

**VULNERABILITY AND THE  
ART OF PROTECTION**

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*Embodiment and Health Care in  
Moroccan Households*

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## CONTENTS

### Figures

|   |      |
|---|------|
| Series Editors' Preface • Wives, Restless Spirits, and Protective Devices | xi   |
| Acknowledgments   | xiii |
| System of Transliteration   | xix  |
|   | xxi  |

### Part I • Medical Pluralism and Embodied Knowledge

|                                    |    |
|------------------------------------|----|
| Chapter 1 • Introduction           | 1  |
| Health Promotion Reconsidered      | 3  |
| Health Behavior in Context         | 5  |
| Culture and the Individual         | 6  |
| The Household Production of Health | 7  |
| Grasping the Elusive               | 10 |
| Vulnerability and Protection       | 15 |
|                                    | 17 |

### Chapter 2 • Errachidia

|                                  |    |
|----------------------------------|----|
| Town and Province                | 21 |
| Politics of Economic Development | 23 |
| Health Care                      | 24 |
| Social Diversity                 | 25 |
| Research Design                  | 27 |
|                                  | 30 |

### Chapter 3 • Maternal-Child Health in Perspective

|                                 |    |
|---------------------------------|----|
| The Politics of Home Birth      | 33 |
| Saharan Constructions of Danger | 36 |
| Humoral Imbalance               | 39 |
| The Eye                         | 40 |
| Spirit Attack                   | 42 |
| Magical Curses                  | 43 |
| Microbes                        | 44 |
|                                 | 45 |

## CHAPTER 1

# INTRODUCTION

This book examines the way culture shapes the experience of vulnerability and the strategies people use to protect themselves. I became interested in the topic inadvertently, through my own sense of vulnerability while conducting ethnographic research on health development, medical pluralism, and household health care in rural Morocco in 1996 and 1997. In particular, I was interested in the local response to national initiatives that promoted family planning, female education, immunizations, and hospital births. At the same time that I was interviewing housewives about the way they addressed health problems, I fell in love and married into a local Berber family.

In the rural Saharan province of Errachidia where I lived, popular conceptions of danger viewed brides-to-be as susceptible to the same kinds of illness agents I was learning about in my interviews on maternal and child health. My background in cultural anthropology had led me to think about folk etiologies, such as evil eye, magical curses, and invisible spirits as symbolic constructs that non-Western cultures used to explain illness and psychosocial distress. As explanatory models (Kleinman 1988), they provided culturally meaningful accounts of illness problems. The etiologies also challenged the power of the biomedical explanations offered at the provincial hospital and in health education campaigns. In the process of interpreting how Moroccan housewives constructed illness, I gave little thought to the dangers their constructs presented to me personally. I understood them as abstract ideas rather than *real* threats. My perspective changed dramatically, however, when local women started using traditional medical knowledge in attempt to cause me harm.

Although I had benefited from Saharan generosity and hospitality in the first months of my fieldwork, my marital engagement interfered with some women's hopes to match my fiancé, Youssef, with young women in their own families. His education, professional employment, and respected family background made him a highly desired bachelor among the struggling households of the southeastern Sahara. I was an easy target in their schemes to undermine our engagement and, later, our marriage. As an outsider living in a community where social ties were vital, I fit the local definition of vulnerable.

The first person to use a symbolic attack against me was Fulanah,<sup>1</sup> a woman from the remote agrarian village where Youssef spent his childhood. She was a formidable middle-aged woman, whose solid build matched a strong personality. The tattooed lines on her chin, the remnants of preventive health strategies in past generations, seemed to accentuate her powerful presence (although I did not have this impression of other women with similar facial markings). On a quiet afternoon in late spring when we were visiting her home, Fulanah greeted me by saying, "*ʿandik SiHa daba, Maria*" (you have health now, Maria). I assumed she meant that I had gained some weight since I saw her last, according to Saharan cultural standards, a thin physique was a sign of illness for women of childbearing age. My recent interviews had revealed that this kind of compliment was dangerous, a way of activating the power of envy through the mechanism of *l-ʿin* (the Eye). To prevent the magical power of contrasts from making me ill, Fulanah should have added "*tabarak Allah*" (may God bless you). Instead, she only smirked.

I gasped as the force of her antagonism struck my chest while Youssef muttered "*khamza fi ʿaynik*" (five in your eye) sharply under his breath to block its effect on me. At that moment my interpretation of the Eye switched from a symbolic construct to a real threat to my well-being. Neither of us considered confronting her more directly at the time; she had higher status than we did, both in terms of age and local residence. We decided, however, that it would be the last time Fulanah would catch us off-guard. Even though Youssef viewed himself as a man of faith both in God and in science, the next day he took me to a Berber jewelry *suq* (market) to buy me an amulet. We chose an ornate brass pendant in the shape of an open hand with a blue bead at its center for added protection.

This new visceral appreciation of the uglier side of Saharan social relations stuck with me and shattered the illusion that I was purely an outside observer of Moroccan culture. My status as a bride-to-be intensified my investment in learning local customs and etiquette to avoid drawing attention to myself, for reasons of both safety and family honor. I started imitating the ways Saharan women protected themselves in the hope that these gestures would quell my nagging sense of vulnerability. Before long, I was using a wide range of local protective strategies habitually, including uttering religious invocations for the first time in my life. The more challenging tasks involved learning how to guard my emotions and to monitor what I said or ate when in the company of people outside our circle of trust. The trouble was that the boundaries of that circle were changing constantly.

Although this change in my subjectivity was disturbing at the time, I later came to see it as an asset to my research. The cultural dimensions of my ex-

perience in Morocco became even more apparent after Youssef and I divorced and I gained emotional distance from the social dynamics that I found to be so threatening when we lived in Morocco. The process through which I came to embody, at least partially, Saharan sensibilities for detecting danger and to employ their strategies of protection shifted my attention to dimensions of health seeking behavior that medical anthropologists have overlooked in the past. My original focus on discourse, meaning, and power provided the foundation for my transition in the field, but it was this unexpected exploration of embodied experience and practical logic that helped me to understand how culture structures the lived meaning of vulnerability and well-being.

## Health Promotion Reconsidered

The motivation for revisiting this research now comes from a connection I see between my insights on the cultural forms of vulnerability in Saharan Morocco and broader research in public health. While working as an applied anthropologist at the U.S. National Cancer Institute (NCI) in 2002 and 2003, I observed that health researchers from a diversity of academic fields were interested in the relationship between culture and behavior. The driving force of this interest at NCI was the political mandate to address health disparities in the U.S. population, which was the main focus of my fellowship (MacPhee, et al. 2005). The applications of anthropology in public health, however, extend beyond this issue.

The distinct particulars of my ethnographic research in rural Morocco and my applied work in suburban Washington, D.C. converged on a common conundrum for health promotion: why do individuals at risk for health problems resist following scientific recommendations for health promotion and disease prevention? Whether the recommendations pertain to the benefits of trained birth attendants in a North African village or smoking cessation in an American city, public health researchers and practitioners have struggled to understand why so many interventions fall short of their goals to change behavior. In the literature on national health disparities and on global health, cultural difference often appears as a possible explanation for why programs fail. The argument juxtaposes cultural beliefs against scientific knowledge. Yet, even culturally tailored interventions (e.g., the use of the local language and terminology) have had limited success.

The insights I gained through my participation on the cancer disparities task force and my research on household health care in Morocco have led me to view the persistence of the conundrum as rooted in the narrow, static way that