them] to know the good and

> the bad... Who can be alone?!... When I was in bed for two months with my hepatitis, I really knew the good from the bad. The last one I thought who would like me is my Christian neighbor Om Majdi but she is the one who insisted on taking me to the doctor when she asked my children and they told her I was ill and my husband was away. She and another friend from the street went with me to the doctor and even to the laboratories everywhere in Cairo for the tests the doctor asked for. She even lent me the money because I did not have much since my husband was away. When the doctor told me that I have a prolapse, I was so weak, she was the one asking questions and even bought the medicine for me... I can never forget her *ma'rouf* (good deed).

Reciprocity in the social networks of these women enabled them to meet a whole range of basic and strategic needs. Networks became an easy way to make decisions, at times, because these networks were quite simply there when needed, or because people learn the skills of reciprocity, and of obtaining the right form of support from the right person in the network at the right time. In traditional neighborhoods of Cairo

> Baladi women, virtually self-sufficient in female friendship, congratulate each other, counsel correct action, test ideas about household projects and personal business. They take refuge with women friends when their spirits are low. They pool tasks to lighten drudgery.
>
> (Early 1993a:132; see also Hoodfar 1988:126)

This scenario is not unfamiliar to many. But looking at survival and well-being from the perspective of social networks and the forms of support they provide opens new doors. It aids an analysis of the impact of social ties and social relations on the general well-being of people. An overall comprehension of the complexity of the role of agency in people's lives beyond the family context is better appreciated. But how does this relate to illness practice?

Social Networks and Health:

Om Ali's life has almost never been illness-free, but lately this limitation has assumed monumental proportions.

> Om Ali was traveling last year to meet her husband in Libya. She took the bus from Cairo alone to go to Libya. On the way, the back of the passenger's seat in front of her broke loose and fell back on her knee carrying the entire weight of the passenger onto her. She felt great pain, which she thought would go away. There was nothing she could do about the passenger or the company. But the pain got more severe as the remaining distance got shorter. A woman sitting behind her with her family suggested that the bus driver stop in *Marsa Matruh* (the last city before the Libyan border on the Egyptian side) to have Om Ali's leg examined. The increasing severity of the pain put a stop to any objection from Om Ali. She was keen to go on, as she knew that her husband was waiting for her. But she agreed and was taken to a government hospital in *Marsa Matruh* where she had an X-ray done on her knee. Afterwards, her leg was put in a plaster cast which she was not to remove for four weeks.
>
> Upon her arrival her husband became increasingly concerned, and after one week of her still feeling pain in her knee despite the cast, he took her to the hospital in Libya where the doctor heard her story and suggested that she come back after the end of the fourth week to be reexamined. After the end of the fourth week she could not bend her knee and could hardly walk. The doctor told her that this was normal after being put in a cast for a long period of time. However when this lasted for two more weeks during which she had her husband obtain from his colleagues the names of other doctors and hospitals, she was taken by him in the car of her husband's only Libyan friend and accompanied by her husband's cousin to a private doctor who put her leg in a cast again for six weeks.
>
> Two weeks later Om Ali had to return to Egypt where she anxiously awaited the removal of her cast. She went to a public hospital near her residence to have it removed. She was accompanied by her younger son, her husband's cousin's wife, and one of her friends. This was followed up by two months of physiotherapy at the

> teaching hospital closest to her residence where she was supposed to go three times a week (she never managed to do this regularly). After 12 sessions, there was still no improvement in joint mobility, even though the pain had subsided considerably while resting, but remained when walking or doing other activities. Finally a friend of her husband had come from Libya with a message from him. When he found out about her condition, he suggested a private doctor in Sayeda Zeinab to whom she went with this friend's sister and her husband's cousin's wife. This doctor told her she had had her patellar ligament torn (a tear in the ligament connecting the patella to muscles in the upper thigh). She was taken to the same teaching hospital the next day, had the operation done by this last doctor in one hour, and was released the same day. With 12 sessions of physiotherapy she was back to normal.

To summarize, Om Ali had a torn knee ligament for which she had at least five interventions: two casts, two sets of physiotherapy sessions, and one operation. Socially, Om Ali had two acquaintances who recommended two actions (cast and private doctor), and she had kin and in-laws suggest three other forms of responding to the problem. This process involved multiple decisions which had to be made. Their positive and negative aspects were laid out according to experiential encounters. In all cases, choice, financial cost and social cost had to be delicately balanced with the level of personal and physical discomfort. However, not all interventions are limited to the sphere of the family. Intervention in illness, whether acute, chronic, reproductive, or other, is a semi-private/semi-public domain.

More complex yet is the fact that members of Om Ali's network provided two types of input. One kind of input was in the form of lay care/therapy, including suggestions for some minor exercises and some creams. The other type was in the form of mediating external

assistance. Types of management were suggested, explained, and weighed to the extent that the limited knowledge about them was available. Om Ali responded either favorably or not. The longer and more painful her condition became, the more malleable she became in terms of acceptance of recommendations.

What is very special about this story has thus far not been recounted. Om Ali had been diagnosed as having a case of secondary infertility (infertility after a period of fertility and parity). The specific reason why she went to visit her husband that previous summer was to see if the medications and remedies taken by her were effective or not. Even though this was Om Ali's top priority, she pushed it aside and her life was almost completely taken over by her knee problem. Her husband's telephone calls once a week were originally to inquire about anticipated pregnancy; later on, when both realized that this had not happened, communications became increasingly preoccupied with his concern for her knee.

The intensity of the reciprocity Om Ali required and demanded for her knee is comparable with what she required or obtained for her infertility. In both cases she had kin, non-kin, acquaintances, friends, young and old, men and women as part of a support network. For infertility she went through three interventions over two years, two medical (D & C and Tubal Insufflation) and one non-medical (Koranic healer).

Rawia, the wife of the train conductor, had a social network which proved to be of instrumental help when she was diagnosed with a condition of a third-degree uterine prolapse. She says:

> It took me a long time to agree to the operation. But my husband was worried about me... I also went with Om Magdi to two doctors...one told me to have an operation and another one told me the operation is useless... I talked to my husband because I was afraid of what he and the children were going to say about having this kind of operation at my age. He finally said, I do not have money for such a big operation, I have to speak to my workmates and see if they can help me... After he borrowed some money from them, I had to beg one of my relatives from the village to come to take care of him and the children while I was in the hospital, I also had to beg the children to be nice to her while she was there... All of this took a long time so Om Gamal [member of savings club] gave me some medication for my backache but it made my stomach very sore... Om Magdi told me to only eat boiled food until I had the operation...When I entered the hospital, I went with my husband, two of my children, Om Magdi, Om Gamal and my sister and her husband who borrowed a car from one of his friends...

I was regularly visiting Rawia before, during and after her operation. I recorded the most important people who visited her at home and at the hospital and the nature of their help. Implicit in this seemingly instrumental help, there is the emotional support that cannot be categorized. It is the kind of support Rawia calls "*il 'ishrah wi il-ma'rouf*," roughly meaning "companionship and good deeds." During the six-week period before, during and after the operation, I made the following incomplete compilation from my notes about who played a part in this drama and their form of support:

1. Mother-in-law: Money and advice to eat well and take medication.
2. Sister-in-law: Housekeeping and advice not to undergo the operation, just push organs in.
3. Sister (1) : Money and advice to quit most housework.
4. Sister (2): Housekeeping and advice to lie on back most days.
5. Husband: Advice to eat well and take medication.
6. Husband of sister-in-law: Advice that no operation is needed; it is a normal condition.
7. A female relative from countryside:

Housekeeping, advice to eat well, pray, and go back to the countryside.

8. A member of savings club:
   Money, advice to eat well, not perform hard work, and go back to the countryside.
9. Workmates of husband:
   Money, advice to eat well, and pray.
10. A female neighbor:
    Housekeeping.
11. Friends of son: Housekeeping chores and errands.
12. Others: Housekeeping, advice to eat well, not perform hard work, pray, quit most housekeeping, lie on back most of the time, take medications, and no need for operation, just push organs in.

Om Ali and Rawia's networks and their support determined what actions they undertook. Granted, the decision was still largely theirs. Om Ali and Rawia's had access to their social network's unlimited resource of comradery and companionship. They had to rely on an ever-expanding circle of people to meet their emotional and informational needs. Even their families, impelled by their inability to contain their conditions successfully, were part of the force behind the expansion of their circle. The end result was a perpetual expansion of the network. It has been noted that

> Networks...are more than the sum of discrete two-person ties, floating free in physical and social space. They are structures that help to determine which persons are available for interaction, what resources are available for use, and the extent to which these resources can flow to network members.
>
> (Wellman et al. 1988:153)

For Om Ali, Rawia and others, this expansion was not a simple process of addition, but a cumulative learning process where pros and cons were weighed. It was a process of balancing physical and social homeostasis. The

longer they were in their conditions, the longer they were willing to take medical risks. The more medical risks these women were embarking on, the more they wanted to minimize the social risk of others saying they were wasting time or money, going through unnecessary medical procedures, or not doing enough about it. Physical risk, medical risk, and social risks are carefully balanced.

Weighing the pros and cons was done not only in terms of implications for illness. It was also done regarding other issues, such as gossip, cost, timing, reciprocity, strengthening ties, or severing ties when necessary, and others (Altorki 1977, 1986; Early 1993a; see Epstein 1969a). Weighing these pros and cons is not directly related to illness or health. It is also a process of enhancing core group affinity and renegotiating the location of an extended group (see Hammer 1983). This exchange is also related to a state of homeostasis of social ties and social relations that is culturally recognized as part of a general well-being that is specific to each social group (see Fischer 1982). The process also indirectly affirms a knowledge of health and illness that is linked to social hierarchy.

Social networks construct the phenomena of health and illness based on the social standing (*mustawa*) of these networks. In the cases of Om Ali and Rawia, most local knowledge in their social networks seemed to revolve around eating, taking medications and adapting to the symptoms. Some of these are not social-category-exclusive areas of knowledge. However, knowledge of health and illness, their construction and selection of care, like other social arenas, represents a process through which 'prestige' and 'reputation' are maintained (see Altorki 1986). As Kleinman notes,

> ...the meanings of chronic illness are created by the sick person and his or her circle to make over a wild, disordered *natural* occurrence into a more or less domesticated, mythologized, ritually controlled, therefore *cultural* experience. (Kleinman 1988a:48)

Health and illness management decision-making must be linked to social interaction which involves multiple social actors and multiple strategies.

> ...it is important to stress the malleability of the ideology of domestic groups. Groups will seek to utilize those parts of the ideology...which can be invoked to benefit their interests. In this respect it is fitting to view the behavior of individuals in terms of their strategies, which represent efforts at reinterpreting ideological imperatives. (Altorki 1986:160)

Conclusions:

One of the serious methodological and conceptual problems encountered during this research was related to the excessive reliance on kinship and familial ties that has been used to explain the mediation of life experiences in general and illness in particular (e.g. Altorki 1986; Inhorn 1996; Wikan 1980, 1996; Rugh 1984). It did not take long during my fieldwork to realize that kinship as a socio-cultural institution does not exist in a political or relational vacuum. Kinship exists as a part of a web of other social relations.[15]

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[15] Moreover, there seems to be a denial among the pro-tradition school that the rise of female-headed households is increasing, particularly in urban Egypt, to estimates higher than 16%. There is also a denial that a substantial segment of street children, for example, are raised in Cairo by nobody but their own networks, who are occasionally supplemented by police officers, social workers and hustlers. For these children and for single mothers, and others in Egypt probably "a primary site for thinking is friendship" (Rabinow 1996:13).

What is presented here is simple and straightforward. In most cases people learn and adapt their lives to their illness conditions in ways which do not put a halt to other activities, needs, and pursuits. Moreover, people adapt and adopt illness strategies which have social ends as well as physical and emotional ends. As Kleinman notes:

> Illness idioms crystallize out of the dynamic dialectic between bodily processes and cultural categories, between experience and meaning. (Kleinman 1988a:14)

Not only did the social networks of Om Ali, Rawia, Zohra and others shape their expectations and access to health care services, but they also shaped their preferred strategies. Social networks influenced decision-making about type, timing, and quality of health care services. Their families, albeit essential to the process, were not alone in shaping decisions, nor in bearing the emotional, practical and financial costs of these decisions. Being an individual with kin and with residential and social relations whose economic and informational means were not unlimited was just as strong a determinant of their illness strategies as gendered identity. The social networks of these women are not unique in their emotional and material reciprocity.

A focus on the family in the literature on health and illness in Egypt obscures the cultural and social particularities of modern Egypt. In the next chapter, the concept of reciprocity and social networks will be further explored with the objective of improving the conceptual framework made use of in studies of Egypt and the Middle East.

CHAPTER FOUR:
WEBS OF SIGNIFICANCE:
RECIPROCITY, EXCHANGE, AND SOCIAL NETWORKS

> No one, no one in the world had any right to weep for her. And I, too, felt ready to start life over again. It was as if that great rush of anger had washed me clean, emptied me of hope, and, gazing up at the dark sky spangled with its signs and stars, for the first time, the first, I laid my heart open to the benign indifference of the universe. To feel it so like myself, indeed so brotherly, made me realize that I'd been happy, and that I was happy still. For all to be accomplished, for me to feel less lonely, all that remained was to hope that on the day of my execution there should be a huge crowd of spectators and that they should greet me with howls of execration.
>
> (Camus 1946:120)

Introduction: *Foul* (Beans), Family, and Friends:

When asked about the most important things in his life, a young man of 22 from Sayeda Zeinab replied: "*Foul* (beans), family and friends." For this young man, life was inconceivable without these items. The "*kebab* of the poor," as he and other Egyptians term the famous Egyptian fava beans (*foul*) fill the stomach, but family and friends fill the mind and heart; they are life itself. "They are my life," he said. Many in Sayeda Zeinab and Egypt would agree with this point of view. Here, the importance of this statement is multi-fold. First, other Egyptians of higher classes would not consider beans among life's most important things, thus revealing that social *mustawayaat* are also associated with internalized values and preferences evident in everyday life. Second, the young man's response reveals that significant others in Egypt include both kin and other people. Third, to varying degrees, people use the three components of this

young man's response to make everyday life decisions about their social and relational identity. He is not alone in his conception and in his pursuits. Therefore, it may be concluded that all exchange in Egyptian society is linked to profound relational aspects of Egyptian culture. It is the relationship between this relational exchange and culture that this chapter attempts to address.

Based on previous chapters, it is possible to point out three important areas where reciprocity with kin and social networks influence decisions in everyday life. First, to cement social relations and emotional bonds. Second, in making decisions in general and mobilizing help-seeking behavior in particular. Third, to consolidate resources and matters of social differentiation. Each of these areas will be discussed in this chapter. This will be followed later by a proposed analytical framework of social networks.

Section One: Reciprocity As A Cement for Moral Values and Emotional Bonds:

Inherent in reciprocity is a dynamic process of emotional and material inclusion where "exchanges and gifts of objects...function on the basis of a common fund of ideas: the object received as a gift, the received object in general, engages, links magically, religiously, morally, juridically, the giver and the receiver" (Mauss 1997:29). This *process* engages members who are related familially, professionally, or residentially. In Sayeda Zeinab, *"radd il wagib"* (return of duty) is how most people refer to the obligation of material and emotional exchange within a social network. This exchange entails versatility of social interaction:

> People did not interact with one another only because they were brothers and sisters or only because there were certain ascribed cultural rules that had to be followed. Many chose to interact with certain of their siblings and relatives as opposed to others... In reality, moral support and compassion are also important factors in determining people's interaction with kin or others.
>
> (Hoodfar 1997:239)

Not everyone has a similar potential to access a specific social network and be part of reciprocity within this network (Thomas 1991). Screening for emotional and material exchange occurs within the parameters of social categorization according to relevant cultural and social categories, as we will come to see below.

Whose Reciprocity?

A person's age, to a large extent, determines the social network that he or she is likely to be welcomed into and the level and style of interaction within this social network (Afifi 1990). Age often determines the form of emotional and material exchange within social networks. Here are the words of another Sayeda Zeinab resident, Om Hamid:

> At the beginning of my marriage, I was the youngest daughter-in-law in my husband's family... He is fifteen years younger than his oldest brother... In most cases I found myself lonely, with no one to turn to at that time. All the other wives of the other brothers were at least ten to fifteen years older than me... With my mother-in-law, they always talked to me as if I were a child... I think they were taking advantage of my young age.

Later she added:

> It was not until I got to go out to fetch water from the public tap or to go shopping that I got to meet more newly married women my age and discovered that I was not alone in this. We used to talk for a long time... I loved it because I felt like they were sympathetic and not always on top of my head (*mush dayman fouk raasi*).

Among Egyptian elders' living in hostels, family affiliation is often tertiary after the primary circle of hostel residence and the secondary circle of surviving friends from the past (Afifi 1990). Changing physical space often implies change in reciprocity patterns. In general, in Sayeda Zeinab, as in other neighborhoods of Cairo:

> With the exception of young unmarried men, men usually describe their relationships in functional rather than affectional terms. Men's relationships with other men, in contrast to women's friendships, did not extend to ties with other household members.
>
> (Hoodfar 1997:229)

Additionally, exchange and reciprocity are linked to the observation that--as in the case of Om Hamid--in most cases, opportunities in social networks are also gender specific (Feiring and Coates 1987). The concept of social networks has been obliquely employed, as in the cases of family ties (Rugh 1984), women's bonds (Early 1993a), therapy-seeking communities (Inhorn 1994), gyneocentric networks of social support (Inhorn 1996), women-centered kin networks (see Friedman 1984:42), women's taxonomy and explanatory models of reproductive illness (Bourqia 1996), and women's webs of relationships (Altorki 1986:21). But, these studies seldom explicate the material and cultural basis of change occurring in social affiliation and reciprocity in Egypt.

Reciprocity takes place on grounds of social differentiation that reveal historical continuities (Thomas 1991). Egyptian women may focus more on reciprocity to support the education of their young children (Naguib and Lloyd 1994), while the fathers may focus more on networking for employment opportunities for

their offspring. Both choices are grounded in local views that link modernity and status to traditional relational obligations.

Notwithstanding age and gender, through socialization, Egyptians internalize a sophisticated perception also of how education, class, residence, and other variables determine reciprocity. This would explain the several areas of interaction between men and women in urban Egypt which do not depend exclusively on being a man or a woman. Ayman, a Sayeda Zeinab man, said:

> I have some good friends in the university, both boys and girls... It is usually easy to talk to the girls while we are in the group together, but when we are not, I--and maybe they too--find it an awkward situation (*mawqif muhrig*) to talk, except briefly about something related to study or other general subjects... Sometimes both they and I feel like we are constantly being watched.

The level of education as a factor is probably most evident in Om Hamid's quote of her husband saying:

> What do you know about friendship, you are uneducated...of course I can have friends because I have been educated, know so many people and can discuss important matters.

In modern Egypt, during formative years, probably the single most influential factor in shaping a person's social network is her/his educational level. For example, university time is often referred to as a "happy period," "the best time of my life," "the only time when I really felt free," "the only time with no worries," "the only time where I knew so many people," "the only time where I had true friends," "the only time I knew so many people with so many different backgrounds." These are only some of the sentiments of young male and female urban Egyptians towards the time when they were in the education system.

Conversely, others express university time as the "worst time in my life, it is the only time I felt so poor," "it is the time I felt that I will never have a chance next to all these people," or

> ...it was like a nightmare, the expectation to be sociable and able to afford the social and financial expectations of being a member of a group [*shilla*].[1]

Accordingly, reciprocity is not the exclusive privilege of a certain *mustawa* or a *fi'ah* (level, group, sing.) of people in Egypt. Personality, class, gender, education, occupation, and family ascription are all factors which determine access to, size of, and resources available for exchange in a social network (Van der Poel 1993, Wellman 1988b, Janes 1986). Reciprocity can imply social solidarity and also it can be a cultural manifestation of social heterogeneity and inequality.

The complexity of reciprocity is therefore not well served by the simply dichotomy between kin and non-kin (Van der Poel 1993:57) in conceptualizing exchange of emotional and material resources. This simple view misleads us into presuming homogeneity in family, friends and the community (e.g. Gliksman et al. 1995). In the case of *Awlad Ali* Bedouins for example, the social world is divided into blood relations and non-blood relations. Similar to what Ibn Khaldoun pointed out centuries ago, it is maintained that primacy is given to blood

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[1] It is not uncommon in Sayeda Zeinab, for example, to meet and learn of people who have kept their friendship since school or university years. This is common in Sayeda Zeinab since it is a traditional area; people do not often move away from the area, and if they do, there is always enough in Sayeda Zeinab to attract them back: religious events, medical services, shopping, entertainment, or just good old friends. Also refer to Rugh (1984) on the concept of *shilla*.

relations. However, this does not preclude non-blood relations attaining a high status within their social milieu, simply by long physical and social proximity, *il ishrah* (see L. Abu-Lughod 1986, Altorki 1977). This is a case of *"garaba min l-galb* (kinship from the heart)" (L. Abu-Lughod 1986:62). Hence, a reciprocity is a cultural means of social inclusion:

> ...an Egyptian manipulates social space by extending the warmth of his personal network temporarily to include others, thereby coopting their support and the quality of their response. (Rugh 1984:43)

Reciprocity and social networks are often perceived in a kinship ethos (Hoodfar 1997:225). But, even if social networks draw upon the ideals of kin reciprocity, they represent a different avenue of social association that remain understudied.

Modern Exchange and Emotional Bonds:

I am in agreement that in the city "intimate relationships of the primary group are weakened and the moral order which rested upon them is gradually dissolved" (Park 1997:23). However, this process is not the abrupt comprehensive dissolution of primary groups as a result of rapid political and economic changes that some of the literature conveys (CSSES 1985, Nawar et al. 1995, Altorki 1986, Dwyer 1978, Singerman and Hoodfar 1996, see Hamed 1982). The gradual--if at times fast--tempo of this process allows for subcultures to emerge (Park 1997) and social networks to be created as will be shown shortly. I am in agreement with Wellman that in looking at "egocentric networks" and

> ...urban "personal communities,"...analyses have demonstrated the continued abundance and vitality of primary relations in social systems transformed by capitalism, urbanization, industrialization, bureaucratization, and technology. (Wellman 1988b:28)

Affiliation is part by emotional selection: *il qalb wi ma yureed* (the heart and what it wants), and structural necessity: *hukm il zaman* (the judgment of time, or fate). It is perhaps a mixture of premodernity and modernity coalescing to produce a local version of reciprocity and social affiliation, as opposed to a linear progress towards a culture of atomization and fragmentation (see Lomnitz 1977). The mixture of premodern exchange based on emotional bonds and moral obligation and the modern monetary and commodity-based forms of exchange creates ambivalence in both affiliation and reciprocity. Perhaps it creates a case of *shouf halak* (look after yourself) as Egyptians say. Karim, a 33-year-old male accountant once told me:

> I know my neighbor and I know many of the owners of the shops in the street... We all see the problems in the street and the area, but who does anything?! I think everybody is just thinking of himself and his family, and saying to himself, I would rather live in the garbage [accumulated in the street] than have the headache... If you want to do something people either put you down or think you want to be a politician or that someone is paying you and you are not telling them...

In Egypt, the rules of reciprocity became more materialistic. Individuals and social groups use old familiar values to face new realities.

The Egyptian Hideyah (Gift):

Reciprocity is a cultural practice that cements social ties. In Egypt, "gifts are never free-standing" (Strathern 1997:303). Rather, they are based on an ethos of *wagib* (duty) and *haq* (right), in other words, not a totally voluntary exchange (see Strathern 1997:304). Everyone has a *wagib* to fulfil and a *haq* to obtain. There is an "obligation to give" and an obligation to receive

(Mauss 1990[1950]:13). With a sorrowful expression, a 50-year-old man told me,

> Since I had my back injury and was forced to get early retirement, I had my bonuses and incentives cut at work. I used to always go to my widowed sister to visit her and her sons during the feast and give them their bonuses... Since that time I stopped going, because I cannot imagine going there and not putting my hands in my pocket to give them money, or entering there with no gift... I would rather they think I don't have time to *awaffihum haquhum* [meet their rights] rather than thinking that I don't do my *wagib*.

Reciprocity is shaped by local values of emotional and material bonds that also act as a distributional mechanism of social benefits. "Networks of relationships" provide the matrix within which systems impose and people mold their own lives and society (Wikan 1996:15). By this process, social ties are created and reproduced from a combination of values that cut across time and space (Thomas 1991). Social interaction and reciprocity become the means to exchange values and valuables. Hence, "the whole idea of a free gift is based on a misunderstanding" (Douglas 1990:vii). Gifts are not free-standing. They are linked to local knowledge of *wagib* and *haq*, which are inherently relational notions.

In Sayeda Zeinab, reciprocity in sadness and happiness involves an exchange of emotional and material obligations that bind everyone in a local moral economy. Material and emotional resources follow premodern patterns where "gift cycles engage persons in permanent commitment that articulate the dominant institutions" (Douglas 1990:ix). Zohra the widow and Rawia with her prolapse depended on local cultural patterns of social interaction with others whose assistance was sought. Fardous, a T.B. patient from Sayeda Zeinab, once said to me:

> ...Thanks, and God keep those who check on me... God increase their number... We [as humans] need a nice [comforting] word [of support]...we are *ghalaabah* [poor, defeated]... The last time my condition got so bad, if it was not for the car of the man who owns the corner grocery store, I would have died...the girl [the older daughter] went to him and asked him to take me to the emergency...

Reciprocity is the practice of emotional and material interdependency:

> Contemporary Western societies may equate autonomy with power, independence, and privacy, all of which are highly valued. Non-Western societies, including Egypt, often place higher value on social interdependence and the support and status from belonging to a group. (Nawar et. al. 1995:152-153)

This interdependence is a local interpretation of "a system of reciprocity in which the honor of giver and recipient are engaged" (Douglas 1990:viii). Thus, the importance in cementing and defining the nature and content of social ties should not be simply defined in instrumental terms; these are concepts which also cement the symbolic world of Egyptians and other Arab socities and are taken to be prominent identity markers. Dwyer asserts that in Morocco "the 'Moroccan' perception, personhood is socially embedded. It unfolds interactionally" (Dwyer 1978:182). Zohra, the widow, is not unique in stressing the fact that friendship is "having someone to talk to at ease." Or as another informant said of her son who got married only after going to Saudi Arabia for work: "He had to cross the seas to break the spell cast on him by those who envied him."

In this frame of analysis, social and illness experience are sophisticated constructs, interactively redrawn through a dynamic process where

> ...people are constantly searching to express themselves and to realize their potentialities in their day-to-day life-experiences in the workplace, the community, and the home.
>
> (Harvey 1989:123)

Temporal Aspects of Reciprocity:

Acts of reciprocity are closely linked to local notions of time and timing. In Sayeda Zeinab, acts of support and reciprocity are continuously reinterpreted long afterward in terms of the quality of the person and the social bond itself. Good or bad relational memories are soon replaced by or remembered along with memories of socially made contributions. Men and women, after years of weddings, funerals, and other social obligations, remembered who did what (good or bad). This is a small emotional and social price to pay, most of the time, to maintain social cohesion, a condition which is idealized in Egyptian society. Furthermore, reciprocity occurs within and in-between social groups, thus developing a sense of social cohesion at times among peers and among groups of different social status (Hoodfar 1997:222).

Modernity and urbanization have made it inevitable that people rely on non-kin social relations to obtain the emotional and social confirmation necessary for human existence (Edgar and Glezer 1994, Wikan 1996). Modern social systems have failed to offer a context for developing emotional exchange and social values comparable to those of traditional societies (Denoeux 1993). At times of social change, Egyptians have had to go back to their dormant forms of capital and reactivate them. Indeed, reciprocity, like modernity itself, is

never free from the local and global history of cultural and material exchange, in keeping with the outcome that "material objects are often assimilated to local categories" (Thomas 1991:196). Thus, people in Sayeda Zeinab are constantly engaged in negotiating the nature of reciprocity that is historically grounded, but also relevant for their current situation. As Zohra, the Sayeda Zeinab widow once said:

> *Zaman* [in the past] the *kwaissin* [good people] were more than the *wihishin* [bad people]. What can I say, now *even your own family* wants to *yinhabouk* [roughly translated: steal you blind]... What you need these days is a heart that is kind and someone you can rely on when you are broke. But, what happens now is that those who have money, hide it from those who don't...people have come to love money more than they love each other, even more than they love their own children....

Currently, for many, practical forms of reciprocity are more desired, even if emotional and moral support is equally needed (Rugh 1984; Wikan 1996; Singerman 1995, 1996). Since in modern Egypt values shift toward defining well-being in material terms, direct and indirect economic benefits become the value standards for reciprocity. In contrast to Harvey's point that in the capitalist city "community-consciousness rather than class-consciousness" dominates (Harvey 1989:122), in Sayeda Zeinab there exists a transitional or even a circular logic. The logic is of heightened consciousness of *mustawayaat*, not community consciousness. As the head of one of the non-governmental organizations in Sayeda Zeinab once told me:

> In the past, *fi hittitna* [in our district], we always had an older person who would settle most of the disputes between people. Maybe this is because most of the residents in our districts come from upper Egypt... It was not like now...people would kill each other for the most trivial reasons [and] the courts were full of

> [countless] cases... Before, a man kept his word even if he died for it...now people don't trust their brothers...

The nature of reciprocity is therefore a marker of individual and communal identities undergoing change under modernization and urbanization. This change in reciprocity effectively becomes a local phenomenon of symbolic and material exchange (Jean and John Comaroff 1991). Thus, localities such as Egypt defy a homogenizing universalization or historic interpretation of emotional and material exchange.

A Perspective on Social Networks:

Barnes and Bott re-initiated the concept of social networks in the 1950s, when its appeal lay partly in the desire to move away from the dominant structural-functional analytical framework (Boissevain 1979:392, see also Bott 1957, Mitchell 1969). This is probably associated with the rise in studies of urban areas where identity, it was found, extended beyond the family sphere (e.g. Epstein 1969a, 1969b; Fischer 1982; Jacobson 1975). Several disciplines then become interested in "the beneficial effect of personal relationships and integration on a person's health and well-being" (Van der Poel 1993:1).

However, in the Middle East, most studies suffer from romanticism of the genre where "both the individual and the society are denied for the sake of the family" (Barakat 1985:30). As Singerman points out:

> Too often in research and analysis about Egypt and the Middle East there are many assumptions about prevailing values and ideals but far less understanding of the ways in which ideals are so deeply contested. (Singerman 1995:16)

Two schools for studying social networks have evolved. The first (culturalist) group highlights the relational context within which people find identity and meaning in life. Followers of this line have developed their inquiry into social networks to include an examination of density, size, and strength, focusing mainly on social networks as a form of personal community (Boissevain 1974; Boissevain and Mitchell 1973; Leinhardt and Holland 1979; Fischer 1982; Sanjek 1978; Jay 1964; Craven and Wellman 1973; Oliver 1988). For this group, social networks are understood as providing links of variable intensity, offering social relations that envelop persons through their morphology, content, frequency, quality of interaction, and demonstrated affection (Mitchell 1987; Boissevain 1974; Epstein 1969b). Attempts to supplement this type of study with some studies of social structure have been limited (e.g. Burt 1982).

The second approach, which is more structuralist/ functionalist in perspective, has produced studies which focus on the supportive function of social relations (e.g. Mitchell 1987; Gottlieb 1981; Pilisuk and Parks 1986). These functions fall into two categories. The first is an emotional/psychological category and the second is a material/instrumental category. The flow of resources includes information, emotional support, money, and other factors. It is noted that the flow of resources is dependent on socio-economic status (Campbell et al. 1986). This approach assumes that "[a] better way of looking at things...is to view *relations* as the basic units of social structure" (Wellman 1988a:15). As structures, social networks seem to defy the delineation

of boundaries that followers of this approach attempted to set (see Mitchell 1969; Jacobson 1985; Hammer 1983).[2]

While both approaches provide useful elements of a relational framework to understand social life, they fall short of explaining the full range of social relations in Egyptian culture. For example, during fieldwork, I came across many women and men in whose world the dead and immortals shared a common space with the living for making decisions about managing illness conditions. Abdel Azim, a 50-year-old man, owner of a shop selling poultry and game in Sayeda Zeinab, told me of many instances, of which this case is an example:

> When my daughter at the age of fifteen had a very heavy bleeding from under [from her genital organs], and after I took her to the *mustawssaf* [small to medium-size outpatient or poly-clinic] on the hill with no stop to the bleeding, I went to a *sheikhah* [female religious person], who told me that she is bleeding because she is sad about something. This is the same thing that my mother told me in a dream around that same time... After taking her to the *sheikhah* for a blessing by the Koran, and after sending her mother to the mosque of Sayeda Zeinab with an amount of money as a *zakat* [tithe] as my mother had told me in a dream, I discovered that my daughter was very sad because she was getting close to being sixteen and that I had promised her cousin to marry her but she wanted to stay in school instead.

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[2] Other attempts have been made to link social networking to rational choice of balancing cost and benefits in a process of social estimation of risk (Van der Poel 1993). This approach provides a hope for a respite from the heavy structuralist view by offering some hope for volition and autonomy. However, it ignores local forms of rationalization. This approach is also closely linked to another assumption that households know how to produce healthy members (see Berman et al. 1994). These views miss the complexity involved in obtaining health and non-health needs, whether this be knowledge or material resources (Berman et al. 1994).

Further, both "culturalists" and "functionalists" share a blind spot about hierarchical relations within social networks and between networks influencing the nature of emotional and material reciprocity. Within each of the social *fi'aat*, and in between them, social interaction is not equal. A young man told me:

> I can never go to my mother to tell her I am in love with my neighbor; I am still a student... I told two of my friends at the university...they give me hints about how to behave in these situations.

A young woman told me:

> It is my family that brought me down, they refused to let me stay in school, they forced me to marry against my will...one of my neighbors is my best friend, she is better than my sister...we talk about everything...she is *min mustawyaya* (my level, my standard) *wi min tobi* (and my cloth)...I love her very much...

Tension between cultural values and liberal economics on different *mustawayaat* is hardly explored in the literature on social networks.[3] While social networks remain formations of "groups of individuals linked to one another by highly personal, non-contractual bonds and loyalties" (Denoeux 1993:3), their levels and purposes are changing according to changes in the political economic situation and the role of the state in the Middle East (Denoeux 1993).

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[3] For example, economic hardship probably exacerbates women's reproductive illness specifically as it takes place within a socially sanctioned self-imposed "culture of silence" (Khattab 1992). Also, since women are the main care givers of all family members, their responsibility usually includes decision-making and money allocation for health care, which, currently, is becoming increasingly sparse for many due to economic hardship (Early 1993, Kanji et al. 1991, Browner 1989, Desai 1993).

Additionally, studies of social networks are largely focused on their mechanical aspects; this makes making emotional exchange hard to capture or comprehend. For Fardous the T.B. patient, for example, her network is not that of friends and workmates. The role of anyone who comes into her network is that of a giver, and her role is that of recipient. Her role is asking, praying, and wishing. But, their role also goes beyond giving monetary support. Some she likes more because they sit and listen to her problems, and do not just give and run *"min 'ala il-bab"* [from the door]. Those who enter, enter her interpretive world as well. They are a source of money, but they also become a source of emotional comfort and reassurance. She learns indirectly that *"il-donyah lissah bi-kheir"* (the world is still good]. The good world does not alter her structural position, but it gives something that still evades our social science models.

Essentializing kinship jeopardizes understanding other social ties, such as friendship, which "constitute a network of support second only to kinship ties and at times equal to them" (Altorki 1986:100). Wikan notes,

> ...every Egyptian I know has a social network, security net, that picks up those who fall by the wayside. Even though it is not always successful, there is comfort in such companionship. People do not just drop in and out of relations; they remain linked with others while engaging as active partisans in the drama.
>
> (Wikan 1996:6)

Studying emotional reciprocity in literature on social network does not reveal much more than what has been termed "companionship" (see Doeglas et al. 1996). This hardly adds to what Durkheim explored decades ago about the impact of social integration on social well-being (Durkheim 1951, Thoits 1982, House et al. 1990). Perhaps

a case in point will illustrate the shortcoming of this gap better.

On one occasion I met with a group of seven Sayeda Zeinab residents whose level of education ranged from secondary schooling to university level. The men and women's ages ranged from 25 to 55 years old. The event was the opening of a new community association for area residents. The topic of conversation was the soft drink called 7-Up. Summing up the qualities many of the people present believed it possessed, I came up with the following list:

1. Helps improve indigestion
2. Helps the absorption of antibiotics
3. Helps cleaning the gut
4. One told a story of a biomedical doctor in Sayeda Zeinab treating children's diarrhea and dehydration by giving 7-Up after shaking it to get rid of the fizz
5. Helps sore throat.

Everyone present contributed to this knowledge, and, no doubt, each acquired additional information on the subject. In the end, all came out with some conviction, or at least anecdotal evidence, that 7-Up has nutritious, medicinal, and healing values. Beyond kin, outside the household, each learned something and contributed something. Equally significant is that each went in other relational spheres with this local knowledge. This interactive broader perspective on social interaction and agency is also advocated by Hannerz, whose view is that:

> ...one can either stick to a concentration on personal relationships--but in that case one has to be aware of how much is left out of the picture--or expand the coverage to include (in principle, although certainly not in every case in practice) all the relationships, all the channels, in which production of meaning and the interpretation of those productions occur. (Hannerz 1992:41)

Reciprocity and Support:

Reciprocity is a cycle of gift exchange that "engage persons in permanent commitments that articulate the dominant institutions" (Douglas 1990:ix). Reciprocity is the medium of exchange of emotional and material resources that reproduce the social order and everyday life strategies.

It can be accepted that social networks offer reciprocal support in terms of emotional support and instrumental/practical support (see Thoits 1982, Suurmeijer et al. 1995; Barrera 1981; Wellman et al. 1988, Kessler et al. 1987).[4] However, support by members of a network is made available by a group's socio-structural position. In whatever form reciprocity shapes the experience of illness.

The concern in the literature is exclusively oriented toward seemingly benign reciprocity and social support (see Mauss 1990[1950], Ell 1996, Wellman et al.

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[4] Among the most widely accepted definitions of social support is that Thoits (1982), who defines social support as "...the degree to which a person's basic needs are gratified through interaction with others. Basic social needs include affection, esteem or approval, belonging, identity, and security. These needs may be met by either the provision of *socio-emotional aid*...or the provision of *instrumental aid*..."(147)

1988:171).[5] The presumed beneficial function of social networks might be overrated. Support may also be a causal factor in stressful life events (Thoits 1982:155, Molassiotis et al. 1997:324, Janes 1986, Barrera 1981:85). In this *process* of reciprocity, both providers and recipients of support are engaged in a dynamic relation:

> Radia, a 38-year-old mother of four, for two years had to accommodate in her two bedroom apartment ten people: her husband, Radia herself, four children, a mother-in-law, two sisters-in-law, Radia's brother. It is hard to imagine the situation, except when seeing it on a first hand basis. Radia had had her mother-in-law living with her since her marriage. The sisters-in-law moved in after being rejected by their other brother in one of the towns in the south of Egypt. Her brother moved to Cairo for a menial job, which does not provide enough to enable him to live independently. Radia suffers from stiffness in her right shoulder that started gradually a year ago, and for which she never sought or obtained any help. Her mother-in-law advised some hot pads for which Radia never had time to apply. Now she constantly wraps her shoulder in an old undershirt. However, she still has to work as a day-care center janitor to be able to support her husband's expenses to sustain everybody residing with them, none of whom have additional income, except for her brother. The last time I saw Radia, she was on her way to one of the hospitals to donate blood in exchange for money, a can of juice, and a packet of cookies. She summed up her condition saying: "I have no hope except in God."

Even Radia's social crisis diminishes in the face of others. Shame/honor killing is an extreme form of

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[5] This denies the observation that for example, within women's networks in urban Egypt mutual control or oppression takes place (Dwyer 1978, Rugh 1984, Inhorn 1996). Moreover, there seems to be a lack of concern that support comes at a hidden cost to those providing it, especially women, whose well-being is rarely considered (Kessler et al. 1987, Gallagher and Mechanic 1996, Hall and Nelson 1996, Ell 1996).

exchange of emotional values and obligations among kin social networking (e.g. *El Wafd* 1996a:10). Another example is the intertwining of kinship, partisanship and patronage in shaping societies and their bureaucracies (Al-Khatib and van Nieuwenhuijze 1982:98; Adams 1986; Springborg 1982; Harbi 1996:28; Eickelman 1981). A cartoon on the cover of an Egyptian magazine is a poignant illustration:

> The cartoon shows a made-up female media interviewer against a background of village homes with straw on their roofs. She is interviewing a middle-aged village man in traditional Egyptian garb, fingers on mouth, eyes wide open in response to her question: "How do you explain the fact that despite your being from Menoufia (*menoufi*)...despite that, you have not until now become a minister or a prime minister?!"
>
> (*Al Yassar* Magazine February 1998: Cover Page)

The humor is inescapable for any Egyptian. Since the time of President Sadat (1970-1981), it seems that a large percentage of high-level posts are filled by people from his home district of Menoufia, including his one-time deputy who is now the president of Egypt.

Moreover, this intertwining of reciprocity on the macro-political level has shaped the main economic direction of Egypt throughout this century, particularly during the past four decades, as Imam notes in *Who Owns Egypt?*,

> ...capitalism of the seventies is a hybrid with multiple roots and branches going back to different historical periods, some of it belongs to the pre-July [1952] revolution (traditional capitalism) and some was born out of the sixties (bureaucratic bourgeoisie) and some out of the seventies (parasitic branch).
>
> (Imam 1991:223, my translation)

She adds that traditional capitalism of the pre-1952 revolution was

> ...the real fermentation point (*nuqtat al takhamur*) for any capitalist fomulation in the Egyptian experience, whether that which crystalized from the middle sixties or that which the society got used to and till lives its experience of since the mid-seventies.
>
> (Imam 1991:223-224, my translation)

Imam concludes:

> Blood relations and inter-marriages (*musaharah* and *nassab*) have been used as one of the means to consolidate political, economic and social authority and maintain it... [The new garb of] the control of the familial character of capitalism of the seventies is that...familial networks and alliances take place now within a larger and more comprehensive frame of social formulation.
>
> (Imam 1991:226, my translation)

Egypt is not different from other African--and no doubt Asian--countries where

> ...kinship in an urban context appears not so much...[to mediate]...between individuals and social institutions...[rather]...it is an important constitutive feature of these institutions themselves.
>
> (Houseman 1995:79)

In this regard, the middle level between the micro and the macro levels is not sufficiently explored. In some cases, micro types of social networks and reciprocity are studied as a subversive form of strategic accommodation of modern political, economic, and social uncertainty. The level of larger formal and informal associations that are not in the form of government institutions or political parties is not factored in. This meso (middle) level of formal and informal social associations strategically employs social networks to mediate between and influence the micro and macro level systems. A focus on the family, household, and the micro level social networks poorly addresses the complexity of reciprocity among groups in Egyptian culture, particularly in the urban context.

Section Two: Reciprocity and Managing Life Strategies:

Reciprocity in social interaction incorporates both emotional (*'atifi*) and material (*maadi*) aspects that become manifested in decisions and strategies about everyday life's events and illnesses. Arabi is a 55-year-old man who has a liver cancer; he is a salesperson in a grocery. In talking about his condition, it became clear that Arabi distinguishes on a scale of at least three levels between people who played a part in the diagnosis, treatment, financing, and emotional support. People are either *qaribah* (near, 'core'), *noss noss* (half and half, 'middle'), or *min bai'd* (far away, 'periphery'). These groups include the following members and the nature of their support:

***Qaribah* Group (Core):**

1. Son (1, of four sons):
   - Reassurance
   - Money

2. Son (2, of four sons):
   - Transportation
   - Accompany to doctors
   - Information about doctors and medical facilities

3. Daughter-in-law (Wife of son # 2):
   - Transportation
   - Housekeeping
   - Information about source of disease (air, food, hard work)

4. Doctor in non-governmental organization clinic:
   - Diagnosis
   - Names of biomedical facilities
   - Reassurance
   - Counseling (causality, prognosis, and options)

5. Sisters (two of five):
    - Housekeeping
    - Reassurance
    - Information about source of disease (environmental)
    - A religious person to make a Koranic amulet

***Noss Noss* Group (Middle):**

1. Two male neighbors:
    - Medications
    - Necessary papers at work

2. Grandson (1 of six):
    - Reassurance
    - Accompany to doctors

3. Two old friends:
    - Reassurance
    - Money as a gift
    - Source of disease (military service in desert as a young man)

4. (Deceased) wife's brother (1 of three):
    - Money from three brothers (loan)

5. Doctor in public hospital:
    - Diagnosis
    - Tests
    - Information concerning operation

***Min Bai'd* Group (Periphery):**

1. Son (3, of four sons):
    - Information about source of disease (water and food)
    - Reassurance

2. Young doctor living in same street:
    - Diagnosis
    - Tests interpretation

3. Pharmacist:

- Effects and side effects of medication
- Names of doctors and facilities
- Sometimes a discount

4. Sheikh of mosque:
   - Source of disease (environmental and metaphysical)
   - Name of a good doctor
   - Reassurance through prayers and reading religious texts.

5. Nurse in public hospital:
   - Information about possible complications of operation
   - Information about temperament of doctor and other staff
   - Information regarding indirect costs (tips, supplies, food, etc.)

Others: Nieces, nephews, grandsons and granddaughters, and others.

Experience from Within:

Arabi's pain, physical discomfort, and seeking help extend to the outer limits of his circle of social interaction. His coping with pain and illness involved the incorporation of his biological existence into a relational social milieu (Khalil 1996, Kleinman et al. 1992). The more reciprocity the less he perceived his burden of the disease. His experience is comparable to other reports that "satisfaction and need for support [are] the strongest predictors of symptomatology" (Barrera 1981:85). Thus, when Arabi says *il hamd li Allah* (Thanks to Allah), he reveals internal acceptance resulting from a reciprocal process where his perceptions are central.[6]

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[6] This acceptance is also termed 'successful adjustment,' whose link to causality is hard to prove (Kessler et al. 1987, Barrera 1981).

On the other hand, Ahlam, a 45 year old woman, with glaucoma in both eyes said:

> My grandchildren are my eyes now...my husband is so old now that we both need help... One of my son's workmates told us that his wife works in a big hospital with many good doctors...my son and oldest granddaughter went with us to the hospital...now in most cases when I go, I have to go with her. Because he works in a private company as a security guard, he can't take so much time off... I think I had better die. If it was not for my grandchildren, children, and my neighbors, I would be really dead rather than living dead as I am now..

Arabi and Ahlam both derived considerable comfort from being in a social network where reciprocity was reliable and accessible. Reciprocity in social networks, like quality and accessibility to services, became determinants of their well-being (Janes 1986, Suurmeijer et al. 1995). An illness experience is a product of a process of cultural mediation (see Kleinman 1988b, Kleinman and Good 1985a), where material resources cement channels of reciprocity. Emotional and material reciprocity compensates for the compromise in personal integrity due to illnesses. Arabi and Ahlam's comfort was both emotional and physical.[7] A good social network, like kin, can facilitate and mediate better health (Molassiotis et al. 1997).

Arabi and Ahlam got emotional and practical support on a daily as well as a problem-specific basis from both kin and non-kin who were *accessible, available, and valuable*

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[7] This comfort stands in contrast to the psychological and physical distress more likely to occur among those who experience life events with less involvement in social relations and support (Thoits 1982, House et al. 1990, Syme 1996, Kessler et al. 1987, Janes 1986).

to them (see Suurmeijer et al. 1995, Doeglas et al. 1996). The latter formed a *magmu'ah qariba* or a "core social network" (Janes 1986:195), or an "inner circle," that was mostly in close proximity to them (Hoodfar 1997:224). These networks have perceptions about interventions whose availability and quality sometimes did not match the reality of the situation. Accordingly, Om Ali of chapter Three, with her knee condition, was taken to various doctors, but they were unable to diagnose her condition properly. She was supported through interventions, but pre-judgment about their efficacy among the members of her network was entirely anecdotal or even non-existent. Om Ali, Arabi, Ahlam and others believed they had the means to access a pool of support through their network--which they did--but it became clear that there were other factors to contend with.

Social Location and Life Strategies:

Any analysis of reciprocity must be broad enough to encompass multiple interconnected circles of social interaction (see Early 1993b, Bongaarts and Watkins 1996). Each circle has a multiplicity of factors differently influencing the degree of social interaction of a person or a group. This becomes evident when we compare the cases of two women of the same age and level of education, but who have different social status. Rihab is a bank teller in a foreign bank in Cairo, and Ragaa is also a bank teller in an Egyptian public bank. Both graduated from the Faculty of Commerce, Cairo University. Both got their jobs at about the same time, and both got their jobs because they had a connection in those banks. Rihab makes about three times as much as Ragaa. She also speaks fluent English, which was required to work in her bank. When the time came close for delivery of their

first babies, Rihab went to the U.S.A where she could stay with her cousin, have a better delivery, and get a Green Card for her offspring. Ragaa, on the other hand, gave birth in the hospital assigned by her medical insurance. Both are young Egyptian women bank employees living in the same neighborhood, but their spheres of social interaction rarely coincide. Their ways of managing life cycle events also rarely coincide. The management of health-related conditions provides, therefore, a clear context for the interconnectedness of social and cultural conditions (see Morsy 1993b).

Section Three: Reciprocity and Consolidating Resources:

Narrowing the study of social interaction and socialization to the exclusive domain of the family mocks the earliest conception of kinship and affiliation by Ibn Khaldoun. According to him, the *'asabah* should be the social unit of study "either in itself or as a segment of a larger social group" (Hamed 1982:9, see also Salem 1996). It is

> ...a local, social, and political group. It is originally an agnatic group. Nevertheless, it admits cognates, affines, and other non-agnates, refugees, outlaws full membership...hence association is based on choice, biological uniqueness, and existential necessity.
> (Hamed 1982:9-10)

This broader view of social interaction indicates that purposefully blurring the social grouping line successfully enhances emotional and material well-being, something current literature fails to capture fully. Thus, reciprocity within social networks is a dynamic mechanism to control the flow of emotional and material resources. This exchange of resources occurs within the parameters of *fi'aat* in Egypt. This is clear from the

story of Nabila, a 50-year-old mother of four children and a general manager of a public sector company who was recently diagnosed with manic-depressive psychosis. Her husband, being a senior police officer, negotiated for her, through personal connections, an unpaid leave for two years. During these two years, she stayed home, occasionally traveling to Alexandria to stay for some time with her married sister. Both she and her husband agreed that she should not go to a public hospital because:

> she will be just like everyone else, just a patient like the poor ones... Also [the] son is a resident doctor in the hospital, and if someone finds out that his mother has this condition it will ruin his career.

Nor could she go to the police hospital because of her husband's sensitive position in the police:

> ...you don't know what people may say to block [his] chances of advancement.

Neither could she go to the hospital where her medical insurance applies because,

> ...my diagnosis may block my chance of advancement in work.

Reciprocity had to operate within a frame of preserving the social *mustawa* (level/standard). Nabila's husband once borrowed the chalet of a colleague in a Mediterranean resort for one month in order for Nabila to relax. He also got another close colleague to arrange for his wife to be seen free of charge by one of the most famous psychiatrists in Cairo. This case also illustrates the view that social networks can reciprocate through making certain resources available either directly or through mediation (Hall and Nelson 1996, Doeglas et al.

1996).[8] Emotional and practical support was obtained to provide a buffer mechanism against stressful events and insults and make appropriate decisions (see Pennix et al. 1997, Van der Poel 1993, Cassel 1976, Broadhead et al. 1983, Gliksman et al. 1995).[9]

The form of social support obtained through social networks is determined *inter alia* by life events, the needs of the person, the pool of resources available in his/her network, the pool of resources available in society, the pool of persons in society from which it is possible to form a network, and cultural principles of aid and reciprocity (see Thoits 1982, Daibes 1991, Altorki 1977, Early 1993a).[10] Clearly, those who are socially (personally, nationally, internationally) active and interactive have a better chance of meeting their economic and health needs. Those who are not are more likely to be unable to retrieve their economic condition and their former health when they start to deteriorate.[11] Additionally, personal perceptions of available emotional

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[8] This is sometimes called the "health-facilitating function" (Suurmeijer et al. 1995:1221).

[9] This is sometimes called the "stress-reducing function" (Suurmeijer et al. 1995:1221).

[10] However, most views on social support seem to be contradictory and lacking in sound conceptualization and operationalization (Thoits 1982:145; Suurmeijer et al. 1995:1227; Kessler et al. 1987:150).

[11] This also becomes more complex as those who are perceived to be too socially interactive are not necessarily in a better health or economic condition. They seem to spend more time and effort in social interaction and less time in purposeful actions. When such actions are needed, they could be either too little or too late.

and material resources are essential to access those forms of support in any culture (Suurmeijer et al. 1995).[12]

This is probably clearest among the educated youth in Sayeda Zeinab. Sameh is a 26-year-old youth from Sayeda Zeinab. He graduated from the Faculty of Commerce four years ago:

> At first, I thought I would be different. I thought I would get a job somewhere so I can depend on myself, but the wind may blow not how ships desire... I got a few jobs here and there, but they pay so little; there are no contracts and no security, and on top of it all, they don't pay enough... The highest salary I got was LE 90/month (app. US$ 25) working as a receptionist in a clinic... My father is not rich or famous, my mother is illiterate, and I know no important people to get me a job. I got the jobs I got over the past four years through going with two friends of mine from the university to different places in response to ads that one of them reads in the newspaper. He is the only one of us whose family can afford to buy the newspaper every day...

Clearly, socio-economic differentiation determines the nature of reciprocity in a social network. This extends to both social and illness events. Huda is a 30-year-old mother of four children. She was educated up to grade six, after which she stayed home to help her mother. She said:

> My life is like one of these series you see on television... I go from one crisis (*azmah*) to the next. I am never out of debt and never have a chance to return anyone's favors. Since my husband died I have not had any help except from my mother who is already very

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[12] Methodologically,"...knowledge of people's subjective appraisals of the adequacy of support is more critical to the prediction of their well-being than simply collecting information about the number of supporters or the quantity of supportive behaviors to which they have access." (Barrera 1981: 85)

> poor. My brothers don't want anything to do with my mother or me... Our neighbor said he sits with a nice man in the coffee shop every evening and that he would ask him to help me get some kind of job in the ministry where he works. His friend accepted to help, but you know the government, its day takes a year (*yum il-hikumah bi sanah*). After running for two months to get the papers they required, I have been waiting for six months now for someone in the ministry to sign the paper so I can work as a cleaning woman... I am not asking to be the minister or an under-secretary or buy a car...but this is our lot in life...

However, the implications of social stratification for access to social networks and the resources they mediate is rarely of concern (Ell 1996). Socio-economic status is a more powerful determinant than social support in prognosis of illness conditions (Greenwood et al. 1995). Nevertheless, the focus is still on social support and risk factors (e.g. Gliksman et al. 1995) revealing an underlying ambivalence about the broader socio-economic determinants of social relations.

Social Networks and Social Hierarchies:

Om Ali who appeared in chapter Three, Sameh the unemployed youth, and others like them find that there are no inroads or outlets for their participation in social (re)production. They are kept on the fringes and within the boundaries of their informal associations (Baden 1992:29; Moghadam 1993:43,56). Many functions formerly dealt with by the family--normally women--are being replaced by other social and political institutions (CSSES 1985:157-158). Within the context of this social change, more educated and active players and primary group ties are slowly being replaced by 'civil society' ties that copy Western models (see Nawar et al. 1995:159, Hegazi 1995). Consequently, alternative forms of formal organization are not accessible to the less educated,

poor and lower social classes, and especially to women. Indeed, in many parts of the Arab world, this type of social organization was never accessible to women, even of the educated upper class (Altorki 1986, Dwyer 1978).

For Om Ali and those like her, primary group ties have been fairly successfully replaced by other social associations forming an eclectic mix of carefully woven emotional and material bonds. Clearly, the needs of Om Ali, Zohra, Rawia, Arabi, Rihab, Ragaa, Sameh and many others, the members of their networks, and the resources available to them and their networks, the means by which they obtain and share their resources are all determined by socio-structural factors which are mostly out of their control and which cannot be labeled as merely cultural. Gender, educational level, employment status, levels of income, forms of material or in-kind resources available, area of residence, and proximity or distance from resources are all determined to a large degree by socio-structural factors. People's position in society has made it possible for them to enter a certain economic level of network having a certain level of social resources.

It is important to note that Om Ali, Rawia, Zohra, Sameh, and others in similar situations had no access to formalized social networks. This excludes them from higher domains of social interaction (*haute* social interaction) one might say. Their current life situation, their education and economic level, their familial milieu, and their economic means situate them such that their participation in party politics, local-level politics, and representation in policy and decision-making are outside their realm. For the masses in a similar situation, social networks become a strategy to subvert class structure itself (Denoeux 1993). For these

masses, cultural practices and social affiliation become markers of identity, as identity itself is constantly being reshaped in modern Egypt and the Middle East (Denoeux 1993). Their conditions resemble those of other deprived groups in society, where

> ...unless the disadvantaged get mobilized and organize themselves to overcome the obstacles depriving them from participating in existing structures [of power and governance], community decisions will only reflect the needs of those in power.
>
> (Badran 1995:67)

Om Ali and the majority of women and men in her *mustawa* (level/standard) remain petty players in the social (re)production of meaning, norms, values, and well-being. They survive in a web of small-time social interaction. Forms of interaction remain limited and occur on very basic levels of social exchange. Input on this level moves horizontally. Limited chances exist of vertical exchange where views and perceptions from the lower social strata can make it to the upper circles of power exchange. In Egypt, human development remains constrained by lack of political participation (INP 1995:51). The environment is one of political liberalization lagging behind economic liberalization (Singerman and Hoodfar 1996:xv, INP 1995:60).

While kin aid "reproduces both the structures of kin relations and class relations" (Stivens 1979:173, see also Joseph 1993, Imam 1991), these are countered by other subversive reciprocity links. Emotional and material exchange enhances the creation of "prosocial communities" (Rhodes 1998:24), potentially altering the locus of social relations from oppressive hierarchical affiliation to powerful horizontal associations.

Reciprocity and Relief:

In the Middle East, much of the literature misses the intertwining of material and non-material aspects of social affiliation. Informal economic networks in Egypt, for example, have a significant component of social and emotional exchange (see Early 1993a, 1993b; Hoodfar 1997).[13] The intertwining increases the fluidity of the boundaries between formal and informal work on the one hand, and the socialist and market economy on the other (Toth 1991, Hopkins 1991b). For example, Early (1993a, 1993b) writes on how women's participation in the informal sector mirrors their economic location in society and their emotional bonds to other women.[14] Only a very few historical and anthropological works have explored the informal economy in the Arab world in depth (e.g. Tucker 1985; Tadros et al. 1990; Early 1993a, 1993b; Hopkins 1991a; Oldham et al. 1987; Al-Khatib and van Nieuwenhuijize [eds.] 1981, 1982).[15]

Diversity in informal economic exchange and the link between economics and cultural values was evident in Sayeda Zeinab. A large segment of my informants in Sayeda Zeinab had very little direct linkage to the formal or informal economy. Their only link was through material and non-material assistance stemming from local values

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[13] See Fukuyama (1995) for a similar argument about other parts of the world.

[14] However, the anthropology of work in general, and of women's involvement in networks of the domestic and informal economy in particular remains underdeveloped (Rugh 1985; Gruenbaum 1990; Hopkins 1991a, 1991b; Kharoufi 1991; Early 1993a, 1993b; B. Ibrahim 1985a, 1985b). Little is known about how it all "fits into the broader socio-economic system" (Hopkins 1991a:3).

[15] Most of this recent work is mainly urban (Cairo) based (cf. Hopkins 1991b).

and emotional bonds. Material assistance was part of a moral economy of reciprocity that also incorporated non material exchange. Many of the poor and needy in Sayeda Zeinab lived off or had their income supplemented by *zakat al mal* (alms of wealth), *zakat il-fitr* (alms of breaking the fast after Ramadan, the fasting month), *nadhr* (vow), *sadaqah* (voluntary alms), *'edeyeh* (feast bonus). These are forms of transfer of wealth which are stipulated in Islam. The poor and the less fortunate can access these forms either directly from the persons offering them, or from the mosques where people donate their money, or from the Ministry of Religious Endowment, or other private and public institutions.[16]

> Fardous lives in one room under the stairs of an old house where she is raising two daughters aged 10 and 12. She has tuberculosis from which her husband died three years ago. She cannot work and her daughters are too young to work, although they go to school. Fardous and her family live entirely on the many forms of assistance mentioned above. Her hopes in life are minimal. However, she also believes that there is always "*ibn halal*" [meaning a kind person], or a "*fa'il kheir*" [good doer] who is willing to help "*min haith la na'lam*" [from where we do not know].

There is no secular law to enforce these payments. But Fardous and others, like her, can access this moral economy through individuals and institutions. For example, it is common for the poor to be exonerated from paying fees at biomedical facilities operated by non-governmental organizations. Fardous gets her T.B. medication from the non-governmental organization's

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[16] The case of the NGOs in Egypt reveals that the most successful are those with a religious mission, even if an implicit one (Kandil 1994). Among the most accepted explanations is the heightened sense of religious affinity in Egypt.

doctor for free every two weeks and her X-ray every six months.

These facilities and alms reallocate some of the social and material benefits in society, but do not challenge inherent inequalities. It is a kind of umbrella social network. However, more significantly, these forms of economic transfer are rarely linked to studies of the informal or formal economy, or of social networks in health or illness. Thus a fundamental cultural and emotional mechanism of affiliation and collectivism which goes beyond the boundaries of kinship is entirely ignored by scholars.

When the new political-economic order of economic reform and privatization in Egypt comes under scrutiny, research into its influence focuses on the family and the household (e.g. Korayem 1988, Singerman and Hoodfar 1996, Singerman 1996)). While the family remains the central economic unit of resource pooling in Egypt, this does not mean that nuclear families (84% in Nawar et al. 1995) are self-sufficient. Nor does this mean that enlarged nuclear families or extended families (16% in Nawar et al. 1995) are the only pool from which a livelihood can be supplemented. Reciprocity in social networks has been used for centuries to supplement and complement economic and emotional gaps that the state and families could not fill (Singerman 1995).

Section Four: Framing Social Networks:

There are at least two areas which have been severely circumscribed by the limited representation of reciprocity in social networks in the Middle East. The first one is related to decision-making and the second is

related to levels of social interaction. Both will be explored briefly.

Social Networks and Decisions:

In the case of health and illness management, there are at least two levels of decision-making at which both the family and social networks play different roles. Most decisions are made on a primary level and then on a secondary level. The primary level is usually concerned with the questions: to do or not to do something. To go or not to go? In Sayeda Zeinab, this type of decision mostly takes place within the family context. Knowledge about this area could benefit population studies on the subject of contraception. For example, in the Egypt Male Survey, there is a distinction between the primary decision of whether or not to use contraception which, depending on the area of Egypt, was either mainly taken by the husband or jointly between the husband and the wife. Once agreement is reached about the need to use contraception, the choice of method is by far and large left to the wife; this can be termed a secondary decision (Sayed et al. 1991; see also Shorter and Anglin 1996, Govindasamy and Malhotra 1996). It is a complex process of negotiating permeable social boundaries, including those of power and authority. Social, cultural, symbolic and material capital are employed to make both medical and non-medical decisions. In the narratives presented thus far, each primary or secondary decision involved some reciprocity in a social network.

Levels of Social Networks and Reciprocity:

One way to explicate further the concept of reciprocity, is to consider the levels of interaction in which social networks and reciprocity take place. These levels can be classified as three: micro, meso and macro levels. The

number of individuals involved, the presence of and/or clarity of goal, relations of power and authority with other social institutions, and access to and possession of assets of power determine the nature of reciprocity in a certain level of a social network.

Micro level social networks and reciprocity occur with kin and non-kin groups in the immediate environment, and are often associated with day-to-day activities, needs, and pursuits. There is variation between rural and urban, and kin and non-kin according to location, economic condition, education, gender etc. This has been studied in some detail among women, particularly within the context of kinship (Fouad 1994, Rugh 1984). Reciprocity on this level is also termed *al khadamat al sha'bieyah* (popular services) (CSSES 1985:174). Traditional values of exchange and reciprocity are quite prevalent on this level. Exchange and networks are largely based on emotional bonds and moral obligations. These are exemplified in reciprocity so as to learn the best shopping bargains, the best doctor to go to, job to apply for, or savings cooperative to use.

Meso level social networks and reciprocity are best described as the level on which informal and formal medium-size organizations are formed. These organizations can be economic, social, political, or cultural or any combination of these. This level is exemplified in most non-governmental organizations (NGOs), cultural and sports clubs, youth and other associations. On this level, the individual is a member of a recognized collectivity--whether official or unofficial. This collectivity is involved in some form of change in practice, activities, or livelihood (see Hegazi 1995). Such change is predicated on reciprocity, where less

traditional values prevail and more modern systems of affiliation are employed. On this level, individuals transcend their differences to some extent to meet the commonly recognized needs of the majority. They create a collective system of *takaful,* or sponsorship, that is parallel to the system of the state, which relies mainly on shared social and cultural values (Singerman 1995, 1996).

However, not all members are equal or are in this association for the same reasons, though in most cases there is something that binds them together for a given period of time. This might be an extended family business, or a movement towards improving living conditions in a local community. More important, there is a binding value. This level is infused with a sense of community which has historically played an important role in pacing social and political change (see Harvey 1989:39). Yet, it remains rare for a large number of Egyptians, particularly women, to participate in any type of association, and this is so even among those who are educated (Nawar et al. 1995:159).

Macro level social networks and reciprocity involve individuals in a movement towards greater societal change. This can be in the form of advocacy, political representation, party politics or other ways. Reciprocity here is based more on modern notions of purposeful association rather than emotional bonds or moral exchange. On this level the person is less likely to be pursuing or reciprocating for personal ends, and more likely to be involved in changes that influences the lives of a large number of people. Still, in a society like Egypt

> ...a consensus about the relationship between private, public, and governmental spheres has not been established...leaving basic questions about individual and collective rights, representation, and the source of government authority. (Singerman 1995:71)

Creation of divisions between these levels may itself seem arbitrary and linear. It is done here to highlight the need to refine views on levels of social interaction and exchange within and in-between these levels. The conventional conceptual splits between tradition, modernity, family, and formal and informal social institutions reveals more about scholarship than about social realities in Egypt and the Middle East (see Singerman 1995).

Conclusions:

Attention is focused on the family because it is understood as one bastion of tradition where "correct" morals are reproduced (cf. Lock 1993c, chapter Five). Hence, scholarship tends to ignore the fact that human beings do not live only in the family milieu. The focus needs to be more sophisticated to consider people's involvement in dynamic social groupings through several mechanisms, the most naturalized of which is probably reciprocity.

Reciprocity is a medium through which personal and social identities are formed. It also provides a frame within which concepts of health, healing, satisfaction, and health systems' utilization are created. Reciprocity helps to internalize perceptions of social action, reaction, and interaction. Indeed, reciprocity shapes the way illness is experienced.

Based on this research, it can be concluded that, in Egypt, there are two broad spheres to which reciprocity contributes. First, *as a major contributor to the creation of meaning and perception in society.* Thus, mediating the sense of self, a sense of self-worth, the sense of well-being, the sense of a social unit, of being a whole person with an identity that is recognized by the person and society. Second, as *the root of actions in everyday life.* Through reciprocity people develop beliefs, attitudes and social behavior.

It will be a long time before we can fully understand how emotional and material exchange in contemporary Egypt represents a marriage between the past and present as well as the local and global. In the meantime, individuals who fall ill are engaged in reciprocity within their social networks to deal with their illnesses, as we shall see in the next chapter. The focus will be on how people practice the art of living at times of ill health in a culture of structured affiliation and symbolic identification.

CHAPTER FIVE:
FI NASS WI FI NASS:
(THERE ARE PEOPLE AND THERE ARE [OTHER] PEOPLE)
CLASS, CULTURE, AND ILLNESS PRACTICE IN EGYPT

> Human activity can never be considered outside of the framework of social relations and their history, which provide the logic of social activity--its rhyme and reason. The meaning of activity cannot, therefore, be considered purely in terms of symbolically constructed meaning, nor with reference only to activity...we cannot interpret the actions or the motive of individuals simply by seeking out the meaning that has inspired their activity. Rather, we must set activity and the individual accounts given of actions and motives in the context of their social logic: that is of social relations and social activity as a whole.
>
> (Burkitt 1991:194)

Section One: Logic and Cultural Construction of Self and Life Strategies:

It is often said that in the Middle East, group affiliation is considered superior to an individual-centered existence. This formulation has been central to discussions of Egyptian and Arab culture over the past several decades. The claim for the importance of group affiliation comes from empirical observation and from the way "natives" speak for themselves. This representation is found in studies of history, sociology, anthropology, political science, and other social sciences (see Patai 1973, Rugh 1984, N. El Messiri Nadim 1985, L. Abu-Lughod 1986, Early 1993, Tucker 1993, Barakat 1985 and 1993, Singerman 1995, Wikan 1996).

One might question the extent to which this limited formulation adequately represents or ever represented the nuances of affiliation in contemporary Egyptian culture.

An equally important question, which is posed in this chapter, is to ask what does this formulation mask? One answer might be to cite an Egyptian saying: *fi nass wi fi nass*, there are people and then there are (other) people. Among one of the most familiar interpretations of this saying is that people are not equal: there are differences based on social standing, economic status, or class. This view proposes that the

> ...oriental formation is a hierarchical one. There are exploited strata and exploiting strata...not to mention the role of the state...which practices oppression under the name of society, or in other terms for the benefit of the dominating stratum. (Siam 1995:76-77)

A narrow representation of social relations is further complicated by the usual reductionist nature of the representation of group affiliation in Egypt by Egyptian and foreign authors, and also social scientists. Group affiliation is often reduced to kinship. Kinship is central to individual and social identification, but reductionism masks any understanding of other forms of group affiliation in different spheres of social organization. Consequently, people's everyday life practices are projected within a more simplified static frame of historicism and culture, rather than being seen as a product of a more dynamic interaction of personal, social, and ideological elements. By upholding culture, these authors are elevating traditions and customs, in their simplest outward expressions, to social and symbolic determinism of an everyday life.

This chapter will show how people's affiliation in Egypt must be situated within a broader relational framework as a prerequisite for studying their ways of dealing with compromised health. For this purpose, I will rely

somewhat on Bourdieu's concepts of class habitus and capital.

This chapter will also show how a person's affiliation in Egypt is not only an individual but a national matter as well. The creation of an individual and his/her identity saturated with specific qualities is nothing short of a national quest (Bhabha 1990b). These personal qualities take on the meaning propagated by the State whose task is the creation of a nationalistic culture in accordance with its national project (Bhabha 1990a). Where Egypt is concerned, modernization is a national quest, and health and illness constitute a primary mode of implementing the symbolic and instrumental aspects of this quest.

Culture, Illness, and Practice:

Reflecting on the work of Bourdieu (1990), it has been noted that the 'logic of practice' of an everyday life, is completely internalized, without being questioned; but practice "is not without its purpose or practical intent" (Williams 1995:582). People are immersed in a Habitus which structures and forms their experiential being in the world (Bourdieu 1984, 1990). Thus, habitus provides individuals with class-dependent 'naturalized' ways of classifying the social world and their location within it (Williams 1995:585-6). It is

> ...a system of general generative schemes that are both durable (inscribed in the social construction of the self) and transposable (from one field to another), [which] function on an unconscious plane, and take place within a structured space of possibilities...it is a system of dispositions that is both objective and subjective. So conceived, the habitus is the dynamic intersection of structure and action, society and the individual... It is meant to capture the practical mastery that people have of their social situation, while grounding that mastery itself socially. (Postone et al. 1993:4)

The concept of class habitus will be employed here to demonstrate that not only kinship relations but also an individual's class and social location inculcates in the person naturalized modes of practice manifested in both instrumental and emotional coping with illness.

Class habitus refers to a mix of social dispositions which are instilled in the person. These dispositions are based on social stratifications that are further reproduced through social actions and interactions, which are in themselves delimited, based on the person's class habitus.

> Through the habitus, the structure which has produced it governs practice, not by the process of a mechanical determinism, but through the mediation of the orientations and limits it assigns to the habitus's operations of invention. (Bourdieu 1977:95)

A person's *mustawa*, as seen earlier, is a local cultural interpretation of what Bourdieu calls class habitus, a status based on accessible material and non-material capital (Bourdieu 1977, 1984). Bourdieu's concept of habitus is a product of an inquiry into the relationship between social and political systems and social and cultural practices which, in turn naturalize specific economic systems. The relevance of the concept of class habitus in relation to Egyptian social classes lies in its contribution to linking social, cultural, economic, and political milieux with choices and behaviors of individuals and groups. The value of the concept of *mustawayaat* is that it reveals the deeper meanings and methods by which cultures and subcultures shape everyday life. *Mustawayaat* and *fi'aat* are local idioms that explain social interaction and behaviors in more profound ways than either the concepts of social class or of class habitus have been able to accomplish.

For Bourdieu, a class habitus is directly linked to capital of which there are at least two categories: material and immaterial (Calhoun 1993). Material capital refers to the financial capital available for the purchase of commodities and products, and is based on the rules of the marketplace. Immaterial capital includes mainly cultural capital (e.g. education), social capital (e.g. social relations and networks), but also symbolic capital (e.g. "reputation for competence and an image of respectability and honourability" [Bourdieu 1984:291]).[1] Of the immaterial capital, the concepts of social and cultural capital have been more frequently employed.

In this chapter, I will illustrate how everyday life is lived by people who both wittingly and unwittingly reproduce the symbolic and the material aspects of their *mustawa*. Accordingly, illness practice of my informants is in part perceptions and in part actions that are, at once, wittingly and unwittingly produced by and reproduce social categories. My attempt is close to the view that:

> ...most passing on and subsequent affirmation of culture take place in the course of interested actions in which people pursue a variety of ends, both conscious and unconscious. (Calhoun 1993:78)

The ethnographic data presented here will show a departure from Bourdieu's view that a person's

> ...actions and works are the product of a *modus operandi* of which he is not the producer and has no conscious mastery... The scheme of thought and expression he has acquired is the basis for this *intentionless invention* of regulated improvisation.
>
> (Bourdieu 1977:79)

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[1] The term "physical capital" has also been referred to by Bourdieu (Williams 1995:587). The concept refers to the body as a resource to be employed to meet different ends, including recreation.

In the Egyptian context, illness practice allows us to observe that the dispositions of the different *mustawayaat* can also be purposefully and self-consciously reproduced. As Moore points out: "social systems consist of social practices situated in space-time and produced and reproduced through the actions of knowledgeable social actors" (Moore 1996:ix).

Bourdieu (1984) proposes that secondary properties (pp. 102-103) and modal trajectories (p. 110) play a substantial role in the creation of class habitus. He proposes that "conditions of the production of habitus" and resultant social conditions are defined by "volume of capital, composition of capital, and change in these two properties over time" (Bourdieu 1984:114). Here, it will be shown that class habitus, as proposed by Bourdieu, mistakenly assumes that homogeneous class objectives, assumptions, and dispositions exist, even if the composition of capital differs within or among different Egyptian *mustawayaat*.

Bourdieu's assumption does not explain what I observed during my research, namely how some individuals from a certain *fi'ah* decide that others in it have more or less of a given amount of capital. Alternatively, they may conclude that certain individuals should not be in their *mustawa* or *fi'ah* (level/standard or social category), and that, consequently, their life and illness practices should not cross paths. According to Bourdieu, this could be attributed to a different composition of capital within class habitus, which might consist of a combination of economic, social, and cultural capital. However, what is proposed here is that these differences, and consequent illness are best understood as locally

produced and historically constituted, creating a particular 'culture' for each *mustawa* that can be termed a 'subculture.' What Bourdieu calls "secondary properties" can best be termed, then, as 'subcultural properties' of *mustawayaat*.[2]

Culture:

In Egypt, illness practice works through a subculture established within a given *fi'ah*, which is mediated through social networks controlling the societal distribution of resources. But before going any further into exploring subcultures of social groups, the concept of culture needs to be explored briefly.

One aspect of culture which will be highlighted here is the relationship between culture and social organization. Culture is considered here in part as a product of a particular form of social organization, which is class based, constituting a piece of a whole puzzle of a life scheme. However, I supplement this conceptualization with the view that specific *fi'aat* (social categories) create their own subsystems of values and ideals which are mostly shared by those occupying them. However, this is not to say that harmony always exists and conflicts do not occur in each category in a given culture.

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[2] But, even with this proposed refinement, a gap remains which is not covered by the work of Bourdieu. His work stops short of analysis of gender differences in class habitus and in terms of availability and/or control over capital. While this limits the possibility of invoking generalizations based on his approach, it does not affect its validity in understanding some of the shared structural parameters of an everyday life. As mentioned earlier, gender relations are part of an overall structure of social relations in society. This gap needs to be tackled head-on, but in this chapter, given limits of space and scope, suffice it to say that some seeds will be sown for this particular problem to be tackled elsewhere.

Egyptian *mustawayaat* and *fi'aat* will be considered here as themselves expressions of a locally sanctioned recipe for culture. This is to say, language, non-verbal expressions, customs, aesthetics, and relational values are the 'ingredients' Egyptians use to maintain their own particular *fi'ah*. It is important to note that the creation of this cultural identity is not free from relationships of class, power and authority, and indeed ambivalence (Bhabha 1990a, 1990b).

Here, I propose to show that there is more pronounced intra-*mustawayaat* conflict, and more interaction between the form of social organization and ingredients of culture than Bourdieu's work reveals. In this case, illness practices will be shown to embody these conflicting subsystems. Furthermore, these conflicts were and still are very much integral to the historical struggle of the State and Egyptians to create a national identity.

Furthermore, for the purpose of this chapter, culture then will be understood as a dynamic product and process. It is a dynamic process embodying and reproducing social categories. Culture also comprises the perceptions, values, and practices which are produced to embody the historically produced principles of social affiliation, as well as elements of social differentiation, in a given society. Culture produces social differentiation, and in turn, it is reproduced by input from different *fi'aat*. Before we turn to Cairo's subcultures, a note on subcultures is necessary here.

Subcultures:

Studies of subcultures have taken several dimensions into consideration: age: for example, youth (Kwong 1994, Moore 1994, Shaw 1994, Young and Craig 1997); location issues: for example rural versus urban location(Fischer 1995, Tittle 1989, Moore 1994, Park 1997); ethnicity (Parker 1989); deviance and unconventional behavior (see Tittle 1989, Parker 1989, Young and Craig 1997); and "scientific subculture" (Mathias 1979). Such studies usurp studying the cultural basis of the formation of subcultures in favor of an emphasis on social structures. Additionally, this literature seems to sideline normal behavior in favor of esoteric and aggressive social behavior (Fischer 1995, Thornton 1997, P. Cohen 1997), thus operating from a presumption that a subculture is necessarily a counter-culture. This could be the result of the interest in documenting separateness from others as crucial to subcultures:

> The defining attribute of 'subcultures', then, lies with the way the accent is put on the distinction between a particular cultural/social group and the larger culture/society. The emphasis is on variance from a larger collectivity who are invariably, but not unproblematically, positioned as a normal, average, and dominant. Subcultures, in other words, are condemned to and/or enjoy a consciousness of 'otherness' or difference.
>
> (Thornton 1997:5)

A study of subculture is then, at once, a study of sameness and otherness, of being social and asocial, as will be shown later in this chapter. Important contributions of this literature assist in interpreting class subcultures in Egypt. First, tension between ideologies and cultural reality produces the conditions for subculture to emerge (Kwong 1994, Shaw 1994), interactively (A. Cohen 1997:48). Second, the more historically rooted are the similarities within a group

and the more historical are the differences with other groups, the more likely a subculture emerges over time (see Kwong 1994, A. Cohen 1997, Maynard-Moody et al. 1986). Judgments of existence of a subculture should not be mistaken for socio-economic groupings (Parker 1989). As it is with a culture, a subculture, requires nurturing through symbols and practice, a "cultural guide" (Moore 1994:16) by which a number of people exist together.

In this chapter, I attempt to show that a study of subculture of *mustawayaat* within a larger social category allows an understanding of the nuanced links between an everyday life, systems, and cultural values. This chapter will argue for a better understanding of the link among the political, economic, cultural and social parameters of the production of subcultures. Subcultures are produced and reproduced when cultural and structural conditions are fulfilled. Hence, there is a need to study the symbols, practices, and social and economic conditions which coexists to enable a subculture to thrive. Moreover, this chapter will also reveal how internalized notions of the social order translate into behaviors, which in turn get translated into a deepening of the rules of social interaction in society, all producing local social categories in a commonsensical way (see Hebdige 1979, Shaw 1994):

> ...the challenge to hegemony which subcultures represent is not issued directly by them. Rather it is expressed obliquely, in style.
> (Hebdige 1979:17)

Hence, the challenge is to show that the particular is connected to the whole on the terms of the whole, even if the particular is in opposition to the whole (Hebdige 1979).

> The subculture provides a means of 'rebirth' without having to undergo the pain of symbolic death. (P. Cohen 1997:96)

Now we turn to see how this fragmentary assimilation takes place in Egypt.

Egyptian Subcultures:

J. Abu-Lughod proposes the existence of three subcities or subareas in Cairo which corresponds to the three urban worlds of the rural, the traditional urban, and the modern one. She points out that the "style of life" in each of these subcities is distinguishable on the basis of socio-economic variables and "values and patterns of social relationships--for which we unfortunately have no detailed data by area" (J. Abu-Lughod 1969:175). I would like to propose that what J. Abu-Lughod is coining as a "style of life" is indeed better termed a subculture. The residents of the subcities indeed have a consciously line of demarcation drawn between them and the 'other'. To some extent, this is documented in other studies of urban poverty, such as those of Wikan (1996) and Early (1993a), where, clearly, socio-economic variations in the urban experience create more than a particular living condition. These socio-economic variations contribute to a *mustawayaat* and *fi'aat* whose occupants have a subculture bounded and reproduced by the urban and social space they occupy. This is more than a "style of life," which gives the impression that residents of these subcities have a choice to step out of their subculture into another.

J. Abu-Lughod's (1969) optimism that boundaries between the styles of life in these subcities are dissolving with the advent of progress does not match with the 1998 awareness that even though the ways of life may be

becoming similar, consciousness of *mustawayaat*, perceptions of urban self and urban other, values and behaviors are not being uprooted. If anything, these perceptions and actions are being further reproduced by the rise of newer more effective trends in social and subcultural demarcation, such as adherence to religious practices, consumerism, and others. Subcultures then are linked to social categories and their everyday practices.

N. El Messiri Nadim goes beyond everyday practices of larger social categories to propose that the residents of the *harah* (alley, narrow street in a traditional neighborhood) have their own subculture because they "share certain historical, ecological, and socio-cultural experiences which point to an identifiable style of life" (N. El Messiri Nadim 1975:200). Thus, their way of life is indeed a "subculture within the larger cultural system of Cairo, and Egypt" (N. El Messiri Nadim 1975:201). To go on to examine the fragmentation of the subcultures and sub-subcultures based on subareas of subareas of subcities, or to suggest that each of these mini communities has its own health subculture encompassing different perceptions, meanings and responses (see Banerji 1982:208) could be eventually the subject matter of another study. What is important to note here is that the concept of subculture is more useful than that of a "style of life" or of a homogeneous culture. The concept of subculture implies more than a subconscious instilling of social dispositions and personal space. It implies some consciousness and awareness of one's *mustawa* and a

bigger role for historical and cultural values than the concept of class habitus conventionally implies.[3]

Culture, Social Affiliation and Affirmation:
Perceptions of the value of a particular composition of capital are based on culturally constructed values that can only be studied when taken as system(s) of subculture(s). These subcultures should be scrutinized independently, while realizing that they are embedded in a larger value system. This suggests that if an individual perceives disparity between members of the *fi'ah* or *mustawa*, this perception is embedded in local knowledge. As we shall see, illness practice is a popular manifestation of an individual's tacit knowledge of his/her social standing.

In this situation, perceptions of 'self' and 'other' are very much a part of the work of culture which produces personal and group identity (see Obeyesekere 1990). Behaviors become the manipulation of different forms of capital available to each *fi'ah* to reaffirm one's self and position in society. As we shall see later, illness practice in selection of health care service, illness disclosure, and conduct in the clinical encounter draw on both implicit internalized choices and preferences and on

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[3] It is necessary to point out that what I write about here is not a euphemism for "culture of poverty" (Lewis 1959, 1970). The latter concept has been employed in the Egyptian context to reach the inaccurate conclusion that the poor in urban communities have their own subculture, but that this is mainly to be attributed to their economic conditions and that somehow the poor lack a fully developed class consciousness (e.g. Ghamri 1980). Far from this conclusion, the point here is that people are not only defined by their economic status, but by local conceptions of social categories, of which economics is but one aspect. Furthermore, the argument is that the occupants of a social category are at once unwittingly and wittingly embracing their social category.

explicit rationalized conscious choices. Reproducing one's position utilizing available capital is an integral part of what is termed here an illness practice. For this purpose, social networks discussed in chapter Four are vital.

One unfortunate common denominator of popular studies of kinship and the scarce studies of social networks, in Egypt and the Middle East, is that they dissociate social networks and reciprocity from the study of social class. Social networks are treated in a social class vacuum.[4] A lack of association between social networks, reciprocity, and social classes in the social sciences is rooted in different conceptual and pragmatic priorities.[5] In Egypt, this gap in knowledge is linked to a focus on familial affiliation to the detriment of other social associations. The result is that the study of social class is either entirely absent (e.g. Pennix 1997, Hall and Nelson 1996, Doeglas et al. 1996), or else, it is metamorphosed into the cultural dichotomy of tradition versus modernity (see Early 1993a), or diluted into the cultural idiom of despair and fatalism (see Wikan 1996).[6]

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[4] This may explain the positive light in which social networks have come to be evaluated (e.g. Barrera 1981, Van der Poel 1993, Suurmeijer 1995, Wellman et al. 1988).

[5] Interest in studies of social support in health in the West can be linked to rising costs, financial cuts and the perceived burden of an aging population in health care and the subsequent promotion of community-based care (e.g. Hall and Nelson 1996, Gliksman et al. 1995).

[6] Denoeux (1993), on the other hand, it has been particularly successful in integrating a study of sociopolitical dissent with religion, class, and the culture of informal networks, directing our attention to the process of creating group

(continued...)

Morsy (1993b) quotes a villager as saying:

> I wish we could live like the city. I wish we could live there [with] all the electricity and water... People in the city have more money, they buy meat at least once a week, not like us. I wish I was born in the city; I would have gone to school and learned to read and write. (Morsy 1993b:211)

It is clear that this villager, in addition to his individual aspirations, shares a commonly held aspiration more fundamental than a change in residence or lifestyle. His aspirations are of a change in *mustawa*. To discuss the possibility of this actually happening in Egypt is beyond the scope of this chapter, but it is important to emphasize that these aspirations are part of "social, political, and spiritual processes of life" which are determined by modes of production or "social existence" (Marx and Engels 1971:16).

In other words, taking these aspirations without situating them in their roots of *fi'aat* produces false impressions of the practice of an everyday life. Taking these aspirations without their local context of cultural values would also produce the false impression that social categorization in Egypt is only an economic phenomenon. Social and ideological concepts are instilled in people and are evident in their aspirations, even if not expressed in their discursive exchange:

> For the peasants...although the language of class is not part of their vocabulary, and neither is the rhetoric of [gender] equality...the consequences of their status as peasants are anything but understated. (Morsy 1993b:192)

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[6](...continued)
consciousness through social interaction.

So, while changes in modes of production have historically created class stratification in Egypt, socio-naturalization of classes as *mustawayaat* and *fi'aat* was accomplished through the integration of class structure into logic, culture, and practice, not only through filial relations.

Section Two: Illness Practice:

Illness practice is a fundamentally *fi'aat*-linked set of activities in most cultures, including Egypt. The relationship between capitalism and ill health is not to "be attributed simply to capitalism in any crude sense" (Doyal and Pennell 1979:27). Furthermore, these links to economic and symbolic aspects of modernity take local forms that must be studied and linked to everyday life and illness experiences. Social class determines the environmental conditions in which people live and their access to services in health care, including referrals and consultations (Morgan et al. 1985:219-220, Blane 1982). But, local idioms and concepts play an equally important role in determining appropriate actions for each *mustawa*. Thus, inequalities in health exist not only as a "product of the differences in their life situations and this reflects the priorities and nature of the wider socio-economic system" (Morgan et al. 1985:233), but also as local cultural experiences.[7]

Let us take the case of the doctor-patient relationship as an element of illness practice. Sachs (1989) proposes

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[7] The relationship between class, disease and illness is explored in sociology (e.g. Doyal and Pennell 1979, Eyer 1984, Morgan et al. 1985, Blane 1982) more than in anthropology.

that negotiation of an outcome in a medical encounter is based on a negotiation of differing cultural and medical traditions and culturally valued expectations. Katon and Kleinman (1981) propose that negotiation becomes an "integral part of the primary care physician's work, a core clinical task" (p. 276). Wiles and Higgins (1996) propose that perceptions of doctor-patient encounters have changed from paternalism to something like "mutuality and consumerism."

It is hard to imagine that in diverse cultural contexts illness practice is void of a class-oriented world view. It is hard to imagine, for example, that in Sri Lanka, peasants do not go to the doctor carrying their social class with them in their consciousness, their practice, and their expectations (see Singer 1987). Equally hard to understand is that in England, "consumerism and mutuality" between doctors and patients are separate from a more generalized class texture of society. According to Bourdieu:

> The individuals grouped in a class that is constructed in a particular respect...always bring with them, in addition to their pertinent properties by which they are classified, secondary properties which are thus smuggled into the explanatory model.
>
> (Bourdieu 1984:102)

In these cases, one is left with the false impression that an outcome of illness may actually improve through the acquisition of technical knowledge and skills, as has been argued by Katon and Kleinman (1981). This false impression produces a controversial view that giving more control to patients is separable from necessary attempts to address the deeper foundation of economic and ideological stratification in society (Singer 1987). Therefore, sensitization or even incorporation of a

sociopolitical perspective in medical training and encounters proposed by Good and Good (1982) would be sufficient. Any transformation needs to be balanced on two prongs, one of culture and one of political economy.

A framework of sociocultural belief explains that:

> Although a person may be (asymptomatically) unaware of the conditions that might later affect his or her well-being, still the state of well-being itself, and thus the source of threat to it, are defined by the thought world of the patient him- or herself.
>
> (Hahn 1995:55)

This frame of sociocultural beliefs must be integrated within a more profound view that

> ...many of the conditions the patients bring to medical settings have their origins in the way in which society is organized--in socially arranged work and leisure activities and their distribution among persons of different "races," genders, social classes, and religious and cultural background. (Hahn 1995:171)

According to these studies, ill health is produced and managed within a dynamic network of material as well as symbolic relations, which is manifested internally as well as externally. Relationships of production produce *fi'aat* whose internal interaction embodies these relationships of production. Thus, forms of social support that were once specific to rural societies became increasingly eroded by the emergence of capitalism (Eyer 1984). But, as we shall see later, new class relations also produce particular dynamics of social support in illness practice, which further assert both the hierarchy of class and practice. However, in dealing with socio-economic systems in sociology, illness practice may appear to be predetermined according to material control and exchange in society. This inadequately addresses the cultural roots of the practice.

On the other hand, it remains to be seen in anthropology how *fi'aat* influence the cultural basis of illness practice. As we shall see, illness practice happens in many cases in spite of a universal logic of social class and more in accordance to a more sophisticated logic of *mustawayaat*. The relation between social categories and illness practice is thus not rational nor a linear one. To belong to one category does not mean sharing the same subculture or sharing a perception of being homogeneous.

It will take more than this study to refine the representation of the links between *mustawayaat* and life and illness practice in Egypt or the Middle East. However, this chapter will present narratives of people whose accounts about themselves reveal a sophisticated local knowledge of culture and social differentiation more so than is routinely captured in anthropology. A definition of illness practice will be coined at the end of this chapter, after explaining some of its potential components and the basis on which I arrived at this definition.

Ayman's 'Us':

Ayman is a 26-year-old university graduate. Both his parents are teachers, one in a secondary school and the other in a preparatory school. His parents moved to Cairo from Ismailia, 100 km East of Cairo, on the Suez Canal, following the 1967 war before Ayman was born. In the name of the father, the family owns a ten feddan farm turned into a rented-out fruit orchard in Ismailia. Ayman finished his studies at the Faculty of Commerce and is currently enrolled in the military to complete his obligatory service. He is enrolled as an 'officer' which means he will have to stay in active service for three years, after which he will be on reserve for a few more

years. He is now completing his last year of military service. He is paid nominally as a conscript.

Ayman tells the story of how six months ago he came back home from the 'Red Sea,' where he was stationed, with the following complaint:

> I was not able to lift my right arm as before. I found it very difficult to carry anything even if it is not heavy, even if for one minute...I had numbness in most of my arm. It was worse just after I woke up and before I went to sleep at night.

He added:

> For two or three weeks I thought perhaps I had squeezed my arm under my body in my sleep, or I had hit my arm against something or even carried something too heavy as we often do in the military...but after a few weeks, I realized that the pain was not going away.

Ayman goes on to explain how his condition progressed:

> I thought it was going to go away, but the numbness started to go higher in my arm so that it was almost up to the middle of my arm [the middle of biceps], but after a while it neither increased, nor decreased.

Ayman adds significantly, "...numbness in the back of my neck came back to me," recalling:

> ...I was so scared, I thought maybe this numbness is going to cover my whole body... I was scared that it would spread to other parts of my body... I stayed up all night waiting for it to go away... I only fell asleep when I was exhausted...then I would wake up at dawn to find it was still there...it did not go away...it was 'clutching' in my neck like the fist of a big strong hand.

Ayman's experience is not restricted to his bodily sensations. The perceptual aspects are culturally constructed through means of social interaction and

social organization. Ayman's numbness is indeed as much a cultural experience as a physical one. To understand this, we need to listen closer to what Ayman has to say.

> After the first few days of the incidence of the numbness in my right hand I told one of my friends who was with me in the military camp, about it. He was a good friend of mine. I only met him [the first time] at the camp. We often shared duties and shifts together. This made it easier on both of us...it always helps to have someone you like, someone who understands who you are and what you want... I told him about my hand. He said to me it is probably nothing, it will go away. Maybe it is something heavy you carried without realizing it.

Ayman recounted that his friend would regularly ask him about his arm. He even told him to do an exercise which would make him feel better. Ayman added:

> I did not want to tell anyone else. Sometimes it was so numb that I thought I had lost all sensations in my arm, but I still did not want to tell anyone.

As to why, he said:

> You know, the other guys in the camp are not really friends, they will think that I am faking.

He added:

> Also, many of them come from a poor *bi'ah* (environment), not even from Cairo. If I tell anyone, it will spread around and they will all make fun of me and talk behind my back and in front of me about 'being like a girl.' I prefer not to share this problem with these people. I discussed it with Mahmoud, my friend, and decided that it is better to just go to a doctor next time during my vacation, which was to be a few days later.

On going home, Ayman was told by his father:

> Why didn't you speak to your superior? He could have given you time off, or given you a pass to go the military doctor or hospital.

The focus of the father was on expenses. This contrasted with the mother's more familiar perspective, with her role as a guardian of the social capital of the son and the family:

> Military hospitals in the Red Sea are useless. I am sure they would have just given him an aspirin and told him to return to his camp. They probably have a doctor *ghalbaan* (meaning a humble, poor doctor). I will speak to your uncle (her brother), he has a clinic for a doctor of nerves (neurologist) on the floor above his apartment in the same building... I will ask him to book an appointment for us... I know that you would have not accomplished anything out of that Red Sea doctor.

Ayman's illness practice was practically mapped out for him. As if all he had to do was feel something, express it, and leave its interpretation largely for others. A more accurate description is that his own interpretation of his condition was a result of a process of mediation between his personal existential experience and the way his mother and his friend saw the world qua social relations. His condition is located in his body, but the full extent of his experience is situated elsewhere, in the bodies of kin and non-kin others around him, in their *mustawa*.[8]

Ayman's experience was located in his *mustawa* with its cultural and material givens that formed a particular subculture. His physical discomfort and pain were experienced through culturally constructed class and

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[8] It is striking to watch this degree of similarity between Ayman and those in his age, gender and class category. However, this homogeneity in the outlook of life masks a subculture of disharmony.

gender filters which finally dictated how culturally salient his presentation of illness could be (see Good 1994 Ch. 5; Kleinman et al. 1992). His body and its already ambiguous pains became wrapped in social categories and a cultural construction of illness. Now let us return to another narrative.

Amina's Burden:

Amina is a 28-year-old graduate of the Faculty of Education. She has been married for four years. She has an eighteen-month-old daughter and a three-year-old son. She was pregnant at the time of the interview. Amina is the daughter of the General Manager of the Personnel Department of one of the government ministries in Cairo. Her mother is not educated and has never worked outside the house. The parents own a four-storey building (*bait*). The family has been living in this *bait* for more than forty years. Now, the upper two floors are inhabited by two of the offsprings: Amina on the third floor with her family, and her brother Salem on the top floor with his family. The ground floor is rented out for shops.

In the third month of her pregnancy Amina experienced some discomfort:

> Last Ramadan I was sitting after the kids went to sleep to watch television waiting for Gamal (her husband) to come home. I was so tired that I did not go down to my parents and also the kids were already asleep... I felt like I was having a discharge. I got up and went to the bathroom... I checked myself... I found some blood, I got worried and did not know what to do.

Amina goes on to say:

> Gamal arrived while I was in the bathroom. I washed my hands and went out to see him. It was so late, that I prepared the *sohour* (last meal Moslems eat before dawn before fasting), and ate with him.

> I must have looked worried because he asked me what was wrong with me. I replied: "nothing", I was just tired from working at the school all day and then dealing with the kids at home.

Amina added:

> He wanted another child so badly. He, in fact, wants two or three more children. I did not want to tell him about this problem because I did not know what was going to happen if he found out.

Amina concluded:

> I had this problem for one week before I told anyone...I did not even tell my mother at first because I knew what her reaction was going to be... I told one of my close friends at work.

Nawal, Amina's colleague, told her:

> I do not think you should tell Gamal yet, he will think again that this is an excuse for not keeping this child or not having another one...but I think you must go to the doctor.

Amina confided that she was completely distressed about this event. Her distress was not caused only because this was the first time she was facing such a problem, but because she thought she had no one to talk to about it. Amina said that if it were not for Nawal, who insisted on knowing why Amina was as pale as a "white sheet of cotton cloth" (*zai el baftah el beedah*), she would have never offered the information voluntarily. Amina was also confused because

> my heart knew what the action of my husband was going to be if I told him; he'll think I don't want any children from him, also I knew the reaction of my mother...I did not want to create a problem for nothing.

In her story, it became clear why Amina was hesitant to reveal her complaint:

> My mother never liked my husband, she thinks he is using me like a *ma'oun* (pot/container), just to have children...she thinks he does this to compensate for the difference of *wad'oh il-iktissadi huwa wi 'eeltoh b-il-nisbah li 'eelty* (his economic status and his family relative to my family's)... She told me many times in front of him and behind his back to be careful with my 'body and health'.

However, after six weeks of looking for a doctor with Nawal, using multiple excuses to leave work early or leave home for such purposes, it was found out that Amina probably had a benign fibroma in the uterine wall. The more the fetus grew the more pressure there would be on her fibrous tumor, the more bleeding and the more danger for her uterus. During her fifth month of pregnancy, Amina was faced with the choice of terminating her pregnancy or continuing at her own risk, and she was also faced with the inescapable task of telling her family.

Section Three: Class, Culture, and Illness Practice:

The area of disease and illness has always been an area for practice of class maintenance in Egypt. For example, Gallagher notes that even though public services were in the minds of upper-class Egyptian women during public health crises, this cannot and should not be separated from their interests in class maintenance (Gallagher 1990:54). Upper-classes women belonged to a *fi'ah* whose expression of emotional and material was a cultural and political matter. Their notion of public service in cases of diseases and illnesses is rooted in their interests to maintain their *mustawa*, in which their very interests in the public service was born in the first place. The lower classes are more preoccupied with 'private' not public service, trying to make ends meet. Illness is thus linked to maintenance of social disposition.

To relate this historical background and to reiterate what has happened in the lives of these two young Egyptians: Amina and Ayman both come from what has been traditionally known in Egypt as "middle-class" families. Or, in other words they both come from a *fi'ah* whose education has granted them a social status based on their distance from manual labor and their proximity to intellectually based work and access to supplementary material capital. In both cases, there is a perceived and actual dichotomy between their *mustawa* and that of others. Both have internalized the parameters of everyday living of their *mustawa*. In the case of illness practice, class loyalty became less unifying and evident in their re-erecting the boundaries between the self as an educated gendered bourgeois and the perceived 'other' as a homogeneous lower class.

Illness and Social Disposition:

Let us go back and examine further the dynamics through which social differentiation has actually influenced some aspects of illness practice. Ayman said:

> I was too embarrassed to ask for a referral to go to the camp based doctor or the military hospital... I knew I needed to go there in order to be allowed a leave, but I could not get myself to ask for one.

This clear statement then was made more complex:

> I could not go there because this means that I trust a doctor working in this place to give diagnosis for my condition...this would mean that I cannot afford to go to a better private doctor.

The puzzle becomes clear when we hear some further explanation from Ayman, who clarifies:

> It is only the poor who go to this kind of doctor...of all of those who are doing their military service on the camp, it is those who

> cannot afford a private doctor, or those who need an excuse to go on leave rather than go to this doctor...all of 'us' don't really like to go there.

Ayman's comments open doors on two interesting additions to his story: who are 'us' and what his condition is. Ayman notes:

> 'We' are the educated people who come from Cairo or other cities...we come from educated families, some of us have parents who are teachers, doctors, general managers, own businesses, etc.

In other words, 'we' are the offspring of the bourgeoisie largely created by the regime of the 50s and 60s in its attempt to break down social class stratification in Egypt and establish itself as the *bienfaiteur superieur* (Gad 1994,1995a; Abdel Mo'ti 1988; Abdel Fattah 1991[1971]; Siam 1995). At that time was created what can be termed as a "state bourgeoisie" (Zaalouk 1989:35) where

> ...access to state power has been one of the main sources of capital accumulation in Egyptian society. The aspirations of new classes and individuals are expressed through the state; then there is the merging of old and new interests...
>
> (Ajami 1982:498)

Ironically, the new bourgeoisie of the 1960s mutated itself in replacing the old bourgeoisie; so instead of dissolving disparities between classes, disparities intensified and class conflict gained momentum (Siam 1995:134).

> The development of state capitalism had in its process allowed for consolidation and enrichment of a new capitalist class. Entrepreneurs became wealthy through wholesale trade, blackmarket activity and contracting mediating activity... A new 'state bourgeoisie' which had acquired power and control over national wealth, had become firmly established within the regime.

> This new bourgeoisie had been largely recruited from families whose ideology, economic interests, opportunities and lifestyle were at best confused with regard to Nasser's [socialist ideology]... Many of the Free Officers [who led the 1952 revolution] married into these families and gradually became 'bourgeois' themselves.
>
> (Zaalouk 1989:54)

In the 1990s, this class is part of yet another class conflict associated with liberal economics (Gad 1994, Siam 1995, Zaalouk 1989). In all cases, the ammunition in the *mustawayaat* conflict consists of cultural, social, and material resources.

Ayman and his group they stand in sharp contrast to other bourgeois and the proletariat. Fitting into a majority, he and others see no need to be too much concerned with others they perceive as being below them, since the others are *nass baladi wi fellahin* or *mustawahum mutawadi'* (traditional people and farmers, or of humble standards). His group seems unwittingly to hold more esteem for those higher than their classes, imitating them in beliefs and actions.

Amina's view, with her similar class affiliation, is not widely divergent from Ayman's ideas:

> Of course I did not mention or ask anyone else from my work for advice on my problem... This is not something one talks about with [women] work colleagues...also most of them are *baladi* coming from a *mustawah mutawadi'* (humble standard/level).

Amina could not talk to her husband and mother for fear of their hijacking her biological, moral and even social life. On the other hand, she could not share her problem except with one friend at work who fitted the *mustawa* perceived to be capable of understanding and appreciating

how she perceived her biological condition. Not only was her physical and material world systematically defined for her, her perceptual world was as well. Her little material capital was being rapidly depleted by weeks of private medical care demands, leaving her with only the cultural and social exchange available in the subculture, to which she had to resort later.

In Egypt, one can share knowledge about bodily dysfunctions while still being loyal to his/her *fi'ah*. A *mustawa* also plays an important role in illness practice, including disclosure and choice of timing and place of receiving health care. While to a great extent the condition itself dictates how malleable a person becomes in seeking and accepting advice (see Inhorn 1994). Views on illness disclosure differ among different *mustawayaat*. As a part of illness practice, this contributes to the diversity in behaviors and the outcome of help-seeking behavior of different *fi'aat*, as we will see later.

Class Infusion in Doctor-Patient Encounter:

It is not an exaggeration to say that in post-revolution medical education in Egypt, medical doctors, in many cases, entered medical schools as members of one class and when they graduated they belonged to another. They are socialized at medical schools by their teachers and more senior students to graduate as members of the bourgeoisie, to a *fi'ah* that has special cultural and material attributes. However, challenges by patients to the bourgeois status of doctors is easier when these doctors lack other assets. Ayman's mother's dissatisfaction with the military doctor was due to a dissonance between his technical and social competence to perform his role. This class conflicts have intensified as the economy of Egypt takes on a different outlook.

Since the advent of the Open Door Economic Policy, many have also become important capitalists with establishments and investments in major private hospitals which line the urban landscape. To make it more complicated, the majority of medical doctors in Egypt are involved in private practice as a means to increase their income. Many of them are not able to purchase or start their own private clinics in the cities due to its high cost. Instead, they supplement their guaranteed government job with work in private clinics or poly-clinics established and operated by a non-government organization or senior medical doctors, who take a predetermined percentage of the fees. Thus, many of them have at least a double class affiliation. But where does that leave patients in relation to them?

Ayman, when he went to the doctor with his wo rried mother, said to the doctor:

> You know I hold down my pains... I do not tell anyone, because in the military I am afraid of being marked as a delicate man who cannot bear the harsh life of the military...this would be the end of my image in the camp.

When probed verbally by the doctor Ayman replied:

> Yes, I worry about many things... I was worried about what others think of me in the camp, and what my mother and father and younger brother think of me... I worry about getting a job and a bride...

Ayman seemed more worried about keeping these problems unnoticed by others than about the problems themselves. The main problem Ayman had was not that his physical condition was gradually taking a powerful hold on his thinking, it was rather how to negotiate his social

disposition in everyday life and in relation to the medical establishment now that his health had altered.

Mahmoud, his friend proved to be a good helper:

> Mahmoud told me that I should tell the doctor everything...tell him exactly when my condition started [and] how it progressed from one step to another... I should be careful to appear concerned, otherwise he [the doctor] would think I was there just to try to get him to recommend a vacation for me or something.

Mahmoud's advice was reaffirmed by matching advice from Ayman's mother, whose concern went beyond maintaining rationality, towards bodily hexis (Bourdieu 1977), including "manners," movement, and presentation of body. She said:

> Of course, when he [the doctor] saw how he [Ayman] was dressed, acted, and spoke, he realized he came from a respectable family [*'ailah mohtaramah*], and was treated respectfully... and with more concern.

On his own, Ayman prepared himself by being clean shaven for his first medical encounter and for each one afterwards, putting on a pair of dressy trousers and an ironed shirt, and wearing some good cologne. He could not explain why, except in terms of relating this interaction to other events which he considered significant for him, for which he would always prepare and dress for the occasion in a certain way.

Amina's pre-clinical encounter preparation included much of the same rationality and aesthetics. Her repertoire, additionally, included some English words which she used in her medical encounter. Words such as 'bleeding,' the 'baby,' and 'weakness' were all used to indicate at once Amina's place on the social ladder and her place on the

illness ladder. She was not told by anyone to use a certain vocabulary, but she 'felt' this would give the doctor(s) a good indication of her educational and social standing, or in other words her material, social, and cultural capital (Bourdieu 1984).

Indeed, with the help of Nawal, she became more versed in the lingo of her condition. Whenever she had to go for another test or to another doctor, she integrated more of her newly acquired medical vocabulary into each encounter. This was now elevated to talking about 'anaemia,' 'fibroma,' 'ultrasonography,' and 'oedema.' The language of the encounter reflected her embracing the medical categorization of her condition. But, more significantly, with the combination of medical knowledge and her *mustawa*, she created what she believed was a suitable illness practice. The logic of her illness practice, thus, is a cultural product that is made by and reproduces her social category.

Illness practice relies on culturally salient stimuli to maintain social categories. Ayman, in his illness practice, preferred, as would other members of his *mustawa*, to go to a private doctor for his condition. Ayman's reasons, beyond perceived technical competence, included perceptual elements which are temporal: "I don't have time in the morning to go to a government hospital where the outpatient clinic operates only until 11:00 am"; spatial: "private doctors are better because one gets a reasonable seat in a waiting room with better lights"; auditory: "one never hears the nurses or aides screaming at each other or at patients, there is also more privacy when you speak to the doctor"; olfactory: "one is less likely to smell garbage or stinking toilets"; and tactile: "one is going to sit in a

comfortable upholstered or at least cushioned and clean chair, not a wooden bench...one does not have to touch filthy examination tables or partition screens." Ayman's sensory experience is infused with the dynamics that articulates his *mustawa*. Body experience is always engaged in the "dynamic distribution of power" (Crawford 1984:95). Illness practice then is a naturalized cultural phenomenon.

In all situations, the discerning criterion for Ayman is to act according to his class subculture: *ana mish zai il nass el baladi wi il fellahin* (I am not like the traditional people and the farmers). In other instances he is less direct: *ana mish zai el tanyeen* (I am not like others). In all cases, the exclusivity of the *fi'ah* to which Ayman and Amina belong is justifiable based on their own perceived notions of themselves as being superior. This is not to deny that there are some objective grounds on which these distinctions are perceived. The point is that "life choices are not randomly distributed" (Young 1982:261), and that in illness, as in life, "choices do not merely co-occur: each helps to determine the other" (Young 1982:261).

It is difficult to know to what extent Ayman and Amina's "bodily hexis" (Bourdieu 1977) and self-presentation influenced the outcome of their clinical encounters. But their commonly shared perception and their illness practice influenced their interaction with the medical system and doctors and provided them with clues as to the quality of and therefore their satisfaction with their encounters. Thus, the logic of medical encounters is located within the dialectics of class subculture in Egypt. This could be explained as

> ...divisions [are] internalized or objectified in distinctive properties, on the basis of which the agents are most likely to divide and come together in reality in their ordinary practices, and also to mobilize themselves or be mobilized (in accordance with the specific logic, linked to a specific history, of the mobilizing organizations) by and for individual or collective political action.
>
> (Bourdieu 1984: 106)

To Create a Logic:

Class stratification in Egypt may have changed throughout history in modern Egypt (see below and also chapter Four), but the logic underlying it still endures. The logic is one of *mustawa* ascription: everyone must have a *mustawa* of a sort; everyone must be put in his/her appropriate category and its subculture; and everyone must uphold he values and mechanisms specific to his *mustawa*. Identification of this is helpful in all aspects of life: in seeking a job, a spouse, an investment, and in education and health care. Furthermore, it is helpful in terms of rationalizing, *inter alia*, either being refused a job or obtaining one, being treated disrespectfully or otherwise at health services, being refused or accepted at private schools, getting along with neighbors or not, getting a fair deal in life or not.

The centrality of hierarchical social categorization to the Egyptian mind and culture and the role of social networks in reproducing it was illustrated in the cases of Ayman and Amina, who in their *fi'ah* were instilled with cultural values and a material outlook that informed their behavior. Their behavior was compatible with the privileges that are distinct from other *mustawayaat* in terms of material and informational resources. Amina and Ayman also had access to knowledge of how to negotiate a

safer exchange in the not-always-predictable medical encounters. However, privileges of social groups are not static and need constant protection "because the best they can expect from the future is the return of the old order, from which they expect the restoration of their social being" (Bourdieu 1984:111). Maintaining and restoring social categories requires the use of the same cultural and material resources already available within a social category.

Through the cultural values lurking in their *fi'aat*, Ayman and Amina learned their physical positioning and psychological make-up in a direct and indirect manner. Ayman may have been advised to dress in a certain way, but he was not directly advised to dress in certain colors or certain designs or a certain combination of colors, as he did. Amina, on the other hand, was never told to sprinkle her medical encounters with English words, but partly wittingly and partly unwittingly, did so. Her language and bodily hexis were contained by the physical space of the clinic and power relations in the clinical setting. However, she embodied the cultural values, gender, and class relations whose boundaries were less visible and more pervasive than that of her family affiliation only. Her condition, logically, followed the seams of her identity as a mother, wife, and obliging daughter, but her language was her own way of creating a space just for her alone. She noticed that, if nothing else, at least her vocabulary helped her overcome her embarrassment about her condition as a middle-class Egyptian women in the position of having to reveal her body and its dysfunctions to others. It is Amina's subculture through which her bodily dysfunctions were experienced and practiced.

Section Four: Discussion

Departing from the anthropological concern of giving a voice to the poor, the aim here has not been to claim that health needs of the bourgeoisie are more pressing. Rather, the point is that being a member of a certain *fi'ah* in Egypt, whether acquired or ascribed, grants the person a subculture which in turn grants at least two fundamental properties: a social network which matches the needs and resources required to maintain one's social disposition, and a certain code of experiential knowledge and corporeality which one employs in different social settings and encounters, including illness practice.

The study of the relation between social categories and illness practice in Egypt has yet to begin. The cultural expression of *fi'aat* and illness escapes cultural studies in general and health studies in particular. To understand the interaction between class and illness in Egyptian culture, an anthropological lens, conflating the cultural expression of both, is what is being proposed. But first, an explanation is overdue of the way social classes emerged and took form in Egypt, which later produced the contemporary *fi'aat* subcultural divisions.

The focus on social classes rather than on other social categories such as ethnicity, gender, and religion in this chapter addresses an existing gap in the extant knowledge about illness behavior. First, it is important to note that the concept of social hierarchy and of distinguishing social categories is familiar to Egyptians from different aspects of their life. These practices are very much part of everyday behavior and discourse. Talk about *mustawayaat* is invoked repeatedly in both its material and symbolic manifestations, and is often

employed to negotiate relationships of social power. Second, to tackle this concept here should, by no means, be understood as a dilution or rejection of the relevance of other categories in operation in Egypt. Rather, it is recognized that social class as a culturally salient category does not operate in isolation from other categories. Hence, a study of a cultural system in Egypt cannot be completed without the study of the interaction between social class and other categories such as gender, religion, and ethnicity. But this is a much more demanding project than the resources available here.

Third, the concept of social class is particularly interesting in Egypt not only because its material manifestations are increasingly so obvious and ostentatious, but the consciousness of a person's class is far from being so. Little is implicit about class in Egypt. In both public discourse and private interaction people consciously refer to their social position to explain their everyday life strategies.

Fourth, in Egypt today, an improvement in socio-economic status often takes the outward manifestation of a higher social class stratum, reducing the role of the family and consciousness of other social categories, even class itself, to a large degree. Last but not least, qualitative studies of social class and health remain the least popular and a least published field of inquiry in social sciences in Egypt.

Evolution of Perspectives:

The recognition of the need for Marxist and Weberian conceptions of class stratification and social organization of modes of production is a recent phenomenon in Egyptian social sciences (Gad 1993).

However, with this development, it is important to note that:

> ...lines of division and class distinction are not an invention of Western thought, but one which is deeply rooted in an intellectual Arab heritage, despite the difference in views and assumptions, and conceptual discrepancy.
>
> (Abdel Fadeel 1988:28, my translation)

Historically, the study of social stratification in the Arab world was a focal interest of many Arab scholars (Abdel Fadeel 1988). It was the Nineteenth Century which witnessed the planting of the seeds of contemporary class structures and conceptualizations in Egypt. These structures were manifested in reform policies in economics, in the role of the state, in the forms of land ownership, state clientism, and bureaucratization of the state and its institutions, including health care (Abdel Fattah 1991, Gad 1994, Kuhnke 1990, Marsot 1984, El Issawi 1989, Baer 1969, Goldschmidt, Jr. 1988). Historically, the state in Egypt has always been a creator of social classes, through transformation of relationships of production and taxation, control of institutions of social welfare and well-being, and by acting as the main benefactor/protector of social order and resources (Abdel Fattah 1991; Abdel Fadeel 1988; Gad 1995a and 1995b).

In Egypt, the late fifties and early sixties witnessed a trend in studies on class structure. Politically, the time was ripe for a post-revolution study of the "social benefits of socialist transformations" (Gad 1993:21, my translation). This was followed in the late seventies and early eighties by the study of "the transformation which took place in class structure in the Egyptian society since announcing the Open Door Economic Policy in 1974"

(Gad 1993:32, my translation; Noweer 1994; Zaalouk 1989). To say the least, the latter policy produced questionable economic results (Goldschmidt, Jr. 1988:148-149).

Studies of class structure in the Arab world and Egypt are predominantly concerned with the study of single social classes, or of class as a background rather than as an integral part of an analysis of particular social problems. Further, a plethora of studies of class structure in the rural context is only matched with the scarcity of class structure studies in the urban context (Gad 1993:39). These studies have suffered from copying lines of inquiry which were formulated in understanding the Nineteenth Century capitalist transition in Europe, and which deflect attention from the cultural specificity in Arab society (Abdel Fadeel 1988:39). Dependency on Western theories and models and the inability to reach a consensus on which means of production predominated in the modern history of Egypt (Gad 1994) make a dynamic study of class, culture, and illness practice a formidable task.

One of the most serious gaps in studies of social classes in the Middle East in general and in Egypt in particular is the neglect of the study of the relationship of social class to the cultural basis of social categorization. Consequently, the study of intra-class relations is usurped by a more conventional study of inter-class differences (Abdel Fadeel 1988). The symbolic unity of the modern Egyptian nation is emphasized by deflecting attention away from the contentious issues of class, gender, and religion. The nation's narrative about itself represents a cultural system where unity and harmony are emphasized, and diversity and its implications are obfuscated. Consequently, because all diverse categories

are inevitably inter-related, a comprehensive understanding of cultural or political-economic issues is severely hampered. Anthropology, it seems to me, is the most suitable discipline to undertake a study of local idioms of social differentiation and how they relate to structural inequalities and local behaviors in health and illness.

The dynamics of the making of individual or collective consciousness based on class habitus (Bourdieu 1977, 1984); an understanding of the degree and nature of ideological conceptualizations embraced by various economic strata (Abdel Fadeel 1988); and the relation between social class and practice (Bourdieu 1977) are all conveniently masked by abstract studies of social organization in Egypt and the Middle East (Abdel Fadeel 1988). Alternatively, other studies focus only on family relationships. Coupled with a severe lack of understanding of the "secondary properties which are thus smuggled into the explanatory model" (Bourdieu 1984:102), and how they are locally produced and interpreted, the end result is a not-so-relevant theory.

During the inter-war and the post-war period the total industrial output grew in Egypt, while a local bourgeoisie emerged, originally composed of foreigners but later replaced by Egyptians (Zaalouk 1989:19). The Egyptian bourgeoisie have traditionally been allied with Euro/America, and their assets were equally divided between the agricultural and industrial spheres (Zaalouk 1989:23, Imam 1991). Pre-revolution Egyptian elites were far from being a homogeneous group (Tignor 1982:40). What is important to note is that neither during the nineteenth-century economic and legal reforms, nor during the inter-war and post-World War II periods did the

Egyptian bourgeoisie emerge as a result of a class struggle similar to that of ope (Tignor 1982, Baer 1969). Rather it was a "bourgeoisie which emerged largely through state intervention, under foreign rule, and with agrarian capital" (Zaalouk 1989:24), thus forfeiting any chance of developing a genuinely Egyptian struggle producing Egyptian style institutions and democracy (Zaalouk 1989:24). "Egyptian populist nationalism," Tignor writes:

> ...grew...in large part by the influx of marginal groups into the cities, the weakness of the middle class, the failure of the working class to develop autonomous labor organizations, and the inability of the peasantry to create a sense of class identity. Thus [they] were available to be manipulated by segments of the middle and lower middle class in competition with each other for power.
>
> (Tignor 1982:50)

The middle of this century witnessed an assault on conventional class structure in Egypt under Nasser's socialist regime (Gad 1994,1995; Abdel Fattah 1991; Noweer 1994). This proved to be a futile exercise because of the failure of the regime to rid itself of conservative tendencies resulting in the creation of a new bourgeoisie, which was born out of the marriage between the old bourgeoisie and the newly instituted regime (Zaalouk 1989), or what could be termed a "bureaucracy bourgeoisie" (Imam 1991:83). This was followed by a rapid economic and structural rebound which occurred following the Open Door Economic Policies and economic liberalization, reestablishing the boundaries between different classes in contemporary Egypt (Noweer 1994, Gad 1995, Zaalouk 1989, Dessouki 1982, Ajami 1982, Morsy 1993b, Imam 1991), regardless of the subequent distributional inequalities (El-Issawi 1982:124). In all stages, the bourgeoisie of Egypt was and continues to be

enmeshed in international economic interests (Zaalouk 1989, Mitchel 1991), constituting a case of enclave economy (see Cardoso and Faletto 1979).

Ayman and Amina are members of a social class produced by and predicated on the post-revolution state in Egypt, which confirms Marx's view that history and social structure change on the basis of a connection between classes and states (Knapp 1994:50). For example, education in Egypt had been the fastest growing, state-sanctioned, popular mechanism of class mobility since the middle of this century. However, nowadays, this is challenged as:

> [The] pattern of disparity in education levels [between poor and rich, urban and rural, men and women] represents an advantage for richer social groups. In other words, disparity in education attainment [and level] becomes the means to reproduce social disparity in society, even intensifying it.
>
> (Fergani 1996:24, my translation)

One could argue that this disparity is due not only to a matter of the state's limited resources, but to the restoration of older forms of hierarchization of social and cultural capital on top of an already existing family identification (see Imam 1991). This process of reallocating non-material resources is equally important as, if not more important than, politics as the system through which individuals, groups and states are interactively engaged in demarcation of social, symbolic, and physical boundaries.

Another factor which resulted in the shake-up of the conventional class structure in Egypt has been the influence of temporary labor migration to other oil-producing Arab countries. This has added another layer to

the differentiation of class in Egypt, or maybe even another class altogether (Himdan 1994c:65). Furthermore, this class/group has stopped the development of class consciousness amongst the poor, and has not in itself represented any threat to the established elites in Egypt. The end result is a symbiotic coexistence that is more pragmatic than ideological.

From the same *fi'ah* of Ayman and Amina, which reproves going to government hospitals and clinics, came those who celebrated the birth of the national health-care system in Egypt in the 50s and 60s. As in England, and other countries earlier in the century, Ayman and Amina's families are only one or two generations away from coming from the same *fi'ah* as the other people with whom their offspring work, but are considered to be of a lower class. The contradictions and double messages signaled by Open Door Economic Policy and market-oriented reforms in the state have reproduced the conflicted nature of Egyptian social categories. Affiliation in Egypt, then, is not only familial. Awareness of and loyalty to subcultures of social categories are also strong predictors of access to resources, social action and illness practices. Kin reproduces class hierarchy (Stivens 1979), that in turn "blocks all channels of social mobility in front of other classes and...produces cultures that preserve their continuity" (Imam 1991:43, my translation). Accordingly, diversity and dynamic class mobility in Egypt (Gad 1995b), which intensify after major political or economic crises (Noweer 1994), preclude a simple theorization of class relations and culture.

> Along with ambitious programs in education and industrialization, and with bold socialist policies of equalizing opportunities, the Egyptian society witnessed more social mobility than in any single

> decade in this century. But [since] the late 1960s...class structure appears to have been hardening again...upward mobility has increasingly become "confined" to children of the middle and upper strata. For younger members of the lowers rungs, such opportunities are to be found outside the Egyptian system.
>
> (Ibrahim 1982:431)

Additionally, belonging to one class and being ascribed another by virtue of affiliation, or being ascribed a certain class by virtue of being a woman or wife (Fergani 1994a) does not make the study of local interpretations of *mustawayaat* in Egypt a neat pursuit.

More interestingly, Egypt is probably unique in that there is more to class structure than one grasps at first sight. The lumpen proletariat, or those who, according to Marx, would be in that category, are indeed in another higher class category due to cultural capital and economic capital transferrals through social networks and social support. In the case of Ayman, his condition of unemployment is different because his bourgeois state is conferred on him through social and economic capital transfers made available to him through reciprocity with his social network. This becomes more complex yet in the case of other members of the lumpen proletariat who obtain their direct and indirect resources from non-kin and/or kin in Egypt or abroad.

The following summarizes the intricacy of the relationship between culture, class, and interaction with the state apparatus. Zayed explains:

> Thus the private world of each social group becomes a safer world...extraneous modernization process which affected the social structure has not changed completely the concepts of affiliation to family, extended family and region. In this light, class structure does

> not allow communication, as modernity has not removed all elements separating people. In light of these circumstances, we expect the person to be more trusting of his [her] relatives, those from his village or city...the matter could go as far as excessive subjectivism when we find the person entwined around his family or himself only...subsequently *self becomes the center of the world.*
>
> (A. Zayed 1990:163, my translation and emphasis)

Clearly, contemporary *fi'aat* in Egypt, even through rooted in the historical materialism of Egypt for over a century, is far from being clearly categorized or easily scrutinized.

Class, Subculture, and Illness:

In the narrowness of the majority of most studies of class stratification, social interaction and practice are usurped. Areas of health, illness and well-being, family and social networks, and micro-management of life are subjected to inquiries in which class, if acknowledged, is reduced solely to the socio-economic dimension. Clearly, theoretical shortcomings in the study of social classes are at the root of our limited understanding of the complexity of the sociocultural and political-economic context of health and illness. In itself, the study of economic modes of production and capital accumulation does not lead us inevitably into a path of knowledge about people's experience in health and illness (Doyal and Pennel 1979).

Stories like those of Ayman and Amina can help us to understand better the dynamic of social categorization in Egypt and how seemingly banal aspects of illness practice are produced. The views of Amina, Ayman and their network represent local knowledge and culture in which the 'other' is constructed in ways that conveniently maintain

the self's relatively advantageous position in social interaction, even in illness. Illness practice, it could be argued, is inspired by the cultural value of continuously reaffirming one's social standing. This is accompanied by eagerness to renew other people's perception of one's disposition, even, or maybe especially, at times when that physical capital is under threat.

Illness practice, then, is a social phenomenon, an embodiment of personal affiliations to kin, gender and *fi'ah*. Systems of culture, politics, and economics are intertwined to reproduce prevailing forms of social differentiation which, in turn, create social and illness practice. Current economic reform does little to reduce the classist ends of illness practice. While state-sponsored health care in the fifties and sixties gave the impression that all people are born with equal access to health care in Egypt, current shortages of funding and maldistribution in health care give the impression that *fi nass wi fi nass* (there are people and there are [other] people) is the rule.

Material capital and cultural capital "cannot function as capital until...inserted into the objective relations between the system...and the system producing the producers" (Bourdieu 1977:186). Hence, subcultures are not only a cultural phenomenon but also deeply political. Neither are they an economic phenomenon as is sometimes mistakenly portrayed. Economics is an important determinant of subculture. However, subcultures are not only materially determined; rather, materialism is put at the service of what is relevant for the larger culture and the smaller subculture at that time; in the service of a particular "style" (Hebdige 1979). If particular

forms of illness practice do not have the potential to be inserted in a value system which is culturally reproducible, they would probably be abandoned. A subculture, therefore, is not a counter culture.

Both Ayman and Amina were instilled with a view that is painfully similar. Their class is not only different from 'others'; they perceive themselves as superior to others. This feeling of superiority is partially attributed to their direct and indirect socio-economic status and the nature and combination of capital and what Bourdieu calls "secondary properties" (Bourdieu 1984:102) available to them through their class habitus. Therefore, Ayman and Amina have internalized the values of their *fi'ah*: they are better, stronger, more knowledgeable and more secure in their feelings; they have *klass* (class), even, or perhaps especially, when they fall ill. Hence, capital, is relative and is culturally recreated to reaffirm social disposition, particularly when this disposition is being challenged.

Class hierarchy is held together by the "unproductive uses of economic surplus" (Eyer 1984:52). Within this hierarchy, lifestyle and choices which define subcultures within each social class always maintain the logic of that class; it is a case of culture giving birth to class-culture giving birth to subculture (Clarke et al. 1997). In Egypt, *mustawayaat* are at once held together and apart by material and cultural capital. Material capital is important to maintain inter-class hierarchy. However, it is the non-material capital that is more significant in maintaining intra-social category diversity. Clearly what transpires is the presence of specific intra-class strategies of employing surplus capital, in its complex combination, to maintain a social

hierarchy. Thus, the ethos of illness practice is not to regain control and overcome "somatic vulnerability" so much (see Crawford 1984:74), but to regain control of the culturally situated self. It is not only about becoming well but about getting even. Just as health is associated with a moral discourse (Crawford 1984:76), illness practice is associated with a political discourse. In this discourse, knowledge follows power, both of which are individually experienced and culturally produced. Hence, a study of subculture is important not because subcultures are necessarily ideological, but because they are always ideologically dependent (Clarke et al. 1997:104).

System, Culture, and Social Categories:

The state is no longer the creator/carer of the urban middle class, yet it is still a substantial provider of the means of production and well-being, including biomedical health care (A. Zayed 1990). In its current form, the public health care system challenges people's self-perception of both the state and their own class. Thus, it recreates and reaffirms the always ambiguous feelings of Egyptians towards their state (A. Zayed 1990). Suspicion, which has been ingrained in the logic of personality and class in Egypt, has been observed to be mediated through circumscribed circles of social interaction which increases as the person "deals with circles a lot farther than ones's own private life...[and]...deals with the state apparatus through its employees" (A. Zayed 1990:161, my translation). This ambivalence could be a response to the cultural categories whose production was promoted by the state through cultural elaboration (see Bhabha 1990a). These cultural categories are in themselves categories of

popular differentiation, which in turn recapitulate the nation's narrative. Subsequently,

> What emerges as an effect of such 'incomplete signification' is a turning of boundaries and limits into the in-between spaces through which the meanings of cultural and political authority are negotiated. [Thus] the 'other' is never outside or beyond us; it emerges forcefully, within cultural discourse, when we think we speak most intimately and indigenously 'between ourselves'.
>
> (Bhabha 1990a:4)

Many anthropological studies of everyday life in Egypt, especially urban Egypt, are now available. Many have had the effect of reproducing a dichotomous view of Egyptians. Early's (1993a) *baladi-afrangi* (roughly translated traditional-Westernized/modern) is one such dichotomous view. Despite the rich anthropological data in this study, it misses the most fundamental structural foundation of this opposition, which is that an everyday life is linked to a host of social categories that marry structural and cultural factors. *Baladi* Egyptians and *afrangi* Egyptians live where they do and act the way they do principally as a result of their social class. Early's extensive portrayal of this binary opposition leaves no room for *afrangi* Egyptians to define themselves in opposition to the 'other' in this relationship. Indeed, the *afrangi* Egyptians portrayed in her study are represented mainly as a mental category in the minds of *baladi* people. The same group referred to as *afrangi* in Early's study prefer to refer to themselves as people who come from *bi'ah mutawasitah* or *bi'ah a'aliah* (middle environment or high environment, meaning middle class or upper class), or that they are *nass klass* (classy people), or *nass 'ala mustawa* (people of standards).

Accordingly, world views of different *fi'aat* are similar in that the construction of the 'other' is based on a host of cultural, economic, and ideological factors, of which taste, residence, and illness practice are only a manifestation of the perceptual foundation of the 'place' of self and other in society. In fact, self at times of social and economic transformation may become too narrowly defined:

> Social structure, which witnesses in its development forms of disharmony, produces a disharmonious class formation, with each stratum of it forming its own world. Thus, social mobility becomes very difficult between the discrepant social and economic classes. Here interaction and communication inside each stratum become more intensified and deepened than interaction with other strata. [Thus] the person who belongs to lower strata is less courageous in dealing with higher strata, as the latter become more closed onto themselves, *practicing rituals which can build around them a fence which meets intruders with arrogance in behavior and forms of despising anything that is lower*.
>
> (A. Zayed 1990:162, my translation and emphasis)

In illness, belonging to a *mustawa* or a *fi'ah* operates on two levels. First, on the level of internalized perceptions, and second, on the level of practice of an everyday life. Through these two levels, people internalize their sense the following: physicality, its disorders, and their responses; categories of self and 'other,' and the practice aspects of this category; useful and accessible capital; strategies of social negotiation of one's 'place' in a given culture. What is learned is what gets engraved on a slate which is configured according to one's location in the universe of social categories.

It has been argued that understanding culture as embraced by different social categories is the first step towards

understanding what is termed an illness practice. The term intentionally implies less rationality than those of "illness management", "illness behavior" (see Richman 1987), or "sickness career" (Twaddle 1981). More than Parson's "sick role" which "as an 'ideal type,' [lacks] spatio-temporal and cultural dimensions [and] has obvious limitations as an empirical referent" (Richman 1987:77), the term illness practice is designed to be more accommodating of the context of class habitus. It is also designed to reveal more of the dynamic cultural work of maintaining social categories.

Illness practice has been used here to imply the following: historically rooted consensual cultural knowledge and actions produced through an interactive process between culturally constructed conscious and subconscious inculcation of values, meanings, and disparities in economic, social, cultural, physical, and symbolic capital in a given social context. It is linked to subcultures of social categories, both of which are always transient and dynamic. Let us hope this concept fuels more studies of social categories, culture, and illness in Egypt and the Arab world. It is also hoped that this may direct our attention to other players and stakeholders in the practice of everyday life other than kin. Indeed in the next chapter, it is going to be argued that nothing short of globalization in culture and economics should be central to our study of cultural practices in the field of health and illness.

CHAPTER SIX:
GLOBALIZATION:
URBAN SPACE, SOCIAL SPACE, AND CLINICAL SPACE IN EGYPT

> ...it is in the cities, towns, and hamlets of the new urban world that the majority of us will live and work in the new century, where the most pollution will be generated and natural resources consumed, where political and social conditions are most likely to boil over into conflict, and where, ultimately, the roots of real global security--true human security--will lie.
>
> (N'Dow 1996:xxii)

Introduction: Globalization, Ideology, and Social Categories

In the previous chapter I explored how illness practice is a type of human action embodying social categories and their subcultures. Now I will turn to how the space itself where subcultures illness practice exist is a reflection of dynamic historic ideological predispositions (see Harvey 1989, 1990). The following are some of the main points which will be raised in this chapter:

1. Location, type, and utilization of biomedical services in Egypt, particularly in Cairo, are inextricably linked to the evolution of and conflict between social classes in modern Egypt.

2. Inequality in health in the urban context must be studied as a continuation of an historical process of differentiated and stratified access to and control over resources, including space.

3. Urban space and clinical space can be read as a text of industrialization, modernization, and globalization inasmuch as urban space and clinical space are products of a dynamic process of reform in economic as well as cultural value systems. Both components need to be examined to understand the experience of illness both in a clinical space and in an urban living space.

There are some inherent difficulties in setting out to study such a topic. First, a serious problem exists in the study of the historically produced relationship between social stratification and space, namely the realization that historical accounts of such subjects are artifacts. This means that, at times, analysis and conclusions may be based on what might be called contested interpretations of history.

Second, the "anthropomorphization" of the already complex concepts of modernization, globalization, and economic reforms is somewhat pervasive and misleading. In other words, giving human qualities to such concepts (as if these concepts, independent of human agency, can "do", "change", "produce", "break", "make", and so on) is misleading. The result is that it is not clear who is doing what to whom. In this chapter it is inevitable that some of this confusion will infiltrate the discussion. However, this is a reflection of the gaps in existing knowledge. Finally, the difficulty of identifying social classes in contemporary Egypt is not to be underestimated (see chapter Five). It is not clear who has what status, who owns the money, which group is conscious of its class position, and which group is in a transitional stage of class mobility.

Consequently, writing about the impact of the historical intertwining of class interests and globalization on illness practice in urban Egypt is a hazardous subject to say the least.

Section One: Class in Space and Time:

As Harvey points out: "space is surely too important to be left exclusively to geographers" (Harvey 1989:3). It is possible to add that time also is too important to be left exclusively to historians. It is in the investigation of illness practice that a complex approach is needed to understand the articulation of time, space, culture, and ideology in the life of people and nations,.

Harvey attempts to understand urbanization and space through adding to and filling in the gaps in historical materialism. His contribution is significant as it brings to the fore at least three relevant points which will be emphasized in this chapter. First, all urban space is a social space in that, urban space is not an abstract ideal, but rather is alive with social relations of a symbolic and material nature (Harvey 1989). Ideology, tradition, and values are constantly engaged in the shaping and reshaping of the space in which people of different *mustawayaat* live in Egypt. It is a dynamic and interactive process through which Egyptians create and find their identity and also their social ties.

Second, an understanding of symbols and material conditions in the urban context requires an encompassing broad theory which expands the scope of inquiry (Harvey 1989, 1990). Harvey extends an invitation to upgrade historical materialism to "historical-geographical materialism [taking] the historical geography of

capitalism [as] the object of our theorizing" (Harvey 1989:6). This includes the broadening of the study of the urban experience to show not only how it is produced, but also how it is reproduced in a finite multitude of ways and contexts. In these various contexts, the larger picture of the urban experience is born and delivered. The context of health and illness is taken here to be one of the finite areas in which ideology and culture interact to reproduce the experience of space and time among different *fi'aat* in the the urban context.

Third, Harvey clearly links the experiential aspects of urban space to the objective manifestations of a capital-labor relationship (Harvey 1989, 1990). Thus, significantly, he situates any study of urban people's experience in the relationships of capital accumulation, material differentiation, and consumption. Accordingly, the locus of the study of health in the Egyptian urban context must be in social categories producing the objective and subjective conditions of experiences of people in different social categories.

To emphasize: in the Egyptian context, it will be argued that illness practice and urban subcultures are expressed spatially and temporally in urban and clinical spaces. This historic expression is as much ideological as it is a cultural artifact of *mustwayaat igtima'eyah* (social levels). Further, space in Egypt is historically built and is rooted in the historical integration of Egypt in the world economy and the global ethos of modernization. It is from this starting point that I explore the subject of globalization, urban space, social space, and clinical space in Egypt. As a start, these terms need to be clarified.

In this chapter, urban space will refer to the spatial, temporal, and institutional organization of physical and symbolic elements of an urban ecology, including the household, streets, official institutions, and so on in the urban context. Clinical space will refer to the spatial, temporal, and institutional context within which biomedical treatment of illness conditions take place; it is the context where patients reveal their illnesses and hope to be cured, and where disease is managed by biomedical professionals. In this chapter, social space is the intermediate link between urban space and clinical space. It refers to the relational context within which social roles and behaviors are defined, enacted, and reproduced in tandem with social *mustawayaat*.

Globalization, the Social, and Personal Experience:

In this chapter, a single question will be investigated: what is the illness practice of patients in the urban and clinical context of Cairo, given that a patient is a product and a reproducer of his/her *mustawa* and a certain amount of capital? Given that a patient belongs to a certain *fi'ah* (category, sing.) that has its own subculture, what kind of illness practice does he/she have? In addition to the work of Harvey, the concepts of class habitus and of capital, central to this argument, are derived (as we have seen in chapter Five) from the work of Bourdieu (1977, 1984). The concept of capital is relevant here because forms of capital exist in the social class of individuals and social groups.

> To account more fully for the differences in life-style between the different fractions [of class habitus]--especially as regards culture--one would have to take account of their distribution in a *socially ranked geographical space*. A group's chance of appropriating any given class of rare assets...depend[s] partly on its capacity for the specific appropriation, defined by the economic, cultural, and social

> capital it can deploy in order to appropriate materially or symbolically the assets in question, that is, its position in social space, and partly on the relationship between its distribution in geographical space and the distribution of the scarce assets in that space. (Bourdieu 1984:124)

Personal space is not static, it is dynamically recharged by practice and movement within itself. A look at the space within which a person moves, and the way persons "carry themselves" (Bourdieu 1984:218), can reveal the underlying ideological configuration of society and of the person's space. In other words, a study of a person's movement in an objective space, such as urban space or clinical space, should help reveal the subjective experience of the person, of his/her class location, and forces shaping both his/her *fi'ah*, and his/her experience.

A subjective experience, however, is dependent on more than class location; it also depends on links outside immediate social space. Ironically, one of the forces least studied in terms of its influence on subjective experience is globalization. This concept has probably been amongst the most misused in the 1990s.

Globalization as a concept has taken on an economic, cultural and political connotations. Much like the concept of development, the term has been used to denote processual as well as normative ends (Goulet 1992). However, the economic connotations of the term are often highlighted to denote what is referred to as the integration of "large areas of the world into...a single

economy" (Gilbert and Gugler 1981:11).[1] Could globalization be just another development orthodoxy reduced to its bare economic skeleton, where subjective experience, if at all studied, is considered completely dependent on economic imperatives? More importantly, could a conventional concern with national economy and global markets obscure more profound global changes in fundamental aspects in people's subjective experience? Could the instrumental institutions and symbolic systems guiding people's subjective experiences be under the knife of globalization? Answers to these questions are hard to come by without an exploration of the everyday life of people touched by globalization.

For the purpose of this chapter, it may appear that the economic connotations of globalization and the role of the state in this process are elevated in importance. Although people's subjective experience is central to this study, an emphasis on economic development and the role of the state is justified. Both economic development and the state have been the "major source of social change in the Middle East in the post-World War II period" (Moghadam 1993:21). However, this will not detract from the exploration of the cultural aspects of globalization in illness practice.

The study of globalization in Medical Anthropology has not yet gathered momentum. However, a change is inevitable. First, an ever increasing number of lives are being touched by one element or another of globalization. Through the modes of production in the work place,

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[1] This global economic fusion is indicated by the "merger frenzy" among companies in all fields and of all different nationalities (Ernsberger, Jr. 1996).

quality of nutrition, psychological and financial stress, or other factors, change is happening, and all of these are legitimate concerns. Second, an increasing number of people and "traditional" communities, usually the focus of study of anthropology, are becoming aware of the process of globalization and its potential and ability to change the configuration not only of their economic life, but the very meaning of life in general. Third, globalization, as a broader concept than the agenda of structural adjustment and economic reform, allows the study of more than the economic relations to health. It has the potential to allow the exploration of the non-economic implications of creating economic uniformity. Cultural and social implications of global uniformity are relatively easier to conceptualize in the study of globalization than are the limitations set by the financial and economic components of economic reform packages. Fourth, at least since the 19th century, illness has grown to be intertwined with the advent of industrialization and Westernization, both of which are very much at the heart of globalization. Thus, it is inevitable that work on the relationship of inequality to ill health explores the historical connections between the emergence of industrialization and biomedicine and the contemporary globalization of economics and biomedicine. The concept of globalization may be ill-defined, but its relation to objective life conditions and subjective experiences cannot be escaped.

The term globalization will be employed to clarify the sociopolitical as well as the sociocultural context within which lines of influence and areas of authority transcend national and regional geographic boundaries for the purpose of transposing uniform value systems and *modus operandi*. The term will be used as the backdrop

against which the creation and use of urban, social, and clinical space take place.

This discussion also emphasizes that globalization is not a recent phenomenon. A person need not search hard to realize that in the case of Egypt, the state, the legal system, the welfare system, the medical system, and the education system which provides the institutional framework for a person's subjective experience in his/her *mustawa* are the product of an historically continuous process of globalization.

> Globalization is viewed as a process, rather than an abrupt phenomenon that emerged in the last decade or even century. Globalization started taking shape the time civilizations began communicating and/or interacting with one another via different means. It has been a cumulative process. (Sirageldin 1996:3)

The current new wave of economic fusion has been part of the Middle East's participation in the internationalization of capital since the 60s and 70s (Moghadam 1993:17). Economic fusion of capital and markets on a global scale is perhaps closer than we think and more urban-biased than many admit (see Mitchel 1991).

> Development strategies and state economic policies are not formulated in a vacuum; they are greatly influenced, for better or for worse, by world-systemic imperatives. (Moghadam 1993:17)

Globalization is also linked to the universal progress of capitalist modes of production, which are, by definition, urban based and class based (Gilbert and Gugler 1981, see Harvey 1989). This means that the articulation of modes of production and labor occurs in the urban space where social space is subsequently created (Harvey 1989). This articulation is economy-dependent, as is globalization. However, the expression of this articulation lies deeper

than economics; it involves nothing short of redrawing spatio-temporal cultural systems shaping personal subjective experience (Harvey 1990).

The discussion hereafter proceeds from the starting point that even though space and social and medical systems in Egypt are largely a product of globalization process, which has accelerated during the last two centuries, Egypt has produced its own local form of this process. The resultant systems are no longer purely global or purely local, they are "global" systems and a local modernity. Class interest in this process has been a major force, operating through preexisting culturally salient material and symbolic systems of hierarchization of *fi'aat*. Thus, it is important to point out that

> ...in part, the impulses of modernization or mutation have come from the West; in part, they are continuations or accentuation of existing tendencies. And, scattered among the many, obvious, mutations are elements which continue almost unchanged.
>
> (Polk 1969:xi)

The choice of Cairo as a site for examining urban, social and clinical space, is partly based on a personal belief in Linden's remark that cities remain very much the bedrock of civilization and that "the fate of the world is entwined with the fate of its cities" (Linden 1993:40). Since Cairocentrism (Himdan 1996) is at once a pragmatic and an ideological position in Egypt, it makes sense to focus on Cairo as a starting point.

Section Two: Globalization, Urban Space, and Social Space in Cairo:

In Egypt, differentiated spatial organization is linked through internalization of local conceptions of *mustawayaat*.[2] The reorganization of space, which has always been an object of social ideology, involves a transformation of logic and of the fundamental cultural beliefs governing human attitudes and behaviors:

> ...rational forms of social organization and rational modes of thought [have] promised liberation from the irrationalities of myth, religion, superstition, release from the arbitrary use of power as well as from the dark side of our own human nature.
>
> (Harvey 1990:12)

The body itself becomes another object of this transformation of logic; it becomes a chaotic space in need of rationalization and reordering to match the time. Transcribing the body, space, and the body-in-space with social differentiation is a dialectical relationship:

> ...it is in the dialectical relationship between the body and a space structured according to the mythico-ritual oppositions that one finds the form par excellence of the structural apprenticeship which leads to the em-bodying of the structure of the world.
>
> (Bourdieu 1977:89)

Hence, the study of *mustawayaat* in Egypt leads to the study of time, space, and the body, just as the study of time, space, and the body leads to the study of social ideology. Furthermore, understanding the spatial organization of urban space in Cairo is necessarily an

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[2] Space embodies the structural relationships in society which are reproducible through the habitus, through "the mediation of the orientations and limits" (Bourdieu 1977:95).

historical process (J. Abu-Lughod 1971). The history of social organization in Cairo is the history of its inculcation in the Egyptian space and body.

At this point, a brief historical exploration is necessary in order to understand how the current organization of urban and social space in Cairo is historically constructed.

Cairo: A Capital City:

Cairo, in its precursor forms (*Al Fustat, Al A'skar, Al Qata'i', Al Qahira*) reached at least two zenith points in its history. The first was when it became the capital of the ruling Fatimids, four years after its establishment (years 969-1171) (Al Razzaz 1995a). The second began in 1800 (J. Abu-Lughod 1973:97) and lasted almost halfway through the reign of the Khedive Ismail period. Cairo's "decisive turning point came between 1867 and 1869, before the delayed impact of Ismail's fiscal responsibility struck" (J. Abu-Lughod 1973:101).

It is significant to note that the introduction of Islam in Egypt did not necessarily mean the integration of Moslem models in all aspects of life. *Al Qahira* in 1050 was still a city designated for the ruler, his statesmen, and some military (Raymond 1994:54, Al Razzaz 1995a). It was not until towards the end of the era of the Fatimids and the take-over by the Ayubids (1171) that the functional boundaries between *Al Fustat* as a trade emporium and *Al Qahira* as a government city were dissolved, and the labor differentiation between the residents of each became increasingly dissolved (Raymond 1994, Al Razzaz 1995a).

As early as the Fatimid period (years 969-1171), trade networks could be found between the countries of the Indian Ocean and Egypt (Raymond 1994:42). Egypt was also a transit hub for imported goods. Cairo was a trading post and a bridge between markets and consumers. Trade was Egypt's known key to global interaction (Zhohni 1995). This was attributable not only to Egypt's central geographic position. The middle geographic location created Egypt's middle/moderate character which became manifested not only in economics, but politics, culture, and more importantly in the socialization of its population. This geographic location produced Egypt's most important character, the "middle" personality, which makes for *shakhsiyet misr* (literally the personality of Egypt) (Himdan 1994a).

By the early eleventh century, Egypt's location also allowed her to be involved in trading cotton, silk, textiles, leather, spices, perfumes, dyes, paints, precious stones, and other chemical and agricultural products with Sicily, Spain, Tunisia, the Asian Orient, Central Asia, and elsewhere (Raymond 1994:60). However, the fifteenth century revealed the diversion of Egypt's orientation from the traditional East towards the Mediterranean (Raymond 1994). This local reorientation was a practical response to the growth of global trade routes to and from ope (Raymond 1994, see Gilbert and Gugler 1981). Cities were the prime space for this to take place. The continuation of the intensification of urbanization in Egypt has been associated with "her incorporation into the world capitalist economy during the last two centuries" (Chaichian 1988:23). This was instigated by the policies of Mohamed Ali, Khedive Ismail and their descendants, and similar to other developing and even capitalist countries (see Harvey 1989, 1990).

***Urban Space and Social Hierarchy*:**

The precursors of modern Cairo always emerged as divided spatial formations according to a particular social class stratification (Ibrahim 1992). *Al Fustat* (Year 642) and *Al 'Askar* (Year 750) were differentiated primarily as military cities. Later, *Al Qata'i'* (Year 868) and *Al Qahira* (969), both precursors of Cairo, even though they were organized mainly on military principles, were nevertheless divided into spatial formations according to material, social, and ethno-religious divisions; these included guilds, Jewish quarters, and rulers' areas (Ibrahim 1992, Kuhnke 1990, Baer 1969, Costello 1977, J. Abu-Lughod 1971). Indeed these "quarters also provided the framework for an active community life through their popular organization" (Raymond 1982:100). In the nineteenth and twentieth centuries, the divisions became more dependent upon modes of production and links to international markets (Costello 1977). In all cases, residential urban space in Cairo was and is stratified according to material and resultant social capital.

> ...since the time of the Mamluks the division between different urban areas was being redrawn based on their functions, which signaled the forthcoming "traditional" organization of the city.
>
> (Raymond 1994:144, my translation)

During the Mamluk period (circa 1250), commercial sections of the city were becoming more distinct than residential sections.[3] Thus, the earlier organic

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[3] Distinct commercial activities existed in the city before the end of the 11th century. Specialized markets such as *souk il shawa'een* (Grilling Specialists Market) appeared as early as 975 (Raymond 1994). However, these activities were mostly owned by the Sultan or remained scattered and incomplete (see Raymond 1994). Circa 1250 was the first optimal period of the functional division of Cairo (continued...)

division, with each area being self-contained in terms of economic, administrative, and religio-cultural institutions, was replaced by a morphology of "residential areas in the city sprawling around the economic activities" (Raymond 1994:147, my translation). These residential areas became the administrative as well as defensive units of the city; each was also called the *harah* (sing.) (Raymond 1994:147, N. El Messiri Nadim 1975). This change meant the dissolution of guilds and older urban space formations and thus represented another pro-globalization step in Egypt. The change was a result of

> ...the influx of opean goods and of Europeans settling in Egypt, or urbanization, and of reorganization of the Egyptian administration. (Baer 1969:217)

A rise of functionally differentiated urban centers and social infrastructure was, as elsewhere is the case, associated with the process of capitalist production, consumption, and exchange (Harvey 1989:24, Harvey 1990). Thus, the "production of built environments [came to serve] capital accumulation and [become] subservient to its dominant logic" (Harvey 1989:27). This is often observed in instances of forced urban cityscaping which are ideologically driven and symbolically mediated. According to Harvey, this required the creation of the mental images of "creative destruction" which symbolized more than anything else the ethos of modernity, that is the erection of a new order on the ruins of what is perceived to be a decrepit old order (Harvey 1990:16).

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[3](...continued)
(Raymond 1994:144).

At least two instances of "creative destruction" can be observed in the evolution of modern Cairo. In both cases, urban space was the outward manifestation of an ideological link between progress and urban rejuvenation. Urban rejuvenation was the preoccupation of the rulers and elites. Space was an expression of a sociopolitical process of social categorization.

> ...the whole basis of urbanization had to change. The preindustrial city had to be disciplined, weaned away as it were from its mercantilist proclivities, its monopolistic practices, and its assertion of the primacy of place over a capitalist organization in which relative rather than absolute locations had to dominate.
>
> (Harvey 1989:28)

An instance of forced urban cityscaping was apparent at the time of Mohamed Ali. A combination of public health problems, new industrialization, and even his daughter's wedding procession (Year 1814) forced the razing of several hundred buildings and public spaces to improve access, ventilation, and transportation (Ibrahim 1992, Raymond 1994). Another instance occurred during the time of Khedive Ismail, Mohamed Ali's grandson, who upon returning from Hausmann's Paris after the World Exhibition (Year 1867) decided to create and reorganize Cairo's urban space *a la francaise* (Raymond 1994:272; J. Abu-Lughod 1973, Mitchel 1988). This was the outward manifestation of modernization.

Until the 1798 French Occupation, urban spaces in Egypt were more like villages with minimal differences in morphological or functional qualities (Himdan 1994b:228), following characteristically the "plan of not planning," being a mere amalgamation of constructions (Himdan 1996:19). With the advent of this new colonial era, transformation took place in urban and social space as

well. Himdan distinguishes two types of urban space which emerged in the course of modern urbanization. The first is an archetype or a recessive type which corresponds to a traditional type urban space. The second is a neotype or a dominant type corresponding to a modern type urban space (Himdan 1994b:228). But continuing urbanization produced a more complex typology of urban space, the purely old, the purely modern, the superimposed model of the modern on top of the old, and lastly the complex ordinance type with the modern and the old horizontally coexisting (Himdan 1994b:229).

> One of the more distinctive characteristics of Cairo's neighborhoods and economies is the mixed use of space. Commercial areas, residences, and even industrial plants coexist--at times, with difficulty. (Singerman 1995:25)

The dissolution of social distinctions in urban and social space has been halted by new modes of economic development, such as the Open Door Economic Policy and privatization, which have created new class interests (Zaalouk 1989). However, it is important to note, that even though urban space boundaries and social space limitations are still not dissolved, the relationship is not simply a dichotomous one as, for example, Early (1993a) proposes. It is not a matter of tradition versus modernity, but a more complex articulation of landscaping of urban and social space. However, Early's contribution is important in that it pinpoints the fact that differentiation in social space is very much alive in contemporary urban space (see Early 1993a).

Globalization, Science, and Identity:

The development of modern urban and social space was very much an integral component of Egypt's entry into global capitalism. Egypt became modernized and "integrated into

global politics and economics" (Raymond 1994:259, my translation). The process was naturalized and conclusive, even logical: "the ideology of capitalism legitimizes urbanization in terms of its contribution to the growth of the gross national product" (Gilbert and Gugler 1981:11).

Drawing the new section of the city according to Western models had the impact of redrawing urban as well as social boundaries based on imported urban models of cityscaping. Modernity was also accompanied by a hierarchy of centralized authority, which became pervasive. New bureaucratic institutions were created to control, monitor, and guide the bodies and minds of Egyptians. The authority of the state became diffused everywhere (Mitchel 1988).

Egypt's modernization has always been touted by the state to be predicated on the "modern" and "civilized" standards of the health and education of its people. The April 17th, 1997 headline of *The Egyptian Gazette* reading "Education and health, two main pillars of Egypt's 21st century civilization" (Ragab 1987:3) could have been read on the eve of the Nineteenth or Twentieth Centuries with only a change its dates. Public schooling and higher education were mechanisms through which Mohamed Ali and his followers sought to bring progress to the land.

By the mid-Nineteenth Century, Western models of the sciences were unabashedly infiltrating and replacing the traditional Arab Islamic sciences. To reach modern health standards, medical education, which originally integrated traditional Islamic medical scientists, was replaced by purely Western models (Kuhnke 1990).

Higher education was made easy by sending waves of schola to capture the essence of modern science and technology. The first wave started in 1813 with scholarships granted to a mixed group of Egyptian residents to study different sciences in Italy, France, and Austria (Ibrahim 1992).[4] These Egyptians

> ...came back with new ideas and opinions not only in science and industry, but in thinking, traditions, and social customs... Most of them came to be in charge of important posts in the state... An example is Rifaa'ah al Tahtawi who represents the trend in the intellectual and cultural renaissance which had awakened Egypt by the beginning of the 19th century.
>
> (Ibrahim 1992:136, my translation)

The reorganization of the sciences and education in Egypt along the lines of increasing standardization of the Western sciences worked indirectly to shape Egyptian identity and urban and social space or, in other words, to create the groundwork for future social distinction and discrimination.[5] Most scholars who went to study in ope were from Cairo, mainly because this was where educated people lived, but also because it was the seat of Al Azhar University, the main educational institution of the time. Thus, the influence of European education in Cairo's urban sphere was centralized. Second, as most of the returnees later came to hold important posts in

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[4] It is noteworthy that earlier waves of scholars were of mixed ethnicity, while later waves were more of what probably was considered then pure Egyptians (Ibrahim 1992). It is not clear whether this was a result of a generalized slow exodus of people of different ethnic background from Egypt, or a result of a deliberate attempt to define who is an Egyptian as an integral component of the creation of the modern state of Egypt.

[5] Now it seems that the investment in education has a very low yield in brain power necessary for the currently fierce global competition. (Sirageldin 1996).

the state, and because the state as structured by Mohamed Ali was centralized, these individuals with their new sciences, customs, and traditions contributed to the reshaping of urban and social space. Third, education and bureaucratization of the state went hand in hand in developing certain districts of Cairo where the government was centered. These scholars, together with other bureaucrats, were the first to inhabit these districts. They were followed later by other civil servants who were probably attracted there because of the proximity to their work (Raymond 1994). They later came to adopt the dress code, manners, and customs of their fellow European-educated, state-employed superiors. Thus, the integration of Egypt into the globalizing world of the Western sciences shaped both the minds and manners of modern Egyptians. Urban and social space were reorganized.

> While at the beginning of the century there were no significant cultural differences among Egyptians, the impact of the West created a gulf between the European ized and educated Egyptian officials and other parts of the upper classes and the great mass of the fellahs and town dwellers, including the lower middle classes.
>
> (Baer 1969:228)

The Nineteenth- and Twentieth-Century economic, urban and social reorganization of Cairo came at an extravagant financial, spatial, and cultural cost. The result was the redrawing of urban space and the confirmation of the hierarchization of Cairo's urban and social space into an "Eastern" traditional poor space and a "Western", modern, wealthier space. Historically, in instances of urban rejuvenation, space becomes the domain of material, social, and cultural conflict. Harvey points out that urban centers were created along the lines of modern capitalism where

> Living spaces were made to represent status, position and prestige. Social competition with respect to life-style and command over social space and its significations became an important aspect of access to life chances. (Harvey 1989:40)

Historically, urban and social space in Egypt embodied a logic of *mustawayaat;* now in contemporary Egypt, residential areas, more than ever, became the manifestation of this hierarchy, where the "place is the status" (Himdan 1996:43). An individuals's position in a social category became the product of an acquired amount of material capital or symbolic capital. It also depended on the ability of individuals and groups to transform material capital into symbolic capital and *vice versa.* (see Bourdieu 1984, Harvey 1990:77).

Section Three: Globalization, Urban Space and Clinical Space in Cairo:

From 332 B.C. until A.D. 1952, "non-Egyptians governed the land while Egyptians toiled to support them" (Goldschmidt, Jr. 1988:5). Nevertheless, Mohameli is considered the creator of modern Egypt. He was concerned with one goal and believed two mechanisms could lead him there. His concern was to spearate from the hegemony of the Ottoman Empire and to establish his own position as the sole ruler of Egypt (Mansfield 1991, Goldschmidt, Jr. 1988). The creation of a strong modern economy and a strong military were the mechanisms to reach this end. These institutions, he came to realize, require able-bodied men capable of working long hours under harsh conditions (Kuhnke 1990).

Rather than working towards the creation of able-bodied men, Mohamed Ali tried to bring about changes in another

way: he was more interested in repairing the bodies of (un)able-bodied men rather their creation in the first place. Biomedicine was the perfect complement to Mohamed Ali's view of men as producers, as a fuel to run the motor of the state which, when broken, needed immediate repair and recharging. Biomedicine came to be intertwined with one man's vision of statehood, modernity, and the role of subjects of the state. The natural outcome was the emergence of an "urban based, curative medicine-oriented Western model which carried the prestige of the successful and prosperous leading nations of the world" (Kuhnke 1990:162). The same vision was shared by his grandson Khedive Ismail, during whose time the number of medical schools was increased and improved with more opportunities for Egyptians. The development of medical facilities was intimately associated with military expansion (Kuhnke 1990).

Repair of Egyptian bodies was entrusted to Clot Bey, who established the first modern hospital in Egypt, and later the first medical school (Kuhnke 1990). These facilities were located appropriately according to the state's organization of defense and production. The first hospital was situated next to the military camp of *Abu Zabel* in 1827, and later moved to *Kasr el Ayni* in 1832, where it became the most important medical school (Jagailloux 1986, Ibrahim 1992, J. Abu Lughod 1971, Kuhnke 1990). The historical proximity of the hospital to other basic functional institutions of the state such as defence and industries (Ibrahim 1992, Jagailloux 1986), came to be the organizing principle of clinical space in modern Egypt.

Modernization and Clinical Space:

At *Al Qata'i'* and the *harah* (alley) administrative divisions of the city, each location retained Islamic and popular healers, in addition to each unit's administrative and commercial base. This historical continuity was to be maintained in Mohamed Ali's era, when work, residence and healing of all kinds were preferably conducted within the same unit of organized space (see Raymond 1994:233). The proximity of clinical space either to workplace or residence, or preferably the two, came, in time, to be colored by interest of class and social stratification.

Favoring this proximity were a few additional factors. First, there was the poor condition of the roads and transportation when the hospitals and medical school were established (Jagailloux 1986). Second, Cairo, as the capital and center of centers in Egypt, was the main site to be defended and protected by the military, hence the attraction of placing medical services in the city. Third, the foreigners brought in by Mohamed Ali, initially to realize his dream of a great hospital system, were more inclined to feel at ease in a city with better facilities, communications, and direct access to Mohamed Ali. Fourth, the dream of industrialization was largely realized in Cairo, resulting in its becoming, in the Twentieth Century, the "industrial capital of Egypt" (Himdan 1996:32, my translation). Thus, the countryside remained deprived of biomedical services, even though all agricultural production (the main economic activity for most Egyptians) took place there. Cairo, meantime, was becoming increasingly biomedicalized.(Jagailloux 1986).

However, this is not the complete picture. Until 1837, non-military patients could be treated in the newly

emerging military hospital only with a personal permit from the Pasha Mohamed Ali (Jagailloux 1986). Access to biomedical hospital services remained rather exclusive (Ibrahim 1992). This, contrasts with the first hospital built in Egypt, by Ibn Tulun, in the early 870s, close to the Ibn Tulun Mosque in the Sayeda Zeinab district with the condition that no soldiers and Mamluks were to be treated there (H. Ramadan 1994:258). It was a hospital for the poor, where they could find a state-of-the-art care based on the Arabic-Islamic medical system (H. Ramadan 1994).

In contrast, the roots of biomedical services in Egypt were not only urban- and Cairo-based, but also class based (Jagailloux 1986). As biomedicine came increasingly to replace the previously predominant classical Arab medical system and popular medicine, its intake of patients was based on class hierarchy. By 1850 the ruling class almost exclusively embraced Western medicine, while retailers and merchants embraced spiritual medicine, and the rural population still largely adhered to healing by saints, shrines and popular medicine (Jagailloux 1986). This stratified access to biomedical knowledge and expertise according to social category dates back to the Nineteenth Century and to the expansion of biomedical knowledge in ope (Kalekin-Fishman 1996:813).

The air of fraternity and public welfare, through which biomedicine and its clinical spaces were embraced, poorly masked a hidden agenda integrating social class, "Westernization" and biomedicalization (Jagailloux 1986). To fulfil the ethos of national economic and social modernization, Mohamed Ali and Clot Bey imported European doctors who buttressed efforts to transform the whole population through the formation of a group of

Westernized,"modern"-minded elites (Jagailloux 1986). These elites were different from traditional elites in that they had more direct links to European trade and education, modern state bureaucracy, and new sources of wealth based on modern industries and technology. This contrasts with the traditional elites whose legitimacy was derived from their mastery over Islamic knowledge, the Arabic language, Islamic jurisprudence, education in Al Azhar University, and traditional arts and crafts. Indeed, the scientific spirit conveyed by biomedicine itself helped shape the modern consciousness of Egyptians (Jagailloux 1986). This occurred without the complete awareness of either the poor, the rural population, or most intellectuals, who were either indifferent or preoccupied with nationalistic political agendas (Jagailloux 1986).

With underdeveloped means of transportation and roads from rural to urban areas and in intra-urban areas, biomedical services were used by a minority of the population, and access to them was conditional upon their proximity to the centers of power or production. In other words, access to curative biomedical services was contingent upon social possessions and hence, social category. This rule, which was overturned for only a very short period in the history of modern Egypt (mid 1950s to early 1970s), was to govern access to medical services in Egypt until the present time, as we will see later.

With this overview of the historical evolution of urban, social, and clinical space in Cairo, we can now turn to some continuities with the present. In the next section, the discussion will turn to ethnographic accounts of subjective experiences as contextualized in contemporary urban, social, and clinical space.

Section Four: Globalization, Social Space, and Clinical Space in Cairo:

The story of Om Ahmed will be interspersed with my own observations and/or elaborations on certain aspects of her account:

> I go to this hospital [public hospital in the district of Sayeda Zeinab] because I don't like to go far. It is a big burden on me if I have to go out for so long. I have so much to do at home that going out delays everything and messes up everything... I like to go to this hospital because it is the closest. I know there is that other bigger hospital which I know is better...but, you know, it is all the same. They all belong to the government, you never get a word to wet your saliva [*kilma tibil ri'ak*]... The government does not care about us, and even if it does, in its hospitals they do not.
>
> You go into the hospital, and it is like you are going into a grave. There is dust all over the place, there is dirt everywhere and it stinks. By the time I walk from the door to the inside of the hospital it is like I walked to the main street from my house. I cannot walk so much or so fast, which is why I went to the hospital. I live in a small place and I hardly ever get out of the *harah* (alley) where I live, so when I go to this hospital it is like I am entering paradise, not in its beauty but in how difficult it is to get where I want to go in it.
>
> In this hospital, the doctor treats us *zai el ghanam* [like sheep]. I am a *sitt ghalbaanah* [poor helpless woman], this does not count; I am a patient, but this does not count; I am dragging my child with me, but this does not count. No one cares, we are in this miserable place [the hospital] which is about to fall on our heads, not because I love it but because I cannot afford to go anywhere else.
>
> Maybe there is one in ten of these doctors who actually cares and treats us like humans. You have to know someone just to get someone to talk to you. You have to see these doctors, how they look at you and treat you.

When my daughter had the operation to remove her gall-bladder, I asked the doctor if I could stay with her, he said you can, but you have to speak to the administration and the head-nurse. I talked to them and they agreed that I could stay until my daughter got well... You cannot imagine what this place looks like, it is as dirty as the street itself. I had to bring clean sheets with me, I had to bring soap, bandages, medications, pillows, and everything with me; either they did not have these things or they were so dirty that you would not want to even touch them.

I think they think that since we are poor this is what we deserve... I think they say to themselves, they are poor so they are dirty, or they are blind, they should be happy with anything...they say what difference does it make to them? At home they sleep on the floor or nine in a room, but here at least they can get a bed. You know what? I slept on the floor next to the bed of my daughter because there was no bed for me, and I saw others in other wards where the patients slept two in a bed!

I live in a small *harah* on the other side of the neighborhood. I have to get up early in the morning to get the kids ready for school and get breakfast ready for their father before he goes to work. The last time I had my pains I talked about it with my neighbor and decided on Tuesday to go to the out-patient clinic of that hospital.

We had to leave as soon as they all had left for work and school [about 7:30 a.m.]. We walked for about fifteen minutes to the bus stop which is on the main street. You know I cannot walk fast, you meet people and you stop sometimes to say hello, to tell them something, or they want to tell you something. By the time I got to the bus stop with my neighbor I was sweating like a donkey, even though it was December. With my knee problem I could not stand up, I sat on the sidewalk till the bus came... When the bus came, it was packed *zai yum el hashr* [as if on Judgment Day]. We managed to get on the steps of the bus when it started moving, luckily there was an *ibn halall* [a nice man] who pulled me saying: *itla'i ya ummi* [come inside mother]. The bus was so crowded and I was so squeezed. There was nothing for me to hold onto; a couple of times I had to hold onto people so I did not slide or fall down in the bus, you know these drivers, they are crazy. By the time we got to the hospital, they

had already started for half an hour to dispense the tickets for the out-patient clinic [app. 8:30 a.m.].

At the *madkhal* (entrance) of the hospital, there is a *baab* (door); it is a metal gate with some geometrical motifs, but one half of it is beneath the ground level. When the sidewalk was redone, it became higher than the gate.

The entrance is always full of people, there is always the doorman. He is always wearing the same trousers, shirt, and pullover. He is always yelling at people for no reason: you can enter, no you cannot, whom do you want? He is not here, come back tomorrow. He seems to always be talking.

Luckily it was a sunny day, so the street between the baab and the window to get the out-patient ticket was not full of water and mud from the winter rain. I still had to walk very slowly, this street was paved many years ago, and now it is so full of holes, and the cars of the doctors or the hospital are coming in and out, so you have to stick your back to the wall. I also have to walk slowly because of my knees, as you know. We got to the ticket window and there was a big crowd in front of it.

The window is a small hole in the wall with iron bars. The iron bars were once painted white, but now this white has worn away to the actual black color of iron. On the upper end of the bars there are still a few blotches of the white paint, which in itself, has become blackened by time. The wall surrounding this little iron window is blackish and glistens in the sun from the dirt and sweat of hands of people leaning on it, trying to get the attention of the person issuing the tickets, or trying to stop being crushed against the wall by the crowd, or just simply to get some rest from the long arduous standing. The ticket itself is a square piece of paper with a handwritten word or two on it, the name of the medical specialty the patient is there for.

I held onto the piece of paper and leaned on my neighbor to walk inside to the out-patient clinic. I had to climb a few steps which were worn down by the large number of people going in and coming out. I walked inside the corridor to get to the out-patient clinic. I walked slowly down the corridor...

The corridor is dark except for very weak lighting from the middle of the high ceiling. The tiles on the floor are so worn that even the cement beneath them is worn. The tiles and floor are not evenly worn: where the person enters, they are quite worn, but against the wall they are in a better shape.

I walked to go to the section where I was supposed to wait. There must have been about fifty or seventy women, some with kids, some with friends or neighbors, a few husbands were there but waited outside. The women were mostly in their *galalib soudah* (black gowns, which are commonly worn by traditional women when going out). I had to ask a relatively young woman to just squeeze in a little bit on the wooden bench so I could sit. I half sat on the bench, with my neighbor sitting on the floor next to me.

When I finally entered to see the doctor, maybe an hour and a half later, I passed through this half opened very high door.

The door is covered with frosted glass but its bottom half is made of wood. The color of the door is yellowish with black botches on it from wear and tear caused by dirty hands. Inside the examination room, there are two little desks with off white sheets on them and small pieces of paper scattered about. The sun comes in through the windows but they are closed. The room is cold but it is full of light. The doctor standing behind one of the low desks appears very tall because the desk is short and narrow and has one leg shorter than the others. When the doctor leans on it he has to regain his posture.

The room is divided into two major sections: the left half and the right half. The left half consists of the two desks facing the entrance, with the back of the person sitting at them facing the large windows. On the left side of the desks there is a sink, and next to it, alongside a frosted glass wall, there is a wooden bench covered with peeled and blotched grayish paint. The legs of the bench and the desks are worn. The right half of the room is divided into three equal-size subsections. Each section consists of an examination table covered by an off-white/yellowish sheet, with a small empty stainless-steel basin on a yellowish metal stand next to it. The three equal-size subsections of the right half of the room are separated by curtains; they, in turn, are separated from the left half of the room by curtains. These are light-weight dark-colored flowered curtains and have apparently not been washed for quite some time. In each of these subsections there is a doctor or two examining a patient.

> The doctor started speaking to me saying: *aywa ya sitti, malik feeh eeh*? [Yes lady/woman, what is wrong with you?] He was standing behind the desk on the right-hand side. I could not stand for long, so I sat on the bench which was on the left-hand side of the room next to my neighbor, and three other people who were waiting for their friends or relatives to be examined by the doctor.

Om Ahmed was examined in this clinical space. She left the hospital around noon and by the time she made her way back home it was an hour and a half later. She still had to prepare lunch for the family who had already started coming back home from school at about 12:30. The young children waited for their mother at her neighbor's place, playing with their peers and watching television.

The experience of Om Ahmed can only be fully understood when contrasted with a very different experience, the

experience of Soraya. Soraya is a middle-class housewife, the same age as Om Ahmed (about 45 years). She has three children about the same age as these of Om Ahmed. Soraya's complaint was of constant cough, sputum production, and a headache.

Om Ahmed's *mustawa* is partially shaped by the physical space in which she lives. She is surrounded by people, architecture, and formal and informal institutions that are considered traditional, that is, what has come to mean a lower-class area. This is in contrast to Soraya, who lives in the West, Westernized half of the city. She lives in the neighborhood of Mohandessin, whose agricultural landscape was transformed into buildings and urban space less than thirty years ago. Soraya's space in Mohandessin includes high-rise buildings, wide boulevards, and narrow streets with newer buildings and growing trees. The physical space that surrounds her, not only includes trees, but many private cars and taxis. It also includes many private hospitals and clinics, all of which are less than thirty years old, and the majority are probably less than ten years old. The youthfulness of Mohandessin stands in sharp contrast to Sayeda Zeinab in terms of urban space, social space, and clinical space and, above all, the material and symbolic capital available to residents.[6]

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[6] The sharp contrast between the two areas is alive in the residents' perception of their own area and of each other's neighborhood, with a considerable degree of stereotyping. The stereotyping is less obvious upon repeated visits to each neighborhood. The contrast, while prominent, is far from polar opposites, and indeed similarities exist, for example in ideals of aesthetics. However, the similarities are more subtle than ostentatious differences. The emphasis here on the prominent differences is to highlight the diversity in the trajectories of negotiating illness conditions.

Soraya, said of her experience:

> I try to leave early in the morning to go to the hospital. This way I try to avoid the morning rush hour on the bridge... I also go early so I can find a parking spot for my car... Usually the day I go to the hospital is a day I can't supervise household chores. I use the day to try to do many errands outside and just fix something from the freezer or a takeaway meal from somewhere when I go back home.

With a deep sense of her ability to influence certain things in both the public and private spheres, Soraya added:

> Even with money, you are not sure what you are getting... You have your money and try to get decent service, but to no avail, unless you know someone, you don't get good services... I had my husband speak to a doctor of his friends at the club [membership-based sports club] to put me in contact with this latest doctor... I tried to depend on myself or even on money, but found it is personal contacts that make the difference.

Soraya's world contrasts with Om Ahmed in several ways. Significantly, she is using social networks in much the same way as Om Ahmed, except that the capital available to each set of networks is different. Soraya's capacity to move or, as we shall see later, maintain gender boundaries is easier with her money, private car, membership in a private club, and her possession, through her husband, of significant social, cultural, material and symbolic capital. Her experience is rooted in her *mustawa*.

Urban Subworlds and Clinical Space:

The social space which constitutes the subworlds of Om Ahmed and Soraya is the space in which their social, cultural and material capital can be contrasted. This same social space shapes their illness and health experience and consequently their clinical experience. Use involves choice, accessibility, and affordability, which are

dependent upon each woman's social, material, and cultural capital. In other words, clinical space is linked to the subculture of each *mustawa* with its available forms of capital.

> ...urban forms, urban issues, urban government, urban ideology can be understood only in terms of the dynamic of the capitalist system. Space is socially determined: the outcome of conflicts between different social classes. (Gilbert and Gugler 1981:2)

Accordingly, the difference between the two Cairo residents is historically constructed. The difference in the illness experience of Soraya and that of Om Ahmed can be attributed to the difference in the material and cultural differences between their *fi'at*. Their experience, while partly determined by their ability to pay to access certain forms of medical care, is equally determined by local cultural concepts of modesty, privacy, social distance, interaction in public, expectations from medical encounters, which are not randomly distributed. Not all people experience their problems in the urban context in the same way. Experience is necessarily a class-dependent, space-linked phenomenon (van der Kloof 1993, Harvey 1989). Experience is embedded in the subcultures of each *mustawa*.

Furthermore, an individual's choice among the forest of medical care facilities in Cairo is not based on the inherent qualities of each clinical space. Choice works in much more nuanced and insidious ways. A person's *mustawa* shapes his/her aesthetics, mobility, temporal and spatial parameters, social relations of choice and action.[7] Yet,

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[7] See in Raymond (1994:319), a summary of research conducted by Galila El Kadi on culturally constructed popular distinction criteria for urban space and social

(continued...)

it is misleading to think that Om Ahmed and Soraya inhabit entirely segregated fields of social space. The subworld of each and the disparity in the subculture of each is equally matched by the commonality in their social roles in society. Both of them are mothers, both are women, both are not employed outside their homes, and both have to move and interact with family and social networks in social spheres which are predominantly urban, within a city space encompassing fourteen million other people. Also, both tend to be skeptical about health care services. This commonality does not mean similarity or identification of one with the other. The commonality of social roles is fissured by the disparity in their *mustawa* in capital and practices. Commonality does not create analogous lives, but merely parallel ones.

To reach a clinic, a person has to travel alongside the arteries of an urban space, a path which is inscribed in a person's world. The clinic Soraya visits, in contrast to that of Om Ahmed, is surrounded by roads which are lined with trees in the west part of the city, and has a limited parking spot for her small car. The road to the clinic has several traffic lights and pedestrian crossings where Soraya is in control of her car, rather than relying upon public transport in which she would have to almost be fatalistic and relinquish all control over her bodily movements.[8] The clinic has a *madkhal* (entrance) made of a

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[7](...continued)
space: for example, density of population, noise level, quality of construction, degree of cleanliness, and services.

[8]
Cairo's public buses are widely perceived to be driven by reckless drivers. Since most of the time the buses are overcrowded to the point that a passenger is unable to hold onto anything, except maybe a fellow passenger, any sharp turns or sudden
(continued...)

dark aluminum door, which actually opens and closes, separating the inside from the outside, emphasizing privacy from the outside world. The texture of the aluminum door may be cold, but it is clean and modern looking. It might not be full of beautiful work made of iron, but it reflects efficiency and certainty, which are missing from the clinical space frequented by occupants of lower *mustawayaat*. Such culturally salient objects and their symbolism comprise the specific ecology of *mustawayaat*:

> ...the poor of Egyptian society, both rural and urban are ecologically centered according to social hierarchy, in certain locations.
> (Shukri et al. 1995:45, my translation)

In addition, the clinic Soraya is attending includes, in contrast to that which Om Ahmed visits, a doorman called a security guard. He has no choice but to dress in a uniform of a light blue shirt a pair of navy trousers and a navy tie. In both cases the doorkeepers are men, but they have a different function in their respective clinical space.

Soraya's clinic also includes functioning elevators and chairs and sofas instead of wooden benches. It includes doors that close and lights that function. Her world includes fluorescent lights and desk lamps rather than ceiling light bulbs, windows, and natural light. Her clinical world includes air which circulates in and out of

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[8](...continued)
application of brakes creates havoc. This, in many cases, results in a real threat to the integrity of the body, especially for women. In public transport, cultural ideals of social space, inter-generational respect and modesty are all thwarted for the sake of finding a place to stand. When combined with reckless driving, this may represent a real physical danger.

air-conditioners rather than air which circulates in and out of windows and alleyways. The air might be the same all over Cairo, but it changes temperature and maybe even composition according to class habitus.

Similar to Om Ahmed's, the clinical world of Soraya may not be under her control, but her world is not shared simultaneously by several others in the same four-walled room. There are doors which separate her and her illness problems from those of other people. Further, there are functioning heavy curtains inside the clinical examination room which separate the examination of her body from the space where she just talks about it. Words in her clinical space are occluded from her body. Because of that, the clinical space is organized to assert the social distinction of her class subculture and its demand for privacy and personal space. This affirms her belief that the quality of a biomedical encounter is space-dependent. Thus, the criteria on which clinical space is situated in the social hierarchy are further reproduced.

Social Space and Accessibility:

Privacy or lack thereof becomes the mark of *mustawayaat*. The ecological space of traditional districts allows easy hearing and seeing of others' private worlds, facilitating discipline and surveillance (Shukri et al. 1995) of both urban space and social space.

> ...instead of incorporating the public domain into the private domain in order to restrict visual intrusion into the house area, the private domain is now the one which is exposed and imposed upon the passage. (N. El Messiri Nadim 1975:103)

The separation between self and other is challenged in socio-economically poor areas of urban space (and rural space).

> Individuals in these families all practice everyday activities in the same single room, sleeping, living, cooking, eating, bathing, studying, etc. In addition, these rooms are mostly humid and dark, with high, narrow, dirty windows, and the doors are always open, hence they lack privacy.
>
> (Shukri et al. 1995:258, my translation)

N. El Messiri Nadim found out that her

> ...female guests [from the *harah*] usually felt more comfortable and relaxed in the bedroom, which invariably ended up as the room in which visiting would take place.
>
> (N. El Messiri Nadim 1975:129)

Easy access is often characteristic of urban space inhabited by the poor. Readily accessible space determines social relations of affiliation and exchange. In other words, space influences the interaction taking place in a given urban space. Space and affiliation are engaged in a dialectic relationship.

> The combination of poverty and physical proximity within Sayeda Zainab produces very densely populated "urban villages": "our house is a popular neighborhood", one woman told us. A popular neighborhood is an area mostly populated by the poor, an area where buildings are quite close...and where residents...know each other quite well. The most important characteristic of a "popular neighborhood" is the interdependence between its residents where the whole of the community...functions like a large family...
>
> (Center for Development Services 1996:19)

Easy access is not only a physical quality of poor people's space, it is also a quality of their social space. Urban space and social space are geared towards meeting a commitment to a particular form of social arrangement. A *mustawa* may have provided the impetus for a particular form of existence in urban space, but social space adorns this form to make it complete and lively. In

contrast to the openness of the poor areas, the upper classes live in buildings and apartments which are protected by a door keeper/porter/*bawaab*. The *bawaab*, who does not exist in lower class areas or many of the lower middle-class areas, is just as much a symbol of social status as he is a functional doorkeeper (J. Abu-Lughod 1990).

The rigid social boundaries of class and the physical borders of inhabited urban space are emphasized by the overlap of private and public sensory stimuli. A sensory stimulus in urban space is a marker of the hierarchy of social space. It is a marker of social distinction. Privacy is a culturally recognized class marker and doors are the tools to demarcate it. It is not surprising to find an exaggerated concern over the opening and closing of doors in Egyptian society. El Messiri Nadim found that in the enclosed community of the *harah*,

> The use of the term "*baab*" [door of the *harah*] symbolically represents the point at which the *harah* is separated from the rest of the city. As such, its presence is a further indication that the passage is more than a way leading to something else.
>
> (N. El Messiri Nadim 1975:104)

In Egypt, doors are consistently used as a tool of social demarcation and separation of self from non-self. The spatio-temporal symbolism of doors could well be an integral part of the healing experience. A door in a clinical space becomes "an instrument for protection and power" (Devisch and Vervaeck 1986:541). Therefore, a door has the potential to be an opening onto a person's world

as well as his/her *mustawa*.[9] A door is a mark of identity which can be manipulated in different contexts in a variety of ways to alter perceptions of identity, the environment, and objects in it. The symbolic and instrumental use of doors is an artifact of *mustawa*. This not only happens unwittingly, but also happens with variable degrees of awareness and assertion.[10]

Differentiation of clinical space provides evidence that Egyptian society is not organized on inter-class harmony, but on inter-class and even intra-class conflict that is naturalized by the choices people make to continue and maximize their class interests (see Bourdieu 1977). This conflict is naturalized in the area of social distinction *par excellence*, that of urban space, and is exemplified in access to and use of clinical space.

It is not an exaggeration to conclude that urban space challenges perceptions of self and other in Egypt. The

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This symbolism of door has been successfully employed in the context of psychiatric care in the Arab world (Devisch and Vervaeck 1986).

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For example, in the clinical space of a diarrhea treatment center in a teaching hospital in a poor urban area of Cairo, Shukri et al. have found that among a sample of poor mothers who came with their children for in-patient treatment, there existed a major problem in terms of overcrowded conditions, lack of sleeping spaces, noise and screaming of children, mothers, and families and lack of cleanliness (Shukri et al. 1995:283-284). This dysfunctional clinical space exacerbates the conditions for which the poor seek clinical space. Mothers refer to contagion by *il nafas* (breath) (Shukri et al. 1995:285). The concept of *il nafas* refers to more than breath contagion, or contagion by air, it refers to contagion by physical proximity and enclosure due to space limitations, which itself is a marker of social distinction. In this case, clinical space makes contagion all the more likely.

challenge to the person's identity, then, becomes operational in practice in social and clinical space.

> Doors and the division they effect obstruct the dialectical interaction that goes on, in space and time, between body and self, self and other, normal and abnormal, the patient and the wider society, and the wider society and its cultural values.
>
> (Devisch and Vervaeck 1986:543)

The rather clear and simple contrast between Soraya's urban and clinical space and Om Ahmed's urban and clinical space is also misleading. While this polarity exists in Cairo, it is not limited to Cairo, and it is not limited to this bipolar opposition. Gradients of both urban space and clinical space exist, and indeed each pole possesses some of the qualities of the other. There are many other variations on the gradient of available clinical space in Egypt, as discussed previously. The extremes were presented here to alert the reader, rather than to make simplistic sweeping generalizations. The focus has been on two extremes of actors' interaction in opposing spheres of urban space and clinical space. However, further analysis is needed beyond this study.

Engendering Clinical Space:

Urban and social spaces are gendered spaces, particularly in the Moslem world (Van der Kloof 1993). Perception and knowledge of the city are associated with gendered social roles (N. El Messiri Nadim 1975:81). Social interaction is laden with the nuances of "the relationship between the sexes [which vary] according to the spaces within which they occur" (N. El Messiri Nadim 1975:90). Furthermore, these gendered urban spaces are stratified: "it is impossible to discuss women in urban centers without reference to urban stratification" (Kandiyoti 1980:123).

However, conventional studies of inequalities of health care or treatment of women in medical care are not enough to explain the gendered subjective experience in health care.

For example, Soraya and Om Ahmed both live in a culture which demands and advocates modesty (Macleod 1991), but in Soraya's subculture, privacy is asserted by her through the link with modesty, while Om Ahmed, moving in different urban and clinical spheres, has to rely more on her bodily hexis (Bourdieu 1977), her body language and comportment, to reach the ideals of modesty. It is the same cultural rule which they have to abide by in social space and clinical space, but the path to reach it, in urban space, is, by necessity, different. According to her *mustawa*, Om Ahmed has to protect her modesty by wearing a dark gown on top of her other gown when she goes out, whereas Soraya dresses in long sleeves and tailored dresses and relatively long skirts. Om Ahmed looks down when she talks to the doctor in the out-patient clinic, particularly when he chides her for not following some of his indications or instructions. Sorayain her *mustawa*, on the other hand, looks at her doctor and uses her serious focus on the topic of her condition to maintain her modesty. Om Ahmed cannot insist on privacy beyond the curtains of the little examination subsection, where three or more patients are examined in the same room, with the curtain not necessarily fully closed, and sometimes not at all. Soraya, in her *mustawa*, needs and gets a space she can call her own when she is being examined by the doctor, a space which is protected by curtains in a room where she is the only patient. The need for privacy, protection and controlled access is, therefore, different among different

mustawayaat, and is efficiently and partially achievable through doors.

In clinical space, modesty is manifested not only physically, but also aesthetically, linguistically, and intellectually. It is not hard to conclude that even though modesty is a cultural ideal, class habitus provides the means through which this ideal is to be reached, and through which *mustawayaat* are engendered and naturalized in the urban context. Hence, what started as a building movement in Egypt's modern history has ended as a strategy of social discrimination. The more Egypt moves towards cost recovery, the more urban space and clinical space become the space of social inequalities.

Section Five: Globalization, Urban, Social, and Clinical Space in Cairo:

The history of modern Egypt is enshrined in its urban space and its organization in Cairo. Space is infused with and reproduces the dominant ideology of social discrimination and are far from being sufficiently studied. Illness practice then embodies a complex web of symbiotic relations which transcend the value of each of its single components to a deeper philosophy of time, space, and objects. Hence, objects and constructions in urban space are memorials to the history of ideology and culturally constructed meaning systems.

One of the historical links between the past and present meaning of urban, social, and clinical space in Cairo can be studied through an examination of the meaning of monuments in urban Egyptian space. Monuments are a form of architectural design with a morphology and a meaning

located in a spatial and temporal structure. They are the punctuation of the cultural text. According to Lawrence, urban space is an artifact of the social and spatial organization of a society (Lawrence 1982). Hence, it is possible to claim that a study of what is constructed and culturally perceived as monuments has the potential to reveal the organization of social knowledge and power.

Clinical space, it will be argued, therefore, is a sort of a public monument and has social, spatial and temporal dimensions that are embedded in its form and function. Clinical space, like architectural and even urban space, could even be read, as proposed by Lawrence, as a text, with objective and subjective interpretations (see Lawrence 1982). The embodiment of clinical space as a monument will be explored to enlarge upon the textual analysis of social distinction.

David Harvey's invitation to see the city, read its text as a discourse (Harvey 1989:1, Harvey 1990:96), and experience its architecture as communication (Harvey 1990:67) can be further complemented by an analysis of space as a text. To yield the best results, this should be done on at least two levels: internal relations and external relations (Moore 1996), in order to find "an interpretive frame within which to locate the million and one surprises that one confronts on the street" (Harvey 1989:1). This allows us to see the assumed "interdependence of parts with the whole, of sense with reference, and of structure with action" (Moore 1996:86). Furthermore, it permits us to conduct a deeper analysis of the internal and external qualities of space as a referent to social relations and organization.

> A literary text is not reducible to the meanings of its individual sentences; a spatial text cannot be brought down to the structure of its material parts; and social action cannot be understood as a mere conglomeration of events. (Moore 1996:87)

Interpreting symbolism in clinical space is what we turn to now.

Monuments and Clinical Space:

As in many other complex societies, history stands as a witness to the ambivalent attitudes of consecutive Egyptian states and rulers towards culture and its expression. At times of major shifts of the political economy of capitalism, a "different set of cultural and political symbols [is produced] to represent what capitalist urbanization is about" (Harvey 1989:13), or what can be termed in short "the aestheticization of politics" (Harvey 1990:108)

Thus, monuments as punctuation in the text are physical structures erected in physical space which link meaning to history and to cultural ideals (Makiyah 1996). However, they rarely preserve the same spatial and temporal value throughout history (Makiyah 1996). Monuments may also retain the same form, but their surrounding social and physical context rarely does. The rise or fall of materialism, of aesthetic ideals, of sociopolitical organizations, and urban space all affect the functional and symbolic aura of monuments. Even when ostensibly devoid of functional qualities, monuments remain a temporal and spatial repository of culturally constructed memories and histories (Makiyah 1996).

> The monument is not just an object with a list of characteristics. It is a relationship between the object, the city, and the community housing it. (Makiyah 1996:41, my translation)

Thus, in Egypt as in many other parts of the world, the space where biomedicine is practiced (clinical space) possessed in the past and continues to possess both functional and symbolic values. Clinical space represents monuments for healing the sick, as well as monuments of modernity and progress. Furthermore, they are ideological monuments that pull people and society towards idealized standards of modernization. Hence, Cairo, the seat of most clinical space in Egypt, became the center for medical progress *qua* modernity, or became the center for modernity *qua* clinical space.

In modern Egypt, an institution of urban clinical space came to be touted as *sarh tibbi* (a medical monument). Obsession with grandeur and new political and cultural symbolism were so powerful that the reorganization of social, clinical, and urban space dominated the agenda of the state. This was manifested in the construction and rejuvenation of large buildings to house bureaucrats, industries, housing projects, together with medical institutions. Clinical space came to symbolize the 1952 revolution and the transformation under which the society was fully modernized. The larger the clinical space the more important symbolically and functionally it was perceived to be. Today, these monuments of clinical space may have become devoid of their function but they are preserved by the state in part as a social and cultural symbol.

In the spatial reorganization of clinical space, a reorganization of the perception of time pressure and constraints also takes place, and this is also context-dependent (Armstrong 1988:214). In the South of Egypt,

where I conducted some research, a new young doctor in a rural health unit was complaining of boredom and lack of things to consume his time in his remote post.[11] He said this after having examined his 18 patients at the out-patient clinic in approximately thirty minutes, with little left to do afterwards. His concept of clinical time was structured in the highly specialized hospital setting in his provincial-capital teaching hospital. In the remote rural location where he was posted, he was unable to adjust his clinical time to his different environment. His time was free for duties which do not exist in his current rural post. Yet he was unable to accommodate an alternative concept of time.[12]

A similarity could be observed in the hospital where Om Ahmed went, where the resident examined her and left the task of writing her prescription and informing her of how to take it to an intern. Apparently pressed for time, he had internalized *a notion that clinical time is short in urban clinical space*. In each *sarh tibbi* (medical monument) the doctors behaved as if pressed for time even if there was no shortage of time (as in the case of the Upper Egypt doctor) or staff (as in the case of the particular out-patient clinic in the public hospital where Om Ahmed went). A monument of clinical space comes with space and time specifications which are only theoretically

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[11] This research was conducted in 1993. It was sponsored by the Population Council, Regional Office of West Asia and North Africa, under the project title "Gender, Family and the Population Policy Debate." Views and responsibility are mine.

[12] The situation is yet more complex because the sense of clinical time conveyed by his supervisors is a mixture of hospital clinical time and slow bureaucratic time, change is not forthcoming, even if priorities and the environment changes.

related to its function but much more to its symbolism. So while Foucault points out that a revolution in medical perception occurred two centuries ago, with subsequent greater concern for efficiency, progress, and enlightenment (Armstrong 1988:218), it can be observed that in Egyptian clinical space there is a sketchy notion of enlightenment and a dearth of functional efficiency and progress.

Progress and Clinical Space:

The creation of the bourgeoisie in Islamic Cairo and modern Cairo was linked not only to the birth of new modes of production but also to new modes of maintaining a healthy labor force. Greater Cairo, as it is now known, still commands the highest percentage of investment in Egypt. This is a continuation of the historical tendency favoring an urban bias in investment in Egypt, including public services (Waterbury 1982).[13] It is logical that Cairo also commands the highest investment in clinical space, in accordance with the pattern of governments in developing countries that spend most of their health care budgets in cities (see Griffin 1989:5).[14]

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[13] An urban bias is evident in Cairo's relative monopoly over *inter alia* 30% of state employees, 52% of all doctors and 59% of all engineers (Waterbury 1982:323), as well as industrial production and number of universities (Waterbury 1982:326).

[14] In 1966, at the height of post-revolution modernization, Cairo with 14% of the population had 33.7% of all doctors in Egypt, 26.9% of all hospital beds, and 35.9% of all pharmacies (Hegazi 1971:35). Compared to one doctor per 910 residents in Cairo, the ratio was 1/1200 in Alexandria, and 1/3420 in Lower Egypt; with one hospital bed per 233 residents in Cairo, the ratio was 1/584 in Upper Egypt, and 1/636 in Lower Egypt (Hegazi 1971:35). In 1976, Cairo with 20.4% of the total population, commanded 46.1% of medical beds and 40.4% of

(continued...)

Urban Cairenes became the envy of the nation. As in other capital cities, it was thought of as a "place of prestige" and civilization, thus accelerating what can be called the city's "infusion of new blood from rural areas" (Gulick 1969:141-2, Suliman 1980). The post-revolution period of the sixties was the main historical period for the growth of Cairo's population by rural migrants (Baer 1969), not because of a general desire to migrate but because of the lack of structural support towards equity reforms (Chaichian 1988:41).[15] However, this did not produce ideal conditions:

> ...the amount of coddling these urban populations receive may appear modest at best. Inadequate, dilapidated public transport, insalubrious housing, broken water mains, power failures, fair-price shops with long lines and no goods, and crowded hospitals that are the source of M.A.S.H.-like tales of medical abuse hardly add up to public pampering... Inadequate as these services and goods may be, the rural areas and small provincial cities scarcely share in them.
> (Waterbury 1982:327)

A cursory look at clinical space in Egypt reveals that diversity in levels of clinical services is directly linked to levels of socio-economic status. There is something for everyone in Cairo's forest of clinical space. But it is a hierarchized, costly system, where illness practice meets the social categorization into

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[14](...continued)
pharmacies in Egypt (Shorter 1989:9). This is not to mention the disparity within each district, especially where private medical care is highly concentrated where it is least needed and absent where it is most needed in the poorest subdistricts.

[15] Tekce, Oldham and Shorter (1994) note that "migration is no longer a major source of growth. Most Cairenes are at least second-generation, more often third or more" (p. 4).

fi'aat and *mustawayaat*.[16] In this world, meaning and values are attached to the spatial organization of clinical space, and access is largely dependent upon *mustawayaat* and not just on socio-economic capacity.

During the reign of Mohamed Ali and his followers, clinical space may have symbolized progress and Westernization (Jagailloux 1986, Ibrahim 1992). More importantly, it symbolized the integration of the body into the surveillance system of the state: bodies of Egyptians became public bodies (Mitchel 1988). People became working bodies, the nuts and bolts of modernization, the fuel of modernity and global economic standards. The development of the modern working class was closely linked to the development of biomedical systems to care for this class. At no other time except the immediate post-1952 revolutionary period has this history repeated itself; clinical space became full of the same political and social symbolism. Illnesses were treated in modern public institutions *sarh tibbi* (medical establishment/monument) which were developed to treat mainly the urban middle class, and then the rural populations. Illness evolved from being a family event or even a community event to being a public and political event. Treatment of illness was increasingly taking place in an ideologically constructed clinical space.

With the passage of time, clinical space became more specialized, more laden with the politics of modernity and

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[16] The forest of medical institutions in Cairo and their clinical space is analogous to Victor Turner's forest of symbols (1967). Each institution in the forest of medical institutions is part of a polysemic symbolic world.

social discrimination. As cities became the location where class relations were being restructured (Harvey 1989), urban and clinical space had to be re-configured accordingly. Clinical space became a manifestation of social hierarchy, alongside the paths of urban space divisions according to categories of social distinction. Urban areas, including Cairo, got a large number of centralized secondary care institutions as well as tertiary care institutions. In contrast, rural areas obtained a large number of primary care centers which were limited in capacity, particularly in comparison to urban facilities (Gallagher 1990:173).

> ...despite claims of revolutionary change, the post-1952 government retained not only the public health structures and policies of the previous governments but also the underlying assumptions and ideas that had formed those structures and policies... The governmental solutions to public health problems remained authoritarian and technocratic. (Gallagher 1990:176)

The end result was a reconfirmation of 'Cairocentrism' (Himdan 1996) and hierarchization of urban and clinical space at one stroke in a local version modernity.

Speedy Recovery?

With the passage of time and variation in economics and class relations, the institutions of clinical space became dysfunctional for several reasons. Inflated bureaucracy, weak government revenues, and an increased number of doctors for the urban middle class, the emergence of a new bourgeoisie, an increase in the financial resources of a minority, the emergence of an ethos of "private equals good", and other reasons have all led to the emptying of these monuments of their functional aspects. This was also accompanied by a change in the relative interpretation of cultural values such as those of time (time became more

precious), quality (more focus on doctor-patient relations, technology and efficacy), and space (hygiene becoming more important). Much like other imported products in the globalized world, cultural values gave clinical space a local meaning that cannot be separated when studying everyday life events and illness practice.

To solve the problem of the dysfunction of an imported globalized biomedical care model, other products have been imported from the global market of health care to improve 'efficiency' and 'quality'. The end result is clearly the further embeddedness of clinical space in the global capitalist market, just as urban and social space themselves are further embedded in the global economic domain. It is even claimed that this is not happening fast enough.

> ...the poor may be less adversely affected by structural adjustment actions than previously thought. In fact, the poor may suffer more from the postponement of economic policy reforms than from the effects of carrying out the reforms. (Fessenden 1993:1)

Ironically, the response has been for imported products, clinical space in this case, to borrow yet more from the West(Badie 1996:158), by introducing among other things, notions of cost-efficiency from liberal economy. In this case, as public institutions of clinical space were being emptied of their effectiveness, they were being reformed as spaces where more expenses are borne by patients, either in direct payment, or through a third party, as for example, insurance schemes. Private biomedical care always existed in Egypt as an alternative for the upper middle and upper classes, but its institutions have never been entangled in naturalizing the reproduction of class , as they are in the present situation.

This naturalization is principally a political-economic and a global process.

> ...the cost of treatment has increased so very much that it has gone beyond the capacity of most of the population, especially civil servants and laborers. In public hospitals...those who are lucky enough to be accepted in them have to bring their medications and cotton wool and what they need in terms of blood transfusions, etc. With the increase in costs and the desire to balance the state budget, the resources for free medical care will further shrink in the near future. If this happens, then there will be a further increase in the waste of human resources, which could have been employed to enhance production and income.
>
> (Abu Ali 1996:10, my translation)[17]

As private medical care progresses rapidly, especially in urban areas along class lines, could it still be that cities are where we should look first to enhance private health care, as proposed by Griffin (1989), following the logic of global capitalist economics? Cost increase is a major concern where the people are "poverty-stricken and the competition between providers is strong" (Haddad and Fournier 1995:751). Lower disposable income for seeking health care and an increase in the total cost of health care even in public institutions (time, examination, medication, transportation) make demands dependent on financial ability and social affordability, not only on illness conditions (Gertler et al. 1987).

Van der Gaag and Barham have analyzed multiple countries in terms of the relations between structural adjustment and public health care expenditure. One of the categories

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[17] Mr. Abu Ali is a former cabinet Minister of Economy in Egypt. Note the resemblance of the ideology underlying this quote to what has been discussed earlier in terms of the pillars of modern Egyptian civilization.

these authors employ includes countries which have not received structural adjustment loans since 1990, and which have witnessed positive growth (called Non-Adjustment Lending Countries, Positive Growth [NAL+]), a category to which Egypt belongs. They conclude that such countries have witnessed an increase in public spending on health care, and they speculate that "increasing private consumption levels have made increased private spending possible" (Van der Gaag and Barham, forthcoming). In their analysis, they advocate the structural adjustment package as a means to indirectly free more per capita expenditures on health care by central governments.

A critique of the full implications of structural adjustment and economic reform on health care and subjective experience is beyond the scope of this research. Only a few points will be raised which are of relevance to the discussion here. What is missing from such propositions as the above is that a more globalized economic standard does not automatically mean an increase in health expenditure. Second, an increase in per capita expenditures does not mean a fair redistribution among classes and populations. Third, an increase in health care expenditure, because of already instituted urban and curative services bias, may not mean any improvement in the health of the majority of the population, including the poor (World Bank 1987). However, the most important point here is that the focus on globalization of economic standards and a single economic network obscures the relationship of economic reform to non-material capital including cultural values, a relationship that makes up the substance of societies where social discrimination and subcultures of deprivation are crucial. In practice there is more to economic reform than meets the eye. Further,

local variations in *mustawayaat* produce the terms of economic reform and subsequent social reform. Not surprisingly, this reform persistently copies a center-periphery formulation. It is always the urban elites reforming the everyday lives of non-elites and the lesser urbanites.

Global structural adjustment is as much a process of achieving uniformity in culture and institutions as in economics. The only difference is that, based on historical power struggles, the shape of this uniformity in a nation-state may take a more hegemonic form than in other countries.

In Egypt, this process has been operationalized through the proliferation of institutions of the private market. More significantly, it has appeared in the form of the partial privatization of institutions with public clinical space through instituting schemes of fee-for-service and a degree of financial support for accommodation, meals, and services. More importantly, it has appeared along with a transformation of logic. No longer is health a kind of capital that should be accessible to all; health has become an acquired privilege that can be purchased in the private market in exchange for financial capital. Health has become a commodity that is not equally affordable socially or economically to all *fi'aat*.

Public institutions of clinical space almost exclusively used by the poor have become places where one gets everything except good quality functional medical care. Clinical space is becoming increasingly empty of the clinical assets of care, while retaining unchanged, the

spacial aspects of the clinic. The result is low quality care for the urban poor.

The title of an article in *The Egyptian Gazette* seems to me to expose the problem with Egyptian health care at a time of intensification of the project of civilizing and modernizing Egypt: "Go mad if you want, but only if you can afford it" (Shebl 1993:5). This is not an uncommon theme in Egyptian public and private discourse. The author of another article wonders how and why the principles of market economy are being applied in the field of health services in Egypt, which are "absolutely unsuitable for exchange according to 'free market mechanisms'" (Zaki 1995:12, my translation).

The historical tendency of the urban bourgeois and the state of joining hands (Harvey 1989:187) in the Egyptian context has worked to consolidate access by the urban bourgeoisie to better clinical space, in part through the resurgence of private clinical space that meets the needs of the upper classes.[18] Favorable investment laws, regulations and shortage of funds in the national health system make the naturalization of differential access to clinical space according to *fi'aat* inevitable. Thus, public institutions of clinical space have become, in some sense, dysfunctional symbols or, more accurately, they have become symbols of social and clinical dysfunction on the urban landscape or a symbol of emptying all that is

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[18] Harvey emphasizes that the state usually operates in favor of the upper class-controlled capital in face of the labor force of the lower classes. Even when the state intervenes "...state intervention is never geared to the transcendence of the capital-labor relation. Yet the state *appears* to be neutral" (Harvey 1989:115).

'public' of its function in a globalized world of economic and cultural assimilation.

Conclusions:

The bourgeoisie created by Mohamed Ali's agricultural and sociopolitical reforms and patronage, Khedive Ismail's modernization plan, and the 1952 revolution all have one thing in common: access of the higher *mustawayaat* to clinical space at the expense of the majority of the population. Social space was the geographic manifestation of social hierarchy. Earlier, clinical space had always functioned to emphasize the urban modernistic trends in Egyptian society. Current clinical space in Egypt copies this process creating a local modernity where social differentiation is the rule.

Historically, it has been shown that differential use of clinical space is attributed to sociopolitical factors and to subcultures that hold various ideas about health, illness, and illness practice. It is the articulation of social categories, clinical space, social space, and urban space with which this chapter has been concerned.

Urban space and clinical space are not a manifestation of the wealth or poverty of Cairo or its people *per se*; they are, rather, a manifestation of an ideological paradigm providing the motor for social hierarchization and its subsequent manifestation. Spatial representations are a product of a dominant interpretation expressing succinctly culturally constructed hierarchies. Hence, it could be argued that clinical space is

> ...not simply a space which constitutes the physical backdrop to social interaction: it is a space with internal and external social boundaries

> which in their turn are intimately linked to the events which occur within them. (Armstrong 1988:207)

From this chapter, it is evident that globalization works through facilitating exchange of symbolism and transposition of cultural values. Space is but one area where this transpires. Thus, the globalization of urban and social space occurs as the result of material and cultural exchange, involving enclaves of cultural and economic dependency. Furthermore, this dependency is not homogeneous, it is hierarchized. An historically informed study of the intertwining of urban, social, and clinical space needs to be further developed. Only then will we truly understand socio-clinico-urban space as a text of globalization and social discrimination.

CHAPTER SEVEN:
CONCLUSIONS: TO BE OR NOT TO BE...CIVILIZED

> After such a night of seeing whole at last, day would come again, the cool glow of morning, the bronze gold of the kiefern trees, the still green pools of lucid water, the enchanted parks and gardens--but none of it was the same as it had been before. For now I knew that there was something else in life as new as morning and as old as hell, a universal ill of man seen here in Germany at its darkest, and here articulated for the first time in a word, regimented now in a scheme of phrases and a system of abominable works. And day by day the thing soaked in, and kept soaking in, until everywhere, in every life I met and touched, I saw the ruin of its unutterable pollutions.
>
> So now another layer had been peeled off the gauze of the seeing eye. And what the eye had seen and understood, I knew that it could nevermore forget or again be blind to.
>
> (Thomas Wolfe 1934[1989]:565)

> ...sometimes she completely lost the ability to distinguish between wrong and right: in every sure right she found a wrong and the potential for a wrong, and in every wrong it was not impossible for her to find a right...in the profane there are many parts of the licit and in the licit there are complete areas of profanity.
>
> Youssef Idris (1963 [1995]:92, my translation)

Civilization, Social Affiliation, and Discrimination:

The changes taking place in Egyptian society require the development of more sophisticated approaches in order to study their implications for Egyptian people and their culture. Change requires "maps of society to intelligently analyse, discuss and intervene in social processes" (Gregory et al. 1994:10). We need to draw the connection

between values and structural systems that reproduce life experiences and illness practice. This endeavor necessitates

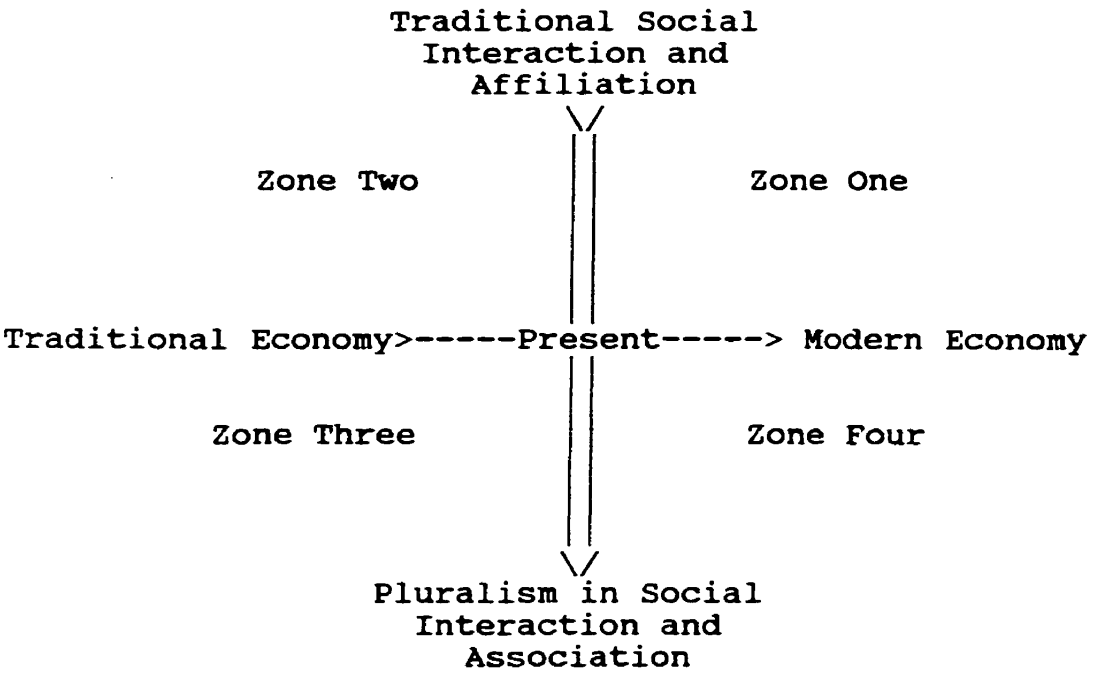
> ...another move--a semiotic return--to local sites of research for further reflection on the way in which competing truth claims and practices are contested as a result of the ceaseless appearance of new knowledge which in turn provides a continual challenge to common-sense knowledge. This semiotic return includes a consideration of body politics--individual and communal.
>
> (Lock and Kaufert 1998:23)

This also means shifting the inquiry to develop approaches and research questions that deliberately blur disciplinary boundaries (see Farmer 1997). In this thesis, following the work of the Comaroffs on modernity, a marriage between historical enquiry and anthropology has been attempted (John and Jean Comaroff 1991, Jean and John Comaroff 1992). It can be concluded, from the previous chapters, that modernity is not a simple chronological process. Rather it is a pluri-chronic or inter-chronic process where old and new symbols interact to produce a moment of contemporary history. This process is by definition a relational one, where a transformation occurs within a given culture and between cultures.

Health is a product of the powerful relational and economic systems which embody prevailing cultural values. It is possible to conclude in this thesis that health and illness are only one of many spheres where social discrimination is practiced in Egypt. Social distinction in a society is always manifested in all spheres of the lives of individuals and society. Labels of *mustawayaat* and *fi'aat* are based on a constellation of social, economic, and cultural variables which shape the everyday life of individuals and groups.

This thesis has also shown that illness practice has a logic that reveals the cultural values cherished by individuals and groups. Practice is therefore an important concept in health and illness because it reveals the logic linking a person's identity, his/her cultural values, and the social and ideological map of a society. The link has not been sufficiently established in Medical Anthropology in Egypt and the Middle East. It is hoped that this thesis will provide a springboard for some of these linkages to be explored in the sphere of health and illness.

The following diagram illustrates the probability of what might occur in the future between types of economies and types of social interactions. In this diagram, the vertical axis refers to the shift from premodern social relations based on trust, emotional, and material reciprocity, and social obligation to other forms of social association based on interest, individual volition, and agency of the individual and pluralistic groups. The horizontal axis refers to the shift towards a liberal market-based economy.



In zone one in the top right corner, alienation occurs as people are unable to meet the requirements of the modern economy--skills, consumption and so on. Simultaneously, people must adjust to a failure to promote social interaction that would get them into the modern economy and still maintain the cultural obligations of traditional social affiliations. After all:

> From an historical perspective, modern societies are still feeling their way toward a satisfactory social organization of the highly integrated productive system which economic development has so recently produced. (Wilkinson 1996:137)

In zone two in the top left corner and zone four in the bottom right corner, personal and collective fulfillment is at its peak where personal and collective skills are suitable for the requirements of the economy, individual needs, and group actualization.

Zone three in the bottom left corner is probably the most improbable scenario; it may even be a utopian one. The

mismatch between the type of economy and the type of social relations might mean either a lack of resources or too much of an association, and not enough time for achieving efficiency in production. But, on the other hand, the match between the type of economy and social relations could mean that a society of freely-made affiliations could actually be self-sufficient emotionally and economically.

Medical Anthropology, Policies, and Well-being in Modern Egypt:

In Medical Anthropology there is a need to fully capture this *diversity* in the relational aspects of health and illness. Illness practice occurs on the micro, meso, and macro levels. This thesis has captured only a fraction of the complexity of the interplay between these levels and the degree of their importance for large segments of the population. For example,

> Health services provided by PVOs [private voluntary organizations] reached about 4.5 million people in 1982, and represented 31.3% of the total expenditures of all PVOs during that year.
>
> (Ibrahim et al. 1996:81)

Now, after years of "reform" and insidious transferral of responsibility, the number is 14 million (in Ibrahim et al. 1996:81). This means that a large segment of the population have voted with their feet, utilizing services offered through meso level social networks to avoid using the state's health care services. Understanding the relational and illness implications of these changes should be a project for further studies in Medical Anthropology in Egypt. The question is: can this be done in a way that emphasizes that:

> ...the quality of the social life of a society is one of the most powerful determinants of health and that this, in turn, is very closely related to the degree of income equality.
>
> (Wilkinson 1996:5)

Probably one of the fundamental policy challenges facing Egypt today is how to make economic reform policies more humane (Awad 1991:291). However, bemoaning the neglect of the non-economic aspects of life while supporting economic reform serves two counter-productive purposes. First, such a stance perpetuates the culture of defeat Egyptians already have towards their lot in life, especially in relation to the role of the state in their lives. Second, it creates a false kind of argument in an interconnected world, where economies rather than human concerns dictate policies.

In conclusion, it is proposed to develop policies and actions which would intensify and diversify the nature of social affiliation in Egypt. Hence, a milieu could be created to shape more culturally-sensitive political and economic policies. Social relations are of prime importance. They are the site where interpretive and political-economic concerns meet.

> Increasingly in the present global political climate, people find themselves marginalized through isolation or expulsion from community and often family. (Lock and Kaufert 1998:24)

In Egypt, modernization occurred in the form of isolating social groups and categories into encapsulated social entities. Thus, everyday life and illness practice became a manifestation of social discrimination in identity, social systems, built environment, social relations, and space. With control over the family, control over 'informal' associations and control over participation in

the macro-political sphere, restrictions on the freedom of affiliation have also become the defining principle of the project of modernity and civilization in Egyptian culture (Moghadam 1993:103-104; Ibrahim et al. 1996). The state, through shaping the structure of the economy, shapes the quality of social life of people, particularly as it fosters the basic structure of income inequality and social stratification in society (Wilkinson 1996). Health and illness then become trapped in an agenda of inequality where value is not placed on achieving equity in health care but on reasserting the person's or the group's disposition as a 'civilized' entity.

It seems that theories and policies fail to comprehend the incongruity between current modern 'civilized' economics on the one hand, and social affiliation and interaction as social and symbolic capital on the other hand. On one hand, liberal economics goes against the grain of conventional forms of social affiliation in Egypt. On the other hand, social relations are becoming more and more geared towards material survival. Social networks and liberal economics are currently meeting at a point where both are in a transitional stage. Survival is increasingly based on how social networks situate themselves to meet the demands of a liberal economy.

It is therefore crucial to advocate policies which promote equality in social capital. Understanding the nature of social capital (Bourdieu 1984, Wilkinson 1996, Fukuyama 1995, Mustard 1996) is a prerequisite for the development of policies where modernization in economics does not come at the expense of cultural values and significant forms of social cohesion and affiliation. Promoting horizontal relational spheres would also help untie the tradition-

versus-modernity debate in Egypt and elsewhere, a debate that has encouraged the impetus towards social discrimination.

As Harvey points out, "we think before we act but learn to think through doing" (Harvey 1989:3). In other words, the need here is to work towards policies which engage all people in a (potentially subversive) dialogue about state-controlled cultural symbols, including those related to health and illness. The modernization of Egypt demands that, as anthropologists, we stand up to the challenge of making "the critique of the civilizing process, begun by evolutionists, more trenchant, less romantic, and less utopian" (Marcus and Fischer 1986:128-129). The experience of making decisions about illness and of illness itself has always been challenged by the very process of social change. However, we now know that social discrimination is at the root of not-so-random illness practices. Clearly, approaches and models in Medical Anthropology need to be redefined so as to promote "thick thinking" and "thick acting" to match the thickness of social and illness experiences (Bibeau 1988). Now the challenge for Medical Anthropology should be to deal with the implications of the civilizing agenda of modernization in Egypt, the Middle East, and other parts of the world.

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